HAWAII DEPARTMENT OF HUMAN SERVICES

MED-QUEST DIVISION

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

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DRAFT

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

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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 Claim Transactions
- *835 Electronic FFS Claims Remittance Advice Transaction*
- 276/277 Claim Status Request and Response Transactions
- U277 Unsolicited Encounter Status Transaction
- 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 transactions and 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 technical interface environment with Med-QUEST, including connectivity requirements and electronic interchange procedures. This document also provides specific information on the fields and values required for transactions sent to or received from 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 1.0 provides general information on Companion Documents and HIPAA and outlines the information to be included in the remainder of the document.
Transaction Overview	Section 2.0 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 3.0 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 4.0 provides information relating to the transactions included in this Companion Document including: ▪ General HIPAA transaction standards ▪ Data interchange conventions applicable to the transactions ▪ Procedures for acknowledgment transactions ▪ Procedures for handling rejected transmissions and transactions
Transaction Specifications	Section 5.0 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 Claims 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 (called the Claims Remittance Advice or Claims RA Transaction in the remainder of this document) is a claim payment reporting transaction, equivalent to the 820 Transaction for capitation payments to health plans. 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 claims, including claims that have not yet completed adjudication, with the Web-based 276 Claim Status Request Transaction.

Like the 820 Capitation Transaction, each 835 Claim RA Transaction must correspond to a payment by check or electronic transfer.

835 RA Transactions and 837 Claim Transactions are closely linked. Although data on 835 Transactions comes from the HPMMIS Database and the financial system operated by the Med-QUEST Fiscal Agent, 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 a claim or 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 both claim and 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 errors.

Lengthy and detailed mapping documents show the relationships between the HPMMIS Reason and Edit/Result Codes that appear on the pre-HIPAA Med-QUEST Remittance Advice and the Adjustment Reason and Remark Codes on the 835 Transaction. HPMMIS continues to generate pre-HIPAA Reason and Edit/Result Codes and to translate them to HIPAA compliant Adjustment Reason and Remark Codes. The mapping documents are the basis for this translation. Med-QUEST's code set mapping strategy for the 835 Transaction is explained further in the Claim Adjudication Codes portion of Section 5.2, 835 Claims Remittance Advice Transaction Specifications.

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 Claims 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. In coordination of benefits (COB) situations, data from prior payer 835s can contribute to COB data on 837s.

3. Technical Infrastructure and Procedures

Med-QUEST Data Center Communications Requirements

Trading partners connect to Med-QUEST by going from the Internet through a Virtual Private Network (VPN) Tunnel to the Med-QUEST File Transfer Protocol (FTP) Server. In standard software-to-hardware VPN connections, VPN client software is installed and configured on each machine at the client site that requires FTP access. Cisco Systems Software to establish provider computers as VPN Clients is available from the sources documented in the Med-QUEST Electronic Claim Submission and Electronic Remittance Advice Requirements document. Detailed information on FTP and VPN setups also appears in that manual.

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 non-testing 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

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 Addenda. The 835 Implementation Guide recommends a maximum of 10,000 CLP (Claim Payment) Segments per transaction. If more than 10,000 CLP Segments are required for a claim submitter, they will appear on separate 835 Transactions within the same functional group and electronic transmission.

Med-QUEST does not impose any further limitation on the number of claims that will appear in the 835 Transaction.

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
  - Transaction

  At the service line level, balancing is between the amount charged for the service, any line-level adjustments 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 Amount, and Paid Amounts. The Paid Amount must always equal the Charged Amount minus Adjustment Amounts.

  At the claim level, balancing includes both line-level and claim-level adjustments. The claim-level Charged Amount is the sum of all line-level Charged Amounts. The claim-level Paid Amount is the Charged Amount for all service lines minus all Adjustment Amounts at the claim and line levels.

  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 provider adjustments, such as settlements, that are not claim-specific. Provider 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.

- 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 check.

Remittance Tracking

The Trace Number (Element TRN02) and the Payer Identification Number (Element TRN03) in the 835 Transaction's Reassociation Trace Number (TRN) Segment should be used to associate the remittance advice data in the 835 Transaction with the payment sent separately by the Affiliated Computer Services (ACS) Fiscal Agent's Financial System. For Med-QUEST, TRN02 is the Payment Number of the check written for provider payment by the ACS Financial System.

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 B1 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 beginning later 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.

