

**835 Health Care Claim Payment
and Remittance Advice
Companion Guide
004010 X091A1**

Version 1.4

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Document Change Log

Version	Changed Date	Changed By	Reason
1.4	7/21/08	EDS (Nicole Roden)	Corrected EDS website address to http://mymedicaid-florida.com . Changed EDI telephone number to 1-866-586-0961.

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1 INTRODUCTION

The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicaid and all other health insurance payers in the United States comply with the EDI standards for health care as established by the Secretary of Health Services. The ANSI X12N implementation guides have been established as the standards of compliance for claim transactions.

The following information is intended to serve only as a companion guide to the HIPAA ANSI X12N implementation guides. The use of this guide is solely for the purpose of clarification. The information describes specific requirements to be used for processing data. This companion guide supplements, but does not contradict any requirements in the X12N implementation guide. Additional companion guides/trading partner agreements will be developed for use with other HIPAA standards, as they become available.

Additional information on the *Final Rule for Standards for Electronic Transactions* can be found at <http://aspe.hhs.gov/admnsimp/final/txfin00.htm>. The HIPAA Implementation Guides can be accessed at http://www.wpc-edi.com/hipaa/HIPAA_40.asp.

1.1 Purpose

According to HIPAA regulations, the 835 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.

It is mandatory under HIPAA that the Agency for Health Care Administration (AHCA) be able to generate this transaction set to report on Payment and Remittance Information.

1.2 Special Considerations for 835 Transactions

1. **Subscriber, Insured = Recipient in the Florida Medicaid Eligibility Verification System:**

The Florida Medicaid Eligibility Verification System does not allow for dependents to be enrolled under a primary subscriber, rather all enrollees/recipients are primary subscribers within each program or MCO (Managed Care Organization).

2. **Provider Identification = Agency for Health Care Administration Medicaid ID or NPI:**

Value contained within the 1000B (Payee Identification) Loop sent on the 835, will contain either the NPI or Provider Tax ID. The Florida Medicaid Provider Number may be returned in the 1000B-REF02, where REF01=1D.

2 TRANSMISSION AND DATA RETRIEVAL METHODS

EDS supports several types of data transport depending upon the trading partner's need. Providers and their representatives can submit and receive data via: Web portal, Remote Access Server (RAS), and Value Added Network (VAN)/Switch Vendors for interactive transactions.

1. Web portal: Transaction files are uploaded/downloaded in the Trade Files menu on the secure Web portal.
2. Remote Access Server (RAS): This option is available to trading partners who do not have an existing Internet connection. The RAS server typically supports those who need a dial-up option. Once the RAS connection is established, transaction files are uploaded/ downloaded in the Trade Files menu on the secure Web portal.
3. Value Added Networks (VANs) or Switch Vendors: VANs or Switch Vendors typically support interactive transactions through a dedicated connection to the fiscal agent. VANs sign a contract with the State and have unique, VAN specific communication arrangements with the fiscal agent. A list of approved vendors is listed on the fiscal agent Web site.

Detailed information to assist with EDI related processes are available on the Provider Public Web site at: <http://mymedicaid-florida.com>.

Information available includes:

1. Remote Access Server connectivity instructions for submitters without an existing Internet connection.
2. Trading Partner Testing Procedures for all new trading partners, or trading partners adding a new transaction.
3. Web Upload/Download instructions for submitters uploading/downloading via the secure Web portal.

2.1 File/System Specifications

EDI will only accept Windows\PC\DOS formatted files.

EDI will allow upload and download of zipped or compressed files.

Note: Only one X12 transaction file is permitted in each “zipped” file.

EDI does not require any specific file extensions. This includes acceptance of files without an extension.

The Web portal is designed to support the following Internet browsers:

1. Internet Explorer, version 6 or later;
2. Firefox, version 1.5 or later; and
3. Opera, version 8.5 or later.

3 TRANSMISSION RESPONSES

For every transaction received, there is an expected response. The available responses are an Interchange Acknowledgement (TA1), a Functional Acknowledgement (997), and an Unsolicited Claim Status (277U).

