

NCPDP
ASC X12N 835 (004010X091A1) Pharmacy Remittance Advice
Template
Last Updated: November 2007

Disclaimer:

The X12N 835 Pharmacy Remittance Advice Template must be used in conjunction with the ASC X12N 835 V4010/4010A1 Implementation Guide. This document does not supersede the HIPAA Implementation Guide. There may be other fields that must be populated that are not noted in this template.

Purpose:

Payers can use this template to convey the important features of supporting the ASC X12N 835 Implementation Guide to their business partners. The document can 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.

Part I - General Information:

Payer Name:	Date:
Processor:	Switch:
Effective as of:	Information Source:
Pharmacy Services Representatives:	Help Desk Phone #:

Part II – High Level Summary

A. File Layout

The 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 sections:

- 1 **Header:** opens the transaction, provides payment information and identifies payer and payee.
- 2 **Detail:** provides claim- and service-specific remittance data.
- 3 **Summary:** provides payee-specific adjustment data and ends the transaction.

The NCPDP 835 Recommended File Layout follows:



Header:

Pos. No.	Seg. ID	Name	Usage	Repeat	Loop Repeat	Notes and Comments
010	ST	Transaction Set Header	R	1		
020	BPR	Financial Information	R	1		
040	TRN	Re-association Trace Number	R	1		
060	REF	Receiver Identification	S	1		
070	DTM	Production Date	S	1		
		LOOP ID - 1000A-Payer Identification			1	
080	N1	Payer Identification	R	1		
100	N3	Payer Address	R	1		

110	N4	Payer City, State, Zip Code	R	1
120	REF	Additional Payer Identification	S	1
LOOP ID - 1000B-Payee Identification				1
080	N1	Payee Identification	R	1
100	N3	Payee Address	S	1
110	N4	Payee City, State, Zip Code	S	1
120	REF	Additional Payee Identification	S	>1

Detail:

Pos. No.	Seg. ID	Name	Usage	Repeat	Loop Repeat	Notes and Comments
LOOP ID - 2000-Header Number						
003	LX	Header Number	S	1		
005	TS3	Provider Summary Information	S	1		
LOOP ID - 2100-Claim Payment Information					>1	
010	CLP	Claim Payment Information	R	1		
020	CAS	Claim Adjustment	S	99		
030	NM1	Patient Name	R	1		
030	NM1	Insured Name	S	1		
030	NM1	Service Provider Name	S	1		
080	DTM	Service Date	S	1		
LOOP ID - 2110-Service Payment Information					999	
070	SVC	Service Payment Information	S	1		
080	DTM	Service Date	S	3		
090	CAS	Service Adjustment	S	99		
130	LQ	Health Care Remark Codes	S	99		

Summary:

Pos. No.	Seg. ID	Name	Usage	Repeat	Loop Repeat	Notes and Comments
010	PLB	Provider Adjustment	S	>1		
020	SE	Transaction Set Trailer	R	1		

Segments Within the 835 that are Not Included in This Template:

Segment ID	Loop ID	Segment Name
CUR		Foreign Currency Information
REF		Version Identification
PER	1000A	Payer Contact Information
TS2	2000	Provider Supplemental Summary Information Corrected
NM1	2100	Patient/Insured Name
NM1	2100	Crossover Carrier Name
NM1	2100	Corrected Priority Payer Name
MIA	2100	Inpatient Adjudication Information
MOA	2100	Outpatient Adjudication Information
REF	2100	Other Claim Related Identification
REF	2100	Rendering Provider Identification
PER	2100	Claim Contact Information
AMT	2100	Claim Supplemental Information
QTY	2100	Claim Supplemental Information Quantity
REF	2110	Service Identification
REF	2110	Rendering Provider Information
AMT	2110	Service Supplemental Amount
QTY	2110	Service Supplemental Quantity

Note: Any segment/data element allowed by the X12N 835 (004010X091A1) Health Care Claim Payment/Advise Implementation Guide may be included.

B. 835 Balancing

Each 835-transaction set corresponds to one Check, unless the transaction amount is \$0.00 in which case no check will be issued. Multiple claims can be referenced within one 835. The transaction limitation for a trading partner is extended to allow more than 10,000 Prescription payments for a given Check. Note: If BPR02 is zero, the BPR01 should be Code H. If the BPR02 is positive, the BPR01 should be Code I.

