Healthcare and Family Services, Bureau of Information Services

HIPAA 5010 - Health Care Claim Payment/Advice (835) Standard Companion Guide

Instructions related to Transactions based on ASC X12 Implementation Guide version 005010X221 and the ERRATA 005010X221A1 dated June 2010

835 Companion Guide Version Number: 1.0

Preface

Companion Guides (CG) may contain two types of data, instructions for electronic communications with the publishing entity (Communications/Connectivity Instructions) and supplemental information for creating transactions for the publishing entity while ensuring compliance with the associated ASC X12 IG (Transaction Instructions). Either the Communications/Connectivity component or the Transaction Instruction component must be included in every CG. The components may be published as separate documents or as a single document.

The Communications/Connectivity component is included in the CG when the publishing entity wants to convey the information needed to commence and maintain communication exchange.

The Transaction Instruction component is included in the CG when the publishing entity wants to clarify the IG instructions for submission of specific electronic transactions. The Transaction Instruction component content is limited by ASCX12's copyrights and Fair Use statement.

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Transaction Instruction (TI)

1 TI Introduction

1.1 Background

1.1.1 Overview of HIPAA Legislation

The 'Health Insurance Portability and Accountability Act' (HIPAA) of 1996 carries provisions for administrative simplification. This requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. HIPAA directs the Secretary to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard HIPAA serves to:

- Create better access to health insurance
- Limit fraud and abuse
- Reduce administrative costs

1.1.2 Compliance according to HIPAA

The HIPAA regulations at 45 CFR 162.915 require that covered entities not enter into a trading partner agreement that would do any of the following:

- Change the definition, data condition, or use of a data element or segment in a standard.
- Add any data elements or segments to the maximum defined data set.
- Use any code or data elements that are marked "not used" in the standard's implementation specifications or are not in the standard's implementation specification(s).
- Change the meaning or intent of the standard's implementation specification(s).

1.1.3 Compliance according to ASC X12

ASC X12 requirements include specific restrictions that prohibit trading partners from:

- Modifying any defining, explanatory, or clarifying content contained in the implementation guide.
- Modifying any requirement contained in the implementation guide.

1.2 Intended Use

The Transaction Instruction component of this companion guide must be used in conjunction with ASC X12 005010X221 Healthcare Claim Payment/Advice (835) and the ERRATA 005010X221A1 dated June 2010. The instructions in this companion guide are not intended to be stand-alone requirements documents. This companion guide conforms to all the requirements of any associated ASC X12 Implementation Guides and is in conformance with ASC X12's Fair Use and Copyright statements.

2 Included ASC X12 Implementation Guides

This table lists the X12N Implementation Guides for which specific transaction Instructions apply and which are included in Section 3 of this document.

Unique ID	Name
005010X221	**Health Care Claim Payment/Advice (835)**
005010X221A1	**A1 ERRATA Healthcare Claim Payment/Advice.**

3 Instruction Tables

These tables contain one or more rows of each segment for which a supplemental instruction is needed.

Legend
SHADED rows represent “segments” in the X12N implementation guide.
NON-SHADED rows represent “data elements” in the X12N implementation guide.

HFS Unique 835 Items

005010X221A1 Health Care Claim Payment/Advice (835)

Loop ID	Reference	Name	Codes	Notes/Comments
Header	BPR	Financial Information		
Header	BPR02	Monetary amount		Will represent the full payment amount for the Payee
Header	BPR04	Payment Method Code		Refer to section 4.1
Header	BPR10	FEIN	Originating Company Identifier	If payment balance is ‘zero’, this will be “1371320118”. If payment is issued this will be “1376002057”

Loop ID	Reference	Name	Codes	Notes/Comments
Header	TRN	Reassociation Trace Number		
Header	TRN02	Reference Identification		Will represent the Check/Warrant Number appended to Voucher Number
Header	DTM	Production Date		
Header	DTM02	Date		Will represent Schedule Date (from Julian date in Voucher Number)
1000A	N1	Payer Identification		
1000A	N102	Name	'ILLINOIS MEDICAID', 'ILLINOIS COMPTROLLER'	If the payment balance is zero, this will be 'ILLINOIS MEDICAID'. If the payment is issued, this will be 'ILLINOIS COMPTROLLER'
1000B	N1	Payee Identification		
1000B	N103	Identification Code Qualifier	'FI'	Will be 'FI'
1000B	N3	Payee Address		

