STATE OF HAWAII

DEPARTMENT OF HUMAN SERVICES

MED-QUEST DIVISION

Companion Document and Transaction Specifications for the HIPAA 835 Claims Remittance Advice Transaction

VERSION 1.4
MARCH 2004

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Revision History

Date	Version	Description	Author
05/21/2003	1.0	Initial draft for posting to the Med-QUEST Web Site	Med-QUEST Systems Office
07/22/2003	1.1	Draft for use in implementation of HIPAA transaction	Med-QUEST Systems Office
09/09/2003	1.2	Draft with revised acknowledgement transactions and detail-level data changes	Med-QUEST Systems Office
12/05/2003	1.3	Draft for use in implementation of HIPAA transaction	Med-QUEST Systems Office
03/05/2004	1.4	Draft for use in implementation of HIPAA transaction	Med-QUEST Systems Office

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Table of Contents

1. Introduction

1.1 Document Purpose

Companion Documents

Companion Documents are available to external entities (health plans, program contractors, providers, third party processors, and billing services) to clarify the information on HIPAA-compliant electronic interfaces with Med-QUEST. The following Companion Documents are being produced:

- 834 Enrollment and 820 Capitation Transactions
- 270 Eligibility Verification and 271 Eligibility Response Transactions
- 837 Claims Transactions
- *835 FFS Claims Remittance Advice Transaction*
- 276 Claim Status Request and 277 Claim Status Response Transactions
- 278 Prior Authorization Transaction

HIPAA Overview

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) require the federal Department of Health and Human Services to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. They also address the security and privacy of health data. The intent of these standards is to improve the efficiency and effectiveness of the nation's health care system by encouraging widespread use of electronic data interchange standards in health care.

The intent of the law is that all electronic transactions for which standards are specified must be conducted according to the standards. These standards were not imposed arbitrarily but were developed by processes that included significant public and private sector input.

Covered entities are required to accept HIPAA Transactions in the standard format in which they are sent and must not delay a transaction or adversely affect an entity that wants to conduct the transactions electronically. Both Med-QUEST and its health plans are HIPAA covered entities.

Document Objective

This Companion Document provides information about the 835 Claim Remittance Advice Transaction that is specific to Med-QUEST and Med-QUEST trading partners. For this transaction, the document describes the ways in which claim submitters receive information from Med-QUEST.

Intended Users

Companion Documents are intended for the technical staff of the external entities who are responsible for electronic transaction/file exchanges.

Relationship to HIPAA Implementation Guides

Companion Documents supplement the HIPAA Implementation Guides for each of the HIPAA transactions. Rules for format, content, and field values can be found in the Implementation Guides. This document describes the Med-QUEST environment and interchange conventions for 835 Claims Remittance Advice Transactions. It also provides specific information on the fields and values required for transactions sent to Med-QUEST.

Companion Documents are intended to supplement rather than replace the standard HIPAA Implementation Guide for each transaction set. Information in these documents is not intended to:

- Modify the definition, data condition, or use of any data element or segment in the standard Implementation Guides.
- Add any additional data elements or segments to the defined data set.
- Utilize any code or data values that are not valid in the standard Implementation Guides.
- Change the meaning or intent of any implementation specifications in the standard Implementation Guides.

Disclaimer

This Companion Document is intended to be a technical document describing the specific technical and procedural requirements for interfaces between Med-QUEST and its trading partners. It does not supersede either health plan contracts or the specific procedure manuals for various operational processes. If there are conflicts between this document and either the health plan contracts or operational procedure manuals, the contract or procedure manual will prevail.

Substantial effort has been taken to minimize conflicts or errors; however, Med-QUEST, the Med-QUEST Systems Office, or its employees will not be liable or responsible for any errors or expenses resulting from the use of information in this document. If you believe there is an error in the document, please notify the Med-QUEST Systems Office immediately.

1.2 Contents of this Companion Document

Introduction	Section 1 provides general information on Companion Documents and HIPAA and outlines the information to be included in the remainder of the document.
Transaction Overview	Section 2 provides an overview of the transactions included in this Companion Document including information on: ▪ The purpose of the transaction(s) ▪ The standard Implementation Guide for the transaction(s) ▪ Replaced and impacted Med-QUEST files and processes ▪ Transmission schedules
Technical Infrastructure	Section 3 provides a brief statement of the technical interfaces required for trading partners to communicate with Med-QUEST via electronic transactions. Readers are referred to the Med-QUEST Electronic Claim Submission and Electronic Remittance Advice Requirements document for operational information.
Transaction Standards	Section 4 provides information relating to the transactions included in this Companion Document including: ▪ General HIPAA transaction standards ▪ Testing criteria and procedures ▪ Data interchange conventions applicable to the transactions ▪ Procedures for acknowledgment transactions ▪ Procedures for handling rejected transmissions and transactions
Transaction Specifications	Section 5 provides more specific information relating to the transaction included in this Companion Document including: ▪ A statement of the purpose of transaction specifications for electronic interchanges between Med-QUEST and other HIPAA covered entities. ▪ Detailed Specifications that show how Med-QUEST populates the data elements in the 835 Claim Remittance Advice Transaction when Med-QUEST uses transaction data elements in ways that are not fully described by information in a HIPAA Implementation Guide.

2. 835 Claim Remittance Advice Transaction

2.1 Transaction Overview

Claim Remittance Advice Transaction

The HIPAA Implementation Guide for the 835 Health Care Claim Payment/Advice Transaction describes the transaction's "business use and definition" in the following way:

> The 835 is intended to meet the particular needs of the health care industry for the payment of claims and transfer of remittance information. The 835 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 from a health care payer to a health care provider, either directly or through a DFI [Depository Financial Institution].

The 835 Transaction (sometimes called the Claims Remittance Advice or Claims RA Transaction in the remainder of this document) is a claims payment reporting transaction. It tells claim submitters the results of payer adjudication at the claim and service line levels.

The 835 Transaction differs from the pre-HIPAA Med-QUEST Claim Remittance Advice in that it does not report on claims that have not yet been processed or have been pended by the Hawaii Prepaid Medical Management Information System (HPMMIS). In the HIPAA environment, submitters can obtain the statuses of all their claims, including claims that have not yet completed adjudication, with the Web-based 276 Claim Status Request Transaction.

835 RA Transactions and 837 Claim Transactions are closely linked. Although data on 835 Transactions comes from the HPMMIS Database and the Affiliated Computer Services (ACS) Financial System, much of it is derived from information on incoming 837s, with the addition of Payment Amounts, Adjustment Reason Codes, and Remark Codes generated by HPMMIS for the Med-QUEST translator. Any change from a billed amount to a paid amount at an inpatient claim or outpatient/professional/dental service line level is called an adjustment in HIPAA nomenclature and is reported on the 835 with an Adjustment Reason Code and an Adjustment Amount.

Adjustment Reason Codes occur at inpatient claim and outpatient/professional/dental service line levels. In addition, the 835 Transaction supports HIPAA compliant Remark Codes at both levels. Remark Codes are not directly associated with changes from billed to payment amounts but are used to provide additional information about claim and service line errors.

Because of the frequent gaps between meanings of the claim adjudication codes used by Med-QUEST and by the 835 Transaction, Med-QUEST has created a sequential Remittance Advice Supplemental File to the FTP Server along with the 835 Transaction. The Supplemental File is available to 835 receivers that request it. It carries claim identification information and the original adjudication codes generated for each institutional claim or professional/dental service line by HPMMIS. The Supplemental File is described in detail in Section 4.5, 835 Supplemental File.

Processes Replaced or Impacted

The primary process affected by the 835 Claim Remittance Advice Transaction is the creation and transmission of the claim remittance advice.

835 Claim Remittance Advice Transaction

Replaced Files
Electronic Claim Remittance Advice File

Impacted Files
None

2.2 835 Claim Remittance Advice Transaction

Standard Implementation Guide	The standard Implementation Guide for the 835 Claim Remittance Advice Transaction is the American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12 Transaction Set Implementation Guide for the Health Care Claim Payment/Advice and all approved Addenda. Versions of the 835 Implementation Guide and Addenda adopted by Med-QUEST and other covered entities and used in preparation of this document are: ▪ ASC X12N 835 (004010X091) ▪ ASC X12N 835 (004010X091A1) (Addenda)
Related Transactions	HIPAA-mandated 837 Claim Transactions provide some of the claim data that Med-QUEST returns to claim submitters on 835 Remittance Advice Transactions.
Transmission Schedules	Med-QUEST sends 835 Remittance Advice Transactions to claim submitters on a weekly basis. They are issued at the same time as claim payments.

3. Technical Infrastructure and Procedures

3.1 Technical Environment

Med-QUEST Data Center Communications Requirements

Authorized receivers of the Web-based 835 Claims Remittance Advice Transactions view and download 835 Transactions from the Med-QUEST Web Server. To access the Server, an eligibility verification requester needs a User Name and Password. All valid Med-QUEST providers can register a User Name and Password when creating an account on the Department of Human Services Medicaid Online web site (https://hiweb.statemedicaid.us). A Med-QUEST assigned Provider ID Number and a Federal Tax ID Number are required.

Med-QUEST verifies provider identification data before authorizing the creation of an account and assigning a User Name and Password. Once this information is validated, Med-QUEST mails a letter containing an Authentication Code to the provider's correspondence address. Providers cannot make interactive or batch eligibility requests until they receive the Authentication Code, which is required to activate their account. Web-based encryption software provides additional security.

The DHS Medicaid Online User Manual can be obtained on the Med-QUEST web site (http://www.med-quest.us). This document explains how to view and download the 835 Claims Remittance Advice Transaction. Additional information about the account creation process for Web-based transactions can be found on the DHS/MQD Online Overview page of the Department of Human Services Medicaid Online web site (https://hiweb.statemedicaid.us).

Technical Assistance and Help

The Provider Inquiry Unit or Call Center maintained by Affiliated Computer Services (ACS), the Med-QUEST Fiscal Agent, provides technical assistance related to questions about electronic claims submission or data communications interfaces. All calls result in Ticket Number assignment and problem tracking. Contact information is:

- **Telephone Number:** Oahu: (808) 952-5570
  Neighbor Islands: (800) 882-4378
- **Hours:** 7:30 AM – 5:00 PM Hawaii Time, Mondays through Fridays
- **Information required for initial call:**
  - Topic of Call (VPN setup, FTP procedures, etc.)
  - Name of caller
  - Organization of caller
  - Telephone number of caller
  - Nature of problem (connection, receipt status, etc.)
- **Information required for follow up call(s):**
  - Ticket Number assigned by the Provider Call Center

3.2 File Naming Conventions

File Naming Conventions

835 Transaction Overview

```
HI-835-01-20031113-HHMMSS-020107.TXT    835 File
HI-835-02-20031113-HHMMSS-020107.TXT    Supplemental File
^  ^   ^      ^       ^      ^    ^
|  |   |      |       |      |    |-- File Extension
|  |   |      |       |      |------- Provider ID
|  |   |      |       |-------------- Time
|  |   |      |---------------------- Process date
|  |   |----------------------------- File Type
|  |--------------------------------- Transaction Code
|------------------------------------ State Code
```

835 Transaction

This is the batch 835 file available for download (in X12 format). Refer to Section 2, 835 Claims Remittance Advice Transaction, for additional information.

