**CMS**

# Standard Companion Guide Transaction Information

**Instructions related to the 835 Health Care Claim Payment/Advice based on ASC X12 Technical Report Type 3 (TR3), version 005010A1**

## Companion Guide Version Number: 3.0 July 25, 2012

**Preface**

Companion Guides (CGs) 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 in conformance with ASC X12’s Fair Use and Copyright statements.

# Table of Contents

[Transaction Instruction (TI) 4](#_bookmark0)

1. [TI Introduction 4](#_bookmark1)
   1. [Background 4](#_bookmark2)
      1. [Overview of HIPAA Legislation 4](#_bookmark3)
      2. [Compliance according to HIPAA 4](#_bookmark4)
      3. [Compliance according to ASC X12 4](#_bookmark5)
   2. [Intended Use 4](#_bookmark6)
2. [Included ASC X12 Implementation Guides 5](#_bookmark7)
3. [Instruction Table 5](#_bookmark8)

[005010X221A1 Health Care Claim Payment/Advice 6](#_bookmark9)

1. [TI Additional Information 10](#_bookmark10)
   1. [Other Resources 10](#_bookmark11)

**Transaction Instruction (TI)**

# TI Introduction

## Background

### 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

### 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).

### 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.

### 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.

# Included ASC X12 Implementation Guides

This table lists the X12N Implementation Guide 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) |

# Instruction Table

This table contains rows for where supplemental instruction information is located. The order of table content follows the order of the implementation transaction set as presented in the corresponding implementation guide.

**Category 1**. Situational Rules that explicitly depend upon and reference knowledge of the transaction receiver's policies or processes.

**Category 2**. Technical characteristics or attributes of data elements that have been assigned by the payer or other receiving entity, including size, and character sets applicable, that a sender must be aware of for preparing a transmission.

**Category 3**. Situational segments and elements that are allowed by the implementation guide but do not impact the receiver’s processing. (applies to inbound transactions)

**Category 4**. Optional business functions supported by an implementation guide that an entity doesn't support.

**Category 5**. To indicate if there needs to be an agreement between PAYER and the transaction sender to send a specific type of transaction (claim/encounter or specific kind of benefit data) where a specific mandate doesn’t already exist.

**Category 6**. To indicate a specific value needed for processing, such that processing may fail without that value, where there are options in the TR3.

**Category 7**. TR3 specification constraints that apply differently between batch and real- time implementations, and are not explicitly set in the guide.

