

eMedNY

New York State Department of Health Office of Health Insurance Programs

835 Health Care Claim: Payment Advice Companion Guide

HIPAA Version 4010X091A1: 835 Health Care Claim Payment Advice

Version: 4.1

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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 (NYSDOH) has provided this Medicaid Companion Guide for the 835 Health Care Claim Payment/Advice ASC X12N Transaction and associated addendum (004010X091A1) to assist Providers, Clearinghouses, and all Covered Entities in preparing HIPAA compliant transactions. This document was prepared using the Addendum version of the transaction. NYSDOH has focused primarily on the rules and policies regulating the processing of NYS Medicaid data that are provided within this Companion Guide. NYSDOH has provided the information on <https://www.nyhipaadesk.com> as a tool to make the Provider's job easier in processing/receiving electronic transactions in a HIPAA compliant manner.

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 NYSDOH 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 NYSDOH policy changes or as HIPAA legislation is updated or revised.

CG MODIFICATION TRACKING:

>V4.1 - eMedNY APG

- 01/31/2009 Corrected information added to CAS segment for APG Service lines.

>V4.0 - eMedNY APG

- 06/30/2008 New information added for Ambulatory Patient Group processing including new AMT and QTY segments (Qualifiers ZK and ZL). This information does not apply to non-APG providers.

>V3.0 - eMedNY NPI Version

09/18/07

- Removed phone system options information from NYS Medicaid Note in front matter, leaving the call center 800 number. Added note to refer to Technical Supplementary Guide.

02/08/07

- Publication Date = 01/31/07
- Change (title name) from Medicaid Management to Health Insurance Programs
- Update to Version 3.0 NPI Edition
- Add NPI User Notes (title and notes)
- Archived CG Modification Track prior to 12/02/05 to (Properties) Notes box
- Duplicated Electronic Remittance Flow: (for NPI Edition)
- Update 'RETROACTIVE RATE ADJUSTMENTS' and 'PROPRIETARY SUPPLEMENTARY FILE' notes.
- Modified NYS Medicaid Note in Loop 1000A (N301) to 'Office of Health Insurance Programs'
- Modified NYS Medicaid Note for NPI in Loop 1000B (N103 & N104)
- Modified NYS Medicaid Note for NPI in Loop 1000B (REF01 & REF02)
- Modified NYS Medicaid Note for NPI in Loop 2100 (NM108 & NM109)
- Modified NYS Medicaid Note for UB04 in Loop 2100 (CLP01)
- Modified NYS Medicaid Note for Fee-for-Service in Loop 2110 (REF01)
- Added NYS Medicaid Note for NPI in Summary for (PLB01)

>V2.3 - eMedNY Phase II

01/13/06

- Publication Date = 01/13/06,
- Updated Loop 2100, PER segment, NYS Medicaid Note to report State Contractor list for NYS state-submitted adjustments and voids, and to provide information for Retroactive Rate Adjustments.

12/23/05

- Publication Date = 12/12/05, Version = 2.3 - Implementation Date = 2/09/06 for cycle 1487.

- Add BPR-01 Qualifier 'H' (Notification Only) when payment amount is zero dollars.
- Add BPR-04 Payment Method Code 'NON' (Non-Payment Data) when payment amount is zero dollars.
- Add to NYS MEDICAID NOTE under Proprietary Supplemental File for added denial information.

PHASE II changes

FUNCTIONALITY:

- PHASE II cuts a separate check for each remittance created. This will allow NYSDOH to comply with the Implementation Guide as written.
- PHASE II uses a 4-character ETIN. Please plan for future ETINs assigned by New York State Department of Health. Outbound transactions will return the ETINs as received on inbound transactions.
- PHASE II uses a 3-digit Location Code that must be submitted on inbound transactions as right justified and zero filled. On outbound transactions, the Code that was submitted will be returned.
- PHASE II uses a 16-digit Transaction Control Number (TCN), but will continue to support the usage of the 15-digit CRN for adjustments and voids when applicable.

- FORMAT OF TCN:

Positions 1 - 5 = Julian Date

Positions 6 - 14 = 9-digit Sequence Number

Position 15 Media (claim submission method)

0 = Paper

2 = Electronic

3 = POS On line (NCPDP or 837P)

Position 16 Claim Type

0 = Original

1 = Credit Adjustment or Credit Void (Reversal)

2 = Debit Adjustment (Correction)

NATIONAL PROVIDER IDENTIFIER (NPI):

NPI will be required reporting for qualified health care providers regulated by the NPI rule. Non-NPI regulated providers will continue to receive and report NYS Medicaid provider identifiers.

ALL NYS MEDICAID PROVIDERS WHO ARE HEALTH CARE PROVIDERS ARE REQUIRED TO VISIT EMEDNY.ORG TO REGISTER THEIR NPI(S) AS SOON AS POSSIBLE.

NYSDOH will not be ready to implement the National Provider Identifier (NPI) in the eMedNY system by the mandated date of May 23, 2007. All submitters should continue to use the NYS Medicaid Provider ID, the Locator Code, and the License Number until NYSDOH announces that the system is ready to accept and return the NPI as the main provider identifier. However, it is encouraged to send the NPI along with the NYS Medicaid Provider ID and Locator Code in electronic claims transactions.

The 835 ERA will continue to return the Medicaid Provider Identifier of record until the NPI is implemented within the NYSDOH systems.

NYSDOH has developed the National Provider Identifier (NPI) Web Enabled Entry process as a means for providers/submitters to register their NPI(s) in the eMedNY system. The NPI Web Enabled Entry system can be accessed by going to www.emedny.org and clicking on "Enter NPI" located in the green box on the right of the screen.

It is required to register all NPIs associated with a NYS Medicaid provider by using the web-enabled application on the emedny.org website. A batch process for reporting the NPI to eMedNY is also available. Refer to the "NPI Information" area at emedny.org for the file specification for the batch process.

All submitters should be aware that after NPI implementation the NPI will be the only permitted provider identifier (except for non-healthcare providers) other than Tax-ID. The NYS Medicaid Provider ID, the Locator Code, and the License Number will all be disallowed.

NYS MEDICAID NOTE:

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

The Companion Guide, which is provided by NYSDOH, 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 sent by NYS Medicaid in transmission of 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 IG that will be required for processing transactions. It is important that Providers use this Companion Guide as a supplement to the IG. Within the IG, there are data elements, which have many different qualifiers available for use. Each qualifier identifies a different item of information. This document omits code qualifiers that are not necessary for NYS Medicaid processing. When necessary, a "NYS MEDICAID NOTE" is included to describe NYS Medicaid specific requirements. These notes provide guidance to ensure understanding of the information contained in the 835 Transaction.

SUPPORT:

Please refer to the Technical Supplementary Companion Guide for information about transaction header structures, transaction size limits, electronic communications methods, and enrollment as a trading partner. This document is available for download at nyhipaadesk.com.

For further assistance, NYSDOH and its fiscal agent, Computer Sciences Corporation (CSC), are urging providers to visit a web community, <https://www.nyhipaadesk.com>, which will provide Companion Guide updates and other pertinent information. In addition, questions may be sent to NYSDOH's Test Support Team at nyhipaadesk@csc.com.

Providers with questions may call the eMedNY Call Center at: 1-800-343-9000.

Please be advised that Unit representatives will only answer questions related to New York Medicaid HIPAA requirements.

Providers can locate information regarding External Code Sources in Appendix C of the IG.

Pharmacy Providers can acquire the NCPDP Implementation Guide from www.ncdp.org.

The ASC X12N Implementation Guides and their associated addenda, and Claim Adjustment Reason Codes and Remittance Remark Codes are available in electronic format at: www.wpc-edi.com/hipaa. NCPDP Remark Codes are available in electronic format at: www.ncdp.org. Additionally, NYSDOH has provided a crosswalk of NYSDOH proprietary edit reason codes to/from the National Code Sets at <https://www.nyhipaadesk.com>.

ELECTRONIC REMITTANCE FLOW: (For non-NPI regulated claims)

For 837I submissions: 835 transactions will be created based on the ETIN submitted in the 837 - NM109 (Loop 1000A), and by the "Pay-to" (Billing) Provider ID.

For 837P and 837D submissions: 835 transactions will be created based on the ETIN submitted in the 837 - NM109 (Loop 1000A), and by the "Pay-to" (Group or Billing Provider ID). (Note: the Group Provider ID overrides the Billing Provider ID in this instance.)

A separate check and a correlating 835 transaction will be cut based on the combination of Pay-to Provider ID and ETIN (submitted in the 837 transaction).

The 835 transaction will be sent back to the User ID requested on the Electronic Remittance 835/820 Request Form (located at <http://www.nyhipaadesk.com> or <http://www.emedny.org>). Said User ID is associated to an ETIN on the Form, and therefore, the ETIN should be the same ETIN as in NM109 (Loop 1000A) of the 837 transaction.

ELECTRONIC REMITTANCE FLOW: (NPI Edition for NPI regulated claims)

For 837I submissions: 835 transactions will be created based on the ETIN submitted in the 837 - NM109 (Loop 1000A), and by the "Pay-to" (Billing) Provider NPI.

For 837P and 837D submissions: 835 transactions will be created based on the ETIN submitted in the 837 - NM109 (Loop 1000A), and by the "Pay-to" (Group NPI or Billing Provider NPI). (Note: the Group Provider NPI overrides the Billing Provider NPI in this instance.)

A separate check and a correlating 835 transaction will be cut based on the combination of Pay-to Provider NPI and ETIN (submitted in the 837 transaction).

The 835 transaction will be sent back to the NPI (User ID for regulated providers) or Medicaid Provider (User ID for non-regulated providers) requested on the Electronic Remittance 835/820 Request Form (located at <http://www.nyhipaadesk.com> or <http://www.emedny.org>). Said NPI or Medicaid Provider (User ID) is associated to an ETIN on the Form, and therefore, the ETIN should be the same ETIN as in NM109 (Loop 1000A) of the 837 transaction.

DEFAULT ETINS (USAGE):

Providers who submit paper claims but prefer to receive an electronic 835 remittance, or providers that do not have an electronic mailbox address must first establish a default ETIN. Please visit <http://www.nyhipaadesk.com> to download the Electronic Remittance 835/820 Request Form.

RATE-BASED CLAIMS AND SERVICE LINES:

Rate-based claims will be reported with claim level information.

In addition to claim level information, Fee-for-Service will be reported with line level detail.