Once a transaction is received, it will go through a ‘front end’ compliance check called a TA1. The TA1 Acknowledgement is a means of replying to an interchange or transmission that has

been sent. The TA1 verifies the envelopes only. The TA1 is a single segment and is unique in the sense that this single segment is transmitted without the GS/GE envelope structure. The TA1 segment provides the capability for the receiving trading partner to notify the sending trading partner of problems that were encountered in the interchange control structure.

Once the transaction has passed the ‘front end’ compliance check it then goes through a syntax compliance edit. This edit is to verify the compliance within the ANSI X12 syntax according to the HIPAA Implementation Guides. The transaction will receive a Functional Acknowledgement (997) to provide feedback on the transaction. The 997 functional acknowledgement contains accepted or rejected information. If the transaction contains any syntactical errors, the segments and elements in which the error occurred will be reported in a rejected acknowledgement. If the transaction contains no syntactical errors, a positive 997 response will be generated and the transaction is passed on for processing.

4 EDI SUPPORT

The EDS EDI Unit is available to support trading partners and providers that exchange transactions electronically. Support functions include:

1. Enrollment processing for trading partners requesting to submit transactions electronically;
2. Installation assistance and submission support for Provider Electronic Solutions (PES) software;
3. Provide assistance to billing agents, clearinghouses and software vendors;
4. Identifying and troubleshooting technical issues; and
5. Data Exchange help.

EDI staff is available Monday through Friday 8:00 a.m. to 5:00 p.m. EST by dialing 1-866-586-0961.

5 CONTROL SEGMENT DEFINITIONS FOR FLORIDA MEDICAID 835 TRANSACTION

Note the page numbers listed below in each of the tables represent the corresponding page number in the X12N 835 HIPAA Implementation Guide.

X12N EDI Control Segments
ISA – Interchange Control Header Segment
IEA – Interchange Control Trailer Segment
GS – Functional Group Header Segment
GE – Functional Group Trailer Segment
ST – Transaction Set Header
SE – Transaction Set Trailer

TA1 – Interchange Acknowledgement

5.1 ISA - Interchange Control Header Segment

Communications transport protocol interchange control header segment. This segment within the X12N implementation guide identifies the start of an interchange of zero or more functional groups and interchange-related control segments. This segment may be thought of traditionally as the file header record.

835 Health Care Claim Payment and Remittance Advice				
Page	Loop	Segment	Data Element	Comments
B.3	N/A	ISA	ISA01 - Authorization Information Qualifier	'00' – No Authorization Information Present
B.3	N/A	ISA	ISA02 - Authorization Information	[space fill]
B.4	N/A	ISA	ISA03 - Security Information Qualifier	'00' – No Security Information Present
B.4	N/A	ISA	ISA04 - Security Information	[space fill]
B.4	N/A	ISA	ISA05 - Interchange ID Qualifier	'ZZ' – Mutually Defined
B.4	N/A	ISA	ISA06 - Interchange Sender ID	'77027' left justified and space filled. Florida Medicaid Sender ID
B.4	N/A	ISA	ISA07 - Interchange ID Qualifier	'ZZ' – Mutually Defined
B.5	N/A	ISA	ISA08 - Interchange Receiver ID	Trading Partner ID Supplied by Florida Medicaid
B.5	N/A	ISA	ISA09 - Interchange Date	The date format is YYMMDD
B.5	N/A	ISA	ISA10 - Interchange Time	The time format is HHMM
B.5	N/A	ISA	ISA11 - Interchange Control Standards Identifier	'U' – Interchange Control Standards Identifier

835 Health Care Claim Payment and Remittance Advice				
Page	Loop	Segment	Data Element	Comments
B.5	N/A	ISA	ISA12 - Interchange Control Version Number	'00401' – Control Version Number
B.5	N/A	ISA	ISA13 - Interchange Control Number	Interchange Unique Control Number
B.6	N/A	ISA	ISA14 - Acknowledgment Requested	'1' – Acknowledgement Requested
B.6	N/A	ISA	ISA15 - Usage Indicator	'T' - Test Data 'P' - Production Data
B.6	N/A	ISA	ISA16 - Component Element Separator	':' – Component Element Separator

5.2 IEA - Interchange Control Trailer

Communications transport protocol interchange control trailer segment. This segment within the X12N implementation guide defines the end of an interchange of zero or more functional groups and interchange-related control segments. This segment may be thought of traditionally as the file trailer record.

