

835 Health Care Claim Payment/Advice

HIPAA/V5010X221A1/835: 835 Health Care Claim Payment/Advice

Version: 1.0 Final

Company:

Blue Cross of Northeastern PA

Publication:

7/20/2011

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835

Health Care Claim Payment/Advice

Functional Group=HP

Purpose: This X12 Transaction Set contains the format and establishes the data contents of the Health Care Claim Payment/Advice Transaction Set (835) for use within the context of the Electronic Data Interchange (EDI) environment. This transaction set can be used to make a payment, send an Explanation of Benefits (EOB) remittance advice, or make a payment and send an EOB remittance advice only from a health insurer to a health care provider either directly or via a financial institution.

Heading:

| <u>Pos</u> | <u>Id</u> | <u>Segment Name</u> | <u>Req</u> | <u>Max Use</u> | <u>Repeat</u> | <u>Notes</u> |
|------------------------|-----------|-------------------------------------|------------|----------------|---------------|-----------------|
| 0100 | ST | Transaction Set Header | M | 1 | | |
| 0200 | BPR | Financial Information | M | 1 | | |
| 0400 | TRN | Reassociation Trace Number | O | 1 | | C1/0400 |
| 0600 | REF | Receiver Identification | O | 1 | | |
| 0700 | DTM | Production Date | O | 1 | | |
| LOOP ID - 1000A | | | | | 1 | C1/0800L |
| 1000 | N3 | Payer Address | O | 1 | | |
| 1100 | N4 | Payer City, State, ZIP Code | O | 1 | | |
| 1200 | REF | Additional Payer Identification | O | 4 | | |
| 1300 | PER | Payer Business Contact Information | O | 1 | | |
| 1300 | PER | Payer Technical Contact Information | O | >1 | | |
| 1300 | PER | Payer WEB Site | O | 1 | | |
| LOOP ID - 1000B | | | | | 1 | C1/0800L |
| 0800 | N1 | Payee Identification | O | 1 | | C1/0800 |
| 1000 | N3 | Payee Address | O | 1 | | |
| 1100 | N4 | Payee City, State, ZIP Code | O | 1 | | |
| 1200 | REF | Payee Additional Identification | O | >1 | | |

Detail:

| <u>Pos</u> | <u>Id</u> | <u>Segment Name</u> | <u>Req</u> | <u>Max Use</u> | <u>Repeat</u> | <u>Notes</u> |
|-----------------------|-----------|---|------------|----------------|---------------|-----------------|
| LOOP ID - 2000 | | | | | >1 | N2/0030L |
| 0030 | LX | Header Number | O | 1 | | N2/0030 |
| LOOP ID - 2100 | | | | | >1 | |
| 0100 | CLP | Claim Payment Information | M | 1 | | |
| 0200 | CAS | Claims Adjustment | O | 99 | | N2/0200 |
| 0300 | NM1 | Patient Name | M | 1 | | |
| 0300 | NM1 | Insured Name | O | 1 | | |
| 0300 | NM1 | Corrected Patient/Insured Name | O | 1 | | |
| 0300 | NM1 | Service Provider Name | O | 1 | | |
| 0300 | NM1 | Corrected Priority Payer Name | O | 1 | | |
| 0300 | NM1 | Other Subscriber Name | O | 1 | | |
| 0330 | MIA | Inpatient Adjudication Information | O | 1 | | |
| 0350 | MOA | Outpatient Adjudication Information | O | 1 | | |
| 0400 | REF | Other Claim Related Identification | O | 5 | | |
| 0500 | DTM | Statement From or To Date | O | 2 | | |
| 0500 | DTM | Coverage Expiration Date | O | 1 | | |
| 0500 | DTM | Claim Received Date | O | 1 | | |
| 0620 | AMT | Claim Supplemental Information | O | 13 | | |
| 0640 | QTY | Claim Supplemental Information Quantity | O | 14 | | |
| LOOP ID - 2110 | | | | | 999 | |
| 0700 | SVC | Service Payment Information | O | 1 | | |
| 0800 | DTM | Service Date | O | 2 | | N2/0800 |
| 0900 | CAS | Service Adjustment | O | 99 | | N2/0900 |
| 1000 | REF | Service Identification | O | 8 | | |

3/25/2011

Health Care Claim Payment/Advice - 835

| | | | | | |
|------|-----|----------------------------------|---|----|--|
| 1000 | REF | Line Item Control Number | O | 1 | |
| 1000 | REF | Rendering Provider Information | O | 10 | |
| 1000 | REF | HealthCare Policy Identification | O | 5 | |
| 1100 | AMT | Service Supplemental Amount | O | 9 | |
| 1300 | LQ | Health Care Remark Codes | O | 99 | |

Summary:

| <u>Pos</u> | <u>Id</u> | <u>Segment Name</u> | <u>Req</u> | <u>Max Use</u> | <u>Repeat</u> | <u>Notes</u> |
|------------|-----------|-------------------------|------------|----------------|---------------|--------------|
| 0100 | PLB | Provider Adjustment | O | >1 | | |
| 0200 | SE | Transaction Set Trailer | M | 1 | | |

ST Transaction Set Header

| | |
|---------------------|-------------|
| Pos: 0100 | Max: 1 |
| Heading - Mandatory | |
| Loop: N/A | Elements: 2 |

Element Summary:

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

The only valid value within this transaction set for ST01 is 835.

| <u>Ref</u> | <u>Id</u> | <u>Code</u> | <u>Name</u> | <u>Req</u> | <u>Type</u> | <u>Min/Max</u> |
|------------|-----------|-------------|----------------------------------|------------|-------------|----------------|
| ST02 | 329 | 835 | Health Care Claim Payment/Advice | M | AN | 4/9 |

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.

TR3 Example:

ST*835*1234~

BPR Financial Information

| | |
|----------------------------|---------------------|
| Pos: 0200 | Max: 1 |
| Heading - Mandatory | |
| Loop: N/A | Elements: 16 |

Element Summary:

| <u>Ref</u> | <u>Id</u> | <u>Element Name</u> | <u>Req</u> | <u>Type</u> | <u>Min/Max</u> |
|------------|-----------|---------------------------|------------|-------------|----------------|
| BPR01 | 305 | Transaction Handling Code | M | ID | 1/2 |

| <u>Code</u> | <u>Name</u> |
|-------------|---|
| H | Notification Only <i>Use this code when the actual provider payment (BPR02) is zero and the transaction is not being used for Prenotification of Future Transfers. This indicates remittance information without any associated payment.</i> |
| I | Remittance Information Only <i>Use this code to indicate to the payee that the remittance detail is moving separately from the payment.</i> |

| | | | | | |
|---|-----|-----------------|---|---|------|
| BPR02 | 782 | Monetary Amount | M | R | 1/18 |
| <i>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. Decimal elements will be limited to a maximum length of 10 characters including reported or implied places for cents (implied value of 00 after the decimal point).</i> | | | | | |

| BPR03 | 478 | Credit/Debit Flag Code | M | ID | 1/1 | | | | | | |
|--|---|------------------------|---|----|-----|-------------|-------------|---|---|---|---|
| <table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>C</td> <td>Credit <i>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.</i></td> </tr> <tr> <td>D</td> <td>Debit <i>Use this code to indicate a debit to the payer's account and a credit to the provider's account, initiated by the provider at the instruction of the payer. Extreme caution must be used when using Debit transactions. Contact your VAB for information about debit transactions. The rest of this segment and document assumes that a credit payment is being used.</i></td> </tr> </tbody> </table> | | | | | | <u>Code</u> | <u>Name</u> | C | Credit <i>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.</i> | D | Debit <i>Use this code to indicate a debit to the payer's account and a credit to the provider's account, initiated by the provider at the instruction of the payer. Extreme caution must be used when using Debit transactions. Contact your VAB for information about debit transactions. The rest of this segment and document assumes that a credit payment is being used.</i> |
| <u>Code</u> | <u>Name</u> | | | | | | | | | | |
| C | Credit <i>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.</i> | | | | | | | | | | |
| D | Debit <i>Use this code to indicate a debit to the payer's account and a credit to the provider's account, initiated by the provider at the instruction of the payer. Extreme caution must be used when using Debit transactions. Contact your VAB for information about debit transactions. The rest of this segment and document assumes that a credit payment is being used.</i> | | | | | | | | | | |

| BPR04 | 591 | Payment Method Code | M | ID | 3/3 | | | | | | | | |
|---|---|---------------------|---|----|-----|-------------|-------------|-----|---|-----|---|-----|--|
| <table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>ACH</td> <td>Automated Clearing House (ACH) <i>Use this code to move money electronically through the ACH, or to notify the provider that an ACH transfer was requested. When this code is used, see BPR05 through BPR15 for additional requirements.</i></td> </tr> <tr> <td>CHK</td> <td>Check <i>Use this code to indicate that a check has been issued for payment.</i></td> </tr> <tr> <td>NON</td> <td>Non-Payment Data <i>Use this code when the Transaction Handling Code (BPR01) is H, indicating that this is information only and no dollars are to be moved.</i></td> </tr> </tbody> </table> | | | | | | <u>Code</u> | <u>Name</u> | ACH | Automated Clearing House (ACH) <i>Use this code to move money electronically through the ACH, or to notify the provider that an ACH transfer was requested. When this code is used, see BPR05 through BPR15 for additional requirements.</i> | CHK | Check <i>Use this code to indicate that a check has been issued for payment.</i> | NON | Non-Payment Data <i>Use this code when the Transaction Handling Code (BPR01) is H, indicating that this is information only and no dollars are to be moved.</i> |
| <u>Code</u> | <u>Name</u> | | | | | | | | | | | | |
| ACH | Automated Clearing House (ACH) <i>Use this code to move money electronically through the ACH, or to notify the provider that an ACH transfer was requested. When this code is used, see BPR05 through BPR15 for additional requirements.</i> | | | | | | | | | | | | |
| CHK | Check <i>Use this code to indicate that a check has been issued for payment.</i> | | | | | | | | | | | | |
| NON | Non-Payment Data <i>Use this code when the Transaction Handling Code (BPR01) is H, indicating that this is information only and no dollars are to be moved.</i> | | | | | | | | | | | | |

| BPR05 | 812 | Payment Format Code | O | ID | 1/10 | | | | |
|---|--|---------------------|---|----|------|-------------|-------------|-----|--|
| <table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>CCP</td> <td>Cash Concentration/Disbursement plus Addenda (CCD+) (ACH) <i>Use the CCD+ format to move money and up to 80 characters of data, enough to</i></td> </tr> </tbody> </table> | | | | | | <u>Code</u> | <u>Name</u> | CCP | Cash Concentration/Disbursement plus Addenda (CCD+) (ACH) <i>Use the CCD+ format to move money and up to 80 characters of data, enough to</i> |
| <u>Code</u> | <u>Name</u> | | | | | | | | |
| CCP | Cash Concentration/Disbursement plus Addenda (CCD+) (ACH) <i>Use the CCD+ format to move money and up to 80 characters of data, enough to</i> | | | | | | | | |

reassociate dollars and data when the dollars are sent through the ACH and the data is sent on a separate path. The addenda must contain a copy of the TRN segment.

BPR06 506 (DFI) ID Number Qualifier X ID 2/2

BPR06 through BPR09 relate to the originating financial institution and the originator's account (payer).

Code **Name**
01 ABA Transit Routing Number Including Check Digits (9 digits)
The ABA transit routing number is a unique number identifying every bank in the United States.

BPR07 507 (DFI) Identification Number X AN 3/12

Use this number for the identifying number of the financial institution sending the transaction into the applicable network.

ExternalCodeList
Name: 91
Description: Canadian Financial Institution Branch and Institution Number

ExternalCodeList
Name: 60
Description: (DFI) Identification Number

ExternalCodeList
Name: 4
Description: ABA Routing Number

BPR08 569 Account Number Qualifier O ID 1/3

Use this code to identify the type of account in BPR09.

Code **Name**
DA Demand Deposit

BPR09 508 Account Number X AN 1/35

Use this number for the originator's account number at the financial institution.

BPR10 509 Originating Company Identifier O AN 10/10

BPR11 510 Originating Company Supplemental Code O AN 9/9

Use this code to further identify the payer by division or region. The element must be left justified and space filled to meet the minimum element size requirements. If used, this code must be identical to TRN04, excluding trailing spaces.

BPR12 506 (DFI) ID Number Qualifier X ID 2/2

BPR12 through BPR15 relate to the receiving financial institution and the receiver's account.

Code **Name**
01 ABA Transit Routing Number Including Check Digits (9 digits)
The ABA transit routing number is a unique number identifying every bank in the United States.

BPR13 507 (DFI) Identification Number X AN 3/12

Use this number for the identifying number of the financial institution receiving the transaction from the applicable network.

ExternalCodeList
Name: 91
Description: Canadian Financial Institution Branch and Institution Number

ExternalCodeList
Name: 60
Description: (DFI) Identification Number

ExternalCodeList

Name: 4

Description: ABA Routing Number

| | | | | | |
|-------|-----|---------------------------------|---|----|-----|
| BPR14 | 569 | Account Number Qualifier | O | ID | 1/3 |
|-------|-----|---------------------------------|---|----|-----|

Use this code to identify the type of account in BPR15.

| <u>Code</u> | <u>Name</u> |
|-------------|----------------|
| DA | Demand Deposit |
| SG | Savings |

| | | | | | |
|-------|-----|-----------------------|---|----|------|
| BPR15 | 508 | Account Number | X | AN | 1/35 |
|-------|-----|-----------------------|---|----|------|

Use this number for the receiver's account number at the financial institution.

| | | | | | |
|-------|-----|-------------|---|----|-----|
| BPR16 | 373 | Date | O | DT | 8/8 |
|-------|-----|-------------|---|----|-----|

Use this for the effective entry date. If BPR04 is ACH, this is the date that the money moves from the payer and is available to the payee. If BPR04 is CHK, this is the check issuance date. If BPR04 is FWT, this is the date that the payer anticipates the money to move. As long as the effective date is a business day, this is the settlement date. If BPR04 is 'NON', enter the date of the 835.

TR3 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.

TR3 Example:

*BPR*C*150000*C*ACH*CTX*01*999999992*DA*123456*1512345678*999999999*01*999988880*DA*98765*20030901~*

TRN Reassociation Trace Number

| | |
|--------------------|-------------|
| Pos: 0400 | Max: 1 |
| Heading - Optional | |
| Loop: N/A | Elements: 3 |

Element Summary:

| <u>Ref</u> | <u>Id</u> | <u>Element Name</u> | <u>Req</u> | <u>Type</u> | <u>Min/Max</u> |
|------------|-----------|---------------------|------------|-------------|----------------|
| TRN01 | 481 | Trace Type Code | M | ID | 1/2 |

| <u>Code</u> | <u>Name</u> |
|-------------|-----------------------------------|
| 1 | Current Transaction Trace Numbers |

| | | | | | |
|-------|-----|---------------------------------|---|----|------|
| TRN02 | 127 | Reference Identification | M | AN | 1/50 |
|-------|-----|---------------------------------|---|----|------|

This number must be unique within the sender/receiver relationship. The number is assigned by the sender. If payment is made by check, this must be the check number. If payment is made by EFT, this must be the EFT reference number. If this is a nonpayment 835, this must be a unique remittance advice identification number.

