

# **New York State Department of Health Office of Medicaid Management 835 Health Care Claim Payment Advice Companion Guide**

**HIPAA Version 004010X091A1: 835 Health Care Claim Payment Advice**

**Version: 1.0 Draft**

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# 835

# Health Care Claim Payment/Advice

## Functional Group=HP

This Draft Standard for Trial Use contains the format and establishes the data contents of the Health Care Claim Payment/Advice Transaction Set (835) for use within the context of the Electronic Data Interchange (EDI) environment. This 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 only from a health insurer to a health care provider either directly or via a financial institution.

### Companion Guide Disclaimer:

The New York State Department of Health (NYS DOH) has provided DRAFT Medicaid Companion Documents for the 837 Dental ASC X12N (004010X097A1), 837 Professional ASC X12N (004010X098A1), 837 Institutional ASC X12N (004010X096A1) Transactions and the 835 Payment/Advice Remittance ASC X12N (004010X091A1) Transaction to assist Providers, Clearinghouses and all Covered Entities in preparing HIPAA compliant transactions. These documents were prepared using the Addenda versions of each transaction. NYS DOH has focused primarily on the rules and policies regulating the submission of Medicaid data that are provided within each Companion Guide document. NYS DOH has provided the information on this website as a tool to make the Provider's job easier in preparing electronic transactions in a HIPAA compliant manner.

NYS DOH does not offer individual training to assist Providers in the use of the ASC X12N transactions provided on this website. However, training will be offered to meet the individual needs of Providers in preparing their transactions to follow NYS Medicaid policy. Additional information regarding training dates and locations will be posted on this website as it becomes available.

The information provided herein is believed to be true and correct based on the Addenda Version of the HIPAA guidelines. These regulations are continuing to evolve, therefore NYS Medicaid makes no guarantee, expressed or implied, as to the accuracy of the information provided herein. Furthermore, this is a living document and the information provided herein is subject to change as NYS DOH policy changes or as HIPAA legislation is updated or revised.

### NYS MEDICAID NOTE:

The ASC X12N 835 (004010X091A1) Implementation Guide for a Health Care Claim Payment/Advice Transaction has been established by Health and Human Services as the standard for Remittance Advice compliance.

The Companion Guide provided by the NYS DOH outlines the required format for the New York State Medicaid Health Care Claim Payment/Advice. It is important that providers study the Companion Guide and become familiar with the data that will be supplied by NYS Medicaid in an 835 Health Care Claim Payment/Advice Transaction.

This Companion Guide does not modify the standards; rather, it puts forth the subset of information from the Implementation Guide (IG) that will be required for processing transactions. It is important to note that providers use this Companion Guide as a supplement to the IG and the NYS Medicaid Provider Manual. Within the IG, there are data elements, which have many different qualifiers available for use. Each of these qualifiers identify a different piece of information. This document omits code qualifiers that are not necessary for NYS Medicaid processing. Although not all available codes are listed in this document, NYS Medicaid will accept any code named or listed in the HIPAA implementation guides. When necessary, a "NYS MEDICAID NOTE" is included to describe NYS Medicaid specific requirements. These notes provide guidance to ensure proper adjudication and subsequent claim payment.

For further assistance, NYS DOH and its fiscal agent, Computer Sciences Corporation (CSC), are urging providers to visit a web community, <http://www.hipaadesk.com/>, which will provide WEDI-SNIP level 1 thru 6 testing capabilities, as well as Companion Guide updates, and other pertinent information.

Understanding ETIN's and how they are used.

An ETIN is the Electronic Transmitter Identification Number. In past implementations it was known as TSN (originally Tape Supplier Number and later Transmission Supplier Number). Generally speaking, this number is used to identify the entity communicating the transaction.

The ETIN is also used to determine who or where the remittance advice is to be sent. Today, the remittance advice is returned back to the ETIN the claim was submitted through. In most cases this is a simple process. However, there are provider groups/facilities who have a need for remittances to be "split" and sent to different ETIN's (electronic addresses). In these cases, a provider with multiple ETIN's would receive a paper check with non-claim related payment adjustments (i.e. recoupments, balance forward adjustments). This check is then sent to the pay-to address on file for that provider ID. In addition, a "claim remittance" is

sent to each ETIN. Within the "claim remittance", there is no direct reference to the paper check. If a paper claim is received, the remittance for that claim will be reported on paper. This paper claim remittance is sent to the same place as the check. All payment totals provided on the claim remittance are specific to that particular remittance. All claim remittance totals plus the non-claim related payment adjustments from the check stub add up to the total check amount.

HIPAA implementation requires the receiver have the ability to definitively balance the check received to the 835 remittance transaction. Providers will continue to receive only one check per provider number. In order to balance the check amount with the 835 remittance, a separate 835 "check" remittance will be created. Providers utilizing multiple ETINs will need to have a primary ETIN to which this check remittance will be returned. The Primary ETIN will initially be assigned to the existing TSN with the highest transaction volume. Providers will be notified as to which TSN has been designated as their primary and have the ability to select an alternate if desired.

In order to meet the balancing requirement, providers with multiple ETIN's will receive a claim remittance (835) for each ETIN. This "claim" remittance will contain claim information for the ETIN that submitted the claims, as it always has. The check amount field for these "claim" remittances will be 0.00. The remittance total will be reported as a balance forward within the PLB segment. In addition, the check number will be provided to enable a direct link.

A "claim" remittance will be created for each ETIN, (primary and non-primary), that had claims processed during a particular cycle. The "claim" remittance will also include the claim detail for all claims submitted on paper claim forms for that provider ID. In addition to the regular "claim remittance" the "Primary ETIN" will also receive a "check remittance". This "check remittance" is an electronic communication of the check total, check number and all non-claim related payment adjustments.

The result of this is providers who have elected to employ multiple ETIN's for remittance processing will receive the following files.

- Primary ETIN
  - o Check remittance 835 – This file includes the actual check information and all non-claim related payment adjustments.
  - o Claim remittance 835 – This file includes detail claim payment and denial information for electronic claims received under this ETIN. It also includes detail claim payment and denial information for any claims submitted on paper for this provider ID.
  - o Pended Claim file – This file includes detail information for electronic claims received under this ETIN that have been pended. It also includes detail information for any claims submitted on paper for this provider ID that have been pended.
- All other ETIN's
  - o Claim remittance 835 – This file includes detail claim payment and denial information for electronic claims received under this ETIN.
  - o Pended Claim file – This file includes detail information for electronic claims received under this ETIN that have been pended.

## Heading:

Pos	Id	Segment Name	Req	Max Use	Repeat	Notes	Usage
010	ST	Transaction Set Header	M	1			Required
020	BPR	Financial Information	M	1			Required
040	TRN	Reassociation Trace Number	O	1		N1/040	Required
060	REF	Receiver Identification	O	1			Situational
060	REF	Version Identification	O	1			Situational
070	DTM	Production Date	O	1			Recommended
<b>LOOP ID - 1000A</b>					<b>1</b>	<b>N1/080L</b>	
080	N1	Payer Identification	O	1		N1/080	Required
100	N3	Payer Address	O	1			Required
110	N4	Payer City, State, ZIP Code	O	1			Required
<b>LOOP ID - 1000B</b>					<b>1</b>	<b>N1/080L</b>	
080	N1	Payee Identification	O	1		N1/080	Required
100	N3	Payee Address	O	1			Situational
110	N4	Payee City, State, ZIP Code	O	1			Situational
120	REF	Payee Additional Identification	O	>1			Situational

**Detail:**

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Notes</u>	<u>Usage</u>
<b>LOOP ID - 2000</b>					<b>&gt;1</b>	<b>N2/003L</b>	
003	LX	Header Number	O	1		N2/003	Situational
005	TS3	Provider Summary Information	O	1			Situational
007	TS2	Provider Supplemental Summary Information	O	1			Situational
<b>LOOP ID - 2100</b>					<b>&gt;1</b>		
010	CLP	Claim Payment Information	M	1			Required
020	CAS	Claim Adjustment	O	99		N2/020	Situational
030	NM1	Patient Name	M	1			Required
030	NM1	Corrected Patient/Insured Name	O	1			Situational
030	NM1	Service Provider Name	O	1			Situational
030	NM1	Corrected Priority Payer Name	O	2			Situational
033	MIA	Inpatient Adjudication Information	O	1			Situational
035	MOA	Outpatient Adjudication Information	O	1			Situational
040	REF	Other Claim Related Identification	O	5			Situational
040	REF	Rendering Provider Identification	O	10			Situational
050	DTM	Claim Date	O	4			Situational
060	PER	Claim Contact Information	O	3			Situational
064	QTY	Claim Supplemental Information Quantity	O	15			Situational
<b>LOOP ID - 2110</b>					<b>999</b>		
070	SVC	Service Payment Information	O	1			Recommended
090	CAS	Service Adjustment	O	99		N2/090	Situational
100	REF	Service Identification	O	7			Situational
130	LQ	Health Care Remark Codes	O	99			Situational

**Summary:**

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Notes</u>	<u>Usage</u>
010	PLB	Provider Adjustment	O	>1			Situational
020	SE	Transaction Set Trailer	M	1			Required

# ST Transaction Set Header

Pos: 010	Max: 1
Heading - Mandatory	
Loop: N/A	Elements: 2

**User Option (Usage):** Required

To indicate the start of a transaction set and to assign a control number

## Example:

ST\*835\*1234~

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>				
ST01	143	<b>Transaction Set Identifier Code</b> <b>Description:</b> Code uniquely identifying a Transaction Set <b>HIPAA IG Note:</b> The only valid value within this transaction set for ST01 is 835.	M	ID	3/3	Required				
		<table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>835</td> <td>Health Care Claim Payment/Advice</td> </tr> </tbody> </table>	<u>Code</u>	<u>Name</u>	835	Health Care Claim Payment/Advice				
<u>Code</u>	<u>Name</u>									
835	Health Care Claim Payment/Advice									
ST02	329	<b>Transaction Set Control Number</b> <b>Description:</b> Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set <b>HIPAA IG Note:</b> The Transaction Set Control Numbers in ST02 and SE02 must be identical. This unique number also aids in error resolution research. Start with a number, for example 0001, and increment from there. This number must be unique within a specific group and interchange, but it can be repeated in other groups and interchanges.	M	AN	4/9	Required				

# BPR Financial Information

Pos: 020	Max: 1
Heading - Mandatory	
Loop: N/A	Elements: 5

User Option (Usage): Required

To indicate the beginning of a Payment Order/Remittance Advice Transaction Set and total payment amount, or to enable related transfer of funds and/or information from payer to payee to occur

**Notes:**

1. Use the BPR to address a single payment to a single payee. A payee may represent a single provider, a provider group, or multiple providers in a chain. The BPR contains mandatory information, even when it is not being used to move funds electronically.

**Example:**

BPR\*C\*150000\*C\*ACH\*CTX\*01\*999999992\*DA\*123456\*1512345678\* 1999999999\*01\*999988880\*DA\*98765\*19960901~

**Element Summary:**

Ref	Id	Element Name	Req	Type	Min/Max	Usage				
BPR01	305	<b>Transaction Handling Code</b> <b>Description:</b> Code designating the action to be taken by all parties <b>NYS MEDICAID NOTE:</b> NYS will provide the value of 'I'. <table border="1"> <thead> <tr> <th>Code</th> <th>Name</th> </tr> </thead> <tbody> <tr> <td>I</td> <td>Remittance Information Only</td> </tr> </tbody> </table> Use this code to indicate to the payee that the remittance detail is moving separately from the payment.	Code	Name	I	Remittance Information Only	M	ID	1/2	Required
Code	Name									
I	Remittance Information Only									
BPR02	782	<b>Monetary Amount</b> <b>Description:</b> Monetary amount <b>Industry:</b> Total Actual Provider Payment Amount <b>HIPAA IG Note:</b> Use BPR02 for the total payment amount for this 835. The total payment amount for this 835 cannot exceed eleven characters, including decimals (99999999.99). Although the value can be zero, the 835 cannot be issued for less than zero dollars. <b>NYS MEDICAID NOTE:</b> If you have only one ETIN (fka TSN), this amount will equal the amount of the check you received. If you are a trading partner with multiple ETIN's, one of these must be designated as your primary ETIN. Please see the introductory section of this document for more detailed instruction.	M	R	1/18	Required				
BPR03	478	<b>Credit/Debit Flag Code</b> <b>Description:</b> Code indicating whether amount is a credit or debit <b>Industry:</b> Credit or Debit Flag Code <b>NYS MEDICAID NOTE:</b> NYS will only provide the value of 'C'. <table border="1"> <thead> <tr> <th>Code</th> <th>Name</th> </tr> </thead> <tbody> <tr> <td>C</td> <td>Credit</td> </tr> </tbody> </table> Use this code to indicate a credit to the provider's account and a debit to the payer's account, initiated by the payer. In the case of an EFT, no additional action is required of the provider. Also use this code when a check is issued for the payment.	Code	Name	C	Credit	M	ID	1/1	Required
Code	Name									
C	Credit									
BPR04	591	<b>Payment Method Code</b> <b>Description:</b> Code identifying the method for the movement of payment instructions	M	ID	3/3	Required				

**NYS MEDICAID NOTE:** NYS will only provide the value of 'CHK'.

<b>Code</b>	<b>Name</b>
CHK	Check

Use this code to indicate that a check has been issued for payment.

BPR16 373

**Date**  
**Description:** Date expressed as CCYYMMDD  
**Industry:** Check Issue or EFT Effective Date  
**HIPAA IG Note:** Use this code for the effective entry date. If BPR04 is ACH, this code is the date that the money moves from the payer and is available to the payee. If BPR04 is CHK, this code is the check issuance date. If BPR04 is FWT, this code is the date that the payer anticipates the money to move. As long as the effective date is a business day, this is the settlement date. If BPR04 is 'NON', enter the date of the 835.

O DT 8/8 Required

# TRN Reassociation Trace Number

Pos: 040	Max: 1
Heading - Optional	
Loop: N/A	Elements: 4

User Option (Usage): Required

To uniquely identify a transaction to an application

**Notes:**

1. This segment's purpose is to uniquely identify this transaction set and to aid in reassociating payments and remittances that have been separated.

