



Health Care Claim Payment/Advice (835)

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1.1	04/29/2014	ODM & HP EDI Team	Added the 2000:TS3 segment
1.2	07/24/2014	ODM & HP EDI Team	Added the 2000:LX segment

Disclosure Statement

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The ODM Companion Guides do not:

- Replace the HIPAA ANSI ASC X12N Implementation Guide.
- Contain any actions that would result in a Non-Compliant Transaction.

The ODM Companion Guides are subject to change without prior notice.

Providers and Trading Partners are responsible for periodically checking for Companion Guide updates on the ODM Trading Partner website - <http://medicaid.ohio.gov/PROVIDERS/Billing/TradingPartners.aspx>.

Each Medicaid Provider and/or Trading Partner has the ultimate responsibility to adhere to the HIPAA Federal Requirements as well as any Ohio State laws that are applicable including the Ohio Administrative Code (<http://codes.ohio.gov/oac/5160-1-20>).

Preface

This Companion Guide to the 5010 ASC X12N Technical Report Type 3 Implementation Guides and associated errata and addenda adopted under Health Insurance Portability and Accountability Act (HIPAA) clarifies and specifies the data content when exchanging electronically with ODM. Transmissions based on this companion guide, used in tandem with 005010 ASC X12 TR3 Implementation Guides, are compliant with both ASC X12 syntax and those guides. This Companion Guide is intended to convey information that is within the framework of the ASC X12N TR3 Implementation Guides adopted for use under HIPAA. The Companion Guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the TR3 Implementation Guides.

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1 INTRODUCTION

This section describes how ASC X12N Implementation Guides (IGs) adopted under HIPAA will be detailed with the use of a table. The tables contain a row for each segment that the Ohio Department of Medicaid has something additional, over and above, the information in the IGs. That information can:

1. Limit the repeat of loops, or segments.
2. Limit the length of a simple data element.
3. Specify a sub-set of the IGs internal code listings.
4. Clarify the use of loops, segments, composite and simple data elements.
5. Any other information tied directly to a loop, segment, composite or simple data element pertinent to trading electronically with the Ohio Department of Medicaid.

In addition to the row for each segment, one or more additional rows are used to describe ODM, usage for composite and simple data elements and for any other information. Notes and comments should be placed at the deepest level of detail. For example, a note about a code value should be placed on a row specifically for that code value, not in a general note about the segment.

The following table specifies the columns and suggested use of the rows for the detailed description of the transaction set companion guides.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
193	2100C	NM1	Subscriber Name			This type of row always exists to indicate that a new segment has begun. It is always shaded at 10% and notes or comment about the segment itself goes in this cell.
195	2100C	NM109	Subscriber Primary Identifier		15	This type of row exists to limit the length of the specified data element.
196	2100C	REF	Subscriber Additional Identification			
197	2100C	REF01	Reference Identification Qualifier	18, 49, 6P, HJ, N6		These are the only codes transmitted by ODM.
			Plan Network Identification Number	N6		This type of row exists when a note for a particular code value is required. For example, this note may say that value N6 is the default. Not populating the first 3 columns makes it clear that the code value belongs to the row immediately above it.
218	2110C	EB	Subscriber Eligibility or Benefit Information			
231	2110C	EB13-1	Product/Service ID Qualifier	AD		This row illustrates how to indicate a component data element in the Reference column and also how to specify that only one code value is applicable.

1.1 Scope

ODM developed 5010 Companion Guides to supplement each 5010 Transaction Implementation Guide, based on Version 5, Release 1, with regards to:

- Specific Codes and/or Values that ODM will default on Outbound Transactions
- Specific Codes and/or Values that are unique to ODM to accept an Inbound Transaction

ODM Companion Guides will not create a Non-Compliant Transaction.

This companion guide is intended to be used in conjunction with the ASC X12N/005010X221A1 Implementation Guide (IG). It provides supplementation instructions not included in the IG that must be followed for implementation and conducting the transaction with ODM. It does not change the requirements of the IG in any way.

1.2 Overview

The Health Insurance Portability and Accountability Act (HIPAA) require all Providers, Trading Partners and Payers in the United States to comply with the Electronic Data Interchange (EDI) Standards for Health Care.

This Companion document contains the format and establishes the data contents of the 835 Health Care Claim Payment/Advice Transaction Set for use within the context of the Electronic Data Interchange (EDI) environment. This transaction set 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 at the same time. This Transaction can only be sent by a Payer/Health Insurer to a Health Care Provider either directly or through an authorized 3rd Party (Trading Partner).

1.3 References

In addition to the resources available on the ODM Trading Partner Website (<http://medicaid.ohio.gov/PROVIDERS/Billing/TradingPartners.aspx>), there are other websites that contain helpful information to assist in the implementation of the electronic data interchange process. Links to these websites are listed below and are separated by category for easy reference.