Translation Specifications Table

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
When data element values are listed in the Implementation Guide, the values 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 TRANSACTION 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		"MED-QUEST" followed by the nine-digit Med-QUEST Federal Tax ID number
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		Med-QUEST Provider or Health Plan ID
NA	ISA	ISA09	INTERCHANGE DATE	Date of the interchange/6 characters		The Interchange Date in YYMMDD format

ISA/IEA INTERCHANGE CONTROL ENVELOPE TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition/Length**	**Valid Values**	**Definition/Format**
NA	ISA	ISA10	INTERCHANGE TIME	Time of the interchange/4 characters		The Interchange Time in HHMM format
NA	ISA	ISA11	INTERCHANGE CONTROL STANDARDS IDENTIFIER	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
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

ISA/IEA INTERCHANGE CONTROL ENVELOPE TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition/Length**	**Valid Values**	**Definition/Format**
						on outgoing transactions: Segment Delimiter - "~' (tilde) Element Delimiter - "{" (left rounded bracket) Composite Component Delimiter (ISA16) - "|" (pipe) These values are used because they are not likely to occur within transaction data.
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

The diagram on the next page, Outbound Transactions from Med-QUEST and Trading Partner Acknowledgements, shows the processes introduced by the Med-QUEST translator when Med-QUEST sends HIPAA compliant transactions to its trading partners. Outgoing Med-QUEST transactions affected by the electronic acknowledgement process are:

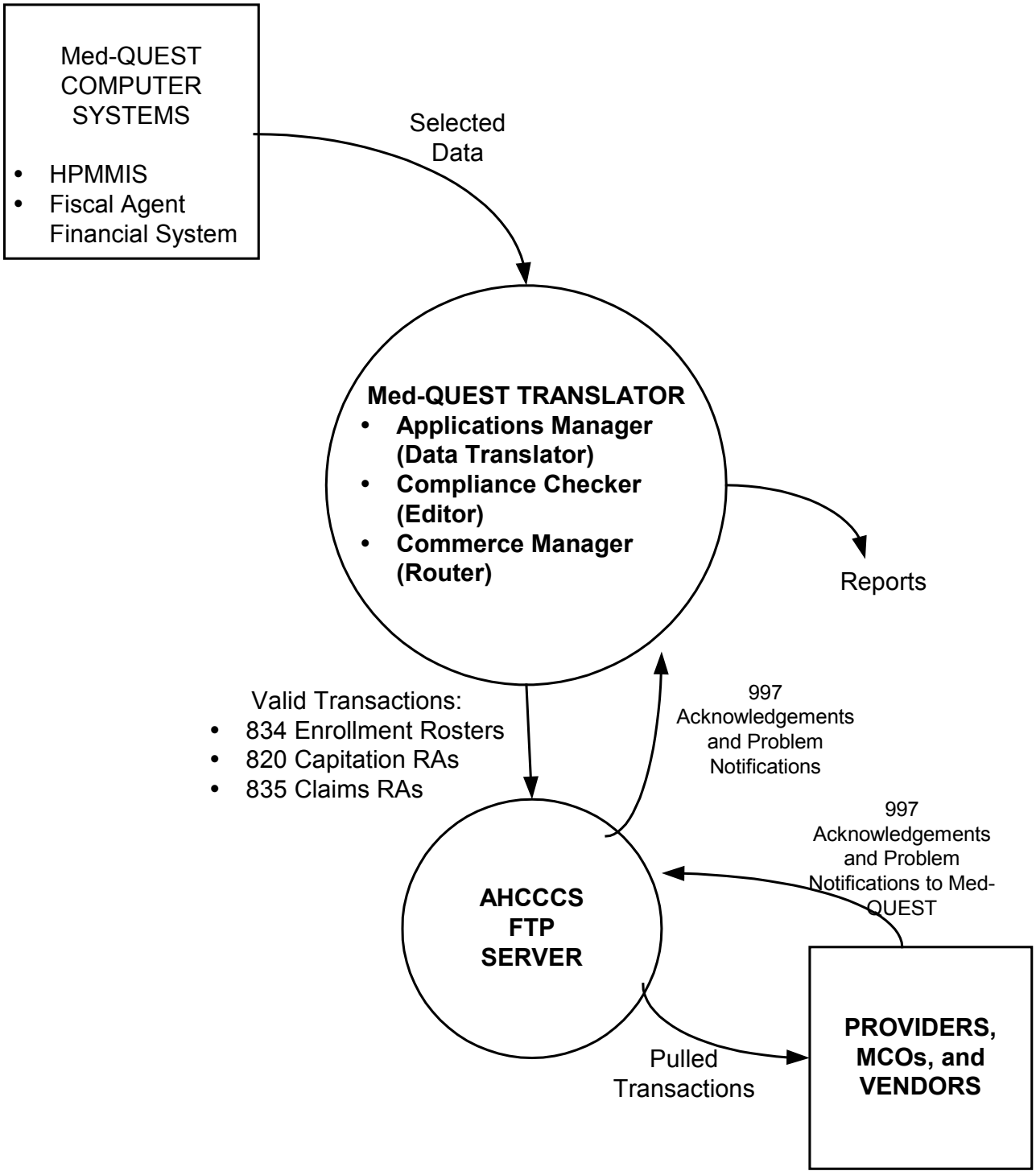
- 834 Enrollment Roster
- 820 Capitation Remittance Advice
- *835 Claims Remittance Advice*

