# NCPDP Pharmacy Reference Guide to the X12/005010X221A1 Health Care Claim Payment/Advice (835)

*VERSION 4.2*

*This paper offers guidance to the pharmacy industry in preparing for the implementation of the X12/05010X221A1 Health Care Claim Payment/Advice (835).*

# NCPDP Pharmacy Reference Guide to the
# X12/005010X221A1 Health Care Claim Payment/Advice (835)

**Version 4.1**

## TABLE OF CONTENTS

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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.*

This Reference Guide must be used in conjunction with the *X12/005010X221A1 Health Care Claim Payment/Advice (835).* This document does not supersede 05010X221A1. There may be other fields that must be populated that are not noted in this reference guide. This guidance only addresses claims submitted through NCPDP transactions or paper claim forms.

- 5 -

# 1. PURPOSE

Payers may use this guidance to convey the important features of supporting *X12/05010X221A1 Health Care Claim Payment/Advice (835)* to their business partners. The document should not be used as a standard form to be filled in by payers to provide information that is important to pharmacy providers, pharmacy reconciliation vendors, and other implementation units. Payers may use this reference guide for specific field information as it relates to the NCPDP Telecommunication Standard vD.0.

- 5 -

# 2. HIGH LEVEL SUMMARY

## 2.1 TRANSACTION SET LISTING

The X12 Health Care Claim Payment/Advice (835) transaction set is designed for the payment of claims and transfer of remittance information of the Health Care Industry. The objective of Health Care Claim Payment/Advice (835) is to support reimbursement processing for health care products and services.

The 835 transaction is divided into these levels:

• The Header level, Table 1, contains general payment information, such as amount, payee, payer, trace number, and payment method[1].
• The Detail level, Table 2, contains the EOB information related to adjudicated claims and services[1].
• The Summary level, Table 3, contains the Provider adjustment segment, PLB which provides information related to adjustments to the payment amount not specific to Table 2 claims.  These adjustments can either increase or decrease the actual payment with respect to the Table 2 claim charges[1].

Figure 8.1 Transaction Set Listing (Figure 8.1 Transaction Set Listing)[1]

### Table 1 - Header

| POS. # | SEG. ID | NAME | USAGE | REPEAT | LOOP REPEAT |
|--------|---------|------|-------|--------|-------------|
| 0100 | ST | Transaction Set Header | R | 1 | |
| 0200 | BPR | Financial Information | R | 1 | |
| ... | | | | | |

### Table 2 - Detail

| POS. # | SEG. ID | NAME | USAGE | REPEAT | LOOP REPEAT |
|--------|---------|------|-------|--------|-------------|
| | | LOOP ID - 2000  HEADER NUMBER | | | >1 |
| 0030 | LX | Header Number | S | 1 | |
| 0050 | TS3 | Provider Summary Information | S | 1 | |
| 0070 | TS2 | Provider Supplemental Summary Information | S | 1 | |
| | | LOOP ID - 2100  CLAIM PAYMENT INFORMATION | | | >1 |
| 0100 | CLP | Claim Payment Information | R | 1 | |
| 0200 | CAS | Claims Adjustment | S | 99 | |
| ... | | | | | |

### Table 3 - Summary

| POS. # | SEG. ID | NAME | USAGE | REPEAT | LOOP REPEAT |
|--------|---------|------|-------|--------|-------------|
| 0100 | PLB | Provider Adjustment | S | >1 | |
| 0200 | SE | Transaction Set Trailer | R | 1 | |

The field usage in the NCPDP Pharmacy Reference Guide reflects the pharmacy industry constraints of 005010X221A1 guidance. In situations where the NCPDP recommended usage gives additional constraints or specific pharmacy usage which is not clearly provided within 005010X221A1, it will be noted in the NCPDP comments column. Whereas required fields within a segment listed are the same as with 005010X221A1, this guide will not report.

