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MVP Health Care

Testing and Implementation Guide

*ANSI X12 835 Version 4010X091A1
Health Care Claim Payment/Remittance
Advice*

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VERSION CHANGE LOG

Version 1.0 Original	October 12, 2003
Version 1.6 – MVP Health Care Chris Johnson	November 20, 2003
Version 1.7 – MVP Health Care Chris Johnson Removed unused segments	January 15, 2004
Version 1.8 – MVP Health Care Chris Johnson Added unused elements for clarification. Modify some elements to Correspond to values produced by the Facets system	August 25, 2005
Version 1.9– MVP Health Care Chris Johnson Updated the current business section. Removed some duplicate statements.	August 25, 2005
Version 2.0 – MVP Health Care Wendy Face Updated for Single Brand Identity.	April 27, 2009

INTRODUCTION

In an effort to reduce the administrative costs of health care across the nation, the Health Insurance Portability and Accountability Act (HIPAA) was passed in 1996. This legislation requires that health insurance payers in the United States comply with the electronic data interchange (EDI) standards for health care, established by the Secretary of Health and Human Services (HHS). For the health care industry to achieve the potential administrative cost savings with EDI, standard transactions and code sets have been developed and need to be implemented consistently by all organizations involved in the electronic exchange of data. The ANSI X12N 835 Health Care Claim Payment/Remittance Advice implementation guide provides the standardized data requirements to be implemented for this transaction.

PURPOSE

The purpose of this document is to provide the information necessary for providers or their intermediaries to receive Health Care Claim Payments/Advice transactions electronically from MVP. **This companion guide is to be used in conjunction with the ANSI X12N implementation guides.** The companion guide supplements, but does not contradict or replace any requirements in the implementation guide. The HIPAA implementation guides can be obtained from the Washington Publishing Company by calling 1-800-972-4334 or are available for download on their web site at www.wpc-edi.com/hipaa/. Other important websites:

Workgroup for Electronic Data Interchange (WEDI) – <http://www.wedi.org>
United States Department of Health and Human Services (DHHS) – <http://aspe.hhs.gov/admsimp/>
Centers for Medicare and Medicaid Services (CMS) – <http://www.cms.gov/hipaa/hipaa2/>
Designated Standard Maintenance Organizations (DSMO) – <http://www.hipaa-dsmo.org/>
National Council of Prescription Drug Programs (NCPDP) – <http://www.ncdp.org/>
National Uniform Billing Committee (NUBC) – <http://www.nubc.org/>
Accredited Standards Committee (ASC X12) – <http://www.x12.org/>

This document identifies how MVP populates X12 835 transactions using available data within the 004010X091A1 implementation guide. If segments and elements are required in the implementation guide, they will not be addressed in this document. We are including usage of situational segments and elements or specifying qualifiers MVP will be supporting. MVP may, at a future date, support additional implementation guide values. This document must be used in conjunction with the implementation guide. Receivers of the X12 835 should have the capability to accept any valid value within the implementation guide.

SPECIAL CONSIDERATIONS

Outbound Transactions Supported

MVP will issue the following outbound transactions (from MVP to the provider or their intermediary), in support of the ASC X12 835 Health Care Claim Payment/Advice:

- 835– Health Care Claim Payment/Advice - **ASC X12N 835 (004010X091A1)**

Response Transactions Supported

In response to 835 transactions sent, MVP requires the following response transactions from providers or their intermediaries:

- 997 Functional Acknowledgement

Communication Specifications

MVP currently supports sending the 835, Health Care Claim Payment/Remittance Advice, in batch mode only. The file can be uploaded via the Internet or FTP (File Transfer Protocol) – with PGP encryption.

File naming conventions will be assigned at part of the testing process.

Delimiters Supported

A delimiter is a character used to separate two data elements or sub-elements, or to terminate a segment. Delimiters are specified in the interchange header segment, ISA. The ISA segment is a 105 byte fixed length record. The data element separator is byte number 4; the component element separator is byte number 105; and the segment terminator is the byte that immediately follows the component element separator. Once specified in the interchange header, delimiters are not to be used in a data element value elsewhere in the transaction.

