

835 Health Care Claim Payment/Advice

Functional Group ID=**HP**

Introduction:

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.

Heading:

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3	013	ISA	Interchange Control Header	R	R	1		
6	015	GS	Functional Group Header	R	R	1		
8	010	ST	Transaction Set Header	R	R	1		
9	020	BPR	Financial Information	R	R	1		
12	040	TRN	Reassociation Trace Number	R	R	1		c1
	050	CUR	Foreign Currency Information	S	Not Used	1		c2
13	060	REF	Receiver Identification	S	S	1		
	060	REF	Version Identification	S	Not Used	1		
14	070	DTM	Production Date	S	S	1		c3
LOOP ID - 1000A							1	
15	080	N1	Payer Identification	R	R	1		
16	100	N3	Payer Address	R	R	1		
17	110	N4	Payer City, State, ZIP Code	R	R	1		
	120	REF	Additional Payer Identification	S	Not Used	4		
18	130	PER	Payer Contact Information	S	R	1		
LOOP ID - 1000B							1	
20	080	N1	Payee Identification	R	R	1		
22	100	N3	Payee Address	S	R	1		
23	110	N4	Payee City, State, ZIP Code	S	R	1		n1
24	120	REF	Payee Additional Identification	S	S	>1		

Detail:

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LOOP ID - 2000							>1	
26	003	LX	Header Number	S	S	1		
27	005	TS3	Provider Summary Information	S	S	1		
	007	TS2	Provider Supplemental Summary Information	S	Not Used	1		
LOOP ID - 2100							>1	
29	010	CLP	Claim Payment Information	R	R	1		
32	020	CAS	Claim Adjustment	S	S	99		
36	030	NM1	Patient Name	R	R	1		n2
	030	NM1	Insured Name	S	Not Used	1		n3
	030	NM1	Corrected Patient/Insured Name	S	Not Used	1		

38	030	NM1	Service Provider Name	S	S	1
	030	NM1	Crossover Carrier Name	S	Not Used	1
40	030	NM1	Corrected Priority Payer Name	S	S	2
42	033	MIA	Inpatient Adjudication Information	S	S	1
45	035	MOA	Outpatient Adjudication Information	S	S	1
47	040	REF	Other Claim Related Identification	S	S	5
48	040	REF	Rendering Provider Identification	S	S	10
49	050	DTM	Claim Date	S	S	2
	060	PER	Claim Contact Information	S	Not Used	3
50	062	AMT	Claim Supplemental Information	S	S	3
51	064	QTY	Claim Supplemental Information Quantity	S	S	4
LOOP ID - 2110						999
52	070	SVC	Service Payment Information	S	S	1
55	080	DTM	Service Date	S	S	1
56	090	CAS	Service Adjustment	S	S	99
60	100	REF	Service Identification	S	S	2
61	100	REF	Rendering Provider Information	S	S	2
	110	AMT	Service Supplemental Amount	S	Not Used	12
	120	QTY	Service Supplemental Quantity	S	Not Used	6
63	130	LQ	Health Care Remark Codes	S	S	99

Summary:

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64	010	PLB	Provider Adjustment	S	S	>1		
70	020	SE	Transaction Set Trailer	R	R	1		
71	030	GE	Functional Group Trailer	R	R	1		
72	040	IEA	Interchange Control Trailer	R	R	1		

Transaction Set Notes

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

Transaction Set Comments

1. The TRN segment is used to uniquely identify a claim payment and advice.
2. The CUR segment does not initiate a foreign exchange transaction.
3. The N1 loop allows for name/address information for the payer and payee which would be utilized to address remittance(s) for delivery.

Segment: **ISA** Interchange Control Header
Position: 013
Loop:
Level: Heading
Usage: Optional
Max Use: 1
Purpose: To start and identify an interchange of zero or more functional groups and interchange-related control segments

Syntax Notes:
Semantic Notes:
Comments:
Notes:

X12N HIPAA Notes

The ISA is a fixed record length segment and all positions within each of the data elements must be filled. The first element separator defines the element separator to be used through the entire interchange. The segment terminator used after the ISA defines the segment terminator to be used throughout the entire interchange. Spaces in the example are represented by "." for clarity.

X12N HIPAA Example

```
ISA*00*.....*01*SECRET...*ZZ*SUBMITTERS.ID..*ZZ*RECEIVERS.ID...*93060
2*1253*U*00401*000000905*1*T*::~
```

ODJFS User Note

```
ISA*00*.....*00*.....*ZZ*MMISODJFS.....*ZZ*EDI Trading Partner
ID*031016*1253*U*00401*000000001*0*T*::~
```

Data Element Summary

<u>Ref.</u> <u>Des.</u>	<u>Data</u> <u>Element</u>	<u>Name</u>	<u>Base</u> <u>Attributes</u>	<u>User</u> <u>Attributes</u>
ISA01	I01	Authorization Information Qualifier	M ID 2/2	R
		Code to identify the type of information in the Authorization Information		
		00 No Authorization Information Present (No Meaningful Information in I02)		
		X12N HIPAA Notes:		
		ADVISED UNLESS SECURITY REQUIREMENTS MANDATE USE OF ADDITIONAL IDENTIFICATION INFORMATION.		
ISA02	I02	Authorization Information	M AN 10/10	R
		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)		
		X12N HIPAA Notes:		
		This field should contain all spaces.		
ISA03	I03	Security Information Qualifier	M ID 2/2	R
		Code to identify the type of information in the Security Information		
		00 No Security Information Present (No Meaningful Information in I04)		
		X12N HIPAA Notes:		
		ADVISED UNLESS SECURITY REQUIREMENTS MANDATE USE OF PASSWORD DATA.		
ISA04	I04	Security Information	M AN 10/10	R
		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)		
		ODJFS User Note:		
		This field should contain all spaces.		
ISA05	I05	Interchange ID Qualifier	M ID 2/2	R
		Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified		
		X12N HIPAA Notes:		

		This ID qualifies the Sender in ISA06.		
		ZZ	Mutually Defined	
ISA06	I06	Interchange Sender ID	M AN 15/15	R
		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		
		ODJFS User Note:		
		This fields will contain the value MMISODJFS (Ohio Department of Job and Family Services). Since this is a fixed length field, it will be filled with spaces to meet the maximum length requirement of 15.		
ISA07	I05	Interchange ID Qualifier	M ID 2/2	R
		Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified		
		X12N HIPAA Notes:		
		This ID qualifies the Receiver in ISA08.		
		ZZ	Mutually Defined	
ISA08	I07	Interchange Receiver ID	M AN 15/15	R
		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		
		ODJFS User Note:		
		This field will contain the 7-digit EDI Trading Partner ID assigned to the receiver of this file by the Department. Since this is a fixed length field, it will be filled with spaces to meet the maximum length requirement of 15.		
ISA09	I08	Interchange Date	M DT 6/6	R
		Date of the interchange		
		X12N HIPAA Notes:		
		The date format is YYMMDD.		
ISA10	I09	Interchange Time	M TM 4/4	R
		Time of the interchange		
		X12N HIPAA Notes:		
		The time format is HHMM.		
ISA11	I10	Interchange Control Standards Identifier	M ID 1/1	R
		Code to identify the agency responsible for the control standard used by the message that is enclosed by the interchange header and trailer		
		U	U.S. EDI Community of ASC X12, TDCC, and UCS	
ISA12	I11	Interchange Control Version Number	M ID 5/5	R
		This version number covers the interchange control segments		
		00401	Draft Standards for Trial Use Approved for Publication by ASC X12 Procedures Review Board through October 1997	
ISA13	I12	Interchange Control Number	M N0 9/9	R
		A control number assigned by the interchange sender		
		X12N HIPAA Notes:		
		The Interchange Control Number, ISA13, must be identical to the associated Interchange Trailer IEA02.		
ISA14	I13	Acknowledgment Requested	M ID 1/1	R
		Code sent by the sender to request an interchange acknowledgment (TA1)		
		X12N HIPAA Notes:		
		See Section A.1.5.1 for interchange acknowledgment information.		
		ODJFS User Note:		
		ODJFS will not return an acknowledgment segment (TA1) for the ISA.		
		0	No Acknowledgment Requested	
ISA15	I14	Usage Indicator	M ID 1/1	R
		Code to indicate whether data enclosed by this interchange envelope is test, production or information		

P Production Data

T Test Data

ISA16

I15

Component Element Separator

M AN 1/1 R

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

Segment: **GS** Functional Group Header
Position: 015
Loop:
Level: Heading
Usage: Optional
Max Use: 1
Purpose: To indicate the beginning of a functional group and to provide control information
Syntax Notes:
Semantic Notes:

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

Comments:

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

Notes:

X12N HIPAA Example
GS*HP*SENDER CODE*RECEIVER CODE*19940331*0802*1*X*004010X091~

ODJFS User Note
GS*HP*MMISODJFS*EDI Trading Partner ID*20030826*0817*1*X*004010X091A1

Data Element Summary

Ref. Des.	Data Element	Name	Base Attributes	User Attributes
GS01	479	Functional Identifier Code Code identifying a group of application related transaction sets HP Health Care Claim Payment/Advice (835)	M ID 2/2	R
GS02	142	Application Sender's Code Code identifying party sending transmission; codes agreed to by trading partners X12N HIPAA Notes: Use this code to identify the unit sending the information. ODJFS User Note: This fields will contain the value MMISODJFS (Ohio Department of Job and Family Services).	M AN 2/15	R
GS03	124	Application Receiver's Code Code identifying party receiving transmission; codes agreed to by trading partners X12N HIPAA Notes: Use this code to identify the unit receiving the information. ODJFS User Note: This field will contain the 7-digit EDI Trading Partner ID assigned to the receiver of this file by the Department.	M AN 2/15	R
GS04	373	Date Date expressed as CCYYMMDD X12N HIPAA Notes: Use this date for the functional group creation date.	M DT 8/8	R
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) X12N HIPAA Notes: Use this time for the creation time. The recommended format is HHMM.	M TM 4/8	R
GS06	28	Group Control Number Assigned number originated and maintained by the sender	M N0 1/9	R
GS07	455	Responsible Agency Code Code used in conjunction with Data Element 480 to identify the issuer of the standard	M ID 1/2	R

Segment: **ST** Transaction Set Header
Position: 010
Loop:
Level: Heading
Usage: Mandatory
Max Use: 1
Purpose: To indicate the start of a transaction set and to assign a control number
Syntax Notes:
Semantic Notes: 1 The transaction set identifier (ST01) is used by the translation routines of the interchange partners to select the appropriate transaction set definition (e.g., 810 selects the Invoice Transaction Set).
Comments:
Notes: **X12N HIPAA Example**
Example: ST*835*1234~

Data Element Summary

<u>Ref.</u>	<u>Data</u>		<u>Base</u>	<u>User</u>
<u>Des.</u>	<u>Element</u>	<u>Name</u>	<u>Attributes</u>	<u>Attributes</u>
ST01	143	Transaction Set Identifier Code	M ID 3/3	R
		Code uniquely identifying a Transaction Set		
		X12N HIPAA Notes:		
		The only valid value within this transaction set for ST01 is 835.		
		INDUSTRY: Transaction Set Identifier Code		
		835 Health Care Claim Payment/Advice		
ST02	329	Transaction Set Control Number	M AN 4/9	R
		Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set		
		X12N HIPAA Notes:		
		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.		
		INDUSTRY: Transaction Set Control Number		

Segment: **BPR** Financial Information
Position: 020
Loop:
Level: Heading
Usage: 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 Notes:**
- 1 If either BPR06 or BPR07 is present, then the other is required.
 - 2 If BPR08 is present, then BPR09 is required.
 - 3 If either BPR12 or BPR13 is present, then the other is required.
 - 4 If BPR14 is present, then BPR15 is required.
 - 5 If either BPR18 or BPR19 is present, then the other is required.
 - 6 If BPR20 is present, then BPR21 is required.