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[1] Accredited Standards Committee X12, Insurance Subcommittee, X12N. "10.1.2 Data Use by Business Use"  Health Care Claim Payment/Advice (835), 005010X221A1. Washington Publishing Company, Apr. 2006. <http://www.wpc-edi.com>. 13

## 2.2 THE NCPDP 835 RECOMMENDED TRANSACTION SET

**Header:**

| Pos. No. | ID | Seg. Name | Usage | Repeat | Loop Repeat | Notes and Comments |
|---|---|---|---|---|---|---|
| 0100 | ST | Transaction Set Header | R | 1 | | |
| 0200 | BPR | Financial Information | R | 1 | | |
| 0400 | TRN | Re-association Trace Number | R | 1 | | |
| 0600 | REF | Receiver Identification | S | 1 | | |
| 0700 | DTM | Production Date | S | 1 | | |
| | | LOOP ID - 1000A-Payer Identification | | | 1 | |
| 0800 | N1 | Payer Identification | R | 1 | | |
| 1000 | N3 | Payer Address | R | 1 | | |
| 1100 | N4 | Payer City, State, Zip Code | R | 1 | | |
| 1200 | REF | Additional Payer Identification | S | 1 | | |
| 1300 | PER | Payer Business Contact Information | S | 1 | | |
| 1300 | PER | Payer Technical Contact Information | R | >1 | | |
| 1300 | PER | Payer WEB Site | S | 1 | | |
| | | LOOP ID - 1000B-Payee Identification | | | 1 | |
| 0800 | N1 | Payee Identification | R | 1 | | |
| 1000 | N3 | Payee Address | S | 1 | | |
| 1100 | N4 | Payee City, State, Zip Code | S | 1 | | |
| 1200 | REF | Additional Payee Identification | S | >1 | | |

**Detail:**

| Pos. No. | ID | Seg. Name | Usage | Repeat | Loop Repeat | Notes and Comments |
|---|---|---|---|---|---|---|
| | 00 | | | | | |
| 0030 | LX | Header Number | S | 1 | | |
| 0050 | TS3 | Provider Summary Information | S | 1 | | |
| | | LOOP ID – 2100-Claim Payment Information | | | >1 | |
| 0100 | CLP | Claim Payment Information | R | 1 | | |
| 0300 | NM1 | Patient Name | R | 1 | | |
| 0300 | NM1 | Insured Name | S | 1 | | |
| 0300 | NM1 | Corrected Patient/Insured Name | S | 1 | | |
| 0300 | NM1 | Service Provider Name | S | 1 | | |
| 0300 | NM1 | Crossover Carrier Name | S | 1 | | |
| 0300 | NM1 | Corrected Priority Payer Name | S | 1 | | |
| 0300 | NM1 | Other Subscriber Name | S | 1 | | |
| 0400 | REF | Other Claim Related Information | S | 5 | | |
| 0400 | REF | Rendering Provider Information | S | 10 | | |
| 0500 | DTM | Coverage Expiration Date | S | 1 | | |
| 0600 | DTM | Claim Received Date | S | 1 | | |
| | | LOOP ID – 2110-Service Payment Information | | | 999 | |
| 0700 | SVC | Service Payment Information | S | 1 | | |
| 0800 | DTM | Service Date | S | 3 | | |
| 0900 | CAS | Service Adjustment | S | 99 | | |
| 1000 | REF | Line Item Control Number | S | 1 | | |
| 1100 | AMT | Service Supplemental Amount | S | 9 | | |
| 1300 | LQ | Health Care Remark Codes | S | 99 | | |

**Summary:**

| Pos. No. | ID | Seg. Name | Usage | Repeat | Loop Repeat | Notes and Comments |
|---|---|---|---|---|---|---|
| 010 | PLB | Provider Adjustment | S | >1 | | |

| 0200 | SE | Transaction Set Trailer | R | 1 |

## 2.3  SEGMENTS WITH SAME USAGE AS 005010X221A1

Segments within the 835 which NCPDP recommends following the same usage as 005010X221A1:

| Segment ID | Loop ID | Segment Name |
|---|---|---|
| ISA | | Interchange Control Header |
| GS | | Function Group Header |
| ST | | Transaction Set Header |
| TRN | | Re-association Trace Number |
| REF | | Receiver Identification |
| DTM | | Production Date |
| N1 | 1000A | Payer Identification |
| N3 | 1000A | Payer Address |
| N4 | 1000A | Payer City, State, Zip Code |
| PER | 1000A | Payer Business Contact Information |
| PER | 1000A | Payer Technical Contact Information |
| PER | 1000A | Payer WEB Site |
| N1 | 1000B | Payee Identification |
| N3 | 1000B | Payee Address |
| N4 | 1000B | Payee City, State, ZIP Code |
| REF | 1000B | Additional Payee Identification |
| LX | 2000 | Header Number |
| NM1 | 2100 | Insured Name |
| NM1 | 2100 | Corrected Patient/Insured Name |
| NM1 | 2100 | Crossover Carrier Name |
| NM1 | 2100 | Corrected Priority Payer Name |
| NM1 | 2100 | Other Subscriber Name |
| REF | 2100 | Rendering Provider Information |
| DTM | 2100 | Claim Received Date |
| REF | 2110 | Line Item Control Number |
| PLB | | Provider Adjustment |
| SE | | Transaction Set Trailer |
| GE | | Function Group Trailer |
| IEA | | Interchange Control Trailer |

## 2.4  SEGMENTS NOT INCLUDED IN GUIDE

Segments within the 835 which are not included in the Reference Guide and are not recommended or required for Pharmacy use.

| Segment ID | Loop ID | Segment Name |
|---|---|---|
| CUR | | Foreign Currency Information |
| REF | | Version Identification |
| RDM | 1000B | Remittance Delivery Method |
| TS2 | 2000 | Provider Supplemental Summary Information Corrected |
| CAS | 2100 | Claim Adjustment |
| MIA | 2100 | Inpatient Adjudication Information |
| MOA | 2100 | Outpatient Adjudication Information |
| PER | 2100 | Claim Contact Information |
| DTM | 2100 | Statement From or To Date |
| AMT | 2100 | Claim Supplemental Information |
| QTY | 2100 | Claim Supplemental Information Quantity |
| REF | 2110 | Service Identification |
| REF | 2110 | Rendering Provider Information |
| REF | 2110 | HealthCare Policy Identification |

| Segment ID | Loop ID | Segment Name |
|---|---|---|
| QTY | 2110 | Service Supplemental Quantity |

Note: Any segment/data element allowed by 005010X221A1 may be included.

# 3. 835 BALANCING

Refer to Section 1.10.2.1 in 005010X221A1 for balancing guidance.

## 4. BALANCE FORWARD PROCESSING

The total payment amount in BPR02 cannot be negative. However, when refunds from reversals and corrections exceed the payment for new claims and results in a net negative payment, utilize PLB03-1 with a code of FB (Forwarding Balance) to adjust the BPR02 to zero. The dollar amount in the PLB04 will be the same as the current negative balance in the BPR02. Once the adjustment is made in the PLB04, applying the formula will result in a BPR02 value of zero. When a balance forward adjustment was reported in a previous 835, a subsequent 835 must use the PLB03-1 (Code FB) to add that money back in order to complete the process. The PLB04 will then contain the same dollar amount as the previous 835 but as a positive value. The positive value reduces the payment in the most current 835.

Example 1: Pharmacy scenario:
Total $100 two claims at $50 each from Pharmacy1 (P1)
One reversal $-150 from the same pharmacy
Forward Balance $-50

BPR*I*0*C*CHK************20090723~
TRN*1*PRN-1*122222222~
CLP*RX1*1*75*50**13*P1-clm1-cyc1~
CLP*RX2*1*75*50**13*P1-clm2-cyc1~
CLP*RX3*22*-180*-150**13*P1-clm3-cyc1~
PLB*1111111111*20091231*FB:PRN-1*-50.~

When a balance forward adjustment was reported in a previous 835, a subsequent 835 must use the PLB03-1 (Code FB forwarding balance) to add that money back in order to complete the process. The PLB04 will then contain the same dollar amount as the previous 835 but as a positive value. The positive value reduces the payment in the most current 835.

# 5. EFT AND 835 LAG TIME

Providers have encountered difficulties posting payment information when the funds are received and there is a significant delay in receiving the corresponding 835 transaction.