1. Service Level (Prescription) Balancing

Within each prescription, the balancing must be such that the Line Item Charge Amount (SVC02) minus the sum of all Adjustment Amounts (CAS03, CAS06, CAS09, CAS12, CAS15, and CAS18) equals the Line Item Provider Payment Amount for this service line (SVC03).

$$SVC03 = SVC02 - (\text{Sum of } (CAS03, CAS06, CAS09, CAS12, CAS15, CAS18))$$

Note: Adjustments within the 835, at the Service Adjustment Segment (CAS), **decrease** the payment when the adjustment amount is **positive**, and **increase** the payment when the adjustment is **negative**.

2. Claim Level Balancing

Within each prescription, the balancing must be such that the Total Claim Charge Amount (CLP03) minus the sum of all Adjustment Amounts (CAS03, CAS06, CAS09, CAS12, CAS15, and CAS18) equals the Line Item Payment Amount for this claim line (CLP04).

$$CLP04 = CLP03 - (\text{Sum of } (CAS03, CAS06, CAS09, CAS12, CAS15, CAS18))$$

The CAS segment at the claim level can be utilized and a claim can contain multiple service lines.

$$CLP03 = SVC02 \text{ (Line Item Charge Amount) or the sum of SVC02}$$

$$CLP04 = SVC03 \text{ (Line Item Payment Amount) or the sum of SVC03}$$

3. Check Level Balancing

Within the Check, the sum of all claim payments plus or minus the sum of all provider level adjustments equals the total payment amount.

$$BPR02 = \text{Sum of All CLP04 adjusted by the Sum of All PLB04}$$

BPR02 is the total payment amount of this 835 transaction.
Sum of ALL CLP04 is the total of all service payments included in this 835.

PLB04 is the provider level adjustment amounts (transmission fee. All other provider level adjustment amounts are to be handled by trading partner agreement between payer/provider).

Note: Adjustments within the 835, at the PLB segments, **decrease** the payment when the adjustment amount is **positive**, and **increase** the payment when the adjustment is **negative**.

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 future 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.

Part III – Matching Payment Dollars to Remittance Data (835)

Per HIPAA Rules, a payer must provide for a re-association via a trace number that links the payment instrument (check/EFT) to the associated 835. Scenarios for accomplishing this are on pages 22 and 53 of the ASC X12N 835 (004010X091A1) Implementation Guide.

There are three HIPAA-compliant ways to re-associate the RA (remittance advice detail) to the money deposited in the bank.

Scenario	Payment Method	835 Transmission to
1	Check	Provider
2	ACH – CCD+	Provider
3	ACH - CTX	Bank (Not Recommended)

- **Scenario 1.** Payers can pay by check and send the RA directly to the provider. The check number from the check that was deposited in the bank will match the check number listed in the TRN segment (TRN field 2 on the 835) of the RA.
- **Scenario 2.** Payers can pay by ACH (CCD+) and send the RA directly to the Provider. According to the HIPAA standards, the EFT tracer number on the ACH transaction should match up to the TRN segment (TRN field 2 on the 835) of the RA. According to banking standards, the tracer number on an ACH transaction without addenda record(s) is assigned by the bank and will NOT match the EFT tracer number on the 835 RA. Effectively, the CCD and PPD formats of ACH transactions will not match up with an 835 RA. There is one compliant version of an ACH transaction (CCD+), which has an addenda record and in this addenda record there are 80 bytes of available information where the TRN segment of the 835 should be populated to allow for re-association with the RA.
- **Scenario 3.** Payers can pay by ACH (CTX) and send the RA to the bank with the ACH transaction. In this scenario the bank would have both the money and the 835 attached (embedded in the ACH transaction), so re-association would not be necessary.

In all EFT/ACH scenarios the payer must coordinate with its originating financial institution and the provider must coordinate with its receiving financial institution to facilitate re-association.

Part IV - Segment and Field Requirements:

Interchange Control Header – ISA

Field #	Loop ID	835 Field Name	Recommended Values
ISA01		Authorization Information Qualifier	00
ISA02		Authorization Information	10 spaces
ISA03		Security Information Qualifier	00
ISA04		Security Information	10 spaces
ISA05		Interchange ID Qualifier	Unique Sender Qualifier and ID, such as 30 = Federal Tax ID
ISA06		Interchange Sender ID	Sender's Tax ID
ISA07		Interchange ID Qualifier	Unique Receiver Qualifier and ID, such as 30 = Federal Tax ID
ISA08		Interchange Receiver ID	Receiver's Tax ID
ISA09		Interchange Date	Creation Date
ISA10		Interchange Time	Creation Time
ISA11		Interchange Control Standards Identifier	U
ISA12		Interchange Control Version Number	00401
ISA13		Interchange Control Number	Control # assigned by Sender
ISA14		Acknowledgement Requested	0
ISA15		Usage Indicator	P
ISA16		Component Element Separator	See the X12N 835 4010 X091A1 Appendix A for usage of delimiters

