835 Health Care Claim Payment/ Advice Companion Guide

Standard Companion Guide Transaction Information

Instructions related to Transactions based on ASC X12 Implementation Guides, version 005010

Companion Guide Version Number: 1.0

March 1, 2011

Preface

Companion Guides (CG) may contain two types of data, instructions for electronic communications with the publishing entity (Communications/Connectivity Instructions) and supplemental information for creating transactions for the publishing entity while ensuring compliance with the associated ASC X12 IG (Transaction Instructions). Either the Communications/Connectivity component or the Transaction Instruction component must be included in every CG. The components may be published as separate documents or as a single document.

The Communications/Connectivity component is included in the CG when the publishing entity wants to convey the information needed to commence and maintain communication exchange.

The Transaction Instruction component is included in the CG when the publishing entity wants to clarify the IG instructions for submission of specific electronic transactions. The Transaction Instruction component content is limited by ASCX12's copyrights and Fair Use statement.

Table of Contents

Transaction Instruction (TI)

1 TI Introduction

1.1 Background

1.1.1 Overview of HIPAA Legislation

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 carries provisions for administrative simplification. This requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. HIPAA directs the Secretary to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard HIPAA serves to:

- Create better access to health insurance
- Limit fraud and abuse
- Reduce administrative costs

1.1.2 Compliance according to HIPAA

The HIPAA regulations at 45 CFR 162.915 require that covered entities not enter into a trading partner agreement that would do any of the following:

- Change the definition, data condition, or use of a data element or segment in a standard.
- Add any data elements or segments to the maximum defined data set.
- Use any code or data elements that are marked “not used” in the standard’s implementation specifications or are not in the standard’s implementation specification(s).
- Change the meaning or intent of the standard’s implementation specification(s).

1.1.3 Compliance according to ASC X12

ASC X12 requirements include specific restrictions that prohibit trading partners from:

- Modifying any defining, explanatory, or clarifying content contained in the implementation guide.
- Modifying any requirement contained in the implementation guide.

1.2 Intended Use

The Transaction Instruction component of this companion guide must be used in conjunction with an associated ASC X12 Implementation Guide. The instructions in this companion guide are not intended to be stand-alone requirements documents. This companion guide conforms to all the requirements of any associated ASC X12 Implementation Guides and is in conformance with ASC X12's Fair Use and Copyright statements.

2 Included ASC X12 Implementation Guides

This table lists the X12N Implementation Guides for which specific transaction instructions apply and which are included in Section 3 of this document.

Unique ID	Name
005010X221A1	Health Care Claim Payment/ Advice (835)

3 Instruction Tables

These tables contain one or more rows for each segment for which a supplemental instruction is needed.

Legend
SHADED rows represent “segments” in the X12N implementation guide.
NON-SHADED rows represent “data elements” in the X12N implementation guide.

3.1 835 Health Care Payment/Advice

The 835 Health Care Payment/Advice Transaction is used to provide health care providers with remittance and payment information regarding claims submitted to the Connecticut Medical Assistance Program. The 835 Health Care Claim Payment/Advice transactions will supply remittance advice information only. Pending claim information is excluded from the 835 Health Care Claim Payment/Advice transactions. The sort order for the 835 Health Care Claim Payment/Advice transactions will follow the current paper RA sort order. These transactions will only be available via a Web download to Connecticut Medical Assistance Program Trading Partners requesting electronic remittance advice information.

The following companion document provides data clarification for the 835 Health Care Payment/Advice (005010X221A1) transaction set.

Special Notes – Applicable to Entire Transaction

Subscriber, Insured, and Member = Client in Connecticut Environment

The Connecticut Medical Assistance Program does not allow for dependents to be enrolled under a primary subscriber, rather all clients are primary subscribers within each program.

Provider Identification = National Provider Identifier (NPI) or Non-medical provider identifier

The Connecticut Medical Assistance Program will use the National Provider ID or Provider Tax ID in N104 in the 1000B (Payee Identification).

Connecticut Medicaid Health Plan ID = Connecticut Federal Tax ID

The Connecticut Medical Assistance program will use the Federal Tax ID in all instances requiring a Health Plan ID. At such a time as the National Health Plan ID is approved and available, that ID will be used.