1.3.1 EDI Basics

For information about EDI software and services, visit: 1EDI Source, Inc (<http://www.1edisource.com>).

1.3.2 Government and Other Associations

- Center for Medicare and Medicaid Services (CMS): <http://www.cms.hhs.gov>
- Answers to Frequently Asked Questions: <https://questions.cms.gov>
- HHS Office for Civil Rights (Privacy) <http://www.hhs.gov/ocr/hipaa>
- WEDI - Workgroup for Electronic Data Interchange: <http://www.wedi.org>
- CMS website for NPI: <http://www.cms.hhs.gov/NationalProvIdentStand>

1.3.3 ASC X12 Standards

- Washington Publishing Company: <http://www.wpc-edi.com>

- Data Interchange Standards Association: <http://disa.org>
- American National Standards Institute: <http://ansi.org>
- Accredited Standards Committee: <http://www.x12.org>

1.4 Additional Information

For additional information, the Trading Partner Information Guide can be found here:
<http://medicaid.ohio.gov/PROVIDERS/Billing/TradingPartners.aspx>

2 GETTING STARTED

To get started, the Trading Partner Information Guide can be found here:

<http://medicaid.ohio.gov/PROVIDERS/Billing/TradingPartners.aspx>

3 TESTING WITH THE PAYER

Details related to testing are in the Trading Partner Information Guide which can be found here:

<http://medicaid.ohio.gov/PROVIDERS/Billing/TradingPartners.aspx>

4 CONNECTIVITY WITH THE PAYER/COMMUNICATIONS

Connectivity information is in the Trading Partner Information Guide which can be found here:

<http://medicaid.ohio.gov/PROVIDERS/Billing/TradingPartners.aspx>

5 CONTACT INFORMATION

5.1 EDI Customer Service

Days Available: Monday through Friday

Time Zone: Eastern Time (ET)

Time Available: 8:00 am to 5:00 pm

Phone: (614) 387-1212

Email: DAS-EDI-Support@das.ohio.gov

5.2 EDI Technical Assistance

Days Available: Monday through Friday

Time Zone: Eastern Time (ET)

Time Available: 8:00 am to 5:00 pm

Phone: (614) 387-1212

Email: DAS-EDI-Support@das.ohio.gov

5.3 Provider Service Number

Provider Assistance Unit 1-800-686-1516. Please listen to the entire message before making your selection.

Web URL: <http://medicaid.ohio.gov/PROVIDERS.aspx>

5.4 Applicable Websites/Email

Ohio Medicaid Website: <http://medicaid.ohio.gov/>

The Trading Partner web page can be found by following: Providers > Billing > Trading Partners
(<http://medicaid.ohio.gov/PROVIDERS/Billing/TradingPartners.aspx>)

To contact Ohio Medicaid for assistance, use the link - <http://medicaid.ohio.gov/CONTACT.aspx>

6 CONTROL SEGMENTS/ENVELOPES

6.1 ISA-IEA

This section describes ODM's use of the interchange control segments. It includes a description of expected sender and receiver codes, authorization information, and delimiters.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
C.3		ISA	Interchange Control Header			
C.4		ISA01	Authorization Information Qualifier	00		No Authorization Information Present (No Meaningful Information in ISA02)
C.4		ISA03	Security Information Qualifier	00		No Security Information Present (No Meaningful Information in ISA04)
C.4		ISA05	Interchange ID Qualifier	ZZ		Mutually Defined
C.4		ISA06	Interchange Sender ID	MMISODJFS		This is a fixed-length field and should be left justified and filled with spaces to meet the minimum length requirement of 15.
C.4		ISA07	Interchange ID Qualifier	ZZ		Mutually Defined
C.4		ISA08	Interchange Receiver ID			7 digit Trading Partner ID assigned by ODM. This is a fixed-length field and should be left justified and filled with spaces to meet the minimum length requirement of 15.
C.5		ISA13	InterChange Control Number			Must be identical to the associated interchange control trailer IEA02
C.6		ISA14	Acknowledgment Requested	0		No Interchange Acknowledgment Requested

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
C.10		IEA	Interchange Control Trailer			
C.10		IEA01	Number of Included Functional Groups			Number of included functional groups.
C.10		IEA02	Interchange Control Number			The control number assigned by the interchange sender. Must be identical to the value in ISA13.