RETROACTIVE RATE ADJUSTMENTS:

Retroactive rate adjustments appear as adjustments (Reversal and Correction) on an 835. As these are internally initiated claim adjustments, they will be reported on an 835 that is transmitted to the applicable ETIN and NPI or Provider ID combination that is submitted on the original claim.

PROPRIETARY SUPPLEMENTARY FILE:

Pends do not appear on the 835 transaction. However, they will be reported on the 835 Supplementary File in a detailed format similar to the information supplied on the former proprietary remittance. Denied claims will also be reported on the 835 Supplemental File with additional Medicaid edit code detail, which is not available on the 835 transaction.

This file is automatically provided and will be transmitted with the 835 transaction. To view the 835 Supplementary File Information Companion Guide, please visit <https://nyhipaadesk.com> or www.emedny.org.

AMBULATORY PATIENT GROUPS (APG):

The eMedNY system will implement Ambulatory Patient Group (APG) processing for certain types of Institutional Outpatient claims. APG is one of the Prospective Payment Systems developed under CMS guidelines. Initial implementation for certain service types is scheduled for 2008 and 2009. Providers who perform these services will receive new rate codes that will cause their services to be priced using APG logic.

APG processing uses software that examines the procedure codes and modifiers reported in each of a claim's service lines and assigns each line an APG code along with other associated values. Each APG code carries a "weight" based on the group's clinical characteristics, from which appropriate payment levels can be established. The APG weight can be multiplied by a percentage to reduce or increase it, depending on the APG grouper's evaluation of the service line, resulting in the service line's "final weight". The final weight is multiplied by a provider-associated base rate ("conversion factor") as part of the APG payment calculation. For some provider types the APG payment is "blended" with a historical weighted average payment of the provider's pre-APG rates to arrive at the final payment amount. A single claim can be assigned one or more APG values, depending on the service line procedure codes, modifiers, and in some cases, diagnosis codes.

APG SERVICE TYPES:

As of the publication date of this document, the initial implementation of APG processing is to be applied for the service types shown below, with additional service types to be added in the future:

- Clinic Services
- Hospital-Based Outpatient Department Services
- Hospital-Based Ambulatory Surgery Services
- Emergency Department Services
- Freestanding Ambulatory Surgery Services
- Diagnostic and Treatment Center Services

EXCLUSIONS:

Certain Outpatient Department, Emergency Department, and Diagnostic and Treatment Center services will not undergo APG processing because not all services for those provider types are accounted for in the APG logic. Additionally, all services certified by the NYS mental hygiene agencies will be excluded. Other clinic services such as weekly dialysis may also be excluded.

APG PAYMENT METHODOLOGY:

APG grouping identifies the claim's significant procedure(s) and ancillary procedure(s) and assigns each line an APG Group Code and Payment Action Code. A "weighting factor" that is associated with the APG Code is multiplied by a percentage associated with

the Payment Action Code. When more than one service line receives the same APG code or a clinically related one, the lines may be bundled ("consolidated" or "packaged" - see below) together. Discounts may be applied for multiple significant procedures or for ancillary procedures. Units are not applied for pricing APG-processed services.

APG PAYMENT ACTION CODES:

- Full Payment (receives 100% of APG weighting factor): normally assigned to significant procedures when only one significant procedure is performed during the visit. Could be assigned to unrelated/unpackaged ancillary procedures also.
- Consolidated (receives 0% of APG weighting factor): if more than one significant procedure is performed during a visit, then it may be "consolidated" - bundled with another significant procedure and receive a 0% final weighting factor.
- Packaged (receives 0% of APG weighting factor): provides a means of including the cost of ancillary services within the reimbursement that is calculated for the significant procedure. An ancillary procedure can be "packaged" - bundled with a significant procedure even if not on the same service date.
- Discounted (receives 50% of APG weighting factor): Discounting provides a way of accounting for cost savings from efficiencies when multiple significant procedures and/or ancillary services (lab or non-lab) are performed during the same visit.
- Bilateral (receives 150% of APG weighting factor): A billed procedure can be identified as bilateral by examining procedure code modifiers.
- Discounted Bilateral (receives 75% of APG weighting factor): Separately billed procedures are discounted when the APG grouper identifies them as bilateral occurrences of the same service.
- Stand-alone: procedures identified as stand-alone will receive \$0.00 payment when they are the only procedures performed on a specific service date. Services that can receive the Stand Alone action code are payable only when performed on the same service date as a payable procedure.
- No Payment: assigned when no other valid value applies.

BLEND PAYMENTS AND EXISTING OPERATING COMPONENT:

APG - processed payment amounts will be phased in for Outpatient Department, Diagnosis and Treatment Center, and Freestanding Ambulatory Surgery providers in order to minimize the financial impact of the transition to APG processing. The APG calculated payment amount will be "blended" with the Existing Operating Component (EOC). The EOC is a weighted average of the provider's "non-APG" rate codes that are being replaced by the APG rate codes. Providers receiving blend payments will be phased in according to the following schedule:

year 1: 25% APG, 75% EOC
 year 2: 50% APG, 50% EOC
 year 3: 75% APG, 25% EOC
 year 4: 100% APG, 0% EOC

Services for Emergency Department and Hospital-based Ambulatory Surgery Centers will be processed using APG logic. However, these provider types will not have EOC payments applied and will not receive blended payments.

APG IMPACT ON PROVIDERS:

LINE LEVEL PROCESSING:

Providers whose services are adjudicated using APG processing may require preparation because their claims will be adjudicated at the service line level. The resulting changes in the Remittance Advice will require modifications to programming logic. Several new key concepts will be involved in claims processing, resulting in new data items being included.

APG UNASSIGNED FLAG - REASON CODES AND REMARK CODES:

The following Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) will be sent in the provider's 835 Remittance Advice when the APG grouper flagged the service line as ungroupable.

CARC RARC APG 999 Error Code

N/A	N/A	99900 - Line Item Assigned
16	N431	99901 - User Ignored (Line Action flag)
5	N428	99902 - Inpatient Procedure
81	N/A	99903 - Invalid Procedure Code

16	N19	99904 - Not Used by APGs
167	N/A	99905 - Invalid Dx for Medical Visit
167	N/A	99906 - E-code Dx for Medical Visit
96	M77	99907 - Non-covered Care or Settings
16	MA31	99908 - Invalid Date (Invalid or Out of Range)
16	M51	99909 - Invalid Procedure, Cannot be Blank
167	N/A	99910 - Direct Per Diem Code Without Qualifying Pdx
96	N20	99911 - Observation Condition Error
96	N20	99912 - DAO Condition Error
10	N/A	99913 - Gender Unknown or Invalid for Medical Gender Specific APG Assignment
96	N20	99914 - Home Management
167	N/A	99915 - User Option for Direct PD Assignment Off

Heading:

<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	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
LOOP ID - 1000A					1	N1/080L	
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
LOOP ID - 1000B					1	N1/080L	
080	N1	Payee Identification	O	1		N1/080	Required
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>
LOOP ID - 2000					≥1	N2/003L	
003	LX	Header Number	O	1		N2/003	Situational
LOOP ID - 2100					≥1		
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 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
050	DTM	Claim Date	O	4			Situational
060	PER	Claim Contact Information	O	3			Situational
LOOP ID - 2110					999		
070	SVC	Service Payment Information	O	1			Recommended
080	DTM	Service Date	O	3		N2/080	Situational
090	CAS	Service Adjustment	O	99		N2/090	Situational
090	CAS	Service Adjustment	O	99		N2/090	Situational
100	REF	Service Identification	O	7			Situational
100	REF	Service Identification	O	7			Situational
110	AMT	Service Supplemental Amount	O	12			Situational
110	AMT	Service Supplemental Amount	O	12			Situational
110	AMT	Service Supplemental Amount	O	12			Situational
120	QTY	Service Supplemental Quantity	O	6			Situational
120	QTY	Service Supplemental Quantity	O	6			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	Transaction Set Identifier Code Description: Code uniquely identifying a Transaction Set HIPAA IG Note: The only valid value within this transaction set for ST01 is 835.	M	ID	3/3	Required
		Code Name 835 Health Care Claim Payment/Advice				
ST02	329	Transaction Set Control Number Description: Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set HIPAA IG Note: 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. NYS MEDICAID NOTE: NYSDOH will return a 9-character control number.	M	AN	4/9	Required

BPR Financial Information

Pos: 020	Max: 1
Heading - Mandatory	
Loop: N/A	Elements: 14

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

HIPAA IG 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* 199999999*01*999988880*DA*98765*19960901~

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
BPR01	305	Transaction Handling Code Description: Code designating the action to be taken by all parties NYS MEDICAID NOTE: NYSDOH will provide value 'H' when the payment amount is zero dollars or the value 'I' when payment amount dollars occur.	M	ID	1/2	Required
		Code Name H Notification Only Use this code to pass information only without any reference to payment. Usually this code is used to pass predetermination of benefits information from a payer to a provider. I Remittance Information Only Use this code to indicate to the payee that the remittance detail is moving separately from the payment.				
BPR02	782	Monetary Amount Description: Monetary amount Industry: Total Actual Provider Payment Amount HIPAA IG Note: 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.	M	R	1/18	Required
BPR03	478	Credit/Debit Flag Code Description: Code indicating whether amount is a credit or debit Industry: Credit or Debit Flag Code NYS MEDICAID NOTE: NYSDOH will provide value 'C'.	M	ID	1/1	Required
		Code Name C Credit 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.				

BPR04 591 Payment Method Code M ID 3/3 Required

Description: Code identifying the method for the movement of payment instructions
NYS MEDICAID NOTE: NYSDOH will provide value 'CHK' or 'FWT' or 'NON'.

<u>Code</u>	<u>Name</u>
CHK	Check Use this code to indicate that a check has been issued for payment.
FWT	Federal Reserve Funds/Wire Transfer - Nonrepetitive Use this code to indicate that the funds were sent through the wire system.
NON	Non-Payment Data Use this code when the Transaction Handling Code (BPR01) is H, indicating that this is information only and no dollars are to be moved.

BPR06 506 (DFI) ID Number Qualifier C ID 2/2 Situational

Description: Code identifying the type of identification number of Depository Financial Institution (DFI)
Industry: Depository Financial Institution (DFI) Identification Number Qualifier
HIPAA IG Note: BPR06 through BPR09 relate to the originating financial institution and the originator's account (payer). This element is required when BPR04 is ACH, BOP or FWT.
NYS MEDICAID NOTE: NYSDOH will provide qualifier '01' if BPR04 is valued with 'FWT'.