To avoid delays in applying the data, this rule requires the payer to send the 835 no later than three business days after the corresponding EFT CCD + Effective Entry Date or paper check is sent (when the payment amount is greater than zero). The 835 may be sent ahead of the corresponding EFT or Check being issued. This minimal gap in time will result in a smaller time lag overall, and the provider will be able to simplify their processes and reduce costs.

This rule applies unless a federal or state regulation already exists.

# 6. MATCHING PAYMENT DOLLARS TO REMITTANCE DATA (835)

Refer to section 1.10 in 005010X221A1 for guidance on payment dollars and remittance data.

# 7. SEGMENT AND FIELD REQUIREMENTS

A data element corresponds to a data field in data processing terminology. A data segment corresponds to a record in data processing terminology.[2]

Each simple data element or composite data structure in a segment is provided a structured code that indicates the segment in which it is used and the sequential position within the segment. The code is composed of the segment identifier followed by a two-digit number that defines the position of the simple element or composite data structure in that segment[3].

**Financial Information – BPR – This segment is required.**

| Field # | Loop ID | Implementation Name | Code | Field R/S | NCPDP Comments | Map |
|---------|---------|---------------------|------|-----------|----------------|-----|
| BPR01 | | Transaction Handling Code | H, I, | R | For Pharmacy, only the following code values may be used: H=Notification Only (use when BPR02 is zero), I=Remittance Information Only (Use when BPR02 is greater than zero) | |
| BPR03 | | Credit/ Debit Flag Code | C | R | For Pharmacy, only the following code value may be used: C = Credit | |

**Additional Payer Identification – REF – This segment is situational but required when the 835 is not being created by the payer, i.e. the Payer or Third Party Administrator sends the necessary data to a clearinghouse who creates the 835 and then forwards to the payee.**

| Field # | Loop ID | Implementation Name | Code | Field R/S | NCPDP Comments | Map |
|---------|---------|---------------------|------|-----------|----------------|-----|
| REF01 | 1000A | Reference Identification Qualifier | EO | R | EO=Submitter Identification Number | |

**Provider Summary Information – TS3 – This segment is situational but pharmacy requires it for reporting of claims summary by provider.**

| Field # | Loop ID | Implementation Name | Code | Field R/S | NCPDP Comments | Map |
|---------|---------|---------------------|------|-----------|----------------|-----|
| TS301 | 2000 | Provider Identifier | | R | | |

**Claim Payment Information – CLP – This segment is required.**

| Field # | Loop ID | Implementation Name | Code | Field R/S | NCPDP Comments | Map |
|---------|---------|---------------------|------|-----------|----------------|-----|
| CLP01 | 2100 | Patient Control Number | | R | Prescription/Service Reference Number or when mutually agreed upon the Prescription/Service Reference Number and Fill Number with the characters 'FILL' preceding the Fill Number. | 402-D2 Or 402-D2 and 403-D3 |
| CLP02 | 2100 | Claim Status Code | | R | **NOTE**: Claim Status Code 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. | |
| CLP03 | 2100 | Total Claim Charge | | R | Gross Amount Due | 430-DU |

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[2] Accredited Standards Committee X12, Insurance Subcommittee, X12N. "B1.1.2.1 Basic Structure"  Health Care Claim Payment/Advice (835), 005010X221A1. Washington Publishing Company, Apr. 2006.   <http://www.wpc-edi.com>. B.2

[3] Accredited Standards Committee X12, Insurance Subcommittee, X12N. "B1.1.3.4 Data Segment"  Health Care Claim Payment/Advice (835), 005010X221A1. Washington Publishing Company, Apr. 2006.   <http://www.wpc-edi.com>. B.11

| Field # | Loop ID | Implementation Name | Code | Field R/S | NCPDP Comments | Map |
|---------|---------|---------------------|------|-----------|----------------|-----|
| | | Amount | | | | |
| CLP04 | 2100 | Claim Payment Amount | | R | Total Amount Paid | 509-F9 |
| CLP05 | 2100 | Patient Responsibility Amount | | S | Patient Pay Amount<br>Please Note: This field is not to be used for reversal transactions | 505-F5 |
| CLP06 | 2100 | Claim Filing Indicator Code | | R | For reporting of Low Income Subsidy Co-Pay Adjustment the value of ZZ Mutually Defined is used. | |

