835 Healthcare Claim Payment/Advice

Chapter 4: 835 – Claim Payment/Advice

Overview to Version 5010

The 835 Health Care Claim Payment/Advice provides detailed payment information about health care claims submitted to BCBSNC. The 835 Transaction may be returned for Professional and Institutional 837 Claim electronic submissions, as well as paper and electronic CMS 1500 and UB04 claims submissions.

835 Claim Payment/Advice Processing

Eligibility for the 835 Transaction

In order to receive a 5010 version of the 835 Claim Payment/Advice, submitters of health care claims must:

- Be a participating provider
- Complete and submit a BCBSNC Trading Partner Agreement to BCBSNC Electronic Solutions; **or** enter a contractual relationship with a clearinghouse or service bureau that has a BCBSNC Trading Partner Agreement in place to submit claims on your behalf.
- Complete an Electronic Connectivity Request (ECR) form, available online at www.bcbsnc.com/content/providers/edi/hipaainfo/agreements.htm . Complete the form and return to Electronic Solutions, per the instructions available at the same Web site location. (Note: The ECR form cannot be completed by a clearinghouse or service bureau on behalf of a provider.)
- Note for non-participating provider submitted claims, if payment is directed to the member, no 835 will be created.

Contact information for Electronic Solutions, ECR forms, and online testing is available at www.bcbsnc.com/content/providers/edi/index.htm .

Frequency of Data Exchange

BCBSNC sends an 835 Claims Payment/Advice batch transaction upon payment release, in response to all processed health care claims, except for Medicare Advantage, Medicare Supplement, and State claims, which process weekly.

Submitters should be aware that the 835 Transaction is not a paired transaction to the 837 Health Care Claim. Batch transmissions of the 835 do not directly correlate to batch transmissions of the 837. Response time to any submitted claim can vary, depending upon the processing requirements of the individual claim sent.

Electronic Funds Transfer (EFT)

The BCBSNC 835 Transaction is for notification only and does not include payment of funds, such as checks or Electronic Funds Transfers (EFT) to financial institutions. Trading partners

who would like to implement EFT should signup for EFT online, via Blue e.[1] A paper form for requesting EFT is also available online at www.bcbsnc.com . For questions about EFT, contact BCBSNC Financial Services at (919)765-2293.

BCBSNC is implementing a number of changes over the course of 2013, in order to be compliant with Health and Human Services (HHS) requirements for the Affordable Care Act related to Operating Rules for Health Care Electronic Funds Transfer (EFT) and Electronic Remittance Advice (HIPAA 5010 835 ERA).

HHS is adopting the CAQH CORE Phase III Operating Rules as recommended by the National Committee on Vital and Health Statistics (NCVHS) over the course of 2013. These operating rules are for standardizing electronic funds transfers (EFT) and health care payment and remittance advice transactions (HIPAA 5010 835 ERA) and include the

- Claim Payment/Advice (835) Infrastructure Rule 350
- Uniform Use of CARCs and RARCs (835) Rule 360 (implementation – June 2013)
- EFT and ERA Reassociation (CCD+/835) Rule 370
- EFT Enrollment Data Rule 380
- ERA Enrollment Data Rule 382

By December 31, 2013, these rules are mandated to be implemented for all BCBSNC systems and lines of business to achieve Healthcare Reform Operating Rule compliance. These rules are effective January 1, 2014. For more information about the CAQH-CORE operating rules, see http://www.caqh.org/CORE_phase3.php

Interchange Envelope (ISA/IEA) Structuring

Each Interchange Envelope (ISA/IEA) will contain all the remittances posted for an individual provider, with separate Transaction Sets (St/SE) within the Interchange containing that provider's remittances for a specific line of business. Usually only one 835 Interchange Envelope is posted to a trading partner per day, with occasional exceptions, such as 835 transmissions for Medicare Advantage products. The electronic bulletin board, or mailbox batch ID for commercial products is P_O_CE835R.

The electronic bulletin board, or mailbox batch ID for Medicare Advantage products is P_O_MA835R. Medicare Advantage 835 transmission happens only once a week, on Tuesdays.

Claims Remittance Processing

Important Notices:

1. The level of detail in the remittance response depends on the level of detail on the associated claim. Claims containing line level detail will receive a line level of detail on the corresponding 835, and claims containing only claim level detail will receive claim level responses in the corresponding 835.

2. BCBSNC generates electronic 835 Transactions only for claims that have a "paid" or "denied" record on file. Claims that are still in the adjudication process or that have been returned with error messages do not receive an 835 response. Electronic submitters wishing to verify receipt of an 837 submission should access their Claims Audit Report, use an X12 276/277 Claim Status Inquiry, or access the Claims Status transaction online in ***Blue***

[1] To manage your EFT account via ***Blue e***, an authorized signatory for the provider must set up an EFT-entrusted user through the ***Blue e*** 'Manage Your Account' transaction. Once your user has been added, he or she will have access to the EFT transaction in ***Blue e***.

e .