HI-835-01-YYYYMMDD-HHMMSS-PROVID.TXT

- HI is the state code
- 835 is the Transaction code
- 01 is the 835 File
- YYYYMMDD is the process date
- HHMMSS is the time expressed in 24-hour clock time
- PROVID is the Provider ID
- TXT is the file extension

Supplemental File

The supplemental file provides additional claim adjudication information not available within the 835 Transaction. This file is not required for determining the status of a claim, but it does provide additional detailed information that Providers may find helpful. Refer to Section 4.5, 835 Supplemental File, for additional information.

HI-835-02-YYYYMMDD-HHMMSS-PROVID.TXT

- HI is the state code
- 835 is the Transaction code
- 02 is the Supplemental File
- YYYYMMDD is the process date
- HHMMSS is the time expressed in 24-hour clock time
- PROVID is the Provider ID
- TXT is the file extension

4. Transaction Standards

4.1 General Information

HIPAA Requirements

HIPAA standards are specified in the Implementation Guide for each mandated transaction and modified by authorized Addenda. Currently, the 835 Claims Remittance Advice Transaction has a draft Addendum (although, for this transaction, it is brief and has little impact). It has been adopted as final and incorporated into Med-QUEST requirements for the 835 Transaction.

An overview of requirements specific to the 835 Transaction can be found in Section 2, Data Overview, of the 835 Implementation Guide. The Data Overview Section contains information related to:

- Format and content of interchanges and functional groups
- Format and content of the header, detailer and trailer segments specific to the transaction
- Code sets and values authorized for use in the transaction
- Allowed exceptions to specific transaction requirements

Size of Transmissions/ Batches

Transmission sizes are limited based on two factors:

- The number of segments recommended by HIPAA Implementation Guides and imposed by lengths of control fields within transactions
- Med-QUEST file transfer limitations

Recommended HIPAA standards for the maximum file size of each transaction are specified in the appropriate Implementation Guide or its authorized Addendum. The 835 Implementation Guide recommends a maximum of 10,000 CLP (Claim Payment) Segments per transaction.

At this time, Med-QUEST imposes no file size limitations for information that it posts to its FTP Server. ACS will contact the claim submitter if an 835 Transaction exceeds the ten megabyte limit.

Other Standards

Balancing Financial Data

There are two types of balancing procedures that affect the 835 Transaction. They are internal and external to the transaction.

- Internal Balancing within the 835 Transaction

  The 835 Implementation Guide discusses balancing within the 835 Transaction by presenting it in three hierarchical levels:

  - Service Line
  - Claim
  - 835 Transaction

  At the professional/dental service line level, balancing is between the amount charged for the service, any line-level adjustment made to the charged amount, and the service line payment amount. The 835 Implementation Guide translates these requirements into specific data elements that carry Charged Amounts, Adjustment Amounts, and Paid Amounts. The Paid Amount must always equal the Charged Amount minus the Adjustment Amount.

  For professional/dental claims, all adjustments are at the service line level. Claim level amount fields, when populated, are summaries of service line amounts and do not affect balancing.

  For institutional claims, balancing is only at the claim level. The claim-level Paid Amount is the amount adjudicated for the entire inpatient or outpatient claim. The difference between these amounts is the claim level Adjustment Amount. Service line data may be present for inpatient institutional claims on 835 Transactions, but Med-QUEST does not use such data in pricing.

  At the transaction level, the Total Payment Amount for all claims in a transaction must equal the sum of all claim-level Payment Amounts minus PLB Segment provider level adjustments, such as settlements, that are not claim-specific. PLB Segment provider level adjustments can be positive or negative.

  For all levels of balancing, positive Adjustment Amounts are subtracted from amounts charged by the provider to create the Payment Amount. Negative Adjustment Amounts, should they occur, are negative to Med-QUEST and are added to the amounts charged by the provider.

For the 835 Transaction, each institutional claim or professional/dental service line becomes a unique CLP Claim Payment Segment with its own unique 14-digit Claim Reference Number (CRN). The last two digits of the 14-digit CRN are for the Service Line Number.

Nursing home claims with additional services are sometimes priced at both claim and line levels. The Med-QUEST 835 Transaction accommodates this situation by defining institutional claims as invoices with multiple lines that are sometimes priced individually and professional/dental claim as single services. This "splitting" of professional/dental claims to create a separate claim with a unique 14-digit CRN for each service is done only for the 835 Transaction.

- Balancing between the 835 Transaction and External Sources

  External balancing involves comparisons between data on 835 Transactions and payment amounts generated by the vouchers that contribute to weekly provider payments. The total amount of the payment to the receiver from each payment source (Element BPR02) is derived from the same voucher amounts that are used to generate the receiver's payment. Amounts should always match.

Remittance Tracking

The Trace Number (Element TRN02) and the Payer Identification Number (Element TRN03) in the 835 Transaction's Reassociation Trace Number (TRN) Segment can be used to reassociate the remittance advice data in the 835 Transaction with the payment sent separately by the ACS Financial System. For Med-QUEST, TRN02 is the Payment Number of the electronic transfer or check written for provider payment by the ACS Financial System.

Claims and Service Lines

As used by Med-QUEST, the structure of the 835 Transaction defines institutional claims at the invoice level and professional and dental claims at the service line level. Each CLP Claim Payment Segment on the 835 Transaction represents an adjudicated payment or denial, an entire multi-line invoice for an institutional claim and a single service for a professional or dental claim. Each CLP Claim Payment Segment has its unique, 14-digit Claim Reference Number.

In most cases, these conventions correspond to the level at which charged amounts are "adjusted" on the 835 Transaction's CAS Adjustment Segments to become Payment Amounts. For professional and dental claims, adjustments are always at the service level. For institutional claims, there are exceptions to the invoice level payment rule that cause pricing to

be at the service level. In these cases, the 835 Transaction shows line level adjustments that contribute to the single invoice level payment:

- Outpatient Institutional Claims
- Inpatient Institutional Claims Paid as Tier Outliers
- Inpatient Institutional Claims Paid on a Cost to Charge Ratio

Nursing home institutional claims can be paid by both daily rates and, at the line level, by payments for ancillary services that are not included in the daily rate. In this situation, it is possible for a claim to have both invoice level and line level adjustments.

4.2 Testing Procedures

Testing Procedures	Med-QUEST has established a policy regarding inclusion of the 835 Transaction in standard testing by receivers. Receivers are required to submit or request the Med-QUEST generation of test claims which will be used to generate 835 test files for retrieval and review by the receiver. Please refer to the DHS Medicaid Online User Manual for further information.

4.3 Data Interchange Conventions

Overview of Data Interchange

When transmitting 835 Transactions to providers, Med-QUEST follows standards developed by the Accredited Standards Committee (ASC) of the American National Standards Institute (ANSI). These standards involve Interchange (ISA/IEA) and Functional Group (GS/GE) Segments or "outer envelopes". All 835 Transactions are enclosed in transmission level ISA/IEA envelopes and, within transmissions, functional group level GS/GE envelopes. The segments and data elements used in outer envelopes are documented in Appendix B of Implementation Guides.

Transaction Agreements that specify how individual data elements are populated by Med-QUEST on ISA/IEA and GS/GE envelopes are shown in the table in this section. This document assumes that security considerations involving user identifiers, passwords, and encryption procedures are handled by the Med-QUEST FTP Server and not through the ISA Segment.

The ISA/IEA Interchange Envelope, unlike most ASC X12 data structures, has fixed fields of a fixed length. Blank fields cannot be left out.

Envelope Specifications Tables

Definitions of table columns follow:

Loop ID
The Implementation Guide's identifier for a data loop within a transaction. Always "NA" in this situation because segments in outer envelopes have segments and elements but not loops.

Segment ID
The Implementation Guide's identifier for a data segment.

Element ID
The Implementation Guide's identifier for a data element within a segment.

Element Name
A data element name as shown in the Implementation Guide. When the industry name differs from the Data Element Dictionary name, the more descriptive industry name is used.

Element Definition/Length
How the data element is defined in the Implementation Guide. For ISA and IEA Segments only, fields are of fixed lengths and are present whether or not they are populated. For this reason, field lengths are provided in this

column after element definitions.

Valid Values
The valid values from the Implementation Guide that are used by Med-QUEST.

Definition/Format
Definitions of valid values used by Med-QUEST and additional information about Med-QUEST data element requirements.

ISA/IEA INTERCHANGE CONTROL ENVELOPE SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition/Length**	**Valid Values**	**Definition/Format**
ISA INTERCHANGE HEADER						
NA	ISA	ISA01	AUTHORIZATION INFORMATION QUALIFIER	Code to identify the type of information in the Authorization Information Element/2 Characters	00	No Authorization Information Present
NA	ISA	ISA02	AUTHORIZATION INFORMATION	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/10 characters		Leave field blank – not used by Med-QUEST.
NA	ISA	ISA03	SECURITY INFORMATION QUALIFIER	Code to identify the type of information in the Security Information/2 characters	00	No Security Information present
NA	ISA	ISA04	SECURITY INFORMATION	This field is used for identifying the security information about the interchange sender and the data in the interchange; the type of information is set by the Security Information Qualifier/10 characters		Leave field blank – not used by Med-QUEST.
NA	ISA	ISA05	INTERCHANGE ID QUALIFIER	Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified/2 characters	ZZ	Mutually Defined
NA	ISA	ISA06	INTERCHANGE SENDER ID	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/15 characters		"MQD" followed by the nine-digit DHS/Med-QUEST Federal Tax ID number (996001089)
NA	ISA	ISA07	INTERCHANGE ID QUALIFIER	Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified/2 characters	ZZ	Mutually Defined
NA	ISA	ISA08	INTERCHANGE RECEIVER ID	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/15 characters		The six-digit Med-QUEST Provider ID
NA	ISA	ISA09	INTERCHANGE DATE	Date of the interchange/6 characters		The Interchange Date in YYMMDD format
NA	ISA	ISA10	INTERCHANGE TIME	Time of the interchange/4 characters		The Interchange Time in HHMM format
NA	ISA	ISA11	INTERCHANGE CONTROL STANDARDS	Code to identify the agency responsible for the control standard used by the message that is enclosed by the interchange header and trailer/1 character	U	U.S. EDI Community of ASC X12, TDCC, and UCS

ISA/IEA INTERCHANGE CONTROL ENVELOPE SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition/Length**	**Valid Values**	**Definition/Format**
			IDENTIFIER			
NA	ISA	ISA12	INTERCHANGE CONTROL VERSION NUMBER	This version number covers the interchange control segments/5 characters	00401	Draft Standards for Trial Use Approved for Publication by ASC X12 Procedure Review Board through October 1997
NA	ISA	ISA13	INTERCHANGE CONTROL NUMBER	A control number assigned by the interchange sender/9 characters		The Interchange Control Number. ISA13 must be identical to the control number in associated Interchange Trailer field IEA02.
NA	ISA	ISA14	ACKNOWLEDGE-MENT REQUESTED	Code sent by the sender to request an Interchange Acknowledgement (TA1)/1 character	0	No Acknowledgement Requested Med-QUEST does not request or expect TA1 Interchange Acknowledgement Segments from its trading partners.
NA	ISA	ISA15	USAGE INDICATOR	Code to indicate whether data enclosed is test, production or information/1 character	P or T	Production Data or Test Data
NA	ISA	ISA16	COMPONENT ELEMENT SEPARATOR	The delimiter value used to separate components of composite data elements/1 character	|	A “pipe” (the symbol above the backslash on most keyboards) is the value used by Med-QUEST for component separation. Segment and element level delimiters are defined by usage in the ISA Segment and do not require separate ISA elements to identify them. Delimiter values, by definition, cannot be used as data, even within free-form messages. The following separator or delimiter values are used by Med-QUEST on outgoing transactions: Segment Delimiter - “~’ (tilde – hexadecimal value X”7E”) Element Delimiter - “{“ (left rounded bracket – hexadecimal value X”7B”) Composite Component Delimiter (ISA16) - “|” (pipe – hexadecimal value X”7C”) These values are used because they are not likely to occur within transaction data.

