



California Department of Health Care Services

Short Doyle/Medi-Cal Phase II

Companion Guide

ADP – 835

Version: 1.2.8

Date: 10/14/09

Versioning, History

Version	Author	Date	Loop	Segment	Element	Change Made
1.2.2	Deepa Pochiraju	01/09/09	1000B	N1 – Payee Identification	N103 – Identification Code Qualifier	Codes 46 and FI are excluded so that N103 shows only ‘XX’ as included – per ADP’s request.
1.2.3	Deepa Pochiraju	02/02/09	2100	REF- Other Claim Related Identification	REF01 – Reference Identification Qualifier	Included Code F8 (Original Reference Number), per CR-32
1.2.4	Deepa Pochiraju	03/16/09	2100	NM1 – Corrected Patient/Insured Name	NM109	Notes updated, per CR-075
1.2.4	Deepa Pochiraju	03/16/09	2100	NM1 – Corrected Patient/Insured Name	-	Example updated, per CR-075
1.2.5	Deepa Pochiraju	05/15/09		PLB – Provider Adjustment	PLB03-01 – Adjustment Reason Code	Included values LE, FB, WO, 72, IS, PL per DHCS / ADP.
1.2.6	Deepa Pochiraju	06/02/09	-	PLB	PLB01, PLB04	Updated to say Billing Provider NPI, per DHCS feedback.
1.2.7	Deepa Pochiraju	09/21/09	-	REF	REF01	Updated to have the valid value of ‘EV’ instead of ‘TJ’.
1.2.8	Deepa Pochiraju	10/14/09	2100	NM1 - Corrected Patient/Insured Name	NM109	Updated the text to say Submitter’s EIN in place of Submitting County Code.

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835

Health Care Claim Payment/Advice

Functional Group=HP

Purpose: The purpose of this companion guide is to provide the information necessary to receive a claims remittance advice electronically from ADP. This companion guide is to be used in conjunction with the ANSI X12N 835 Health Care Claim Payment Advice Implementation Guides (IGs). This is commonly called an Implementation Guide (IG) and is referred to as an IG throughout this document. The companion guide supplements, but does not contradict or replace any requirements in the IG or ADP regulations, Letters, and Notices. In the context of Short-Doyle Medi-Cal, the 835 transaction is used to send an Explanation of Benefits (EOB) remittance advice.

Not Defined:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Notes</u>	<u>Usage</u>
	ISA	Interchange Control Header	M	1			Required
	GS	Functional Group Header	M	1			Required

Heading:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Notes</u>	<u>Usage</u>
010	ST	Transaction Set Header	M	1			Required
020	BPR	Financial Information	M	1			Required
040	TRN	Reassociation Trace Number	O	1		N1/040	Required
060	REF	Receiver Identification	O	1			Situational
070	DTM	Production Date	O	1			Required
LOOP ID - 1000A					1	N1/080L	
080	N1	Payer Identification	O	1		N1/080	Required
100	N3	Payer Address	O	1			Required
110	N4	Payer City, State, ZIP Code	O	1			Required
LOOP ID - 1000B					1	N1/080L	
080	N1	Payee Identification	O	1		N1/080	Required
120	REF	Payee Additional Identification	O	>1			Situational

Detail:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Notes</u>	<u>Usage</u>
LOOP ID - 2000					≥1	N2/003L	
003	LX	Header Number	O	1		N2/003	Required
LOOP ID - 2100					≥1		
010	CLP	Claim Payment Information	M	1			Required
020	CAS	Claim Adjustment	O	99		N2/020	Situational
030	NM1	Patient Name	M	1			Required
030	NM1	Corrected Patient/Insured Name	O	1			Situational
030	NM1	Service Provider Name	O	1			Situational
030	NM1	Corrected Priority Payer Name	O	2			Situational
035	MOA	Outpatient Adjudication Information	O	1			Situational
040	REF	Other Claim Related Identification	O	5			Situational
050	DTM	Claim Date	O	4			Situational
062	AMT	Claim Supplemental	O	14			Situational

Information						
<u>LOOP ID - 2110</u>				<u>999</u>		
070	SVC	Service Payment Information	O	1		Required
080	DTM	Service Date	O	3	N2/080	Required
090	CAS	Service Adjustment	O	99	N2/090	Situational
100	REF	Service Identification	O	7		Situational
100	REF	Rendering Provider Information	O	10		Situational
110	AMT	Service Supplemental Amount	O	12		Situational
130	LQ	Health Care Remark Codes	O	99		Situational

Summary:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Notes</u>	<u>Usage</u>
010	PLB	Provider Adjustment	O	>1			Situational
020	SE	Transaction Set Trailer	M	1			Required

Not Defined:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Notes</u>	<u>Usage</u>
	GE	Functional Group Trailer	M	1			Required
	IEA	Interchange Control Trailer	M	1			Required

Notes:

- 1/040 The TRN segment is used to uniquely identify a claim payment and advice.
- 1/080L The N1 loop allows for name/address information for the payer and payee which would be utilized to address remittance(s) for delivery.
- 1/080 The N1 loop allows for name/address information for the payer and payee which would be utilized to address remittance(s) for delivery.
- 1/080L The N1 loop allows for name/address information for the payer and payee which would be utilized to address remittance(s) for delivery.
- 1/080 The N1 loop allows for name/address information for the payer and payee which would be utilized to address remittance(s) for delivery.
- 2/003L The LX segment is used to provide a looping structure and logical grouping of claim payment information.
- 2/003 The LX segment is used to provide a looping structure and logical grouping of claim payment information.
- 2/020 The CAS segment is used to reflect changes to amounts within Table 2.
- 2/080 The DTM segment in the SVC loop is to be used to express dates and date ranges specifically related to the service identified in the SVC segment.
- 2/090 The CAS segment is used to reflect changes to amounts within Table 2.

ISA Interchange Control Header

Pos:	Max: 1
Not Defined - Mandatory	
Loop: N/A	Elements: 16

User Option (Usage): Required

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

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
ISA01	I01	Authorization Information Qualifier	M	ID	2/2	Required

Description: Code to identify the type of information in the Authorization Information

<u>Code</u>	<u>Name</u>
00	No Authorization Information Present (No Meaningful Information in I02) <i>ADVISED UNLESS SECURITY REQUIREMENTS MANDATE USE OF ADDITIONAL IDENTIFICATION.</i>

ISA02	I02	Authorization Information	M	AN	10/10	Required
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Description: Information used for additional identification or authorization of the interchange sender or the data in the interchange; the type of information is set by the Authorization Information Qualifier (I01)

Valid values: 10 blanks

ISA03	I03	Security Information Qualifier	M	ID	2/2	Required
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Description: Code to identify the type of information in the Security Information

<u>Code</u>	<u>Name</u>
00	No Security Information Present (No Meaningful Information in I04) <i>ADVISED UNLESS SECURITY REQUIREMENTS MANDATE USE OF PASSWORD DATA.</i>

ISA04	I04	Security Information	M	AN	10/10	Required
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Description: This is used for identifying the security information about the interchange sender or the data in the interchange; the type of information is set by the Security Information Qualifier (I03)

Industry: Valid values: 10 blanks

ISA05	I05	Interchange ID Qualifier	M	ID	2/2	Required
-------	-----	--------------------------	---	----	-----	----------

Description: Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified

<u>Code</u>	<u>Name</u>
ZZ	Mutually Defined

ISA06	I06	Interchange Sender ID	M	AN	15/15	Required
-------	-----	-----------------------	---	----	-------	----------

Description: Identification code published by the sender for other parties to use as the receiver ID to route data to them; the sender always codes this value in the sender ID element

Valid values: SDMCPHASETWOADP

ISA07	I05	Interchange ID Qualifier	M	ID	2/2	Required
-------	-----	--------------------------	---	----	-----	----------

Description: Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified

<u>Code</u>	<u>Name</u>
30	U.S. Federal Tax Identification Number

ISA08	I07	Interchange Receiver ID	M	AN	15/15	Required						
<p>Description: Identification code published by the receiver of the data; When sending, it is used by the sender as their sending ID, thus other parties sending to them will use this as a receiving ID to route data to them</p> <p><i>Valid Format:</i> County or Direct Contract Provider: 9 digit EIN established by Trading Partner agreement + 6 Spaces Example: 923456789</p>												
ISA09	I08	Interchange Date	M	DT	6/6	Required						
<p>Description: Date of the interchange</p>												
ISA10	I09	Interchange Time	M	TM	4/4	Required						
<p>Description: Time of the interchange</p>												
ISA11	I10	Interchange Control Standards Identifier	M	ID	1/1	Required						
<p>Description: Code to identify the agency responsible for the control standard used by the message that is enclosed by the interchange header and trailer</p> <p><i>Valid Value:</i> U - U.S. EDI Community of ASC X12, TDCC, and UCS All valid standard codes are used.</p>												
ISA12	I11	Interchange Control Version Number	M	ID	5/5	Required						
<p>Description: Code specifying the version number of the interchange control segments</p> <table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>00401</td> <td>Draft Standards for Trial Use Approved for Publication by ASC X12 Procedures Review Board through October 1997</td> </tr> </tbody> </table>							<u>Code</u>	<u>Name</u>	00401	Draft Standards for Trial Use Approved for Publication by ASC X12 Procedures Review Board through October 1997		
<u>Code</u>	<u>Name</u>											
00401	Draft Standards for Trial Use Approved for Publication by ASC X12 Procedures Review Board through October 1997											
ISA13	I12	Interchange Control Number	M	N0	9/9	Required						
<p>Description: A control number assigned by the interchange sender</p>												
ISA14	I13	Acknowledgment Requested	M	ID	1/1	Required						
<p>Description: Code sent by the sender to request an interchange acknowledgment (TA1)</p> <table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>0</td> <td>No Acknowledgment Requested</td> </tr> </tbody> </table>							<u>Code</u>	<u>Name</u>	0	No Acknowledgment Requested		
<u>Code</u>	<u>Name</u>											
0	No Acknowledgment Requested											
ISA15	I14	Usage Indicator	M	ID	1/1	Required						
<p>Description: Code to indicate whether data enclosed by this interchange envelope is test, production or information</p> <table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>P</td> <td>Production Data</td> </tr> <tr> <td>T</td> <td>Test Data</td> </tr> </tbody> </table>							<u>Code</u>	<u>Name</u>	P	Production Data	T	Test Data
<u>Code</u>	<u>Name</u>											
P	Production Data											
T	Test Data											
ISA16	I15	Component Element Separator	M		1/1	Required						
<p>Description: Type is not applicable; the component element separator is a delimiter and not a data element; this field provides the delimiter used to separate component data elements within a composite data structure; this value must be different than the data element separator and the segment terminator</p> <p><i>The component element separator is a delimiter and not a data element. It is used with composite data elements such as CLM05.</i></p> <p><i>Valid value - :</i></p>												

Notes:

The ISA is a fixed record length segment and all positions within each of the data elements must be filled. The first element separator defines the element separator to be used through the entire interchange. The segment



terminator used after the ISA defines the segment terminator to be used throughout the entire interchange. Spaces in the example are represented by '.' for clarity.

Delimiters are specified in the Interchange Header Segment. The values are as follows:

* Asterisk Data Element Separator

: Colon Sub element Separator

~ Tilde Segment Terminator

Example:

```
ISA*00*      *00*      *ZZ*SDMCPHASETWOADP*30*923456789
*030930*1256*U*00401*000000636*0*P*::~~
```

GS Functional Group Header

Pos:	Max: 1
Not Defined - Mandatory	
Loop: N/A	Elements: 8

User Option (Usage): Required

Purpose: To indicate the beginning of a functional group and to provide control information

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
GS01	479	Functional Identifier Code	M	ID	2/2	Required
Description: Code identifying a group of application related transaction sets						
		<u>Code</u>	<u>Name</u>			
		HP	Health Care Claim Payment/Advice (835)			
GS02	142	Application Sender's Code	M	AN	2/15	Required
Description: Code identifying party sending transmission; codes agreed to by trading partners						
<i>Use this code to identify the unit sending the information.</i>						
<i>Valid values: SDMCPHASETWOADP</i>						
GS03	124	Application Receiver's Code	M	AN	2/15	Required
Description: Code identifying party receiving transmission; codes agreed to by trading partners						
<i>Valid Format:</i>						
<i>County or Direct Contract Provider: 9 digit EIN established by Trading Partner agreement</i>						
<i>Example: 923456789</i>						
GS04	373	Date	M	DT	8/8	Required
Description: Date expressed as CCYYMMDD						
<i>Use this date for the functional group creation date. CCYYMMDD</i>						
GS05	337	Time	M	TM	4/8	Required
Description: Time expressed in 24-hour clock time as follows: HHMM, or HHMMSS, or HHMMSSD, or HHMMSSDD, where H = hours (00-23), M = minutes (00-59), S = integer seconds (00-59) and DD = decimal seconds; decimal seconds are expressed as follows: D = tenths (0-9) and DD = hundredths (00-99)						
<i>Use this time for the creation time. The recommended format is HHMMSS.</i>						
GS06	28	Group Control Number	M	NO	1/9	Required
Description: Assigned number originated and maintained by the sender						
GS07	455	Responsible Agency Code	M	ID	1/2	Required
Description: Code identifying the issuer of the standard; this code is used in conjunction with Data Element 480						
		<u>Code</u>	<u>Name</u>			
		X	Accredited Standards Committee X12			
GS08	480	Version / Release / Industry Identifier Code	M	AN	1/12	Required
Description: Code indicating the version, release, subrelease, and industry identifier of the EDI standard being used, including the GS and GE segments; if code in DE455 in GS segment is X, then in DE 480 positions 1-3 are the version number; positions 4-6 are the release and subrelease, level of the version; and positions 7-12 are the industry or trade association identifiers (optionally assigned by user); if code in DE455 in GS segment is T, then other formats are allowed						

<u>Code</u>	<u>Name</u>
004010X091 A1	Draft Standards Approved for Publication by ASC X12 Procedures Review Board through October 1997, as published in this implementation guide.