<u>Code</u>	<u>Name</u>
01	ABA Transit Routing Number Including Check Digits (9 digits) ABA is a unique number identifying every bank in the United States. CODE SOURCE: 4: ABA Routing Number

BPR07 507 (DFI) Identification Number C AN 3/12 Situational

Description: Depository Financial Institution (DFI) identification number
Industry: Sender DFI Identifier
CODE SOURCE: 60: (DFI) Identification Number
HIPAA IG Note: Use this number for the identifying number of the financial institution sending the transaction into the ACH network. This element is required when BPR04 is ACH, BOP or FWT.

ExternalCodeList
Name: 4
Description: ABA Routing Number

ExternalCodeList
Name: 91
Description: Canadian Financial Institution Branch and Institution Number

BPR08 569 Account Number Qualifier O ID 1/3 Situational

Description: Code indicating the type of account
HIPAA IG Note: Use this code to identify the type of account in BPR09. This element is required when BPR04 is ACH, BOP or FWT.
NYS MEDICAID NOTE: NYSDOH will provide qualifier 'DA' if BPR04 is valued with 'FWT'.

<u>Code</u>	<u>Name</u>
-------------	-------------

DA Demand Deposit

BPR09 508 Account Number C AN 1/35 Situational

Description: Account number assigned
Industry: Sender Bank Account Number
HIPAA IG Note: Use this number for the originator's account number at his or her financial institution. This element is required when BPR04 is ACH, BOP or FWT.

BPR10 509 Originating Company Identifier O AN 10/10 Situational

Description: 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
Industry: Payer Identifier
HIPAA IG Note: BPR10 must be the Federal Tax ID Number, preceeded by a "1." When BPR10 is used, it must be identical to TRN03. This element is required when BPR04 is ACH, BOP or FWT.
NYS MEDICAID NOTE: NYSDOH will provide value '1141797357' if BPR04 is valued with 'FWT'.

BPR12 506 (DFI) ID Number Qualifier C ID 2/2 Situational

Description: Code identifying the type of identification number of Depository Financial Institution (DFI)
Industry: Depository Financial Institution (DFI) Identification Number Qualifier
HIPAA IG Note: BPR12 through BPR15 relate to the receiving financial institution and the receiver's account. This element is required when BPR04 is ACH, BOP or FWT.
NYS MEDICAID NOTE: NYSDOH will provide qualifier '01' if BPR04 is valued with 'FWT'.

Code Name
01 ABA Transit Routing Number Including Check Digits (9 digits)
ABA is a unique number identifying every bank in the United States.
CODE SOURCE:
4: ABA Routing Number

BPR13 507 (DFI) Identification Number C AN 3/12 Situational

Description: Depository Financial Institution (DFI) identification number
Industry: Receiver or Provider Bank ID Number
CODE SOURCE: 60: (DFI) Identification Number
HIPAA IG Note: Use this number for the identifying number of the financial institution receiving the transaction from the ACH network. This element is required when BPR04 is ACH, BOP or FWT.
ExternalCodeList
Name: 4
Description: ABA Routing Number
ExternalCodeList
Name: 91

		Description: Canadian Financial Institution Branch and Institution Number				
BPR14	569	Account Number Qualifier	O	ID	1/3	Situational
		Description: Code indicating the type of account HIPAA IG Note: Use this code to identify the type of account in BPR15. This element is required when BPR04 is ACH, BOP or FWT. NYS MEDICAID NOTE: NYSDOH will provide value 'DA' or 'SG' if BPR04 is valued with 'FWT'.				
		Code		Name		
		DA		Demand Deposit		
		SG		Savings		
BPR15	508	Account Number	C	AN	1/35	Situational
		Description: Account number assigned Industry: Receiver or Provider Account Number HIPAA IG Note: Use this number for the receiver's account number at the financial institution. This element is required when BPR04 is ACH, BOP or FWT.				
BPR16	373	Date	O	DT	8/8	Required
		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.				

TRN Reassociation Trace Number

Pos: 040	Max: 1
Heading - Optional	
Loop: N/A	Elements: 3

User Option (Usage): Required

To uniquely identify a transaction to an application

HIPAA IG 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:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>				
TRN01	481	Trace Type Code Description: Code identifying which transaction is being referenced <table border="0"> <tr> <td><u>Code</u></td> <td><u>Name</u></td> </tr> <tr> <td>1</td> <td>Current Transaction Trace Numbers</td> </tr> </table>	<u>Code</u>	<u>Name</u>	1	Current Transaction Trace Numbers	M	ID	1/2	Required
<u>Code</u>	<u>Name</u>									
1	Current Transaction Trace Numbers									
TRN02	127	Reference Identification Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier Industry: Check or EFT Trace Number HIPAA IG Note: 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. NYS MEDICAID NOTE: NYSDOH will provide the Check or EFT Trace Number. NYSDOH will return 'NO PAYMENT', if BPR02 is equal to 0.0.	M	AN	1/30	Required				
TRN03	509	Originating Company Identifier Description: 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 Industry: Payer Identifier HIPAA IG Note: TRN03 must contain the Federal Tax ID Number, preceded by a "1." When BPR10 is	O	AN	10/10	Required				

used, it must be identical to TRN03.
NYS MEDICAID NOTE: NYSDOH will provide value
'1141797357'.

REF Receiver Identification

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

User Option (Usage): Situational

To specify identifying information

HIPAA IG 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	Reference Identification Qualifier Description: Code qualifying the Reference Identification	M	ID	2/3	Required
		Code Name EV Receiver Identification Number				
REF02	127	Reference Identification Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier Industry: Receiver Identifier Alias: Receiver Identification NYS MEDICAID NOTE: NYSDOH will provide ETIN as submitted.	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

HIPAA IG 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	Reference Identification Qualifier Description: Code qualifying the Reference Identification Code Name F2 Version Code - Local	M	ID	2/3	Required
REF02	127	Reference Identification Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier Industry: Version Identification Code NYS MEDICAID NOTE: NYSDOH will provide '004010X091A1'.	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

HIPAA IG 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	Date/Time Qualifier Description: Code specifying type of date or time, or both date and time Industry: Date Time Qualifier	M	ID	3/3	Required
		Code 405		Name Production		
						Use this code for the end date for the adjudication production cycle for claims included in this 835.
DTM02	373	Date Description: Date expressed as CCYYMMDD Industry: Production Date	C	DT	8/8	Required

N1 Payer Identification

Pos: 080	Max: 1
Heading - Optional	
Loop: 1000A	Elements: 2

User Option (Usage): Required

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

HIPAA IG 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:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>				
N101	98	Entity Identifier Code Description: Code identifying an organizational entity, a physical location, property or an individual <table border="0"> <tr> <td><u>Code</u></td> <td><u>Name</u></td> </tr> <tr> <td>PR</td> <td>Payer</td> </tr> </table>	<u>Code</u>	<u>Name</u>	PR	Payer	M	ID	2/3	Required
<u>Code</u>	<u>Name</u>									
PR	Payer									
N102	93	Name Description: Free-form name Industry: Payer Name HIPAA IG Note: Required if the National PlanID is not transmitted in N104. NYS MEDICAID NOTE: NYSDOH will provide 'NYSDOH'.	C	AN	1/60	Situational				

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:

<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	Address Information Description: Address information Industry: Payer Address Line NYS MEDICAID NOTE: NYSDOH will provide 'Office of Health Insurance Programs'.	M	AN	1/55	Required
N302	166	Address Information Description: Address information Industry: Payer Address Line HIPAA IG Note: Required if a second address line exists. NYS MEDICAID NOTE: NYSDOH 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	City Name Description: Free-form text for city name Industry: Payer City Name NYS MEDICAID NOTE: NYSDOH will provide value 'Albany'.	O	AN	2/30	Required
N402	156	State or Province Code Description: Code (Standard State/Province) as defined by appropriate government agency Industry: Payer State Code CODE SOURCE: 22: States and Outlying Areas of the U.S. NYS MEDICAID NOTE: NYSDOH will provide value 'NY'. ExternalCodeList Name: 22 Description: States and Outlying Areas of the U.S.	O	ID	2/2	Required
N403	116	Postal Code Description: Code defining international postal zone code excluding punctuation and blanks (zip code for United States) Industry: Payer Postal Zone or ZIP Code CODE SOURCE: 51: ZIP Code NYS MEDICAID NOTE: NYSDOH will provide '122370080'. ExternalCodeList Name: 51 Description: 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

HIPAA IG 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:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
N101	98	Entity Identifier Code Description: Code identifying an organizational entity, a physical location, property or an individual	M	ID	2/3	Required
		Code Name PE Payee				
N102	93	Name Description: Free-form name Industry: Payee Name HIPAA IG Note: Required when N104 does not contain the National Provider Identifier. NYS MEDICAID NOTE: This is the provider name of the payee, as determined by the inbound claim.	C	AN	1/60	Situational
N103	66	Identification Code Qualifier Description: Code designating the system/method of code structure used for Identification Code (67) HIPAA IG Note: Required when N104 does not contain the National Provider Identifier. NYS MEDICAID NOTE: NYSDOH will provide qualifier 'XX'.	C	ID	1/2	Required
		Code Name XX Health Care Financing Administration National Provider Identifier				
N104	67	Identification Code Description: Code identifying a party or other code Industry: Payee Identification Code NYS MEDICAID NOTE: This is the National Provider Identifier number of the payee.	C	AN	2/80	Required

ExternalCodeList

Name: 537

Description: Health Care Financing Administration National Provider Identifier

REF Payee Additional Identification

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

User Option (Usage): Situational

To specify identifying information

HIPAA IG 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:

<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	Reference Identification Qualifier Description: Code qualifying the Reference Identification NYS MEDICAID NOTE: NYSDOH will provide qualifier 'TJ'. <u>Code</u> <u>Name</u> TJ Federal Taxpayer's Identification Number This information should be in the N1 segment unless the National Provider ID was used in N103/04. For individual providers as payees, use this number to represent the Social Security Number.	M	ID	2/3	Required
REF02	127	Reference Identification Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier Industry: Additional Payee Identifier NYS MEDICAID NOTE: NYSDOH will provide the Federal Tax ID of the payee.	C	AN	1/30	Required

ExternalCodeList

Name: 307

Description: National Association of Boards of Pharmacy Number

LX

Header Number

Pos: 003	Max: 1
Detail - Optional	
Loop: 2000	Elements: 1

User Option (Usage): Situational

To reference a line number in a transaction set

HIPAA IG 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	Assigned Number	M	NO	1/6	Required
<p>Description: Number assigned for differentiation within a transaction set</p> <p>NYS MEDICAID NOTE: NYSDOH will return value '1'.</p>						

CLP Claim Payment Information

Pos: 010	Max: 1
Detail - Mandatory	
Loop: 2100	Elements: 11

User Option (Usage): Required

To supply information common to all services of a claim

Example:

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

NYS MEDICAID NOTE:

For claims processed using Ambulatory Patient Group methodology and for fee-for-service claims, NYSDOH will provide a CLP segment with a corresponding SVC segment(s) - the CAS segment will be at the SVC level.