**Example:**

TRN\*1\*12345\*1512345678\*199999999~

**Element Summary:**

Ref	Id	Element Name	Req	Type	Min/Max	Usage				
TRN01	481	<b>Trace Type Code</b> <b>Description:</b> Code identifying which transaction is being referenced <table border="1"> <thead> <tr> <th>Code</th> <th>Name</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>Current Transaction Trace Numbers</td> </tr> </tbody> </table>	Code	Name	1	Current Transaction Trace Numbers	M	ID	1/2	Required
Code	Name									
1	Current Transaction Trace Numbers									
TRN02	127	<b>Reference Identification</b> <b>Description:</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier <b>Industry:</b> Check or EFT Trace Number <b>HIPAA IG Note:</b> This number must be unique within the sender/receiver relationship. The number is assigned by the sender. For example, if a payment is made by check, this number should be the check number. There may be a number of uses for the trace number. If payment and remittance detail are separated, this number is used to reassociate data to dollars. See 2.2.3, Reassociation of Data and Dollars. <b>NYS MEDICAID NOTE:</b> NYS will provide either the check number or the claim remittance number. See the section titled Understanding ETIN's and How They Are Used for an explanation of check remittances vs claim remittances.	M	AN	1/30	Required				
TRN03	509	<b>Originating Company Identifier</b> <b>Description:</b> A unique identifier designating the company initiating the funds transfer instructions. The first character is one-digit ANSI identification code designation (ICD) followed by the nine-digit identification number which may be an IRS employer identification number (EIN), data universal numbering system (DUNS), or a user assigned number; the ICD for an EIN is 1, DUNS is 3, user assigned number is 9 <b>Industry:</b> Payer Identifier <b>HIPAA IG Note:</b> TRN03 must contain the Federal Tax ID Number, preceded by a "1." When BPR10 is used, it must be identical to TRN03. <b>NYS MEDICAID NOTE:</b> NYS will provide the value '1141797357'	O	AN	10/10	Required				

TRN04 127

**Reference Identification**

O

AN

1/30

Situational

**Description:** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

**Industry:** Originating Company Supplemental Code

**HIPAA IG Note:** If both TRN04 and BPR11 are used, they must be identical.

This element is required when information beyond the Originating Company Identifier in TRN03 is necessary for the payee to identify the source of the payment.

# REF Receiver Identification

Pos: 060	Max: 1
Heading - Optional	
Loop: N/A	Elements: 2

User Option (Usage): Situational

To specify identifying information

**Notes:**

1. Use this segment only when the receiver of the transaction is other than the payee (e.g., Clearing House or billing service ID).

**Example:**

REF\*EV\*1235678~

**Element Summary:**

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>				
REF01	128	<b>Reference Identification Qualifier</b> <b>Description:</b> Code qualifying the Reference Identification <table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>EV</td> <td>Receiver Identification Number</td> </tr> </tbody> </table>	<u>Code</u>	<u>Name</u>	EV	Receiver Identification Number	M	ID	2/3	Required
<u>Code</u>	<u>Name</u>									
EV	Receiver Identification Number									
REF02	127	<b>Reference Identification</b> <b>Description:</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier <b>Industry:</b> Receiver Identifier <b>Alias:</b> Receiver Identification <b>NYS MEDICAID NOTE:</b> NYS will provide the ETIN as provided in the incoming claim.	C	AN	1/30	Required				

# REF Version Identification

Pos: 060	Max: 1
Heading - Optional	
Loop: N/A	Elements: 2

**User Option (Usage):** Situational

To specify identifying information

**Notes:**

1. Use this Reference Number Segment to report the version number of the adjudication system that generated the claim payments in this transaction. Update this reference number whenever a change in the version or release number affects the 835. (This is not the ANSI ASCX12 version number as reported in the GS segment.)
2. Provide the version number when this information is required by the PAYER in order to resolve customer service questions from the PAYEE.

**Example:**

REF\*F2\*FS3.21~

**Element Summary:**

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>				
REF01	128	<b>Reference Identification Qualifier</b> <b>Description:</b> Code qualifying the Reference Identification <table border="0"> <tr> <td><u>Code</u></td> <td><u>Name</u></td> </tr> <tr> <td>F2</td> <td>Version Code - Local</td> </tr> </table>	<u>Code</u>	<u>Name</u>	F2	Version Code - Local	M	ID	2/3	Required
<u>Code</u>	<u>Name</u>									
F2	Version Code - Local									
REF02	127	<b>Reference Identification</b> <b>Description:</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier <b>Industry:</b> Version Identification Code <b>NYS MEDICAID NOTE:</b> NYS will provide '0040X091A1'.	C	AN	1/30	Required				

# DTM Production Date

Pos: 070	Max: 1
Heading - Optional	
Loop: N/A	Elements: 2

**User Option (Usage):** Recommended

To specify pertinent dates and times

**Notes:**

1. The production date must be supplied when the cutoff date of the adjudication system is different from the date of the 835.

**Example:**

DTM\*405\*19960317~

**Element Summary:**

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
DTM01	374	<b>Date/Time Qualifier</b> <b>Description:</b> Code specifying type of date or time, or both date and time <b>Industry:</b> Date Time Qualifier	M	ID	3/3	Required
		<b>Code</b> <b>Name</b> 405                Production Use this code for the end date for the adjudication production cycle for claims included in this 835.				
DTM02	373	<b>Date</b> <b>Description:</b> Date expressed as CCYYMMDD <b>Industry:</b> Production Date	C	DT	8/8	Required

# N1 Payer Identification

Pos: 080	Max: 1
Heading - Optional	
Loop: 1000A	Elements: 4

**User Option (Usage):** Required

To identify a party by type of organization, name, and code

## Notes:

1. Use this N1 loop to provide the name/address information for the payer. The payer's secondary identifying reference number should be provided in N104, if necessary.

## Example:

N1\*PR\*INSURANCE COMPANY OF TIMBUCKTU\*XV\*88888888~

## Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
N101	98	<b>Entity Identifier Code</b> <b>Description:</b> Code identifying an organizational entity, a physical location, property or an individual <b>Code</b> <b>Name</b> PR            Payer	M	ID	2/3	Required
N102	93	<b>Name</b> <b>Description:</b> Free-form name <b>Industry:</b> Payer Name <b>HIPAA IG Note:</b> Required if the National PlanID is not transmitted in N104. <b>NYS MEDICAID NOTE:</b> NYS will provide 'New York State Department of Health'.	C	AN	1/60	Situational
N103	66	<b>Identification Code Qualifier</b> <b>Description:</b> Code designating the system/method of code structure used for Identification Code (67) <b>HIPAA IG Note:</b> Required if the National PlanID is transmitted in N104. <b>Code</b> <b>Name</b> XV            Health Care Financing Administration National Payer Identification Number (PAYERID) Required if the National PlanID is mandated for use.	C	ID	1/2	Recommended
N104	67	<b>Identification Code</b> <b>Description:</b> Code identifying a party or other code <b>Industry:</b> Payer Identifier <b>HIPAA IG Note:</b> Required if the National Plan ID is mandated for use. <b>ExternalCodeList</b> <b>Name:</b> 540 <b>Description:</b> Health Care Financing Administration National PlanID	C	AN	2/80	Recommended

# N3 Payer Address

Pos: 100	Max: 1
Heading - Optional	
Loop: 1000A	Elements: 2

User Option (Usage): Required

To specify the location of the named party

**Example:**

N3\*100 MAIN STREET~

**Element Summary:**

Ref	Id	Element Name	Req	Type	Min/Max	Usage
N301	166	<b>Address Information</b> Description: Address information Industry: Payer Address Line NYS MEDICAID NOTE: NYS will provide 'Office of Medicaid Management'.	M	AN	1/55	Required
N302	166	<b>Address Information</b> Description: Address information Industry: Payer Address Line HIPAA IG Note: Required if a second address line exists. NYS MEDICAID NOTE: NYS will provide 'Corning Tower, Empire State Plaza'.	O	AN	1/55	Situational

# N4 Payer City, State, ZIP Code

Pos: 110	Max: 1
Heading - Optional	
Loop: 1000A	Elements: 3

**User Option (Usage):** Required

To specify the geographic place of the named party

## Example:

N4\*KANSAS CITY\*MO\*64108~

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
N401	19	<b>City Name</b> <b>Description:</b> Free-form text for city name <b>Industry:</b> Payer City Name <b>NYS MEDICAID NOTE:</b> NYS will provide 'Albany'.	O	AN	2/30	Required
N402	156	<b>State or Province Code</b> <b>Description:</b> Code (Standard State/Province) as defined by appropriate government agency <b>Industry:</b> Payer State Code <b>CODE SOURCE:</b> 22: States and Outlying Areas of the U.S. <b>NYS MEDICAID NOTE:</b> NYS will provide 'NY'. <u>ExternalCodeList</u> <b>Name:</b> 22 <b>Description:</b> States and Outlying Areas of the U.S.	O	ID	2/2	Required
N403	116	<b>Postal Code</b> <b>Description:</b> Code defining international postal zone code excluding punctuation and blanks (zip code for United States) <b>Industry:</b> Payer Postal Zone or ZIP Code <b>CODE SOURCE:</b> 51: ZIP Code <b>NYS MEDICAID NOTE:</b> NYS will provide '122370080'. <u>ExternalCodeList</u> <b>Name:</b> 51 <b>Description:</b> ZIP Code	O	ID	3/15	Required

# N1 Payee Identification

Pos: 080	Max: 1
Heading - Optional	
Loop: 1000B	Elements: 4

**User Option (Usage):** Required

To identify a party by type of organization, name, and code

## Notes:

1. Use this N1 loop to provide the name/address information of the payee. The identifying reference number should be provided in N104.

## Example:

N1\*PE\*CYBILS MENTAL HOSPITAL\*XX\*12345678~

## Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
N101	98	<b>Entity Identifier Code</b> <b>Description:</b> Code identifying an organizational entity, a physical location, property or an individual <b>Code</b> <b>Name</b> PE                  Payee	M	ID	2/3	Required
N102	93	<b>Name</b> <b>Description:</b> Free-form name <b>Industry:</b> Payee Name <b>HIPAA IG Note:</b> Required when N104 does not contain the National Provider Identifier.	C	AN	1/60	Situational
N103	66	<b>Identification Code Qualifier</b> <b>Description:</b> Code designating the system/method of code structure used for Identification Code (67) <b>HIPAA IG Note:</b> Required when N104 does not contain the National Provider Identifier. <b>NYS MEDICAID NOTE:</b> NYS will provide the qualifier 'FI'. <b>Code</b> <b>Name</b> FI                  Federal Taxpayer's Identification Number For individual providers as payees, use this number to represent the Social Security Number.	C	ID	1/2	Required
N104	67	<b>Identification Code</b> <b>Description:</b> Code identifying a party or other code <b>Industry:</b> Payee Identification Code <b>ExternalCodeList</b> <b>Name:</b> 537 <b>Description:</b> Health Care Financing Administration National Provider Identifier	C	AN	2/80	Required

# N3

# Payee Address

Pos: 100	Max: 1
Heading - Optional	
Loop: 1000B	Elements: 2

**User Option (Usage):** Situational

To specify the location of the named party

**Notes:**

1. Use of this segment is at the discretion of the payer for situations where the sender needs to communicate the payee address to a transaction receiver (for example, a VAB or a Clearinghouse).

**Example:**

N3\*Suite 200\*1000 Main Street~

**Element Summary:**

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
N301	166	<b>Address Information</b> Description: Address information Industry: Payee Address Line	M	AN	1/55	Required
N302	166	<b>Address Information</b> Description: Address information Industry: Payee Address Line HIPAA IG Note: Required if a second address line exists.	O	AN	1/55	Situational

**N4****Payee City, State, ZIP Code**

Pos: 110	Max: 1
Heading - Optional	
Loop: 1000B	Elements: 4

**User Option (Usage):** Situational

To specify the geographic place of the named party

**Notes:**

1. Using this segment is at the discretion of the payer contingent on the business needs of the payee (receiver).

**Example:**

N4\*Beverly Hills\*CA\*90210~

**Element Summary:**

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
N401	19	<b>City Name</b> <b>Description:</b> Free-form text for city name <b>Industry:</b> Payee City Name	O	AN	2/30	Required
N402	156	<b>State or Province Code</b> <b>Description:</b> Code (Standard State/Province) as defined by appropriate government agency <b>Industry:</b> Payee State Code <b>CODE SOURCE:</b> 22: States and Outlying Areas of the U.S. <b>ExternalCodeList</b> <b>Name:</b> 22	O	ID	2/2	Required
N403	116	<b>Postal Code</b> <b>Description:</b> Code defining international postal zone code excluding punctuation and blanks (zip code for United States) <b>Industry:</b> Payee Postal Zone or ZIP Code <b>CODE SOURCE:</b> 51: ZIP Code <b>ExternalCodeList</b> <b>Name:</b> 51	O	ID	3/15	Required
N404	26	<b>Country Code</b> <b>Description:</b> Code identifying the country <b>CODE SOURCE:</b> 5: Countries, Currencies and Funds <b>HIPAA IG Note:</b> Required if country is other than USA. <b>ExternalCodeList</b> <b>Name:</b> 5 <b>Description:</b> Countries, Currencies and Funds	O	ID	2/3	Situational

# REF Payee Additional Identification

Pos: 120	Max: >1
Heading - Optional	
Loop: 1000B	Elements: 2

User Option (Usage): Situational

To specify identifying information

**Notes:**

1. Use this REF segment only when more than one identification number is required to identify the payee. Always use the ID number available in the N1 segment before using the REF segment.

**Example:**

REF\*PQ\*12345678~

**Element Summary:**

Ref	Id	Element Name	Req	Type	Min/Max	Usage				
REF01	128	<b>Reference Identification Qualifier</b> <b>Description:</b> Code qualifying the Reference Identification <b>NYS MEDICAID NOTE:</b> NYS will provide the qualifier 'PQ'.	M	ID	2/3	Required				
		<table border="1"> <thead> <tr> <th>Code</th> <th>Name</th> </tr> </thead> <tbody> <tr> <td>PQ</td> <td>Payee Identification</td> </tr> </tbody> </table>	Code	Name	PQ	Payee Identification				
Code	Name									
PQ	Payee Identification									
REF02	127	<b>Reference Identification</b> <b>Description:</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier <b>Industry:</b> Additional Payee Identifier <b>NYS MEDICAID NOTE:</b> NYS will provide the Medicaid Provider ID.	C	AN	1/30	Required				
		<b>ExternalCodeList</b> <b>Name:</b> 307 <b>Description:</b> National Association of Boards of Pharmacy Number								

**LX****Header Number**

<b>Pos: 003</b>	<b>Max: 1</b>
<b>Detail - Optional</b>	
<b>Loop: 2000</b>	<b>Elements: 1</b>

**User Option (Usage):** Situational

To reference a line number in a transaction set

**Notes:**

1. The LX segment is required whenever any information in the LX loop is included in the transaction. In the event that claim/service information must be sorted, the LX segment must precede each series of claim level and service level segments.
2. Any Table 2 data must commence with an LX segment. Multiple sorts are accomplished through multiple LX loops.
3. For Medicare Part A, write/read the LX segment once for each provider's fiscal period end year and month/type of bill summary break in the file (TTYMM in LX01). For Medicare Part B, write/read the LX segment once for unassigned claims using the value of "zero" and once for assigned claims using the value of "one".

**Example:**

LX\*1~  
LX\*961011~

**Element Summary:**

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
LX01	554	<b>Assigned Number</b> <b>Description:</b> Number assigned for differentiation within a transaction set	M	N0	1/6	Required

**TS3****Provider Summary Information**

Pos: 005	Max: 1
Detail - Optional	
Loop: 2000	Elements: 24

**User Option (Usage):** Situational

To supply provider-level control information

**Notes:**

1. Payers and payees outside the Medicare Part A community may need to use this segment to identify provider subsidiaries whose remittance information is contained in the 835 transactions transmitted to a single provider entity (i.e., the corporate office of a hospital chain). For this purpose, TS301 identifies the subsidiary provider. The remaining mandatory elements (TS302 through 05) must be valid with appropriate data, as defined by the TS3 segment. Only Medicare Part A should use the data elements in TS306-24. Each total is for that provider for this type of bill for this fiscal period.
2. When available, use the National Provider ID in TS301.
3. All situational quantities and amounts in this segment are required when the value of the item is different than zero.