See 1.10.2.3, Reassociation of Dollars and Data, for additional information.

| | | | | | |
|-------|-----|---------------------------------------|---|----|-------|
| TRN03 | 509 | Originating Company Identifier | O | AN | 10/10 |
|-------|-----|---------------------------------------|---|----|-------|

This must be a 1 followed by the payer's EIN (or TIN).

TR3 Notes:

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

TR3 Example:

*TRN*1*12345*1512345678*999999999~*

REF Receiver Identification

| | |
|--------------------|-------------|
| Pos: 0600 | Max: 1 |
| Heading - Optional | |
| Loop: N/A | Elements: 2 |

Element Summary:

| <u>Ref</u> | <u>Id</u> | <u>Element Name</u> | <u>Req</u> | <u>Type</u> | <u>Min/Max</u> |
|------------|-----------|--|------------|-------------|----------------|
| REF01 | 128 | Reference Identification Qualifier | M | ID | 2/3 |
| | | <u>Code</u> <u>Name</u> | | | |
| | | EV Receiver Identification Number | | | |
| REF02 | 127 | Reference Identification | X | AN | 1/50 |

Situational Rule:

Required when the receiver of the transaction is other than the payee (e.g., a clearinghouse or billing service). If not required by this implementation guide, may be provided at sender's discretion, but cannot be required by the receiver.

TR3 Notes:

1. This is the business identification information for the transaction receiver. This may be different than the EDI address or identifier of the receiver. This is the initial receiver of the transaction. This information must not be updated if the transaction is routed through multiple intermediaries, such as clearinghouses, before reaching the payee.

TR3 Example:

REF*EV*1235678~

DTM Production Date

| | |
|--------------------|-------------|
| Pos: 0700 | Max: 1 |
| Heading - Optional | |
| Loop: N/A | Elements: 2 |

Element Summary:

| <u>Ref</u> | <u>Id</u> | <u>Element Name</u> | <u>Req</u> | <u>Type</u> | <u>Min/Max</u> |
|------------|-----------|-------------------------|------------|-------------|----------------|
| DTM01 | 374 | Date/Time Qualifier | M | ID | 3/3 |
| | | <u>Code</u> <u>Name</u> | | | |
| | | 405 Production | | | |
| DTM02 | 373 | Date | X | DT | 8/8 |

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

Situational Rule:

Required when the cut off date of the adjudication system remittance run is different from the date of the 835 as identified in the related GS04 element. If not required by this implementation guide, may be provided at the sender's discretion, but cannot be required by the receiver.

TR3 Notes:

1. If your adjudication cycle completed on Thursday and your 835 is produced on Saturday, you are required to populate this segment with Thursday's date.

TR3 Example:

*DTM*405*20020317~*

N3 Payer Address

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

Element Summary:

| <u>Ref</u> | <u>Id</u> | <u>Element Name</u> | <u>Req</u> | <u>Type</u> | <u>Min/Max</u> |
|------------|-----------|---------------------|------------|-------------|----------------|
| N301 | 166 | Address Information | M | AN | 1/55 |
| N302 | 166 | Address Information | O | AN | 1/55 |

TR3 Example:

N3*100 MAIN STREET~

N4 Payer City, State, ZIP Code

| | |
|--------------------|-------------|
| Pos: 1100 | Max: 1 |
| Heading - Optional | |
| Loop: 1000A | Elements: 3 |

Element Summary:

| <u>Ref</u> | <u>Id</u> | <u>Element Name</u> | <u>Req</u> | <u>Type</u> | <u>Min/Max</u> |
|------------|-----------|---|------------|-------------|----------------|
| N401 | 19 | City Name | O | AN | 2/30 |
| N402 | 156 | State or Province Code | X | ID | 2/2 |
| | | <u>ExternalCodeList</u> Name: 22C Description: States and Provinces | | | |
| N403 | 116 | Postal Code | O | ID | 3/15 |
| | | <u>ExternalCodeList</u> Name: 51 Description: ZIP Code | | | |
| | | <u>ExternalCodeList</u> Name: 932 Description: Universal Postal Codes | | | |

TR3 Example:

N4*KANSAS CITY*MO*64108~

REF Additional Payer Identification

| | |
|--------------------|-------------|
| Pos: 1200 | Max: 4 |
| Heading - Optional | |
| Loop: 1000A | Elements: 2 |

Element Summary:

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

| <u>Code</u> | <u>Name</u> |
|-------------|--|
| NF | National Association of Insurance Commissioners (NAIC) Code |
| | <i>This is the preferred value when identifying the payer.</i> |

| | | | | | |
|-------|-----|--------------------------|---|----|------|
| REF02 | 127 | Reference Identification | X | AN | 1/50 |
|-------|-----|--------------------------|---|----|------|

ExternalCodeList
Name: 245
Description: National Association of Insurance Commissioners (NAIC) Code

ExternalCodeList
Name: 121
Description: Health Industry Number

Situational Rule:

Required when additional payer identification numbers beyond those in the TRN and Payer N1 segments are needed. If not required by this implementation guide, do not send.

TR3 Notes:

1. The ID available in the TRN and N1 segments must be used before using the REF segment.

TR3 Example:

REF*2U*98765~

PER Payer Business Contact Information

| | |
|--------------------|-------------|
| Pos: 1300 | Max: 1 |
| Heading - Optional | |
| Loop: 1000A | Elements: 3 |

Element Summary:

| <u>Ref</u> | <u>Id</u> | <u>Element Name</u> | <u>Req</u> | <u>Type</u> | <u>Min/Max</u> |
|------------|-----------|--|------------|-------------|----------------|
| PER01 | 366 | Contact Function Code | M | ID | 2/2 |
| | | <u>Code</u> <u>Name</u> | | | |
| | | CX Payers Claim Office | | | |
| PER02 | 93 | Name | O | AN | 1/60 |
| | | <i>HMO Provider Service Unit 1-800-822-8752</i> | | | |
| | | <i>BlueCare PPO Provider Service Unit 1-866-262-5635</i> | | | |
| PER04 | 364 | Communication Number | X | AN | 1/256 |
| | | <i>HMO Provider Service Unit 1-800-822-8752</i> | | | |
| | | <i>BlueCare PPO Provider Service Unit 1-866-262-5635</i> | | | |

Situational Rule:

Required when there is a business contact area that would apply to this remittance and all the claims. If not required by this implementation guide, do not send.

TR3 Notes:

1. When the communication number represents a telephone number in the United States and other countries using the North American Dialing Plan (for voice, data, fax, etc.), the communication number always includes the area code and phone number using the format AAABBBCCCC. Where AAA is the area code, BBB is the telephone number prefix, and CCCC is the telephone number (e.g. (800) 555-1212 would be represented as 8005551212). The extension number, when applicable, is identified in the next element pair (Communications Number Qualifier and Communication Number) immediately after the telephone number.

TR3 Example:

*PER*CX*JOHN WAYNE*TE*8005551212~*

PER Payer Technical Contact Information

| | |
|--------------------|-------------|
| Pos: 1300 | Max: >1 |
| Heading - Optional | |
| Loop: 1000A | Elements: 4 |

Element Summary:

| <u>Ref</u> | <u>Id</u> | <u>Element Name</u> | <u>Req</u> | <u>Type</u> | <u>Min/Max</u> |
|---|-----------|----------------------------------|------------|-------------|----------------|
| PER01 | 366 | Contact Function Code | M | ID | 2/2 |
| | | <u>Code</u> <u>Name</u> | | | |
| | | BL Technical Department | | | |
| PER02 | 93 | Name | O | AN | 1/60 |
| Use this data element when the name of the individual to contact is not already defined or is different than the name within the prior name segment (e.g. N1 or NM1). | | | | | |
| PER03 | 365 | Communication Number Qualifier | X | ID | 2/2 |
| | | <u>Code</u> <u>Name</u> | | | |
| | | EM Electronic Mail | | | |
| PER04 | 364 | Communication Number | X | AN | 1/256 |
| ProviderERA@bcnepa.com | | | | | |

TR3 Notes:

1. Required to report technical contact information for this remittance advice.

TR3 Example:

PER*BL*JOHN WAYNE*TE*8005551212*EX*123~

PER Payer WEB Site

| | |
|--------------------|-------------|
| Pos: 1300 | Max: 1 |
| Heading - Optional | |
| Loop: 1000A | Elements: 3 |

Element Summary:

| <u>Ref</u> | <u>Id</u> | <u>Element Name</u> | <u>Req</u> | <u>Type</u> | <u>Min/Max</u> |
|------------|-----------|--|------------|-------------|----------------|
| PER01 | 366 | Contact Function Code | M | ID | 2/2 |
| | | <u>Code</u> <u>Name</u> | | | |
| | | IC Information Contact | | | |
| PER03 | 365 | Communication Number Qualifier | X | ID | 2/2 |
| | | <u>Code</u> <u>Name</u> | | | |
| | | UR Uniform Resource Locator (URL) | | | |
| PER04 | 364 | Communication Number | X | AN | 1/256 |

www.bcnepa.com/ohpExperMedPol.aspx for First Priority Health only.

Situational Rule:

Required when any 2110 loop Healthcare Policy REF Segment is used. If not required by this implementation guide, do not send.

TR3 Notes:

This is a direct link to the policy location of the un-secure website.

TR3 Example:

*PER*IC**UR*www.anyhealthplan.com/policies.html~*

N1 Payee Identification

| | |
|---------------------------|--------------------|
| Pos: 0800 | Max: 1 |
| Heading - Optional | |
| Loop: 1000B | Elements: 4 |

Element Summary:

| <u>Ref</u> | <u>Id</u> | <u>Element Name</u> | <u>Req</u> | <u>Type</u> | <u>Min/Max</u> |
|------------|-----------|-------------------------------|------------|-------------|----------------|
| N101 | 98 | Entity Identifier Code | M | ID | 2/3 |
| | | <u>Code</u> <u>Name</u> | | | |
| | | PE Payee | | | |
| N102 | 93 | Name | X | AN | 1/60 |
| N103 | 66 | Identification Code Qualifier | X | ID | 1/2 |

| <u>Code</u> | <u>Name</u> |
|-------------|---|
| XX | Centers for Medicare and Medicaid Services National Provider Identifier <i>This is REQUIRED when the National Provider Identifier is mandated for use and the payee is a covered health care provider under the mandate.</i> |

| | | | | | |
|------|----|---------------------|---|----|------|
| N104 | 67 | Identification Code | X | AN | 2/80 |
|------|----|---------------------|---|----|------|

Please send NPI for Facility. Please send Group or Individual (Solo Practitioner) NPI, for professional providers.

ExternalCodeList

Name: 537

Description: Centers for Medicare and Medicaid Services National Provider Identifier

ExternalCodeList

Name: 540

Description: Centers for Medicare and Medicaid Services PlanID

TR3 Notes:

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

TR3 Example:

N1*PE*MID-STATE MENTAL HOSPITAL*XX*12345678~

N3 Payee Address

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

Element Summary:

| <u>Ref</u> | <u>Id</u> | <u>Element Name</u> | <u>Req</u> | <u>Type</u> | <u>Min/Max</u> |
|------------|-----------|---------------------|------------|-------------|----------------|
| N301 | 166 | Address Information | M | AN | 1/55 |
| N302 | 166 | Address Information | O | AN | 1/55 |

Situational Rule:

Required when the sender needs to communicate the payee address to a transaction receiver, e.g., a VAN or a clearinghouse. If not required by this implementation guide, may be provided at the sender's discretion, but cannot be required by the receiver.

TR3 Example:

N3*SUITE 200*1000 MAIN STREET~

N4 Payee City, State, ZIP Code

| | |
|--------------------|-------------|
| Pos: 1100 | Max: 1 |
| Heading - Optional | |
| Loop: 1000B | Elements: 3 |

Element Summary:

| <u>Ref</u> | <u>Id</u> | <u>Element Name</u> | <u>Req</u> | <u>Type</u> | <u>Min/Max</u> |
|------------|-----------|---|------------|-------------|----------------|
| N401 | 19 | City Name | O | AN | 2/30 |
| N402 | 156 | State or Province Code | X | ID | 2/2 |
| | | <u>ExternalCodeList</u> Name: 22C Description: States and Provinces | | | |
| N403 | 116 | Postal Code | O | ID | 3/15 |
| | | <u>ExternalCodeList</u> Name: 51 Description: ZIP Code | | | |
| | | <u>ExternalCodeList</u> Name: 932 Description: Universal Postal Codes | | | |

Situational Rule:

Required when the sender needs to communicate the payee address to a transaction receiver , e.g., a VAN or the clearinghouse. If not required by this implementation guide, may be provided at the sender's discretion, but cannot be required by the receiver.

TR3 Example:

N4*KANSAS CITY*MO*64108~

REF Payee Additional Identification

| | |
|--------------------|-------------|
| Pos: 1200 | Max: >1 |
| Heading - Optional | |
| Loop: 1000B | Elements: 2 |

Element Summary:

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

Code Name

TJ Federal Taxpayer's Identification Number

This information must be in the N1 segment unless the National Provider ID or the National Health Plan Identifier was used in N103/04. For individual providers as payees, use this number to represent the Social Security Number. TJ also represents the Employer Identification Number (EIN). According to the IRS, TIN and EIN can be used interchangeably.

| | | | | | |
|-------|-----|--------------------------|---|----|------|
| REF02 | 127 | Reference Identification | X | AN | 1/50 |
|-------|-----|--------------------------|---|----|------|

Please send the Federal Tax id number.

ExternalCodeList

Name: 307

Description: National Council for Prescription Drug Programs Pharmacy Number

Situational Rule:

Required when identification of the payee is dependent upon an identification number beyond that supplied in the N1 segment. If not required by this implementation guide, may be provided at the sender's discretion, but cannot be required by the receiver.

TR3 Example:

REF*PQ*12345678~

LX

Header Number

| | |
|-------------------|-------------|
| Pos: 0030 | Max: 1 |
| Detail - Optional | |
| Loop: 2000 | Elements: 1 |

Element Summary:

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

Situational Rule:

Required when claim/service information is being provided in the transaction. If not required by this implementation guide, do not send.

TR3 Notes:

1. The purpose of LX01 is to provide an identification of a particular grouping of claims for sorting purposes.
2. In the event that claim/service information must be sorted, the LX segment must precede each series of claim level and service level segments. This number is intended to be unique within each transaction.

