

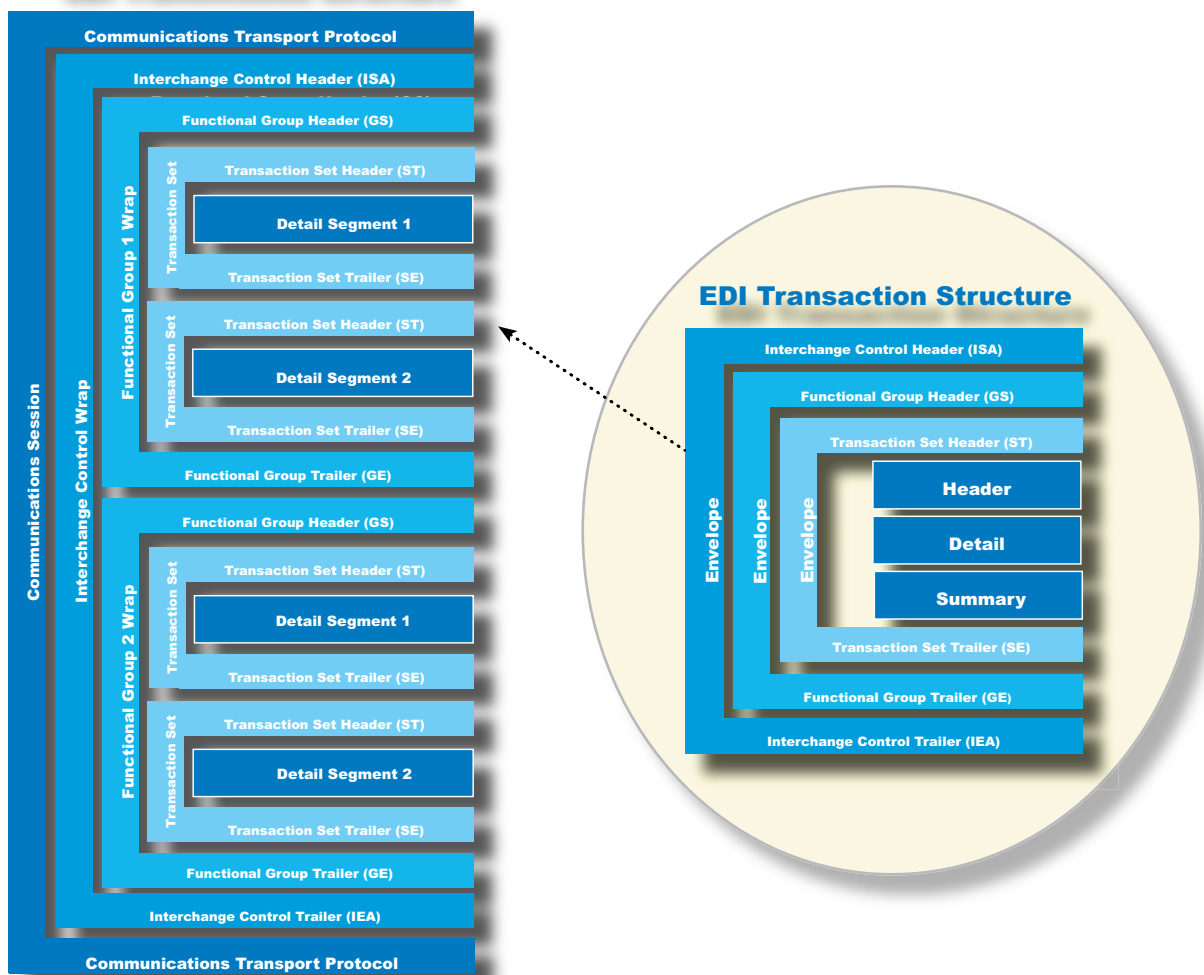
# 835 Health Care Claim Payment/Advice

## Basic Instructions

This section provides information to help you prepare for the ANSI ASC X12 Health Care Claim Payment/Advice (835) transaction. The remaining sections of this appendix include tables that provide information about 835 segments and data elements that are used to efficiently process transactions through BlueChoice HealthPlan Medicaid systems.