Loop ID	Reference	Name	Codes	Notes/Comments
1000B	N301	Address Information	‘201 SOUTH GRAND AVENUE EAST’, ‘325 WEST ADAMS ST’	If the payment balance is zero, this will be ‘201 SOUTH GRAND AVENUE EAST’. If payment is issued, this will be “325 WEST ADAMS ST”
1000B	N4	Payee City, State, Zip Code		
1000B	N401	City Name	‘SPRINGFIELD’	Will be ‘SPRINGFIELD’
1000B	N402	State or Province Code	‘IL’	Will be ‘IL’
1000B	N403	Postal Code	‘62763’, ‘627041871’	If the payment balance is zero, this will be ‘627630001 ’. If the payment is issued, this will be ‘627041871’
2000	TS3	Provider Summary Information		
2000	TS302	Facility Code Value		For Professional Claims (837P), HFS will report code 11 (office) as place of

Loop ID	Reference	Name	Codes	Notes/Comments
				service, if the 837P contains more than one value. For Long Term Care Claims, HFS will report code '11'. For Institutional Claims (837I), HFS will report the first two-bytes of the bill type code. For Pharmaceutical Claims, the code will be "99" (other).
2100	CLP	Claim Payment Information		
2100	CLP02	Claim Status Code	'1', '2', '3', '4', '22'	Will be "1","2","3", "4" or "22".
2100	CLP03	Monetary Amount		Will be the total billed amount
2100	CLP04	Monetary Amount		Will be total paid amount
2100	CLP06	Claim Filing Indicator Code	'MC'	Will be "MC"
2100	CLP07	Reference Identification		Will be the Document Control Number (DCN)
2100	CLP08	Facility Value		This is the first 2-

Loop ID	Reference	Name	Codes	Notes/Comments
		Code		bytes of the Bill Type Code
2100	CAS	Claim Adjustment		
2100	CAS01	Claim Adjustment Group Code	'PR', 'CO', 'OA'	Will be "PR", "CO" or "OA"
2100	NM1	Patient Name		
2100	NM103	Name Last or Organization Name		Will be Recipient's Last Name
2100	NM104	Name First		Will be Recipient's First Name
2100	NM108	Identification Code Qualifier		Will be "MR"
2100	NM1	Corrected Patient/Insured Name		
2100	NM102	Entity Type Qualifier	'1'	If used, will be "1"
2100	NM103	Name Last or Organization Name		If used, will be Recipient's Last Name
2100	NM104	Name First		If used, will be Recipients' First

Loop ID	Reference	Name	Codes	Notes/Comments
				Name
2100	NM1	Service Provider Name		
2100	NM103	Name Last of Organization Name		Will be the Provider's Name as it appears on the Provider Information Sheet
2100	NM108	Identification Code Qualifier	'MC' or 'FI'	Will be "MC" or "FI".
2100	DTM	Statement FROM or TO date		
2100	DTM01	Date/Time Qualifier	'232', '233'	Will be "232" or "233"
2100	AMT	Claim Supplemental Information		
2100	AMT01	Amount Qualifier Code	'DY', 'F5'	Will be 'DY' for 'Per Day Limit' and 'F5' for Patient Amount Paid
2100	QTY	Claim Supplemental Information Quantity		

Loop ID	Reference	Name	Codes	Notes/Comments
2100	QTY01	Quantity Qualifier	'CA'	Will be 'CA'
2110	SVC	Service Payment Information		
2110	SVC02	Monetary Amount		Will be the "billed" amount
2110	SVC03	Monetary Amount		Will be the "payment" amount
2110	PLB	Provider Adjustment		
2110	PLB01	Reference Identification		Will be the Medicaid Provider ID number, of Provider NPI when available.
2110	PLB03-2	Reference Identification		Will be the 'HFS Process Type' Code, the 'Recipient Identification Number' and the 'Document Control Number' (DCN) for Professional Claims, NCPDP (Pharmacy) and 'Long Term Care' Claims. For Institutional claims,

Loop ID	Reference	Name	Codes	Notes/Comments
				the ‘Patient Control Number’ will be reported

4 TI Additional Information

4.1 Payer Specific Business Rules and Limitations

Transmission Information:

The Department’s Medical Electronic Data Interchange (MEDI) system is designed to communicate electronic RA (835) information. After obtaining the proper MEDI authorization, these electronic transactions can be retrieved by the Payee. Most, but not all, of these registrations will take place using the new MEDI/IEC system once that system becomes available. Certain payees, such as managed care organizations, the dental services contractor, and other State of Illinois agencies, will require a manual registration process; and they will be contacted individually prior to these systems becoming available.