TR3 Example:

LX*1~
LX*110210~

CLP Claim Payment Information

| | |
|---------------------------|---------------------|
| Pos: 0100 | Max: 1 |
| Detail - Mandatory | |
| Loop: 2100 | Elements: 12 |

Element Summary:

| <u>Ref</u> | <u>Id</u> | <u>Element Name</u> | <u>Req</u> | <u>Type</u> | <u>Min/Max</u> |
|--|-----------|-------------------------------------|------------|-------------|----------------|
| CLP01 | 1028 | Claim Submitter's Identifier | M | AN | 1/38 |
| <p><i>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 a single 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).</i></p> <p><i>This data element is the primary key for posting the remittance information into the provider's database. In the case of pharmacy claims, this is the prescription reference number (field 402-02 in the NCPDP 5.1 format).</i></p> | | | | | |

| | | | | | |
|---|------|--------------------------|---|----|-----|
| CLP02 | 1029 | Claim Status Code | M | ID | 1/2 |
| <p><i>To determine the full claim status reference Claim adjustment reason codes in the CAS segment in conjunction with this claim status code.</i></p> | | | | | |

| <u>Code</u> | <u>Name</u> |
|-------------|--|
| 1 | <p>Processed as Primary</p> <p><i>Use this code if the claim was adjudicated by the current payer as primary regardless of whether any part of the claim was paid.</i></p> |
| 2 | <p>Processed as Secondary</p> <p><i>Use this code if the claim was adjudicated by the current payer as secondary regardless of whether any part of the claim was paid.</i></p> |
| 3 | <p>Processed as Tertiary</p> <p><i>Use this code if the claim was adjudicated by the current payer as tertiary (or subsequent) regardless of whether any part of the claim was paid.</i></p> |
| 4 | <p>Denied</p> <p><i>Usage of this code would apply if the Patient/Subscriber is not recognized, and the claim was not forwarded to another payer.</i></p> |
| 19 | <p>Processed as Primary, Forwarded to Additional Payer(s)</p> <p><i>When this code is used, the Crossover Carrier Name NM1 segment is required.</i></p> |
| 20 | <p>Processed as Secondary, Forwarded to Additional Payer(s)</p> <p><i>When this code is used, the Crossover Carrier Name NM1 segment is required.</i></p> |
| 21 | <p>Processed as Tertiary, Forwarded to Additional Payer(s)</p> <p><i>When this code is used, the Crossover Carrier Name NM1 segment is required.</i></p> |
| 22 | <p>Reversal of Previous Payment</p> <p><i>See section 1.10.2.8 for usage information.</i></p> |
| 23 | <p>Not Our Claim, Forwarded to Additional Payer(s)</p> <p><i>Usage of this code would apply if the patient/subscriber is not recognized, the claim was not adjudicated by the payer, but other payers are known and the claim has been forwarded to another payer. When this code is used, the Crossover Carrier Name NM1 segment is required.</i></p> |
| 25 | <p>Predetermination Pricing Only - No Payment</p> |

| | | | | | |
|--|-----|------------------------|---|---|------|
| CLP03 | 782 | Monetary Amount | M | R | 1/18 |
| <p><i>See 1.10.2.1, Balancing, in this implementation guide for additional information.</i></p> <p><i>Use this monetary amount for the submitted charges for this claim. The amount can be positive, zero or negative. An example of a situation with a negative charge is a reversal claim. See section 1.10.2.8 for additional information.</i></p> <p><i>Decimal elements will be limited to a maximum length of 10 characters including reported or implied places for cents (implied value of 00 after the decimal point). This applies to all subsequent 782 elements.</i></p> | | | | | |

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

See 1.10.2.1, *Balancing*, in this implementation guide for additional information. See section 1.10.2.9 for information about interest considerations.

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

CLP05 782 **Monetary Amount** O R 1/18

Amounts in CLP05 must have supporting adjustments reflected in CAS segments at the 2100 (CLP) or 2110 (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 is not used for reversals and corrections. See section 1.10.2.8, *Reversals and Corrections*, for additional information.

CLP06 1032 **Claim Filing Indicator Code** O ID 1/2

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 or BPR10 for all product lines or contractual relationships, the CLP06 is used by the provider as a table pointer in combination with the TRN03 or 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. For example the BL from the SBR09 in the 837 would be returned as 12, 13, 15, in the 835 when more details are known. The 837 SBR09 code CI (Commercial Insurance) is generic, if through adjudication the specific type of plan is obtained a more specific code must be returned in the 835.

The 837 and 835 transaction code lists for this element are not identical by design. There are some business differences between the two transactions. When a code from the 837 is not available in the 835 another valid code from the 835 must be assigned by the payer.

| <u>Code</u> | <u>Name</u> |
|-------------|--|
| 12 | Preferred Provider Organization (PPO) <i>This code is also used for Blue Cross/Blue Shield participating provider arrangements.</i> |
| 14 | Exclusive Provider Organization (EPO) |
| 15 | Indemnity Insurance <i>This code is also used for Blue Cross/Blue Shield non-participating provider arrangements.</i> |
| HM | Health Maintenance Organization |

CLP07 127 **Reference Identification** O AN 1/50

Use this number for the payer's internal control number. This number must apply to the entire claim.

CLP08 1331 **Facility Code Value** O AN 1/2

Since professional or dental claims can have different place of service codes for services within a single claim, default to the place of service of the first service line when the service lines are not all for the same place of service.

This number was received in CLM05-1 of the 837 claim.

CLP09 1325 **Claim Frequency Type Code** O ID 1/1

This number was received in CLM05-3 of the 837 Claim.

ExternalCodeList

Name: 235

Description: Claim Frequency Type Code

CLP11 1354 **Diagnosis Related Group (DRG) Code** O ID 1/4

ExternalCodeList

Name: 229

Description: Diagnosis Related Group Number (DRG)

| | | | | | |
|-------|-----|-----------------|---|---|------|
| CLP12 | 380 | Quantity | O | R | 1/15 |
|-------|-----|-----------------|---|---|------|

This is the adjudicated DRG Weight.

| | | | | | |
|-------|-----|------------------------------|---|---|------|
| CLP13 | 954 | Percentage as Decimal | O | R | 1/10 |
|-------|-----|------------------------------|---|---|------|

This is the adjudicated discharge fraction.

TR3 Notes:

1. For CLP segment occurrence limitations, see section 1.3.2, Other Usage Limitations.

TR3 Example:

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

CAS Claims Adjustment

| | |
|-------------------|--------------|
| Pos: 0200 | Max: 99 |
| Detail - Optional | |
| Loop: 2100 | Elements: 19 |

Element Summary:

| <u>Ref</u> | <u>Id</u> | <u>Element Name</u> | <u>Req</u> | <u>Type</u> | <u>Min/Max</u> |
|--|-----------|------------------------------------|------------|-------------|----------------|
| CAS01 | 1033 | Claim Adjustment Group Code | M | ID | 1/2 |
| <p><i>Evaluate the usage of 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 1.10.2.4, 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> | | | | | |

| <u>Code</u> | <u>Name</u> |
|-------------|---|
| CO | Contractual Obligations <i>Use this code when a joint payer/payee contractual agreement or a regulatory requirement resulted in an adjustment.</i> |
| OA | Other adjustments <i>Avoid using the Other Adjustment Group Code (OA) except for business situations described in sections 1.10.2.6, 1.10.2.7 and 1.10.2.13.</i> |
| 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 |
| <p><i>Required to report a non-zero adjustment applied at the claim level for the claim adjustment group code reported in CAS01.</i></p> | | | | | |

ExternalCodeList
Name: 139
Description: Claim Adjustment Reason Code

| | | | | | |
|--|-----|------------------------|---|---|------|
| CAS03 | 782 | Monetary Amount | M | R | 1/18 |
| <p><i>Use this monetary amount for the adjustment amount. A negative amount increases the payment, and a positive amount decreases the payment contained in CLP04.</i></p> | | | | | |

Decimal elements will be limited to a maximum length of 10 characters including reported or implied places for cents (implied value of 00 after the decimal point). This applies to all subsequent 782 elements.

| | | | | | |
|---|-----|-----------------|---|---|------|
| CAS04 | 380 | Quantity | O | R | 1/15 |
| <p><i>See section 1.10.2.4.1 for additional information.</i></p> <p><i>A positive value decreases the covered days, and a negative number increases the covered days.</i></p> | | | | | |

| | | | | | |
|-------|------|-------------------------------------|---|----|-----|
| CAS05 | 1034 | Claim Adjustment Reason Code | X | ID | 1/5 |
|-------|------|-------------------------------------|---|----|-----|

ExternalCodeList
Name: 139
Description: Claim Adjustment Reason Code

| | | | | | |
|--------------------------|-----|------------------------|---|---|------|
| CAS06 | 782 | Monetary Amount | X | R | 1/18 |
| <p><i>See CAS03.</i></p> | | | | | |

| | | | | | |
|--------------------------|-----|-----------------|---|---|------|
| CAS07 | 380 | Quantity | X | R | 1/15 |
| <p><i>See CAS04.</i></p> | | | | | |

| | | | | | |
|-------|------|-------------------------------------|---|----|-----|
| CAS08 | 1034 | Claim Adjustment Reason Code | X | ID | 1/5 |
|-------|------|-------------------------------------|---|----|-----|

ExternalCodeList

Name: 139
Description: Claim Adjustment Reason Code

CAS09 782 **Monetary Amount** X R 1/18

See CAS03.

CAS10 380 **Quantity** X R 1/15

See CAS04.

CAS11 1034 **Claim Adjustment Reason Code** X ID 1/5

ExternalCodeList

Name: 139
Description: Claim Adjustment Reason Code

CAS12 782 **Monetary Amount** X R 1/18

See CAS03.

CAS13 380 **Quantity** X R 1/15

See CAS04.

CAS14 1034 **Claim Adjustment Reason Code** X ID 1/5

ExternalCodeList

Name: 139
Description: Claim Adjustment Reason Code

CAS15 782 **Monetary Amount** X R 1/18

See CAS03.

CAS16 380 **Quantity** X R 1/15

See CAS04.

CAS17 1034 **Claim Adjustment Reason Code** X ID 1/5

ExternalCodeList

Name: 139
Description: Claim Adjustment Reason Code

CAS18 782 **Monetary Amount** X R 1/18

See CAS03.

CAS19 380 **Quantity** X R 1/15

See CAS04.

Situational Rule:

Required when dollar amounts and/or quantities are being adjusted at the claim level. If not required by this implementation guide, do not send.

TR3 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. See 1.10.2.1, Balancing, and 1.10.2.4, Claim Adjustment and Service Adjustment Segment Theory, for additional information.*
- 2. See the SVC segment note #1 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 must be the first non-zero adjustment and 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).*

TR3 Example:

CAS*PR*1*793**3*25~

CAS*CO*131*250~

NM1 Patient Name

| | |
|---------------------------|--------------------|
| Pos: 0300 | Max: 1 |
| Detail - Mandatory | |
| Loop: 2100 | Elements: 8 |

Element Summary:

| <u>Ref</u> | <u>Id</u> | <u>Element Name</u> | <u>Req</u> | <u>Type</u> | <u>Min/Max</u> |
|---|-----------|--|------------|-------------|----------------|
| NM101 | 98 | Entity Identifier Code | M | ID | 2/3 |
| | | <u>Code</u> <u>Name</u> | | | |
| | | QC Patient | | | |
| NM102 | 1065 | Entity Type Qualifier | M | ID | 1/1 |
| | | <u>Code</u> <u>Name</u> | | | |
| | | 1 Person | | | |
| NM103 | 1035 | Name Last or Organization Name | X | AN | 1/60 |
| NM104 | 1036 | Name First | O | AN | 1/35 |
| NM105 | 1037 | Name Middle | O | AN | 1/25 |
| <i>If this data element is used and contains only one character, it is assumed to represent the middle initial.</i> | | | | | |
| NM107 | 1039 | Name Suffix | O | AN | 1/10 |
| <i>An example of this is when a Junior and Senior are covered under the same subscriber.</i> | | | | | |
| NM108 | 66 | Identification Code Qualifier | X | ID | 1/2 |
| | | <u>Code</u> <u>Name</u> | | | |
| | | MI Member Identification Number | | | |
| NM109 | 67 | Identification Code | X | AN | 2/80 |

TR3 Notes:

1. Provide the patient's identification number in NM109.
2. This segment must provide the information from the original claim. For example, when the claim is submitted as an ASC X12 837 transaction, this is the 2010CA loop NM1 Patient Name Segment unless not present on the original claim, then it is 2010BA loop NM1 Subscriber name segment.
3. The Corrected Patient/Insured Name NM1 segment identifies the adjudicated Insured Name and ID information if different than what was submitted on the claim.

TR3 Example:

NM1*QC*1*SHEPHARD*SAM*O***HN*66666666A~

NM1 Insured Name

| | |
|--------------------------|--------------------|
| Pos: 0300 | Max: 1 |
| Detail - Optional | |
| Loop: 2100 | Elements: 8 |

Element Summary:

| <u>Ref</u> | <u>Id</u> | <u>Element Name</u> | <u>Req</u> | <u>Type</u> | <u>Min/Max</u> |
|------------|-----------|---|------------|-------------|----------------|
| NM101 | 98 | Entity Identifier Code | M | ID | 2/3 |
| | | <u>Code</u> <u>Name</u> | | | |
| | | IL Insured or Subscriber | | | |
| NM102 | 1065 | Entity Type Qualifier | M | ID | 1/1 |
| | | CodeList Summary (Total Codes: 16, Included: 1) | | | |
| | | <u>Code</u> <u>Name</u> | | | |
| | | 1 Person | | | |
| NM103 | 1035 | Name Last or Organization Name | X | AN | 1/60 |
| NM104 | 1036 | Name First | O | AN | 1/35 |
| NM105 | 1037 | Name Middle | O | AN | 1/25 |
| | | <i>If this data element is used and contains only one character, it is assumed to represent the middle initial.</i> | | | |
| NM107 | 1039 | Name Suffix | O | AN | 1/10 |
| | | <i>For example, use when necessary to differentiate between a Junior and Senior under the same contract.</i> | | | |
| NM108 | 66 | Identification Code Qualifier | X | ID | 1/2 |
| | | <u>Code</u> <u>Name</u> | | | |
| | | MI Member Identification Number | | | |
| | | <i>The code MI is intended to identify that the subscriber's identification number as assigned by the payer will be conveyed in NM109. Payers use different terminology to convey the same number, therefore, the 835 workgroup recommends using MI (Member Identification number) to convey the same categories of numbers as represented in the 837 IGs for the inbound claims.</i> | | | |
| NM109 | 67 | Identification Code | X | AN | 2/80 |

Situational Rule:

Required when the original claim reported the insured or subscriber (for example 837 2010BA loop Subscriber Name NM1 Segment) that is different from the patient. If not required by this implementation guide, do not send.

TR3 Notes:

1. In the case of Medicare and Medicaid, the insured patient is always the subscriber and this segment is not used.
2. This segment contains the same information as reported on the claim (for example 837 2010BA loop Subscriber Name NM1 Segment when the patient was reported in the 2010CA loop Patient Name NM1 Segment).

TR3 Example:

NM1*IL*1*SHEPARD*JESSICA****HN*999887777A~

NM1

Corrected Patient/Insured Name

| | |
|-------------------|-------------|
| Pos: 0300 | Max: 1 |
| Detail - Optional | |
| Loop: 2100 | Elements: 8 |

Element Summary:

| Ref | Id | Element Name | Req | Type | Min/Max |
|---|------|---|-----|------|---------|
| NM101 | 98 | Entity Identifier Code | M | ID | 2/3 |
| | | <u>Code</u> <u>Name</u> | | | |
| | | 74 Corrected Insured | | | |
| NM102 | 1065 | Entity Type Qualifier | M | ID | 1/1 |
| | | <u>Code</u> <u>Name</u> | | | |
| | | 1 Person | | | |
| NM103 | 1035 | Name Last or Organization Name | X | AN | 1/60 |
| NM104 | 1036 | Name First | O | AN | 1/35 |
| NM105 | 1037 | Name Middle | O | AN | 1/25 |
| <i>If this data element is used and contains only one character, it is assumed to represent the middle initial.</i> | | | | | |
| NM107 | 1039 | Name Suffix | O | AN | 1/10 |
| NM108 | 66 | Identification Code Qualifier | X | ID | 1/2 |
| | | <u>Code</u> <u>Name</u> | | | |
| | | C Insured's Changed Unique Identification Number | | | |
| NM109 | 67 | Identification Code | X | AN | 2/80 |

Situational Rule:

Required when needed to provide corrected information about the patient or insured. If not required by this implementation guide, do not send.