MVP will support the following default delimiters or any delimiter specified by the trading partner in the ISA/IEA envelope structure:

Description	Default Delimiter	Delimiter Used by MVP
Data element separator	* Asterisk	* Asterisk
Sub-element separator	: Colon	: Colon
Segment Terminator	~ Tilde	~ Tilde

Maximum Limitations

The length of monetary amounts in the 835 is limited to 10 characters (not including decimal point and leading sign if used). No monetary amount in 835's issued by MVP will exceed: \$99,999,999.99.

MVP will not limit the quantity of claims and service lines in one 835.

Description	Maximum from MVP
ST-SE envelope	CLP segments – no limits SVC segments – no limits

HIPAA IMPACT ON CURRENT BUSINESS PROCESSES

In the Final Transaction Rule, health plans are required to support the remittance advice portion of the 835 Health Care Claim Payment/Advice, for providers who request electronic transmission of this information.

The 835 can also be used to carry payment instructions; an option not mandated by HIPAA.

The 835 and payment from MVP:

- MVP will send 835 (RA only) to Payee or their intermediary (e.g. billing agent or clearinghouse) and will mail check to Payee

The 835 Remittance Advice will only be produced for:

- An entity (Payee or intermediary) whereas this entity has been established as an Electronic Trade Partner with MVP before a check run.

Payment Mode: MVP will issue the 835 to support the following payment mode:

- Credit transaction – initiated by MVP

Currency: MVP will:

- Only accepts claim charges in US dollars and pays in US dollars
- 835 Remittance Advice monetary amounts from MVP are always in units of US dollars.

Version Identification: MVP will include information on the specific MVP adjudication system used to produce payments and remittance information through use of the Version Identification segment in the 835 (*Table 1 – Header – Version Identification – REF02*).

Production Date: MVP will also include, via the Production Date segment (*Table 1 – Header – DTM02*), the end date of the adjudication system for the claims represented in the 835. Please include this information in any queries to MVP concerning an 835 you have received from us.

Payer Claim Control Number: In addition to incorporating the Patient Control Number in the 835 (*Table 2, Detail – Loop 2100 - CLP01*), MVP will also transmit the Payer Claim Control Number (*Table 2, Detail – Loop 2100, CLP07*). The Payer Claim Control Number is the number assigned by MVP to the submitted claim. Please include this information in any queries to MVP Health Care concerning an 835 you have received from us.

Dates: MVP will include the following dates regarding claims information included in the 835:

- MVP may send date information at the service line level (*Loop 2110 – DTM02*); but will always send date information at the claim level (*Loop 2100 – DTM02*).
- Please refer to the claim/service date level when querying about a specific claim or service line level payment.

Important definition: the 835 supports the conveyance of “adjustment information” at several levels: the claim, claim service line, and at the provider level. Please note that the 835 Implementation Guide’s usage of the term “adjustment” is not always the customary manner that the term “adjustment” is used in the health care industry. Adjustment as defined in this document (and in the 835 Implementation Guide) – means simply (in the case of claims), the difference between the monetary amount submitted (“billed charges”) and the amount paid. In the case of provider level adjustments, “adjustment” generally means an additional payment, withholding, or deduction – unrelated to any claim.

Remarks: MVP includes Remark Codes where needed, to supply additional adjudication information concerning specific service lines (*Loop 2110 – LQ02*). Please review codes transmitted by us prior to contacting MVP. Many times these codes will answer questions you may have about a particular service line.

Implementation of Health Care Claim Payment/Remittance Advice

There will be four phases of implementation.

1. Development Phase – MVP EDI Services will contact the client's IT Representative to review these procedures. MVP will set up a client specific profile to send claim payment advice transactions to the trading partner. The client will create or modify their programs as necessary to accept these transactions from MVP with the required data.
2. Test Phase – MVP will notify the client when they are ready to begin submitting test files. MVP and the client will set up a schedule to send/receive data across the desired media. Upon receiving the file, the client will validate the file format and data for accuracy. The client will run the file through their payment advice receipt process, which will do a series of error checking. MVP will work with the client to identify any errors that will assist with submitting clean health care payment advice transactions. MVP EDI Services will test and identify all technical errors. During the testing phase, the EDI Coordinator will be responsible for the education of providers/hospitals with regard to EDI errors/failures. MVP EDI Services will work closely with the EDI Coordinator to address all aspects of clean payment advice submissions for the client. Client will review and discuss any questions or problems with MVP. The goal will be to achieve a 100% HIPAA compliant remittance advice submission prior to going live.
3. Production - Once testing has reached a 100% acceptance level and both parties have signed off, MVP will move the process into production and go live with the health care payment advice transactions. Health Care Claim Payment/Remittance Advice files will be available after 6:00am. **Providers/hospitals may contact Provider Claims Services or Provider Relations with questions regarding individual claim payment questions.** All transaction error questions should be directed to the EDI Coordinators: 877-461-4911
4. Post Production - MVP will monitor the client's health care payment advice transactions. The client is responsible for providing MVP with information regarding the addition of any new providers, as well as changes to the status of any existing providers, as they occur. In order to ensure inclusion/exclusion of providers appropriately, timely receipt of this information is critical. Also, the client should inform MVP of any questions, issues or problems in a timely fashion.