Functional Group Header - GS

Field #	Loop ID	835 Field Name	Recommended Values
GS01		Functional Identifier Code	HP
GS02		Application Sender's Code	Unique Sender ID, such as Tax ID
GS03		Application Receiver's Code	GS03=ISA08
GS04		Date	Creation Date
GS05		Time	Creation Time
GS06		Group Control Number	Sender assigned number
GS07		Responsibility Agency Code	X
GS08		Version/Release/Industry Identifier Code	004010X091A1

BEGINNING OF 835 TRANSACTION SET

Transaction Set Header – ST

Field #	Loop ID	835 Field Name	Recommended Values
ST01		Transaction Set Identifier Code	835
ST02		Transaction Set Control Number	Sender assigned number

Financial Information – BPR

Field #	Loop ID	835 Field Name	Recommended Values
BPR01		Transaction Handling Code	H=Notification Only (use when BPR02 is zero), I=Remittance Information Only (Use when BPR02 is greater than zero)
BPR02		Monetary Amount	Total Actual Provider Payment Amount
BPR03		Credit/Debit Flag Code	Always use C=Credit

BPR04		Payment Method Code	If BPR01 is H, use NON. If BPR01 is I, use one of ACH=Automated Clearing House, CHK=Check, or FWT=Federal Reserve Wire Transfer If BPR04=ACH use BPR05 through BPR15 IF BPR04=FWT use BPR06 through BPR15
BPR05		Payment Format Code	CCD=Cash Concentration Disbursement CTX=Corporate Trade Exchange
BPR06		DFI ID Number Qualifier	01=ABA, 04=Canadian Bank Branch ID
BPR07		DFI Identification Number	
BPR08		Account Number Qualifier	DA=Demand Deposit
BPR09		Account Number	Sender Bank Account Number
BPR10		Originating Company Identifier	Federal Tax ID preceded by a "1"
BPR12		DFI ID Number Qualifier	01=ABA, 04=Canadian Bank Branch ID
BPR13		DFI Identification Number	Receiver or Provider Bank ID Number
BPR14		Account Number Qualifier	DA=Demand Deposit, SG=Savings Account
BPR15		Account Number	Receiver or Provider Account Number
BPR16		Date	Check Issue or EFT Effective Date (for Code I only) Or the date of the 835 (for Code H only)

Reassociation Trace Number – TRN

Field #	Loop ID	835 Field Name	Recommended Values
TRN01		Trace Type Code	1 = Current Transaction Trace Numbers
TRN02		Reference Identification	Check or EFT Trace # (for Code I only) or Unique Notification Tracking # which is handled through trading partner agreement (for Code H only)
TRN03		Originating Company Identifier	Must Contain Federal Tax ID preceded by a "1"

Receiver Identification – REF

Field #	Loop ID	835 Field Name	Recommended Values
REF01		Reference Identification Qualifier	EV = Receiver Identification Number
REF02		Reference Identifier	Receiver Identifier

Production Date – DTM

Field #	Loop ID	835 Field Name	Recommended Values
DTM01		Date/Time Qualifier	405 = Production
DTM02		Date	Production Date (Cycle End Date)

Payer Identification – N1

Field #	Loop ID	835 Field Name	Recommended Values
N101	1000A	Entity Identifier Code	PR = Payer
N102	1000A	Name	Payer Name
N103	1000A	Identification Code Qualifier	May use only XV = National Health Plan ID (When National Health Plan ID is available)
N104	1000A	Identification Code	National Health Plan ID (When National Health Plan ID is available)

Payer Address – N3

Field #	Loop ID	835 Field Name	Recommended Values
N301	1000A	Address Information	Payer Address Line
N302	1000A	Address Information	Payer Address Line

Payer City, State, ZIP Code – N4

Field #	Loop ID	835 Field Name	Recommended Values
N401	1000A	City Name	Payer City Name
N402	1000A	State or Province Code	Payer State Code
N403	1000A	Postal Code	Payer Postal Zone or Zip Code

Additional Payer Identification – REF

Field #	Loop ID	835 Field Name	Recommended Values
REF01	1000A	Reference Identification Qualifier	2U=Payer Identification Number
REF02	1000A	Reference Identification	Payer ID Number