005010X221A1 835 Health Care Claim Payment/Advice

Loop ID	Reference	Name	Codes	Notes/Comments
	ST	Transaction Set Header		
	ST02	Transaction Set Control Number		Connecticut's remittance advice number.
	BPR	Financial Information		
	BPR01	Transaction Handling Code		Always "I" = Remittance Information Only
	BPR03	Credit/Debit Flag Code		Always "C" = Credit
	BPR04	Payment Method Code		"ACH" = Automated Clearing House (ACH) "CHK" = Check "NON" = No Payment (applicable for State Transfers of funds between State Agencies)
	BPR07	(DFI) Identification Number		When BPR06 = "01" value in BPR07 is ABA Routing Number "011900571"
	TRN	Reassociation Trace Number		
	TRN02	Reference Identification		Check Number or EFT Trace Number When BPR04 = ACH, the Trace Number will begin with 01190057 plus the payee routing number and a unique trace number for the transaction.
	TRN03	Originating Company Identifier		Connecticut's Federal Tax ID preceded by "1" = "061274678"
1000A	N1	Payer Identification		
1000A	N102	Name		"CT DSS MMIS CONTRACT ADMINISTRATOR" All caps
1000A	PER	Payer Business Contact Information		
1000A	PER01	PAYER CONTACT INFORMATION	CX	"HP PROVIDER ASSISTANCE CENTER"
1000A	PER02	Name		"HP PROVIDER ASSISTANCE CENTER"
1000A	PER03	Communication Number Qualifier	TE	Always "TE" = Telephone
1000A	PER04	Communication Number		Connecticut Provider Assistance Center phone number for issues related to the Remittance/Payment Advice. (8008428440)
1000A	PER	PAYER BUSINESS CONTACT		

Loop ID	Reference	Name	Codes	Notes/Comments
		INFORMATION (Payer Technical Contact Information)		
1000A	PER01	Payer Technical Contact Information)	BL	Connecticut EDI Help Desk phone number for file and technical issues related to the 835
	PER02	Name		EDI HELP DESK
	PER03	Communication Number Qualifier	TE	Always "TE" = Telephone
	PER04	Communication Number		8006880503
1000B	N1	Payee Identification		
1000B	N103	Identification Code Qualifier		"FI" – Federal Taxpayer's Identification Number "XX" - Centers for Medicare & Medicaid Services (CMS) National Provider Identifier.
1000B	N104	Identification Code		Value based on qualifier from N103.
1000B	REF	Payee Additional Identification		
1000B	REF01	Reference Identification Qualifier		"PQ" – Payee Identification
1000B	REF02	Reference Identification		The taxonomy code (10 digits) followed by a comma (,) followed by zip code of 5 or 9 digits. Total field length of 20.
1000B	REF01	Reference Identification Qualifier		"TJ" – Federal Taxpayer's Identification Number is populated in this 2nd REF segment, when a qualifier of XX is present in N103 and the NPI in N104, if supplied on the incoming 837 transaction.
1000B	REF02	Reference Identification		Federal Taxpayer's Identification Number is populated in this 2nd REF segment, when a qualifier of XX is present in N103 and the NPI is in N104, if supplied on the incoming 837 transaction.
2100	CLP	Claim Payment Information		
2100	CLP05	Monetary Amount		Patient Liability Amount on Nursing Home claims or Patient Responsibility Amount for Cost Share.
2100	CLP06	Claim Filing Indicator		"MC"=Medicaid

Loop ID	Reference	Name	Codes	Notes/Comments
		Code		
2100	CLP07	Reference Identification		Will contain the 13-character ICN (Internal Control Number) of Claim – Important for all inquiries on claim status and adjustments to original claims
2100	NM1	Patient Name		
2100	NM108	Identification Code Qualifier		Assigned Client ID; will be left justified
2100	NM109	Identification Code		"MC" – Non-medical Provider Identifier "XX" - Centers for Medicare & Medicaid Services (CMS) National Provider Identifier
2100	NM1	Service Provider Name		
2100	NM108	Identification Code Qualifier		"MC" – Non-medical Provider Identifier "XX" - Centers for Medicare & Medicaid Services (CMS) National Provider Identifier
2100	NM109	Identification Code		Value based on qualifier from NM108.
2100	REF	Other Claim Related Identification		
2100	REF01	Reference Identification Qualifier		"EA" – Medical Record Identification Number or "SY" = Social Security Number (Only provided if submitted on original claim) Format not to include "-" characters. (e.g. 000000000 not 000-00-0000).
2100	REF02	Reference Identification		Medical Record Identification Number or Social Security Number as indicated from REF01 qualifier. (Only provided if submitted on original claim)

4 TI Additional Information

Generic information will be provided later.

5 TI Change Summary

Not applicable; V1.0