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

Comments:
Notes:

X12N HIPAA Notes

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.

X12N HIPAA Example

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

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
BPR01	305	Transaction Handling Code Code designating the action to be taken by all parties X12N HIPAA Notes: INDUSTRY: Transaction Handling Code	M ID 1/2	R
		I Remittance Information Only X12N HIPAA Notes: Use this code to indicate to the payee that the remittance detail is moving separately from the payment.		
BPR02	782	Monetary Amount Monetary amount X12N HIPAA Notes: 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.	M R 1/10	R

INDUSTRY: Total Actual Provider Payment Amount

ODJFS User Note:

Reimbursement Amount; sum of all claims.

BPR03 478 Credit/Debit Flag Code M ID 1/1 R

Code indicating whether amount is a credit or debit

X12N HIPAA Notes:

INDUSTRY: Credit or Debit Flag Code

C Credit

X12N HIPAA Notes:

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

BPR04 591 Payment Method Code M ID 3/3 R

Code identifying the method for the movement of payment instructions

X12N HIPAA Notes:

INDUSTRY: Payment Method Code

ODJFS User Note:

The Ohio Department of Job and Family Services will continue to use the existing methodology for EFT. The Ohio Department of Job and Family Services is not using the 835 transaction for electronic funds transfer therefore CHK is used.

CHK Check

X12N HIPAA Notes:

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

BPR05 812 Payment Format Code O ID 1/10 N/U

CCP Cash Concentration/Disbursement plus Addenda (CCD+) (ACH)

CTX Corporate Trade Exchange (CTX) (ACH)

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

01 ABA Transit Routing Number Including Check Digits (9 digits)

04 Canadian Bank Branch and Institution Number

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

BPR08 569 Account Number Qualifier O ID 1/3 N/U

DA Demand Deposit

BPR09 508 Account Number X AN 1/35 N/U

BPR10 509 Originating Company Identifier O AN 10/10 N/U

BPR11 510 Originating Company Supplemental Code O AN 9/9 N/U

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

01 ABA Transit Routing Number Including Check Digits (9 digits)

04 Canadian Bank Branch and Institution Number

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

BPR14 569 Account Number Qualifier O ID 1/3 N/U

DA Demand Deposit

SG Savings

BPR15 508 Account Number X AN 1/35 N/U

BPR16 373 Date O DT 8/8 R

Date expressed as CCYYMMDD

X12N HIPAA Notes:

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.

INDUSTRY: Check Issue or EFT Effective Date

ODJFS User Note:

Date Paid

Segment: **TRN** Reassociation Trace Number
Position: 040
Loop:
Level: Heading
Usage: Optional (Must Use)
Max Use: 1
Purpose: To uniquely identify a transaction to an application
Syntax Notes:
Semantic Notes:

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

Comments:
Notes:

X12N HIPAA Notes

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

X12N HIPAA Example

Example: TRN*1*12345*1512345678*19999999~

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
TRN01	481	Trace Type Code Code identifying which transaction is being referenced X12N HIPAA Notes: INDUSTRY: Trace Type Code 1 Current Transaction Trace Numbers	M ID 1/2	R
TRN02	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier X12N HIPAA Notes: 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. INDUSTRY: Check or EFT Trace Number ODJFS User Note: Combination of 2 fields: Remittance/Advice Number + Warrant Number	M AN 1/30	R
TRN03	509	Originating Company Identifier 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 X12N HIPAA Notes: TRN03 must contain the Federal Tax ID Number, preceded by a "1." When BPR10 is used, it must be identical to TRN03. INDUSTRY: Payer Identifier ODJFS User Note: Value = 1 followed by the ODJFS Tax ID Number	O AN 10/10	R

Segment: **REF** Receiver Identification
Position: 060
Loop:
Level: Heading
Usage: Optional
Max Use: 1
Purpose: To specify identifying information
Syntax Notes:
Semantic Notes: 1 REF04 contains data relating to the value cited in REF02.
Comments:
Notes:

X12N HIPAA Notes

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

X12N HIPAA Example

Example: REF*EV*1235678~

Data Element Summary

<u>Ref.</u>	<u>Data</u>	<u>Name</u>	<u>Base</u>	<u>User</u>
<u>Des.</u>	<u>Element</u>		<u>Attributes</u>	<u>Attributes</u>
REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification	M ID 2/3	R
		X12N HIPAA Notes: INDUSTRY: Reference Identification Qualifier		
		EV Receiver Identification Number A unique number identifying the organization/site location designated to receive the current transmitted transaction set		
REF02	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	O AN 1/30	R
		X12N HIPAA Notes: ALIAS: Receiver Identification		
		INDUSTRY: Receiver Identifier		
		ODJFS User Note: Receiver 7-digit Trading Partner ID		

Segment: **DTM** Production Date
Position: 070
Loop:
Level: Heading
Usage: Optional (Recommended)
Max Use: 1
Purpose: To specify pertinent dates and times
Syntax Notes:
Semantic Notes:
Comments:
Notes:

X12N HIPAA Notes

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

X12N HIPAA Example

Example: DTM*405*19960317~

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
DTM01	374	Date/Time Qualifier Code specifying type of date or time, or both date and time	M ID 3/3	R
X12N HIPAA Notes:				
INDUSTRY: Date Time Qualifier				
		405 Production		
		Used to identify dates and times that operations or processes were performed		
X12N HIPAA Notes:				
Use this code for the end date for the adjudication production cycle for claims included in this 835.				
DTM02	373	Date Date expressed as CCYYMMDD	O DT 8/8	R
X12N HIPAA Notes:				
INDUSTRY: Production Date				
ODJFS User Note:				
Cut-off date				
Used for the end date of the adjudication production cycle for the claims included in this 835.				

Segment: **N1 Payer Identification**
Position: 080
Loop: 1000A Optional (Must Use)
Level: Heading
Usage: Optional (Must Use)
Max Use: 1
Purpose: To identify a party by type of organization, name, and code
Syntax Notes: 1 At least one of N102 or N103 is required.
2 If either N103 or N104 is present, then the other is required.

Semantic Notes:
Comments: 1 This segment, used alone, provides the most efficient method of providing organizational identification. To obtain this efficiency the "ID Code" (N104) must provide a key to the table maintained by the transaction processing party.

Notes: **X12N HIPAA Notes**
Use this N1 loop to provide the name/address information for the payer. The payer's secondary identifying reference number should be provided in N104, if necessary.
X12N HIPAA Example
Example: N1*PR*INSURANCE COMPANY OF TIMBUCKTU*XV*88888888~

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
N101	98	Entity Identifier Code Code identifying an organizational entity, a physical location, property or an individual X12N HIPAA Notes: INDUSTRY: Entity Identifier Code PR Payer	M ID 2/3	R
N102	93	Name Free-form name X12N HIPAA Notes: Required if the National PlanID is not transmitted in N104. INDUSTRY: Payer Name ODJFS User Note: Ohio Department of Job and Family Services	X AN 1/60	S AN 1/50
N103	66	Identification Code Qualifier Code designating the system/method of code structure used for Identification Code (67) X12N HIPAA Notes: Required if the National PlanID is transmitted in N104. INDUSTRY: Identification Code Qualifier XV Health Care Financing Administration National Payer Identification Number (PAYERID) X12N HIPAA Notes: Required if the National PlanID is mandated for use.	X ID 1/2	S
N104	67	Identification Code Code identifying a party or other code X12N HIPAA Notes: Required if the National PlanID is mandated for use. INDUSTRY: Payer Identifier	X AN 2/80	S AN 2/20

Segment: N3 Payer Address
Position: 100
Loop: 1000A Optional (Must Use)
Level: Heading
Usage: Optional (Must Use)
Max Use: 1
Purpose: To specify the location of the named party
Syntax Notes:
Semantic Notes:
Comments:
Notes: X12N HIPAA Example

Example: N3*100 MAIN STREET~

Data Element Summary

Ref. Des.	Data Element	Name	Base Attributes		User Attributes	
			M	AN 1/55	R	AN 1/20
N301	166	Address Information Address information X12N HIPAA Notes: INDUSTRY: Payer Address Line ODJFS User Note: 30 E. Broad St.	M	AN 1/55	R	AN 1/20
N302	166	Address Information Address information X12N HIPAA Notes: Required if a second address line exists. INDUSTRY: Payer Address Line ODJFS User Note: 31st Floor	O	AN 1/55	S	AN 1/15

Segment: **N4** Payer City, State, ZIP Code
Position: 110
Loop: 1000A Optional (Must Use)
Level: Heading
Usage: Optional (Must Use)
Max Use: 1
Purpose: To specify the geographic place of the named party
Syntax Notes:
Semantic Notes:
Comments: 1 N402 is required only if city name (N401) is in the U.S. or Canada.
Notes: **X12N HIPAA Example**
 Example: N4*KANSAS CITY*MO*64108~

Data Element Summary

<u>Ref.</u>	<u>Data</u>	<u>Name</u>	<u>Base</u>	<u>User</u>
<u>Des.</u>	<u>Element</u>		<u>Attributes</u>	<u>Attributes</u>
N401	19	City Name Free-form text for city name X12N HIPAA Notes: INDUSTRY: Payer City Name ODJFS User Note: Columbus	O AN 2/30	R AN 2/8
N402	156	State or Province Code Code (Standard State/Province) as defined by appropriate government agency X12N HIPAA Notes: INDUSTRY: Payer State Code ODJFS User Note: OH	O ID 2/2	R
N403	116	Postal Code Code defining international postal zone code excluding punctuation and blanks (zip code for United States) X12N HIPAA Notes: INDUSTRY: Payer Postal Zone or ZIP Code ODJFS User Note: 43215-3414	O ID 3/15	R

Segment: **PER** Payer Contact Information
Position: 130
Loop: 1000A Optional (Must Use)
Level: Heading
Usage: Optional (Must Use)
Max Use: 1
Purpose: To identify a person or office to whom administrative communications should be directed
Syntax Notes:

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

Semantic Notes:

Comments:

Notes:

X12N HIPAA Notes

This should be used anytime the PAYEE can not be reasonably expected to know how to contact the Payer about this remittance advice.

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.

By definition of the standard, if PER03 is used, PER04 is required.