ISA/IEA INTERCHANGE CONTROL ENVELOPE SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition/Length**	**Valid Values**	**Definition/Format**
IEA INTERCHANGE TRAILER						
NA	IEA	IEA01	NUMBER OF INCLUDED FUNCTIONAL GROUPS	A count of the number of functional groups included in an interchange/5 characters		The number of functional groups of transactions in the interchange
NA	IEA	IEA02	INTERCHANGE CONTROL NUMBER	A control number assigned by the interchange sender/9 characters		A control number identical to the header-level Interchange Control Number in ISA13.

GS/GE FUNCTIONAL GROUP ENVELOPE TRANSACTION SPECIFICATIONS							
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition/Length**	**Valid Value**	**Definition/Format**	**Source**
GS FUNCTIONAL GROUP HEADER							
NA	GS	GS01	FUNCTIONAL IDENTIFIER CODE	Code identifying a group of application related transaction sets	HP	Health Care Claim Payment/Advice (835)	HIPAA Code Set
NA	GS	GS02	APPLICATION SENDER'S CODE	Code identifying party sending transmission; codes agreed to by trading partners		Med-QUEST repeats the Sender Identifier used in the ISA Segment.	Transmission sender
NA	GS	GS03	APPLICATION RECEIVER'S CODE	Codes identifying party receiving transmission. Codes agreed to by trading partners		Med-QUEST repeats the Receiver Identifier used in the ISA Segment.	Transmission sender
NA	GS	GS04	DATE	Date expressed as CCYYMMDD		The functional group creation date.	Transmission sender
NA	GS	GS05	TIME	Time on a 24-hour clock in HHMM format.		The functional group creation time.	Transmission sender
NA	GS	GS06	GROUP CONTROL NUMBER	Assigned number originated and maintained by the sender		A control number for the functional group of transactions.	Transaction sender
NA	GS	GS07	RESPONSIBLE AGENCY CODE	Code used in conjunction with Element GS08 to identify the issuer of the standard	X	Accredited Standards Committee X12	HIPAA Code Set
NA	GS	GS08	VERSION/ RELEASE/ INDUSTRY IDENTIFIER CODE	Code that identifies the version of the transaction(s) in the functional group		004010X091A1 Med-QUEST uses Addenda versions of all HIPAA Transactions. This Version Number incorporates the final Addenda.	HIPAA Code Set
GE FUNCTIONAL GROUP TRAILER							
NA	GE	GE01	NUMBER OF TRANSACTION SETS INCLUDED	The number of transactions in the functional group ended by this trailer segment			Transmission sender
NA	GE	GE02	GROUP CONTROL NUMBER	Assigned number originated and maintained by the sender		This number must match the control number in GS06.	Transmission sender

4.4 Acknowledgment Procedures

Overview of Electronic Acknowledgment Processes

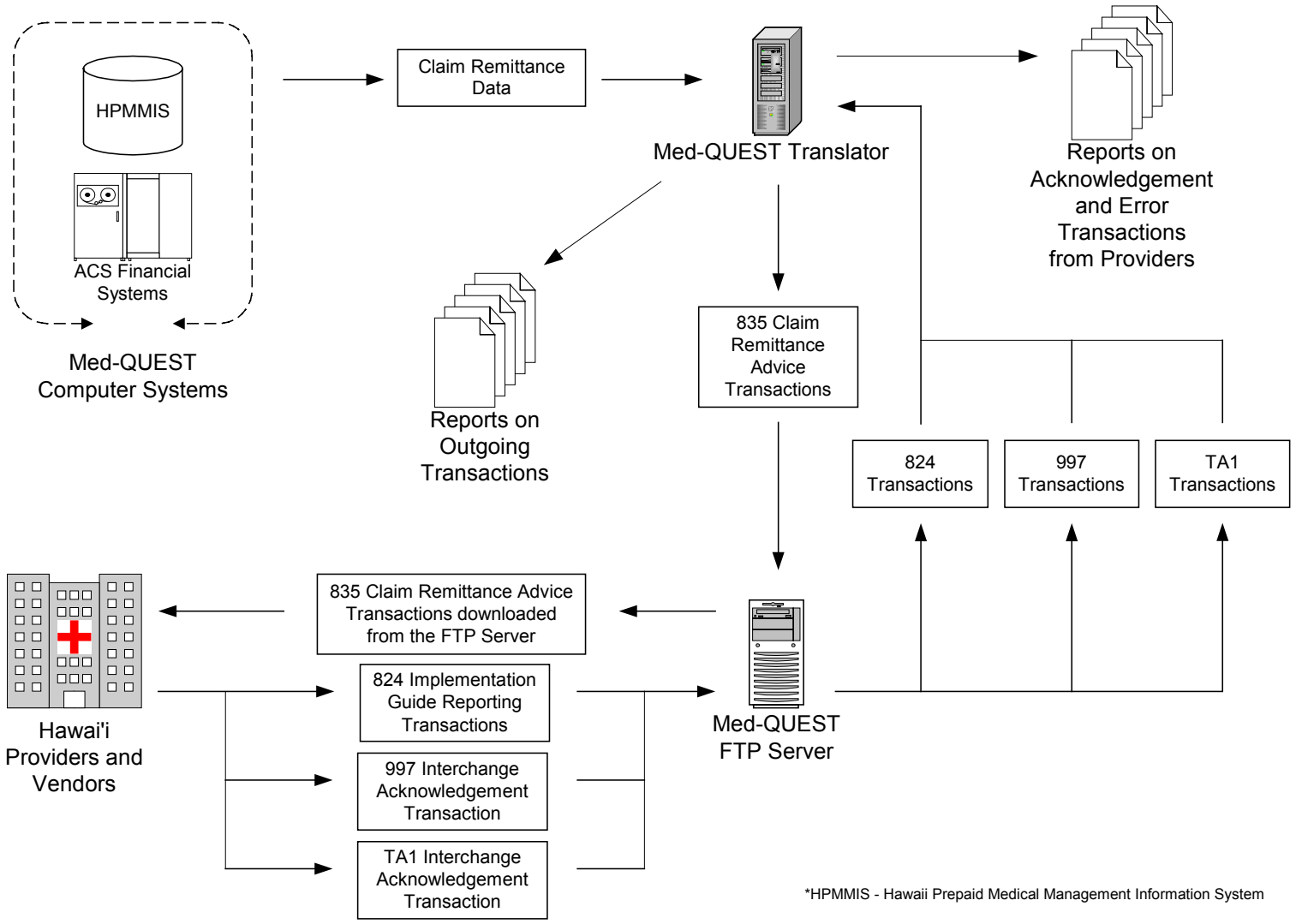
Med-QUEST uses the Financial System of its fiscal agent, Affiliated Computer Services (ACS), to pay fee-for-service claims on a weekly basis. Both the ACS Financial System and HPMMIS maintain data for use on 835 Claims Remittance Advice Transactions. At the time of claim payment, Med-QUEST generates electronic 835 RA Transactions for all providers who have requested 835 Transactions rather than paper RAs.

Med-QUEST accepts and processes TA1 Interchange Acknowledgement Transactions, 997 Functional Acknowledgement Transactions, and 824 Implementation Guide Reporting Transactions from trading partners in response to 835 transmissions. The Agency recommends that trading partners follow Med-QUEST conventions in terms of how each of these transactions is used. Under these conversions, TA1 Segments report errors within ISA/IEA outer envelopes, 997 Transactions report acceptance of valid transactions, and the 824 Transactions report syntactical errors within transactions.

Med-QUEST does not anticipate extensive syntactical problems on 835 Transactions because it applies translator edits to outgoing and well as incoming transactions and corrects any problems revealed by the translator prior to 835 transmission. Discrepancies are possible, however, due to variations in sender and receiver edits.

For providers that request it, Med-QUEST posts an 835 Remittance Advice Supplemental File to the FTP Server along with each 835 Transaction. The Supplemental File carries HPMMIS adjudication codes as they are generated prior to 835 translation. It is described more fully in Section 4.5, 835 Supplemental File.

Med-QUEST Interchange Flow - 835 Transaction



4.5 835 Supplemental File

Supplemental File Summary

A basic purpose of all claim remittance advices, including the 835 Transaction, is to communicate to claim submitters the reasons why billed services are paid or denied. Both the current paper RA used by Med-QUEST and the electronic 835 Transaction have many adjudication code values and messages that serve this purpose.

Frequently, however, HIPAA offers no reasonable translation for detailed Med-QUEST Pricing, Edit, and Reason Codes. For this reason, Med-QUEST has created an 835 Remittance Advice Supplemental File to accompany each 835 Transaction. The Supplemental File supplies all of the claim or service line pricing and adjudication codes that are generated by HPMMIS prior to translation and that are included on paper RAs.

In terms of claim level and line level information, the Supplemental File follows the structure of the Med-QUEST 835 Transaction. Claims are defined as multi-line invoices for institutional claims and single services for professional and dental claims.

Institutional claims are paid at the invoice level and have only invoice level data on the Supplemental File. Professional and dental claims are "split" for the 835 Transaction so that each service line becomes a claim with a unique, 14-digit CRN.