**Patient Name – NM1 – This segment is required.**

| Field # | Loop ID | Implementation Name | Code | Field R/S | NCPDP Comments | Map |
|---------|---------|---------------------|------|-----------|----------------|-----|
| NM103 | 2100 | Patient Last Name | | S | Patient Last Name is required for pharmacy. Report as submitted on the claim. | 311-CB |
| NM104 | 2100 | Patient First Name | | S | Patient First Name is required if submitted on the claim. | 310-CA |
| NM108 | 2100 | Identification Code Qualifier | MI | R | For Pharmacy, only the following code value may be used:<br>MI=Member ID | |
| NM109 | 2100 | Patient Identifier | | R | Cardholder ID or when mutually agreed upon the Cardholder ID and the Person Code as submitted on the claim. | 302-C2<br>Or<br>302-C2<br>303-C3 |

**Service Provider Name – NM1 – This segment is situational but required when the Rendering Provider is different from the Payee.**

| Field # | Loop ID | Implementation Name | Code | Field R/S | NCPDP Comments | Map |
|---------|---------|---------------------|------|-----------|----------------|-----|
| NM103 | 2100 | Rendering Provider Last Name or Organization Name | | S | If submitting pharmacy is not equal to payee, return name of pharmacy as on file from payer. | |

**Other Claim Related Identification – REF – This segment is situational.**

| Field # | Loop ID | Implementation Name | Code | Field R/S | NCPDP Comments | Map |
|---------|---------|---------------------|------|-----------|----------------|-----|
| REF02 | 2100 | Other Claim Related Identifier | | R | One occurrence is required with the REF01=BB, then NCPDP Field 503-F3 (Authorization Number)<br>If REF01=1L, then NCPDP Field 301-C1 (Group ID)<br>If REF01=G1, then NCPDP Field 462-EV (Prior Authorization Number Submitted)<br>If REF01=CE, then enter Network ID (545-2F) | 503-F3<br>301-C1<br>462-EV<br>545-2F |

**Statement From or To Date – DTM –This segment is situational. For Retail Pharmacy claims use the 2110 Loop for Prescription Fill Date. Use 2100 only when 2110 cannot be populated. The Claim Statement Period Start Date (232) should be used to indicate the fill date of the prescription.**

| Field # | Loop ID | Implementation Name | Code | Field R/S | NCPDP Comments | Map |
|---------|---------|---------------------|------|-----------|----------------|-----|
| DTM01 | 2100 | Date Time Qualifier | 232 | R | 232=Claim Statement Period Start | |
| DTM02 | 2100 | Claim Date | | R | Date of Service | 401-D1 |

**Coverage Expiration Date – DTM – This segment is situational but required when payment is denied because of expiration of coverage and NCPDP Reject Code (F11-FB) is equal to 68 or 69.**

**Service Payment Information – SVC (Note: An Rx is a service) - This segment is situation but required for pharmacy transactions.**

| Field # | Loop ID | Implementation Name | Code | Field R/S | NCPDP Comments | Map |
|---------|---------|---------------------|------|-----------|----------------|-----|
| SVC01-1 | 2110 | Product or Service ID Qualifier | N4, HC, | R | N4=NDC<br>HC=HCPCS Code<br><br>For Multi-Ingredient Compound report as N4 | |
| SVC01-2 | 2110 | Adjudicated Procedure Code | | R | Report Product/Service ID without dashes<br>For Multi-Ingredient Compounds report a valid Product/Service ID as submitted in compound | 407-D7<br>Or<br>489-TE |
| SVC02 | 2110 | Line Item Charge Amount | | R | NCPDP Gross Amount Due<br>For Multi-Ingredient Compound report amount for the entire compound and not individual ingredients. | 430-DU |
| SVC03 | 2110 | Line Item Provider Payment Amount | | R | Total Amount Paid<br>For Multi-Ingredient Compound report amount for the entire compound and not individual ingredients. | 509-F9 |
| SVC05 | 2110 | Units of Service Paid Count | | S | Quantity Dispensed | 442-E7 |