Semantics:

1. GS04 is the group date.
2. GS05 is the group time.
3. The data interchange control number GS06 in this header must be identical to the same data element in the associated functional group trailer, GE02.

Comments:

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

Notes:

The functional group header used for the 837P is HC.

Example:

*GS*HP*SDMCPHASETWOADP*923456789*20030930*1256*614*X*004010X091A1~*

ST Transaction Set Header

Pos: 010	Max: 1
Heading - Mandatory	
Loop: N/A	Elements: 2

User Option (Usage): Required
Purpose: To indicate the start of a transaction set and to assign a control number

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
ST01	143	Transaction Set Identifier Code	M	ID	3/3	Required

Description: Code uniquely identifying a Transaction Set
The only valid value within this transaction set for ST01 is 835.

<u>Code</u>	<u>Name</u>
835	Health Care Claim Payment/Advice

ST02	329	Transaction Set Control Number	M	AN	4/9	Required
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Description: Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set
The Transaction Set Control Numbers in ST02 and SE02 must be identical. This unique number also aids in error resolution research. Start with a number, for example 0001, and increment from there. This number must be unique within a specific group and interchange, but it can be repeated in other groups and interchanges.

Semantics:

1. The transaction set identifier (ST01) used by the translation routines of the interchange partners to select the appropriate transaction set definition (e.g., 810 selects the Invoice Transaction Set).

Notes:

This segment begins the transaction.

Example:

ST*835*0196~



BPR Financial Information

Pos: 020	Max: 1
Heading - Mandatory	
Loop: N/A	Elements: 5

User Option (Usage): Required

Purpose: To indicate the beginning of a Payment Order/Remittance Advice Transaction Set and total payment amount, or to enable related transfer of funds and/or information from payer to payee to occur

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
BPR01	305	Transaction Handling Code	M	ID	1/2	Required

Description: Code designating the action to be taken by all parties
H means the claim is denied and no payment information is included.
I means the claims is approved and the check is in the mail.
The payment is moving separate from the remittance detail.

Code	Name
H	Notification Only
I	Remittance Information Only

Use this code to pass information only without any reference to payment.
Usually this code is used to pass predetermination of benefits information from a payer to a provider.

Use this code to indicate to the payee that the remittance detail is moving separately from the payment.

BPR02	782	Monetary Amount	M	R	1/18	Required
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Description: Monetary amount

Industry: Total Actual Provider Payment Amount

Use BPR02 for the total payment amount for this 835. The total payment amount for this 835 cannot exceed eleven characters, including decimals (99999999.99). Although the value can be zero, the 835 cannot be issued for less than zero dollars.

BPR03	478	Credit/Debit Flag Code	M	ID	1/1	Required
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Description: Code indicating whether amount is a credit or debit

Industry: Credit or Debit Flag Code

Code	Name
C	Credit

Use this code to indicate a credit to the provider's account and a debit to the payer's account, initiated by the payer. In the case of an EFT, no additional action is required of the provider. Also use this code when a check is issued for the payment.

BPR04	591	Payment Method Code	M	ID	3/3	Required
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Description: Code identifying the method for the movement of payment instructions

If BPR01 is H, this value will be NON indicating no financial information is available. The 835 is for information only and no payment will be made.

If BPR01 is I, this value will be CHK. The check has been sent by the State Controller's Office.

Code	Name
CHK	Check
NON	Non-Payment Data

Use this code to indicate that a check has been issued for payment.

Use this code when the Transaction Handling Code (BPR01) is H, indicating that this is information only and no dollars are to be moved.

BPR16	373	Date	O	DT	8/8	Required
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Description: Date expressed as CCYYMMDD

Industry: *Check Issue or EFT Effective Date*

Use this code for the effective entry date.

If BPR04 is 'NON', enter the date of the 835 creation.

If BPR04 is 'CHK', enter Check issuance date.

Syntax Rules:

1. P0607 - If either BPR06 or BPR07 is present, then the other is required.
2. C0809 - If BPR08 is present, then BPR09 is required.
3. P1213 - If either BPR12 or BPR13 is present, then the other is required.
4. C1415 - If BPR14 is present, then BPR15 is required.
5. P1819 - If either BPR18 or BPR19 is present, then the other is required.
6. C2021 - If BPR20 is present, then BPR21 is required.

Semantics:

1. BPR02 specifies the payment amount.
2. When using this transaction set to initiate a payment, all or some of BPR06 through BPR16 may be required, depending on the conventions of the specific financial channel being used.
3. BPR06 and BPR07 relate to the originating depository financial institution (ODFI).
4. BPR08 is a code identifying the type of bank account or other financial asset.
5. BPR09 is the account of the company originating the payment. This account may be debited or credited depending on the type of payment order.
6. BPR12 and BPR13 relate to the receiving depository financial institution (RDFI).
7. BPR14 is a code identifying the type of bank account or other financial asset.
8. BPR15 is the account number of the receiving company to be debited or credited with the payment order.
9. BPR16 is the date the originating company intends for the transaction to be settled (i.e., Payment Effective Date).
10. BPR17 is a code identifying the business reason for this payment.
11. BPR18, BPR19, BPR20 and BPR21, if used, identify a third bank identification number and account to be used for return items only.
12. BPR20 is a code identifying the type of bank account or other financial asset.

Notes:

1. Use the BPR to address a single payment to a single payee. A payee may represent a single provider, a provider group, or multiple providers in a chain. The BPR contains mandatory information, even when it is not being used to move funds electronically.

The usage of this segment by ADP is only as a Notification. No Remittance information is included.

Example:

*BPR*H*0*C*NON*****20031001~*

TRN Reassociation Trace Number

Pos: 040	Max: 1
Heading - Optional	
Loop: N/A	Elements: 4

User Option (Usage): Required
Purpose: To uniquely identify a transaction to an application

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
TRN01	481	Trace Type Code	M	ID	1/2	Required
		Description: Code identifying which transaction is being referenced				
		Code		Name		
		1		Current Transaction Trace Numbers		
TRN02	127	Reference Identification	M	AN	1/30	Required
		Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier				
		Industry: <i>Check or EFT Trace Number</i>				
		<i>This number must be unique within the sender/receiver relationship. The number is assigned by the sender.</i>				
		<i>The warrant number on which payment has been issued will be identified here.</i>				
TRN03	509	Originating Company Identifier	O	AN	10/10	Required
		Description: A unique identifier designating the company initiating the funds transfer instructions. The first character is one-digit ANSI identification code designation (ICD) followed by the nine-digit identification number which may be an IRS employer identification number (EIN), data universal numbering system (DUNS), or a user assigned number; the ICD for an EIN is 1, DUNS is 3, user assigned number is 9				
		Industry: <i>Payer Identifier</i>				
		<i>TRN03 must contain the ADP's Federal Tax ID Number, preceded by a "1." When BPR10 is used, it must be identical to TRN03.</i>				
TRN04	127	Reference Identification	O	AN	1/30	Required
		Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier				
		Industry: <i>Originating Company Supplemental Code</i>				
		<i>If both TRN04 and BPR11 are used, they must be identical.</i>				
		<i>This element is required when information beyond the Originating Company Identifier in TRN03 is necessary for the payee to identify the source of the payment.</i>				
		<i>Used to identify the appropriate State Department (ADP).</i>				
		<i>Valid values: ADP</i>				

Semantics:

1. TRN02 provides unique identification for the transaction.
2. TRN03 identifies an organization.
3. TRN04 identifies a further subdivision within the organization.

Notes:

1. This segment's purpose is to uniquely identify this transaction set and to aid in reassociating payments and remittances that have been separated.



Example:

*TRN*1*192003061003*482003030101*ADP~*

REF Receiver Identification

Pos: 060	Max: 1
Heading - Optional	
Loop: N/A	Elements: 2

User Option (Usage): Situational
Purpose: To specify identifying information

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
REF01	128	Reference Identification Qualifier	M	ID	2/3	Required

Description: Code qualifying the Reference Identification

<u>Code</u>	<u>Name</u>
EV	Receiver Identification Number

REF02	127	Reference Identification	C	AN	1/30	Required
-------	-----	--------------------------	---	----	------	----------

Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

Industry: Receiver Identifier

Alias: Receiver Identification

Medical Sender ID from loop 1000A, NM109 in the 837 Transaction

Syntax Rules:

1. R0203 - At least one of REF02 or REF03 is required.

Semantics:

1. REF04 contains data relating to the value cited in REF02.

Notes:

1. Use this segment only when the receiver of the transaction is other than the payee (e.g., Clearing House or billing service ID).

This segment identifies the Medical Sender ID.

Example:

REF*TJ*923456789~

DTM Production Date

Pos: 070	Max: 1
Heading - Optional	
Loop: N/A	Elements: 2

User Option (Usage): Required
Purpose: To specify pertinent dates and times

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
DTM01	374	Date/Time Qualifier	M	ID	3/3	Required

Description: Code specifying type of date or time, or both date and time
Industry: *Date Time Qualifier*

<u>Code</u>	<u>Name</u>
405	Production

Use this code for the end date for the adjudication production cycle for claims included in this 835.

DTM02	373	Date	C	DT	8/8	Required
-------	-----	------	---	----	-----	----------

Description: Date expressed as CCYYMMDD
Industry: *Production Date*
This is the date SD/MC processed the claims on this 835.

Syntax Rules:

1. R020305 - At least one of DTM02, DTM03 or DTM05 is required.
2. C0403 - If DTM04 is present, then DTM03 is required.
3. P0506 - If either DTM05 or DTM06 is present, then the other is required.

Notes:

1. The production date must be supplied when the cutoff date of the adjudication system is different from the date of the 835.

Example:

*DTM*405*20030820~*

Loop Payer Identification

Pos: 080	Repeat: 1
	Optional
Loop: 1000A	Elements: N/A

User Option (Usage): Required
Purpose: To identify a party by type of organization, name, and code

Loop Summary:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Usage</u>
080	N1	Payer Identification	O	1		Required
100	N3	Payer Address	O	1		Required
110	N4	Payer City, State, ZIP Code	O	1		Required

Comments:

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

Notes:

1. Use this N1 loop to provide the name/address information for the payer. The payer's secondary identifying reference number should be provided in N104, if necessary.

Example:

N1*PR*INSURANCE COMPANY OF TIMBUCKTU*XV*88888888~



N1 Payer Identification

Pos: 080	Max: 1
Heading - Optional	
Loop: 1000A	Elements: 4

User Option (Usage): Required
Purpose: To identify a party by type of organization, name, and code

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>				
N101	98	Entity Identifier Code	M	ID	2/3	Required				
<p>Description: Code identifying an organizational entity, a physical location, property or an individual</p> <table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>PR</td> <td>Payer</td> </tr> </tbody> </table>							<u>Code</u>	<u>Name</u>	PR	Payer
<u>Code</u>	<u>Name</u>									
PR	Payer									
N102	93	Name	C	AN	1/60	Required				
<p>Description: Free-form name Industry: <i>Payer Name</i> <i>Required if the National PlanID is not transmitted in N104.</i></p> <p><i>Valid Values: 20 or 25</i></p>										
N103	66	Identification Code Qualifier	C	ID	1/2	Situational				
<p>Description: Code designating the system/method of code structure used for Identification Code (67) <i>Required if the National PlanID is transmitted in N104.</i></p> <table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>XV</td> <td>Health Care Financing Administration National Payer Identification Number (PAYERID)</td> </tr> </tbody> </table> <p><i>Required if the National PlanID is mandated for use.</i></p> <p>CODE SOURCE: 540: Health Care Financing Administration National PlanID</p>							<u>Code</u>	<u>Name</u>	XV	Health Care Financing Administration National Payer Identification Number (PAYERID)
<u>Code</u>	<u>Name</u>									
XV	Health Care Financing Administration National Payer Identification Number (PAYERID)									
N104	67	Identification Code	C	AN	2/80	Situational				
<p>Description: Code identifying a party or other code Industry: <i>Payer Identifier</i> <i>Required if the National Plan ID is mandated for use.</i></p> <p>ExternalCodeList Name: 540 Description: Health Care Financing Administration National PlanID</p>										

Syntax Rules:

1. R0203 - At least one of N102 or N103 is required.
2. P0304 - If either N103 or N104 is present, then the other is required.

