National Electronic Data Interchange Transaction Set Implementation Guide

Health Care Claim Payment/Advice

835

ASC X12N 835 (004010X091)

May 2000

$72.18 - Bound Document
$80.00 - Portable Document (PDF) on CD-ROM

Portable Documents may be downloaded at no charge.

Contact **Washington Publishing Company** for more Information.

(425) 831-4999
www.wpc-edi.com

Second Printing

© 2000 WPC
Copyright for the members of ASC X12N by Washington Publishing Company.
Permission is hereby granted to any organization to copy and distribute this material internally as long as this copyright statement is included, the contents are not changed, and the copies are not sold.

Table of Contents

1 Purpose and Business Overview 9

1.1 Document Purpose 9
- **1.1.1 Trading Partner Agreements** 9
- **1.1.2 HIPAA Role in Implementation Guides** 10

1.2 Transaction Limitations 10

1.3 Version and Release 10

1.4 Business Use and Definition 11

1.5 Information Flows 11

2 Data Overview 12

2.1 Overall Data Architecture 12
- **2.1.1 Payment** 12
- **2.1.2 Flows (Dollars and Data)** 12
  - 2.1.2.1 ERA with Payment by Check 13
  - 2.1.2.2 ERA and EFT through DFI 13
  - 2.1.2.3 ERA with Payment by Separate EFT 14
  - 2.1.2.4 ERA and Payment Delivered Separately but Processed by a Value-Added Bank (VAB) 14
  - 2.1.2.5 ERA with Debit EFT 15
- **2.1.3 Electronic Funds Transfer** 15
- **2.1.4 Remittance** 16

2.2 Data Use by Business Use 18
- **2.2.1 Balancing** 19
  - 2.2.1.1 Service Line Balancing 19
  - 2.2.1.2 Claim Balancing 20
  - 2.2.1.3 Transaction Balancing 21
- **2.2.2 Remittance Tracking** 22
- **2.2.3 Reassociation of Dollars and Data** 22
- **2.2.4 Claim Adjustment and Service Adjustment Segment Theory** 23
  - 2.2.4.1 Institutional-Specific Use 25
- **2.2.5 Data Relationship with Other Transactions (837, 277, NCPDP 3.2)** 25
- **2.2.6 Procedure Code Bundling and Unbundling** 25
- **2.2.7 Predetermination of Benefits** 28
- **2.2.8 Reversals and Corrections** 28
- **2.2.9 Interest and Prompt Payment Discounts** 29
- **2.2.10 Capitation and Related Payments or Adjustments** 31
- **2.2.11 Definition of a Claim** 33

3 Transaction Set 34

3.1 Presentation Examples 34

Transaction Set Listing 39

Segments

ST Transaction Set Header 43
BPR Financial Information 44
TRN Reassociation Trace Number 52
CUR Foreign Currency Information 54
REF Receiver Identification 57
REF Version Identification 58
DTM Production Date 60
N1 Payer Identification 62
N3 Payer Address 64
N4 Payer City, State, ZIP Code 65
REF Additional Payer Identification 67
PER Payer Contact Information 69
N1 Payee Identification 72
N3 Payee Address 74
N4 Payee City, State, ZIP Code 75
REF Payee Additional Identification 77
LX Header Number 79
TS3 Provider Summary Information 80
TS2 Provider Supplemental Summary Information 85
CLP Claim Payment Information 89
CAS Claim Adjustment 95
NM1 Patient Name 102
NM1 Insured Name 105
NM1 Corrected Patient/Insured Name 108
NM1 Service Provider Name 111
NM1 Crossover Carrier Name 114
NM1 Corrected Priority Payer Name 116
MIA Inpatient Adjudication Information 118
MOA Outpatient Adjudication Information 123
REF Other Claim Related Identification 126
REF Rendering Provider Identification 128
DTM Claim Date 130
PER Claim Contact Information 132
AMT Claim Supplemental Information 135
QTY Claim Supplemental Information Quantity 137
SVC Service Payment Information 139
DTM Service Date 146
CAS Service Adjustment 148
REF Service Identification 154
REF Rendering Provider Information 156
AMT Service Supplemental Amount 158
QTY Service Supplemental Quantity 160
LQ Health Care Remark Codes 162
PLB Provider Adjustment 164
SE Transaction Set Trailer 173

4 EDI Transmission Examples for Different Business Uses 175

4.1 Business Scenario 1 175
4.1.1 Assumptions 175
4.1.2 Transmission 175

4.2 Business Scenario 2 177
4.2.1 Assumptions 177
4.2.2 Transmission 177

A ASC X12 Nomenclature A.1

A.1 Interchange and Application Control Structures A.1
A.1.1 Interchange Control Structure A.1
A.1.2 Application Control Structure Definitions and Concepts A.2
A.1.2.1 Basic Structure A.2
A.1.2.2 Basic Character Set A.2
A.1.2.3 Extended Character Set A.2
A.1.2.4 Control Characters A.3
A.1.2.5 Base Control Set A.3
A.1.2.6 Extended Control Set A.3
A.1.2.7 Delimiters A.4
A.1.3 Business Transaction Structure Definitions and Concepts A.4
A.1.3.1 Data Element A.4
A.1.3.2 Composite Data Structure A.6
A.1.3.3 Data Segment A.7
A.1.3.4 Syntax Notes A.7
A.1.3.5 Semantic Notes A.7
A.1.3.6 Comments A.7
A.1.3.7 Reference Designator A.7
A.1.3.8 Condition Designator A.8
A.1.3.9 Absence of Data A.9
A.1.3.10 Control Segments A.9
A.1.3.11 Transaction Set A.10
A.1.3.12 Functional Group A.12
A.1.4 Envelopes and Control Structures A.12
A.1.4.1 Interchange Control Structures A.12
A.1.4.2 Functional Groups A.13
A.1.4.3 HL Structures A.13
A.1.5 Acknowledgments A.14
A.1.5.1 Interchange Acknowledgment, TA1 ..... A.14
A.1.5.2 Functional Acknowledgment, 997 ..... A.14

B EDI Control Directory B.1

B.1 Control Segments B.3
- **ISA Interchange Control Header** B.3
- **IEA Interchange Control Trailer** B.7
- **GS Functional Group Header** B.8
- **GE Functional Group Trailer** B.10
- **TA1 Interchange Acknowledgment** B.11

B.2 Functional Acknowledgment Transaction Set, 997 ..... B.15
- **ST Transaction Set Header** B.16
- **AK1 Functional Group Response Header** B.18
- **AK2 Transaction Set Response Header** B.19
- **AK3 Data Segment Note** B.20
- **AK4 Data Element Note** B.22
- **AK5 Transaction Set Response Trailer** B.24
- **AK9 Functional Group Response Trailer** B.27
- **SE Transaction Set Trailer** B.30

C External Code Sources C.1
- **4 ABA Routing Number** C.1
- **5 Countries, Currencies and Funds** C.1
- **22 States and Outlying Areas of the U.S.** C.2
- **51 ZIP Code** C.2
- **60 (DFI) Identification Number** C.3
- **77 X12 Directories** C.4
- **91 Canadian Financial Institution Branch and Institution Number** C.4
- **121 Health Industry Identification Number** C.5
- **130 Health Care Financing Administration Common Procedural Coding System** C.5
- **131 International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure** C.5
- **132 National Uniform Billing Committee (NUBC) Codes** C.6
- **134 National Drug Code** C.6
- **135 American Dental Association Codes** C.7
- **139 Claim Adjustment Reason Code** C.7
- **229 Diagnosis Related Group Number (DRG)** C.7
- **235 Claim Frequency Type Code** C.8
- **240 National Drug Code by Format** C.8
- **245 National Association of Insurance Commissioners (NAIC) Code** C.8
- **307 National Association of Boards of Pharmacy Number** C.9
- **411 Remittance Remark Codes** C.9
- **513 Home Infusion EDI Coalition (HIEC) Product/Service Code List** C.10
- **530 National Council for Prescription Drug Programs Reject/Payment Codes** C.10
- **537 Health Care Financing Administration National Provider Identifier** C.10
- **540 Health Care Financing Administration National PlanID** C.11

D Change Summary D.1
D.1 Change Summary D.1
D.2 Change Detail D.2

E Data Element Name Index E.1

1 Purpose and Business Overview

1.1 Document Purpose

For the health care industry to achieve the potential administrative cost savings with Electronic Data Interchange (EDI), standards have been developed and need to be implemented consistently by all organizations. To facilitate a smooth transition into the EDI environment, uniform implementation is critical.

The purpose of this implementation guide is to provide standardized data requirements and content for all users of ANSI ASC X12.85, Health Care Claim Payment/Advice (835). This implementation guide provides a detailed explanation of the transaction set by defining data content, identifying valid code tables, and specifying values that are applicable for electronic claims payment. The intention of the developers of the 835 is represented in this guide.

This implementation guide is designed to assist those who send and/or receive Electronic Remittance Advice (ERA) and/or payments in the 835 format.

Health care providers receiving the 835 include, but are not limited to, hospitals, nursing homes, laboratories, physicians, dentists, and allied professional groups. Organizations sending the 835 include insurance companies, Third Party Administrators (TPAs), service corporations, state and federal agencies and their contractors, plan purchasers, and any other entities that process health care reimbursements. Other business partners affiliated with the 835 include Depository Financial Institutions (DFIs), billing services, consulting services, vendors of systems, software and EDI translators, EDI network intermediaries such as Automated Clearing Houses, value-added networks, and telecommunication services.

1.1.1 Trading Partner Agreements

It is appropriate and prudent for payers to have trading partner agreements that go with the standard Implementation Guides. This is because there are 2 levels of scrutiny that all electronic transactions must go through.

First is standards compliance. These requirements MUST be completely described in the Implementation Guides for the standards, and NOT modified by specific trading partners.

Second is the specific processing, or adjudication, of the transactions in each trading partner's individual system. Since this will vary from site to site (e.g., payer to payer), additional documentation which gives information regarding the processing, or adjudication, will prove helpful to each site's trading partners (e.g., providers), and will simplify implementation.

It is important that these trading partner agreements NOT:

- Modify the definition, condition, or use of a data element or segment in the standard Implementation Guide
- Add any additional data elements or segments to this Implementation Guide
- Utilize any code or data values which are not valid in this Implementation Guide

- Change the meaning or intent of this Implementation Guide

These types of companion documents should exist solely for the purpose of clarification, and should not be required for acceptance of a transaction as valid.

1.1.2 HIPAA Role in Implementation Guides

The Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191 - known as HIPAA) includes provisions for Administrative Simplification, which require the Secretary of Department of Health and Human Services to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. HIPAA directs the Secretary to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard.

Detailed Implementation Guides for each standard must be available at the time of the adoption of HIPAA standards so that health plans, providers, clearinghouses, and software vendors can ready their information systems and application software for compliance with the standards. Consistent usage of the standards, including loops, segments, data elements, etc., across all guides is mandatory to support the Secretary's commitment to standardization.

This Implementation Guide has been developed for use as a HIPAA Implementation Guide for Health Claims Payment Advice. Should the Secretary adopt the X12N 835 Health Care Claims Payment Advice transaction as an industry standard, this Implementation Guide describes the consistent industry usage called for by HIPAA. If adopted under HIPAA, the X12N 835 Health Care Claims Payment Advice transaction cannot be implemented except as described in this Implementation Guide.

1.2 Transaction Limitations

Receiving trading partners may have system limitations regarding the size of the transmission they can receive. Some submitters may have the capability and the desire to transmit enormous 835 transactions with thousands of claims contained in them. The developers of this implementation guide recommend that trading partners limit the size of the transaction (ST-SE envelope) to a maximum of 10,000 CLP segments. There is no recommended limit to the number of ST-SE transactions within a GS-GE or ISA-IEA. Willing trading partners can agree to set limits higher. Note -When payment is via an electronic funds transfer and the remittance information is moved through the banking system, other size limitations due to limits within the banking network may further limit the size of the 835 transaction.

1.3 Version and Release

This implementation guide is based on the October 1997 ASC X12 standards, referred to as Version 4, Release 1, Sub-release 0 (004010). The previous guide is based upon Version 3, Release 7, Sub-release 0 (003070) of the 835 and is dated June 1997.

1.4 Business Use and Definition

The 835 is intended to meet the particular needs of the health care industry for the payment of claims and transfer of remittance information. The 835 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 from a health care payer to a health care provider, either directly or through a DFI.

1.5 Information Flows

Figure 1, Information Flow, illustrates the flow of information from payer to payee directly or through their Depository Financial Institutions.

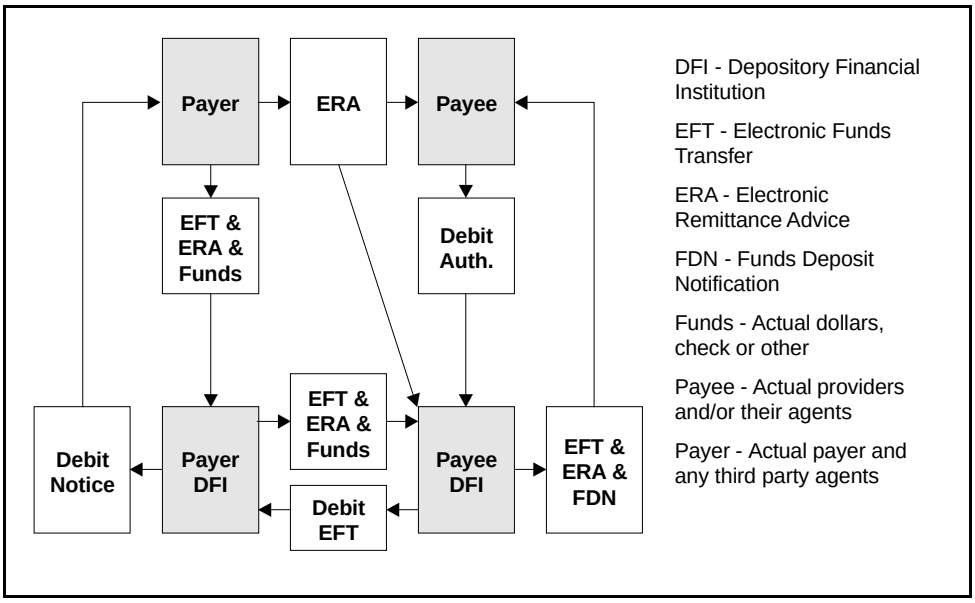


Figure 1. Information Flow

2 Data Overview

2.1 Overall Data Architecture

NOTE
See Appendix A, ASC X12 Nomenclature, to review the transaction set structure, including descriptions of segments, data elements, levels, and loops.

2.1.1 Payment

NOTE
In all instances, “payee” refers to the actual providers and/or their agents. Likewise, “payer” refers not only to the actual payer but to any third party agent as well.

The 835 contains information about the payee, the payer, the amount, and any identifying information of the payment. In addition, the 835 can authorize a payee to have a DFI take funds **from** the payer’s account and **transfer** those funds to the payee’s account.

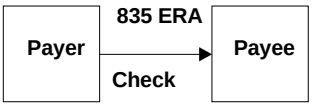
The 835 can authorize a DFI to move funds. In this mode, the 835 is sent to the payer’s DFI. The 835 includes information about the payer’s account; the payee’s DFI, account, and timing; and the method and amount of the funds transfer. This process is known as an “Electronic Funds Transfer” (EFT). The result of an EFT is that funds are deposited directly into the payee’s account. The remittance information may or may not have been transmitted to and through the banking network.

One 835 transaction set reflects a single payment device. In other words, one 835 corresponds to one check or one EFT payment. Multiple claims can be referenced within one 835.

2.1.2 Flows (Dollars and Data)

With the various capabilities inherent in the 835, many ways exist to combine the Electronic Remittance Advice (ERA) and the actual payment ($). Figures 2 through 6 illustrate several methods.

2.1.2.1 ERA with Payment by Check

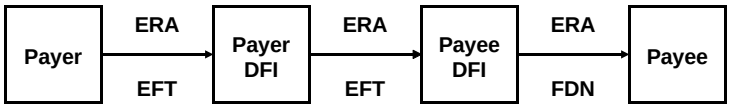


- Payer sends $ via check through the mail.
  - Payer sends ERA directly to the Payee.
    - Payee deposits the check and reconciles the ERA.
      (Reassociation of dollars and data is necessary.)

      NOTE
      See 2.2.3, Reassociation of Dollars and Data, for a description of reassociation.

Figure 2. ERA with Payment by Check

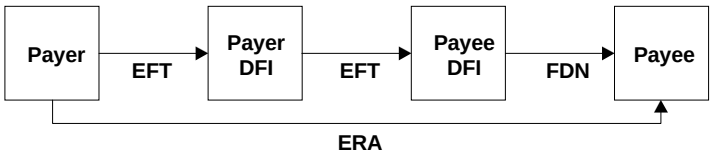
2.1.2.2 ERA and EFT through DFI



- Payer sends $ and ERA in an 835 to the Payer's DFI.
  - Payer's DFI sends $ and ERA to Payee's DFI.
    - Payee's DFI notifies Payee of the $ via FDN (Funds Deposit Notification) and delivers the ERA.
      (Reassociation of dollars and data is not necessary.)

Figure 3. ERA and EFT through DFI

2.1.2.3 ERA with Payment by Separate EFT

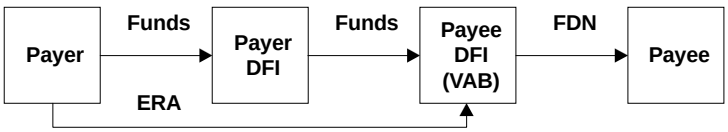


- Payer sends $ via EFT instructions to the Payer's DFI.
  - Payer sends ERA directly to Payee.
    - Payer's DFI sends $ to Payee's DFI.
      - Payee's DFI notifies Payee of $.
        - Payee reconciles ERA with $.
          (Reassociation of dollars and data is necessary.)

NOTE
See 2.2.3, Reassociation of Dollars and Data, for a description of reassociation.

Figure 4. ERA with Payment by Separate EFT

2.1.2.4 ERA and Payment Delivered Separately but Processed by a Value-Added Bank (VAB)

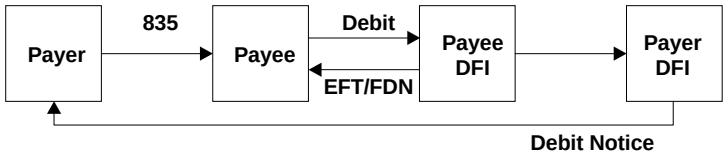


- Payer sends $ as appropriate for EFT or check to Payee's DFI.
  - Payer sends ERA to Payee's DFI.
    - Payee's DFI reconciles ERA and $ and notifies Payee.
      (Reassociation of dollars and data is performed by the VAB.)

NOTE
See 2.2.3, Reassociation of Dollars and Data, for a description of reassociation.

Figure 5. ERA and Payment Separate, Processed by VAB

2.1.2.5 ERA with Debit EFT



- Payer sends 835 with ERA and debit authorization to Payee.
  - Payee instructs DFI to take funds from the Payer's DFI.
    - Payee's DFI gets funds from Payer's DFI and notifies Payee. (Reassociation of dollars and data is necessary.)

NOTES
A debit EFT transaction is not explained in this guide. Should any Payer decide to support the Debit EFT, detailed instructions must be obtained from the applicable DFIs and provided to the affected providers.
See 2.2.3, Reassociation of Dollars and Data, for a description of reassociation.

Figure 6. ERA with Debit EFT

2.1.3 Electronic Funds Transfer

Electronic Funds Transfer (EFT), as it was previously defined, is the electronic mechanism that payers use to instruct one DFI to move money from one account to another account at the same or at another DFI. The information required for the funds transfer is communicated electronically. Many formats are available for the actual data in the electronic message, and different formats apply at each stage. The formats can be proprietary to a particular institution, standard Automated Clearing House (ACH) formats, or ASC X12 transaction sets (820 or 835). See matrix 1, Data Formats, for the data formats that apply at each stage.

Stage (credit transaction)	Proprietary	ACH	ASC X12
Payer to Payer's DFI	Yes	Yes	Yes
Payer's DFI to Payee's DFI	No	Yes (note)	No
Payee's DFI to Payee	Yes	Yes	Yes
Stage (debit transaction)			
Payee to Payee's DFI	Yes	Yes	Yes
Payee's DFI to Payer's DFI	No	Yes (note)	No
Payer's DFI to Payer	Yes	Yes	Yes

NOTE
An 835 moves from one DFI to another DFI encapsulated within an ACH transaction when the DFIs use the ACH network.

Matrix 1. Data Formats

NOTE
See Appendix A, ASC X12 Nomenclature, to review the transaction set structure, including segment descriptions, data elements, levels, and loops.

Specific EFT formats can carry varying degrees of remittance information through the banking industry's ACH. When the remittance information accompanying the EFT goes through the ACH, the payee receives direct information about the reason for the payment. When the remittance information is not conveyed with the dollar information, a way to reassociate the dollars and the remittance data is needed. A unique number related to the specific funds transfer is used for identification when the 835 is used as the remittance carrier. This unique number is the trace number contained in the 835 in the Reassociation Key Segment, TRN. The trace number must be conveyed in the EFT request, and eventually the number is delivered to the payee with notification of the payment. When sending the TRN in an 835 with the EFT, the Cash Concentration/Disbursement plus Addenda (CCD+) ACH format is specified in the Financial Segment, BPR, using the code value CCP in BPR05. Then the TRN is transferred within the CCD+ as an addenda record and passed to the payee. It is prudent for any payer to contact their DFI to work out details for initiating an EFT. For federal agencies paying through the Department of the Treasury, the Department of the Treasury is their DFI.

2.1.4 Remittance

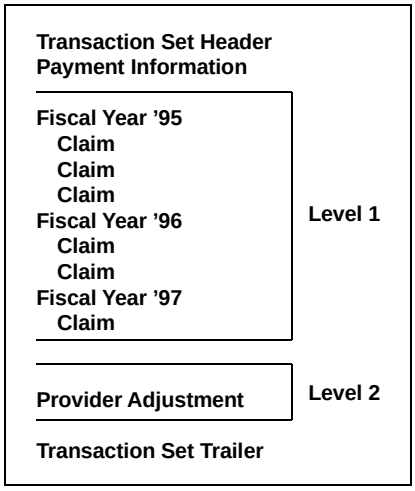


Figure 7. Remittance Information Levels

As a remittance advice, the 835 provides detailed payment information relative to a health care claim(s) and, if applicable, describes why the total original charges have not been paid in full. This remittance information is provided as "justification" for the payment, as well as input to the payee's patient accounting system/accounts receivable (A/R) and general ledger applications. The remittance information consists of two separate levels. See figure 7, Remittance Information Levels. Level one consists of claim and service information "packaged" within the Detail Loop, Table 2. The loop may occur multiple times to provide a logical grouping of the claim and service information. For instance, Medicare Part A Institutional 835 transactions provide claims data organized within Detail Loops, based upon the bill type and provider fiscal year. Appropriate to this claims grouping, the Detail Loop provides subtotal and non-financial information specific to Medicare Part A in the Provider Summary Statistics Segment, TS3, and the Provider Supplemental Statistics Segment, TS2.

Level two consists of remittance information that is not specific to the claim(s) and service(s) contained in level one. This remittance information is contained in the Provider Adjustment Segment, PLB. The PLB segment provides for reporting increases or reductions to the amount remitted in conjunction with reference numbers for further identification.

Example

A payer carrier notifies a provider by letter to refund $100 in overpayments within 30 days or have the amount deducted from a future payment. A financial control number is included on the letter for identification purposes. The provider does not remit the amount; therefore, a deduction is made. The $100 is deducted from a payment and reported in an 835 by referencing the financial control number and the amount in PLB.

When the 835 does not contain remittance information, Table 2 and the PLB are omitted.

The 835 must be balanced whenever remittance information is included in an 835 transaction. For a balanced 835, the total payment must agree with the remittance information detailing that payment. The remittance information must also reflect an internal numeric consistency. See 2.2.1, Balancing, for complete details.

2.2 Data Use by Business Use

The 835 is divided into three levels, or tables. See 3, Transaction Set, for a description of the format presented in figure 8, 835 Transaction Set Listing.

Table 1 - Header

POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
010	ST	Transaction Set Header	R	1	
020	BPR	Financial Information	R	1	
...					

Table 2 - Detail

POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
		LOOP ID - 2000 HEADER NUMBER			>1
003	LX	Header Number	S	1	
005	TS3	Provider Summary Information	S	1	
007	TS2	Provider Supplemental Summary Information	S	1	
		LOOP ID - 2100 CLAIM PAYMENT INFORMATION			>1
010	CLP	Claim Payment Information	R	1	
020	CAS	Claims Adjustment	S	99	
...					

Table 3 - Summary

POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
010	PLB	Provider Adjustment	S	>1	
020	SE	Transaction Set Trailer	R	1	

Figure 8. 835 Transaction Set Listing

- The Header level, Table 1, contains general payment information, such as amount, payee, payer, trace number, and payment method.
- The Detail level, Table 2, contains the Explanation of Benefits (EOB) information related to adjudicated claims and services.
- The Summary level, Table 3, contains the Provider Level Adjustment Segment, PLB, which provides information related to adjustments to the payment amount not specific to Table 2 claims. These adjustments can either increase or decrease the actual payment with respect to the Table 2 claim charges.

Although the remittance information in Tables 2 and 3 are not always provided, the intention of this business use of the 835 is for payers to provide some claim or provider-specific information along with the payment information.

When dollars and data are delivered separately, an 835 with no Table 2 or PLB information can initiate a financial transaction.

NOTE
The 835 is used to transmit payment and data needed for the posting by a provider subsequent to the adjudication of a claim. Non-adjudicated claim information should be carried in the ASC X12 Health Care Claim Status Notification Transaction Set (277).

2.2.1 Balancing

The amounts reported in the 835, if present, ***MUST*** balance at three different levels — the service line, the claim, and the transaction. Adjustments within the 835, through use of the Claim Adjustment and Service Adjustment Segments, CAS, or Provider Adjustment Segments, PLB, ***DECREASE*** the payment when the adjustment amount is ***POSITIVE***, and ***INCREASE*** the payment when the adjustment amount is ***NEGATIVE.*** See 2.2.4, Claim Adjustment and Service Adjustment Segment Theory, for more details.

2.2.1.1 Service Line Balancing

Table 2 - Detail

POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
...					
		LOOP ID - 2110 SERVICE PAYMENT INFORMATION			**999**
070	**SVC**	Service Payment Information	**S**	**1**	
...					
090	**CAS**	Service Adjustment	**S**	**99**	
...					

Figure 9. Service Line Balancing Segments

Although the service payment information is optional, it is ***REQUIRED*** for all professional claims or anytime payment adjustments are related to specific line items from the original submitted claim. When used, the submitted service charge minus the sum of all monetary adjustments must equal the amount paid for this service line.

Amount 1 - Amount 2 = Amount 3

where:

Amount 1 — transmitted in the Service Payment Information Segment, SVC02 — is the submitted charge for this service.

Amount 2 — transmitted in the Service Adjustment Segment, the sum of CAS03, 06, 09, 12, 15, and 18 — is the monetary adjustment amount applied to this service.

Amount 3 — transmitted in the Service Payment Information Segment, SVC03 — is the paid amount for this service.

NOTES

- Adjustments within CAS ***DECREASE*** the payment when the adjustment amount is ***POSITIVE***, and ***INCREASE*** the payment when the adjustment amount is ***NEGATIVE***.
- Providing service detail is critical for business, especially when professional or fee-based services are involved.
- If any service detail is reported in the claim payment, all services for the claim payment should be reported.

2.2.1.2 Claim Balancing

Table 2 - Detail

POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
...					
		LOOP ID - 2100 CLAIM PAYMENT INFORMATION			**>1**
010	**CLP**	Claim Payment Information	**R**	**1**	
020	**CAS**	Claim Adjustment	**S**	**99**	
...					
		LOOP ID - 2110 SERVICE PAYMENT INFORMATION			**999**
070	**SVC**	Service Payment Information	**S**	**1**	
...					
090	**CAS**	Service Adjustment	**S**	**99**	

Figure 10. Claim Balancing Segments

Balancing must occur within each Claim Payment loop so that the submitted charges for the claim minus the sum of all monetary adjustments equals the claim paid amount.

When the Service Payment Information loop is not present, the following formula applies:

Amount 4 - Amount 5 = Amount 6

where,

Amount 4 — transmitted in the Claim Payment Segment, CLP03 — is the total submitted charge for the claim.

Amount 5 — transmitted in the Claim Adjustment Segment, the sum of CAS03, 06, 09, 12, 15, and 18 — is the monetary adjustment amount applied to this claim.

Amount 6 — transmitted in the Claim Payment Segment, CLP04 — is the paid amount for this claim.

When the Service Payment Information loop is present, the following formula applies:

Amount 7 - Amount 8 = Amount 9

where,

Amount 7 — transmitted in the Claim Payment Segment, CLP03 — is the total submitted charge for the claim.

Amount 8 — transmitted in the Claim Adjustment Segment and/or Service Adjustment Segment, the sum of CAS03, 06, 09, 12, 15, and 18 — is the monetary adjustment amount applied to this claim.

Amount 9 — transmitted in the Claim Payment Segment, CLP04 — is the paid amount for this claim.

NOTES

Adjustments within the Claim Adjustment or Service Adjustment Segments ***DECREASE*** the payment when the adjustment amount is ***POSITIVE*** and ***INCREASE*** the payment when the adjustment amount is ***NEGATIVE***.

The difference between balancing with or without the Service Payment Information Loop is the inclusion or exclusion of the Claim Adjustment or Service Adjustment monetary amounts.

When the Service Payment Information loop is present, adjustments are reported in either the Claim Adjustment or the Service Adjustment Segments but not in both. For example, if a $100 deductible adjustment is taken at the service level, do not repeat that deductible at the claim level. It is preferred that the adjustment be shown at the service level when possible.

When specific service detail is presented, the claim level balancing includes balancing the total claim charge (CLP03) to the sum of the related service charges (SVC02). Service lines that are not finalized should be adjusted with a CAS segment using a Claim Adjustment Group code (CAS01) of 'OA' (Other Adjustment), a Claim Adjustment Reason code (CAS02) of 133 (This service is suspended pending further review) and the full dollar amount for the service in CAS03. When finalized, the claim must be reported using the instructions found in the Reversal and Correction section. See 2.2.11, Definition of a Claim, for variations related to claim splitting situations.

2.2.1.3 Transaction Balancing

Table 1 - Header

POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
...					
020	BPR	Financial Information	R	1	
...					

Table 2 - Detail

POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
...					
		LOOP ID - 2100 CLAIM PAYMENT INFORMATION			**>1**
010	CLP	Claim Payment Information	R	1	
...					

Table 3 - Summary

POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
010	PLB	Provider Adjustment	S	>1	

Figure 11. Transaction Balancing Segments

Within the transaction, the sum of all claim payments minus the sum of all provider level adjustments equals the total payment amount.

Amount 10 - Amount 11 = Amount 12

where:

Amount 10 — the sum of all CLP04 amounts transmitted in the Claim Payment Segment — is the total of all claim amounts included in this transaction set.

Amount 11 — the sum of PLB04, 06, 08, 10, 12, and 14 transmitted in the Provider Adjustments Segment — is the provider level adjustment made to the claim payment.

Amount 12 — transmitted in the Financial Information Segment, BPR02 — is the total payment amount of this claim payment.

NOTE
A ***POSITIVE*** amount in PLB indicates a ***DECREASE*** in the payment amount. A ***NEGATIVE*** amount in PLB indicates an ***INCREASE*** in the payment amount.

2.2.2 Remittance Tracking

Table 1 - Header

POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
...					
040	TRN	Reassociation Trace Number	R	1	
...					

Figure 12. Remittance Tracking Segment

The Reassociation Key Segment, TRN, contains a trace number for the transaction set. Trace Number, TRN02, which is used to reassociate payments and remittances sent separately, should be a unique number.

- For check payments, TRN02 is the check number.
- For Electronic Funds Transfer (EFT) payments, TRN02 is the unique number assigned by the payer to identify this EFT.
- For non-payment transactions, TRN02 is a unique number generated by the transaction set originator as that 835's identification number (e.g., a control number plus a suffix).

In addition, TRN03 is the payer's identification number. TRN03 allows the payee to avoid matching problems in case multiple payers use the same number in TRN02.

2.2.3 Reassociation of Dollars and Data

The 835 is capable of sending health care claim payment remittance data with or without the dollars represented by the data. It is important to facilitate reassociation when the remittance data is sent separately from the monetary amounts. Reassociation requires that both remittance and monetary data contain information that allows a system to match the items received. The provider should have a

method to ensure that payment and remittance advice are reconciled in the patient accounting/accounts receivable system.

Two key pieces of information facilitate reassociation — the trace number in the Reassociation Key Segment, TRN02, and the Company ID Number, TRN03. The trace number in conjunction with the company ID number provides a unique number that identifies the transaction.

The two ways of sending payment for health care remittance data are check or Automated Clearing House (ACH). In the case of a payment received by check, the check number is the trace number in TRN02, and the company ID number is in TRN03. When the check is processed, the check number and account information is captured. A table could be required to cross reference the account information from the check to the company ID number received in TRN03. This information should be gathered when the transaction is implemented with the payer.

When sending a separate ACH payment, the CCD+ ACH format is used. Using this method, the Reassociation Key Segment in its entirety is contained in the ACH Addenda Record.

For complete details on reassociation and ACH file formats, contact either your local Value Added Bank (VAB) or the National Automated Clearing House Association at (703) 742-9190.

2.2.4 Claim Adjustment and Service Adjustment Segment Theory

Table 2 - Detail

POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
...					
		LOOP ID - 2100 CLAIM PAYMENT INFORMATION			**>1**
...					
020	**CAS**	Claim Adjustment	**S**	**99**	
...					
		SERVICE PAYMENT INFORMATION			**999**
...					
090	**CAS**	Service Adjustment	**S**	**99**	

Figure 13. Claim and Service Adjustment Segments

The Claim Adjustment and Service Adjustment Segments 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). The summation of the adjustments at the claim and service levels is the total adjustment for the entire claim. Service level adjustments are not repeated at the claim level.

A standardized list of claim adjustment reason codes is used in the Claim Adjustment and Service Adjustment Segments. See Appendix C, External Code Sources, for the list of codes. These codes provide the “explanation” for the positive or negative financial adjustments specific to particular claims or services that are referenced in the transmitted 835. Other financial adjustments can be expressed in the Provider Adjustments Segment; however, the claim adjustment reason code list is not used for provider level adjustments.

To facilitate and expedite reason code maintenance, the list was established external to the ASC X12 standards. The Blue Cross Blue Shield Association created a committee of payer and provider representatives to maintain the list. As with any external code list, maintenance requests should be addressed to the responsible entity. Send maintenance requests in writing to the Blue Cross Blue Shield Association or submit online via www.wpc-edi.com (preferred).

The Claim Adjustment Group Code, CAS01, categorizes the adjustment reason codes that are contained in a particular CAS. The Claim Adjustment Group Codes are evaluated according to the following order:

1. Is the amount adjusted in this segment the patient’s responsibility?
   Use code **PR - Patient Responsibility.**
2. Is the amount adjusted not the patient’s responsibility under any circumstances due to either a contractual obligation between the provider and the payer or a regulatory requirement?
   Use code **CO - Contractual Obligation.**

   An example of a contractual obligation might be a Participating Provider Agreement.
3. In the payer’s opinion, is the amount in this segment not the responsibility of the patient, without a supporting contract between the provider and the payer?
   Use code **PI - Payer Initiated.**
4. Is this claim the reversal of a previously reported claim or claim payment, indicated by Claim Status Code = 22, Reversal of Previous Payment?
   Use code **CR - Correction and Reversals.**
5. If no other category is appropriate, do the following:
   Use code **OA - Other Adjustment.**

Avoid the Other Adjustment Group Code (OA) for financial adjustments, except when doing predetermination of benefits.

Only use the Claim Adjustment Segment if needed.

At either position — the claim level or the service level — each CAS can report up to six different adjustments related to a particular Claim Adjustment Group. This can be seen by noting the re-occurrence of the Claim Adjustment Reason, Monetary Amount, and Quantity data elements, referred to as “an adjustment trio,” in the CAS. There is no direct correlation between any particular kind of adjustment and a specific adjustment data element trio. For example, a co-insurance adjustment does not belong at any specific position in the segment. The assumption is that no adjustment trio is used if no meaningful data is included. For efficiency, the first significant adjustment is placed at the first trio — CAS02, 03, and 04.

2.2.4.1 Institutional-Specific Use

Within the institutional environment, certain circumstances require special handling. Although it is customary in the non-institutional and outpatient environment to provide adjustments and full service line detail with the remittance advice, this situation is unusual for inpatient claims. There are circumstances when there is a need to provide service-specific adjustments, but it is not desirable to provide all service information. When working with room rate adjustments, administrative days, or non-covered days, it may be appropriate to provide these adjustments at the claim level and not provide service level detail. Claim Adjustment Reason Code 78, Non-covered Days/Room Charge Adjustment, is used in the claim level Claim Adjustment Segment to report an adjustment in the room rate or in the number of days covered. The associated adjustment amount provides the total dollar adjustment related to reductions in the number of covered days and the per day rate. The associated adjustment quantity is used to report the actual number of non-covered days.

2.2.5 Data Relationship with Other Transactions (837, 277, NCPDP 3.2)

A one-for-one relationship does not exist among the Health Care Claim Transaction Set (837), the Health Care Claim Status Notification Transaction Set (277), and the 835. One 835 transaction set can account for claims submitted using multiple 837 transactions. The Claim Submitter's Identifier reported in the claim within the 837 is returned in the 835 transaction for tracking purposes. The Claim Submitter's Identifier is located in the 837 in CLM01. In the 835, the Claim Submitter's Identifier, for example, a patient control number, is in CLP01.

The 277's primary use is to convey status information on non-adjudicated claims; the 835 is used to transmit data needed for posting subsequent to the adjudication of a claim. The 277 also can account for claims already paid by an 835. In this case, a one-for-one relationship does not exist between the transactions.

The Claim Submitter's Identifier, reported in the claim within the 837 always is returned in the 835 and frequently is returned in the 277 transaction for tracking purposes. When used in the 277, the Claim Submitter's Identifier is located in TRN02.

There is also a Prescription Drug Claim Transaction (NCPDP 3.2). (NCPDP is the acronym for National Council for Prescription Drug Programs.) Similar to the 837 transaction, a one-for-one relationship does not exist between the NCPDP 3.2 and the 835. One 835 transaction can account for claims submitted using multiple NCPDP 3.2 transactions. The Claim Submitter's Identifier is located in the NCPDP 3.2 Claim Information Section, field 402-D2, Prescription Number.

2.2.6 Procedure Code Bundling and Unbundling

Procedure code bundling or unbundling occurs when a **payer** believes that the actual services performed and reported for a claim payment can be represented by a different group of procedure codes. Grouping usually results in a lower payment from the payer. Bundling occurs when two or more reported procedures are going to be paid under only one procedure code. Unbundling occurs when one submitted procedure code is to be paid and reported back as two or more procedure codes.

When bundling or unbundling occurs, the information must be reported back to the payee accurately to facilitate automatic entry into a patient accounting/accounts receivable system. In the interest of standardization, payers are to report bundling or unbundling in a consistent manner.

When bundling, report all of the originally submitted procedures in the remittance advice. Report all procedures as paying on the changed (bundled) procedure code, and reference the original submitted code in SVC06. The bundled service line must be adjusted up by an amount equal to the sum of the other line charges. This is reported as a CAS segment with a group code OA (Other Adjustments) and a reason code of 94 (Processed in Excess of Charges) with a negative dollar amount. From that point, apply all normal CAS adjustments to derive the reimbursement amount. Report the other procedure or procedures as originally submitted, with an adjudicated code of the bundled procedure code and a Claim Adjustment Reason Code of 97 (payment is included in the allowance for the basic service) and an adjustment amount equal to the submitted charge. The Adjustment Group is either CO (Contractual Obligation) or PI (Payer Initiated) depending on the provider/payer relationship.

NOTE
The following examples illustrate bundling and unbundling within a PPO environment. Some segment use may vary from payer type to payer type.

Bundling Example

This is an example of a Preferred Provider Organization (PPO) claim. This example leaves out the date and other segments not necessary to bundling.

- The provider submits procedure code “A” and “B” for $100.00 each to his or her PPO as primary coverage. The procedures were performed on the same date of service.
- The PPO’s adjudication system screens the submitted procedures and notes that procedure “C” covers the services rendered by the provider on that single date of service.
- The PPO’s maximum allowed amount for procedure “C” is $120.00.
- The patient’s co-insurance amount for procedure “C” is $20.00.
- The patient has not met the $50.00 deductible.

```
CLP*123456789*1*200*50*70*12~
CAS*PR*1*50~
SVC*HC:C*100*100**1*HC:A~
CAS*OA*94*-100~
CAS*CO*45*80~
CAS*PR*2*20~
SVC*HC:C*100*0**1*HC:B~
CAS*CO*97*100~
```

When unbundling, report the original service as the first of the new services with the original submitted charge in SVC02. Use subsequent SVC loops for the other new services. For these other services, report the submitted charge as zero dollars ($0.00). As in bundling, CAS is used to increase the submitted charge from $0.00 to the allowed amount for each procedure. Report the original procedure

code in all of the SVC loops in SVC06. **Balancing must be maintained for all service lines.**

Unbundling Example

- The same PPO provider submits a claim for one service.
- The service code is “A” with a claim submitted charge and service charge of $200.00.
- The payer unbundles this into 2 services — “B” and “C” — each with an allowed amount of $60.00.
- There is no deductible or co-insurance amount.

Only segments specific to unbundling are included in the example. Adjustment reason code 45, “charges exceed your contracted/legislated fee arrangement,” is used for each service.

```
CLP*123456789*1*200*120*0*12~
SVC*HC:B*200*60**1*HC:A~
CAS*CO*45*140~
SVC*HC:C*0*60**1*HC:A~
CAS*CO*94*-60~
```

Partial Unbundling

Partial unbundling may occur when a bundled panel of services, such as a lab panel or a surgical panel, is billed under a single HCPCS assigned to that panel, and a denial or reduction is made related to only one or some of the services in that panel. For example, two lab panels may include the same lab test. The full amount would be payable for the first panel, but a lesser amount may be due for the second panel due to the overlap.

Rather than totally unbundle the panels to be able to report detail on individual services within the panel, it is possible to do a partial unbundling to highlight only the individual service being adjusted. If this is done, however, you must report the regular allowed and payable amounts for the panel, then use a negative payment with the single adjusted service to offset for that reduction and to link that individual service to the HCPCS for the affected panel. The allowed amount for the single unbundled adjusted service in the panel must be reported as 0 when there is partial unbundling.

Partial Unbundling Example (Two lab panels billed and one test repeated in each):

```
CLP*123456789*1*72*66*0*12~
SVC*HC:80049*42*42~
SVC*HC:80054*30*30~
SVC*HC:82435*0*-6**1*HC:80054~
CAS*CO*18*6~
```

2.2.7 Predetermination of Benefits

Tables 2 and 3 in the 835 also may contain information about future remittances that are to be paid when specified services are completed. The future payment is expressed as an adjustment in one of the CAS segments. Use a Claim Adjustment Group code of OA, “other adjustment,” and a Claim Adjustment Reason Code of 101, ‘‘predetermination, anticipated payment upon completion of services.’’ A predetermination must balance within a transaction set in the same way that claim payments must balance. Because the payment amount is actually zero now, adjustments must be adequate to reduce the claim balance to zero.

A predetermination is identified by code value 25, ‘‘predetermination pricing only — no payment,” in CLP02. Effectively, a predetermination is informational only and can be contained in an 835 that pays other claims.

Adjustment	Amount	Claim Adjustment Reason Code
Deductible	$50.00	Code 1
Coinsurance	$200.00	Code 2
Exceeded the fee schedule	$200.00	Code 45

Matrix 2. Example Adjustments

Example

A provider submits a claim for predetermination of benefits to the PPO for a total claim charge amount of $1000.00. The payer determines that, if the claim is to be paid, the adjustments shown in matrix 2, Example Adjustments, are to be applied.