MVP Requirements for the ANSI X12 835 Transaction – Health Care Claim Payment/Remittance Advice

REQUIRED	ELEMENT	ELEMENT DESCRIPTION	VALUES	DESCRIPTION
		INTERCHANGE/FUNCTION HEADERS		
R	ISA	INTERCHANGE CONTROL HEADER		
R	ISA01	AUTHORIZATION INFORMATION QUALIFIER	00	No Authorization Information Present in I02
R	ISA02	AUTHORIZATION INFORMATION		Blank
R	ISA03	SECURITY INFORMATION QUALIFIER	00	No Security Information Present in I04
R	ISA04	SECURITY INFORMATION		Blank
R	ISA05	INTERCHANGE ID QUALIFIER	30, ZZ	30-Federal Tax ID, ZZ-Mutually Defined
R	ISA06	INTERCHANGE SENDER ID	141650868 PREFERRED CARENY	MVP Tax ID Preferred Care ID
R	ISA07	INTERCHANGE ID QUALIFIER	30, ZZ	30-Federal Tax ID, ZZ-Mutually Defined
R	ISA08	INTERCHANGE RECEIVER ID		Trading Partner Tax ID
R	ISA09	INTERCHANGE DATE	YYMMDD	Date of interchange
R	ISA10	INTERCHANGE TIME	HHMM	Time of interchange
R	ISA11	INTERCHANGE CONTROL STANDARDS IDENTIFIER	U	U.S. EDI Community of ASC X12, TDCC and UCS
R	ISA12	INTERCHANGE CONTROL VERSION NUMBER	00401	Draft Standards Approved by ASC X12 thru October 1997
R	ISA13	INTERCHANGE CONTROL NUMBER		Must match IEA02
R	ISA14	ACKNOWLEDGMENT REQUESTED	0	0= NO
R	ISA15	TEST INDICATOR	P OR T	P = production T= test
R	ISA16	COMPONENT ELEMENT SEPARATOR	:	Delimiter
R	GS	FUNCTIONAL GROUP HEADER		
R	GS01	FUNCTIONAL IDENTIFIER CODE	HP	Health Care Claim Payment Advice (835)
R	GS02	APPLICATION SENDER'S CODE	141650868 PREFERRED CARENY	MVP Federal Tax ID Preferred Care ID
R	GS03	APPLICATION RECEIVER'S CODE		Trading Partner Tax ID, or any other agreed upon identifier.
R	GS04	DATE	CCYYMMDD	Group Creation Date
R	GS05	TIME	HHMMSS	Creation Time
R	GS06	GROUP CONTROL NUMBER		Assigned by MVP