6.2 GS-GE

This section describes ODM's use of the functional group control segments. It includes a description of expected application sender and receiver codes. Also included in this section is a description concerning how ODM expects functional groups to be sent and how ODM will send functional groups. These discussions will describe how similar

transaction sets will be packaged and ODM use of functional group control numbers.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
C.7		GS	Functional Group Header			
C.7		GS02	Application Sender's Code	MMISODJFS		
C.7		GS03	Application Receiver's Code			7 digit Trading Partner ID assigned by ODM
C.8		GS06	Group Control Number			Must be identical to the value in GE02.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
C.9		GE	Functional Group Trailer			
C.9		GE01	Number of Transaction Sets Included			Number of included transaction sets.
C.9		GE02	Group Control Number			The functional group control number. Must be the same value as GS06.

6.3 ST-SE

This section describes how ODM uses transaction set control numbers.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
68		ST	Transaction Set Header			
68		ST02	Transaction Set Control Number			Identical to the value in SE02

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
228		SE	Transaction Set Trailer			
228		SE01	Number of Included Segments			Total number of segments included in a transaction set including ST and SE segments
228		SE02	Transaction Set Control Number			Transaction set control number. Identical to the value in ST02.

7 PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS

In order to receive 835 X12 transactions, trading partners must be authorized by Ohio Medicaid and in active status. These details are documented in the Trading Partner Information Guide which can be found at this link - <http://medicaid.ohio.gov/PROVIDERS/Billing/TradingPartners.aspx>.

8 ACKNOWLEDGEMENTS AND/OR REPORTS

The 835 is an outbound transaction and there are no associated reports.

9 TRADING PARTNER AGREEMENTS

These details can be found in the Trading Partner Information Guide which can be found at this link - <http://medicaid.ohio.gov/PROVIDERS/Billing/TradingPartners.aspx>.

10 TRANSACTION SPECIFIC INFORMATION

This section describes how ASC X12N Implementation Guides (IGs) adopted under HIPAA will be detailed with the use of a table. The tables contain a row for each segment that ODM has something additional, over and above, the information in the IGs. That information can:

1. Limit the repeat of loops, or segments.
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5. Any other information tied directly to a loop, segment, composite or simple data element pertinent to trading electronically with ODM.

In addition to the row for each segment, one or more additional rows are used to describe ODM's usage for composite and simple data elements and for any other information. Notes and comments should be placed at the deepest level of detail. For example, a note about a code value should be placed on a row specifically for that code value, not in a general note about the segment.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
69		BPR	Financial Information			ODM is not using the 835 for Electronic Funds transfers, and the 835 Remittance Advice is separate from the check.
70		BPR01	Transaction Handling Code	H, I		H = Notification only I = Remittance Information only
72		BPR04	Payment Method Code	CHK, NON		CHK = Set to check when a payment is made. See TRN02 for method of payment in position 10. NON = Non-Payment Data
76		BPR16	Date			Check Issue Date for this 835 Transaction.
77		TRN	Re-association Trace Number			
77		TRN02	Reference Identification			This is a combination of 2 fields: Remittance/Advice Number + Warrant Number. Position 10 = E for EFT and W for warrant.
78		TRN03	Payer Identifier	1311334825		ODM Federal Tax ID
82		REF	Receiver Identification			
82		REF02	Reference Identification			7-digit Trading Partner ID assigned by ODM
85		DTM	Production Date			Required when the cutoff date for the Adjudication system Remittance run is different from the date in GS04
86		DTM02	Production Date			

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
87	1000A	N1	Payer Identification			
87	1000A	N102	Name	MMISODJFS		
89	1000A	N3	Payer Address			
89	1000A	N301	Payer Address Line	30 E Broad St		
89	1000A	N302	Payer Address Line	31st Floor		
90	1000A	N4	Payer City, State, Zip Code			
90	1000A	N401	Payer City Name	Columbus		
91	1000A	N402	Payer State Code	OH		
91	1000A	N403	Payer Postal Zone or ZIP Code	432153414		
92	1000A	REF	Additional Payer Identification			
92	1000A	REF01	Reference Identification Qualifier	2U		
93	1000A	REF02	Additional Payer Identifier	MMISODJFS		
94	1000A	PER	Payer Business Contact Information			
95	1000A	PER02	Payer Contact Name	Provider Call Service Center		
95	1000A	PER03	Communication Number Qualifier	TE		Telephone
95	1000A	PER04	Payer Contact Communication Number	8006861516		
102	1000B	N1	Payee Identification			
103	1000B	N103	Identification Code Qualifier	XX, FI		XX = 'Typical' Providers NPI FI = 'Atypical' Provider's Social Security Number, if Payee is an Individual - or - Health Plan's Federal Tax ID, if the Payee is NOT an individual
103	1000B	N104				
107	1000B	REF	Payee Additional Identification			