Payee Identification – N1

Field #	Loop ID	835 Field Name	Recommended Values
N101	1000B	Entity Identifier Code	PE = Payee
N102	1000B	Name	Payee Name (such as, Chain Name or Pharmacy Name)
N103	1000B	Identification Code Qualifier	<p>For HIPAA covered transactions use XX National Provider Identifier (NPI)</p> <ul style="list-style-type: none"> ✓ If the Payee is a chain pharmacy with the chain and all member stores operating under the same tax ID, this is the NPI of the chain. ✓ If the Payee is the Service/Rendering Provider or no agreement exists to pay the chain, this is the NPI of the Service/Rendering Provider. ✓ If the Payee is a chain pharmacy with the chain operating under a different tax ID than the member stores and the chain obtained a chain NPI, this is the NPI of the chain. <p>FI Federal Tax Identifier</p> <ul style="list-style-type: none"> ✓ If the Payee is a chain pharmacy with the chain operating under a different tax ID than the member stores and the chain did not obtain an NPI, this is the tax ID of the chain. ✓ If the Payee is NOT a covered entity, then this the tax ID of the payee. <p>For non HIPAA covered transactions use</p> <ul style="list-style-type: none"> ✓ FI Federal Tax Identifier of the payee. (See Appendix B, Frequently asked Question –HIR#462 and CMS FAQs)
N104	1000B	Identification Code	<p>If N103 is XX report the Payee's NPI.</p> <p>If N103 is FI report the Payee's Federal Tax ID.</p>

Payee Address – N3

Field #	Loop ID	835 Field Name	Recommended Values
N301	1000B	Address Information	Payee Address Line
N302	1000B	Address Information	Payee Address Line

Payee City, State, ZIP Code – N4

Field #	Loop ID	835 Field Name	Recommended Values
N401	1000B	City Name	Payee City Name
N402	1000B	State or Province Code	Payee State Code
N403	1000B	Postal Code	Payee Postal Zone or Zip Code

Payee Additional Identification – REF

Field #	Loop ID	835 Field Name	Recommended Values
REF01	1000B	Reference Identification Qualifier	When the value in N103 of this Loop is XX use TJ Tax Identifier. When the value in N103 of this Loop is FI use any of the HIPAA Recommended Codes. (See Appendix A, List of HIPAA Recommended Codes)
REF02	1000B	Reference Identification	If REF01 is TJ report the Payee's Federal Tax ID in REF02. If REF01 is not TJ report the referenced identification number.

Header Number – LX

Field #	Loop ID	835 Field Name	Recommended Values
LX01	2000	Assigned Number	Assigned Number (Payer assigned Unique Loop Number)

Provider Summary Information – TS3

This segment is required when the entity reported in 1000B Loop is not the Service/Rendering Provider, otherwise optional.

Field #	Loop ID	835 Field Name	Recommended Values
TS301	2000	Reference Identification	For HIPAA covered transactions this is the National Provider Identifier (NPI) of the Service/Rendering Provider (such as NPI, Value 1 of Service Provider ID Qualifier, 202-B2) For non HIPAA covered transactions this is Service/Rendering Provider Number (such as NCPDP ID, Value 7 of Service Provider ID Qualifier, 202-B2) (See Appendix B, Frequently asked Question –HIR#462.)
TS302	2000	Facility Code Value	99 = Other
TS303	2000	Date	Last day of the provider's current fiscal year (default=December 31 of current year)
TS304	2000	Quantity	Total Claim Count (total claims or CLP Loops for the Provider referenced in TS301)
TS305	2000	Monetary Amount	Total Reported Charges for All Claims (Sum of CLP03 within the Loop)

Claim Payment Information – CLP (Occurrences can exceed 10,000)

Field #	Loop ID	835 Field Name	Recommended Values
CLP01-1	2100	Claim Submitter's Identifier	Patient Control Number (NCPDP Prescription/Service Reference Number 402-D2)
CLP01-2	2100	Claim Submitter's Identifier	If new Refill # is needed per trading partner agreement (403-D3)

CLP02	2100	Claim Status Code	Any of the HIPAA Recommended Codes (See Appendix A)
CLP03	2100	Monetary Amount (Total Claim Charge Amount)	Total Submitted charges for the claim (NCPDP Gross Amount Due, 430-DU)
CLP04	2100	Monetary Amount (Claim Payment Amount)	Amount Paid for this Claim (NCPDP Total Amount Paid, 509-F9)
CLP05	2100	Monetary Amount (Patient Responsibility Amount)	Patient Responsibility Amount (NCPDP Patient Pay Amount, 505-F5)
CLP06	2100	Claim Filing Indicator Code	Any of the HIPAA Recommended Codes (See Appendix A)
CLP07	2100	Reference Identification	Payer's Internal Control Number