The projected payment amount is then $550.

```
CLP*1234567890*25*1000*0*250*12*9012345678~
CAS*PR*1*50**2*200~
CAS*CO*45*200~
CAS*OA*101*550~
```

2.2.8 Reversals and Corrections

When a claim is paid in error, the method for correcting it is to reverse the original claim payment and resend the corrected data. This helps the providers control the accuracy and integrity of their receivable systems.

NOTE
Handling reversals internal to the 835 may cause system changes that need to be addressed as part of the implementation plan.

Example

In the original Preferred Provider Organization (PPO) payment, the reported charges were as follows in matrix 3, Reported Charges:

Submitted charges	$100.00
Adjustments	
Disallowed amount	$20.00
Coinsurance	$16.00
Deductible	$24.00
Payment amount	$40.00

Matrix 3. Reported Charges

Original Payment

```
CLP*1234567890*1*100*40*40*12~
CAS*PR*1*24**2*16~
CAS*CO*45*20~
```

The payer found an error in the original claim adjudication that requires a correction. In this case, the disallowed amount should have been $40.00 instead of the original $20.00. The co-insurance amount should have been $12.00 instead of $16.00, and the deductible amount did remain the same.

Reversal Method

Reverse the original payment, restoring the patient accounting system to the pre-posting balance for this patient. Then, the payer sends the corrected claim payment to the provider for posting to the account.

It is anticipated that the provider has the ability to post these reversals electronically, without any human intervention.

Reversing the original claim payment is accomplished with code 22, "reversal of previous payment", in CLP02; code CR, "corrections and reversals", in CAS01; and appropriate adjustments. All original charge, payment, and adjustment amounts are negated.

```
CLP*1234567890*22*-100*-40**12~
CAS*CR*1*-24**2*-16**45*-20~
```

NOTE
The reversal does not contain any patient responsibility amount in CLP or a patient responsibility-specific CAS segment.

The corrected claim payment is provided as if it were the original payment.

```
CLP*1234567890*1*100*24*36*12~
CAS*PR*1*24**2*12~
CAS*CO*45*40~
```

NOTES

- Caution, while the claim paid amount (CLP04) for this claim can be zero or less, the reversal method included in 2.2.8, Reversals and Corrections, must not cause the total payment for this 835 (BPR02) to become negative.
- The example does not provide service line detail. If the service line detail had been on the original payment, then the reversal should apply the same reversal logic to the claim and service lines.

2.2.9 Interest and Prompt Payment Discounts

Payer-provider level interest and prompt payment discounts refer to adjustments that specific payer and provider contractual agreements or regulations require. Convey these types of financial adjustments in the Provider Adjustment Segment. Such adjustments are financially independent from the formula for determining benefit payments on behalf of the beneficiary receiving care. Consequently, providers must be able to post these types of adjustments to the general ledger rather than to the patient's account receivable. Additionally, providers must

be able to examine the claim-specific information to validate the payer's adjudication calculation.

Convey claim-specific information in the Supplemental Claim Information Segment, AMT. Use code I, for "Interest," or use D8, "discount amount," for a prompt payment discount, in AMT01.

The nature of the financial adjustments conveyed in the Provider Adjustment Segment is identified in PLB03, Composite Adjustment Identifier. The payments can either increase — reported as a negative number — or decrease — reported as a positive number — the payment. The code values used for interest and prompt pay discounts within the PLB03 composite are as follows:

- L6 - Interest Owed

Refers to interest adjustments made as part of the contractual agreement for handling claim obligations beyond the timelines established

- 90 - Early Payment Discount

Refers to a prompt payment discount or the amount that is allowed for quickly paying a claim according to the terms of the contractual agreement

NOTE
Managed care contracts also can show similar types of adjustments within the Provider Adjustment Segment. See 2.2.10, Capitation and Related Payments or Adjustments, for the appropriate managed care references.

Summary

- Use the Provider Adjustment Segment for interest and prompt pay discounts to reflect payer-provider agreements.
- Supplemental Claim or Service Amounts in the AMT segments do not influence balancing the Claim or Service Payment loops or balancing the 835 for benefit payments made on behalf of the patient.
- To reference Interest and prompt payment discounts use codes L6, "interest," and 90, "early payment discount," in PLB03.
- If any interest responsibility and/or prompt pay discounts are extended to the patient, report the data in the Claim Adjustment Segment, which impacts CLP04, Claim Payment Amount. Do not report the data in the AMT and PLB segments.

Example

- Acme Insurance and Dr. Doe have an agreement whereby Acme pays Dr. Doe a 5% annual percentage rate (.0137% per day) of the claim payment for any claim that is not remitted or denied within 30 days, for each day over 20 days.
- Melvin Jones (patient) has covered charges of $10,000, submitted electronically to Acme on November 10, 1994.
- Acme processes the claim and determines that benefits payable are $9,000 with a patient deductible of $1,000.
- Payment is remitted on January 24, 1995. The amount paid includes interest due for 55 days.
- The interest amount is $67.81.

Interest information is provided in the Supplemental Claim Information Amounts Segment. The Provider Adjustment Segment is used to report provider level financial adjustment detail to be used within the balancing routine.

NOTE
For demonstration purposes, the payment adjustment "interest" is used in PLB03-1, and the PLB03-2 is the payer's "received date." Example — PLB*(assigned by payer)*951201*I6:-67.81~.

```
CLP*2528278*1*10000*9000*1000**951910002~
CAS*PR*1*1000~
NM1*QC*1*Jones*Melvin~
AMT*I*67.81~
PLB*(assigned by payer)*19951201*L6:-67.81~
```

2.2.10 Capitation and Related Payments or Adjustments

The 835 is used to provide financial notification of capitation payments from a Managed Care Organization (MCO) to a capitated care provider. The 835 does not contain the capitation details or membership roster. Use an associated Eligibility and Benefits Notification Transaction Set (271) to communicate these details. Capitation payments may be included with claims payment information in a single 835 or they may be passed alone. In either case, the existing balancing process for the 835 applies.

Capitation payments and adjustments are reported in the Provider Adjustment Segment. Individual amounts are reported in PLB04, 06, 08, 10, 12, and 14.

NOTE
A ***POSITIVE*** amount reduces payment. A ***NEGATIVE*** amount increases payment.

PLB03, 05, 07, 09, 11, and 13 are used to provide the Adjustment Reason Code and the reference number associated with the payments and adjustments. In the case of a capitation payment related to a member list provided in a 271 transaction, the reference number from the Reassociation Key Segment identifying the 271 is provided as a PLB reference number for the appropriate dollar amount.

For identification and explanation purposes, use the following codes in Position 1 of the Composite Adjustment Identifier in the PLB segment.

- BN - Bonus
  Bonus Payment is an additional payment made to a primary care physician or other capitated provider at a set time agreed upon by both parties, usually to recognize performance above usual standards. The bonus payment may be based upon utilization parameters, quality measurements, membership services performed, or other factors.
- CT - Capitation Payment
  Capitation Payment is a set dollar amount paid to the primary care physician or other capitated provider selected by the member for the provision of services agreed upon by the provider and the MCO. The dollar amount may be based upon a member's age, sex, specific plan under which the member is enrolled, benefit limitations, or other predetermined factors. The payment is made at periodic set times generally defined in the contractual arrangement between the provider and the MCO.

- FC - Fund Allocation
  Fund Allocation is a methodology used to distribute payments made to the primary care or other capitated provider from funds designated for allocation. Funds may be prepaid amounts where deductions are withdrawn over a set period as services are provided.
- IP - Incentive Premium Payments
  Incentive Premium Payments are additional payments made to a capitated provider to acknowledge high quality services or to provide additional services that are not routinely considered as capitated services by the MCO. This payment also may be used as a financial incentive to sign new providers to the managed care network.
- CR - Capitation Interest
  Interest payments represent a percentage payment in excess of the usual amount, paid to the capitated provider as a result of a late payment by the MCO or as a result of funds previously withheld.
- AM - Applied to Borrowers Account
  Loan Repayment is a repayment to the MCO of monies previously paid to the capitated provider for purchasing equipment. The repayment amount is deducted from the usual periodic payment that the provider would otherwise receive from the MCO.
- L3 - Penalty
  A Penalty is a deduction made in the financial payment to the capitated provider as a result of non-fulfillment of a requirement stipulated in the contractual agreement between the provider and the MCO. Generally, the actual sum forfeited is defined in the agreement.
- RA - Retro-Activity Adjustment
  Retro-activity payments, adjustments, and notification are given to the capitated provider for an enrolled member who had selected or changed a capitation provider for a time period before the current payment period. This adjustment usually occurs because of late notification from an employer and/or member after the set cutoff time for a capitation payment/notification. This adjustment may result in a payment deduction to the provider in circumstances where the member disenrolled or was terminated from coverage under the MCO during a previous payment period.
- TL - Third Party Liability
  Third Party Liability indicates that another entity is liable for the payment of health care expenses. The capitation payment may be reduced for the reported time period as a result of the payment from the other responsible party.
- E3 - Withholding
  Withholding is a set dollar amount or percentage of the capitation payment deducted per the contractual agreement between the provider and the MCO. This amount may be returned to the provider at a later date, usually as a result of meeting specific performance requirements defined in the agreement.

2.2.11 Definition of a Claim

A claim submitted to a payer may, due to a payer's adjudication system requirement(s), have service line(s) separated from the original claim. The commonly used term for this process is 'splitting the claim'. Each portion of a claim that has been split has a separate claim control number, assigned by the payer and the sum of the service line(s) charge submitted on each split claim becomes the split claim total charge.

An example of this type of processing is a multi-line claim that contains a service line which requires further information to finalize. By splitting the pending service line to a separate claim, the payer can then adjudicate the remainder of the claim/service lines submitted. Once the split claim is finalized, the adjudication information for the split claim will be returned to the provider.

To assist the provider in reconciling their patient accounts, the payer must retain and return basic original claim information in each of the adjudicated claims. The original Claim Submitter's Identifier (CLM01) must be returned on all split claims in CLP01. The providers original submitted line item control number from the claim must be returned in the REF segment, position 2110. If the original claim did not contain a specific line item control number for the service lines, the line item sequence number (LX01) from the original claim should be used in the 835 REF segment instead.

3 Transaction Set

NOTE
See Appendix A, ASC X12 Nomenclature, to review the transaction set structure, including descriptions of segments, data elements, levels, and loops.

3.1 Presentation Examples

The ASC X12 standards are generic. For example, multiple trading communities use the same PER segment to specify administrative communication contacts. Each community decides which elements to use and which code values in those elements are applicable. This implementation guide uses a format that depicts both the generalized standard and the trading community-specific implementation.

The transaction set detail is comprised of two main sections with subsections within the main sections.

Transaction Set Listing

- Implementation
- Standard

Segment Detail

- Implementation
- Standard
- Diagram
- Element Summary

The examples in figures 14 through 19 define the presentation of the transaction set which follows.

The following pages provide illustrations, in the same order they appear in this implementation guide, to describe the format.

IMPLEMENTATION

Indicates that this section is the implementation and not the standard

835 Health Care Claim Payment/Advice

Table 1 - Header

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
53	010	ST	835 Header	R	1	
54	020	BPR	Financial Information	R	1	
60	040	TRN	Reassociation Key	R	1	
62	050	CUR	Non-US Dollars Currency	S	1	
65	060	REF	Receiver ID	S	1	
66	060	REF	Version Number	S	1	
68	070	DTM	Production Date	S	1	
			PAYER NAME			1
70	080	N1	Payer Name	R	1	
72	100	N3	Payer Address	S	1	
75	110	N4	Payer City, State, Zip	S	1	
76	120	REF	Additional Payer Reference Number	S	1	
78	130	PER	Payer Contact	S	1	
			PAYEE NAME			1
79	080	N1	Payee Name	R	1	
81	100	N3	Payee Address	S	1	
82	110	N4	Payee City, State, Zip	S	1	
84	120	REF	Payee Additional Reference Number	S	>1	

Each segment is assigned an industry specific name. Not used segments do not appear

Each loop is assigned an industry specific name

Segment repeats and loop repeats reflect actual usage

R=Required
S=Situational

Position Numbers and Segment IDs retain their X12 values

Individual segments and entire loops are repeated

Figure 14. Transaction Set Key — Implementation

STANDARD

Indicates that this section is identical to the ASC X12 standard

See *Appendix A, ASC X12 Nomenclature* for a complete description of the standard

835 Health Care Claim Payment/Advice

Functional Group ID: **HP**

This Draft Standard for Trial Use contains the format and establishes the data contents of the Health Care Claim Payment/Advice Transaction Set (835) 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.

Table 1 - Header

POS. #	SEG. ID	NAME	REQ. DES.	MAX USE	LOOP REPEAT
010	ST	Transaction Set Header	M	1	
020	BPR	Beginning Segment for Payment Order/Remittance Advice	M	1	
030	NTE	Note/Special Instruction	O	>1	
040	TRN	Trace	O	1	

Figure 15. Transaction Set Key — Standard

IMPLEMENTATION

Industry Usage

PAYER NAME ← Industry assigned Segment Name

Loop: PAYER NAME **Repeat:** 1 ← Industry Loop Repeat

Usage: SITUATIONAL ← Industry assigned Loop Name

Industry Segment Repeat → **Repeat:** 1

Advisory: Under most circumstances, this segment is expected to be sent.

Industry Notes → **Notes:** 1. This N1 loop provides the name/address information for the payer. The payer's secondary identifying reference number should be provided in N104, if necessary.

Example → **Example:** N1*PR*INSURANCE COMPANY OF TIMBUCKTU*NI*88888888~

Figure 16. Segment Key — Implementation

STANDARD

N1 Name ← X12 ID and Name

Level: Header ← X12 Level

Position: 080 ← X12 Position Number

Loop: N1 **Repeat:** 200 ← X12 Loop Information

Requirement: Optional ← X12 Requirement

Max Use: 1 ← X12 Maximum Use

Purpose: To identify a party by type of organization, name and code

Syntax: **1** **R0203**
At least one of N102 or N103 is required.

2 **P0304**
If either N103 or N104 is present, then the other is required.

X12 Syntax Notes

Figure 17. Segment Key — Standard

DIAGRAM

Indicates a Required Element

Element Delimiter

Abbreviated Element Name

Segment Terminator

N1	*	N101 98 Entity ID Code M ID 2/2	*	N102 93 Name X AN 1/35	*	N103 66 ID Code Qualifier X ID 1/2	*	N104 67 ID Code X AN 2/20	*	N105 706 ~~Entity Relat Code~~ O ID 2/2	*	N106 98 ~~Entity ID Code~~ O ID 2/2	~

Segment ID

Requirement Designator

Minimum/ Maximum Length

Data Type

Indicates a Not Used Element

Figure 18. Segment Key — Diagram

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**SVC01**	**C003**	**COMPOSITE MEDICAL PROCEDURE IDENTIFIER** To identify a medical procedure by its standardized codes and applicable modifiers	**M**

Industry Usages:
See the following page for complete descriptions

X12 Semantic Note

Industry Note

SEMANTIC NOTES
03 C003-03 modifies the value in C003-02.
04 C003-04 modifies the value in C003-02.
05 C003-05 modifies the value in C003-02.
06 C003-06 modifies the value in C003-02.
07 C003-07 is the description of the procedure identified in C003-02.

Use the adjudicated Medical Procedure Code.

REQUIRED	**SVC01 - 1**	**235**	**Product/Service ID Qualifier** Code identifying the type/source of the descriptive number used in Product/Service ID (234)	**M**	**ID** **2/2**

Selected Code Values

See Appendix C for external code source reference

CODE	DEFINITION
AD	**American Dental Association Codes**

CODE SOURCE **135:** American Dental Association Codes

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**N101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	**M** **ID** **2/3**
SITUATIONAL	**N102**	**93**	**Name** Free-form name SYNTAX: R0203	**X** **AN** **1/60**
SITUATIONAL	**N103**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67)	**X** **ID** **1/2**
SITUATIONAL	**N104**	**67**	**Identification Code** Code identifying a party or other code	**X** **AN** **2/20**

Reference Designator

Data Element Number

SYNTAX: P0304

X12 Syntax Note

ADVISORY: Under most circumstances, this element is expected to be sent.

X12 Comment

COMMENT: This segment, used alone, provides the most efficient method of providing organizational identification. To obtain this efficiency the “ID Code” (N104) must provide a key to the table maintained by the transaction processing party.

Figure 19. Segment Key — Element Summary

Industry Usages:

Required This item must be used to be compliant with this implementation guide.

Not Used This item should not be used when complying with this implementation guide.

Situational The use of this item varies, depending on data content and business context. The defining rule is generally documented in a syntax or usage note attached to the item.* The item should be used whenever the situation defined in the note is true; otherwise, the item should not be used.

**** NOTE***
If no rule appears in the notes, the item should be sent if the data is available to the sender.

Loop Usages:
Loop usage within ASC X12 transactions and their implementation guides can be confusing. Care must be used to read the loop requirements in terms of the context or location within the transaction. The usage designator of a loop's beginning segment indicates the usage of the loop. Segments within a loop cannot be sent without the beginning segment of that loop.

If the first segment is Required, the loop must occur at least once unless it is nested in a loop that is not being used. A note on the Required first segment of a nested loop will indicate dependency on the higher level loop.

If the first segment is Situational, there will be a Segment Note addressing use of the loop. Any required segments in loops beginning with a Situational segment only occur when the loop is used. Similarly, nested loops only occur when the higher level loop is used.

IMPLEMENTATION

835 Health Care Claim Payment/Advice

Table 1 - Header

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
43	010	ST	Transaction Set Header	R	1	
44	020	BPR	Financial Information	R	1	
52	040	TRN	Reassociation Trace Number	R	1	
54	050	CUR	Foreign Currency Information	S	1	
57	060	REF	Receiver Identification	S	1	
58	060	REF	Version Identification	S	1	
60	070	DTM	Production Date	S	1	
			LOOP ID - 1000A PAYER IDENTIFICATION			1
62	080	N1	Payer Identification	R	1	
64	100	N3	Payer Address	R	1	
65	110	N4	Payer City, State, ZIP Code	R	1	
67	120	REF	Additional Payer Identification	S	4	
69	130	PER	Payer Contact Information	S	1	
			LOOP ID - 1000B PAYEE IDENTIFICATION			1
72	080	N1	Payee Identification	R	1	
74	100	N3	Payee Address	S	1	
75	110	N4	Payee City, State, ZIP Code	S	1	
77	120	REF	Payee Additional Identification	S	>1	

Table 2 - Detail

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
			LOOP ID - 2000 HEADER NUMBER			>1
79	003	LX	Header Number	S	1	
80	005	TS3	Provider Summary Information	S	1	
85	007	TS2	Provider Supplemental Summary Information	S	1	
			LOOP ID - 2100 CLAIM PAYMENT INFORMATION			>1
89	010	CLP	Claim Payment Information	R	1	
95	020	CAS	Claim Adjustment	S	99	
102	030	NM1	Patient Name	R	1	
105	030	NM1	Insured Name	S	1	
108	030	NM1	Corrected Patient/Insured Name	S	1	
111	030	NM1	Service Provider Name	S	1	
114	030	NM1	Crossover Carrier Name	S	1	
116	030	NM1	Corrected Priority Payer Name	S	2	
118	033	MIA	Inpatient Adjudication Information	S	1	
123	035	MOA	Outpatient Adjudication Information	S	1	
126	040	REF	Other Claim Related Identification	S	5	
128	040	REF	Rendering Provider Identification	S	10	
130	050	DTM	Claim Date	S	4	
132	060	PER	Claim Contact Information	S	3	
135	062	AMT	Claim Supplemental Information	S	14	

137	064	QTY	Claim Supplemental Information Quantity	S	15	
			LOOP ID - 2110 SERVICE PAYMENT INFORMATION			999
139	070	SVC	Service Payment Information	S	1	
146	080	DTM	Service Date	S	3	
148	090	CAS	Service Adjustment	S	99	
154	100	REF	Service Identification	S	7	
156	100	REF	Rendering Provider Information	S	10	
158	110	AMT	Service Supplemental Amount	S	12	
160	120	QTY	Service Supplemental Quantity	S	6	
162	130	LQ	Health Care Remark Codes	S	99	

Table 3 - Summary

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
164	010	PLB	Provider Adjustment	S	>1	
173	020	SE	Transaction Set Trailer	R	1	

STANDARD

835 Health Care Claim Payment/Advice

Functional Group ID: HP

This Draft Standard for Trial Use 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.

Table 1 - Header

POS. #	SEG. ID	NAME	REQ. DES.	MAX USE	LOOP REPEAT
010	ST	Transaction Set Header	M	1	
020	BPR	Beginning Segment for Payment Order/Remittance Advice	M	1	
030	NTE	Note/Special Instruction	O	>1	
040	TRN	Trace	O	1	
050	CUR	Currency	O	1	
060	REF	Reference Identification	O	>1	
070	DTM	Date/Time Reference	O	>1	
		LOOP ID - 1000			**200**
080	N1	Name	O	1	
090	N2	Additional Name Information	O	>1	
100	N3	Address Information	O	>1	
110	N4	Geographic Location	O	1	
120	REF	Reference Identification	O	>1	
130	PER	Administrative Communications Contact	O	>1	
140	RDM	Remittance Delivery Method	O	1	
150	DTM	Date/Time Reference	O	1	

Table 2 - Detail

POS. #	SEG. ID	NAME	REQ. DES.	MAX USE	LOOP REPEAT
		LOOP ID - 2000			**>1**
003	LX	Assigned Number	O	1	
005	TS3	Transaction Statistics	O	1	
007	TS2	Transaction Supplemental Statistics	O	1	
		LOOP ID - 2100			**>1**
010	CLP	Claim Level Data	M	1	
020	CAS	Claims Adjustment	O	99	
030	NM1	Individual or Organizational Name	M	9	
033	MIA	Medicare Inpatient Adjudication	O	1	
035	MOA	Medicare Outpatient Adjudication	O	1	
040	REF	Reference Identification	O	99	
050	DTM	Date/Time Reference	O	9	
060	PER	Administrative Communications Contact	O	3	
062	AMT	Monetary Amount	O	20	

064	QTY	Quantity	O	20	
		LOOP ID - 2110			999
070	SVC	Service Information	O	1	
080	DTM	Date/Time Reference	O	9	
090	CAS	Claims Adjustment	O	99	
100	REF	Reference Identification	O	99	
110	AMT	Monetary Amount	O	20	
120	QTY	Quantity	O	20	
130	LQ	Industry Code	O	99	

Table 2 - Detail

POS. #	SEG. ID	NAME	REQ. DES.	MAX USE	LOOP REPEAT
010	PLB	Provider Level Adjustment	O	>1	
020	SE	Transaction Set Trailer	M	1	

NOTES:

1/040 The TRN segment is used to uniquely identify a claim payment and advice.

1/050 The CUR segment does not initiate a foreign exchange transaction.

1/080 The N1 loop allows for name/address information for the payer and payee which would be utilized to address remittance(s) for delivery.

2/003 The LX segment is used to provide a looping structure and logical grouping of claim payment information.

2/020 The CAS segment is used to reflect changes to amounts within Table 2.

2/080 The DTM segment in the SVC loop is to be used to express dates and date ranges specifically related to the service identified in the SVC segment.

2/090 The CAS segment is used to reflect changes to amounts within Table 2.

IMPLEMENTATION

TRANSACTION SET HEADER

Usage: **REQUIRED**

Repeat: **1**

Example: **ST*835*1234~**

STANDARD

ST Transaction Set Header

Level: Header

Position: 010

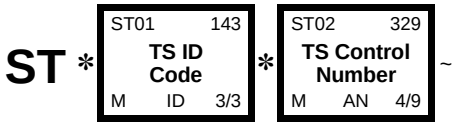
Loop: ____

Requirement: Mandatory

Max Use: 1

Purpose: To indicate the start of a transaction set and to assign a control number

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**ST01**	**143**	**Transaction Set Identifier Code** Code uniquely identifying a Transaction Set SEMANTIC: The transaction set identifier (ST01) used by the translation routines of the interchange partners to select the appropriate transaction set definition (e.g., 810 selects the Invoice Transaction Set). **The only valid value within this transaction set for ST01 is 835.** CODE — DEFINITION **835** — **Health Care Claim Payment/Advice**	**M ID 3/3**
REQUIRED	**ST02**	**329**	**Transaction Set Control Number** Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set **The Transaction Set Control Numbers in ST02 and SE02 must be identical. This unique number also aids in error resolution research. Start with a number, for example 0001, and increment from there. This number must be unique within a specific group and interchange, but it can be repeated in other groups and interchanges.**	**M AN 4/9**

IMPLEMENTATION

FINANCIAL INFORMATION

Usage: **REQUIRED**

Repeat: **1**

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.**

Example: **BPR*C*150000*C*ACH*CTX*01*999999992*DA*123456*1512345678*1999999999*01*999988880*DA*98765*19960901~**

STANDARD

BPR Beginning Segment for Payment Order/Remittance Advice

Level: Header

Position: 020

Loop: ____

Requirement: Mandatory

Max Use: 1

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

Syntax:

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

DIAGRAM

BPR *

BPR01 305	**Transaction Handle Code**	M ID 1/2	
BPR02 782	**Monetary Amount**	M R 1/18	
BPR03 478	**Cred/Debit Flag Code**	M ID 1/1	
BPR04 591	**Payment Method Code**	M ID 3/3	
BPR05 812	**Payment Format**	O ID 1/10	
BPR06 506	**DFI ID No Qualifier**	X ID 2/2	
BPR07 507	**DFI ID Number**	X AN 3/12	
BPR08 569	**Acct Number Qualifier**	O ID 1/3	
BPR09 508	**Account Number**	X AN 1/35	
BPR10 509	**Originating Company ID**	O AN 10/10	
BPR11 510	**Originating Co Code**	O AN 9/9	
BPR12 506	**DFI ID No Qualifier**	X ID 2/2	
BPR13 507	**DFI ID Number**	X AN 3/12	
BPR14 569	**Acct Number Qualifier**	O ID 1/3	
BPR15 508	**Account Number**	X AN 1/35	
BPR16 373	**Date**	O DT 8/8	
BPR17 1048	~~**Business Funct Code**~~	O ID 1/3	
BPR18 506	~~**DFI ID No Qualifier**~~	X ID 2/2	
BPR19 507	~~**DFI ID Number**~~	X AN 3/12	
BPR20 569	~~**Acct Number Qualifier**~~	O ID 1/3	
BPR21 508	~~**Account Number**~~	X AN 1/35	~

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**BPR01**	**305**	**Transaction Handling Code** Code designating the action to be taken by all parties	**M ID 1/2**

CODE	DEFINITION
C	**Payment Accompanies Remittance Advice** **Use this code to instruct your third party processor to move both funds and remittance detail together through the banking system.**
D	**Make Payment Only** **Use this code to instruct your third party processor to move only funds through the banking system and to ignore any remittance information.**
H	**Notification Only** **Use this code to pass information only without any reference to payment. Usually this code is used to pass predetermination of benefits information from a payer to a provider.**
I	**Remittance Information Only** **Use this code to indicate to the payee that the remittance detail is moving separately from the payment.**
P	**Prenotification of Future Transfers** **This code is used only by the payer and the banking system to initially validate account numbers before beginning an EFT relationship. Contact your VAB for additional information.**

U	**Split Payment and Remittance** **Use this code to instruct the third party processor to split the payment and remittance detail, and send each on a separate path.**
X	**Handling Party's Option to Split Payment and Remittance** **Use this code to instruct the third party processor to move the payment and remittance detail, either together or separately, based upon end point requests or capabilities.**

REQUIRED **BPR02** **782** **Monetary Amount** **M** **R** **1/18**
Monetary amount

INDUSTRY: ***Total Actual Provider Payment Amount***

SEMANTIC: BPR02 specifies the payment amount.

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

REQUIRED **BPR03** **478** **Credit/Debit Flag Code** **M** **ID** **1/1**
Code indicating whether amount is a credit or debit

INDUSTRY: ***Credit or Debit Flag Code***

CODE	DEFINITION
C	**Credit** **Use this code to indicate a credit to the provider's account and a debit to the payer's account, initiated by the payer. In the case of an EFT, no additional action is required of the provider. Also use this code when a check is issued for the payment.**
D	**Debit** **NOT ADVISED** **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. Contact your VAB for information about debit transactions. The rest of this segment and document assumes that a credit payment is being used.**

REQUIRED **BPR04** **591** **Payment Method Code** **M** **ID** **3/3**
Code identifying the method for the movement of payment instructions

CODE	DEFINITION
ACH	**Automated Clearing House (ACH)** **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, information in BPR05 through BPR15 must also be included.**

BOP	**Financial Institution Option** **Use this code to indicate that the third party processor will choose the method of payment based upon end point requests or capabilities.**
CHK	**Check** **Use this code to indicate that a check has been issued for payment.**
FWT	**Federal Reserve Funds/Wire Transfer - Nonrepetitive** **Use this code to indicate that the funds were sent through the wire system.**
NON	**Non-Payment Data** **Use this code when the Transaction Handling Code (BPR01) is H, indicating that this is information only and no dollars are to be moved.**

SITUATIONAL **BPR05** **812** **Payment Format Code** **O** **ID** **1/10**
Code identifying the payment format to be used

When BPR04 is ACH, the recommended code values for BPR05 are CCP and CTX. When BPR04 is any other code, this data element should not be used.

CODE	DEFINITION
CCP	**Cash Concentration/Disbursement plus Addenda (CCD+) (ACH)** **Use the CCD+ format to move money and up to 80 characters of data, enough to reassociate dollars and data when the dollars are sent through the ACH and the data is sent on a separate path. The addenda should contain a copy of the TRN segment.**
CTX	**Corporate Trade Exchange (CTX) (ACH)** **Use the CTX format to move dollars and data through the ACH. The CTX format can contain up to 9,,999 addenda records of 80 characters each. The CTX encapsulates the complete 835 and all envelope segments.**

SITUATIONAL **BPR06** **506** **(DFI) ID Number Qualifier** **X** **ID** **2/2**
Code identifying the type of identification number of Depository Financial Institution (DFI)

INDUSTRY: ***Depository Financial Institution (DFI) Identification Number Qualifier***

SYNTAX: P0607

SEMANTIC: When using this transaction set to initiate a payment, all or some of BPR06 through BPR16 may be required, depending on the conventions of the specific financial channel being used.

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

This element is required when BPR04 is ACH, BOP or FWT.

CODE	DEFINITION
01	**ABA Transit Routing Number Including Check Digits (9 digits)** **ABA is a unique number identifying every bank in the United States.** CODE SOURCE **4:** ABA Routing Number
04	**Canadian Bank Branch and Institution Number** CODE SOURCE **91:** Canadian Financial Institution Branch and Institution Number

SITUATIONAL **BPR07** **507** **(DFI) Identification Number** **X** **AN** **3/12**
Depository Financial Institution (DFI) identification number

INDUSTRY: ***Sender DFI Identifier***

SYNTAX: P0607

CODE SOURCE **60:** (DFI) Identification Number

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

This element is required when BPR04 is ACH, BOP or FWT.

SITUATIONAL **BPR08** **569** **Account Number Qualifier** **O** **ID** **1/3**
Code indicating the type of account

SYNTAX: C0809

SEMANTIC: BPR08 is a code identifying the type of bank account or other financial asset.

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

This element is required when BPR04 is ACH, BOP or FWT.

CODE	DEFINITION
DA	**Demand Deposit**

SITUATIONAL **BPR09** **508** **Account Number** **X AN 1/35**
Account number assigned

INDUSTRY: ***Sender Bank Account Number***

SYNTAX: C0809

SEMANTIC: BPR09 is the account of the company originating the payment. This account may be debited or credited depending on the type of payment order.

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

This element is required when BPR04 is ACH, BOP or FWT.

SITUATIONAL **BPR10** **509** **Originating Company Identifier** **O AN 10/10**
A unique identifier designating the company initiating the funds transfer instructions. The first character is one-digit ANSI identification code designation (ICD) followed by the nine-digit identification number which may be an IRS employer identification number (EIN), data universal numbering system (DUNS), or a user assigned number; the ICD for an EIN is 1, DUNS is 3, user assigned number is 9

INDUSTRY: ***Payer Identifier***

BPR10 must be the Federal Tax ID Number, preceeded by a "1." When BPR10 is used, it must be identical to TRN03.

This element is required when BPR04 is ACH, BOP or FWT.

SITUATIONAL **BPR11** **510** **Originating Company Supplemental Code** **O AN 9/9**
A code defined between the originating company and the originating depository financial institution (ODFI) that uniquely identifies the company initiating the transfer instructions

Use this code to further identify the payer by division or region. If used, this code must be identical to TRN04.

This element is required when BPR10 is used and additional information is necessary for the payee to identify the source of the payment.

SITUATIONAL **BPR12** **506** **(DFI) ID Number Qualifier** **X ID 2/2**
Code identifying the type of identification number of Depository Financial Institution (DFI)

INDUSTRY: ***Depository Financial Institution (DFI) Identification Number Qualifier***

SYNTAX: P1213

SEMANTIC: BPR12 and BPR13 relate to the receiving depository financial institution (RDFI).

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

This element is required when BPR04 is ACH, BOP or FWT.

CODE	DEFINITION
01	**ABA Transit Routing Number Including Check Digits (9 digits)** **ABA is a unique number identifying every bank in the United States.** **CODE SOURCE 4:** ABA Routing Number
04	**Canadian Bank Branch and Institution Number**

CODE SOURCE **91:** Canadian Financial Institution Branch and Institution Number

SITUATIONAL	**BPR13**	**507**	**(DFI) Identification Number** Depository Financial Institution (DFI) identification number	**X**	**AN**	**3/12**

INDUSTRY: ***Receiver or Provider Bank ID Number***

SYNTAX: P1213

CODE SOURCE **60:** (DFI) Identification Number

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

This element is required when BPR04 is ACH, BOP or FWT.

SITUATIONAL	**BPR14**	**569**	**Account Number Qualifier** Code indicating the type of account	**O**	**ID**	**1/3**

SYNTAX: C1415

SEMANTIC: BPR14 is a code identifying the type of bank account or other financial asset.

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

This element is required when BPR04 is ACH, BOP or FWT.

CODE	DEFINITION
DA	**Demand Deposit**
SG	**Savings**

SITUATIONAL	**BPR15**	**508**	**Account Number** Account number assigned	**X**	**AN**	**1/35**

INDUSTRY: ***Receiver or Provider Account Number***

SYNTAX: C1415

SEMANTIC: BPR15 is the account number of the receiving company to be debited or credited with the payment order.

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

This element is required when BPR04 is ACH, BOP or FWT.

REQUIRED	**BPR16**	**373**	**Date** Date expressed as CCYYMMDD	**O**	**DT**	**8/8**

INDUSTRY: ***Check Issue or EFT Effective Date***

SEMANTIC: BPR16 is the date the originating company intends for the transaction to be settled (i.e., Payment Effective Date).

Use this code for the effective entry date. If BPR04 is ACH, this code is the date that the money moves from the payer and is available to the payee. If BPR04 is CHK, this code is the check issuance date. If BPR04 is FWT, this code 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.

NOT USED	**BPR17**	**1048**	**Business Function Code**	**O**	**ID**	**1/3**
NOT USED	**BPR18**	**506**	**(DFI) ID Number Qualifier**	**X**	**ID**	**2/2**
NOT USED	**BPR19**	**507**	**(DFI) Identification Number**	**X**	**AN**	**3/12**

NOT USED	BPR20	569	Account Number Qualifier	O	ID	1/3
NOT USED	BPR21	508	Account Number	X	AN	1/35

IMPLEMENTATION

REASSOCIATION TRACE NUMBER

Usage: **REQUIRED**

Repeat: **1**

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

Example: **TRN*1*12345*1512345678*199999999~**

STANDARD

TRN Trace

Level: Header

Position: 040

Loop: ____

Requirement: Optional

Max Use: 1

Purpose: To uniquely identify a transaction to an application

Set Notes: **1.** The TRN segment is used to uniquely identify a claim payment and advice.

DIAGRAM

TRN	*	TRN01 481 **Trace Type Code** M ID 1/2	*	TRN02 127 **Reference Ident** M AN 1/30	*	TRN03 509 **Originating Company ID** O AN 10/10	*	TRN04 127 **Reference Ident** O AN 1/30	~

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**TRN01**	**481**	**Trace Type Code** Code identifying which transaction is being referenced	**M**	**ID**	**1/2**

CODE	DEFINITION
1	**Current Transaction Trace Numbers**

REQUIRED **TRN02** **127** **Reference Identification** **M AN 1/30**
Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

INDUSTRY: ***Check or EFT Trace Number***

SEMANTIC: TRN02 provides unique identification for the transaction.

This number must be unique within the sender/receiver relationship. The number is assigned by the sender. For example, if a payment is made by check, this number should be the check number.

There may be a number of uses for the trace number. If payment and remittance detail are separated, this number is used to reassociate data to dollars. See 2.2.3, Reassociation of Data and Dollars.

REQUIRED **TRN03** **509** **Originating Company Identifier** **O AN 10/10**
A unique identifier designating the company initiating the funds transfer instructions. The first character is one-digit ANSI identification code designation (ICD) followed by the nine-digit identification number which may be an IRS employer identification number (EIN), data universal numbering system (DUNS), or a user assigned number; the ICD for an EIN is 1, DUNS is 3, user assigned number is 9

INDUSTRY: ***Payer Identifier***

SEMANTIC: TRN03 identifies an organization.

TRN03 must contain the Federal Tax ID Number, preceded by a "1." When BPR10 is used, it must be identical to TRN03.

SITUATIONAL **TRN04** **127** **Reference Identification** **O AN 1/30**
Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

INDUSTRY: ***Originating Company Supplemental Code***

SEMANTIC: TRN04 identifies a further subdivision within the organization.

If both TRN04 and BPR11 are used, they must be identical.

This element is required when information beyond the Originating Company Identifier in TRN03 is necessary for the payee to identify the source of the payment.

IMPLEMENTATION

FOREIGN CURRENCY INFORMATION

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Use the CUR segment in the 835 to specify the currency and exchange rate, if applicable, when the payment is not being made in United States dollars or when the payment is made in a currency different from that in the original claim.**

Example: **CUR*PR*CAN*1.2~**

STANDARD

CUR Currency

Level: Header

Position: 050

Loop: ____

Requirement: Optional

Max Use: 1

Purpose: To specify the currency (dollars, pounds, francs, etc.) used in a transaction

Set Notes:

1. The CUR segment does not initiate a foreign exchange transaction.

Syntax:

1. **C0807**
   If CUR08 is present, then CUR07 is required.
2. **C0907**
   If CUR09 is present, then CUR07 is required.
3. **L101112**
   If CUR10 is present, then at least one of CUR11 or CUR12 are required.
4. **C1110**
   If CUR11 is present, then CUR10 is required.
5. **C1210**
   If CUR12 is present, then CUR10 is required.
6. **L131415**
   If CUR13 is present, then at least one of CUR14 or CUR15 are required.
7. **C1413**
   If CUR14 is present, then CUR13 is required.
8. **C1513**
   If CUR15 is present, then CUR13 is required.
9. **L161718**
   If CUR16 is present, then at least one of CUR17 or CUR18 are required.
10. **C1716**
    If CUR17 is present, then CUR16 is required.
11. **C1816**
    If CUR18 is present, then CUR16 is required.

12. L192021
If CUR19 is present, then at least one of CUR20 or CUR21 are required.

13. C2019
If CUR20 is present, then CUR19 is required.

14. C2119
If CUR21 is present, then CUR19 is required.

DIAGRAM

CUR *

CUR01 98 **Entity ID Code** M ID 2/3	*	CUR02 100 **Currency Code** M ID 3/3	*	CUR03 280 **Exchange Rate** O R 4/10	*	CUR04 98 ~~Entity ID Code~~ O ID 2/3	*	CUR05 100 ~~Currency Code~~ O ID 3/3	*	CUR06 669 ~~Curr Market /Exchg Code~~ O ID 3/3	*	CUR07 374 ~~Date/Time Qualifier~~ X ID 3/3	*	CUR08 373 ~~Date~~ O DT 8/8	*	CUR09 337 ~~Time~~ O TM 4/8	*	CUR10 374 ~~Date/Time Qualifier~~ X ID 3/3	*	CUR11 373 ~~Date~~ X DT 8/8	*	CUR12 337 ~~Time~~ X TM 4/8	*
CUR13 374 ~~Date/Time Qualifier~~ X ID 3/3	*	CUR14 373 ~~Date~~ X DT 8/8	*	CUR15 337 ~~Time~~ X TM 4/8	*	CUR16 374 ~~Date/Time Qualifier~~ X ID 3/3	*	CUR17 373 ~~Date~~ X DT 8/8	*	CUR18 337 ~~Time~~ X TM 4/8	*	CUR19 374 ~~Date/Time Qualifier~~ X ID 3/3	*	CUR20 373 ~~Date~~ X DT 8/8	*	CUR21 337 ~~Time~~ X TM 4/8	~						

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**CUR01**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual CODE — DEFINITION **PR** — **Payer** **REQUIRED**	**M ID 2/3**
REQUIRED	**CUR02**	**100**	**Currency Code** Code (Standard ISO) for country in whose currency the charges are specified CODE SOURCE **5:** Countries, Currencies and Funds	**M ID 3/3**
SITUATIONAL	**CUR03**	**280**	**Exchange Rate** Value to be used as a multiplier conversion factor to convert monetary value from one currency to another **Use this element when the currency for payment is not the same as the currency specified in the original claims submitted for payment. For instance, when the claims were submitted in United States (US) dollars and paid in Canadian dollars, present the exchange rate from US dollars to Canadian dollars here.**	**O R 4/10**
NOT USED	**CUR04**	**98**	**Entity Identifier Code**	**O ID 2/3**
NOT USED	**CUR05**	**100**	**Currency Code**	**O ID 3/3**

NOT USED	CUR06	669	Currency Market/Exchange Code	O	ID	3/3
NOT USED	CUR07	374	Date/Time Qualifier	X	ID	3/3
NOT USED	CUR08	373	Date	O	DT	8/8
NOT USED	CUR09	337	Time	O	TM	4/8
NOT USED	CUR10	374	Date/Time Qualifier	X	ID	3/3
NOT USED	CUR11	373	Date	X	DT	8/8
NOT USED	CUR12	337	Time	X	TM	4/8
NOT USED	CUR13	374	Date/Time Qualifier	X	ID	3/3
NOT USED	CUR14	373	Date	X	DT	8/8
NOT USED	CUR15	337	Time	X	TM	4/8
NOT USED	CUR16	374	Date/Time Qualifier	X	ID	3/3
NOT USED	CUR17	373	Date	X	DT	8/8
NOT USED	CUR18	337	Time	X	TM	4/8
NOT USED	CUR19	374	Date/Time Qualifier	X	ID	3/3
NOT USED	CUR20	373	Date	X	DT	8/8
NOT USED	CUR21	337	Time	X	TM	4/8

IMPLEMENTATION

RECEIVER IDENTIFICATION

Usage: **SITUATIONAL**

Repeat: **1**

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

Example: **REF*EV*1235678~**

STANDARD

REF Reference Identification

Level: Header

Position: 060

Loop: ____

Requirement: Optional

Max Use: >1

Purpose: To specify identifying information

Syntax:
1. **R0203**
   At least one of REF02 or REF03 is required.