835 Health Care Claim Payment and Remittance Advice				
Page	Loop	Segment	Data Element	Comments
B.7	N/A	IEA	IEA01 - Number of Included Functional Groups	Number of included Functional Groups
B.7	N/A	IEA	IEA02 - Interchange Control Number	Must be identical to the value in ISA13.

5.3 GS – Functional Group Header

Communications transport protocol functional group header segment. This segment within the X12N implementation guide indicates the beginning of a functional group and provides control information concerning the batch of transactions. This segment may be thought of traditionally as the batch header record.

835 Health Care Claim Payment and Remittance Advice				
Page	Loop	Segment	Data Element	Comments
B.8	N/A	GS	GS01 - Functional ID Code	'HP' – Health Care Claim Payment/Advice (835)
B.8	N/A	GS	GS02 - Application Sender's Code	This will be equal to the value in ISA06.
B.8	N/A	GS	GS03 - Application Receiver's Code	This will be equal to the value in ISA08.
B.8	N/A	GS	GS04 - Date	The date format is CCYYMMDD.
B.8	N/A	GS	GS05 – Time	The time format is HHMM.
B.9	N/A	GS	GS06 - Group Control Number	Group Control Number
B.9	N/A	GS	GS07 - Responsible Agency Code	'X' – Responsible Agency Code
B.9	N/A	GS	GS08 - Version/ Release/ Industry ID Code	'004010X091A1' – Version/ Release/ Industry Identifier Code

5.4 GE – Functional Group Trailer

Communications transport protocol functional group trailer segment. This segment within the X12N implementation guide indicates the end of a functional group and provides control information concerning the batch of transactions. This segment may be thought of traditionally as the batch trailer record.

835 Health Care Claim Payment and Remittance Advice				
Page	Loop	Segment	Data Element	Comments
B.10	N/A	GE	GE01 – Number of Transaction Sets Included	Number of included Transaction Sets
B.10	N/A	GE	GE02 – Group Control Number	Must be identical to the value in GS06

5.5 ST – Transaction Set Header

Communications transport protocol transaction set header segment. This segment within the X12N implementation guide indicates the start of the transaction set and assigns a control number to the transaction. This segment may be thought of traditionally as the claim header record.

835 Health Care Claim Payment and Remittance Advice				
Page	Loop	Segment	Data Element	Comments
43	N/A	ST	ST01 – Transaction Set Identifier Code	'835' – Health Care Claim Payment/Advice
43	N/A	ST	ST02 – Transaction Set Control Number	Transaction Control Number

5.6 SE – Transaction Set Trailer

Communications transport protocol transaction set trailer. This segment within the X12N implementation guide indicates the end of the transaction set and provides the count of transmitted segments (including the beginning (ST) and ending (SE) segments). This segment may be thought of traditionally as the claim trailer record.

835 Health Care Claim Payment and Remittance Advice				
Page	Loop	Segment	Data Element	Comments
173	N/A	SE	SE01 – Number of Included Segments	Total number of segments included in Transaction Set including ST and SE.
173	N/A	SE	SE02 – Transaction Set Control Number	Must be identical to the value in ST02.

5.7 Valid Delimiters

The delimiters documented below will be used for Florida Medicaid, unless otherwise requested by a trading partner.