3. BCBCNC returns an Explanation of Payment (EOP) in addition to the electronic 835 Transaction for both paper claims and 837 electronic claims. If BCBSNC is unable to produce a HIPAA compliant 835 Claim Payment Advice, the payment is still recorded on the EOP. Providers can review their EOPs online in ***Blue e*** . Providers who have not registered for the free ***Blue e*** service can do so at www.bcbsnc.com/providers/edi/bluee.cfm . Providers who elect not to use ***Blue e*** receive paper EOPs by post.

Batch Matching and Claims Matching

Submitters should note that there is no batch matching between 837 Health Care Claims and 835 Remittances. Claims submitted via batch transactions might be split and regrouped in bundles that are inconsistent with the original batch received. Submitters must match specific claims with specific remittance advice received on the 835 Transaction by the Patient Control Number (Patient Account Number) from the Claims Payment Information Loop, CLP01. This control number matches the 837 Health Care Claim Element CLM01.

Bundling and Unbundling for Professional Services

As claims are processed, professional services reflected by procedure codes are bundled or unbundled according to BCBNSC business processes. Procedure codes are returned for professional health care claims as processed, reflecting the BCBSNC payment record. Procedure codes are also returned for claims submitted via 837, per HIPAA TR3 regulation.

Reporting

The 835-PLB CS Adjustment Report is distributed to any trading partner receiving the 835 Remittance Advice transaction when the PLB03-1 segment equals "CS" and PLB03-2 segment equals "Paper Payment". The adjustment report identifies those health care claims remittances not listed in the 835 transaction due to failure to pass HIPAA Technical Report (Type 3) edits. BCBSNC expects the claims remittances listed on this report to be a very small proportion of any provider's total remittances.

This report should assist BCBSNC trading partners and health care providers in reconciling their billing systems if they have been using only the 835 Remittance for reconciliation of accounts. Providers should manually post the remittances listed in the ***835-PLB CS Adjustment Report*** to their internal systems, cross-referencing with their Explanation of Payment (EOP) for complete claims remittance information.

Remittance information on this report is claim payment information and does not include line item detail. The detail of the report includes the Claim ID (Processing System ID), Patient Account Number, Patient/Subscriber ID, Patient Name, Service Start and End Date, Charge Amount, Paid Amount from the payment record that are reported on the paper notification.

See a sample of the 835-PLB CS Adjustment Report at the end of this chapter. The report provides the number of claims remitted and total money value of the remittances sent within the 835 transaction, as well as totals for those claims remittances listed on the report.

Trading partners can find their ***835-PLB CS Adjustment Report*** by looking in their mailboxes for the following batch ID: **P_O_CE835M_Posting_Report**

Business Processes

835 Mapping from 837

Any mapping conditions particular to BCBSNC business rules are identified on the 835 Data Element Table contained in this chapter.

Identification Codes and Numbers

In creating the 835 Transaction, BCBSNC uses the standard medical and non-medical codes sets prescribed in Appendix A of the 835 Technical Report (Type 3). Discretionary identifiers within the 835 Transaction are listed below, with explanations of BCBSNC usage for those identifiers.

Provider Identifier

The 835 Transaction returns the National Provider Identifier (NPI) in1000B, Payee ID, N104 and the Payee's Tax ID in a subsequent iteration of the1000B, Payee Additional ID, REF02 (where REF01=TJ).

Subscriber Identifier

The Subscriber Identifier returned on the 835 Claim Payment/Advice is the Membership ID as it appears within the BCBSNC system. If this identifier differs from that which was submitted on the health care claim, assume that the identifier returned on the 835 transaction is correct.

Payer Claim Control Number

The Claims Identifier is the BCBSNC generated number for tracking the claim. This identifier is returned on the 835 in the 2100 Loop, CLP07. Receivers of the 835 are advised to use their patient account numbers (Patient Control Number CLP01) and dates of service, in conjunction with the CLP07 value, to match submitted claims with remittances. For non-837 submitted claims, submitters should note that the patient account number fields on the CMS1500 and UB04 claims are not used for processing by BCBSNC. For these claims, a default value of zero is used for CLP01.

If the claim is for a BlueCard Subscriber and handled through Blue Exchange, the CLP07 value consists of the Payer Claim Control Number (first 11 digits) and the SCCF number (subsequent 15 digits). Submitters should use all 26 digits when making customer support inquiries about claims.

Payment Identifier

The Payment Identifier is contained in the Version Identification REF02. Use the Re-association Trace Number (TRN02) and the Version Identification (REF02) to identify the record when making customer support inquiries about payment received via an 835.

Adjustment Group and Reason Codes

The 835 Transaction Standard limits the content of the Claim and Service Adjustment Group and Adjustment Reason Code Elements (CAS01 and CAS02*) to those codes listed in Washington Publishing Company's (WPC) Health Care Claim Adjustment Reason Code Guide (see the **WEDI** Web site at **www.wpc-edi.com/codes** for the complete code list).

*Note that the CAS Elements reporting at the claim level and appear in the 2100 Loop; if the claim adjudicated at the line level, the CAS segments report in the 2110 Loop.

Remittance Advice Remark Codes

The HIPAA 835 transaction provides the ability for a payer to further describe details of reimbursement results through the use of Remittance Advice Remark (RAR) Codes. There are three locations within the 835 transaction where these codes can be placed. Depending on

whether the claim adjudicated at the claim or line level, and whether the patient was a Medicare inpatient or outpatient, determines what element contains the RAR codes.