Although additional HIPAA Transactions, including 271 Eligibility Response and 277 Claim Status Response Transactions, are also sent by Med-QUEST, they do not have the legal and contractual significance of Roster and Remittance Advice Transactions and do not require the same electronic acknowledgement procedures.

As shown at the top of the Outbound Transactions Diagram, Med-QUEST computer systems generate extract files with all of the data required to produce membership rosters or financial statements. The translator acquired by Med-QUEST includes an Applications Manager component that translates data from Med-QUEST to standard HIPAA transaction formats and code sets. The translator's Compliance Checker then subjects each reformatted outgoing transaction to the same edits that it would perform on an incoming transaction of the same type. These "syntactical" edits are needed to ensure that complex electronic transactions are assembled and formatted correctly. If an outgoing transaction fails to pass an internal edit, the translator generates an error report and Med-QUEST corrects and reprocesses the transmission.

The translator's third major component, the Commerce Manager, then transmits valid 834, 820, and 835 Transactions to the Med-QUEST FTP Server. Authorized trading partners can retrieve HIPAA Transactions from the Server in the same way that they do in the pre-HIPAA environment. When data retrieval of HIPAA Transactions occurs, MED-QUEST requires trading partners to return 997 Functional Acknowledgement Transactions for each "functional group" of one or more HIPAA Transactions that they receive.

Outbound Transactions from Med-QUEST and Trading Partner Acknowledgements



997 Functional Acknowledgement

When an outgoing functional group of one or more transactions has passed a receiving trading partner's edits, the trading partner returns a 997 Functional Acknowledgement Transaction with a Functional Group Acknowledge Code (AK901) value of "A" (Accepted) to signify acceptance. If a problem is detected, the 997 should be used to reject the functional group of transactions (Functional Group Acknowledge Code = "R" [Rejected]) and to make use of standard 997 error codes and error location designators to say why. Receivers that reject functional groups of transactions should not subject erroneous data to further processing or use it to update their systems. Med-QUEST will replace rejected data in its entirety.

In general, the 997 Transaction supports "syntactical" rather than "semantic" error reporting at transaction, data segment, and data element levels. Syntactical errors involve the structure rather than the meaning of transaction data. The list of 997 Data Element Syntax Error Code (AK403) values in every HIPAA X12 Implementation Guide gives a more specific idea of the kinds of errors be reported with the 997 (there are similar code sets at the segment and transaction levels). The ten valid error code values at the data element level are:

1 Mandatory data element missing
2 Conditional required data element missing.
3 Too many data elements.
4 Data element too short.
5 Data element too long.
6 Invalid character in data element.
7 Invalid code value.
8 Invalid Date
9 Invalid Time
10 Exclusion Condition Violated

In addition to carrying Data Element Syntax Error Codes, the 997 shows the relative location of erroneous elements with error position designators. For a large transaction, each of the ten values listed above could be repeated in thousands of code to element combinations. Standards for all of the above edits are based on HIPAA Implementation Guides and are not specific to Med-QUEST. Other X12 trading partners can be expected to use the same conventions.

These and other aspects of the 997 Functional Acknowledgement Transaction are documented in detail in Appendix B of all HIPAA X12 Implementation Guides.

4.5 Rejected Transmissions and Transactions

Overview of Rejection Process

Since Med-QUEST asks its trading partners to return 997 Transactions for each functional group of received transactions pulled from the FTP Server, the Agency endeavors to limit its X12 transmissions to single functional groups of one or more transactions. This means that trading partners need return only a single 997 for each pulled transmission. The 997 Acknowledgement should accept or reject an entire functional group (AK901 Functional Group Acknowledge Code = "A" [Accepted] or "R" [Rejected]). When a trading partner rejects an X12 transmission, Med-QUEST will correct, recreate, and re-send the entire 834, 820, or 835 transmission upon receipt of a 997 Transaction with appropriate acknowledgement and error codes.

Med-QUEST is aware that TA1 Interchange Acknowledgement Transactions and 824 Implementation Guide Reporting Transactions can also perform acknowledgement and problem notification functions in the HIPAA environment. After consultation with trading partners, Med-QUEST has determined not to require that they return either of these transactions in response to X12 transactions from Med-QUEST. If they are sent, Med-QUEST does not expect to be able to receive or process them.