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REQUIRED	ELEMENT	ELEMENT DESCRIPTION	VALUES	DESCRIPTION
R	GS07	RESPONSIBLE AGENCY CODE	X	Accredited Standards Committee X12
R	GS08	VERSION/RELEASE/INDUSTRY IDENTIFIER CODE	004010X091A1	
TABLE 1 - TRANSACTION HEADER				
R	ST	TRANSACTION SET HEADER		
R	ST01	TRANSACTION SET IDENTIFIER CODE	835	Health Care Claim/Payment Advice
R	ST02	TRANSACTION SET CONTROL NUMBER		Must match SE02 control number
R	BPR	FINANCIAL INFORMATION		Use the BPR to address a single payment to a single payee. The BPR contains mandatory information, even when it is not being used to move funds electronically.
R	BPR01	TRANSACTION HANDLING CODE	I	Code relaying whether and how money and information are to be processed. MVP uses code I = Remittance Information Only
R	BPR02	TOTAL ACTUAL PROVIDER PAYMENT AMOUNT		Total amount being paid for this 835.
R	BPR03	CREDIT OR DEBIT FLAG CODE	C	Credit
R	BPR04	PAYMENT METHOD CODE	CHK	Code specifying how payment is being made (i.e. check, automated clearing house) MVP - uses code CHK=check
NOT USED	BPR05	PAYMENT FORMAT CODE		NOT USED
NOT USED	BPR06	(DFI) ID NUMBER QUALIFIER		NOT USED
NOT USED	BPR07	(DFI) IDENTIFICATION NUMBER		NOT USED
NOT USED	BPR08	ACCOUNT NUMBER QUALIFIER		NOT USED
NOT USED	BPR09	ACCOUNT NUMBER		NOT USED
NOT USED	BPR10	ORIGINATING COMPANY IDENTIFIER		NOT USED
NOT USED	BPR11	ORIGINATING COMPANY SUPPLEMENTAL CODE		NOT USED
NOT USED	BPR12	(DFI) ID NUMBER QUALIFIER		NOT USED
NOT USED	BPR13	(DFI) IDENTIFICATION NUMBER		NOT USED
NOT USED	BPR14	ACCOUNT NUMBER QUALIFIER		NOT USED
NOT USED	BPR15	ACCOUNT NUMBER		NOT USED
R	BPR16	DATE	CCYYMMDD	Check issue date
R	TRN	REASSOCIATION KEY		Aids re-associating payment and remittance data that have been separated.
R	TRN01	TRACE TYPE CODE	1	1 = Current Transaction Trace Numbers

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REQUIRED	ELEMENT	ELEMENT DESCRIPTION	VALUES	DESCRIPTION
R	TRN02	CHECK OR EFT TRACE NUMBER		This number must be unique within the sender/receiver relationship. The sender assigns this number. If a payment is made by check, this number should be the check number.
R	TRN03	PAYER IDENTIFIER	1141650868 1161507474	TRN03 must contain the Federal Tax ID Number, preceded by a "1." If used, must = BRP10.
S	REF	VERSION IDENTIFICATION		Use this to report the version number of the adjudication system that generated the claim payments in this transaction.
R	REF01	REFERENCE ID QUALIFIER	EV	Receiver Identification Number
R	REF02	VERSION IDENTIFICATION CODE		Receiver Identification
S	DTM	PRODUCTION DATE		Under most circumstances, this segment is expected to be sent.
R	DTM01	DATE/TIME QUALIFIER	405	405 = Production Use this code for the end date for the adjudication production cycle for claims included in this 835.
R	DTM02	PRODUCTION DATE	CCYYMMDD	
Loop 1000A	R	PAYER IDENTIFICATION		
R	N1	PAYER IDENTIFICATION		Use this N1 loop to provide the name/address information for the payer.
R	N101	ENTITY ID CODE	PR	Payer
S	N102	PAYER NAME	MVP Health Plan PREFERRED CARE NY	Payer Name
R	N3	PAYER ADDRESS		
R	N301	PAYER ADDRESS LINE	625 State Street 220 Alexander Street	Payer Address Line
S	N302	PAYER ADDRESS LINE		Required if a second address line exists.
R	N4	PAYER CITY, STATE, ZIP CODE		
R	N401	PAYER CITY NAME	Schenectady Rochester	Payer City
R	N402	PAYER STATE CODE	NY	Payer state code
R	N403	PAYER ZIP CODE	12305 14607	Payer zip code

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REQUIRED	ELEMENT	ELEMENT DESCRIPTION	VALUES	DESCRIPTION
Loop 1000B	R	PAYEE IDENTIFICATION		
R	N1	PAYEE IDENTIFICATION		Use this N1 loop to provide the name/address information for the payee.
R	N101	ENTITY ID CODE	PE	Payee
S	N102	PAYEE NAME		Payee name
R	N103	IDENTIFICATION CODE QUALIFIER	FI, XX	FI = Federal Taxpayer's Identification Number For individual providers as payees, use this number to represent the Social Security Number. XX = HCFA NPI (when instated)
R	N104	PAYEE IDENTIFICATION CODE		If N103= FI NPI number if N103 = XX
S	N3	PAYEE ADDRESS		
R	N301	PAYEE ADDRESS LINE		Payee Address
S	N302	PAYEE ADDRESS LINE		Required if a second address line exists.
S	N4	PAYEE CITY, STATE, ZIP CODE		
R	N401	PAYEE CITY NAME		Payee City
R	N402	PAYEE STATE CODE		Payee state code
R	N403	PAYEE ZIP CODE		Payee Zip Code
S	REF	PAYEE ADDITIONAL IDENTIFICATION		Use this REF segment only when more than one identification number is required to identify the payee. Always use the ID number available in the N1 segment before using the REF segment.
R	REF01	REFERENCE ID QUALIFIER	PQ, TJ	PQ=Payee Identification, TJ=Federal Tax ID
R	REF02	ADDITIONAL PAYEE IDENTIFIER		[MVP Assigned ID]

