

Version 2.0

Utah State Dept. of Health
Division of Health Care Financing

835 REMITTANCE
COMPANION GUIDE

Utah Specific Transaction Instructions

835 Health Care Claim Payment/Advice: **Electronic Remittance Advice (RA)**
ASCX12N 835 (004010X091A1)

The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicaid, and all health insurance payers in the United States, comply with the Electronic Data Interchange (EDI) standards for healthcare as established by the Secretary of Health and Human Services. The ANSI ASC X12N 835 Version 4010 implementation guide has been established as the standard of compliance. The implementation guide is available electronically at www.wpc-edi.com. The following supplemental requirements are specific to Utah Medicaid and are intended to serve as a companion guide to the HIPAA ANSI X12N implementation guide.

Requirements:

1. For questions or suggestions about this companion guide, call (800) 662-9651 menu 3, menu 5, or (801) 538-6155 menu 3, menu 5, Operational Support and Development (OS&D). Go to <http://health.utah.gov/hipaa/guides.htm> to obtain the latest version of this guide. OS&D can help resolve issues on electronic transmissions.
2. ALL electronic data must pass through the Utah Health Information Network (UHIN), an independent, not-for-profit, value added network. Contact UHIN at www.UHIN.com or (801) 466-7705 x200. UHIN will assign a Trading Partner Number (TPN) for electronic data interchange (EDI).
3. Use your TPN and your Utah Medicaid Provider number to complete the online Utah Medicaid EDI Enrollment Form at <http://health.utah.gov/hcferoll> (do not mail or fax, simply click on submit). Medicaid posts each 835 to the TPN listed on the online EDI Enrollment Form. Without a successfully completed EDI enrollment, the Medicaid computer system will not generate an 835. NOTE: The electronic RA will not affect the delivery of the paper RA. If you desire to terminate delivery of your paper RA, you must submit your written request to the Provider Enrollment team at providerenroll@utah.gov or fax your request to Provider Enrollment at (801) 536-0471.
4. 835s are available for pickup (download) by noon on the first business day of each week. They will remain available for pickup for one month.

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5. Electronic claims received before the End of Business on Thursday usually adjudicate that weekend. Transactions received after the End of Business on Thursday may miss the adjudication cycle and will process the following weekend.
6. When Medicaid splits an 837 healthcare claim, the provider is notified through the 277 Front End Acknowledgment. The 835 will report line level information relating to each individual claim (split claim). A provider may receive multiple 835 responses to a single 837. NOTE: Claims held in suspense will not appear on the 835.
7. Electronic Funds Transfer (EFT) is independent from EDI. The form of payment (Warrant or EFT) has no bearing on whether claims arrived via paper claim or EDI. Medicaid highly recommends EFT and providers should register for EFT by using the form at <http://health.utah.gov/medicaid/pdfs/EFTapril2005.pdf>.
8. Adjustments in any CAS segment decreases the payment when the adjustment amount is positive, and increases the payment when the adjustment amount is negative. For an 835 transaction to balance the sum of all submitted charges minus the sum of all provider adjustments must equal the total payment amount.
9. Many providers who bill for non-medical transportation, respite care, medical alert systems, construction of wheel chair ramps, meals on wheels, or other non-medical services may not be authorized to obtain a National Provider Identifier (NPI). These providers, known as “atypical” providers, may continue to use the 12-digit Utah Medicaid Contract number for their electronic claims and requests after the NPI deadline of May 23, 2007.

Page	Loop	Segment	Data Element	Values / Comments
43		ST01	Transaction Set Identifier Code	“835” – Health Care Claim Payment/Advice
45		BPR01	Transaction Handling Code	“T” – Remittance Information Only
46		BPR02	Monetary Amount	Total Actual Provider Payment Amount
46		BPR04	Payment Method Code	“CHK” – Warrant “ACH” – EFT (Direct Deposit)
48		BPR13	(DFI) Identification Number	Routing number for the receiving bank (EFT only).
48		BPR15	Account Number	Receiving bank account number (EFT only).
50		BPR16	Date	Warrant issue date or date money is available to the payee.