The 835 Supplemental File is a fixed-length sequential file with 197 byte records. It is more similar in structure to pre-HIPAA Med-QUEST interface files than to the 835 Transaction. It has four record types:

- A single Header Record with identification information on the payer and billing provider
- Multiple Claim Report Records with Patient Account Numbers, Med-QUEST Claim Reference Numbers (CRNs), and HPMMIS adjudication codes within each HPMMIS Comment Type

- A single Processing Notes Record with HPMMIS adjudication code descriptions for all HPMMIS adjudication codes generated for claims submitted by a billing provider
- A single Trailer Record with a control count

A single Header and Trailer Record appears at the beginning and end of each Supplemental File. A Claim Report Record appears for each institutional claim or professional/dental service line. A Processing Notes Record is created for each billing provider. It provides messages associated with the HPMMIS adjudication codes on the billing provider's Claim Report Records.

Data element level information on the 835 Supplemental File appears in the remainder of this section.

835 SUPPLEMENTAL FILE SPECIFICATIONS				
Record Type	**Field Name**	**Field Description**	**Field Length/ Usage**	**Comments**
HEADER RECORD – 1 record per 835 Transaction				
Header	Record Type	A code for one of the four Record Types on the 835 Supplemental File	2/AN	"HR" = Header Record
Header	File Name	A descriptive name for the file	35/AN	"835 REMITTANCE ADVICE SUPPLEMENTAL FILE"
Header	Payer Name	The name of the claim payer	50/AN	"HAWAII"
Header	Payer's Tax ID	The Federal Tax ID of the claim payer	20/AN	"996001089"
Header	Billing Provider ID	The Med-QUEST Identification Number assigned to the Billing Provider	8/AN	
Header	Billing Provider Name	The name of the Billing Provider	25/AN	The full name of the billing provider with intervening spaces between name components
Header	Billing Provider Tax ID	The Federal Tax ID of the Billing Provider	20/AN	
Header	Filler		37/AN	Filled with spaces
CLAIM REPORT RECORD – 1 or more records per 835 Transaction				
Claim Report	Record Type	A code for one of the four Record Types on the 835 Supplemental File	2/AN	"S1" = Claim Report Record
Claim Report	Patient Account Number	The claim submitter's ID Number for the patient	20/AN	
Claim Report	Med-QUEST Claim Number	The Claim Reference Number (CRN) or Service Line Reference Number assigned by Med-QUEST	14/AN	For institutional claims reported at the claim level, the final two characters are zeros. For professional and dental service lines, the final two characters carry the Line Number with a value of more than zero.
Claim Report	Recipient ID	The Med-QUEST ID Number for the recipient	10/AN	The nine-character Med-QUEST Recipient ID
Claim Report	Claim Status Code	The claim or line level status code	1/AN	For institutional claims, this Status Code is always at the claim level. For professional and dental claims, it is at the service line level without an equivalent claim level code on the 835. Valid values are: • "1" = Paid • "2" = Adjusted • "3" = Voided • "4" = Denied

835 SUPPLEMENTAL FILE SPECIFICATIONS				
Record Type	**Field Name**	**Field Description**	**Field Length/ Usage**	**Comments**
Claim Report	Claim Status Date	The date on which the HPMMIS Status Code from which the Claim Status Code is derived was assigned.	8/AN	Format is CCYYMMDD.
Claim Report	Comment Type	An MED-QUEST code for the type of comment in the Comment Text field.	2/AN	Code values correspond to the four Comment Type descriptions identified below.

835 SUPPLEMENTAL FILE SPECIFICATIONS				
Record Type	**Field Name**	**Field Description**	**Field Length/ Usage**	**Comments**
Claim Report	Comment Text	A field defined separately for each type of Comment generated by HPMMIS.	140/AN	A description of the HPMMIS Comment Type appears at the beginning of each comment. Comment Types identified by descriptions are: • PRICE EXPL – An explanation of the pricing methodology used to price the claim or service line, for example, “APD” for Ancillary Per Discharge Rate on an inpatient claim. • REASON CDS – Claim Reason or Edit/Result Codes generated by HPMMIS to explain denials and payment cut-backs, for example “H129.2” for Primary Diagnosis Code is Invalid for Recipient Age. • TIER DATA – The pricing tier or tiers at which an inpatient claim is paid, for example “SUR” for Surgery Tier. • COMMENTS – Additional comments entered by reviewers, for example, “OUTLIER REQUESTED, NOT QUALIFIED”. Descriptions of all codes used on an 835 Transaction appear in the Processing Notes Record. Layout for the comment text field follows: NOTE: The Comment Text field contains different formats, depending on the Comment Type. Comment Type ‘A’: There are three different formats for this type: (1) Price Explanation Code 3 characters 10 Occurrences of X(14) Price Explanation Reason 2 characters Filler 9 characters (2) Price Explanation Ind. 1 character 10 Occurrences of X(14) Price Explanation Rate 3 characters Filler 10 characters

835 SUPPLEMENTAL FILE SPECIFICATIONS				
Record Type	**Field Name**	**Field Description**	**Field Length/ Usage**	**Comments**
				(3) Filler 1 character 10 Occurrences of X(14) Price Expl. Type Ind. 1 character Price Explanation Type 3 characters Filler 9 characters Comment Type 'R': There is one format for this type: (1) Reason Code 6 characters 17 Occurrences of X(8) Filler 2 characters Comment Type 'T': There is one format for this type: (1) Tier 1 5 characters 1 Occurrence of X(140) Filler 51 characters Reason 1 5 characters Filler 8 characters Tier 2 3 characters Filler 53 characters Reason 2 5 characters Filler 10 characters Comment Type 'X': Used to indicate free form. There is no format for this type.
PROCESSING NOTES RECORD – 1 record per 835 Transaction				
Notes	Record Type	A code for one of the Record Types on the 835 Supplemental File	2/AN	"S2" = Processing Notes Record
Notes	Processing Note Code	An MED-QUEST Adjudication Code that appears in the Comment Text Field on Claim Records.	6/AN	A HPMMIS claim or service line adjudication code that appears in the Comment Text field of a Claim Report Record for a billing provider.
Notes	Processing Note Description	The message associated with the MED-QUEST Adjudication Code.	140/AN	A description of the claim or service line adjudication code. Code values generated for all claims for a billing provider are unduplicated.
Notes	Filler		49	
TRAILER RECORD – 1 record per 835 Transaction				
Trailer	Record Type	A code for one of the Record Types on the 835 Supplemental File	2/AN	"TR" = Trailer Record
Trailer	Trailer Record Count	The number of records in the 835 Supplemental File, including the Header and Trailer Records.	9/N	
Trailer	Filler		186	

5. Transaction Specifications

5.1 About Transaction Specifications

Purpose

Transaction Specifications document the codes that Med-QUEST allows between trading partners and specify the type and format of the information included in data elements. In some cases, these values are subsets of the data element values listed or referenced in Implementation Guides. In others, they are specific to Med-QUEST requirements.

For example, in the Subscriber Number Loop of a transaction in the Implementation Guide, Element REF02 is defined as an alphanumeric identification element that is between one and thirty characters long. In the Transaction Specifications, REF02 is defined as the member's Med-QUEST ID. The length and format of the field are based on the characteristics of the Med-QUEST Recipient ID rather than on the variable field size defined for the transaction by the Implementation Guide.

Relationship to HIPAA Implementation Guides

Transaction Specifications supplement information in the Implementation Guides for each HIPAA Transaction with additional information specific to the trading partners using the transaction.

The information in the Transaction Specifications is not intended to:

- Modify the definition, data condition, or use of any data element or segment in the standard Implementation Guides.
- Add any additional data elements or segments to the defined data set.
- Utilize any code or data values that are not valid in the standard Implementation Guides.
- Change the meaning or intent of any implementation specifications in the standard Implementation Guides.

5.2 835 Claims Remittance Advice Transaction Specifications

Overview

The purpose of these Transaction Specifications is to identify the data elements used in the 835 Claims Remittance Advice Transaction so that providers and other entities that receive 835 Transactions from Med-QUEST will be able to understand and process transaction data. The 835 Transaction does not include or accompany claim payments. Rather, it serves as a detailed remittance advice that shows payments, adjustments, and denials for each inpatient claim and outpatient, professional, or dental service line submitted by the provider that receives the 835.

The ACS Financial System implements Agency policy by writing weekly checks or generating weekly electronic payments or checks to providers paid on a fee-for-service basis. To be consistent with this payment policy, the Agency generates weekly 835 Transactions at the same times as provider payments. Each 835 includes identification, medical, and financial data on paid and denied claims adjudicated during the previous week. Pended claims and claims received but not yet processed by Med-QUEST are not included. Claim replacements and voids are identified and reported but do not appear in separate sections.

The following entities can receive 835 Transactions from Med-QUEST:

- Authorized fee-for-service providers that submit claims to Med-QUEST
- Provider groups that serve as billing providers for individual physicians or other practitioners
- Billing agents that transmit claims and collect receivables for fee-for-service providers

Three special considerations that affect the Med-QUEST 835 Transactions are discussed in further detail. They are:

- Claim Adjudication Codes
- Billing and Servicing Providers
- Provider Level Adjustments

Claim Adjudication Codes

The most important data variations between the current Med-QUEST Claims Remittance Advice and the 835 Transaction are in the code sets that tell claim submitters the results of each claim's adjudication. On its pre-HIPAA RAs, Med-QUEST relied on several code sets to inform submitters of claims and service lines that are paid, denied, pended, and not yet processed.

Detailed mappings between Med-QUEST and HIPAA claim adjudication codes are used in code set translation. They only apply to Med-QUEST denial Reason Codes for which there are appropriate and reasonable translations. The following categories of Med-QUEST Edit/Result and Claim Reason Codes have been excluded from the code set mappings:

- Med-QUEST Codes for pended and not-yet-processed claims and service lines
  The 835 is a financial transaction that supports only adjudicated (paid or denied) claims and service lines.

- Med-QUEST Codes for claim adjustments and voids
  Although the 835 Transaction supports replacements and voids, it does not have detailed Adjustment Reason or Remark Code to explain them. They are identified in other ways.

- Med-QUEST Codes used on paid claims that cannot be reasonably translated
  Both Med-QUEST and HIPAA Code Sets have some values that are not at all equivalent. These values have been dropped from the mapping. One of a set of standard Adjustment Reason Codes appears for financial adjustments even when Med-QUEST codes are untranslatable. Additional information is communicated through Remark Codes on the 835.

On the HIPAA code set side, there are also three code sets that describe the results of claim adjudication: Adjustment Group Code, Adjustment Reason Code, and Remark Code. Adjustment Group and Adjustment Reason Codes explain the differences between Charged Amounts and Paid Amounts at both claim and service line levels. For the 835, adjustments are variations between Charged and Paid Amounts that result from claim adjudication. High-level Adjustment Group Codes and more specific Adjustment Reason Codes are associated with an Adjustment Amount on the 835 Transaction. Remark Codes have no direct relationship to dollar amounts, although many Remark Codes explain why a claim or service line is denied.