Claim Adjustment – CAS

Field #	Loop ID	835 Field Name	Recommended Values
CAS01	2100	Claim Adjustment Group Code	Any of the HIPAA recommended codes (See Appendix A)
CAS02*	2100	Claim Adjustment Reason Code	Use the 139 Code List. For non-specific codes, such as 15, 16, 27, 29, 39, 52, 58, 96, 119, and 125 send the LQ segment, which would contain the NCPDP Reject Adjustment code.
CAS03*	2100	Monetary Amount	Adjustment Amount
CAS04*	2100	Quantity	Units of service being adjusted
CAS05*	2100	Claim Adjustment Reason Code	(See CAS02 above)
CAS06*	2100	Monetary Amount	Adjustment Amount
CAS07*	2100	Quantity	Units of service being adjusted
CAS08*	2100	Claim Adjustment Reason Code	(See CAS02 above)
CAS09*	2100	Monetary Amount	Adjustment Amount
CAS10*	2100	Quantity	Units of service being adjusted
CAS11*	2100	Claim Adjustment Reason Code	(See CAS02 above)
CAS12*	2100	Monetary Amount	Adjustment Amount
CAS13*	2100	Quantity	Units of service being adjusted
CAS14*	2100	Claim Adjustment Reason Code	(See CAS02 above)
CAS15*	2100	Monetary Amount	Adjustment Amount
CAS16*	2100	Quantity	Units of service being adjusted
CAS17*	2100	Claim Adjustment Reason Code	(See CAS02 above)
CAS18*	2100	Monetary Amount	Adjustment Amount
CAS19*	2100	Quantity	Units of service being adjusted

* 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).

Please refer to <http://www.wpc-edi.com/products/codelists/alertservice> for the X12 139 Claim Adjustment Reason Codes.

Patient Name – NM1

Field #	Loop ID	835 Field Name	Recommended Values
NM101	2100	Entity Identifier Code	QC = Patient
NM102	2100	Entity Type Qualifier	1 = Person
NM103	2100	Name Last or Organization Name	Patient Last Name (If not available, use 'Name on file with Provider')
NM104	2100	Name First	Patient First Name (If not available, use 'Name on file with Provider')
NM108	2100	Identification Code Qualifier	MI=Member ID #
NM109	2100	Identification Code	Submitted NCPDP Cardholder ID (30202) and, if submitted, Person Code (303C3) Recommended format=Cardholder ID and Person Code separated by a hyphen.

Insured Name – NM1 (This segment is populated when the Patient is Dependent.)

Field #	Loop ID	835 Field Name	Recommended Values
NM101	2100	Entity Identifier Code	IL = Insured or Subscriber
NM102	2100	Entity Type Qualifier	1 = Person
NM103	2100	Name Last or Organization Name	Subscriber Last Name (If not available, use 'Name on file with Provider')
NM104	2100	Name First	Subscriber First Name (If not available, use 'Name on file with Provider')
NM108	2100	Identification Code Qualifier	MI=Member ID #
NM109	2100	Identification Code	Submitted NCPDP Cardholder ID (30202) and, if submitted, Person Code (303C3) Recommended format=Cardholder ID and Person Code separated by a hyphen.

Service Provider Name – NM1

Field #	Loop ID	835 Field Name	Recommended Values
NM101	2100	Entity Identifier Code	82 = Rendering Provider
NM102	2100	Entity Type Qualifier	2 = Non-Person Entity
NM103	2100	Name Last or Organization Name	Rendering Provider Name (Pharmacy Name)
NM108	2100	Identification Code Qualifier	For HIPAA covered transactions use XX National Provider Identifier (NPI) For non HIPAA covered transactions use any of the HIPAA Recommended Codes that identifies the number being sent for the Service Provider (such as MC=Medicaid Provider Number, PC=Provider Commercial Number).
NM109	2100	Identification Code	If NM108 is XX report the Service/ Rendering Provider's NPI. If NM108 is not XX report the report the referenced identification number (such as MC report the Medicaid Provider Number or PC report NCPDP Provider Number).