X12N HIPAA Example

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

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
PER01	366	Contact Function Code Code identifying the major duty or responsibility of the person or group named X12N HIPAA Notes: INDUSTRY: Contact Function Code CX Payers Claim Office Location responsible for paying bills related to medical care received	M ID 2/2	R
PER02	93	Name Free-form name X12N HIPAA Notes: 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). INDUSTRY: Payer Contact Name ODJFS User Note: Provider Call Service Center	O AN 1/60	R AN 1/35
PER03	365	Communication Number Qualifier Code identifying the type of communication number X12N HIPAA Notes: Required if a contact communications number is to be transmitted. INDUSTRY: Communication Number Qualifier TE Telephone	X ID 2/2	R

PER04	364	Communication Number	X AN 1/80 R AN 1/10
		Complete communications number including country or area code when applicable	
		X12N HIPAA Notes:	
		Required if a contact communications number is to be transmitted.	
		INDUSTRY: Payer Contact Communication Number	
		ODJFS User Note:	
		In-state telephone number: 8006861516	
PER05	365	Communication Number Qualifier	X ID 2/2 R
		Code identifying the type of communication number	
		X12N HIPAA Notes:	
		Required if a contact communications number is to be transmitted.	
		INDUSTRY: Communication Number Qualifier	
		TE Telephone	
PER06	364	Communication Number	X AN 1/80 R AN 1/10
		Complete communications number including country or area code when applicable	
		X12N HIPAA Notes:	
		Required if a contact communications number is to be transmitted.	
		INDUSTRY: Payer Contact Communication Number	
		ODJFS User Note:	
		Out-of-state telephone number: 6147283288	

Segment: **N1 Payee Identification**
Position: 080
Loop: 1000B Optional (Must Use)
Level: Heading
Usage: Optional (Must Use)
Max Use: 1
Purpose: To identify a party by type of organization, name, and code
Syntax Notes: 1 At least one of N102 or N103 is required.
2 If either N103 or N104 is present, then the other is required.
Semantic Notes:
Comments: 1 This segment, used alone, provides the most efficient method of providing organizational identification. To obtain this efficiency the "ID Code" (N104) must provide a key to the table maintained by the transaction processing party.
Notes: **X12N HIPAA Notes**

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

X12N HIPAA Example

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

ODJFS User Note

ODJFS will have an NPI dual identifier period similar to Medicare. This dual identifier period will extend until December 31, 2007. ODJFS will send both the Medicaid legacy Provider ID and the National Provider Identifier that were received on the 837 transaction in the 1000B N1 loop. The NPI information being sent is not necessarily the information that was disclosed to ODJFS; there is no edit against the disclosed information in our provider master file at this time. Providers and Trading Partners will be notified in the event ODJFS believes the dual identification period can end sooner than December 31, 2007, or needs to be extended to the CMS approved date of May 23, 2008.

For Typical providers, ODJFS will send the NPI with the XX qualifier in the N103 and the NPI in the N104. Typical Providers will receive their EIN or SSN in the REF segment of this loop.

For Atypical providers with no NPI, ODJFS will send the EIN or SSN in the N104 element and the Medicaid legacy Provider ID in the REF segment of this loop.

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
N101	98	Entity Identifier Code	M ID 2/3	R
		Code identifying an organizational entity, a physical location, property or an individual		
		X12N HIPAA Notes:		
		INDUSTRY: Entity Identifier Code		
		PE Payee		
N102	93	Name	X AN 1/60	S
		Free-form name		
		X12N HIPAA Notes:		
		Required when N104 does not contain the National Provider Identifier.		
		INDUSTRY: Payee Name		
N103	66	Identification Code Qualifier	X ID 1/2	R
		Code designating the system/method of code structure used for Identification Code (67)		
		X12N HIPAA Notes:		
		Required when N104 does not contain the National Provider Identifier.		
		INDUSTRY: Identification Code Qualifier		
		ODJFS User Note:		
		For Typical providers, ODJFS will send the XX qualifier for the NPI in the N103.		

For Atypical providers with no NPI, ODJFS will send the FI qualifier for the EIN or the SSN in the N103.

FI Federal Taxpayer's Identification Number

X12N HIPAA Notes:

For individual providers as payees, use this number to represent the Social Security Number.

XX Health Care Financing Administration National Provider Identifier

N104

67

Identification Code

X AN 2/80 R AN 2/10

Code identifying a party or other code

X12N HIPAA Notes:

INDUSTRY: Payee Identification Code

ODJFS User Note:

For Typical providers, ODJFS will send the NPI in the N104. Typical Providers will receive their EIN or SSN in the 1000B REF02.

Atypical Providers with no NPI will receive their EIN or SSN in the N104.

Segment: **N3** Payee Address
Position: 100
Loop: 1000B Optional (Must Use)
Level: Heading
Usage: Optional (Must Use)
Max Use: 1
Purpose: To specify the location of the named party
Syntax Notes:
Semantic Notes:
Comments:
Notes:

X12N HIPAA Notes

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).

ODJFS Application Notes

This information is derived from the ODJFS MMIS Provider Master File.

X12N HIPAA Example

Example: N3*Suite 200*1000 Main Street~

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
N301	166	Address Information Address information X12N HIPAA Notes: INDUSTRY: Payee Address Line	M AN 1/55	R
N302	166	Address Information Address information X12N HIPAA Notes: Required if a second address line exists. INDUSTRY: Payee Address Line	O AN 1/55	S

Segment: **N4** Payee City, State, ZIP Code
Position: 110
Loop: 1000B Optional (Must Use)
Level: Heading
Usage: Optional (Must Use)
Max Use: 1
Purpose: To specify the geographic place of the named party
Syntax Notes:
Semantic Notes:
Comments: 1 N402 is required only if city name (N401) is in the U.S. or Canada.
Notes: **X12N HIPAA Notes**
 Using this segment is at the discretion of the payer contingent on the business needs of the payee (receiver).
X12N HIPAA Example
 Example: N4*Beverly Hills*CA*90210~

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
N401	19	City Name Free-form text for city name X12N HIPAA Notes: INDUSTRY: Payee City Name	O AN 2/30	R
N402	156	State or Province Code Code (Standard State/Province) as defined by appropriate government agency X12N HIPAA Notes: INDUSTRY: Payee State Code	O ID 2/2	R
N403	116	Postal Code Code defining international postal zone code excluding punctuation and blanks (zip code for United States) X12N HIPAA Notes: INDUSTRY: Payee Postal Zone or ZIP Code	O ID 3/15	R
N404	26	Country Code Code identifying the country X12N HIPAA Notes: Required if country is other than USA. INDUSTRY: Country Code	O ID 2/3	S

Segment: **REF** Payee Additional Identification
Position: 120
Loop: 1000B Optional (Must Use)
Level: Heading
Usage: Optional
Max Use: >1
Purpose: To specify identifying information
Syntax Notes:
Semantic Notes: 1 REF04 contains data relating to the value cited in REF02.
Comments:
Notes:

X12N HIPAA Notes

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

X12N HIPAA Example

Example: REF*PQ*12345678~

ODJFS User Note

ODJFS will have an NPI dual identifier period similar to Medicare. This dual identifier period will extend until December 31, 2007. ODJFS will send both the Medicaid legacy Provider ID and the National Provider Identifier that were received on the 837 transaction. The NPI information being sent is not necessarily the information that was disclosed to ODJFS; there is no edit against the disclosed information in our provider master file at this time. Providers and Trading Partners will be notified in the event ODJFS believes the dual identification period can end sooner than December 31, 2007, or needs to be extended to the CMS approved date of May 23, 2008.

For Typical providers, ODJFS will send the EIN or SSN in the 1000B REF segment.

During the dual identifier period, for Typical providers, ODJFS will also send an occurrence of the 1000B REF for the Medicaid legacy Provider ID.

For Atypical providers with no NPI, ODJFS will send the EIN or SSN in the N104 element and the Medicaid legacy Provider Identifier in the 1000B REF segment.

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
REF01	128	Reference Identification Qualifier	M ID 2/3	R

Code qualifying the Reference Identification

X12N HIPAA Notes:

INDUSTRY: Reference Identification Qualifier

ODJFS User Note:

For Typical providers, ODJFS will send the TJ qualifier for the EIN or the SSN.

During the dual identifier period, for Typical providers, ODJFS will also send the 1D qualifier for the Medicaid legacy Provider ID.

For Atypical providers with no NPI, ODJFS will send the 1D qualifier for the Medicaid legacy Provider ID.

ID Medicaid Provider Number

X12N HIPAA Notes:

NOT ADVISED

TJ Federal Taxpayer's Identification Number

X12N HIPAA Notes:

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.

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

X12N HIPAA Notes:

INDUSTRY: Additional Payee Identifier

ODJFS User Note:

For Typical providers, ODJFS will send the EIN or the SSN.

During the dual identifier period, for Typical providers, ODJFS will also send the Medicaid legacy Provider ID.

For Atypical providers with no NPI, ODJFS will send the Medicaid legacy Provider ID.

Segment: **LX** Header Number
Position: 003
Loop: 2000 Optional
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To reference a line number in a transaction set
Syntax Notes:
Semantic Notes:
Comments:
Notes:

X12N HIPAA Notes

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.

Any Table 2 data must commence with an LX segment. Multiple sorts are accomplished through multiple LX loops.

For Medicare Part A, write/read the LX segment once for each provider's fiscal period end year and month/type of bill summary break in the file (TTYMM in LX01). For Medicare Part B, write/read the LX segment once for unassigned claims using the value of "zero" and once for assigned claims using the value of "one".

X12N HIPAA Example

Example: LX*1~

LX*961011~

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
LX01	554	Assigned Number	M N0 1/6	R

Number assigned for differentiation within a transaction set

X12N HIPAA Notes:

INDUSTRY: Assigned Number

ODJFS User Note:

Claim Input Form Indicator	LX01 Value	Description
A	21	Transportation
C	02	Capitation (HMO)
D	05	Credit Finder
E	08	EPSDT
F	17	Medicare Part B Crossover
G	14	Medical Supply
H	10	Home Health
I	06	Dental
J	13	Independent Lab
K	22	Vision
L	19	Physician
M	20	Prior Authorization
N	18	Nursing Home
O	12	Outpatient Hospital
P	11	Inpatient Hospital
Q	03	Clinic
R	07	Drug/Pharmacy
U	15	Inpatient Crossover
W	16	Outpatient Crossover
X	09	Gross Adjustment
Y	01	Adjustment
Z	04	Credit

Segment: **TS3** **Provider Summary Information**
Position: 005
Loop: 2000 Optional
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To supply provider-level control information
Syntax Notes:
Semantic Notes:

- 1 TS301 is the provider number.
- 2 TS303 is the last day of the provider's fiscal year.
- 3 TS304 is the total number of claims.
- 4 TS305 is the total of reported charges.
- 5 TS310 is the total amount of interest paid.

Comments:
Notes:

X12N HIPAA Notes

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.

When available, use the National Provider ID in TS301.

All situational quantities and amounts in this segment are required when the value of the item is different than zero.

X12N HIPAA Example

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

ODJFS User Note

ODJFS will have an NPI dual identifier period similar to Medicare. This dual identifier period will extend until December 31, 2007. ODJFS will send the National Provider Identifier that was received on the 837 transaction. The NPI information being sent is not necessarily the information that was disclosed to ODJFS; there is no edit against the disclosed information in our provider master file at this time. Providers and Trading Partners will be notified in the event ODJFS believes the dual identification period can end sooner than December 31, 2007, or needs to be extended to the CMS approved date of May 23, 2008.

For Typical providers, ODJFS will send the NPI.