Comments:

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



Notes:

1. Use this N1 loop to provide the name/address information for the payer. The payer's secondary identifying reference number should be provided in N104, if necessary.

This segment identifies a Party by type of organization, name, and code

Example:

N1*PR*01~

N3 Payer Address

Pos: 100	Max: 1
Heading - Optional	
Loop: 1000A	Elements: 2

User Option (Usage): Required
Purpose: To specify the location of the named party

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
N301	166	Address Information <i>Description:</i> Address information <i>Industry:</i> Payer Address Line	M	AN	1/55	Required
N302	166	Address Information <i>Description:</i> Address information <i>Industry:</i> Payer Address Line <i>Required if a second address line exists.</i>	O	AN	1/55	Situational

Notes:
This segment conveys Street Address information

Example:
*N3*1700 K Street*Room 130~*



N4**Payer City, State, ZIP Code**

Pos: 110	Max: 1
Heading - Optional	
Loop: 1000A	Elements: 3

User Option (Usage): Required**Purpose:** To specify the geographic place of the named party**Element Summary:**

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
N401	19	City Name	O	AN	2/30	Required
		Description: Free-form text for city name Industry: <i>Payer City Name</i>				
N402	156	State or Province Code	O	ID	2/2	Required
		Description: Code (Standard State/Province) as defined by appropriate government agency Industry: <i>Payer State Code</i>				
		ExternalCodeList Name: 22 Description: States and Outlying Areas of the U.S.				
N403	116	Postal Code	O	ID	3/15	Required
		Description: Code defining international postal zone code excluding punctuation and blanks (zip code for United States) Industry: <i>Payer Postal Zone or ZIP Code</i>				
		ExternalCodeList Name: 51 Description: ZIP Code				

Syntax Rules:

1. C0605 - If N406 is present, then N405 is required.

Comments:

1. A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location.
2. N402 is required only if city name (N401) is in the U.S. or Canada.

Example:

```
N4*SACRAMENTO*CA*95811~
```

Loop Payee Identification

Pos: 080	Repeat: 1
	Optional
Loop: 1000B	Elements: N/A

User Option (Usage): Required
Purpose: To identify a party by type of organization, name, and code

Loop Summary:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Usage</u>
080	N1	Payee Identification	O	1		Required
120	REF	Payee Additional Identification	O	>1		Situational

Comments:

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

Notes:

1. Use this N1 loop to provide the name/address information of the payee. The identifying reference number should be provided in N104.

Example:

N1*PE*CYBILS MENTAL HOSPITAL*XX*12345678~



N1 Payee Identification

Pos: 080	Max: 1
Heading - Optional	
Loop: 1000B	Elements: 4

User Option (Usage): Required
Purpose: To identify a party by type of organization, name, and code

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
N101	98	Entity Identifier Code	M	ID	2/3	Required
Description: Code identifying an organizational entity, a physical location, property or an individual						
		<u>Code</u>	<u>Name</u>			
		PE	Payee			
N102	93	Name	C	AN	1/60	Required
Description: Free-form name						
Industry: Payee Name						
<i>Same name as Submitter Last Name (NM103, Loop 1000A) from 837.</i>						
N103	66	Identification Code Qualifier	C	ID	1/2	Required
Description: Code designating the system/method of code structure used for Identification Code (67)						
		<u>Code</u>	<u>Name</u>			
		XX	Health Care Financing Administration National Provider Identifier			
N104	67	Identification Code	C	AN	2/80	Required
Description: Code identifying a party or other code						
Industry: Payee Identification Code						
<i>This will be the Billing Provider ID from the 837.</i>						
ExternalCodeList						
Name: 537						
Description: Health Care Financing Administration National Provider Identifier						

Syntax Rules:

1. R0203 - At least one of N102 or N103 is required.
2. P0304 - If either N103 or N104 is present, then the other is required.

Comments:

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

Notes:

1. Use this N1 loop to provide the name/address information of the payee. The identifying reference number should be provided in N104.

This segment identifies the Payee in the transaction.

Example:

N1*PE*LOS ANGELS*FI*22~



REF Payee Additional Identification

Pos: 120	Max: >1
Heading - Optional	
Loop: 1000B	Elements: 2

User Option (Usage): Situational
Purpose: To specify identifying information

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
REF01	128	Reference Identification Qualifier	M	ID	2/3	Required

Description: Code qualifying the Reference Identification

Code	Name
TJ	Federal Taxpayer's Identification Number

This information should be in the N1 segment unless the National Provider ID was used in N103/04. For individual providers as payees, use this number to represent the Social Security Number.

REF02	127	Reference Identification	C	AN	1/30	Required
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Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

Industry: *Additional Payee Identifier*
Valid Values: EIN

ExternalCodeList
Name: 307
Description: National Association of Boards of Pharmacy Number

Syntax Rules:

- R0203 - At least one of REF02 or REF03 is required.

Semantics:

- REF04 contains data relating to the value cited in REF02.

Notes:

- Use this REF segment only when more than one identification number is required to identify the payee. Always use the ID number available in the N1 segment before using the REF segment.

Example:

REF*TJ*123456789~

Loop Header Number

Pos: 003	Repeat: >1
Optional	
Loop: 2000	Elements: N/A

User Option (Usage): Situational

Purpose: To reference a line number in a transaction set

Loop Summary:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Usage</u>
003	LX	Header Number	O	1		Required
010		Loop 2100	M		>1	Required

Notes:

1. The LX segment is required whenever any information in the LX loop is included in the transaction. In the event that claim/service information must be sorted, the LX segment must precede each series of claim level and service level segments.
2. Any Table 2 data must commence with an LX segment. Multiple sorts are accomplished through multiple LX loops.
3. For Medicare Part A, write/read the LX segment once for each provider's fiscal period end year and month/type of bill summary break in the file (TTYMM in LX01). For Medicare Part B, write/read the LX segment once for unassigned claims using the value of "zero" and once for assigned claims using the value of "one".

Example:

LX*1~
LX*961011~

LX

Header Number

Pos: 003	Max: 1
Detail - Optional	
Loop: 2000	Elements: 1

User Option (Usage): Required
Purpose: To reference a line number in a transaction set

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
LX01	554	Assigned Number	M	NO	1/6	Required

Description: Number assigned for differentiation within a transaction set

Notes:

1. The LX segment is required whenever any information in the LX loop is included in the transaction. In the event that claim/service information must be sorted, the LX segment must precede each series of claim level and service level segments.
2. Any Table 2 data must commence with an LX segment. Multiple sorts are accomplished through multiple LX loops.
3. For Medicare Part A, write/read the LX segment once for each provider's fiscal period end year and month/type of bill summary break in the file (TTYMM in LX01). For Medicare Part B, write/read the LX segment once for unassigned claims using the value of "zero" and once for assigned claims using the value of "one".

Example:

LX*1~



Loop Claim Payment Information

Pos: 010 Repeat: >1
 Mandatory
 Loop: 2100 Elements: N/A

User Option (Usage): Required

Purpose: To supply information common to all services of a claim

Loop Summary:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Usage</u>
010	CLP	Claim Payment Information	M	1		Required
020	CAS	Claim Adjustment	O	99		Situational
030	NM1	Patient Name	M	1		Required
030	NM1	Corrected Patient/Insured Name	O	1		Situational
030	NM1	Service Provider Name	O	1		Situational
030	NM1	Corrected Priority Payer Name	O	2		Situational
035	MOA	Outpatient Adjudication Information	O	1		Situational
040	REF	Other Claim Related Identification	O	5		Situational
050	DTM	Claim Date	O	4		Situational
062	AMT	Claim Supplemental Information	O	14		Situational
070		Loop 2110	O		999	Required

Semantics:

1. CLP03 is the amount of submitted charges this claim.
2. CLP04 is the amount paid this claim.
3. CLP05 is the patient responsibility amount.
4. CLP07 is the payer's internal control number.
5. CLP12 is the diagnosis-related group (DRG) weight.
6. CLP13 is the discharge fraction.

Example:

CLP*7722337*1*211366.97*138018.4**12*119932404007801~

CLP Claim Payment Information

Pos: 010	Max: 1
Detail - Mandatory	
Loop: 2100	Elements: 9

User Option (Usage): Required

Purpose: To supply information common to all services of a claim

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
CLP01	1028	Claim Submitter's Identifier	M	AN	1/38	Required

Description: Identifier used to track a claim from creation by the health care provider through payment

Industry: Patient Control Number

Use this number for the patient control number assigned by the provider. If the patient control number is not present on the incoming claim, enter zero. The value in CLP01 must be identical to any value received as a Claim Submitter's Identifier on the original claim (CLM01 of the ANSI ASC X12 837, if applicable). This data element is the primary key for posting the remittance information into the provider's database.

This is the value from CLM01 on 837 - Patient Account Number

CLP02	1029	Claim Status Code	M	ID	1/2	Required
-------	------	-------------------	---	----	-----	----------

Description: Code identifying the status of an entire claim as assigned by the payor, claim review organization or repricing organization

Code	Name
1	Processed as Primary
2	Processed as Secondary
4	Denied
22	Reversal of Previous Payment

CLP03	782	Monetary Amount	M	R	1/18	Required
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Description: Monetary amount

Industry: Total Claim Charge Amount

This amount does not include interest.

Use this monetary amount for the submitted charges for this claim. The amount can be zero or less, but the value in BPR02 may not be negative.

Taken from CLM02 in 837 Transaction

CLP04	782	Monetary Amount	M	R	1/18	Required
-------	-----	-----------------	---	---	------	----------

Description: Monetary amount

Industry: Claim Payment Amount

This amount does not include interest.

Use this monetary amount for the amount paid for this claim. It can be zero or less, but the value in BPR02 may not be negative.

This will reflect the amount of all services on the claim.

CLP05	782	Monetary Amount	O	R	1/18	Situational
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Description: Monetary amount

Industry: Patient Responsibility Amount

Amounts in CLP05 should have supporting adjustments reflected in CAS segments at the CLP or SVC loop level with a Claim Adjustment Group (CAS01) code of PR (Patient Responsibility).

Use this monetary amount for the payer's statement of the patient responsibility amount for this claim, which can include such items as deductible, non-covered services, co-pay, and

co-insurance.
This amount must be entered if it is greater than zero.
For Medicare, this must be reported by carriers but is not used by intermediaries.

This will not be used to report Patient Share of Cost. Share of Cost will be reported in Claim Supplemental Information

CLP06	1032	Claim Filing Indicator Code	O	ID	1/2	Required
-------	------	------------------------------------	---	----	-----	----------

Description: Code identifying type of claim
For many providers to electronically post the 835 remittance data to their patient accounting systems without human intervention, a unique, provider-specific insurance plan code is needed. This code allows the provider to separately identify and manage the different product lines or contractual arrangements between the payer and the provider. Because most payers maintain the same Originating Company Identifier in the TRN03/BPR10 for all product lines or contractual relationships, the CLP06 is used by the provider as a table pointer in combination with the TRN03/BPR10 to identify the unique, provider-specific insurance plan code needed to post the payment without human intervention. The value should mirror the value received in the original claim (2-005 SBR09 of the 837), if applicable, or provide the value as assigned or edited by the payer.

<u>Code</u>	<u>Name</u>
MC	Medicaid

CLP07	127	Reference Identification	O	AN	1/30	Required
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Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier
Industry: Payer Claim Control Number
Use this number for the payer's internal control number. This number must apply to the entire claim. Report service variations at the SVC loop.
This must be provided whenever the PAYER assigns an internal claim number and desires this reference from the provider as a part of any customer service contact or appeal process.

CLP08	1331	Facility Code Value	O	AN	1/2	Situational
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Description: Code identifying the type of facility where services were performed; the first and second positions of the Uniform Bill Type code or the Place of Service code from the Electronic Media Claims National Standard Format
Industry: Facility Type Code
State the facility code here when the submitted code has been modified through adjudication. This code is expected to be from the same code list as that identified in the original claim.
This number was received in CLM05-1 of the 837 claim.

Only used if adjudication changed the value from what was originally sent on the claim

CLP09	1325	Claim Frequency Type Code	O	ID	1/1	Situational
-------	------	----------------------------------	---	----	-----	-------------

Description: Code specifying the frequency of the claim; this is the third position of the Uniform Billing Claim Form Bill Type
Industry: Claim Frequency Code
This data element is specific to institutional claims and is required when it was received on the original claim. This does not apply to other types of claims.
This number was received in CLM05-2 of the 837 claim.

ExternalCodeList

Name: 235

Description: Claim Frequency Type Code

Semantics:

1. CLP03 is the amount of submitted charges this claim.
2. CLP04 is the amount paid this claim.
3. CLP05 is the patient responsibility amount.

4. CLP07 is the payer's internal control number.
5. CLP12 is the diagnosis-related group (DRG) weight.
6. CLP13 is the discharge fraction.

Notes:

This segment supplies information common to all services of a claim.

Example:

*CLP*1234567890*4*562*0**MC~*

CAS Claim Adjustment

Pos: 020	Max: 99
Detail - Optional	
Loop: 2100	Elements: 19

User Option (Usage): Situational

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

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
CAS01	1033	Claim Adjustment Group Code	M	ID	1/2	Required

Description: Code identifying the general category of payment adjustment
Evaluate the group codes in CAS01 based on the following order for their applicability to a set of one or more adjustments: PR, CO, PI, CR, OA. See 2.2.4, Claim Adjustment and Service Adjustment Segment Theory, for additional information. (Note: This does not mean that the adjustments must be reported in this order.)

