NCPDP IMPLEMENTATION GUIDANCE FOR THE X12/005010X221A1 Health Care Claim Payment/Advice (835)

VERSION 1.1

This paper offers guidance to the healthcare industry for the implementation of X12/005010X221A1 Health Care Claim Payment/Advice (835)

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March 2017

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Published by:
National Council for Prescription Drug Programs

Publication History:
Version 1.0 November 2010
Version 1.1 March 2017

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Disclaimer

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The writers of this paper will review and possibly update their recommendations should any significant changes occur.

This document is for Education and Awareness Use Only.

Please refer to the http://store.x12.org/hipaa.html to obtain a copy of the 005010X221A1 Health Care Claim/Payment Advice TR3.

1. PURPOSE

Entities such as health care providers, health plans, health care clearinghouses as well as business associates such as prescription benefit managers (PBMs) and vendors that support all of these entities will need to modify their business processes for implementation of the 005010X221A1.

The NCPDP Work Group 45 External Standards Assessment, Harmonization and Implementation Guidance has developed this White Paper as guidance to the pharmacy industry to prepare for the implementation of the 005010X221A1.

2. SCOPE

The recommendations were created in response to questions that were generated in an effort to provide guidance. The questions were created using current experience with the use of 835.

3. TIMELINE

Each column shown below indicates the items that should occur within a given period. It was determined that a twelve-month development and testing period was needed in order to facilitate testing and certification and to insure a high degree of interoperability across trading partners.

Start Date	August 2008	January 2010	January 2011	September 2011	January 1, 2012
	Business Planning	Development and Formal or Informal Testing	Transition To Full Compliance Period	NCPDP Compliance Date	Regulatory Compliance Date
Length of Time	17 Months	12 Months	8 months	4 months	

3.1.1 BUSINESS PLANNING

The business planning activities include such items as:

- Determine the Scope
- Define the Business Requirements
- Identify Budget Requirements including Resources
- Perform Risk Assessment

3.1.2 DEVELOPMENT AND FORMAL AND INFORMAL TESTING

Examples of processes that should be completed within this time period are:

- Systems analysis
- Coding
- Internal testing (may include parallel testing)
- Infrastructure planning
    - Hardware
    - Software
    - Network

During this time frame, trading partners participate in testing designed to demonstrate the ability of their systems to comply with the requirements of the standard(s). No trading partner should require another trading partner to begin testing prior to the start of this period. Parallel testing may occur at this time. Upon completion of successful testing, if trading partners mutually agree, they may immediately move to the transition to full compliance period. No trading partner can require another trading partner to use the newly mandated version of a standard during this period for submission of production transactions.

3.1.3 TRANSITION TO FULL COMPLIANCE

Trading partners must support both versions of the standards during this period for production transactions. No trading partner can force exclusive use of the newly mandated version during this period. Entities should implement the revised standards during this period in a timely manner to assure that they are prepared to meet the regulatory compliance date.

3.1.4 REGULATORY COMPLIANCE DATE

The date by which all processes above must be completed and the industry has transitioned to the newly mandated versions of existing HIPAA-named standards.

3.1.5 RECOMMENDATIONS

- It is recommended that companion guides be released by processors to providers, switches and other intermediaries as far in advance of the Informal Testing Period as possible.
- All entities move to the new versions of the standards during the Transition to Full Compliance Period as shown in 3.1.3.
- To ensure a smooth transition, processors should develop a series of implementation dates as milestones and communicate those dates to the providers who will be impacted. Processors should monitor progress. Processors and Providers should adhere to those communicated milestones.
- NCPDP recommends that when producing an 835 that it is not tied to the claim version being submitted. This recommendation is being provided as we know from past experience that pharmacies will move to a new standard over a period of time.
- NCPDP recommends that any trading partner begins support of the5010 version of the 835 at the same time based upon agreement between the processor and trading partner.
- NCPDP recommends that rejects are not reported on an 835 transaction if they have already been reported to the pharmacy in a NCPDP Telecommunications vD.0 Response Transaction.
- NCPDP recommends that the pharmacy industry report accepted reversals with the indication of who initiated the reversal as noted in Section 5.1 and 5.2 when the payment is or has been reported in an 835. Note: Audit Transactions are handled differently as noted in Section 6.