For Atypical providers with no NPI, ODJFS will send the Medicaid legacy Provider ID.

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
TS301	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier X12N HIPAA Notes: Use this number for the provider number. INDUSTRY: Provider Identifier ODJFS User Note: For Typical providers, ODJFS will send the NPI. For Atypical providers with no NPI, ODJFS will send the Medicaid legacy Provider ID.	M AN 1/30	R AN 1/11
TS302	1331	Facility Code Value	M AN 1/2	R

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

X12N HIPAA Notes:

INDUSTRY: Facility Type Code

ODJFS User Note:

For Professional and Dental Claims, this is the Place of Service
For Institutional Claims, this is the Type of Bill

TS303 373 Date M DT 8/8 R

Date expressed as CCYYMMDD

X12N HIPAA Notes:

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.

INDUSTRY: Fiscal Period Date

TS304 380 Quantity M R 1/15 R

Numeric value of quantity

X12N HIPAA Notes:

Use this number for the total number of claims.

INDUSTRY: Total Claim Count

TS305 782 Monetary Amount M R 1/10 R

Monetary amount

X12N HIPAA Notes:

Use this monetary amount for the total reported charges for all claims.

INDUSTRY: Total Claim Charge Amount

Segment: **CLP** Claim Payment Information
Position: 010
Loop: 2100 Mandatory
Level: Detail
Usage: Mandatory
Max Use: 1
Purpose: To supply information common to all services of a claim
Syntax Notes:
Semantic Notes:

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

Comments:

Notes: **X12N HIPAA Example**

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

Data Element Summary

<u>Ref.</u>	<u>Data</u>	<u>Name</u>	<u>Base</u>	<u>User</u>
<u>Des.</u>	<u>Element</u>		<u>Attributes</u>	<u>Attributes</u>
CLP01	1028	Claim Submitter's Identifier	M AN 1/38	R AN 1/20
		Identifier used to track a claim from creation by the health care provider through payment		
		X12N HIPAA Notes:		
		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.		
		INDUSTRY: Patient Control Number		
CLP02	1029	Claim Status Code	M ID 1/2	R
		Code identifying the status of an entire claim as assigned by the payor, claim review organization or repricing organization		
		X12N HIPAA Notes:		
		INDUSTRY: Claim Status Code		
		1 Processed as Primary		
		2 Processed as Secondary		
		3 Processed as Tertiary		
		4 Denied		
		22 Reversal of Previous Payment		
CLP03	782	Monetary Amount	M R 1/10	R
		Monetary amount		
		X12N HIPAA Notes:		
		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.		
		INDUSTRY: Total Claim Charge Amount		
CLP04	782	Monetary Amount	M R 1/10	R
		Monetary amount		
		X12N HIPAA Notes:		
		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.

CLP05 782 Monetary Amount O R 1/10 Rec

Monetary amount

X12N HIPAA Notes:

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.

INDUSTRY: Patient Responsibility Amount

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

Code identifying type of claim

X12N HIPAA Notes:

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.

INDUSTRY: Claim Filing Indicator Code

- 16 Health Maintenance Organization (HMO) Medicare Risk
- MA Medicare Part A
- MB Medicare Part B
- MC Medicaid

CLP07 127 Reference Identification O AN 1/30 Rec

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

X12N HIPAA Notes:

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.

INDUSTRY: Payer Claim Control Number

ODJFS User Note:

ODJFS Transaction Control Number (TCN)

CLP08 1331 Facility Code Value O AN 1/2 S

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

X12N HIPAA Notes:

State the facility code here when the submitted code has been modified through

Segment: **CAS** Claim Adjustment

Position: 020

Loop: 2100 Mandatory

Level: Detail

Usage: 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

- Syntax Notes:**
- 1 If CAS05 is present, then at least one of CAS06 or CAS07 is required.
 - 2 If CAS06 is present, then CAS05 is required.
 - 3 If CAS07 is present, then CAS05 is required.
 - 4 If CAS08 is present, then at least one of CAS09 or CAS10 is required.
 - 5 If CAS09 is present, then CAS08 is required.
 - 6 If CAS10 is present, then CAS08 is required.
 - 7 If CAS11 is present, then at least one of CAS12 or CAS13 is required.
 - 8 If CAS12 is present, then CAS11 is required.
 - 9 If CAS13 is present, then CAS11 is required.
 - 10 If CAS14 is present, then at least one of CAS15 or CAS16 is required.
 - 11 If CAS15 is present, then CAS14 is required.
 - 12 If CAS16 is present, then CAS14 is required.
 - 13 If CAS17 is present, then at least one of CAS18 or CAS19 is required.
 - 14 If CAS18 is present, then CAS17 is required.
 - 15 If CAS19 is present, then CAS17 is required.

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

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

Notes: **X12N HIPAA Notes**

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.

See the SVC segment note #2 for details about per diem adjustments.

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).

X12N HIPAA Example

Example: CAS*PR*1*793~

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
CAS01	1033	Claim Adjustment Group Code Code identifying the general category of payment adjustment X12N HIPAA Notes: 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.) INDUSTRY: Claim Adjustment Group Code	M ID 1/2	R
		CO Contractual Obligations X12N HIPAA Notes: Use this code when a joint payer/payee contractual agreement or a regulatory requirement resulted in an adjustment.		
		CR Correction and Reversals X12N HIPAA Notes: 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 X12N HIPAA Notes: 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		
CAS02	1034	Claim Adjustment Reason Code Code identifying the detailed reason the adjustment was made X12N HIPAA Notes: INDUSTRY: Adjustment Reason Code	M ID 1/5	R
CAS03	782	Monetary Amount Monetary amount X12N HIPAA Notes: Use this monetary amount for the adjustment amount. A negative amount increases the payment, and a positive amount decreases the payment contained in CLP04. INDUSTRY: Adjustment Amount	M R 1/10	R
CAS04	380	Quantity Numeric value of quantity X12N HIPAA Notes: 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. INDUSTRY: Adjustment Quantity	O R 1/15	S
CAS05	1034	Claim Adjustment Reason Code Code identifying the detailed reason the adjustment was made X12N HIPAA Notes: Used when additional adjustments apply within the group identified in CAS01. INDUSTRY: Adjustment Reason Code	X ID 1/5	S
CAS06	782	Monetary Amount	X R 1/10	S

Monetary amount

X12N HIPAA Notes:

See CAS03.

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

INDUSTRY: Adjustment Amount

CAS07 380 Quantity X R 1/15 S

Numeric value of quantity

X12N HIPAA Notes:

See CAS04.

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

INDUSTRY: Adjustment Quantity

CAS08 1034 Claim Adjustment Reason Code X ID 1/5 S

Code identifying the detailed reason the adjustment was made

X12N HIPAA Notes:

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

INDUSTRY: Adjustment Reason Code

CAS09 782 Monetary Amount X R 1/10 S

Monetary amount

X12N HIPAA Notes:

See CAS03.

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

INDUSTRY: Adjustment Amount

CAS10 380 Quantity X R 1/15 S

Numeric value of quantity

X12N HIPAA Notes:

See CAS04.

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

INDUSTRY: Adjustment Quantity

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

Code identifying the detailed reason the adjustment was made

X12N HIPAA Notes:

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

INDUSTRY: Adjustment Reason Code

CAS12 782 Monetary Amount X R 1/10 S

Monetary amount

X12N HIPAA Notes:

See CAS03.

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

INDUSTRY: Adjustment Amount

CAS13 380 Quantity X R 1/15 S

Numeric value of quantity

X12N HIPAA Notes:

See CAS04.

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

CAS14	1034	INDUSTRY: Adjustment Quantity			
		Claim Adjustment Reason Code	X	ID 1/5	S
		Code identifying the detailed reason the adjustment was made			
		X12N HIPAA Notes: Used when additional adjustments apply within the group identified in CAS01.			
CAS15	782	INDUSTRY: Adjustment Reason Code			
		Monetary Amount	X	R 1/10	S
		Monetary amount			
		X12N HIPAA Notes: See CAS03. Used when additional adjustments apply within the group identified in CAS01.			
CAS16	380	INDUSTRY: Adjustment Amount			
		Quantity	X	R 1/15	S
		Numeric value of quantity			
		X12N HIPAA Notes: See CAS04. Used when additional adjustments apply within the group identified in CAS01.			
CAS17	1034	INDUSTRY: Adjustment Quantity			
		Claim Adjustment Reason Code	X	ID 1/5	S
		Code identifying the detailed reason the adjustment was made			
		X12N HIPAA Notes: Used when additional adjustments apply within the group identified in CAS01.			
CAS18	782	INDUSTRY: Adjustment Reason Code			
		Monetary Amount	X	R 1/10	S
		Monetary amount			
		X12N HIPAA Notes: See CAS03. Used when additional adjustments apply within the group identified in CAS01.			
CAS19	380	INDUSTRY: Adjustment Amount			
		Quantity	X	R 1/15	S
		Numeric value of quantity			
		X12N HIPAA Notes: See CAS04. Used when additional adjustments apply within the group identified in CAS01. INDUSTRY: Adjustment Quantity			

Segment: **NM1 Patient Name**
Position: 030
Loop: 2100 Mandatory
Level: Detail
Usage: Mandatory
Max Use: 1
Purpose: To supply the full name of an individual or organizational entity
Syntax Notes: 1 If either NM108 or NM109 is present, then the other is required.
Semantic Notes: 1 NM102 qualifies NM103.
Comments:
Notes:

X12N HIPAA Notes

Provide the patient's identification number in NM109.

ODJFS Application Notes

Same as shown on RMF.

X12N HIPAA Example

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

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
NM101	98	Entity Identifier Code Code identifying an organizational entity, a physical location, property or an individual X12N HIPAA Notes: INDUSTRY: Entity Identifier Code QC Patient Individual receiving medical care	M ID 2/3	R
NM102	1065	Entity Type Qualifier Code qualifying the type of entity X12N HIPAA Notes: INDUSTRY: Entity Type Qualifier 1 Person	M ID 1/1	R
NM103	1035	Name Last or Organization Name Individual last name or organizational name X12N HIPAA Notes: INDUSTRY: Patient Last Name	O AN 1/35	R
NM104	1036	Name First Individual first name X12N HIPAA Notes: INDUSTRY: Patient First Name	O AN 1/25	R
NM105	1037	Name Middle Individual middle name or initial X12N HIPAA Notes: 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. INDUSTRY: Patient Middle Name	O AN 1/25	S
NM106	1038	Name Prefix	O AN 1/10	N/U
NM107	1039	Name Suffix	O AN 1/10	N/U
NM108	66	Identification Code Qualifier Code designating the system/method of code structure used for Identification Code (67) X12N HIPAA Notes:	X ID 1/2	S

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

INDUSTRY: Identification Code Qualifier

MI Member Identification Number

NM109

67

Identification Code

X AN 2/80 S AN 12/12

Code identifying a party or other code

X12N HIPAA Notes:

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

INDUSTRY: Patient Identifier

ODJFS User Note:

12-digit Medicaid Recipient ID

Segment: **NM1** Service Provider Name
Position: 030
Loop: 2100 Mandatory
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To supply the full name of an individual or organizational entity
Syntax Notes: 1 If either NM108 or NM109 is present, then the other is required.
Semantic Notes: 1 NM102 qualifies NM103.
Comments:
Notes:

X12N HIPAA Notes

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.