Use this companion document in conjunction with both the Transaction Set Implementation Guide "Health Care Claim Payment/Advice, 835, ASCX12N 835 (004010X091)", May 2000, and the subsequent Addenda (004010X091A1), October 2002, published by the Washington Publishing Co.

### EDI Transmission Structure



## **1 Registration Process - Remittances and Electronic Funds Transfer (EFT)**

All trading partners are eligible to receive the 835 payment Advice but require prior registration with EDI Solutions (1-800-470-9630) for the necessary set up and instructions.

As part of the process, the Payment Advice/Remittance Registration Form must be completed. It is available from the EDI website (<http://www.BlueChoiceSCMedicaid.com>, Register, EDI Registration Forms). Changes to the provider or tax identification number may affect the distribution of the 835 Payment/Advice. Providers should notify Provider Services and EDI Solutions when these types of changes do occur.

## **2 Basic Format of the 835 File - Payment by Payee ID**

Claim payments are made based on the Payee ID assigned to the provider. Depending on the provider reimbursement arrangement, multiple providers may be paid under the same Payee ID. Therefore, when a provider in a group practice requests an 835, by default all other providers linked to the same Payee ID will also receive an 835.

The format of the 835 file will show multiple checks and/or payment information tied to the provider group or individual provider on a given day. If this occurs, the checks and/or payment information will be bundled and uniquely identified within the same 835 file.

Multiple checks and/or payment information within one 835 file may cause difficulty and require system changes for providers who directly download 835 files.

## **3 X12 and HIPAA Compliance Checking, and Business Edits**

BlueChoice HealthPlan Medicaid responds to every provider-payable paper and electronic claim by sending, to the receiver, an 835 Payment/Advice. Each transaction passes through the Enterprise EDI Gateway/Clearinghouse.

## **4 Paper Claims**

A compliant 835 Payment/Advice with required elements will be generated in response to all claim submissions regardless if they are submitted on paper or electronically in the 837 format.

## **5 Paper Remittance Advices**

BlueChoice HealthPlan Medicaid will continue to produce paper remittance advices along with electronic remittances advices for an undetermined period of time.

## 6 Delimiters

BlueChoice HealthPlan Medicaid will use the delimiters as defined in the table below for all outbound transactions.

Delimiter	Character Name	Character
Data Element Separator	Asterisk	*
Sub-Element Separator	Bar	
Segment Terminator	Tilde	~

## 7 Scheduling

The delivery of 835 files is coordinated with their corresponding check remit dates. Under normal operating conditions, the 835 file is available the next business day. For example, payment information for the check remit date Monday 7/12 will be available and posted in the 835 file on Tuesday 7/13.

Company closings or holidays may affect delivery of 835 files. Scheduling resumes when production begins on the next opening business day. The following table provides the check remit dates for payment of institutional and professional claims.

CHECK REMIT DATE							
		Monday	Tuesday	Wednesday	Thursday	Friday	
System	Line of Business						
D950	BlueChoice HealthPlan Medicaid	SC	Institutional Professional	Institutional Professional	Institutional Professional	Institutional Professional	Institutional Professional

## 8 Claim Adjustment Group Code

The Claim Adjustment and Service Adjustment Segments (CAS) provide the reasons, amounts, and quantities of any adjustments that the payer made either to the original submitted charge or to the units related to the claim or service(s). Specifically, the **Claim Adjustment Group Code** (CAS01) categorizes the adjustment reason codes contained in a particular CAS and are evaluated according to the following order:

1. **Patient Responsibility** (PR) — indicates the amount adjusted in CAS segment is the patient's responsibility.
2. **Contractual Obligations** (CO) — indicates the amount adjusted in CAS segment is not the patient's responsibility and due to a contractual obligation between the provider and the payer.
3. **Payer Initiated Reductions** (PI) — indicates the amount adjusted in CAS segment is not the patient's responsibility and not due to a contractual obligation between the provider and the payer.
4. **Correction and Reversals** (CR) — indicates the claim is the reversal of a previously reported claim or claim payment.
5. **Other Adjustments** (OA) — indicates the amount adjusted does not fall in any of the above categories.