For rate-based claims the CLP segment and other segments in loop 2100 will report all payment and adjustment information.

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	Claim Submitter's Identifier Description: Identifier used to track a claim from creation by the health care provider through payment Industry: Patient Control Number HIPAA IG Note: 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. NYS MEDICAID NOTE: NYSDOH will return the information received in CLM01 of the 837. For NCPDP claims, NYSDOH will provide the prescription number entered as Prescription/Service Reference Number (402-D2). In some cases, NYSDOH will provide 'NOT PROVIDED' in instances when the Patient Control Number is not available, such as when processing adjustments or voids to 'old' history claims. For new eMedNY paper claim submissions, NYSDOH will return: - Office Account Number submitted on the new Claim Form A. - Patient Account Number submitted on the new NYS 1500. - Prescription Order Number submitted on the new Pharmacy form. - Patient Control Number submitted on the UB-92 form or after 5/21/07 on the new UB-04 form.	M	AN	1/38	Required
CLP02	1029	Claim Status Code Description: Code identifying the status of an entire	M	ID	1/2	Required
NYSDOH						eMedNY

claim as assigned by the payor, claim review organization or repricing organization
NYS MEDICAID NOTE: NYSDOH will also support the following values as applicable for this element:

<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	Monetary Amount Description: Monetary amount Industry: Total Claim Charge Amount HIPAA IG Note: 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	Monetary Amount Description: Monetary amount Industry: Claim Payment Amount HIPAA IG Note: 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	Monetary Amount 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.	O	R	1/18	Situational
CLP06	1032	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	O	ID	1/2	Required

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: NYSDOH will provide value 'MC'.

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

CLP07	127	Reference Identification	O	AN	1/30	Situational
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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.
NYS MEDICAID NOTE: NYSDOH will provide the internally generated Transaction Control Number (TCN), formerly known as CRN.
 FORMAT OF TCN:
 Positions 1 – 5: Julian Date.
 Positions 6 – 14: 9-digit Sequence Number
 Position 15: Media (how claim came in)
 0 = Paper
 2 = Electronic
 3 = POS Online (NCPDP or 837P)
 Position 16: Claim Type
 0 = Original
 1 = Credit Adjustment or Credit Void (Reversal)
 2 = Debit Adjustment (Correction)

CLP08	1331	Facility Code Value	O	AN	1/2	Situational
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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.
NYS MEDICAID NOTE: NYSDOH will return this data element for rate-based claims only.

CLP09	1325	Claim Frequency Type Code	O	ID	1/1	Situational
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Description: Code specifying the frequency of the claim; this is the third position of the Uniform Billing Claim Form Bill Type

Industry: Claim Frequency Code
CODE SOURCE: 235: Claim Frequency Type Code
HIPAA IG Note: 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.
NYS MEDICAID NOTE: NYSDOH will return data when received in CLM05, Loop 2300 of the 837 transaction. A code of '7' will be returned for retroactive rate adjustments.

ExternalCodeList

Name: 235

Description: Claim Frequency Type Code

CLP11 1354

Diagnosis Related Group (DRG) Code

O ID 1/4 Situational

Description: Code indicating a patient's diagnosis group based on a patient's illness, diseases, and medical problems

CODE SOURCE: 229: Diagnosis Related Group Number (DRG)

HIPAA IG Note: 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.

NYS MEDICAID NOTE: For Institutional claims, NYSDOH will provide the value generated during claim processing.

ExternalCodeList

Name: 229

Description: Diagnosis Related Group Number (DRG)

CLP12 380

Quantity

O R 1/15 Situational

Description: Numeric value of quantity

Industry: Diagnosis Related Group (DRG) Weight

HIPAA IG Note: 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.

NYS MEDICAID NOTE: For Institutional claims, NYSDOH will provide the DRG weight, otherwise known as Service Intensity Weight.

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

HIPAA IG 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:

NYSDOH will provide claim level adjustments for rate-based claims in this segment. For all other claim types, NYSDOH will provide the CAS segment at the Loop 2110, segment SVC level.

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	Claim Adjustment Group Code	M	ID	1/2	Required
<p>Description: Code identifying the general category of payment adjustment</p> <p>HIPAA IG Note: 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.)</p> <p>NYS MEDICAID NOTE: NYSDOH will provide value 'CO', 'CR', 'OA' or 'PR'.</p>						
		Code	Name			
		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			
		PR	Patient Responsibility			
CAS02	1034	Claim Adjustment Reason Code	M	ID	1/5	Required
<p>Description: Code identifying the detailed reason the adjustment was made</p> <p>Industry: Adjustment Reason Code</p> <p>CODE SOURCE: 139: Claim Adjustment Reason</p>						

Code
NYS MEDICAID NOTE: Refer to NYS MEDICAID NOTE in Introduction for information regarding a crosswalk of Adjustment Reason Codes and MMIS Edit Reason Codes. Adjustment Reason Codes will be provided for approved and denied claims.

ExternalCodeList

Name: 139

Description: Claim Adjustment Reason Code

CAS03	782	Monetary Amount Description: Monetary amount Industry: Adjustment Amount HIPAA IG Note: Use this monetary amount for the adjustment amount. A negative amount increases the payment, and a positive amount decreases the payment contained in CLP04.	M	R	1/18	Required
CAS04	380	Quantity Description: Numeric value of quantity Industry: Adjustment Quantity HIPAA IG Note: 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. NYS MEDICAID NOTE: NYSDOH will report the difference between submitted units and paid units for clinic dialysis claims in the instance where submitted units have been changed during claim adjudication.	O	R	1/15	Situational
CAS05	1034	Claim Adjustment Reason Code Description: Code identifying the detailed reason the adjustment was made Industry: Adjustment Reason Code CODE SOURCE: 139: Claim Adjustment Reason Code HIPAA IG Note: Used when additional adjustments apply within the group identified in CAS01. NYS MEDICAID NOTE: Refer to NYS MEDICAID NOTE in CAS02.	C	ID	1/5	Situational
CAS06	782	Monetary Amount Description: Monetary amount Industry: Adjustment Amount HIPAA IG Note: See CAS03. Used when additional adjustments apply within the group identified in CAS01.	C	R	1/18	Situational
CAS07	380	Quantity Description: Numeric value of quantity Industry: Adjustment Quantity HIPAA IG Note: See CAS04. Used when additional adjustments apply within the group identified in CAS01. NYS MEDICAID NOTE: Refer to NYS MEDICAID NOTE in CAS04.	C	R	1/15	Situational
CAS08	1034	Claim Adjustment Reason Code Description: Code identifying the detailed reason	C	ID	1/5	Situational

the adjustment was made
Industry: Adjustment Reason Code
CODE SOURCE: 139: Claim Adjustment Reason Code
HIPAA IG Note: Used when additional adjustments apply within the group identified in CAS01.
NYS MEDICAID NOTE: Refer to NYS MEDICAID NOTE in CAS02.

ExternalCodeList

Name: 139

Description: Claim Adjustment Reason Code

CAS09	782	Monetary Amount	C	R	1/18	Situational
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Description: Monetary amount
Industry: Adjustment Amount
HIPAA IG Note: See CAS03.
 Used when additional adjustments apply within the group identified in CAS01.

CAS10	380	Quantity	C	R	1/15	Situational
-------	-----	-----------------	---	---	------	-------------

Description: Numeric value of quantity
Industry: Adjustment Quantity
HIPAA IG Note: See CAS04.
 Used when additional adjustments apply within the group identified in CAS01.
NYS MEDICAID NOTE: Refer to NYS MEDICAID NOTE in CAS04.

CAS11	1034	Claim Adjustment Reason Code	C	ID	1/5	Situational
-------	------	-------------------------------------	---	----	-----	-------------

Description: Code identifying the detailed reason the adjustment was made
Industry: Adjustment Reason Code
CODE SOURCE: 139: Claim Adjustment Reason Code
HIPAA IG Note: Used when additional adjustments apply within the group identified in CAS01.
NYS MEDICAID NOTE: Refer to NYS MEDICAID NOTE in CAS02.

ExternalCodeList

Name: 139

Description: Claim Adjustment Reason Code

CAS12	782	Monetary Amount	C	R	1/18	Situational
-------	-----	------------------------	---	---	------	-------------

Description: Monetary amount
Industry: Adjustment Amount
HIPAA IG Note: See CAS03.
 Used when additional adjustments apply within the group identified in CAS01.

CAS13	380	Quantity	C	R	1/15	Situational
-------	-----	-----------------	---	---	------	-------------

Description: Numeric value of quantity
Industry: Adjustment Quantity
HIPAA IG Note: See CAS04.
 Used when additional adjustments apply within the group identified in CAS01.
NYS MEDICAID NOTE: Refer to NYS MEDICAID NOTE in CAS04.

CAS14	1034	Claim Adjustment Reason Code	C	ID	1/5	Situational
-------	------	-------------------------------------	---	----	-----	-------------

Description: Code identifying the detailed reason the adjustment was made
Industry: Adjustment Reason Code
CODE SOURCE: 139: Claim Adjustment Reason

Code
HIPAA IG Note: Used when additional adjustments apply within the group identified in CAS01.
NYS MEDICAID NOTE: Refer to NYS MEDICAID NOTE in CAS02.

ExternalCodeList

Name: 139

Description: Claim Adjustment Reason Code

CAS15	782	Monetary Amount	C	R	1/18	Situational
-------	-----	------------------------	---	---	------	-------------

Description: Monetary amount
Industry: Adjustment Amount
HIPAA IG Note: See CAS03.
 Used when additional adjustments apply within the group identified in CAS01.