Once payees are authorized by a provider and registered with the Department, the Department will create an electronic RA in the 835 format regardless of the method by which the claim was submitted. Authorized payees are those parties to whom the provider has authorized the Department to make claim payments. Consistent with Department policy, only authorized payees will have access to RA notices, regardless of the format. The Department can only create the electronic RA, in the 835 format, beginning with the date upon which the authorized payee registers with the Department. The Department will make the 835 available to authorized and registered payees for a maximum period of 60 calendar days from the date of posting to the MEDI/IEC web site.

As with the paper RA, the Department will create a weekly electronic version of the 835 that contains only rejected claims. Please review these carefully to determine if a claim can be corrected and resubmitted to the Department for payment consideration.

Note: The Department will not report suspended claims on the 835. Information regarding a suspended claim can be obtained by sending a Claim Status Request (276 transaction) to the Department.

When necessary, the Department may exceed the Implementation Guide’s recommended limit of 10,000 CLP (claim) segments per ST-SE envelope.

Vouchers Under One Dollar

The Comptroller will not pay vouchers under a dollar. In order to report these vouchers while maintaining HIPAA compliance, HFS will use the PLB segment to reduce the

payment (element BPR02) to zero. Element PLB04 will be the total for the current voucher that is under one dollar. A qualifier code of “J1” will be used in element PLB03 to indicate that the payment was reduced due to a limitation that prevents payment.

In order for the payees to determine the exact cause for the payment reduction, they will need to examine the claim detail for individual payment amounts. When the payee sees the voucher total is below one dollar, he/she should conclude this is why no payment was received.

Zero Dollar Vouchers

There will be cases where the payment amount for a voucher is zero. Since the Comptroller will not create a check for less than a dollar, the 835 will still be made available to the payee. There will not be a check number. The payment date in element BPR16 will be replaced with the adjudication date of the voucher**.**

Reporting Procedure Codes for Outpatient Institutional Claims

In order to tell the provider what code was used to reimburse the claim, all procedure codes or revenue codes will be reported in the 835, regardless of whether the codes were used in adjudication. The procedure code or revenue code used for adjudication will be reported in element SVC01.

Exception: Institutional Outpatient Medicare crossover claims will not be reported on a service line item basis on the 835, but will instead be reported on a “claim” basis.

Claim Adjustment

An adjustment must be reflected at either the claim level or the service level but cannot be reflected in both. There can be only one claim adjustment reason code per dollar amount. If a claim has more than one error, only one reason code will be reported on the 835.

Service Provider Name

This segment will be used only if the provider is different from the Payee. HFS will always complete this loop because the payee number is always different from the Billing Provider Number. In Loop 2100, NM102 (ID Code), the provider will always be coded as a non-person because HFS’s provider database does not differentiate between person and non-person entities.

Corrected Priority Payer Name

This segment can only be used when HFS’s Recipient file shows that another payer has priority for making a payment and the provider has not reported this payer in the 837. In Loop 2100, NM109, the ID Code will contain HFS’s three-digit TPL code for that insurance company, followed by the group number.

Per Diem Reimbursement

The AMT segment will be used to report the per diem amount paid.

Disproportionate Share

The total amount reported on the 835 will include the disproportionate share amount.

Replacement and Void of Prior Claim Transactions

Provider initiated voids will be processed on the next available voucher. A provider initiated replacement claim (void/re-bill) will be vouchered on the same date as the void's matching re-bill claim. This will mean that the void will be held in the MMIS system until the replacement claim is adjudicated (paid or rejected).
When a post adjudication adjustment is created by either HFS or the provider, the original claim or service section will be voided/reversed and then recreated with the adjusted amount on the 835.