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.

X12N HIPAA Example

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

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
NM101	98	Entity Identifier Code Code identifying an organizational entity, a physical location, property or an individual X12N HIPAA Notes: INDUSTRY: Entity Identifier Code	M ID 2/3	R
		82 Rendering Provider		
NM102	1065	Entity Type Qualifier Code qualifying the type of entity X12N HIPAA Notes: INDUSTRY: Entity Type Qualifier	M ID 1/1	R
		1 Person		
		2 Non-Person Entity		
NM103	1035	Name Last or Organization Name	O AN 1/35	N/U
NM104	1036	Name First	O AN 1/25	N/U
NM105	1037	Name Middle	O AN 1/25	N/U
NM106	1038	Name Prefix	O AN 1/10	N/U
NM107	1039	Name Suffix	O AN 1/10	N/U
NM108	66	Identification Code Qualifier Code designating the system/method of code structure used for Identification Code (67) X12N HIPAA Notes: INDUSTRY: Identification Code Qualifier	X ID 1/2	R
		MC Medicaid Provider Number Number assigned to a health care provider for submitting claims covered by Medicaid benefits		
		XX Health Care Financing Administration National Provider Identifier X12N HIPAA Notes: ADVISED ODJFS User Note: Future Use		
NM109	67	Identification Code Code identifying a party or other code	X AN 2/80	R AN 7/7

X12N HIPAA Notes:

INDUSTRY: Rendering Provider Identifier

ODJFS User Note:

For Typical providers, ODJFS will send the NPI.

For Atypical providers with no NPI, ODJFS will send the Medicaid legacy Provider ID.

Segment: **NM1** Corrected Priority Payer Name
Position: 030
Loop: 2100 Mandatory
Level: Detail
Usage: Optional
Max Use: 2
Purpose: To supply the full name of an individual or organizational entity
Syntax Notes: 1 If either NM108 or NM109 is present, then the other is required.
Semantic Notes: 1 NM102 qualifies NM103.
Comments:
Notes:

X12N HIPAA Notes

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.

X12N HIPAA Example

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

ODJFS User Note

An Other Payer (TPL) NM101= PR is used only if the recipient has third party insurance coverage and the claim is denied because of this coverage.

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
NM101	98	Entity Identifier Code Code identifying an organizational entity, a physical location, property or an individual X12N HIPAA Notes: INDUSTRY: Entity Identifier Code PR Payer ODJFS User Note: Other Payer	M ID 2/3	R
NM102	1065	Entity Type Qualifier Code qualifying the type of entity X12N HIPAA Notes: INDUSTRY: Entity Type Qualifier 2 Non-Person Entity	M ID 1/1	R
NM103	1035	Name Last or Organization Name Individual last name or organizational name X12N HIPAA Notes: INDUSTRY: Corrected Priority Payer Name	O AN 1/35	R
NM104	1036	Name First	O AN 1/25	N/U
NM105	1037	Name Middle	O AN 1/25	N/U
NM106	1038	Name Prefix	O AN 1/10	N/U
NM107	1039	Name Suffix	O AN 1/10	N/U
NM108	66	Identification Code Qualifier Code designating the system/method of code structure used for Identification Code (67) X12N HIPAA Notes: INDUSTRY: Identification Code Qualifier NI National Association of Insurance Commissioners (NAIC) Identification X12N HIPAA Notes: ADVISED PI Payor Identification	X ID 1/2	R
NM109	67	Identification Code	X AN 2/80	R AN 2/20

Code identifying a party or other code

X12N HIPAA Notes:

INDUSTRY: Corrected Priority Payer Identification Number

ODJFS User Note:

Other Payer's Insurance Identification Number

Segment: **MIA** Inpatient Adjudication Information
Position: 033
Loop: 2100 Mandatory
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To provide claim-level data related to the adjudication of Medicare inpatient claims
Syntax Notes:
Semantic Notes:

- 1 MIA01 is the covered days.
- 2 MIA02 is the lifetime reserve days.
- 3 MIA03 is the lifetime psychiatric days.
- 4 MIA04 is the Diagnosis Related Group (DRG) amount.
- 5 MIA05 is the Claim Payment Remark Code. See Code Source 411.
- 6 MIA06 is the disproportionate share amount.
- 7 MIA07 is the Medicare Secondary Payer (MSP) pass-through amount.
- 8 MIA08 is the total Prospective Payment System (PPS) capital amount.
- 9 MIA09 is the Prospective Payment System (PPS) capital, federal specific portion, Diagnosis Related Group (DRG) amount.
- 10 MIA10 is the Prospective Payment System (PPS) capital, hospital specific portion, Diagnosis Related Group (DRG), amount.
- 11 MIA11 is the Prospective Payment System (PPS) capital, disproportionate share, hospital Diagnosis Related Group (DRG) amount.
- 12 MIA12 is the old capital amount.
- 13 MIA13 is the Prospective Payment System (PPS) capital indirect medical education claim amount.
- 14 MIA14 is hospital specific Diagnosis Related Group (DRG) Amount.
- 15 MIA15 is the cost report days.
- 16 MIA16 is the federal specific Diagnosis Related Group (DRG) amount.
- 17 MIA17 is the Prospective Payment System (PPS) Capital Outlier amount.
- 18 MIA18 is the indirect teaching amount.
- 19 MIA19 is the professional component amount billed but not payable.
- 20 MIA20 is the Claim Payment Remark Code. See Code Source 411.
- 21 MIA21 is the Claim Payment Remark Code. See Code Source 411.
- 22 MIA22 is the Claim Payment Remark Code. See Code Source 411.
- 23 MIA23 is the Claim Payment Remark Code. See Code Source 411.
- 24 MIA24 is the capital exception amount.

Comments:

Notes:

X12N HIPAA Notes

This segment should be generated by Medicare intermediaries.

Either MIA or MOA will appear, but not both.

This segment should not be used for covered days or lifetime reserve days. Use the Supplemental Claim Information Quantities Segment in the Claim Payment Loop.

All situational quantities and amounts in this segment are required when the value of the item is different than zero.

Payers and Payees outside of Medicare community may need to use this segment.

X12N HIPAA Example

Example: MIA*0***138018.4~

Data Element Summary

<u>Ref.</u>	<u>Data</u>	<u>Name</u>	<u>Base</u>	<u>User</u>
<u>Des.</u>	<u>Element</u>	<u>Quantity</u>	<u>Attributes</u>	<u>Attributes</u>
MIA01	380		M R 1/15	R

Numeric value of quantity

X12N HIPAA Notes:

Implementers of this guideline always transmit the number zero. See the QTY segment at

		the claim level for covered days or visits count.		
		INDUSTRY: Covered Days or Visits Count		
MIA02	380	Quantity	O R 1/15	S
		Numeric value of quantity		
		X12N HIPAA Notes:		
		Use this to report PPS Operating Outlier.		
		Additional payment for excessive cost incurred by provider.		
		INDUSTRY: PPS Operating Outlier Amount		
MIA03	380	Quantity	O R 1/15	N/U
MIA04	782	Monetary Amount	O R 1/10	S
		Monetary amount		
		X12N HIPAA Notes:		
		Use this monetary amount for the DRG amount.		
		INDUSTRY: Claim DRG Amount		
MIA05	127	Reference Identification	O AN 1/30	S
		Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier		
		X12N HIPAA Notes:		
		Used when a Remittance Remark Code applies to this claim.		
		INDUSTRY: Remark Code		
MIA06	782	Monetary Amount	O R 1/10	N/U
MIA07	782	Monetary Amount	O R 1/10	N/U
MIA08	782	Monetary Amount	O R 1/10	N/U
MIA09	782	Monetary Amount	O R 1/10	N/U
MIA10	782	Monetary Amount	O R 1/10	N/U
MIA11	782	Monetary Amount	O R 1/10	N/U
MIA12	782	Monetary Amount	O R 1/10	N/U
MIA13	782	Monetary Amount	O R 1/10	N/U
MIA14	782	Monetary Amount	O R 1/10	N/U
MIA15	380	Quantity	O R 1/15	S
		Numeric value of quantity		
		X12N HIPAA Notes:		
		Use this number for the cost report days.		
		INDUSTRY: Cost Report Day Count		
MIA16	782	Monetary Amount	O R 1/10	N/U
MIA17	782	Monetary Amount	O R 1/10	N/U
MIA18	782	Monetary Amount	O R 1/10	N/U
MIA19	782	Monetary Amount	O R 1/10	N/U
MIA20	127	Reference Identification	O AN 1/30	S
		Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier		
		X12N HIPAA Notes:		
		Used when additional remittance remarks apply to this claim.		
		INDUSTRY: Remark Code		
MIA21	127	Reference Identification	O AN 1/30	S
		Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier		
		X12N HIPAA Notes:		

Segment: **MOA** **Outpatient Adjudication Information**
Position: 035
Loop: 2100 Mandatory
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To convey claim-level data related to the adjudication of Medicare claims not related to an inpatient setting

Syntax Notes:

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

Comments:

Notes: **X12N HIPAA Notes**

This segment should be generated by Medicare carriers or Intermediaries.

Either MIA or MOA will appear, but not both.

All situational quantities and amounts in this segment are required when the value of the item is different than zero.

Payers and payees outside of Medicare community may need to use this segment.

X12N HIPAA Example

Example: MOA***MA01~

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
MOA01	954	Percent	O R 1/10	N/U
MOA02	782	Monetary Amount	O R 1/10	N/U
MOA03	127	Reference Identification	O AN 1/30	S
		Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier		
		X12N HIPAA Notes:		
		Used when a Remittance Remark Code applies to this claim.		
		INDUSTRY: Remark Code		
MOA04	127	Reference Identification	O AN 1/30	S
		Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier		
		X12N HIPAA Notes:		
		See MOA03.		
		Used when additional remittance remarks apply to this claim.		
		INDUSTRY: Remark Code		
MOA05	127	Reference Identification	O AN 1/30	S
		Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier		
		X12N HIPAA Notes:		
		See MOA03.		

Used when additional remittance remarks apply to this claim.

MOA06

127

INDUSTRY: Remark Code

Reference Identification

O AN 1/30 S

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

X12N HIPAA Notes:

See MOA03.

Used when additional remittance remarks apply to this claim.

MOA07

127

INDUSTRY: Remark Code

Reference Identification

O AN 1/30 S

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

X12N HIPAA Notes:

See MOA03.

Used when additional remittance remarks apply to this claim.

INDUSTRY: Remark Code

Segment: **REF** Other Claim Related Identification
Position: 040
Loop: 2100 Mandatory
Level: Detail
Usage: Optional
Max Use: 5
Purpose: To specify identifying information
Syntax Notes:
Semantic Notes: 1 REF04 contains data relating to the value cited in REF02.
Comments:
Notes:

X12N HIPAA Notes

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.