Med-QUEST electronic transaction acceptance and rejection procedures have a different orientation when applied to incoming 837 Claim and Encounter Transactions. Procedures for these transactions are described in 837 Transaction Companion Documents.

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 1 and 30 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 agreements 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 claim and service line.

The Financial System maintained by Affiliated Computer Services (ACS), the Med-QUEST Fiscal Agent, implements Agency policy by writing weekly checks (or, in the future, generating weekly electronic payments) to providers paid on a fee-for-service basis. To be consistent with this payment policy, the Agency generates 835 Transactions on a weekly basis. 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 adjustments (called "replacements" in the HIPAA environment) and voids are identified and reported but do not appear in separate sections.

The following entities 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

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

- Claim Adjudication Codes
- Billing and Servicing Providers

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 relies on two code sets, Edit/Result Codes and Claim Reason Codes, to inform submitters of claims and service lines that are paid, denied, pended, and not yet processed. Edit/Result Codes generally relate to specific errors that involve particular named data elements. Claim Reason Codes usually involve more complex claim situations and are more specific to Med-QUEST.

On the 835 side, there are also two primary code sets that describe the results of claim adjudication: Adjustment Reason Codes and Remark Codes. Adjustment Reason Codes are designed to 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. Each Adjustment Reason Code is associated with a required Adjustment Amount on the 835 Transaction (although Med-QUEST manipulates this requirement by including Adjustment Reason Codes with zero Adjustment Amounts). 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:

- Adjustment Reason Codes and related data elements in the 835 Transaction have structures that assume that payers adjudicate claims by "adjusting" amounts charged by providers. Med-QUEST, however, pays most claims based on Allowed Amounts determined by PMMIS independently of provider charges. The only connection 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 kinds of situations.

- When the Payment Amount for a claim or line is different from the Charged Amount, at least one Adjustment Reason Code is required, along with an Adjustment Amount. When the amounts are equal, the CAS Segment with its Adjustment Reason Codes is not required. In theory, a Paid Amount could be greater than a Charged Amount (in

which case an Adjustment Reason Code would be required). This is not expected to happen, however, because Med-QUEST always pays the lesser of the Charged or the Allowed Amount.

Med-QUEST has adopted a three-step approach to population of Adjustment Reason and Remark Codes on 835 Transactions.

Step 1: Determine whether a claim or service line needs an Adjustment Reason Code.

In theory, a Remark Code can occur without an Adjustment Reason Code on the same claim or service line. In practice, this will seldom happen because most Remark Codes explain Reasons for denials or cut-backs that will generate Adjustment Reason Codes and Adjustment Amounts as well.

- **Step 2:** If Charged and Payment Amounts for a claim or service line are different, create an initial Adjustment Reason Code on the 835 Transaction, along with an Adjustment Amount and Adjustment Quantity.

  For the initial Adjustment Reason Code, there are five possibilities:

  - "3" (Co-payment Amount) – Used when a Share of Cost Amount or other patient payment covers some of the Charged Amount.
  - "2" (Coinsurance Amount) – Used when some of the Charged Amount has been paid by another carrier.
  - "B13" (Previously paid. Payment for this claim/service may have been provided in a previous payment.) – Used when some of the Charged Amount was previously paid by Med-QUEST.
  - "A1" (Claim denied charges.) – Used when a claim or service line is entirely denied.
  - "A2" (Contractual Adjustment) – Used when the Payment is less than the Charged Amount but greater than zero.

  In each of these situations, the Adjustment Amount associated with the Adjustment Reason Code will represent the difference between the Charged and Paid Amounts. If present, the Adjustment Quantity will be the difference between the units or service or inpatient days charged by the provider and paid by Med-QUEST.

- **Step 3:** Translate Med-QUEST Code Sets.

  The third step involves translation of Med-QUEST Codes to HIPAA Codes and generation of subsequent Adjustment Reason and Remark Codes on the 835 Transaction. The Transaction supports up to 593

additional Adjustment Reason Codes translated from Med-QUEST Edit/Result or Claim Reason Code at the claim or service line levels. Each of these supplementary Codes has a zero Adjustment Amount. The situational Adjustment Quantity element is not populated.

Code set translations also generate Remark Codes for the 835 Transaction. They populate MIA and MOA Segments at the claim level and LQ Segments when generated at the service line level. MIA and MOA Segments support a maximum of 495 claim-level Remark Codes for inpatient and outpatient (i.e., non-inpatient) services. At the line level, the LQ Segment can occur up to 99 times.

Med-QUEST "unduplicates" both Adjustment Reason Codes and 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 by the translator.