4. REJECT PROCESSING

- Where applicable other HIPAA allowed values may be used except for the Claim Adjustment or Service Adjustment (CAS) and Health Care Remark Codes (LQ) codes.
- If reporting a patient not found reject, please refer to section 4.7.
- For purposes of reporting rejects on an 835, a rejected transmission should be excluded

4.1 NCPDP TELECOMMUNICATION VD.0 REJECTION (CAS AND LQRX)

NCPDP recommends that rejects are not reported on an 835 transaction if they have already been reported to the pharmacy in a NCPDP Telecommunications vD.0 Response Transaction.

When an online rejection is reported on the 835 the patient copay field should be zero. In this transaction a Claim Adjustment Reason Code (CAS) 16 is sent along with a National Council for Prescription Drug Programs Reject/Payment Code (LQ RX) to further explain the online rejection (i.e. LQ02 = 19 is an example of a NCPDP Reject Code). The LQRX code sent back on the 835 should be the same as that which was returned to the pharmacy during adjudication.

Reference Designator Definition		
Claim Submitter's Identifier	CLP01:	1234589
Claim Status Code	CLP02:	1
Total Claim Charge Amount	CLP03:	13.5
Claim Payment Amount	CLP04:	0
Patient Responsibility Amount	CLP05:	0
Claim Filing Indicator Code	CLP06:	13
Entity Identifier Code	NM101:	QC
Entity Type	NM102:	1
Patient Last Name	NM103:	Last
Patient First Name	NM104:	First
Identification Code Qualifier	NM108:	MI
Patient Identifier	NM109:	987654321
Composite Medical Procedure Code	SVC01:	N4
Procedure Code	SVC01-2:	12345678901
Line Item Charge Amount	SVC02:	13.5
Line Item Provider Payment Amount	SVC03:	0
Quantity	SVC05:	30
Date Time Qualifier	DTM01:	472
Service Date	DTM02:	20060701
Claim Adjustment Group Code	CAS01:	CO/PI
Claim Adjustment Reason Code	CAS02:	16*
Adjustment Amount	CAS03:	13.5
Claim Adjustment Group Code	LQ01:	RX
Claim Adjustment Reason Code	LQ02:	19

Adjustment Amount		
Code List Qualifier Code		
Remark Code		

* CAS 16 = Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

4.2 NCPDP BATCH V1.2 AND MEDICAID SUBROGATION V3.0 (CAS AND LQRX)

The rejection is reported on the 835 and the patient copay field should be zero. In this transaction a Claim Adjustment Reason Code (CAS) 16 is sent along with a National Council for Prescription Drug Programs Reject/Payment Code (LQ RX) to further explain the rejection (i.e. LQ02 = 19 is an example of a NCPDP Reject Code). The LQRX code sent back on the 835 should be the same as that which was returned to the pharmacy during processing.

Reference Designator Definition		
Claim Submitter's Identifier	CLP01:	1234589
Claim Status Code	CLP02:	1
Total Claim Charge Amount	CLP03:	13.5
Claim Payment Amount	CLP04:	0
Patient Responsibility Amount	CLP05:	0
Claim Filing Indicator Code	CLP06:	13
Entity Identifier Code	NM101:	QC
Entity Type	NM102:	1
Patient Last Name	NM103:	Last
Patient First Name	NM104:	First
Identification Code Qualifier	NM108:	MI
Patient Identifier	NM109:	987654321
Composite Medical Procedure Code	SVC01:	N4
Procedure Code	SVC01-2:	12345678901
Line Item Charge Amount	SVC02:	13.5
Line Item Provider Payment Amount	SVC03:	0
Quantity	SVC05:	30
Date Time Qualifier	DTM01:	472
Service Date	DTM02:	20060701
Claim Adjustment Group Code	CAS01:	CO/PI
Claim Adjustment Reason Code	CAS02:	16*
Adjustment Amount	CAS03:	13.5
Claim Adjustment Group Code	LQ01:	RX
Claim Adjustment Reason Code	LQ02:	19
Adjustment Amount		
Code List Qualifier Code		
Remark Code		

*CAS 16 = Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

4.3 BILLING ERROR (CAS AND LQRX)

NCPDP recommends that when multiple billing errors are processed due to receipt of multiple claims submission during the same pay cycle and non-payment occurs, separate rejections are reported in the 835 for each submission. If payment occurs within the same cycle for that claim then no rejection is reported.

This transaction should include the usage of a Claim Adjustment Reason Code (CAS) 125 to communicate a rejection. In this transaction a National Council for Prescription Drug Programs Reject/Payment Code (LQ RX) is sent along with the CAS to further explain the billing error (i.e. LQ02 = M4 is an example of a NCPDP Reject Code). The patient copay should be returned on this transaction if provided in the original response, i.e. claim capture billing/response.