DIAGRAM

REF	*	REF01 128 **Reference Ident Qual** M ID 2/3	*	REF02 127 **Reference Ident** X AN 1/30	*	REF03 352 ~~**Description**~~ X AN 1/80	*	REF04 C040 ~~**Reference Identifier**~~ O	~

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**
			CODE / DEFINITION **EV** — **Receiver Identification Number**	
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Receiver Identifier*** *ALIAS:* ***Receiver Identification*** SYNTAX: R0203	**X AN 1/30**
NOT USED	**REF03**	**352**	**Description**	**X AN 1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**

IMPLEMENTATION

VERSION IDENTIFICATION

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Use this Reference Number Segment to report the version number of the adjudication system that generated the claim payments in this transaction. Update this reference number whenever a change in the version or release number affects the 835. (This is not the ANSI ASCX12 version number as reported in the GS segment.)**

2. **Provide the version number when this information is required by the PAYER in order to resolve customer service questions from the PAYEE.**

Example: **REF*F2*FS3.21~**

STANDARD

REF Reference Identification

Level: Header

Position: 060

Loop: ____

Requirement: Optional

Max Use: >1

Purpose: To specify identifying information

Syntax:

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

DIAGRAM

REF	*	REF01 128 Reference Ident Qual M ID 2/3	*	REF02 127 Reference Ident X AN 1/30	*	REF03 352 ~~Description~~ X AN 1/80	*	REF04 C040 ~~Reference Identifier~~ O	~

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**
			CODE / DEFINITION **F2** — **Version Code - Local**	
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Version Identification Code*** SYNTAX: R0203	**X AN 1/30**

NOT USED	REF03	352	Description	X	AN	1/80
NOT USED	REF04	C040	REFERENCE IDENTIFIER	O		

IMPLEMENTATION

PRODUCTION DATE

Usage: **SITUATIONAL**

Repeat: **1**

Advisory: **Under most circumstances, this segment is expected to be sent.**

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

Example: **DTM*405*19960317~**

STANDARD

DTM Date/Time Reference

Level: Header

Position: 070

Loop: ____

Requirement: Optional

Max Use: >1

Purpose: To specify pertinent dates and times

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

DIAGRAM

DTM	*	DTM01 374 **Date/Time Qualifier** M ID 3/3	*	DTM02 373 **Date** X DT 8/8	*	DTM03 337 ~~**Time**~~ X TM 4/8	*	DTM04 623 ~~**Time Code**~~ O ID 2/2	*	DTM05 1250 ~~**Date Time format Qual**~~ X ID 2/3	*	DTM06 1251 ~~**Date Time Period**~~ X AN 1/35	~

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTM01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time	**M ID 3/3**

INDUSTRY: ***Date Time Qualifier***

CODE	DEFINITION
405	**Production** **Use this code for the end date for the adjudication production cycle for claims included in this 835.**

REQUIRED	**DTM02**	**373**	**Date** Date expressed as CCYYMMDD *INDUSTRY:* ***Production Date*** SYNTAX: R020305	**X**	**DT**	**8/8**
NOT USED	**DTM03**	**337**	**Time**	**X**	**TM**	**4/8**
NOT USED	**DTM04**	**623**	**Time Code**	**O**	**ID**	**2/2**
NOT USED	**DTM05**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**DTM06**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**

IMPLEMENTATION

PAYER IDENTIFICATION

Loop: **1000A — PAYER IDENTIFICATION** **Repeat:** **1**

Usage: **REQUIRED**

Repeat: **1**

Notes:
1. **Use this N1 loop to provide the name/address information for the payer. The payer's secondary identifying reference number should be provided in N1O4, if necessary.**

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

STANDARD

N1 Name

Level: Header

Position: 080

Loop: 1000 **Repeat:** 200

Requirement: Optional

Max Use: 1

Purpose: To identify a party by type of organization, name, and code

Set Notes:
1. The N1 loop allows for name/address information for the payer and payee which would be utilized to address remittance(s) for delivery.

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

DIAGRAM

N1	*	N101 98 **Entity ID Code** M ID 2/3	*	N102 93 **Name** X AN 1/60	*	N103 66 **ID Code Qualifier** X ID 1/2	*	N104 67 **ID Code** X AN 2/80	*	N105 706 ~~**Entity Relat Code**~~ O ID 2/2	*	N106 98 ~~**Entity ID Code**~~ O ID 2/3	~

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**N101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	**M ID 2/3**

CODE	DEFINITION
PR	**Payer**

SITUATIONAL	**N102**	**93**	**Name** Free-form name *INDUSTRY:* ***Payer Name*** SYNTAX: R0203 **Required if the National PlanID is not transmitted in N104.**	**X**	**AN**	**1/60**
SITUATIONAL	**N103**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) SYNTAX: R0203, P0304 ADVISORY: Under most circumstances, this element is expected to be sent. **Required if the National PlanID is not transmitted in N104.**	**X**	**ID**	**1/2**

CODE	DEFINITION
XV	**Health Care Financing Administration National PlanID** ***Required if the National PlanID is mandated for use. Otherwise, one of the other listed codes may be used.*** CODE SOURCE **540:** Health Care Financing Administration National PlanID

SITUATIONAL	**N104**	**67**	**Identification Code** Code identifying a party or other code *INDUSTRY:* ***Payer Identifier*** SYNTAX: P0304 ADVISORY: Under most circumstances, this element is expected to be sent. COMMENT: This segment, used alone, provides the most efficient method of providing organizational identification. To obtain this efficiency the “ID Code” (N104) must provide a key to the table maintained by the transaction processing party. **Required if the National PlanID is not transmitted in N104.**	**X**	**AN**	**2/80**
NOT USED	**N105**	**706**	**Entity Relationship Code**	**O**	**ID**	**2/2**
NOT USED	**N106**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**

IMPLEMENTATION

PAYER ADDRESS

Loop: **1000A — PAYER IDENTIFICATION**

Usage: **REQUIRED**

Repeat: **1**

Example: **N3*100 MAIN STREET~**

STANDARD

N3 Address Information

Level: Header

Position: 100

Loop: 1000

Requirement: Optional

Max Use: >1

Purpose: To specify the location of the named party

DIAGRAM

N3 * [N301 166 **Address Information** M AN 1/55] * [N302 166 **Address Information** O AN 1/55] ~

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**N301**	**166**	**Address Information** Address information *INDUSTRY:* ***Payer Address Line***	**M**	**AN**	**1/55**
SITUATIONAL	**N302**	**166**	**Address Information** Address information *INDUSTRY:* ***Payer Address Line***	**O**	**AN**	**1/55**
			Required if a second address line exists.			

IMPLEMENTATION

PAYER CITY, STATE, ZIP CODE

Loop: **1000A — PAYER IDENTIFICATION**

Usage: **REQUIRED**

Repeat: **1**

Example: **N4*KANSAS CITY*MO*64108~**

STANDARD

N4 Geographic Location

Level: Header

Position: 110

Loop: 1000

Requirement: Optional

Max Use: 1

Purpose: To specify the geographic place of the named party

Syntax: **1. C0605**
If N406 is present, then N405 is required.

DIAGRAM

N4	*	N401 19 **City Name** O AN 2/30	*	N402 156 **State or Prov Code** O ID 2/2	*	N403 116 **Postal Code** O ID 3/15	*	N404 26 ~~**Country Code**~~ O ID 2/3	*	N405 309 ~~**Location Qualifier**~~ X ID 1/2	*	N406 310 ~~**Location Identifier**~~ O AN 1/30	~

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**N401**	**19**	**City Name** Free-form text for city name *INDUSTRY:* ***Payer City Name*** COMMENT: A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location.	**O AN 2/30**
REQUIRED	**N402**	**156**	**State or Province Code** Code (Standard State/Province) as defined by appropriate government agency *INDUSTRY:* ***Payer State Code*** COMMENT: N402 is required only if city name (N401) is in the U.S. or Canada. CODE SOURCE **22:** States and Outlying Areas of the U.S.	**O ID 2/2**
REQUIRED	**N403**	**116**	**Postal Code** Code defining international postal zone code excluding punctuation and blanks (zip code for United States) *INDUSTRY:* ***Payer Postal Zone or ZIP Code*** CODE SOURCE **51:** ZIP Code	**O ID 3/15**
NOT USED	**N404**	**26**	**Country Code**	**O ID 2/3**

NOT USED	N405	309	Location Qualifier	X	ID	1/2
NOT USED	N406	310	Location Identifier	O	AN	1/30

IMPLEMENTATION

ADDITIONAL PAYER IDENTIFICATION

Loop: **1000A — PAYER IDENTIFICATION**

Usage: **SITUATIONAL**

Repeat: **4**

Advisory: **Under most circumstances, this segment is not sent.**

Notes:

1. **Use this REF segment whenever additional payer identification numbers are required. The ID numbers available in the TRN and N1 segments should be used before using the REF segment.**

Example: **REF*2U*98765~**

STANDARD

REF Reference Identification

Level: Header

Position: 120

Loop: 1000

Requirement: Optional

Max Use: >1

Purpose: To specify identifying information

Syntax:

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

DIAGRAM

REF	*	REF01 128 **Reference Ident Qual** M ID 2/3	*	REF02 127 **Reference Ident** X AN 1/30	*	REF03 352 ~~**Description**~~ X AN 1/80	*	REF04 C040 ~~**Reference Identifier**~~ O	~

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M**	**ID**	**2/3**

CODE	DEFINITION
2U	**Payer Identification Number** **For Medicare carriers or intermediaries, use this number for the Medicare carrier or intermediary ID number. For Blue Cross and Blue Shield Plans, use this number for the Blue Cross Blue Shield association plan code.**

			EO	**Submitter Identification Number** **This should be considered required when the transaction sender is not the payer or is identified by an identifier other than those already provided.**			
			HI	**Health Industry Number (HIN)** CODE SOURCE **121:** Health Industry Identification Number			
			NF	**National Association of Insurance Commissioners (NAIC) Code** **ADVISED** CODE SOURCE **245:** National Association of Insurance Commissioners (NAIC) Code			
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Additional Payer Identifier*** SYNTAX: R0203		**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**		**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**		**O**		

IMPLEMENTATION

PAYER CONTACT INFORMATION

Loop: **1000A — PAYER IDENTIFICATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **This should be used anytime the PAYEE can not be reasonably expected to know how to contact the Payer about this remittance advice.**
2. **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 should always include 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. (534)224-2525 would be represented as 5342242525). The extension, when applicable, should be included in the communication number immediately after the telephone number.**
3. **By definition of the standard, if PER03 is used, PER04 is required.**

Example: **PER*CX*JOHN WAYNE*TE*3035551212~**

STANDARD

PER Administrative Communications Contact

Level: Header

Position: 130

Loop: 1000

Requirement: Optional

Max Use: >1

Purpose: To identify a person or office to whom administrative communications should be directed

Syntax:

1. **P0304**
   If either PER03 or PER04 is present, then the other is required.
2. **P0506**
   If either PER05 or PER06 is present, then the other is required.
3. **P0708**
   If either PER07 or PER08 is present, then the other is required.

DIAGRAM

PER * PER01 366 **Contact Funct Code** M ID 2/2 * PER02 93 **Name** O AN 1/60 * PER03 365 **Comm Number Qual** X ID 2/2 * PER04 364 **Comm Number** X AN 1/80 * PER05 365 **Comm Number Qual** X ID 2/2 * PER06 364 **Comm Number** X AN 1/80

* PER07 365 **Comm Number Qual** X ID 2/2 * PER08 364 **Comm Number** X AN 1/80 * PER09 443 ~~**Contact Inq Reference**~~ O AN 1/20 ~

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**PER01**	**366**	**Contact Function Code** Code identifying the major duty or responsibility of the person or group named	**M ID 2/2**

CODE	DEFINITION
CX	**Payers Claim Office**

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
SITUATIONAL	**PER02**	**93**	**Name** Free-form name *INDUSTRY:* ***Payer Contact Name*** **Required if identifying an individual or other contact point to discuss information related to this transaction.** **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).**	**O AN 1/60**
SITUATIONAL	**PER03**	**365**	**Communication Number Qualifier** Code identifying the type of communication number SYNTAX: P0304 **Required if a contact communications number is to be transmitted.**	**X ID 2/2**

CODE	DEFINITION
EM	**Electronic Mail**
FX	**Facsimile**
TE	**Telephone**

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
SITUATIONAL	**PER04**	**364**	**Communication Number** Complete communications number including country or area code when applicable *INDUSTRY:* ***Payer Contact Communication Number*** SYNTAX: P0304 **Required if a contact communications number is to be transmitted.**	**X AN 1/80**

SITUATIONAL	**PER05**	**365**	**Communication Number Qualifier** Code identifying the type of communication number SYNTAX: P0506 **Required if a contact communications number is to be transmitted.**	**X**	**ID**	**2/2**

CODE	DEFINITION
EM	**Electronic Mail**
EX	**Telephone Extension** **When used, the value following this code is the extension for the preceding communications contact number.**
FX	**Facsimile**
TE	**Telephone**

SITUATIONAL	**PER06**	**364**	**Communication Number** Complete communications number including country or area code when applicable *INDUSTRY:* ***Payer Contact Communication Number*** SYNTAX: P0506 **Required if a contact communications number is to be transmitted.**	**X**	**AN**	**1/80**
SITUATIONAL	**PER07**	**365**	**Communication Number Qualifier** Code identifying the type of communication number SYNTAX: P0708 **Use this code only to provide the extension for the previous communications contact number.** **Required to convey a second communications contact number.**	**X**	**ID**	**2/2**

CODE	DEFINITION
EX	**Telephone Extension**

SITUATIONAL	**PER08**	**364**	**Communication Number** Complete communications number including country or area code when applicable *INDUSTRY:* ***Payer Contact Communication Number*** SYNTAX: P0708 **Use this code only to provide the extension for the previous communications contact number.** **Required to convey a second communications contact number.**	**X**	**AN**	**1/80**
NOT USED	**PER09**	**443**	**Contact Inquiry Reference**	**O**	**AN**	**1/20**

IMPLEMENTATION

PAYEE IDENTIFICATION

Loop: **1000B — PAYEE IDENTIFICATION** **Repeat:** **1**

Usage: **REQUIRED**

Repeat: **1**

Notes:
1. **Use this N1 loop to provide the name/address information of the payee. The identifying reference number should be provided in N1O4.**

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

STANDARD

N1 Name

Level: Header

Position: 080

Loop: 1000 **Repeat:** 200

Requirement: Optional

Max Use: 1

Purpose: To identify a party by type of organization, name, and code

Set Notes:
1. The N1 loop allows for name/address information for the payer and payee which would be utilized to address remittance(s) for delivery.

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

DIAGRAM

N1	*	N101	98	**Entity ID Code**	M	ID	2/3	*	N102	93	**Name**	X	AN	1/60	*	N103	66	**ID Code Qualifier**	X	ID	1/2	*	N104	67	**ID Code**	X	AN	2/80	*	N105	706	~~**Entity Relat Code**~~	O	ID	2/2	*	N106	98	~~**Entity ID Code**~~	O	ID	2/3	~

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**N101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	**M ID 2/3**

CODE	DEFINITION
PE	**Payee**

SITUATIONAL	**N102**	**93**	**Name** Free-form name *INDUSTRY:* ***Payee Name*** SYNTAX: R0203 **Required when N104 does not contain the National Provider Identifier.**	**X**	**AN**	**1/60**
REQUIRED	**N103**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) SYNTAX: R0203, P0304 **Required when N104 does not contain the National Provider Identifier.**	**X**	**ID**	**1/2**
REQUIRED	**N104**	**67**	**Identification Code** Code identifying a party or other code *INDUSTRY:* ***Payee Identification Code*** SYNTAX: P0304 COMMENT: This segment, used alone, provides the most efficient method of providing organizational identification. To obtain this efficiency the "ID Code" (N104) must provide a key to the table maintained by the transaction processing party.	**X**	**AN**	**2/80**
NOT USED	**N105**	**706**	**Entity Relationship Code**	**O**	**ID**	**2/2**
NOT USED	**N106**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**

CODE	DEFINITION
FI	**Federal Taxpayer's Identification Number** **For individual providers as payees, use this number to represent the Social Security Number.**
XX	**Health Care Financing Administration National Provider Identifier** ***Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.***

IMPLEMENTATION

PAYEE ADDRESS

Loop: **1000B — PAYEE IDENTIFICATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **Use of this segment is at the discretion of the payer for situations where the sender needs to communicate the payee address to a transaction receiver (for example, a VAB or a Clearinghouse).**

Example: **N3∗Suite 200∗1000 Main Street~**

STANDARD

N3 Address Information

Level: Header

Position: 100

Loop: 1000

Requirement: Optional

Max Use: >1

Purpose: To specify the location of the named party

DIAGRAM

N3	∗	N301 166 **Address Information** M AN 1/55	∗	N302 166 **Address Information** O AN 1/55	~

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**N301**	**166**	**Address Information** Address information *INDUSTRY:* ***Payee Address Line***	**M**	**AN**	**1/55**
SITUATIONAL	**N302**	**166**	**Address Information** Address information *INDUSTRY:* ***Payee Address Line***	**O**	**AN**	**1/55**
			Required if a second address line exists.			

IMPLEMENTATION

PAYEE CITY, STATE, ZIP CODE

Loop: **1000B — PAYEE IDENTIFICATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **Using this segment is at the discretion of the payer contingent on the business needs of the payee (receiver).**

Example: **N4*Beverly Hills*CA*90210~**

STANDARD

N4 Geographic Location

Level: Header

Position: 110

Loop: 1000

Requirement: Optional

Max Use: 1

Purpose: To specify the geographic place of the named party

Syntax:
1. **C0605**
   If N406 is present, then N405 is required.

DIAGRAM

N4	*	N401 19 **City Name** O AN 2/30	*	N402 156 **State or Prov Code** O ID 2/2	*	N403 116 **Postal Code** O ID 3/15	*	N404 26 **Country Code** O ID 2/3	*	N405 309 ~~**Location Qualifier**~~ X ID 1/2	*	N406 310 ~~**Location Identifier**~~ O AN 1/30	~

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**N401**	**19**	**City Name** Free-form text for city name *INDUSTRY:* ***Payee City Name*** COMMENT: A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location.	**O AN 2/30**
REQUIRED	**N402**	**156**	**State or Province Code** Code (Standard State/Province) as defined by appropriate government agency *INDUSTRY:* ***Payee State Code*** COMMENT: N402 is required only if city name (N401) is in the U.S. or Canada. CODE SOURCE **22:** States and Outlying Areas of the U.S.	**O ID 2/2**

REQUIRED	**N403**	**116**	**Postal Code** Code defining international postal zone code excluding punctuation and blanks (zip code for United States) *INDUSTRY:* ***Payee Postal Zone or ZIP Code*** CODE SOURCE **51:** ZIP Code	**O**	**ID**	**3/15**
SITUATIONAL	**N404**	**26**	**Country Code** Code identifying the country CODE SOURCE **5:** Countries, Currencies and Funds **Required if country is other than USA.**	**O**	**ID**	**2/3**
NOT USED	**N405**	**309**	**Location Qualifier**	**X**	**ID**	**1/2**
NOT USED	**N406**	**310**	**Location Identifier**	**O**	**AN**	**1/30**

IMPLEMENTATION

PAYEE ADDITIONAL IDENTIFICATION

Loop: **1000B — PAYEE IDENTIFICATION**

Usage: **SITUATIONAL**

Repeat: **>1**

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

Example: **REF*PQ*12345678~**

STANDARD

REF Reference Identification

Level: Header

Position: 120

Loop: 1000

Requirement: Optional

Max Use: >1

Purpose: To specify identifying information

Syntax:
1. **R0203**
   At least one of REF02 or REF03 is required.

DIAGRAM

REF	*	REF01 128 **Reference Ident Qual** M ID 2/3	*	REF02 127 **Reference Ident** X AN 1/30	*	REF03 352 ~~**Description**~~ X AN 1/80	*	REF04 C040 ~~**Reference Identifier**~~ O	~

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**

CODE	DEFINITION
0B	**State License Number**
1A	**Blue Cross Provider Number** **NOT ADVISED**
1B	**Blue Shield Provider Number** **NOT ADVISED**
1C	**Medicare Provider Number** **NOT ADVISED**

			1D	**Medicaid Provider Number** **NOT ADVISED**		
			1E	**Dentist License Number** **NOT ADVISED**		
			1F	**Anesthesia License Number** **NOT ADVISED**		
			1G	**Provider UPIN Number**		
			1H	**CHAMPUS Identification Number** **NOT ADVISED**		
			D3	**National Association of Boards of Pharmacy Number** CODE SOURCE **307:** National Association of Boards of Pharmacy Number		
			G2	**Provider Commercial Number** **NOT ADVISED**		
			N5	**Provider Plan Network Identification Number** **NOT ADVISED**		
			PQ	**Payee Identification**		
			TJ	**Federal Taxpayer's Identification Number** **This information should be in the N1 segment unless the National Provider ID was used in N103/04. For individual providers as payees, use this number to represent the Social Security Number.**		
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Additional Payee Identifier*** SYNTAX: R0203	**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**	**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**		

IMPLEMENTATION

HEADER NUMBER

Loop: **2000 — HEADER NUMBER** **Repeat:** **>1**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

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

Example: **LX*1~**

Example: **LX*961011~**

STANDARD

LX Assigned Number

Level: Detail

Position: 003

Loop: 2000 **Repeat:** >1

Requirement: Optional

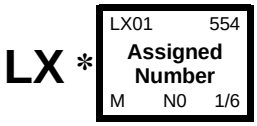
Max Use: 1

Purpose: To reference a line number in a transaction set

Set Notes:

1. The LX segment is used to provide a looping structure and logical grouping of claim payment information.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**LX01**	**554**	**Assigned Number** Number assigned for differentiation within a transaction set	**M**	**N0**	**1/6**

IMPLEMENTATION

PROVIDER SUMMARY INFORMATION

Loop: **2000 — HEADER NUMBER**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Payers and payees outside the Medicare Part A community may need to use this segment to identify provider subsidiaries whose remittance information is contained in the 835 transactions transmitted to a single provider entity (i.e., the corporate office of a hospital chain). For this purpose, TS301 identifies the subsidiary provider. The remaining mandatory elements (TS302 through 05) must be valid with appropriate data, as defined by the TS3 segment. Only Medicare Part A should use the data elements in TS306-24. Each total is for that provider for this type of bill for this fiscal period.**
2. **When available, use the National Provider ID in TS301.**
3. **All situational quantities and amounts in this segment are required when the value of the item is different than zero.**

Example: **TS3*123456*11*19961031*10*130957.66~**

STANDARD

TS3 Transaction Statistics

Level: Detail

Position: 005

Loop: 2000

Requirement: Optional

Max Use: 1

Purpose: To supply provider-level control information

DIAGRAM

TS3

*	TS301 127 **Reference Ident** M AN 1/30	*	TS302 1331 **Facility Code** M AN 1/2	*	TS303 373 **Date** M DT 8/8	*	TS304 380 **Quantity** M R 1/15	*	TS305 782 **Monetary Amount** M R 1/18	*	TS306 782 **Monetary Amount** O R 1/18	
*	TS307 782 **Monetary Amount** O R 1/18	*	TS308 782 **Monetary Amount** O R 1/18	*	TS309 782 **Monetary Amount** O R 1/18	*	TS310 782 **Monetary Amount** O R 1/18	*	TS311 782 **Monetary Amount** O R 1/18	*	TS312 782 **Monetary Amount** O R 1/18	
*	TS313 782 **Monetary Amount** O R 1/18	*	TS314 782 **Monetary Amount** O R 1/18	*	TS315 782 **Monetary Amount** O R 1/18	*	TS316 782 **Monetary Amount** O R 1/18	*	TS317 782 **Monetary Amount** O R 1/18	*	TS318 782 **Monetary Amount** O R 1/18	
*	TS319 782 **Monetary Amount** O R 1/18	*	TS320 782 **Monetary Amount** O R 1/18	*	TS321 782 **Monetary Amount** O R 1/18	*	TS322 782 **Monetary Amount** O R 1/18	*	TS323 380 **Quantity** O R 1/15	*	TS324 782 **Monetary Amount** O R 1/18	~

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**TS301**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Provider Identifier*** **SEMANTIC:** TS301 is the provider number. **Use this number for the provider number.**	**M AN 1/30**
REQUIRED	**TS302**	**1331**	**Facility Code Value** Code identifying the type of facility where services were performed; the first and second positions of the Uniform Bill Type code or the Place of Service code from the Electronic Media Claims National Standard Format *INDUSTRY:* ***Facility Type Code***	**M AN 1/2**
REQUIRED	**TS303**	**373**	**Date** Date expressed as CCYYMMDD *INDUSTRY:* ***Fiscal Period Date*** **SEMANTIC:** TS303 is the last day of the provider's fiscal year. **Use this date for the last day of the provider's fiscal year. If the end of the provider's fiscal year is not known, use December 31st of the current year.**	**M DT 8/8**
REQUIRED	**TS304**	**380**	**Quantity** Numeric value of quantity *INDUSTRY:* ***Total Claim Count*** **SEMANTIC:** TS304 is the total number of claims. **Use this number for the total number of claims.**	**M R 1/15**

REQUIRED	**TS305**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Total Claim Charge Amount*** SEMANTIC: TS305 is the total of reported charges. **Use this monetary amount for the total reported charges for all claims.**	**M**	**R**	**1/18**
SITUATIONAL	**TS306**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Total Covered Charge Amount*** SEMANTIC: TS306 is the total of covered charges. **Use this monetary amount for the total covered charges. This is submitted charges less the non-covered charges.**	**O**	**R**	**1/18**
SITUATIONAL	**TS307**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Total Noncovered Charge Amount*** SEMANTIC: TS307 is the total of noncovered charges. **Use this monetary amount for the total of non-covered charges.**	**O**	**R**	**1/18**
SITUATIONAL	**TS308**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Total Denied Charge Amount*** SEMANTIC: TS308 is the total of denied charges. **Use this monetary amount for the total of denied charges.**	**O**	**R**	**1/18**
SITUATIONAL	**TS309**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Total Provider Payment Amount*** SEMANTIC: TS309 is the total provider payment. **Use this monetary amount for the total provider payment. The total provider payment amount includes the total of all interest paid. The amount can be less than zero.**	**O**	**R**	**1/18**
SITUATIONAL	**TS310**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Total Interest Amount*** SEMANTIC: TS310 is the total amount of interest paid. **Use this monetary amount for the total amount of interest paid.**	**O**	**R**	**1/18**
SITUATIONAL	**TS311**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Total Contractual Adjustment Amount*** SEMANTIC: TS311 is the total contractual adjustment. **Use this monetary amount for the total contractual adjustment.**	**O**	**R**	**1/18**

SITUATIONAL	**TS312**	**782**	**Monetary Amount** Monetary amount	**O**	**R**	**1/18**

INDUSTRY: ***Total Gramm-Rudman Reduction Amount***

SEMANTIC: TS312 is the total Gramm-Rudman Reduction.

Use this monetary amount for the total Gramm-Rudman adjustment.

SITUATIONAL	**TS313**	**782**	**Monetary Amount** Monetary amount	**O**	**R**	**1/18**

INDUSTRY: ***Total MSP Payer Amount***

SEMANTIC: TS313 is the total Medicare Secondary Payer (MSP) primary payer amount.

Use this monetary amount for the total MSP primary payer amount.

SITUATIONAL	**TS314**	**782**	**Monetary Amount** Monetary amount	**O**	**R**	**1/18**

INDUSTRY: ***Total Blood Deductible Amount***

SEMANTIC: TS314 is the total blood deductible amount in dollars.

Use this monetary amount for the total blood deductible amount in dollars.

SITUATIONAL	**TS315**	**782**	**Monetary Amount** Monetary amount	**O**	**R**	**1/18**

INDUSTRY: ***Total Non-Lab Charge Amount***

SEMANTIC: TS315 is the summary of non-lab charges.

Use this monetary amount for the sum of non-lab charges.

SITUATIONAL	**TS316**	**782**	**Monetary Amount** Monetary amount	**O**	**R**	**1/18**

INDUSTRY: ***Total Coinsurance Amount***

SEMANTIC: TS316 is the total coinsurance amount.

Use this monetary amount for the total co-insurance amount.

SITUATIONAL	**TS317**	**782**	**Monetary Amount** Monetary amount	**O**	**R**	**1/18**

INDUSTRY: ***Total HCPCS Reported Charge Amount***

SEMANTIC: TS317 is the Health Care Financing Administration Common Procedural Coding System (HCPCS) reported charges.

Use this monetary amount for the total of HCPCS reported charges.

SITUATIONAL	**TS318**	**782**	**Monetary Amount** Monetary amount	**O**	**R**	**1/18**

INDUSTRY: ***Total HCPCS Payable Amount***

SEMANTIC: TS318 is the total Health Care Financing Administration Common Procedural Coding System (HCPCS) payable amount.

Use this monetary amount for the total HCPCS payable amount.

SITUATIONAL	**TS319**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Total Deductible Amount*** SEMANTIC: TS319 is the total deductible amount. **Use this monetary amount for the total cash deductible.**	**O**	**R**	**1/18**
SITUATIONAL	**TS320**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Total Professional Component Amount*** SEMANTIC: TS320 is the total professional component amount. **Use this monetary amount for the total professional component amount. The professional component amount must also be reported in the CAS segment with a Claim Adjustment Reason Code value of 89.**	**O**	**R**	**1/18**
SITUATIONAL	**TS321**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Total MSP Patient Liability Met Amount*** SEMANTIC: TS321 is the total Medicare Secondary Payer (MSP) patient liability met. **Use this monetary amount for the total MSP patient liability met amount.**	**O**	**R**	**1/18**
SITUATIONAL	**TS322**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Total Patient Reimbursement Amount*** SEMANTIC: TS322 is the total patient reimbursment. **Use this monetary amount for the total patient reimbursement.**	**O**	**R**	**1/18**
SITUATIONAL	**TS323**	**380**	**Quantity** Numeric value of quantity *INDUSTRY:* ***Total PIP Claim Count*** SEMANTIC: TS323 is the total periodic interim payment (PIP) number of claims. **Use this number for the total PIP number of claims.**	**O**	**R**	**1/15**
SITUATIONAL	**TS324**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Total PIP Adjustment Amount*** SEMANTIC: TS324 is total periodic interim payment (PIP) adjustment. **Use the monetary amount for the payment amount for PIP claims.**	**O**	**R**	**1/18**

IMPLEMENTATION

PROVIDER SUPPLEMENTAL SUMMARY INFORMATION

Loop: **2000 — HEADER NUMBER**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Use the TS2 segment only after a TS3 segment. This segment provides summary information specific to an iteration of the LX loop (Table 2). This segment is expected to be used only for Medicare Part A claims.**

2. **All situational quantities and amounts in this segment are required when the value of the item is different than zero. Each total is for that provider for this type of bill for this fiscal period.**

Example: **TS2*59786*55375.77~**

STANDARD

TS2 Transaction Supplemental Statistics

Level: Detail

Position: 007

Loop: 2000

Requirement: Optional

Max Use: 1

Purpose: To provide supplemental summary control information by provider fiscal year and bill type

DIAGRAM

TS2 * TS201 782 **Monetary Amount** O R 1/18 * TS202 782 **Monetary Amount** O R 1/18 * TS203 782 **Monetary Amount** O R 1/18 * TS204 782 **Monetary Amount** O R 1/18 * TS205 782 **Monetary Amount** O R 1/18 * TS206 782 **Monetary Amount** O R 1/18

* TS207 380 **Quantity** O R 1/15 * TS208 782 **Monetary Amount** O R 1/18 * TS209 782 **Monetary Amount** O R 1/18 * TS210 380 **Quantity** O R 1/15 * TS211 380 **Quantity** O R 1/15 * TS212 380 **Quantity** O R 1/15

* TS213 380 **Quantity** O R 1/15 * TS214 380 **Quantity** O R 1/15 * TS215 782 **Monetary Amount** O R 1/18 * TS216 380 **Quantity** O R 1/15 * TS217 782 **Monetary Amount** O R 1/18 * TS218 782 **Monetary Amount** O R 1/18

* TS219 782 **Monetary Amount** O R 1/18 ~

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
SITUATIONAL	TS201	782	**Monetary Amount** Monetary amount *INDUSTRY:* ***Total DRG Amount*** SEMANTIC: TS201 is the total diagnosis related group (DRG) amount. **Use this monetary amount for the total DRG amount.** **For Medicare, this includes: operating federal-specific amount, operating hospital-specific amount, operating Indirect Medical Education amount, and operating Disproportionate Share Hospital amount. It does not include any operating outlier amount.**	O	R	1/18
SITUATIONAL	TS202	782	**Monetary Amount** Monetary amount *INDUSTRY:* ***Total Federal Specific Amount*** SEMANTIC: TS202 is the total federal specific amount. **Use this monetary amount for the total federal-specific amount.**	O	R	1/18
SITUATIONAL	TS203	782	**Monetary Amount** Monetary amount *INDUSTRY:* ***Total Hospital Specific Amount*** SEMANTIC: TS203 is the total hospital specific amount. **Use this monetary amount for the total hospital-specific amount.**	O	R	1/18
SITUATIONAL	TS204	782	**Monetary Amount** Monetary amount *INDUSTRY:* ***Total Disproportionate Share Amount*** SEMANTIC: TS204 is the total disproportionate share amount. **Use this monetary amount for the total disproportionate share amount.**	O	R	1/18
SITUATIONAL	TS205	782	**Monetary Amount** Monetary amount *INDUSTRY:* ***Total Capital Amount*** SEMANTIC: TS205 is the total capital amount. **Use this monetary amount for the total capital amount.** **For Medicare, this includes: capital federal-specfic amount, hospital federal-specfic amount, hold harmless amount, Indirect Medical Education amount, Disproportionate Share Hospital amount, and the exception amount. It does not include any capital outlier amount.**	O	R	1/18

SITUATIONAL	**TS206**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Total Indirect Medical Education Amount*** SEMANTIC: TS206 is the total indirect medical education amount. **Use this monetary amount for the total indirect medical education amount.**	**O**	**R**	**1/18**
SITUATIONAL	**TS207**	**380**	**Quantity** Numeric value of quantity *INDUSTRY:* ***Total Outlier Day Count*** SEMANTIC: TS207 is the total number of outlier days. **Use this number for the total number of outlier days.**	**O**	**R**	**1/15**
SITUATIONAL	**TS208**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Total Day Outlier Amount*** SEMANTIC: TS208 is the total day outlier amount. **Use this monetary amount for the total day outlier amount.**	**O**	**R**	**1/18**
SITUATIONAL	**TS209**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Total Cost Outlier Amount*** SEMANTIC: TS209 is the total cost outlier amount. **Use this monetary amount for the total cost outlier amount.**	**O**	**R**	**1/18**
SITUATIONAL	**TS210**	**380**	**Quantity** Numeric value of quantity *INDUSTRY:* ***Average DRG Length of Stay*** SEMANTIC: TS210 is the diagnosis related group (DRG) average length of stay. **Use this number for the DRG average length of stay.**	**O**	**R**	**1/15**
SITUATIONAL	**TS211**	**380**	**Quantity** Numeric value of quantity *INDUSTRY:* ***Total Discharge Count*** SEMANTIC: TS211 is the total number of discharges. **Use this number for the total number of discharges.** **For Medicare, this is the discharge count produced by PPS PRICER SOFTWARE.**	**O**	**R**	**1/15**
SITUATIONAL	**TS212**	**380**	**Quantity** Numeric value of quantity *INDUSTRY:* ***Total Cost Report Day Count*** SEMANTIC: TS212 is the total number of cost report days. **Use this number for the total number of cost report days.**	**O**	**R**	**1/15**

SITUATIONAL	TS213	380	**Quantity** Numeric value of quantity *INDUSTRY:* ***Total Covered Day Count*** SEMANTIC: TS213 is the total number of covered days. **Use this number for the total number of covered days.**	O	R	1/15
SITUATIONAL	TS214	380	**Quantity** Numeric value of quantity *INDUSTRY:* ***Total Noncovered Day Count*** SEMANTIC: TS214 is total number of non-covered days. **Use this number for the total number of non-covered days.**	O	R	1/15
SITUATIONAL	TS215	782	**Monetary Amount** Monetary amount *INDUSTRY:* ***Total MSP Pass-Through Amount*** SEMANTIC: TS215 is the total Medicare Secondary Payer (MSP) pass- through amount calculated for a non-Medicare payer. **Use this amount for is the total MSP pass through amount calculated for a non-Medicare payer.**	O	R	1/18
SITUATIONAL	TS216	380	**Quantity** Numeric value of quantity *INDUSTRY:* ***Average DRG weight*** SEMANTIC: TS216 is the average diagnosis-related group (DRG) weight. **Use this number for the average DRG weight.**	O	R	1/15
SITUATIONAL	TS217	782	**Monetary Amount** Monetary amount *INDUSTRY:* ***Total PPS Capital FSP DRG Amount*** SEMANTIC: TS217 is the total prospective payment system (PPS) capital, federal-specific portion, diagnosis-related group (DRG) amount. **Use this monetary amount for the total PPS capital, federal-specific portion DRG amount.**	O	R	1/18
SITUATIONAL	TS218	782	**Monetary Amount** Monetary amount *INDUSTRY:* ***Total PPS Capital HSP DRG Amount*** SEMANTIC: TS218 is the total prospective payment system (PPS) capital, hospital-specific portion, diagnosis-related group (DRG) amount. **Use this monetary amount for the total PPS capital, hospital-specific portion DRG amount.**	O	R	1/18
SITUATIONAL	TS219	782	**Monetary Amount** Monetary amount *INDUSTRY:* ***Total PPS DSH DRG Amount*** SEMANTIC: TS219 is the total prospective payment system (PPS) disproportionate share, hospital diagnosis-related group (DRG) amount. **Use this monetary amount for the total PPS disproportionate share, hospital DRG amount.**	O	R	1/18

IMPLEMENTATION

CLAIM PAYMENT INFORMATION

Loop: **2100 — CLAIM PAYMENT INFORMATION** **Repeat:** **>1**

Usage: **REQUIRED**

Repeat: **1**

Example: **CLP∗7722337∗1∗211366.97∗138018.4∗∗12∗119932404007801~**

STANDARD

CLP Claim Level Data

Level: Detail

Position: 010

Loop: 2100 **Repeat:** >1

Requirement: Mandatory

Max Use: 1

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

DIAGRAM

CLP ∗ CLP01 1028 **Claim Submt Identifier** M AN 1/38 ∗ CLP02 1029 **Claim Status Code** M ID 1/2 ∗ CLP03 782 **Monetary Amount** M R 1/18 ∗ CLP04 782 **Monetary Amount** M R 1/18 ∗ CLP05 782 **Monetary Amount** O R 1/18 ∗ CLP06 1032 **Claim File Ind Code** O ID 1/2

∗ CLP07 127 **Reference Ident** O AN 1/30 ∗ CLP08 1331 **Facility Code** O AN 1/2 ∗ CLP09 1325 **Claim Freq Type Code** O ID 1/1 ∗ CLP10 1352 ~~**Patient Status Code**~~ O ID 1/2 ∗ CLP11 1354 **DRG Code** O ID 1/4 ∗ CLP12 380 **Quantity** O R 1/15

∗ CLP13 954 **Percent** O R 1/10 ~

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**CLP01**	**1028**	**Claim Submitter's Identifier** Identifier used to track a claim from creation by the health care provider through payment *INDUSTRY:* ***Patient Control Number*** **Use this number for the patient control number assigned by the provider. If the patient control number is not present on the incoming claim, enter zero. The value in CLP01 must be identical to any value received as a Claim Submitter's Identifier on the original claim (CLM01 of the ANSI ASC X12 837, if applicable). This data element is the primary key for posting the remittance information into the provider's database.**	**M AN 1/38**

REQUIRED **CLP02** **1029** **Claim Status Code** **M** **ID** **1/2**

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

CODE	DEFINITION
1	Processed as Primary
2	Processed as Secondary
3	Processed as Tertiary
4	Denied
5	Pended NOT ADVISED Claims with this status should be reported in the Claim Status (277) transaction when the payer implements it.
10	Received, but not in process NOT ADVISED Claims with this status should be reported in the Claim Status (277) transaction when the payer implements it.
13	Suspended NOT ADVISED Claims with this status should be reported in the Claim Status (277) transaction when the payer implements it.
15	Suspended - investigation with field NOT ADVISED Claims with this status should be reported in the Claim Status (277) transaction when the payer implements it.
16	Suspended - return with material NOT ADVISED Claims with this status should be reported in the Claim Status (277) transaction when the payer implements it.
17	Suspended - review pending NOT ADVISED Claims with this status should be reported in the Claim Status (277) transaction when the payer implements it.
19	Processed as Primary, Forwarded to Additional Payer(s)
20	Processed as Secondary, Forwarded to Additional Payer(s)

			21 **Processed as Tertiary, Forwarded to Additional Payer(s)**			
			22 **Reversal of Previous Payment**			
			23 **Not Our Claim, Forwarded to Additional Payer(s)**			
			25 **Predetermination Pricing Only - No Payment**			
			27 **Reviewed** **NOT ADVISED** **Claims with this status should be reported in the Claim Status (277) transaction when the payer implements it.**			
REQUIRED	**CLP03**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Total Claim Charge Amount*** SEMANTIC: CLP03 is the amount of submitted charges this claim. **See 2.2.1, Balancing, in this implementation guide for additional information. This amount does not include interest.** **Use this monetary amount for the submitted charges for this claim. The amount can be zero or less, but the value in BPR02 may not be negative.**	**M**	**R**	**1/18**
REQUIRED	**CLP04**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Claim Payment Amount*** SEMANTIC: CLP04 is the amount paid this claim. **See 2.2.1, Balancing, in this implementation guide for additional information. This amount does not include interest.** **Use this monetary amount for the amount paid for this claim. It can be zero or less, but the value in BPR02 may not be negative.**	**M**	**R**	**1/18**
SITUATIONAL	**CLP05**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Patient Responsibility Amount*** ADVISORY: Under most circumstances, this element is expected to be sent. SEMANTIC: CLP05 is the patient responsibility amount. **Amounts in CLP05 should have supporting adjustments reflected in CAS segments at the CLP or SVC loop level with a Claim Adjustment Group (CAS01) code of PR (Patient Responsibility).** **Use this monetary amount for the payer's statement of the patient responsibility amount for this claim, which can include such items as deductible, non-covered services, co-pay, and co-insurance. This amount must be entered if it is greater than zero. See 2.2.1, Balancing, and 2.2.9, Interest and Prompt Payment Discounts, for additional information.** **For Medicare, this must be reported by carriers but is not used by intermediaries.**	**O**	**R**	**1/18**

REQUIRED	CLP06	1032	**Claim Filing Indicator Code** Code identifying type of claim	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/BPR10 for all product lines or contractual relationships, the CLP06 is used by the provider as a table pointer in combination with the TRN03/BPR10 to identify the unique, provider-specific insurance plan code needed to post the payment without human intervention. The value should mirror the value received in the original claim (2-005 SBR09 of the 837), if applicable, or provide the value as assigned or edited by the payer.

CODE	DEFINITION
12	Preferred Provider Organization (PPO) Use this code for Blue Cross/Blue Shield par arrangements.
13	Point of Service (POS)
14	Exclusive Provider Organization (EPO)
15	Indemnity Insurance Use this code for Blue Cross/Blue Shield non-par arrangements.
16	Health Maintenance Organization (HMO) Medicare Risk
AM	Automobile Medical
CH	Champus
DS	Disability
HM	Health Maintenance Organization
LM	Liability Medical
MA	Medicare Part A
MB	Medicare Part B
MC	Medicaid
OF	Other Federal Program Use this code for the Black Lung Program.
TV	Title V
VA	Veteran Administration Plan
WC	Workers' Compensation Health Claim

SITUATIONAL	**CLP07**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Payer Claim Control Number*** ADVISORY: Under most circumstances, this element is expected to be sent. SEMANTIC: CLP07 is the payer's internal control number. **Use this number for the payer's internal control number. This number must apply to the entire claim. Report service variations at the SVC loop.** **This must be provided whenever the PAYER assigns an internal claim number and desires this reference from the provider as a part of any customer service contact or appeal process.**	**O**	**AN**	**1/30**
SITUATIONAL	**CLP08**	**1331**	**Facility Code Value** Code identifying the type of facility where services were performed; the first and second positions of the Uniform Bill Type code or the Place of Service code from the Electronic Media Claims National Standard Format *INDUSTRY:* ***Facility Type Code*** **State the facility code here when the submitted code has been modified through adjudication. This code is expected to be from the same code list as that identified in the original claim.** **This number was received in CLM05-1 of the 837 claim.**	**O**	**AN**	**1/2**
SITUATIONAL	**CLP09**	**1325**	**Claim Frequency Type Code** Code specifying the frequency of the claim; this is the third position of the Uniform Billing Claim Form Bill Type *INDUSTRY:* ***Claim Frequency Code*** CODE SOURCE **235:** 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 claim.**	**O**	**ID**	**1/2**
NOT USED	**CLP10**	**1352**	**Patient Status Code**	**O**	**ID**	**1/2**
SITUATIONAL	**CLP11**	**1354**	**Diagnosis Related Group (DRG) Code** Code indicating a patient's diagnosis group based on a patient's illness, diseases, and medical problems CODE SOURCE **229:** Diagnosis Related Group Number (DRG) **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.**	**O**	**ID**	**1/4**
SITUATIONAL	**CLP12**	**380**	**Quantity** Numeric value of quantity *INDUSTRY:* ***Diagnosis Related Group (DRG) Weight*** SEMANTIC: CLP12 is the diagnosis-related group (DRG) weight. **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.** **Use this number for the DRG Weight.**	**O**	**R**	**1/15**

SITUATIONAL	**CLP13**	**954**	**Percent** Percentage expressed as a decimal	**O**	**R**	**1/10**

INDUSTRY: ***Discharge Fraction***

SEMANTIC: CLP13 is the discharge fraction.