CAS16	380	Quantity	C	R	1/15	Situational
-------	-----	-----------------	---	---	------	-------------

Description: Numeric value of quantity
Industry: Adjustment Quantity
HIPAA IG Note: See CAS04.
 1418 Used when additional adjustments apply within the group identified in CAS01.
NYS MEDICAID NOTE: Refer to NYS MEDICAID NOTE in CAS04.

CAS17	1034	Claim Adjustment Reason Code	C	ID	1/5	Situational
-------	------	-------------------------------------	---	----	-----	-------------

Description: Code identifying the detailed reason the adjustment was made
Industry: Adjustment Reason Code
CODE SOURCE: 139: Claim Adjustment Reason Code
HIPAA IG Note: Used when additional adjustments apply within the group identified in CAS01.
NYS MEDICAID NOTE: Refer to NYS MEDICAID NOTE in CAS02.

ExternalCodeList

Name: 139

Description: Claim Adjustment Reason Code

CAS18	782	Monetary Amount	C	R	1/18	Situational
-------	-----	------------------------	---	---	------	-------------

Description: Monetary amount
Industry: Adjustment Amount
HIPAA IG Note: See CAS03.
 Used when additional adjustments apply within the group identified in CAS01.

CAS19	380	Quantity	C	R	1/15	Situational
-------	-----	-----------------	---	---	------	-------------

Description: Numeric value of quantity
Industry: Adjustment Quantity
HIPAA IG Note: See CAS04.
 Used when additional adjustments apply within the group identified in CAS01.
NYS MEDICAID NOTE: Refer to NYS MEDICAID NOTE in CAS04.

NM1 Patient Name

Pos: 030	Max: 1
Detail - Mandatory	
Loop: 2100	Elements: 7

User Option (Usage): Required

To supply the full name of an individual or organizational entity

HIPAA IG Notes:

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

Example:

NM1*QC*1*SHEPHARD*SAM*O***HN*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	Entity Identifier Code Description: Code identifying an organizational entity, a physical location, property or an individual <u>Code</u> <u>Name</u> QC Patient	M	ID	2/3	Required
NM102	1065	Entity Type Qualifier Description: Code qualifying the type of entity <u>Code</u> <u>Name</u> 1 Person	M	ID	1/1	Required
NM103	1035	Name Last or Organization Name Description: Individual last name or organizational name Industry: Patient Last Name	O	AN	1/35	Required
NM104	1036	Name First Description: Individual first name Industry: Patient First Name	O	AN	1/25	Required
NM105	1037	Name Middle Description: Individual middle name or initial Industry: Patient Middle Name HIPAA IG Note: 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
NM108	66	Identification Code Qualifier Description: Code designating the system/method of code structure used for Identification Code (67) HIPAA IG Note: Required if the patient identifier is known or was reported on the health care claim. NYS MEDICAID NOTE: NYSDOH will provide qualifier 'MI'. <u>Code</u> <u>Name</u>	C	ID	1/2	Situational

MI Member Identification Number

NM109 67

Identification Code

C

AN

2/80

Situational

Description: Code identifying a party or other code
Industry: Patient Identifier
HIPAA IG Note: Required if the patient identifier is known or was reported on the health care claim.
NYS MEDICAID NOTE: NYSDOH will provide Member Identification Number.

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

HIPAA IG 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:

Ref	Id	Element Name	Req	Type	Min/Max	Usage				
NM101	98	Entity Identifier Code Description: Code identifying an organizational entity, a physical location, property or an individual <table border="0"> <tr> <td><u>Code</u></td> <td><u>Name</u></td> </tr> <tr> <td>PR</td> <td>Payer</td> </tr> </table>	<u>Code</u>	<u>Name</u>	PR	Payer	M	ID	2/3	Required
<u>Code</u>	<u>Name</u>									
PR	Payer									
NM102	1065	Entity Type Qualifier Description: Code qualifying the type of entity <table border="0"> <tr> <td><u>Code</u></td> <td><u>Name</u></td> </tr> <tr> <td>2</td> <td>Non-Person Entity</td> </tr> </table>	<u>Code</u>	<u>Name</u>	2	Non-Person Entity	M	ID	1/1	Required
<u>Code</u>	<u>Name</u>									
2	Non-Person Entity									
NM103	1035	Name Last or Organization Name Description: Individual last name or organizational name Industry: Corrected Priority Payer Name	O	AN	1/35	Required				
NM108	66	Identification Code Qualifier Description: Code designating the system/method of code structure used for Identification Code (67) NYS MEDICAID NOTE: NYSDOH will provide qualifier 'PI'. <table border="0"> <tr> <td><u>Code</u></td> <td><u>Name</u></td> </tr> <tr> <td>PI</td> <td>Payor Identification</td> </tr> </table>	<u>Code</u>	<u>Name</u>	PI	Payor Identification	C	ID	1/2	Required
<u>Code</u>	<u>Name</u>									
PI	Payor Identification									
NM109	67	Identification Code Description: Code identifying a party or other code Industry: Corrected Priority Payer Identification Number NYS MEDICAID NOTE: NYSDOH will provide the payor code that currently exists in the NYS Medicaid Third Party Liability files. This identifier is the same identifier reported in the current eligibility transaction. The NYSDOH Identifier is a two (2)-character alpha/numeric data element.	C	AN	2/80	Required				

MIA Inpatient Adjudication Information

Pos: 033	Max: 1
Detail - Optional	
Loop: 2100	Elements: 6

User Option (Usage): Situational

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

HIPAA IG 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~

NYS MEDICAID NOTE:

This segment will be provided in order to provide remittance remark codes if applicable. Additionally, NYSDOH may return this segment for NYS state-submitted adjustments or voids.

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
MIA01	380	Quantity Description: Numeric value of quantity Industry: Covered Days or Visits Count HIPAA IG Note: 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
MIA05	127	Reference Identification Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier Industry: Remark Code HIPAA IG Note: Used when a Remittance Remark Code applies to this claim. NYS MEDICAID NOTE: For denied claims, Remittance Remark Code will be mapped to MIA05, and if applicable, MIA20, MIA21, MIA22 and MIA23. This code is used in conjunction with Claim Adjustment Reason Code (CAS02) for denied claims. NYSDOH may provide this element for NYS state-submitted adjustments or voids. Please refer to Loop 2100, PER segment for additional information for these claim types.	O	AN	1/30	Situational
MIA20	127	ExternalCodeList Name: 411 Description: Remittance Remark Codes	O	AN	1/30	Situational

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

Industry: Remark Code

HIPAA IG Note: Used when additional remittance remarks apply to this claim.

NYS MEDICAID NOTE: For denied claims, Remittance Remark Code will be mapped to MIA05, and if applicable, MIA20, MIA21, MIA22 and MIA23. This code is used in conjunction with Claim Adjustment Reason Code (CAS02) for denied claims.

ExternalCodeList

Name: 411

Description: Remittance Remark Codes

MIA21 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: Remark Code

HIPAA IG Note: Used when additional remittance remarks apply to this claim.

NYS MEDICAID NOTE: For denied claims, Remittance Remark Code will be mapped to MIA05, and if applicable, MIA20, MIA21, MIA22 and MIA23. This code is used in conjunction with Claim Adjustment Reason Code (CAS02) for denied claims.

ExternalCodeList

Name: 411

Description: Remittance Remark Codes

MIA22 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: Remark Code

HIPAA IG Note: Used when additional remittance remarks apply to this claim.

NYS MEDICAID NOTE: For denied claims, Remittance Remark Code will be mapped to MIA05, and if applicable, MIA20, MIA21, MIA22 and MIA23. This code is used in conjunction with Claim Adjustment Reason Code (CAS02) for denied claims.

ExternalCodeList

Name: 411

Description: Remittance Remark Codes

MIA23 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: Remark Code

HIPAA IG Note: Used when additional remittance remarks apply to this claim.

NYS MEDICAID NOTE: For denied claims, Remittance Remark Code will be mapped to MIA05, and if applicable, MIA20, MIA21, MIA22 and MIA23. This code is used in conjunction with Claim Adjustment Reason Code (CAS02) for denied

claims.

ExternalCodeList

Name: 411

Description: Remittance Remark Codes

MOA Outpatient Adjudication Information

Pos: 035	Max: 1
Detail - Optional	
Loop: 2100	Elements: 5

User Option (Usage): Situational

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

HIPAA IG 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~

NYS MEDICAID NOTE:

This segment will be provided in order to provide remittance remark codes if applicable. Additionally, NYSDOH may return this segment for NYS state-submitted adjustments or voids.

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>
MOA03	127	Reference Identification Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier Industry: Remark Code HIPAA IG Note: Used when a Remittance Remark Code applies to this claim. NYS MEDICAID NOTE: For denied claims, remittance remark code will be mapped to MOA03 and if applicable, MOA04, MOA05, MOA06, and MOA07. This code is used in conjunction with Claim Adjustment Reason Code (CAS02) for denied claims. NYSDOH may provide this element for NYS state-submitted adjustments or voids. Please refer to Loop 2100, PER segment for additional information for these claim types.	O	AN	1/30	Situational
MOA04	127	Reference Identification Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier Industry: Remark Code HIPAA IG Note: See MOA03. Used when additional remittance remarks apply to this claim.	O	AN	1/30	Situational

		Name: 411				
		Description: Remittance Remark Codes				
MOA05	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: Remark Code				
		HIPAA IG Note: See MOA03.				
		Used when additional remittance remarks apply to this claim.				
		ExternalCodeList				
		Name: 411				
		Description: Remittance Remark Codes				
MOA06	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: Remark Code				
		HIPAA IG Note: See MOA03.				
		Used when additional remittance remarks apply to this claim.				
		ExternalCodeList				
		Name: 411				
		Description: Remittance Remark Codes				
MOA07	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: Remark Code				
		HIPAA IG Note: See MOA03.				
		Used when additional remittance remarks apply to this claim.				
		ExternalCodeList				
		Name: 411				
		Description: Remittance Remark Codes				

REF Other Claim Related Identification

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

User Option (Usage): Situational

To specify identifying information

HIPAA IG 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~

NYS MEDICAID NOTE:

This segment may repeat three times to report the Medical Record Number, the related Claim Reference Number (CRN) or Transaction Control Number (TCN), and/or the Reimbursed Rate Code. This segment is not used for Retroactive Rate Adjustments.