Reference Designator Definition		Billing Error
Claim Submitter's Identifier	CLP01:	1234589
Claim Status Code	CLP02:	1
Total Claim Charge Amount	CLP03:	13.5
Claim Payment Amount	CLP04:	0
Patient Responsibility Amount	CLP05:	3
Claim Filing Indicator Code	CLP06:	13
Entity Identifier Code	NM101:	QC
Entity Type	NM102:	1
Patient Last Name	NM103:	Last
Patient First Name	NM104:	First
Identification Code Qualifier	NM108:	MI
Patient Identifier	NM109:	987654321
Composite Medical Procedure Code	SVC01:	N4
Procedure Code	SVC01-2:	12345678901
Line Item Charge Amount	SVC02:	13.5
Line Item Provider Payment Amount	SVC03:	0
Quantity	SVC05:	30
Date Time Qualifier	DTM01:	472
Service Date	DTM02:	20060701
Claim Adjustment Group Code	CAS01:	PR
Claim Adjustment Reason Code	CAS02:	3
Adjustment Amount	CAS03:	3
Claim Adjustment Group Code	CAS01:	CO/PI
Claim Adjustment Reason Code	CAS02/05:	125*
Adjustment Amount	CAS03/06:	10.5
Code List Qualifier Code	LQ01:	RX
Remark Code	LQ02:	M4

* CAS 125 = Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

4.4 BILLING ERROR (CAS ONLY)

NCPDP recommends that when multiple billing errors are processed due to receipt of multiple claims submission during the same pay cycle and non-payment occurs, separate rejections are reported in the 835 for each submission. If payment occurs within the same cycle for that claim then no rejection is reported.

This transaction should be sent when errors are made during the pharmacy billing process resulting in a billing error. This transaction should include the usage of a valid Claim Adjustment Reason Code (CAS) to communicate a rejection. The patient copay should be returned on this transaction if provided to the provider in a response.

Reference Designator Definition		Billing Error
Claim Submitter's Identifier	CLP01:	1234589
Claim Status Code	CLP02:	1
Total Claim Charge Amount	CLP03:	13.5
Claim Payment Amount	CLP04:	0
Patient Responsibility Amount	CLP05:	3
Claim Filing Indicator Code	CLP06:	13
Entity Identifier Code	NM101:	QC
Entity Type	NM102:	1
Patient Last Name	NM103:	Last
Patient First Name	NM104:	First
Identification Code Qualifier	NM108:	MI
Patient Identifier	NM109:	987654321
Composite Medical Procedure Code	SVC01:	N4
Procedure Code	SVC01-2:	12345678901
Line Item Charge Amount	SVC02:	13.5
Line Item Provider Payment Amount	SVC03:	0
Quantity	SVC05:	30
Date Time Qualifier	DTM01:	472
Service Date	DTM02:	20060701
Claim Adjustment Group Code	CAS01:	PR
Claim Adjustment Reason Code	CAS02:	3
Adjustment Amount	CAS03:	3
Claim Adjustment Group Code	CAS01:	CO/PI
Claim Adjustment Reason Code	CAS02/05:	119
Adjustment Amount	CAS03/06:	10.5

4.5 BILLING ERROR (CAS AND LQHE)

NCPDP recommends that when multiple billing errors are processed due to receipt of multiple claims submission during the same pay cycle and non-payment occurs, separate rejections are reported in the 835 for each submission. If payment occurs within the same cycle for that claim then no rejection is reported.

This transaction should include the usage of a Claim Adjustment Reason Code (CAS) 125 to communicate a rejection. In this transaction a National Council for Prescription Drug Programs Reject/Payment Code (LQ RX) is

sent along with the CAS to further explain the billing error. The patient copay should be returned on this transaction if provided in the original response, i.e. claim capture billing/response

In this transaction a Remittance Advice Remark Code (LQHE) is sent along with the CAS to further explain the billing error.