Code Name

CO	Contractual Obligations <i>Use this code when a joint payer/payee contractual agreement or a regulatory requirement resulted in an adjustment.</i>
CR	Correction and Reversals <i>Use this code for corrections and reversals to PRIOR claims. Use when CLP02=22, Reversal of Previous Payment.</i>
OA	Other adjustments
PI	Payor Initiated Reductions <i>Use this code when, in the opinion of the payer, the adjustment is not the responsibility of the patient, but there is no supporting contract between the provider and the payer (i.e., medical review or professional review organization adjustments).</i>
PR	Patient Responsibility

CAS02	1034	Claim Adjustment Reason Code	M	ID	1/5	Required
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Description: Code identifying the detailed reason the adjustment was made
Industry: Adjustment Reason Code

ExternalCodeList

Name: 139

Description: Claim Adjustment Reason Code

CAS03	782	Monetary Amount	M	R	1/18	Required
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Description: Monetary amount
Industry: Adjustment Amount
Use this monetary amount for the adjustment amount. A negative amount increases the payment, and a positive amount decreases the payment contained in CLP04.

CAS04	380	Quantity	O	R	1/15	Situational
-------	-----	----------	---	---	------	-------------

Description: Numeric value of quantity
Industry: Adjustment Quantity
*A positive value decreases the paid units of service, and a negative number increases the paid units.
 This element may be used only when the units of service are being adjusted.*

CAS05	1034	Claim Adjustment Reason Code	C	ID	1/5	Situational
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Description: Code identifying the detailed reason the adjustment was made
Industry: Adjustment Reason Code
Used when additional adjustments apply within the group identified in CAS01.

ExternalCodeList

Name: 139

Description: Claim Adjustment Reason Code

CAS06	782	Monetary Amount	C	R	1/18	Situational
-------	-----	------------------------	---	---	------	-------------

Description: Monetary amount

Industry: Adjustment Amount

See CAS03.

Used when additional adjustments apply within the group identified in CAS01.

CAS07	380	Quantity	C	R	1/15	Situational
-------	-----	-----------------	---	---	------	-------------

Description: Numeric value of quantity

Industry: Adjustment Quantity

See CAS04.

Used when additional adjustments apply within the group identified in CAS01.

CAS08	1034	Claim Adjustment Reason Code	C	ID	1/5	Situational
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Description: Code identifying the detailed reason the adjustment was made

Industry: Adjustment Reason Code

Used when additional adjustments apply within the group identified in CAS01.

ExternalCodeList

Name: 139

Description: Claim Adjustment Reason Code

CAS09	782	Monetary Amount	C	R	1/18	Situational
-------	-----	------------------------	---	---	------	-------------

Description: Monetary amount

Industry: Adjustment Amount

See CAS03.

Used when additional adjustments apply within the group identified in CAS01.

CAS10	380	Quantity	C	R	1/15	Situational
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Description: Numeric value of quantity

Industry: Adjustment Quantity

See CAS04.

Used when additional adjustments apply within the group identified in CAS01.

CAS11	1034	Claim Adjustment Reason Code	C	ID	1/5	Situational
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Description: Code identifying the detailed reason the adjustment was made

Industry: Adjustment Reason Code

Used when additional adjustments apply within the group identified in CAS01.

ExternalCodeList

Name: 139

Description: Claim Adjustment Reason Code

CAS12	782	Monetary Amount	C	R	1/18	Situational
-------	-----	------------------------	---	---	------	-------------

Description: Monetary amount

Industry: Adjustment Amount

See CAS03.

Used when additional adjustments apply within the group identified in CAS01.

CAS13	380	Quantity	C	R	1/15	Situational
-------	-----	-----------------	---	---	------	-------------

Description: Numeric value of quantity

Industry: Adjustment Quantity

See CAS04.

Used when additional adjustments apply within the group identified in CAS01.

CAS14	1034	Claim Adjustment Reason Code	C	ID	1/5	Situational
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Description: Code identifying the detailed reason the adjustment was made
Industry: *Adjustment Reason Code*
Used when additional adjustments apply within the group identified in CAS01.

ExternalCodeList

Name: 139

Description: Claim Adjustment Reason Code

CAS15	782	Monetary Amount	C	R	1/18	Situational
-------	-----	------------------------	---	---	------	-------------

Description: Monetary amount
Industry: *Adjustment Amount*
See CAS03.

Used when additional adjustments apply within the group identified in CAS01.

CAS16	380	Quantity	C	R	1/15	Situational
-------	-----	-----------------	---	---	------	-------------

Description: Numeric value of quantity
Industry: *Adjustment Quantity*
See CAS04.

1418 Used when additional adjustments apply within the group identified in CAS01.

CAS17	1034	Claim Adjustment Reason Code	C	ID	1/5	Situational
-------	------	-------------------------------------	---	----	-----	-------------

Description: Code identifying the detailed reason the adjustment was made
Industry: *Adjustment Reason Code*

Used when additional adjustments apply within the group identified in CAS01.

ExternalCodeList

Name: 139

Description: Claim Adjustment Reason Code

CAS18	782	Monetary Amount	C	R	1/18	Situational
-------	-----	------------------------	---	---	------	-------------

Description: Monetary amount
Industry: *Adjustment Amount*
See CAS03.

Used when additional adjustments apply within the group identified in CAS01.

CAS19	380	Quantity	C	R	1/15	Situational
-------	-----	-----------------	---	---	------	-------------

Description: Numeric value of quantity
Industry: *Adjustment Quantity*
See CAS04.

Used when additional adjustments apply within the group identified in CAS01.

Syntax Rules:

1. L050607 - If CAS05 is present, then at least one of CAS06 or CAS07 is required.
2. C0605 - If CAS06 is present, then CAS05 is required.
3. C0705 - If CAS07 is present, then CAS05 is required.
4. L080910 - If CAS08 is present, then at least one of CAS09 or CAS10 is required.
5. C0908 - If CAS09 is present, then CAS08 is required.
6. C1008 - If CAS10 is present, then CAS08 is required.
7. L111213 - If CAS11 is present, then at least one of CAS12 or CAS13 is required.
8. C1211 - If CAS12 is present, then CAS11 is required.
9. C1311 - If CAS13 is present, then CAS11 is required.
10. L141516 - If CAS14 is present, then at least one of CAS15 or CAS16 is required.
11. C1514 - If CAS15 is present, then CAS14 is required.
12. C1614 - If CAS16 is present, then CAS14 is required.
13. L171819 - If CAS17 is present, then at least one of CAS18 or CAS19 is required.
14. C1817 - If CAS18 is present, then CAS17 is required.
15. C1917 - If CAS19 is present, then CAS17 is required.

Semantics:

1. CAS03 is the amount of adjustment.
2. CAS04 is the units of service being adjusted.
3. CAS06 is the amount of the adjustment.
4. CAS07 is the units of service being adjusted.
5. CAS09 is the amount of the adjustment.
6. CAS10 is the units of service being adjusted.
7. CAS12 is the amount of the adjustment.
8. CAS13 is the units of service being adjusted.
9. CAS15 is the amount of the adjustment.
10. CAS16 is the units of service being adjusted.
11. CAS18 is the amount of the adjustment.
12. CAS19 is the units of service being adjusted.

Comments:

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

Notes:

1. *Payers must use this CAS segment to report claim level adjustments that cause the amount paid to differ from the amount originally charged.*
2. *See the SVC segment note #2 for details about per diem adjustments.*
3. *A single CAS segment contains six repetitions of the "adjustment trio" composed of adjustment reason code, adjustment amount, and adjustment quantity. These six adjustment trios are used to report up to six adjustments related to a particular Claim Adjustment Group Code (CAS01). The first adjustment is reported in the first adjustment trio (CAS02-CAS04). If there is a second non-zero adjustment, it is reported in the second adjustment trio (CAS05-CAS07), and so on through the sixth adjustment trio (CAS17-CAS19).*

Example:

CAS*PR*1*793~

NM1 Patient Name

Pos: 030	Max: 1
Detail - Mandatory	
Loop: 2100	Elements: 8

User Option (Usage): Required

Purpose: To supply the full name of an individual or organizational entity

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
NM101	98	Entity Identifier Code	M	ID	2/3	Required

Description: Code identifying an organizational entity, a physical location, property or an individual

<u>Code</u>	<u>Name</u>
QC	Patient

NM102	1065	Entity Type Qualifier	M	ID	1/1	Required
-------	------	------------------------------	---	----	-----	----------

Description: Code qualifying the type of entity

<u>Code</u>	<u>Name</u>
1	Person

NM103	1035	Name Last or Organization Name	O	AN	1/35	Required
-------	------	---------------------------------------	---	----	------	----------

Description: Individual last name or organizational name

Industry: *Patient Last Name*

However, only the first 3 letters of the first name and only the first 11 letters of the last name will be transfer to the SD/MC - EOB

NM104	1036	Name First	O	AN	1/25	Required
-------	------	-------------------	---	----	------	----------

Description: Individual first name

Industry: *Patient First Name*

However, only the first 3 letters of the first name and only the first 11 letters of the last name will be transfer to the SD/MC - EOB

NM105	1037	Name Middle	O	AN	1/25	Situational
-------	------	--------------------	---	----	------	-------------

Description: Individual middle name or initial

Industry: *Patient Middle Name*

If this data element is used and contains only one character, it is assumed to represent the middle initial.

The middle name or initial is required when the individual has a middle name or initial and it is known.

NM107	1039	Name Suffix	O	AN	1/10	Situational
-------	------	--------------------	---	----	------	-------------

Description: Suffix to individual name

Industry: *Patient Name Suffix*

The Suffix should be reported whenever this information is necessary for identification of the individual, for instance when a Junior and Senior are covered under the same subscriber.

NM108	66	Identification Code Qualifier	C	ID	1/2	Situational
-------	----	--------------------------------------	---	----	-----	-------------

Description: Code designating the system/method of code structure used for Identification Code (67)

Required if the patient identifier is known or was reported on the health care claim.

<u>Code</u>	<u>Name</u>
HN	Health Insurance Claim (HIC) Number
	ADVISED

NM109 67 **Identification Code** C AN 2/80 Situational

Description: Code identifying a party or other code

Industry: *Patient Identifier*

Required if the patient identifier is known or was reported on the health care claim.

CIN, BIC, etc. This is the value that was reported on the 837.

Syntax Rules:

1. P0809 - If either NM108 or NM109 is present, then the other is required.
2. C1110 - If NM111 is present, then NM110 is required.

Semantics:

1. NM102 qualifies NM103.

Comments:

1. NM110 and NM111 further define the type of entity in NM101.

Notes:

1. *Provide the patient's identification number in NM109.
This segment identifies the Patient associated with a claim.*

Example:

*NM1*QC*1*Doe*John*MI***HN*1234567890~*

NM1 Corrected Patient/Insured Name

Pos: 030	Max: 1
Detail - Optional	
Loop: 2100	Elements: 8

User Option (Usage): Situational

Purpose: To supply the full name of an individual or organizational entity

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
NM101	98	Entity Identifier Code	M	ID	2/3	Required
		Description: Code identifying an organizational entity, a physical location, property or an individual				
		<u>Code</u>		<u>Name</u>		
		74		Corrected Insured		
NM102	1065	Entity Type Qualifier	M	ID	1/1	Required
		Description: Code qualifying the type of entity				
		<u>Code</u>		<u>Name</u>		
		1		Person		
NM103	1035	Name Last or Organization Name	O	AN	1/35	Situational
		Description: Individual last name or organizational name				
		Industry: <i>Corrected Patient or Insured Last Name</i>				
		<i>Required when corrected information for the Insured is available.</i>				
NM104	1036	Name First	O	AN	1/25	Situational
		Description: Individual first name				
		Industry: <i>Corrected Patient or Insured First Name</i>				
		<i>Required when corrected information for the Insured is available.</i>				
		<i>This element may only be used when NM102 is 1 (person).</i>				
NM105	1037	Name Middle	O	AN	1/25	Situational
		Description: Individual middle name or initial				
		Industry: <i>Corrected Patient or Insured Middle Name</i>				
		<i>If this data element is used and contains only one character, it is assumed to represent the middle initial.</i>				
		<i>Required when corrected information for the Insured is available.</i>				
		<i>This element may only be used when NM102 is 1 (person).</i>				
NM107	1039	Name Suffix	O	AN	1/10	Situational
		Description: Suffix to individual name				
		Industry: <i>Corrected Patient or Insured Name Suffix</i>				
		<i>Required when corrected information for the Insured is available.</i>				
		<i>This element may only be used when NM102 is 1 (person).</i>				
NM108	66	Identification Code Qualifier	C	ID	1/2	Required
		Description: Code designating the system/method of code structure used for Identification Code (67)				
		<i>Required when a value is reported in NM109.</i>				
		<u>Code</u>		<u>Name</u>		
		C		Insured's Changed Unique Identification Number		
NM109	67	Identification Code	C	AN	2/80	Required
		Description: Code identifying a party or other code				

Industry: *Corrected Insured Identification Indicator*
Required when corrected information for the Insured is available.