## 9 Claim Adjustment Reason Codes and Remittance Advice Remark Codes

A claim adjustment reason code (CAS segment) is used to communicate that an adjustment was made at the claim/service line, and provides the reason for why the payment differs from what was billed. The adjustment reason code list is available on the internet, [http://www.wpc-edi.com/codes/claim adjustment](http://www.wpc-edi.com/codes/claim%20adjustment) and review by the Claim Adjustment Status Code maintenance committee three times a year.

A claim remittance advice remark code (LQ segment) provides supplemental explanation for an adjustment already described by an adjustment reason code. Previously, the remittance remark code list was created and supported for Medicare only, but now it is appropriate for use by all payers. The remark code list is available on the internet, <http://www.wpc-edi.com/codes/remittanceadvice>, and reviewed by the Remittance Advice Code Maintenance Committee whose members represent various components from CMS.

It is important to continue referring to the code lists maintained by the committees. Updated code lists are published tri-annually at the end of March, July, and November.

The use of HIPAA standards has imposed a limitation on what detailed explanation is reported on the 835 Payment/Advice. It has been determined that proprietary disposition codes may not map one-for-one to a standard HIPAA claim adjustment reason and/or remittance advice remark code.

## 10 National Provider Identifier (NPI)

Beginning May 23, 2007 through May 23, 2008, providers can submit either their legacy provider identifiers or their registered NPI on claim submissions. Invalid or registered NPIs will result in the rejection of their claims. On and after the compliance date of May 23, 2008, providers are required to use NPI as their primary ID (replaces the legacy provider identifier) for all electronic transactions and on paper claims as required for active participating providers. The legacy provider identifier will no longer appear on the 835 electronic remittance. Instead, the NPI will be populated in its 10-position, all numeric format.

DUAL RECEIPT (end date 5/23/08)						
<b>Loop 1000B - Payee Identification</b>		<b>N101</b>	<b>N103</b>	<b>N104</b>	<b>REF01</b>	<b>REF02</b>
<b>N1 Payee Identification</b>	NPI	PE	XX	NPI	TJ	Tax ID
<b>REF Payee Additional Identification</b>	No NPI		24	Tax ID	PQ	Legacy Provider ID
<b>Loop 2100 - Claim Payment Information</b>		<b>NM101</b>	<b>NM108</b>	<b>NM109</b>		
<b>NM1 Service Provider Name</b>	NPI	82	XX	NPI		
	No NPI		BD	BC Provider ID		
			BS	BS Provider ID		
			FI	Tax ID		
			MC	Medicaid Provider ID		
<p><b>*Note to Non-Exempt Providers</b>            Effective 5/24/08 - Since NPI must be submitted as primary ID and legacy identifiers are not accepted on inbound claims, NPI identifier (N1 &amp; NM1 segments) will be returned with no legacy identifiers PQ (REF segment), BD/BS/MC (NM1 segment) on outbound 835.</p>						

## 11 Balancing

To ensure HIPAA compliance, editing is performed on the 835 transaction as it is routed through the Enterprise EDI Gateway/Clearinghouse. Successful outbound routing to the 835 trading partner depends on the balancing of the file where the total payment must agree with the remittance information detailing that payment.