**Service Date – DTM – This segment is situational, but required for pharmacy claims.**

| Field # | Loop ID | Implementation Name | Code | Field R/S | NCPDP Comments | Map |
|---------|---------|---------------------|------|-----------|----------------|-----|
| DTM01 | 2110 | Date Time Qualifier | 472 | R | 472=Service | |
| DTM02 | 2110 | Service Date | | R | Date of Service | 401-D1 |

**Service Adjustment – CAS – This segment is situational. NCPDP recommends that the CAS Segment should be created in 2110 Loop.).**

| Field # | Loop ID | Implementation Name | Code | Field R/S | NCPDP Comments | Map |
|---------|---------|---------------------|------|-----------|----------------|-----|
| CAS01 | 2110 | Claim Adjustment Group Code | | R | See the NCPDP Claim Adjustment Reason Code/NCPDP Reject Code Mapping document at:<br><br>http://ncpdp.org/Resources/Guidance-Documents | |
| CAS02* | 2110 | Claim Adjustment Reason Code | | R | See the NCPDP Claim Adjustment Reason Code/NCPDP Reject Code Mapping document at:<br><br>http://ncpdp.org/Resources/Guidance-Documents | |
| CAS05* | 2110 | Claim Adjustment Reason Code | | S | See the NCPDP Claim Adjustment Reason Code/NCPDP Reject Code Mapping document at:<br><br>http://ncpdp.org/Resources/Guidance-Documents | |
| CAS08* | 2110 | Claim Adjustment Reason Code | | S | See the NCPDP Claim Adjustment Reason Code/NCPDP Reject Code Mapping document at:<br><br>http://ncpdp.org/Resources/Guidance-Documents | |
| CAS11* | 2110 | Claim Adjustment Reason Code | | S | See the NCPDP Claim Adjustment Reason Code/NCPDP Reject Code Mapping document at:<br><br>http://ncpdp.org/Resources/Guidance-Documents | |
| CAS14* | 2110 | Claim Adjustment Reason Code | | S | See the NCPDP Claim Adjustment Reason Code/NCPDP Reject Code Mapping document at:<br><br>http://ncpdp.org/Resources/Guidance-Documents | |
| CAS17* | 2110 | Claim Adjustment Reason Code | | S | See the NCPDP Claim Adjustment Reason Code/NCPDP Reject Code Mapping document at:<br><br>http://ncpdp.org/Resources/Guidance-Documents | |

**\* A single CAS segment may contain up to six repetitions of the "adjustment trio" composed of adjustment reason code, adjustment amount, and adjustment quantity. These six adjustment trios are used to report up to six adjustments related to a particular Claim Adjustment Group Code**

**(CAS01). The first adjustment is reported in the first adjustment trio (CAS02-04). The second adjustment is reported in the second adjustment trio (CAS05-CAS07), and so on through the sixth adjustment trio (CAS17-CAS19).**

### Service Supplemental Information – AMT – This segment is situational but required for pharmacy.

| Field # | Loop ID | Implementation Name | Code | Field R/S | NCPDP Comments | Map |
|---------|---------|---------------------|------|-----------|----------------|-----|
| AMT01 | 2110 | Amount Code Qualifier | T | | For Pharmacy, only the following code values may be used:<br>T - Tax | |
| AMT02 | 2110 | Service Supplemental Amount | | R | If AMT01=T, report tax as the sum of Flat Sales Tax Amount Paid (558-AW) and Percentage Sales Tax Paid (559-AX) | |

### Health Care Remark Codes – LQ

| Field # | Loop ID | Implementation Name | Code | Field R/S | NCPDP Comments | Map |
|---------|---------|---------------------|------|-----------|----------------|-----|
| LQ01 | 2110 | Code List Qualifier Code | RX | R | RX=NCPDP Reject Code when available | |
| LQ02 | 2110 | Industry Code | | R | Most current External Code List as found under members only standards downloads at http://www.ncpdp.org | |

# 8. APPENDIX A – EXTERNAL 835 FREQUENTLY ASKED QUESTIONS CMS FAQS & X12 HIRS

## Appendix A –External 835 Frequently Asked Questions
### CMS FAQs & X12 HIRS

Additional information can be found concerning 005010X221A1 on the CMS website:
http://questions.cms.hhs.gov
- · #8449
- · #8450