Submitter's EIN, approved Aid Code, CIN from SD/MC, County of Responsibility, EPSDT Indicator, and File-name of the transaction file that the claim was submitted on, in that order.

Syntax Rules:

1. P0809 - If either NM108 or NM109 is present, then the other is required.
2. C1110 - If NM111 is present, then NM110 is required.

Semantics:

1. NM102 qualifies NM103.

Comments:

1. NM110 and NM111 further define the type of entity in NM101.

Notes:

1. Use this NM1 segment to provide corrected information about the patient or insured. Because the patient is always the insured for Medicare and Medicaid, this segment always provides corrected patient information for Medicare and Medicaid. For other carriers, this will always be the corrected insured information.

Assumed to be corrected patient information for Medicare and Medicaid.

Example:

*NM1*74*1*****C*48,30,90002839A,48,Y,02032009-ADP-34-837P-02032009-671.dat~*

NM1 Service Provider Name

Pos: 030	Max: 1
Detail - Optional	
Loop: 2100	Elements: 8

User Option (Usage): Situational

Purpose: To supply the full name of an individual or organizational entity

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
NM101	98	Entity Identifier Code	M	ID	2/3	Required
Description: Code identifying an organizational entity, a physical location, property or an individual						
		<u>Code</u>	<u>Name</u>			
		82	Rendering Provider			
NM102	1065	Entity Type Qualifier	M	ID	1/1	Required
Description: Code qualifying the type of entity						
		<u>Code</u>	<u>Name</u>			
		1	Person			
		2	Non-Person Entity			
NM103	1035	Name Last or Organization Name	O	AN	1/35	Situational
Description: Individual last name or organizational name						
Industry: <i>Rendering Provider Last or Organization Name Required when needed to confirm the identifier in NM109.</i>						
NM104	1036	Name First	O	AN	1/25	Situational
Description: Individual first name						
Industry: <i>Rendering Provider First Name</i>						
<i>If NM102 is a "2" this element is not used.</i>						
<i>Used when NM102=1 and the information is known.</i>						
NM105	1037	Name Middle	O	AN	1/25	Situational
Description: Individual middle name or initial						
Industry: <i>Rendering Provider Middle Name</i>						
<i>If NM102 is a "2" this element is not used.</i>						
<i>If this data element is used and contains only one character, it is assumed to represent the middle initial.</i>						
<i>The Middle name or initial is required when the individual has a middle name or initial.</i>						
<i>Used when NM102=1 and the information is known.</i>						
NM107	1039	Name Suffix	O	AN	1/10	Situational
Description: Suffix to individual name						
Industry: <i>Rendering Provider Name Suffix</i>						
<i>The Suffix should be reported whenever this information is necessary for identification of the individual, for instance when a Junior and Senior are covered under the same subscriber.</i>						
NM108	66	Identification Code Qualifier	C	ID	1/2	Required
Description: Code designating the system/method of code structure used for Identification Code (67)						
		<u>Code</u>	<u>Name</u>			
		XX	Health Care Financing Administration National Provider Identifier			
		ADVISED				
NM109	67	Identification Code	C	AN	2/80	Required

Description: Code identifying a party or other code

Industry: *Rendering Provider Identifier*

ExternalCodeList

Name: 537

Description: Health Care Financing Administration National Provider Identifier

Syntax Rules:

1. P0809 - If either NM108 or NM109 is present, then the other is required.
2. C1110 - If NM111 is present, then NM110 is required.

Semantics:

1. NM102 qualifies NM103.

Comments:

1. NM110 and NM111 further define the type of entity in NM101.

Notes:

1. Use this NM1 segment to provide information about the rendering provider. Any reference number should be provided in NM109. This segment is required when the rendering provider is different from the Payee.
2. This information is provided to facilitate identification of the claim within a payee's system. Other providers related to the claim but not directly related to the payment are not supported and are not necessary for claim identification.

Example:

NM1*82*2*****XX*1234567893~

NM1 Corrected Priority Payer Name

Pos: 030	Max: 2
Detail - Optional	
Loop: 2100	Elements: 5

User Option (Usage): Situational

Purpose: To supply the full name of an individual or organizational entity

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
NM101	98	Entity Identifier Code	M	ID	2/3	Required
Description: Code identifying an organizational entity, a physical location, property or an individual						
		<u>Code</u>	<u>Name</u>			
		PR	Payer			
NM102	1065	Entity Type Qualifier	M	ID	1/1	Required
Description: Code qualifying the type of entity						
		<u>Code</u>	<u>Name</u>			
		2	Non-Person Entity			
NM103	1035	Name Last or Organization Name	O	AN	1/35	Required
Description: Individual last name or organizational name						
Industry: <i>Corrected Priority Payer Name</i>						
NM108	66	Identification Code Qualifier	C	ID	1/2	Required
Description: Code designating the system/method of code structure used for Identification Code (67)						
		<u>Code</u>	<u>Name</u>			
		PI	Payor Identification			
NM109	67	Identification Code	C	AN	2/80	Required
Description: Code identifying a party or other code						
Industry: <i>Corrected Priority Payer Identification Number</i>						
ExternalCodeList						
Name: 245						
Description: National Association of Insurance Commissioners (NAIC) Code						
ExternalCodeList						
Name: 540						
Description: Health Care Financing Administration National PlanID						

Syntax Rules:

1. P0809 - If either NM108 or NM109 is present, then the other is required.
2. C1110 - If NM111 is present, then NM110 is required.

Semantics:

1. NM102 qualifies NM103.

Comments:

1. NM110 and NM111 further define the type of entity in NM101.

Notes:

1. This segment is required when the current payer believes that another payer has priority for making a payment.



Provide any reference numbers in NM109. Use of this segment identifies the priority payer. It is not necessary to use the Crossover Carrier NM1 segment in addition to this segment.

This segment identifies Rendering Information.

Example:

*NM1*PR*2*Medicare Part A and Part B****PI*Z~*

MOA Outpatient Adjudication Information

Pos: 035	Max: 1
Detail - Optional	
Loop: 2100	Elements: 9

User Option (Usage): Situational
Purpose: To convey claim-level data related to the adjudication of Medicare claims not related to an inpatient setting

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
MOA01	954	Percent	O	R	1/10	Situational
<p>Description: Percentage expressed as a decimal Industry: <i>Reimbursement Rate</i> <i>Use this number for the reimbursement rate.</i> <i>This does not apply to claims processed by Medicare Carriers.</i></p>						
MOA02	782	Monetary Amount	O	R	1/18	Situational
<p>Description: Monetary amount Industry: <i>Claim HCPCS Payable Amount</i> <i>Use this monetary amount for the HCPCS payable amount.</i> <i>This does not apply to claims processed by Medicare Carriers.</i></p>						
MOA03	127	Reference Identification	O	AN	1/30	Situational
<p>Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier Industry: <i>Remark Code</i> <i>Used when a Remittance Remark Code applies to this claim.</i></p> <p>ExternalCodeList Name: 411 Description: Remittance Remark Codes</p>						
MOA04	127	Reference Identification	O	AN	1/30	Situational
<p>Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier Industry: <i>Remark Code</i> <i>See MOA03.</i> <i>Used when additional remittance remarks apply to this claim.</i></p> <p>ExternalCodeList Name: 411 Description: Remittance Remark Codes</p>						
MOA05	127	Reference Identification	O	AN	1/30	Situational
<p>Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier Industry: <i>Remark Code</i> <i>See MOA03.</i> <i>Used when additional remittance remarks apply to this claim.</i></p> <p>ExternalCodeList Name: 411 Description: Remittance Remark Codes</p>						
MOA06	127	Reference Identification	O	AN	1/30	Situational
<p>Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier Industry: <i>Remark Code</i></p>						



See MOA03.
Used when additional remittance remarks apply to this claim.

ExternalCodeList

Name: 411

Description: Remittance Remark Codes

MOA07	127	Reference Identification	O	AN	1/30	Situational
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Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

Industry: Remark Code

See MOA03.

Used when additional remittance remarks apply to this claim.

ExternalCodeList

Name: 411

Description: Remittance Remark Codes

MOA08	782	Monetary Amount	O	R	1/18	Situational
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Description: Monetary amount

Industry: Claim ESRD Payment Amount

Use this monetary amount for the ESRD payment amount.

This does not apply to claims processed by Medicare Carriers.

MOA09	782	Monetary Amount	O	R	1/18	Situational
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Description: Monetary amount

Industry: Nonpayable Professional Component Amount

Use this monetary amount for the professional component amount billed but not payable.

This does not apply to claims processed by Medicare Carriers.

Semantics:

1. MOA01 is the reimbursement rate.
2. MOA02 is the claim Health Care Financing Administration Common Procedural Coding System (HCPCS) payable amount.
3. MOA03 is the Claim Payment Remark Code. See Code Source 411.
4. MOA04 is the Claim Payment Remark Code. See Code Source 411.
5. MOA05 is the Claim Payment Remark Code. See Code Source 411.
6. MOA06 is the Claim Payment Remark Code. See Code Source 411.
7. MOA07 is the Claim Payment Remark Code. See Code Source 411.
8. MOA08 is the End Stage Renal Disease (ESRD) payment amount.
9. MOA09 is the professional component amount billed but not payable.

Notes:

1. This segment should be generated by Medicare carriers or Intermediaries.
2. Either MIA or MOA will appear, but not both.
3. All situational quantities and amounts in this segment are required when the value of the item is different than zero.
4. Payers and payees outside of Medicare community may need to use this segment.

Example:

MOA***MA01~

REF Other Claim Related Identification

Pos: 040	Max: 5
Detail - Optional	
Loop: 2100	Elements: 2

User Option (Usage): Situational
Purpose: To specify identifying information

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
REF01	128	Reference Identification Qualifier	M	ID	2/3	Required

Description: Code qualifying the Reference Identification

Code	Name
1W	Member Identification Number
EA	Medical Record Identification Number
F8	Original Reference Number
SY	Social Security Number

REF02	127	Reference Identification	C	AN	1/30	Required
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Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

Industry: Other Claim Related Identifier

Syntax Rules:

1. R0203 - At least one of REF02 or REF03 is required.

Semantics:

1. REF04 contains data relating to the value cited in REF02.

Notes:

1. Use this REF segment for reference numbers specific to the claim identified in the CLP segment. This is used to provide additional information used in the process of adjudicating this claim.

The additional patient identifiers found on the EOB are reported here.

This segment is repeated 3 times to provide EA, SY, W values.

Example:

```
REF*EA*002606567~
REF*SY*548909368~
REF*1W*486HM548909368~
```

DTM Claim Date

Pos: 050	Max: 4
Detail - Optional	
Loop: 2100	Elements: 2

User Option (Usage): Situational
Purpose: To specify pertinent dates and times

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
DTM01	374	Date/Time Qualifier	M	ID	3/3	Required

Description: Code specifying type of date or time, or both date and time
Industry: *Date Time Qualifier*

<u>Code</u>	<u>Name</u>
036	Expiration <i>Use this code to convey the expiration date of coverage.</i>
050	Received <i>Use this code to convey the date that the claim was received by the payer.</i>
232	Claim Statement Period Start <i>If the claim statement period start date is conveyed without a subsequent claim statement period end date, the end date is assumed to be the same as the start date. This date or code 233 should be considered required when service level dates are not provided in the remittance advice.</i>
233	Claim Statement Period End <i>If a claim statement period end date is conveyed without a claim statement period start date, then the start date is assumed to be different from the end date but not conveyed at the payer's discretion. See the note on code 232.</i>

DTM02	373	Date	C	DT	8/8	Required
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Description: Date expressed as CCYYMMDD
Industry: *Claim Date*
Date Received by ADP
 CCYYMMDD

Syntax Rules:

1. R020305 - At least one of DTM02, DTM03 or DTM05 is required.
2. C0403 - If DTM04 is present, then DTM03 is required.
3. P0506 - If either DTM05 or DTM06 is present, then the other is required.

Notes:

1. Dates must be provided at the claim level (2-050-DTM), the service line level (2-080-DTM), or both. Dates at the claim level apply to the entire claim, including all service lines. Dates at the service line level apply only to the service line where they appear.
2. When claim dates are not provided, service dates are required for every service line.
3. When claim dates are provided, service dates are not required, but they may be used to "override" the claim dates for individual service lines.

This segment provides claim date information.

Example:

DTM*050*20030814~

AMT Claim Supplemental Information

Pos: 062	Max: 14
Detail - Optional	
Loop: 2100	Elements: 2

User Option (Usage): Situational
Purpose: To indicate the total monetary amount

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
AMT01	522	Amount Qualifier Code	M	ID	1/3	Required
		Description: Code to qualify amount				
		<u>Code</u>		<u>Name</u>		
		F5		Patient Amount Paid		
		<i>Use this monetary amount for the amount the patient has already paid.</i>				
AMT02	782	Monetary Amount	M	R	1/18	Required
		Description: Monetary amount				
		Industry: Claim Supplemental Information Amount				
		<i>Medi-Cal Patient Share of Cost Reported on the 837 AMT*F5</i>				

Notes:

1. Use this segment to convey information only. It is not part of the financial balancing of the 835.
2. Use this segment only when the value of specific amounts identified in the AMT01 qualifier are Non-zero.