**Example:**

TS3\*123456\*11\*19961031\*10\*130957.66~

**NYS MEDICAID NOTE:**

NYS will not use this segment.

**Element Summary:**

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
TS301	127	<b>Reference Identification</b> <b>Description:</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier <b>Industry:</b> Provider Identifier <b>HIPAA IG Note:</b> Use this number for the provider number.	M	AN	1/30	Required
TS302	1331	<b>Facility Code Value</b> <b>Description:</b> Code identifying the type of facility where services were performed; the first and second positions of the Uniform Bill Type code or the Place of Service code from the Electronic Media Claims National Standard Format <b>Industry:</b> Facility Type Code	M	AN	1/2	Required
TS303	373	<b>Date</b> <b>Description:</b> Date expressed as CCYYMMDD <b>Industry:</b> Fiscal Period Date <b>HIPAA IG Note:</b> Use this date for the last day of the provider's fiscal year. If the end of the provider's fiscal year is not known, use December 31st of the current year.	M	DT	8/8	Required
TS304	380	<b>Quantity</b> <b>Description:</b> Numeric value of quantity <b>Industry:</b> Total Claim Count <b>HIPAA IG Note:</b> Use this number for the total number of claims.	M	R	1/15	Required
TS305	782	<b>Monetary Amount</b> <b>Description:</b> Monetary amount <b>Industry:</b> Total Claim Charge Amount <b>HIPAA IG Note:</b> Use this monetary amount for the total reported charges for all claims.	M	R	1/18	Required
TS306	782	<b>Monetary Amount</b> <b>Description:</b> Monetary amount	O	R	1/18	Situational

		<b>Industry:</b> Total Covered Charge Amount <b>HIPAA IG Note:</b> Use this monetary amount for the total covered charges. This is submitted charges less the non-covered charges.				
TS307	782	<b>Monetary Amount</b> <b>Description:</b> Monetary amount <b>Industry:</b> Total Noncovered Charge Amount <b>HIPAA IG Note:</b> Use this monetary amount for the total of non-covered charges.	O	R	1/18	Situational
TS308	782	<b>Monetary Amount</b> <b>Description:</b> Monetary amount <b>Industry:</b> Total Denied Charge Amount <b>HIPAA IG Note:</b> Use this monetary amount for the total of denied charges.	O	R	1/18	Situational
TS309	782	<b>Monetary Amount</b> <b>Description:</b> Monetary amount <b>Industry:</b> Total Provider Payment Amount <b>HIPAA IG Note:</b> Use this monetary amount for the total provider payment. The total provider payment amount includes the total of all interest paid. The amount can be less than zero.	O	R	1/18	Situational
TS310	782	<b>Monetary Amount</b> <b>Description:</b> Monetary amount <b>Industry:</b> Total Interest Amount <b>HIPAA IG Note:</b> Use this monetary amount for the total amount of interest paid.	O	R	1/18	Situational
TS311	782	<b>Monetary Amount</b> <b>Description:</b> Monetary amount <b>Industry:</b> Total Contractual Adjustment Amount <b>HIPAA IG Note:</b> Use this monetary amount for the total contractual adjustment.	O	R	1/18	Situational
TS312	782	<b>Monetary Amount</b> <b>Description:</b> Monetary amount <b>Industry:</b> Total Gramm-Rudman Reduction Amount <b>HIPAA IG Note:</b> Use this monetary amount for the total Gramm-Rudman adjustment.	O	R	1/18	Situational
TS313	782	<b>Monetary Amount</b> <b>Description:</b> Monetary amount <b>Industry:</b> Total MSP Payer Amount <b>HIPAA IG Note:</b> Use this monetary amount for the total MSP primary payer amount.	O	R	1/18	Situational
TS314	782	<b>Monetary Amount</b> <b>Description:</b> Monetary amount <b>Industry:</b> Total Blood Deductible Amount <b>HIPAA IG Note:</b> Use this monetary amount for the total blood deductible amount in dollars.	O	R	1/18	Situational
TS315	782	<b>Monetary Amount</b> <b>Description:</b> Monetary amount <b>Industry:</b> Total Non-Lab Charge Amount <b>HIPAA IG Note:</b> Use this monetary amount for the sum of non-lab charges.	O	R	1/18	Situational
TS316	782	<b>Monetary Amount</b> <b>Description:</b> Monetary amount <b>Industry:</b> Total Coinsurance Amount <b>HIPAA IG Note:</b> Use this monetary amount for the total co-insurance amount.	O	R	1/18	Situational
TS317	782	<b>Monetary Amount</b> <b>Description:</b> Monetary amount <b>Industry:</b> Total HCPCS Reported Charge Amount <b>HIPAA IG Note:</b> Use this monetary amount for the total of HCPCS reported charges.	O	R	1/18	Situational
TS318	782	<b>Monetary Amount</b>	O	R	1/18	Situational

		<b>Description:</b> Monetary amount <b>Industry:</b> Total HCPCS Payable Amount <b>HIPAA IG Note:</b> Use this monetary amount for the total HCPCS payable amount.				
TS319	782	<b>Monetary Amount</b> <b>Description:</b> Monetary amount <b>Industry:</b> Total Deductible Amount <b>HIPAA IG Note:</b> Use this monetary amount for the total cash deductible.	O	R	1/18	Situational
TS320	782	<b>Monetary Amount</b> <b>Description:</b> Monetary amount <b>Industry:</b> Total Professional Component Amount <b>HIPAA IG Note:</b> Use this monetary amount for the total professional component amount. The professional component amount must also be reported in the CAS segment with a Claim Adjustment Reason Code value of 89.	O	R	1/18	Situational
TS321	782	<b>Monetary Amount</b> <b>Description:</b> Monetary amount <b>Industry:</b> Total MSP Patient Liability Met Amount <b>HIPAA IG Note:</b> Use this monetary amount for the total MSP patient liability met amount.	O	R	1/18	Situational
TS322	782	<b>Monetary Amount</b> <b>Description:</b> Monetary amount <b>Industry:</b> Total Patient Reimbursement Amount <b>HIPAA IG Note:</b> Use this monetary amount for the total patient reimbursement.	O	R	1/18	Situational
TS323	380	<b>Quantity</b> <b>Description:</b> Numeric value of quantity <b>Industry:</b> Total PIP Claim Count <b>HIPAA IG Note:</b> Use this number for the total PIP number of claims.	O	R	1/15	Situational
TS324	782	<b>Monetary Amount</b> <b>Description:</b> Monetary amount <b>Industry:</b> Total PIP Adjustment Amount <b>HIPAA IG Note:</b> Use the monetary amount for the payment amount for PIP claims.	O	R	1/18	Situational

**TS2****Provider Supplemental Summary Information**

Pos: 007	Max: 1
Detail - Optional	
Loop: 2000	Elements: 19

**User Option (Usage):** Situational

To provide supplemental summary control information by provider fiscal year and bill type

**Notes:**

1. Use the TS2 segment only after a TS3 segment. This segment provides summary information specific to an iteration of the LX loop (Table 2). This segment is expected to be used only for Medicare Part A claims.
2. All situational quantities and amounts in this segment are required when the value of the item is different than zero. Each total is for that provider for this type of bill for this fiscal period.

**Example:**

TS2\*59786\*55375.77~

**NYS MEDICAID NOTE:**

NYS will not use this segment.

**Element Summary:**

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
TS201	782	<b>Monetary Amount</b> <b>Description:</b> Monetary amount <b>Industry:</b> Total DRG Amount <b>HIPAA IG Note:</b> Use this monetary amount for the total DRG amount. For Medicare, this includes: operating federal-specific amount, operating hospital-specific amount, operating Indirect Medical Education amount, and operating Disproportionate Share Hospital amount. It does not include any operating outlier amount.	O	R	1/18	Situational
TS202	782	<b>Monetary Amount</b> <b>Description:</b> Monetary amount <b>Industry:</b> Total Federal Specific Amount <b>HIPAA IG Note:</b> Use this monetary amount for the total federal-specific amount.	O	R	1/18	Situational
TS203	782	<b>Monetary Amount</b> <b>Description:</b> Monetary amount <b>Industry:</b> Total Hospital Specific Amount <b>HIPAA IG Note:</b> Use this monetary amount for the total hospital-specific amount.	O	R	1/18	Situational
TS204	782	<b>Monetary Amount</b> <b>Description:</b> Monetary amount <b>Industry:</b> Total Disproportionate Share Amount <b>HIPAA IG Note:</b> Use this monetary amount for the total disproportionate share amount.	O	R	1/18	Situational
TS205	782	<b>Monetary Amount</b> <b>Description:</b> Monetary amount <b>Industry:</b> Total Capital Amount <b>HIPAA IG Note:</b> Use this monetary amount for the total capital amount. For Medicare, this includes: capital federal-specific amount, hospital federal-specific amount, hold harmless amount, Indirect Medical Education amount, Disproportionate Share Hospital amount, and the exception amount. It does not include any	O	R	1/18	Situational

		capital outlier amount.				
TS206	782	<b>Monetary Amount</b> <b>Description:</b> Monetary amount <b>Industry:</b> Total Indirect Medical Education Amount <b>HIPAA IG Note:</b> Use this monetary amount for the total indirect medical education amount.	O	R	1/18	Situational
TS207	380	<b>Quantity</b> <b>Description:</b> Numeric value of quantity <b>Industry:</b> Total Outlier Day Count <b>HIPAA IG Note:</b> Use this number for the total number of outlier days.	O	R	1/15	Situational
TS208	782	<b>Monetary Amount</b> <b>Description:</b> Monetary amount <b>Industry:</b> Total Day Outlier Amount <b>HIPAA IG Note:</b> Use this monetary amount for the total day outlier amount.	O	R	1/18	Situational
TS209	782	<b>Monetary Amount</b> <b>Description:</b> Monetary amount <b>Industry:</b> Total Cost Outlier Amount <b>HIPAA IG Note:</b> Use this monetary amount for the total cost outlier amount.	O	R	1/18	Situational
TS210	380	<b>Quantity</b> <b>Description:</b> Numeric value of quantity <b>Industry:</b> Average DRG Length of Stay <b>HIPAA IG Note:</b> Use this number for the DRG average length of stay.	O	R	1/15	Situational
TS211	380	<b>Quantity</b> <b>Description:</b> Numeric value of quantity <b>Industry:</b> Total Discharge Count <b>HIPAA IG Note:</b> Use this number for the total number of discharges. For Medicare, this is the discharge count produced by PPS PRICER SOFTWARE.	O	R	1/15	Situational
TS212	380	<b>Quantity</b> <b>Description:</b> Numeric value of quantity <b>Industry:</b> Total Cost Report Day Count <b>HIPAA IG Note:</b> Use this number for the total number of cost report days.	O	R	1/15	Situational
TS213	380	<b>Quantity</b> <b>Description:</b> Numeric value of quantity <b>Industry:</b> Total Covered Day Count <b>HIPAA IG Note:</b> Use this number for the total number of covered days.	O	R	1/15	Situational
TS214	380	<b>Quantity</b> <b>Description:</b> Numeric value of quantity <b>Industry:</b> Total Noncovered Day Count <b>HIPAA IG Note:</b> Use this number for the total number of non-covered days.	O	R	1/15	Situational
TS215	782	<b>Monetary Amount</b> <b>Description:</b> Monetary amount <b>Industry:</b> Total MSP Pass-Through Amount <b>HIPAA IG Note:</b> Use this amount for is the total MSP pass through amount calculated for a non-Medicare payer.	O	R	1/18	Situational
TS216	380	<b>Quantity</b> <b>Description:</b> Numeric value of quantity <b>Industry:</b> Average DRG weight <b>HIPAA IG Note:</b> Use this number for the average DRG weight.	O	R	1/15	Situational
TS217	782	<b>Monetary Amount</b> <b>Description:</b> Monetary amount <b>Industry:</b> Total PPS Capital FSP DRG Amount	O	R	1/18	Situational

		<b>HIPAA IG Note:</b> Use this monetary amount for the total PPS capital, federal-specific portion DRG amount.				
TS218	782	<b>Monetary Amount</b> <b>Description:</b> Monetary amount <b>Industry:</b> Total PPS Capital HSP DRG Amount <b>HIPAA IG Note:</b> Use this monetary amount for the total PPS capital, hospital-specific portion DRG amount.	O	R	1/18	Situational
TS219	782	<b>Monetary Amount</b> <b>Description:</b> Monetary amount <b>Industry:</b> Total PPS DSH DRG Amount <b>HIPAA IG Note:</b> Use this monetary amount for the total PPS disproportionate share, hospital DRG amount.	O	R	1/18	Situational

# CLP Claim Payment Information

Pos: 010	Max: 1
Detail - Mandatory	
Loop: 2100	Elements: 12

User Option (Usage): Required

To supply information common to all services of a claim

## Example:

CLP\*7722337\*1\*211366.97\*138018.4\*\*12\*119932404007801~

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>												
CLP01	1028	<b>Claim Submitter's Identifier</b> <b>Description:</b> Identifier used to track a claim from creation by the health care provider through payment <b>Industry:</b> Patient Control Number <b>HIPAA IG Note:</b> Use this number for the patient control number assigned by the provider. If the patient control number is not present on the incoming claim, enter zero. The value in CLP01 must be identical to any value received as a Claim Submitter's Identifier on the original claim (CLM01 of the ANSI ASC X12 837, if applicable). This data element is the primary key for posting the remittance information into the provider's database.	M	AN	1/38	Required												
CLP02	1029	<b>Claim Status Code</b> <b>Description:</b> Code identifying the status of an entire claim as assigned by the payor, claim review organization or repricing organization <b>NYS MEDICAID NOTE:</b> NYS will only support the following codes for this element. <table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>1</td> <td>Processed as Primary</td> </tr> <tr> <td>2</td> <td>Processed as Secondary</td> </tr> <tr> <td>3</td> <td>Processed as Tertiary</td> </tr> <tr> <td>4</td> <td>Denied</td> </tr> <tr> <td>22</td> <td>Reversal of Previous Payment</td> </tr> </tbody> </table>	<u>Code</u>	<u>Name</u>	1	Processed as Primary	2	Processed as Secondary	3	Processed as Tertiary	4	Denied	22	Reversal of Previous Payment	M	ID	1/2	Required
<u>Code</u>	<u>Name</u>																	
1	Processed as Primary																	
2	Processed as Secondary																	
3	Processed as Tertiary																	
4	Denied																	
22	Reversal of Previous Payment																	
CLP03	782	<b>Monetary Amount</b> <b>Description:</b> Monetary amount <b>Industry:</b> Total Claim Charge Amount <b>HIPAA IG Note:</b> See 2.2.1, Balancing, in this implementation guide for additional information. This amount does not include interest. Use this monetary amount for the submitted charges for this claim. The amount can be zero or less, but the value in BPR02 may not be negative.	M	R	1/18	Required												
CLP04	782	<b>Monetary Amount</b> <b>Description:</b> Monetary amount <b>Industry:</b> Claim Payment Amount <b>HIPAA IG Note:</b> See 2.2.1, Balancing, in this implementation guide for additional information. This amount does not include interest. Use this monetary amount for the amount paid for this claim. It can be zero or less, but the value in BPR02 may not be negative.	M	R	1/18	Required												
CLP05	782	<b>Monetary Amount</b>	O	R	1/18	Recommended												

**Description:** Monetary amount  
**Industry:** Patient Responsibility Amount  
**HIPAA IG Note:** Amounts in CLP05 should have supporting adjustments reflected in CAS segments at the CLP or SVC loop level with a Claim Adjustment Group (CAS01) code of PR (Patient Responsibility).  
 Use this monetary amount for the payer's statement of the patient responsibility amount for this claim, which can include such items as deductible, non-covered services, co-pay, and co-insurance. This amount must be entered if it is greater than zero. See 2.2.1, Balancing, and 2.2.9, Interest and Prompt Payment Discounts, for additional information.  
 For Medicare, this must be reported by carriers but is not used by intermediaries.