And the X12N Interpretations Portal:
http://www.x12n.org/portal
- · #451
- · #462

# 9. APPENDIX B. HISTORY OF CHANGES

1. Version 1.0 of the guide was never published
2. December 2010 – Version 1.1 included editorial modifications for typographical errors found in document and the modifications to the TR3 name due to the errata.
3. April 2011 – Version 2 never published
4. April 2011 – Version 3 included modifications made for creation of the 835 Operating Rules for pharmacy. Changes include the following:
    a. Part 1 – added section D – EFT and 835 Lag Time and removed AMT in loop 2100 from the transaction setting list and section E – NCPDP Telecommunication VD.0 Rejections.
    b. Added N3 (Payee Name), N4 (Payee City, State, ZIP Code), NM1 (Insured Patient Name) and MN1 (Corrected Patient/Insured Name) to the "Segments Within the 835 which NCPDP recommends following the same usage as 005010X221A1" table.
    c. Added AMT (Claim Supplemental Information) in the 2100 loop to the "Segments Within the 835 which are not included in the Reference Guide and are not recommended or required for Pharmacy use" table.
    d. Part III – Segment and Field Requirements
        i. Made required and situational statements consistent
        ii. Removed the Payee Address, Payee City, State, ZIP Code, Insured Name, Corrected Patient/Insured Name, Claim Supplemental Amount (in 2100 loop) segments
        iii. Added clarification to BPR01 (Transaction Handling Code) and BPR02 (Credit/Debit Flag)
        iv. Removed reference to Appendix A in TS301 (Provider Identifier)
        v. Added additional mapping and comments to CLP01 (Patient Control Number)
        vi. Added 'Please note:" to CLP05 (Patient Responsibility Amount) comments
        vii. Added additional comments to NM103 (Patient Last Name) and NM104 (Patient First Name)
        viii. Removed NM105 (Patient Middle Name or Initial) and MN107 (Patient Name Suffix) from the Patient Name Segment
        ix. Added additional mapping and comments to NM109 (Patient Identifier)
        x. Removed NM104 (Rendering Provider First Name), NM105 (Rendering Provider Middle Name or Initial) and NM107 (Rendering Provider Name Suffix)
        xi. Added additional mapping and modified the comments in REF01 (Other Claim Related Identification)
        xii. Added additional mapping and modified comments in SVC01-2 (Adjudicated Procedure Code)
        xiii. Removed SVC04 (National Uniform Billing Committee Revenue Code)
        xiv. Added AMT01 (Amount Code Qualifier) and added comments for allowed values
        xv. Modified comments in AMT02 (Service Supplemental Amount)
        xvi. Added CAS and LQ segments into Part III
        xvii. Removed CAS and LQ segments from "Segments Within the 835 which are not included in the Reference Guide and are not recommended or required for Pharmacy use" table.
        xviii. Removed citation appendix and made citations footnotes.
        xix. Modified situation on Health Care Remark Codes.
    e. Removed Appendix C
5. March 2012 – Corrected name of SVC03 to Line Item Provider Payment Amount and added DISA copyright for 2012.
    a. August 2012 - Removed DTM Segment in the 2100 Loop from the table of NCPDP 835 Recommended Transaction Set
    b. Added DTM in 2100 Loop to Segments Not Included in Guide
    c. Added CLP06 Claim Filling Indicator Code to CLP Segment with note that the value of "ZZ" is to be used to represent Low Income Subsidy Co-Pay Adjustments.
    d. Removed use of the value of "U1" from SVC01-1
    e. Removed segment repeat on the Service Adjustment (CAS) Segment

      f.    Removed situation from Health Care Remark Codes Segment

6. August 2013 – Editorial update to Section 5 to align with the ***CAQH Committee on Operating Rules for Information Exchange (CORE) Phase III CORE 370 EFT & ERA Reassociation (CCD+/835) Rule version 3.0.0 June 2012.***

7. 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, updated NCPDP Resources URL and X12 name change from ASC X12 to X12.