Example:
 AMT*F5*10~



Loop Service Payment Information

Pos: 070 Repeat: 999
 Optional
 Loop: 2110 Elements: N/A

User Option (Usage): Required

Purpose: To supply payment and control information to a provider for a particular service

Loop Summary:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Usage</u>
070	SVC	Service Payment Information	O	1		Required
080	DTM	Service Date	O	3		Required
090	CAS	Service Adjustment	O	99		Situational
100	REF	Service Identification	O	7		Situational
100	REF	Rendering Provider Information	O	10		Situational
110	AMT	Service Supplemental Amount	O	12		Situational
130	LQ	Health Care Remark Codes	O	99		Situational

Semantics:

1. SVC01 is the medical procedure upon which adjudication is based.
2. SVC02 is the submitted service charge.
3. SVC03 is the amount paid this service.
4. SVC04 is the National Uniform Billing Committee Revenue Code.
5. SVC05 is the paid units of service.
6. SVC06 is the original submitted medical procedure.
7. SVC07 is the original submitted units of service.

Comments:

1. For Medicare Part A claims, SVC01 would be the Health Care Financing Administration (HCFA) Common Procedural Coding System (HCPCS) Code (see code source 130) and SVC04 would be the Revenue Code (see code source 132).

Notes:

1. Although the SVC loop is optional, there are times when it should be considered mandatory. Whenever the actual payment has been reduced due to service line specific adjustments, the SVC loop is necessary in order to understand the remittance information. This situation is particularly applicable to professional and fee-based services.
2. An exception to note 1 occurs with institutional claims when the room per diem is the only service line adjustment. In this instance, a claim level CAS adjustment to the per diem is appropriate (i.e., CAS*CO*78*25~).
3. See 2.2.6, Procedure Code Bundling and Unbundling, for important SVC segment usage information.

Example:

SVC*HC:99214*100*80~

SVC Service Payment Information

Pos: 070	Max: 1
Detail - Optional	
Loop: 2110	Elements: 7

User Option (Usage): Required
Purpose: To supply payment and control information to a provider for a particular service

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
SVC01	C003	Composite Medical Procedure Identifier	M	Comp		Required
<p>Description: To identify a medical procedure by its standardized codes and applicable modifiers <i>Use the adjudicated Medical Procedure Code. This code is a composite data structure.</i></p>						
SVC01-01	235	Product/Service ID Qualifier	M	ID	2/2	Required
<p>Description: Code identifying the type/source of the descriptive number used in Product/Service ID (234) Industry: <i>Product or Service ID Qualifier</i> <i>The value in SVC01-01 qualifies the values in SVC01-02, SVC01-03, SVC01-04, SVC01-05, and SVC01-06.</i></p>						
		Code		Name		
		AD		American Dental Association Codes		
				CODE SOURCE:		
				<i>135: American Dental Association Codes</i>		
		ER		Jurisdiction Specific Procedure and Supply Codes		
				<i>This is specific to Workman's Compensation Claims.</i>		
		HC		Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes		
				<i>Because the CPT codes of the American Medical Association are also level 1 HCPCS codes, they are reported under the code HC.</i>		
				CODE SOURCE:		
				<i>130: Health Care Financing Administration Common Procedural Coding System</i>		
		ID		International Classification of Diseases Clinical Modification (ICD-9-CM) - Procedure		
				CODE SOURCE:		
				<i>131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure</i>		
		IV		Home Infusion EDI Coalition (HIEC) Product/Service Code		
				<i>This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used 1) If a new rule names HIEC as an allowable code set under HIPAA. 2) For Property & Casualty claims/encounters that are not covered under HIPAA.</i>		
				CODE SOURCE:		
				<i>513: Home Infusion EDI Coalition (HIEC) Product/Service Code List</i>		
		N4		National Drug Code in 5-4-2 Format		
				CODE SOURCE:		
				<i>240: National Drug Code by Format</i>		
		NU		National Uniform Billing Committee (NUBC) UB92 Codes		
				CODE SOURCE:		
				<i>132: National Uniform Billing Committee (NUBC) Codes</i>		
		RB		National Uniform Billing Committee (NUBC) UB82 Codes		



CODE SOURCE:

132: National Uniform Billing Committee (NUBC) Codes

ZZ Mutually Defined

This is used to convey the Health Insurance Prospective Payment System (HIPPS) Skilled Nursing Facility Rate Code. This code list is available from: Division of Institutional Care Health Care Financing Administration S1-03-06 7500 Security Boulevard Baltimore, MD 21244-1850

SVC01-02 234 **Product/Service ID** M AN 1/48 Required

Description: Identifying number for a product or service

Industry: Procedure Code

This is the procedure or revenue code on the 837P

ExternalCodeList

Name: 130

Description: Health Care Financing Administration Common Procedural Coding System

ExternalCodeList

Name: 131P

Description: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure

ExternalCodeList

Name: 132

Description: National Uniform Billing Committee (NUBC) Codes

ExternalCodeList

Name: 135

Description: American Dental Association Codes

ExternalCodeList

Name: 240

Description: National Drug Code by Format

ExternalCodeList

Name: 513

Description: Home Infusion EDI Coalition (HIEC) Product/Service Code List

ExternalCodeList

Name: SNFR

Description: Skilled Nursing Facility Rate Code

SVC01-03 1339 **Procedure Modifier** O AN 2/2 Situational

Description: This identifies special circumstances related to the performance of the service, as defined by trading partners

Required when procedure code modifiers apply to this service.

This is the first Modifier Reported on the procedure code from the 837P Transaction

ExternalCodeList

Name: 130

Description: Health Care Financing Administration Common Procedural Coding System

ExternalCodeList

Name: 513

Description: Home Infusion EDI Coalition (HIEC) Product/Service Code List

SVC01-04 1339 **Procedure Modifier** O AN 2/2 Situational

Description: This identifies special circumstances related to the performance of the service, as defined by trading partners

Required when procedure code modifiers apply to this service.

This is the second Modifier Reported on the procedure code from the 837P Transaction

ExternalCodeList



		Name: 130				
		Description: Health Care Financing Administration Common Procedural Coding System				
		ExternalCodeList				
		Name: 513				
		Description: Home Infusion EDI Coalition (HIEC) Product/Service Code List				
SVC01-05	1339	Procedure Modifier	O	AN	2/2	Situational
		Description: This identifies special circumstances related to the performance of the service, as defined by trading partners				
		<i>Required when procedure code modifiers apply to this service.</i>				
		<i>This is the third Modifier Reported on the procedure code from the 837P Transaction</i>				
		ExternalCodeList				
		Name: 130				
		Description: Health Care Financing Administration Common Procedural Coding System				
		ExternalCodeList				
		Name: 513				
		Description: Home Infusion EDI Coalition (HIEC) Product/Service Code List				
SVC01-06	1339	Procedure Modifier	O	AN	2/2	Situational
		Description: This identifies special circumstances related to the performance of the service, as defined by trading partners				
		<i>Required when procedure code modifiers apply to this service.</i>				
		<i>This is the fourth Modifier Reported on the procedure code from the 837P Transaction</i>				
		ExternalCodeList				
		Name: 130				
		Description: Health Care Financing Administration Common Procedural Coding System				
		ExternalCodeList				
		Name: 513				
		Description: Home Infusion EDI Coalition (HIEC) Product/Service Code List				
SVC01-07	352	Description	O	AN	1/80	Situational
		Description: A free-form description to clarify the related data elements and their content				
		Industry: <i>Procedure Code Description</i>				
		<i>Avoid using the description to make it easier for the computer to process the information provided.</i>				
		<i>Used only when a description was received for the service on the original claim, and the adjudicated code is the submitted code.</i>				
SVC02	782	Monetary Amount	M	R	1/18	Required
		Description: Monetary amount				
		Industry: <i>Line Item Charge Amount</i>				
		<i>Use this monetary amount for the submitted service charge amount.</i>				
		<i>Amount billed.</i>				
SVC03	782	Monetary Amount	O	R	1/18	Situational
		Description: Monetary amount				
		Industry: <i>Line Item Provider Payment Amount</i>				
		<i>Use this number for the service amount paid. The value in SVC03 should equal the value in SVC02 minus all monetary amounts in the subsequent CAS segments of this loop.</i>				
SVC04	234	Product/Service ID	O	AN	1/48	Situational
		Description: Identifying number for a product or service				
		Industry: <i>National Uniform Billing Committee Revenue Code</i>				

Use the National Uniform Billing Committee Revenue Code. Required when an NUBC revenue code was considered during adjudication in addition to a procedure code already identified in SVC01. If the original claim and adjudication only referenced an NUBC revenue code, that is supplied in SVC01 and this element is not used.

ExternalCodeList

Name: 132

Description: National Uniform Billing Committee (NUBC) Codes

SVC05	380	Quantity	O	R	1/15	Situational
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Description: Numeric value of quantity

Industry: Units of Service Paid Count

Use this number for the paid units of service. If not present, the value is assumed to be one.

This value can be either units of service or units of time.

SVC06	C003	Composite Medical Procedure Identifier	O	Comp		Not used
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Description: To identify a medical procedure by its standardized codes and applicable modifiers

This is REQUIRED when the adjudicated procedure code provided in SVC01 is different from the submitted procedure code from the original claim. This is NOT USED when the submitted code is the same as the code on SVC01.

This code is a composite data structure.

SVC06-01	235	Product/Service ID Qualifier	M	ID	2/2	Not used
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Description: Code identifying the type/source of the descriptive number used in Product/Service ID (234)

Industry: Product or Service ID Qualifier

The value in SVC06-01 qualifies the values in SVC06-02, SVC06-03, SVC06-04, SVC06-05, and SVC06-06.

Code

Name

AD American Dental Association Codes

CODE SOURCE:

135: American Dental Association Codes

ER Jurisdiction Specific Procedure and Supply Codes

This is specific to Workman's Compensation Claims.

HC Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes

Because the CPT codes of the American Medical Association are also level 1 HCPCS codes, they are reported under the code HC.

CODE SOURCE:

130: Health Care Financing Administration Common Procedural Coding System

ID International Classification of Diseases Clinical Modification (ICD-9-CM) - Procedure

CODE SOURCE:

131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure

IV Home Infusion EDI Coalition (HIEC) Product/Service Code

This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used 1) If a new rule names HIEC as an allowable code set under HIPAA. 2) For Property & Casualty claims/encounters that are not covered under HIPAA.

CODE SOURCE:

513: Home Infusion EDI Coalition (HIEC) Product/Service Code List

N4 National Drug Code in 5-4-2 Format

CODE SOURCE:

240: National Drug Code by Format

NU National Uniform Billing Committee (NUBC) UB92 Codes
CODE SOURCE:
 132: National Uniform Billing Committee (NUBC) Codes

RB National Uniform Billing Committee (NUBC) UB82 Codes
CODE SOURCE:
 132: National Uniform Billing Committee (NUBC) Codes

ZZ Mutually Defined
 This is used to convey the Health Insurance Prospective Payment System (HIPPS) Skilled Nursing Facility Rate Code. This code list is available from: Division of Institutional Care Health Care Financing Administration S1-03-06
 7500 Security Boulevard Baltimore, MD 21244-1850

SVC06-02 234 **Product/Service ID** M AN 1/48 Not used

Description: Identifying number for a product or service
Industry: Procedure Code

ExternalCodeList

Name: 130
Description: Health Care Financing Administration Common Procedural Coding System

ExternalCodeList

Name: 131P
Description: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure

ExternalCodeList

Name: 132
Description: National Uniform Billing Committee (NUBC) Codes

ExternalCodeList

Name: 135
Description: American Dental Association Codes

ExternalCodeList

Name: 240
Description: National Drug Code by Format

ExternalCodeList

Name: 513
Description: Home Infusion EDI Coalition (HIEC) Product/Service Code List

ExternalCodeList

Name: SNFR
Description: Skilled Nursing Facility Rate Code

SVC06-03 1339 **Procedure Modifier** O AN 2/2 Not used

Description: This identifies special circumstances related to the performance of the service, as defined by trading partners
Required when procedure code modifiers apply to this service.

ExternalCodeList

Name: 130
Description: Health Care Financing Administration Common Procedural Coding System

ExternalCodeList

Name: 513
Description: Home Infusion EDI Coalition (HIEC) Product/Service Code List

SVC06-04 1339 **Procedure Modifier** O AN 2/2 Not used

Description: This identifies special circumstances related to the performance of the service, as defined by trading partners
Required when procedure code modifiers apply to this service.