- The MIA and MOA segments on the Claim Payment Information loop (2100 Loop) return the Remittance Advice Remarks Codes for claims processed at the claim level. Each of these segments allow up to 5 different Remittance Remark Codes for each claim.

- The LQ segment on the Service Payment Information loop (2110) is used to send up to 99 different Remittance Remark Codes for each line on a line-level detail claim.

Special Handling

In the event that an electronic 835 Remittance Advice cannot be generated from an adjudicated health care claim, only an NOP or EOP is generated, and the remittance will be included in 835-PLB CS Adjustment Report. Submitters are advised that the turn-around time for a paper remittance advice is generally longer than that of an electronically generated 835 transaction.

Corrections and Reversals

Corrected claims will generate an 835 transaction showing the claim reversal and a separate transaction showing the corrected claim.

For Medicare Advantage products, the service line is adjusted and the original claim and claim number is retained. The service line numbers will change. The correction will show as a reversal of the service line, and not a reversal of the claim.

Inquiries

The following section provides guidelines for making successful inquiries about 835 Remittances or Payment Advice.

File Transmission Inquiries

For inquiries about file transmission or file errors, contact the eSolutions HelpDesk at (919) 765-3514 or (888) 333-8594 or email them at EDICUSSUP@bcbsnc.com . Callers should reference the following 835 data elements when making inquiries about specific remittance files or transmissions:

835 Data Element ID	835 Segment Name	TR3 Element
Header, TRN02	Re-association Trace Number	Reference Identification
Header, REF02	Version Identification	Reference Identification (For a list of version identifiers used by BCBSNC, see the Data Element Table below.)
Header, DTM02	Production Date	Date

Remittance Amount Inquiries

For inquiries about the total on the remittance/advice or receipt of a NOP/EOP, contact BCBSNC Financial Services at (919)765-2293. For inquiries regarding specific claim payment, contact the proper area of BCBSNC business by using the telephone number on the subscriber's identification card. Callers should reference the following 835 data elements when making inquiries about specific claim remittances:

835 Data Element ID	835 Segment Name

Loop 2100, NM103	Patient Name (Last Name)
Loop 2100, NM109	Patient Name (Patient ID)

State Plan Inquiries

For Inquiries about claims remittances for State Employees Health Plan, contact 1-888-234-2416.

835 Data Element Table

The following Data Element Table defines some of the specific BCBSNC business rules applicable to the 835 Remittance.

Transaction: 835 Health Care Claim Payment/Advice					
Loop ID	**Segment Type**	**Segment Designator**	**Element ID**	**Data Element**	**BCBSNC Business Rules**
	BPR	Financial Information			
			01	Transaction Handling Code	BCBSNC uses only values H or I, Notification or Remittance Information.
			02	Monetary Amount	This value reflects the total monetary amount of claims remitted electronically. On a paper remittance (EOP), this value equals the total check amount.
			04	Payment Method Code	BCBSNC returns one of two possible values: ACH (electronic funds transfer) or CHK (check).
			15	Account Number	If payment method is 'ACH' then populate with the payee's account number
			16	Date	If payment method is 'CHK, then populate with the check date. If the payment method is 'ACH' populate with the check date + 2 days
	TRN	Re-association Trace Number			
			02	Reference identification	When making inquiries about the 835, use the TRN02 and the REF02 for Version Identification to identify the record.
	REF	Version Identification			
			02	Reference identification	The following identifiers are used: • BEBFAA053D (Blue, State, & NCHC Products) • BEBFAA068D (IPP/BlueCard Host) • CLMA278DF1 (Federal Employees Plan) • CLMA003DF3 (Federal Employees Plan) • MPAMISYS (Medicare Supplemental) These numbers are helpful in problem resolution when contacting Customer Support regarding an 835.
	DTM	Production Date			
			02	Date	This value reflects the payment system run date.
1000A	PER	Payer Technical Contact Information			
			02	Contact Function Code	BCBSNC returns a value of “BL”
			03	Communication Qualifier	BCBSNC returns a value of TE
			04	Communication Number	BCBSNC returns a value of 8883338594.

Transaction: 835 Health Care Claim Payment/Advice					
Loop ID	**Segment Type**	**Segment Designator**	**Element ID**	**Data Element**	**BCBSNC Business Rules**
	PER	Payer Web Site			Note: this segment is not returned for any local member 835, and will only be sent IF the IPP Host plan has sent BCBSNC a Medical Policy ID for use in the 2100 REF Segment.
			03	Communication Qualifier	BCBSNC returns a value of UR
			04	Communication Number	If the host plan has sent us the 2100 REF Segment, BCBSNC sends a value of www.bcbsnc.com/content/services/medical-policy/index.htm
1000B	N1	Payee identification			
			02	Name	Payee Name from BCBSNC internal systems
			03	Identification Code Qualifier	BCBSNC returns a value of XX , except for Medicaid Subrogation payments, which are identified by a value of FI.
			04	Identification Code	Your National Provider ID number is returned; or, when N103 = FI, the Medicaid Tax ID or EIN is returned
	N3	Payee Address			
			01	Address Information	Payee Address 1 from BCBSNC internal systems
			02	Address Information	Payee Address 2 from BCBSNC internal systems
	N4	Payee City/State/Zip Code			
			01	City Name	Payee City from BCBSNC internal systems
			02	State or Province Code	Payee State Code from BCBSNC internal systems
			03	Postal Code	Payee Zip Code from BCBSNC internal systems
	REF	Additional Payee Identification			
			01	Reference Identification Qualifier	A value of TJ (Federal Tax ID) is returned.
			02	Payee Identification	The REF02 value is your Federal Tax ID.
2100	CLP	Claim Payment Information			
			01	Claim submitter's Identifier	This data element references the "Patient Control/Account Number" submitted on either the 837 Institutional or the 837 Professional (Loop 2300 CLM01); if this value has not been submitted on a paper claim, the default value is "0".
			02	Claim Status Code	BCBSNC uses only the following code values: • 1 (Processed as Primary)