The amounts reported in the file must balance at three different levels; the service line, the claim, and the transaction. When service payment information is provided, the submitted service charge (SVC02) minus the sum of all monetary adjustments (CAS segments) must equal the amount paid for the service line (SVC02). Similarly within the claim payment loop, the submitted charge for the claim (CLP03) minus the sum of all monetary adjustments (CAS segments) must equal the claim paid amount (CLP04). The total claim charge (CLP03) must balance the sum of the related service charges (SVC02), if applicable.

Further balancing within the transaction ensures that the sum of all claim payments (CLP04) minus the sum of all provider level adjustments (PLB segments) equals the total payment amount (BPR02).

All balancing measures must be met in order for an 835 file to be delivered to the Gateway. Occasionally, balancing issues may delay the delivery of an 835 file. Delays are generally no later than 24 hours beyond the scheduled delivery.

## 835 Health Care Claim Payment/Advice – Header

The 835 Payment/Advice Header contains general payment information, such as Amount, Payee, Payer, Trace Number and Payment method. The following table explains the header segments and data elements that require specific information for BlueChoice HealthPlan Medicaid processing.

835 Health Care Claim Payment/Advice—Header				
IG	Segment	Reference Designator(s)	Value	Definitions and Notes Specific to BlueChoice HealthPlan Medicaid
P.44	BPR Financial Information	<b>BPR01</b> Transaction Handling Code	<i>I</i> <i>H</i>	I - Remittance Information Only H - Notification only
		<b>BPR03</b> Credit/Debit Flag	<i>C</i>	C - Credit to the provider's account
		<b>BPR04</b> Payment Method Code	<i>ACH</i> <i>CHK</i> <i>NON</i>	ACH - Automated Clearing House (EFT) CHK - Check NON - Non-Payment Data
		<b>BPR05</b> Payment Format Code	<i>CCP</i> <i>CTX</i>	CCP - Cash Concentration/Disbursement plus Addenda CTX - Corporate Trade Exchange
		<b>BPR06</b> (DFI) ID Number Qualifier	<i>(Depository Financial Institution ID Qualifier)</i>	01 - ABA Transit Routing Number  Unique number identifying bank in US.
		<b>BPR07</b> (DFI) Identification	<i>(Sender DFI Identifier)</i>	Represents Bank Number
		<b>BPR09</b> Account Number	<i>(Sender Bank Account No.)</i>	Represents Bank Account Number
		<b>BPR12</b> (DFI) ID No. Qualifier	<i>01</i>	01 - ABA Transit Routing Number unique number identifying bank in US
		<b>BPR13</b> Receiver (DFI) ID	<i>(Receiver DFI ID)</i>	Represents Receiver/Provider's Bank Number
		<b>BPR15</b> Receiver Bank Account Number	<i>(Receiver Bank Account No.)</i>	Represents Receiver/Provider's Bank Number
		<b>BPR16</b> Check Issue or EFT Effective Date	<i>(Check Issue Date)</i>	check issue date or EFT effective date
P.52	TRN Reassociation Trace No.	<b><i>When the payment is separate from the 835 remittance, the TRN segment provides a trace No. to reassociate the dollars and the remittance data.</i></b>		
		<b>TRN02</b> Trace Code Type	<i>(Check or EFT Trace Number)</i>	Check No. - for paper check Advice No. - for EFT 'NO PAYMENT' - if BPR02 equals \$0.00
		<b>TRN03</b> Originating Company Identifier	<i>(Payer Identifier)</i>	Format: prefix of '1' followed by federal tax ID number. (company code)
P.57	REF Receiver Identification	<b>REF01</b> Reference Identification	<i>EV</i>	EV - Receiver ID No. Displays if receiver of 835 differs from payee (i.e., clearinghouse, billing service)
		<b>REF02</b> Receiver Identifier	<i>(Receiver Identifier)</i>	Electronic routing address identifier of the Clearinghouse or Billing Service, if applicable

## 835 Health Care Claim Payment/Advice – Detail

The 835 Payment/Advice Detail level contains the explanations of benefits/charges paid, reduced or denied, related to the adjudicated claims and services. The following table identifies the situational segments and data elements, and specific values of the required segments and data elements, in these Loops that are used for BlueChoice HealthPlan Medicaid processing.