Definition	ASCII	Decimal	Hexadecimal
Segment Separator	~	126	7E
Element Separator	*	42	2A
Compound Element Separator	:	58	3A

6 COMPANION GUIDE FOR THE 835 TRANSACTION

835 Health Care Claim Payment and Remittance Advice				
Page	Loop	Segment	Data Element	Comments
45-46	N/A	BPR	BPR01 - Transaction Handling Code	'I' – Remittance Information Only 'H' – Notification Only
46	N/A	BPR	BPR02 - Monetary Amount (Total Actual Provider Payment Amount)	Check Amount - Total payment amount for paid and denied claims will always contain the correct total payment amount for the week.
46	N/A	BPR	BPR03 - Credit/Debit Flag	'C' - Credit
46-47	N/A	BPR	BPR04 - Payment Method Code	'ACH' – Automated Clearing House 'CHK' – Check 'NON' – Non-Payment Data
50	N/A	BPR	BPR16 - Date (Check Issue or EFT Effective Date)	Cycle Date
52	N/A	TRN	TRN01 - Trace Type Code	'1' – Current Transaction Trace No.
53	N/A	TRN	TRN02 - Reference Identification (Check or EFT Trace Number)	Check Number OR Internal Trace Number (The RA number will be moved to the payment number when the paid amount is zero.)
53	N/A	TRN	TRN03 - Originating Company Identifier (Payer Identifier)	'593452939' - Florida Medicaid Tax ID
57	N/A	REF	REF01 - Reference Identification Qualifier	'EV' – Receiver Identification Number
57	N/A	REF	REF02 - Reference Identification	Florida Medicaid Receiver ID (if different than Florida Medicaid Provider ID)
61	N/A	DTM	DTM02 - Date (Production Date)	Cycle Date

835 Health Care Claim Payment and Remittance Advice				
Page	Loop	Segment	Data Element	Comments
63	1000A	N1	N102 - Name (Payer Name)	'STATE OF FLORIDA MEDICAID'
64	1000A	N3	N301 - Address Information	'SUITE 100'
65	1000A	N4	N401 - City Name	'TALLAHASSEE'
65	1000A	N4	N402 - State or Province Code	'FL'
65	1000A	N4	N403 - Postal Code	'323093574'
73	1000B	N1	N103 - Identification Code Qualifier	'FI' – Federal Taxpayer's Identification Number 'XX' – Health Care Financing Administration National Provider Identifier
73	1000B	N1	N104 - Identification Code	If NM108='FI' - Federal Tax ID If NM108='XX' - NPI
77-78	1000B	REF	REF01 - Reference Identification Qualifier	'1D' – Medicaid Provider Number 'TJ' – Federal Tax ID
78	1000B	REF	REF02 - Reference Identification (Additional Payee Identifier)	If REF01='1D' – Florida Medicaid Provider Number If REF01='TJ' – Provider Tax ID
89	2100	CLP	CLP01 - Claim Submitter's Identifier (Patient Control Number)	Patient Account Number
90	2100	CLP	CLP02 - Claim Status Code	'1' – Processed as Primary (Regular Medicaid Claims) '2' – Processed as Secondary (Medicare Crossover Claims) '4' – All Denied (Regular & Crossover)
92	2100	CLP	CLP06 - Claim Filing	'MC' - Medicaid