Transaction: 835 Health Care Claim Payment/Advice					
Loop ID	**Segment Type**	**Segment Designator**	**Element ID**	**Data Element**	**BCBSNC Business Rules**
					• 2 (Processed as Secondary) • 3 (Processed as Tertiary) • 4 (Denied as patient is not active on DOS) • 22 (Reversal of Previous Payment).
			03	Monetary Amount (Total Charge)	This value reflects the Claim Charge Amount.
			04	Monetary Amount (Claim Payment)	This value reflects the Claim Paid Amount..
			05	Monetary Amount (Patient Response)	This value reflects the Claim Patient Responsibility Amount
			07	Reference Identification	Use CLP07 when making inquiries regarding claim payment.
			08	Facility Code Value	This value is returned when sent on the original claim.
			09	Claim Frequency Type Code	This value is returned when sent on the original claim.
2100	CAS	Claim Adjustment			
				Entire Segment	This segment is relevant only for Institutional claims processed at the claim level.
			01	Claim Adjustment Group Code	• CO= Contractual Obligation • OA = Other Adjustments • PI = Payor Initiated Reductions • PR = Patient Responsibility
			02	Claim Adjustment Reason Code	BCBSNC uses the standard Claim Adjustment Reason Codes.
			03	Monetary Amount	Dollar amount of the adjustment. Negative numbers indicate payment increases. Positive numbers indicate payment reductions.
	NM1	Patient Name			
			03-5	Name	BCBNC returns the patient name as it appears in the system.
			09	Identification Code	Member's identification number.
2100	NM1	Insured Name			
			03-5	Name	This element is returned only if the insured name in the claim is different from that of the BCBNC processing system. If used, BCBSNC returns the insured name as it appears in the processing system.
			09	Identification Code	Member's identification number.
	MIA	Inpatient Adjudication Information			

Transaction: 835 Health Care Claim Payment/Advice					
Loop ID	**Segment Type**	**Segment Designator**	**Element ID**	**Data Element**	**BCBSNC Business Rules**
				Whole Segment	This segment is not returned if the claim is reported at the line level. If the claim adjudicated at the line level, the Reason Adjustment Remark Code can be found in the LQ segment.
	MOA	Outpatient Adjudication Information			
				Whole Segment	This segment is not returned if the claim is reported at the line level. If the claim adjudicated at the line level, the Reason Adjustment Remark Code can be found in the LQ segment.
	NM1	Other Subscriber Name			This segment is present only when the Corrected Payer Loop is populated and either the Other Subscriber Name (NM103) or Member ID (NM108/NM109) is available in the payment system.
	REF	Other Claim Related Identification Segment			This segment is included for corrected claims with a new claim ID (REF01=F8 and REF02= the claim ID of the reversed claim).
	DTM	Coverage Expiration Date			
			01	Date/Time Qualifier	BCBSNC sends a value of 36 when CLM02 equals 4 (i.e. the patient is no longer a member).
	AMT	Claim Supplemental Information			
			01	Amount Qualifier Code	BCBSNC uses only a value of "I" (Interest) for this qualifier.
			02	Monetary Amount	Claim interest amount at the claim level.
2110	SVC	Service Payment Information			
				Entire Segment	This segment is relevant only for claims processed at the line level.
			01-1	Product/Service ID Qualifier	BCBSNC utilizes only the following codes: • AD, for Dental Claims • HC, for Professional Claims • NU, for Institutional Claims processed at the line level
			01-2	Product/Service Identifier	The code used for adjudication is reported in this data element.
			01-4	Product/Service Identifier	Only present when the SVC01-2 contains a revenue code. This element is NOT sent for a professional claim.
	CAS	Claim Adjustment			
				Entire Segment	Used only for claims adjudicated and paid at the line level.