TR3 Notes:

1. Since 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.

TR3 Example:

NM1*74*1*SHEPARD*SAMUEL*O***C*66666666A~

NM1 Service Provider Name

| | |
|-------------------|-------------|
| Pos: 0300 | Max: 1 |
| Detail - Optional | |
| Loop: 2100 | Elements: 7 |

Element Summary:

| Ref | Id | Element Name | Req | Type | Min/Max |
|---|------|--|-----|------|---------|
| NM101 | 98 | Entity Identifier Code | M | ID | 2/3 |
| | | <u>Code</u> <u>Name</u> | | | |
| | | 82 Rendering Provider | | | |
| NM102 | 1065 | Entity Type Qualifier | M | ID | 1/1 |
| | | <u>Code</u> <u>Name</u> | | | |
| | | 1 Person | | | |
| | | 2 Non-Person Entity | | | |
| NM103 | 1035 | Name Last or Organization Name | X | AN | 1/60 |
| NM104 | 1036 | Name First | O | AN | 1/35 |
| NM105 | 1037 | Name Middle | O | AN | 1/25 |
| <i>If this data element is used and contains only one character, it represents the middle initial.</i> | | | | | |
| NM108 | 66 | Identification Code Qualifier | X | ID | 1/2 |
| | | <u>Code</u> <u>Name</u> | | | |
| | | XX Centers for Medicare and Medicaid Services National Provider Identifier | | | |
| <i>Required value if the National Provider ID is mandated for use and the provider is a covered health care provider under the mandate. Otherwise, one of the other listed codes may be used.</i> | | | | | |
| NM109 | 67 | Identification Code | X | AN | 2/80 |
| | | <u>ExternalCodeList</u> | | | |
| | | Name: 537 | | | |
| | | Description: Centers for Medicare and Medicaid Services National Provider Identifier | | | |

Situational Rule:

Required when the rendering provider is different from the payee. If not required by this implementation guide, do not send.

TR3 Notes:

- 1. This segment provides information about the rendering provider. An identification number is provided in NM109.*
- 2. This information is provided to facilitate identification of the claim within a payee's system. Other providers (e.g., Referring provider, supervising provider) related to the claim but not directly related to the payment are not supported and are not necessary for claim identification.*

TR3 Example:

NM1*82*2*****XX*12345678~

NM1 Corrected Priority Payer Name

| | |
|-------------------|-------------|
| Pos: 0300 | Max: 1 |
| Detail - Optional | |
| Loop: 2100 | Elements: 5 |

Element Summary:

| <u>Ref</u> | <u>Id</u> | <u>Element Name</u> | <u>Req</u> | <u>Type</u> | <u>Min/Max</u> |
|------------|-----------|---|------------|-------------|----------------|
| NM101 | 98 | Entity Identifier Code | M | ID | 2/3 |
| | | <u>Code</u> <u>Name</u> | | | |
| | | PR Payer | | | |
| NM102 | 1065 | Entity Type Qualifier | M | ID | 1/1 |
| | | <u>Code</u> <u>Name</u> | | | |
| | | 2 Non-Person Entity | | | |
| NM103 | 1035 | Name Last or Organization Name | X | AN | 1/60 |
| NM108 | 66 | Identification Code Qualifier | X | ID | 1/2 |
| | | <u>Code</u> <u>Name</u> | | | |
| | | AD Blue Cross Blue Shield Association Plan Code | | | |
| | | FI Federal Taxpayer's Identification Number | | | |
| | | NI National Association of Insurance Commissioners (NAIC) Identification | | | |
| | | PI Payor Identification | | | |
| NM109 | 67 | Identification Code | X | AN | 2/80 |
| | | <u>ExternalCodeList</u> | | | |
| | | Name: 245 | | | |
| | | Description: National Association of Insurance Commissioners (NAIC) Code | | | |
| | | <u>ExternalCodeList</u> | | | |
| | | Name: 540 | | | |
| | | Description: Centers for Medicare and Medicaid Services PlanID | | | |

Situational Rule:

Required when current payer believes that another payer has priority for making a payment and the claim is not being automatically transferred to that payer. If not required by this implementation guide, do not send.

TR3 Notes:

1. Provide any reference numbers in NM109. Use of this segment identifies the priority payer. Do not use this segment when the Crossover Carrier NM1 segment is used.

TR3 Example:

NM1*PR*2*ACME INSURANCE*****XV*123456789~

NM1 Other Subscriber Name

| | |
|-------------------|-------------|
| Pos: 0300 | Max: 1 |
| Detail - Optional | |
| Loop: 2100 | Elements: 7 |

Element Summary:

| Ref | Id | Element Name | Req | Type | Min/Max |
|--|------|--|-----|------|---------|
| NM101 | 98 | Entity Identifier Code | M | ID | 2/3 |
| | | <u>Code</u> <u>Name</u> | | | |
| | | GB Other Insured | | | |
| NM102 | 1065 | Entity Type Qualifier | M | ID | 1/1 |
| | | <u>Code</u> <u>Name</u> | | | |
| | | 1 Person | | | |
| | | 2 Non-Person Entity | | | |
| NM103 | 1035 | Name Last or Organization Name | X | AN | 1/60 |
| <i>At least one of NM103 or NM109 must be present.</i> | | | | | |
| NM104 | 1036 | Name First | O | AN | 1/35 |
| NM107 | 1039 | Name Suffix | O | AN | 1/10 |
| NM108 | 66 | Identification Code Qualifier | X | ID | 1/2 |
| | | <u>Code</u> <u>Name</u> | | | |
| | | FI Federal Taxpayer's Identification Number | | | |
| | | <i>Not Used when NM102=1.</i> | | | |
| | | MI Member Identification Number | | | |
| | | <i>Use this code when supplying the Payer's ID number for the subscriber in NM109.</i> | | | |
| NM109 | 67 | Identification Code | X | AN | 2/80 |
| <i>At least one of NM103 or NM109 must be present.</i> | | | | | |

Situational Rule:

Required when a corrected priority payer has been identified in another NM1 segment AND the name or ID of the other subscriber is known. If not required by this implementation guide, do not send.

TR3 Notes:

1. This is the name and ID number of the other subscriber when a corrected priority payer has been identified. When used, either the name or ID must be supplied.

TR3 Example:

*NM1*GB*Smith*Jane~*

MIA Inpatient Adjudication Information

| | |
|-------------------|-------------|
| Pos: 0330 | Max: 1 |
| Detail - Optional | |
| Loop: 2100 | Elements: 6 |

Element Summary:

| <u>Ref</u> | <u>Id</u> | <u>Element Name</u> | <u>Req</u> | <u>Type</u> | <u>Min/Max</u> |
|---|-----------|---------------------------------|------------|-------------|----------------|
| MIA01 | 380 | Quantity | M | R | 1/15 |
| <i>Implementers utilizing the MIA segment always transmit the number zero. See the QTY segment at the claim level for covered days or visits count.</i> | | | | | |
| MIA05 | 127 | Reference Identification | O | AN | 1/50 |
| ExternalCodeList Name: 411 Description: Remittance Advice Remark Codes | | | | | |
| MIA20 | 127 | Reference Identification | O | AN | 1/50 |
| ExternalCodeList Name: 411 Description: Remittance Advice Remark Codes | | | | | |
| MIA21 | 127 | Reference Identification | O | AN | 1/50 |
| ExternalCodeList Name: 411 Description: Remittance Advice Remark Codes | | | | | |
| MIA22 | 127 | Reference Identification | O | AN | 1/50 |
| ExternalCodeList Name: 411 Description: Remittance Advice Remark Codes | | | | | |
| MIA23 | 127 | Reference Identification | O | AN | 1/50 |
| ExternalCodeList Name: 411 Description: Remittance Advice Remark Codes | | | | | |

Situational Rule:

Required for all inpatient claims when there is a need to report Remittance Advice Remark Codes at the claim level or, the claim is paid by Medicare or Medicaid under the Prospective Payment System (PPS). If not required by this implementation guide, do not send.

TR3 Notes:

1. When used outside of the Medicare and Medicaid community only MIA01, 05, 20, 21, 22 and 23 may be used.
2. Either MIA or MOA may appear, but not both.
3. This segment must not be used for covered days or lifetime reserve days. For covered or lifetime reserve days, use the Supplemental Claim Information Quantities Segment in the Claim Payment Loop.
4. All situational quantities and/or monetary amounts in this segment are required when the value of the item is different than zero.

TR3 Example:

MIA*0***138018.4~

MOA Outpatient Adjudication Information

| | |
|-------------------|-------------|
| Pos: 0350 | Max: 1 |
| Detail - Optional | |
| Loop: 2100 | Elements: 5 |

Element Summary:

| <u>Ref</u> | <u>Id</u> | <u>Element Name</u> | <u>Req</u> | <u>Type</u> | <u>Min/Max</u> |
|------------|-----------|---|------------|-------------|----------------|
| MOA03 | 127 | Reference Identification | O | AN | 1/50 |
| | | <u>ExternalCodeList</u> Name: 411 Description: Remittance Advice Remark Codes | | | |
| MOA04 | 127 | Reference Identification | O | AN | 1/50 |
| | | <u>ExternalCodeList</u> Name: 411 Description: Remittance Advice Remark Codes | | | |
| MOA05 | 127 | Reference Identification | O | AN | 1/50 |
| | | <u>ExternalCodeList</u> Name: 411 Description: Remittance Advice Remark Codes | | | |
| MOA06 | 127 | Reference Identification | O | AN | 1/50 |
| | | <u>ExternalCodeList</u> Name: 411 Description: Remittance Advice Remark Codes | | | |
| MOA07 | 127 | Reference Identification | O | AN | 1/50 |
| | | <u>ExternalCodeList</u> Name: 411 Description: Remittance Advice Remark Codes | | | |

Situational Rule:

Required for outpatient/professional claims where there is a need to report a Remittance Advice Remark Code at the claim level or when the payer is Medicare or Medicaid and MOA01, 02, 08 or 09 are non-zero. If not required by this implementation guide, do not send.

TR3 Notes:

1. Either MIA or MOA may appear, but not both.
2. All situational quantities and/or monetary amounts in this segment are required when the value of the item is different than zero.

TR3 Example:

MOA***MA01~

REF Other Claim Related Identification

| | |
|-------------------|-------------|
| Pos: 0400 | Max: 5 |
| Detail - Optional | |
| Loop: 2100 | Elements: 2 |

Element Summary:

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

| <u>Code</u> | <u>Name</u> |
|-------------|--|
| 1L | Group or Policy Number <i>Use this code when conveying the Group Number in REF02.</i> |
| CE | Class of Contract Code <i>See section 1.10.2.15 for information on the use of Class of Contract Code.</i> |
| EA | Medical Record Identification Number |
| F8 | Original Reference Number <i>When this is a correction claim and CLP07 does not equal the CLP07 value from the original claim payment, one iteration of this REF segment using this qualifier is REQUIRED to identify the original claim CLP07 value in REF02. See section 1.10.2.8, Reversals and Corrections, for additional information.</i> |
| G1 | Prior Authorization Number <i>Use this qualifier when reporting the number received with the original claim as a preauthorization number (in the 837 that was at table 2, position 180, REF segment, using the same qualifier of G1).</i> |

| | | | | | |
|-------|-----|--------------------------|---|----|------|
| REF02 | 127 | Reference Identification | X | AN | 1/50 |
|-------|-----|--------------------------|---|----|------|

Situational Rule:

Required when additional reference numbers specific to the claim in the CLP segment are provided to identify information used in the process of adjudicating this claim. If not required by this implementation guide, do not send.

TR3 Example:

REF*EA*666123~

DTM Statement From or To Date

| | |
|-------------------|-------------|
| Pos: 0500 | Max: 2 |
| Detail - Optional | |
| Loop: 2100 | Elements: 2 |

Element Summary:

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

| <u>Code</u> | <u>Name</u> |
|-------------|---|
| 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 is 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 | X | DT | 8/8 |
|-------|-----|-------------|---|----|-----|

Situational Rule:

Required when the "Statement From or To Dates" are not supplied at the service (2110 loop) level. If not required by this implementation guide, may be provided at senders discretion, but cannot be required by the receiver.

TR3 Notes:

1. 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 if used they override the claim dates for individual service lines.
4. For retail pharmacy claims, the Claim Statement Period Start Date is equivalent to the prescription filled date.
5. For predeterminations, where there is no service date, the value of DTM02 must be 19000101. Use only when the CLP02 value is 25 - Predetermination Pricing Only - No Payment.
6. When payment is being made in advance of services, the use of future dates is allowed.

TR3 Example:

DTM*233*20020916~

DTM Coverage Expiration Date

| | |
|-------------------|-------------|
| Pos: 0500 | Max: 1 |
| Detail - Optional | |
| Loop: 2100 | Elements: 2 |

Element Summary:

| <u>Ref</u> | <u>Id</u> | <u>Element Name</u> | <u>Req</u> | <u>Type</u> | <u>Min/Max</u> |
|------------|-----------|---------------------|------------|-------------|----------------|
| DTM01 | 374 | Date/Time Qualifier | M | ID | 3/3 |
| | | <u>Code</u> | | | |
| | | 036 | | | |
| | | <u>Name</u> | | | |
| | | Expiration | | | |
| DTM02 | 373 | Date | X | DT | 8/8 |

This is the expiration date of the patient's coverage.

Situational Rule:

Required when payment is rejected because of the expiration of coverage. If not required by this implementation guide, do not send.

TR3 Example:

*DTM*036*20011001~*

DTM Claim Received Date

| | |
|-------------------|-------------|
| Pos: 0500 | Max: 1 |
| Detail - Optional | |
| Loop: 2100 | Elements: 2 |

Element Summary:

| <u>Ref</u> | <u>Id</u> | <u>Element Name</u> | <u>Req</u> | <u>Type</u> | <u>Min/Max</u> |
|------------|-----------|---------------------|------------|-------------|----------------|
| DTM01 | 374 | Date/Time Qualifier | M | ID | 3/3 |
| | | <u>Code</u> | | | |
| | | 050 | | | |
| | | <u>Name</u> | | | |
| | | Received | | | |
| DTM02 | 373 | Date | X | DT | 8/8 |

This is the date that the claim was received by the payer.

Situational Rule:

Required whenever state or federal regulations or the provider contract mandate interest payment or prompt payment discounts based upon the receipt date of the claim by the payer. If not required by this implementation guide, may be provided at sender's discretion, but cannot be required by the receiver.

TR3 Example:

DTM*050*20011124~

AMT

Claim Supplemental Information

| | |
|-------------------|-------------|
| Pos: 0620 | Max: 13 |
| Detail - Optional | |
| Loop: 2100 | Elements: 2 |

Element Summary:

| <u>Ref</u> | <u>Id</u> | <u>Element Name</u> | <u>Req</u> | <u>Type</u> | <u>Min/Max</u> |
|------------|-----------|-----------------------|------------|-------------|----------------|
| AMT01 | 522 | Amount Qualifier Code | M | ID | 1/3 |

| <u>Code</u> | <u>Name</u> |
|-------------|-------------|
| I | Interest |

See section 1.10.2.9 for additional information.

| | |
|----|---------------------|
| F5 | Patient Amount Paid |
|----|---------------------|

Use this monetary amount for the amount the patient has already paid.

| | | | | | |
|-------|-----|-----------------|---|---|------|
| AMT02 | 782 | Monetary Amount | M | R | 1/18 |
|-------|-----|-----------------|---|---|------|

Decimal elements will be limited to a maximum length of 10 characters including reported or implied places for cents (implied value of 00 after the decimal point). This applies to all subsequent 782 elements.