Detailed mappings between Med-QUEST and HIPAA claim adjudication codes are used in code set translation (Step 3 above). They only apply to Med-QUEST codes for which they are appropriate and reasonable. 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 Adjustment Reason or Remark Code to explain them. They are identified in other ways.
- Med-QUEST Codes 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 the five Step 2 Adjustment Reason Codes will appear for financial adjustments even when Med-QUEST RA codes are entirely untranslatable.

Billing and Servicing Providers

Med-QUEST has two kinds of situations that involve billing and servicing or rendering providers that require adaptation in the 835 Transaction. They are:

- Servicing Providers with multiple locations – the Servicing 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) and the Provider IDs for the various locations appear, with Location suffixes, as service providers (Loop 2000/Element TS301and Loop 2100/Element NM109 in the Servicing Provider Name NM1 Segment).

- Provider Groups and Billing Agents – the Servicing 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 Providers 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 service providers (Loop 2000/Element TS301and Loop 2100/Element NM109 in the Service Provider Name NM1 Segment) with Location Codes.

  If a servicing 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 servicing provider.

A third identifier is required, in Element REF02 of the Receiver Identification REF Segment in the Transaction Header, when, in the words of the Implementation Guide, "the receiver of the transaction is different from the payee". In this situation, Med-QUEST makes use of the Electronic Supplier Number assigned by Med-QUEST to all electronic trading partners.

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
When data element values are listed in the Implementation Guide, the values 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	Transaction Set Number
N/A	ST	ST02	Transaction Set Control Number	The unique identification number within a transaction set		Nine-digit number starting with 1 and increasing sequentially. The 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	U	Split Payment and Remittance Advice
N/A	BPR	BPR02	Total Actual Provider 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 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 Service Provider (Loop 2100, Element NM109) are the same, balancing is for a single 835 provider/receiver.
N/A	BPR	BPR03	Credit or Debit Flag Code	Code indicating whether amount is a credit or debit	C	Credit Negative dollar amounts are made with the Credit Flag by assigning a negative value to BPR02.
N/A	BPR	BPR04	Payment Method Code	Code identifying the method for the movement of payment instructions	CHK	Check Med-QUEST currently makes claim payments by check.
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 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	TRN03	Originating Company Identifier	A unique identifier designating the company originating the transaction		The Federal Tax ID Number preceded by the number “1”. For the organization originating the transaction.

835 CLAIMS REMITTANCE ADVICE TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
N/A	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	EV	Receiver Identification Number This REF Segment is used only when the transaction receiver is not the payee (i.e., a clearinghouse).
N/A	REF	REF02	Receiver Identifier	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier		A single zero followed by the five-digit Electronic Supplier Number assigned by the Med-QUEST Systems Office. This is the identification number assigned to transaction submitters whether or not they are payees.
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.”		Claim production 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	N1	N103	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	FI	Federal Taxpayer ID Number
1000A	N1	N104	Payer Identifier	Number identifying the organization remitting the payment	996001089	The DHS Federal Tax ID Number used by Med-QUEST
1000A	N3	N301	Payer Address Line	Address line for the payer's address		MED-QUEST Street Address Line 1 Used when this element appears on a check (BPR04 = CHK).
1000A	N4	N401	Payer City Name	The city name of the payer's address		MED-QUEST City Used when this element appears on a check (BPR04 = CHK).
1000A	N4	N402	Payer State Code	State postal code of the payer's address		MED-QUEST State Code Used when this element appears on a check (BPR04 = CHK).

835 CLAIMS REMITTANCE ADVICE TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
1000A	N4	N403	Payer Postal Zone or ZIP Code	The postal zone code of the payer's address		MED-QUEST Zip Code Used when this element appears on a check (BPR04 = CHK).
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 Used when this element appears on a check (BPR04 = CHK).
1000B	N3	N302	Payee Address Line	The payee's address line		Payee's Street Address Line 2 Used when this element appears on a check (BPR04 = CHK).
1000B	N4	N401	Payee City Name	The City Name of the payee's address		Payee's City Used when this element appears on a check (BPR04 = CHK).
1000B	N4	N402	Payee State Code	The State Postal Code of the payee's address		Payee's State Used when this element appears on a check (BPR04 = CHK).
1000B	N4	N403	Payee Postal Zone or ZIP Code	The Zip Code of the payee's address		Payee's Zip Code Used when this element appears on a check (BPR04 = CHK).
1000B	REF	REF01	Reference Identification Qualifier	Code qualifying the Reference Identification	1D	Medicaid Provider Number