This data element is specific to institutional claims and is required when considered in the adjudication process. This does not apply to other types of claims.

Use this number for the discharge fraction.

IMPLEMENTATION

CLAIM ADJUSTMENT

Loop: **2100 — CLAIM PAYMENT INFORMATION**

Usage: **SITUATIONAL**

Repeat: **99**

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 2.2.1, Balancing, and 2.2.4, Claim Adjustment and Service Adjustment Segment Theory, for additional information.**
2. **See the SVC segment note #2 for details about per diem adjustments.**
3. **A single CAS segment contains six repetitions of the "adjustment trio" composed of adjustment reason code, adjustment amount, and adjustment quantity. These six adjustment trios are used to report up to six adjustments related to a particular Claim Adjustment Group Code (CAS01). The first adjustment is reported in the first adjustment trio (CAS02-CAS04). If there is a second non-zero adjustment, it is reported in the second adjustment trio (CAS05-CAS07), and so on through the sixth adjustment trio (CAS17-CAS19).**

Example: **CAS*PR*1*793~**

STANDARD

CAS Claims Adjustment

Level: Detail

Position: 020

Loop: 2100

Requirement: Optional

Max Use: 99

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

Set Notes:

1. The CAS segment is used to reflect changes to amounts within Table 2.

Syntax:

1. **L050607**
   If CAS05 is present, then at least one of CAS06 or CAS07 are required.
2. **C0605**
   If CAS06 is present, then CAS05 is required.
3. **C0705**
   If CAS07 is present, then CAS05 is required.
4. **L080910**
   If CAS08 is present, then at least one of CAS09 or CAS10 are required.
5. **C0908**
   If CAS09 is present, then CAS08 is required.

6. **C1008**
   If CAS10 is present, then CAS08 is required.
7. **L111213**
   If CAS11 is present, then at least one of CAS12 or CAS13 are required.
8. **C1211**
   If CAS12 is present, then CAS11 is required.
9. **C1311**
   If CAS13 is present, then CAS11 is required.
10. **L141516**
    If CAS14 is present, then at least one of CAS15 or CAS16 are required.
11. **C1514**
    If CAS15 is present, then CAS14 is required.
12. **C1614**
    If CAS16 is present, then CAS14 is required.
13. **L171819**
    If CAS17 is present, then at least one of CAS18 or CAS19 are required.
14. **C1817**
    If CAS18 is present, then CAS17 is required.
15. **C1917**
    If CAS19 is present, then CAS17 is required.

DIAGRAM

CAS *

CAS01 1033	CAS02 1034	CAS03 782	CAS04 380	CAS05 1034	CAS06 782
Claim Adj Group Code	**Claim Adj Reason Code**	**Monetary Amount**	**Quantity**	**Claim Adj Reason Code**	**Monetary Amount**
M ID 1/2	M ID 1/5	M R 1/18	O R 1/15	X ID 1/5	X R 1/18

*

CAS07 380	CAS08 1034	CAS09 782	CAS10 380	CAS11 1034	CAS12 782
Quantity	**Claim Adj Reason Code**	**Monetary Amount**	**Quantity**	**Claim Adj Reason Code**	**Monetary Amount**
X R 1/15	X ID 1/5	X R 1/18	X R 1/15	X ID 1/5	X R 1/18

*

CAS13 380	CAS14 1034	CAS15 782	CAS16 380	CAS17 1034	CAS18 782
Quantity	**Claim Adj Reason Code**	**Monetary Amount**	**Quantity**	**Claim Adj Reason Code**	**Monetary Amount**
X R 1/15	X ID 1/5	X R 1/18	X R 1/15	X ID 1/5	X R 1/18

*

CAS19 380
Quantity
X R 1/15

~

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**CAS01**	**1033**	**Claim Adjustment Group Code** Code identifying the general category of payment adjustment	**M**	**ID**	**1/2**

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

CODE	DEFINITION
CO	**Contractual Obligations** **Use this code when a joint payer/payee contractual agreement or a regulatory requirement resulted in an adjustment.**
CR	**Correction and Reversals** **Use this code for corrections and reversals to PRIOR claims. Use when CLP02=22, Reversal of Previous Payment.**
OA	**Other adjustments**
PI	**Payor Initiated Reductions** **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).**
PR	**Patient Responsibility**

REQUIRED	**CAS02**	**1034**	**Claim Adjustment Reason Code** Code identifying the detailed reason the adjustment was made	**M**	**ID**	**1/5**

INDUSTRY: ***Adjustment Reason Code***

CODE SOURCE 139: Claim Adjustment Reason Code

REQUIRED	**CAS03**	**782**	**Monetary Amount** Monetary amount	**M**	**R**	**1/18**

INDUSTRY: ***Adjustment Amount***

SEMANTIC: CAS03 is the amount of adjustment.

COMMENT: When the submitted charges are paid in full, the value for CAS03 should be zero.

Use this monetary amount for the adjustment amount. A negative amount increases the payment, and a positive amount decreases the payment contained in CLP04.

SITUATIONAL	**CAS04**	**380**	**Quantity** Numeric value of quantity	**O**	**R**	**1/15**

INDUSTRY: ***Adjustment Quantity***

SEMANTIC: CAS04 is the units of service being adjusted.

A positive value decreases the paid units of service, and a negative number increases the paid units.

This element may be used only when the units of service are being adjusted.

SITUATIONAL	**CAS05**	**1034**	**Claim Adjustment Reason Code** Code identifying the detailed reason the adjustment was made	**X**	**ID**	**1/5**

INDUSTRY: ***Adjustment Reason Code***

SYNTAX: L050607, C0605, C0705

CODE SOURCE 139: Claim Adjustment Reason Code

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

SITUATIONAL	**CAS06**	**782**	**Monetary Amount** Monetary amount	**X**	**R**	**1/18**

INDUSTRY: ***Adjustment Amount***

SYNTAX: L050607, C0605

SEMANTIC: CAS06 is the amount of the adjustment.

See CAS03.

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

SITUATIONAL	**CAS07**	**380**	**Quantity** Numeric value of quantity	**X**	**R**	**1/15**

INDUSTRY: ***Adjustment Quantity***

SYNTAX: L050607, C0705

SEMANTIC: CAS07 is the units of service being adjusted.

See CAS04.

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

SITUATIONAL	**CAS08**	**1034**	**Claim Adjustment Reason Code** Code identifying the detailed reason the adjustment was made	**X**	**ID**	**1/5**

INDUSTRY: ***Adjustment Reason Code***

SYNTAX: L080910, C0908, C1008

CODE SOURCE 139: Claim Adjustment Reason Code

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

SITUATIONAL	**CAS09**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Adjustment Amount*** SYNTAX: L080910, C0908 SEMANTIC: CAS09 is the amount of the adjustment. **See CAS03.** **Used when additional adjustments apply within the group identified in CAS01.**	**X**	**R**	**1/18**
SITUATIONAL	**CAS10**	**380**	**Quantity** Numeric value of quantity *INDUSTRY:* ***Adjustment Quantity*** SYNTAX: L080910, C1008 SEMANTIC: CAS10 is the units of service being adjusted. **See CAS04.** **Used when additional adjustments apply within the group identified in CAS01.**	**X**	**R**	**1/15**
SITUATIONAL	**CAS11**	**1034**	**Claim Adjustment Reason Code** Code identifying the detailed reason the adjustment was made *INDUSTRY:* ***Adjustment Reason Code*** SYNTAX: L111213, C1211, C1311 CODE SOURCE **139:** Claim Adjustment Reason Code **Used when additional adjustments apply within the group identified in CAS01.**	**X**	**ID**	**1/5**
SITUATIONAL	**CAS12**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Adjustment Amount*** SYNTAX: L111213, C1211 SEMANTIC: CAS12 is the amount of the adjustment. **See CAS03.** **Used when additional adjustments apply within the group identified in CAS01.**	**X**	**R**	**1/18**
SITUATIONAL	**CAS13**	**380**	**Quantity** Numeric value of quantity *INDUSTRY:* ***Adjustment Quantity*** SYNTAX: L111213, C1311 SEMANTIC: CAS13 is the units of service being adjusted. **See CAS04.** **Used when additional adjustments apply within the group identified in CAS01.**	**X**	**R**	**1/15**

SITUATIONAL	**CAS14**	**1034**	**Claim Adjustment Reason Code** Code identifying the detailed reason the adjustment was made *INDUSTRY:* ***Adjustment Reason Code*** SYNTAX: L141516, C1514, C1614 CODE SOURCE **139:** Claim Adjustment Reason Code **Used when additional adjustments apply within the group identified in CAS01.**	**X**	**ID**	**1/5**
SITUATIONAL	**CAS15**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Adjustment Amount*** SYNTAX: L141516, C1514 SEMANTIC: CAS15 is the amount of the adjustment. **See CAS03.** **Used when additional adjustments apply within the group identified in CAS01.**	**X**	**R**	**1/18**
SITUATIONAL	**CAS16**	**380**	**Quantity** Numeric value of quantity *INDUSTRY:* ***Adjustment Quantity*** SYNTAX: L141516, C1614 SEMANTIC: CAS16 is the units of service being adjusted. **See CAS04.** **Used when additional adjustments apply within the group identified in CAS01.**	**X**	**R**	**1/15**
SITUATIONAL	**CAS17**	**1034**	**Claim Adjustment Reason Code** Code identifying the detailed reason the adjustment was made *INDUSTRY:* ***Adjustment Reason Code*** SYNTAX: L171819, C1817, C1917 CODE SOURCE **139:** Claim Adjustment Reason Code **Used when additional adjustments apply within the group identified in CAS01.**	**X**	**ID**	**1/5**
SITUATIONAL	**CAS18**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Adjustment Amount*** SYNTAX: L171819, C1817 SEMANTIC: CAS18 is the amount of the adjustment. **See CAS03.** **Used when additional adjustments apply within the group identified in CAS01.**	**X**	**R**	**1/18**

SITUATIONAL	**CAS19**	**380**	**Quantity** Numeric value of quantity	**X**	**R**	**1/15**

INDUSTRY: ***Adjustment Quantity***

SYNTAX: L171819, C1917

SEMANTIC: CAS19 is the units of service being adjusted.

See CAS04.

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

IMPLEMENTATION

PATIENT NAME

Loop: **2100 — CLAIM PAYMENT INFORMATION**

Usage: **REQUIRED**

Repeat: **1**

Notes:
1. **Provide the patient's identification number in NM109.**

Example: **NM1*QC*1*SHEPHARD*SAM*O***HN*666666666A~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 030

Loop: 2100

Requirement: Mandatory

Max Use: 9

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

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

DIAGRAM

NM1	*	NM101 98 **Entity ID Code** M ID 2/3	*	NM102 1065 **Entity Type Qualifier** M ID 1/1	*	NM103 1035 **Name Last/ Org Name** O AN 1/35	*	NM104 1036 **Name First** O AN 1/25	*	NM105 1037 **Name Middle** O AN 1/25	*	NM106 1038 ~~**Name Prefix**~~ O AN 1/10	
*	NM107 1039 **Name Suffix** O AN 1/10	*	NM108 66 **ID Code Qualifier** X ID 1/2	*	NM109 67 **ID Code** X AN 2/80	*	NM110 706 ~~**Entity Relat Code**~~ X ID 2/2	*	NM111 98 ~~**Entity ID Code**~~ O ID 2/3	~			

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	**M ID 2/3**

CODE	DEFINITION
QC	**Patient**

REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103.	**M**	**ID**	**1/1**

CODE	DEFINITION
1	**Person**

REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name *INDUSTRY:* ***Patient Last Name***	**O**	**AN**	**1/35**
REQUIRED	**NM104**	**1036**	**Name First** Individual first name *INDUSTRY:* ***Patient First Name***	**O**	**AN**	**1/25**
SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial *INDUSTRY:* ***Patient Middle Name***	**O**	**AN**	**1/25**

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

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

NOT USED	**NM106**	**1038**	**Name Prefix**	**O**	**AN**	**1/10**
SITUATIONAL	**NM107**	**1039**	**Name Suffix** Suffix to individual name *INDUSTRY:* ***Patient Name Suffix*** ADVISORY: Under most circumstances, this element is not sent.	**O**	**AN**	**1/10**

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

SITUATIONAL	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) SYNTAX: P0809 ADVISORY: Under most circumstances, this element is expected to be sent.	**X**	**ID**	**1/2**

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

CODE	DEFINITION
34	**Social Security Number**
HN	**Health Insurance Claim (HIC) Number** **ADVISED**
II	**United States National Individual Identifier** **This code is not part of the ASC X12 004010 release. Use this code if mandated in a final Federal Rule.**
MI	**Member Identification Number**
MR	**Medicaid Recipient Identification Number**

SITUATIONAL	**NM109**	**67**	**Identification Code** Code identifying a party or other code *INDUSTRY:* ***Patient Identifier*** SYNTAX: P0809 ADVISORY: Under most circumstances, this element is expected to be sent. **Required if the patient identifier is known or was reported on the health care claim.**	**X**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**

IMPLEMENTATION

INSURED NAME

Loop: **2100 — CLAIM PAYMENT INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Use this NM1 segment to identify the insured or subscriber whenever the insured or subscriber is different from the patient. Any necessary identification number should be provided in NM109.**
2. **In the case of Medicare and Medicaid, the insured patient is always the subscriber and this segment should not be used.**

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

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 030

Loop: 2100

Requirement: Mandatory

Max Use: 9

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

Syntax:

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

DIAGRAM

NM1	*	NM101 98 **Entity ID Code** M ID 2/3	*	NM102 1065 **Entity Type Qualifier** M ID 1/1	*	NM103 1035 **Name Last/ Org Name** O AN 1/35	*	NM104 1036 **Name First** O AN 1/25	*	NM105 1037 **Name Middle** O AN 1/25	*	NM106 1038 ~~**Name Prefix**~~ O AN 1/10	
*	NM107 1039 **Name Suffix** O AN 1/10	*	NM108 66 **ID Code Qualifier** X ID 1/2	*	NM109 67 **ID Code** X AN 2/80	*	NM110 706 ~~**Entity Relat Code**~~ X ID 2/2	*	NM111 98 ~~**Entity ID Code**~~ O ID 2/3	~			

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	NM101	98	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	M	ID	2/3
			CODE — DEFINITION **IL** — **Insured or Subscriber**			
REQUIRED	NM102	1065	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103.	M	ID	1/1
			CODE — DEFINITION **1** — **Person** **2** — **Non-Person Entity**			
SITUATIONAL	NM103	1035	**Name Last or Organization Name** Individual last name or organizational name *INDUSTRY: **Subscriber Last Name***	O	AN	1/35
SITUATIONAL	NM104	1036	**Name First** Individual first name *INDUSTRY: **Subscriber First Name*** **Required when the subscriber is a person (NM102=1).**	O	AN	1/25
SITUATIONAL	NM105	1037	**Name Middle** Individual middle name or initial *INDUSTRY: **Subscriber Middle Name*** **If this data element is used and contains only one character, it is assumed to represent the middle initial.** **The Middle name or initial is required when the individual has a middle name or initial.** **Required if the subscriber is a person (NM102=1) and the information is known.**	O	AN	1/25
NOT USED	NM106	1038	**Name Prefix**	O	AN	1/10
SITUATIONAL	NM107	1039	**Name Suffix** Suffix to individual name *INDUSTRY: **Subscriber Name Suffix*** ADVISORY: Under most circumstances, this element is not sent. **The Suffix should be reported whenever this information is necessary for identification of the individual, for instance when a Junior and Senior are covered under the same subscriber.** **Required if the subscriber is a person (NM102=1) and the information is known.**	O	AN	1/10

REQUIRED	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) SYNTAX: P0809	**X**	**ID**	**1/2**

CODE	DEFINITION
34	**Social Security Number**
HN	**Health Insurance Claim (HIC) Number**
MI	**Member Identification Number** **Use this number for the payer's ID number for the insured.**

REQUIRED	**NM109**	**67**	**Identification Code** Code identifying a party or other code *INDUSTRY:* ***Subscriber Identifier*** SYNTAX: P0809	**X**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**

IMPLEMENTATION

CORRECTED PATIENT/INSURED NAME

Loop: **2100 — CLAIM PAYMENT INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

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

Example: **NM1*74*1*SHEPARD*SAMUEL*O***C*666666666A~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 030

Loop: 2100

Requirement: Mandatory

Max Use: 9

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

Syntax:

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

DIAGRAM

NM1	*	NM101 98 **Entity ID Code** M ID 2/3	*	NM102 1065 **Entity Type Qualifier** M ID 1/1	*	NM103 1035 **Name Last/ Org Name** O AN 1/35	*	NM104 1036 **Name First** O AN 1/25	*	NM105 1037 **Name Middle** O AN 1/25	*	NM106 1038 **~~Name Prefix~~** O AN 1/10	*	NM107 1039 **Name Suffix** O AN 1/10	*	NM108 66 **ID Code Qualifier** X ID 1/2	*	NM109 67 **ID Code** X AN 2/80	*	NM110 706 **~~Entity Relat Code~~** X ID 2/2	*	NM111 98 **~~Entity ID Code~~** O ID 2/3	~

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	**M ID 2/3**

CODE	DEFINITION
74	**Corrected Insured**

REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity	**M**	**ID**	**1/1**

SEMANTIC: NM102 qualifies NM103.

CODE	DEFINITION
1	**Person**
2	**Non-Person Entity**

SITUATIONAL	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name	**O**	**AN**	**1/35**

INDUSTRY: ***Corrected Patient or Insured Last Name***

Required when corrected information for the Insured is available.

SITUATIONAL	**NM104**	**1036**	**Name First** Individual first name	**O**	**AN**	**1/25**

INDUSTRY: ***Corrected Patient or Insured First Name***

Required when corrected information for the Insured is available.

This element may only be used when NM102 is 1 (person).

SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial	**O**	**AN**	**1/25**

INDUSTRY: ***Corrected Patient or Insured Middle Name***

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

Required when corrected information for the Insured is available.

This element may only be used when NM102 is 1 (person).

NOT USED	**NM106**	**1038**	**Name Prefix**	**O**	**AN**	**1/10**
SITUATIONAL	**NM107**	**1039**	**Name Suffix** Suffix to individual name	**O**	**AN**	**1/10**

INDUSTRY: ***Corrected Patient or Insured Name Suffix***

ADVISORY: Under most circumstances, this element is not sent.

Required when corrected information for the Insured is available.

This element may only be used when NM102 is 1 (person).

SITUATIONAL	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67)	**X**	**ID**	**1/2**

SYNTAX: P0809

Required when a value is reported in NM109.

CODE	DEFINITION
C	**Insured's Changed Unique Identification Number**

SITUATIONAL	**NM109**	**67**	**Identification Code** Code identifying a party or other code *INDUSTRY:* ***Corrected Insured Identification Indicator*** SYNTAX: P0809 **Required when corrected information for the Insured is available.**	**X**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**

IMPLEMENTATION

SERVICE PROVIDER NAME

Loop: **2100 — CLAIM PAYMENT INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

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

Example: **NM1*82*2******XX*12345678~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 030

Loop: 2100

Requirement: Mandatory

Max Use: 9

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

Syntax:

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

DIAGRAM

NM1	*	NM101 98 **Entity ID Code** M ID 2/3	*	NM102 1065 **Entity Type Qualifier** M ID 1/1	*	NM103 1035 **Name Last/ Org Name** O AN 1/35	*	NM104 1036 **Name First** O AN 1/25	*	NM105 1037 **Name Middle** O AN 1/25	*	NM106 1038 ~~**Name Prefix**~~ O AN 1/10	
	*	NM107 1039 **Name Suffix** O AN 1/10	*	NM108 66 **ID Code Qualifier** X ID 1/2	*	NM109 67 **ID Code** X AN 2/80	*	NM110 706 ~~**Entity Relat Code**~~ X ID 2/2	*	NM111 98 ~~**Entity ID Code**~~ O ID 2/3	~		

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	**M**	**ID**	**2/3**
			CODE — DEFINITION **82** — **Rendering Provider**			
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103.	**M**	**ID**	**1/1**
			CODE — DEFINITION **1** — **Person** **2** — **Non-Person Entity**			
SITUATIONAL	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name *INDUSTRY:* ***Rendering Provider Last or Organization Name*** **Required when needed to confirm the identifier in NM109.**	**O**	**AN**	**1/35**
SITUATIONAL	**NM104**	**1036**	**Name First** Individual first name *INDUSTRY:* ***Rendering Provider First Name*** **If NM102 is a "2" this element is not used.** **Used when NM102=1 and the information is known.**	**O**	**AN**	**1/25**
SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial *INDUSTRY:* ***Rendering Provider Middle Name*** **If NM102 is a "2" this element is not used.** **If this data element is used and contains only one character, it is assumed to represent the middle initial.** **The Middle name or initial is required when the individual has a middle name or initial.** **Used when NM102=1 and the information is known.**	**O**	**AN**	**1/25**
NOT USED	**NM106**	**1038**	**Name Prefix**	**O**	**AN**	**1/10**
SITUATIONAL	**NM107**	**1039**	**Name Suffix** Suffix to individual name *INDUSTRY:* ***Rendering Provider Name Suffix*** ADVISORY: Under most circumstances, this element is not sent. **The Suffix should be reported whenever this information is necessary for identification of the individual, for instance when a Junior and Senior are covered under the same subscriber.**	**O**	**AN**	**1/10**

REQUIRED	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) SYNTAX: P0809	**X**	**ID**	**1/2**

CODE	DEFINITION
BD	**Blue Cross Provider Number**
BS	**Blue Shield Provider Number**
FI	**Federal Taxpayer's Identification Number** **ADVISED** **For individual providers as payees, use this number to represent the Social Security Number.**
MC	**Medicaid Provider Number**
PC	**Provider Commercial Number**
SL	**State License Number**
UP	**Unique Physician Identification Number (UPIN)**
XX	**Health Care Financing Administration National Provider Identifier** ***Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.*** **ADVISED**

REQUIRED	**NM109**	**67**	**Identification Code** Code identifying a party or other code INDUSTRY: ***Rendering Provider Identifier*** SYNTAX: P0809	**X**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**

IMPLEMENTATION

CROSSOVER CARRIER NAME

Loop: **2100 — CLAIM PAYMENT INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Use this NM1 segment to provide information about the crossover carrier. Provide any reference numbers in NM109. The crossover carrier is defined as any payer to which the claim is transferred for further payment after being finalized by the current payer.**

Example: **NM1*TT*2*ACME INSURANCE*****XV*123456789~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 030

Loop: 2100

Requirement: Mandatory

Max Use: 9

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

Syntax:

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

DIAGRAM

NM1	*	NM101 98 **Entity ID Code** M ID 2/3	*	NM102 1065 **Entity Type Qualifier** M ID 1/1	*	NM103 1035 **Name Last/ Org Name** O AN 1/35	*	NM104 1036 ~~**Name First**~~ O AN 1/25	*	NM105 1037 ~~**Name Middle**~~ O AN 1/25	*	NM106 1038 ~~**Name Prefix**~~ O AN 1/10
	*	NM107 1039 ~~**Name Suffix**~~ O AN 1/10	*	NM108 66 **ID Code Qualifier** X ID 1/2	*	NM109 67 **ID Code** X AN 2/80	*	NM110 706 ~~**Entity Relat Code**~~ X ID 2/2	*	NM111 98 ~~**Entity ID Code**~~ O ID 2/3	~	

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	**M ID 2/3**

CODE	DEFINITION
TT	**Transfer To**

REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103.	**M**	**ID**	**1/1**

CODE	DEFINITION
2	**Non-Person Entity**

REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name *INDUSTRY:* ***Coordination of Benefits Carrier Name*** **Name of the crossover carrier associated with this claim.**	**O**	**AN**	**1/35**
NOT USED	**NM104**	**1036**	**Name First**	**O**	**AN**	**1/25**
NOT USED	**NM105**	**1037**	**Name Middle**	**O**	**AN**	**1/25**
NOT USED	**NM106**	**1038**	**Name Prefix**	**O**	**AN**	**1/10**
NOT USED	**NM107**	**1039**	**Name Suffix**	**O**	**AN**	**1/10**
REQUIRED	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) SYNTAX: P0809	**X**	**ID**	**1/2**

CODE	DEFINITION
AD	**Blue Cross Blue Shield Association Plan Code**
FI	**Federal Taxpayer's Identification Number**
NI	**National Association of Insurance Commissioners (NAIC) Identification** **ADVISED**
PI	**Payor Identification**
PP	**Pharmacy Processor Number**
XV	**Health Care Financing Administration National PlanID** ***Required if the National PlanID is mandated for use. Otherwise, one of the other listed codes may be used.*** **ADVISED**

CODE SOURCE **540:** Health Care Financing Administration National PlanID

REQUIRED	**NM109**	**67**	**Identification Code** Code identifying a party or other code *INDUSTRY:* ***Coordination of Benefits Carrier Identifier*** SYNTAX: P0809	**X**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**

IMPLEMENTATION

CORRECTED PRIORITY PAYER NAME

Loop: **2100 — CLAIM PAYMENT INFORMATION**

Usage: **SITUATIONAL**

Repeat: **2**

Notes:

1. **This segment is required when the current payer believes that another payer has priority for making a payment. Provide any reference numbers in NM109. Use of this segment identifies the priority payer. It is not necessary to use the Crossover Carrier NM1 segment in addition to this segment.**

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

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 030

Loop: 2100

Requirement: Mandatory

Max Use: 9

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

Syntax:

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

DIAGRAM

NM1	*	NM101 98 **Entity ID Code** M ID 2/3	*	NM102 1065 **Entity Type Qualifier** M ID 1/1	*	NM103 1035 **Name Last/ Org Name** O AN 1/35	*	NM104 1036 ~~**Name First**~~ O AN 1/25	*	NM105 1037 ~~**Name Middle**~~ O AN 1/25	*	NM106 1038 ~~**Name Prefix**~~ O AN 1/10
	*	NM107 1039 ~~**Name Suffix**~~ O AN 1/10	*	NM108 66 **ID Code Qualifier** X ID 1/2	*	NM109 67 **ID Code** X AN 2/80	*	NM110 706 ~~**Entity Relat Code**~~ X ID 2/2	*	NM111 98 ~~**Entity ID Code**~~ O ID 2/3	~	

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	**M ID 2/3**

CODE	DEFINITION
PR	**Payer**

REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103.	**M**	**ID**	**1/1**

CODE	DEFINITION
2	**Non-Person Entity**

REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name *INDUSTRY:* ***Corrected Priority Payer Name***	**O**	**AN**	**1/35**
NOT USED	**NM104**	**1036**	**Name First**	**O**	**AN**	**1/25**
NOT USED	**NM105**	**1037**	**Name Middle**	**O**	**AN**	**1/25**
NOT USED	**NM106**	**1038**	**Name Prefix**	**O**	**AN**	**1/10**
NOT USED	**NM107**	**1039**	**Name Suffix**	**O**	**AN**	**1/10**
REQUIRED	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) SYNTAX: P0809	**X**	**ID**	**1/2**

CODE	DEFINITION
AD	**Blue Cross Blue Shield Association Plan Code**
FI	**Federal Taxpayer's Identification Number**
NI	**National Association of Insurance Commissioners (NAIC) Identification** **ADVISED**
PI	**Payor Identification**
PP	**Pharmacy Processor Number**
XV	**Health Care Financing Administration National PlanID** ***Required if the National PlanID is mandated for use. Otherwise, one of the other listed codes may be used.*** **ADVISED**

CODE SOURCE **540:** Health Care Financing Administration National PlanID

REQUIRED	**NM109**	**67**	**Identification Code** Code identifying a party or other code *INDUSTRY:* ***Corrected Priority Payer Identification Number*** SYNTAX: P0809	**X**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**

IMPLEMENTATION

INPATIENT ADJUDICATION INFORMATION

Loop: **2100 — CLAIM PAYMENT INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

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

Example: **MIA*0***138018.4~**

STANDARD

MIA Medicare Inpatient Adjudication

Level: Detail

Position: 033

Loop: 2100

Requirement: Optional

Max Use: 1

Purpose: To provide claim-level data related to the adjudication of Medicare inpatient claims

DIAGRAM

MIA *

MIA01 380 **Quantity** M R 1/15	MIA02 380 **Quantity** O R 1/15	MIA03 380 **Quantity** O R 1/15	MIA04 782 **Monetary Amount** O R 1/18
MIA05 127 **Reference Ident** O AN 1/30	MIA06 782 **Monetary Amount** O R 1/18	MIA07 782 **Monetary Amount** O R 1/18	MIA08 782 **Monetary Amount** O R 1/18
MIA09 782 **Monetary Amount** O R 1/18	MIA10 782 **Monetary Amount** O R 1/18	MIA11 782 **Monetary Amount** O R 1/18	MIA12 782 **Monetary Amount** O R 1/18
MIA13 782 **Monetary Amount** O R 1/18	MIA14 782 **Monetary Amount** O R 1/18	MIA15 380 **Quantity** O R 1/15	MIA16 782 **Monetary Amount** O R 1/18
MIA17 782 **Monetary Amount** O R 1/18	MIA18 782 **Monetary Amount** O R 1/18	MIA19 782 **Monetary Amount** O R 1/18	MIA20 127 **Reference Ident** O AN 1/30
MIA21 127 **Reference Ident** O AN 1/30	MIA22 127 **Reference Ident** O AN 1/30	MIA23 127 **Reference Ident** O AN 1/30	MIA24 782 **Monetary Amount** O R 1/18 ~

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**MIA01**	**380**	**Quantity** Numeric value of quantity *INDUSTRY:* ***Covered Days or Visits Count*** **SEMANTIC:** MIA01 is the covered days. **Implementers of this guideline always transmit the number zero. See the QTY segment at the claim level for covered days or visits count.**	**M R 1/15**
SITUATIONAL	**MIA02**	**380**	**Quantity** Numeric value of quantity *INDUSTRY:* ***PPS Operating Outlier Amount*** **SEMANTIC:** MIA02 is the lifetime reserve days. **Use this to report PPS Operating Outlier.** **Additional payment for excessive cost incurred by provider.**	**O R 1/15**
SITUATIONAL	**MIA03**	**380**	**Quantity** Numeric value of quantity *INDUSTRY:* ***Lifetime Psychiatric Days Count*** **SEMANTIC:** MIA03 is the lifetime psychiatric days. **Use this number for the lifetime psychiatric days.**	**O R 1/15**

SITUATIONAL	**MIA04**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Claim DRG Amount*** **SEMANTIC:** MIA04 is the Diagnosis Related Group (DRG) amount. **Use this monetary amount for the DRG amount.**	**O**	**R**	**1/18**
SITUATIONAL	**MIA05**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Remark Code*** **SEMANTIC:** MIA05 is the Remittance Remark Code. See Code Source 411. **Used when a Remittance Remark Code applies to this claim.**	**O**	**AN**	**1/30**
SITUATIONAL	**MIA06**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Claim Disproportionate Share Amount*** **SEMANTIC:** MIA06 is the disproportionate share amount. **Use this monetary amount for the disproportionate share amount.**	**O**	**R**	**1/18**
SITUATIONAL	**MIA07**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Claim MSP Pass-through Amount*** **SEMANTIC:** MIA07 is the Medicare Secondary Payer (MSP) pass-through amount. **Use this monetary amount for the MSP pass through amount.**	**O**	**R**	**1/18**
SITUATIONAL	**MIA08**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Claim PPS Capital Amount*** **SEMANTIC:** MIA08 is the total Prospective Payment System (PPS) capital amount. **Use this monetary amount for the total PPS capital amount.**	**O**	**R**	**1/18**
SITUATIONAL	**MIA09**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***PPS-Capital FSP DRG Amount*** **SEMANTIC:** MIA09 is the Prospective Payment System (PPS) capital, federal specific portion, Diagnosis Related Group (DRG) amount. **Use this monetary amount for the PPS capital, federal-specific portion DRG amount.**	**O**	**R**	**1/18**
SITUATIONAL	**MIA10**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***PPS-Capital HSP DRG Amount*** **SEMANTIC:** MIA10 is the Prospective Payment System (PPS) capital, hospital specific portion, Diagnosis Related Group (DRG), amount. **Use this monetary amount for the PPS capital, hospital-specific portion DRG amount.**	**O**	**R**	**1/18**

SITUATIONAL	**MIA11**	**782**	**Monetary Amount** Monetary amount	**O**	**R**	**1/18**

INDUSTRY: ***PPS-Capital DSH DRG Amount***

SEMANTIC: MIA11 is the Prospective Payment System (PPS) capital, disaproportionate share, hospital Diagnosis Related Group (DRG) amount.

Use this monetary amount for the PPS capital, disproportionate share, hospital DRG amount.

SITUATIONAL	**MIA12**	**782**	**Monetary Amount** Monetary amount	**O**	**R**	**1/18**

INDUSTRY: ***Old Capital Amount***

SEMANTIC: MIA12 is the old capital amount.

Use this monetary amount for the old capital amount.

SITUATIONAL	**MIA13**	**782**	**Monetary Amount** Monetary amount	**O**	**R**	**1/18**

INDUSTRY: ***PPS-Capital IME amount***

SEMANTIC: MIA13 is the Prospective Payment System (PPS) capital indirect medical education claim amount.

Use this monetary amount for the PPS capital indirect medical education claim amount.

SITUATIONAL	**MIA14**	**782**	**Monetary Amount** Monetary amount	**O**	**R**	**1/18**

INDUSTRY: ***PPS-Operating Hospital Specific DRG Amount***

SEMANTIC: MIA14 is hospital specifc Diagnosis Related Group (DRG) Amount.

Use this monetary amount for the PPS (operating)/hospital-specific DRG amount.

SITUATIONAL	**MIA15**	**380**	**Quantity** Numeric value of quantity	**O**	**R**	**1/15**

INDUSTRY: ***Cost Report Day Count***

SEMANTIC: MIA15 is the cost report days.

Use this number for the cost report days.

SITUATIONAL	**MIA16**	**782**	**Monetary Amount** Monetary amount	**O**	**R**	**1/18**

INDUSTRY: ***PPS-Operating Federal Specific DRG Amount***

SEMANTIC: MIA16 is the federal specific Diagnosis Related Group (DRG) amount.

Use this monetary amount for the PPS (operating)/federal-specific DRG amount.

SITUATIONAL	**MIA17**	**782**	**Monetary Amount** Monetary amount	**O**	**R**	**1/18**

INDUSTRY: ***Claim PPS Capital Outlier Amount***

SEMANTIC: MIA17 is the Prospective Payment System (PPS) Capital Outlier amount.

Use this monetary amount for the PPS capital outlier amount. This amount excludes the operating outlier amount, which is reflected in the AMT segment.

SITUATIONAL	**MIA18**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Claim Indirect Teaching Amount*** **SEMANTIC:** MIA18 is the indirect teaching amount. **Use this monetary amount for the indirect teaching amount.**	**O**	**R**	**1/18**
SITUATIONAL	**MIA19**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Nonpayable Professional Component Amount*** **SEMANTIC:** MIA19 is the professional component amount billed but not payable. **Use this monetary amount for the professional component amount billed but not payable.**	**O**	**R**	**1/18**
SITUATIONAL	**MIA20**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Remark Code*** **SEMANTIC:** MIA20 is the Remittance Remark Code. See Code Source 411. **Used when additional remittance remarks apply to this claim.**	**O**	**AN**	**1/30**
SITUATIONAL	**MIA21**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Remark Code*** **SEMANTIC:** MIA21 is the Remittance Remark Code. See Code Source 411. **Used when additional remittance remarks apply to this claim.**	**O**	**AN**	**1/30**
SITUATIONAL	**MIA22**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Remark Code*** **SEMANTIC:** MIA22 is the Remittance Remark Code. See Code Source 411. **Used when additional remittance remarks apply to this claim.**	**O**	**AN**	**1/30**
SITUATIONAL	**MIA23**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Remark Code*** **SEMANTIC:** MIA23 is the Remittance Remark Code. See Code Source 411. **Used when additional remittance remarks apply to this claim.**	**O**	**AN**	**1/30**
SITUATIONAL	**MIA24**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***PPS-Capital Exception Amount*** **SEMANTIC:** MIA24 is the capital exception amount. **Use this monetary amount for the capital exception amount.**	**O**	**R**	**1/18**

IMPLEMENTATION

OUTPATIENT ADJUDICATION INFORMATION

Loop: **2100 — CLAIM PAYMENT INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

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

Example: **MOA***MA01~

STANDARD

MOA Medicare Outpatient Adjudication

Level: Detail

Position: 035

Loop: 2100

Requirement: Optional

Max Use: 1

Purpose: To convey claim-level data related to the adjudication of Medicare claims not related to an inpatient setting

DIAGRAM

MOA * MOA01 954 **Percent** O R 1/10 * MOA02 782 **Monetary Amount** O R 1/18 * MOA03 127 **Reference Ident** O AN 1/30 * MOA04 127 **Reference Ident** O AN 1/30 * MOA05 127 **Reference Ident** O AN 1/30 * MOA06 127 **Reference Ident** O AN 1/30

* MOA07 127 **Reference Ident** O AN 1/30 * MOA08 782 **Monetary Amount** O R 1/18 * MOA09 782 **Monetary Amount** O R 1/18 ~

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
SITUATIONAL	MOA01	954	**Percent** Percentage expressed as a decimal *INDUSTRY:* ***Reimbursement Rate*** SEMANTIC: MOA01 is the reimbursement rate. **Use this number for the reimbursement rate.** **This does not apply to claims processed by Medicare Carriers.**	O	R	1/10
SITUATIONAL	MOA02	782	**Monetary Amount** Monetary amount *INDUSTRY:* ***Claim HCPCS Payable Amount*** SEMANTIC: MOA02 is the claim Health Care Financing Administration Common Procedural Coding System (HCPCS) payable amount. **Use this monetary amount for the HCPCS payable amount.** **This does not apply to claims processed by Medicare Carriers.**	O	R	1/18
SITUATIONAL	MOA03	127	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Remark Code*** SEMANTIC: MOA03 is the Remittance Remark Code. See Code Source 411. **Used when a Remittance Remark Code applies to this claim.**	O	AN	1/30
SITUATIONAL	MOA04	127	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Remark Code*** SEMANTIC: MOA04 is the Remittance Remark Code. See Code Source 411. **See MOA03.** **Used when additional remittance remarks apply to this claim.**	O	AN	1/30
SITUATIONAL	MOA05	127	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Remark Code*** SEMANTIC: MOA05 is the Remittance Remark Code. See Code Source 411. **See MOA03.** **Used when additional remittance remarks apply to this claim.**	O	AN	1/30

SITUATIONAL	**MOA06**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Remark Code*** SEMANTIC: MOA06 is the Remittance Remark Code. See Code Source 411. **See MOA03.** **Used when additional remittance remarks apply to this claim.**	**O**	**AN**	**1/30**
SITUATIONAL	**MOA07**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Remark Code*** SEMANTIC: MOA07 is the Remittance Remark Code. See Code Source 411. **See MOA03.** **Used when additional remittance remarks apply to this claim.**	**O**	**AN**	**1/30**
SITUATIONAL	**MOA08**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Claim ESRD Payment Amount*** SEMANTIC: MOA08 is the End Stage Renal Disease (ESRD) payment amount. **Use this monetary amount for the ESRD payment amount.** **This does not apply to claims processed by Medicare Carriers.**	**O**	**R**	**1/18**
SITUATIONAL	**MOA09**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Nonpayable Professional Component Amount*** SEMANTIC: MOA09 is the professional component amount billed but not payable. **Use this monetary amount for the professional component amount billed but not payable.** **This does not apply to claims processed by Medicare Carriers.**	**O**	**R**	**1/18**

IMPLEMENTATION

OTHER CLAIM RELATED IDENTIFICATION

Loop: **2100 — CLAIM PAYMENT INFORMATION**

Usage: **SITUATIONAL**

Repeat: **5**

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

Example: **REF*EA*666123~**

STANDARD

REF Reference Identification

Level: Detail

Position: 040

Loop: 2100

Requirement: Optional

Max Use: 99

Purpose: To specify identifying information

Syntax:
1. **R0203**
   At least one of REF02 or REF03 is required.

DIAGRAM

REF	*	REF01 128 Reference Ident Qual M ID 2/3	*	REF02 127 Reference Ident X AN 1/30	*	REF03 352 ~~Description~~ X AN 1/80	*	REF04 C040 ~~Reference Identifier~~ O	~

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**

CODE	DEFINITION
1L	**Group or Policy Number**
1W	**Member Identification Number**
9A	**Repriced Claim Reference Number**
9C	**Adjusted Repriced Claim Reference Number**
A6	**Employee Identification Number**
BB	**Authorization Number**
CE	**Class of Contract Code**

			EA	**Medical Record Identification Number**		
			F8	**Original Reference Number**		
			G1	**Prior Authorization Number**		
			G3	**Predetermination of Benefits Identification Number**		
			IG	**Insurance Policy Number**		
			SY	**Social Security Number**		
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Other Claim Related Identifier*** SYNTAX: R0203	**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**	**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**		

IMPLEMENTATION

RENDERING PROVIDER IDENTIFICATION

Loop: **2100 — CLAIM PAYMENT INFORMATION**

Usage: **SITUATIONAL**

Repeat: **10**

Notes:

1. **This REF segment should be used to provide reference numbers that are not already identified in NM1 segments within the CLP loop. The NM1 segment should always contain the primary reference number. This segment should only be used when additional reference numbers were submitted on the original claim.**

Example: **REF*1C*12345678~**

STANDARD

REF Reference Identification

Level: Detail

Position: 040

Loop: 2100

Requirement: Optional

Max Use: 99

Purpose: To specify identifying information

Syntax:

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

DIAGRAM

REF	*	REF01 128 **Reference Ident Qual** M ID 2/3	*	REF02 127 **Reference Ident** X AN 1/30	*	REF03 352 ~~**Description**~~ X AN 1/80	*	REF04 C040 ~~**Reference Identifier**~~ O	~

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M**	**ID**	**2/3**

CODE	DEFINITION
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**		
			D3	**National Association of Boards of Pharmacy Number**		
				CODE SOURCE **307:** National Association of Boards of Pharmacy Number		
			G2	**Provider Commercial Number**		
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Rendering Provider Secondary Identifier*** SYNTAX: R0203	**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**	**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**		

IMPLEMENTATION

CLAIM DATE

Loop: **2100 — CLAIM PAYMENT INFORMATION**

Usage: **SITUATIONAL**

Repeat: **4**

Notes:

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

Example: **DTM*233*19960916~**

STANDARD

DTM Date/Time Reference

Level: Detail

Position: 050

Loop: 2100

Requirement: Optional

Max Use: 9

Purpose: To specify pertinent dates and times

Syntax:

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

DIAGRAM

DTM	*	DTM01 374 **Date/Time Qualifier** M ID 3/3	*	DTM02 373 **Date** X DT 8/8	*	DTM03 337 ~~**Time**~~ X TM 4/8	*	DTM04 623 ~~**Time Code**~~ O ID 2/2	*	DTM05 1250 ~~**Date Time format Qual**~~ X ID 2/3	*	DTM06 1251 ~~**Date Time Period**~~ X AN 1/35	~

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**DTM01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time *INDUSTRY:* ***Date Time Qualifier***	**M**	**ID**	**3/3**

CODE	DEFINITION
036	**Expiration** **Use this code to convey the expiration date of coverage.**
050	**Received** **Use this code to convey the date that the claim was received by the payer.**
232	**Claim Statement Period Start** **If the claim statement period start date is conveyed without a subsequent claim statement period end date, the end date is assumed to be the same as the start date. This date or code 233 should be considered required when service level dates are not provided in the remittance advice.**
233	**Claim Statement Period End** **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.**

REQUIRED	**DTM02**	**373**	**Date** Date expressed as CCYYMMDD *INDUSTRY:* ***Claim Date*** SYNTAX: R020305	**X**	**DT**	**8/8**
NOT USED	**DTM03**	**337**	**Time**	**X**	**TM**	**4/8**
NOT USED	**DTM04**	**623**	**Time Code**	**O**	**ID**	**2/2**
NOT USED	**DTM05**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**DTM06**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**

IMPLEMENTATION

CLAIM CONTACT INFORMATION

Loop: **2100 — CLAIM PAYMENT INFORMATION**

Usage: **SITUATIONAL**

Repeat: **3**

Notes:

1. **This segment should only be used when there is a claim specific communications contact instruction.**
2. **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 should always include 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. (534)224-2525 would be represented as 5342242525). The extension, when applicable, should be included in the communication number immediately after the telephone number.**
3. **By definition of the standard, if PER03 is used, PER04 is required.**

Example: **PER*CX**TE*8005551212~**

STANDARD

PER Administrative Communications Contact

Level: Detail

Position: 060

Loop: 2100

Requirement: Optional

Max Use: 3

Purpose: To identify a person or office to whom administrative communications should be directed

Syntax:

1. **P0304**
   If either PER03 or PER04 is present, then the other is required.
2. **P0506**
   If either PER05 or PER06 is present, then the other is required.
3. **P0708**
   If either PER07 or PER08 is present, then the other is required.