		<u>ExternalCodeList</u>				
		Name: 130				
		Description: Health Care Financing Administration Common Procedural Coding System				
		<u>ExternalCodeList</u>				
		Name: 513				
		Description: Home Infusion EDI Coalition (HIEC) Product/Service Code List				
SVC06-05	1339	Procedure Modifier	O	AN	2/2	Not used
		Description: This identifies special circumstances related to the performance of the service, as defined by trading partners <i>Required when procedure code modifiers apply to this service.</i>				
		<u>ExternalCodeList</u>				
		Name: 130				
		Description: Health Care Financing Administration Common Procedural Coding System				
		<u>ExternalCodeList</u>				
		Name: 513				
		Description: Home Infusion EDI Coalition (HIEC) Product/Service Code List				
SVC06-06	1339	Procedure Modifier	O	AN	2/2	Not used
		Description: This identifies special circumstances related to the performance of the service, as defined by trading partners <i>Required when procedure code modifiers apply to this service.</i>				
		<u>ExternalCodeList</u>				
		Name: 130				
		Description: Health Care Financing Administration Common Procedural Coding System				
		<u>ExternalCodeList</u>				
		Name: 513				
		Description: Home Infusion EDI Coalition (HIEC) Product/Service Code List				
SVC06-07	352	Description	O	AN	1/80	Not used
		Description: A free-form description to clarify the related data elements and their content Industry: <i>Procedure Code Description</i> <i>Avoid using the description to make it easier for the computer to process the information provided.</i> <i>Required when a description was received for the service on the original claim.</i>				
SVC07	380	Quantity	O	R	1/15	Situational
		Description: Numeric value of quantity Industry: <i>Original Units of Service Count</i> <i>This is REQUIRED when the paid units of service provided in SVC05 is different from the submitted units of service from the original claim. This is NOT USED when the submitted units is the same as the value in SVC05.</i> <i>This value is required when the value of SVC07 is different than SVC05.</i>				

Semantics:

1. SVC01 is the medical procedure upon which adjudication is based.
2. SVC02 is the submitted service charge.
3. SVC03 is the amount paid this service.
4. SVC04 is the National Uniform Billing Committee Revenue Code.
5. SVC05 is the paid units of service.
6. SVC06 is the original submitted medical procedure.
7. SVC07 is the original submitted units of service.

Comments:

1. For Medicare Part A claims, SVC01 would be the Health Care Financing Administration (HCFA) Common Procedural Coding System (HCPCS) Code (see code source 130) and SVC04 would be the Revenue Code (see code source 132).

Notes:

1. *Although the SVC loop is optional, there are times when it should be considered mandatory. Whenever the actual payment has been reduced due to service line specific adjustments, the SVC loop is necessary in order to understand the remittance information. This situation is particularly applicable to professional and fee-based services.*

2. *An exception to note 1 occurs with institutional claims when the room per diem is the only service line adjustment. In this instance, a claim level CAS adjustment to the per diem is appropriate (i.e., CAS*CO*78*25~).*

The number of SVC Segments can be >1 based on the number of services performed.

Example:

SVC*HC:H2012:HF:H9*40.9*0**0**4~

DTM Service Date

Pos: 080	Max: 3
Detail - Optional	
Loop: 2110	Elements: 2

User Option (Usage): Required

Purpose: To specify pertinent dates and times

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
DTM01	374	Date/Time Qualifier	M	ID	3/3	Required

Description: Code specifying type of date or time, or both date and time

Industry: *Date Time Qualifier*

Code

Name

150	Service Period Start <i>Use this code only for reporting the beginning of multi-day services.</i>
151	Service Period End <i>Use this code only for reporting the end of multi-day services.</i>
472	Service <i>ADVISED</i> <i>Use this code to indicate a single day service.</i>

DTM02	373	Date	C	DT	8/8	Required
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Description: Date expressed as CCYYMMDD

Industry: *Service Date*
CCYYMMDD

Syntax Rules:

1. R020305 - At least one of DTM02, DTM03 or DTM05 is required.
2. C0403 - If DTM04 is present, then DTM03 is required.
3. P0506 - If either DTM05 or DTM06 is present, then the other is required.

Notes:

1. Dates must be provided at the claim level (2-050-DTM), the service line level (2-080-DTM), or both. Dates at the claim level apply to the entire claim, including all service lines. Dates at the service line level apply only to the service line where they appear.
2. When claim dates are not provided, service dates are required for every service line.
3. When claim dates are provided, service dates are not required, but they may be used to "override" the claim dates for individual service lines.
4. For Medicare service, this segment is required (for Part A, use "through date" if no service date is present).

This segment will be sent once for single day services and twice for multi-day services.

Example:

*DTM*472*20030609~*

CAS Service Adjustment

Pos: 090	Max: 99
Detail - Optional	
Loop: 2110	Elements: 19

User Option (Usage): Situational
Purpose: To supply adjustment reason codes and amounts as needed for an entire claim or for a particular service within the claim being paid

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>												
CAS01	1033	Claim Adjustment Group Code	M	ID	1/2	Required												
<p>Description: Code identifying the general category of payment adjustment <i>Evaluate the group codes in CAS01 based on the following order for their applicability to a set of one or more adjustments: PR, CO, PI, CR, OA. See 2.2.4, Claim Adjustment and Service Adjustment Segment Theory, for additional information. (Note: This does not mean that the adjustments must be reported in this order.)</i></p> <table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>CO</td> <td>Contractual Obligations <i>Use this code when a joint payer/payee agreement or a regulatory requirement has resulted in an adjustment.</i></td> </tr> <tr> <td>CR</td> <td>Correction and Reversals <i>Use this code for corrections and reversals to PRIOR claims. Use when CLP02=22.</i></td> </tr> <tr> <td>OA</td> <td>Other adjustments</td> </tr> <tr> <td>PI</td> <td>Payor Initiated Reductions <i>Use this code when, in the opinion of the payer, the adjustment is not the responsibility of the patient, but no supporting contract exists between the provider and the payer.</i></td> </tr> <tr> <td>PR</td> <td>Patient Responsibility</td> </tr> </tbody> </table>							<u>Code</u>	<u>Name</u>	CO	Contractual Obligations <i>Use this code when a joint payer/payee agreement or a regulatory requirement has resulted in an adjustment.</i>	CR	Correction and Reversals <i>Use this code for corrections and reversals to PRIOR claims. Use when CLP02=22.</i>	OA	Other adjustments	PI	Payor Initiated Reductions <i>Use this code when, in the opinion of the payer, the adjustment is not the responsibility of the patient, but no supporting contract exists between the provider and the payer.</i>	PR	Patient Responsibility
<u>Code</u>	<u>Name</u>																	
CO	Contractual Obligations <i>Use this code when a joint payer/payee agreement or a regulatory requirement has resulted in an adjustment.</i>																	
CR	Correction and Reversals <i>Use this code for corrections and reversals to PRIOR claims. Use when CLP02=22.</i>																	
OA	Other adjustments																	
PI	Payor Initiated Reductions <i>Use this code when, in the opinion of the payer, the adjustment is not the responsibility of the patient, but no supporting contract exists between the provider and the payer.</i>																	
PR	Patient Responsibility																	
CAS02	1034	Claim Adjustment Reason Code	M	ID	1/5	Required												
<p>Description: Code identifying the detailed reason the adjustment was made Industry: <i>Adjustment Reason Code</i> <i>See Appendix.</i></p> <p>ExternalCodeList Name: 139 Description: Claim Adjustment Reason Code</p>																		
CAS03	782	Monetary Amount	M	R	1/18	Required												
<p>Description: Monetary amount Industry: <i>Adjustment Amount</i> <i>Use this monetary amount for the adjustment amount. A negative amount increases the payment, and a positive amount decreases the payment contained in SVC03 and CLP04.</i></p> <p><i>This field contains the amount of the adjustment.</i></p>																		
CAS04	380	Quantity	O	R	1/15	Situational												
<p>Description: Numeric value of quantity Industry: <i>Adjustment Quantity</i> <i>This element may be used only when the units of service are being adjusted. A positive number decreases paid units, and a negative value increases paid units.</i></p> <p><i>This field is used when the units of service are being adjusted. A Positive Amount decreases the payment contained in SVC03 and CLP04. A negative amount increase the payment contained in SVC03 and CLP04.</i></p>																		



CAS05 1034 **Claim Adjustment Reason Code** C ID 1/5 Situational

Description: Code identifying the detailed reason the adjustment was made

Industry: *Adjustment Reason Code*

See CAS02.

Used when additional adjustments apply within the group identified in CAS01.

ExternalCodeList

Name: 139

Description: Claim Adjustment Reason Code

CAS06 782 **Monetary Amount** C R 1/18 Situational

Description: Monetary amount

Industry: *Adjustment Amount*

See CAS03.

1437 Used when additional adjustments apply within the group identified in CAS01.

CAS07 380 **Quantity** C R 1/15 Situational

Description: Numeric value of quantity

Industry: *Adjustment Quantity*

See CAS04.

Used when additional adjustments apply within the group identified in CAS01.

CAS08 1034 **Claim Adjustment Reason Code** C ID 1/5 Situational

Description: Code identifying the detailed reason the adjustment was made

Industry: *Adjustment Reason Code*

See CAS02.

Used when additional adjustments apply within the group identified in CAS01.

ExternalCodeList

Name: 139

Description: Claim Adjustment Reason Code

CAS09 782 **Monetary Amount** C R 1/18 Situational

Description: Monetary amount

Industry: *Adjustment Amount*

See CAS03.

Used when additional adjustments apply within the group identified in CAS01.

CAS10 380 **Quantity** C R 1/15 Situational

Description: Numeric value of quantity

Industry: *Adjustment Quantity*

See CAS04.

Used when additional adjustments apply within the group identified in CAS01.

CAS11 1034 **Claim Adjustment Reason Code** C ID 1/5 Situational

Description: Code identifying the detailed reason the adjustment was made

Industry: *Adjustment Reason Code*

See CAS02.

Used when additional adjustments apply within the group identified in CAS01.

ExternalCodeList

Name: 139

Description: Claim Adjustment Reason Code

CAS12 782 **Monetary Amount** C R 1/18 Situational

Description: Monetary amount

Industry: *Adjustment Amount*

See CAS03.

Used when additional adjustments apply within the group identified in CAS01.

CAS13	380	Quantity	C	R	1/15	Situational
Description: Numeric value of quantity Industry: <i>Adjustment Quantity</i> <i>See CAS04.</i> <i>Used when additional adjustments apply within the group identified in CAS01.</i>						
CAS14	1034	Claim Adjustment Reason Code	C	ID	1/5	Situational
Description: Code identifying the detailed reason the adjustment was made Industry: <i>Adjustment Reason Code</i> <i>See CAS02.</i> <i>Used when additional adjustments apply within the group identified in CAS01.</i>						
ExternalCodeList						
Name: 139						
Description: Claim Adjustment Reason Code						
CAS15	782	Monetary Amount	C	R	1/18	Situational
Description: Monetary amount Industry: <i>Adjustment Amount</i> <i>See CAS03.</i> <i>Used when additional adjustments apply within the group identified in CAS01.</i>						
CAS16	380	Quantity	C	R	1/15	Situational
Description: Numeric value of quantity Industry: <i>Adjustment Quantity</i> <i>See CAS04.</i> <i>Used when additional adjustments apply within the group identified in CAS01.</i>						
CAS17	1034	Claim Adjustment Reason Code	C	ID	1/5	Situational
Description: Code identifying the detailed reason the adjustment was made Industry: <i>Adjustment Reason Code</i> <i>See CAS02.</i> <i>Used when additional adjustments apply within the group identified in CAS01.</i>						
ExternalCodeList						
Name: 139						
Description: Claim Adjustment Reason Code						
CAS18	782	Monetary Amount	C	R	1/18	Situational
Description: Monetary amount Industry: <i>Adjustment Amount</i> <i>See CAS03.</i> <i>Used when additional adjustments apply within the group identified in CAS01.</i>						
CAS19	380	Quantity	C	R	1/15	Situational
Description: Numeric value of quantity Industry: <i>Adjustment Quantity</i> <i>See CAS04.</i> <i>Used when additional adjustments apply within the group identified in CAS01.</i>						

Syntax Rules:

1. L050607 - If CAS05 is present, then at least one of CAS06 or CAS07 is required.
2. C0605 - If CAS06 is present, then CAS05 is required.
3. C0705 - If CAS07 is present, then CAS05 is required.
4. L080910 - If CAS08 is present, then at least one of CAS09 or CAS10 is required.
5. C0908 - If CAS09 is present, then CAS08 is required.
6. C1008 - If CAS10 is present, then CAS08 is required.
7. L111213 - If CAS11 is present, then at least one of CAS12 or CAS13 is required.

8. C1211 - If CAS12 is present, then CAS11 is required.
9. C1311 - If CAS13 is present, then CAS11 is required.
10. L141516 - If CAS14 is present, then at least one of CAS15 or CAS16 is required.
11. C1514 - If CAS15 is present, then CAS14 is required.
12. C1614 - If CAS16 is present, then CAS14 is required.
13. L171819 - If CAS17 is present, then at least one of CAS18 or CAS19 is required.
14. C1817 - If CAS18 is present, then CAS17 is required.
15. C1917 - If CAS19 is present, then CAS17 is required.

Semantics:

1. CAS03 is the amount of adjustment.
2. CAS04 is the units of service being adjusted.
3. CAS06 is the amount of the adjustment.
4. CAS07 is the units of service being adjusted.
5. CAS09 is the amount of the adjustment.
6. CAS10 is the units of service being adjusted.
7. CAS12 is the amount of the adjustment.
8. CAS13 is the units of service being adjusted.
9. CAS15 is the amount of the adjustment.
10. CAS16 is the units of service being adjusted.
11. CAS18 is the amount of the adjustment.
12. CAS19 is the units of service being adjusted.