835 CLAIMS REMITTANCE ADVICE TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
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 If the billing provider and the service provider are the same and the provider has only a single location, include the Provider ID's Location Code suffix. If the Billing and Service Provider are different and/or the provider has multiple Locations, the six-character MED-QUEST Provider Number will not have a Location Code.
2000	LX	LX01	Assigned Number	Number assigned for differentiation within a transaction set	1 – 999999	Use the single-element LX Segment 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 service providers and/or facilities within it. The LX Segment is also needed when the Billing and Service Providers are the same and the provider has multiple Location Codes. 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 and the LX Segment is not needed.
2000	TS3	TS301	Provider Identifier	Number assigned by the payer, regulatory authority, or other authorized body or agency to identify the provider		Like the LX Segment, the Provider Summary Information TS3 Segment is needed only when the 835 is sent to a provider group or billing agent that includes multiple service providers and/or facilities within it and/or the provider has multiple Location Codes. In provider group, billing agent, and multiple location situations, the eight-character MED-QUEST Provider Identification Number (including Location Code) for the servicing provider who appears in TS301.

835 CLAIMS REMITTANCE ADVICE TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
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	In provider group, billing agent, and multiple Location situations, MED-QUEST uses Facility Type Code “99” (Other Unlisted Facility) to populate this required field. Facility Type 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		In provider group, billing agent, and multiple Location situations, 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		In provider group, billing agent, and multiple location situations, the number of paid and denied claims reported for the service 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		In provider group, billing agent, and multiple location situations, the total charges for all paid and denied claims reported for the service provider in Element TS301.
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. This element carries the Patient Number assigned by the provider, whether received on an 837 Transaction or a paper claim.

835 CLAIMS REMITTANCE ADVICE TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2100	CLP	CLP02	Claim Status Code	Code specifying the status of a claim submitted by the provider to the payor for processing	1 or 4 or 22	Paid as Primary or Denied or Reversal of Previous Payment 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 with Adjustment Reason Code “3” (Co-payment Amount).
2100	CLP	CLP06	Claim Filing Indicator Code	Code identifying type of claim or expected adjudication process	MC	Medicaid
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 12-character Claim Reference Number (CRN) assigned by MED-QUEST.

835 CLAIMS REMITTANCE ADVICE TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
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 PMMIS 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 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.
2100	CAS	CAS01	Claim Adjustment Group Code	Code identifying the general category of payment adjustment	PR OA PI	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 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 a claim 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 makes use of only some of the more than one hundred available Adjustment Reason Codes

835 CLAIMS REMITTANCE ADVICE TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**

						because of limited correspondences between Med-QUEST and HIPAA code sets.
						
						Within each of the three Claim Adjustment Group Codes listed above for CAS01, MED-QUEST uses the following Adjustment Reason Codes:
						
						▪ CAS01 = "PR" (Patient Responsibility) – Adjustment Reason Code "3" (Co-payment Amount) – One adjustment trio for each of the up to six Share of Cost Amounts that affect the claim.
						▪ CAS01 = "OA" (Other Adjustment) – One of the following codes as an initial Adjustment Reason Code:
						  ▪ "22" (Payment adjusted because this care may be covered by another carrier per coordination of benefits.)
						  ▪ "B13" (Payment for this claim/service may have been provided in a previous payment.)
						▪ CAS01 = "PI" (Payer Initiated Reduction) – One of the following codes as an initial Adjustment Reason Codes:
						  ▪ "A1" (Claim denied charges) – Claim or service line denials caused by missing or erroneous claim data or by billing for non-covered services.
						  ▪ "A2" (Contractual adjustment) – Claim or service line payment made at less than the Charged Amount
						For payer initiated reductions, "A2" is the default Adjustment Reason Code when no better match can be found. Initial Adjustment Reason Codes within CAS Segments have Adjustment Amounts associated with them. Subsequent Adjustment Reason Codes and unduplicated and have zero Adjustment Amounts.

835 CLAIMS REMITTANCE ADVICE TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
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. Except for Share of Cost CAS Segments (on which SOC Amounts can appear up to six times), non-zero Adjustment Amounts always appear within the initial adjustment trio on CAS Segments. Subsequent adjustment trios carry additional Adjustment Reason Codes and Adjustment Amounts of zero.
2100	CAS	CAS04	Adjustment Quantity	Numeric quantity associated with the related reason code for coordination of benefits		This element is present when MED-QUEST changes the Units of Service for which it pays from the Units or Service on the submitted claim. A positive number when the paid units are less than the submitted units. For denied claims, the Adjustment Quantity will equal the submitted Quantity.
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	CAS07	Adjustment Quantity	Numeric quantity associated with the related reason code for coordination of benefits		If needed, the second Adjustment Quantity
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	CAS10	Adjustment Quantity	Numeric quantity associated with the related reason code for coordination of benefits		If needed, the third Adjustment Quantity
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

835 CLAIMS REMITTANCE ADVICE TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2100	CAS	CAS13	Adjustment Quantity	Numeric quantity associated with the related reason code for coordination of benefits		If needed, the fourth Adjustment Quantity
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	CAS16	Adjustment Quantity	Numeric quantity associated with the related reason code for coordination of benefits		If needed, the fifth Adjustment Quantity
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	CAS	CAS19	Adjustment Quantity	Numeric quantity associated with the related reason code for coordination of benefits		If needed, the sixth Adjustment Quantity
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.
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 Med-QUEST ID.