Situational Rule:

Required when the value of any specific amount identified by the AMT01 qualifier is non-zero. If not required by this implementation guide, do not send.

TR3 Notes:

- 1. Use this segment to convey information only. It is not part of the financial balancing of the 835.*
- 2. Send/receive one AMT for each applicable non-zero value. Do not report any zero values.*

TR3 Example:

*AMT*T*49~*

QTY

Claim Supplemental Information Quantity

| | |
|-------------------|-------------|
| Pos: 0640 | Max: 14 |
| Detail - Optional | |
| Loop: 2100 | Elements: 2 |

Element Summary:

| <u>Ref</u> | <u>Id</u> | <u>Element Name</u> | <u>Req</u> | <u>Type</u> | <u>Min/Max</u> |
|------------|-----------|-------------------------|------------|-------------|----------------|
| QTY01 | 673 | Quantity Qualifier | M | ID | 2/2 |
| | | <u>Code</u> | | | |
| | | <u>Name</u> | | | |
| | | CA | | | |
| | | Covered - Actual | | | |
| | | CD | | | |
| | | Co-insured - Actual | | | |
| | | NE | | | |
| | | Non-Covered - Estimated | | | |
| | | VS | | | |
| | | Visits | | | |
| QTY02 | 380 | Quantity | X | R | 1/15 |

Situational Rule:

Required when the value of a specific quantity identified by the QTY01 qualifier is non-zero. If not required by this implementation guide, do not send.

TR3 Notes:

1. Use this segment to convey information only. It is not part of the financial balancing of the 835.
2. Send one QTY for each non-zero value. Do not report any zero values.

TR3 Example:

QTY*ZK*3~

SVC Service Payment Information

| | |
|-------------------|-------------|
| Pos: 0700 | Max: 1 |
| Detail - Optional | |
| Loop: 2110 | Elements: 7 |

Element Summary:

| <u>Ref</u> | <u>Id</u> | <u>Element Name</u> | <u>Req</u> | <u>Type</u> | <u>Min/Max</u> |
|--|-----------|---|------------|-------------|----------------|
| SVC01 | C003 | Composite Medical Procedure Identifier | M | Comp | |
| <i>This is the adjudicated medical procedure information.</i> | | | | | |
| <i>This code is a composite data structure.</i> | | | | | |
| SVC01-01 | 235 | Product/Service ID Qualifier | M | ID | 2/2 |
| <i>The value in SVC01-1 qualifies the values in SVC01-2, SVC01-3, SVC01-4, SVC01-5, SVC01-6 and SVC01-7.</i> | | | | | |

| <u>Code</u> | <u>Name</u> |
|---|--|
| AD | American Dental Association Codes |
| 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> | |
| HP | Health Insurance Prospective Payment System (HIPPS) Skilled Nursing Facility Rate Code |
| <i>Medicare uses this code to reflect the Skilled Nursing Facility Group as well as the Home Health Agency Outpatient Prospective Payment System.</i> | |
| NU | National Uniform Billing Committee (NUBC) UB92 Codes |

| | | | | | |
|--|-----|---------------------------|---|----|------|
| SVC01-02 | 234 | Product/Service ID | M | AN | 1/48 |
| <i>This is the adjudicated procedure code or revenue code as identified by the qualifier in SVC01-1.</i> | | | | | |

- ExternalCodeList**
Name: 576
Description: Workers Compensation Specific Procedure and Supply Codes
- ExternalCodeList**
Name: 843
Description: Complimentary, Alternative, or Holistic Procedure Codes
- ExternalCodeList**
Name: 41
Description: Universal Product Code
- ExternalCodeList**
Name: 132
Description: National Uniform Billing Committee (NUBC) 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: 716
Description: Health Insurance Prospective Payment System (HIPPS) Rate Code for Skilled Nursing Facilities
- ExternalCodeList**
Name: 130
Description: Healthcare Common Procedural Coding System
- ExternalCodeList**
Name: 135

Description: American Dental Association
 SVC01-03 1339 **Procedure Modifier** O AN 2/2

ExternalCodeList

Name: 843

Description: Complimentary, Alternative, or Holistic Procedure Codes

ExternalCodeList

Name: 513

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

ExternalCodeList

Name: 130

Description: Healthcare Common Procedural Coding System

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

ExternalCodeList

Name: 843

Description: Complimentary, Alternative, or Holistic Procedure Codes

ExternalCodeList

Name: 513

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

ExternalCodeList

Name: 130

Description: Healthcare Common Procedural Coding System

SVC01-05 1339 **Procedure Modifier** O AN 2/2

ExternalCodeList

Name: 843

Description: Complimentary, Alternative, or Holistic Procedure Codes

ExternalCodeList

Name: 513

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

ExternalCodeList

Name: 130

Description: Healthcare Common Procedural Coding System

SVC01-06 1339 **Procedure Modifier** O AN 2/2

ExternalCodeList

Name: 843

Description: Complimentary, Alternative, or Holistic Procedure Codes

ExternalCodeList

Name: 513

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

ExternalCodeList

Name: 130

Description: Healthcare Common Procedural Coding System

SVC02 782 **Monetary Amount** M R 1/18

Use this monetary amount for the submitted service charge amount.

Decimal elements will be limited to a maximum length of 10 characters including reported or implied places for cents (implied value of 00 after the decimal point). This applies to all subsequent 782 elements.

SVC03 782 **Monetary Amount** O R 1/18

Use this number for the service amount paid. The value in SVC03 must equal the value in SVC02 minus all monetary amounts in the subsequent CAS segments of this loop. See 1.10.2.1, Balancing, for additional information.

SVC04 234 **Product/Service ID** O AN 1/48

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

If not present, the value is assumed to be one.

SVC06 C003 **Composite Medical Procedure Identifier** O Comp

This code is a composite data structure.

This is the Submitted Procedure Code information.

SVC06-01 235 **Product/Service ID Qualifier** M ID 2/2

The value in SVC06-1 qualifies the value in SVC06-2, SVC06-3, SVC06-4, SVC06-5, SVC06-6 and SVC06-7.

Code

Name

AD American Dental Association Codes

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.

HP Health Insurance Prospective Payment System (HIPPS) Skilled Nursing Facility Rate Code

Medicare uses this code to reflect the Skilled Nursing Facility Group as well as the Home Health Agency Outpatient Prospective Payment System.

NU National Uniform Billing Committee (NUBC) UB92 Codes

SVC06-02 234 **Product/Service ID** M AN 1/48

ExternalCodeList

Name: 843

Description: Complimentary, Alternative, or Holistic Procedure Codes

ExternalCodeList

Name: 576

Description: Workers Compensation Specific Procedure and Supply Codes

ExternalCodeList

Name: 132

Description: National Uniform Billing Committee (NUBC) 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: 716

Description: Health Insurance Prospective Payment System (HIPPS) Rate Code for Skilled Nursing Facilities

ExternalCodeList

Name: 130

Description: Healthcare Common Procedural Coding System

ExternalCodeList

Name: 135

Description: American Dental Association

| | | | | | |
|----------|------|--|---|----|------|
| SVC06-03 | 1339 | Procedure Modifier | O | AN | 2/2 |
| | | <u>ExternalCodeList</u> Name: 843 Description: Complimentary, Alternative, or Holistic Procedure Codes <u>ExternalCodeList</u> Name: 513 Description: Home Infusion EDI Coalition (HIEC) Product/Service Code List <u>ExternalCodeList</u> Name: 130 Description: Healthcare Common Procedural Coding System | | | |
| SVC06-04 | 1339 | Procedure Modifier | O | AN | 2/2 |
| | | <u>ExternalCodeList</u> Name: 843 Description: Complimentary, Alternative, or Holistic Procedure Codes <u>ExternalCodeList</u> Name: 513 Description: Home Infusion EDI Coalition (HIEC) Product/Service Code List <u>ExternalCodeList</u> Name: 130 Description: Healthcare Common Procedural Coding System | | | |
| SVC06-05 | 1339 | Procedure Modifier | O | AN | 2/2 |
| | | <u>ExternalCodeList</u> Name: 843 Description: Complimentary, Alternative, or Holistic Procedure Codes <u>ExternalCodeList</u> Name: 513 Description: Home Infusion EDI Coalition (HIEC) Product/Service Code List <u>ExternalCodeList</u> Name: 130 Description: Healthcare Common Procedural Coding System | | | |
| SVC06-06 | 1339 | Procedure Modifier | O | AN | 2/2 |
| | | <u>ExternalCodeList</u> Name: 843 Description: Complimentary, Alternative, or Holistic Procedure Codes <u>ExternalCodeList</u> Name: 513 Description: Home Infusion EDI Coalition (HIEC) Product/Service Code List <u>ExternalCodeList</u> Name: 130 Description: Healthcare Common Procedural Coding System | | | |
| SVC06-07 | 352 | Description | O | AN | 1/80 |
| SVC07 | 380 | Quantity | O | R | 1/15 |

Situational Rule:

Required for all service lines in a professional or outpatient claim priced at the service line level or whenever payment for any service line of the claim is different than the original submitted charges due to service line specific adjustments (excluding cases where the only service specific adjustment is for room per diem). If not required by this implementation guide, do not send.

TR3 Notes:

1. See section 1.10.2.1.1 (Service Line Balancing) for additional information.
2. The exception to the situational rule 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~). See section 1.10.2.4.1 for additional information.*

3. See 1.10.2.6, Procedure Code Bundling and Unbundling, and section 1.10.2.1.1, Service Line Balancing, for important SVC segment usage information.

TR3 Example:

SVC*HC:99214*100*80~

DTM Service Date

| | |
|-------------------|-------------|
| Pos: 0800 | Max: 2 |
| Detail - Optional | |
| Loop: 2110 | Elements: 2 |

Element Summary:

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

| <u>Code</u> | <u>Name</u> |
|-------------|---|
| 150 | Service Period Start <i>This qualifier is required for reporting the beginning of multi-day services. If not required by this implementation guide, do not send.</i> |
| 151 | Service Period End <i>This qualifier is required for reporting the end of multi-day services. If not required by this implementation guide, do not send.</i> |
| 472 | Service <i>This qualifier is required to indicate a single day service. If not required by this implementation guide, do not send.</i> |

| | | | | | |
|-------|-----|------|---|----|-----|
| DTM02 | 373 | Date | X | DT | 8/8 |
|-------|-----|------|---|----|-----|

Situational Rule:

Required when claim level Statement From or Through Dates are not supplied or the service dates are not the same as reported at the claim level. If not required by this implementation guide, may be provided at sender's discretion, but cannot be required by the receiver.

TR3 Notes:

1. Dates at the service line level apply only to the service line where they appear.
2. If used for inpatient claims and no service date was provided on the claim then report the through date from the claim level.
3. When claim dates are not provided, service dates are required for every service line.
4. When claim dates are provided, service dates are not required, but if used they override the claim dates for individual service lines.
5. For retail pharmacy claims, the service date is equivalent to the prescription filled date.
6. For predeterminations, where there is no service date, the value of DTM02 must be 19000101. Use only when the CLP02 value is 25 - Predetermination Pricing Only - No Payment.
7. When payment is being made in advance of services, the use of future dates is allowed.

TR3 Example:

DTM*472*20021031~

CAS Service Adjustment

| | |
|--------------------------|---------------------|
| Pos: 0900 | Max: 99 |
| Detail - Optional | |
| Loop: 2110 | Elements: 19 |

Element Summary:

| <u>Ref</u> | <u>Id</u> | <u>Element Name</u> | <u>Req</u> | <u>Type</u> | <u>Min/Max</u> |
|--|-----------|------------------------------------|------------|-------------|----------------|
| CAS01 | 1033 | Claim Adjustment Group Code | M | ID | 1/2 |
| <p><i>Evaluate the usage of group codes in CAS01 based on the following order for their applicability to a set of one or more adjustments: PR, CO, PI, OA. See 1.10.2.4, Claim Adjustment and Service Adjustment Segment Theory, for additional information.</i></p> <p><i>(Note: This does not mean that the adjustments must be reported in this order.)</i></p> | | | | | |

| <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> |
| OA | Other adjustments <i>Avoid using the Other Adjustment Group Code (OA) except for business situations described in sections 1.10.2.6, 1.10.2.7 and 1.10.2.13.</i> |
| 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 |
| <p><i>Required to report a non-zero adjustment applied at the service level for the claim adjustment group code reported in CAS01.</i></p> | | | | | |

ExternalCodeList
Name: 139
Description: Claim Adjustment Reason Code

| | | | | | |
|--|-----|------------------------|---|---|------|
| CAS03 | 782 | Monetary Amount | M | R | 1/18 |
| <p><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> | | | | | |

Decimal elements will be limited to a maximum length of 10 characters including reported or implied places for cents (implied value of 00 after the decimal point). This applies to all subsequent 782 elements.

| | | | | | |
|--|-----|-----------------|---|---|------|
| CAS04 | 380 | Quantity | O | R | 1/15 |
| <p><i>A positive number decreases paid units, and a negative value increases paid units.</i></p> | | | | | |

| | | | | | |
|--------------------------|------|-------------------------------------|---|----|-----|
| CAS05 | 1034 | Claim Adjustment Reason Code | X | ID | 1/5 |
| <p><i>See CAS02.</i></p> | | | | | |

ExternalCodeList
Name: 139
Description: Claim Adjustment Reason Code

| | | | | | |
|--------------------------|-----|------------------------|---|---|------|
| CAS06 | 782 | Monetary Amount | X | R | 1/18 |
| <p><i>See CAS03.</i></p> | | | | | |

| | | | | | |
|--------------------------|-----|-----------------|---|---|------|
| CAS07 | 380 | Quantity | X | R | 1/15 |
| <p><i>See CAS04.</i></p> | | | | | |

| | | | | | |
|--------------------------|------|-------------------------------------|---|----|-----|
| CAS08 | 1034 | Claim Adjustment Reason Code | X | ID | 1/5 |
| <p><i>See CAS02.</i></p> | | | | | |

ExternalCodeList**Name:** 139**Description:** Claim Adjustment Reason Code

| | | | | | |
|-------|-----|------------------------|---|---|------|
| CAS09 | 782 | Monetary Amount | X | R | 1/18 |
|-------|-----|------------------------|---|---|------|

See CAS03.

| | | | | | |
|-------|-----|-----------------|---|---|------|
| CAS10 | 380 | Quantity | X | R | 1/15 |
|-------|-----|-----------------|---|---|------|

See CAS04.

| | | | | | |
|-------|------|-------------------------------------|---|----|-----|
| CAS11 | 1034 | Claim Adjustment Reason Code | X | ID | 1/5 |
|-------|------|-------------------------------------|---|----|-----|

*See CAS02.***ExternalCodeList****Name:** 139**Description:** Claim Adjustment Reason Code

| | | | | | |
|-------|-----|------------------------|---|---|------|
| CAS12 | 782 | Monetary Amount | X | R | 1/18 |
|-------|-----|------------------------|---|---|------|

See CAS03.

| | | | | | |
|-------|-----|-----------------|---|---|------|
| CAS13 | 380 | Quantity | X | R | 1/15 |
|-------|-----|-----------------|---|---|------|

See CAS04.

| | | | | | |
|-------|------|-------------------------------------|---|----|-----|
| CAS14 | 1034 | Claim Adjustment Reason Code | X | ID | 1/5 |
|-------|------|-------------------------------------|---|----|-----|

*See CAS02.***ExternalCodeList****Name:** 139**Description:** Claim Adjustment Reason Code

| | | | | | |
|-------|-----|------------------------|---|---|------|
| CAS15 | 782 | Monetary Amount | X | R | 1/18 |
|-------|-----|------------------------|---|---|------|

See CAS03.

| | | | | | |
|-------|-----|-----------------|---|---|------|
| CAS16 | 380 | Quantity | X | R | 1/15 |
|-------|-----|-----------------|---|---|------|

See CAS04.

| | | | | | |
|-------|------|-------------------------------------|---|----|-----|
| CAS17 | 1034 | Claim Adjustment Reason Code | X | ID | 1/5 |
|-------|------|-------------------------------------|---|----|-----|

*See CAS02.***ExternalCodeList****Name:** 139**Description:** Claim Adjustment Reason Code

| | | | | | |
|-------|-----|------------------------|---|---|------|
| CAS18 | 782 | Monetary Amount | X | R | 1/18 |
|-------|-----|------------------------|---|---|------|

See CAS03.

| | | | | | |
|-------|-----|-----------------|---|---|------|
| CAS19 | 380 | Quantity | X | R | 1/15 |
|-------|-----|-----------------|---|---|------|

*See CAS04.***Situational Rule:**

Required when dollar amounts are being adjusted specific to the service or when the paid amount for a service line (SVC03) is different than the original submitted charge amount for the service (SVC02). If not required by this implementation guide, do not send.