Note: According to the 835 Implementation Guide, the reversal does not contain any patient responsibility amount in CLP or CAS segments.

Mass Adjustment

A mass adjustment is used to adjust a paid claim when no detail is available on claims history, deposit a check received from a provider with no detail, and recover an amount owed to the Department due to an audit or possibly an open aged adjustment. There are several adjustment process types that are considered mass adjustments such as 09D, 32C, 15C, and 06C.

Mass-to-Detail (M-T-D) Adjustment

A calculated net adjustment comprised of one or more lines of detail adjustments processed by recipient and date of service. The net adjustment (mass) of the detail lines is posted as a credit or debit and paid or recovered on the remittance advice and can be identified as an "alien recipient". A report is mailed separately to provider, which provides the detail of the mass adjustment. The mass adjustment can be matched with the detail by using the document control number (DCN) on the remittance advice and detail report.

REMITTANCE ADVICE TRANSACTION SET AND TOTAL PAYMENT AMOUNT

When the payment amount in element BPR02 is 0 the following elements will be set as follows:

BPR01 = ‘H’
BPR04 = ‘NON’
N102 in loop 1000A (payer name) will be "ILLINOIS MEDICAID" .
N301 in loop 1000A (payer street address) will be "201 SOUTH GRAND AVENUE EAST"
N401 in loop 1000A (Payer city) will be "SPRINGFIELD"
N402 in loop 1000A (Payer state) will ‘IL’
N403 in loop 1000A (Payer ZIP) will be ‘62763’
When the payment amount in element BPR02 is greater than or equal to $1 the following elements will be set as follows:

BPR01 = ‘I’
BPR04 = ‘CHK’ or ‘ACH’
N102 in loop 1000A (payer name) will be "ILLINOIS COMPTROLLER" .
N301 in loop 1000A (payer street address) will be "325 W. ADAMS ST"
N401 in loop 1000A (Payer city) will be ‘SPRINGFIELD’
N402 in loop 1000A (Payer state) will ‘IL’
N403 in loop 1000A (Payer ZIP) will be ‘627041871’

4.2 Claim Overpayment and Recovery

The Department’s claims processing system will recognize that money is owed to the Department by a payee in several situations. One of these situations is when a previously paid claim is voided or is reduced as a result of a post-payment adjustment. Another situation, not related to specific claims, is when a review or a financial recovery instance results in the payee owing money to the Department.

In each situation, when it is recognized that the payee owes money to the Department, the amount of the credit due is posted to the Department’s accounting system. However, the credit may or may not be recouped or ‘applied’ within the same 835 transaction. A PLB segment containing the overpayment recovery (“WO”) qualifier in PLB03-1, with the negative dollar amount of the credit posted will be provided within the 835 to show that the credit is due but not yet recouped. When a recovery is made to satisfy this credit (either within the same 835 or a later 835) another PLB segment will be provided containing the dollar amount of the recovery (application of credit) expressed as a positive value and containing the overpayment recovery (“WO”) qualifier in PLB03-1.

=These two types of PLB segments will be provided in addition to the CLP segments (for detail claim voids or adjustments) and the PLB segments (for provider level adjustments) that caused the credit to be owed to the Department initially. These PLB segments serve to allow the 835 to balance to the amount paid. They also allow the payee to be notified of each instance of a credit amount due the Department and each application or

recovery of a credit, even when the application does not fully recover the entire amount owed to the Department. For Professional Claims, NCPDP (Pharmacy Claims) & Long Term Care Claims, three items of information will be included in the PLB03-2 element to enable the PLB segment to be associated with the original claim or provider level adjustment:

1. HFS Process Type code
2. Recipient Identification Number
3. Document Control Number (DCN) of the original claim or of the provider level adjustment.

For Institutional Claims, the patient control number will be reported in the PLB03-2 element to enable the PLB segment to be associated with the original claim or provider level adjustment.
The Department will not use the "forwarding balance" method, as allowed by the 835 - Implementation Guide, to denote the amount owed by the Payee.