Reference Designator Definition		Billing Error
Claim Submitter's Identifier	CLP01:	1234589
Claim Status Code	CLP02:	1
Total Claim Charge Amount	CLP03:	13.5
Claim Payment Amount	CLP04:	0
Patient Responsibility Amount	CLP05:	3
Claim Filing Indicator Code	CLP06:	13
Entity Identifier Code	NM101:	QC
Entity Type	NM102:	1
Patient Last Name	NM103:	Last
Patient First Name	NM104:	First
Identification Code Qualifier	NM108:	MI
Patient Identifier	NM109:	987654321
Composite Medical Procedure Code	SVC01:	N4
Procedure Code	SVC01-2:	12345678901
Line Item Charge Amount	SVC02:	13.5
Line Item Provider Payment Amount	SVC03:	0
Quantity	SVC05:	30
Date Time Qualifier	DTM01:	472
Service Date	DTM02:	20060701
Claim Adjustment Group Code	CAS01:	PR
Claim Adjustment Reason Code	CAS02:	3
Adjustment Amount	CAS03:	3
Claim Adjustment Group Code	CAS01:	CO/PI
Claim Adjustment Reason Code	CAS02/05:	125*
Adjustment Amount	CAS03/06:	10.5
Code List Qualifier Code	LQ01:	HE
Remark Code	LQ02:	M37

*Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

4.6 REJECTION CAS WITH LQRX AND LQHE

NCPDP recommends that when multiple billing errors are processed due to receipt of multiple claims submission during the same pay cycle and non-payment occurs, separate rejections are reported in the 835 for each submission. If payment occurs within the same cycle for that claim then no rejection is reported.

This transaction should include the usage of a Claim Adjustment Reason Code (CAS) 125 to communicate a rejection. In this transaction a National Council for Prescription Drug Programs Reject/Payment Code (LQ RX) is

sent along with the CAS to further explain the billing error. A remittance Advice Remark Code (LQHE) is sent along with the CAS to further explain the billing error.

The patient copay should be returned on this transaction if provided in the original response, i.e. claim capture billing/response.

Reference Designator Definition		Billing Error
Claim Submitter's Identifier	CLP01:	1234589
Claim Status Code	CLP02:	1
Total Claim Charge Amount	CLP03:	13.5
Claim Payment Amount	CLP04:	0
Patient Responsibility Amount	CLP05:	3
Claim Filing Indicator Code	CLP06:	13
Entity Identifier Code	NM101:	QC
Entity Type	NM102:	1
Patient Last Name	NM103:	Last
Patient First Name	NM104:	First
Identification Code Qualifier	NM108:	MI
Patient Identifier	NM109:	987654321
Composite Medical Procedure Code	SVC01:	N4
Procedure Code	SVC01-2:	12345678901
Line Item Charge Amount	SVC02:	13.5
Line Item Provider Payment Amount	SVC03:	0
Quantity	SVC05:	30
Date Time Qualifier	DTM01:	472
Service Date	DTM02:	20060701
Claim Adjustment Group Code	CAS01:	PR
Claim Adjustment Reason Code	CAS02:	3
Adjustment Amount	CAS03:	3
Claim Adjustment Group Code	CAS01:	CO/PI
Claim Adjustment Reason Code	CAS02/05:	125*
Adjustment Amount	CAS03/06:	10.5
Code List Qualifier Code	LQ01:	RX
Remark Code	LQ02:	M4
Code List Qualifier Code	LQ01:	HE
Remark Code	LQ02:	M37

*Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

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4.7 UNKNOWN PATIENT/SUBSCRIBER (CLP02 = 4)

If you are reporting rejections, this transaction should be sent when the patient/subscriber is not recognized for the accepted transmission, and the claim was not forwarded to another payer. This transaction should include the usage of a claims status code of 4. The patient copay CLP05 should be zero.

NOTE: CLP02 = 4 (deny) may only be returned if the patient is not found and LQ should be returned with NCPDP Reject Code N1 – No Patient Found.

Reference Designator Definition		Billing Error
Claim Submitter's Identifier	CLP01:	1234589
Claim Status Code	CLP02:	4
Total Claim Charge Amount	CLP03:	13.5
Claim Payment Amount	CLP04:	0
Patient Responsibility Amount	CLP05:	0
Claim Filing Indicator Code	CLP06:	13
Entity Identifier Code	NM101:	QC
Entity Type	NM102:	1
Patient Last Name	NM103:	Last
Patient First Name	NM104:	First
Identification Code Qualifier	NM108:	MI
Patient Identifier	NM109:	987654321
Composite Medical Procedure Code	SVC01:	N4
Procedure Code	SVC01-2:	12345678901
Line Item Charge Amount	SVC02:	13.5
Line Item Provider Payment Amount	SVC03:	0
Quantity	SVC05:	30
Date Time Qualifier	DTM01:	472
Service Date	DTM02:	20060701
Claim Adjustment Group Code	CAS01:	CO/PI
Claim Adjustment Reason Code	CAS02:	31
Adjustment Amount	CAS03:	13.5
Code List Qualifier Code	LQ01:	RX
Remark Code	LQ02:	N1

5. CORRECTION AND REVERSALS

Claim level corrections and reversals must be reported at the claim level in the Claim Payment Information Segment (CLP). Note: Audit Transactions are handled differently as noted in Section 6.