835 Health Care Claim Payment/Advice—Detail				
IG	Segment	Reference Designator(s)	Value	Definitions and Notes Specific to BlueChoice HealthPlan Medicaid
<b>Loop ID 1000B—Payee Identification</b>				
P.72	N1 Payee Identification	N103 Identification Code Qualifier	<i>FI</i> <i>XX **</i>	FI - Federal Taxpayer's ID Number XX - Health Care Financing Administration NPI
		N104 Identification Code	<i>(Payee Identification Code)</i>	Tax ID (with FI qualifier) NPI (with XX qualifier)
P.77	REF Payee Additional Identification	REF01 Reference Identification	<i>PQ</i> <i>TJ</i>	PQ - Payee Identification TJ - Federal Taxpayer's Identification number
		REF02 Reference Identification	<i>(Additional Payee Identifier)</i>	Provider No. (with PQ qualifier) Tax ID (with TJ qualifier)
<b>Loop ID 2100—Claim Payment Information</b>				
P.89	CLP Claim	CLP01 Claim Submitter's	<i>(Patient Control Number)</i>	As submitted on 837 or claim. '0', if control number not available.
		CLP02 Claim Status Code	<i>1</i> <i>2</i> <i>3</i> <i>4</i> <i>22</i>	1 - Claim processed as Primary 2 - Claim processed as Secondary 3 - Claim processed as Tertiary 4 - Denied 22 - Reversal of previous payment
		CLP05 Monetary Amount	<i>(Patient Responsibility Amount)</i>	Patient responsibility amount for the particular claim.
		CLP06 Claim Filing Indicator Code	<i>MC</i>	MC - Medicaid
		CLP07 Reference Identification	<i>(Payer Claim Control Number)</i>	Assigned claim number
		P.102	NM1 Patient Name	NM108 Identification Code
		NM109 Identification Code	<i>(Subscriber Identifier)</i>	Assigned Membership Number
P.105	NM1 Insured Name	NM102 Entity Type Code	<i>1</i>	1 - Person
		NM108 Identification Code Qualifier	<i>MI</i>	MI - Member Identification Number
		NM109 Identification Code	<i>(Subscriber Identifier)</i>	Assigned Membership Number

835 Health Care Claim Payment/Advice—Detail				
IG	Segment	Reference Designator(s)	Value	Definitions and Notes Specific to BlueChoice HealthPlan Medicaid
<b>Loop ID 2100—Claim Payment Information (cont'd)</b>				
P.111	NM1 Service Provider Name	NM108 Identification Code Qualifier	BD BS FI XX **	BD - Blue Cross Provider Number BS - Blue Shield Provider Number FI - Federal Tax Identification Number XX - NPI
		NM109 Identification Code	(Rendering Prov Identifier)	Tax ID (with FI qualifier) NPI (with XX qualifier)
P.130	DTM Claim Date	DTM01 Date/Time Qualifier	050	050 - Received
<b>Loop ID 2110—Service Payment Information</b>				
P.139	SVC Service Payment Information	SVC01-1 Product or Service ID Qualifier	AD HC ID N4 NU ZZ	qualifies values in SVC06-2 -6: AD - American Dental Association Codes; HC - HCPCS; ID - ICD-9-CM; N4 - National Drug Code in 5-4-2 format; NU - NUBC; ZZ - Mutually Defined
		SVC01-2 Product or Service ID	(Procedure Code)	If charges are rebundled, then adjudicated code will be reflected
		SVC06 Composite Medical Procedure Identifier	See SVC06-1 through SVC06-7	Used when 1) adjudicated proc code in SVC01 differs from orig submitted proc code, 2) referencing orig submitted procedures on a rebundled claim, or 3) referencing medical policy change
		SVC06-1 Product or Service ID Qualifier	AD HC ID N4 NU ZZ	references orig submitted proc code: AD - American Dental Association Codes; HC - HCPCS; ID - ICD-9-CM; N4 - National Drug Code in 5-4-2 format; NU - NUBC; ZZ - Mutually Defined
P.148	CAS Claim Adjustment	CAS02,5,8,11,14,17 Claim Adjustment Reason Code	(Adjustment Reason Code)	Adjustments reported when the amount paid differs from the amount originally charged
P.154	REF Service Identification	REF01 Reference Identification Qualifier	6R	6R - Provider Control Number
		REF02 Reference Identification	(Line Item Control Number)	value submitted on 837
P.162	LQ Health Care Remark Codes	LQ01 Code List Qualifier Code	HE	HE - Claim Payment Remark Codes
		LQ02 Industry Code	(Remark Code)	May include up to 5 codes per line