Transaction: 835 Health Care Claim Payment/Advice					
Loop ID	**Segment Type**	**Segment Designator**	**Element ID**	**Data Element**	**BCBSNC Business Rules**
			01	Claim Adjustment Group Code	• CO= Contractual Obligation • OA = Other Adjustments • PI = Payor Initiated Reductions • PR = Patient Responsibility
			02	Claim Adjustment Reason Code	BCBSNC uses the standard Claim Adjustment Reason Codes.
			03	Monetary Amount	Dollar amount of the adjustment. Negative numbers indicate payment increases. Positive numbers indicate payment reductions.
	REF	Line Item Control Number			BCBSNC returns this segment if: 1. BCBSNC received the line item control number in the REF02, Loop 2400 of the 837 Institutional (and REF01=6R) and we paid and report the claim at the line level; or 2. BCBSNC received the line item control number in the REF02, Loop2400 of an 837.
	REF	Health Care Policy Identification			This segment may be sent only for BlueCard remittances if the data has been returned from the Blue home plan. If present, the 1000A PER Medical Policy URL segment is also sent.
2110	LQ	Health Care Remarks Code			
			02	Industry code	If needed, B CBSNC sends the Remittance Advice Remark Codes for line-level adjudicated claims.
	PLB	Provider Adjustment			
				Entire Segment	Payee level Adjustments
			03-1	Adjustment Reason Code	BCBSNC uses only the following PLB03:1 values: • 72 = Authorized Return, used for Refund (Note: This value is not returned for Medicare Advantage or Medicare Supplemental products.) • CS = Adjustment • FB = Forwarding balance • L6=Interest Owed, used for Total Interest Paid • WO=Overpayment Recovery, used for Voucher Deduct
			03-2	Reference Identification	BCBSNC always sends a reference ID; the value is dependent upon the Adjustment Reason Code in PLB03:1. • If PLB03:1 equals CS, FB, L6, or WO, the PLB03:2 equals the TRN02 value • If PLB03:1 equals 72, the PLB03:2 equals the claim number.

Transaction: 835 Health Care Claim Payment/Advice					
Loop ID	Segment Type	Segment Designator	Element ID	Data Element	BCBSNC Business Rules
			04	Monetary Amount	Dollar amount of the adjustment. Negative numbers indicate payment increases. Positive numbers indicate payment reductions.

835 Transaction Samples

Sample 1 – 835 Remittance for Unbundling Professional Claim

Scenario

This scenario depicts the use of the ANSI ASC X12 835 in a Professional Health Care environment. In this scenario, one provider is involved with one unbundling claim.

The following assumptions pertain:

- The Receiver is XYZ Regional Healthcare Corporation
- Their Tax ID 987654321
- Their mailing address is PO Box XYZ, Charlotte, NC 28234
- Check number is 02790758
- Check date is 01/08/2011; Check amount is $1922.86

Claim:

- Claim total charge is $2100.00
- Claim paid amount is $1922.86, paid as primary indemnity coverage.
- Patient account number is 20030964A52
- Claim number is 94151100100 (all 11 digits of our claim number)
- Claim receiver date is 01/03/2011
- Subscriber and patient is Mary Dough – Member ID is YPB123456789001
- Patient Responsibility is $142.54

Claim Line 1:

- Health Service Code is 59430
- Line charge is $1210.00
- Line Paid Amount is $1057.86
- Date of Service is 12/31/2010
- Denied CO (Contractual Obligation) amount is $34.60
- Denied reason code is 45 (charges exceed our fee schedule or maximum allowable amount)
- Claim Adjustment Group Code PR (Patient Responsibility) amount is $117.54
- Claim Adjustment Reason code is 2 (coinsurance)
- Allowed amount is $1175.40

Claim Line 2:

- Health Service Code is 59440
- Line charge is $890.00

- Line paid amount is $865.00
- Date of Service is 12/31/2010
- Denied PR (patient responsibility) amount $25.00
- Denial reason 3 (copayment)
- Allowed amount $148.00

Claim Line 3:

- Health Service Code is 59426
- Line charge $742.00
- Line paid amount $742.00
- Date of Service is 12/31/10
- Allowed Amount is $742.00

Data String Example

This is an example of the actual data string that would be transmitted in the 835 Payment/Advice. The data is presented in an unwrapped format, with carriage returns separating each Segment.

ST*835*1234~
BPR*I*1922.86*C*CHK**********20110108~
TRN*1*02790758*560894904~
REF*F2*LCLA438D~
DTM*405*20110104~
N1*PR*BLUE CROSS AND BLUE SHIELD OF NORTH CAROLINA~
N3*P O BOX 2291~
N4*DURHAM*NC*27702~
PER*CX*TE*8005554844~
N1*PE*XYZ HEALTHCARE CORPORATION*XX*0987654321~
N3*P O BOX XYZ~
N4*CHARLOTTE*NC*28234~
REF*TJ*123456789~
LX*1~
CLP*200200964A52*1*2100*1922.86*142.54*15*94151100100~
NM1*QC*1*Dough*Mary****MI* YPB123456789001~
DTM*050*20110103~
SVC*HC:59430*1210*1057.86**1*HC:59410~
DTM*472*20101231~
CAS*CO*42*34.6~
CAS*PR*2*117.54~
REF*6R*0001~
AMT*B6*1175.4~
SVC*HC:59440*890*865**1*HC:59410~
DTM*472*20101231~
CAS*PR*3*25~
REF*6R*0002~
SVC*HC:59426******742*742**1~
DTM*472*20101231~
REF*6R*0003~
AMT*B6*742~
SE*33*1234~