Service Date – DTM

Field #	Loop ID	835 Field Name	Recommended Values
DTM01	2100	Date/Time Qualifier	232 = Service
DTM02	2100	Date	Prescription Fill Date

Service Payment Information – SVC

Field #	Loop ID	835 Field Name	Recommended Values
SVC01-1	2110	Product/Service ID Qualifier	N4=NDC, HC=HCPCS Code
SVC01-2	2110	Product/Service ID	NDC (without dashes), HCPCS
SVC02	2110	Monetary Amount (Line Item Charge Amount)	Line Item Charge Amount (NCPDP Gross Amount Due, 430-DU)
SVC03	2110	Monetary Amount (Line Item Provider Payment Amount)	Line Item Provider Payment Amount (NCPDP Total Amount Paid, 509-F9)
SVC05	2110	Quantity (Units of Service Paid Count)	Paid Units of Service (NCPDP Quantity Dispensed, 442-E7)
SVC07	2110	Quantity (Original Units of Service Count)	Original submitted units of service. (Not sent if same as SVC05)

Service Date – DTM

Field #	Loop ID	835 Field Name	Recommended Values
DTM01	2110	Date/Time Qualifier	472 = Service
DTM02	2110	Date	Prescription Fill Date

Service Adjustment – CAS

Field #	Loop ID	835 Field Name	Recommended Values
CAS01	2110	Service Adjustment Group Code	Any of the HIPAA recommended codes (See Appendix A)
CAS02*	2110	Service Adjustment Reason Code	Use the 139 Code List. For non-specific codes, such as 15, 16, 27, 29, 39, 52, 58, 96, 119, and 125 send the LQ segment, which would contain the NCPDP Reject Adjustment code.
CAS03*	2110	Monetary Amount	Adjustment Amount
CAS04*	2110	Quantity	Units of service being adjusted
CAS05*	2110	Claim Adjustment Reason Code	(See CAS02 above)
CAS06*	2110	Monetary Amount	Adjustment Amount
CAS07*	2110	Quantity	Units of service being adjusted
CAS08*	2110	Claim Adjustment Reason Code	(See CAS02 above)
CAS09*	2110	Monetary Amount	Adjustment Amount
CAS10*	2110	Quantity	Units of service being adjusted
CAS11*	2110	Claim Adjustment Reason Code	(See CAS02 above)
CAS12*	2110	Monetary Amount	Adjustment Amount
CAS13*	2110	Quantity	Units of service being adjusted
CAS14*	2110	Claim Adjustment Reason Code	(See CAS02 above)
CAS15*	2110	Monetary Amount	Adjustment Amount
CAS16*	2110	Quantity	Units of service being adjusted
CAS17*	2110	Claim Adjustment Reason Code	(See CAS02 above)
CAS18*	2110	Monetary Amount	Adjustment Amount
CAS19*	2110	Quantity	Units of service being adjusted

* 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).

Please refer to <http://www.wpc-edi.com/products/codelists/alertservice> for the X12 139 Claim Adjustment Reason Codes.

Health Care Remark Codes – LQ (Maximum 5 occurrences)

Field #	Loop ID	835 Field Name	Recommended Values
LQ01	2110	Code List Qualifier Code	RX = NCPDP Reject Code
LQ02	2110	Industry Code	NCPDP Reject Code (See NCPDP Data Dictionary, September 1999, Appendix F)

Provider Adjustment – PLB

Field #	Loop ID	835 Field Name	Recommended Values
PLB01		Reference Identification	<p>When the provider is a covered entity under the National Provider Identifier (NPI) mandate, this must be the NPI assigned to the provider.</p> <p>When the provider is not covered under the mandate, this is the provider identifier as assigned by the payer.</p> <p>If the Payee reported in 1000 B is the Service/Rendering Provider, the identifier in PLB01 will be the provider identified in N104.</p> <p>If the TS301 is used and the adjustment is reported for the Service/Rendering Provider level, the identifier in PLB01 will be the provider identified in TS301.</p> <p>If the adjustment is not for the Service/Rendering Provider level, the PLB may contain an identifier assigned by the payer. (See Appendix B, Frequently asked Questions –HIR#451.)</p>
PLB02		Date	Last day of the provider's fiscal year (Default=December 31 of the current year)
PLB03-1		Adjustment Reason Code**	For Transmission fee use AH. Use of other codes is based on trading partner agreement between payer and provider. (See Appendix A)
PLB03-2		Reference Identification**	Provider Adjustment Identifier (payers internally assigned reference identifier)
PLB04		Monetary Amount**	Provider adjustment amount
PLB05-1		Adjustment Reason Code**	For Transmission fee use AH. Use of other codes is based on trading partner agreement between payer and provider. (See Appendix A)
PLB05-2		Reference Identification**	Provider Adjustment Identifier (payers internally assigned reference identifier)
PLB06		Monetary Amount**	Provider adjustment amount
PLB07-1		Adjustment Reason Code**	For Transmission fee use AH. Use of other codes is based on trading partner agreement between payer and provider. (See Appendix A).
PLB07-2		Reference Identification**	Provider Adjustment Identifier (payers internally assigned reference identifier)
PLB08		Monetary Amount**	Provider adjustment amount
PLB09-1		Adjustment Reason Code**	For Transmission fee use AH. Use of other codes is based on trading partner agreement between payer and provider. (See Appendix A)
PLB09-2		Reference Identification**	Provider Adjustment Identifier (payers internally assigned reference identifier)
PLB10		Monetary Amount**	Provider adjustment amount
PLB11-1		Adjustment Reason Code**	For Transmission fee use AH. Use of other codes is based on trading partner agreement between payer and provider. (See Appendix A)
PLB11-2		Reference Identification**	Provider Adjustment Identifier (payers internally assigned reference identifier)
PLB12		Monetary Amount**	Provider adjustment amount