DIAGRAM

PER	PER01 366 Contact Funct Code M ID 2/2	PER02 93 Name O AN 1/60	PER03 365 Comm Number Qual X ID 2/2	PER04 364 Comm Number X AN 1/80	PER05 365 Comm Number Qual X ID 2/2	PER06 364 Comm Number X AN 1/80

PER07 365 Comm Number Qual X ID 2/2	PER08 364 Comm Number X AN 1/80	PER09 443 ~~Contact Inq Reference~~ O AN 1/20 ~

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**PER01**	**366**	**Contact Function Code** Code identifying the major duty or responsibility of the person or group named CODE / DEFINITION **CX** — **Payers Claim Office**	**M ID 2/2**
SITUATIONAL	**PER02**	**93**	**Name** Free-form name *INDUSTRY:* ***Claim Contact Name*** **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).**	**O AN 1/60**
SITUATIONAL	**PER03**	**365**	**Communication Number Qualifier** Code identifying the type of communication number SYNTAX: P0304 **Required if a contact communications number is to be transmitted.** CODE / DEFINITION **EM** — **Electronic Mail** **FX** — **Facsimile** **TE** — **Telephone**	**X ID 2/2**
SITUATIONAL	**PER04**	**364**	**Communication Number** Complete communications number including country or area code when applicable *INDUSTRY:* ***Claim Contact Communications Number*** SYNTAX: P0304 **Required if a contact communications number is to be transmitted.**	**X AN 1/80**

SITUATIONAL	**PER05**	**365**	**Communication Number Qualifier** Code identifying the type of communication number SYNTAX: P0506 **Required if a contact communications number is to be transmitted.**	**X**	**ID**	**2/2**

CODE	DEFINITION
EM	**Electronic Mail**
EX	**Telephone Extension** **When used, the value following this code is the extension for the preceding communications contact number.**
FX	**Facsimile**
TE	**Telephone**

SITUATIONAL	**PER06**	**364**	**Communication Number** Complete communications number including country or area code when applicable *INDUSTRY: **Claim Contact Communications Number*** SYNTAX: P0506 **Required if a contact communications number is to be transmitted.**	**X**	**AN**	**1/80**
SITUATIONAL	**PER07**	**365**	**Communication Number Qualifier** Code identifying the type of communication number SYNTAX: P0708 **Use this code only to provide the extension for the previous communications contact number.** **Required to convey a second communications contact number.**	**X**	**ID**	**2/2**

CODE	DEFINITION
EX	**Telephone Extension**

SITUATIONAL	**PER08**	**364**	**Communication Number** Complete communications number including country or area code when applicable *INDUSTRY: **Communication Number Extension*** SYNTAX: P0708 **Use this code only to provide the extension for the previous communications contact number.** **Required to convey a second communications contact number.**	**X**	**AN**	**1/80**
NOT USED	**PER09**	**443**	**Contact Inquiry Reference**	**O**	**AN**	**1/20**

IMPLEMENTATION

CLAIM SUPPLEMENTAL INFORMATION

Loop: **2100 — CLAIM PAYMENT INFORMATION**

Usage: **SITUATIONAL**

Repeat: **14**

Notes:

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

Example: **AMT*T*49~**

STANDARD

AMT Monetary Amount

Level: Detail

Position: 062

Loop: 2100

Requirement: Optional

Max Use: 20

Purpose: To indicate the total monetary amount

DIAGRAM

AMT	*	AMT01 522 **Amount Qual Code** M ID 1/3	*	AMT02 782 **Monetary Amount** M R 1/18	*	AMT03 478 ~~**Cred/Debit Flag Code**~~ O ID 1/1	~	

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**AMT01**	**522**	**Amount Qualifier Code** Code to qualify amount	**M ID 1/3**

CODE	DEFINITION
AU	**Coverage Amount** **Use this monetary amount to report the total covered charges.**
D8	**Discount Amount** **Prompt Pay Discount Amount**
DY	**Per Day Limit**
F5	**Patient Amount Paid** **Use this monetary amount for the amount the patient has already paid.**

			I Interest			
			NL Negative Ledger Balance Used only by Medicare Part A and Medicare Part B.			
			T Tax			
			T2 Total Claim Before Taxes			
			ZK Federal Medicare or Medicaid Payment Mandate - Category 1			
			ZL Federal Medicare or Medicaid Payment Mandate - Category 2			
			ZM Federal Medicare or Medicaid Payment Mandate - Category 3			
			ZN Federal Medicare or Medicaid Payment Mandate - Category 4			
			ZO Federal Medicare or Medicaid Payment Mandate - Category 5			
			ZZ Mutually Defined NOT ADVISED Use this number for the operational cost or day outlier amount. (Used exclusively by Medicare Part A.)			
REQUIRED	**AMT02**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Claim Supplemental Information Amount***	**M**	**R**	**1/18**
NOT USED	**AMT03**	**478**	**Credit/Debit Flag Code**	**O**	**ID**	**1/1**

IMPLEMENTATION

CLAIM SUPPLEMENTAL INFORMATION QUANTITY

Loop: **2100 — CLAIM PAYMENT INFORMATION**

Usage: **SITUATIONAL**

Repeat: **15**

Notes:

1. **Use this segment to convey information only. It is not part of the financial balancing of the 835.**
2. **Use this segment only when the value of specific quantities identified in the QTY01 qualifier are Non-zero.**

Example: **QTY*ZK*3~**

STANDARD

QTY Quantity

Level: Detail

Position: 064

Loop: 2100

Requirement: Optional

Max Use: 20

Purpose: To specify quantity information

Syntax:

1. **R0204**
   At least one of QTY02 or QTY04 is required.
2. **E0204**
   Only one of QTY02 or QTY04 may be present.

DIAGRAM

QTY	*	QTY01 673 Quantity Qualifier M ID 2/2	*	QTY02 380 Quantity X R 1/15	*	QTY03 C001 ~~Composite Unit of Mea~~ O	*	QTY04 61 ~~Free-Form Message~~ X AN 1/30	~

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	QTY01	673	**Quantity Qualifier** Code specifying the type of quantity	M ID 2/2

CODE	DEFINITION
CA	Covered - Actual
CD	Co-insured - Actual
LA	Life-time Reserve - Actual
LE	Life-time Reserve - Estimated

			NA Number of Non-covered Days			
			NE Non-Covered - Estimated			
			NR Not Replaced Blood Units			
			OU Outlier Days			
			PS Prescription			
			VS Visits			
			ZK Federal Medicare or Medicaid Payment Mandate - Category 1			
			ZL Federal Medicare or Medicaid Payment Mandate - Category 2			
			ZM Federal Medicare or Medicaid Payment Mandate - Category 3			
			ZN Federal Medicare or Medicaid Payment Mandate - Category 4			
			ZO Federal Medicare or Medicaid Payment Mandate - Category 5			
REQUIRED	**QTY02**	**380**	**Quantity** Numeric value of quantity *INDUSTRY:* ***Claim Supplemental Information Quantity*** SYNTAX: R0204, E0204	**X**	**R**	**1/15**
NOT USED	**QTY03**	**C001**	**COMPOSITE UNIT OF MEASURE**	**O**		
NOT USED	**QTY04**	**61**	**Free-Form Message**	**X**	**AN**	**1/30**

IMPLEMENTATION

SERVICE PAYMENT INFORMATION

Loop: **2110 — SERVICE PAYMENT INFORMATION** **Repeat:** **999**

Usage: **SITUATIONAL**

Repeat: **1**

Advisory: **Under most circumstances, this segment is expected to be sent.**

Notes:

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

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

3. **See 2.2.6, Procedure Code Bundling and Unbundling, for important SVC segment usage information.**

Example: **SVC*HC:99214*100*80~**

STANDARD

SVC Service Information

Level: Detail

Position: 070

Loop: 2110 **Repeat:** 999

Requirement: Optional

Max Use: 1

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

DIAGRAM

SVC	*	SVC01 C003 **Comp. Med. Proced. ID** M	*	SVC02 782 **Monetary Amount** M R 1/18	*	SVC03 782 **Monetary Amount** O R 1/18	*	SVC04 234 **Product/ Service ID** O AN 1/48	*	SVC05 380 **Quantity** O R 1/15	*	SVC06 C003 **Comp. Med. Proced. ID** O	
	*	SVC07 380 **Quantity** O R 1/15	~										

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**SVC01**	**C003**	**COMPOSITE MEDICAL PROCEDURE IDENTIFIER** To identify a medical procedure by its standardized codes and applicable modifiers	**M**
			Use the adjudicated Medical Procedure Code.	
			This code is a composite data structure.	
REQUIRED	**SVC01 - 1**		**235 Product/Service ID Qualifier** Code identifying the type/source of the descriptive number used in Product/Service ID (234) *INDUSTRY:* ***Product or Service ID Qualifier***	**M ID 2/2**
			The value in SVC01-01 qualifies the values in SVC01-02, SVC01-03, SVC01-04, SVC01-05, and SVC01-06.	

CODE	DEFINITION
AD	**American Dental Association Codes** CODE SOURCE **135:** American Dental Association Codes
ER	**Jurisdiction Specific Procedure and Supply Codes** **This is specific to Workman's Compensation Claims.**
HC	**Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes** **Because the CPT codes of the American Medical Association are also level 1 HCPCS codes, they are reported under the code HC.** CODE SOURCE **130:** Health Care Financing Administration Common Procedural Coding System
ID	**International Classification of Diseases Clinical Modification (ICD-9-CM) - Procedure** CODE SOURCE **131:** International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure
IV	**Home Infusion EDI Coalition (HIEC) Product/Service Code** CODE SOURCE **513:** Home Infusion EDI Coalition (HIEC) Product/Service Code List
N1	**National Drug Code in 4-4-2 Format** CODE SOURCE **240:** National Drug Code by Format
N2	**National Drug Code in 5-3-2 Format** CODE SOURCE **240:** National Drug Code by Format
N3	**National Drug Code in 5-4-1 Format** CODE SOURCE **240:** National Drug Code by Format
N4	**National Drug Code in 5-4-2 Format** CODE SOURCE **240:** National Drug Code by Format
ND	**National Drug Code (NDC)** CODE SOURCE **134:** National Drug Code

		NU	**National Uniform Billing Committee (NUBC) UB92 Codes** CODE SOURCE **132:** National Uniform Billing Committee (NUBC) Codes			
		RB	**National Uniform Billing Committee (NUBC) UB82 Codes** CODE SOURCE **132:** National Uniform Billing Committee (NUBC) Codes			
		ZZ	**Mutually Defined** **This is used to convey the Health Insurance Prospective Payment System (HIPPS) Skilled Nursing Facility Rate Code. This code list is available from:** **Division of Institutional Care** **Health Care Financing Administration** **S1-03-06** **7500 Security Boulevard** **Baltimore, MD 21244-1850**			
REQUIRED	**SVC01 - 2**	**234**	**Product/Service ID** Identifying number for a product or service *INDUSTRY:* ***Procedure Code***	**M**	**AN**	**1/48**
SITUATIONAL	**SVC01 - 3**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners **Required when procedure code modifiers apply to this service.**	**O**	**AN**	**2/2**
SITUATIONAL	**SVC01 - 4**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners **Required when procedure code modifiers apply to this service.**	**O**	**AN**	**2/2**
SITUATIONAL	**SVC01 - 5**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners **Required when procedure code modifiers apply to this service.**	**O**	**AN**	**2/2**
SITUATIONAL	**SVC01 - 6**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners **Required when procedure code modifiers apply to this service.**	**O**	**AN**	**2/2**
SITUATIONAL	**SVC01 - 7**	**352**	**Description** A free-form description to clarify the related data elements and their content *INDUSTRY:* ***Procedure Code Description*** ADVISORY: Under most circumstances, this component is not sent **Avoid using the description to make it easier for the computer to process the information provided.**	**O**	**AN**	**1/80**

Used only when a description was received for the service on the original claim, and the adjudicated code is the submitted code.

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

INDUSTRY: ***Line Item Charge Amount***

SEMANTIC: SVC02 is the submitted service charge.

Use this monetary amount for the submitted service charge amount.

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

INDUSTRY: ***Line Item Provider Payment Amount***

SEMANTIC: SVC03 is the amount paid this service.

Use this number for the service amount paid. The value in SVC03 should equal the value in SVC02 minus all monetary amounts in the subsequent CAS segments of this loop. See 2.2.1, Balancing, for additional information.

SITUATIONAL	**SVC04**	**234**	**Product/Service ID** Identifying number for a product or service	**O**	**AN**	**1/48**

INDUSTRY: ***National Uniform Billing Committee Revenue Code***

SEMANTIC: SVC04 is the National Uniform Billing Committee 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. If the original claim and adjudication only referenced an NUBC revenue code, that is supplied in SVC01 and this element is not used.

SITUATIONAL	**SVC05**	**380**	**Quantity** Numeric value of quantity	**O**	**R**	**1/15**

INDUSTRY: ***Units of Service Paid Count***

SEMANTIC: SVC05 is the paid units of service.

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

SITUATIONAL	**SVC06**	**C003**	**COMPOSITE MEDICAL PROCEDURE IDENTIFIER** To identify a medical procedure by its standardized codes and applicable modifiers	**O**

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

This code is a composite data structure.

REQUIRED **SVC06 - 1** **235** **Product/Service ID Qualifier** **M ID 2/2**

Code identifying the type/source of the descriptive number used in Product/Service ID (234)

INDUSTRY: ***Product or Service ID Qualifier***

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

CODE	DEFINITION
AD	**American Dental Association Codes**
	CODE SOURCE **135:** American Dental Association Codes
ER	**Jurisdiction Specific Procedure and Supply Codes** **This is specific to Workman's Compensation Claims.**
HC	**Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes** **Because the CPT codes of the American Medical Association are also level 1 HCPCS codes, they are reported under the code HC.**
	CODE SOURCE **130:** Health Care Financing Administration Common Procedural Coding System
ID	**International Classification of Diseases Clinical Modification (ICD-9-CM) - Procedure**
	CODE SOURCE **131:** International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure
IV	**Home Infusion EDI Coalition (HIEC) Product/Service Code**
	CODE SOURCE **513:** Home Infusion EDI Coalition (HIEC) Product/Service Code List
N1	**National Drug Code in 4-4-2 Format**
	CODE SOURCE **240:** National Drug Code by Format
N2	**National Drug Code in 5-3-2 Format**
	CODE SOURCE **240:** National Drug Code by Format
N3	**National Drug Code in 5-4-1 Format**
	CODE SOURCE **240:** National Drug Code by Format
N4	**National Drug Code in 5-4-2 Format**
	CODE SOURCE **240:** National Drug Code by Format
ND	**National Drug Code (NDC)**
	CODE SOURCE **134:** National Drug Code
NU	**National Uniform Billing Committee (NUBC) UB92 Codes**
	CODE SOURCE **132:** National Uniform Billing Committee (NUBC) Codes
RB	**National Uniform Billing Committee (NUBC) UB82 Codes**
	CODE SOURCE **132:** National Uniform Billing Committee (NUBC) Codes

		ZZ	**Mutually Defined** **This is used to convey the Health Insurance Prospective Payment System (HIPPS) Skilled Nursing Facility Rate Code. This code list is available from:** **Division of Institutional Care** **Health Care Financing Administration** **S1-03-06** **7500 Security Boulevard** **Baltimore, MD 21244-1850**			
REQUIRED	**SVC06 - 2**	**234**	**Product/Service ID** Identifying number for a product or service *INDUSTRY:* ***Procedure Code***	**M**	**AN**	**1/48**
SITUATIONAL	**SVC06 - 3**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners **Required when procedure code modifiers apply to this service.**	**O**	**AN**	**2/2**
SITUATIONAL	**SVC06 - 4**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners **Required when procedure code modifiers apply to this service.**	**O**	**AN**	**2/2**
SITUATIONAL	**SVC06 - 5**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners **Required when procedure code modifiers apply to this service.**	**O**	**AN**	**2/2**
SITUATIONAL	**SVC06 - 6**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners **Required when procedure code modifiers apply to this service.**	**O**	**AN**	**2/2**
SITUATIONAL	**SVC06 - 7**	**352**	**Description** A free-form description to clarify the related data elements and their content *INDUSTRY:* ***Procedure Code Description*** ADVISORY: Under most circumstances, this component is not sent **Avoid using the description to make it easier for the computer to process the information provided.** **Required when a description was received for the service on the original claim.**	**O**	**AN**	**1/80**

SITUATIONAL	**SVC07**	**380**	**Quantity** Numeric value of quantity	**O**	**R**	**1/15**

INDUSTRY: ***Original Units of Service Count***

SEMANTIC: SVC07 is the original submitted units of service.

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.

IMPLEMENTATION

SERVICE DATE

Loop: **2110 — SERVICE PAYMENT INFORMATION**

Usage: **SITUATIONAL**

Repeat: **3**

Notes:

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

Example: **DTM*472*19961031~**

STANDARD

DTM Date/Time Reference

Level: Detail

Position: 080

Loop: 2110

Requirement: Optional

Max Use: 9

Purpose: To specify pertinent dates and times

Set Notes:

1. The DTM segment in the SVC loop is to be used to express dates and date ranges specifically related to the service identified in the SVC segment.

Syntax:

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

DIAGRAM

DTM	DTM01 374 Date/Time Qualifier M ID 3/3	DTM02 373 Date X DT 8/8	DTM03 337 ~~Time~~ X TM 4/8	DTM04 623 ~~Time Code~~ O ID 2/2	DTM05 1250 ~~Date Time format Qual~~ X ID 2/3	DTM06 1251 ~~Date Time Period~~ X AN 1/35	~

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**DTM01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time *INDUSTRY:* ***Date Time Qualifier***	**M**	**ID**	**3/3**
			CODE / **DEFINITION**			
			150 — **Service Period Start** **Use this code only for reporting the beginning of multi-day services.**			
			151 — **Service Period End** **Use this code only for reporting the end of multi-day services.**			
			472 — **Service ADVISED** **Use this code to indicate a single day service.**			
REQUIRED	**DTM02**	**373**	**Date** Date expressed as CCYYMMDD *INDUSTRY:* ***Service Date*** SYNTAX: R020305	**X**	**DT**	**8/8**
NOT USED	**DTM03**	**337**	**Time**	**X**	**TM**	**4/8**
NOT USED	**DTM04**	**623**	**Time Code**	**O**	**ID**	**2/2**
NOT USED	**DTM05**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**DTM06**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**

IMPLEMENTATION

SERVICE ADJUSTMENT

Loop: **2110 — SERVICE PAYMENT INFORMATION**

Usage: **SITUATIONAL**

Repeat: **99**

Notes:

1. **This CAS segment is optional and is intended to reflect reductions in payment due to adjustments particular to a specific service in the claim. An example of this level of CAS is the reduction for the part of the service charge that exceeds the usual and customary charge for the service. See 2.2.1, Balancing, and 2.2.4, 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).**

Example: **CAS*CO*A2*20~**

STANDARD

CAS Claims Adjustment

Level: Detail

Position: 090

Loop: 2110

Requirement: Optional

Max Use: 99

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

Set Notes:

1. The CAS segment is used to reflect changes to amounts within Table 2.

Syntax:

1. **L050607**
   If CAS05 is present, then at least one of CAS06 or CAS07 are required.
2. **C0605**
   If CAS06 is present, then CAS05 is required.
3. **C0705**
   If CAS07 is present, then CAS05 is required.
4. **L080910**
   If CAS08 is present, then at least one of CAS09 or CAS10 are required.
5. **C0908**
   If CAS09 is present, then CAS08 is required.

6. **C1008**
   If CAS10 is present, then CAS08 is required.
7. **L111213**
   If CAS11 is present, then at least one of CAS12 or CAS13 are required.
8. **C1211**
   If CAS12 is present, then CAS11 is required.
9. **C1311**
   If CAS13 is present, then CAS11 is required.
10. **L141516**
    If CAS14 is present, then at least one of CAS15 or CAS16 are required.
11. **C1514**
    If CAS15 is present, then CAS14 is required.
12. **C1614**
    If CAS16 is present, then CAS14 is required.
13. **L171819**
    If CAS17 is present, then at least one of CAS18 or CAS19 are required.
14. **C1817**
    If CAS18 is present, then CAS17 is required.
15. **C1917**
    If CAS19 is present, then CAS17 is required.

DIAGRAM

CAS * CAS01 1033 **Claim Adj Group Code** M ID 1/2 * CAS02 1034 **Claim Adj Reason Code** M ID 1/5 * CAS03 782 **Monetary Amount** M R 1/18 * CAS04 380 **Quantity** O R 1/15 * CAS05 1034 **Claim Adj Reason Code** X ID 1/5 * CAS06 782 **Monetary Amount** X R 1/18

* CAS07 380 **Quantity** X R 1/15 * CAS08 1034 **Claim Adj Reason Code** X ID 1/5 * CAS09 782 **Monetary Amount** X R 1/18 * CAS10 380 **Quantity** X R 1/15 * CAS11 1034 **Claim Adj Reason Code** X ID 1/5 * CAS12 782 **Monetary Amount** X R 1/18

* CAS13 380 **Quantity** X R 1/15 * CAS14 1034 **Claim Adj Reason Code** X ID 1/5 * CAS15 782 **Monetary Amount** X R 1/18 * CAS16 380 **Quantity** X R 1/15 * CAS17 1034 **Claim Adj Reason Code** X ID 1/5 * CAS18 782 **Monetary Amount** X R 1/18

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

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**CAS01**	**1033**	**Claim Adjustment Group Code** Code identifying the general category of payment adjustment	**M**	**ID**	**1/2**

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

CODE	DEFINITION
CO	**Contractual Obligations** **Use this code when a joint payer/payee agreement or a regulatory requirement has resulted in an adjustment.**
CR	**Correction and Reversals** **Use this code for corrections and reversals to PRIOR claims. Use when CLP02=22.**
OA	**Other adjustments**
PI	**Payor Initiated Reductions** **Use this code when, in the opinion of the payer, the adjustment is not the responsibility of the patient, but no supporting contract exists between the provider and the payer.**
PR	**Patient Responsibility**

REQUIRED	**CAS02**	**1034**	**Claim Adjustment Reason Code** Code identifying the detailed reason the adjustment was made	**M**	**ID**	**1/5**

INDUSTRY: ***Adjustment Reason Code***

CODE SOURCE 139: Claim Adjustment Reason Code

REQUIRED	**CAS03**	**782**	**Monetary Amount** Monetary amount	**M**	**R**	**1/18**

INDUSTRY: ***Adjustment Amount***

SEMANTIC: CAS03 is the amount of adjustment.

COMMENT: When the submitted charges are paid in full, the value for CAS03 should be zero.

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.

SITUATIONAL	**CAS04**	**380**	**Quantity** Numeric value of quantity	**O**	**R**	**1/15**

INDUSTRY: ***Adjustment Quantity***

SEMANTIC: CAS04 is the units of service being adjusted.

This element may be used only when the units of service are being adjusted. A positive number decreases paid units, and a negative value increases paid units.

SITUATIONAL	**CAS05**	**1034**	**Claim Adjustment Reason Code** Code identifying the detailed reason the adjustment was made *INDUSTRY:* ***Adjustment Reason Code*** **SYNTAX:** L050607, C0605, C0705 **CODE SOURCE 139:** Claim Adjustment Reason Code **See CAS02.** **Used when additional adjustments apply within the group identified in CAS01.**	**X**	**ID**	**1/5**
SITUATIONAL	**CAS06**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Adjustment Amount*** **SYNTAX:** L050607, C0605 **SEMANTIC:** CAS06 is the amount of the adjustment. **See CAS03.** **Used when additional adjustments apply within the group identified in CAS01.**	**X**	**R**	**1/18**
SITUATIONAL	**CAS07**	**380**	**Quantity** Numeric value of quantity *INDUSTRY:* ***Adjustment Quantity*** **SYNTAX:** L050607, C0705 **SEMANTIC:** CAS07 is the units of service being adjusted. **See CAS04.** **Used when additional adjustments apply within the group identified in CAS01.**	**X**	**R**	**1/15**
SITUATIONAL	**CAS08**	**1034**	**Claim Adjustment Reason Code** Code identifying the detailed reason the adjustment was made *INDUSTRY:* ***Adjustment Reason Code*** **SYNTAX:** L080910, C0908, C1008 **CODE SOURCE 139:** Claim Adjustment Reason Code **See CAS02.** **Used when additional adjustments apply within the group identified in CAS01.**	**X**	**ID**	**1/5**
SITUATIONAL	**CAS09**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Adjustment Amount*** **SYNTAX:** L080910, C0908 **SEMANTIC:** CAS09 is the amount of the adjustment. **See CAS03.** **Used when additional adjustments apply within the group identified in CAS01.**	**X**	**R**	**1/18**

SITUATIONAL	**CAS10**	**380**	**Quantity** Numeric value of quantity *INDUSTRY:* ***Adjustment Quantity*** SYNTAX: L080910, C1008 SEMANTIC: CAS10 is the units of service being adjusted. **See CAS04.** **Used when additional adjustments apply within the group identified in CAS01.**	**X**	**R**	**1/15**
SITUATIONAL	**CAS11**	**1034**	**Claim Adjustment Reason Code** Code identifying the detailed reason the adjustment was made *INDUSTRY:* ***Adjustment Reason Code*** SYNTAX: L111213, C1211, C1311 CODE SOURCE **139:** Claim Adjustment Reason Code **See CAS02.** **Used when additional adjustments apply within the group identified in CAS01.**	**X**	**ID**	**1/5**
SITUATIONAL	**CAS12**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Adjustment Amount*** SYNTAX: L111213, C1211 SEMANTIC: CAS12 is the amount of the adjustment. **See CAS03.** **Used when additional adjustments apply within the group identified in CAS01.**	**X**	**R**	**1/18**
SITUATIONAL	**CAS13**	**380**	**Quantity** Numeric value of quantity *INDUSTRY:* ***Adjustment Quantity*** SYNTAX: L111213, C1311 SEMANTIC: CAS13 is the units of service being adjusted. **See CAS04.** **Used when additional adjustments apply within the group identified in CAS01.**	**X**	**R**	**1/15**
SITUATIONAL	**CAS14**	**1034**	**Claim Adjustment Reason Code** Code identifying the detailed reason the adjustment was made *INDUSTRY:* ***Adjustment Reason Code*** SYNTAX: L141516, C1514, C1614 CODE SOURCE **139:** Claim Adjustment Reason Code **See CAS02.** **Used when additional adjustments apply within the group identified in CAS01.**	**X**	**ID**	**1/5**

SITUATIONAL	**CAS15**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Adjustment Amount*** SYNTAX: L141516, C1514 SEMANTIC: CAS15 is the amount of the adjustment. **See CAS03.** **Used when additional adjustments apply within the group identified in CAS01.**	**X**	**R**	**1/18**
SITUATIONAL	**CAS16**	**380**	**Quantity** Numeric value of quantity *INDUSTRY:* ***Adjustment Quantity*** SYNTAX: L141516, C1614 SEMANTIC: CAS16 is the units of service being adjusted. **See CAS04.** **Used when additional adjustments apply within the group identified in CAS01.**	**X**	**R**	**1/15**
SITUATIONAL	**CAS17**	**1034**	**Claim Adjustment Reason Code** Code identifying the detailed reason the adjustment was made *INDUSTRY:* ***Adjustment Reason Code*** SYNTAX: L171819, C1817, C1917 CODE SOURCE **139:** Claim Adjustment Reason Code **See CAS02.** **Used when additional adjustments apply within the group identified in CAS01.**	**X**	**ID**	**1/5**
SITUATIONAL	**CAS18**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Adjustment Amount*** SYNTAX: L171819, C1817 SEMANTIC: CAS18 is the amount of the adjustment. **See CAS03.** **Used when additional adjustments apply within the group identified in CAS01.**	**X**	**R**	**1/18**
SITUATIONAL	**CAS19**	**380**	**Quantity** Numeric value of quantity *INDUSTRY:* ***Adjustment Quantity*** SYNTAX: L171819, C1917 SEMANTIC: CAS19 is the units of service being adjusted. **See CAS04.** **Used when additional adjustments apply within the group identified in CAS01.**	**X**	**R**	**1/15**

IMPLEMENTATION

SERVICE IDENTIFICATION

Loop: **2110 — SERVICE PAYMENT INFORMATION**

Usage: **SITUATIONAL**

Repeat: **7**

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

Example: **REF*RB*100~**

STANDARD

REF Reference Identification

Level: Detail

Position: 100

Loop: 2110

Requirement: Optional

Max Use: 99

Purpose: To specify identifying information

Syntax:
1. **R0203**
   At least one of REF02 or REF03 is required.

DIAGRAM

REF	*	REF01 128 Reference Ident Qual M ID 2/3	*	REF02 127 Reference Ident X AN 1/30	*	REF03 352 ~~Description~~ X AN 1/80	*	REF04 C040 ~~Reference Identifier~~ O	~

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**

CODE	DEFINITION
1S	**Ambulatory Patient Group (APG) Number**
6R	**Provider Control Number** **This is the Line Item Control Number submitted in the 837, which is utilized by the provider for tracking purposes, if submitted on the claim this must be returned on remittance advice.**
BB	**Authorization Number**
E9	**Attachment Code**

			G1	**Prior Authorization Number**		
			G3	**Predetermination of Benefits Identification Number**		
			LU	**Location Number**		
			RB	**Rate code number**		
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Provider Identifier*** SYNTAX: R0203	**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**	**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**		

IMPLEMENTATION

RENDERING PROVIDER INFORMATION

Loop: **2110 — SERVICE PAYMENT INFORMATION**

Usage: **SITUATIONAL**

Repeat: **10**

Notes:

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

Example: **REF*HPI*12345678~**

STANDARD

REF Reference Identification

Level: Detail

Position: 100

Loop: 2110

Requirement: Optional

Max Use: 99

Purpose: To specify identifying information

Syntax:

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

DIAGRAM

REF	*	REF01 128 Reference Ident Qual M ID 2/3	*	REF02 127 Reference Ident X AN 1/30	*	REF03 352 ~~Description~~ X AN 1/80	*	REF04 C040 ~~Reference Identifier~~ O	~

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**

CODE	DEFINITION
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**		
			HPI	**Health Care Financing Administration National Provider Identifier**		
				CODE SOURCE **537:** Health Care Financing Administration National Provider Identifier		
			SY	**Social Security Number**		
			TJ	**Federal Taxpayer's Identification Number**		
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Rendering Provider Identifier*** SYNTAX: R0203	**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**	**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**		

IMPLEMENTATION

SERVICE SUPPLEMENTAL AMOUNT

Loop: **2110 — SERVICE PAYMENT INFORMATION**

Usage: **SITUATIONAL**

Repeat: **12**

Notes:

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

Example: **AMT*B6*425~**

STANDARD

AMT Monetary Amount

Level: Detail

Position: 110

Loop: 2110

Requirement: Optional

Max Use: 20

Purpose: To indicate the total monetary amount

DIAGRAM

AMT	*	AMT01 522 **Amount Qual Code** M ID 1/3	*	AMT02 782 **Monetary Amount** M R 1/18	*	AMT03 478 ~~**Cred/Debit Flag Code**~~ O ID 1/1	~	

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**AMT01**	**522**	**Amount Qualifier Code** Code to qualify amount	**M ID 1/3**

CODE	DEFINITION
B6	**Allowed - Actual**
DY	**Per Day Limit** **NOT ADVISED** **Medicare uses this to report the provider per diem amount, where applicable.**
KH	**Deduction Amount** **Late Filing Reduction**
NE	**Net Billed** **NOT ADVISED**
T	**Tax**

			T2	**Total Claim Before Taxes** **Use this monetary amount for the service charge before taxes.**		
			ZK	**Federal Medicare or Medicaid Payment Mandate - Category 1**		
			ZL	**Federal Medicare or Medicaid Payment Mandate - Category 2**		
			ZM	**Federal Medicare or Medicaid Payment Mandate - Category 3**		
			ZN	**Federal Medicare or Medicaid Payment Mandate - Category 4**		
			ZO	**Federal Medicare or Medicaid Payment Mandate - Category 5**		
REQUIRED	**AMT02**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Service Supplemental Amount***	**M**	**R**	**1/18**
NOT USED	**AMT03**	**478**	**Credit/Debit Flag Code**	**O**	**ID**	**1/1**

IMPLEMENTATION

SERVICE SUPPLEMENTAL QUANTITY

Loop: **2110 — SERVICE PAYMENT INFORMATION**

Usage: **SITUATIONAL**

Repeat: **6**

Notes:

1. **Use this segment to convey information only. It is not part of the financial balancing of the 835.**
2. **Use this segment only when the value of specific quantities identified in the QTY01 qualifier are Non-zero.**

Example: **QTY*ZL*3.75~**

STANDARD

QTY Quantity

Level: Detail

Position: 120

Loop: 2110

Requirement: Optional

Max Use: 20

Purpose: To specify quantity information

Syntax:

1. **R0204**
   At least one of QTY02 or QTY04 is required.
2. **E0204**
   Only one of QTY02 or QTY04 may be present.

DIAGRAM

QTY	*	QTY01 673 **Quantity Qualifier** M ID 2/2	*	QTY02 380 **Quantity** X R 1/15	*	QTY03 C001 ~~**Composite Unit of Mea**~~ O	*	QTY04 61 ~~**Free-Form Message**~~ X AN 1/30	~

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**QTY01**	**673**	**Quantity Qualifier** Code specifying the type of quantity	**M ID 2/2**

CODE	DEFINITION
NE	**Non-Covered - Estimated** **Use this code for actual line item non-covered visits.**
ZK	**Federal Medicare or Medicaid Payment Mandate - Category 1**
ZL	**Federal Medicare or Medicaid Payment Mandate - Category 2**

			ZM **Federal Medicare or Medicaid Payment Mandate - Category 3**			
			ZN **Federal Medicare or Medicaid Payment Mandate - Category 4**			
			ZO **Federal Medicare or Medicaid Payment Mandate - Category 5**			
REQUIRED	**QTY02**	**380**	**Quantity** Numeric value of quantity *INDUSTRY:* ***Service Supplemental Quantity Count*** SYNTAX: R0204, E0204	**X**	**R**	**1/15**
NOT USED	**QTY03**	**C001**	**COMPOSITE UNIT OF MEASURE**	**O**		
NOT USED	**QTY04**	**61**	**Free-Form Message**	**X**	**AN**	**1/30**

IMPLEMENTATION

HEALTH CARE REMARK CODES

Loop: **2110 — SERVICE PAYMENT INFORMATION**

Usage: **SITUATIONAL**

Repeat: **99**

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.**

Example: **LQ*HE*12345~**

STANDARD

LQ Industry Code

Level: Detail

Position: 130

Loop: 2110

Requirement: Optional

Max Use: 99

Purpose: Code to transmit standard industry codes

Syntax:
1. **C0102**
   If LQ01 is present, then LQ02 is required.

DIAGRAM

LQ	*	LQ01 1270 **Code List Qual Code** O ID 1/3	*	LQ02 1271 **Industry Code** X AN 1/30	~

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**LQ01**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list SYNTAX: C0102	**O**	**ID**	**1/3**

CODE	DEFINITION
HE	**Claim Payment Remark Codes** CODE SOURCE **411:** Remittance Remark Codes
RX	**National Council for Prescription Drug Programs Reject/Payment Codes** CODE SOURCE **530:** National Council for Prescription Drug Programs Reject/Payment Codes

REQUIRED	**LQ02**	**1271**	**Industry Code** Code indicating a code from a specific industry code list *INDUSTRY:* ***Remark Code*** **SYNTAX:** C0102	**X**	**AN**	**1/30**

IMPLEMENTATION

PROVIDER ADJUSTMENT

Usage: **SITUATIONAL**

Repeat: **>1**

Notes:

1. **Use the PLB segment to allow adjustments that are NOT specific to a particular claim or service to the amount of the actual payment. These adjustments can either decrease the payment (a positive number) or increase the payment (a negative number). Some examples of PLB adjustments are a loan repayment or a capitation payment. Multiple adjustments can be placed in one PLB segment, grouped by the provider identified in PLB01 and the period identified in PLB02. Although the PLB reference numbers are not standardized, refer to 2.2.10, Capitation and Related Payments or Adjustments, and 2.2.9, Interest and Prompt Payment Discounts, as well as to the HCFA Medicare Part A and B instructions for code suggestions and usage guidelines.**

Example: **PLB*123456*19960930*CV:9876514*-1.27~**

STANDARD

PLB Provider Level Adjustment

Level: Summary

Position: 010

Loop: ____

Requirement: Optional

Max Use: >1

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

Syntax:

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

DIAGRAM

PLB * PLB01 127 **Reference Ident** M AN 1/30 * PLB02 373 **Date** M DT 8/8 * PLB03 C042 **Adjustment Identifier** M * PLB04 782 **Monetary Amount** M R 1/18 * PLB05 C042 **Adjustment Identifier** X * PLB06 782 **Monetary Amount** X R 1/18

* PLB07 C042 **Adjustment Identifier** X * PLB08 782 **Monetary Amount** X R 1/18 * PLB09 C042 **Adjustment Identifier** X * PLB10 782 **Monetary Amount** X R 1/18 * PLB11 C042 **Adjustment Identifier** X * PLB12 782 **Monetary Amount** X R 1/18

* PLB13 C042 **Adjustment Identifier** X * PLB14 782 **Monetary Amount** X R 1/18 ~

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**PLB01**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Provider Identifier*** **SEMANTIC:** PLB01 is the provider number assigned by the payer. **Use this number for the provider identifier as assigned by the payer.**	**M AN 1/30**
REQUIRED	**PLB02**	**373**	**Date** Date expressed as CCYYMMDD *INDUSTRY:* ***Fiscal Period Date*** **SEMANTIC:** PLB02 is the last day of the provider's fiscal year. **Use this date for the last day of the provider's fiscal year. If the end of the provider's fiscal year is not known by the payer, use December 31st of the current year.**	**M DT 8/8**
REQUIRED	**PLB03**	**C042**	**ADJUSTMENT IDENTIFIER** To provide the category and identifying reference information for an adjustment **This code is a composite data structure. The composite identifies the reason and identifying information for the adjustment dollar amount in PLB04.**	**M**
REQUIRED	**PLB03 - 1**		**426 Adjustment Reason Code** Code indicating reason for debit or credit memo or adjustment to invoice, debit or credit memo, or payment	**M ID 2/2**

CODE	DEFINITION
50	**Late Charge** **Use this code for the Late Claim Filing Penalty or Medicare Late Cost Report Penalty. PLB03-2 identifies the Medicare Late Cost Report Penalty with a code value of LR.**

51	Interest Penalty Charge Use this code for the interest assessment for late filing. Medicare Part A provides code “IP” in PLB03-2.
72	Authorized Return This monetary amount is the provider refund adjustment. This adjustment acknowledges a refund received from a provider for previous overpayment. PLB03-2 should always contain an identifying reference number when the value isused. PLB04 should contain a negative value. This adjustment should always be offset by some other PLB adjustment referring to the original refund request or reason. For balancing purposes, the amount related to this adjustment reason code must be directly offset. Medicare A will provide code “PR” in PLB03-2.
90	Early Payment Allowance
AM	Applied to Borrower’s Account See 2.2.10, Capitation and Related Payments or Adjustments, for additional information. Use this monetary amount for the loan repayment amount.
AP	Acceleration of Benefits Use this code to reflect accelerated payment amounts or withholdings. 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. Medicare Part A will provide code “AP” for accelerated payment amounts and code “AW” for accelerated payment withholdings in PLB03-2.
B2	Rebate Use this code for the refund adjustment. Medicare Part A will provide code “RF” in PLB03-2.
B3	Recovery Allowance This code is used by Medicare to represent 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. Part A or Part B trust fund for Medicare use is identified in PLB03-2. “RA” is used for Medicare A. “RB” is used for Medicare Part B. PLB04 should contain a NEGATIVE value. This adjustment should always be offset by some other PLB adjustment referring to the original refund request or reason. For balancing purposes, the amount related to this adjustment reason code must be directly offset.

BD	**Bad Debt Adjustment** **Use this code for the bad debt passthrough. Medicare Part A will provide code "BD" in PLB03-2.**
BN	**Bonus** **See 2.2.10, Capitation and Related Payments or Adjustments, for additional information.**
C5	**Temporary Allowance** **This is the tentative adjustment. Medicare Part A will provide code "TS" in PLB03-2.**
CR	**Capitation Interest** **See 2.2.10, Capitation and Related Payments or Adjustments, for additional information.**
CS	**Adjustment** **Provide supporting identification information in PLB03-2. Medicare Part A will provide code "CA" for Manual Claim Adjustment, "AA" for Receivable Today. Medicare Part A and Part B will provide code "RI" for Reissued Check Amount in PLB03-2.**
CT	**Capitation Payment** **See 2.2.10, Capitation and Related Payments or Adjustments, for additional information.**
CV	**Capital Passthru** **Medicare Part A will provide code "CP" in PLB03-2.**
CW	**Certified Registered Nurse Anesthetist Passthru** **Medicare Part A will provide code "CR" in PLB03-2.**
DM	**Direct Medical Education Passthru** **Medicare Part A will provide code "DM" in PLB03-2.**
E3	**Withholding** **See 2.2.10, Capitation and Related Payments or Adjustments, for additional information. Medicare Part A will provide code "CW" in PLB03-2.**
FB	**Forwarding Balance** **Use this monetary amount for the balance forward. A negative value in PLB04 represents a balance moving forward to a future payment advice. A positive value represents a balance being applied from a previous payment advice. A reference number should be supplied in PLB03-2 for tracking purposes. Medicare Part A will provide code "BF" for negative values and "CO" for positive values in PLB03-2.**

FC	**Fund Allocation** **See 2.2.10, Capitation and Related Payments or Adjustments, for additional information. The specific fund should be identified in PLB03-2.**
GO	**Graduate Medical Education Passthru** **Medicare Part A will provide code "GM" in PLB03-2.**
IP	**Incentive Premium Payment** **See 2.2.10, Capitation and Related Payments or Adjustments, for additional information.**
IR	**Internal Revenue Service Withholding**
IS	**Interim Settlement** **Use this number for the interim rate lump sum adjustment. Medicare Part A will provide code "IR" in PLB03-2.**
J1	**Nonreimbursable** **Use this to offset claim or service level data that reflects what could be paid if not for demonstration program or other limitation that prevents issuance of payment.**
L3	**Penalty** **Use this number for the capitation-related penalty, penalty withholding, or penalty release adjustment. Withholding or release is identified by the sign in PLB04. See 2.2.10, Capitation and Related Payments or Adjustments, for additional information. Medicare Part A will provide code "PW" for Penalty Withhold, "RS" for Penalty Release, and "SW" for Settlement Withhold Amount in PLB03-2.**
L6	**Interest Owed** **Use this monetary amount for the interest paid on claims in this 835. Support the amounts related to this adjustment by 2-062 AMT amounts, where AMT01 is "I. "Medicare Part A will provide code "IN" in PLB03-2.**
LE	**Levy** **IRS Levy**

LS	Lump Sum Use this for a disproportionate share adjustment, indirect medical education passthrough, non-physician passthrough, passthrough lump sum adjustment, or other passthrough amount. The specific type of lump sum adjustment must be identified in PLB03-2. Medicare Part A will provide code “DS” for Dispropiortinate Share Adjustment, “IM” for Indirect Medical Education Passthrough, “NP” for Non-physician Passthrough, “PS” for Passthrough Lump Sum, and “PO” for Other Passthrough in PLB03-2.
OA	Organ Acquisition Passthru Medicare Part A will provide code “KA” in PLB03-2.
OB	Offset for Affiliated Providers Part A or Part B trust fund identification for the source of the offset is in PLB03-2. Use “OA” for the Part A trust fund and “OB” for the Part B trust fund in PLB03-2.
PI	Periodic Interim Payment Use this monetary amount for the PIP lump sum, PIP payment, or adjustment after PIP. The sign of the amount in PLB04 determines whether this is a payment (negative) or adjustment (positive). Medicare Part A will provide code “PL” for PIP Lump Sum, “PP” for PIP Payment, and “PA” for Adjustment After PIP in PLB03-2.
PL	Payment Final Use this number for the final settlement. Medicare Part A will provide code “FS” in PLB03-2.
RA	Retro-activity Adjustment See 2.2.10, Capitation and Related Payments and Adjustments, for additional information. Medicare Part A will provide code “TR” in PLB03-2.
RE	Return on Equity Medicare Part A will provide code “RE” in PLB03-2.
SL	Student Loan Repayment
TL	Third Party Liability See 2.2.10, Capitation and Related Payments or Adjustments, for additional information.
WO	Overpayment Recovery Use this for the recovery of previous overpayment. An identifying number should be provided in PLB03-2. See the notes on codes 72 and B3 for additional information about balancing against a provider refund. Medicare Part A will provide code “OR” in PLB03-2.