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
107	1000B	REF01	Reference Identification Qualifier	PQ		
108	1000B	REF02	Additional Payee Identifier			'Atypical' Provider ID assigned by ODM
111	2000	LX	Header Number			
111	2000	LX01	Assigned Number	1, 2, 3, 4, 8, 9, 12, 13, 15, 16, 17		Indicates type of claims grouped together. 1 = Inpatient Crossover 2 = Professional Crossover 3 = Outpatient Crossover 4 = Dental 8 = Home Health (UB) 9 = Inpatient 12 = Long Term Care 13 = Professional 15 = Outpatient 16 = Pharmacy 17 = Compound Drug
112	2000	TS3	Provider Summary Information			
113	2000	TS302	Facility Type Code	11, 99		Place of service on all claims. If all claims for the provider in TS301 don't have the same value, a default value is used. 11 = Default value for professional and dental claims 99 = Default value for pharmaceutical claims and other instances where the place of service is not the same.
113	2000	TS303	Fiscal Period Date			This date will be December 31 st of the current year based on the financial cycle date. Format - CCYYMMDD
123	2100	CLP	Claim Payment Information			
124	2100	CLP02	Claim Status Code	1, 2, 3, 4, 22		1 = Processed as Primary 2 = Processed as Secondary 3 = Processed as Tertiary 4 = Denied 22 = Reversal of Previous Payment
126	2100	CLP06	Claim Filing Indicator Code	16, MA, MB, MC		16 = Health Maintenance Organization (HMO) Medicare Risk - Means ODM processed as Medicare Part C crossover claim MA = Medicare Part A - Means ODM processed as Original Medicare Part A crossover claim

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						MB = Medicare Part B - Means ODM processed as Original Medicare part B crossover claim MC = Medicaid - Means ODM processed as Medicaid or other ODM program claim
127	2100	CLP07	Payer Claim Control Number			Internal Control Number (ICN) assigned by ODM to each claim.
127	2100	CLP08	Facility Type Code			CLM05-1 value from the original 837.
127	2100	CLP09	Claim Frequency Code			CLM05-3 value from the original 837.
128	2100	CLP11	Diagnosis Related Group (DRG) Code			Only on Inpatient Institutional Claim – IF the claim was adjudicated using a DRG.
137	2100	NM1	Patient Name			
139	2100	NM108	Identification Code Qualifier	MI		Member Identification Number
139	2100	NM109	Patient Identifier			12-digit Recipient ID assigned by ODM – must match what was submitted on the original 837 Claim
146	2100	NM1	Service Provider Name			
148	2100	NM108	Identification Code Qualifier	XX		
149	2100	NM109	Rendering Provider Identifier			'Typical' Provider NPI
169	2100	REF	Other Claim Related Identification			
169	2100	REF01	Reference Identification Qualifier	1L, BB, EA, F8, G1, IG		IL = Group or Policy Number BB = Authorization number – that was not assigned prior to the service EA = Medical Record Identification Number F8 = Original Reference Number (ODM ICN) G1 = Prior Authorization Number – that was assigned prior to the service IG = Insurance Policy Number
171	2100	REF	Rendering Provider Identification			
171	2100	REF01	Reference Identification Qualifier	1D		
172	2100	REF02	Rendering Provider Secondary Identifier			'Atypical' Provider ID assigned by ODM
173	2100	DTM	Statement From or To Date			

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
174	2100	DTM01	Date Time Qualifier	232, 233		232 = Claim Statement Period Start - First Date of Service, IF no End Date was submitted 233 = Claim Statement Period End - Last Date of Service, IF no Start Date was submitted
182	2100	AMT	Claim Supplemental Information			
182	2100	AMT01	Amount Qualifier Code	AU, F5, I		AU = Amount of the claim allowed by Medicaid F5 = Amount reported on the claim as PL/SD amount, not necessarily the amount submitted as AMT01 = F5. For Institutional claims, it is submitted as F3. I = Interest
184	2100	QTY	Claim Supplemental Information Quantity			
184	2100	QTY01	Quantity Qualifier	CA, LA, NE, OU		CA = Number of Covered Days – Actual. LA = Life-time Reserve – Actual. Medicare hospital insurance includes extra hospital days to be used if the patient has a long illness and is required to stay in the hospital over a specified number of days; this is the actual number of days in reserve NE = Number of Non-covered Days - estimated OU = Outlier Days
217	2110	PLB	Provider Adjustment			
218	2110	PLB01	Provider Identifier			'Typical' Provider NPI
218	2110	PLB02	Fiscal Period Date			December 31 of the current year
222	2110	PLB03-2	Provider Adjustment Identifier			Combination of 2 fields: Remittance /Advice Number + Warrant Number

APPENDICES

This section contains one or more appendices.

A. Implementation Checklist

See Trading Partner Information Guide found here: <http://medicaid.ohio.gov/PROVIDERS/Billing/TradingPartners.aspx>.

B. Frequently Asked Questions

See Trading Partner Information Guide found here: <http://medicaid.ohio.gov/PROVIDERS/Billing/TradingPartners.aspx>.