There are major differences between the Med-QUEST and the HIPAA compliant code sets used to explain the results of claim adjudication. Two kinds of distinctions are especially important:

- Med-QUEST pays most claims based on Allowed Amounts determined by HPMMIS independently of provider charges. The only connection between charges and payments is that Med-QUEST does not pay more than the Charged Amount even if the Med-QUEST Allowed Amount is greater.

- Few Med-QUEST and HIPAA code set values have solid, unambiguous matches at the same level of detail. This is true both because Med-QUEST codes are more detailed and specific than HIPAA codes and because they frequently cover different situations.

In light of these considerations, Med-QUEST has adopted a three-step approach to population of Adjustment Group, Adjustment Reason, and Remark Codes on 835 Transactions.

Step 1: Determine whether an institutional claim or professional/dental service line needs a CAS Claim or Service Line Adjustment Segment with an Adjustment Group Code, Adjustment Reason Code, and Adjustment Amount.

When the Payment Amount for a claim or line is different from the Charged Amount, a CAS Segment is required. When the amounts are equal, the CAS Segment with its adjustment codes is not needed.

In theory, a Remark Code can occur without a CAS Segment for a claim or service line. In practice, this seldom happens because most Remark Codes explain reasons for denials or cut-backs that generate adjustment codes and Adjustment Amounts.

Step 2: If Charged and Payment Amounts for an inpatient claim or outpatient/professional/dental service line are different, the 835 carries Adjustment Group and Adjustment Reason Codes on the 835 Transaction, along with an Adjustment Amount.

Adjustment code combinations are based on two factors. The first is the status categories that are assigned by HPMMIS:

- Original Paid Claims or Service Lines
- Replacement Claims
- Voided Claims
- Denied Claims or Service Lines

The second factor in adjustment code assignment is the reason for the adjustment. The following adjustment types (in addition to provider level adjustments that are not claim specific) are accommodated:

- Share of Cost Amounts paid by the patient
- Amounts paid by other health care carriers
- Amounts previously paid by Med-QUEST
- Pricing adjustments - reductions in Payment Amounts from Charged Amounts due to use of Med-QUEST Allowed Amounts in payment

Adjustment Group and Adjustment Reason Codes and messages used by Med-QUEST on the 835 Transaction are shown in the chart on the next page.

Step 3: Translate Med-QUEST Code Sets.

The third step involves translation of Med-QUEST Reason Codes for denials to HIPAA Remarks Codes on the 835 Transaction. Further translations of Med-QUEST codes to Adjustment Group and Reason Codes are not attempted.

Remarks Codes populate MIA (inpatient) and MOA (outpatient) Segments at the institutional claim level and LQ (Health Care Remark Codes) Segments when generated at the professional/dental service line level. Med-QUEST "unduplicates" Remark Codes for the 835 Transaction. This means that each code value appears only once for a claim or service line even when the same HIPAA code value is generated repeatedly.

ADJUSTMENT GROUP AND REASON CODES ON THE MED-QUEST 835 TRANSACTION

Status Category	Adjustment Type	835 Adjustment Group	835 Adjustment Reason
Original or Replacement	Share of Cost	"PR" – Patient Responsibility	"2" – Coinsurance Amount
Original or Replacement	Other Carrier	"OA" – Other Adjustment	"23" – Payment adjusted because charges have been paid by another payer.
Original or Replacement	Prior MED-QUEST Payment	"OA" – Other Adjustment	"B13" – Previously paid. Payment for this claim/service may have been provided in a previous payment.
Original or Replacement	Pricing	"PI" – Payer Initiated	"A2" - Contractual Adjustment
Void	Share of Cost	"CR" – Correction and Reversals	"2" – Coinsurance Amount
Void	Other Carrier	"CR" – Correction and Reversals	"23" – Payment adjusted because charges have been paid by another payer.
Void	Prior MED-QUEST Payment	"CR" – Correction and Reversals	"B13" – Previously paid. Payment for this claim/service may have been provided in a previous payment.
Void	Pricing	"CR" – Correction and Reversals	"A2" - Contractual Adjustment
Denial	Pricing	"PI" – Payer Initiated	"A1" – Claim denied charges

All of these conditions can occur at both claim and service line levels. Inpatient institutional claims paid by tier-based pricing or nursing home rates are priced and adjusted at the claim invoice level. All other claims are priced and adjusted by service line.

Billing and Rendering Providers

Med-QUEST has two kinds of situations involving Billing and Servicing or Rendering Providers that require recognition in the 835 Transaction. They are:

- Rendering Providers with multiple locations – the Rendering Provider is also the Billing Provider.

  In this situation, the provider's Med-QUEST ID Number, without a Location Code suffix, appears as the Billing Provider (Loop 1000B/Element REF02 in the Payee Additional Identifier REF Segment). The Provider IDs for the various locations appear, with Location suffixes, as rendering providers (Loop 2000/Element TS301and Loop 2100/Element NM109 in the Rendering Provider Name NM1 Segment).

- Provider Groups and Billing Agents – the Rendering Provider and Billing Provider are different.

  In this situation, Med-QUEST assigns Provider IDs to the group or billing agent. The group or billing agent appears on the 835 as a Billing Provider (Loop 1000B/Element REF02 in the Payee Additional Identifier REF Segment) without a Location Code. Members of the group have different Med-QUEST Provider IDs. They appear as Rendering Providers (Loop 2000/Element TS301and Loop 2100/Element NM109 in the Rendering Provider Name NM1 Segment) with Location Codes.

If a rendering provider with multiple locations is a member of a billing group, the group is the billing provider on the 835 and each location is a different rendering provider.

Provider Level Adjustments

In addition to supporting financial adjustments (changes from charged to paid amounts) at claim and service line levels, the 835 Transaction's PLB Provider Adjustment Segment allows claim payers to notify billing providers of payments and withholds that are not claim specific. Med-QUEST uses the provider level adjustment feature in two ways:

- To report non-claim specific payments to (and withholds from) billing providers. Settlements and returned checks are examples of items that can be handled by this segment.

- To offset negative payment amounts to billing providers when the total provider payment balance on the 835 is negative. This function is needed because the ACS Financial System used by Med-QUEST does not issue negative payments.

Payments to and withholds from billing providers that are not specific to claims are included in transaction level balancing along with claim based payments. They have PLB03 Adjustment Reason Codes of "AM" (Applied to Borrower's Account). The negative offset function also affects 835 balancing requirements. Negative offsets are needed when, on a particular claim payment cycle, recoveries from a billing provider add up to more than payments.

In negative payment situations, Med-QUEST creates a provider level offset adjustment in the PLB Segment with a PLB03 Adjustment Reason Code of "FB" (Forwarding Balance). The provider level adjustment is for a negative amount equal to the calculated negative amount of the recovery from the provider. A negative rather than a positive amount is required due to the 835 Transaction's balancing requirements. According to the 835 Implementation Guide (Page 169), "These adjustments can either decrease the payment (a positive number) or increase the payment (a negative number)." When the calculated Total Payment Amount on an 835 Transaction is negative, it must be offset with a corresponding increase in payment. The final payment amount in the BPR02 Total Actual Provider Payment Amount element on the 835 Transaction is then zero.

PLB offset Segments are created whenever a calculated total payment amount is negative. This can be due to either claim voids or replacements or to provider adjustments specified on other PLB Segments.

Transaction Specifications Table

835 Claims Remittance Advice Transaction Specifications for individual data elements are shown in the table beginning on the next page. Definitions of table columns follow:

Loop ID
The Implementation Guide's identifier for a data loop within a transaction.

Segment ID
The Implementation Guide's identifier for a data segment within a loop.

Element ID
The Implementation Guide's identifier for a data element within a segment.

Element Name
A data element name as shown in the Implementation Guide. When the industry name differs from the Data Element Dictionary name, the more descriptive industry name is used.

Element Definition
How the data element is defined in the Implementation Guide.

Valid Values
The valid values from the Implementation Guide that are used by Med-QUEST.

Definition/Format
Definitions of valid values used by Med-QUEST and additional information about Med-QUEST data element requirements.

835 CLAIMS REMITTANCE ADVICE TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
N/A	ST	ST01	Transaction Set Identifier Code	Code uniquely identifying a Transaction Set	835	Health Care Claim Payment/Advice
N/A	ST	ST02	Transaction Set Control Number	The unique identification number within a transaction set		This number is unique within a functional group of similar transactions. The value of this element is the same as that of the SE02 element at the end of the transaction.
N/A	BPR	BPR01	Transaction Handling Code	This code designates whether and how the money and remittance information will be processed	I	Remittance Information Only
N/A	BPR	BPR02	Total Actual Provider Payment Amount	The total payment for this batch or transaction		The Total Payment Amount on the 835 Transaction This is the amount of the weekly check or electronic transfer to the billing provider from Med-QUEST. The Med-QUEST translator verifies that it balances to sums of 835 Transaction payment totals at service provider, claim and service line levels. When the Billing Provider that receives the transaction (REF02 within the transaction header) and the Rendering Provider (Loop 2100, Element NM109) are the same, balancing is for a single 835 provider/receiver. If the Total Payment Amount on an 835 Transaction is negative due to a preponderance of payment recoveries, zero appears in this element. Positive and negative amounts are available at the institutional claim or professional/dental service line level.
N/A	BPR	BPR03	Credit or Debit Flag Code	Code indicating whether amount is a credit or debit	C	Credit
N/A	BPR	BPR04	Payment Method Code	Code identifying the method for the movement of payment instructions	ACH CHK FWT	Automated Clearing House Check Wire Transfer Med-QUEST makes claim payments in all three ways, primarily by automated clearing house (ACH). Most elements in the BPR Segment are required for the “ACH” and “FWT” options.
N/A	BPR	BPR05	Payment Format Code	Type of format chosen to send payment	CCP	Concentration/Addenda plus Disbursement Used only when BPR02 = “ACH” or “FWT”.

835 CLAIMS REMITTANCE ADVICE TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
N/A	BPR	BPR06	Depository Financial Institution (DFI) Identification Number Qualifier	Code identifying the type of identification number of Depository Financial Institution (DFI)	01	ABA Transit Routing Number Appears when BPR04 is “ACH” or “FWT”. Otherwise absent.
N/A	BPR	BPR07	Originating Depository Financial Institution (DFI) Identifier	Number identifying the financial institution originating the transaction in an ACH network		The nine-digit Transit Routing Number including check digits Appears when BPR04 is “ACH” or “FWT”. Otherwise absent.
N/A	BPR	BPR08	Account Number Qualifier	Code indicating the type of account	DA	Demand Deposit Used when BPR04 is “ACH” or “FWT”.
N/A	BPR	BPR09	Sender Bank Account Number	The sender's bank account number at the Originating Depository Financial Institution		Bank Account Number of the entity originating the transaction when BPR04 is “ACH” or “FWT”.
N/A	BPR	BPR10	Originating Company Identifier	A unique identifier designating the company originating the transaction	1996001089	The DHS/Med-QUEST Federal Tax ID Number preceded by the number “1”. For the organization originating the transaction. Used when BPR04 is “ACH” or “FWT”.
N/A	BPR	BPR12	Depository Financial Institution (DFI) Identification Number Qualifier	Code identifying the type of identification number of Depository Financial Institution (DFI)	01	ABA Transit Routing Number Appears when BPR04 is “ACH” or “FWT”. Otherwise absent.
N/A	BPR	BPR13	Receiving Depository Financial Institution (DFI) Identifier	Number identifying the financial institution receiving the transaction from an ACH network		The nine-digit Transit Routing Number including check digits Appears when BPR04 is “ACH” or “FWT”. Otherwise absent.
N/A	BPR	BPR14	Account Number Qualifier	Code indicating the type of account	DA	Demand Deposit Used when BPR04 is ACH or “FWT”.
N/A	BPR	BPR15	Receiver Bank Account Number	The receiver's bank account number at the Receiving Depository Financial Institution		Bank Account Number of the entity receiving the transaction when BPR04 is “ACH” or “FWT”.