835 CLAIMS REMITTANCE ADVICE TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
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 The Rendering Provider NM1 Segment appears when the service or rendering provider is different from the payee in the 1000B Loop. If the Billing Provider and the Service Provider are the same, this NM1 Segment is not needed.
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		When the service provider is different from the payee in Loop 1000B, the full name of the service provider. This is how the Provider Name appears in PMMIS.
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		When the service provider is different from the payee in Loop 1000B, the six-character MED-QUEST ID of the 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		The number of non-covered visits. If there are Inpatient Remark Codes not associated directly with non-covered visits, MIA01 will be "000".

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, the claim-level Remark Code on an institutional claim. Multiple PMMIS claim error codes can trigger multiple Remarks. Remark Codes are translated from MED-QUEST Reason and Edit/Result Codes. They are descriptive but, unlike Adjustment Reason Codes, have no direct financial impact. 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 Inpatient 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 Inpatient 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 Inpatient 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 Inpatient 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 PMMIS claim error codes can trigger multiple Remarks. Remark Codes are translated from Med-QUEST Reason and Edit/Result Codes. They are descriptive but, unlike Adjustment Reason Codes, have no direct financial impact. 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.

835 CLAIMS REMITTANCE ADVICE TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
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.
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 12 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 Discount Amount Coverage Amount Patient Amount Paid Med-QUEST uses these valid values in this segment in the following ways: “I” = Additional payment due to a provider because of a late claim payment penalty imposed on Med-QUEST by the provider’s contract. “Interest” is an additional payment to a provider and appears on the CAS Segment as a negative amount. “D8” = Amount subtracted from the payment to the provider due to a prompt pay discount in the provider’s contract with Med-QUEST. Discount Amounts appear on 835s as positive values. “AU” = The total Allowed Amount for the claim determined by Med-QUEST. Appears as a positive amount. “F5” = The Share of Cost Amount paid to the provider by the recipient. Appears as a positive amount. An Allowed Amount is present for every claim. Other amounts are reported on separate AMT Segments if they are used by Med-QUEST in claim adjudication. 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

835 CLAIMS REMITTANCE ADVICE TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2100	QTY	QTY02	Claim Supplemental Information Quantity	Numeric value of the quantity of supplemental information associated with the claim		The number of Units of Service on the claim that were covered by Med-QUEST.
2110	SVC	SVC01-1	Product or Service ID Qualifier	Code identifying the type/source of the descriptive number used in Product/Service ID	HC AD NU	HCPCS Procedure and Supply Codes American Dental Association Codes National Uniform Billing Committee (NUBC) Revenue Codes These are the codes currently used by Med-QUEST to define service line procedures. HCPCS Codes appear on professional claims, ADA Codes on dental claims, and Revenue Codes on inpatient institutional 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 or ADA 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 or ADA 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 or ADA 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 or ADA 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 or ADA 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.

835 CLAIMS REMITTANCE ADVICE TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
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.
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 AD NU	HCPCS Procedure and Supply Codes American Dental Association Codes National Uniform Billing Committee (NUBC) Revenue Codes Composite Element SVC06 appears only when a payer has changed some of the information within it during claim adjudication. Med-QUEST sometimes changes Modifiers although it does not change Procedure or Revenue Codes. When a Modifier value has been changed, all Procedure and Modifier values on the submitted claim appear in this element.
2110	SVC	SVC06-2	Procedure Code	Code identifying the procedure, product or service		The HCPCS or ADA 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 or ADA 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 or ADA 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 or ADA Codes 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 or ADA 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	151 152 472	Service Period Start Service Period End Service Med-QUEST uses “472” when a line has a single Service Date and “151” and “152” on separate DTM Segments when the service spans multiple dates. This segment is only needed when line level Service Dates differ from claim level Service Dates.
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	OA PI	Other Adjustment – Amounts Paid by Another Carrier and Previously Paid Amounts 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 the Paid Amount at the service line rather than the claim 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 a claim 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. Med-QUEST does not pay more than the Charged Amount. Note that the “PR” (Patient Responsibility) code does not appear at the service line level. Share of Cost Amounts are only reported at the claim level.

