

Health New England  
X12 835 Claims Payment Advice Companion Guide

HNE has developed the following Companion Guide as a support tool for the *Health Care Claim Payment/Advice, ASC X12 835 version 004010 HIPAA Implementation Guide, First Addenda*. The implementation guide is 004010X091A1; published in October 2002 and available from <http://www.wpc-edi.com> (free PDF download for registered users.)

HNE will work with our Trading Partners to select the method for transferring claim remittances:

- Organizations within Baystate Health Systems can use our private FTP server over the private network between HNE and BHS.
- HNE can place files on our secure FTP Server for our Trading Partner to pull.
- HNE can send files to your secure FTP Server.
- HNE can receive and send files through NEHEN if you are registered with NEHEN. See <http://www.nehen.com> for more information on membership benefits.
- Clearinghouses – See Clearinghouse under HIPAA for a complete list.

EDI files are processed on Monday nights and are available on Tuesday morning. If a Monday falls on a holiday, the schedule moves forward one day. The holiday schedule for next year is published in mid-December of the current year.

HNE uses ECTMap and ECTGateway from Sybase to process X12 transactions. This software is very flexible allowing us to create a wide range of content, though we do have several preferences.

Appendix B. of the HIPAA Implementation Guide allows for some flexibility in the format of EDI Control Segments.

The default delimiters are:

*	Element
>	Subelement
new line	Segment

If you need to receive different delimiters we can easily accommodate your requirements.

### **ISA Interchange Control Header Segment**

The ISA segment is the first line that HNE sends in an EDI file. Some elements within each ISA segment have a number of possible values. Please use the following values for each ISA element

ISA01	00
ISA02	10 spaces
ISA03	00

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ISA04	10 spaces
ISA05	01
ISA06	152427324
ISA07	30
ISA08	Your EIN.

For other ISA elements, please follow the implementation guide. We can customize these elements to meet your requirements.

### **GS Functional Group Header Segment**

Please use the following values for each GS element:

GS01	HP
GS02	152427324
GS03	Your EIN.

For other GS elements, please follow the implementation guide. We can customize these elements to meet your requirements.

### **Envelope**

HNE will create multiple ST-SE envelopes within a single GS-GE, one for each line of business (fully insured and self funded.)

### **Compliance Test**

All files must pass a stringent HIPAA Implementation Guide compliance test before releasing the 835 to you. This test interprets the “gray box” information in the *HIPAA Implementation Guides*.

### **Paper Checks and Check Trace Number**

At this time HNE cannot produce an EFT or ACH transaction. All payments will be on a paper check. The Check Trace number is in the TRN02 segment and is printed on every check.

HNE can produce an 835 in conjunction with the current paper Explanation of Payment (EOP). The EOP also has the Check Trace number on it. We will only stop printing paper EOPs at your direction.

During testing of the 835 HNE usually uses claims and payments from our production environment, but can use test environments if the need arises.

### **Transaction Content**

Loop 2100

In loop 2100, in the CLP segment, the CLP01 element “Patient Control Number” will contain the patient control number from the claim submitted. In most cases we can return up to 20 characters in

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this element. The exception is claims submitted in 837 Professional format or on CMS-1500 forms, in which case only up to 12 characters are returned.

#### Loop 2110

In loop 2110, the CAS segment, we have established a translation from internal codes to standard Claim Adjustment Group Codes and Claim Adjustment Reason Codes. These are described in Appendix A of this document. In loop 2110, the LQ segment, we have established a translation from internal codes to standard Claim Payment Remark Codes. These are described in a separate MS Excel spreadsheet “EXCodesRemarks.XLS”.

#### **997 Functional Acknowledgement Transaction**

HNE would like to receive a 997 Functional Acknowledgement for each 835 transaction, but do not require one. See Appendix B in the *HIPAA Implementation Guide* for a description of the 997.

For each trading partner and each transaction we would like to keep track of primary and secondary contacts (name, phone, e-mail) and a street address. Please provide this in an e-mail to [provideroperations@hne.com](mailto:provideroperations@hne.com)

## Health New England

### AMISYS Advance GA Code Set Mapping Analysis

#### ASC X12 835 Health Care Claim Payment/Advice Version 004010

### Background

AMISYS Advance provides support for the HIPAA-mandated ASC X12 835 Health Care Claim Payment/Advice EDI transaction version 004010 (“the 835”). As part of the Claims Payable extract, post and check writer, records are written to several “REMIT\_” tables in the Oracle database. The Create 835 EOP File process, CPP0835, formats these records into a flat file. HNE uses an EDI Translation Map (CPO0100) to create the 835 file.

The 835 reports the difference between what the provider charged and what the health plan paid at the service level. Providers can use this information to reconcile their accounts receivable and verify what payment, if any, can be collected from the patient. All health plans must use standard Claim Adjustment Group Codes (full list follows) and Claim Adjustment Reason Codes (full list at <http://www.wpc-edi.com/codes/Codes.asp>) in the 835. These codes are used in the CAS segment of the 835. HNE only uses CAS segments in the 2110 Service Payment Information loop.

Each health plan must map the AMISYS Advance Paid Equation to the Adjustment Group and Adjustment Reason using the new GA codeset.

### Claim Adjustment Group Codes

(This is copied verbatim from the 835 004010 Implementation Guide.)