(NOTE: When reporting the new adjudication of an adjusted claim, the related CRN/TCN provided will be the CRN/TCN of the prior claim that has been reversed. When reporting the reversal of a claim to be adjusted or voided, the CRN/TCN of the original claim is provided.)

FORMAT OF TCN:

Positions 1 – 5: Julian Date.

Positions 6 – 14: 9-digit Sequence Number

Position 15: Media (how claim came in)

- 0 = Paper
- 2 = Electronic
- 3 = POS Online (NCPDP or 837P)

Position 16: Claim Type

- 0 = Original
- 1 = Credit Adjustment or Credit Void (Reversal)
- 2 = Debit Adjustment (Replacement)

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage								
REF01	128	Reference Identification Qualifier	M	ID	2/3	Required								
Description: Code qualifying the Reference Identification NYS MEDICAID NOTE: NYSDOH will provide one of the following qualifiers:														
		<table border="1"> <thead> <tr> <th>Code</th> <th>Name</th> </tr> </thead> <tbody> <tr> <td>9A</td> <td>Repriced Claim Reference Number</td> </tr> <tr> <td>EA</td> <td>Medical Record Identification Number</td> </tr> <tr> <td>F8</td> <td>Original Reference Number</td> </tr> </tbody> </table>	Code	Name	9A	Repriced Claim Reference Number	EA	Medical Record Identification Number	F8	Original Reference Number				
Code	Name													
9A	Repriced Claim Reference Number													
EA	Medical Record Identification Number													
F8	Original Reference Number													
REF02	127	Reference Identification	C	AN	1/30	Required								
Description: Reference information as defined for a														

particular Transaction Set or as specified by the
Reference Identification Qualifier

Industry: Other Claim Related Identifier

NYS MEDICAID NOTE: NYSDOH will provide the
related CRN/TCN and/or Medical Record Number
and/or Reimbursed Rate Code.

DTM Claim Date

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

User Option (Usage): Situational

To specify pertinent dates and times

HIPAA IG 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~

NYS MEDICAID NOTE:

NYSDOH will provide Date(s) of Service.

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	Date/Time Qualifier Description: Code specifying type of date or time, or both date and time Industry: Date Time Qualifier NYS MEDICAID NOTE: NYSDOH will provide qualifier '232' or '232' and '233'.	M	ID	3/3	Required
		Code Name				
		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	Date Description: Date expressed as CCYYMMDD Industry: Claim Date	C	DT	8/8	Required

PER Claim Contact Information

Pos: 060	Max: 3
Detail - Optional	
Loop: 2100	Elements: 2

User Option (Usage): Situational

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

HIPAA IG 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~

NYS MEDICAID NOTE:

NYSDOH will provide State Contractor information when the claim is a NYS state- submitted adjustment or void. List follows:

- Bureau of Third Party Liability
- Center for Medicare Advocacy
- DOH (Department of Health)
- Health Management Systems
- Island Peer Review Organization
- New York State
- New York State Contractor
- NYS Office of Mental Health
- NYS Quality Review Alliance
- Public Consulting Group

For more information on state submitted adjustments or voids, refer to Loop 2100, segments MIA and MOA.

This segment will also be used to provide information indicating "Retro Rate Reversal" or "Retro Rate Correction" in the event of a Retroactive Rate Adjustment.

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>
PER01	366	Contact Function Code	M	ID	2/2	Required
Description: Code identifying the major duty or responsibility of the person or group named						
		<u>Code</u>		<u>Name</u>		
		CX		Payers Claim Office		
PER02	93	Name	O	AN	1/60	Situational
Description: Free-form name						
Industry: Claim Contact Name						
HIPAA IG Note: 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).						
NYS MEDICAID NOTE: NYSDOH will provide the name of the State Contractor when the claim is a NYS-state submitted adjustment or void.						
This data element will also be used to provide a						

message in PER02 indicating "Retro Rate Reversal" (credit adjustment) or "Retro Rate Correction" (debit adjustment) in the event of a Retroactive Rate Adjustment.

SVC Service Payment Information

Pos: 070	Max: 1
Detail - Optional	
Loop: 2110	Elements: 4

User Option (Usage): Recommended

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

HIPAA IG 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:

NYSDOH will only provide line level information for claims that are processed as Fee for Service (i.e. Physician, DME, Eye Care, etc.) or for claims processed using the Ambulatory Patient Group (APG) methodology. For these claim types, NYSDOH will provide a corresponding CLP segment - the CAS segment in this situation will be at the SVC level. For rate-based claims, service line information will not be provided in 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>
SVC01	C003	Composite Medical Procedure Identifier Description: To identify a medical procedure by its standardized codes and applicable modifiers HIPAA IG Note: Use the adjudicated Medical Procedure Code. This code is a composite data structure.	M	Comp		Required
	235	Product/Service ID Qualifier Description: Code identifying the type/source of the descriptive number used in Product/Service ID (234) Industry: Product or Service ID Qualifier HIPAA IG Note: The value in SVC01-01 qualifies the values in SVC01-02, SVC01-03, SVC01-04, SVC01-05, and SVC01-06. NYS MEDICAID NOTE: NYSDOH will provide qualifiers 'HC' or 'NU'. 'HC' will be sent if there was a HCPCS Procedure Code reported in the service line. If there was no HCPCS code 'NU' will be sent to indicate that an NUBC Revenue Code follows.	M	ID	2/2	Required
		Code Name AD American Dental Association Codes CODE SOURCE: 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. CODE SOURCE: 130: Health Care Financing Administration Common Procedural Coding System				

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
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	Product/Service ID	M	AN	1/48	Required
	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	Procedure Modifier	O	AN	2/2	Situational
	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	Procedure Modifier	O	AN	2/2	Situational
	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	Procedure Modifier	O	AN	2/2	Situational
	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	Procedure Modifier	O	AN	2/2	Situational

		<p>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.</p>				
SVC02	782	<p>Monetary Amount</p> <p>Description: Monetary amount Industry: Line Item Charge Amount HIPAA IG Note: Use this monetary amount for the submitted service charge amount.</p>	M	R	1/18	Required
SVC03	782	<p>Monetary Amount</p> <p>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.</p>	O	R	1/18	Required
SVC06	C003	<p>Composite Medical Procedure Identifier</p> <p>Description: To identify a medical procedure by its standardized codes and applicable modifiers HIPAA IG Note: 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. NYS MEDICAID NOTE: NYSDOH will send this Composite Data Element for APG processed claims only, for service lines that received zero payment and were consolidated into a paid line.</p>	O	Comp		Situational
	235	<p>Product/Service ID Qualifier</p> <p>Description: Code identifying the type/source of the descriptive number used in Product/Service ID (234) Industry: Product or Service ID Qualifier HIPAA IG Note: The value in SVC06-01 qualifies the values in SVC06-02, SVC06-03, SVC06-04, SVC06-05, and SVC06-06. NYS MEDICAID NOTE: NYSDOH will send this sub-element for APG processed claims only. NYSDOH will send this sub-element with a Qualifier of 'HC'.</p>	M	ID	2/2	Required
		<p>Code Name</p> <p>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.</p> <p>CODE SOURCE: 130: Health Care Financing Administration Common Procedural Coding System</p>				
	234	<p>Product/Service ID</p> <p>Description: Identifying number for a product or service Industry: Procedure Code NYS MEDICAID NOTE: NYSDOH will send this sub-element for APG processed claims only. NYSDOH will send this sub-element with the HCPCS code identifying the significant procedure from the paid line with which this line was consolidated.</p> <p>ExternalCodeList Name: 130</p>	M	AN	1/48	Required

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	Procedure Modifier	O	AN	2/2	Situational
	<p>Description: This identifies special circumstances related to the performance of the service, as defined by trading partners</p> <p>HIPAA IG Note: Required when procedure code modifiers apply to this service.</p> <p>NYS MEDICAID NOTE: NYSDOH will not report data in this field.</p>				
1339	Procedure Modifier	O	AN	2/2	Situational
	<p>Description: This identifies special circumstances related to the performance of the service, as defined by trading partners</p> <p>HIPAA IG Note: Required when procedure code modifiers apply to this service.</p> <p>NYS MEDICAID NOTE: NYSDOH will not report data in this field.</p>				
1339	Procedure Modifier	O	AN	2/2	Situational
	<p>Description: This identifies special circumstances related to the performance of the service, as defined by trading partners</p> <p>HIPAA IG Note: Required when procedure code modifiers apply to this service.</p> <p>NYS MEDICAID NOTE: NYSDOH will not report data in this field.</p>				
1339	Procedure Modifier	O	AN	2/2	Situational
	<p>Description: This identifies special circumstances related to the performance of the service, as defined by trading partners</p> <p>HIPAA IG Note: Required when procedure code modifiers apply to this service.</p> <p>NYS MEDICAID NOTE: NYSDOH will not report data in this field.</p>				
352	Description	O	AN	1/80	Not recommended
	<p>Description: A free-form description to clarify the related data elements and their content</p> <p>Industry: Procedure Code Description</p> <p>HIPAA IG Note: Avoid using the description to make</p>				

it easier for the computer to process the information provided.
Required when a description was received for the service on the original claim.
NYS MEDICAID NOTE: NYSDOH will not report data in this field.

DTM

Service Date

Pos: 080	Max: 3
Detail - Optional	
Loop: 2110	Elements: 2

User Option (Usage): Situational

To specify pertinent dates and times

HIPAA IG 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.
4. For Medicare service, this segment is required (for Part A, use “through date” if no service date is present).

Example:

DTM*472*19961031~

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	Date/Time Qualifier	M	ID	3/3	Required
<p>Description: Code specifying type of date or time, or both date and time Industry: Date Time Qualifier NYS MEDICAID NOTE: NYSDOH will provide qualifier '472'.</p>						
		<u>Code</u>	<u>Name</u>			
		472	Service			
			ADVISED Use this code to indicate a single day service.			
DTM02	373	Date	C	DT	8/8	Required
<p>Description: Date expressed as CCYYMMDD Industry: Service Date</p>						

CAS Service Adjustment

Pos: 090	Max: 99
Detail - Optional	
Loop: 2110	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

HIPAA IG 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:

NYSDOH will report service line specific adjustments here.

APG processing results in certain specific adjustment types necessary for balancing at the service line level. The APG-specific adjustments are caused by APG consolidation and APG packaging.

For lines that have been bundled - either packaged or consolidated into the line for a significant procedure - this segment is sent for balancing purposes to account for the charges of the bundled line(s).