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TABLE 2 - DETAIL				
Loop 2000	S	HEADER NUMBER		
S	LX	HEADER NUMBER		In the event that claim/service information must be sorted, the LX segment must precede each series of claim level and service level segments.
R	LX01	Assigned Number		Line Number
S	TS3	Provider Summary Information		To identify provider subsidiaries whose remittance information is contained in the 835 transactions.
R	TS301	Reference Information		NPI
R	TS302	Facility Code Value		Facility Type Code
R	TS303	Date		Fiscal Period Date
R	TS304	Quantity		Total Claim Count
R	TS305	Monetary Amount		Total Claim Charge Amount
Loop 2100	R	CLAIM PAYMENT INFORMATION		
R	CLP	CLAIM PAYMENT INFORMATION		
R	CLP01	PATIENT CONTROL NUMBER		Use this number for the patient control number assigned by the provider. If the patient control number is not present on the incoming claim, enter zero. The value in CLP01 must be identical to any value received as a Claim Submitter's Identifier on the original claim (CLM01 of the ANSI ASC X12 837, if applicable). This data element is the primary key for posting the remittance information into the provider's database.
R	CLP02	CLAIM STATUS CODE	1,2,4, 22	1 = Primary, 2 = Secondary, 4=Denied, 22 = Reversal
R	CLP03	CLAIM CHARGE AMOUNT - TOTAL		Use this monetary amount for the submitted charges for this claim.
R	CLP04	CLAIM PAYMENT AMOUNT		Use this monetary amount for the amount paid for this claim.
S	CLP05	PATIENT RESPONSIBILITY AMOUNT		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.
R	CLP06	CLAIM FILING INDICATOR CODE	HM	This value should mirror the value received in the original claim (2-005 SBR09 of the 837). HM = Health Maintenance Organization. If 837 value does not match the indicator codes in the 835 file, use default value of HM.
S	CLP07	PAYER CLAIM CONTROL NUMBER		Use this number for the payer's internal control number. This number must apply to the entire claim.

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S	CLP08	FACILITY CODE VALUE		State the facility code here when the submitted code has been modified through adjudication. This number was received in CLM05-1 of the 837 claims.
S	CLP09	CLAIM FREQUENCY TYPE CODE		This data element is specific to institutional claims and is required when it was received on the original claim. This does not apply to other types of claims. This number was received in CLM05-2 of the 837 claims.
NOT USED	CLP10	DRG CODE		NOT USED
S	CLP11	DRG CODE		This data element is specific to institutional claims and is required when adjudication considers the DRG. This does not apply to other types of claims.
S	CAS	CLAIM ADJUSTMENT		Payers must use this CAS segment to report claim level adjustments that cause the amount paid to differ from the amount originally charged. A single CAS segment contains six repetitions of the “adjustment trio” composed of adjustment reason code, adjustment amount, and adjustment quantity.
R	CAS01	GROUP CODE	PR, CO, PI, CR, OA	Evaluate the group codes in CAS01 based on the following order for their applicability to a set of one or more adjustments: PR, CO, PI, CR, and OA. PR = Patient Responsibility CO = Contractual Obligations PI = Payer Initiated Reductions CR = Corrections and Reversals OA = Other Adjustments
R	CAS02	REASON CODE		CODE SOURCE 139: Claim Adjustment Reason Code. See http://www.wpc-edi.com/codes/
R	CAS03	AMOUNT		Use this monetary amount for the adjustment amount. A negative amount increases the payment, and a positive amount decreases the payment contained in CLP04.
R	NM1	PATIENT NAME		
R	NM101	ENTITY IDENTIFIER CODE	QC	Patient
R	NM102	ENTITY TYPE QUALIFIER	1	1=Person
R	NM103	PATIENT LAST NAME		Patient Last Name
R	NM104	PATIENT FIRST NAME		Patient First Name
S	NM105	PATIENT MIDDLE NAME		Middle Name
NOT USED	NM106	PATIENT PREFIX		NOT USED
S	NM107	PATIENT SUFFIX		Suffix