			WU	**Unspecified Recovery** **Use this for the outside recovery adjustment. Medicare Part A will provide code "OS" in PLB03-2.**		
			ZZ	**Mutually Defined** **NOT ADVISED** **Use this to report hemophilia clotting factor supplement amount until data maintenance approved by ASC X12.**		
SITUATIONAL	**PLB03 - 2**		**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Provider Adjustment Identifier*** **Medicare intermediaries must enter the applicable Medicare code (see Medicare A notes in PLB03-1) in positions 1-2, the Financial Control Number or other pertinent identifier in positions 3-19, and the patient's Health Insurance Claim Number (HIC) in positions 20-30 when the adjustment is related to a previously processed claim.** **Non-Medicare payers report any internally assigned reference identifier for the related adjustment.**	**O**	**AN**	**1/30**
REQUIRED	**PLB04**	**782**		**Monetary Amount** Monetary amount *INDUSTRY:* ***Provider Adjustment Amount*** SEMANTIC: PLB04 is the adjustment amount. **Use this monetary amount for the adjustment amount for the preceding adjustment reason.**	**M**	**R**	**1/18**
SITUATIONAL	**PLB05**	**C042**		**ADJUSTMENT IDENTIFIER** To provide the category and identifying reference information for an adjustment **See PLB03 for details.** **Used when additional adjustments apply.**	**X**		
REQUIRED	**PLB05 - 1**		**426**	**Adjustment Reason Code** Code indicating reason for debit or credit memo or adjustment to invoice, debit or credit memo, or payment	**M**	**ID**	**2/2**
SITUATIONAL	**PLB05 - 2**		**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Provider Adjustment Identifier***	**O**	**AN**	**1/30**
SITUATIONAL	**PLB06**	**782**		**Monetary Amount** Monetary amount *INDUSTRY:* ***Provider Adjustment Amount*** SYNTAX: P0506 SEMANTIC: PLB06 is the adjustment amount. **Use this monetary amount for the adjustment amount for the preceding adjustment reason.**	**X**	**R**	**1/18**

SITUATIONAL	PLB07	C042		**ADJUSTMENT IDENTIFIER** To provide the category and identifying reference information for an adjustment	X		
				See PLB03 for details.			
				Used when additional adjustments apply.			
REQUIRED	PLB07 - 1		426	**Adjustment Reason Code** Code indicating reason for debit or credit memo or adjustment to invoice, debit or credit memo, or payment	M	ID	2/2
SITUATIONAL	PLB07 - 2		127	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Provider Adjustment Identifier***	O	AN	1/30
SITUATIONAL	PLB08	782		**Monetary Amount** Monetary amount *INDUSTRY:* ***Provider Adjustment Amount*** SYNTAX: P0708 SEMANTIC: PLB08 is the adjustment amount.	X	R	1/18
				Use this monetary amount for the adjustment amount for the preceding adjustment reason.			
SITUATIONAL	PLB09	C042		**ADJUSTMENT IDENTIFIER** To provide the category and identifying reference information for an adjustment	X		
				See PLB03 for details.			
				Used when additional adjustments apply.			
REQUIRED	PLB09 - 1		426	**Adjustment Reason Code** Code indicating reason for debit or credit memo or adjustment to invoice, debit or credit memo, or payment	M	ID	2/2
SITUATIONAL	PLB09 - 2		127	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Provider Adjustment Identifier***	O	AN	1/30
SITUATIONAL	PLB10	782		**Monetary Amount** Monetary amount *INDUSTRY:* ***Provider Adjustment Amount*** SYNTAX: P0910 SEMANTIC: PLB10 is the adjustment amount.	X	R	1/18
				Use this monetary amount for the adjustment amount for the preceding adjustment reason.			
SITUATIONAL	PLB11	C042		**ADJUSTMENT IDENTIFIER** To provide the category and identifying reference information for an adjustment	X		
				See PLB03 for details.			
				Used when additional adjustments apply.			
REQUIRED	PLB11 - 1		426	**Adjustment Reason Code** Code indicating reason for debit or credit memo or adjustment to invoice, debit or credit memo, or payment	M	ID	2/2

SITUATIONAL	**PLB11 - 2**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Provider Adjustment Identifier***	**O**	**AN**	**1/30**
SITUATIONAL	**PLB12**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Provider Adjustment Amount*** SYNTAX: P1112 SEMANTIC: PLB12 is the adjustment amount. **Use this monetary amount for the adjustment amount for the preceding adjustment reason.**	**X**	**R**	**1/18**
SITUATIONAL	**PLB13**	**C042**	**ADJUSTMENT IDENTIFIER** To provide the category and identifying reference information for an adjustment **See PLB03 for details.** **Used when additional adjustments apply.**	**X**		
REQUIRED	**PLB13 - 1**	**426**	**Adjustment Reason Code** Code indicating reason for debit or credit memo or adjustment to invoice, debit or credit memo, or payment	**M**	**ID**	**2/2**
SITUATIONAL	**PLB13 - 2**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Provider Adjustment Identifier***	**O**	**AN**	**1/30**
SITUATIONAL	**PLB14**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Provider Adjustment Amount*** SYNTAX: P1314 SEMANTIC: PLB14 is the adjustment amount. **Use this monetary amount for the adjustment amount for the preceding adjustment reason.**	**X**	**R**	**1/18**

IMPLEMENTATION

TRANSACTION SET TRAILER

Usage: **REQUIRED**

Repeat: **1**

Example: **SE*45*1234~**

STANDARD

SE Transaction Set Trailer

Level: Summary

Position: 020

Loop: ____

Requirement: Mandatory

Max Use: 1

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

DIAGRAM

SE * [SE01 96 **Number of Inc Segs** M N0 1/10] * [SE02 329 **TS Control Number** M AN 4/9] ~

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**SE01**	**96**	**Number of Included Segments** Total number of segments included in a transaction set including ST and SE segments *INDUSTRY:* ***Transaction Segment Count***	**M N0 1/10**
REQUIRED	**SE02**	**329**	**Transaction Set Control Number** Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set **The Transaction Set Control Numbers in ST02 and SE02 must be identical. 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.**	**M AN 4/9**

4 EDI Transmission Examples for Different Business Uses

4.1 Business Scenario 1

Dollars and data are being sent together through the banking system to pay Medicare Part A institutional claims.

This scenario depicts the use of the ANSI ASC X12 835 in a governmental institutional environment. The electronic transmission of funds request and the remittance detail are contained within this single 835. In this scenario, one or more Depository Financial Institutions is involved in transferring information from the sender to the receiver.

4.1.1 Assumptions

The following assumptions pertain to scenario one:

- The dollars move using the ACH network from the Bank of Payorea, ABA# 999999992, account number 123456 to the Bank of No Return, ABA# 999988880, checking account number 98765. The money moves on September 13, 1996.
- The Insurance Company of Timbucktu, Federal tax ID # 512345678 and Medicare Intermediary ID# 999, is paying Cybil Mental Hospital, National Provider Number 6543210903. This is for one inpatient and one outpatient claim.
- For the inpatient claim, the patient's name is Sam O. Shepard. The Health Insurance Claim Number is 666-66-6666A. The Claim Submitter's Identifier is 666123. The date of the hospitalization was August 16, 1996 to August 24, 1996. Total charges reported are $211,366.97. Paid amount is $138,018.40. There is no patient responsibility. Contractual adjustment is $73,348.57. No service line detail is provided.
- For the outpatient claim, the patient's name is Liz E. Borden, Health Insurance Claim Number 996-66-9999B. The Claim Submitter's Identifier is 777777. The date of service is May 12, 1996. Total charges reported are $15,000. Paid amount is $11,980.33. Contractual adjustment is $3,019.67. There is no service line information.
- There is a Capital Pass Through Amount (CV) payment to the provider for $1.27.

4.1.2 Transmission

```
ST*835*1234~
BPR*C*150000*C*ACH*CTX*01*999999992*DA*123456
  *1512345678**01*999988880*DA*98765*19960913~
TRN*1*12345*1512345678~
DTM*405*19960916~
```

```
N1*PR*INSURANCE COMPANY OF TIMBUCKTU~
N3*1 MAIN STREET~
N4*TIMBUCKTU*AK*89111~
REF*2U*999~
N1*PE*CYBIL MENTAL HOSPITAL*XX*6543210903~
LX*961211~
TS3*6543210903*11*19961231*1*211366.97*138018.4***
  138018.4**73348.57~
TS2*2178.45*1919.71**56.82*197.69*4.23~
CLP*666123*1*211366.97*138018.4**MA*1999999444444*
  11*1~
CAS*CO*A2*73348.57~
NM1*QC*1*SHEPARD*SAM*O***HN*666666666A~
MIA*0***138018.4~
DTM*232*19960816~
DTM*233*19960824~
QTY*CA*8~
LX*961213~
TS3*6543210909*13*19961231*1*15000*15000**
  *11980.33**3019.67~
CLP*777777*1*15000*11980.33**MB*1999999444445*13*
  1~
CAS*CO*A2*3019.67~
NM1*QC*1*BORDEN*LIZ*E***HN*996669999B~
MOA***MA02~
DTM*232*19960512~
PLB*6543210903*19961231*CV:CP*-1.27~
SE*28*1234~
```

4.2 Business Scenario 2

Dollars and data are sent separately. Scenario 2 depicts the use of the 835 in a managed care environment. The funds are moved separately from the remittance detail. In this scenario, the funds are sent by EFT to the provider's account, and the remittance data is transmitted directly to the provider.

4.2.1 Assumptions

The following assumptions pertain to scenario two:

- The dollars move from the Hudson River Bank, ABA# 888999777, account number 24681012 to the Amazon Bank, ABA# 111333555, checking account number 144444 using the ACH network. The money moves on March 16, 1996.
- The insurance company, Rushmore Life, Federal tax ID # 935665544, is paying ACME Medical Center, Federal tax ID # 777667755, a total of $945.00. Rushmore Life and ACME Medical Center have an agreement that a certain portion of their payments will be withheld for future use as specified in their managed medical contract.
- The first patient's name is William Budd, patient number 5554555444 and member ID # 33344555510. Total reported charges are $800.00. Amount paid is $450.00. Patient responsibility is $300.00. Contractual adjustment (for withhold amount) is $50.00. The service code for the procedure performed is CPT code 99211. The service start date is March 1, 1996. The service end date is March 4, 1996.
- The second patient's name is Susan Settle, patient number 8765432112 and member ID # 44455666610. Total reported charges are $1200.00. Amount paid is $495.00. Patient responsibility is $600.00. Contractual adjustment is $50.00. Contractual adjustment (for withhold amount) was $55.00. The procedure code for the service performed is CPT code 93555. The service start date is March 10, 1996. The service end date is March 12, 1996.

4.2.2 Transmission

```
ST*835*112233~
BPR*I*945*C*ACH*CCP*01*888999777*DA*24681012
  *1935665544**01*111333555*DA*144444*19960316~
TRN*1*71700666555*1935665544~
DTM*405*19960314~
N1*PR*RUSHMORE LIFE~
N3*10 SOUTH AVENUE~
N4*RAPID CITY*SD*55111~
N1*PE*ACME MEDICAL CENTER*FI*777667755~
LX*1~
CLP*5554555444*1*800*450*300*12*94060555410000~
```

```
CAS*CO*A2*50~
NM1*QC*1*BUDD*WILLIAM****MI*33344555510~
SVC*HC:99211*800*500~
DTM*150*19960301~
DTM*151*19960304~
CAS*PR*1*300~
CLP*8765432112*1*1200*495*600*12*9407779923000~
CAS*CO*A2*55~
NM1*QC*1*SETTLE*SUSAN****MI*44455666610~
SVC*HC:93555*1200*550~
DTM*150*19960310~
DTM*151*19960312~
CAS*PR*1*600~
CAS*CO*45*50~
SE*25*112233~
```

A ASC X12 Nomenclature

A.1 Interchange and Application Control Structures

A.1.1 Interchange Control Structure

The transmission of data proceeds according to very strict format rules to ensure the integrity and maintain the efficiency of the interchange. Each business grouping of data is called a transaction set. For instance, a group of benefit enrollments sent from a sponsor to a payer is considered a transaction set.

Each transaction set contains groups of logically related data in units called segments. For instance, the N4 segment used in the transaction set conveys the city, state, ZIP Code, and other geographic information. A transaction set contains multiple segments, so the addresses of the different parties, for example, can be conveyed from one computer to the other. An analogy would be that the transaction set is like a freight train; the segments are like the train's cars; and each segment can contain several data elements the same as a train car can hold multiple crates.

The sequence of the elements within one segment is specified by the ASC X12 standard as well as the sequence of segments in the transaction set. In a more conventional computing environment, the segments would be equivalent to records, and the elements equivalent to fields.

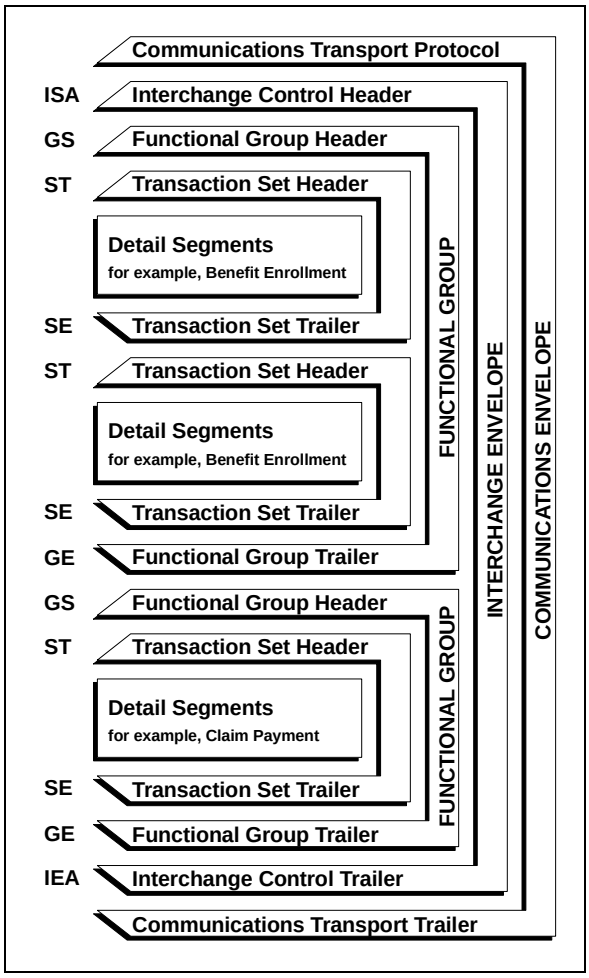


Figure A1. Transmission Control Schematic

Similar transaction sets, called "functional groups," can be sent together within a transmission. Each functional group is prefaced by a group start segment; and a functional group is terminated by a group end segment. One or more functional groups are prefaced by an interchange header and followed by an interchange trailer. Figure A1, Transmission Control Schematic, illustrates this interchange control.

The interchange header and trailer segments envelop one or more functional groups or interchange-related control segments and perform the following functions:

1. Define the data element separators and the data segment terminator.
2. Identify the sender and receiver.
3. Provide control information for the interchange.
4. Allow for authorization and security information.

A.1.2 Application Control Structure Definitions and Concepts

A.1.2.1 Basic Structure

A data element corresponds to a data field in data processing terminology. The data element is the smallest named item in the ASC X12 standard. A data segment corresponds to a record in data processing terminology. The data segment begins with a segment ID and contains related data elements. A control segment has the same structure as a data segment; the distinction is in the use. The data segment is used primarily to convey user information, but the control segment is used primarily to convey control information and to group data segments.

A.1.2.2 Basic Character Set

The section that follows is designed to have representation in the common character code schemes of EBCDIC, ASCII, and CCITT International Alphabet 5. The ASC X12 standards are graphic-character-oriented; therefore, common character encoding schemes other than those specified herein may be used as long as a common mapping is available. Because the graphic characters have an implied mapping across character code schemes, those bit patterns are not provided here.

The basic character set of this standard, shown in figure A2, Basic Character Set, includes those selected from the uppercase letters, digits, space, and special characters as specified below.

A...Z	**0...9**	**!**	**“**	**&**	**’**	**(**	**)**	*****	**+**
,	**-**	**.**	**/**	**:**	**;**	**?**	**=**	**“ ” (space)**	

Figure A2. Basic Character Set

A.1.2.3 Extended Character Set

An extended character set may be used by negotiation between the two parties and includes the lowercase letters and other special characters as specified in figure A3, Extended Character Set.

a..z	**%**	**~**	**@**	**[**	**]**	**_**	**{**
}	****	**|**	**<**	**>**	**#**	**$**	

Figure A3. Extended Character Set

Note that the extended characters include several character codes that have multiple graphical representations for a specific bit pattern. The complete list appears

in other standards such as CCITT S.5. Use of the USA graphics for these codes presents no problem unless data is exchanged with an international partner. Other problems, such as the translation of item descriptions from English to French, arise when exchanging data with an international partner, but minimizing the use of codes with multiple graphics eliminates one of the more obvious problems.

A.1.2.4 Control Characters

Two control character groups are specified; they have only restricted usage. The common notation for these groups is also provided, together with the character coding in three common alphabets. In the matrix A1, Base Control Set, the column IA5 represents CCITT V.3 International Alphabet 5.

A.1.2.5 Base Control Set

The base control set includes those characters that will not have a disruptive effect on most communication protocols. These are represented by:

NOTATION	NAME	EBCDIC	ASCII	IA5
BEL	bell	2F	07	07
HT	horizontal tab	05	09	09
LF	line feed	25	0A	0A
VT	vertical tab	0B	0B	0B
FF	form feed	0C	0C	0C
CR	carriage return	0D	0D	0D
FS	file separator	1C	1C	1C
GS	group separator	1D	1D	1D
RS	record separator	1E	1E	1E
US	unit separator	1F	1F	1F
NL	new line	15		

Matrix A1. Base Control Set

The Group Separator (GS) may be an exception in this set because it is used in the 3780 communications protocol to indicate blank space compression.

A.1.2.6 Extended Control Set

The extended control set includes those that may have an effect on a transmission system. These are shown in matrix A2, Extended Control Set.

NOTATION	NAME	EBCDIC	ASCII	IA5
SOH	start of header	01	01	01
STX	start of text	02	02	02
ETX	end of text	03	03	03
EOT	end of transmission	37	04	04
ENQ	enquiry	2D	05	05
ACK	acknowledge	2E	06	06
DC1	device control 1	11	11	11
DC2	device control 2	12	12	12
DC3	device control 3	13	13	13
DC4	device control 4	3C	14	14
NAK	negative acknowledge	3D	15	15
SYN	synchronous idle	32	16	16
ETB	end of block	26	17	17

Matrix A2. Extended Control Set

A.1.2.7 Delimiters

A delimiter is a character used to separate two data elements (or subelements) or to terminate a segment. The delimiters are an integral part of the data.

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, the delimiters are not to be used in a data element value elsewhere in the interchange. For consistency, this implementation guide uses the delimiters shown in matrix A3, Delimiters, in all examples of EDI transmissions.

CHARACTER	NAME	DELIMITER
*	Asterisk	Data Element Separator
:	Colon	Subelement Separator
~	Tilde	Segment Terminator

Matrix A3. Delimiters

The delimiters above are for illustration purposes only and are not specific recommendations or requirements. Users of this implementation guide should be aware that an application system may use some valid delimiter characters within the application data. Occurrences of delimiter characters in transmitted data within a data element can result in errors in translation programs. The existence of asterisks (*) within transmitted application data is a known issue that can affect translation software.

A.1.3 Business Transaction Structure Definitions and Concepts

The ASC X12 standards define commonly used business transactions (such as a health care claim) in a formal structure called “transaction sets.” A transaction set is composed of a transaction set header control segment, one or more data segments, and a transaction set trailer control segment. Each segment is composed of the following:

- A unique segment ID
- One or more logically related data elements each preceded by a data element separator
- A segment terminator

A.1.3.1 Data Element

The data element is the smallest named unit of information in the ASC X12 standard. Data elements are identified as either simple or component. A data element that occurs as an ordinally positioned member of a composite data structure is identified as a component data element. A data element that occurs in a segment outside the defined boundaries of a composite data structure is identified as a simple data element. The distinction between simple and component data elements is strictly a matter of context because a data element can be used in either capacity.

Data elements are assigned a unique reference number. Each data element has a name, description, type, minimum length, and maximum length. For ID type data elements, this guide provides the applicable ASC X12 code values and their descriptions or references where the valid code list can be obtained.

Each data element is assigned a minimum and maximum length. The length of the data element value is the number of character positions used except as noted for numeric, decimal, and binary elements.

The data element types shown in matrix A4, Data Element Types, appear in this implementation guide.

SYMBOL	TYPE
Nn	Numeric
R	Decimal
ID	Identifier
AN	String
DT	Date
TM	Time
B	Binary

Matrix A4. Data Element Types

A.1.3.1.1 Numeric

A numeric data element is represented by one or more digits with an optional leading sign representing a value in the normal base of 10. The value of a numeric data element includes an implied decimal point. It is used when the position of the decimal point within the data is permanently fixed and is not to be transmitted with the data.

This set of guides denotes the number of implied decimal positions. The representation for this data element type is “Nn” where N indicates that it is numeric and n indicates the number of decimal positions to the right of the implied decimal point.

If n is 0, it need not appear in the specification; N is equivalent to N0. For negative values, the leading minus sign (-) is used. Absence of a sign indicates a positive value. The plus sign (+) should not be transmitted.

EXAMPLE
A transmitted value of 1234, when specified as numeric type N2, represents a value of 12.34.

Leading zeros should be suppressed unless necessary to satisfy a minimum length requirement. The length of a numeric type data element does not include the optional sign.

A.1.3.1.2 Decimal

A decimal data element may contain an explicit decimal point and is used for numeric values that have a varying number of decimal positions. This data element type is represented as “R.”

The decimal point always appears in the character stream if the decimal point is at any place other than the right end. If the value is an integer (decimal point at the right end) the decimal point should be omitted. For negative values, the leading minus sign (-) is used. Absence of a sign indicates a positive value. The plus sign (+) should not be transmitted.

Leading zeros should be suppressed unless necessary to satisfy a minimum length requirement. Trailing zeros following the decimal point should be suppressed unless necessary to indicate precision. The use of triad separators (for example, the commas in 1,000,000) is expressly prohibited. The length of a decimal type data element does not include the optional leading sign or decimal point.

EXAMPLE
A transmitted value of 12.34 represents a decimal value of 12.34.

A.1.3.1.3 Identifier

An identifier data element always contains a value from a predefined list of codes that is maintained by the ASC X12 Committee or some other body recognized by the Committee. Trailing spaces should be suppressed unless they are necessary to satisfy a minimum length. An identifier is always left justified. The representation for this data element type is “ID.”

A.1.3.1.4 String

A string data element is a sequence of any characters from the basic or extended character sets. The significant characters shall be left justified. Leading spaces, when they occur, are presumed to be significant characters. Trailing spaces should be suppressed unless they are necessary to satisfy a minimum length. The representation for this data element type is “AN.”

A.1.3.1.5 Date

A date data element is used to express the standard date in either YYMMDD or CCYYMMDD format in which CC is the first two digits of the calendar year, YY is the last two digits of the calendar year, MM is the month (01 to 12), and DD is the day in the month (01 to 31). The representation for this data element type is “DT.” Users of this guide should note that all dates within transactions are 8-character dates (millennium compliant) in the format CCYYMMDD. The only date data element that is in format YYMMDD is the Interchange Date data element in the ISA segment, and also used in the TA1 Interchange Acknowledgment, where the century can be readily interpolated because of the nature of an interchange header.

A.1.3.1.6 Time

A time data element is used to express the ISO standard time HHMMSSd..d format in which HH is the hour for a 24 hour clock (00 to 23), MM is the minute (00 to 59), SS is the second (00 to 59) and d..d is decimal seconds. The representation for this data element type is “TM.” The length of the data element determines the format of the transmitted time.

EXAMPLE
Transmitted data elements of four characters denote HHMM. Transmitted data elements of six characters denote HHMMSS.

A.1.3.2 Composite Data Structure

The composite data structure is an intermediate unit of information in a segment. Composite data structures are composed of one or more logically related simple data elements, each, except the last, followed by a sub-element separator. The final data element is followed by the next data element separator or the segment terminator. Each simple data element within a composite is called a component.

Each composite data structure has a unique four-character identifier, a name, and a purpose. The identifier serves as a label for the composite. A composite data structure can be further defined through the use of syntax notes, semantic notes, and comments. Each component within the composite is further characterized by a reference designator and a condition designator. The reference designators and the condition designators are described below.

A.1.3.3 Data Segment

The data segment is an intermediate unit of information in a transaction set. In the data stream, a data segment consists of a segment identifier, one or more composite data structures or simple data elements each preceded by a data element separator and succeeded by a segment terminator.

Each data segment has a unique two- or three-character identifier, a name, and a purpose. The identifier serves as a label for the data segment. A segment can be further defined through the use of syntax notes, semantic notes, and comments. Each simple data element or composite data structure within the segment is further characterized by a reference designator and a condition designator.

A.1.3.4 Syntax Notes

Syntax notes describe relational conditions among two or more data segment units within the same segment, or among two or more component data elements within the same composite data structure. For a complete description of the relational conditions, See A.1.3.8, Condition Designator.

A.1.3.5 Semantic Notes

Simple data elements or composite data structures may be referenced by a semantic note within a particular segment. A semantic note provides important additional information regarding the intended meaning of a designated data element, particularly a generic type, in the context of its use within a specific data segment. Semantic notes may also define a relational condition among data elements in a segment based on the presence of a specific value (or one of a set of values) in one of the data elements.

A.1.3.6 Comments

A segment comment provides additional information regarding the intended use of the segment.

A.1.3.7 Reference Designator

Each simple data element or composite data structure in a segment is provided a structured code that indicates the segment in which it is used and the sequential position within the segment. The code is composed of the segment identifier followed by a two-digit number that defines the position of the simple data element or composite data structure in that segment.

For purposes of creating reference designators, the composite data structure is viewed as the hierarchical equal of the simple data element. Each component data element in a composite data structure is identified by a suffix appended to the reference designator for the composite data structure of which it is a member.

This suffix is a two-digit number, prefixed with a hyphen, that defines the position of the component data element in the composite data structure.

EXAMPLE

- The first simple element of the CLP segment would be identified as CLP01.
- The first position in the SVC segment is occupied by a composite data structure that contains seven component data elements, the reference designator for the second component data element would be SVC01-02.

A.1.3.8 Condition Designator

This section provides information about X12 standard conditions designators. It is provided so that users will have information about the general standard. Implementation guides may impose other conditions designators. See implementation guide section 3.1 Presentation Examples for detailed information about the implementation guide Industry Usage requirements for compliant implementation.

Data element conditions are of three types: mandatory, optional, and relational. They define the circumstances under which a data element may be required to be present or not present in a particular segment.

DESIGNATOR	DESCRIPTION
M- Mandatory	The designation of mandatory is absolute in the sense that there is no dependency on other data elements. This designation may apply to either simple data elements or composite data structures. If the designation applies to a composite data structure, then at least one value of a component data element in that composite data structure shall be included in the data segment.
O- Optional	The designation of optional means that there is no requirement for a simple data element or composite data structure to be present in the segment. The presence of a value for a simple data element or the presence of value for any of the component data elements of a composite data structure is at the option of the sender.
X- Relational	Relational conditions may exist among two or more simple data elements within the same data segment based on the presence or absence of one of those data elements (presence means a data element must not be empty). Relational conditions are specified by a condition code (see table below) and the reference designators of the affected data elements. A data element may be subject to more than one relational condition. The definitions for each of the condition codes used within syntax notes are detailed below:

CONDITION CODE	DEFINITION
P- Paired or Multiple	If any element specified in the relational condition is present, then all of the elements specified must be present.
R- Required	At least one of the elements specified in the condition must be present.
E- Exclusion	Not more than one of the elements specified in the condition may be present.
C- Conditional	If the first element specified in the condition is present, then all other elements must be present. However, any or all of the elements not specified as the first element in the condition may appear without requiring that the first element be present. The order of the elements in the condition does not have to be the same as the order of the data elements in the data segment.
L- List	

Conditional	If the first element specified in the condition is present, then at least one of the remaining elements must be present. However, any or all of the elements not specified as the first element in the condition may appear without requiring that the first element be present. The order of the elements in the condition does not have to be the same as the order of the data elements in the data segment.

Table A5. Condition Designator

A.1.3.9 Absence of Data

Any simple data element that is indicated as mandatory must not be empty if the segment is used. At least one component data element of a composite data structure that is indicated as mandatory must not be empty if the segment is used. Optional simple data elements and/or composite data structures and their preceding data element separators that are not needed should be omitted if they occur at the end of a segment. If they do not occur at the end of the segment, the simple data element values and/or composite data structure values may be omitted. Their absence is indicated by the occurrence of their preceding data element separators, in order to maintain the element's or structure's position as defined in the data segment.

Likewise, when additional information is not necessary within a composite, the composite may be terminated by providing the appropriate data element separator or segment terminator.

A.1.3.10 Control Segments

A control segment has the same structure as a data segment, but it is used for transferring control information rather than application information.

A.1.3.10.1 Loop Control Segments

Loop control segments are used only to delineate bounded loops. Delineation of the loop shall consist of the loop header (LS segment) and the loop trailer (LE segment). The loop header defines the start of a structure that must contain one or more iterations of a loop of data segments and provides the loop identifier for this loop. The loop trailer defines the end of the structure. The LS segment appears only before the first occurrence of the loop, and the LE segment appears only after the last occurrence of the loop. Unbounded looping structures do not use loop control segments.

A.1.3.10.2 Transaction Set Control Segments

The transaction set is delineated by the transaction set header (ST segment) and the transaction set trailer (SE segment). The transaction set header identifies the start and identifier of the transaction set. The transaction set trailer identifies the end of the transaction set and provides a count of the data segments, which includes the ST and SE segments.

A.1.3.10.3 Functional Group Control Segments

The functional group is delineated by the functional group header (GS segment) and the functional group trailer (GE segment). The functional group header starts and identifies one or more related transaction sets and provides a control number

and application identification information. The functional group trailer defines the end of the functional group of related transaction sets and provides a count of contained transaction sets.

A.1.3.10.4 Relations among Control Segments

The control segment of this standard must have a nested relationship as is shown and annotated in this subsection. The letters preceding the control segment name are the segment identifier for that control segment. The indentation of segment identifiers shown below indicates the subordination among control segments.

GS Functional Group Header, starts a group of related transaction sets.

- **ST** Transaction Set Header, starts a transaction set.
  - **LS** Loop Header, starts a bounded loop of data segments but is not part of the loop.
    - **LS** Loop Header, starts an inner, nested, bounded loop.
    - **LE** Loop Trailer, ends an inner, nested bounded loop.
  - **LE** Loop Trailer, ends a bounded loop of data segments but is not part of the loop.
- **SE** Transaction Set Trailer, ends a transaction set.

GE Functional Group Trailer, ends a group of related transaction sets.

More than one ST/SE pair, each representing a transaction set, may be used within one functional group. Also more than one LS/LE pair, each representing a bounded loop, may be used within one transaction set.

A.1.3.11 Transaction Set

The transaction set is the smallest meaningful set of information exchanged between trading partners. The transaction set consists of a transaction set header segment, one or more data segments in a specified order, and a transaction set trailer segment. See figure A1, Transmission Control Schematic.

A.1.3.11.1 Transaction Set Header and Trailer

A transaction set identifier uniquely identifies a transaction set. This identifier is the first data element of the Transaction Set Header Segment (ST). A user assigned transaction set control number in the header must match the control number in the Trailer Segment (SE) for any given transaction set. The value for the number of included segments in the SE segment is the total number of segments in the transaction set, including the ST and SE segments.

A.1.3.11.2 Data Segment Groups

The data segments in a transaction set may be repeated as individual data segments or as unbounded or bounded loops.

A.1.3.11.3 Repeated Occurrences of Single Data Segments

When a single data segment is allowed to be repeated, it may have a specified maximum number of occurrences defined at each specified position within a given transaction set standard. Alternatively, a segment may be allowed to repeat

an unlimited number of times. The notation for an unlimited number of repetitions is “>1.”

A.1.3.11.4 Loops of Data Segments

Loops are groups of semantically related segments. Data segment loops may be unbounded or bounded.

A.1.3.11.4.1 Unbounded Loops

To establish the iteration of a loop, the first data segment in the loop must appear once and only once in each iteration. Loops may have a specified maximum number of repetitions. Alternatively, the loop may be specified as having an unlimited number of iterations. The notation for an unlimited number of repetitions is “>1.”

A specified sequence of segments is in the loop. Loops themselves are optional or mandatory. The requirement designator of the beginning segment of a loop indicates whether at least one occurrence of the loop is required. Each appearance of the beginning segment defines an occurrence of the loop.

The requirement designator of any segment within the loop after the beginning segment applies to that segment for each occurrence of the loop. If there is a mandatory requirement designator for any data segment within the loop after the beginning segment, that data segment is mandatory for each occurrence of the loop. If the loop is optional, the mandatory segment only occurs if the loop occurs.

A.1.3.11.4.2 Bounded Loops

The characteristics of unbounded loops described previously also apply to bounded loops. In addition, bounded loops require a Loop Start Segment (LS) to appear before the first occurrence and a Loop End Segment (LE) to appear after the last occurrence of the loop. If the loop does not occur, the LS and LE segments are suppressed.

A.1.3.11.5 Data Segments in a Transaction Set

When data segments are combined to form a transaction set, three characteristics are applied to each data segment: a requirement designator, a position in the transaction set, and a maximum occurrence.

A.1.3.11.6 Data Segment Requirement Designators

A data segment, or loop, has one of the following requirement designators for health care and insurance transaction sets, indicating its appearance in the data stream of a transmission. These requirement designators are represented by a single character code.

DESIGNATOR	DESCRIPTION
M- Mandatory	This data segment must be included in the transaction set. (Note that a data segment may be mandatory in a loop of data segments, but the loop itself is optional if the beginning segment of the loop is designated as optional.)
O- Optional	The presence of this data segment is the option of the sending party.

A.1.3.11.7 Data Segment Position

The ordinal positions of the segments in a transaction set are explicitly specified for that transaction. Subject to the flexibility provided by the optional requirement designators of the segments, this positioning must be maintained.

A.1.3.11.8 Data Segment Occurrence

A data segment may have a maximum occurrence of one, a finite number greater than one, or an unlimited number indicated by “>1.”

A.1.3.12 Functional Group

A functional group is a group of similar transaction sets that is bounded by a functional group header segment and a functional group trailer segment. The functional identifier defines the group of transactions that may be included within the functional group. The value for the functional group control number in the header and trailer control segments must be identical for any given group. The value for the number of included transaction sets is the total number of transaction sets in the group. See figure A1, Transmission Control Schematic.

A.1.4 Envelopes and Control Structures

A.1.4.1 Interchange Control Structures

Typically, the term “interchange” connotes the ISA/IEA envelope that is transmitted between trading/business partners. Interchange control is achieved through several “control” components. The interchange control number is contained in data element ISA13 of the ISA segment. The identical control number must also occur in data element 02 of the IEA segment. Most commercial translation software products will verify that these two fields are identical. In most translation software products, if these fields are different the interchange will be “suspended” in error.

There are many other features of the ISA segment that are used for control measures. For instance, the ISA segment contains data elements such as authorization information, security information, sender identification, and receiver identification that can be used for control purposes. These data elements are agreed upon by the trading partners prior to transmission and are contained in the written trading partner agreement. The interchange date and time data elements as well as the interchange control number within the ISA segment are used for debugging purposes when there is a problem with the transmission or the interchange.

Data Element ISA12, Interchange Control Version Number, indicates the version of the ISA/IEA envelope. The ISA12 does not indicate the version of the transaction set that is being transmitted but rather the envelope that encapsulates the transaction. An Interchange Acknowledgment can be denoted through data element ISA14. The acknowledgment that would be sent in reply to a “yes” condition in data element ISA14 would be the TA1 segment. Data element ISA15, Test Indicator, is used between trading partners to indicate that the transmission is in a “test” or “production” mode. This becomes significant when the production phase of the project is to commence. Data element ISA16, Subelement Separator, is used by the translator for interpretation of composite data elements.

The ending component of the interchange or ISA/IEA envelope is the IEA segment. Data element IEA01 indicates the number of functional groups that are included within the interchange. In most commercial translation software products, an aggregate count of functional groups is kept while interpreting the interchange. This count is then verified with data element IEA01. If there is a discrep-

ancy, in most commercial products, the interchange is suspended. The other data element in the IEA segment is IEA02 which is referenced above.

See the Appendix B, EDI Control Directory, for a complete detailing of the interchange control header and trailer.

A.1.4.2 Functional Groups

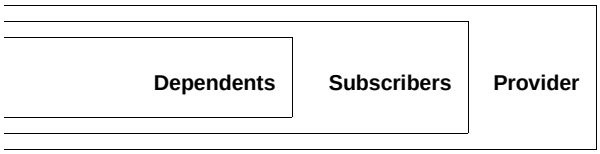
Control structures within the functional group envelope include the functional identifier code in GS01. The Functional Identifier Code is used by the commercial translation software during interpretation of the interchange to determine the different transaction sets that may be included within the functional group. If an inappropriate transaction set is contained within the functional group, most commercial translation software will suspend the functional group within the interchange. The Application Sender's Code in GS02 can be used to identify the sending unit of the transmission. The Application Receiver's Code in GS03 can be used to identify the receiving unit of the transmission. For health care, this unit identification can be used to differentiate between managed care, indemnity, and Medicare. The functional group contains a creation date (GS04) and creation time (GS05) for the functional group. The Group Control Number is contained in GS06. These data elements (GS04, GS05, AND GS06) can be used for debugging purposes during problem resolution. GS08,Version/Release/Industry Identifier Code is the version/release/sub-release of the transaction sets being transmitted in this functional group. Appendix B provides guidance for the value for this data element. The GS08 does not represent the version of the interchange (ISA/IEA) envelope but rather the version/release/sub-release of the transaction sets that are encompassed within the GS/GE envelope.

The Functional Group Control Number in GS06 must be identical to data element 02 of the GE segment. Data element GE01 indicates the number of transaction sets within the functional group. In most commercial translation software products, an aggregate count of the transaction sets is kept while interpreting the functional group. This count is then verified with data element GE01.

See the Appendix B, EDI Control Directory, for a complete detailing of the functional group header and trailer.

A.1.4.3 HL Structures

The HL segment is used in several X12 transaction sets to identify levels of detail information using a hierarchical structure, such as relating dependents to a subscriber. Hierarchical levels may differ from guide to guide. The following diagram, from transaction set 837, illustrates a typical hierarchy.



Each provider can bill for one or more subscribers, each subscriber can have one or more dependents and the subscriber and the dependents can make one or more claims. Each guide states what levels are available, the level's requirement, a repeat value, and whether that level has subordinate levels within a transmission.

A.1.5 Acknowledgments

A.1.5.1 Interchange Acknowledgment, TA1

The Interchange or TA1 Acknowledgment is a means of replying to an interchange or transmission that has been sent. The TA1 verifies the envelopes only. Transaction set-specific verification is accomplished through use of the Functional Acknowledgment Transaction Set, 997. See A.1.5.2, Functional Acknowledgment, 997, for more details. The TA1 is a single segment and is unique in the sense that this single segment is transmitted without the GS/GE envelope structures. A TA1 can be included in an interchange with other functional groups and transactions.

Encompassed in the TA1 are the interchange control number, interchange date and time, interchange acknowledgment code, and the interchange note code. The interchange control number, interchange date and time are identical to those that were present in the transmitted interchange from the sending trading partner. This provides the capability to associate the TA1 with the transmitted interchange. TA104, Interchange Acknowledgment Code, indicates the status of the interchange control structure. This data element stipulates whether the transmitted interchange was accepted with no errors, accepted with errors, or rejected because of errors. TA105, Interchange Note Code, is a numerical code that indicates the error found while processing the interchange control structure. Values for this data element indicate whether the error occurred at the interchange or functional group envelope.

The TA1 segment provides the capability for the receiving trading partner to notify the sending trading partner of problems that were encountered in the interchange control structure.

Due to the uniqueness of the TA1, implementation should be predicated upon the ability for the sending and receiving trading partners commercial translators to accommodate the uniqueness of the TA1. Unless named as mandatory in the Federal Rules implementing HIPAA, use of the TA1, although urged by the authors, is not mandated.

See the Appendix B, EDI Control Directory, for a complete detailing of the TA1 segment.

A.1.5.2 Functional Acknowledgment, 997

The Functional Acknowledgment Transaction Set, 997, has been designed to allow trading partners to establish a comprehensive control function as a part of their business exchange process. This acknowledgment process facilitates control of EDI. There is a one-to-one correspondence between a 997 and a functional group. Segments within the 997 can identify the acceptance or rejection of the functional group, transaction sets or segments. Data elements in error can also be identified. There are many EDI implementations that have incorporated the acknowledgment process in all of their electronic communications. Typically, the 997 is used as a functional acknowledgment to a previously transmitted functional group. Many commercially available translators can automatically generate this transaction set through internal parameter settings. Additionally translators will automatically reconcile received acknowledgments to functional groups that have been sent. The benefit to this process is that the sending trading partner

can determine if the receiving trading partner has received ASC X12 transaction sets through reports that can be generated by the translation software to identify transmissions that have not been acknowledged.

As stated previously the 997 is a transaction set and thus is encapsulated within the interchange control structure (envelopes) for transmission.

As with any information flow, an acknowledgment process is essential. If an “automatic” acknowledgment process is desired between trading partners then it is recommended that the 997 be used. Unless named as mandatory in the Federal Rules implementing HIPAA, use of the 997, although urged by the authors, is not mandated.

See Appendix B, EDI Control Directory, for a complete detailing of transaction set 997.

