CMS

Standard Companion Guide Transaction Information

Instructions related to the 835 Health Care Claim Payment/Advice based on ASC X12 Technical Report Type 3 (TR3), version 005010A1

Companion Guide Version Number: 3.0
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Preface

Companion Guides (CGs) 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 in conformance with ASC X12's Fair Use and Copyright statements.

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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 an associated ASC X12 Implementation Guide. 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 Guide for which specific transaction Instructions apply and which are included in Section 3 of this document.

Unique ID	Name
005010X221A1	Health Care Claim Payment/Advice (835)

3. Instruction Table

This table contains rows for where supplemental instruction information is located. The order of table content follows the order of the implementation transaction set as presented in the corresponding implementation guide.

Category 1. Situational Rules that explicitly depend upon and reference knowledge of the transaction receiver's policies or processes.

Category 2. Technical characteristics or attributes of data elements that have been assigned by the payer or other receiving entity, including size, and character sets applicable, that a sender must be aware of for preparing a transmission.

Category 3. Situational segments and elements that are allowed by the implementation guide but do not impact the receiver's processing. (applies to inbound transactions)

Category 4. Optional business functions supported by an implementation guide that an entity doesn't support.

Category 5. To indicate if there needs to be an agreement between PAYER and the transaction sender to send a specific type of transaction (claim/encounter or specific kind of benefit data) where a specific mandate doesn't already exist.

Category 6. To indicate a specific value needed for processing, such that processing may fail without that value, where there are options in the TR3.

Category 7. TR3 specification constraints that apply differently between batch and real-time implementations, and are not explicitly set in the guide.

Category 8. To identify data values sent by a sender to the receiver.

Category 9. To identify processing schedules or constraints that are important to trading partner expectations.

Category 10. To identify situational data values or elements that are never sent.

005010X221A1 Health Care Claim Payment/Advice

Loop	Reference	Name	Codes	Notes/Comments	Category	LOB A	LOB B	LOB DME
	BPR03	Credit or Debit Flag Code	C	Code D does not apply to Medicare.	8	X	X	X
	BPR04	Payment Method Code	ACH/CHK/ NON	Codes BOP and FWT do not apply to Medicare	4	X	X	X
	BPR06	Depository Financial Institution (DFI) Identification Number Qualifier	01	Code 04 does not apply to Medicare.	8	X	X	X
	BPR11	Originating Company Supplemental Code		Reported by Institutional	6	X	-	-
	BPR12	Depository Financial Institution (DFI) Identification Number Qualifier	01	Code 04 does not apply to Medicare.	8	X	X	X
	TRN04	Reference Identification		Reported by Institutional	6	X	-	-
	CUR – Segment Rule	CUR - FOREIGN CURRENCY INFORMATION		Does not apply to Medicare	10	X	X	X
1000 A	REF – Segment Rule	REF - ADDITIONAL PAYER IDENTIFICATION	2U	Codes EO, HI, and NF not used by Medicare	8	X	X	X
1000 B	REF – Segment Rule	REF - PAYEE ADDITIONAL IDENTIFICATION	TJ	Required for Medicare to report the Taxpayer Identification Number (TIN)	8	X	X	X

Loop	Reference	Name	Codes	Notes/Comments	Category	LOB A	LOB B	LOB DME
2000	LX – Segment Rule	LX - HEADER NUMBER		Required for Medicare FISS uses TTYYMM- Facility Code/year/month. MCS/VMS uses 000000 for unassigned and 000001 for assigned claims	2	X	X	X
2100	CLP02	Claim Status Code		25 Predetermination Pricing Only - No Payment does not apply to Medicare	2	X	X	X
2100	CLP06	Claim Filing Indicator Code	MA	Required for Part A	6	X	-	-
2100	CLP06	Claim Filing Indicator Code	MB	Required for Part B	6	-	X	X
2100	CAS01	Claim Adjustment Group Code	CO OA PR	Medicare contractors are limited to use of the CO, OA, and PR group codes. PI is not used by Medicare.	4	X	X	X
2100	NM108	PATIENT NAME Identification Code Qualifier	HN	"HN" for Medicare	8	X	X	X
2100	NM1	INSURED NAME		Segment not used by Medicare.	10	X	X	X
2100	NM102	CORRECTED PATIENT/INSURED NAME - Entity Type Qualifier	1	Code 2 does not apply to Medicare	8	X	X	X
2100	NM108	SERVICE PROVIDER NAME-IDENTIFICATION CODE QUALIFIER	XX	Medicare reports NPI	8	X	X	X