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S	NM108	ID CODE QUALIFIER	MI	MVP Member Identification Number Required if the patient identifier is known or was reported on the health care claim.
S	NM109	PATIENT IDENTIFIER		Required if the patient identifier is known or was reported on the health care claim.
R	NM1	INSURED/SUBSCRIBER NAME		
R	NM101	ENTITY IDENTIFIER CODE	IL	Subscriber
R	NM102	ENTITY TYPE QUALIFIER	1	1=Person
R	NM103	SUBSCRIBER LAST NAME		Subscriber Last Name
R	NM104	SUBSCRIBER FIRST NAME		Subscriber First Name
S	NM105	SUBSCRIBER MIDDLE NAME		Subscriber Middle Name
NOT USED	NM106	SUBSCRIBER PREFIX		NOT USED
S	NM107	SUBSCRIBER SUFFIX		Subscriber Suffix
S	NM108	ID CODE QUALIFIER	MI	MVP Member Identification Number
S	NM109	SUBSCRIBER IDENTIFIER		Required if the patient identifier is known or was reported on the health care claim.
S	NM1	CORRECTED PATIENT/INSURED NAME		Use this NM1 segment to provide corrected information about the patient or insured.
R	NM101	ENTITY IDENTIFIER CODE	74	Corrected Insured
R	NM102	ENTITY TYPE QUALIFIER	1	1=Person
S	NM103	CORRECTED PATIENT LAST NAME		Patient Last Name
S	NM104	CORRECTED PATIENT FIRST NAME		Patient First Name
S	NM105	CORRECTED PATIENT MIDDLE NAME		Patient Middle Name
NOT USED	NM106	PATIENT PREFIX		NOT USED
S	NM107	PATIENT SUFFIX		Patient Suffix
S	NM108	ID CODE QUALIFIER	C	C = Insured's Changed Unique Identification Number Required when a value is reported in NM109.
S	NM109	CORRECTED PATIENT IDENTIFIER		Required when corrected information for the Insured is available.

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S	NM1	SERVICE PROVIDER NAME		Use this NM1 segment to provide information about the rendering provider. This segment is required when the rendering provider is different from the Payee.
R	NM101	ENTITY IDENTIFIER CODE	82	Rendering Provider
R	NM102	ENTITY TYPE QUALIFIER	1, 2	1=Person 2 = Non person entity
S	NM103	RENDERING PROVIDER OR ORGANIZATION LAST NAME		Rendering Provider Last Name
S	NM104	RENDERING PROVIDER FIRST NAME		Rendering Provider First Name
S	NM105	RENDERING PROVIDER MIDDLE NAME		Rendering Provider Middle Name
NOT USED	NM106	RENDERING PROVIDER PREFIX		NOT USED
S	NM107	RENDERING PROVIDER SUFFIX		Rendering Provider Suffix
R	NM108	ID CODE QUALIFIER	FI, XX	FI=Federal Taxpayer's Identification Number XX=NPI
R	NM109	RENDERING PROVIDER IDENTIFIER		Rendering Provider Identifier
S	MIA	INPATIENTADJUDICATION INFORMATION		This segment should be generated by Medicare intermediaries. Either MIA or MOA will appear, but not both. This segment should not be used for covered days or lifetime reserve days. Use the Supplemental Claim Information Quantities Segment in the Claim Payment Loop. All situational quantities and amounts in this segment are required when the value of the item is different than zero. Payers and Payees outside of Medicare community may need to use this segment.
S	MIA01	QUANTITY		Covered Days or Visits Count
NOT USED	MIA02	QUANTITY		NOT USED
NOT USED	MIA03	QUANTITY		NOT USED
NOT USED	MIA04	MONETARY AMOUNT		NOT USED
S	MIA05	REFERENCE IDENTIFIER		Remark Code

