Companion Document

835

835 Health Care Claim Payment / Advice

This companion document is for informational purposes only to describe certain aspects and expectations regarding the transaction and is not a complete guide. The details contained in this document are supplemental and should be used in conjunction with the ASC X12 Standards for Electronic Data Interchange Technical Report Type 3 (TR3) as published by the Washington Publishing Company.

Section 1 – 835 Health Care Claim Payment / Advice: Basic Instructions

Section 2 – 835 Health Care Claim Payment / Advice: Enveloping

Section 3 – 835 Health Care Claim Payment / Advice: Charts for Situational Rules

Any questions?

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Section 1 - Basic Instructions

1.1 835 Overview

The 835 Health Care Payment / Advice, also known as the Electronic Remittance Advice (ERA), provides information for the payee regarding claims in their final status, including information about the payee, the payer, the payment amount, and any payment identifying information.

1.2 Basic Format of 835 File

- Claim payments are made based on the NPI (or Payee ID) and Tax ID Number. Depending on the reimbursement arrangement, multiple providers may be paid under their group NPI (or group Payee ID) and Tax ID. Therefore, when a provider group requests an 835, by default all provider payments linked to the group NPI (or group Payee ID) will appear on the 835.
- The format of the 835 file may show multiple checks and/or payment information tied to the provider group or individual provider on a given day in one or multiple ERA files. Checks and/or payment information can be bundled within the same 835 file.
- Multiple checks and/or payment information within one 835 file may cause difficulty and require system changes for providers who directly download 835 files.

1.3 X12 and HIPAA Compliance Checking, and Business Edits

Each transaction passes through the Enterprise EDI Gateway/Clearinghouse for HIPAA Level 1-8 compliance editing before delivery to the trading partner mailbox.

1.4 Delimiters

As specified in the TR3, the basic character set includes uppercase letters, digits, space, and other special characters.

- Suggested delimiters for the outbound transaction are assigned as part of the trading partner set up. EDI Representative will discuss options with trading partners, if applicable.

Outbound Delimiters		
	Suggested Value	
Data Element Separator	*	Asterisk
Sub-Element Separator	:	Colon
Segment Terminator	~	Tilde
Repetition Separator	^	Caret

- To avoid syntax errors, Amerigroup will not use the following special characters as part of any data element value: asterisk (*), less than/greater than signs (<, >), colon (:), and slash (/). This minimizes the risk for a special character to be recognized as a delimiter.

  Example: Provider assigns a Patient Control Number '12*3456789'. Although an asterisk (*) is a valid special character, it adversely affects processing since it is also a common delimiter. The value '12*3456789' may incorrectly be identified as two separate data element values '12' and '3456789'.

1.5 Scheduling

Under normal operating conditions, the 835 file is available the next business day. For example, payment information for the check remit date of Monday will be available and posted in the 835 file on Tuesday.

Company closings or holidays may affect delivery of 835 files. Scheduling resumes when production begins on the next business day.

1.6 Claim Adjustment Reason Codes (CARC)/ Remittance Advice Remark Codes (RARC)

A claim adjustment reason code (CAS segment) is used to communicate that an adjustment was made at the claim/service line, and provides the reason for why the payment differs from what was billed. The adjustment reason code list is available at the Washington Publishing Company website (http://www.wpc-edi.com/codes, select **Claim Adjustment Reason Codes**) and updated by the Claim Adjustment Status Code maintenance committee tri-annually at the end of March, July, and November.

NOTE: It is important to monitor these code lists throughout the year.

A claim remittance advice remark code (LQ segment) provides supplemental explanation for an adjustment already described by an adjustment reason code. Previously, the remittance remark code list was created and supported for Medicare only, but now it is appropriate for use by all payers. The remark code list is available (http://www.wpc-edi.com/codes, select **Remittance Advice Remark Codes**) and updated by the Remittance Advice Code Maintenance Committee whose members represent various components from CMS.

The use of HIPAA standards has imposed a limitation on what detailed explanation is reported on the 835 Payment/Advice. Proprietary disposition codes do not always map exactly to a standard HIPAA claim adjustment reason and/or remittance advice remark code.

1.7 Provider Level Adjustment (PLB)

The provider level adjustment, PLB segment, is reported after all the claim payments in Table 3 - summary of the 835 transaction. This segment is used for adjustments such as interest payments, takeback notification and actual takebacks. Up to six adjustments can be reported per PLB segment.

Example with one adjustment: `PLB*1111111112*20101231*IR:FEDER*135.31.`

Provider Identifier	End of Fiscal Year	Adj Reas Code	Adjusted Amount

The third data element, PLB03, in the PLB segment is a composite segment with distinct values.

- PLB03-1: The Adjustment Reason Code (FB, IR, PI, L6, WO) identifies the type of adjustment.
- PLB03-2: Text and/or numerical reference information associated to adjustment reason code.
- PLB04: The PLB will **decrease** when the adjustment amount is **positive**.
  The PLB will **increase** when the adjustment amount is **negative**.