CLP06	1032		O	ID	1/2	Required
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**Claim Filing Indicator Code**  
**Description:** Code identifying type of claim  
**HIPAA IG Note:** For many providers to electronically post the 835 remittance data to their patient accounting systems without human intervention, a unique, provider-specific insurance plan code is needed. This code allows the provider to separately identify and manage the different product lines or contractual arrangements between the payer and the provider. Because most payers maintain the same Originating Company Identifier in the TRN03/BPR10 for all product lines or contractual relationships, the CLP06 is used by the provider as a table pointer in combination with the TRN03/BPR10 to identify the unique, provider-specific insurance plan code needed to post the payment without human intervention. The value should mirror the value received in the original claim (2-005 SBR09 of the 837), if applicable, or provide the value as assigned or edited by the payer.  
**NYS MEDICAID NOTE:** NYS will provide the value 'MC'.

<u>Code</u>	<u>Name</u>
MC	Medicaid

CLP07	127		O	AN	1/30	Recommended
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**Reference Identification**  
**Description:** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier  
**Industry:** Payer Claim Control Number  
**HIPAA IG Note:** Use this number for the payer's internal control number. This number must apply to the entire claim. Report service variations at the SVC loop.  
 This must be provided whenever the PAYER assigns an internal claim number and desires this reference from the provider as a part of any customer service contact or appeal process.

CLP08	1331		O	AN	1/2	Situational
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**Facility Code Value**  
**Description:** Code identifying the type of facility where services were performed; the first and second positions of the Uniform Bill Type code or the Place of Service code from the Electronic Media Claims National Standard Format  
**Industry:** Facility Type Code  
**HIPAA IG Note:** State the facility code here when the submitted code has been modified through

		adjudication. This code is expected to be from the same code list as that identified in the original claim. This number was received in CLM05-1 of the 837 claim.				
CLP09	1325	<p><b>Claim Frequency Type Code</b>  <b>Description:</b> Code specifying the frequency of the claim; this is the third position of the Uniform Billing Claim Form Bill Type  <b>Industry:</b> Claim Frequency Code  <b>CODE SOURCE:</b> 235: Claim Frequency Type Code  <b>HIPAA IG Note:</b> This data element is specific to institutional claims and is required when it was received on the original claim. This does not apply to other types of claims.  This number was received in CLM05-2 of the 837 claim.</p> <p><b>ExternalCodeList</b>  <b>Name:</b> 235  <b>Description:</b> Claim Frequency Type Code</p>	O	ID	1/1	Situational
CLP11	1354	<p><b>Diagnosis Related Group (DRG) Code</b>  <b>Description:</b> Code indicating a patient's diagnosis group based on a patient's illness, diseases, and medical problems  <b>CODE SOURCE:</b> 229: Diagnosis Related Group Number (DRG)  <b>HIPAA IG Note:</b> This data element is specific to institutional claims and is required when adjudication considers the DRG. This does not apply to other types of claims.</p> <p><b>ExternalCodeList</b>  <b>Name:</b> 229  <b>Description:</b> Diagnosis Related Group Number (DRG)</p>	O	ID	1/4	Situational
CLP12	380	<p><b>Quantity</b>  <b>Description:</b> Numeric value of quantity  <b>Industry:</b> Diagnosis Related Group (DRG) Weight  <b>HIPAA IG Note:</b> This data element is specific to institutional claims and is required when adjudication considers the DRG. This does not apply to other types of claims.  Use this number for the DRG Weight.</p>	O	R	1/15	Situational
CLP13	954	<p><b>Percent</b>  <b>Description:</b> Percentage expressed as a decimal  <b>Industry:</b> Discharge Fraction  <b>HIPAA IG Note:</b> This data element is specific to institutional claims and is required when considered in the adjudication process. This does not apply to other types of claims.  Use this number for the discharge fraction.</p>	O	R	1/10	Situational

# CAS Claim Adjustment

Pos: 020	Max: 99
Detail - Optional	
Loop: 2100	Elements: 19

**User Option (Usage):** Situational

To supply adjustment reason codes and amounts as needed for an entire claim or for a particular service within the claim being paid

## Notes:

1. Payers must use this CAS segment to report claim level adjustments that cause the amount paid to differ from the amount originally charged. See 2.2.1, Balancing, and 2.2.4, Claim Adjustment and Service Adjustment Segment Theory, for additional information.
2. See the SVC segment note #2 for details about per diem adjustments.
3. A single CAS segment contains 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-CAS04). If there is a second non-zero adjustment, it is reported in the second adjustment trio (CAS05-CAS07), and so on through the sixth adjustment trio (CAS17-CAS19).

## Example:

CAS\*PR\*1\*793~

## NYS MEDICAID NOTE:

NYS will provide claim level adjustments only for rate based claims.

## Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
CAS01	1033	<b>Claim Adjustment Group Code</b> <b>Description:</b> Code identifying the general category of payment adjustment <b>HIPAA IG Note:</b> Evaluate the group codes in CAS01 based on the following order for their applicability to a set of one or more adjustments: PR, CO, PI, CR, OA. See 2.2.4, Claim Adjustment and Service Adjustment Segment Theory, for additional information. (Note: This does not mean that the adjustments must be reported in this order.)	M	ID	1/2	Required
		<b>Code</b> <b>Name</b>				
		CO      Contractual Obligations Use this code when a joint payer/payee contractual agreement or a regulatory requirement resulted in an adjustment.				
		CR      Correction and Reversals Use this code for corrections and reversals to PRIOR claims. Use when CLP02=22, Reversal of Previous Payment.				
		OA      Other adjustments				
		PI      Payor Initiated Reductions Use this code when, in the opinion of the payer, the adjustment is not the responsibility of the patient, but there is no supporting contract between the provider and the payer (i.e., medical review or professional review organization adjustments).				
		PR      Patient Responsibility				
CAS02	1034	<b>Claim Adjustment Reason Code</b> <b>Description:</b> Code identifying the detailed reason the adjustment was made <b>Industry:</b> Adjustment Reason Code <b>CODE SOURCE:</b> 139: Claim Adjustment Reason Code	M	ID	1/5	Required
		<b>ExternalCodeList</b> <b>Name:</b> 139				

CAS03	782	<p><b>Description:</b> Claim Adjustment Reason Code</p> <p><b>Monetary Amount</b>  <b>Description:</b> Monetary amount  <b>Industry:</b> Adjustment Amount  <b>HIPAA IG Note:</b> Use this monetary amount for the adjustment amount. A negative amount increases the payment, and a positive amount decreases the payment contained in CLP04.</p>	M	R	1/18	Required
CAS04	380	<p><b>Quantity</b>  <b>Description:</b> Numeric value of quantity  <b>Industry:</b> Adjustment Quantity  <b>HIPAA IG Note:</b> A positive value decreases the paid units of service, and a negative number increases the paid units.  This element may be used only when the units of service are being adjusted.</p>	O	R	1/15	Situational
CAS05	1034	<p><b>Claim Adjustment Reason Code</b>  <b>Description:</b> Code identifying the detailed reason the adjustment was made  <b>Industry:</b> Adjustment Reason Code  <b>CODE SOURCE:</b> 139: Claim Adjustment Reason Code  <b>HIPAA IG Note:</b> Used when additional adjustments apply within the group identified in CAS01.  <b>ExternalCodeList</b>  <b>Name:</b> 139</p>	C	ID	1/5	Situational
CAS06	782	<p><b>Description:</b> Claim Adjustment Reason Code</p> <p><b>Monetary Amount</b>  <b>Description:</b> Monetary amount  <b>Industry:</b> Adjustment Amount  <b>HIPAA IG Note:</b> See CAS03.  Used when additional adjustments apply within the group identified in CAS01.</p>	C	R	1/18	Situational
CAS07	380	<p><b>Quantity</b>  <b>Description:</b> Numeric value of quantity  <b>Industry:</b> Adjustment Quantity  <b>HIPAA IG Note:</b> See CAS04.  Used when additional adjustments apply within the group identified in CAS01.</p>	C	R	1/15	Situational
CAS08	1034	<p><b>Claim Adjustment Reason Code</b>  <b>Description:</b> Code identifying the detailed reason the adjustment was made  <b>Industry:</b> Adjustment Reason Code  <b>CODE SOURCE:</b> 139: Claim Adjustment Reason Code  <b>HIPAA IG Note:</b> Used when additional adjustments apply within the group identified in CAS01.  <b>ExternalCodeList</b>  <b>Name:</b> 139</p>	C	ID	1/5	Situational
CAS09	782	<p><b>Description:</b> Claim Adjustment Reason Code</p> <p><b>Monetary Amount</b>  <b>Description:</b> Monetary amount  <b>Industry:</b> Adjustment Amount  <b>HIPAA IG Note:</b> See CAS03.  Used when additional adjustments apply within the group identified in CAS01.</p>	C	R	1/18	Situational
CAS10	380	<p><b>Quantity</b>  <b>Description:</b> Numeric value of quantity  <b>Industry:</b> Adjustment Quantity  <b>HIPAA IG Note:</b> See CAS04.  Used when additional adjustments apply within the</p>	C	R	1/15	Situational

CAS11	1034	group identified in CAS01. <b>Claim Adjustment Reason Code</b> <b>Description:</b> Code identifying the detailed reason the adjustment was made <b>Industry:</b> Adjustment Reason Code <b>CODE SOURCE:</b> 139: Claim Adjustment Reason Code <b>HIPAA IG Note:</b> Used when additional adjustments apply within the group identified in CAS01. <b>ExternalCodeList</b> <b>Name:</b> 139 <b>Description:</b> Claim Adjustment Reason Code	C	ID	1/5	Situational
CAS12	782	<b>Monetary Amount</b> <b>Description:</b> Monetary amount <b>Industry:</b> Adjustment Amount <b>HIPAA IG Note:</b> See CAS03. Used when additional adjustments apply within the group identified in CAS01.	C	R	1/18	Situational
CAS13	380	<b>Quantity</b> <b>Description:</b> Numeric value of quantity <b>Industry:</b> Adjustment Quantity <b>HIPAA IG Note:</b> See CAS04. Used when additional adjustments apply within the group identified in CAS01.	C	R	1/15	Situational
CAS14	1034	<b>Claim Adjustment Reason Code</b> <b>Description:</b> Code identifying the detailed reason the adjustment was made <b>Industry:</b> Adjustment Reason Code <b>CODE SOURCE:</b> 139: Claim Adjustment Reason Code <b>HIPAA IG Note:</b> Used when additional adjustments apply within the group identified in CAS01. <b>ExternalCodeList</b> <b>Name:</b> 139 <b>Description:</b> Claim Adjustment Reason Code	C	ID	1/5	Situational
CAS15	782	<b>Monetary Amount</b> <b>Description:</b> Monetary amount <b>Industry:</b> Adjustment Amount <b>HIPAA IG Note:</b> See CAS03. Used when additional adjustments apply within the group identified in CAS01.	C	R	1/18	Situational
CAS16	380	<b>Quantity</b> <b>Description:</b> Numeric value of quantity <b>Industry:</b> Adjustment Quantity <b>HIPAA IG Note:</b> See CAS04. 1418 Used when additional adjustments apply within the group identified in CAS01.	C	R	1/15	Situational
CAS17	1034	<b>Claim Adjustment Reason Code</b> <b>Description:</b> Code identifying the detailed reason the adjustment was made <b>Industry:</b> Adjustment Reason Code <b>CODE SOURCE:</b> 139: Claim Adjustment Reason Code <b>HIPAA IG Note:</b> Used when additional adjustments apply within the group identified in CAS01. <b>ExternalCodeList</b> <b>Name:</b> 139 <b>Description:</b> Claim Adjustment Reason Code	C	ID	1/5	Situational
CAS18	782	<b>Monetary Amount</b> <b>Description:</b> Monetary amount	C	R	1/18	Situational

CAS19	380	<b>Industry:</b> Adjustment Amount <b>HIPAA IG Note:</b> See CAS03. Used when additional adjustments apply within the group identified in CAS01.	C	R	1/15	Situational
		<b>Quantity</b> <b>Description:</b> Numeric value of quantity <b>Industry:</b> Adjustment Quantity <b>HIPAA IG Note:</b> See CAS04. Used when additional adjustments apply within the group identified in CAS01.				

# NM1 Patient Name

Pos: 030	Max: 1
Detail - Mandatory	
Loop: 2100	Elements: 8

**User Option (Usage):** Required

To supply the full name of an individual or organizational entity

## Notes:

1. Provide the patient's identification number in NM109.

## Example:

NM1\*QC\*1\*SHEPHARD\*SAM\*O\*\*\*HN\*666666666A~

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
NM101	98	<b>Entity Identifier Code</b> <b>Description:</b> Code identifying an organizational entity, a physical location, property or an individual <b>Code</b> <b>Name</b> QC                Patient	M	ID	2/3	Required
NM102	1065	<b>Entity Type Qualifier</b> <b>Description:</b> Code qualifying the type of entity <b>Code</b> <b>Name</b> 1                 Person	M	ID	1/1	Required
NM103	1035	<b>Name Last or Organization Name</b> <b>Description:</b> Individual last name or organizational name <b>Industry:</b> Patient Last Name	O	AN	1/35	Required
NM104	1036	<b>Name First</b> <b>Description:</b> Individual first name <b>Industry:</b> Patient First Name	O	AN	1/25	Required
NM105	1037	<b>Name Middle</b> <b>Description:</b> Individual middle name or initial <b>Industry:</b> Patient Middle Name <b>HIPAA IG Note:</b> If this data element is used and contains only one character, it is assumed to represent the middle initial. The middle name or initial is required when the individual has a middle name or initial and it is known.	O	AN	1/25	Situational
NM107	1039	<b>Name Suffix</b> <b>Description:</b> Suffix to individual name <b>Industry:</b> Patient Name Suffix <b>HIPAA IG Note:</b> The Suffix should be reported whenever this information is necessary for identification of the individual, for instance when a Junior and Senior are covered under the same subscriber.	O	AN	1/10	Not recommended
NM108	66	<b>Identification Code Qualifier</b> <b>Description:</b> Code designating the system/method of code structure used for Identification Code (67) <b>HIPAA IG Note:</b> Required if the patient identifier is known or was reported on the health care claim. <b>NYS MEDICAID NOTE:</b> NYS will provide the qualifier 'MR'. <b>Code</b> <b>Name</b>	C	ID	1/2	Recommended

MR Medicaid Recipient Identification Number

NM109	67	<b>Identification Code</b> <b>Description:</b> Code identifying a party or other code <b>Industry:</b> Patient Identifier <b>HIPAA IG Note:</b> Required if the patient identifier is known or was reported on the health care claim. <b>NYS MEDICAID NOTE:</b> NYS will provide the Medicaid Recipient ID.	C	AN	2/80	Recommended
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**NM1****Corrected Patient/Insured Name**

Pos: 030	Max: 1
Detail - Optional	
Loop: 2100	Elements: 8

**User Option (Usage):** Situational

To supply the full name of an individual or organizational entity

**Notes:**

1. Use this NM1 segment to provide corrected information about the patient or insured. Because the patient is always the insured for Medicare and Medicaid, this segment always provides corrected patient information for Medicare and Medicaid. For other carriers, this will always be the corrected insured information.