Example of a Voided Claim

When a claim is voided, it will be reported in the 835 by using a CLP segment with a status code of 22. This CLP reversal will reduce the total payment amount represented in element BPR02. Since the amount owed to the Department as a result of voiding the previously paid claim may not be recovered within this 835, it is necessary to offset this amount to cause the payment in BPR02 to match the amount actually paid by the check associated with this 835. This is done by issuing a PLB segment with an adjustment qualifier of WO and a negative amount equaling the net effect of the reversal CLP segment.

RA on which the claim is voided:

CLP*1234*22*-100*-100****orig DCN 1*~
REF*F8*DCN of previous adjustment ~
PLB*prov num*20031231*WO:PRCS type recip ID orig DCN 1*-100~

A later RA on which the money owed is recovered:

PLB*prov num*20031231*WO:*PRCS type recip ID orig DCN 1**100~

Example of Voided Claim with Returned Check
When a claim is voided by the Payee remitting to the Department the amount of the net payment for the claim, the RA will reflect a PLB segment which contains a "WO" adjustment reason code for the amount as well as an offsetting adjustment "72" reason code and amount. No CLP segment will be returned. "PLB03-2" and "PLB05-2" will vary depending on the type of claim. Institutional claims will contain the patient account number, professional claims will contain adjustment process type, recipient number, and the original DCN, and Pharmacy claims will contain the prescription number.

RA on which the voided claim with returned check is shown:

PLB*prov num*19870430*WO:ClaimIdentifier*100*72:ClaimIdentifier*-100~

Example of a Re-billed Claim (Bill Frequency 7)

RA on which the original claim is reversed and replaced:
CLP*1234*22*-100*-100***orig DCN 1~*
REF*F8*DCN of previous adjustment~
CLP*1234*1*100*90***new DCN 2~*
REF*F8*orig DCN 1~
PLB*prov num*20031231*WO: PRCS type recip ID orig DCN 1*-100~

In this case, claim DCN 1 originally paid at $100 is being reversed. A new claim has been adjudicated at the new payment amount of $90. The PLB prevents the total payment of the voucher from being reduced and informs the payee that the money owed is not being recovered at this point.

RA on which the money owed is recovered:
PLB*prov num*20031231*WO: *PRCS type recip ID orig DCN 1**100~

The REF segment in loop 2100

Use of this segment is only for Long Term Care (LTC) claims and adjustments. The REF segment may be used in reversal CLP segments. This segment will carry the DCN of the previous adjustment if this claim has been adjusted prior to the current adjustment. If the current adjustment is the first adjustment then the REF segment will not be used. Element REF01 will have the qualifier F8 and element REF02 will have the DCN. This will allow the department to create a history chain from the most recent adjustment to the original claim.

This will include DCNs of the detail portions of MASS-to-DETAIL adjustments. The MASS-to-DETAIL adjustments are not sent in the 835 using the CLP reversal and correction process. MASS-to-DETAIL adjustments are reported in the PLB using the DCN of the mass portion of the MASS-to-DETAIL. In order to maintain the history chain in the reversal and correction process, the REF segment in the reversal CLP may refer to the DCN of a detail portion of a MASS-to-DETAIL adjustment. If the REF segment refers to a MASS-to-DETAIL DCN then the provider will not find that DCN in a CLP segment of a previous claim.

There will always be a REF segment in the correction CLP of all adjustments that create correction CLP segments. This REF segment will refer back to element CLP07 of the associated reversal segment, not the REF segment of the reversal CLP segment. Element REF01 will have the qualifier F8 and element REF02 will have the DCN.

PATIENT NAME (NM1) SEGMENT

The patient name is a required segment in the 835; however the patient name may not be available when processing a claim that was submitted prior to the implementation of HIPAA. Even prior to HIPAA, HFS would reject a claim submitted without the recipient

name or number; however, it is possible that HFS may have to reprocess pre-HIPAA claim data through the adjudication system.

When the 835 system encounters a rejected claim that has no recipient data then HFS will return “not received” in elements NM103 (last name) and NM104 (first name). If the recipient number is missing, HFS will return ‘000000000’ in element NM109 (identification code).
Questions, comments, or suggestions regarding this information should be directed to the HFS Webmaster.

5 TI Change Summary

Revision Date:	Revision Description:
Revision Date:	**Revision Description:**
Revision Date:	**Revision Description:**
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