**NOTE. National Provider Identifier (NPI) Information for Non-Exempt Providers.**

\*\*Under CMS guidance, BlueChoice HealthPlan Medicaid is allowing a contingency period for usage of the NPI. Either legacy provider identifiers or valid & registered NPI will be accepted through May 23, 2008. Effective May 24, 2008, NPI-only submissions accepted; Legacy identifiers 0B, 1A, 1B, 1C, 1D, 1G, 1H, E2, LU, N5, X5 will be rejected. If applicable, please alert your Billing Service, Software vendor, and/or Clearinghouse of this dual receipt time period.

## 835 Health Care Claim Payment/Advice – Summary

The 835 Payment/Advice Summary level contains the Provider level adjustments, which provides information related to adjustments to the payment amount not specific to the claims in the 835 Payment/Advice Detail level. The following table identifies the situational segments and data elements, and specific values of the required segments and data elements, in these Loops that are used for BlueChoice HealthPlan Medicaid processing.

835 Health Care Claim Payment/Advice—Summary				
IG	Segment	Reference Designator(s)	Value	Definitions and Notes Specific to BlueChoice HealthPlan Medicaid
<b>Used to allow adjustments that are NOT specific to a particular claim or service</b>				
P.164	PLB Provider Adjustment	PLB01 Reference Identification	<i>(Provider Identifier)</i>	Pay-to Provider / Payee ID Number
		PLB03-1 Adjustment Reason Code	<i>FB IR L6 PI</i>	FB - Forwarding Balance IR - Internal Revenue Service Withholding L6 - Interest Owed PI - Periodic Interim Payment

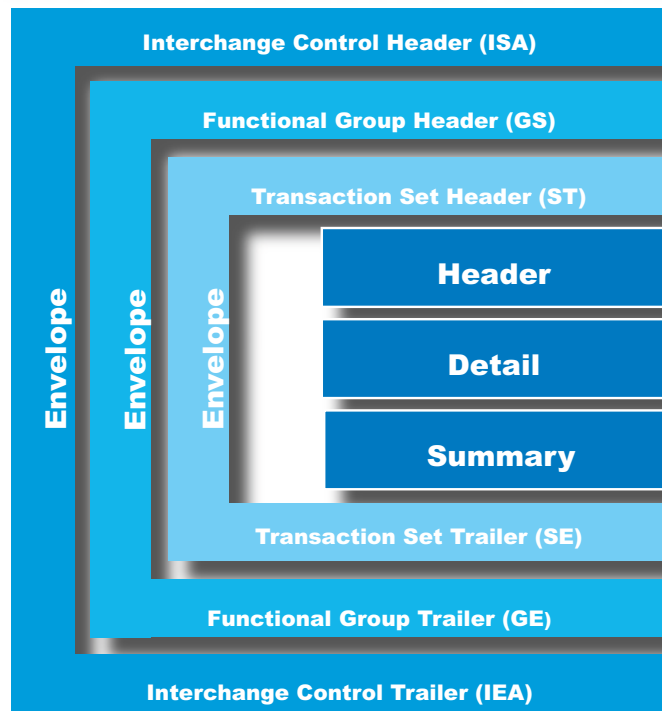
## Enveloping

This section explains EDI enveloping of the 835 Payment/Advice transaction that will help you when receiving responses from BlueChoice HealthPlan Medicaid.