**Example:**

NM1\*74\*1\*SHEPARD\*SAMUEL\*O\*\*\*C\*66666666A~

**Element Summary:**

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
NM101	98	<b>Entity Identifier Code</b> <b>Description:</b> Code identifying an organizational entity, a physical location, property or an individual <b>Code</b> <b>Name</b> 74                  Corrected Insured	M	ID	2/3	Required
NM102	1065	<b>Entity Type Qualifier</b> <b>Description:</b> Code qualifying the type of entity <b>Code</b> <b>Name</b> 1                  Person	M	ID	1/1	Required
NM103	1035	<b>Name Last or Organization Name</b> <b>Description:</b> Individual last name or organizational name <b>Industry:</b> Corrected Patient or Insured Last Name <b>HIPAA IG Note:</b> Required when corrected information for the Insured is available.	O	AN	1/35	Situational
NM104	1036	<b>Name First</b> <b>Description:</b> Individual first name <b>Industry:</b> Corrected Patient or Insured First Name <b>HIPAA IG Note:</b> Required when corrected information for the Insured is available. This element may only be used when NM102 is 1 (person).	O	AN	1/25	Situational
NM105	1037	<b>Name Middle</b> <b>Description:</b> Individual middle name or initial <b>Industry:</b> Corrected Patient or Insured Middle Name <b>HIPAA IG Note:</b> If this data element is used and contains only one character, it is assumed to represent the middle initial. Required when corrected information for the Insured is available. This element may only be used when NM102 is 1 (person).	O	AN	1/25	Situational
NM107	1039	<b>Name Suffix</b> <b>Description:</b> Suffix to individual name <b>Industry:</b> Corrected Patient or Insured Name Suffix <b>HIPAA IG Note:</b> Required when corrected information for the Insured is available. This element may only be used when NM102 is 1 (person).	O	AN	1/10	Not recommended

NM108	66	<b>Identification Code Qualifier</b> <b>Description:</b> Code designating the system/method of code structure used for Identification Code (67) <b>HIPAA IG Note:</b> Required when a value is reported in NM109. <b>All valid standard codes are used.</b>	C	ID	1/2	Situational
NM109	67	<b>Identification Code</b> <b>Description:</b> Code identifying a party or other code <b>Industry:</b> Corrected Insured Identification Indicator <b>HIPAA IG Note:</b> Required when corrected information for the Insured is available.	C	AN	2/80	Situational

# NM1 Service Provider Name

Pos: 030	Max: 1
Detail - Optional	
Loop: 2100	Elements: 8

**User Option (Usage):** Situational

To supply the full name of an individual or organizational entity

## Notes:

1. Use this NM1 segment to provide information about the rendering provider. Any reference number should be provided in NM109. This segment is required when the rendering provider is different from the Payee.
2. This information is provided to facilitate identification of the claim within a payee's system. Other providers related to the claim but not directly related to the payment are not supported and are not necessary for claim identification.

## Example:

NM1\*82\*2\*\*\*\*\*XX\*12345678~

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
NM101	98	<b>Entity Identifier Code</b> <b>Description:</b> Code identifying an organizational entity, a physical location, property or an individual <b>Code</b> <b>Name</b> 82                  Rendering Provider	M	ID	2/3	Required
NM102	1065	<b>Entity Type Qualifier</b> <b>Description:</b> Code qualifying the type of entity <b>Code</b> <b>Name</b> 1                  Person 2                  Non-Person Entity	M	ID	1/1	Required
NM103	1035	<b>Name Last or Organization Name</b> <b>Description:</b> Individual last name or organizational name <b>Industry:</b> Rendering Provider Last or Organization Name <b>HIPAA IG Note:</b> Required when needed to confirm the identifier in NM109.	O	AN	1/35	Situational
NM104	1036	<b>Name First</b> <b>Description:</b> Individual first name <b>Industry:</b> Rendering Provider First Name <b>HIPAA IG Note:</b> If NM102 is a "2" this element is not used. Used when NM102=1 and the information is known.	O	AN	1/25	Situational
NM105	1037	<b>Name Middle</b> <b>Description:</b> Individual middle name or initial <b>Industry:</b> Rendering Provider Middle Name <b>HIPAA IG Note:</b> If NM102 is a "2" this element is not used. If this data element is used and contains only one character, it is assumed to represent the middle initial. The Middle name or initial is required when the individual has a middle name or initial. Used when NM102=1 and the information is known.	O	AN	1/25	Situational
NM107	1039	<b>Name Suffix</b> <b>Description:</b> Suffix to individual name <b>Industry:</b> Rendering Provider Name Suffix <b>HIPAA IG Note:</b> The Suffix should be reported whenever this information is necessary for	O	AN	1/10	Not recommended

identification of the individual, for instance when a Junior and Senior are covered under the same subscriber.

NM108 66 **Identification Code Qualifier** C ID 1/2 Required  
**Description:** Code designating the system/method of code structure used for Identification Code (67)  
**NYS MEDICAID NOTE:** NYS will provide the qualifier 'FI'.

<u>Code</u>	<u>Name</u>
FI	Federal Taxpayer's Identification Number
	ADVISED For individual providers as payees, use this number to represent the Social Security Number.

NM109 67 **Identification Code** C AN 2/80 Required  
**Description:** Code identifying a party or other code  
**Industry:** Rendering Provider Identifier  
**NYS MEDICAID NOTE:** NYS will provide the provider's tax id number.

**ExternalCodeList**  
**Name:** 537  
**Description:** Health Care Financing Administration National Provider Identifier

**NM1****Corrected Priority Payer Name**

Pos: 030	Max: 2
Detail - Optional	
Loop: 2100	Elements: 5

**User Option (Usage):** Situational

To supply the full name of an individual or organizational entity

**Notes:**

1. This segment is required when the current payer believes that another payer has priority for making a payment. Provide any reference numbers in NM109. Use of this segment identifies the priority payer. It is not necessary to use the Crossover Carrier NM1 segment in addition to this segment.

**Example:**

NM1\*PR\*2\*ACME INSURANCE\*\*\*\*\*XV\*123456789~

**Element Summary:**

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
NM101	98	<b>Entity Identifier Code</b> <b>Description:</b> Code identifying an organizational entity, a physical location, property or an individual <b>Code</b> <b>Name</b> PR                Payer	M	ID	2/3	Required
NM102	1065	<b>Entity Type Qualifier</b> <b>Description:</b> Code qualifying the type of entity <b>Code</b> <b>Name</b> 2                 Non-Person Entity	M	ID	1/1	Required
NM103	1035	<b>Name Last or Organization Name</b> <b>Description:</b> Individual last name or organizational name <b>Industry:</b> Corrected Priority Payer Name	O	AN	1/35	Required
NM108	66	<b>Identification Code Qualifier</b> <b>Description:</b> Code designating the system/method of code structure used for Identification Code (67) <b>NYS MEDICAID NOTE:</b> NYS will provide qualifier 'PI'. <b>Code</b> <b>Name</b> PI                Payor Identification	C	ID	1/2	Required
NM109	67	<b>Identification Code</b> <b>Description:</b> Code identifying a party or other code <b>Industry:</b> Corrected Priority Payer Identification Number <b>NYS MEDICAID NOTE:</b> NYS will provide the payer code that currently exists in the NYS Medicaid Third Party Liability files. This identifier is the same identifier reported in the current eligibility transaction.	C	AN	2/80	Required

# MIA Inpatient Adjudication Information

Pos: 033	Max: 1
Detail - Optional	
Loop: 2100	Elements: 24

**User Option (Usage):** Situational

To provide claim-level data related to the adjudication of Medicare inpatient claims

## Notes:

1. This segment should be generated by Medicare intermediaries.
2. Either MIA or MOA will appear, but not both.
3. This segment should not be used for covered days or lifetime reserve days. Use the Supplemental Claim Information Quantities Segment in the Claim Payment Loop.
4. All situational quantities and amounts in this segment are required when the value of the item is different than zero.
5. Payers and Payees outside of Medicare community may need to use this segment.

## Example:

MIA\*0\*\*\*138018.4~

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
MIA01	380	<b>Quantity</b> <b>Description:</b> Numeric value of quantity <b>Industry:</b> Covered Days or Visits Count <b>HIPAA IG Note:</b> Implementers of this guideline always transmit the number zero. See the QTY segment at the claim level for covered days or visits count.	M	R	1/15	Required
MIA02	380	<b>Quantity</b> <b>Description:</b> Numeric value of quantity <b>Industry:</b> PPS Operating Outlier Amount <b>HIPAA IG Note:</b> Use this to report PPS Operating Outlier. Additional payment for excessive cost incurred by provider.	O	R	1/15	Situational
MIA03	380	<b>Quantity</b> <b>Description:</b> Numeric value of quantity <b>Industry:</b> Lifetime Psychiatric Days Count <b>HIPAA IG Note:</b> Use this number for the lifetime psychiatric days.	O	R	1/15	Situational
MIA04	782	<b>Monetary Amount</b> <b>Description:</b> Monetary amount <b>Industry:</b> Claim DRG Amount <b>HIPAA IG Note:</b> Use this monetary amount for the DRG amount.	O	R	1/18	Situational
MIA05	127	<b>Reference Identification</b> <b>Description:</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier <b>Industry:</b> Remark Code <b>HIPAA IG Note:</b> Used when a Remittance Remark Code applies to this claim. <b>ExternalCodeList</b> <b>Name:</b> 411	O	AN	1/30	Situational
MIA06	782	<b>Monetary Amount</b> <b>Description:</b> Remittance Remark Codes <b>Description:</b> Monetary amount	O	R	1/18	Situational

MIA07	782	<p><b>Industry:</b> Claim Disproportionate Share Amount  <b>HIPAA IG Note:</b> Use this monetary amount for the disproportionate share amount.</p> <p><b>Monetary Amount</b>  <b>Description:</b> Monetary amount</p>	O	R	1/18	Situational
MIA08	782	<p><b>Industry:</b> Claim MSP Pass-through Amount  <b>HIPAA IG Note:</b> Use this monetary amount for the MSP pass through amount.</p> <p><b>Monetary Amount</b>  <b>Description:</b> Monetary amount</p>	O	R	1/18	Situational
MIA09	782	<p><b>Industry:</b> Claim PPS Capital Amount  <b>HIPAA IG Note:</b> Use this monetary amount for the total PPS capital amount.</p> <p><b>Monetary Amount</b>  <b>Description:</b> Monetary amount</p>	O	R	1/18	Situational
MIA10	782	<p><b>Industry:</b> PPS-Capital FSP DRG Amount  <b>HIPAA IG Note:</b> Use this monetary amount for the PPS capital, federal-specific portion DRG amount.</p> <p><b>Monetary Amount</b>  <b>Description:</b> Monetary amount</p>	O	R	1/18	Situational
MIA11	782	<p><b>Industry:</b> PPS-Capital HSP DRG Amount  <b>HIPAA IG Note:</b> Use this monetary amount for the PPS capital, hospital-specific portion DRG amount.</p> <p><b>Monetary Amount</b>  <b>Description:</b> Monetary amount</p>	O	R	1/18	Situational
MIA12	782	<p><b>Industry:</b> PPS-Capital DSH DRG Amount  <b>HIPAA IG Note:</b> Use this monetary amount for the PPS capital, disproportionate share, hospital DRG amount.</p> <p><b>Monetary Amount</b>  <b>Description:</b> Monetary amount</p>	O	R	1/18	Situational
MIA13	782	<p><b>Industry:</b> Old Capital Amount  <b>HIPAA IG Note:</b> Use this monetary amount for the old capital amount.</p> <p><b>Monetary Amount</b>  <b>Description:</b> Monetary amount</p>	O	R	1/18	Situational
MIA14	782	<p><b>Industry:</b> PPS-Capital IME amount  <b>HIPAA IG Note:</b> Use this monetary amount for the PPS capital indirect medical education claim amount.</p> <p><b>Monetary Amount</b>  <b>Description:</b> Monetary amount</p>	O	R	1/18	Situational
MIA15	380	<p><b>Industry:</b> PPS-Operating Hospital Specific DRG Amount  <b>HIPAA IG Note:</b> Use this monetary amount for the PPS (operating)/hospital-specific DRG amount.</p> <p><b>Quantity</b>  <b>Description:</b> Numeric value of quantity</p>	O	R	1/15	Situational
MIA16	782	<p><b>Industry:</b> Cost Report Day Count  <b>HIPAA IG Note:</b> Use this number for the cost report days.</p> <p><b>Monetary Amount</b>  <b>Description:</b> Monetary amount</p>	O	R	1/18	Situational
MIA17	782	<p><b>Industry:</b> PPS-Operating Federal Specific DRG Amount  <b>HIPAA IG Note:</b> Use this monetary amount for the PPS (operating)/federal-specific DRG amount.</p> <p><b>Monetary Amount</b>  <b>Description:</b> Monetary amount</p>	O	R	1/18	Situational
		<p><b>Industry:</b> Claim PPS Capital Outlier Amount  <b>HIPAA IG Note:</b> Use this monetary amount for the PPS capital outlier amount. This amount excludes</p>				

		the operating outlier amount, which is reflected in the AMT segment.				
MIA18	782	<b>Monetary Amount</b> <b>Description:</b> Monetary amount <b>Industry:</b> Claim Indirect Teaching Amount <b>HIPAA IG Note:</b> Use this monetary amount for the indirect teaching amount.	O	R	1/18	Situational
MIA19	782	<b>Monetary Amount</b> <b>Description:</b> Monetary amount <b>Industry:</b> Nonpayable Professional Component Amount <b>HIPAA IG Note:</b> Use this monetary amount for the professional component amount billed but not payable.	O	R	1/18	Situational
MIA20	127	<b>Reference Identification</b> <b>Description:</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier <b>Industry:</b> Remark Code <b>HIPAA IG Note:</b> Used when additional remittance remarks apply to this claim. <b>ExternalCodeList</b> <b>Name:</b> 411 <b>Description:</b> Remittance Remark Codes	O	AN	1/30	Situational
MIA21	127	<b>Reference Identification</b> <b>Description:</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier <b>Industry:</b> Remark Code <b>HIPAA IG Note:</b> Used when additional remittance remarks apply to this claim. <b>ExternalCodeList</b> <b>Name:</b> 411 <b>Description:</b> Remittance Remark Codes	O	AN	1/30	Situational
MIA22	127	<b>Reference Identification</b> <b>Description:</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier <b>Industry:</b> Remark Code <b>HIPAA IG Note:</b> Used when additional remittance remarks apply to this claim. <b>ExternalCodeList</b> <b>Name:</b> 411 <b>Description:</b> Remittance Remark Codes	O	AN	1/30	Situational
MIA23	127	<b>Reference Identification</b> <b>Description:</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier <b>Industry:</b> Remark Code <b>HIPAA IG Note:</b> Used when additional remittance remarks apply to this claim. <b>ExternalCodeList</b> <b>Name:</b> 411 <b>Description:</b> Remittance Remark Codes	O	AN	1/30	Situational
MIA24	782	<b>Monetary Amount</b> <b>Description:</b> Monetary amount <b>Industry:</b> PPS-Capital Exception Amount <b>HIPAA IG Note:</b> Use this monetary amount for the capital exception amount.	O	R	1/18	Situational

# MOA Outpatient Adjudication Information

Pos: 035	Max: 1
Detail - Optional	
Loop: 2100	Elements: 9

User Option (Usage): Situational

To convey claim-level data related to the adjudication of Medicare claims not related to an inpatient setting

## Notes:

1. This segment should be generated by Medicare carriers or Intermediaries.
2. Either MIA or MOA will appear, but not both.
3. All situational quantities and amounts in this segment are required when the value of the item is different than zero.
4. Payers and payees outside of Medicare community may need to use this segment.