Occasionally APG processing may not be able to assign a weighted APG code to a service line. These lines will receive a zero payment and their charges will be reported as adjustments in 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>
CAS01	1033	Claim Adjustment Group Code	M	ID	1/2	Required
<p>Description: Code identifying the general category of payment adjustment</p> <p>HIPAA IG Note: 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.)</p> <p>NYS MEDICAID NOTE: NYSDOH will return value 'CO', 'CR', 'OA', or 'PR'.</p> <p>When this line's charges have been bundled - packaged or consolidated into a significant procedure's line as a result of APG processing - this data element will contain 'CO'.</p>						
		<u>Code</u>	<u>Name</u>			
		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

PR Patient Responsibility

CAS02 1034 **Claim Adjustment Reason Code** M ID 1/5 Required

Description: Code identifying the detailed reason the adjustment was made
Industry: Adjustment Reason Code
CODE SOURCE: 139: Claim Adjustment Reason Code
NYS MEDICAID NOTE: Refer to NYS MEDICAID NOTE in introduction for information regarding a crosswalk of Adjustment Reason Codes and MMIS Edit Reason Codes. Adjustment Reason Codes will be provided for approved and denied claims.

When this line's charges have been bundled - packaged or consolidated into a significant procedure's line as a result of APG processing - this data element will contain '97'.

ExternalCodeList

Name: 139
Description: Claim Adjustment Reason Code

CAS03 782 **Monetary Amount** M R 1/18 Required

Description: Monetary amount
Industry: Adjustment Amount
HIPAA IG Note: 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.

CAS04 380 **Quantity** O R 1/15 Situational

Description: Numeric value of quantity
Industry: Adjustment Quantity
HIPAA IG Note: 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.

CAS05 1034 **Claim Adjustment Reason Code** C ID 1/5 Situational

Description: Code identifying the detailed reason the adjustment was made
Industry: Adjustment Reason Code
CODE SOURCE: 139: Claim Adjustment Reason Code
HIPAA IG Note: See CAS02. Used when additional adjustments apply within the group identified in CAS01.
NYS MEDICAID NOTE: Refer to NYS MEDICAID NOTE in CAS02.

ExternalCodeList

Name: 139
Description: Claim Adjustment Reason Code

CAS06 782 **Monetary Amount** C R 1/18 Situational

Description: Monetary amount
Industry: Adjustment Amount

		HIPAA IG Note: See CAS03. 1437 Used when additional adjustments apply within the group identified in CAS01.				
CAS07	380	Quantity Description: Numeric value of quantity Industry: Adjustment Quantity HIPAA IG Note: See CAS04. Used when additional adjustments apply within the group identified in CAS01.	C	R	1/15	Situational
CAS08	1034	Claim Adjustment Reason Code Description: Code identifying the detailed reason the adjustment was made Industry: Adjustment Reason Code CODE SOURCE: 139: Claim Adjustment Reason Code HIPAA IG Note: See CAS02. Used when additional adjustments apply within the group identified in CAS01. NYS MEDICAID NOTE: Refer to NYS MEDICAID NOTE in CAS02.	C	ID	1/5	Situational
		ExternalCodeList Name: 139 Description: Claim Adjustment Reason Code				
CAS09	782	Monetary Amount Description: Monetary amount Industry: Adjustment Amount HIPAA IG Note: See CAS03. Used when additional adjustments apply within the group identified in CAS01.	C	R	1/18	Situational
CAS10	380	Quantity Description: Numeric value of quantity Industry: Adjustment Quantity HIPAA IG Note: See CAS04. Used when additional adjustments apply within the group identified in CAS01.	C	R	1/15	Situational
CAS11	1034	Claim Adjustment Reason Code Description: Code identifying the detailed reason the adjustment was made Industry: Adjustment Reason Code CODE SOURCE: 139: Claim Adjustment Reason Code HIPAA IG Note: See CAS02. Used when additional adjustments apply within the group identified in CAS01. NYS MEDICAID NOTE: Refer to NYS MEDICAID NOTE in CAS02.	C	ID	1/5	Situational
		ExternalCodeList Name: 139 Description: Claim Adjustment Reason Code				
CAS12	782	Monetary Amount Description: Monetary amount Industry: Adjustment Amount HIPAA IG Note: See CAS03. Used when additional adjustments apply within the group identified in CAS01.	C	R	1/18	Situational
CAS13	380	Quantity	C	R	1/15	Situational

		<p>Description: Numeric value of quantity Industry: Adjustment Quantity HIPAA IG Note: See CAS04. Used when additional adjustments apply within the group identified in CAS01.</p>				
CAS14	1034	<p>Claim Adjustment Reason Code</p> <p>Description: Code identifying the detailed reason the adjustment was made Industry: Adjustment Reason Code CODE SOURCE: 139: Claim Adjustment Reason Code HIPAA IG Note: See CAS02. Used when additional adjustments apply within the group identified in CAS01. NYS MEDICAID NOTE: Refer to NYS MEDICAID NOTE in CAS02.</p> <p>ExternalCodeList Name: 139 Description: Claim Adjustment Reason Code</p>	C	ID	1/5	Situational
CAS15	782	<p>Monetary Amount</p> <p>Description: Monetary amount Industry: Adjustment Amount HIPAA IG Note: See CAS03. Used when additional adjustments apply within the group identified in CAS01.</p>	C	R	1/18	Situational
CAS16	380	<p>Quantity</p> <p>Description: Numeric value of quantity Industry: Adjustment Quantity HIPAA IG Note: See CAS04. Used when additional adjustments apply within the group identified in CAS01.</p>	C	R	1/15	Situational
CAS17	1034	<p>Claim Adjustment Reason Code</p> <p>Description: Code identifying the detailed reason the adjustment was made Industry: Adjustment Reason Code CODE SOURCE: 139: Claim Adjustment Reason Code HIPAA IG Note: See CAS02. Used when additional adjustments apply within the group identified in CAS01. NYS MEDICAID NOTE: Refer to NYS MEDICAID NOTE in CAS02.</p> <p>ExternalCodeList Name: 139 Description: Claim Adjustment Reason Code</p>	C	ID	1/5	Situational
CAS18	782	<p>Monetary Amount</p> <p>Description: Monetary amount Industry: Adjustment Amount HIPAA IG Note: See CAS03. Used when additional adjustments apply within the group identified in CAS01.</p>	C	R	1/18	Situational
CAS19	380	<p>Quantity</p> <p>Description: Numeric value of quantity Industry: Adjustment Quantity HIPAA IG Note: See CAS04. Used when additional adjustments apply within the</p>	C	R	1/15	Situational

group identified in CAS01.

CAS Service Adjustment

Pos: 090	Max: 99
Detail - Optional	
Loop: 2110	Elements: 3

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

HIPAA IG 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:

NYSDOH will send this CAS segment for the service line that received the highest final weight in APG processing, only if other lines received a zero payment and were bundled into the payment for this line. This segment will be sent for balancing purposes to allow for the charges of the packaged lines and for the Capital Add On Amount when provided for disbursement.

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	Claim Adjustment Group Code	M	ID	1/2	Required								
<p>Description: Code identifying the general category of payment adjustment</p> <p>HIPAA IG Note: 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.)</p> <p>NYS MEDICAID NOTE: NYSDOH will provide a value of 'CO' for Capital Add On Amount and 'OA' for the total service line charge that is bundled for this service line in this data element.</p> <table border="1" style="width: 100%;"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>CO</td> <td>Contractual Obligations</td> </tr> <tr> <td colspan="2" style="text-align: center;">Use this code when a joint payer/payee agreement or a regulatory requirement has resulted in an adjustment.</td> </tr> <tr> <td>OA</td> <td>Other adjustments</td> </tr> </tbody> </table>							<u>Code</u>	<u>Name</u>	CO	Contractual Obligations	Use this code when a joint payer/payee agreement or a regulatory requirement has resulted in an adjustment.		OA	Other adjustments
<u>Code</u>	<u>Name</u>													
CO	Contractual Obligations													
Use this code when a joint payer/payee agreement or a regulatory requirement has resulted in an adjustment.														
OA	Other adjustments													
CAS02	1034	Claim Adjustment Reason Code	M	ID	1/5	Required								
<p>Description: Code identifying the detailed reason the adjustment was made</p> <p>Industry: Adjustment Reason Code</p> <p>CODE SOURCE: 139: Claim Adjustment Reason Code</p>														

NYS MEDICAID NOTE: NYSDOH will provide '94' in this data element.

ExternalCodeList

Name: 139

Description: Claim Adjustment Reason Code

CAS03	782	Monetary Amount	M	R	1/18	Required
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Description: Monetary amount

Industry: Adjustment Amount

HIPAA IG Note: 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.

NYS MEDICAID NOTE: NYSDOH will provide the total of the service line charge amounts bundled into this service line and/or the Capital Add On Amount dispersed.

REF Service Identification

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

User Option (Usage): Situational

To specify identifying information

HIPAA IG 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~

NYS MEDICAID NOTE:

NYSDOH will provide the Line Item Sequence Control Number in 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>
REF01	128	Reference Identification Qualifier Description: Code qualifying the Reference Identification NYS MEDICAID NOTE: NYSDOH will provide a Qualifier of '6R' in this element.	M	ID	2/3	Required
		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.				
REF02	127	Reference Identification Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier Industry: Provider Identifier NYS MEDICAID NOTE: NYSDOH will provide the Line Item Sequence Number in this element.	C	AN	1/30	Required

REF Service Identification

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

User Option (Usage): Situational

To specify identifying information

HIPAA IG 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~

NYS MEDICAID NOTE:

NYSDOH will provide the APG Code in 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>
REF01	128	Reference Identification Qualifier Description: Code qualifying the Reference Identification NYS MEDICAID NOTE: NYSDOH will provide a Qualifier of '1S' in this element.	M	ID	2/3	Required
		Code Name 1S Ambulatory Patient Group (APG) Number				
REF02	127	Reference Identification Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier Industry: Provider Identifier NYS MEDICAID NOTE: NYSDOH will provide the APG Code in this element.	C	AN	1/30	Required

AMT Service Supplemental Amount

Pos: 110	Max: 12
Detail - Optional	
Loop: 2110	Elements: 2

User Option (Usage): Situational

To indicate the total monetary amount

HIPAA IG Notes:

1. This segment is used to convey information only. It is not part of the financial balancing of the 835. Use this segment only when the value of specific amounts identified in the AMT01 qualifier are Non-zero.