835 Health Care Claim Payment and Remittance Advice				
Page	Loop	Segment	Data Element	Comments
			Indicator Code	
93	2100	CLP	CLP11 - Diagnosis Related Group (DRG) Code	Institutional claims only
93	2100	CLP	CLP12 - Quantity (Diagnosis Related Group (DRG) Weight)	The diagnosis-related group (DRG) weight – Institutional claims only
97-100	2100	CAS	CAS02, CAS05, CAS08, CAS11, CAS14, CAS17 - Claim Adjustment Reason Code	Adjustment Code can be found on http://www.wpc-edi.com
97-100	2100	CAS	CAS03, CAS06, CAS09, CAS12, CAS15, CAS18 - Monetary Amount (Adjustment Amount)	Displays the Adjustment (cutback) Amount. The X12N 835 will contain information regarding the difference between the submitted charge, (Loop 2100 Segment CLP03) and the approved payment amount, (Loop 2100 Segment (CLP04). For example: If a provider bills \$750.00 for a procedure that allows a maximum of \$500.00, \$250.00 will be reported as a cutback amount.
102	2100	NM1	NM101 - Entity Identifier Code	'QC' - Patient
103	2100	NM1	NM103 - Name Last or Organization Name	Recipient last name as stored on Florida Medicaid file. If recipient not found on file, the value will be the recipient last name submitted on claim.
103	2100	NM1	NM104 - Name First	Recipient first name as stored on Florida Medicaid file. If recipient not found on file, the value will be the recipient first name submitted on claim.
103	2100	NM1	NM108 - Identification	'MR' – Medicaid Recipient

835 Health Care Claim Payment and Remittance Advice				
Page	Loop	Segment	Data Element	Comments
			Code Qualifier	Identification Number
104	2100	NM1	NM109 - Identification Code	Florida Recipient 10-digit Medicaid ID
112	2100	NM1	NM101 - Entity Identifier Code	'82' – Rendering Provider
113	2100	NM1	NM108 - Identification Code Qualifier	'MC' – Medicaid Provider Number 'XX' – Health Care Financing Administration National Provider Identifier
113	2100	NM1	NM109 - Identification Code (Rendering Provider Identifier)	If NM108='MC' - Florida Medicaid Provider Number If NM108='XX' - NPI
116	2100	NM1	NM101 - Entity Identifier Code	'PR' – Payer
117	2100	NM1	NM108 - Identification Code Qualifier	'PI' – Payer Identification
117	2100	NM1	NM109 - Identification Code (Corrected Priority Payer Identification Number)	TPL Carrier Code
119	2100	MIA	MIA01 - Quantity (Covered Days or Visits Count)	Default to '0' – Institutional only
120	2100	MIA	MIA04 - Monetary Amount (Claim DRG Amount)	Use this monetary amount for the DRG dollar amount. – Institutional only
120	2100	MIA	MIA05 - Reference Identification (Remark Code)	HIPAA Remark Code for Inpatient and Institutional Regular and Crossover claims. Remark Codes can be found on http://www.wpc-edi.com
122	2100	MIA	MIA20 - Reference Identification (Remark Code)	HIPAA Remark Code for Inpatient and Institutional Regular and Crossover claims

835 Health Care Claim Payment and Remittance Advice				
Page	Loop	Segment	Data Element	Comments
				(2)
124	2100	MOA	MOA03 - Reference Identification (Remark Code)	HIPAA Remark Code for Outpatient/Professional Crossover claims. Remark Codes can be found on http://www.wpc-edi.com
124	2100	MOA	MOA04 - Reference Identification (Remark Code)	HIPAA Remark Code for Outpatient/Professional Crossover claims (2)
126-127	2100	REF	REF01 - Reference Identification Code	'EA' – Medical Record ID Number
127	2100	REF	REF02 - Reference Identification (Other Claim Related Identifier)	Medical Record ID Number as submitted on claim.
126-127	2100	REF	REF01 - Reference Identification Code	'SY' –SSN
127	2100	REF	REF02 - Reference Identification (Other Claim Related Identifier)	Recipient SSN
126-127	2100	REF	REF01 - Reference Identification Code	'9C' – Adjusted Repriced Claim Reference
127	2100	REF	REF02 - Reference Identification (Other Claim Related Identifier)	Adjusted ICN
126-127	2100	REF	REF01 - Reference Identification Code	'F8' – Original Reference Number
127	2100	REF	REF02 - Reference Identification (Other Claim Related Identifier)	Duplicate ICN
131	2100	DTM	DTM01 - Date/Time Qualifier	'232' – Claim Statement Period Start '233' – Claim Statement Period End
131	2100	DTM	DTM02 - Claim Date	If DTM01='232' value will contain Start Date. If DTM01='233' value will