Section 2 - Enveloping

EDI envelopes control and track communications between you and Amerigroup. One envelope may contain many transaction sets grouped into the following:

- Interchange Control Header (ISA)
- Functional Group Header (GS)
- Functional Group Trailer (GE)
- Interchange Control Trailer (IEA)

835 Health Care Claim Payment/Advice–Envelope Specific from Amerigroup (TR3, Appendix C)

ISA—Interchange Control Header	
ISA01	00
ISA02	*10 spaces*
ISA03	00
ISA04	*10 spaces*
ISA05	ZZ
ISA06	ANTHEM
ISA07	ZZ
ISA08	*RECEIVER ID*
ISA09	*refer to TR3*
ISA10	*refer to TR3*
ISA11	*^ (5E)*
ISA12	00501
ISA13	*refer to TR3*
ISA14	0
ISA15	*refer to TR3*
ISA16	*refer to TR3*

GS—Functional Group Header	
GS01	HP
GS02	ANTHEMFCS
GS03	*RECEIVER ID*
GS04	*refer to TR3*
GS05	*refer to TR3*
GS06	*refer to TR3*
GS07	X
GS08	005010X221A1

GE—Functional Group Trailer	
GE01	*refer to TR3*
GE02	*refer to TR3*

IEA—Interchange Control Trailer	
IEA01	*refer to TR3*
IEA02	*refer to TR3*

Section 3 - Charts for Situational Rules

Listed below are loops, segments, and data elements required for proper processing by Amerigroup per the situational rules in the 835 TR3.

835 Health Care Claim Payment / Advice					
TR3	**Segment**		**Reference Designator(s)**	**Value**	**Definitions and Notes Specific to Amerigroup**
P.68	**ST**	*Transaction Set Header - Refer to TR3*			
P.69	**BPR**	*Financial Information - Refer to TR3*			
P.77	**TRN**	*Reassociation Trace Number - Refer to TR3*			
P.79	**CUR**	*Foreign Currency Information - Refer to TR3*			
P.82	**REF** Receiver Identification		**REF02** Ref ID Qualifier	***EV***	EV - Receiver ID Number
			REF02 Reference Identification	***AGP***	AGP - for Amerigroup payments
P.84	**REF**	*Version Identification - Refer to TR3*			
P.85	**DTM**	*Production Date - Refer to TR3*			
Loop ID 1000A—Payer Identification					
P.87	**N1**	*Payer Identification - Refer to TR3*			
P.89	**N3**	*Payer Address - Refer to TR3*			
P.90	**N4**	*Payer City, State, ZIP Code - Refer to TR3*			
P.92	**REF**	*Additional Payer Identification - Refer to TR3*			
P.94	**PER**	*Payer Business Contact Information - Refer to TR3*			
P.97	**PER**	*Payer Technical Contact Information - Refer to TR3*			
P.100	**PER**	*Payer WEB Site - Refer to TR3*			
Loop ID 1000B—Payee Identification					
P.102	**N1**	*Payee Identification - Refer to TR3*			
P.104	**N3**	*Payee Address - Refer to TR3*			
P.105	**N4**	*Payee City, State, ZIP Code - Refer to TR3*			
P.107	**REF**	*Payee Additional Identification - Refer to TR3*			
P.109	**RDM**	*Remittance Delivery Method - Refer to TR3*			
Loop ID 2000—Header Number					
P.111	**LX**	*Header Number - Refer to TR3*			
P.112	**TS3**	*Provider Summary Information - Refer to TR3*			
P.117	**TS2**	*Provider Supplemental Summary Information - Refer to TR3*			
Loop ID 2100—Claim Payment Information					
P.123	**CLP**	*Claim Payment Information - Refer to TR3*			
P.129	**CAS**	*Claim Adjustment - Refer to TR3*			
P.137	**NM1**	*Patient Name - Refer to TR3*			
P.140	**NM1**	*Insured Name - Refer to TR3*			
P.143	**NM1**	*Corrected Patient/Insured Name - Refer to TR3*			
P.146	**NM1**	*Service Provider Name - Refer to TR3*			
P.150	**NM1**	*Crossover Carrier Name - Refer to TR3*			
P.153	**NM1**	*Corrected Priority Payer Name - Refer to TR3*			
P.156	**NM1**	*Other Subscriber Name - Refer to TR3*			

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835 Health Care Claim Payment / Advice				
TR3	**Segment**	**Reference Designator(s)**	**Value**	**Definitions and Notes Specific to Amerigroup**
Loop ID 2100—Claim Payment Information (cont'd)				
P.159	**MIA**	*Inpatient Adjudication Information - Refer to TR3*		
P.166	**MOA**	*Outpatient Adjudication Information - Refer to TR3*		
P.169	**REF**	*Other Claim Related Identification - Refer to TR3*		
P.171	**REF**	*Rendering Provider Identification - Refer to TR3*		
P.173	**DTM**	*Statement From or To Date - Refer to TR3*		
P.175	**DTM**	*Coverage Expiration Date - Refer to TR3*		
P.177	**DTM**	*Claim Received Date - Refer to TR3*		
P.179	**PER**	*Claim Contact Information - Refer to TR3*		
P.182	**AMT**	*Claim Supplemental Information - Refer to TR3*		
P.184	**QTY**	*Claim Supplemental Information Quantity - Refer to TR3*		
Loop ID 2110—Service Payment Information				
P.186	**SVC**	*Service Payment Information - Refer to TR3*		
P.194	**DTM**	*Service Date - Refer to TR3*		
P.196	**CAS**	*Service Adjustment - Refer to TR3*		
P.204	**REF**	*Service Identification - Refer to TR3*		
P.206	**REF**	*Line Item Control Number - Refer to TR3*		
P.207	**REF**	*Rendering Provider Information - Refer to TR3*		
P.209	**REF**	*HealthCare Policy Identification - Refer to TR3*		
P.211	**AMT**	*Service Supplemental Amount - Refer to TR3*		
P.213	**QTY**	*Service Supplemental Quantity - Refer to TR3*		
P.215	**LQ**	*Health Care Remark Codes - Refer to TR3*		
The PLB Segment is used to allow adjustments that are NOT specific to a particular claim or service.				
P.217	**PLB**	*Provider Adjustment - Refer to TR3*		
P.228	**SE**	*Transaction Set Trailer - Refer to TR3*		