Comments:

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

Notes:

1. This CAS segment is optional and is intended to reflect reductions in payment due to adjustments particular to a specific service in the claim. An example of this level of CAS is the reduction for the part of the service charge that exceeds the usual and customary charge for the service.
2. A single CAS segment contains six repetitions of the "adjustment trio" composed of adjustment reason code, adjustment amount, and adjustment quantity. These six adjustment trios are used to report up to six adjustments related to a particular Claim Adjustment Group Code (CAS01). The first adjustment is reported in the first adjustment trio (CAS02-CAS04). If there is a second non-zero adjustment, it is reported in the second adjustment trio (CAS05-CAS07), and so on through the sixth adjustment trio (CAS17-CAS19).

Adjustments reflected here correlate to error messages and transactions code errors on the EOB.

Example:

CAS*CO*31*50*1~

REF Service Identification

Pos: 100	Max: 7
Detail - Optional	
Loop: 2110	Elements: 2

User Option (Usage): Situational

Purpose: To specify identifying information

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
REF01	128	Reference Identification Qualifier	M	ID	2/3	Required

Description: Code qualifying the Reference Identification

Code

6R

Name

Provider Control Number

This is the Line Item Control Number submitted in the 837, which is utilized by the provider for tracking purposes, if submitted on the claim this must be returned on remittance advice.

REF02	127	Reference Identification	C	AN	1/30	Required
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Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

Industry: Provider Identifier

If 6R exists in 837P then it is returned.

Syntax Rules:

1. R0203 - At least one of REF02 or REF03 is required.

Semantics:

1. REF04 contains data relating to the value cited in REF02.

Notes:

1. Use this REF segment for reference numbers specific to the service identified by the SVC segment. This is used to provide additional information used in the process of adjudicating this service.

Example:

REF*6R*A090500242~

REF Rendering Provider Information

Pos: 100	Max: 10
Detail - Optional	
Loop: 2110	Elements: 2

User Option (Usage): Situational
Purpose: To specify identifying information

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
REF01	128	Reference Identification Qualifier	M	ID	2/3	Required

Description: Code qualifying the Reference Identification

<u>Code</u>	<u>Name</u>
HPI	Health Care Financing Administration National Provider Identifier

CODE SOURCE:

537: Health Care Financing Administration National Provider Identifier

REF02	127	Reference Identification	C	AN	1/30	Required
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Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

Industry: Rendering Provider Identifier

ExternalCodeList

Name: 537

Description: Health Care Financing Administration National Provider Identifier

Syntax Rules:

1. R0203 - At least one of REF02 or REF03 is required.

Semantics:

1. REF04 contains data relating to the value cited in REF02.

Notes:

1. Use this REF segment for reference numbers specific to the service identified by the SVC segment. The provider-related reference number at this level should be the rendering provider number, but only if the provider number is specific to this particular service line.

Only use when rendering provider is specific to this service line, as would be indicated on the 837.

Example:

REF*HPI*1234567893~

AMT Service Supplemental Amount

Pos: 110	Max: 12
Detail - Optional	
Loop: 2110	Elements: 2

User Option (Usage): Situational
Purpose: To indicate the total monetary amount

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
AMT01	522	Amount Qualifier Code	M	ID	1/3	Required
		Description: Code to qualify amount				
		<u>Code</u>		<u>Name</u>		
		B6		Allowed - Actual		
		ZK		Federal Medicare or Medicaid Payment Mandate - Category 1		
		ZL		Federal Medicare or Medicaid Payment Mandate - Category 2		
AMT02	782	Monetary Amount	M	R	1/18	Required

Description: Monetary amount
Industry: Service Supplemental Amount
SD/MC Maximum Allowable Amount (for B6)
Or
SD/MC FFP Approved Amount (for ZK) appears only for approved claims.
Or
SD/MC SGF Approved Amount (for ZL) appears only for approved claims.

Notes:
1. This segment is used to convey information only. It is not part of the financial balancing of the 835. Use this segment only when the value of specific amounts identified in the AMT01 qualifier are Non-zero.

Example:
AMT*B6*20~

LQ

Health Care Remark Codes

Pos: 130	Max: 99
Detail - Optional	
Loop: 2110	Elements: 2

User Option (Usage): Situational
Purpose: Code to transmit standard industry codes

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
LQ01	1270	Code List Qualifier Code	O	ID	1/3	Required

Description: Code identifying a specific industry code list

<u>Code</u>	<u>Name</u>
HE	Claim Payment Remark Codes

CODE SOURCE:
 411: Remittance Remark Codes

LQ02	1271	Industry Code	C	AN	1/30	Required
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Description: Code indicating a code from a specific industry code list
Industry: Remark Code
 Use for adjustments that are not specific to a particular claim or service. See Appendix.

ExternalCodeList
Name: 411
Description: Remittance Remark Codes
ExternalCodeList
Name: 530
Description: National Council for Prescription Drug Programs Reject/Payment Codes

Syntax Rules:

1. C0102 - If LQ01 is present, then LQ02 is required.

Notes:

1. Use this segment to provide informational remarks only. This segment has no impact on the actual payment. Changes in claim payment amounts are provided in the CAS segments.

Remarks reflected here should be combined with the adjustment reason codes sent to correlate to error messages in SD/MC Phase II.

Example:

LQ*HE*MA130~

PLB Provider Adjustment

Pos: 010	Max: >1
Summary - Optional	
Loop: N/A	Elements: 4

User Option (Usage): Situational

Purpose: To convey provider level adjustment information for debit or credit transactions such as, accelerated payments, cost report settlements for a fiscal year and timeliness report penalties unrelated to a specific claim or service

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
PLB01	127	Reference Identification	M	AN	1/30	Required

Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

Industry: *Provider Identifier*

Use this number for the provider identifier as assigned by the payer. Billing Provider NPI

PLB02	373	Date	M	DT	8/8	Required
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Description: Date expressed as CCYYMMDD

Industry: *Fiscal Period Date*

Use this date for the last day of the provider's fiscal year. If the end of the provider's fiscal year is not known by the payer, use December 31st of the current year.

PLB03	C042	Adjustment Identifier	M	Comp		Required
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Description: To provide the category and identifying reference information for an adjustment

This code is a composite data structure. The composite identifies the reason and identifying information for the adjustment dollar amount in PLB04.

PLB03-01	426	Adjustment Reason Code	M	ID	2/2	Required
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Description: Code indicating reason for debit or credit memo or adjustment to invoice, debit or credit memo, or payment

<u>Code</u>	<u>Name</u>
72	Authorized Return

This monetary amount is the provider refund adjustment. This adjustment acknowledges a refund received from a provider for previous overpayment. PLB03-2 should always contain an identifying reference number when the value is used. PLB04 should contain a negative value. This adjustment should always be offset by some other PLB adjustment referring to the original refund request or reason. For balancing purposes, the amount related to this adjustment reason code must be directly offset. Medicare A will provide code "PR" in PLB03-2.

CS	Adjustment
----	------------

Provide supporting identification information in PLB03-2. Medicare Part A will provide code "CA" for Manual Claim Adjustment, "AA" for Receivable Today. Medicare Part A and Part B will provide code "RI" for Reissued Check Amount in PLB03-2.

FB	Forwarding Balance
----	--------------------

Use this monetary amount for the balance forward. A negative value in PLB04 represents a balance moving forward to a future payment advice. A positive value represents a balance being applied from a previous payment advice. A reference number should be supplied in PLB03-2 for tracking purposes. Medicare Part A will provide code "BF" for negative values and "CO" for positive values in PLB03-2.

IS	Interim Settlement
----	--------------------

	<i>Use this number for the interim rate lump sum adjustment. Medicare Part A will provide code "IR" in PLB03-2.</i>
LE	Levy IRS Levy
PL	Payment Final <i>Use this number for the final settlement. Medicare Part A will provide code "FS" in PLB03-2.</i>
WO	Overpayment Recovery <i>Use this for the recovery of previous overpayment. An identifying number should be provided in PLB03-2. See the notes on codes 72 and B3 for additional information about balancing against a provider refund. Medicare Part A will provide code "OR" in PLB03-2.</i>

PLB03-02 127 **Reference Identification** O AN 1/30 Required

Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier
Industry: Provider Adjustment Identifier
*Medicare intermediaries must enter the applicable Medicare code (see Medicare A notes in PLB03-1) in positions 1-2, the Financial Control Number or other pertinent identifier in positions 3-19, and the patient's Health Insurance Claim Number (HIC) in positions 20-30 when the adjustment is related to a previously processed claim.
 Non-Medicare payers report any internally assigned reference identifier for the related adjustment.*
This is the Transaction File Name or a unique reference number for the PLB loop.

PLB04 782 **Monetary Amount** M R 1/18 Required

Description: Monetary amount
Industry: Provider Adjustment Amount
Use this monetary amount for the adjustment amount for the preceding adjustment reason.
*This amount reflects the sum of all approved amounts for services for the Billing provider ID on the 835.
 Since this is a non-payment transaction, the PLB segments are used to balance the transaction to zero. The PLB segments indirectly provide a summary report to submitters as they list each provider and the amount approved for that provider.*

Syntax Rules:

1. P0506 - If either PLB05 or PLB06 is present, then the other is required.
2. P0708 - If either PLB07 or PLB08 is present, then the other is required.
3. P0910 - If either PLB09 or PLB10 is present, then the other is required.
4. P1112 - If either PLB11 or PLB12 is present, then the other is required.
5. P1314 - If either PLB13 or PLB14 is present, then the other is required.

Semantics:

1. PLB01 is the provider number assigned by the payer.
2. PLB02 is the last day of the provider's fiscal year.
3. PLB03 is the adjustment information as defined by the payer.
4. PLB04 is the adjustment amount.
5. PLB05 is the adjustment information as defined by the payer.
6. PLB06 is the adjustment amount.
7. PLB07 is adjustment information as defined by the payer.
8. PLB08 is the adjustment amount.
9. PLB09 is adjustment information as defined by the payer.
10. PLB10 is the adjustment amount.
11. PLB11 is adjustment information as defined by the payer.

12. PLB12 is the adjustment amount.
13. PLB13 is adjustment information as defined by the payer.
14. PLB14 is the adjustment amount.

Notes:

1. Use the PLB segment to allow adjustments that are NOT specific to a particular claim or service to the amount of the actual payment. These adjustments can either decrease the payment (a positive number) or increase the payment (a negative number). Some examples of PLB adjustments are a loan repayment or a capitation payment. Multiple adjustments can be placed in one PLB segment, grouped by the provider identified in PLB01 and the period identified in PLB02.

One occurrence will be generated per unique SD/MC Provider NPI at the service level.

Example:

PLB*4814*20031231*CS:482003030101*0~

SE Transaction Set Trailer

Pos: 020	Max: 1
Summary - Mandatory	
Loop: N/A	Elements: 2

User Option (Usage): Required
Purpose: To indicate the end of the transaction set and provide the count of the transmitted segments (including the beginning (ST) and ending (SE) segments)

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
SE01	96	Number of Included Segments	M	NO	1/10	Required
<p>Description: Total number of segments included in a transaction set including ST and SE segments Industry: <i>Transaction Segment Count</i></p>						
SE02	329	Transaction Set Control Number	M	AN	4/9	Required
<p>Description: Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set <i>The Transaction Set Control Numbers in ST02 and SE02 must be identical. The originator assigns the Transaction Set Control Number, which must be unique within a functional group (GS-GE). This unique number also aids in error resolution research.</i></p>						

Comments:

- SE is the last segment of each transaction set.

Notes:
Transaction Set Trailer Counts

Example:
*SE*26*0197~*

GE

Functional Group Trailer

Pos:	Max: 1
Not Defined - Mandatory	
Loop: N/A	Elements: 2

User Option (Usage): Required**Purpose:** To indicate the end of a functional group and to provide control information**Element Summary:**

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
GE01	97	Number of Transaction Sets Included	M	N0	1/6	Required
Description: Total number of transaction sets included in the functional group or interchange (transmission) group terminated by the trailer containing this data element						
GE02	28	Group Control Number	M	N0	1/9	Required
Description: Assigned number originated and maintained by the sender <i>Same as GS06</i>						

Semantics:

1. The data interchange control number GE02 in this trailer must be identical to the same data element in the associated functional group header, GS06.

Comments:

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

Example:

```
GE*5*399876323~
```

IEA Interchange Control Trailer

Pos: Not Defined - Mandatory	Max: 1
Loop: N/A	Elements: 2

User Option (Usage): Required
Purpose: To define the end of an interchange of zero or more functional groups and interchange-related control segments

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
IEA01	I16	Number of Included Functional Groups	M	NO	1/5	Required
Description: A count of the number of functional groups included in an interchange <i>Number of functional groups included in this interchange envelope.</i>						
IEA02	I12	Interchange Control Number	M	NO	9/9	Required
Description: A control number assigned by the interchange sender <i>Same as ISA13</i>						

Example:

*IEA*1*000000636~*