X12N HIPAA Example

Example: REF*EA*666123~

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification X12N HIPAA Notes: INDUSTRY: Reference Identification Qualifier	M ID 2/3	R
		IL Group or Policy Number		
		BB Authorization Number Proves that permission was obtained to provide a service ODJFS User Note: Pre-certification Number		
		EA Medical Record Identification Number A unique number assigned to each patient by the provider of service (hospital) to assist in retrieval of medical records		
		F8 Original Reference Number ODJFS User Note: Original Claim Transaction Control Number (TCN). This is the original TCN of the paid claim.		
		G1 Prior Authorization Number An authorization number acquired prior to the submission of a claim		
		IG Insurance Policy Number		
REF02	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier X12N HIPAA Notes: INDUSTRY: Other Claim Related Identifier	O AN 1/30	R

Segment: **REF** Rendering Provider Identification
Position: 040
Loop: 2100 Mandatory
Level: Detail
Usage: Optional
Max Use: 10
Purpose: To specify identifying information
Syntax Notes:
Semantic Notes: 1 REF04 contains data relating to the value cited in REF02.
Comments:
Notes:

X12N HIPAA Notes

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.

X12N HIPAA Example

Example: REF*1D*7654321~

ODJFS User Note

ODJFS will have an NPI dual identifier period similar to Medicare. This dual identifier period will extend until December 31, 2007. For Typical providers, when there is a Rendering Provider, ODJFS will send the Medicaid legacy Provider ID that was received on the 837 transaction. Providers and Trading Partners will be notified in the event ODJFS believes the dual identification period can end sooner than December 31, 2007, or needs to be extended to the CMS approved date of May 23, 2008.

During the dual identifier period, for Typical providers, when there is a Rendering Provider, ODJFS will send the 1D qualifier for the Medicaid legacy Provider ID.

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification X12N HIPAA Notes: INDUSTRY: Reference Identification Qualifier ODJFS User Note: During the dual identifier period, for Typical providers, ODJFS will send the 1D qualifier for the Medicaid legacy Provider ID.	M ID 2/3	R
REF02	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier X12N HIPAA Notes: INDUSTRY: Rendering Provider Secondary Identifier ODJFS User Note: During the dual identifier period, for Typical providers, when there is a Rendering Provider, ODJFS will send the seven-digit Medicaid legacy Provider ID.	O AN 1/30	R

Segment: **DTM** Claim Date
Position: 050
Loop: 2100 Mandatory
Level: Detail
Usage: Optional
Max Use: 2
Purpose: To specify pertinent dates and times
Syntax Notes:
Semantic Notes:
Comments:
Notes:

X12N HIPAA Notes

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.

When claim dates are not provided, service dates are required for every service line.

When claim dates are provided, service dates are not required, but they may be used to "override" the claim dates for individual service lines.

X12N HIPAA Example

Example: DTM*233*19960916~

Data Element Summary

<u>Ref.</u>	<u>Data</u>	<u>Name</u>	<u>Base</u>	<u>User</u>
<u>Des.</u>	<u>Element</u>		<u>Attributes</u>	<u>Attributes</u>
DTM01	374	Date/Time Qualifier	M ID 3/3	R
		Code specifying type of date or time, or both date and time		
		X12N HIPAA Notes:		
		INDUSTRY: Date Time Qualifier		
		232 Claim Statement Period Start		
		X12N HIPAA Notes:		
		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.		
		ODJFS User Note:		
		First Date of Service		
		233 Claim Statement Period End		
		X12N HIPAA Notes:		
		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.		
		ODJFS User Note:		
		Last Date of Service		
DTM02	373	Date	O DT 8/8	R
		Date expressed as CCYYMMDD		
		X12N HIPAA Notes:		
		INDUSTRY: Claim Date		

Segment: **AMT** Claim Supplemental Information
Position: 062
Loop: 2100 Mandatory
Level: Detail
Usage: Optional
Max Use: 3
Purpose: To indicate the total monetary amount
Syntax Notes:
Semantic Notes:
Comments:
Notes:

X12N HIPAA Notes

Use this segment 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.

X12N HIPAA Example

Example: AMT*T*49~

Data Element Summary

<u>Ref.</u>	<u>Data</u>	<u>Name</u>	<u>Base</u>	<u>User</u>
<u>Des.</u>	<u>Element</u>	<u>Code</u>	<u>Attributes</u>	<u>Attributes</u>
AMT01	522	Amount Qualifier Code Code to qualify amount X12N HIPAA Notes: INDUSTRY: Amount Qualifier Code	M ID 1/3	R
		AU Coverage Amount The dollar amount of property coverage provided by a specific policy contract X12N HIPAA Notes: Use this monetary amount to report the total covered charges.		
		F5 Patient Amount Paid Monetary amount value already paid by one receiving medical care X12N HIPAA Notes: Use this monetary amount for the amount the patient has already paid.		
AMT02	782	I Interest Monetary Amount Monetary amount X12N HIPAA Notes: INDUSTRY: Claim Supplemental Information Amount	M R 1/10	R

Segment: **QTY** Claim Supplemental Information Quantity
Position: 064
Loop: 2100 Mandatory
Level: Detail
Usage: Optional
Max Use: 4
Purpose: To specify quantity information
Syntax Notes: 1 At least one of QTY02 or QTY04 is required.
 2 Only one of QTY02 or QTY04 may be present.
Semantic Notes: 1 QTY04 is used when the quantity is non-numeric.
Comments:
Notes:

X12N HIPAA Notes

Use this segment to convey information only. It is not part of the financial balancing of the 835.

Use this segment only when the value of specific quantities identified in the QTY01 qualifier are Non-zero.

X12N HIPAA Example

Example: QTY*ZK*3~

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
QTY01	673	Quantity Qualifier	M ID 2/2	R
		Code specifying the type of quantity		
		X12N HIPAA Notes:		
		INDUSTRY: Quantity Qualifier		
		CA Covered - Actual		
		Days covered on this service		
		LA Life-time Reserve - Actual		
		Medicare hospital insurance includes extra hospital days to be used if the patient has a long illness and is required to stay in the hospital over a specified number of days; this is the actual number of days in reserve		
		NA Number of Non-covered Days		
		OU Outlier Days		
QTY02	380	Quantity	X R 1/15	R
		Numeric value of quantity		
		X12N HIPAA Notes:		
		INDUSTRY: Claim Supplemental Information Quantity		

Segment: **SVC** Service Payment Information
Position: 070
Loop: 2110 Optional
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To supply payment and control information to a provider for a particular service
Syntax Notes:
Semantic Notes:

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

Comments:

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

Notes:

X12N HIPAA Notes

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.

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~).

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

X12N HIPAA Example

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

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
SVC01	C003	Composite Medical Procedure Identifier	M	R
		To identify a medical procedure by its standardized codes and applicable modifiers		
		X12N HIPAA Notes:		
		Use the adjudicated Medical Procedure Code.		
		This code is a composite data structure.		
C00301	235	Product/Service ID Qualifier	M ID 2/2	R
		Code identifying the type/source of the descriptive number used in Product/Service ID (234)		
		X12N HIPAA Notes:		
		The value in SVC01-01 qualifies the values in SVC01-02, SVC01-03, SVC01-04, SVC01-05, and SVC01-06.		
		INDUSTRY: Product or Service ID Qualifier		
		AD American Dental Association Codes		
		This association's membership consists of U.S. dentists. It sets standards for the dental profession		
		ODJFS User Note:		
		Claim Input Form Indicator	Field Value	

		I-Dental Claim	ADA Dental Code	
		HC Health Care Financing Administration Common Procedural Coding		

System (HCPCS) Codes

HCFA coding scheme to group procedure(s) performed on an outpatient basis for payment to hospital under Medicare; primarily used for ambulatory surgical and other diagnostic departments

X12N HIPAA Notes:

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

ODJFS User Note:

Claim Input Form Indicator	Field Value

A-Transportation Claim	HCPCS Code
F-Part B Crossover Claim	HCPCS Code
G-Medical Supply Claim	HCPCS Code
O-Outpatient Claim	HCPCS Code
	If CPT present on claim
All other values	HCPCS Code

N4

National Drug Code in 5-4-2 Format

5-digit manufacturer ID, 4-digit product ID, 2-digit trade package size

NU

National Uniform Billing Committee (NUBC) UB92 Codes

ODJFS User Note:

Claim Input Form Indicator	Field Value

R-Drug Pharmacy Claim	UB92 Rev Code
H-Home health Claim	UB92 Rev Code
U-Inpatient Crossover Claim	UB92 Rev Code
W-Outpatient Crossover Claim	UB92 Rev Code
P-Inpatient Claim	UB92 Rev Code
O-Outpatient Claim	UB92 Rev Code
	If no CPT present on claim

C00302 234 Product/Service ID M AN 1/48 R AN 1/11

Identifying number for a product or service

X12N HIPAA Notes:

INDUSTRY: Procedure Code

C00303 1339 Procedure Modifier O AN 2/2 S

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

X12N HIPAA Notes:

Required when procedure code modifiers apply to this service.

INDUSTRY: Procedure Modifier

C00304 1339 Procedure Modifier O AN 2/2 S

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

X12N HIPAA Notes:

Required when procedure code modifiers apply to this service.

INDUSTRY: Procedure Modifier

C00305 1339 Procedure Modifier O AN 2/2 S

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

X12N HIPAA Notes:

Required when procedure code modifiers apply to this service.

INDUSTRY: Procedure Modifier

C00306 1339 Procedure Modifier O AN 2/2 S

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

X12N HIPAA Notes:

Required when procedure code modifiers apply to this service.

INDUSTRY: Procedure Modifier

C00307	352	Description	O	AN 1/80	N/U
SVC02	782	Monetary Amount	M	R 1/10	R

Monetary amount

X12N HIPAA Notes:

Use this monetary amount for the submitted service charge amount.

INDUSTRY: Line Item Charge Amount

SVC03	782	Monetary Amount	O	R 1/10	R
--------------	------------	------------------------	----------	---------------	----------

Monetary amount

X12N HIPAA Notes:

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.

INDUSTRY: Line Item Provider Payment Amount

ODJFS User Note:

Line Item Allowed Charge Amount

SVC04	234	Product/Service ID	O	AN 1/48	S	AN 1/5
--------------	------------	---------------------------	----------	----------------	----------	---------------

Identifying number for a product or service

X12N HIPAA Notes:

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.

INDUSTRY: National Uniform Billing Committee Revenue Code

ODJFS User Note:

Used for Institutional Claims only

SVC05	380	Quantity	O	R 1/15	S	R 1/5
--------------	------------	-----------------	----------	---------------	----------	--------------

Numeric value of quantity

X12N HIPAA Notes:

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

INDUSTRY: Units of Service Paid Count

SVC06	C003	Composite Medical Procedure Identifier	O		N/ U
--------------	-------------	---	----------	--	-----------------

SVC07	380	Quantity	O	R 1/15	S	R 1/5
--------------	------------	-----------------	----------	---------------	----------	--------------

Numeric value of quantity

X12N HIPAA Notes:

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.

INDUSTRY: Original Units of Service Count

ODJFS User Note:

Line item submitted units of service (only on medical claims)

Required when the paid units of service provided in SVC05 is different from the submitted units of service from the original claim. Not used when the submitted units is the same value in SVC05.

Segment: **DTM** Service Date
Position: 080
Loop: 2110 Optional
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To specify pertinent dates and times
Syntax Notes:
Semantic Notes:
Comments:
Notes:

X12N HIPAA Notes

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.

When claim dates are not provided, service dates are required for every service line.