S	MOA	OUTPATIENT ADJUDICATION INFORMATION		This segment should be generated by Medicare carriers or Intermediaries. Either MIA or MOA will appear, but not both. All situational quantities and amounts in this segment are required when the value of the item is different than zero. Payers and payees outside of Medicare community may need to use this segment.
NOT USED	MOA01	PERCENT		NOT USED
NOT USED	MOA02	MONETARY AMOUNT		NOT USED
S	MOA03	REFERENCE IDENTIFIER		Remark Code
S	REF	OTHER CLAIM RELATED IDENTIFICATION		Use this REF segment for reference numbers specific to the claim identified in the CLP segment. This is used to provide additional information used in the process of adjudicating this claim.
R	REF01	REFERENCE ID QUALIFIER	BB, IL, SY	BB = Authorization Num, IL=Group/Policy Num, SY=SSN
R	REF02	OTHER CLAIM RELATED IDENTIFIER		Identifier quantified by the value in REF01
S	DTM	CLAIM DATE		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. When claim dates are provided, service dates are not required, but they may be used to “override” the claim dates for individual service lines.
R	DTM01	DATE/TIME QUALIFIER	050, 232, 233	050 = Received 232 = Claim Statement Period Start 233 = Claim Statement Period End
R	DTM02	CLAIM DATE		Claim Date in format: CCYYMMDD
S	AMT	CLAIM SUPPLEMENTAL INFORMATION		Use this segment only when the value of specific amounts identified in the AMT01 qualifier are non-zero.
R	AMT01	AMOUNT QUALIFIER CODE	AU, F5	AU = Coverage Amount F5 = Patient Amount Paid
R	AMT02	AMOUNT		Amount qualified by AMT01

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Loop 2110	S	SERVICE PAYMENT INFORMATION		
S	SVC	SERVICE PAYMENT INFORMATION		Although the SVC loop is optional, there are times when it should be considered mandatory. Whenever the actual payment has been reduced due to service line specific adjustments, the SVC loop is necessary in order to understand the remittance information.
R	SVC01-01	PRODUCT/SERVICE ID QUALIFIER	HC, NU	HC = HCPCS Codes NU = NUBC Codes
R	SVC01-02	PROCEDURE CODE		Procedure Code
S	SVC01-03	PROCEDURE MODIFIER		PROCEDURE MODIFIER
S	SVC01-04	PROCEDURE MODIFIER		PROCEDURE MODIFIER
S	SVC01-05	PROCEDURE MODIFIER		PROCEDURE MODIFIER
S	SVC01-06	PROCEDURE MODIFIER		PROCEDURE MODIFIER
S	SVC01-07	PROCEDURE CODE DESCRIPTION		Used only when a description was received for the service on the original claim, and the adjudicated code is the submitted code.
R	SVC02	LINE ITEM CHARGE AMOUNT		Use this monetary amount for the submitted service charge amount.
R	SVC03	LINE ITEM PROVIDER PAYMENT AMOUNT		Use this number for the service amount paid.
S	SVC04	NUBC REVENUE CODE		Use the National Uniform Billing Committee Revenue Code. Required when an NUBC revenue code was considered during adjudication in addition to a procedure code already identified in SVC01.
S	SVC05	UNITS OF SERVICE PAID COUNT		Use this number for the paid units of service. If not present, the value is assumed to be one.
R	SVC06-01	PRODUCT/SERVICE ID QUALIFIER	HC, NU	This is REQUIRED when the adjudicated procedure code provided in SVC01 is different from the submitted procedure code from the original claim. This is NOT USED when the submitted code is the same as the code on SVC01.
R	SVC06-02	PROCEDURE CODE		Procedure Code
S	SVC06-03	PROCEDURE MODIFIER		PROCEDURE MODIFIER.
S	SVC06-04	PROCEDURE MODIFIER		PROCEDURE MODIFIER
S	SVC06-05	PROCEDURE MODIFIER		PROCEDURE MODIFIER
S	SVC06-06	PROCEDURE MODIFIER		PROCEDURE MODIFIER
S	SVC06-07	PROCEDURE CODE DESCRIPTION		Used only when a description was received for the service on the original claim.