File Map – 835 Remittance for Unbundled Professional Health Claim

File Map – 835 Remittance for Unbundled Professional Health Claim										
	Loop ID		Segments	Elements						
1		Transaction Set Header	ST	ST01	ST02					
				835	1234~					
1		Financial Information	BPR	BPR01	BPR02	BPR03	BPR04	BPR05	BPR06	BPR07
				I	1922.86	C	CHK			
		Financial Information - CONTINUED		BPR09	BPR10	BPR11	BPR12	BPR13	BPR14	BPR16
										20120108~
1		Reassociation Trace Number	TRN	TRN01	TRN02	TRN03				
				1	02790758	560894904				
1		Version Identification	REF	REF01	REF02					
				F2	LCLA438D~					
1		Production Date	DTM	DTM01	DTM02					
				405 (Payment run date)	20100104~					
1	1000A	Payer Identification	N1	N101	N102					
				PR	BLUE CROSS AND BLUE SHIELD OF NORTH CAROLINA~					
1	1000A	Payer Address	N3	N301						
				P O BOX 2291~						
1	1000A	Payer City, State, Zip Code	N4	N401	N402	N403				
				DURHAM	NC	27702~				
1	1000A	Payer Contact Information	PER	PER01	PER02	PER03	PER04			
				CX		TE	1-800-555-4844~			
1	1000B	Payee Identification	N1	N101	N102	N103	N104			

File Map – 835 Remittance for Unbundled Professional Health Claim

	Loop ID		Segments	Elements						
				PE	XYZ HEALTHCARE CORPORATION	XX	0987654321~			
1	1000B	Payee Address	N3	N301						
				P O BOX XYZ~						
1	1000B	Payee City/State/zip	N4	N401	N402	N403				
				Charlotte	NC	28234~				
1	1000B	Additional Payee Identification	REF	REF01	REF02					
				PQ	0275W~					
1	1000B	Additional Payee Identification	REF	REF01	REF02					
				TJ	123456789~					
1	2100	Claim Payment Information	CLP	CLP01 (Pat Control #)	CLP02 (Claim Status Cd)	CLP03 (Claim Charge)	CLP04 (Claim Pmt)	CLP05 (Pat Resp)	CLP06 (LOB Indemnity)	CLP07 (Clm ID SCCF)
				200200964A52	1	2100	1922.86	142.54	15	94151100100~
1	2100	Patient Name	NM1	NM101	NM102	NM103	NM104	NM108	NM109	
				QC	1	Dough	Mary	MI	YPB123456789001	
1	2100	Claim Date	DTM	DTM01	DTM02					
				50	20120103~					
1	2110	Service information	SVC	SVC01-1 (Product Identifer)	SVC01-2 (Code)	SVC02 (Line Charge Amount)	SVC03 (Line Paid Amount)	SVC04 (Revenue Code)	SVC05 (Paid Units of Service)	
				HC	59430	1210	1057.86		1	
		Service information CONTINUED		SVC06-1 (Product Identifer)	SVC06-2 (Code)					
				HC	59410~					
1	2110	Service Date	DTM	DTM01	DTM02					
				472	20101231~					

File Map – 835 Remittance for Unbundled Professional Health Claim										
	Loop ID		Segments	Elements						
1	2110	Service Adjustment	CAS	CAS01	CAS02	CAS03				
				CO	42(CHARGES EXCEED OUR FEE SCHEDULE OR MAXIMUM ALLOWED AMOUNT)	34.6~				
1	2110	Service Adjustment	CAS	CAS01	CAS02	CAS03				
				PR	2(COINSURANCE)	117.54~				
1	2110	Service Identification	REF	REF01	REF02					
				6R	01~					
1	2110	Service Supplemental Information (Allowed amount)	AMT	AMT01	AMT02					
				B6	1175.4~					
1	2110	Service information	SVC	SVC01-1 (Product Identifer)	SVC01-2 (Code)	SVC02 (Line Charge Amount)	SVC03 (Line Paid Amount)	SVC04 (Revenue Code)	SVC05 (Paid Units of Service)	SVC06
				HC	59440	890	865		1	HC:59410~
1	2110	Service Date	DTM	DTM01	DTM02					
				472	20101231~					
1	2110	Service Adjustment	CAS	CAS01	CAS02	CAS03				
				PR	3(COPAY)	25~				
1	2110	Service Identification	REF	REF01	REF02					
				6R	01~					
1	2110	Service Supplemental Information (Allowed amount)	AMT	AMT01	AMT02					
				B6	148~					
1	2110	Service information	SVC	SVC01-1 (Product Identifer)	SVC01-2 (Code)	SVC02 (Line Charge Amount)	SVC03 (Line Paid Amount)	SVC04 (Revenue Code)	SVC05 (Paid Units of Service)	
				HC	59426	742	742		1~	

File Map – 835 Remittance for Unbundled Professional Health Claim

	Loop ID		Segments		Elements						
1	**2110**	**Service Date**	**DTM**		**DTM01**	**DTM02**					
					472	20101231~					
1	**2110**	**Service Identification**	**REF**		**REF01**	**REF02**					
					6R	01~					
1	**2110**	**Service Supplemental Information (Allowed amount)**	**AMT**		**AMT01**	**AMT02**					
					B6	742~					
1		**Transaction Set Trailer**	**SE**		**SE01**	**SE02**					
32					32	1234~					

Sample 2 - 835 Remittance for Institutional Claim
(Diagnosis Related Group (DRG) Rate Greater Than Actual Charge)

Scenario
This scenario depicts the use of the ANSI ASCX12 835 in an Institutional Health Care environment. In this scenario, an inpatient claim has a DRG rate greater than charge.