Example:

AMT*B6*425~

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>
AMT01	522	Amount Qualifier Code Description: Code to qualify amount NYS MEDICAID NOTE: NYSDOH will provide qualifier 'B6'.	M	ID	1/3	Required
		Code Name B6 Allowed - Actual				
AMT02	782	Monetary Amount Description: Monetary amount Industry: Service Supplemental Amount NYS MEDICAID NOTE: NYSDOH will provide the allowed actual amount.	M	R	1/18	Required

AMT Service Supplemental Amount

Pos: 110	Max: 12
Detail - Optional	
Loop: 2110	Elements: 2

User Option (Usage): Situational

To indicate the total monetary amount

HIPAA IG Notes:

1. This segment is used to convey information only. It is not part of the financial balancing of the 835. Use this segment only when the value of specific amounts identified in the AMT01 qualifier are Non-zero.

Example:

AMT*B6*425~

NYS MEDICAID NOTE:

For claims that were processed using the Ambulatory Patient Group methodology, NYSDOH will provide this segment to report the APG payment amount for paid lines.

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>
AMT01	522	Amount Qualifier Code Description: Code to qualify amount NYS MEDICAID NOTE: NYSDOH will provide qualifier 'ZK'.	M	ID	1/3	Required
		Code Name ZK Federal Medicare or Medicaid Payment Mandate - Category 1				
AMT02	782	Monetary Amount Description: Monetary amount Industry: Service Supplemental Amount NYS MEDICAID NOTE: NYSDOH will provide the APG paid amount.	M	R	1/18	Required

AMT Service Supplemental Amount

Pos: 110	Max: 12
Detail - Optional	
Loop: 2110	Elements: 2

User Option (Usage): Situational

To indicate the total monetary amount

HIPAA IG Notes:

1. This segment is used to convey information only. It is not part of the financial balancing of the 835. Use this segment only when the value of specific amounts identified in the AMT01 qualifier are Non-zero.

Example:

AMT*B6*425~

NYS MEDICAID NOTE:

For claims that were processed using the Ambulatory Patient Group methodology, NYSDOH will provide this segment to report the Blend Existing Paid Amount (Existing Operating Component) for paid lines for APG providers who receive blended rate payments.

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>
AMT01	522	Amount Qualifier Code Description: Code to qualify amount NYS MEDICAID NOTE: NYSDOH will provide qualifier 'ZL'.	M	ID	1/3	Required
		Code Name ZL Federal Medicare or Medicaid Payment Mandate - Category 2				
AMT02	782	Monetary Amount Description: Monetary amount Industry: Service Supplemental Amount NYS MEDICAID NOTE: NYSDOH will provide the Blend Existing Paid Amount.	M	R	1/18	Required

QTY Service Supplemental Quantity

Pos: 120	Max: 6
Detail - Optional	
Loop: 2110	Elements: 2

User Option (Usage): Situational

To specify quantity information

HIPAA IG 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*ZL*3.75~

NYS MEDICAID NOTE:

For claims that were processed using the Ambulatory Patient Group methodology, NYSDOH will provide this segment to report the APG Full Weight.

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	Quantity Qualifier	M	ID	2/2	Required
		Description: Code specifying the type of quantity NYS MEDICAID NOTE: NYSDOH will provide qualifier 'ZK'.				
		<u>Code</u>		<u>Name</u>		
		ZK		Federal Medicare or Medicaid Payment Mandate - Category 1		
QTY02	380	Quantity	C	R	1/15	Required
		Description: Numeric value of quantity Industry: Service Supplemental Quantity Count NYS MEDICAID NOTE: NYSDOH will provide the APG Full Weight with up to 5 decimal positions.				

QTY Service Supplemental Quantity

Pos: 120	Max: 6
Detail - Optional	
Loop: 2110	Elements: 2

User Option (Usage): Situational

To specify quantity information

HIPAA IG 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*ZL*3.75~

NYS MEDICAID NOTE:

For claims that were processed using the Ambulatory Patient Group methodology, NYSDOH will provide this segment to report the APG Allowed Percentage.

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	Quantity Qualifier	M	ID	2/2	Required
		Description: Code specifying the type of quantity				
		Industry: NYSDOH will provide qualifier 'ZL'.				
		<u>Code</u>		<u>Name</u>		
		ZL		Federal Medicare or Medicaid Payment Mandate - Category 2		
QTY02	380	Quantity	C	R	1/15	Required
		Description: Numeric value of quantity				
		Industry: Service Supplemental Quantity Count				
		NYS MEDICAID NOTE: NYSDOH will provide the APG Allowed Percentage in this data element. This will be 50, 75, 100, or 150. The segment will be suppressed when the percentage is zero.				

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

HIPAA IG 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	Code List Qualifier Code Description: Code identifying a specific industry code list	O	ID	1/3	Required
		Code Name HE Claim Payment Remark Codes				
		CODE SOURCE: 411: Remittance Remark Codes				
		RX National Council for Prescription Drug Programs Reject/Payment Codes				
		CODE SOURCE: 530: National Council for Prescription Drug Programs Reject/Payment Codes				
LQ02	1271	Industry Code Description: Code indicating a code from a specific industry code list Industry: Remark Code NYS MEDICAID NOTE: Refer to NYS MEDICAID NOTE in introduction for information regarding a crosswalk of Remittance Remark Codes to MMIS Edit Reason Codes. Remittance Remark Codes will be provided for denied claims if applicable.	C	AN	1/30	Required
		ExternalCodeList Name: 411 Description: Remittance Remark Codes				
		ExternalCodeList Name: 530 Description: 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

HIPAA IG 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	Reference Identification Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier Industry: Provider Identifier HIPAA IG Note: Use this number for the provider identifier as assigned by the payer. NYS MEDICAID NOTE: NYSDOH will provide NYS Medicaid Provider ID for non-regulated NPI claims and the National Provider ID (NPI) for all NPI regulated claims.	M	AN	1/30	Required
PLB02	373	Date Description: Date expressed as CCYYMMDD Industry: Fiscal Period Date HIPAA IG Note: 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	Adjustment Identifier Description: To provide the category and identifying reference information for an adjustment HIPAA IG Note: 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	Adjustment Reason Code Description: Code indicating reason for debit or credit memo or adjustment to invoice, debit or credit memo, or payment NYS MEDICAID NOTE: NYSDOH will provide the following values:	M	ID	2/2	Required

<u>Code</u>	<u>Name</u>
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.
LS	Lump Sum Use this for a disproportionate share adjustment, indirect medical education passthrough, non-physician passthrough, passthrough lump sum adjustment, or other passthrough amount. The specific type of lump sum adjustment must be identified in PLB03-2. Medicare Part A will provide code "DS" for Disproportionate Share Adjustment, "IM" for Indirect Medical Education Passthrough, "NP" for Non-physician Passthrough, "PS" for Passthrough Lump Sum, and "PO" for Other Passthrough in PLB03-2.
WO	Overpayment Recovery Use this for the recovery of previous overpayment. An identifying number should be provided in PLB03-2. See the notes on codes 72 and B3 for additional information about balancing against a provider refund. Medicare Part A will provide code "OR" in PLB03-2.
WU	Unspecified Recovery Use this for the outside recovery adjustment. Medicare Part A will provide code "OS" in PLB03-2.

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: Provider Adjustment Identifier
HIPAA IG Note: 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.
NYS MEDICAID NOTE: NYSDOH will provide Financial Control Number.

PLB04 782 **Monetary Amount** M R 1/18 Required

Description: Monetary amount
Industry: Provider Adjustment Amount
HIPAA IG Note: Use this monetary amount for the adjustment amount for the preceding adjustment reason.

PLB05 C042 **Adjustment Identifier** C Comp Situational

Description: To provide the category and identifying reference information for an adjustment
HIPAA IG Note: See PLB03 for details. Used when additional adjustments apply.

426 **Adjustment Reason Code** M ID 2/2 Required

Description: Code indicating reason for debit or credit memo or adjustment to invoice, debit or credit memo, or payment
NYS MEDICAID NOTE: NYSDOH will provide the following values:

<u>Code</u>	<u>Name</u>
FB	Forwarding Balance
LS	Lump Sum
WO	Overpayment Recovery

		WU	Unspecified Recovery														
	127	Reference Identification		O	AN	1/30	Situational										
		<p>Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier Industry: Provider Adjustment Identifier NYS MEDICAID NOTE: NYSDOH will provide Financial Control Number.</p>															
PLB06	782	Monetary Amount		C	R	1/18	Situational										
		<p>Description: Monetary amount Industry: Provider Adjustment Amount HIPAA IG Note: Use this monetary amount for the adjustment amount for the preceding adjustment reason.</p>															
PLB07	C042	Adjustment Identifier		C	Comp		Situational										
		<p>Description: To provide the category and identifying reference information for an adjustment HIPAA IG Note: See PLB03 for details. Used when additional adjustments apply.</p>															
	426	Adjustment Reason Code		M	ID	2/2	Required										
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PLB08	782	Monetary Amount		C	R	1/18	Situational										
		<p>Description: Monetary amount Industry: Provider Adjustment Amount HIPAA IG Note: Use this monetary amount for the adjustment amount for the preceding adjustment reason.</p>															
PLB09	C042	Adjustment Identifier		C	Comp		Situational										
		<p>Description: To provide the category and identifying reference information for an adjustment HIPAA IG Note: See PLB03 for details. Used when additional adjustments apply.</p>															
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 WU Unspecified Recovery

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

NYS MEDICAID NOTE: NYSDOH will provide the following values:

<u>Code</u>	<u>Name</u>
FB	Forwarding Balance
LS	Lump Sum
WO	Overpayment Recovery
WU	Unspecified Recovery

	127	Reference Identification	O	AN	1/30	Situational
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Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

Industry: Provider Adjustment Identifier

NYS MEDICAID NOTE: NYSDOH will provide Financial Control Number.

PLB14	782	Monetary Amount	C	R	1/18	Situational
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Description: Monetary amount

Industry: Provider Adjustment Amount

HIPAA IG Note: Use this monetary amount for the adjustment amount for the preceding adjustment reason.

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	Number of Included Segments Description: Total number of segments included in a transaction set including ST and SE segments Industry: Transaction Segment Count	M	N0	1/10	Required
SE02	329	Transaction Set Control Number Description: Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set HIPAA IG Note: 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