## Example:

MOA\*\*\*MA01~

## Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
MOA01	954	<b>Percent</b> <b>Description:</b> Percentage expressed as a decimal <b>Industry:</b> Reimbursement Rate <b>HIPAA IG Note:</b> Use this number for the reimbursement rate. This does not apply to claims processed by Medicare Carriers.	O	R	1/10	Situational
MOA02	782	<b>Monetary Amount</b> <b>Description:</b> Monetary amount <b>Industry:</b> Claim HCPCS Payable Amount <b>HIPAA IG Note:</b> Use this monetary amount for the HCPCS payable amount. This does not apply to claims processed by Medicare Carriers.	O	R	1/18	Situational
MOA03	127	<b>Reference Identification</b> <b>Description:</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier <b>Industry:</b> Remark Code <b>HIPAA IG Note:</b> Used when a Remittance Remark Code applies to this claim. <b>ExternalCodeList</b> <b>Name:</b> 411 <b>Description:</b> Remittance Remark Codes	O	AN	1/30	Situational
MOA04	127	<b>Reference Identification</b> <b>Description:</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier <b>Industry:</b> Remark Code <b>HIPAA IG Note:</b> See MOA03. Used when additional remittance remarks apply to this claim. <b>ExternalCodeList</b> <b>Name:</b> 411 <b>Description:</b> Remittance Remark Codes	O	AN	1/30	Situational
MOA05	127	<b>Reference Identification</b> <b>Description:</b> Reference information as defined for a particular Transaction Set or as specified by the	O	AN	1/30	Situational

		Reference Identification Qualifier <b>Industry:</b> Remark Code <b>HIPAA IG Note:</b> See MOA03. Used when additional remittance remarks apply to this claim.				
MOA06	127	<b>ExternalCodeList</b> <b>Name:</b> 411 <b>Description:</b> Remittance Remark Codes <b>Reference Identification</b> <b>Description:</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier <b>Industry:</b> Remark Code <b>HIPAA IG Note:</b> See MOA03. Used when additional remittance remarks apply to this claim.	O	AN	1/30	Situational
MOA07	127	<b>ExternalCodeList</b> <b>Name:</b> 411 <b>Description:</b> Remittance Remark Codes <b>Reference Identification</b> <b>Description:</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier <b>Industry:</b> Remark Code <b>HIPAA IG Note:</b> See MOA03. Used when additional remittance remarks apply to this claim.	O	AN	1/30	Situational
MOA08	782	<b>Monetary Amount</b> <b>Description:</b> Monetary amount <b>Industry:</b> Claim ESRD Payment Amount <b>HIPAA IG Note:</b> Use this monetary amount for the ESRD payment amount. This does not apply to claims processed by Medicare Carriers.	O	R	1/18	Situational
MOA09	782	<b>Monetary Amount</b> <b>Description:</b> Monetary amount <b>Industry:</b> Nonpayable Professional Component Amount <b>HIPAA IG Note:</b> Use this monetary amount for the professional component amount billed but not payable. This does not apply to claims processed by Medicare Carriers.	O	R	1/18	Situational

# REF Other Claim Related Identification

Pos: 040	Max: 5
Detail - Optional	
Loop: 2100	Elements: 2

User Option (Usage): Situational

To specify identifying information

**Notes:**

1. Use this REF segment for reference numbers specific to the claim identified in the CLP segment. This is used to provide additional information used in the process of adjudicating this claim.

**Example:**

REF\*EA\*666123~

**Element Summary:**

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>						
REF01	128	<b>Reference Identification Qualifier</b> <b>Description:</b> Code qualifying the Reference Identification <b>NYS MEDICAID NOTE:</b> NYS will provide qualifier 'EA' or 'F8'.	M	ID	2/3	Required						
		<table border="0"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>EA</td> <td>Medical Record Identification Number</td> </tr> <tr> <td>F8</td> <td>Original Reference Number</td> </tr> </tbody> </table>	<u>Code</u>	<u>Name</u>	EA	Medical Record Identification Number	F8	Original Reference Number				
<u>Code</u>	<u>Name</u>											
EA	Medical Record Identification Number											
F8	Original Reference Number											
REF02	127	<b>Reference Identification</b> <b>Description:</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier <b>Industry:</b> Other Claim Related Identifier	C	AN	1/30	Required						

# REF Rendering Provider Identification

Pos: 040	Max: 10
Detail - Optional	
Loop: 2100	Elements: 2

User Option (Usage): Situational

To specify identifying information

**Notes:**

1. This REF segment should be used to provide reference numbers that are not already identified in NM1 segments within the CLP loop. The NM1 segment should always contain the primary reference number. This segment should only be used when additional reference numbers were submitted on the original claim.

**Example:**

REF\*1C\*12345678~

**Element Summary:**

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>				
REF01	128	<b>Reference Identification Qualifier</b> <b>Description:</b> Code qualifying the Reference Identification <b>NYS MEDICAID NOTE:</b> NYS will provide qualifier '1D'.	M	ID	2/3	Required				
REF02	127	<table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>1D</td> <td>Medicaid Provider Number</td> </tr> </tbody> </table> <b>Reference Identification</b> <b>Description:</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier <b>Industry:</b> Rendering Provider Secondary Identifier <b>ExternalCodeList</b> <b>Name:</b> 307 <b>Description:</b> National Association of Boards of Pharmacy Number	<u>Code</u>	<u>Name</u>	1D	Medicaid Provider Number	C	AN	1/30	Required
<u>Code</u>	<u>Name</u>									
1D	Medicaid Provider Number									

# DTM Claim Date

Pos: 050	Max: 4
Detail - Optional	
Loop: 2100	Elements: 2

**User Option (Usage):** Situational

To specify pertinent dates and times

**Notes:**

1. Dates must be provided at the claim level (2-050-DTM), the service line level (2-080-DTM), or both. Dates at the claim level apply to the entire claim, including all service lines. Dates at the service line level apply only to the service line where they appear.
2. When claim dates are not provided, service dates are required for every service line.
3. When claim dates are provided, service dates are not required, but they may be used to "override" the claim dates for individual service lines.

**Example:**

DTM\*233\*19960916~

**Element Summary:**

Ref	Id	Element Name	Req	Type	Min/Max	Usage
DTM01	374	<b>Date/Time Qualifier</b> <b>Description:</b> Code specifying type of date or time, or both date and time <b>Industry:</b> Date Time Qualifier <b>NYS MEDICAID NOTE:</b> NYS will provide qualifier '232' and/or '233'.	M	ID	3/3	Required
		<b>Code</b> <b>Name</b>				
		232      Claim Statement Period Start If the claim statement period start date is conveyed without a subsequent claim statement period end date, the end date is assumed to be the same as the start date. This date or code 233 should be considered required when service level dates are not provided in the remittance advice.				
		233      Claim Statement Period End If a claim statement period end date is conveyed without a claim statement period start date, then the start date is assumed to be different from the end date but not conveyed at the payer's discretion. See the note on code 232.				
DTM02	373	<b>Date</b> <b>Description:</b> Date expressed as CCYYMMDD <b>Industry:</b> Claim Date	C	DT	8/8	Required

# PER Claim Contact Information

Pos: 060	Max: 3
Detail - Optional	
Loop: 2100	Elements: 8

**User Option (Usage):** Situational

To identify a person or office to whom administrative communications should be directed

## Notes:

1. This segment should only be used when there is a claim specific communications contact instruction.
2. When the communication number represents a telephone number in the United States and other countries using the North American Dialing Plan (for voice, data, fax, etc.), the communication number should always include the area code and phone number using the format AAABBBCCCC. Where AAA is the area code, BBB is the telephone number prefix, and CCCC is the telephone number (e.g. (534)224-2525 would be represented as 5342242525). The extension, when applicable, should be included in the communication number immediately after the telephone number.
3. By definition of the standard, if PER03 is used, PER04 is required.

## Example:

PER\*CX\*\*TE\*8005551212~

## Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
PER01	366	<b>Contact Function Code</b> <b>Description:</b> Code identifying the major duty or responsibility of the person or group named <b>Code</b> <b>Name</b> CX                Payers Claim Office	M	ID	2/2	Required
PER02	93	<b>Name</b> <b>Description:</b> Free-form name <b>Industry:</b> Claim Contact Name <b>HIPAA IG Note:</b> Use this data element when the name of the individual to contact is not already defined or is different than the name within the prior name segment (e.g. N1 or NM1).	O	AN	1/60	Situational
PER03	365	<b>Communication Number Qualifier</b> <b>Description:</b> Code identifying the type of communication number <b>HIPAA IG Note:</b> Required if a contact communications number is to be transmitted. <b>Code</b> <b>Name</b> EM                Electronic Mail FX                Facsimile TE                Telephone	C	ID	2/2	Situational
PER04	364	<b>Communication Number</b> <b>Description:</b> Complete communications number including country or area code when applicable <b>Industry:</b> Claim Contact Communications Number <b>HIPAA IG Note:</b> Required if a contact communications number is to be transmitted.	C	AN	1/80	Situational
PER05	365	<b>Communication Number Qualifier</b> <b>Description:</b> Code identifying the type of communication number <b>HIPAA IG Note:</b> Required if a contact communications number is to be transmitted. <b>Code</b> <b>Name</b> EM                Electronic Mail EX                Telephone Extension	C	ID	2/2	Situational

When used, the value following this code is the extension for the preceding communications contact number.

FX Facsimile  
TE Telephone

PER06	364	<b>Communication Number</b>	C	AN	1/80	Situational
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**Description:** Complete communications number including country or area code when applicable  
**Industry:** Claim Contact Communications Number  
**HIPAA IG Note:** Required if a contact communications number is to be transmitted.

PER07	365	<b>Communication Number Qualifier</b>	C	ID	2/2	Situational
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**Description:** Code identifying the type of communication number  
**HIPAA IG Note:** Use this code only to provide the extension for the previous communications contact number.  
Required to convey a second communications contact number.

<u>Code</u>	<u>Name</u>
EX	Telephone Extension

PER08	364	<b>Communication Number</b>	C	AN	1/80	Situational
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**Description:** Complete communications number including country or area code when applicable  
**Industry:** Communication Number Extension  
**HIPAA IG Note:** Use this code only to provide the extension for the previous communications contact number.  
Required to convey a second communications contact number.

**QTY**

# Claim Supplemental Information Quantity

Pos: 064	Max: 15
Detail - Optional	
Loop: 2100	Elements: 2

**User Option (Usage):** Situational

To specify quantity information

**Notes:**

1. Use this segment to convey information only. It is not part of the financial balancing of the 835.
2. Use this segment only when the value of specific quantities identified in the QTY01 qualifier are Non-zero.

**Example:**

QTY\*ZK\*3~

**Element Summary:**

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
QTY01	673	<b>Quantity Qualifier</b> <b>Description:</b> Code specifying the type of quantity <b>NYS MEDICAID NOTE:</b> NYS will provide qualifiers 'CA', 'CD', or 'OU'.	M	ID	2/2	Required
		<b>Code</b> <b>Name</b>				
		CA                  Covered - Actual				
		CD                  Co-insured - Actual				
		OU                  Outlier Days				
QTY02	380	<b>Quantity</b> <b>Description:</b> Numeric value of quantity <b>Industry:</b> Claim Supplemental Information Quantity	C	R	1/15	Required

# SVC Service Payment Information

Pos: 070	Max: 1
Detail - Optional	
Loop: 2110	Elements: 7

**User Option (Usage):** Recommended

To supply payment and control information to a provider for a particular service

**Notes:**

1. Although the SVC loop is optional, there are times when it should be considered mandatory. Whenever the actual payment has been reduced due to service line specific adjustments, the SVC loop is necessary in order to understand the remittance information. This situation is particularly applicable to professional and fee-based services.
2. An exception to note 1 occurs with institutional claims when the room per diem is the only service line adjustment. In this instance, a claim level CAS adjustment to the per diem is appropriate (i.e., CAS\*CO\*78\*25~).
3. See 2.2.6, Procedure Code Bundling and Unbundling, for important SVC segment usage information.

**Example:**

SVC\*HC:99214\*100\*80~

**NYS MEDICAID NOTE:**

NYS will only provide line level information for claims that are processed as Fee for Service. (i.e. physician, DME, eye care, etc...)