TR3 Notes:

- 1. 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. See sections 1.10.2.1, Balancing, and 1.10.2.4, Claim Adjustment and Service adjustment Segment Theory, for additional information.*
- 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).*

TR3 Example:

*CAS*PR*1*793**3*25~*

*CAS*CO*131*250~*

REF Service Identification

| | |
|-------------------|-------------|
| Pos: 1000 | Max: 8 |
| Detail - Optional | |
| Loop: 2110 | Elements: 2 |

Element Summary:

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

| <u>Code</u> | <u>Name</u> |
|-------------|-----------------|
| LU | Location Number |

This is the Payer's identification for the provider location. This is REQUIRED when the specific site of service affected the payment of the claim.

| | | | | | |
|-------|-----|--------------------------|---|----|------|
| REF02 | 127 | Reference Identification | X | AN | 1/50 |
|-------|-----|--------------------------|---|----|------|

ExternalCodeList

Name: 468

Description: Ambulatory Payment Classification

Situational Rule:

Required when related service specific reference identifiers were used in the process of adjudicating this service. If not required by this implementation guide, do not send.

TR3 Example:

REF*RB*100~

REF

Line Item Control Number

| | |
|-------------------|-------------|
| Pos: 1000 | Max: 1 |
| Detail - Optional | |
| Loop: 2110 | Elements: 2 |

Element Summary:

| <u>Ref</u> | <u>Id</u> | <u>Element Name</u> | <u>Req</u> | <u>Type</u> | <u>Min/Max</u> |
|------------|-----------|------------------------------------|------------|-------------|----------------|
| REF01 | 128 | Reference Identification Qualifier | M | ID | 2/3 |
| | | <u>Code</u> | | | |
| | | 6R | | | |
| | | <u>Name</u> | | | |
| | | Provider Control Number | | | |
| REF02 | 127 | Reference Identification | X | AN | 1/50 |

Situational Rule:

Required when a Line Item Control Number was received on the original claim or when claim or service line splitting has occurred. If not required by this implementation guide, do not send.

TR3 Notes:

1. This is the Line Item Control Number submitted in the 837, which is utilized by the provider for tracking purposes. See section 1.10.2.11 and 1.10.2.14.1 for additional information on usage with split claims or services. Note - the value in REF02 can include alpha characters.

TR3 Example:

REF*6R*A78910~

REF Rendering Provider Information

| | |
|-------------------|-------------|
| Pos: 1000 | Max: 10 |
| Detail - Optional | |
| Loop: 2110 | Elements: 2 |

Element Summary:

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

| <u>Code</u> | <u>Name</u> |
|-------------|---|
| 0B | State License Number |
| 1A | Blue Cross Provider Number |
| 1B | Blue Shield Provider Number |
| 1C | Medicare Provider Number |
| 1D | Medicaid Provider Number |
| 1G | Provider UPIN Number |
| 1H | CHAMPUS Identification Number |
| 1J | Facility ID Number |
| D3 | National Council for Prescription Drug Programs Pharmacy Number |
| G2 | Provider Commercial Number |
| SY | Social Security Number |
| TJ | Federal Taxpayer's Identification Number |
| HPI | Centers for Medicare and Medicaid Services National Provider Identifier |

This qualifier is REQUIRED when the National Provider Identifier is mandated for use and the provider is a covered health care provider under that mandate.

| | | | | | |
|-------|-----|--------------------------|---|----|------|
| REF02 | 127 | Reference Identification | X | AN | 1/50 |
|-------|-----|--------------------------|---|----|------|

ExternalCodeList

Name: 537

Description: Centers for Medicare and Medicaid Services National Provider Identifier

ExternalCodeList

Name: 307

Description: National Council for Prescription Drug Programs Pharmacy Number

Situational Rule:

Required when the rendering provider for this service is different than the rendering provider applicable at the claim level. If not required by this implementation guide, do not send.

TR3 Example:

REF*HPI*1234567891~

REF HealthCare Policy Identification

| | |
|-------------------|-------------|
| Pos: 1000 | Max: 5 |
| Detail - Optional | |
| Loop: 2110 | Elements: 2 |

Element Summary:

| <u>Ref</u> | <u>Id</u> | <u>Element Name</u> | <u>Req</u> | <u>Type</u> | <u>Min/Max</u> |
|------------|-----------|------------------------------------|------------|-------------|--------------------------------|
| REF01 | 128 | Reference Identification Qualifier | M | ID | 2/3 |
| | | <u>Code</u> | | | |
| | | <u>Name</u> | | | |
| | | 0K | | | Policy Form Identifying Number |
| REF02 | 127 | Reference Identification | X | AN | 1/50 |

Situational Rule:

Required when;

- The payment is adjusted in accordance with the Payer's published Healthcare Policy Code list and
- A Claim Adjustment Reason Code identified by the notation, "refer to 835 Healthcare Policy identification segment", in the Claim Adjustment Reason Code List is present in a related CAS segment and
- The payer has a published enumerated healthcare policy code list available to healthcare providers via an un-secure public website and
- The payer wishes to supply this policy detail to reduce provider inquiries. If not required by this implementation guide, may be provided at the sender's discretion, but cannot be required by the receiver.

TR3 Notes:

1. Healthcare Policy - A clinical/statutory rule use to determine claim adjudication that cannot be explained by the sole use of a claim adjustment reason code in the CAS segment and Remittance Advise Remark code when appropriate.
2. The term Healthcare Policy is intended to include Medical Review Policy, Dental Policy Review, Property and Casualty Policies, Workers Comp Policies and Pharmacy Policies for example Medicare LMRP's.(Local Medicare Review policies) and NCD (National Coverage Determinations).
3. This policy segment must not be used to provide a proprietary explanation code or reason for adjustment.
4. Supply the Healthcare policy identifier in REF02 as provided by the payer's published Healthcare policy code list. This policy code will be used to explain the policy used to process the claim which resulted in the adjusted payment.
5. If this segment is used, the PER (Payer Web Site) segment is required to provide an un-secure WEB contact point where the provider can access the payer's enumerated, published healthcare policy.

TR3 Example:

REF*0K*L12345678910~

AMT Service Supplemental Amount

| | |
|-------------------|-------------|
| Pos: 1100 | Max: 9 |
| Detail - Optional | |
| Loop: 2110 | Elements: 2 |

Element Summary:

| <u>Ref</u> | <u>Id</u> | <u>Element Name</u> | <u>Req</u> | <u>Type</u> | <u>Min/Max</u> |
|------------|-----------|-----------------------|------------|-------------|----------------|
| AMT01 | 522 | Amount Qualifier Code | M | ID | 1/3 |

| <u>Code</u> | <u>Name</u> |
|-------------|------------------|
| B6 | Allowed - Actual |

Allowed amount is the amount the payer deems payable prior to considering patient responsibility.

| | | | | | |
|-------|-----|-----------------|---|---|------|
| AMT02 | 782 | Monetary Amount | M | R | 1/18 |
|-------|-----|-----------------|---|---|------|

Decimal elements will be limited to a maximum length of 10 characters including reported or implied places for cents (implied value of 00 after the decimal point). This applies to all subsequent 782 elements.

Situational Rule:

Required when the value of any specific amount identified by the AMT01 qualifier is non-zero. If not required by this implementation guide, do not send.

TR3 Notes:

1. This segment is used to convey information only. It is not part of the financial balancing of the 835.

TR3 Example:

*AMT*B6*425~*

LQ

Health Care Remark Codes

| | |
|-------------------|-------------|
| Pos: 1300 | Max: 99 |
| Detail - Optional | |
| Loop: 2110 | Elements: 2 |

Element Summary:

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

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

| | | | | | |
|------|------|---------------|---|----|------|
| LQ02 | 1271 | Industry Code | X | AN | 1/30 |
|------|------|---------------|---|----|------|

ExternalCodeList

Name: 530

Description: National Council for Prescription Drug Programs Reject/Payment Codes

ExternalCodeList

Name: 411

Description: Remittance Advice Remark Codes

Situational Rule:

Required when remark codes or NCPDP Reject/Payment codes are necessary for the provider to fully understand the adjudication message for a given service line. If not required by this implementation guide, may be provided at the sender's discretion, but cannot be required by the receiver.

TR3 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.

TR3 Example:

LQ*HE*12345~

PLB Provider Adjustment

| | |
|--------------------|--------------|
| Pos: 0100 | Max: >1 |
| Summary - Optional | |
| Loop: N/A | Elements: 14 |

Element Summary:

| <u>Ref</u> | <u>Id</u> | <u>Element Name</u> | <u>Req</u> | <u>Type</u> | <u>Min/Max</u> |
|--|-----------|---------------------------------|------------|-------------|----------------|
| PLB01 | 127 | Reference Identification | M | AN | 1/50 |
| <p><i>When the National Provider Identifier (NPI) is mandated and the provider is a covered health care provider under that mandate, this must be the NPI assigned to the provider. Until the NPI is mandated, this is the provider identifier as assigned by the payer.</i></p> | | | | | |
| PLB02 | 373 | Date | M | DT | 8/8 |
| <p><i>This is 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.</i></p> | | | | | |
| PLB03 | C042 | Adjustment Identifier | M | Comp | |
| <p><i>This identifier is a composite data structure. The composite identifies the reason and identifying information for the related adjustment dollar amount (PLB04 for PLB03).</i></p> | | | | | |
| PLB03-01 | 426 | Adjustment Reason Code | M | ID | 2/2 |

| <u>Code</u> | <u>Name</u> |
|-------------|---|
| 50 | Late Charge <i>This is the Late Claim Filing Penalty or Medicare Late Cost Report Penalty.</i> |
| 51 | Interest Penalty Charge <i>This is the interest assessment for late filing.</i> |
| 72 | Authorized Return <i>This is the provider refund adjustment. This adjustment acknowledges a refund received from a provider for previous overpayment. PLB03-2 must always contain an identifying reference number when the value is used. PLB04 must contain a negative value. This adjustment must 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.</i> |
| 90 | Early Payment Allowance |
| AH | Origination Fee <i>This is the claim transmission fee. This is used for transmission fees that are not specific to or dependent upon individual claims.</i> |
| AM | Applied to Borrower's Account <i>See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information. Use this code to identify the loan repayment amount. This is capitation specific.</i> |
| AP | Acceleration of Benefits <i>This is the accelerated payment amount or withholding. Withholding or payment identification is indicated by the sign of the amount in PLB04. A positive value represents a withholding. A negative value represents a payment.</i> |
| B2 | Rebate <i>This adjustment code applies when a provider has remitted an overpayment to a health plan in excess of the amount requested by the health plan. The amount accepted by the health plan is reported using code 72 (Authorized Return) and offset by the amount with code WO (Overpayment Recovery). The excess returned by the provider is reported as a negative amount using code B2, returning the excess funds to the provider.</i> |
| B3 | Recovery Allowance <i>This represents the check received from the provider for overpayments generated by payments from other payers. This code differs from the provider refund adjustment identified with code 72. This adjustment must 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.</i> |
| BD | Bad Debt Adjustment |

| | |
|----|--|
| | <i>This is the bad debt passthrough.</i> |
| BN | Bonus <i>This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.</i> |
| C5 | Temporary Allowance <i>This is the tentative adjustment.</i> |
| CR | Capitation Interest <i>This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.</i> |
| CS | Adjustment <i>Provide supporting identification information in PLB03-2.</i> |
| CT | Capitation Payment <i>This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.</i> |
| CV | Capital Passthru |
| CW | Certified Registered Nurse Anesthetist Passthru |
| DM | Direct Medical Education Passthru |
| E3 | Withholding <i>See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.</i> |
| FB | Forwarding Balance <i>This is 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 must be supplied in PLB03-2 for tracking purposes. See 1.10.2.12, Balance Forward Processing, for further information.</i> |
| FC | Fund Allocation <i>This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information. The specific fund must be identified in PLB03-2.</i> |
| GO | Graduate Medical Education Passthru |
| HM | Hemophilia Clotting Factor Supplement |
| IP | Incentive Premium Payment <i>This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.</i> |
| IR | Internal Revenue Service Withholding |
| IS | Interim Settlement <i>This is the interim rate lump sum adjustment.</i> |
| J1 | Nonreimbursable <i>This offsets the claim or service level data that reflects what could be paid if not for demonstration program or other limitation that prevents issuance of payment.</i> |
| L3 | Penalty <i>This is the capitation-related penalty. Withholding or release is identified by the sign in PLB04. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.</i> |
| L6 | Interest Owed <i>This is the interest paid on claims in this 835. Support the amounts related to this adjustment by 2-062 AMT amounts, where AMT01 is "I".</i> |
| LS | Lump Sum <i>This is the disproportionate share adjustment, indirect medical education passthrough, nonphysician passthrough, passthrough lump sum adjustment, or other passthrough amount. The specific type of lump sum adjustment must be identified in PLB03-2.</i> |
| OB | Offset for Affiliated Providers <i>Identification of the affiliated providers must be made on PLB03-2.</i> |
| PI | Periodic Interim Payment <i>This is the periodic interim lump sum payments and reductions (PIP). The payments are made to a provider at the beginning of some period in advance of claims. These payments are advances on the expected claims for the period. The reductions are the recovery of actual claims payments during the period. For instance, when a provider has a PIP payment, claims within this remittance advice covered by that payment would be offset using this code to remove the claim payment from the current check. The sign</i> |