PLB13-1		Adjustment Reason Code**	For Transmission fee use AH. Use of other codes is based on trading partner agreement between payer and provider. (See Appendix A).
PLB13-2		Reference Identification**	Provider Adjustment Identifier (payers internally assigned reference identifier)
PLB14		Monetary Amount**	Provider adjustment amount

** A single PLB segment may contain up to six repetitions of the "adjustment group" composed of Adjustment Reason Code, Reference Identification and Monetary Amount.

Transaction Set Trailer – SE

Field #	Loop ID	835 Field Name	Recommended Values
SE01		Number of Included Segments	Refer to X12 835 4010X091A1 Implementation guide for field use and values
SE02		Transaction Set Control Number	Same as ST02

END OF 835 TRANSACTION SET

Functional Group Trailer - GE

Field #	Loop ID	835 Field Name	Recommended Values
GE01		Number of Transaction Sets Included	Refer to X12 835 4010X091A1 Implementation guide for field use and values
GE02		Group Control Number	Same as GS06

Interchange Control Trailer -IEA

Field #	Loop ID	835 Field Name	Recommended Values
IEA01		Number of Included Functional Groups	Refer to X12 835 4010X091A1 Implementation guide for field use and values
IEA02		Interchange Control Number	Same as ISA13

Appendix A -- List of HIPAA Recommended Codes

Segment/Element	Recommended Codes
REF01 (Payee – Reference Identification Qualifier)	0B = State License Number TJ=Tax ID D3 = NCPDP Number PQ = Payee Identification
CLP02 (Claim Status Code)	1 = Processed as Primary 2 = Processed as Secondary 3 = Processed as Tertiary 4 = Denied 19 = Processed as Primary, Forwarded to Additional Payers 20 = Processed as Secondary, Forwarded to Additional Payers 21 = Processed as Tertiary, Forwarded to Additional Payers 22 = Reversal of Previous Payment 23 = Not our Claim, Forwarded to Additional Payers 25 = Predetermination Pricing Only – No Payment
CLP06 (Claim Filing Indicator Code)	12 = Preferred Provider Organization (PPO) 13 = Point of Service 14 = Exclusive Provider Organization (EPO) 15 = Indemnity Insurance 16 = Health Maintenance Organization (HMO) Medicare Risk AM = Automobile Medical CH = Champus DS = Disability HM = Health Maintenance Organization (HMO) LM = Liability Medical MA = Medicare Part A MB = Medicare Part B MC = Medicaid OF = Medicare Part D TV = Title V VA = Veteran Administration Plan WC = Workers' Compensation Health Claim
Segment/Element	Recommended Codes
CAS01 (Claim Adjustment Group Code)	CO = Contractual Obligations CR = Correction and Reversals OA = Other Adjustments PI = Payer initiated Reductions PR = Patient Responsibility

<p>PLB03-1, PLB05-1, PLB07-1, PLB09-1, PLB11-1, PLB131 (Adjustment Reason Code)</p>	<p>50 = Late Charge 51 = Interest Penalty Charge 72 = Authorized Return 90 = Early Payment Allowance AH = Origination Fee (Transmission Fee) AM = Applied to Borrower's Account AP = Acceleration of Benefits B2 = Rebate BD = Bad Debt Adjustment BN = Bonus C5 = Temporary Allowance CR = Capitalization Interest CS = Adjustment CT = Capitation Payment CV = Capital Passthu CW = Certified Registered Nurse Anesthetist Passthu DM = Direct Medical Education Passthu E3 = Withholding FB = Forwarding Balance FC = Fund Allocation GO = Graduate Medical Education Passthu IP = Incentive Premium Payment IR = Internal Revenue Service Withholding IS = Interim Settlement J1 = Nonreimbursable L3 = Penalty L6 = Interest Owed LE = evy LS = Lump Sum OA = Organ Acquisition Passthu PI = Periodic Interim Payment PL = Payment Final RA = Retro-Activity Adjustment RE = Return on Equity SL = Student Loan Repayment TL = Third Party Liability WO = Overpayment Recovery WU = Unspecified Recovery</p>
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CAS Segment Codes:

Claim Adjustment Group Codes and Claim Adjustment Reason Codes

<http://www.wpc-edi.com/products/codelists/alertservice> or

<http://www.wpc-edi.com> then select HIPAA Code Lists.