EDI envelopes control and track communications between you and BlueChoice HealthPlan Medicaid. One envelope may contain many transaction sets grouped into functional groups. The envelope includes the following components:

- Interchange Control Header (ISA)
- Functional Group Header (GS)
- Functional Group Trailer (GE)
- Interchange Control Trailer (IEA)

### 835 EDI Transaction Structure



## 835 Envelope Control Segments – Outbound

### 1 835 Health Care Claims Interchange Control Header (ISA)

The ISA segment is the beginning, outermost envelope of the interchange control structure. Containing authorization and security information, it clearly identifies the Sender, Receiver, Date, Time, and Interchange Control Number. Use the following table to supplement the 835 Implementation Guide. This information does not modify the 835 Implementation Guide.

835 Health Care Claim Payment / Advice Interchange Control Header (ISA)			
Segment	Reference Designator(s)	Value	Definitions and Notes Specific to BlueChoice HealthPlan Medicaid
<b>ISA</b> Interchange Control Header	<b>ISA01</b> Authorization Information Qualifier	00	00 - No Authorization Information Present
	<b>ISA02</b> Authorization Information	(10 Spaces)	10 position value populated on 837 transaction.
	<b>ISA03</b> Security Information Qualifier	00	00 - No Security Information Present
	<b>ISA04</b> Security Information	(10 Spaces)	10 position value populated on 837 transaction.
	<b>ISA05</b> Interchange ID Qualifier	ZZ	ZZ - Mutually Defined
	<b>ISA06</b> Interchange Sender ID	BCBSCAIDSC	<ul style="list-style-type: none"> <li>▪ BCBSCAIDSC - BlueChoice HealthPlan Medicaid</li> <li>▪ left-justified followed by nine trailing spaces</li> </ul>
	<b>ISA07</b> Interchange ID Qualifier	ZZ	ZZ - Mutually Defined
	<b>ISA08</b> Interchange Receiver ID	(Receiver ID)	<ul style="list-style-type: none"> <li>▪ represents assigned Sender ID, identical to GS03</li> <li>▪ left-justified followed by trailing spaces</li> </ul>
	<b>ISA09</b> Interchange Date	(YYMMDD)	Valid date in YYMMDD format.
	<b>ISA10</b> Interchange Time	(HHMM)	Valid time in HHMM format.
	<b>ISA11</b> Interchange Control Standards Identifier	U	U - U.S. EDI Community of ASC X12, TDCC, and UCS
	<b>ISA12</b> Interchange Control Version Number	00401	00401 - Draft Standards for Trial Used Approved for Publication by ASC X12 Procedures Review Board through October 1997
	<b>ISA13</b> Interchange Control Number	(Assigned by System)	<ul style="list-style-type: none"> <li>▪ 9 position numeric value; unique &amp; greater than zero.</li> <li>▪ right-justified filled with leading zeroes</li> </ul>
	<b>ISA14</b> Acknowledgment Requested	0	0 - No Acknowledgment Requested
	<b>ISA15</b> Usage Indicator	P, T	Sender must be approved for production data. P - Production Data; T - Test Data
	<b>ISA16</b> Component Element Separator		BlueChoice HealthPlan Medicaid returns ' ' (bar) as Component Element Separator

## 2 835 Health Care Claims Functional Group Header (GS)

The GS segment identifies the collection of transaction sets that are included within the functional group. More specifically, the GS segment identifies the functional control group, sender, receiver, date, time, group control number and version/release/industry code for the transaction sets. Use the following table, specific to BlueChoice HealthPlan Medicaid, to supplement the 835 Implementation Guide. This information does not modify the 835 Implementation Guide.