*of the amount in PLB04 determines whether this is a payment (negative) or reduction (positive).
This payment and recoupment is effectively a loan to the provider and loan repayment. See section 1.10.2.5, Advance Payments and Reconciliation, for additional information.*

| | | |
|----|---------------------------|--|
| PL | Payment Final | <i>This is the final settlement.</i> |
| RA | Retro-activity Adjustment | <i>This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.</i> |
| TL | Third Party Liability | <i>This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.</i> |
| WO | Overpayment Recovery | <i>This is the recovery of previous overpayment. An identifying number must be provided in PLB03-2. See the notes on codes 72 and B3 for additional information about balancing against a provider refund.</i> |
| WU | Unspecified Recovery | <i>Medicare is currently using this code to represent penalty collections withheld for the IRS (an outside source).</i> |

| | | | | | |
|----------|-----|---------------------------------|---|----|------|
| PLB03-02 | 127 | Reference Identification | O | AN | 1/50 |
|----------|-----|---------------------------------|---|----|------|

Use when necessary to assist the receiver in identifying, tracking or reconciling the adjustment. See sections 1.10.2.10 (Capitation and Related Payments), 1.10.2.5 (Advanced Payments and Reconciliation) and 1.10.2.12 (Balance Forward Processing) for further information.

| | | | | | |
|-------|-----|------------------------|---|---|------|
| PLB04 | 782 | Monetary Amount | M | R | 1/18 |
|-------|-----|------------------------|---|---|------|

*This is the adjustment amount for the preceding adjustment reason.
Decimal elements will be limited to a maximum length of 10 characters including reported or implied places for cents (implied value of 00 after the decimal point). This applies to all subsequent 782 elements.*

| | | | | |
|-------|------|------------------------------|---|------|
| PLB05 | C042 | Adjustment Identifier | X | Comp |
|-------|------|------------------------------|---|------|

See PLB03 for details.

| | | | | | |
|----------|-----|-------------------------------|---|----|-----|
| PLB05-01 | 426 | Adjustment Reason Code | M | ID | 2/2 |
|----------|-----|-------------------------------|---|----|-----|

| <u>Code</u> | <u>Name</u> |
|-------------|---|
| 50 | Late Charge <i>This is the Late Claim Filing Penalty or Medicare Late Cost Report Penalty.</i> |
| 51 | Interest Penalty Charge <i>This is the interest assessment for late filing.</i> |
| 72 | Authorized Return <i>This is the provider refund adjustment. This adjustment acknowledges a refund received from a provider for previous overpayment. PLB03-2 must always contain an identifying reference number when the value is used. PLB04 must contain a negative value. This adjustment must 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.</i> |
| 90 | Early Payment Allowance |
| AH | Origination Fee <i>This is the claim transmission fee. This is used for transmission fees that are not specific to or dependent upon individual claims.</i> |
| AM | Applied to Borrower's Account <i>See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information. Use this code to identify the loan repayment amount. This is capitation specific.</i> |
| AP | Acceleration of Benefits <i>This is the accelerated payment amount or withholding. Withholding or payment identification is indicated by the sign of the amount in PLB04. A positive value represents a withholding. A negative value represents a payment.</i> |

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| B2 | <p>Rebate</p> <p><i>This adjustment code applies when a provider has remitted an overpayment to a health plan in excess of the amount requested by the health plan. The amount accepted by the health plan is reported using code 72 (Authorized Return) and offset by the amount with code WO (Overpayment Recovery). The excess returned by the provider is reported as a negative amount using code B2, returning the excess funds to the provider.</i></p> |
| B3 | <p>Recovery Allowance</p> <p><i>This represents the check received from the provider for overpayments generated by payments from other payers. This code differs from the provider refund adjustment identified with code 72. This adjustment must 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.</i></p> |
| BD | <p>Bad Debt Adjustment</p> <p><i>This is the bad debt passthrough.</i></p> |
| BN | <p>Bonus</p> <p><i>This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.</i></p> |
| C5 | <p>Temporary Allowance</p> <p><i>This is the tentative adjustment.</i></p> |
| CR | <p>Capitation Interest</p> <p><i>This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.</i></p> |
| CS | <p>Adjustment</p> <p><i>Provide supporting identification information in PLB03-2.</i></p> |
| CT | <p>Capitation Payment</p> <p><i>This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.</i></p> |
| CV | Capital Passthru |
| CW | Certified Registered Nurse Anesthetist Passthru |
| DM | Direct Medical Education Passthru |
| E3 | <p>Withholding</p> <p><i>See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.</i></p> |
| FB | <p>Forwarding Balance</p> <p><i>This is 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 must be supplied in PLB03-2 for tracking purposes. See 1.10.2.12, Balance Forward Processing, for further information.</i></p> |
| FC | <p>Fund Allocation</p> <p><i>This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information. The specific fund must be identified in PLB03-2.</i></p> |
| GO | Graduate Medical Education Passthru |
| HM | Hemophilia Clotting Factor Supplement |
| IP | <p>Incentive Premium Payment</p> <p><i>This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.</i></p> |
| IR | Internal Revenue Service Withholding |
| IS | <p>Interim Settlement</p> <p><i>This is the interim rate lump sum adjustment.</i></p> |
| J1 | <p>Nonreimbursable</p> <p><i>This offsets the claim or service level data that reflects what could be paid if not for demonstration program or other limitation that prevents issuance of payment.</i></p> |
| L3 | <p>Penalty</p> <p><i>This is the capitation-related penalty. Withholding or release is identified by the sign in PLB04. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.</i></p> |
| L6 | <p>Interest Owed</p> <p><i>This is the interest paid on claims in this 835. Support the amounts related to this adjustment by 2-062 AMT amounts, where AMT01 is "1".</i></p> |
| LE | Levy |

| | | | | | |
|----|--|---|--|--|--|
| | | <i>IRS Levy</i> | | | |
| LS | | Lump Sum | | | |
| | | <i>This is the disproportionate share adjustment, indirect medical education passthrough, nonphysician passthrough, passthrough lump sum adjustment, or other passthrough amount. The specific type of lump sum adjustment must be identified in PLB03-2.</i> | | | |
| OA | | Organ Acquisition Passthru | | | |
| OB | | Offset for Affiliated Providers | | | |
| | | <i>Identification of the affiliated providers must be made on PLB03-2.</i> | | | |
| PI | | Periodic Interim Payment | | | |
| | | <i>This is the periodic interim lump sum payments and reductions (PIP). The payments are made to a provider at the beginning of some period in advance of claims. These payments are advances on the expected claims for the period. The reductions are the recovery of actual claims payments during the period. For instance, when a provider has a PIP payment, claims within this remittance advice covered by that payment would be offset using this code to remove the claim payment from the current check. The sign of the amount in PLB04 determines whether this is a payment (negative) or reduction (positive). This payment and recoupment is effectively a loan to the provider and loan repayment. See section 1.10.2.5, Advance Payments and Reconciliation, for additional information.</i> | | | |
| PL | | Payment Final | | | |
| | | <i>This is the final settlement.</i> | | | |
| RA | | Retro-activity Adjustment | | | |
| | | <i>This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.</i> | | | |
| RE | | Return on Equity | | | |
| SL | | Student Loan Repayment | | | |
| TL | | Third Party Liability | | | |
| | | <i>This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.</i> | | | |
| WO | | Overpayment Recovery | | | |
| | | <i>This is the recovery of previous overpayment. An identifying number must be provided in PLB03-2. See the notes on codes 72 and B3 for additional information about balancing against a provider refund.</i> | | | |
| WU | | Unspecified Recovery | | | |
| | | <i>Medicare is currently using this code to represent penalty collections withheld for the IRS (an outside source).</i> | | | |

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|----------|------|---|---|------|------|
| PLB05-02 | 127 | Reference Identification | O | AN | 1/50 |
| PLB06 | 782 | Monetary Amount | X | R | 1/18 |
| | | <i>This is the adjustment amount for the preceding adjustment reason.</i> | | | |
| PLB07 | C042 | Adjustment Identifier | X | Comp | |
| | | <i>See PLB03 for details.</i> | | | |
| PLB07-01 | 426 | Adjustment Reason Code | M | ID | 2/2 |

| <u>Code</u> | <u>Name</u> |
|-------------|--|
| 50 | Late Charge |
| | <i>This is the Late Claim Filing Penalty or Medicare Late Cost Report Penalty.</i> |
| 51 | Interest Penalty Charge |
| | <i>This is the interest assessment for late filing.</i> |
| 72 | Authorized Return |
| | <i>This is the provider refund adjustment. This adjustment acknowledges a refund received from a provider for previous overpayment. PLB03-2 must always contain an identifying reference number when the value is used. PLB04 must contain a negative value. This adjustment must 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.</i> |
| 90 | Early Payment Allowance |

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|----|--|
| AH | Origination Fee <i>This is the claim transmission fee. This is used for transmission fees that are not specific to or dependent upon individual claims.</i> |
| AM | Applied to Borrower's Account <i>See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information. Use this code to identify the loan repayment amount. This is capitation specific.</i> |
| AP | Acceleration of Benefits <i>This is the accelerated payment amount or withholding. Withholding or payment identification is indicated by the sign of the amount in PLB04. A positive value represents a withholding. A negative value represents a payment.</i> |
| B2 | Rebate <i>This adjustment code applies when a provider has remitted an overpayment to a health plan in excess of the amount requested by the health plan. The amount accepted by the health plan is reported using code 72 (Authorized Return) and offset by the amount with code WO (Overpayment Recovery). The excess returned by the provider is reported as a negative amount using code B2, returning the excess funds to the provider.</i> |
| B3 | Recovery Allowance <i>This represents the check received from the provider for overpayments generated by payments from other payers. This code differs from the provider refund adjustment identified with code 72. This adjustment must 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.</i> |
| BD | Bad Debt Adjustment <i>This is the bad debt passthrough.</i> |
| BN | Bonus <i>This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.</i> |
| C5 | Temporary Allowance <i>This is the tentative adjustment.</i> |
| CR | Capitation Interest <i>This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.</i> |
| CS | Adjustment <i>Provide supporting identification information in PLB03-2.</i> |
| CT | Capitation Payment <i>This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.</i> |
| CV | Capital Passthru |
| CW | Certified Registered Nurse Anesthetist Passthru |
| DM | Direct Medical Education Passthru |
| E3 | Withholding <i>See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.</i> |
| FB | Forwarding Balance <i>This is 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 must be supplied in PLB03-2 for tracking purposes. See 1.10.2.12, Balance Forward Processing, for further information.</i> |
| FC | Fund Allocation <i>This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information. The specific fund must be identified in PLB03-2.</i> |
| GO | Graduate Medical Education Passthru |
| HM | Hemophilia Clotting Factor Supplement |
| IP | Incentive Premium Payment <i>This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.</i> |
| IR | Internal Revenue Service Withholding |
| IS | Interim Settlement <i>This is the interim rate lump sum adjustment.</i> |

| | | |
|----|---------------------------------|---|
| J1 | Nonreimbursable | <i>This offsets the claim or service level data that reflects what could be paid if not for demonstration program or other limitation that prevents issuance of payment.</i> |
| L3 | Penalty | <i>This is the capitation-related penalty. Withholding or release is identified by the sign in PLB04. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.</i> |
| L6 | Interest Owed | <i>This is the interest paid on claims in this 835. Support the amounts related to this adjustment by 2-062 AMT amounts, where AMT01 is "I".</i> |
| LE | Levy | IRS Levy |
| LS | Lump Sum | <i>This is the disproportionate share adjustment, indirect medical education passthrough, nonphysician passthrough, passthrough lump sum adjustment, or other passthrough amount. The specific type of lump sum adjustment must be identified in PLB03-2.</i> |
| OA | Organ Acquisition Passthru | |
| OB | Offset for Affiliated Providers | <i>Identification of the affiliated providers must be made on PLB03-2.</i> |
| PI | Periodic Interim Payment | <i>This is the periodic interim lump sum payments and reductions (PIP). The payments are made to a provider at the beginning of some period in advance of claims. These payments are advances on the expected claims for the period. The reductions are the recovery of actual claims payments during the period. For instance, when a provider has a PIP payment, claims within this remittance advice covered by that payment would be offset using this code to remove the claim payment from the current check. The sign of the amount in PLB04 determines whether this is a payment (negative) or reduction (positive). This payment and recoupment is effectively a loan to the provider and loan repayment. See section 1.10.2.5, Advance Payments and Reconciliation, for additional information.</i> |
| PL | Payment Final | <i>This is the final settlement.</i> |
| RA | Retro-activity Adjustment | <i>This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.</i> |
| RE | Return on Equity | |
| SL | Student Loan Repayment | |
| TL | Third Party Liability | <i>This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.</i> |
| WO | Overpayment Recovery | <i>This is the recovery of previous overpayment. An identifying number must be provided in PLB03-2. See the notes on codes 72 and B3 for additional information about balancing against a provider refund.</i> |
| WU | Unspecified Recovery | <i>Medicare is currently using this code to represent penalty collections withheld for the IRS (an outside source).</i> |

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|---|------|---------------------------------|---|------|------|
| PLB07-02 | 127 | Reference Identification | O | AN | 1/50 |
| PLB08 | 782 | Monetary Amount | X | R | 1/18 |
| <i>This is the adjustment amount for the preceding adjustment reason.</i> | | | | | |
| PLB09 | C042 | Adjustment Identifier | X | Comp | |
| <i>See PLB03 for details.</i> | | | | | |
| PLB09-01 | 426 | Adjustment Reason Code | M | ID | 2/2 |

Code **Name**
 50 Late Charge

| | |
|----|--|
| | <i>This is the Late Claim Filing Penalty or Medicare Late Cost Report Penalty.</i> |
| 51 | Interest Penalty Charge |
| | <i>This is the interest assessment for late filing.</i> |
| 72 | Authorized Return |
| | <i>This is the provider refund adjustment. This adjustment acknowledges a refund received from a provider for previous overpayment. PLB03-2 must always contain an identifying reference number when the value is used. PLB04 must contain a negative value. This adjustment must 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.</i> |
| 90 | Early Payment Allowance |
| AH | Origination Fee |
| | <i>This is the claim transmission fee. This is used for transmission fees that are not specific to or dependent upon individual claims.</i> |
| AM | Applied to Borrower's Account |
| | <i>See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information. Use this code to identify the loan repayment amount. This is capitation specific.</i> |
| AP | Acceleration of Benefits |
| | <i>This is the accelerated payment amount or withholding. Withholding or payment identification is indicated by the sign of the amount in PLB04. A positive value represents a withholding. A negative value represents a payment.</i> |
| B2 | Rebate |
| | <i>This adjustment code applies when a provider has remitted an overpayment to a health plan in excess of the amount requested by the health plan. The amount accepted by the health plan is reported using code 72 (Authorized Return) and offset by the amount with code WO (Overpayment Recovery). The excess returned by the provider is reported as a negative amount using code B2, returning the excess funds to the provider.</i> |
| B3 | Recovery Allowance |
| | <i>This represents the check received from the provider for overpayments generated by payments from other payers. This code differs from the provider refund adjustment identified with code 72. This adjustment must 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.</i> |
| BD | Bad Debt Adjustment |
| | <i>This is the bad debt passthrough.</i> |
| BN | Bonus |
| | <i>This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.</i> |
| C5 | Temporary Allowance |
| | <i>This is the tentative adjustment.</i> |
| CR | Capitation Interest |
| | <i>This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.</i> |
| CS | Adjustment |
| | <i>Provide supporting identification information in PLB03-2.</i> |
| CT | Capitation Payment |
| | <i>This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.</i> |
| CV | Capital Passthru |
| CW | Certified Registered Nurse Anesthetist Passthru |
| DM | Direct Medical Education Passthru |
| E3 | Withholding |
| | <i>See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.</i> |
| FB | Forwarding Balance |
| | <i>This is 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 must be supplied in PLB03-2 for tracking purposes. See 1.10.2.12, Balance Forward Processing, for further information.</i> |