**Element Summary:**

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
SVC01	C003	<b>Composite Medical Procedure Identifier</b> <b>Description:</b> To identify a medical procedure by its standardized codes and applicable modifiers <b>HIPAA IG Note:</b> Use the adjudicated Medical Procedure Code. This code is a composite data structure.	M	Comp		Required
	235	<b>Product/Service ID Qualifier</b> <b>Description:</b> Code identifying the type/source of the descriptive number used in Product/Service ID (234) <b>Industry:</b> Product or Service ID Qualifier <b>HIPAA IG Note:</b> The value in SVC01-01 qualifies the values in SVC01-02, SVC01-03, SVC01-04, SVC01-05, and SVC01-06. <b>NYS MEDICAID NOTE:</b> NYS will provide qualifiers 'HC', 'N4', or 'AD'.	M	ID	2/2	Required
		<b>Code</b> <b>Name</b>				
		AD      American Dental Association Codes				
		<b>CODE SOURCE:</b> 135: American Dental Association Codes				
		HC      Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes Because the CPT codes of the American Medical Association are also level 1 HCPCS codes, they are reported under the code HC.				
		<b>CODE SOURCE:</b> 130: Health Care Financing Administration Common Procedural Coding System				
		N4      National Drug Code in 5-4-2 Format				
		<b>CODE SOURCE:</b> 240: National Drug Code by Format				
	234	<b>Product/Service ID</b> <b>Description:</b> Identifying number for a product or service <b>Industry:</b> Procedure Code	M	AN	1/48	Required
		<b>ExternalCodeList</b> <b>Name:</b> 130				

**Description:** Health Care Financing Administration Common Procedural Coding System

**ExternalCodeList**

**Name:** 131

**Description:** International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure

**ExternalCodeList**

**Name:** 132

**Description:** National Uniform Billing Committee (NUBC) Codes

**ExternalCodeList**

**Name:** 135

**Description:** American Dental Association Codes

**ExternalCodeList**

**Name:** 240

**Description:** National Drug Code by Format

**ExternalCodeList**

**Name:** 513

**Description:** Home Infusion EDI Coalition (HIEC) Product/Service Code List

**ExternalCodeList**

**Name:** SNFR

**Description:** Skilled Nursing Facility Rate Code

1339		<b>Procedure Modifier</b>	O	AN	2/2		Situational
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**Description:** This identifies special circumstances related to the performance of the service, as defined by trading partners

**HIPAA IG Note:** Required when procedure code modifiers apply to this service.

1339		<b>Procedure Modifier</b>	O	AN	2/2		Situational
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**Description:** This identifies special circumstances related to the performance of the service, as defined by trading partners

**HIPAA IG Note:** Required when procedure code modifiers apply to this service.

1339		<b>Procedure Modifier</b>	O	AN	2/2		Situational
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**Description:** This identifies special circumstances related to the performance of the service, as defined by trading partners

**HIPAA IG Note:** Required when procedure code modifiers apply to this service.

1339		<b>Procedure Modifier</b>	O	AN	2/2		Situational
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**Description:** This identifies special circumstances related to the performance of the service, as defined by trading partners

**HIPAA IG Note:** Required when procedure code modifiers apply to this service.

352		<b>Description</b>	O	AN	1/80		Not recommended
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**Description:** A free-form description to clarify the related data elements and their content

**Industry:** Procedure Code Description

**HIPAA IG Note:** Avoid using the description to make it easier for the computer to process the information provided.

Used only when a description was received for the service on the original claim, and the adjudicated code is the submitted code.

SVC02	782	<b>Monetary Amount</b>	M	R	1/18		Required
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**Description:** Monetary amount

**Industry:** Line Item Charge Amount

**HIPAA IG Note:** Use this monetary amount for the submitted service charge amount.

SVC03	782	<b>Monetary Amount</b>	O	R	1/18		Required
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**Description:** Monetary amount  
**Industry:** Line Item Provider Payment Amount  
**HIPAA IG Note:** Use this number for the service amount paid. The value in SVC03 should equal the value in SVC02 minus all monetary amounts in the subsequent CAS segments of this loop. See 2.2.1, Balancing, for additional information.

SVC04	234	<p><b>Product/Service ID</b>  <b>Description:</b> Identifying number for a product or service  <b>Industry:</b> National Uniform Billing Committee Revenue Code  <b>HIPAA IG Note:</b> Use the National Uniform Billing Committee Revenue Code. Required when an NUBC revenue code was considered during adjudication in addition to a procedure code already identified in SVC01. If the original claim and adjudication only referenced an NUBC revenue code, that is supplied in SVC01 and this element is not used.</p>	O	AN	1/48	Situational
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**ExternalCodeList**

**Name:** 132

SVC05	380	<p><b>Description:</b> National Uniform Billing Committee (NUBC) Codes  <b>Quantity</b>  <b>Description:</b> Numeric value of quantity  <b>Industry:</b> Units of Service Paid Count  <b>HIPAA IG Note:</b> Use this number for the paid units of service. If not present, the value is assumed to be one.</p>	O	R	1/15	Situational
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SVC06	C003	<p><b>Composite Medical Procedure Identifier</b>  <b>Description:</b> To identify a medical procedure by its standardized codes and applicable modifiers  <b>HIPAA IG Note:</b> This is REQUIRED when the adjudicated procedure code provided in SVC01 is different from the submitted procedure code from the original claim. This is NOT USED when the submitted code is the same as the code on SVC01. This code is a composite data structure.</p>	O	Comp		Situational
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	235	<p><b>Product/Service ID Qualifier</b>  <b>Description:</b> Code identifying the type/source of the descriptive number used in Product/Service ID (234)  <b>Industry:</b> Product or Service ID Qualifier  <b>HIPAA IG Note:</b> The value in SVC06-01 qualifies the values in SVC06-02, SVC06-03, SVC06-04, SVC06-05, and SVC06-06.</p>	M	ID	2/2	Required
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<u>Code</u>	<u>Name</u>
AD	American Dental Association Codes <b>CODE SOURCE:</b> 135: American Dental Association Codes
ER	Jurisdiction Specific Procedure and Supply Codes This is specific to Workman's Compensation Claims.
HC	Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes Because the CPT codes of the American Medical Association are also level 1 HCPCS codes, they are reported under the code HC. <b>CODE SOURCE:</b> 130: Health Care Financing Administration Common Procedural Coding System
ID	International Classification of Diseases Clinical Modification (ICD-9-CM) - Procedure <b>CODE SOURCE:</b> 131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure
IV	Home Infusion EDI Coalition (HIEC) Product/Service Code

This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used 1) If a new rule names HIEC as an allowable code set under HIPAA. 2) For Property & Casualty claims/encounters that are not covered under HIPAA.

**CODE SOURCE:**

513: Home Infusion EDI Coalition (HIEC) Product/Service Code List

N4 National Drug Code in 5-4-2 Format

**CODE SOURCE:**

240: National Drug Code by Format

NU National Uniform Billing Committee (NUBC) UB92 Codes

**CODE SOURCE:**

132: National Uniform Billing Committee (NUBC) Codes

RB National Uniform Billing Committee (NUBC) UB82 Codes

**CODE SOURCE:**

132: National Uniform Billing Committee (NUBC) Codes

ZZ Mutually Defined

This is used to convey the Health Insurance Prospective Payment System (HIPPS) Skilled Nursing Facility Rate Code. This code list is available from: Division of Institutional Care Health Care Financing Administration S1-03-06

7500 Security Boulevard Baltimore, MD 21244-1850

234	<b>Product/Service ID</b>	M	AN	1/48	Required
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**Description:** Identifying number for a product or service

**Industry:** Procedure Code

**ExternalCodeList**

**Name:** 130

**Description:** Health Care Financing Administration Common Procedural Coding System

**ExternalCodeList**

**Name:** 131

**Description:** International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure

**ExternalCodeList**

**Name:** 132

**Description:** National Uniform Billing Committee (NUBC) Codes

**ExternalCodeList**

**Name:** 135

**Description:** American Dental Association Codes

**ExternalCodeList**

**Name:** 240

**Description:** National Drug Code by Format

**ExternalCodeList**

**Name:** 513

**Description:** Home Infusion EDI Coalition (HIEC) Product/Service Code List

**ExternalCodeList**

**Name:** SNFR

**Description:** Skilled Nursing Facility Rate Code

1339	<b>Procedure Modifier</b>	O	AN	2/2	Situational
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**Description:** This identifies special circumstances related to the performance of the service, as defined by trading partners

**HIPAA IG Note:** Required when procedure code modifiers apply to this service.

1339	<b>Procedure Modifier</b>	O	AN	2/2	Situational
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**Description:** This identifies special circumstances related to the performance of the service, as defined by trading partners

**HIPAA IG Note:** Required when procedure code

		modifiers apply to this service.				
	1339	<b>Procedure Modifier</b> <b>Description:</b> This identifies special circumstances related to the performance of the service, as defined by trading partners <b>HIPAA IG Note:</b> Required when procedure code modifiers apply to this service.	O	AN	2/2	Situational
	1339	<b>Procedure Modifier</b> <b>Description:</b> This identifies special circumstances related to the performance of the service, as defined by trading partners <b>HIPAA IG Note:</b> Required when procedure code modifiers apply to this service.	O	AN	2/2	Situational
	352	<b>Description</b> <b>Description:</b> A free-form description to clarify the related data elements and their content <b>Industry:</b> Procedure Code Description <b>HIPAA IG Note:</b> Avoid using the description to make it easier for the computer to process the information provided. Required when a description was received for the service on the original claim.	O	AN	1/80	Not recommended
SVC07	380	<b>Quantity</b> <b>Description:</b> Numeric value of quantity <b>Industry:</b> Original Units of Service Count <b>HIPAA IG Note:</b> This is REQUIRED when the paid units of service provided in SVC05 is different from the submitted units of service from the original claim. This is NOT USED when the submitted units is the same as the value in SVC05.	O	R	1/15	Situational

# CAS Service Adjustment

<b>Pos: 090</b>	<b>Max: 99</b>
<b>Detail - Optional</b>	
<b>Loop: 2110</b>	<b>Elements: 19</b>

**User Option (Usage):** Situational

To supply adjustment reason codes and amounts as needed for an entire claim or for a particular service within the claim being paid

**Notes:**

1. This CAS segment is optional and is intended to reflect reductions in payment due to adjustments particular to a specific service in the claim. An example of this level of CAS is the reduction for the part of the service charge that exceeds the usual and customary charge for the service. See 2.2.1, Balancing, and 2.2.4, Claim Adjustment and Service Adjustment Segment Theory, for additional information.
2. A single CAS segment contains 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-CAS04). If there is a second non-zero adjustment, it is reported in the second adjustment trio (CAS05-CAS07), and so on through the sixth adjustment trio (CAS17-CAS19).

**Example:**

CAS\*CO\*A2\*20~

**NYS MEDICAID NOTE:**

NYS will report service line specific adjustments here.

**Element Summary:**

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>																		
CAS01	1033	<b>Claim Adjustment Group Code</b> <b>Description:</b> Code identifying the general category of payment adjustment <b>HIPAA IG Note:</b> Evaluate the group codes in CAS01 based on the following order for their applicability to a set of one or more adjustments: PR, CO, PI, CR, OA. See 2.2.4, Claim Adjustment and Service Adjustment Segment Theory, for additional information. (Note: This does not mean that the adjustments must be reported in this order.)	M	ID	1/2	Required																		
		<table border="0"> <tr> <td><b>Code</b></td> <td><b>Name</b></td> </tr> <tr> <td>CO</td> <td>Contractual Obligations</td> </tr> <tr> <td></td> <td>Use this code when a joint payer/payee agreement or a regulatory requirement has resulted in an adjustment.</td> </tr> <tr> <td>CR</td> <td>Correction and Reversals</td> </tr> <tr> <td></td> <td>Use this code for corrections and reversals to PRIOR claims. Use when CLP02=22.</td> </tr> <tr> <td>OA</td> <td>Other adjustments</td> </tr> <tr> <td>PI</td> <td>Payor Initiated Reductions</td> </tr> <tr> <td></td> <td>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.</td> </tr> <tr> <td>PR</td> <td>Patient Responsibility</td> </tr> </table>	<b>Code</b>	<b>Name</b>	CO	Contractual Obligations		Use this code when a joint payer/payee agreement or a regulatory requirement has resulted in an adjustment.	CR	Correction and Reversals		Use this code for corrections and reversals to PRIOR claims. Use when CLP02=22.	OA	Other adjustments	PI	Payor Initiated Reductions		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	Patient Responsibility				
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PR	Patient Responsibility																							
CAS02	1034	<b>Claim Adjustment Reason Code</b> <b>Description:</b> Code identifying the detailed reason the adjustment was made <b>Industry:</b> Adjustment Reason Code <b>CODE SOURCE:</b> 139: Claim Adjustment Reason Code <b>ExternalCodeList</b> <b>Name:</b> 139 <b>Description:</b> Claim Adjustment Reason Code	M	ID	1/5	Required																		

CAS03	782	<b>Monetary Amount</b> <b>Description:</b> Monetary amount <b>Industry:</b> Adjustment Amount <b>HIPAA IG Note:</b> Use this monetary amount for the adjustment amount. A negative amount increases the payment, and a positive amount decreases the payment contained in SVC03 and CLP04.	M	R	1/18	Required
CAS04	380	<b>Quantity</b> <b>Description:</b> Numeric value of quantity <b>Industry:</b> Adjustment Quantity <b>HIPAA IG Note:</b> This element may be used only when the units of service are being adjusted. A positive number decreases paid units, and a negative value increases paid units.	O	R	1/15	Situational
CAS05	1034	<b>Claim Adjustment Reason Code</b> <b>Description:</b> Code identifying the detailed reason the adjustment was made <b>Industry:</b> Adjustment Reason Code <b>CODE SOURCE:</b> 139: Claim Adjustment Reason Code <b>HIPAA IG Note:</b> See CAS02. Used when additional adjustments apply within the group identified in CAS01. <u><b>ExternalCodeList</b></u> <b>Name:</b> 139 <b>Description:</b> Claim Adjustment Reason Code	C	ID	1/5	Situational
CAS06	782	<b>Monetary Amount</b> <b>Description:</b> Monetary amount <b>Industry:</b> Adjustment Amount <b>HIPAA IG Note:</b> See CAS03. 1437 Used when additional adjustments apply within the group identified in CAS01.	C	R	1/18	Situational
CAS07	380	<b>Quantity</b> <b>Description:</b> Numeric value of quantity <b>Industry:</b> Adjustment Quantity <b>HIPAA IG Note:</b> See CAS04. Used when additional adjustments apply within the group identified in CAS01.	C	R	1/15	Situational
CAS08	1034	<b>Claim Adjustment Reason Code</b> <b>Description:</b> Code identifying the detailed reason the adjustment was made <b>Industry:</b> Adjustment Reason Code <b>CODE SOURCE:</b> 139: Claim Adjustment Reason Code <b>HIPAA IG Note:</b> See CAS02. Used when additional adjustments apply within the group identified in CAS01. <u><b>ExternalCodeList</b></u> <b>Name:</b> 139 <b>Description:</b> Claim Adjustment Reason Code	C	ID	1/5	Situational
CAS09	782	<b>Monetary Amount</b> <b>Description:</b> Monetary amount <b>Industry:</b> Adjustment Amount <b>HIPAA IG Note:</b> See CAS03. Used when additional adjustments apply within the group identified in CAS01.	C	R	1/18	Situational
CAS10	380	<b>Quantity</b> <b>Description:</b> Numeric value of quantity <b>Industry:</b> Adjustment Quantity <b>HIPAA IG Note:</b> See CAS04. Used when additional adjustments apply within the group identified in CAS01.	C	R	1/15	Situational