Loop	Reference	Name	Codes	Notes/Comments	Category	LOB A	LOB B	LOB DME
2100	NM1	CROSSOVER CARRIER NAME		Although Medicare may send claim and payment information to multiple secondary payers, the 835 does not permit identification of more than one of those secondary payers. When COB transmissions are sent to more than one secondary payer for the same claim, report remark code N89 in a claim level remark code data element.	9	X	X	X
2100	NM108	CROSSOVER CARRIER NAME - Identification Code Qualifier	PI, XV	AD, FI, NI, and PP do not apply to Medicare	4	X	X	X
2100	NM108	CORRECTED PRIORITY PAYER NAME - IDENTIFICATION CODE QUALIFIER	PI, XV	AD, FI, NI, and PP do not apply to Medicare	4	X	X	X
2100	NM1	Other Subscriber Name		Not used by Medicare	10	X	X	X
2100	REF01	Other Claim Related Information-Reference Identification Qualifier	28, 6P, EA, F8	Medicare does not use 1L, 1W, 9A, 9C,BB, CE, G1, G3 and IG	4	X	X	X
2100	REF – Segment Rule	Rendering Provider Identification		Segment not used by Medicare.	10	X	X	X

Loop	Reference	Name	Codes	Notes/Comments	Category	LOB A	LOB B	LOB DME
2100	AMT01	Claim Supplemental Information-Amount Qualifier Code	AU, DY, F5, I, NL, ZK, ZL, ZM, ZN, ZO	Medicare does not use D8, T and T2	4	X	X	X
2100	AMT01	Claim Supplemental Information Quantity-Quantity Qualifier	CA, CD, LA, OU, ZK, ZL, ZM, ZN, ZO	Medicare does not use LE, NE, NR, PS and VS	4	X	X	X
2110	SVC01-1	Product or Service ID Qualifier	HC NU N4 HP	Only HC, NU, N4, and HP apply to Medicare	4	X	X	X
2110	SVC06-1	Product or Service ID Qualifier	HC NU N4 HP	Only HC, NU, N4, and HP apply to Medicare	4	X	X	X
2110	CAS01	Claim Adjustment Group Code	CO OA PR	Medicare contractors are limited to use of the CO, OA, and PR group codes. PI is not used by Medicare.	4	X	X	X
2110	REF – Segment Rule	Service Identification-Reference Identification Qualifier	LU, 1S, APC, RB	Medicare does not use BB, E9, G1 AND G3	4	X	X	X
2110	REF – Segment Rule	Rendering Provider Information - Reference Identification Qualifier	HPI, SY, TJ, 1C, 1G	Medicare does not use 0B, 1A, 1B, 1D, 1H, 1J, D3 AND G2	4	X	X	X
2110	REF – Segment Rule	Health Care Policy Identification		Medicare will report the LCD/NCD code in REF 02	2	X	X	X
2110	AMT01	Service Supplemental Amount - Amount Qualifier Code	B6, KH, 2K, ZL, ZM, ZN, ZO	Medicare does not use T AND T2	4	X	X	X

Loop	Reference	Name	Codes	Notes/Comments	Category	LOB A	LOB B	LOB DME
2110	LQ01	HEALTH CARE REMARK CODES-Code List Qualifier Code	HE	Only "HE" applies to Medicare	8	X	X	X
	PLB03-1	Adjustment Reason Code	50, 51, 72, 90, AP, B2, B3, BD, BN, C5, CS, CV, DM, E3, FB, GO, HM, IP, IS, IR, J1, L3, L6, LE, LS, OA, OB, PI, PL, RA, RE, SL, TL, WO, WU	Medicare does not use AH, AM, CR,CT, CW AND FC,	4	X	X	X

4. TI Additional Information

4.1 Other Resources

The following Websites provide information for where to obtain documentation for Medicare adopted EDI transactions, code sets and additional resources of use during the 5010 transition year.

Resource	Web Address
ASC X12 TR3 Implementation Guides	http://store.x12.org
Washington Publishing Company Health Care Code Sets	http://www.wpc-edi.com/content/view/711/401/
Central Version 005010 and D.0 Webpage on CMS website	http://www.cms.gov/Versions5010andD0/
Educational Resources (including MLN articles, fact sheets, readiness checklists, brochures, quick reference charts and guides, and transcripts from national provider calls)	http://www.cms.gov/Versions5010andD0/40_Educational_Resources.asp#TopOfPage
Dedicated HIPAA 005010/D.0 Project Web page (including technical documents and communications at national conferences)	http://www.cms.gov/MFFS5010D0/
Frequently Asked Questions	http://questions.cms.hhs.gov/app/answers/list/kw/5010
To request changes to HIPAA adopted standards	http://www.hipaa-dsmo.org/