B EDI Control Directory

B.1 Control Segments

- **ISA**
  Interchange Control Header Segment
- **IEA**
  Interchange Control Trailer Segment
- **GS**
  Functional Group Header Segment
- **GE**
  Functional Group Trailer Segment
- **TA1**
  Interchange Acknowledgment Segment

B.2 Functional Acknowledgment Transaction Set, 997

IMPLEMENTATION

INTERCHANGE CONTROL HEADER

Notes: **1. The ISA is a fixed record length segment and all positions within each of the data elements must be filled. The first element separator defines the element separator to be used through the entire interchange. The segment terminator used after the ISA defines the segment terminator to be used throughout the entire interchange. Spaces in the example are represented by "." for clarity.**

Example: **ISA* 00* .....* 01* SECRET....* ZZ* SUBMITTERS.ID..* ZZ* RECEIVERS.ID...* 930602* 1253* U* 00401* 000000905* 1* T* :~**

STANDARD

ISA Interchange Control Header

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

DIAGRAM

ISA *

ISA01 I01	ISA02 I02	ISA03 I03	ISA04 I04	ISA05 I05	ISA06 I06
Author Info Qualifer	**Author Information**	**Security Info Qual**	**Security Information**	**Interchange ID Qual**	**Interchange Sender ID**
M ID 2/2	M AN 10/10	M ID 2/2	M AN 10/10	M ID 2/2	M AN 15/15

*

ISA07 I05	ISA08 I07	ISA09 I08	ISA10 I09	ISA11 I10	ISA12 I11
Interchange ID Qual	**Interchange Receiver ID**	**Interchange Date**	**Interchange Time**	**Inter Ctrl Stand Ident**	**Inter Ctrl Version Num**
M ID 2/2	M AN 15/15	M DT 6/6	M TM 4/4	M ID 1/1	M ID 5/5

*

ISA13 I12	ISA14 I13	ISA15 I14	ISA16 I15
Inter Ctrl Number	**Ack Requested**	**Usage Indicator**	**Component Elem Sepera**
M N0 9/9	M ID 1/1	M ID 1/1	M 1/1

*

~

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**ISA01**	**I01**	**Authorization Information Qualifier** Code to identify the type of information in the Authorization Information	**M ID 2/2**

CODE	DEFINITION
00	**No Authorization Information Present (No Meaningful Information in I02)** **ADVISED UNLESS SECURITY REQUIREMENTS MANDATE USE OF ADDITIONAL IDENTIFICATION INFORMATION.**
03	**Additional Data Identification**

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

REQUIRED **ISA03** **I03** **Security Information Qualifier** **M ID 2/2**
Code to identify the type of information in the Security Information

CODE	DEFINITION
00	**No Security Information Present (No Meaningful Information in I04)** **ADVISED UNLESS SECURITY REQUIREMENTS MANDATE USE OF PASSWORD DATA.**
01	**Password**

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

REQUIRED **ISA05** **I05** **Interchange ID Qualifier** **M ID 2/2**
Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified

This ID qualifies the Sender in ISA06.

CODE	DEFINITION
01	**Duns (Dun & Bradstreet)**
14	**Duns Plus Suffix**
20	**Health Industry Number (HIN)** CODE SOURCE **121: Health Industry Identification Number**
27	**Carrier Identification Number as assigned by Health Care Financing Administration (HCFA)**
28	**Fiscal Intermediary Identification Number as assigned by Health Care Financing Administration (HCFA)**
29	**Medicare Provider and Supplier Identification Number as assigned by Health Care Financing Administration (HCFA)**
30	**U.S. Federal Tax Identification Number**
33	**National Association of Insurance Commissioners Company Code (NAIC)**
ZZ	**Mutually Defined**

REQUIRED **ISA06** **I06** **Interchange Sender ID** **M AN 15/15**
Identification code published by the sender for other parties to use as the receiver ID to route data to them; the sender always codes this value in the sender ID element

REQUIRED **ISA07** **I05** **Interchange ID Qualifier** **M ID 2/2**
Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified

This ID qualifies the Receiver in ISA08.

CODE	DEFINITION
01	**Duns (Dun & Bradstreet)**

			14	**Duns Plus Suffix**		
			20	**Health Industry Number (HIN)**		
				CODE SOURCE **121: Health Industry Identification Number**		
			27	**Carrier Identification Number as assigned by Health Care Financing Administration (HCFA)**		
			28	**Fiscal Intermediary Identification Number as assigned by Health Care Financing Administration (HCFA)**		
			29	**Medicare Provider and Supplier Identification Number as assigned by Health Care Financing Administration (HCFA)**		
			30	**U.S. Federal Tax Identification Number**		
			33	**National Association of Insurance Commissioners Company Code (NAIC)**		
			ZZ	**Mutually Defined**		
REQUIRED	**ISA08**	**I07**	**Interchange Receiver ID** Identification code published by the receiver of the data; When sending, it is used by the sender as their sending ID, thus other parties sending to them will use this as a receiving ID to route data to them	**M**	**AN**	**15/15**
REQUIRED	**ISA09**	**I08**	**Interchange Date** Date of the interchange	**M**	**DT**	**6/6**
			The date format is YYMMDD.			
REQUIRED	**ISA10**	**I09**	**Interchange Time** Time of the interchange	**M**	**TM**	**4/4**
			The time format is HHMM.			
REQUIRED	**ISA11**	**I10**	**Interchange Control Standards Identifier** Code to identify the agency responsible for the control standard used by the message that is enclosed by the interchange header and trailer	**M**	**ID**	**1/1**
			CODE / DEFINITION			
			U / **U.S. EDI Community of ASC X12, TDCC, and UCS**			
REQUIRED	**ISA12**	**I11**	**Interchange Control Version Number** This version number covers the interchange control segments	**M**	**ID**	**5/5**
			CODE / DEFINITION			
			00401 / **Draft Standards for Trial Use Approved for Publication by ASC X12 Procedures Review Board through October 1997**			
REQUIRED	**ISA13**	**I12**	**Interchange Control Number** A control number assigned by the interchange sender	**M**	**N0**	**9/9**
			The Interchange Control Number, ISA13, must be identical to the associated Interchange Trailer IEA02.			

REQUIRED	**ISA14**	**I13**	**Acknowledgment Requested** Code sent by the sender to request an interchange acknowledgment (TA1)	**M**	**ID**	**1/1**

See Section A.1.5.1 for interchange acknowledgment information.

CODE	DEFINITION
0	**No Acknowledgment Requested**
1	**Interchange Acknowledgment Requested**

REQUIRED	**ISA15**	**I14**	**Usage Indicator** Code to indicate whether data enclosed by this interchange envelope is test, production or information	**M**	**ID**	**1/1**

CODE	DEFINITION
P	**Production Data**
T	**Test Data**

REQUIRED	**ISA16**	**I15**	**Component Element Separator** Type is not applicable; the component element separator is a delimiter and not a data element; this field provides the delimiter used to separate component data elements within a composite data structure; this value must be different than the data element separator and the segment terminator	**M**	**1/1**

IMPLEMENTATION

INTERCHANGE CONTROL TRAILER

Example: **IEA*1*000000905~**

STANDARD

IEA Interchange Control Trailer

Purpose: To define the end of an interchange of zero or more functional groups and interchange-related control segments

DIAGRAM

IEA * [IEA01 I16 **Num of Incl Funct Group** M N0 1/5] * [IEA02 I12 **Inter Ctrl Number** M N0 9/9] ~

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**IEA01**	**I16**	**Number of Included Functional Groups** A count of the number of functional groups included in an interchange	**M**	**N0**	**1/5**
REQUIRED	**IEA02**	**I12**	**Interchange Control Number** A control number assigned by the interchange sender	**M**	**N0**	**9/9**

IMPLEMENTATION

FUNCTIONAL GROUP HEADER

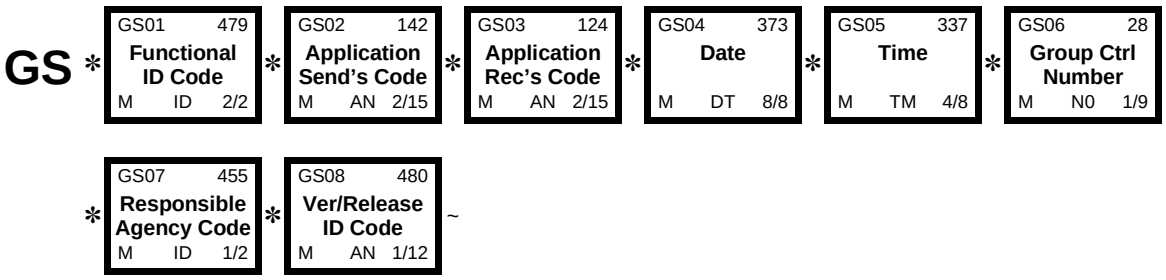
Example: **GS∗HP∗SENDER CODE∗RECEIVER CODE∗19940331∗0802∗1∗X∗004010X091~**

STANDARD

GS Functional Group Header

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

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**GS01**	**479**	**Functional Identifier Code** Code identifying a group of application related transaction sets CODE — DEFINITION **HP** — **Health Care Claim Payment/Advice (835)**	**M ID 2/2**
REQUIRED	**GS02**	**142**	**Application Sender's Code** Code identifying party sending transmission; codes agreed to by trading partners **Use this code to identify the unit sending the information.**	**M AN 2/15**
REQUIRED	**GS03**	**124**	**Application Receiver's Code** Code identifying party receiving transmission. Codes agreed to by trading partners **Use this code to identify the unit receiving the information.**	**M AN 2/15**
REQUIRED	**GS04**	**373**	**Date** Date expressed as CCYYMMDD SEMANTIC: GS04 is the group date. **Use this date for the functional group creation date.**	**M DT 8/8**
REQUIRED	**GS05**	**337**	**Time** Time expressed in 24-hour clock time as follows: HHMM, or HHMMSS, or HHMMSSD, or HHMMSSDD, where H = hours (00-23), M = minutes (00-59), S = integer seconds (00-59) and DD = decimal seconds; decimal seconds are expressed as follows: D = tenths (0-9) and DD = hundredths (00-99) SEMANTIC: GS05 is the group time. **Use this time for the creation time. The recommended format is HHMM.**	**M TM 4/8**

REQUIRED	**GS06**	**28**	**Group Control Number** Assigned number originated and maintained by the sender SEMANTIC: The data interchange control number GS06 in this header must be identical to the same data element in the associated functional group trailer, GE02.	**M**	**N0**	**1/9**
REQUIRED	**GS07**	**455**	**Responsible Agency Code** Code used in conjunction with Data Element 480 to identify the issuer of the standard	**M**	**ID**	**1/2**

CODE	DEFINITION
X	**Accredited Standards Committee X12**

REQUIRED	**GS08**	**480**	**Version / Release / Industry Identifier Code** Code indicating the version, release, subrelease, and industry identifier of the EDI standard being used, including the GS and GE segments; if code in DE455 in GS segment is X, then in DE 480 positions 1-3 are the version number; positions 4-6 are the release and subrelease, level of the version; and positions 7-12 are the industry or trade association identifiers (optionally assigned by user); if code in DE455 in GS segment is T, then other formats are allowed	**M**	**AN**	**1/12**

CODE	DEFINITION
004010X091	**Draft Standards Approved for Publication by ASC X12 Procedures Review Board through October 1997, as published in this implementation guide.**

IMPLEMENTATION

FUNCTIONAL GROUP TRAILER

Example: **GE∗1∗1~**

STANDARD

GE Functional Group Trailer

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

DIAGRAM

GE	∗	GE01 97 **Number of TS Included** M N0 1/6	∗	GE02 28 **Group Ctrl Number** M N0 1/9	~

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**GE01**	**97**	**Number of Transaction Sets Included** Total number of transaction sets included in the functional group or interchange (transmission) group terminated by the trailer containing this data element	**M**	**N0**	**1/6**
REQUIRED	**GE02**	**28**	**Group Control Number** Assigned number originated and maintained by the sender **SEMANTIC:** The data interchange control number GE02 in this trailer must be identical to the same data element in the associated functional group header, GS06.	**M**	**N0**	**1/9**

IMPLEMENTATION

INTERCHANGE ACKNOWLEDGMENT

Notes:

1. **All fields must contain data.**
2. **This segment acknowledges the reception of an X12 interchange header and trailer from a previous interchange. If the header/trailer pair was received correctly, the TA1 reflects a valid interchange, regardless of the validity of the contents of the data included inside the header/trailer envelope.**
3. **See Section A.1.5.1 for interchange acknowledgment information.**
4. **Use of TA1 is subject to trading partner agreement and is neither mandated or prohibited in this Appendix.**

Example: **TA1*000000905*940101*0100*A*000~**

STANDARD

TA1 Interchange Acknowledgment

Purpose: To report the status of processing a received interchange header and trailer or the non-delivery by a network provider

DIAGRAM

TA1	*	TA101 I12 **Inter Ctrl Number** M N0 9/9	*	TA102 I08 **Interchange Date** M DT 6/6	*	TA103 I09 **Interchange Time** M TM 4/4	*	TA104 I17 **Interchange Ack Code** M ID 1/1	*	TA105 I18 **Interchange Note Code** M ID 3/3	~

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**TA101**	**I12**	**Interchange Control Number** A control number assigned by the interchange sender	**M**	**N0**	**9/9**
			This number uniquely identifies the interchange data to the sender. It is assigned by the sender. Together with the sender ID it uniquely identifies the interchange data to the receiver. It is suggested that the sender, receiver, and all third parties be able to maintain an audit trail of interchanges using this number.			
			In the TA1, this should be the interchange control number of the original interchange that this TA1 is acknowledging.			
REQUIRED	**TA102**	**I08**	**Interchange Date** Date of the interchange	**M**	**DT**	**6/6**
			This is the date of the original interchange being acknowledged. (YYMMDD)			
REQUIRED	**TA103**	**I09**	**Interchange Time** Time of the interchange	**M**	**TM**	**4/4**
			This is the time of the original interchange being acknowledged. (HHMM)			

REQUIRED **TA104** **I17** **Interchange Acknowledgment Code** **M** **ID** **1/1**

This indicates the status of the receipt of the interchange control structure

CODE	DEFINITION
A	The Transmitted Interchange Control Structure Header and Trailer Have Been Received and Have No Errors.
E	The Transmitted Interchange Control Structure Header and Trailer Have Been Received and Are Accepted But Errors Are Noted. This Means the Sender Must Not Resend This Data.
R	The Transmitted Interchange Control Structure Header and Trailer are Rejected Because of Errors.

REQUIRED **TA105** **I18** **Interchange Note Code** **M** **ID** **3/3**

This numeric code indicates the error found processing the interchange control structure

CODE	DEFINITION
000	No error
001	The Interchange Control Number in the Header and Trailer Do Not Match. The Value From the Header is Used in the Acknowledgment.
002	This Standard as Noted in the Control Standards Identifier is Not Supported.
003	This Version of the Controls is Not Supported
004	The Segment Terminator is Invalid
005	Invalid Interchange ID Qualifier for Sender
006	Invalid Interchange Sender ID
007	Invalid Interchange ID Qualifier for Receiver
008	Invalid Interchange Receiver ID
009	Unknown Interchange Receiver ID
010	Invalid Authorization Information Qualifier Value
011	Invalid Authorization Information Value
012	Invalid Security Information Qualifier Value
013	Invalid Security Information Value
014	Invalid Interchange Date Value
015	Invalid Interchange Time Value
016	Invalid Interchange Standards Identifier Value
017	Invalid Interchange Version ID Value
018	Invalid Interchange Control Number Value

019	Invalid Acknowledgment Requested Value
020	Invalid Test Indicator Value
021	Invalid Number of Included Groups Value
022	Invalid Control Structure
023	Improper (Premature) End-of-File (Transmission)
024	Invalid Interchange Content (e.g., Invalid GS Segment)
025	Duplicate Interchange Control Number
026	Invalid Data Element Separator
027	Invalid Component Element Separator
028	Invalid Delivery Date in Deferred Delivery Request
029	Invalid Delivery Time in Deferred Delivery Request
030	Invalid Delivery Time Code in Deferred Delivery Request
031	Invalid Grade of Service Code

STANDARD

997 Functional Acknowledgment

Functional Group ID: FA

This Draft Standard for Trial Use contains the format and establishes the data contents of the Functional Acknowledgment Transaction Set (997) for use within the context of an Electronic Data Interchange (EDI) environment. The transaction set can be used to define the control structures for a set of acknowledgments to indicate the results of the syntactical analysis of the electronically encoded documents. The encoded documents are the transaction sets, which are grouped in functional groups, used in defining transactions for business data interchange. This standard does not cover the semantic meaning of the information encoded in the transaction sets.

Table 1 - Header

POS. #	SEG. ID	NAME	REQ. DES.	MAX USE	LOOP REPEAT
010	ST	Transaction Set Header	M	1	
020	AK1	Functional Group Response Header	M	1	
		LOOP ID - AK2			**999999**
030	AK2	Transaction Set Response Header	O	1	
		LOOP ID - AK2/AK3			**999999**
040	AK3	Data Segment Note	O	1	
050	AK4	Data Element Note	O	99	
060	AK5	Transaction Set Response Trailer	M	1	
070	AK9	Functional Group Response Trailer	M	1	
080	SE	Transaction Set Trailer	M	1	

NOTES:

1/010 These acknowledgments shall not be acknowledged, thereby preventing an endless cycle of acknowledgments of acknowledgments. Nor shall a Functional Acknowledgment be sent to report errors in a previous Functional Acknowledgment.

1/010 The Functional Group Header Segment (GS) is used to start the envelope for the Functional Acknowledgment Transaction Sets. In preparing the functional group of acknowledgments, the application sender's code and the application receiver's code, taken from the functional group being acknowledged, are exchanged; therefore, one acknowledgment functional group responds to only those functional groups from one application receiver's code to one application sender's code.

1/010 There is only one Functional Acknowledgment Transaction Set per acknowledged functional group.

1/020 AK1 is used to respond to the functional group header and to start the acknowledgement for a functional group. There shall be one AK1 segment for the functional group that is being acknowledged.

1/030 AK2 is used to start the acknowledgement of a transaction set within the received functional group. The AK2 segments shall appear in the same order as the transaction sets in the functional group that has been received and is being acknowledged.

1/040 The data segments of this standard are used to report the results of the syntactical analysis of the functional groups of transaction sets; they report the extent to which the syntax complies with the standards for transaction sets and functional groups. They do not report on the semantic meaning of the transaction sets (for example, on the ability of the receiver to comply with the request of the sender).

IMPLEMENTATION

TRANSACTION SET HEADER

Usage: **REQUIRED**

Repeat: **1**

Notes:

1. **Use of the 997 transaction is subject to trading partner agreement or accepted usage and is neither mandated nor prohibited in this Appendix.**

Example: **ST*997*1234~**

STANDARD

ST Transaction Set Header

Level: Header

Position: 010

Loop: ____

Requirement: Mandatory

Max Use: 1

Purpose: To indicate the start of a transaction set and to assign a control number

Set Notes:

1. These acknowledgments shall not be acknowledged, thereby preventing an endless cycle of acknowledgments of acknowledgments. Nor shall a Functional Acknowledgment be sent to report errors in a previous Functional Acknowledgment.
2. The Functional Group Header Segment (GS) is used to start the envelope for the Functional Acknowledgment Transaction Sets. In preparing the functional group of acknowledgments, the application sender's code and the application receiver's code, taken from the functional group being acknowledged, are exchanged; therefore, one acknowledgment functional group responds to only those functional groups from one application receiver's code to one application sender's code.
3. There is only one Functional Acknowledgment Transaction Set per acknowledged functional group.

DIAGRAM

ST	*	ST01 143 **TS ID Code** M ID 3/3	*	ST02 329 **TS Control Number** M AN 4/9	~

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**ST01**	**143**	**Transaction Set Identifier Code** Code uniquely identifying a Transaction Set	**M**	**ID**	**3/3**

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

CODE	DEFINITION
997	**Functional Acknowledgment**

REQUIRED	**ST02**	**329**	**Transaction Set Control Number** Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set	**M**	**AN**	**4/9**

The Transaction Set Control Numbers in ST02 and SE02 must be identical. The number is assigned by the originator and must be unique within a functional group (GS-GE). The number also aids in error resolution research. For example, start with the number 0001 and increment from there.

Use the corresponding value in SE02 for this transaction set.

IMPLEMENTATION

FUNCTIONAL GROUP RESPONSE HEADER

Usage: **REQUIRED**

Repeat: **1**

Example: **AK1*HP*1~**

STANDARD

AK1 Functional Group Response Header

Level: Header

Position: 020

Loop: ____

Requirement: Mandatory

Max Use: 1

Purpose: To start acknowledgment of a functional group

Set Notes:

1. AK1 is used to respond to the functional group header and to start the acknowledgement for a functional group. There shall be one AK1 segment for the functional group that is being acknowledged.

DIAGRAM

AK1 * [AK101 479 **Functional ID Code** M ID 2/2] * [AK102 28 **Group Ctrl Number** M N0 1/9] ~

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**AK101**	**479**	**Functional Identifier Code** Code identifying a group of application related transaction sets **SEMANTIC:** AK101 is the functional ID found in the GS segment (GS01) in the functional group being acknowledged.	**M**	**ID**	**2/2**
			CODE / **DEFINITION** **HP** — **Health Care Claim Payment/Advice (835)**			
REQUIRED	**AK102**	**28**	**Group Control Number** Assigned number originated and maintained by the sender **SEMANTIC:** AK102 is the functional group control number found in the GS segment in the functional group being acknowledged.	**M**	**N0**	**1/9**

IMPLEMENTATION

TRANSACTION SET RESPONSE HEADER

Loop: **AK2 — TRANSACTION SET RESPONSE HEADER** **Repeat:** **999999**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **Required when communicating information about a transaction set within the functional group identified in AK1.**

Example: **AK2*835*000000905~**

STANDARD

AK2 Transaction Set Response Header

Level: Header

Position: 030

Loop: AK2 **Repeat:** 999999

Requirement: Optional

Max Use: 1

Purpose: To start acknowledgment of a single transaction set

Set Notes:
1. AK2 is used to start the acknowledgement of a transaction set within the received functional group. The AK2 segments shall appear in the same order as the transaction sets in the functional group that has been received and is being acknowledged.

DIAGRAM

AK2	*	AK201 143 TS ID Code M ID 3/3	*	AK202 329 TS Control Number M AN 4/9	~

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**AK201**	**143**	**Transaction Set Identifier Code** Code uniquely identifying a Transaction Set SEMANTIC: AK201 is the transaction set ID found in the ST segment (ST01) in the transaction set being acknowledged. CODE: **835** DEFINITION: **Health Care Claim Payment/Advice**	**M ID 3/3**
REQUIRED	**AK202**	**329**	**Transaction Set Control Number** Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set SEMANTIC: AK202 is the transaction set control number found in the ST segment in the transaction set being acknowledged.	**M AN 4/9**

IMPLEMENTATION

DATA SEGMENT NOTE

Loop: **AK2/AK3 — DATA SEGMENT NOTE** **Repeat:** **999999**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Used when there are errors to report in a transaction.**

Example: **AK3*NM1*37*2010BB*7~**

STANDARD

AK3 Data Segment Note

Level: Header

Position: 040

Loop: AK2/AK3 **Repeat:** 999999

Requirement: Optional

Max Use: 1

Purpose: To report errors in a data segment and identify the location of the data segment

Set Notes: **1.** The data segments of this standard are used to report the results of the syntactical analysis of the functional groups of transaction sets; they report the extent to which the syntax complies with the standards for transaction sets and functional groups. They do not report on the semantic meaning of the transaction sets (for example, on the ability of the receiver to comply with the request of the sender).

DIAGRAM

AK3	*	AK301 721 **Segment ID Code** M ID 2/3	*	AK302 719 **Segment Pos in TS** M N0 1/6	*	AK303 447 **Loop ID Code** O AN 1/6	*	AK304 720 **Segment Syn Error Code** O ID 1/3	~			

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**AK301**	**721**	**Segment ID Code** Code defining the segment ID of the data segment in error (See Appendix A - Number 77) CODE SOURCE **77:** X12 Directories **This is the 2 or 3 characters which occur at the beginning of a segment.**	**M ID 2/3**
REQUIRED	**AK302**	**719**	**Segment Position in Transaction Set** The numerical count position of this data segment from the start of the transaction set: the transaction set header is count position 1 **This is a data count, not a segment position in the standard description.**	**M N0 1/6**

SITUATIONAL **AK303** **447** **Loop Identifier Code** **O AN 1/6**
The loop ID number given on the transaction set diagram is the value for this data element in segments LS and LE

Use this code to identify a loop within the transaction set that is bounded by the related LS and LE segments (corresponding LS and LE segments must have the same value for loop identifier). (Note: The loop ID number given on the transaction set diagram is recommended as the value for this data element in the segments LS and LE.)

SITUATIONAL **AK304** **720** **Segment Syntax Error Code** **O ID 1/3**
Code indicating error found based on the syntax editing of a segment

This code is required if an error exists.

CODE	DEFINITION
1	Unrecognized segment ID
2	Unexpected segment
3	Mandatory segment missing
4	Loop Occurs Over Maximum Times
5	Segment Exceeds Maximum Use
6	Segment Not in Defined Transaction Set
7	Segment Not in Proper Sequence
8	Segment Has Data Element Errors

IMPLEMENTATION

DATA ELEMENT NOTE

Loop: **AK2/AK3 — DATA SEGMENT NOTE**

Usage: **SITUATIONAL**

Repeat: **99**

Notes:
1. **Used when there are errors to report in a data element or composite data structure.**

Example: **AK4*1*98*7~**

STANDARD

AK4 Data Element Note

Level: Header

Position: 050

Loop: AK2/AK3

Requirement: Optional

Max Use: 99

Purpose: To report errors in a data element or composite data structure and identify the location of the data element

DIAGRAM

AK4	*	AK401 C030 **Position in Segment** M	*	AK402 725 **Data Elemnt Ref Number** O N0 1/4	*	AK403 723 **Data Elemnt Error Code** M ID 1/3	*	AK404 724 **Copy of Bad Data Elemnt** O AN 1/99	~	

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**AK401**	**C030**	**POSITION IN SEGMENT** Code indicating the relative position of a simple data element, or the relative position of a composite data structure combined with the relative position of the component data element within the composite data structure, in error; the count starts with 1 for the simple data element or composite data structure immediately following the segment ID	**M**
REQUIRED	**AK401 - 1**	**722**	**Element Position in Segment** This is used to indicate the relative position of a simple data element, or the relative position of a composite data structure with the relative position of the component within the composite data structure, in error; in the data segment the count starts with 1 for the simple data element or composite data structure immediately following the segment ID	**M N0 1/2**
SITUATIONAL	**AK401 - 2**	**1528**	**Component Data Element Position in Composite** To identify the component data element position within the composite that is in error **Used when an error occurs in a composite data element and the composite data element position can be determined.**	**O N0 1/2**

SITUATIONAL **AK402** **725** **Data Element Reference Number** **O** **N0** **1/4**
Reference number used to locate the data element in the Data Element Dictionary

ADVISORY: Under most circumstances, this element is expected to be sent.

CODE SOURCE **77:** X12 Directories

The Data Element Reference Number for this data element is 725. For example, all reference numbers are found with the segment descriptions in this guide.

REQUIRED **AK403** **723** **Data Element Syntax Error Code** **M** **ID** **1/3**
Code indicating the error found after syntax edits of a data element

CODE	DEFINITION
1	Mandatory data element missing
2	Conditional required data element missing.
3	Too many data elements.
4	Data element too short.
5	Data element too long.
6	Invalid character in data element.
7	Invalid code value.
8	Invalid Date
9	Invalid Time
10	Exclusion Condition Violated

SITUATIONAL **AK404** **724** **Copy of Bad Data Element** **O** **AN** **1/99**
This is a copy of the data element in error

SEMANTIC: In no case shall a value be used for AK404 that would generate a syntax error, e.g., an invalid character.

Used to provide copy of erroneous data to the original submitter, but this is not used if the error reported in an invalid character.

IMPLEMENTATION

TRANSACTION SET RESPONSE TRAILER

Loop: **AK2/AK3 — DATA SEGMENT NOTE**

Usage: **REQUIRED**

Repeat: **1**

Example: **AK5*E*5~**

STANDARD

AK5 Transaction Set Response Trailer

Level: Header

Position: 060

Loop: AK2

Requirement: Mandatory

Max Use: 1

Purpose: To acknowledge acceptance or rejection and report errors in a transaction set

DIAGRAM

AK5	*	AK501 717 **TS Ack Code** M ID 1/1	*	AK502 718 **TS Syntax Error Code** O ID 1/3	*	AK503 718 **TS Syntax Error Code** O ID 1/3	*	AK504 718 **TS Syntax Error Code** O ID 1/3	*	AK505 718 **TS Syntax Error Code** O ID 1/3	*	AK506 718 **TS Syntax Error Code** O ID 1/3	~

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**AK501**	**717**	**Transaction Set Acknowledgment Code** Code indicating accept or reject condition based on the syntax editing of the transaction set	**M ID 1/1**

CODE	DEFINITION
A	**Accepted** **ADVISED**
E	**Accepted But Errors Were Noted**
M	**Rejected, Message Authentication Code (MAC) Failed**
R	**Rejected** **ADVISED**
W	**Rejected, Assurance Failed Validity Tests**
X	**Rejected, Content After Decryption Could Not Be Analyzed**

SITUATIONAL **AK502** **718** **Transaction Set Syntax Error Code** **O** **ID** **1/3**
Code indicating error found based on the syntax editing of a transaction set

This code is required if an error exists.

CODE	DEFINITION
1	Transaction Set Not Supported
2	Transaction Set Trailer Missing
3	Transaction Set Control Number in Header and Trailer Do Not Match
4	Number of Included Segments Does Not Match Actual Count
5	One or More Segments in Error
6	Missing or Invalid Transaction Set Identifier
7	Missing or Invalid Transaction Set Control Number
8	Authentication Key Name Unknown
9	Encryption Key Name Unknown
10	Requested Service (Authentication or Encrypted) Not Available
11	Unknown Security Recipient
12	Incorrect Message Length (Encryption Only)
13	Message Authentication Code Failed
15	Unknown Security Originator
16	Syntax Error in Decrypted Text
17	Security Not Supported
23	Transaction Set Control Number Not Unique within the Functional Group
24	S3E Security End Segment Missing for S3S Security Start Segment
25	S3S Security Start Segment Missing for S3E Security End Segment
26	S4E Security End Segment Missing for S4S Security Start Segment
27	S4S Security Start Segment Missing for S4E Security End Segment

SITUATIONAL **AK503** **718** **Transaction Set Syntax Error Code** **O** **ID** **1/3**
Code indicating error found based on the syntax editing of a transaction set

Use the same codes indicated in AK502.

SITUATIONAL	**AK504**	**718**	**Transaction Set Syntax Error Code** Code indicating error found based on the syntax editing of a transaction set	**O**	**ID**	**1/3**
			Use the same codes indicated in AK502.			
SITUATIONAL	**AK505**	**718**	**Transaction Set Syntax Error Code** Code indicating error found based on the syntax editing of a transaction set	**O**	**ID**	**1/3**
			Use the same codes indicated in AK502.			
SITUATIONAL	**AK506**	**718**	**Transaction Set Syntax Error Code** Code indicating error found based on the syntax editing of a transaction set	**O**	**ID**	**1/3**
			Use the same codes indicated in AK502.			

IMPLEMENTATION

FUNCTIONAL GROUP RESPONSE TRAILER

Usage: **REQUIRED**

Repeat: **1**

Example: **AK9∗A∗1∗1∗1~**

STANDARD

AK9 Functional Group Response Trailer

Level: Header

Position: 070

Loop: ____

Requirement: Mandatory

Max Use: 1

Purpose: To acknowledge acceptance or rejection of a functional group and report the number of included transaction sets from the original trailer, the accepted sets, and the received sets in this functional group

DIAGRAM

AK9	∗	AK901 715 **Funct Group Ack Code** M ID 1/1	∗	AK902 97 **Number of TS Included** M N0 1/6	∗	AK903 123 **Number of Received TS** M N0 1/6	∗	AK904 2 **Number of Accepted TS** M N0 1/6	∗	AK905 716 **Funct Group Error Code** O ID 1/3	∗	AK906 716 **Funct Group Error Code** O ID 1/3	∗	AK907 716 **Funct Group Error Code** O ID 1/3	∗	AK908 716 **Funct Group Error Code** O ID 1/3	∗	AK909 716 **Funct Group Error Code** O ID 1/3	~				

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**AK901**	**715**	**Functional Group Acknowledge Code** Code indicating accept or reject condition based on the syntax editing of the functional group COMMENT: If AK901 contains the value “A” or “E”, then the transmitted functional group is accepted.	**M ID 1/1**

CODE	DEFINITION
A	**Accepted** **ADVISED**
E	**Accepted, But Errors Were Noted.**
M	**Rejected, Message Authentication Code (MAC) Failed**

			P	**Partially Accepted, At Least One Transaction Set Was Rejected** **ADVISED**		
			R	**Rejected** **ADVISED**		
			W	**Rejected, Assurance Failed Validity Tests**		
			X	**Rejected, Content After Decryption Could Not Be Analyzed**		
REQUIRED	**AK902**	**97**	**Number of Transaction Sets Included** Total number of transaction sets included in the functional group or interchange (transmission) group terminated by the trailer containing this data element	**M**	**N0**	**1/6**
			This is the value in the original GE01.			
REQUIRED	**AK903**	**123**	**Number of Received Transaction Sets** Number of Transaction Sets received	**M**	**N0**	**1/6**
REQUIRED	**AK904**	**2**	**Number of Accepted Transaction Sets** Number of accepted Transaction Sets in a Functional Group	**M**	**N0**	**1/6**
SITUATIONAL	**AK905**	**716**	**Functional Group Syntax Error Code** Code indicating error found based on the syntax editing of the functional group header and/or trailer	**O**	**ID**	**1/3**
			This code is required if an error exists.			

CODE	DEFINITION
1	**Functional Group Not Supported**
2	**Functional Group Version Not Supported**
3	**Functional Group Trailer Missing**
4	**Group Control Number in the Functional Group Header and Trailer Do Not Agree**
5	**Number of Included Transaction Sets Does Not Match Actual Count**
6	**Group Control Number Violates Syntax**
10	**Authentication Key Name Unknown**
11	**Encryption Key Name Unknown**
12	**Requested Service (Authentication or Encryption) Not Available**
13	**Unknown Security Recipient**
14	**Unknown Security Originator**
15	**Syntax Error in Decrypted Text**
16	**Security Not Supported**
17	**Incorrect Message Length (Encryption Only)**
18	**Message Authentication Code Failed**

			23	**S3E Security End Segment Missing for S3S Security Start Segment**		
			24	**S3S Security Start Segment Missing for S3E End Segment**		
			25	**S4E Security End Segment Missing for S4S Security Start Segment**		
			26	**S4S Security Start Segment Missing for S4E Security End Segment**		
SITUATIONAL	**AK906**	**716**	**Functional Group Syntax Error Code** Code indicating error found based on the syntax editing of the functional group header and/or trailer	**O**	**ID**	**1/3**
			Use the same codes indicated in AK905.			
SITUATIONAL	**AK907**	**716**	**Functional Group Syntax Error Code** Code indicating error found based on the syntax editing of the functional group header and/or trailer	**O**	**ID**	**1/3**
			Use the same codes indicated in AK905.			
SITUATIONAL	**AK908**	**716**	**Functional Group Syntax Error Code** Code indicating error found based on the syntax editing of the functional group header and/or trailer	**O**	**ID**	**1/3**
			Use the same codes indicated in AK905.			
SITUATIONAL	**AK909**	**716**	**Functional Group Syntax Error Code** Code indicating error found based on the syntax editing of the functional group header and/or trailer	**O**	**ID**	**1/3**
			Use the same codes indicated in AK905.			

IMPLEMENTATION

TRANSACTION SET TRAILER

Usage: **REQUIRED**

Repeat: **1**

Example: **SE*27*1234~**

STANDARD

SE Transaction Set Trailer

Level: Header

Position: 080

Loop: ____

Requirement: Mandatory

Max Use: 1

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

DIAGRAM

SE	*	SE01 96 **Number of Inc Segs** M N0 1/10	*	SE02 329 **TS Control Number** M AN 4/9	~

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**SE01**	**96**	**Number of Included Segments** Total number of segments included in a transaction set including ST and SE segments	**M**	**N0**	**1/10**
REQUIRED	**SE02**	**329**	**Transaction Set Control Number** Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set	**M**	**AN**	**4/9**

The Transaction Set Control Numbers in ST02 and SE02 must be identical. The number is assigned by the originator and must be unique within a functional group (GS-GE). The number also aids in error resolution research. For example, start with the number 0001 and increment from there.

C External Code Sources

4 ABA Routing Number

SIMPLE DATA ELEMENT/CODE REFERENCES

66/13, 506/01, 647/806, 20

SOURCE

Key to American Bankers Association Routing Numbers

AVAILABLE FROM

Rank McNally & Company
P. O. Box 7600
Chicago, IL 60680

ABSTRACT

Contains the Federal Reserve Routing Codes. The first four digits identify the Federal Reserve District, the next four the institution, and the last is a check digit.

5 Countries, Currencies and Funds

SIMPLE DATA ELEMENT/CODE REFERENCES

235/CH, 26, 100

SOURCE

Codes for Representation of Names of Countries, ISO 3166-(Latest Release)
Codes for Representation of Currencies and Funds, ISO 4217-(Latest Release)

AVAILABLE FROM

American National Standards Institute
11 West 42nd Street, 13th Floor
New York, NY 10036

ABSTRACT

This international standard provides a two-letter alphabetic code for representing the names of countries, dependencies, and other areas of special geopolitical interest for purposes of international exchange and general directions for the maintenance of the code. The standard is intended for use in any application requiring expression of entitles in coded form. Most currencies are those of the geopolitical entities that are listed in ISO 3166, Codes for the Representation of Names of Countries. The code may be a three-character alphabetic or three-digit numeric. The two leftmost characters of the alphabetic code identify the currency authority to which the code is assigned (using the two character alphabetic code from ISO 3166, if applicable). The rightmost character is a mnemonic derived from the name of the major currency unit or fund. For currencies not associated with a single geographic entity, a specially-allocated two-character alphabetic code, in the range XA to XZ identifies the currency authority. The rightmost character is derived from the name of the geographic area concerned, and is mnemonic to the extent possible. The numeric codes are identical to those assigned to the geographic entities listed in ISO 3166. The range 950-998 is reserved for identification of funds and currencies not associated with a single entity listed in ISO 3166.

22 States and Outlying Areas of the U.S.

SIMPLE DATA ELEMENT/CODE REFERENCES

66/SJ, 771/009, 235/A5, 156

SOURCE

National Zip Code and Post Office Directory

AVAILABLE FROM

U.S. Postal Service
National Information Data Center
P.O. Box 2977
Washington, DC 20013

ABSTRACT

Provides names, abbreviations, and codes for the 50 states, the District of Columbia, and the outlying areas of the U.S. The entities listed are considered to be the first order divisions of the U.S.

Microfiche available from NTIS (same as address above).
The Canadian Post Office lists the following as “official” codes for Canadian Provinces:

AB - Alberta
BC - British Columbia
MB - Manitoba
NB - New Brunswick
NF - Newfoundland
NS - Nova Scotia
NT - North West Territories
ON - Ontario
PE - Prince Edward Island
PQ - Quebec
SK - Saskatchewan
YT - Yukon

51 ZIP Code

SIMPLE DATA ELEMENT/CODE REFERENCES

66/16, 309/PQ, 309/PR, 309/PS, 771/010, 116

SOURCE

National ZIP Code and Post Office Directory, Publication 65

The USPS Domestic Mail Manual

AVAILABLE FROM

U.S Postal Service
Washington, DC 20260

New Orders
Superintendent of Documents
P.O. Box 371954
Pittsburgh, PA 15250-7954

ABSTRACT

The ZIP Code is a geographic identifier of areas within the United States and its territories for purposes of expediting mail distribution by the U.S. Postal Service. It is five or nine numeric digits. The ZIP Code structure divides the U.S. into ten large groups of states. The leftmost digit identifies one of these groups. The next two digits identify a smaller geographic area within the large group. The two rightmost digits identify a local delivery area. In the nine-digit ZIP Code, the four digits that follow the hyphen further subdivide the delivery area. The two leftmost digits identify a sector which may consist of several large buildings, blocks or groups of streets. The rightmost digits divide the sector into segments such as a street, a block, a floor of a building, or a cluster of mailboxes.

The USPS Domestics Mail Manual includes information on the use of the new 11-digit zip code.

60 (DFI) Identification Number

SIMPLE DATA ELEMENT/CODE REFERENCES

507

SOURCE

a) Thompson Bank Directory: American Bankers Association (ABA) Routing Numbers

b) New York Clearinghouse Association: Clearinghouse Interbank Payment System (CHIPS) Participant Numbers

c) Canadian Payments Association Directory: Canadian Bank Transit Numbers

d) ISO/S.W.I.F.T. Bank Identifier Code Directory: ISO Bank Identifier Codes

AVAILABLE FROM

a) Thompson Financial Publishing
P.O. Box 65
Skokie, IL 60076-0065

b) New York Clearinghouse Association
450 West 33rd Street
New York, New York 10001

c) Bowne of Toronto
60 Gervais Drive
Toronto, Ontario
Canada M3C 1Z3

d) S.W.I.F.T. SC
Avenue Adele 1
B-1310 La Hulpe
Belguim

ABSTRACT

Assigned alphanumeric codes identifying depository financial institution.

77 X12 Directories

SIMPLE DATA ELEMENT/CODE REFERENCES

721, 725

SOURCE

X12.3 Data Element Dictionary
X12.22 Segment Directory

AVAILABLE FROM

Data Interchange Standards Association, Inc. (DISA)
Suite 200
1800 Diagonal Road
Alexandria, VA 22314-2852

ABSTRACT

The data element dictionary contains the format and descriptions of data elements used to construct X12 segments. It also contains code lists associated with these data elements. The segment directory contains the format and definitions of the data segments used to construct X12 transaction sets.

91 Canadian Financial Institution Branch and Institution Number

SIMPLE DATA ELEMENT/CODE REFERENCES

128/04, 506/04, 66/CF, 647/806

SOURCE

Canadian Payments Association (CPA) Financial Institution Directories
Volume 1 - Banks
Volume 2 - Credit Unions and Caisses Populaires
Volume 3 - Trust Companies, Loan Companies and other Deposit-taking Institutions

AVAILABLE FROM

Bowne of Canada, Ltd.
60 Gervais Drive
Toronto, Ontario M3C 1Z3
Canada

ABSTRACT

Contains the Canadian financial institutions transit and branch numbers. The first four digits represent the financial institution ID.

121 Health Industry Identification Number

SIMPLE DATA ELEMENT/CODE REFERENCES

128/HI, 66/21, I05/20, 1270/HI

SOURCE

Health Industry Number Database

AVAILABLE FROM

Health Industry Business Communications Council
5110 North 40th Street
Phoenix, AZ 85018

ABSTRACT

The HIN is a coding system, developed and administered by the Health Industry Business Communications Council, that assigns a unique code number to hospitals and other provider organizations - the customers of health industry manufacturers and distributors.

130 Health Care Financing Administration Common Procedural Coding System

SIMPLE DATA ELEMENT/CODE REFERENCES

235/HC, 1270/BO, 1270/BP

SOURCE

Health Care Finance Administration Common Procedural Coding System

AVAILABLE FROM

www.hcfa.gov/medicare/hcpcs.htm
Health Care Financing Administration
Center for Health Plans and Providers
CCPP/DCPC
C5-08-27
7500 Security Boulevard
Baltimore, MD 21244-1850

ABSTRACT

HCPCS is Health Care Finance Administration's (HFCA) coding scheme to group procedures performed for payment to providers.

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

SIMPLE DATA ELEMENT/CODE REFERENCES

235/ID, 235/DX, 1270/BF, 1270/BJ, 1270/BK, 1270/BN, 1270/BQ, 1270/BR, 1270/SD, 1270/TD, 1270/DD, 128/ICD

SOURCE

International Classification of Diseases, 9th Revision, Clincal Modification (ICD-9-CM)

AVAILABLE FROM

U.S. National Center for Health Statistics
Commission of Professional and Hospital Activities

1968 Green Road
Ann Arbor, MI 48105

ABSTRACT

The International Classification of Diseases, 9th Revision, Clinical Modification, describes the classification of morbidity and mortality information for statistical purposes and for the indexing of hospital records by disease and operations.