835 CLAIMS REMITTANCE ADVICE TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
N/A	BPR	BPR16	Check Issue or EFT Effective Date	Date the check was issued or the electronic funds transfer (EFT) effective date		Date that the check was issued or that Med-QUEST intends the transaction to be settled in CCYYMMDD format.
N/A	TRN	TRN01	Trace Type Code	Code identifying the type of reassociation which needs to be performed	1	Current Transaction Trace Numbers
N/A	TRN	TRN02	Check or EFT Trace Number	Check number or Electronic Funds Transfer (EFT) number that is unique within the sender/receiver relationship		Electronic Trace Number (if BPR04 = “ACH” or “FWT”) or Check Number (if BPR04 = “CHK”).
N/A	TRN	TRN03	Originating Company Identifier	A unique identifier designating the company originating the transaction	1996001089	The DHS/Med-QUEST Federal Tax ID Number preceded by the number “1”. For the organization originating the transaction.
N/A	DTM	DTM01	Date Time Qualifier	Code specifying the type of date or time or both date and time	405	Production
N/A	DTM	DTM02	Production Date	According to the 835 Implementation Guide, “the end date for the adjudication production cycle for claims included in this 835.”		Financial information date in CCYYMMDD format.
1000A	N1	N101	Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	PR	Payer
1000A	N1	N102	Payer Name	Name identifying the organization remitting the payment	MED-QUEST	Name of organization making the payment.
1000A	N3	N301	Payer Address Line	Address line for the payer's address		Med-QUEST Street Address Line 1
1000A	N4	N401	Payer City Name	The city name of the payer's address		Med-QUEST City
1000A	N4	N402	Payer State Code	State postal code of the payer's address		Med-QUEST State Code
1000A	N4	N403	Payer Postal Zone or ZIP Code	The postal zone code of the payer's address		Med-QUEST Zip Code

835 CLAIMS REMITTANCE ADVICE TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
1000B	N1	N101	Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	PE	Payee
1000B	N1	N102	Information Receiver Last or Organization Name	The name of the organization or last name of the individual that expects to receive information or is receiving information		Receiver Name
1000B	N1	N103	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	FI	The payee's Federal Taxpayer's ID Number
1000B	N1	N104	Payee Identifier	Number identifying the organization receiving the payment		Payee's Tax ID Number
1000B	N3	N301	Payee Address Line	The payee's address line		Payee's Street Address Line 1
1000B	N3	N302	Payee Address Line	The payee's address line		Payee's Street Address Line 2
1000B	N4	N401	Payee City Name	The City Name of the payee's address		Payee's City
1000B	N4	N402	Payee State Code	The State Postal Code of the payee's address		Payee's State
1000B	N4	N403	Payee Postal Zone or ZIP Code	The Zip Code of the payee's address		Payee's Zip Code
1000B	REF	REF01	Reference Identification Qualifier	Code qualifying the Reference Identification	1D	Medicaid Provider Number
1000B	REF	REF02	Additional Payee Identifier	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier		The billing provider's Med-QUEST ID Always present. The Billing Provider can be the same as or different from the Institutional Claim Facility or the Professional/Dental Rendering Provider

835 CLAIMS REMITTANCE ADVICE TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2000	LX	LX01	Assigned Number	Number assigned for differentiation within a transaction set	1 – 999999	The single-element LX Segment is especially needed when the 835 Transaction has multiple 2000 Header Number Loops for different rendering providers. This can happen when the 835 is sent to a provider group or billing agent that includes multiple rendering providers and/or facilities within it. If the payee identified in Payee Identification Loop 1000B is the same as the Service or Rendering Provider and the provider has only a single Location, there is only one 2000 Loop.
2000	TS3	TS301	Provider Identifier	Number assigned by the payer, regulatory authority, or other authorized body or agency to identify the provider		The eight-character Med-QUEST Provider Identification Number (including Location Code) for the rendering provider appears in TS301.
2000	TS3	TS302	Facility Type Code	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	99	Med-QUEST uses Location Code “99” (Other Unlisted Facility) to populate this required field. Location Codes that more truly indicate where the service was performed appear at the claim level.
2000	TS3	TS303	Fiscal Period Date	Last day of provider's fiscal year		December 31 of the current year in CCYY1231 format. All claims reported for a provider will always fall within the same fiscal period.
2000	TS3	TS304	Total Claim Count	Total number of claims in this 2000 Loop		The number of paid and denied claims reported for the rendering provider in Element TS301. Pended claims and claims not yet processed are not included in the 835 Transaction.
2000	TS3	TS305	Total Claim Charge Amount	The sum of all charges included within this 2000 Loop		The total charges for all paid and denied claims reported for the rendering provider in Element TS301.

835 CLAIMS REMITTANCE ADVICE TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2100	CLP	CLP01	Patient Control Number	Patient's unique alpha-numeric identification number for this claim assigned by the provider to facilitate retrieval of individual case records and posting of payment		The Loop 2100 CLP Claim Payment Information Segment begins data on each individual claim for a service provider within the 835 Transaction. Institutional claims appear on the 835 as header-level invoices and professional/dental claims as header/service line combinations with a new duplicate header for each new line. This element carries the Patient Control Number assigned by the provider, whether received on 837 Transactions or paper claims. CLP01 is zero if no Patient Control Number is present.
2100	CLP	CLP02	Claim Status Code	Code specifying the status of a claim submitted by the provider to the payor for processing	1 4 22	Paid as Primary (Original Paid and Replacement Claims) Denied Reversal of Previous Payment (Void Claims and the void component of Replacement Claims) These are the Claim Status Code values used by Med-QUEST on 835 Transactions. “Paid as Primary” indicates a normal payment. For claim reversals, two claims appear, one to void the original (CLP02 = “22”) and the other to create a new replacement claim (CLP02 = “1”).
2100	CLP	CLP03	Total Claim Charge Amount	The sum of all charges included within this claim		The Total Charged Amount for the claim. This amount includes Share of Cost payments by the patient and amounts paid by other carriers prior to Med-QUEST.
2100	CLP	CLP04	Claim Payment Amount	Net provider reimbursement amount for this claim (includes all payments to the provider)		The Med-QUEST Total Paid Amount for the claim.
2100	CLP	CLP05	Patient Responsibility Amount	The amount determined to be the patient's responsibility for payment		The Share of Cost Amount paid by the recipient. If a Share of Cost Amount is paid by a patient, it is included in the provider’s Charged Amount and shown on the claim level CAS Segment.
2100	CLP	CLP06	Claim Filing Indicator Code	Code identifying type of claim or expected adjudication process	MC	Medicaid

835 CLAIMS REMITTANCE ADVICE TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2100	CLP	CLP07	Payer Claim Control Number	A number assigned by the payer to identify a claim The number is usually referred to as an Internal Control Number (ICN), Claim Control Number (CCN) or a Document Control Number (DCN)		The 14-character Claim Reference Number (CRN) assigned by Med-QUEST. At the claim level, the last two digits of the CRN are zeros.
2100	CLP	CLP08	Facility Type Code	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		For Professional and Dental Claims, CLP08 is the Place of Service. Since HPMMIS maintains Place of Service at the line rather than the claim level, CLP08 is the Place of Service from the initial line. For Institutional Claims, CLP08 consists of the first and second characters of the claim level Type Bill Code.
2100	CLP	CLP09	Claim Frequency Code	Code specifying the frequency of the claim This is the third position of the Uniform Billing Claim Form Bill Type		CLP09 Claim Frequency Code values of “7” (Replacement) and “8” (Void) indicate claims that perform these functions. All other valid Claim Frequency values are for original claims.

835 CLAIMS REMITTANCE ADVICE TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2100	CAS	CAS01	Claim Adjustment Group Code	Code identifying the general category of payment adjustment	PR OA PI CR	Patient Responsibility – Share of Cost Payments Other Adjustment – Amounts Paid by Another Carrier and Previously Paid Amounts Payer Initiated Reduction – Amounts Changed by Med-QUEST Adjudication and Claim Denials Correction and Reversals Claim Adjustment CAS Segments in the 2100 Loop appear when there is a difference between the Charged Amount and Paid Amount due to a pricing decision made at the claim rather than the service line level. Med-QUEST uses each of the above Adjustment Group Codes at the beginning of CAS Segments for basic Med-QUEST payment categories. A new CAS Segment is created when an institutional claim or a professional/dental line has more than one Adjustment Group Code. Med-QUEST pricing is determined by contractual agreements with providers rather than by comparisons between Charged and Paid Amounts. All the same, Med-QUEST does not pay more than the Charged Amount.
2100	CAS	CAS02	Adjustment Reason Code	Code that indicates the reason for the adjustment		This occurrence of Adjustment Reason Code begins the first of the up to six “adjustment trios” that can appear on a CAS Segment. Adjustment trios consist of Adjustment Reason Code, Adjustment Amount, and (optionally) Adjustment Quantity. Med-QUEST does not populate Adjustment Quantities and makes use of only some of the more than one hundred available Adjustment Reason Codes. Correspondences between Med-QUEST and HIPAA code sets are limited. Refer to the Claim Adjudication Codes information at the beginning of this section for more information.
2100	CAS	CAS03	Adjustment Amount	Adjustment amount for the associated reason code		The amount of the difference between the Charged Amount and the Paid Amount. A positive number when the Paid Amount is less than the Charged Amount. For denied claims, the Adjustment Amount will equal the Charged Amount.