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 makes use of only some of the more than one hundred available Adjustment Reason Codes because of limited correspondences between Med-QUEST and HIPAA code sets. Within each of the Claim Adjustment Group Codes listed above for CAS01, Med-QUEST uses the following Adjustment Reason Codes: ▪ CAS01 = "OA" (Other Adjustment) – One of the following codes as an initial Adjustment Reason Code: ▪ "22" (Payment adjusted because this care may be covered by another carrier per coordination of benefits.) ▪ "B13" (Payment for this claim/service may have been provided in a previous payment.) ▪ "PI" (Payer Initiated Reduction) – One of the following codes as an initial Adjustment Reason Codes: ▪ "A1" (Claim denied charges) – Claim or service line denials caused by missing or erroneous claim data or by billing for non-covered services. ▪ "A2" (Contractual adjustment) – Claim or service line payment made at less than the Charged Amount For payer initiated reductions, "A2" is the default Adjustment Reason Code when no better match can be found. Initial Adjustment Reason Codes within CAS Segments have Adjustment Amounts associated with them. Subsequent Adjustment Reason Codes are unduplicated and have zero Adjustment Amounts.

835 CLAIMS REMITTANCE ADVICE TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
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. Non-zero Adjustment Amounts always appear within the initial adjustment trio on CAS Segments. Subsequent adjustment trios on payee initiated CAS Segments carry up to five additional Adjustment Reason Codes and Adjustment Amounts of zero.
2110	CAS	CAS04	Adjustment Quantity	The units of service being adjusted		This element is present when MED-QUEST changes the Units of Service for which it pays from the Units or Service on the submitted line. A positive number when the paid units are less than the submitted units. For denied lines, the Adjustment Quantity will equal the submitted Quantity.
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	CAS7	Adjustment Quantity	Numeric quantity associated with the related reason code for coordination of benefits		If needed, the second service line Adjustment Quantity.
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	CAS10	Adjustment Quantity	Numeric quantity associated with the related reason code for coordination of benefits		If needed, the third service line Adjustment Quantity.
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	CAS13	Adjustment Quantity	Numeric quantity associated with the related reason code for coordination of benefits		If needed, the fourth service line Adjustment Quantity.

835 CLAIMS REMITTANCE ADVICE TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
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	CAS16	Adjustment Quantity	Numeric quantity associated with the related reason code for coordination of benefits		If needed, the fifth service line Adjustment Quantity.
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
2110	CAS	CAS19	Adjustment Quantity	Numeric quantity associated with the related reason code for coordination of benefits		If needed, the sixth service line Adjustment Quantity.
2110	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	6R G1	Provider Control Number Prior Authorization Number Med-QUEST uses the Service Identification REF Segment in two ways: ▪ If a service line level Provider Control or Patient Account Number was submitted on an 837 Claim, it is returned in an iteration of this segment. ▪ If the service line has a Med-QUEST assigned Prior Authorization Number, the PA Number is returned on a separate iteration of this segment. Within HPMMIS, Med-QUEST maintains all PA Numbers at the service line level even when the same PA Number applies to every line.
2110	REF	REF02	Provider Identifier	Number assigned by the payer, regulatory authority, or other authorized body or agency to identify the provider		If present ,the Provider Control Number or PA Number for the service line.

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	1D	Medicaid Provider Number This REF Segment is used only 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.
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 Allowed Amount for the service line when Med-QUEST used an Allowed Amount during line level pricing.
2110	QTY	QTY01	Quantity Qualifier	Code specifying the type of quantity	NE	Non-Covered – Estimated Med-QUEST creates QTY Segments when not all services or visits on a line are covered.
2110	QTY	QTY02	Service Supplemental Quantity Count	Quantity of additional items associated with service		The number or non-covered services or visits.
2110	LQ	LQ01	Code List Qualifier Code	Code identifying a specific industry code list	HE	Claim Payment Remark Codes
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.

835 CLAIMS REMITTANCE ADVICE TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
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 to report non-claim specific payments to (and withholds from) billing providers. Settlements and returned checks are examples of items that can be handled in this segment.
N/A	PLB	PLB02	Fiscal Period Date	Last day of provider's fiscal year through date of the bill		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		The Adjustment Reason Code value listed in the 835 Implementation Guide that best describes the reason for the provider-level adjustment. Note that PLB Adjustment Reason Codes are different from the Adjustment Reason Codes used at the claim and service line levels.
/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		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 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	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	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

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	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	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		Nine-digit number unique within a functional group of 835 Transactions starting with 1 and increasing sequentially. This number will be the same number that is in data element ST02.