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| FC | Fund Allocation <i>This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information. The specific fund must be identified in PLB03-2.</i> |
| GO | Graduate Medical Education Passthru |
| HM | Hemophilia Clotting Factor Supplement |
| IP | Incentive Premium Payment <i>This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.</i> |
| IR | Internal Revenue Service Withholding |
| IS | Interim Settlement <i>This is the interim rate lump sum adjustment.</i> |
| J1 | Nonreimbursable <i>This offsets the claim or service level data that reflects what could be paid if not for demonstration program or other limitation that prevents issuance of payment.</i> |
| L3 | Penalty <i>This is the capitation-related penalty. Withholding or release is identified by the sign in PLB04. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.</i> |
| L6 | Interest Owed <i>This is the interest paid on claims in this 835. Support the amounts related to this adjustment by 2-062 AMT amounts, where AMT01 is "I".</i> |
| LE | Levy <i>IRS Levy</i> |
| LS | Lump Sum <i>This is the disproportionate share adjustment, indirect medical education passthrough, nonphysician passthrough, passthrough lump sum adjustment, or other passthrough amount. The specific type of lump sum adjustment must be identified in PLB03-2.</i> |
| OA | Organ Acquisition Passthru |
| OB | Offset for Affiliated Providers <i>Identification of the affiliated providers must be made on PLB03-2.</i> |
| PI | Periodic Interim Payment <i>This is the periodic interim lump sum payments and reductions (PIP). The payments are made to a provider at the beginning of some period in advance of claims. These payments are advances on the expected claims for the period. The reductions are the recovery of actual claims payments during the period. For instance, when a provider has a PIP payment, claims within this remittance advice covered by that payment would be offset using this code to remove the claim payment from the current check. The sign of the amount in PLB04 determines whether this is a payment (negative) or reduction (positive). <i>This payment and recoupment is effectively a loan to the provider and loan repayment. See section 1.10.2.5, Advance Payments and Reconciliation, for additional information.</i></i> |
| PL | Payment Final <i>This is the final settlement.</i> |
| RA | Retro-activity Adjustment <i>This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.</i> |
| RE | Return on Equity |
| SL | Student Loan Repayment |
| TL | Third Party Liability <i>This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.</i> |
| WO | Overpayment Recovery <i>This is the recovery of previous overpayment. An identifying number must be provided in PLB03-2. See the notes on codes 72 and B3 for additional information about balancing against a provider refund.</i> |
| WU | Unspecified Recovery <i>Medicare is currently using this code to represent penalty collections withheld for the IRS (an outside source).</i> |

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|---|------|-------------------------------|---|------|------|
| PLB10 | 782 | Monetary Amount | X | R | 1/18 |
| <i>This is the adjustment amount for the preceding adjustment reason.</i> | | | | | |
| PLB11 | C042 | Adjustment Identifier | X | Comp | |
| <i>See PLB03 for details.</i> | | | | | |
| PLB11-01 | 426 | Adjustment Reason Code | M | ID | 2/2 |

| <u>Code</u> | <u>Name</u> |
|-------------|---|
| 50 | Late Charge <i>This is the Late Claim Filing Penalty or Medicare Late Cost Report Penalty.</i> |
| 51 | Interest Penalty Charge <i>This is the interest assessment for late filing.</i> |
| 72 | Authorized Return <i>This is the provider refund adjustment. This adjustment acknowledges a refund received from a provider for previous overpayment. PLB03-2 must always contain an identifying reference number when the value is used. PLB04 must contain a negative value. This adjustment must 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.</i> |
| 90 | Early Payment Allowance |
| AH | Origination Fee <i>This is the claim transmission fee. This is used for transmission fees that are not specific to or dependent upon individual claims.</i> |
| AM | Applied to Borrower's Account <i>See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information. Use this code to identify the loan repayment amount. This is capitation specific.</i> |
| AP | Acceleration of Benefits <i>This is the accelerated payment amount or withholding. Withholding or payment identification is indicated by the sign of the amount in PLB04. A positive value represents a withholding. A negative value represents a payment.</i> |
| B2 | Rebate <i>This adjustment code applies when a provider has remitted an overpayment to a health plan in excess of the amount requested by the health plan. The amount accepted by the health plan is reported using code 72 (Authorized Return) and offset by the amount with code WO (Overpayment Recovery). The excess returned by the provider is reported as a negative amount using code B2, returning the excess funds to the provider.</i> |
| B3 | Recovery Allowance <i>This represents the check received from the provider for overpayments generated by payments from other payers. This code differs from the provider refund adjustment identified with code 72. This adjustment must 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.</i> |
| BD | Bad Debt Adjustment <i>This is the bad debt passthrough.</i> |
| BN | Bonus <i>This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.</i> |
| C5 | Temporary Allowance <i>This is the tentative adjustment.</i> |
| CR | Capitation Interest <i>This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.</i> |
| CS | Adjustment <i>Provide supporting identification information in PLB03-2.</i> |
| CT | Capitation Payment <i>This is capitation specific. See 1.10.2.10, Capitation and Related Payments or</i> |

| | |
|----|--|
| | <i>Adjustments, for additional information.</i> |
| CV | Capital Passthru |
| CW | Certified Registered Nurse Anesthetist Passthru |
| DM | Direct Medical Education Passthru |
| E3 | Withholding |
| | <i>See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.</i> |
| FB | Forwarding Balance |
| | <i>This is 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 must be supplied in PLB03-2 for tracking purposes. See 1.10.2.12, Balance Forward Processing, for further information.</i> |
| FC | Fund Allocation |
| | <i>This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information. The specific fund must be identified in PLB03-2.</i> |
| GO | Graduate Medical Education Passthru |
| HM | Hemophilia Clotting Factor Supplement |
| IP | Incentive Premium Payment |
| | <i>This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.</i> |
| IR | Internal Revenue Service Withholding |
| IS | Interim Settlement |
| | <i>This is the interim rate lump sum adjustment.</i> |
| J1 | Nonreimbursable |
| | <i>This offsets the claim or service level data that reflects what could be paid if not for demonstration program or other limitation that prevents issuance of payment.</i> |
| L3 | Penalty |
| | <i>This is the capitation-related penalty. Withholding or release is identified by the sign in PLB04. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.</i> |
| L6 | Interest Owed |
| | <i>This is the interest paid on claims in this 835. Support the amounts related to this adjustment by 2-062 AMT amounts, where AMT01 is "I".</i> |
| LE | Levy |
| | <i>IRS Levy</i> |
| LS | Lump Sum |
| | <i>This is the disproportionate share adjustment, indirect medical education passthrough, nonphysician passthrough, passthrough lump sum adjustment, or other passthrough amount. The specific type of lump sum adjustment must be identified in PLB03-2.</i> |
| OA | Organ Acquisition Passthru |
| OB | Offset for Affiliated Providers |
| | <i>Identification of the affiliated providers must be made on PLB03-2.</i> |
| PI | Periodic Interim Payment |
| | <i>This is the periodic interim lump sum payments and reductions (PIP). The payments are made to a provider at the beginning of some period in advance of claims. These payments are advances on the expected claims for the period. The reductions are the recovery of actual claims payments during the period. For instance, when a provider has a PIP payment, claims within this remittance advice covered by that payment would be offset using this code to remove the claim payment from the current check. The sign of the amount in PLB04 determines whether this is a payment (negative) or reduction (positive).</i> |
| | <i>This payment and recoupment is effectively a loan to the provider and loan repayment. See section 1.10.2.5, Advance Payments and Reconciliation, for additional information.</i> |
| PL | Payment Final |
| | <i>This is the final settlement.</i> |
| RA | Retro-activity Adjustment |
| | <i>This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.</i> |
| RE | Return on Equity |
| SL | Student Loan Repayment |

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| TL | Third Party Liability | <i>This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.</i> |
| WO | Overpayment Recovery | <i>This is the recovery of previous overpayment. An identifying number must be provided in PLB03-2. See the notes on codes 72 and B3 for additional information about balancing against a provider refund.</i> |
| WU | Unspecified Recovery | <i>Medicare is currently using this code to represent penalty collections withheld for the IRS (an outside source).</i> |

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|---|------|---------------------------------|---|------|------|
| PLB11-02 | 127 | Reference Identification | O | AN | 1/50 |
| PLB12 | 782 | Monetary Amount | X | R | 1/18 |
| <i>This is the adjustment amount for the preceding adjustment reason.</i> | | | | | |
| PLB13 | C042 | Adjustment Identifier | X | Comp | |
| <i>See PLB03 for details.</i> | | | | | |
| PLB13-01 | 426 | Adjustment Reason Code | M | ID | 2/2 |

| <u>Code</u> | <u>Name</u> |
|-------------|---|
| 50 | Late Charge <i>This is the Late Claim Filing Penalty or Medicare Late Cost Report Penalty.</i> |
| 51 | Interest Penalty Charge <i>This is the interest assessment for late filing.</i> |
| 72 | Authorized Return <i>This is the provider refund adjustment. This adjustment acknowledges a refund received from a provider for previous overpayment. PLB03-2 must always contain an identifying reference number when the value is used. PLB04 must contain a negative value. This adjustment must 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.</i> |
| 90 | Early Payment Allowance |
| AH | Origination Fee <i>This is the claim transmission fee. This is used for transmission fees that are not specific to or dependent upon individual claims.</i> |
| AM | Applied to Borrower's Account <i>See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information. Use this code to identify the loan repayment amount. This is capitation specific.</i> |
| AP | Acceleration of Benefits <i>This is the accelerated payment amount or withholding. Withholding or payment identification is indicated by the sign of the amount in PLB04. A positive value represents a withholding. A negative value represents a payment.</i> |
| B2 | Rebate <i>This adjustment code applies when a provider has remitted an overpayment to a health plan in excess of the amount requested by the health plan. The amount accepted by the health plan is reported using code 72 (Authorized Return) and offset by the amount with code WO (Overpayment Recovery). The excess returned by the provider is reported as a negative amount using code B2, returning the excess funds to the provider.</i> |
| B3 | Recovery Allowance <i>This represents the check received from the provider for overpayments generated by payments from other payers. This code differs from the provider refund adjustment identified with code 72. This adjustment must 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.</i> |
| BD | Bad Debt Adjustment <i>This is the bad debt passthrough.</i> |
| BN | Bonus |

| | |
|----|---|
| | <i>This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.</i> |
| C5 | Temporary Allowance <i>This is the tentative adjustment.</i> |
| CR | Capitation Interest <i>This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.</i> |
| CS | Adjustment <i>Provide supporting identification information in PLB03-2.</i> |
| CT | Capitation Payment <i>This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.</i> |
| CV | Capital Passthru |
| CW | Certified Registered Nurse Anesthetist Passthru |
| DM | Direct Medical Education Passthru |
| E3 | Withholding <i>See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.</i> |
| FB | Forwarding Balance <i>This is 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 must be supplied in PLB03-2 for tracking purposes. See 1.10.2.12, Balance Forward Processing, for further information.</i> |
| FC | Fund Allocation <i>This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information. The specific fund must be identified in PLB03-2.</i> |
| GO | Graduate Medical Education Passthru |
| HM | Hemophilia Clotting Factor Supplement |
| IP | Incentive Premium Payment <i>This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.</i> |
| IR | Internal Revenue Service Withholding |
| IS | Interim Settlement <i>This is the interim rate lump sum adjustment.</i> |
| J1 | Nonreimbursable <i>This offsets the claim or service level data that reflects what could be paid if not for demonstration program or other limitation that prevents issuance of payment.</i> |
| L3 | Penalty <i>This is the capitation-related penalty. Withholding or release is identified by the sign in PLB04. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.</i> |
| L6 | Interest Owed <i>This is the interest paid on claims in this 835. Support the amounts related to this adjustment by 2-062 AMT amounts, where AMT01 is "I".</i> |
| LE | Levy <i>IRS Levy</i> |
| LS | Lump Sum <i>This is the disproportionate share adjustment, indirect medical education passthrough, nonphysician passthrough, passthrough lump sum adjustment, or other passthrough amount. The specific type of lump sum adjustment must be identified in PLB03-2.</i> |
| OA | Organ Acquisition Passthru |
| OB | Offset for Affiliated Providers <i>Identification of the affiliated providers must be made on PLB03-2.</i> |
| PI | Periodic Interim Payment <i>This is the periodic interim lump sum payments and reductions (PIP). The payments are made to a provider at the beginning of some period in advance of claims. These payments are advances on the expected claims for the period. The reductions are the recovery of actual claims payments during the period. For instance, when a provider has a PIP payment, claims within this remittance advice covered by that payment would</i> |

be offset using this code to remove the claim payment from the current check. The sign of the amount in PLB04 determines whether this is a payment (negative) or reduction (positive). This payment and recoupment is effectively a loan to the provider and loan repayment. See section 1.10.2.5, Advance Payments and Reconciliation, for additional information.

| | | |
|----|---------------------------|--|
| PL | Payment Final | <i>This is the final settlement.</i> |
| RA | Retro-activity Adjustment | <i>This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.</i> |
| RE | Return on Equity | |
| SL | Student Loan Repayment | |
| TL | Third Party Liability | <i>This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.</i> |
| WO | Overpayment Recovery | <i>This is the recovery of previous overpayment. An identifying number must be provided in PLB03-2. See the notes on codes 72 and B3 for additional information about balancing against a provider refund.</i> |
| WU | Unspecified Recovery | <i>Medicare is currently using this code to represent penalty collections withheld for the IRS (an outside source).</i> |

| | | | | | |
|----------|-----|---------------------------------|---|----|------|
| PLB13-02 | 127 | Reference Identification | O | AN | 1/50 |
| PLB14 | 782 | Monetary Amount | X | R | 1/18 |

This is the adjustment amount for the preceding adjustment reason.

Situational Rule:

Required when reporting adjustments to the actual payment that are NOT specific to a particular claim or service. If not required by this implementation guide, do not send.

TR3 Notes:

- 1. These adjustments can either decrease the payment (a positive number) or increase the payment (a negative number). Zero dollar adjustments are not allowed. Some examples of PLB adjustments are a Periodic Interim Payment (loans and 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. Although the PLB reference numbers are not standardized, refer to 1.10.2.9 (Interest and Prompt Payment Discounts), 1.10.2.10 (Capitation and Related Payments or Adjustments), 1.10.2.12 (Balance Forward Processing), 1.10.2.16 (Post Payment Recovery) and 1.10.2.17 (Claim Overpayment Recovery) for code suggestions and usage guidelines.*
- 2. The codes and notations under PLB03 and its components apply equally to PLB05, 07, 09, 11 and 13.*

TR3 Example:

*PLB*1234567890*20000930*CV:9876514*-1.27~*

SE Transaction Set Trailer

| | |
|---------------------|-------------|
| Pos: 0200 | Max: 1 |
| Summary - Mandatory | |
| Loop: N/A | Elements: 2 |

Element Summary:

| <u>Ref</u> | <u>Id</u> | <u>Element Name</u> | <u>Req</u> | <u>Type</u> | <u>Min/Max</u> |
|------------|-----------|--------------------------------|------------|-------------|----------------|
| SE01 | 96 | Number of Included Segments | M | NO | 1/10 |
| SE02 | 329 | Transaction Set Control Number | M | AN | 4/9 |

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.

TR3 Example:

SE*45*1234~