835 CLAIMS REMITTANCE ADVICE TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2100	CAS	CAS05	Adjustment Reason Code	Code that indicates the reason for the adjustment		If needed, the second Adjustment Reason Code
2100	CAS	CAS06	Adjustment Amount	Adjustment amount for the associated reason code		If needed, the second Adjustment Amount
2100	CAS	CAS08	Adjustment Reason Code	Code that indicates the reason for the adjustment		If needed, the third Adjustment Reason Code
2100	CAS	CAS09	Adjustment Amount	Adjustment amount for the associated reason code		If needed, the third Adjustment Amount
2100	CAS	CAS11	Adjustment Reason Code	Code that indicates the reason for the adjustment		If needed, the fourth Adjustment Reason Code
2100	CAS	CAS12	Adjustment Amount	Adjustment amount for the associated reason code		If needed, the fourth Adjustment Amount
2100	CAS	CAS14	Adjustment Reason Code	Code that indicates the reason for the adjustment		If needed, the fifth Adjustment Reason Code
2100	CAS	CAS15	Adjustment Amount	Adjustment amount for the associated reason code		If needed, the fifth Adjustment Amount
2100	CAS	CAS17	Adjustment Reason Code	Code that indicates the reason for the adjustment		If needed, the sixth Adjustment Reason Code
2100	CAS	CAS18	Adjustment Amount	Adjustment amount for the associated reason code		If needed, the sixth Adjustment Amount
2100	NM1	NM101	Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	QC	Patient
2100	NM1	NM102	Entity Type Qualifier	Code qualifying the type of entity	1	Person
2100	NM1	NM103	Patient Last Name	The last name of the individual to whom the services were provided		The patient’s Last Name as submitted on the claim.
2100	NM1	NM104	Patient First Name	The first name of the individual to whom the services were provided		The patient’s First Name as submitted on the claim.
2100	NM1	NM105	Patient Middle Name	The middle name of the individual to whom the services were provided		If present, the patient’s Middle Name or Middle Initial as submitted on the claim.

835 CLAIMS REMITTANCE ADVICE TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2100	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	MR	Medicaid Recipient Identification Number
2100	NM1	NM109	Patient Identifier	Patient identification code		The recipient's nine-character HAWI/Med-QUEST ID.
2100	NM1	NM101	Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	74	Corrected Insured
2100	NM1	NM102	Entity Type Qualifier	Code qualifying the type of entity	1	Person
2100	NM1	NM103	Corrected Patient or Insured Last Name	Corrected last name of the patient or insured		The recipient's Last Name as known to Med-QUEST.
2100	NM1	NM104	Corrected Patient or Insured First Name	Corrected first name of the patient or insured		The recipient's First Name as known to Med-QUEST.
2100	NM1	NM105	Corrected Patient or Insured Middle Name	Corrected middle name of the patient or insured		If present, the recipient's Middle Initial as known to Med-QUEST.
2100	NM1	NM101	Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	82	Rendering Provider
2100	NM1	NM102	Entity Type Qualifier	Code qualifying the type of entity	2	Non-Person Entity
2100	NM1	NM103	Rendering Provider Last or Organization Name	The last name or organization of the provider who performed the service		The full name of the service provider. This is how the Provider Name appears in HPMMIS.
2100	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	MC	Medicaid Provider Number
2100	NM1	NM109	Rendering Provider Identifier	The identifier assigned by the payer to the provider who performed the service		The six-character Med-QUEST ID of the rendering or service provider followed by a two-character Provider Location Code.
2100	MIA	MIA01	Covered Days or Visits Count	Number of days or visits covered by the primary payer or days/visits that would have been covered had Medicare been primary	0	This element is required by HIPAA on MIA Segments but is not populated by Med-QUEST.

835 CLAIMS REMITTANCE ADVICE TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2100	MIA	MIA05	Remark Code	Code indicating a code from a specific industry code list, such as the Health Care Claim Status Code list		If present, a claim-level Remark Code on an institutional claim. Multiple HPMMIS claim error codes can trigger multiple Remark. Remark Codes are translated from Med-QUEST Reason and Edit/Result Codes. Remark Codes on the 835 Transactions are unduplicated to avoid repetition.
2100	MIA	MIA22	Remark Code	Code indicating a code from a specific industry code list, such as the Health Care Claim Status Code list		The second Institutional Claim Remark Code, if needed.
2100	MIA	MIA20	Remark Code	Code indicating a code from a specific industry code list, such as the Health Care Claim Status Code list		The third Institutional Claim Remark Code, if needed.
2100	MIA	MIA21	Remark Code	Code indicating a code from a specific industry code list, such as the Health Care Claim Status Code list		The fourth Institutional Claim Remark Code, if needed.
2100	MIA	MIA23	Remark Code	Code indicating a code from a specific industry code list, such as the Health Care Claim Status Code list		The fifth Institutional Claim Remark Code, if needed.
2100	MOA	MOA03	Remark Code	Code indicating a code from a specific industry code list, such as the Health Care Claim Status Code list		If present, the claim-level Remark Code on a professional, dental or outpatient institutional claim. Multiple HPMMIS claim error codes can trigger multiple Remark. Remark Codes are translated from Med-QUEST Reason and Edit/Result Codes. Remark Codes on the 835 Transactions are unduplicated to avoid repetition.
2100	MOA	MOA04	Remark Code	Code indicating a code from a specific industry code list, such as the Health Care Claim Status Code list		The second Professional/Dental/Outpatient Claim Remark Code, if needed.
2100	MOA	MOA05	Remark Code	Code indicating a code from a specific industry code list, such as the Health Care Claim Status Code list		The third Professional/Dental/Outpatient Claim Remark Code, if needed.

835 CLAIMS REMITTANCE ADVICE TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2100	MOA	MOA06	Remark Code	Code indicating a code from a specific industry code list, such as the Health Care Claim Status Code list		The fourth Professional/Dental/Outpatient Claim Remark Code, if needed.
2100	MOA	MOA07	Remark Code	Code indicating a code from a specific industry code list, such as the Health Care Claim Status Code list		The fifth Professional/Dental/Outpatient Claim Remark Code, if needed.
2100	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	F8	Original Reference Number Med-QUEST uses this REF Segment to show the Med-QUEST CRN of a claim being replaced or voided.
2100	REF	REF02	Other Claim Related Identifier	Code identifying other claim related reference numbers		The 14 character Claim Reference Number (CRN) of the claim being replaced or voided when the Claim Frequency Code (CLP09) has a value of “7” (Replacement) or “8” (Void).
2100	DTM	DTM01	Date Time Qualifier	Code specifying the type of date or time or both date and time	232 and 233	Claim Statement Period Start and Claim Statement Period End Claim level Service Begin and End Dates appear in this DTP Segment for all MED-QUEST claim types. Two DTP Segments are generated.
2100	DTM	DTM02	Claim Date	Date associated with the claim		The Service Begin or End Date in CCYYMMDD format.

835 CLAIMS REMITTANCE ADVICE TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2100	AMT	AMT01	Amount Qualifier Code	Code to qualify amount	I D8 AU F5	Interest (an additional amount paid by Med-QUEST to the provider due to late claim payment) Discount Amount (a reduction in the amount paid by Med-QUEST to the provider due to a prompt pay discount in the provider's contract) Coverage Amount (the Med-QUEST Allowed Amount) Patient Amount Paid (a Share of Cost Amount) An Allowed Amount is present for every claim. Other amounts are reported on separate AMT Segments when they are present. Amounts in this segment are independent of amounts in CAS Segments and are not referenced for internal balancing. They do, however, contribute to differences between Charged and Paid Amount reported in the CAS Segment. When this happens, the same Amount appears in both places.
2100	AMT	AMT02	Claim Supplemental Information Amount	Amount of supplemental information values associated with the claim		The positive or negative dollar amount described by the qualifier in AMT01.
2100	QTY	QTY01	Quantity Qualifier	Code specifying the type of quantity	CA	Covered - Actual
2100	QTY	QTY02	Claim Supplemental Information Quantity	Numeric value of the quantity of supplemental information associated with the claim		Allowed Units - the number of Units of Service on the claim that were covered by Med-QUEST.

835 CLAIMS REMITTANCE ADVICE TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2110	SVC	SVC01-1	Product or Service ID Qualifier	Code identifying the type/source of the descriptive number used in Product/Service ID	HC NU ND	HCPCS Procedure and Supply Codes National Uniform Billing Committee (NUBC) Revenue Codes Pharmacy Codes (not used at present) These are the codes available to Med-QUEST to define service line procedures used by Med-QUEST in claim adjudication. HCPCS Codes appear on professional and dental claims. On outpatient institutional claims, HCPCS Codes appear in this element and associated Revenue Codes in SVC04. Med-QUEST is enhancing data extraction procedures for the 835 Transaction so that service line level data as well as claim level data appears on RAs for outpatient institutional claims.
2110	SVC	SVC01-2	Procedure Code	Code identifying the procedure, product or service		The HCPCS Procedure Code for the service line.
2110	SVC	SVC01-3	Procedure Modifier	This identifies special circumstances related to the performance of the service		If present, the first Modifier of HCPCS Codes.
2110	SVC	SVC01-4	Procedure Modifier	This identifies special circumstances related to the performance of the service		If present, the second Modifier of HCPCS Codes.
2110	SVC	SVC01-5	Procedure Modifier	This identifies special circumstances related to the performance of the service		If present, the third Modifier of HCPCS Codes.
2110	SVC	SVC01-6	Procedure Modifier	This identifies special circumstances related to the performance of the service		If present, the fourth Modifier of HCPCS Codes.
2110	SVC	SVC02	Line Item Charge Amount	Charges related to this service		The Charged Amount submitted for the service line. Service line level Charged Amounts are required on professional, dental, and outpatient institutional claims.
2110	SVC	SVC03	Line Item Provider Payment Amount	The actual amount paid to the provider for this service line		The Amount Paid by Med-QUEST for this service line when pricing is at the line level.
2110	SVC	SVC04	National Uniform Billing Committee Revenue Code	Code values from the National Uniform Billing Committee Revenue Codes		For outpatient institutional claims, the Revenue Code submitted in association with the HCPCS Procedure Code.

835 CLAIMS REMITTANCE ADVICE TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2110	SVC	SVC05	Units of Service Paid Count	Number of the paid units of service		The number of Units of Service paid by Med-QUEST for this service line.
2110	SVC	SVC06-1	Product or Service ID Qualifier	Code identifying the type/source of the descriptive number used in Product/Service ID	HC NU ND	HCPCS Procedure and Supply Codes National Uniform Billing Committee (NUBC) Revenue Codes Pharmacy (not used at present) These are the codes available to Med-QUEST to define service line procedures originally submitted by the provider. HCPCS Codes appear on professional and dental claims. On outpatient institutional claims, HCPCS Codes appear in this element and associated Revenue Codes in SVC04. Med-QUEST is enhancing data extraction procedures for the 835 Transaction so that service line level data as well as claim level data appears on RAs for outpatient institutional claims.
2110	SVC	SVC06-2	Procedure Code	Code identifying the procedure, product or service		The HCPCS Procedure Code that was originally submitted for the service line.
2110	SVC	SVC06-3	Procedure Modifier	This identifies special circumstances related to the performance of the service		If present, the first Modifier of HCPCS Codes originally submitted for this service line.
2110	SVC	SVC06-4	Procedure Modifier	This identifies special circumstances related to the performance of the service		If present, the second Modifier of HCPCS Codes originally submitted for this service line.
2110	SVC	SVC06-5	Procedure Modifier	This identifies special circumstances related to the performance of the service		If present, the third Modifier of HCPCS Codes originally submitted for this service line originally submitted for this service line.
2110	SVC	SVC06-6	Procedure Modifier	This identifies special circumstances related to the performance of the service		If present, the fourth Modifier of HCPCS Codes originally submitted for this service line.
2110	SVC	SVC07	Original Units of Service Count	Original units of service that were submitted by the provider (in days or units)		The Units of Service originally submitted by the provider.