132 National Uniform Billing Committee (NUBC) Codes

SIMPLE DATA ELEMENT/CODE REFERENCES

235/RB, 235/NU, 1270/BE, 1270/BG, 1270/BH, 1270/BI

SOURCE

National Uniform Billing Data Element Specifications

AVAILABLE FROM

National Uniform Billing Committee
American Hospital Association
840 Lake Shore Drive
Chicago, IL 60697

ABSTRACT

Revenue codes are a classification of hospital charges in a standard grouping that is controlled by the National Uniform Billing Committee. Place of service codes specify the type of location where a service is provided.

134 National Drug Code

SIMPLE DATA ELEMENT/CODE REFERENCES

235/ND, 1270/NDC

SOURCE

Blue Book, Price Alert, National Drug Data File

AVAILABLE FROM

First Databank, The Hearst Corporation
1111 Bayhill Drive
San Bruno, CA 94066

ABSTRACT

The National Drug Code is a coding convention established by the Food and Drug Administration to identify the labeler, product number, and package sizes of FDA-approved prescription drugs. There are over 170,000 National Drug Codes on file.

135 American Dental Association Codes

SIMPLE DATA ELEMENT/CODE REFERENCES

235/AD, 1270/JO, 1270/JP

SOURCE

Current Dental Terminology (CDT) Manual

AVAILABLE FROM

Salable Materials
American Dental Association
211 East Chicago Avenue
Chicago, IL 60611-2678

ABSTRACT

The CDT contains the American Dental Association's codes for dental procedures and nomenclature and is the nationally accepted set of numeric codes and descriptive terms for reporting dental treatments.

139 Claim Adjustment Reason Code

SIMPLE DATA ELEMENT/CODE REFERENCES

1034

SOURCE

National Health Care Claim Payment/Advice Committee Bulletins

AVAILABLE FROM

www.wpc-edi.com
Washington Publishing Company
PMB 161
5284 Randolph Road
Rockville, MD 20852-2116

ABSTRACT

Bulletins describe standard codes and messages that detail the reason why an adjustment was made to a health care claim payment by the payer.

229 Diagnosis Related Group Number (DRG)

SIMPLE DATA ELEMENT/CODE REFERENCES

1270/DR, 1354

SOURCE

Federal Register and Health Insurance Manual 15 (HIM 15)

AVAILABLE FROM

Superintendant of Documents
U.S. Government Printing Office
Washington, DC 20402

ABSTRACT

A patient classification scheme that clusters patients into categories on the basis of patient's illness, diseases, and medical problems.

235 Claim Frequency Type Code

SIMPLE DATA ELEMENT/CODE REFERENCES

1325

SOURCE

National Uniform Billing Data Element Specifications Type of Bill Position 3

AVAILABLE FROM

National Uniform Billing Committee
American Hospitial Association
840 Lake Shore Drive
Chicago, IL 60697

ABSTRACT

A variety of codes explaining the frequency of the bill submission.

240 National Drug Code by Format

SIMPLE DATA ELEMENT/CODE REFERENCES

235/N1, 235/N2, 235/N3, 235/N4, 1270/NDC, 235/N5, 235/N6

SOURCE

Drug Establishment Registration and Listing Instruction Booklet

AVAILABLE FROM

Federal Drug Listing Branch HFN-315
5600 Fishers Lane
Rockville, MD 20857

ABSTRACT

Publication includes manufacturing and labeling information as well as drug packaging sizes.

245 National Association of Insurance Commissioners (NAIC) Code

SIMPLE DATA ELEMENT/CODE REFERENCES

128/NF

SOURCE

National Association of Insurance Commissioners Company Code List Manual

AVAILABLE FROM

National Association of Insurance Commission Publications Department
12th Street, Suite 1100
Kansas City, MO 64105-1925

ABSTRACT

Codes that uniquely identify each insurance company.

307 National Association of Boards of Pharmacy Number

SIMPLE DATA ELEMENT/CODE REFERENCES

128/D3

SOURCE

National Association of Boards of Pharmacy Database and Listings

AVAILABLE FROM

National Council for Prescription Drug Programs
4201 North 24th Street, Suite 365
Phoenix, AZ 85016

ABSTRACT

A unique number assigned in the U.S. and its territories to individual clinic, hospital, chain, and independent pharmacy locations that conduct business at retail by billing third-party drug benefit payers. The National Council for Prescription Drug Programs (NCPDP) maintains this database under contract from the National Association of Boards of Pharmacy. The National Association of Boards of Pharmacy is a seven-digit numeric number with the following format SSNNNNC, where SS=NCPDP assigned state code number, NNNN=NCPDP assigned pharmacy location number, and C=check digit calculated by algorithm from previous six digits.

411 Remittance Remark Codes

SIMPLE DATA ELEMENT/CODE REFERENCES

1270/HE, 1271

SOURCE

Medicare Part A Specification for the ASC X12 835 (7/1/94)
or
Medicare Part B Specification for the ASC X12 835 (7/1/94)
or
National Standard Format Electronic Remittance Advice (Version 001.04)

AVAILABLE FROM

Washington Publishing Company
http://www.wpc-edi.com
or
Health Care Financing Administration (HCFA)
http://www.hcfa.gov/medicare/edi/edi.htm

ABSTRACT

These codes represent non-financial information critical to understanding the adjudication of a health insurance claim.

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

SIMPLE DATA ELEMENT/CODE REFERENCES

235/IV

SOURCE

Home Infusion EDI Coalition (HIEC) Coding System

AVAILABLE FROM

Home Infusion EDI Coalition — affiliated with National Home Infusion Association
205 Daingerfield Road
Alexandria, Virginia 22314
Telephone: 703-549-3740
FAX: 703-683-1484

ABSTRACT

This list contains codes identifying home infusion therapy products/services.

530 National Council for Prescription Drug Programs Reject/Payment Codes

SIMPLE DATA ELEMENT/CODE REFERENCES

1270/RX, 1271

SOURCE

National Council for Prescription Drug Programs Data Dictionary

AVAILABLE FROM

NCPDP
4201 North 24th Street
Suite 365
Phoenix, AZ 85016

ABSTRACT

A listing of NCPDPs payment and reject reason codes, the explanation of the code, and the field number in error (if rejected).

537 Health Care Financing Administration National Provider Identifier

SIMPLE DATA ELEMENT/CODE REFERENCES

128/HPI

SOURCE

National Provider System

AVAILABLE FROM

Health Care Financing Administration
Office of Information Services
Security and Standards Group
Director, Division of Health Care Information Systems
7500 Security Boulevard
Baltimore, MD 21244-1850

ABSTRACT

The Health Care Financing Administration is developing the National Provider Identifiers, which is proposed as the standard unique identifier for each health care provider under the Health Insurance Portability and Accountability Act of 1996.

540 Health Care Financing Administration National PlanID

SIMPLE DATA ELEMENT/CODE REFERENCES

66/XV

SOURCE

PlanID Database

AVAILABLE FROM

Health Care Financing Administration
Center for Beneficiary Services
Administration Group
Division of Membership Operations
S1-05-06
7500 Security Boulevard
Baltimore, MD 21244-1850

ABSTRACT

The Health care Financing Administration is developing the PlanID, which will be proposed as the standard unique identifier for each health plan under the Health Insurance Portability and Accountability Act of 1996.

D Change Summary

D.1 Change Summary

This is the ASC X12N implementation guide for the 835. The following substantive changes have occurred since the previous guide, which was based upon Version 3070 of the 835:

1. All DTM segments changes to facilitate millennium changes. All DTM05 and DTM06 element usage changed to NOT USED. These changes affect 3.1, Presentation Examples, for the DTM at Table 1, position 070, and Table 2, positions 050 and 080.
2. Provider Summary TS301 comment changed to read “USE the National Provider ID when available”. Theses changes affects 3.1, Presentation Examples, for TS3 segment at Table 2, position 005.
3. Support of code 9A (Re-priced Claim Reference Number) and 9C (Adjusted Re-priced Claim Reference Number) was added to the REF segment in 3.1, Presentation Examples, REF segment at Table 2, position 040.
4. All segment examples in 3.1, Presentation Examples, and the scenarios in 4.1, and 4.2 were updated to reflect all other modifications.
5. Support of Code “RB” Ambulatory Surgical Center (ASC) Rate was added to REF segment in 3.1, Presentation Examples, REF segment 2, position 100 Service Identification.
6. Alternate Reversal removed from 2.2.8 Reversals and Corrections.
7. Removed 2.3 Data Transaction Set Model with Usage Matrix.
8. Section 1.2 Transaction Limitations added.
9. Section 1.1.1 Trading Partner Agreements added.
10. Section 1.1.2 HIPAA Role in Implementation Guides added.
11. Section 2.2.11 Definition of a Claim added.
12. Partial Unbundling Example added.

D.2 Change Detail

Section 1.1
Add Section 1.1.1 Trading Partner Agreements.
Add Section 1.1.2 HIPAA Role in Implementation Guides.

Section 1.2
Update the version and Release to 004010.
Add Section 1.2 Transaction Limitations

Section 2.2
Changed sub-element separator in examples to ":".
Changed dates in examples to be millennium compliant.
Add Section 2.2.11 Definition of a Claim

Section 2.2.8
Removed Alternate Reversal Method

Section 2.3
Removed section.

Section 3.1

Table 1
Position 020 – Segment BPR (Financial Information)
Changed example.

Position 070 – Segment DTM (Production Date)
Changed example.
Changed usage of DTM05 to NOT USED.
Changed usage of DTM06 to NOT USED.

Position 070 – Production Date
Changed usage of DTM02 to REQUIRED

Position 080 — Segment N1 (Payer Identification)
Changed comments for N103 Code "XV".

Position 080 — Payee Identification
Changed note 1.

Position 100 — Payee Address
Changed note 1.
Changed segment usage to SITUATIONAL
Added N302 comment.

Position 110 — Payee City, State, ZIP Code
Changed note 1.
Changed segment usage to SITUATIONAL
Change N401 usage to REQUIRED
Change N402 usage to REQUIRED
Change N403 usage to REQUIRED

Position 120 — Additional Payer Identification
Removed notes 2.

Position 130 — Payer Contact Information
Added PER03 comment.

Table 2

Position 003 – Segment LX (Header Number)
Changed example.

Position 005 – Segment TS3 (Provider Summary Information)
Changed TS301 element note.

Position 010 — Claim Payment Information
Changed usage of CLP06 to REQUIRED.
Deleted CLP06 Advisory.
Changed CLP06 note.
Deleted CLP06 note 2.
Changed usage of CLP10 to NOT USED.

Position 020 — Claim Adjustment
Changed note 3.

Position 030 — Patient Name
Changed usage of NM106 NOT USED

Position 030 — Insured Name
Changed note 1.
Added note 2.

Position 030 — Crossover Carrier Name
Changed Example.
Added NM103 comment.

Position 030 – Segment NM1 (Service Provider Name)
Changed example.

Position 030 – Segment NM1 (Crossover Carrier Name)
Changed example.

Position 030 – Segment NM1 (Corrected Priority Payer Name)
Changed example.

Position 033 — Inpatient Adjudication Information
Changed note 1.
Added note 5.

Position 035 — Outpatient Adjudication Information
Changed note 1.
Added note 4.

Position 040 – Segment REF (Other Claim Related Identification)
Added note to code CE in REF01.
Added code 9A, 9C in REF01.

Position 040 - Segment REF (Other Claim Related Identification)
Added support of codes (1W,A6,I6,SY) to REF01

Position 040 — Other Claim Related Identification
Now supports REF01 codes 1L, 9A, 9C, BB, CE, EA, F8, G1 and G3.
Changed note 1.

Position 040 — Rendering Provider Identification
Added Position 040 Rendering Provider Identification
Added codes 1A, 1B, 1C, 1D, 1G, 1H, D3 and G2 to REF01.
Added note 1.
Added example.

Position 050 – Segment DTM (Claim Date)
Changed example.
Changed usage of DTM05 to NOT USED.
Changed usage of DTM06 to NOT USED.

Position 080 – Segment DTM (Dates of Service)
Changed example.
Changed usage of DTM05 to NOT USED.
Changed usage of DTM06 to NOT USED.

Position 090 — Service Adjustment
Changed note 2

Position 100 — Service Identification
Now supports REF01 codes 1S, 6R, BB, E9, G1, G3, LU.
Changed example.
Changed note 1.
Added code “RB” to REF01.

Position 100 — Rendering Provider Identification
Added Position 100 Rendering Provider Identification
Added codes 1A, 1B, 1C, 1D, 1G, 1H, 1J, HPI, SY, TJ to REF01.
Added note 1.
Added example.

Position 100 – Segment REF (Service Identification)
Changed example.

Position 110 — Service Supplemental Amount
Removed codes “1A” and “A9" from AMT01.

Position 130 – Segment LQ (Health Care Remark Codes)
Changed note.

Table 3
Position 010 0 Segment PLB (Provider Adjustment)
Changed example.

Section 4.1.2
Updated the transmission examples.

Section 4.2.2
Updated the transmission examples.

Appendix C
Changed Code List 411 address.
Changed Code List 507 address.
Changed Code List 508 address.
Changed Code List 537 address.
Changed Code List 537 abstract.
Changed Code List 540 abstract.

E Data Element Name Index

This appendix contains an alphabetic listing of data elements used in this implementation guide. Consult the Data Element Dictionary for the complete list. Data element names in normal type are generic ASC X12 names. Italic type indicates a health care industry defined name.

Name — ***Payment Date***
Definition — Date of payment.
Transaction Set ID — **277**
Locator Key — D | 2200D | SPA12 | C001-2 | 373 ..... **156**

H=Header, D=Detail, S=Summary
Loop ID
Segment ID/Reference Designator
Composite ID-Sequence
Data Element Number
Page Number

Account Number Qualifier

Code indicating the type of account

H		BPR08	-	569	**48**
H		BPR14	-	569	**50**

Additional Payee Identifier

Additional unique identifier designating the payee.

H	1000B	REF02	-	127	**78**

Additional Payer Identifier

Additional unique identifier designating the payer.

H	1000A	REF02	-	127	**68**

Adjustment Amount

Adjustment amount for the associated reason code.

D	2100	CAS03	-	782	**97**
D	2100	CAS06	-	782	**98**
D	2100	CAS09	-	782	**99**
D	2100	CAS12	-	782	**99**
D	2100	CAS15	-	782	**100**
D	2100	CAS18	-	782	**100**
D	2110	CAS03	-	782	**150**
D	2110	CAS06	-	782	**151**
D	2110	CAS09	-	782	**151**
D	2110	CAS12	-	782	**152**
D	2110	CAS15	-	782	**153**
D	2110	CAS18	-	782	**153**

Adjustment Quantity

Numeric quantity associated with the related reason code for coordination of benefits.

D	2100	CAS04	-	380	**98**
D	2100	CAS07	-	380	**98**
D	2100	CAS10	-	380	**99**
D	2100	CAS13	-	380	**99**
D	2100	CAS16	-	380	**100**
D	2100	CAS19	-	380	**101**
D	2110	CAS04	-	380	**150**
D	2110	CAS07	-	380	**151**
D	2110	CAS10	-	380	**152**
D	2110	CAS13	-	380	**152**
D	2110	CAS16	-	380	**153**
D	2110	CAS19	-	380	**153**

Adjustment Reason Code

Code that indicates the reason for the adjustment.

D	2100	CAS02	-	1034	**97**
D	2100	CAS05	-	1034	**98**
D	2100	CAS08	-	1034	**98**
D	2100	CAS11	-	1034	**99**
D	2100	CAS14	-	1034	**100**
D	2100	CAS17	-	1034	**100**
D	2110	CAS02	-	1034	**150**
D	2110	CAS05	-	1034	**151**
D	2110	CAS08	-	1034	**151**
D	2110	CAS11	-	1034	**152**
D	2110	CAS14	-	1034	**152**
D	2110	CAS17	-	1034	**153**
S		PLB03	C042-1	426	**165**
S		PLB05	C042-1	426	**170**
S		PLB07	C042-1	426	**171**
S		PLB09	C042-1	426	**171**
S		PLB11	C042-1	426	**171**
S		PLB13	C042-1	426	**172**

Amount Qualifier Code

Code to qualify amount.

D	2100	AMT01	-	522	**135**
D	2110	AMT01	-	522	**158**

Assigned Number

Number assigned for differentiation within a transaction set.

D	2000	LX01	-	554	**79**

Average DRG Length of Stay

Average length of stay for DRGs for this provider for this type of bill summary, for this fiscal period, for this interchange transmission.

D | 2000 | TS210 | - | 380 ..... **87**

Average DRG weight

Average DRG weight for DRGs for this provider for this type of bill summary, for this fiscal period, for this interchange transmission.

D | 2000 | TS216 | - | 380 ..... **88**

Check Issue or EFT Effective Date

Date the check was issued or the electronic funds transfer (EFT) effective date.

H | | BPR16 | - | 373 ..... **50**

Check or EFT Trace Number

Check number or Electronic Funds Transfer (EFT) number that is unique within the sender/receiver relationship.

H | | TRN02 | - | 127 ..... **53**

Claim Adjustment Group Code

Code identifying the general category of payment adjustment.

D | 2100 | CAS01 | - | 1033 ..... **97**
D | 2110 | CAS01 | - | 1033 ..... **150**

Claim Contact Communications Number

Complete claim contact communications number, including country or area code when applicable.

D | 2100 | PER04 | - | 364 ..... **133**
D | 2100 | PER06 | - | 364 ..... **134**

Claim Contact Name

Name of the payer's contact person associated with the claim.

D | 2100 | PER02 | - | 93 ..... **133**

Claim DRG Amount

Total of Prospective Payment System operating and capital amounts for this claim.

D | 2100 | MIA04 | - | 782 ..... **120**

Claim Date

Date associated with the claim.

D | 2100 | DTM02 | - | 373 ..... **131**

Claim Disproportionate Share Amount

Sum of operating capital disproportionate share amounts for this claim.

D | 2100 | MIA06 | - | 782 ..... **120**

Claim ESRD Payment Amount

End Stage Renal Disease (ESRD) payment amount for the claim.

D | 2100 | MOA08 | - | 782 ..... **125**

Claim Filing Indicator Code

Code identifying type of claim or expected adjudication process.

D | 2100 | CLP06 | - | 1032 ..... **92**

Claim Frequency Code

Code specifying the frequency of the claim. This is the third position of the Uniform Billing Claim Form Bill Type.

D | 2100 | CLP09 | - | 1325 ..... **93**

Claim HCPCS Payable Amount

Sum of payable line item amounts for HCPCs codes billed on this claim.

D | 2100 | MOA02 | - | 782 ..... **124**

Claim Indirect Teaching Amount

Total of operating and capital indirect teaching amounts for this claim.

D | 2100 | MIA18 | - | 782 ..... **122**

Claim MSP Pass-through Amount

Interim cost pass-though amount used to determine Medicare Secondary Payer liability.

D | 2100 | MIA07 | - | 782 ..... **120**

Claim PPS Capital Amount

Total Prospective Payment System (PPS) capital amount payable for this claim as output by PPS PRICER.

D | 2100 | MIA08 | - | 782 ..... **120**

Claim PPS Capital Outlier Amount

Total Prospective Payment System capital day or cost outlier payable for this claim, excluding operating outlier amount.

D | 2100 | MIA17 | - | 782 ..... **121**

Claim Payment Amount

Net provider reimbursement amount for this claim (includes all payment to the provider).

D | 2100 | CLP04 | - | 782 ..... **91**

Claim Status Code

Code specifying the status of a claim submitted by the provider to the payor for processing.

D | 2100 | CLP02 | - | 1029 ..... **90**

Claim Supplemental Information Amount

Amount of supplemental information values associated with the claim.

D | 2100 | AMT02 | - | 782 ..... **136**

Claim Supplemental Information Quantity

Numeric value of the quantity of supplemental information associated with the claim.

D | 2100 | QTY02 | - | 380 ..... **138**

Code List Qualifier Code

Code identifying a specific industry code list.

D | 2110 | LQ01 | - | 1270 ..... **162**

Communication Number Extension

Extension for the previous communications number.

D | 2100 | PER08 | - | 364 ..... **134**

Communication Number Qualifier

Code identifying the type of communication number

H | 1000A | PER03 | - | 365 ..... **70**
H | 1000A | PER05 | - | 365 ..... **71**
H | 1000A | PER07 | - | 365 ..... **71**
D | 2100 | PER03 | - | 365 ..... **133**
D | 2100 | PER05 | - | 365 ..... **134**
D | 2100 | PER07 | - | 365 ..... **134**

Contact Function Code

Code identifying the major duty or responsibility of the person or group named.

H | 1000A | PER01 | - | 366 ..... **70**
D | 2100 | PER01 | - | 366 ..... **133**

Coordination of Benefits Carrier Identifier

Number assigned by the payer to identify the coordination of benefits carrier.

D | 2100 | NM109 | - | 67 .....**115**

Coordination of Benefits Carrier Name

Name of the crossover carrier associated with the claim.

D | 2100 | NM103 | - | 1035 .....**115**

Corrected Insured Identification Indicator

Indicator used to identify an insured's identification number which was incorrectly submitted and subsequently changed.

D | 2100 | NM109 | - | 67 .....**110**

Corrected Patient or Insured First Name

Corrected first name of the patient or insured.

D | 2100 | NM104 | - | 1036 ..... **109**

Corrected Patient or Insured Last Name

Corrected last name of the patient or insured.

D | 2100 | NM103 | - | 1035 ..... **109**

Corrected Patient or Insured Middle Name

Corrected middle name of the patient or insured.

D | 2100 | NM105 | - | 1037 ..... **109**

Corrected Patient or Insured Name Suffix

Corrected suffix for the name of the patient or insured.

D | 2100 | NM107 | - | 1039 ..... **109**

Corrected Priority Payer Identification Number

Number assigned by the payer to identify the corrected priority payer name.

D | 2100 | NM109 | - | 67 .....**117**

Corrected Priority Payer Name

Name of the corrected priority payer.

D | 2100 | NM103 | - | 1035 .....**117**

Cost Report Day Count

The number of days that may be claimed as Medicare patient days on a cost report.

D | 2100 | MIA15 | - | 380 ..... **121**

Country Code

Code indicating the geographic location.

H | 1000B | N404 | - | 26 ..... **76**

Covered Days or Visits Count

Number of days or visits covered by the primary payer or days/visits that would have been covered had Medicare been primary.

D | 2100 | MIA01 | - | 380 .....**119**

Credit or Debit Flag Code

Code indicating whether amount is a credit or debit

H | | BPR03 | - | 478 ..... **46**

Currency Code

Code for country in whose currency the charges are specified.

H | | CUR02 | - | 100 ..... **55**

Date Time Qualifier

Code specifying the type of date or time or both date and time.

H		DTM01	-	374	**60**
D	2100	DTM01	-	374	**131**
D	2110	DTM01	-	374	**147**

Depository Financial Institution (DFI) Identification Number Qualifier

Code identifying the type of identification number of Depository Financial Institution (DFI).

H		BPR06	-	506	**48**
H		BPR12	-	506	**49**

Diagnosis Related Group (DRG) Code

Diagnosis related group for this claim.

D	2100	CLP11	-	1354	**93**

Diagnosis Related Group (DRG) Weight

Diagnosis related group weight for this claim

D	2100	CLP12	-	380	**93**

Discharge Fraction

The number of days billed are divided by the Average Length of Stay.

D	2100	CLP13	-	954	**94**

Entity Identifier Code

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

H		CUR01	-	98	**55**
H	1000A	N101	-	98	**62**
H	1000B	N101	-	98	**72**
D	2100	NM101	-	98	**102**
D	2100	NM101	-	98	**106**
D	2100	NM101	-	98	**108**
D	2100	NM101	-	98	**112**
D	2100	NM101	-	98	**114**
D	2100	NM101	-	98	**116**

Entity Type Qualifier

Code qualifying the type of entity

D	2100	NM102	-	1065	**103**
D	2100	NM102	-	1065	**106**
D	2100	NM102	-	1065	**109**
D	2100	NM102	-	1065	**112**
D	2100	NM102	-	1065	**115**
D	2100	NM102	-	1065	**117**

Exchange Rate

Value to be used as a multiplier conversion factor to convert monetary value from one currency to another.

H		CUR03	-	280	**55**

Facility Type Code

Code identifying the type of facility where services were performed; the first and second positions of the Uniform Bill Type code or the Place of Service code from the Electronic Media Claims National Standard Format.

D	2000	TS302	-	1331	**81**
D	2100	CLP08	-	1331	**93**

Fiscal Period Date

Last day of provider's fiscal year through date of the bill.

D	2000	TS303	-	373	**81**
S		PLB02	-	373	**165**

Identification Code Qualifier

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

H	1000A	N103	-	66	**63**
H	1000B	N103	-	66	**73**
D	2100	NM108	-	66	**103**
D	2100	NM108	-	66	**107**
D	2100	NM108	-	66	**109**
D	2100	NM108	-	66	**113**
D	2100	NM108	-	66	**115**
D	2100	NM108	-	66	**117**

Lifetime Psychiatric Days Count

Number of lifetime psychiatric days used for this claim.

D	2100	MIA03	-	380	**119**

Line Item Charge Amount

Charges related to this service.

D	2110	SVC02	-	782	**142**

Line Item Provider Payment Amount

The actual amount paid to the provider for this service line.

D	2110	SVC03	-	782	**142**

National Uniform Billing Committee Revenue Code

Code values from the National Uniform Billing Committee Revenue Codes.

D	2110	SVC04	-	234	**142**

Nonpayable Professional Component Amount

Professional fees billed but not payable by payer.

D	2100	MIA19	-	782	**122**
D	2100	MOA09	-	782	**125**

Old Capital Amount

The amount for old capital for this claim.

D	2100	MIA12	-	782	**121**

Original Units of Service Count

Original units of service that were submitted by the provider (in days or units).

D | 2110 | SVC07 | - | 380 ..... **145**

Originating Company Supplemental Code

Number identifying a further subdivision within the entity originating the transaction.

H | | BPR11 | - | 510 ..... **49**
H | | TRN04 | - | 127 ..... **53**

Other Claim Related Identifier

Code identifying other claim related reference numbers.

D | 2100 | REF02 | - | 127 ..... **127**

PPS Operating Outlier Amount

Prospective Payment System addition to payment rate as excessive costs incurred.

D | 2100 | MIA02 | - | 380 .....**119**

PPS-Capital DSH DRG Amount

PPS-capital disproportionate share amount for this claim as output by PPS-PRICER.

D | 2100 | MIA11 | - | 782 ..... **121**

PPS-Capital Exception Amount

A per discharge payment exception paid to the hospital. It is a flat-rate add-on to the PPS payment.

D | 2100 | MIA24 | - | 782 ..... **122**

PPS-Capital FSP DRG Amount

PPS-capital federal portion for this claim as output by PPS-PRICER.

D | 2100 | MIA09 | - | 782 ..... **120**

PPS-Capital HSP DRG Amount

Hospital-Specific portion for PPS-capital for this claim as output by PPS-PRICER.

D | 2100 | MIA10 | - | 782 ..... **120**

PPS-Capital IME amount

PPS-capital indirect medical expenses for this claim as output by PPS-PRICER.

D | 2100 | MIA13 | - | 782 ..... **121**

PPS-Operating Federal Specific DRG Amount

Sum of federal operating portion of the DRG amount this claim as output by PPS-PRICER.

D | 2100 | MIA16 | - | 782 ..... **121**

PPS-Operating Hospital Specific DRG Amount

Sum of hospital specific operating portion of DRG amount for this claim as output by PPS-PRICER.

D | 2100 | MIA14 | - | 782 ..... **121**

Patient Control Number

Patient's unique alpha-numeric identification number for this claim assigned by the provider to facilitate retrieval of individual case records and posting of payment.

D | 2100 | CLP01 | - | 1028 ..... **89**

Patient First Name

The first name of the individual to whom the services were provided.

D | 2100 | NM104 | - | 1036 ..... **103**

Patient Identifier

Patient identification code

D | 2100 | NM109 | - | 67 ..... **104**

Patient Last Name

The last name of the individual to whom the services were provided.

D | 2100 | NM103 | - | 1035 ..... **103**

Patient Middle Name

The middle name of the individual to whom the services were provided.

D | 2100 | NM105 | - | 1037 ..... **103**

Patient Name Suffix

Suffix to the name of the individual to whom the services were provided.

D | 2100 | NM107 | - | 1039 ..... **103**

Patient Responsibility Amount

The amount determined to be the patient's responsibility for payment..

D | 2100 | CLP05 | - | 782 ..... **91**

Payee Address Line

Payee's claim mailing address for this particular payee organization identification and claim office.

H | 1000B | N301 | - | 166 ..... **74**
H | 1000B | N302 | - | 166 ..... **74**

Payee City Name

Name of the city of the payee's claim mailing address for this particular payee ID and claim office.

H | 1000B | N401 | - | 19 ..... **75**

Payee Identification Code

Code identifying the entity to whom payment will be directed.

H	1000B	N104	-	67	**73**

Payee Name

Name identifying the payee organization to whom payment is directed.

H	1000B	N102	-	93	**73**

Payee Postal Zone or ZIP Code

Zip code of the payee's claim mailing address for this particular payee organization identification and claim office.

H	1000B	N403	-	116	**76**

Payee State Code

State postal code of the payee's claim mailing address for this particular payee organization identification and claim office.

H	1000B	N402	-	156	**75**

Payer Address Line

Address line of the Payer's claim mailing address for this particular payer organization identification and claim office.

H	1000A	N301	-	166	**64**
H	1000A	N302	-	166	**64**

Payer City Name

The City Name of the Payer's claim mailing address for this particular payer ID and claim office.

H	1000A	N401	-	19	**65**

Payer Claim Control Number

A number assigned by the payer to identify a claim. The number is usually referred to as an Internal Control Number (ICN), Claim Control Number (CCN) or a Document Control Number (DCN).

D	2100	CLP07	-	127	**93**

Payer Contact Communication Number

Complete payer contact communications number, including country or area code when applicable.

H	1000A	PER04	-	364	**70**
H	1000A	PER06	-	364	**71**
H	1000A	PER08	-	364	**71**

Payer Contact Name

Name identifying the payer organization's contact person.

H	1000A	PER02	-	93	**70**

Payer Identifier

Number identifying the payer organization.

H		BPR10	-	509	**49**
H		TRN03	-	509	**53**
H	1000A	N104	-	67	**63**

Payer Name

Name identifying the payer organization.

H	1000A	N102	-	93	**63**

Payer Postal Zone or ZIP Code

The ZIP Code of the Payer's claim mailing address for this particular payer organization identification and claim office.

H	1000A	N403	-	116	**65**

Payer State Code

State Postal Code of the Payer's claim mailing address for this particular payor organization identification and claim office.

H	1000A	N402	-	156	**65**

Payment Format Code

Type of format chosen to send payment

H		BPR05	-	812	**47**

Payment Method Code

Code identifying the method for the movement of payment instructions.

H		BPR04	-	591	**46**

Procedure Code

Code identifying the procedure, product or service.

D	2110	SVC01	C003-2	234	**141**
D	2110	SVC06	C003-2	234	**144**

Procedure Code Description

Description clarifying the Product/Service Procedure Code and related data elements.

D	2110	SVC01	C003-7	352	**141**
D	2110	SVC06	C003-7	352	**144**

Procedure Modifier

This identifies special circumstances related to the performance of the service.

D	2110	SVC01	C003-3	1339	**141**
D	2110	SVC01	C003-4	1339	**141**
D	2110	SVC01	C003-5	1339	**141**
D	2110	SVC01	C003-6	1339	**141**
D	2110	SVC06	C003-3	1339	**144**
D	2110	SVC06	C003-4	1339	**144**
D	2110	SVC06	C003-5	1339	**144**
D	2110	SVC06	C003-6	1339	**144**

Product or Service ID Qualifier

Code identifying the type/source of the descriptive number used in Product/Service ID (234).

D	2110	SVC01	C003-1	235	**140**
D	2110	SVC06	C003-1	235	**143**

Production Date

End date for the adjudication production cycle for the claims in the transmission.

H		DTM02	-	373	**61**

Provider Adjustment Amount

Provider adjustment amount. The adjustment amount is to the total provider payment and is not related to a specific claim or service.

S		PLB04	-	782	**170**
S		PLB06	-	782	**170**
S		PLB08	-	782	**171**
S		PLB10	-	782	**171**
S		PLB12	-	782	**172**
S		PLB14	-	782	**172**

Provider Adjustment Identifier

Unique identifying number for the provider adjustment.

S		PLB03	C042-2	127	**170**
S		PLB05	C042-2	127	**170**
S		PLB07	C042-2	127	**171**
S		PLB09	C042-2	127	**171**
S		PLB11	C042-2	127	**172**
S		PLB13	C042-2	127	**172**

Provider Identifier

Number assigned by the payer, regulatory authority, or other authorized body or agency to identify the provider.

D	2000	TS301	-	127	**81**
D	2110	REF02	-	127	**155**
S		PLB01	-	127	**165**

Quantity Qualifier

Code specifying the type of quantity

D	2100	QTY01	-	673	**137**
D	2110	QTY01	-	673	**160**

Receiver Identifier

Number identifying the organization receiving the payment.

H		REF02	-	127	**57**

Receiver or Provider Account Number

The receiver's/provider's Bank Account Number into which payment has been or will be deposited according to the previously identified receiving depository financial institution.

H		BPR15	-	508	**50**

Receiver or Provider Bank ID Number

The American Banking Association Identification Number used to identify the receiving depository financial institution or provider's bank within the Federal Reserve System when an EFT is being sent.

H		BPR13	-	507	**50**

Reference Identification Qualifier

Code qualifying the reference identification

H		REF01	-	128	**57**
H		REF01	-	128	**58**
H	1000A	REF01	-	128	**67**
H	1000B	REF01	-	128	**77**
D	2100	REF01	-	128	**126**
D	2100	REF01	-	128	**128**
D	2110	REF01	-	128	**154**
D	2110	REF01	-	128	**156**

Reimbursement Rate

Rate used when payment is based upon a percentage of applicable charges.

D	2100	MOA01	-	954	**124**

Remark Code

Code indicating a code from a specific industry code list, such as the Health Care Claim Status Code list.

D	2100	MIA05	-	127	**120**
D	2100	MIA20	-	127	**122**
D	2100	MIA21	-	127	**122**
D	2100	MIA22	-	127	**122**
D	2100	MIA23	-	127	**122**
D	2100	MOA03	-	127	**124**
D	2100	MOA04	-	127	**124**
D	2100	MOA05	-	127	**124**
D	2100	MOA06	-	127	**125**
D	2100	MOA07	-	127	**125**
D	2110	LQ02	-	1271	**163**

Rendering Provider First Name

The first name of the provider who performed the service.

D	2100	NM104	-	1036	**112**

Rendering Provider Identifier

The identifier assigned by the Payor to the provider who performed the service.

D	2100	NM109	-	67	**113**
D	2110	REF02	-	127	**157**

Rendering Provider Last or Organization Name

The last name or organization of the provider who performed the service

D	2100	NM103	-	1035	**112**

Rendering Provider Middle Name

Middle name of the provider who has provided the services to the patient.

D | 2100 | NM105 | - | 1037 ..... **112**

Rendering Provider Name Suffix

Name suffix of the provider who has provided the services to the patient.

D | 2100 | NM107 | - | 1039 ..... **112**

Rendering Provider Secondary Identifier

Additional identifier for the provider providing care to the patient.

D | 2100 | REF02 | - | 127 ..... **129**

Sender Bank Account Number

The sender's bank account number at the Originating Depository Financial Institution.

H | | BPR09 | - | 508 ..... **49**

Sender DFI Identifier

The Depository Financial Institution (DFI) identification number of the originator of the transaction.

H | | BPR07 | - | 507 ..... **48**

Service Date

Date of service, such as the start date of the service, the end date of the service, or the single day date of the service.

D | 2110 | DTM02 | - | 373 ..... **147**

Service Supplemental Amount

Additional amount or charge associated with the service.

D | 2110 | AMT02 | - | 782 ..... **159**

Service Supplemental Quantity Count

Quantity of additional items associated with service.

D | 2110 | QTY02 | - | 380 ..... **161**

Subscriber First Name

The first name of the insured individual or subscriber to the coverage

D | 2100 | NM104 | - | 1036 ..... **106**

Subscriber Identifier

Insured's or subscriber's unique identification number assigned by a payer.

D | 2100 | NM109 | - | 67 ..... **107**

Subscriber Last Name

The surname of the insured individual or subscriber to the coverage

D | 2100 | NM103 | - | 1035 ..... **106**

Subscriber Middle Name

The middle name of the subscriber to the indicated coverage or policy.

D | 2100 | NM105 | - | 1037 ..... **106**

Subscriber Name Suffix

Suffix of the insured individual or subscriber to the coverage.

D | 2100 | NM107 | - | 1039 ..... **106**

Total Actual Provider Payment Amount

The actual payment to the provider for this batch, transaction, or summary.

H | | BPR02 | - | 782 ..... **46**

Total Blood Deductible Amount

Sum of blood deductible fields for this provider for this type of bill summary for this fiscal period.

D | 2000 | TS314 | - | 782 ..... **83**

Total Capital Amount

Sum of claim Prospective Payment System capital amount fields for this provider for this type of bill summary, for this fiscal period.

D | 2000 | TS205 | - | 782 ..... **86**

Total Claim Charge Amount

The sum of all charges included within this claim.

D | 2000 | TS305 | - | 782 ..... **82**
D | 2100 | CLP03 | - | 782 ..... **91**

Total Claim Count

Total number of claims in this transaction.

D | 2000 | TS304 | - | 380 ..... **81**

Total Coinsurance Amount

Amount deducted from this transaction, by the payers, from the allowed amount to meet the co-insurance provisions.

D | 2000 | TS316 | - | 782 ..... **83**

Total Contractual Adjustment Amount

Total of contractual adjustments for this provider.

D | 2000 | TS311 | - | 782 ..... **82**

Total Cost Outlier Amount

Sum of outlier amount fields from each claim for this provider, for this type of bill summary, for this fiscal period.

D | 2000 | TS209 | - | 782 ..... **87**

Total Cost Report Day Count

Sum of cost report days fields for this provider, for this type of bill summary, for this fiscal period.

D | 2000 | TS212 | - | 380 ..... **87**

Total Covered Charge Amount

Total covered charges for this provider, for this type of bill summary, for this fiscal period.

D | 2000 | TS306 | - | 782 ..... **82**

Total Covered Day Count

Sum of covered days fields for this provider, for this type of bill summary, for this fiscal period.

D | 2000 | TS213 | - | 380 ..... **88**

Total DRG Amount

Total of claim level DRG amount fields for this provider, for this type of bill summary, for this fiscal period.

D | 2000 | TS201 | - | 782 ..... **86**

Total Day Outlier Amount

Sum of outlier amount and claim Prospective Payment System capital outlier amount for this provider, for this type of bill summary, for this fiscal period.

D | 2000 | TS208 | - | 782 ..... **87**

Total Deductible Amount

Sum of cash deductible fields for this provider, for this batch or for this type of bill summary, for this fiscal period.

D | 2000 | TS319 | - | 782 ..... **84**

Total Denied Charge Amount

Total denied charges for this transaction.

D | 2000 | TS308 | - | 782 ..... **82**

Total Discharge Count

Sum of discharges for this provider for this type of bill summary, for this fiscal period.

D | 2000 | TS211 | - | 380 ..... **87**

Total Disproportionate Share Amount

Sum of disproportionate share amount fields for this provider, for this type of bill summary, for this fiscal period.

D | 2000 | TS204 | - | 782 ..... **86**

Total Federal Specific Amount

Total of federal-specific DRG amount fields for this provider, for this fiscal period.

D | 2000 | TS202 | - | 782 ..... **86**

Total Gramm-Rudman Reduction Amount

Total of Gramm-Rudman reduction fields for this provider, for this type of bill summary, for this fiscal period or for this batch.

D | 2000 | TS312 | - | 782 ..... **83**

Total HCPCS Payable Amount

Sum of claim HCPCS payable amount fields for this provider, for this type of bill summary, for this fiscal period.

D | 2000 | TS318 | - | 782 ..... **83**

Total HCPCS Reported Charge Amount

Sum of reported charge fields for the line items billed by this provider, for this type of bill summary, for this fiscal period.

D | 2000 | TS317 | - | 782 ..... **83**

Total Hospital Specific Amount

Total hospital-specific DRG amount fields for this provider, for this type of bill summary, for this fiscal period.

D | 2000 | TS203 | - | 782 ..... **86**

Total Indirect Medical Education Amount

Total of indirect teaching amount fields for this provider, for this type of bill summary, for this fiscal period.

D | 2000 | TS206 | - | 782 ..... **87**

Total Interest Amount

Total of interest included fields for this provider, for this type of bill summary, for this fiscal period or for this batch.

D | 2000 | TS310 | - | 782 ..... **82**

Total MSP Pass-Through Amount

Sum of claim Medicare Secondary Payer pass-through amount fields for this provider for this type of bill summary for this fiscal period for this transmission.

D | 2000 | TS215 | - | 782 ..... **88**

Total MSP Patient Liability Met Amount

Sum of Medicare secondary payer patient liability met by patients for Medicare secondary payer for this provider, for this type of bill summary, for this fiscal period.

D | 2000 | TS321 | - | 782 ..... **84**

Total MSP Payer Amount

Sum of Medicare secondary payer(s) amounts for this provider, for this type of bill summary for this fiscal period.

D | 2000 | TS313 | - | 782 ..... **83**

Total Non-Lab Charge Amount

Total covered charges minus sum of amounts for revenue codes 300-319.

D | 2000 | TS315 | - | 782 ..... **83**

Total Noncovered Charge Amount

This is the sum of non-covered charges for this file, transaction, or loop.

D | 2000 | TS307 | - | 782 ..... **82**

Total Noncovered Day Count

Sum of non-covered days fields for this provider, for this type of bill summary, for this fiscal period.

D | 2000 | TS214 | - | 380 ..... **88**

Total Outlier Day Count

Sum of outlier days for this provider, for this type of bill summary, for this fiscal period.

D | 2000 | TS207 | - | 380 ..... **87**

Total PIP Adjustment Amount

Total value of Period Interim Payment adjustment for this provider, for this type of bill summary, for this fiscal period.

D | 2000 | TS324 | - | 782 ..... **84**

Total PIP Claim Count

Total number of Periodic Interim Payment claims for this provider, for this type of bill summary, for this fiscal period.

D | 2000 | TS323 | - | 380 ..... **84**

Total PPS Capital FSP DRG Amount

Sum of Prospective Payment System-capital federal specific DRG amount fields for this provider, for this type of bill summary, for this fiscal period.

D | 2000 | TS217 | - | 782 ..... **88**

Total PPS Capital HSP DRG Amount

Sum of Prospective Payment System-capital hospital specific DRG amount fields for this provider, for this type of bill summary, for this fiscal period.

D | 2000 | TS218 | - | 782 ..... **88**

Total PPS DSH DRG Amount

Sum of Prospective Payment System disproportionate share of DRG amount fields for this provider, for this type of bill summary, for this fiscal period.

D | 2000 | TS219 | - | 782 ..... **88**

Total Patient Reimbursement Amount

Total of patient refund amount fields for this provider for this type of bill summary, for this fiscal period.

D | 2000 | TS322 | - | 782 ..... **84**

Total Professional Component Amount

Sum of professional component fields for this provider, for this type of bill summary, for this fiscal period.

D | 2000 | TS320 | - | 782 ..... **84**

Total Provider Payment Amount

Total payment made to the provider for this transaction.

D | 2000 | TS309 | - | 782 ..... **82**

Trace Type Code

Code identifying the type of reassociation which needs to be performed.

H | | TRN01 | - | 481 ..... **52**

Transaction Handling Code

This code designates whether and how the money and remittance information will be processed.

H | | BPR01 | - | 305 ..... **45**

Transaction Segment Count

A tally of all segments between the ST and the SE segments including the ST and SE segments.

S | | SE01 | - | 96 ..... **173**

Transaction Set Control Number

The unique identification number within a transaction set.

H | | ST02 | - | 329 ..... **43**
S | | SE02 | - | 329 ..... **173**

Transaction Set Identifier Code

Code uniquely identifying a Transaction Set.

H | | ST01 | - | 143 ..... **43**

Units of Service Paid Count

Number of the paid units of service.

D | 2110 | SVC05 | - | 380 ..... **142**

Version Identification Code

Revision level of a particular format, program, technique or algorithm

H | | REF02 | - | 127 ..... **58**