<u>Code</u>	<u>Definition</u>
CO	<b>Contractual Obligations</b> Use this code when a joint payer/payee agreement or a regulatory requirement has resulted in an adjustment.
CR	<b>Correction and Reversals</b> Use this code for corrections and reversals to PRIOR claims. Use when CLP02=22.
OA	<b>Other adjustments</b>
PI	<b>Payer Initiated Reductions</b> Use this code when, in the opinion of the payer, the adjustment is not the responsibility of the patient, but no supporting contract exists between the provider and the payer.
PR	<b>Patient Responsibility</b>

Each of these Group Codes should be entered as a GA codeset (GACO, GAOA, GAPI and GAPR.) The codeset keywords will map the Paid Equation Code to the Group Code and the Reason Code.

The exception is Group Code CR. When a claim is reversed (CLP02=22) then the Group Code should always be set to CR, essentially overriding the Group Code derived from the other four codesets.

## Paid Equation to Group Code & Reason Code Mapping

<u>Paid Equation Code</u>	<u>Description</u>	<u>Group Code</u>	<u>Reason Code</u>	<u>Description</u>
06	Discount (PHO User Fee)	CO	104	Managed care withholding.
07	Risk Withhold	CO	104	Managed care withholding.
14	Denied (most EX codes)	CO	A1	Non-covered charge(s).
14	Denied, EX=K1,K2,K4,K5,K6, K7,K8,K9,KA,CQ,DH, RT,RU,CA,CG,CK,CM, CQ,CU,DN,ES,GA,OB, OS,RI	CO	97 <sup>1</sup>	Payment is included in the allowance for another service/procedure.
19	Amount Fill Fee	CO	91	Dispensing fee adjustment.
31 <sup>2</sup>	Amount Fee For Service Equivalence	CO	24	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan
41	Disallow amounts (most EX codes)	CO	45 <sup>3</sup>	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
41	Disallow, EX=K6, K9, RT	CO	97 <sup>4</sup>	Payment is included in the allowance for another service/procedure.
12	Third Party Payment Applied	OA	23	Payment adjusted because charges have been paid by another payer.
14	Denied, EX=2L, 3L	OA	23 <sup>5</sup>	Payment adjusted because charges have been paid by another payer.
18	Amount Paid (Medicare)	OA	23	Payment adjusted because charges have been paid by another payer.
42	Discrepancies	OA	123	*Dummy code, should not be sent to providers.
03	Copay	PR	3	Co-payment Amount
04	Coinsurance	PR	2	Coinsurance Amount
08	Deductible	PR	1	Deductible Amount
25	Prompt payment discount <sup>6</sup>			
<u>Paid Equation Code</u>	<u>Description</u>	<u>Group Code</u>	<u>Reason Code</u>	<u>Description</u>

<sup>1</sup> 97 is used for these Explanation Codes as the service is covered and would normally be paid if it was rendered by itself. These EX codes have a DENY keyword to prevent counters from being created.

<sup>2</sup> HNE created this value. We changed CPP0100.COBOL to look for X in the 2<sup>nd</sup> byte of CLAIM-TYPE. It will map to 31 instead of 42 (Discrepancies.)

<sup>3</sup> Until 4/17/09 we used 42 "Charges exceed our fee schedule or maximum allowable amount." 42 was discontinued on 6/1/2007.

<sup>4</sup> 97 is used for these Explanation Codes as the service is covered and would normally be paid if it was rendered by itself. These EX codes have a PAY keyword and the payclass is set to allow zero.

<sup>5</sup> 23 is used for these Explanation Codes as the service is covered and would normally be paid if another payer had not already made full payment.

<sup>6</sup> Prompt payment discount is to be reported in AMT and PLB segments, not a CAS segment.

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26	Late payment interest penalty <sup>7</sup>			
45	Third Party Claim Processor (Claim Check, Code Review) Payment Codes			
94	Third Party Claim Processor Payment Codes			
97	Third Party Claim Processor Payment Codes <sup>8</sup>			
01	Provider Allow	N/A	N/A	
02	Benefit Allow	N/A	N/A	

At this time HNE doesn't use Provider Allow or Benefit Allow as part of the paid equation; we have not mapped them.

We have not yet determined a Reason Code to use with 42 "Discrepancies". Testing to date has revealed that capitated services (claim type ending in X) will use 42 in this way:

$$\text{Charge} - \text{Disallow} - \text{Copay} - \text{Discrepancy} = \text{Paid} = 0$$

$$\text{E.g. } \$100 - \$17 - \$10 - \$73 = 0$$

Inappropriate use of the AMT action on the service level readjudication and adjustment screens may lead to FFS services that are out-of-balance; the discrepancy would be used to balance these services.

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<sup>7</sup> At this time HNE computes late payment interest penalties outside of AMISYS Advance for commercial claims. For Medicare Advantage HNE uses the AMISYS Advance late payment function. Interest is supposed to be reported in AMT and PLB segments, not a CAS segment.

<sup>8</sup> HNE does not use a Third Party Claim Processor.

## Sample GA Codeset Entry

MODE:F ACTION:	Code Set	RF0300	05/06/09
OP#:828		01.00.00.01	15:43
01 Code#	<u>GAPR</u>		
	2	3	4
Description	5	6	7
1...+...0...+...0...+...0...+...0...+...0...+...0...+...0...			
02	<u>PR PATIENT RESPONSIBILITY</u>		
	2	3	4
Keywords	5	6	7
1...+...0...+...0...+...0...+...0...+...0...+...0...+...0...			
03	<u>03-3</u>	<u>04-2</u>	<u>08-1</u>
	2	3	4
Keywords	5	6	7
1...+...0...+...0...+...0...+...0...+...0...+...0...+...0...			
04			
Trans code: <u>AD</u> Date: <u>04/02/2004</u> OP#: <u>050</u>			