**Category 8**. To identify data values sent by a sender to the receiver.

**Category 9**. To identify processing schedules or constraints that are important to trading partner expectations.

**Category 10**. To identify situational data values or elements that are never sent.

## 005010X221A1 Health Care Claim Payment/Advice

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Loop** | **Reference** | **Name** | **Codes** | **Notes/Comments** | **Category** | **LOB A** | **LOB B** | **LOB DME** |
|  | BPR03 | Credit or Debit Flag Code | C | Code D does not apply to Medicare. | 8 | X | X | X |
|  | BPR04 | Payment Method Code | ACH/CHK/ NON | Codes BOP and FWT do not apply to Medicare | 4 | X | X | X |
|  | BPR06 | Depository Financial Institution (DFI) Identification Number Qualifier | 01 | Code 04 does not apply to Medicare. | 8 | X | X | X |
|  | BPR11 | Originating Company Supplemental Code |  | Reported by Institutional | 6 | X | - | - |
|  | BPR12 | Depository Financial Institution (DFI) Identification Number Qualifier | 01 | Code 04 does not apply to Medicare. | 8 | X | X | X |
|  | TRN04 | Reference Identification |  | Reported by Institutional | 6 | X | - | - |
|  | CUR –  Segment Rule | CUR - FOREIGN CURRENCY INFORMATION |  | Does not apply to Medicare | 10 | X | X | X |
| 1000  A | REF –  Segment Rule | REF - ADDITIONAL PAYER IDENTIFICATION | 2U | Codes EO, HI, and NF not used by Medicare | 8 | X | X | X |
| 1000  B | REF –  Segment Rule | REF - PAYEE ADDITIONAL IDENTIFICATION | TJ | Required for Medicare to report the Taxpayer Identification Number (TIN) | 8 | X | X | X |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Loop** | **Reference** | **Name** | **Codes** | **Notes/Comments** | **Category** | **LOB A** | **LOB B** | **LOB DME** |
| 2000 | LX –  Segment Rule | LX - HEADER NUMBER |  | Required for Medicare FISS uses TTYYMM-  Facility Code/year/month. MCS/VMS uses 000000 for unassigned and 000001 for assigned claims | 2 | X | X | X |
| 2100 | CLP02 | Claim Status Code |  | 25  Predetermination Pricing Only - No Payment does not apply to Medicare | 2 | X | X | X |
| 2100 | CLP06 | Claim Filing Indicator Code | MA | Required for Part A | 6 | X | - | - |
| 2100 | CLP06 | Claim Filing Indicator Code | MB | Required for Part B | 6 | - | X | X |
| 2100 | CAS01 | Claim Adjustment Group Code | CO OA PR | Medicare contractors are limited to use of the CO, OA, and PR group codes. PI is not used by Medicare. | 4 | X | X | X |
| 2100 | NM108 | PATIENT NAME  Identification Code Qualifier | HN | “HN” for Medicare | 8 | X | X | X |
| 2100 | NM1 | INSURED NAME |  | Segment not used by Medicare. | 10 | X | X | X |
| 2100 | NM102 | CORRECTED PATIENT/INSURE  D NAME - Entity Type Qualifier | 1 | Code 2 does not apply to Medicare | 8 | X | X | X |
| 2100 | NM108 | SERVICE PROVIDER NAME- IDENTIFICATION CODE QUALIFIER | XX | Medicare reports NPI | 8 | X | X | X |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Loop** | **Reference** | **Name** | **Codes** | **Notes/Comments** | **Category** | **LOB A** | **LOB B** | **LOB DME** |
| 2100 | NM1 | CROSSOVER CARRIER NAME |  | Although Medicare may send claim and payment information to multiple secondary payers, the 835 does not permit identification of more than one of those secondary payers. When COB  transmissions are sent to more than one secondary payer for the same claim, report remark code N89 in a claim level remark code data element. | 9 | X | X | X |
| 2100 | NM108 | CROSSOVER CARRIER NAME -  Identification Code Qualifier | PI, XV | AD, FI, NI, and  PP do not apply to Medicare | 4 | X | X | X |
| 2100 | NM108 | CORRECTED PRIORITY PAYER NAME - IDENTIFICATION CODE QUALIFIER | PI, XV | AD, FI, NI, and  PP do not apply to Medicare | 4 | X | X | X |
| 2100 | NM1 | Other Subscriber Name |  | Not used by Medicare | 10 | X | X | X |
| 2100 | REF01 | Other Claim Related Information- Reference Identification Qualifier | 28, 6P, EA, F8 | Medicare does not use 1L, 1W, 9A, 9C,BB, CE, G1,  G3 and IG | 4 | X | X | X |
| 2100 | REF –  Segment Rule | Rendering Provider Identification |  | Segment not used by Medicare. | 10 | X | X | X |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Loop** | **Reference** | **Name** | **Codes** | **Notes/Comments** | **Category** | **LOB A** | **LOB B** | **LOB DME** |
| 2100 | AMT01 | Claim Supplemental Information- Amount Qualifier Code | AU, DY, F5, I, NL, ZK, ZL,  ZM, ZN, ZO | Medicare does not use D8, T and T2 | 4 | X | X | X |
| 2100 | AMT01 | Claim Supplemental Information Quantity-Quantity Qualifier | CA, CD,  LA, OU,  ZK, ZL,  ZM, ZN, ZO | Medicare does not use LE, NE, NR,  PS and VS | 4 | X | X | X |
| 2110 | SVC01-1 | Product or Service ID Qualifier | HC NU N4 HP | Only HC, NU, N4,  and HP apply to Medicare | 4 | X | X | X |
| 2110 | SVC06-1 | Product or Service ID Qualifier | HC NU N4 HP | Only HC, NU, N4,  and HP apply to Medicare | 4 | X | X | X |
| 2110 | CAS01 | Claim Adjustment Group Code | CO OA PR | Medicare contractors are limited to use of the CO, OA, and PR group codes. PI is not used by Medicare. | 4 | X | X | X |
| 2110 | REF –  Segment Rule | Service Identification- Reference Identification Qualifier | LU, 1S, APC, RB | Medicare does not use BB, E9, G1 AND G3 | 4 | X | X | X |
| 2110 | REF –  Segment Rule | Rendering Provider Information - Reference Identification Qualifier | HPI, SY, TJ, 1C, 1G | Medicare does not use 0B, 1A, 1B, 1D, 1H, 1J, D3 AND G2 | 4 | X | X | X |
| 2110 | REF –  Segment Rule | Health Care Policy Identification |  | Medicare will report the LCD/NCD code in REF 02 | 2 | X | X | X |
| 2110 | AMT01 | Service Supplemental Amount - Amount Qualifier Code | B6, KH, 2K, ZL, ZM, ZN, ZO | Medicare does not use T AND T2 | 4 | X | X | X |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Loop** | **Reference** | **Name** | **Codes** | **Notes/Comments** | **Category** | **LOB A** | **LOB B** | **LOB DME** |
| 2110 | LQ01 | HEALTH CARE REMARK CODES-  Code List Qualifier Code | HE | Only “HE” applies to Medicare | 8 | X | X | X |
|  | PLB03-1 | Adjustment Reason Code | 50, 51, 72,  90, AP, B2, B3, BD, BN, C5, CS, CV, DM, E3, FB, GO,  HM, IP, IS,  IR, J1, L3,  L6, LE, LS,  OA, OB, PI,  PL, RA, RE, SL, TL, WO, WU | Medicare does not use AH, AM, CR,CT, CW AND FC, | 4 | X | X | X |

# 4. TI Additional Information

## 4.1 Other Resources

The following Websites provide information for where to obtain documentation for Medicare adopted EDI transactions, code sets and additional resources of use during the 5010 transition year.

|  |  |
| --- | --- |
| **Resource** | **Web Address** |
| ASC X12 TR3 Implementation Guides | [http://store.x12.org](http://store.x12.org/) |
| Washington Publishing Company Health Care Code Sets | [http://www.wpc-](http://www.wpc-edi.com/content/view/711/401/) [edi.com/content/view/711/401/](http://www.wpc-edi.com/content/view/711/401/) |
| Central Version 005010 and D.0 Webpage on CMS website | <http://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/Versions5010andD0/index.html> |
| Educational Resources (including MLN articles, fact sheets, readiness checklists, brochures, quick reference charts and guides, and transcripts from national provider calls) | <http://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/Versions5010andD0/40_Educational_Resources.html> |
| Dedicated HIPAA 005010/D.0 Project Web page (including technical documents and communications at national conferences) | <http://www.cms.gov/MFFS5010D0/> |
| Frequently Asked Questions | <https://questions.cms.gov/> |
| To request changes to HIPAA adopted standards | <http://www.hipaa-dsmo.org/> |