When claim dates are provided, service dates are not required, but they may be used to "override" the claim dates for individual service lines.

For Medicare service, this segment is required (for Part A, use "through date" if no service date is present).

X12N HIPAA Example

Example: DTM*472*19961031~

Data Element Summary

<u>Ref.</u>	<u>Data</u>	<u>Name</u>	<u>Base</u>	<u>User</u>
<u>Des.</u>	<u>Element</u>	<u>Date/Time</u>	<u>Attributes</u>	<u>Attributes</u>
DTM01	374	Date/Time Qualifier	M ID 3/3	R
		Code specifying type of date or time, or both date and time		
		X12N HIPAA Notes:		
		INDUSTRY: Date Time Qualifier		
		472 Service		
		Begin and end dates of the service being rendered		
		X12N HIPAA Notes:		
		ADVISED		
		Use this code to indicate a single day service.		
DTM02	373	Date	O DT 8/8	R
		Date expressed as CCYYMMDD		
		X12N HIPAA Notes:		
		INDUSTRY: Service Date		

Segment: **CAS** Service Adjustment

Position: 090

Loop: 2110 Optional

Level: Detail

Usage: 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

- Syntax Notes:**
- 1 If CAS05 is present, then at least one of CAS06 or CAS07 is required.
 - 2 If CAS06 is present, then CAS05 is required.
 - 3 If CAS07 is present, then CAS05 is required.
 - 4 If CAS08 is present, then at least one of CAS09 or CAS10 is required.
 - 5 If CAS09 is present, then CAS08 is required.
 - 6 If CAS10 is present, then CAS08 is required.
 - 7 If CAS11 is present, then at least one of CAS12 or CAS13 is required.
 - 8 If CAS12 is present, then CAS11 is required.
 - 9 If CAS13 is present, then CAS11 is required.
 - 10 If CAS14 is present, then at least one of CAS15 or CAS16 is required.
 - 11 If CAS15 is present, then CAS14 is required.
 - 12 If CAS16 is present, then CAS14 is required.
 - 13 If CAS17 is present, then at least one of CAS18 or CAS19 is required.
 - 14 If CAS18 is present, then CAS17 is required.
 - 15 If CAS19 is present, then CAS17 is required.

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

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

Notes: **X12N HIPAA Notes**

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.

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).

X12N HIPAA Example

Example: CAS*CO*A2*20~

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
CAS01	1033	Claim Adjustment Group Code Code identifying the general category of payment adjustment X12N HIPAA Notes: 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.) INDUSTRY: Claim Adjustment Group Code	M ID 1/2	R
		CO Contractual Obligations X12N HIPAA Notes: Use this code when a joint payer/payee agreement or a regulatory requirement has resulted in an adjustment.		
		CR Correction and Reversals X12N HIPAA Notes: Use this code for corrections and reversals to PRIOR claims. Use when CLP02=22.		
		OA Other adjustments		
		PI Payor Initiated Reductions X12N HIPAA Notes: 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		
CAS02	1034	Claim Adjustment Reason Code Code identifying the detailed reason the adjustment was made X12N HIPAA Notes: INDUSTRY: Adjustment Reason Code	M ID 1/5	R
CAS03	782	Monetary Amount Monetary amount X12N HIPAA Notes: 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. INDUSTRY: Adjustment Amount ODJFS User Note: Adjustment Amount Difference between the amount of the service line submitted amount and the service line allowed amount.	M R 1/10	R
CAS04	380	Quantity Numeric value of quantity X12N HIPAA Notes: 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. INDUSTRY: Adjustment Quantity	O R 1/15	S R 1/5
CAS05	1034	Claim Adjustment Reason Code Code identifying the detailed reason the adjustment was made X12N HIPAA Notes: See CAS02. Used when additional adjustments apply within the group identified in CAS01.	X ID 1/5	S

CAS06	782	INDUSTRY: Adjustment Reason Code				
		Monetary Amount	X	R 1/10	S	
		Monetary amount				
		X12N HIPAA Notes: See CAS03. Used when additional adjustments apply within the group identified in CAS01.				
CAS07	380	INDUSTRY: Adjustment Amount				
		Quantity	X	R 1/15	S	R 1/5
		Numeric value of quantity				
		X12N HIPAA Notes: See CAS04. Used when additional adjustments apply within the group identified in CAS01.				
CAS08	1034	INDUSTRY: Adjustment Quantity				
		Claim Adjustment Reason Code	X	ID 1/5	S	
		Code identifying the detailed reason the adjustment was made				
		X12N HIPAA Notes: See CAS02. Used when additional adjustments apply within the group identified in CAS01.				
CAS09	782	INDUSTRY: Adjustment Reason Code				
		Monetary Amount	X	R 1/10	S	
		Monetary amount				
		X12N HIPAA Notes: See CAS03. Used when additional adjustments apply within the group identified in CAS01.				
CAS10	380	INDUSTRY: Adjustment Amount				
		Quantity	X	R 1/15	S	R 1/5
		Numeric value of quantity				
		X12N HIPAA Notes: See CAS04. Used when additional adjustments apply within the group identified in CAS01.				
CAS11	1034	INDUSTRY: Adjustment Quantity				
		Claim Adjustment Reason Code	X	ID 1/5	S	
		Code identifying the detailed reason the adjustment was made				
		X12N HIPAA Notes: See CAS02. Used when additional adjustments apply within the group identified in CAS01.				
CAS12	782	INDUSTRY: Adjustment Reason Code				
		Monetary Amount	X	R 1/10	S	
		Monetary amount				
		X12N HIPAA Notes: See CAS03. Used when additional adjustments apply within the group identified in CAS01.				
		INDUSTRY: Adjustment Amount				

CAS13	380	Quantity Numeric value of quantity X12N HIPAA Notes: See CAS04. Used when additional adjustments apply within the group identified in CAS01. INDUSTRY: Adjustment Quantity	X	R 1/15	S	R 1/5
CAS14	1034	Claim Adjustment Reason Code Code identifying the detailed reason the adjustment was made X12N HIPAA Notes: See CAS02. Used when additional adjustments apply within the group identified in CAS01. INDUSTRY: Adjustment Reason Code	X	ID 1/5	S	
CAS15	782	Monetary Amount Monetary amount X12N HIPAA Notes: See CAS03. Used when additional adjustments apply within the group identified in CAS01. INDUSTRY: Adjustment Amount	X	R 1/10	S	
CAS16	380	Quantity Numeric value of quantity X12N HIPAA Notes: See CAS04. Used when additional adjustments apply within the group identified in CAS01. INDUSTRY: Adjustment Quantity	X	R 1/15	S	R 1/5
CAS17	1034	Claim Adjustment Reason Code Code identifying the detailed reason the adjustment was made X12N HIPAA Notes: See CAS02. Used when additional adjustments apply within the group identified in CAS01. INDUSTRY: Adjustment Reason Code	X	ID 1/5	S	
CAS18	782	Monetary Amount Monetary amount X12N HIPAA Notes: See CAS03. Used when additional adjustments apply within the group identified in CAS01. INDUSTRY: Adjustment Amount	X	R 1/10	S	
CAS19	380	Quantity Numeric value of quantity X12N HIPAA Notes: See CAS04. Used when additional adjustments apply within the group identified in CAS01. INDUSTRY: Adjustment Quantity	X	R 1/15	S	R 1/5

Segment: **REF** Service Identification
Position: 100
Loop: 2110 Optional
Level: Detail
Usage: Optional
Max Use: 2
Purpose: To specify identifying information
Syntax Notes:
Semantic Notes: 1 REF04 contains data relating to the value cited in REF02.
Comments:
Notes:

X12N HIPAA Notes

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.

X12N HIPAA Example

Example: REF*RB*100~

ODJFS User Note

ODJFS will have an NPI dual identifier period similar to Medicare. This dual identifier period will extend until December 31, 2007. ODJFS will send the Service Facility Location number that was received on the 837 transaction in the 2310E loop. Providers and Trading Partners will be notified in the event ODJFS believes the dual identification period can end sooner than December 31, 2007, or needs to be extended to the CMS approved date of May 23, 2008.

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification	M ID 2/3	R
X12N HIPAA Notes:				
INDUSTRY: Reference Identification Qualifier				
	6R	Provider Control Number Number assigned by information provider company for tracking and billing purposes		
X12N HIPAA Notes:				
	G1	Prior Authorization Number An authorization number acquired prior to the submission of a claim		
	LU	Location Number		
X12N HIPAA Notes:				
		Used for nursing facilities to report the seven-digit facility location number (ODJFS legacy number) on room and board and Medicare Part A co-insurance claims.		
REF02	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	O AN 1/30	R AN 1/10
X12N HIPAA Notes:				
INDUSTRY: Provider Identifier				

Segment: **REF** Rendering Provider Information
Position: 100
Loop: 2110 Optional
Level: Detail
Usage: Optional
Max Use: 2
Purpose: To specify identifying information
Syntax Notes:
Semantic Notes: 1 REF04 contains data relating to the value cited in REF02.
Comments:
Notes:

X12N HIPAA Notes

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.

X12N HIPAA Example

Example: REF*HPI*12345678~

ODJFS User Note

ODJFS will have an NPI dual identifier period similar to Medicare. This dual identifier period will extend until December 31, 2007. ODJFS will send the Medicaid legacy Provider ID and the NPI that was received on the 837 transaction in the 2110 REF segment. Providers and Trading Partners will be notified in the event ODJFS believes the dual identification period can end sooner than December 31, 2007, or needs to be extended to the CMS approved date of May 23, 2008.

For Typical providers, ODJFS will send the NPI in this REF segment.

During the dual identifier period, for Typical providers, ODJFS will also send an occurrence of the REF for the Medicaid legacy Provider ID.

For Atypical providers with no NPI, ODJFS will send the Medicaid legacy Provider Identifier in the REF02 element.

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification	M ID 2/3	R
X12N HIPAA Notes:				
INDUSTRY: Reference Identification Qualifier				
ODJFS User Note:				
For Typical providers, ODJFS will send the HPI qualifier for the NPI.				
During the dual identifier period, for Typical providers, ODJFS will also send the 1D qualifier for the Medicaid legacy Provider ID.				
For Atypical providers with no NPI, ODJFS will send the 1D qualifier for the Medicaid legacy Provider ID.				
		1D Medicaid Provider Number		
		HPI Health Care Financing Administration National Provider Identifier		
REF02	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	O AN 1/30	R AN 1/11
X12N HIPAA Notes:				
INDUSTRY: Rendering Provider Identifier				
ODJFS User Note:				
For Typical providers, ODJFS will send the NPI.				

During the dual identifier period, for Typical providers, ODJFS will also send the Medicaid legacy Provider ID.

For Atypical providers with no NPI, ODJFS will send the Medicaid legacy Provider ID.

Segment: **LQ** Health Care Remark Codes
Position: 130
Loop: 2110 Optional
Level: Detail
Usage: Optional
Max Use: 99
Purpose: Code to transmit standard industry codes
Syntax Notes: 1 If LQ01 is present, then LQ02 is required.
Semantic Notes:
Comments:
Notes:

X12N HIPAA Notes

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.