835 Health Care Claim Payment and Remittance Advice				
Page	Loop	Segment	Data Element	Comments
				contain End Date If Invalid date received on original claim, value will contain default date of 19000101.
137	2100	QTY	QTY01 – Quantity Qualifier	‘CA’ – Covered (Actual)
138	2100	QTY	QTY02 – Quantity	Covered Days Institutional only
140-141	2110	SVC	SVC01-1 - Product/Service ID Qualifier	‘AD’ – American Dental Association Codes ‘HC’ – Health Care Financing Administration Common Procedural Coding System ‘N4’ – National Drug Code (NDC) ‘NU’ – National Uniform Billing Committee (NUBC) UB92
141	2110	SVC	SVC01-3 to SVC01-6	Up to four (4) Procedure Code Modifiers per Detail.
143	2110	SVC	SVC06-1 - Product/Service ID Qualifier	Used if adjudicated procedure code provided in SVC01 is different from the submitted procedure code in the original claim. ‘AD’ – American Dental Association Codes ‘HC’ – Health Care Financing Administration Common Procedural Coding System ‘N4’ – National Drug Code (NDC) ‘NU’ – National Uniform Billing Committee (NUBC)

835 Health Care Claim Payment and Remittance Advice				
Page	Loop	Segment	Data Element	Comments
				UB92
144	2110	SVC	SVC06-2 - Product/Service ID (Procedure Code)	Reports original code billed on claim.
144	2110	SVC	SVC06-3 to SVC06-6	Up to four (4) Procedure Code Modifiers per Detail.
145	2110	SVC	SVC07 - Quantity (Original Units of Service Count)	Units of Service are reported here if different than the original billed units.
150-153	2110	CAS	CAS02, CAS05, CAS08, CAS11, CAS14, CAS17 - Claim Adjustment Reason Code	Adjustment Code can be found on http://www.wpc-edi.com
150-153	2110	CAS	CAS03, CAS06, CAS09, CAS12, CAS15, CAS18 - Monetary Amount (Adjustment Amount)	Difference between the line billed charge and line Medicaid paid amount
154	2110	REF	REF01 - Reference Identification Qualifier	'6R' – Provider Control Number
155	2110	REF	REF02 - Reference Identification	Original Line Item Control Number from 837-claim line
156-157	2110	REF	REF01 - Reference Identification Qualifier	'1D' – Medicaid Provider Number 'HPI' - NPI
155	2110	REF	REF02 - Reference Identification	If REF01='1D' – Florida Medicaid Provider Number If REF01='HPI' – NPI
158	2110	AMT	AMT01 - Amount Qualifier Code	'B6' – Allowed Actual
162	2110	LQ	LQ01 - Code List Qualifier Code	'HE' – Claim Payment Remark Codes
163	2110	LQ	LQ02 - Industry Code (Remark Code)	Remark Codes if needed to communicate additional information about the denial or adjustment of a claim or service line that cannot be

835 Health Care Claim Payment and Remittance Advice				
Page	Loop	Segment	Data Element	Comments
				thoroughly explained by a Claim Adjustment Reason Code. Remark Codes can be found on http://www.wpc-edi.com
165	Summary	PLB	PLB01 - Reference Identification (Provider Identifier)	Florida Medicaid Provider Number or NPI
165	Summary	PLB	PLB02 - Date (Fiscal Period Date)	Accounts Receivable Financial Cost Settlement Fiscal Year End Date or Set-up date for A/R transaction. For a Negative Net Payment Amount this field contains the Remittance Date.
170 – 172	Summary	PLB	PLB04, PLB06, PLB08, PLB10, PLB12, and PLB14. Monetary Amount (Provider Adjustment Amount)	The monetary amount for the adjustment to the preceding adjustment code. Amount of increase/decrease OR amount received/recouped OR Negative Net Payment Amount. Note: As required for HIPAA compliance, only amounts that affect the remittance check amount will be reported in the PLB segment.