835 CLAIMS REMITTANCE ADVICE TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2110	DTM	DTM01	Date Time Qualifier	Code specifying the type of date or time or both date and time	151 152	Service Period Start Service Period End Codes “151” and “152” appear on separate DTM Segments even when they are the same date.
2110	DTM	DTM02	Service Date	Date of service, such as the start date of the service, the end date of the service, or the single day date of the service		The date described by the above qualifier in CCYYMMDD format.
2110	CAS	CAS01	Claim Adjustment Group Code	Code identifying the general category of payment adjustment	PR OA PI	Patient Responsibility (Share of Cost Payments) Other Amounts (Amount Paid by Another Carrier and Previously Paid Amount) Payer Initiated Reduction (Amounts Changed by Med-QUEST Adjudication and Claim Denials) Claim Adjustment CAS Segments in the 2110 Loop appear when there is a difference between the Charged Amount and Paid Amount due to a pricing decision made at the lineather than the claim level. Med-QUEST uses each of the above Adjustment Group Codes at the beginning of CAS Segments for basic Med-QUEST payment categories. A new CAS Segment is created when an institutional claim or a professional/dental line has more than one Adjustment Group Code. Med-QUEST pricing is determined by contractual agreements with providers rather than by comparisons between Charged and Paid Amounts. All the same, Med-QUEST does not pay more than the Charged Amount.

835 CLAIMS REMITTANCE ADVICE TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2110	CAS	CAS02	Adjustment Reason Code	Code that indicates the reason for the adjustment		This occurrence of Adjustment Reason Code begins the first of the up to six “adjustment trios” that can appear on a CAS Segment. Adjustment trios consist of Adjustment Reason Code, Adjustment Amount, and (optionally) Adjustment Quantity. Med-QUEST does not populate Adjustment Quantities and makes use of only some of the more than one hundred available Adjustment Reason Codes. Correspondences between Med-QUEST and HIPAA code sets are limited. Refer to the Claim Adjudication Codes information at the beginning of this section for more information.
2110	CAS	CAS03	Adjustment Amount	Adjustment amount for the associated reason code		The amount of the difference between the Charged Amount and the Paid Amount. A positive number when the Paid Amount is less than the Charged Amount. For denied claims, the Adjustment Amount will equal the Charged Amount.
2110	CAS	CAS05	Adjustment Reason Code	Code that indicates the reason for the adjustment		If needed, the second service line Adjustment Reason Code
2110	CAS	CAS06	Adjustment Amount	Adjustment amount for the associated reason code		If needed, the second service line Adjustment Amount
2110	CAS	CAS8	Adjustment Reason Code	Code that indicates the reason for the adjustment		If needed, the third service line Adjustment Reason Code
2110	CAS	CAS9	Adjustment Amount	Adjustment amount for the associated reason code		If needed, the third service line Adjustment Amount
2110	CAS	CAS11	Adjustment Reason Code	Code that indicates the reason for the adjustment		If needed, the fourth service line Adjustment Reason Code
2110	CAS	CAS12	Adjustment Amount	Adjustment amount for the associated reason code		If needed, the fourth service line Adjustment Amount
2110	CAS	CAS14	Adjustment Reason Code	Code that indicates the reason for the adjustment		If needed, the fifth service line Adjustment Reason Code
2110	CAS	CAS15	Adjustment Amount	Adjustment amount for the associated reason code		If needed, the fifth service line Adjustment Amount
2110	CAS	CAS17	Adjustment Reason Code	Code that indicates the reason for the adjustment		If needed, the sixth service line Adjustment Reason Code
2110	CAS	CAS18	Adjustment Amount	Adjustment amount for the associated reason code		If needed, the sixth service line Adjustment Amount

835 CLAIMS REMITTANCE ADVICE TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2110	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	6R	Provider Control Number
2110	REF	REF02	Provider Identifier	Reference information as defined for a particular transaction set or as specified by the Reference Identification Qualifier		The submitting provider's Line Item Control Number This number is returned to the provider from electronic claims on 837 Transactions received and adjudicated by Med-QUEST. Providers sometimes use this number to reference service or accounting categories.
2110	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	LU	Location Number
2110	REF	REF02	Provider Identifier	Number assigned by the payer, regulatory authority, or other authorized body or agency to identify the provider		The last two digits of the 14-digit CRN
2110	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	1D	Medicaid Provider Number This REF Segment is needed when the service line level Service Provider is different from the claim level Service Provider. Med-QUEST does not pay claims formatted in this manner but can return this REF Segment for denied claims.
2110	REF	REF02	Rendering Provider Identifier	The identifier assigned by the Payor to the provider who performed the service		The Med-QUEST ID Number of the Rendering Provider on denied service lines when the line level Rendering Provider differs from the claim level Rendering Provider. Med-QUEST does not allow multiple rendering providers on the same claim but can return this REF Segment for denied claims.
2110	AMT	AMT01	Amount Qualifier Code	Code to qualify amount	B6	Allowed - Actual
2110	AMT	AMT02	Service Supplemental Amount	Additional amount or charge associated with the service		The Med-QUEST Allowed Amount for the service line
2110	LQ	LQ01	Code List Qualifier Code	Code identifying a specific industry code list	HE	Claim Payment Remark Codes

835 CLAIMS REMITTANCE ADVICE TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2110	LQ	LQ02	Remark Code	Code indicating a code from a specific industry code list, such as the Health Care Claim Status Code list		The first service line level Remark Code Remark Codes are translated from HPMMIS claim error codes and can occur multiple times per service line. The LQ Remark Code Segment can occur up to 99 times. Remark Codes are translated from HPMMIS Reason and Edit/Result Codes and are "unduplicated" to avoid the same Remark appearing more than once for a service line.
N/A	PLB	PLB01	Provider Identifier	Number assigned by the payer, regulatory authority, or other authorized body or agency to identify the provider		The Med-QUEST ID Number of the Billing Provider in the Loop 1000B Payee Identification REF Segment at the beginning of the transaction. Med-QUEST uses the PLB Provider Adjustment Segment in two ways: • To report on non-claim specific payments to (and withholds from) billing providers. Settlements and returned checks are examples of items that can be handled by this segment. • To offset negative payment amounts to billing providers when the total provider payment balance on the 835 is negative If neither of these conditions exists for an 835 receiver, the PLB Segment is absent. See the description of Provider Level Adjustments at the beginning of this section for more information.
N/A	PLB	PLB02	Fiscal Period Date	Last day of provider's fiscal year through date of the bill	CCYY1231	December 31 of the processing year. Format is CCYY1231.
N/A	PLB	PLB03-1	Adjustment Reason Code	Code that indicates the reason for the adjustment	AM	Applied to Borrowers Account
N/A	PLB	PLB03-2	Provider Adjustment Identifier	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier		The Invoice Number assigned by the MED-QUEST Financial System.

835 CLAIMS REMITTANCE ADVICE TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
N/A	PLB	PLB04	Provider Adjustment Amount	Provider adjustment amount The adjustment amount is to the total provider payment and is not related to a specific claim or service		PLB04 and subsequent Provider Adjustment Amounts in the PLB Segment. Credits and debits are relative to the payer. Payments to providers are negative amounts and withholds are positive amounts. If present, PLB Amounts are used, along with claim and service line Payment Amounts, in transaction level balancing.
N/A	PLB	PLB05-1	Adjustment Reason Code	Code that indicates the reason for the adjustment		If needed, the second Provider Adjustment Reason Code
N/A	PLB	PLB05-2	Provider Adjustment Identifier	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier		If needed, the second Invoice Number assigned by the Med-QUEST Financial System.
N/A	PLB	PLB06	Provider Adjustment Amount	Provider adjustment amount The adjustment amount is to the total provider payment and is not related to a specific claim or service		In needed, the second Provider Adjustment Amount
N/A	PLB	PLB07-1	Adjustment Reason Code	Code that indicates the reason for the adjustment		If needed, the third Provider Adjustment Reason Code
N/A	PLB	PLB07-2	Provider Adjustment Identifier	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier		If needed, the third Invoice Number assigned by the Med-QUEST Financial System.
N/A	PLB	PLB08	Provider Adjustment Amount	Provider adjustment amount The adjustment amount is to the total provider payment and is not related to a specific claim or service		In needed, the third Provider Adjustment Amount
N/A	PLB	PLB09-1	Adjustment Reason Code	Code that indicates the reason for the adjustment		If needed, the fourth Provider Adjustment Reason Code
N/A	PLB	PLB09-2	Provider Adjustment Identifier	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier		If needed, the fourth Invoice Number assigned by the Med-QUEST Financial System.

835 CLAIMS REMITTANCE ADVICE TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
N/A	PLB	PLB10	Provider Adjustment Amount	Provider adjustment amount The adjustment amount is to the total provider payment and is not related to a specific claim or service		In needed, the fourth Provider Adjustment Amount
N/A	PLB	PLB11-1	Adjustment Reason Code	Code that indicates the reason for the adjustment		If needed, the fifth Provider Adjustment Reason Code
N/A	PLB	PLB11-2	Provider Adjustment Identifier	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier		If needed, the fifth Invoice Number assigned by the Med-QUEST Financial System.
N/A	PLB	PLB12	Provider Adjustment Amount	Provider adjustment amount The adjustment amount is to the total provider payment and is not related to a specific claim or service		In needed, the fifth Provider Adjustment Amount
N/A	PLB	PLB13-1	Adjustment Reason Code	Code that indicates the reason for the adjustment		If needed, the sixth Provider Adjustment Reason Code
N/A	PLB	PLB13-2	Provider Adjustment Identifier	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier		If needed, the sixth Invoice Number assigned by the Med-QUEST Financial System.
N/A	PLB	PLB14	Provider Adjustment Amount	Provider adjustment amount The adjustment amount is to the total provider payment and is not related to a specific claim or service		In needed, the sixth Provider Adjustment Amount
N/A	SE	SE01	Transaction Segment Count	A tally of all segments between the ST and the SE segments including the ST and SE segments		A count of all segments between the ST and SE Segments, including the ST and SE Segments. Format is numeric from 1 to 10 digits.
N/A	SE	SE02	Transaction Set Control Number	The unique identification number within a transaction set		Number unique within a functional group of 835 Transactions. This number is the same number that is in data element ST02.