The following assumptions pertain:
- The receiver is provider Acme University Health System, Tax ID number 1234567890 Mailing Address – PO Box AAA1, Durham, NC 27701-6508
- Check Number 70408535
- Check dates 20100923
- Total check amount $15,096.46

Claim data:
- Total charge is $3,740.60
- Claim paid amount, paid as primary is $5,451.04
- Subscriber and patient is Roger Rabbit, Member ID is RUN123456789

Reported on NOP and Payment Record:
- Charge amount is $3,740.60
- Case Rate $3490.00
- Paid $5451.04
- Payment adjustment due to contract obligation - CO (contractual obligation) $-1710.44/drg exceeds charge.

Data String Example
This is an example of the actual data string that would be transmitted in the 835 Payment/Advice. The data is presented in an unwrapped format, with carriage returns separating each Segment.

```
ST*835*1234~
BPR*I*15096.46*C*CHK**********20100923~
TRN*1*70408535*15714001~
REF*F2*slca435w~
DTM*405*20100923~
N1*PR*NC TEACHERS & STATE EMPLOYEES HEALTH PLAN & HEALTH CHOICE~
N3*P O BOX 30025~
N4*DURHAM*NC*27702~
PER*CX**TE*8002144844~
N1*PE*ACME UNIV HLTH SYS INC*XX*1234567890~
N3*P O BOX AAA1~
N4*DURHAM*NC*27701~
REF*TJ*123456789~
CLP*474623UB001CW0321*1*3740.6*5451.04**15*80209000000*11*1**397*0.7309~
CAS*CO*94*-1710.44~
NM1*QC*1*Rabbit*Roger*B***MI* RUN123456789~
MIA*0~
REF*EA*CW0321~
```

DTM*232*20100307~
DTM*233*20100310~
DTM*50*20100918~
AMT*AU*5451.04~
SE*21*1234~

File Map – 835 Remittance for Institutional Claim (DRG Rate Greater Than Actual Charge)

File Map – 835 Remittance for Institutional Claim (DRG Rate Greater Than Actual Charge)															
	Loop ID	**Segment Name**	**ID**	**Elements**											
1		**Transaction Set Header**	**ST**	**ST01**	**ST02**										
				835	1234~										
1		**Financial Information**	**BPR**	**BPR01**	**BPR02 (check amount)**	**BPR03**	**BPR04**	**BPR05**	**BPR06**	**BPR07**	**BPR08**				
				I	15096.46	C	CHK								
		Financial Information - CONTINUED		**BPR09**	**BPR10**	**BPR11**	**BPR12**	**BPR13**	**BPR14**	**BPR15**	**BPR16**				
											20100323~				
1		**Reassociation Trace Number**	**TRN**	**TRN01**	**TRN02**	**TRN03**									
				1	70408535	15714001~									
1		**Version Identification**	**REF**	**REF01**	**REF02**										
				F2	SLCA435W~										
1		**Production Date**	**DTM**	**DTM01**	**DTM02**										
				405 (Payment run date)	20100323~										
1	**1000A**	**Payer Identification**	**N1**	**N101**	**N102**										
				PR	NC TEACHERS' & STATE EMPLOYEES' HEALTH PLAN & HEALTH CHOICE~										
1	**1000A**	**Payer Address**	**N3**	**N301**											
				P O BOX 30025~											
1	**1000A**	**Payer City, State, Zip Code**	**N4**	**N401**	**N402**	**N403**									
				DURHAM	NC	27702~									
1	**1000A**	**Payer Contact Information**	**PER**	**PER01**	**PER02**	**PER03**	**PER04**								

File Map – 835 Remittance for Institutional Claim (DRG Rate Greater Than Actual Charge)

	Loop ID	Segment Name	ID	Elements										
				CX		TE	1-800-214-4844~							
1	**1000B**	**Payee Identification**	**N1**	**N101**	**N102**	**N103**	**N104**							
				PE	ACME UNIV HLTH SYS INC	XX	1234567890~							
1	**1000B**	**Payee Address**	**N3**	**N301**										
				P O BOX AAA1~										
1	**1000B**	**Payee City/State/zip**	**N4**	**N401**	**N402**	**N403**								
				DURHAM	NC	27701-1737~								
1	**1000B**	**Additional Payee Identification**	**REF**	**REF01**	**REF02**									
				PQ	0003R~									
1	**1000B**	**Additional Payee Identification**	**REF**	**REF01**	**REF02**									
				TJ	123456789~									
1	**2100**	**Claim Payment Information**	**CLP**	**CLP01 (Pat Control #)**	**CLP02 (Claim Status Cd)**	**CLP03 (Claim Charge)**	**CLP04 (Claimm Pmt)**	**CLP05 (Pat Resp)**	**CLP06 (LOB Indemnity)**	**CLP07 (Clm ID SCCF)**	**CLP08 (Clm Fam Type Cd)**	**CLP09 (Clm Freq Cd)**	**CLP11 (DRG Code)**	**CLP12 (DRG Wt)**
				474623UB001CW0321	1	3740.6	5451.04		15	80209000000	11	1	397	0.7309~
1	**2100**	**Claim Adjustment**	**CAS**	**CAS01**	**CAS02**	**CAS03**								
				CO	94	-1710.44~								
1	**2100**	**Patient Name**	**NM1**	**NM101**	**NM102**	**NM103 (Last Name)**	**NM104 (First Name)**	**NM105 (M Initial)**	**NM106**	**NM107**	**NM108**	**NM109 (Subscriber ID)**		
				QC	1	Rabbit	Roger	B			MI	RUN123456789~		