Since the definition of 'PI' was modified by X12 in June of 2009, NCPDP recommends that you review the definition to determine if the use of the 'PI' code in your business needs to be modified.

The 005010X221A1 no longer supports a Claim Adjustment or Service Adjustment (CAS) – Group Code of "CR" (correction/reversal).

5.1 REVERSALS

The 005010X221A1 front matter has been modified see Section 1.10.2.8 Reversals and Corrections.

NCPDP recommends the use of value "13" (Point of Service – POS) in Claim Filing Indictor Code (CLP06) if reversal is initiated through electronic submission (submission/response as allowed by HIPAA between provider/payer).

6. AUDIT TRANSACTION

NCPDP recommends the following guidance to the pharmacy sector of the health care industry for reporting the outcome of payer-initiated post payment audit adjustments of pharmacy claims using the X12/005010X221A1 Health Care Claim Payment/Advice 835.

This recommendation facilitates audit communication between payers and providers and endorses the use of Health Care Remark Codes (LQ) segment with Remittance Advice Remark Code (RARC) N199. It also endorses the following activities:

- Standard methodology among the payer and provider communities
- Ability to track audits at the claim level electronically in the A/R System
- Enhanced transactional controls between payer and provider
- Under B2B relationships, standardizes an NCPDP recommended method that includes specifications regarding industry claim payment remark codes for audit transactions.
- Standardizes an NCPDP supported method to report audits utilizing specified Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC).

7. CROSS OVER CLAIMS

Although there have been no changes between v4010 and v5010 of the 835, NCPDP has not previously given guidance on cross over claims. Crossovers are used for exchanging member eligibility information and crossover claims between Medicare and Secondary Payers including Supplemental, Medigap and State Medicaids.

NCPDP has identified two different situations where a crossover can occur:

1 – The pharmacy claim is adjudicated by one payer/processor who then delivers claim to another for final action/payment. The adjudicated payer takes no action on claim. Submitter is not always aware of who has responsibility for reconciling/paying claim.

2 – The pharmacy claim submitted to one payer is then submitted by that payer to another payer without knowledge to the original submitter. Original payer takes action on claim prior to submitting the claim on behalf of the original submitter to the next payer for their action.

In both situations, the original submitter is not aware that the claim sent was sent to another payer for action to be taken.

Within the 835 transaction a crossover should be communicated through a combination of various segments inclusive of claim status, crossover carrier name, and remittance advice remark codes.

8. COMPOUNDS

NCPDP recommends the following for multi-ingredient compounds on the 835:

SVC01-1 will be N4 for NDC
SVC01-2 will contain a valid NDC number submitted from the compound segment
SVC02 will report the Gross Amount Due for the entire compound
SVC03 will report the provider payment for the entire compound

AMT02 in both the 2100 and 2110 loops will contain the tax amount for the entire compound and not individual ingredients

9. ADDITIONAL GUIDANCE

NCPDP recommends the following guidance although there were no changes between 4010 and 5010 specific:

- When a PBM or other entity charges a fee for transaction/transmission at the individual provider level as reported in TS301 and these fees are not part of the Total Amount Paid (509-F9), then the amount for the transaction/transmission fee is reported in the Provider Adjustment (PLB) segment with a qualifier of AH. The transaction/transmission fees should be summarized by individual provider included on the check and reported on the 835.

- If the PBM or other entity charges a fee per claim and the fee is included in Total Amount Paid (509-F9) then the fee is reported using the Claim Adjustment or Service Adjustment (CAS) segment with a Claim Adjustment Reason Code (CARC) of 130 – Claim submission fee.

- All claims (including paper) submitted for payment should be reported on the 835 in the Claim Payment Information loop (2100).

10. APPENDIX A. HISTORY OF CHANGES

1. March 2017 – Editorial updates to remove slashed zeros (Ø) and replace with zero (0). Also updated the copyright statement as revised 2016, the NCPDP logo and X12 name change from ASC X12 to X12.