835 Health Care Payment / Advice Functional Group Header (GS)			
Segment	Reference Designator(s)	Value	Definitions and Notes Specific to BlueChoice HealthPlan Medicaid
<b>GS</b> Functional Group Header	<b>GS01</b> Functional Identifier Code	<i>HP</i>	HP - Health Care Claim Payment/Advice (835)
	<b>GS02</b> Application Sender's Code	<i>BCBSCAIDSC</i>	Used for batched transactions in separate functional groups Routing from: BCBSCAIDSC - BlueChoice HealthPlan Medicaid Application
	<b>GS03</b> Application Receiver's Code	<i>** (Receiver ID)</i>	**Sender ID used on 837 transaction.
	<b>GS04</b> Date	<i>(CCYYMMDD)</i>	Valid date in CCYYMMDD format.
	<b>GS05</b> Time	<i>(HHMM)</i>	Valid time in HHMM format.
	<b>GS06</b> Group Control Number	<i>(Assigned by BlueChoice HealthPlan Medicaid)</i>	<ul style="list-style-type: none"> <li>▪ Format - 1 through 9 positions, numeric</li> <li>▪ Unique and not duplicated value</li> <li>▪ Value greater than zero</li> <li>▪ Left-justified with no leading or trailing zeroes</li> <li>▪ Identical to GE02</li> </ul>
	<b>GS07</b> Responsible Agency Code	<i>X</i>	X - Accredited Standards Committee X12
	<b>GS08</b> Version / Release / Industry Identifier Code	<i>004010X091A1</i>	Operationally used to identify the 835 Health Care Claim Payment/Advice transaction

### 3 835 Health Care Claims Functional Group Trailer (GE)

The GE segment indicates the end of the functional group and provides control information. Use the following table, specific to BlueChoice HealthPlan Medicaid, to supplement the 835 Implementation Guide. This information does not modify the 835 Implementation Guide.

835 Health Care Payment / Advice Functional Group Trailer (GE)			
Segment	Reference Designator(s)	Value	Definitions and Notes Specific to BlueChoice HealthPlan Medicaid
GE Functional Group Trailer	GE01 Number of Transaction Sets Included	(n)	<ul style="list-style-type: none"> <li>Format - 1-6 positions, numeric</li> <li>Left-justified with no leading zeroes</li> </ul>
	GE02 Group Control Number	(Identical to GS06)	<ul style="list-style-type: none"> <li>Format - 1-9 positions, numeric</li> <li>Unique value greater than zero</li> <li>Left-justified with no leading or trailing zeroes</li> <li>Identical to GS06</li> </ul>

### 4 835 Health Care Claims Interchange Control Trailer (IEA)

The IEA segment is the ending, outermost level of the interchange control structure. It indicates and verifies the number of functional groups included within the interchange and the interchange control number (the same number indicated in the ISA segment). Use the following table, specific to BlueChoice HealthPlan Medicaid, to supplement the 835 Implementation Guide. This information does not modify the 835 Implementation Guide.

835 Health Care Payment / Advice Interchange Control Trailer (IEA)			
Segment	Reference Designator(s)	Value	Definitions and Notes Specific to BlueChoice HealthPlan Medicaid
IEA Interchange Control Trailer	IEA01 Number of Included Functional Groups	(n)	<ul style="list-style-type: none"> <li>Format - 1-5 positions, numeric</li> <li>Equal to the number of functional groups (GS/GE pairs) included in the interchange.</li> <li>Left-justified with no leading or trailing zeroes</li> </ul>
	IEA02 Interchange Control Number	(Identical to ISA13)	<ul style="list-style-type: none"> <li>Format - 9 positions, numeric</li> <li>Unique value greater than zero</li> </ul>