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

CMS Responses and Recommendations

<http://questions.cms.hhs.gov>

CMS#8449

Can payment for multiple pharmacies be consolidated and sent to a non covered entity?

Can the X12 835 payment and/or remittance for multiple pharmacies (If the National Provider Identifier (NPI) is different for the pharmacies) be consolidated if the corporate organization (payee) is not a covered entity?

Response:

Payment and remittances for multiple pharmacies, with different NPIs, may be consolidated and sent to non-covered entities other than the pharmacy if these two conditions are met: First the non-covered entity must have a different Tax ID than all of the associated pharmacies and second there must be an agreement with the payer for a bulk remittance. Examples of such organizations or non-covered entities that may receive consolidated payments on behalf of pharmacies include but are not limited to banks, administrative services organizations, third party billing agents or consolidators, co-ops, etc. These entities are not health care providers as defined in the NPI final

CMS#8450

Can payment for multiple pharmacies be consolidated and sent to a covered entity?

If several pharmacies, each with their own National Provider Identifier (NPI), are owned by the same covered organization health care provider (payee), may the X12 835 payment and remittance advice for these pharmacies be consolidated and sent to the covered organization health care provider (i.e., the “parent”)?”

Response:

Payment and remittances for multiple pharmacies, each with their own NPIs, may be consolidated when the receiving entity (payee) shares the same Taxpayer Identification Number (TIN) as those pharmacies. The pharmacies are subparts of the payee. In order for the payment and remittance to be consolidated, the payee identification at the Header Level must be the NPI of the entity designated to receive the payment. It is important to note that while the consolidation of remittances is technically feasible, this fact does not obligate a payer to execute such consolidation – this is a business decision and contract issue to be negotiated between trading partners.

X12 Responses and Recommendations

<http://www.x12n.org/portal>

HIR #451

11/10/2006

NPI in the 835 PLB01?

Would the NPI be appropriately placed in the PLB01? The note states "Use this number for the provider identifier as assigned by the payer".

Response:

This issue is not explicitly addressed in guide 004010X091. While the guide states to use the provider identifier as assigned by the payer if they are a covered entity, the NPI final rule supersedes the IG notes. Under that rule, the only provider IDs that can be used in Standard Transactions are the NPI and the Federal Tax ID, with extreme limitations on the use of the tax ID. As a result, the NPI is appropriate content for PLB01.

HIR#462

11/22/06

TS3 and NPI

If I roll claim payments to a Corporate Entity and use the TS3 segment to sort by Billing Provider, must the TS3 Provider ID be an NPI? If it must be an NPI, must it be the same Billing Provider as submitted on the claim?

Response:

Although there is no explicit requirement to return the same NPI that was submitted on the claim, the intent and expectation was an identifier should flow through the life cycle of the claim.

Recommendation

Based upon the workgroup's understanding of the rule and business:

When the Payee NPI is other than the submitted Billing Provider, the TS3 segment is used to group like Billing Provider NPIs within the ERA. An NPI under which multiple Billing Provider NPI are bulked must be the Payee NPI MUTUALLY agreed upon between the provider and the payer. When there is such an agreement, the information transmitted in the TS3 segment will be the Billing Provider NPI values received on the claim. TS3 is not required to be used if there is no such agreement.

Please see responses to HIR 400, 451, 461 for additional information related the 835 and NPI.

Revision History

Original document:

Updated March 19, 2006:

Update November 2007:

The document was updated to add specific instructions for reporting the National Provider Identifier (NPI) in the Payee N1, Provider NM1, TS3 and PLB Segments of the 835.

Other changes made to correct errata in the March 2006 document:

- Page 2, Loop2100 - correct AS to CAS, Position Number 090 to 030 and move to the correct order in the diagram
- Page 3, Item 2, line 1 – correct 'Line Item' to 'Total Claim'
- Page 8, Payee Additional Information, REF02, Recommended Value second conditional statement – change the XX to TJ
- Pages 8 and 9, Move the diagram for the Claim Adjustment, CAS, Segment to the position after Claim Payment Information Segment.

Appendix B was added to provide related X12 and CMS guidance.