CAS11	1034	<p><b>Claim Adjustment Reason Code</b>  <b>Description:</b> Code identifying the detailed reason the adjustment was made  <b>Industry:</b> Adjustment Reason Code  <b>CODE SOURCE:</b> 139: Claim Adjustment Reason Code  <b>HIPAA IG Note:</b> See CAS02.  Used when additional adjustments apply within the group identified in CAS01.  <u><b>ExternalCodeList</b></u>  <b>Name:</b> 139  <b>Description:</b> Claim Adjustment Reason Code</p>	C	ID	1/5	Situational
CAS12	782	<p><b>Monetary Amount</b>  <b>Description:</b> Monetary amount  <b>Industry:</b> Adjustment Amount  <b>HIPAA IG Note:</b> See CAS03.  Used when additional adjustments apply within the group identified in CAS01.</p>	C	R	1/18	Situational
CAS13	380	<p><b>Quantity</b>  <b>Description:</b> Numeric value of quantity  <b>Industry:</b> Adjustment Quantity  <b>HIPAA IG Note:</b> See CAS04.  Used when additional adjustments apply within the group identified in CAS01.</p>	C	R	1/15	Situational
CAS14	1034	<p><b>Claim Adjustment Reason Code</b>  <b>Description:</b> Code identifying the detailed reason the adjustment was made  <b>Industry:</b> Adjustment Reason Code  <b>CODE SOURCE:</b> 139: Claim Adjustment Reason Code  <b>HIPAA IG Note:</b> See CAS02.  Used when additional adjustments apply within the group identified in CAS01.  <u><b>ExternalCodeList</b></u>  <b>Name:</b> 139  <b>Description:</b> Claim Adjustment Reason Code</p>	C	ID	1/5	Situational
CAS15	782	<p><b>Monetary Amount</b>  <b>Description:</b> Monetary amount  <b>Industry:</b> Adjustment Amount  <b>HIPAA IG Note:</b> See CAS03.  Used when additional adjustments apply within the group identified in CAS01.</p>	C	R	1/18	Situational
CAS16	380	<p><b>Quantity</b>  <b>Description:</b> Numeric value of quantity  <b>Industry:</b> Adjustment Quantity  <b>HIPAA IG Note:</b> See CAS04.  Used when additional adjustments apply within the group identified in CAS01.</p>	C	R	1/15	Situational
CAS17	1034	<p><b>Claim Adjustment Reason Code</b>  <b>Description:</b> Code identifying the detailed reason the adjustment was made  <b>Industry:</b> Adjustment Reason Code  <b>CODE SOURCE:</b> 139: Claim Adjustment Reason Code  <b>HIPAA IG Note:</b> See CAS02.  Used when additional adjustments apply within the group identified in CAS01.  <u><b>ExternalCodeList</b></u>  <b>Name:</b> 139  <b>Description:</b> Claim Adjustment Reason Code</p>	C	ID	1/5	Situational

CAS18	782	<b>Monetary Amount</b> <b>Description:</b> Monetary amount <b>Industry:</b> Adjustment Amount <b>HIPAA IG Note:</b> See CAS03. Used when additional adjustments apply within the group identified in CAS01.	C	R	1/18	Situational
CAS19	380	<b>Quantity</b> <b>Description:</b> Numeric value of quantity <b>Industry:</b> Adjustment Quantity <b>HIPAA IG Note:</b> See CAS04. Used when additional adjustments apply within the group identified in CAS01.	C	R	1/15	Situational

# REF Service Identification

Pos: 100	Max: 7
Detail - Optional	
Loop: 2110	Elements: 2

User Option (Usage): Situational

To specify identifying information

**Notes:**

1. Use this REF segment for reference numbers specific to the service identified by the SVC segment. This is used to provide additional information used in the process of adjudicating this service.

**Example:**

REF\*RB\*100~

**Element Summary:**

Ref	Id	Element Name	Req	Type	Min/Max	Usage						
REF01	128	<b>Reference Identification Qualifier</b> <b>Description:</b> Code qualifying the Reference Identification <b>NYS MEDICAID NOTE:</b> NYS will provide two iterations of this segment. one using qualifier 'LU' and one using qualifier '6R'.	M	ID	2/3	Required						
		<table border="1"> <thead> <tr> <th>Code</th> <th>Name</th> </tr> </thead> <tbody> <tr> <td>6R</td> <td>                     Provider Control Number                      This is the Line Item Control Number submitted in the 837, which is utilized by the provider for tracking purposes, if submitted on the claim this must be returned on remittance advice.                 </td> </tr> <tr> <td>LU</td> <td>Location Number</td> </tr> </tbody> </table>	Code	Name	6R	Provider Control Number This is the Line Item Control Number submitted in the 837, which is utilized by the provider for tracking purposes, if submitted on the claim this must be returned on remittance advice.	LU	Location Number				
Code	Name											
6R	Provider Control Number This is the Line Item Control Number submitted in the 837, which is utilized by the provider for tracking purposes, if submitted on the claim this must be returned on remittance advice.											
LU	Location Number											
REF02	127	<b>Reference Identification</b> <b>Description:</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier <b>Industry:</b> Provider Identifier	C	AN	1/30	Required						

# LQ

# Health Care Remark Codes

Pos: 130	Max: 99
Detail - Optional	
Loop: 2110	Elements: 2

**User Option (Usage):** Situational

Code to transmit standard industry codes

**Notes:**

1. Use this segment to provide informational remarks only. This segment has no impact on the actual payment. Changes in claim payment amounts are provided in the CAS segments.

**Example:**

LQ\*HE\*12345~

**Element Summary:**

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
LQ01	1270	<b>Code List Qualifier Code</b> <b>Description:</b> Code identifying a specific industry code list	O	ID	1/3	Required
		<b>Code</b> <b>Name</b> HE                              Claim Payment Remark Codes				
		<b>CODE SOURCE:</b> 411: Remittance Remark Codes				
		RX                              National Council for Prescription Drug Programs Reject/Payment Codes				
		<b>CODE SOURCE:</b> 530: National Council for Prescription Drug Programs Reject/Payment Codes				
LQ02	1271	<b>Industry Code</b> <b>Description:</b> Code indicating a code from a specific industry code list <b>Industry:</b> Remark Code	C	AN	1/30	Required
		<b>ExternalCodeList</b> <b>Name:</b> 411 <b>Description:</b> Remittance Remark Codes				
		<b>ExternalCodeList</b> <b>Name:</b> 530 <b>Description:</b> National Council for Prescription Drug Programs Reject/Payment Codes				

# PLB Provider Adjustment

Pos: 010	Max: >1
Summary - Optional	
Loop: N/A	Elements: 14

User Option (Usage): Situational

To convey provider level adjustment information for debit or credit transactions such as, accelerated payments, cost report settlements for a fiscal year and timeliness report penalties unrelated to a specific claim or service

**Notes:**

1. Use the PLB segment to allow adjustments that are NOT specific to a particular claim or service to the amount of the actual payment. These adjustments can either decrease the payment (a positive number) or increase the payment (a negative number). Some examples of PLB adjustments are a loan repayment or a capitation payment. Multiple adjustments can be placed in one PLB segment, grouped by the provider identified in PLB01 and the period identified in PLB02. Although the PLB reference numbers are not standardized, refer to 2.2.10, Capitation and Related Payments or Adjustments, and 2.2.9, Interest and Prompt Payment Discounts, as well as to the HCFA Medicare Part A and B instructions for code suggestions and usage guidelines.

**Example:**

PLB\*123456\*19960930\*CV:9876514\*-1.27~

**Element Summary:**

Ref	Id	Element Name	Req	Type	Min/Max	Usage
PLB01	127	<b>Reference Identification</b> <b>Description:</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier <b>Industry:</b> Provider Identifier <b>HIPAA IG Note:</b> Use this number for the provider identifier as assigned by the payer.	M	AN	1/30	Required
PLB02	373	<b>Date</b> <b>Description:</b> Date expressed as CCYYMMDD <b>Industry:</b> Fiscal Period Date <b>HIPAA IG Note:</b> Use this date for the last day of the provider's fiscal year. If the end of the provider's fiscal year is not known by the payer, use December 31st of the current year.	M	DT	8/8	Required
PLB03	C042	<b>Adjustment Identifier</b> <b>Description:</b> To provide the category and identifying reference information for an adjustment <b>HIPAA IG Note:</b> This code is a composite data structure. The composite identifies the reason and identifying information for the adjustment dollar amount in PLB04.	M	Comp		Required
	426	<b>Adjustment Reason Code</b> <b>Description:</b> Code indicating reason for debit or credit memo or adjustment to invoice, debit or credit memo, or payment <b>NYS MEDICAID NOTE:</b> NYS will provide qualifier 'FB'.	M	ID	2/2	Required
		<b>Code</b> <b>Name</b> FB                              Forwarding Balance  Use this monetary amount for the balance forward. A negative value in PLB04 represents a balance moving forward to a future payment advice. A positive value represents a balance being applied from a previous payment advice. A reference number should be supplied in PLB03-2 for tracking purposes. Medicare Part A will provide code "BF" for negative values and "CO" for positive values in PLB03-2.				
	127	<b>Reference Identification</b> <b>Description:</b> Reference information as defined for a	O	AN	1/30	Situational

		particular Transaction Set or as specified by the Reference Identification Qualifier <b>Industry:</b> Provider Adjustment Identifier <b>HIPAA IG Note:</b> Medicare intermediaries must enter the applicable Medicare code (see Medicare A notes in PLB03-1) in positions 1-2, the Financial Control Number or other pertinent identifier in positions 3-19, and the patient's Health Insurance Claim Number (HIC) in positions 20-30 when the adjustment is related to a previously processed claim. Non-Medicare payers report any internally assigned reference identifier for the related adjustment. <b>NYS MEDICAID NOTE:</b> For both 'Claim Remittance' and 'Check Remittance', PLB03-2 contains the check number. (If no check is issued, i.e. in the case of a sumout, Remittance Number will be reported).				
PLB04	782	<b>Monetary Amount</b> <b>Description:</b> Monetary amount <b>Industry:</b> Provider Adjustment Amount <b>HIPAA IG Note:</b> Use this monetary amount for the adjustment amount for the preceding adjustment reason. <b>NYS MEDICAID NOTE:</b> For 'Claim Remittance', PLB04 will equal the sum of all the Claim Payment Amounts (CLP04) for this transaction, as required to balance the 835 transaction. For 'Check Remittance', PLB04 will equal the negative of the sum of all Claim Payment Amounts (CLP04) for this Pay-to Provider over all TSN's receiving an 835 Remittance/Advice.	M	R	1/18	Required
PLB05	C042	<b>Adjustment Identifier</b> <b>Description:</b> To provide the category and identifying reference information for an adjustment <b>HIPAA IG Note:</b> See PLB03 for details. Used when additional adjustments apply. <b>NYS MEDICAID NOTE:</b> Each non-claim specific adjustment is comprised of a composite adjustment identifier (PLB05-1 and PLB05-2) and an adjustment amount (PLB06).	C	Comp		Situational
	426	<b>Adjustment Reason Code</b> <b>Description:</b> Code indicating reason for debit or credit memo or adjustment to invoice, debit or credit memo, or payment <b>Code</b> <b>Name</b> WU                Unspecified Recovery	M	ID	2/2	Required
	127	<b>Reference Identification</b> <b>Description:</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier <b>Industry:</b> Provider Adjustment Identifier	O	AN	1/30	Situational
PLB06	782	<b>Monetary Amount</b> <b>Description:</b> Monetary amount <b>Industry:</b> Provider Adjustment Amount <b>HIPAA IG Note:</b> Use this monetary amount for the adjustment amount for the preceding adjustment reason.	C	R	1/18	Situational
PLB07	C042	<b>Adjustment Identifier</b> <b>Description:</b> To provide the category and identifying reference information for an adjustment <b>HIPAA IG Note:</b> See PLB03 for details. Used when additional adjustments apply.	C	Comp		Situational

	426	<b>Adjustment Reason Code</b> <b>Description:</b> Code indicating reason for debit or credit memo or adjustment to invoice, debit or credit memo, or payment <b>All valid standard codes are used.</b>	M	ID	2/2	Required
	127	<b>Reference Identification</b> <b>Description:</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier <b>Industry:</b> Provider Adjustment Identifier	O	AN	1/30	Situational
PLB08	782	<b>Monetary Amount</b> <b>Description:</b> Monetary amount <b>Industry:</b> Provider Adjustment Amount <b>HIPAA IG Note:</b> Use this monetary amount for the adjustment amount for the preceding adjustment reason.	C	R	1/18	Situational
PLB09	C042	<b>Adjustment Identifier</b> <b>Description:</b> To provide the category and identifying reference information for an adjustment <b>HIPAA IG Note:</b> See PLB03 for details. Used when additional adjustments apply.	C	Comp		Situational
	426	<b>Adjustment Reason Code</b> <b>Description:</b> Code indicating reason for debit or credit memo or adjustment to invoice, debit or credit memo, or payment <b>All valid standard codes are used.</b>	M	ID	2/2	Required
	127	<b>Reference Identification</b> <b>Description:</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier <b>Industry:</b> Provider Adjustment Identifier	O	AN	1/30	Situational
PLB10	782	<b>Monetary Amount</b> <b>Description:</b> Monetary amount <b>Industry:</b> Provider Adjustment Amount <b>HIPAA IG Note:</b> Use this monetary amount for the adjustment amount for the preceding adjustment reason.	C	R	1/18	Situational
PLB11	C042	<b>Adjustment Identifier</b> <b>Description:</b> To provide the category and identifying reference information for an adjustment <b>HIPAA IG Note:</b> See PLB03 for details. Used when additional adjustments apply.	C	Comp		Situational
	426	<b>Adjustment Reason Code</b> <b>Description:</b> Code indicating reason for debit or credit memo or adjustment to invoice, debit or credit memo, or payment <b>All valid standard codes are used.</b>	M	ID	2/2	Required
	127	<b>Reference Identification</b> <b>Description:</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier <b>Industry:</b> Provider Adjustment Identifier	O	AN	1/30	Situational
PLB12	782	<b>Monetary Amount</b> <b>Description:</b> Monetary amount <b>Industry:</b> Provider Adjustment Amount <b>HIPAA IG Note:</b> Use this monetary amount for the adjustment amount for the preceding adjustment reason.	C	R	1/18	Situational
PLB13	C042	<b>Adjustment Identifier</b> <b>Description:</b> To provide the category and identifying reference information for an adjustment <b>HIPAA IG Note:</b> See PLB03 for details.	C	Comp		Situational

		Used when additional adjustments apply.				
	426	<b>Adjustment Reason Code</b> <b>Description:</b> Code indicating reason for debit or credit memo or adjustment to invoice, debit or credit memo, or payment <b>All valid standard codes are used.</b>	M	ID	2/2	Required
	127	<b>Reference Identification</b> <b>Description:</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier <b>Industry:</b> Provider Adjustment Identifier	O	AN	1/30	Situational
PLB14	782	<b>Monetary Amount</b> <b>Description:</b> Monetary amount <b>Industry:</b> Provider Adjustment Amount <b>HIPAA IG Note:</b> Use this monetary amount for the adjustment amount for the preceding adjustment reason.	C	R	1/18	Situational

# SE Transaction Set Trailer

Pos: 020	Max: 1
Summary - Mandatory	
Loop: N/A	Elements: 2

**User Option (Usage):** Required

To indicate the end of the transaction set and provide the count of the transmitted segments (including the beginning (ST) and ending (SE) segments)

## Example:

SE\*45\*1234~

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
SE01	96	<b>Number of Included Segments</b> <b>Description:</b> Total number of segments included in a transaction set including ST and SE segments <b>Industry:</b> Transaction Segment Count	M	N0	1/10	Required
SE02	329	<b>Transaction Set Control Number</b> <b>Description:</b> Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set <b>HIPAA IG Note:</b> The Transaction Set Control Numbers in ST02 and SE02 must be identical. The originator assigns the Transaction Set Control Number, which must be unique within a functional group (GS-GE). This unique number also aids in error resolution research.	M	AN	4/9	Required