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S	SVC07	ORIGINAL UNITS OF SERVICE COUNT		This is REQUIRED when the paid units of service provided in SVC05 is different from the submitted units of service from the original claim. This is NOT USED when the submitted units is the same as the value in SVC05.
S	DTM	SERVICE DATE		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. When claim dates are not provided, service dates are required for every service line.
R	DTM01	DATE/TIME QUALIFIER	150, 151, 472	150 = Service Period Start 151 = Service Period End 472 (Advised) = Service - Use this code to indicate a single day service.
R	DTM02	CLAIM DATE		Service Date in format: CCYYMMDD
S	CAS	SERVICE ADJUSTMENT		This CAS segment is optional and is intended to reflect reductions in payment due to adjustments particular to a specific service in the claim. A single CAS segment contains six repetitions of the “adjustment trio” composed of adjustment reason code, adjustment amount, and adjustment quantity.
R	CAS01	GROUP CODE	PR, CO, PI, CR, OA	Evaluate the group codes in CAS01 based on the following order for their applicability to a set of one or more adjustments: PR, CO, PI, CR, and OA. PR = Patient Responsibility CO = Contractual Obligations PI = Payer Initiated Reductions CR = Corrections and Reversals OA = Other Adjustments
R	CAS02	REASON CODE		CODE SOURCE 139: Claim Adjustment Reason Code. See http://www.wpc-edi.com/codes/
R	CAS03	AMOUNT		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.
S	AMT	SERVICE SUPPLEMENTAL AMOUNT		Use this segment only when the value of specific amounts identified in the AMT01 qualifier are non-zero.
R	AMT01	AMOUNT QUALIFIER CODE	B6	B6 = Actual Allowed Amount
R	AMT02	AMOUNT		Service Supplemental Amount

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S	LQ	HEALTH CARE REMARK CODES		Use this segment to provide informational remarks only.
R	LQ01	Code List Qualifier Code	HE	Claim Payment Remark Codes CODE SOURCE 411: Remittance Remark Codes
R	LQ02	Remark Code		Remark Code
TABLE 3 - SUMMARY				
S	PLB	PROVIDER ADJUSTMENT		Use the PLB segment to allow adjustments that are NOT specific to a particular claim or service to the amount of the actual payment. These adjustments can either decrease the payment (a positive number) or increase the payment (a negative number).
R	PLB01	PROVIDER IDENTIFIER		Use this number for the provider identifier as assigned by the payer.
R	PLB02	FISCAL PERIOD DATE	CCYYMMDD	Use this date for the last day of the provider's fiscal year.
R	PLB03-01	ADJUSTMENT REASON CODE	90, L6, WO	Refer to 835 IG for further explanation of allowable codes 90=Early Payment Allowance L6=Interest Owed WO=Overpayment Recovery
S	PLB03-02	PROVIDER ADJUSTMENT IDENTIFIER		
R	PLB04	PROVIDER ADJUSTMENT AMOUNT		Use this monetary amount for the adjustment amount for the preceding adjustment reason.
R	PLB05-01	ADJUSTMENT REASON CODE		Refer to 835 IG for further explanation of allowable codes.
S	PLB05-02	PROVIDER ADJUSTMENT IDENTIFIER		
R	PLB06	PROVIDER ADJUSTMENT AMOUNT		Use this monetary amount for the adjustment amount for the preceding adjustment reason.
R	PLB07-01	ADJUSTMENT REASON CODE		Refer to 835 IG for further explanation of allowable codes.
S	PLB07-02	PROVIDER ADJUSTMENT IDENTIFIER		
R	PLB08	PROVIDER ADJUSTMENT AMOUNT		Use this monetary amount for the adjustment amount for the preceding adjustment reason.
R	PLB09-01	ADJUSTMENT REASON CODE		Refer to 835 IG for further explanation of allowable codes.
S	PLB09-02	PROVIDER ADJUSTMENT IDENTIFIER		
R	PLB10	PROVIDER ADJUSTMENT AMOUNT		Use this monetary amount for the adjustment amount for the preceding adjustment reason.
R	PLB11-01	ADJUSTMENT REASON CODE		Refer to 835 IG for further explanation of allowable codes.
S	PLB11-02	PROVIDER ADJUSTMENT IDENTIFIER		
R	PLB12	PROVIDER ADJUSTMENT AMOUNT		Use this monetary amount for the adjustment amount for the preceding adjustment reason.
R	PLB13-01	ADJUSTMENT REASON CODE		Refer to 835 IG for further explanation of allowable codes.
S	PLB13-02	PROVIDER ADJUSTMENT IDENTIFIER		

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R	PLB14	PROVIDER ADJUSTMENT AMOUNT		Use this monetary amount for the adjustment amount for the preceding adjustment reason.
		TRANSACTION TRAILER		
R	SE	TRANSACTION SET TRAILER		
R	SE01	TRANSACTION SEGMENT COUNT		Transaction Segment Count
R	SE02	TRANSACTION SET CONTROL NUMBER		Same as ST02