File Map – 835 Remittance for Institutional Claim (DRG Rate Greater Than Actual Charge)

	Loop ID	Segment Name	ID	Elements										
1	2100	Inpatient Adjudication Information	MIA	MIA01 (Default = 0 if segment is used)	MIA02	MIA03	MIA04	MIA05	MIA06 (Dir Med Factor)	MIA07	MIA10	MIA11 (Disp Shr Factor)	MIA12	MIA13 (Indir MED ED/Ind Med Factor
				0					89.05			173.29		374.98~
1	2100	Other Claim Related Identification	REF	REF01	REF02									
				EA	CW0321~									
1	2100	Claim Date	DTM	DTM01	DTM02									
				50 (Receive date)	20100318~									
	2100	Claim Supplemental Information	AMT	AMT01	AMT02									
				AU	5451.04~									
1	2100	Claim Date	DTM	DTM01	DTM02									
		(Start Service)		232	20100307~									
1	2100	Claim Date	DTM	DTM01	DTM02									
		(End Service)		233	20100310~									
1		Transaction Set Trailer	SE	SE01	SE02									
21				21	1234~									

Sample: 835-PLB CS Adjustment Report (Claim Level)

(Note: This report is returned for all lines of business, including Medicare Advantage.)

```
ED835R01                                BlueCross BlueShield of North Carolina            07/15/2010       Page: 1 of 1
                                                 835/PLB CS Adjustment Report
 Transaction Receiver: 561561561

 BATCH Level Information:
                                                                                 Good        Good       Bad          Bad          Total
                    Check/EFT       Check/EFT       Total Check                Claims      Claims     Claims       Claims       Batch
   Payee ID           Number           Date           Amount                   Count       Dollars    Count        Dollars      Count
-------------------------------------------------------------------------------------------------------------------------------------
Batch

6786786783        1002051930001069   07/03/2010      $77,210.55               1194      $76,625.00    5          $575.55       1199


 Patient ID                Patient Acct #        Patient Last Name/        Patient First Name/                    Paid
 Claim ID                  Service Start               Service End             Charged Amount                   Amount
-------------------------------------------------------------------------------------------------------------------------------------
Claim(s)
YPP11122233301             235A45666                    DOUGH                    JOHN
0105011005501             07/01/2010                  07/01/2010                500.55                        300.55


YPZ11122333301             235A45J678                    LADY                   LOVELY
0105131005501             07/01/2010                  07/01/2010                100.00                         50.00


ZCS11123456701             235A451178                   CHEEK                   ROSIE
0105141005501             07/01/2010                  07/01/2010                 75.00                         25.00

YPH11223333301                AAA7878                   MOUSER                  MICKEY
0105011005601             07/01/2010                  07/01/2010                400.00                        300.00

YPY11122342451                 ZZZ235                    SMITH                   JOHN
0105011005701             07/01/2010                  07/01/2010               -250.00                       -100.00
```

For additional information regarding these claims, please refer to the Explanation of Payment.

This report is generated to assist in balancing provider accounts and should be used in conjunction with the HIPAA 835 Remittance.

Document Change Log

The following change log identifies changes that have been made from version 1.0 of *Chapter 4: 835 Health Care Claim Payment/Advice* (originally published to the EDI Web site October 2010)

Chapter Section	Change Description	Date of Change	Version
Corrections and Reversals; 835 Data Element Table	Inclusion of exception information for Medicare Advantage and Medicare Supplemental lines of business	January 2011	1.0
835 Data Element Table	Added the following system identifiers for Version Identification, REF02; Modified the note under the Adjustment Report Sample heading to reference Medicare Supplemental as the only excluded line of business.	April 2011	2.0
Reporting	Added information about segment indicators for the 835PLB-CS Adjustment Report.	May 2011	2.1
Electronic Funds Transfer (EFT)	Added information about CAQH-CORE compliance that will be effective in 2013.	May 2013	2.2
Interchange Envelope (ISA/IEA) Structuring	Added information about 835 mailbox information for Medicare Advantage claims.	December 2013	2.4
835 Data Element Table	Removed a note from PLB03:01 segment to reflect that a value of L6 (Interest owed) is returned for Senior Segment products (Medicare Advantage and Medicare Supplement) starting with July 28, 2014 payment run.`	July 2014	2.5
Interchange Envelope (ISA/IEA) Structuring	Revised the 835 Batch ID for Medicare Advantage products.	August 2014	2.6
Eligibility for the 835 Transaction	Statement added regarding non-participating provider submitted claims	November 2022	3.0