X12N HIPAA Example

Example: LQ*HE*12345~

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
LQ01	1270	Code List Qualifier Code Code identifying a specific industry code list	O ID 1/3	R
X12N HIPAA Notes:				
INDUSTRY: Code List Qualifier Code				
		HE Claim Payment Remark Codes		
		RX National Council for Prescription Drug Programs Reject/Payment Codes		
LQ02	1271	Industry Code Code indicating a code from a specific industry code list	X AN 1/30	R AN 1/7
X12N HIPAA Notes:				
INDUSTRY: Remark Code				

Segment: **PLB** Provider Adjustment
Position: 010
Loop:
Level: Summary
Usage: 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 Notes:

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

Semantic Notes:

- 1 PLB01 is the provider number assigned by the payer.
- 2 PLB02 is the last day of the provider's fiscal year.
- 3 PLB03 is the adjustment information as defined by the payer.
- 4 PLB04 is the adjustment amount.
- 5 PLB05 is the adjustment information as defined by the payer.
- 6 PLB06 is the adjustment amount.
- 7 PLB07 is adjustment information as defined by the payer.
- 8 PLB08 is the adjustment amount.
- 9 PLB09 is adjustment information as defined by the payer.
- 10 PLB10 is the adjustment amount.
- 11 PLB11 is adjustment information as defined by the payer.
- 12 PLB12 is the adjustment amount.
- 13 PLB13 is adjustment information as defined by the payer.
- 14 PLB14 is the adjustment amount.

Comments:

Notes: **X12N HIPAA Notes**

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.

X12N HIPAA Example

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

ODJFS User Note

This segment is always created. If there is no recoupment or cost settlement adjustment amount for this provider, the Provider Recoupment Amount (PLB04) is zero.

Data Element Summary

<u>Ref.</u>	<u>Data</u>	<u>Name</u>	<u>Base</u>	<u>User</u>
<u>Des.</u>	<u>Element</u>		<u>Attributes</u>	<u>Attributes</u>
PLB01	127	Reference Identification	M AN 1/30	R AN 1/11
		Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier		
		X12N HIPAA Notes:		
		Use this number for the provider identifier as assigned by the payer.		
		INDUSTRY: Provider Identifier		
		ODJFS User Note:		
		Pay-to 7-digit Medicaid Provider ID		
PLB02	373	Date	M DT 8/8	R

Date expressed as CCYYMMDD

X12N HIPAA Notes:

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.

INDUSTRY: Fiscal Period Date

ODJFS User Note:

December 31 of the current year

PLB03 C042 Adjustment Identifier M R
To provide the category and identifying reference information for an adjustment

X12N HIPAA Notes:

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

C04201 426 Adjustment Reason Code M ID 2/2 R

Code indicating reason for debit or credit memo or adjustment to invoice, debit or credit memo, or payment

X12N HIPAA Notes:

INDUSTRY: Adjustment Reason Code

BD Bad Debt Adjustment

X12N HIPAA Notes:

Use this code for the bad debt passthrough. Medicare Part A will provide code "BD" in PLB03-2.

CS Adjustment

X12N HIPAA Notes:

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

FB Forwarding Balance

X12N HIPAA Notes:

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.

IR Internal Revenue Service Withholding

IS Interim Settlement

X12N HIPAA Notes:

Use this number for the interim rate lump sum adjustment. Medicare Part A will provide code "IR" in PLB03-2.

L3 Penalty

The dollar value of the penalty assessed a business entity for a past due debt

X12N HIPAA Notes:

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.

LE Levy

X12N HIPAA Notes:

IRS Levy

		LS	Lump Sum X12N HIPAA Notes: 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 Disproportionate 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.
		PL	Payment Final X12N HIPAA Notes: Use this number for the final settlement. Medicare Part A will provide code "FS" in PLB03-2.
		RA	Retro-activity Adjustment X12N HIPAA Notes: See 2.2.10, Capitation and Related Payments and Adjustments, for additional information. Medicare Part A will provide code "TR" in PLB03-2.
		TL	Third Party Liability X12N HIPAA Notes: See 2.2.10, Capitation and Related Payments or Adjustments, for additional information.
		WO	Overpayment Recovery X12N HIPAA Notes: 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.
C04202	127	Reference Identification	O AN 1/30 S Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier X12N HIPAA Notes: 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. INDUSTRY: Provider Adjustment Identifier ODJFS User Note: Combination of 2 fields: Remittance/Advice Number + Warrant Number
PLB04	782	Monetary Amount	M R 1/10 R Monetary amount X12N HIPAA Notes: Use this monetary amount for the adjustment amount for the preceding adjustment reason. INDUSTRY: Provider Adjustment Amount ODJFS User Note: Provider Recoupment Amount
PLB05	C042	Adjustment Identifier	X S To provide the category and identifying reference information for an adjustment X12N HIPAA Notes: See PLB03 for details.

		Used when additional adjustments apply.			
C04201	426	Adjustment Reason Code	M	ID 2/2	R
		Code indicating reason for debit or credit memo or adjustment to invoice, debit or credit memo, or payment			
		X12N HIPAA Notes:			
		INDUSTRY: Adjustment Reason Code			
		Refer to 004010X091A1 Data Element Dictionary for acceptable code values.			
C04202	127	Reference Identification	O	AN 1/30	S
		Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier			
		X12N HIPAA Notes:			
		INDUSTRY: Provider Adjustment Identifier			
PLB06	782	Monetary Amount	X	R 1/10	S
		Monetary amount			
		X12N HIPAA Notes:			
		Use this monetary amount for the adjustment amount for the preceding adjustment reason.			
		INDUSTRY: Provider Adjustment Amount			
PLB07	C042	Adjustment Identifier	X		S
		To provide the category and identifying reference information for an adjustment			
		X12N HIPAA Notes:			
		See PLB03 for details.			
		Used when additional adjustments apply.			
C04201	426	Adjustment Reason Code	M	ID 2/2	R
		Code indicating reason for debit or credit memo or adjustment to invoice, debit or credit memo, or payment			
		X12N HIPAA Notes:			
		INDUSTRY: Adjustment Reason Code			
		Refer to 004010X091A1 Data Element Dictionary for acceptable code values.			
C04202	127	Reference Identification	O	AN 1/30	S
		Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier			
		X12N HIPAA Notes:			
		INDUSTRY: Provider Adjustment Identifier			
PLB08	782	Monetary Amount	X	R 1/10	S
		Monetary amount			
		X12N HIPAA Notes:			
		Use this monetary amount for the adjustment amount for the preceding adjustment reason.			
		INDUSTRY: Provider Adjustment Amount			
PLB09	C042	Adjustment Identifier	X		S
		To provide the category and identifying reference information for an adjustment			
		X12N HIPAA Notes:			
		See PLB03 for details.			
		Used when additional adjustments apply.			
C04201	426	Adjustment Reason Code	M	ID 2/2	R
		Code indicating reason for debit or credit memo or adjustment to invoice, debit or credit memo, or payment			
		X12N HIPAA Notes:			
		INDUSTRY: Adjustment Reason Code			
		Refer to 004010X091A1 Data Element Dictionary for acceptable code values.			
C04202	127	Reference Identification	O	AN 1/30	S

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

X12N HIPAA Notes:

INDUSTRY: Provider Adjustment Identifier

PLB10 782 Monetary Amount X R 1/10 S

Monetary amount

X12N HIPAA Notes:

Use this monetary amount for the adjustment amount for the preceding adjustment reason.

INDUSTRY: Provider Adjustment Amount

PLB11 C042 Adjustment Identifier X S

To provide the category and identifying reference information for an adjustment

X12N HIPAA Notes:

See PLB03 for details.

Used when additional adjustments apply.

C04201 426 Adjustment Reason Code M ID 2/2 R

Code indicating reason for debit or credit memo or adjustment to invoice, debit or credit memo, or payment

X12N HIPAA Notes:

INDUSTRY: Adjustment Reason Code

Refer to 004010X091A1 Data Element Dictionary for acceptable code values.

C04202 127 Reference Identification O AN 1/30 S

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

X12N HIPAA Notes:

INDUSTRY: Provider Adjustment Identifier

PLB12 782 Monetary Amount X R 1/10 S

Monetary amount

X12N HIPAA Notes:

Use this monetary amount for the adjustment amount for the preceding adjustment reason.

INDUSTRY: Provider Adjustment Amount

PLB13 C042 Adjustment Identifier X S

To provide the category and identifying reference information for an adjustment

X12N HIPAA Notes:

See PLB03 for details.

Used when additional adjustments apply.

C04201 426 Adjustment Reason Code M ID 2/2 R

Code indicating reason for debit or credit memo or adjustment to invoice, debit or credit memo, or payment

X12N HIPAA Notes:

INDUSTRY: Adjustment Reason Code

Refer to 004010X091A1 Data Element Dictionary for acceptable code values.

C04202 127 Reference Identification O AN 1/30 S

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

X12N HIPAA Notes:

INDUSTRY: Provider Adjustment Identifier

PLB14 782 Monetary Amount X R 1/10 S

Monetary amount

X12N HIPAA Notes:

Use this monetary amount for the adjustment amount for the preceding adjustment reason.

Segment: **SE** Transaction Set Trailer
Position: 020
Loop:
Level: Summary
Usage: 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)

Syntax Notes:

Semantic Notes:

Comments: 1 SE is the last segment of each transaction set.

Notes: **X12N HIPAA Example**

Example: SE*45*1234~

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
SE01	96	Number of Included Segments	M N0 1/10	R
		Total number of segments included in a transaction set including ST and SE segments		
		X12N HIPAA Notes:		
		INDUSTRY: Transaction Segment Count		
SE02	329	Transaction Set Control Number	M AN 4/9	R
		Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set		
		X12N HIPAA Notes:		
		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.		
		INDUSTRY: Transaction Set Control Number		

Segment: **GE** Functional Group Trailer
Position: 030
Loop:
Level: Summary
Usage: Optional
Max Use: 1
Purpose: To indicate the end of a functional group and to provide control information
Syntax Notes:
Semantic Notes: 1 The data interchange control number GE02 in this trailer must be identical to the same data element in the associated functional group header, GS06.
Comments: 1 The use of identical data interchange control numbers in the associated functional group header and trailer is designed to maximize functional group integrity. The control number is the same as that used in the corresponding header.
Notes: **X12N HIPAA Example**
 GE*1*1~

Data Element Summary

<u>Ref.</u>	<u>Data</u>	<u>Name</u>	<u>Base</u>	<u>User</u>
<u>Des.</u>	<u>Element</u>		<u>Attributes</u>	<u>Attributes</u>
GE01	97	Number of Transaction Sets Included	M N0 1/6	R
		Total number of transaction sets included in the functional group or interchange (transmission) group terminated by the trailer containing this data element		
GE02	28	Group Control Number	M N0 1/9	R
		Assigned number originated and maintained by the sender		

Segment: **IEA** Interchange Control Trailer
Position: 040
Loop:
Level: Summary
Usage: Optional
Max Use: 1
Purpose: To define the end of an interchange of zero or more functional groups and interchange-related control segments

Syntax Notes:

Semantic Notes:

Comments:

Notes: X12N HIPAA Example

IEA*1*000000905~

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
IEA01	I16	Number of Included Functional Groups A count of the number of functional groups included in an interchange	M N0 1/5	R
IEA02	I12	Interchange Control Number A control number assigned by the interchange sender	M N0 9/9	R