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Page	Loop	Segment	Data Element	Values / Comments
53		TRN02	Check or EFT Trace Number	Warrant or EFT number
53		TRN03	Payer Identifier	“1876000545”
62	1000A	N101	Entity Identifier Code	“PR” – Payer
63	1000A	N102	Name	“Utah Dept of Health”
70	1000A	PER01	Contact Function Code	“CX” – Payer’s claim office
70	1000A	PER03	Communication Number Qualifier	“TE” – telephone
70	1000A	PER04	Communication Number	“8015386155”
72	1000B	N101	Entity Identifier Code	“PE” – Payee
73	1000B	N102	Name	Payee Name
73	1000B	N103	Identification Code Qualifier	“FI” – EIN “XX” – NPI
73	1000B	N104	Identification Code	EIN NPI
77	1000B	REF01	Reference Identification Qualifier	“1D” – Medicaid Provider Number Not used after May 22, 2007, unless an atypical provider.
78	1000B	REF02	Additional Payee Identifier	The 12-digit identifier assigned by Medicaid. Not used after May 22, 2007, unless an atypical provider.
79	2000	LX01	Assigned Number	Assigned number unique to this particular line.
89	2100	CLP01	Patient Control Number	Assigned by the provider on the original 837.
90	2100	CLP02	Claim Status Code	“1” – Processed as primary “2” – Processed as secondary “3” – Processed as tertiary “4” – Denied “22” – Reversal of previous payment
91	2100	CLP03	Total Claim Charge Amount	Total submitted charges for this claim
91	2100	CLP04	Claim Payment Amount	Total paid for the claim
91	2100	CLP05	Patient Responsibility Amount	Co-pay, co-insurance assigned to patient.
92	2100	CLP06	Claim Filing Indicator Code	“MC” – Medicaid
93	2100	CLP07	Payer Claim Control Number	Transaction Control Number (TCN) assigned by Medicaid.
93	2100	CLP11	Diagnosis Related Group (DRG) Code	Related to Institutional claims only.

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Page	Loop	Segment	Data Element	Values / Comments
97	2100	CAS01	Claim Adjustment Group Code	“CO” – Contractual Obligations “CR” – Correction and Reversals “OA” – Other adjustments “PR” – Patient Responsibility
97	2100	CAS02	Adjustment Reason Code	HIPAA Code List www.wpc-edi.com
97	2100	CAS03	Adjustment Amount	Monetary amount of adjustment
102	2100	NM101	Entity Identifier Code	“QC” – Patient
103	2100	NM102	Entity Type Qualifier	“1” – Person
103	2100	NM103	Patient Last Name	Patient’s last name as reported on the 837 or Point of Sale (POS).
103	2100	NM104	Patient First Name	Patient’s first name as reported on the 837 or POS.
103	2100	NM108	Identification Code Qualifier	“MI” – Patient ID number
104	2100	NM109	Patient Identifier	Patient ID as reported on the 837 or POS.
108	2100	NM101	Entity Identifier Code	“74” – Corrected Insured
109	2100	NM102	Entity Type Qualifier	“1” – Person
109	2100	NM103	Last Name	Corrected patient last name
109	2100	NM104	First Name	Corrected patient first name
109	2100	NM108	Identification Code Qualifier	“C” – Corrected client ID
109	2100	NM109	Identification Code	Corrected client ID
118	2100	MIA	Inpatient Adjudication Information	Used for claim level remark codes
120	2100	MIA05	Remark Code	HIPAA Code List www.wpc-edi.com
123	2100	MOA	Outpatient Adjudication Information	Used for claim level remark codes
124	2100	MOA03 thru MOA07	Remark Code	HIPAA Code List www.wpc-edi.com
126	2100	REF01	Reference Identification Qualifier	“CE” – Name of Plan
127	2100	REF02	Other Claim Related Identifier	Example: Medicaid Traditional, PCN, NTM, BYB, etc.
128	2100	REF01	ID Qualifier	“1D” – Medicaid Provider Number After May 22, 2007, not used, unless rendering provider is atypical.
129	2100	REF02	Rendering Provider Secondary Identifier	12-digit Provider number assigned by Medicaid After May 22, 2007, not used, unless rendering provider is atypical.

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Page	Loop	Segment	Data Element	Values / Comments
131	2100	DTM01	Date Time Qualifier	“232” – Start date “233” – End date When omitted start and end date are the same.
131	2100	DTM02	Claim Date	Date (CCYYMMDD)
139	2110	SVC01	Service Payment Information	Procedure/Rev codes information used in the adjudication process
140	2110	SVC01-1	Product or Service ID Qualifier	“HC” – HCPCS “NU” – Rev codes “N4” - NDC
141	2110	SVC01-2	Procedure Code	Code for product or service
141	2110	SVC01-3 thru SVC01-6	Procedure Modifier	Procedure code modifier
142	2110	SVC02	Line Item Charge Amount	Submitted service charge amount
142	2110	SVC03	Line Item Provider Payment Amount	Service amount paid
142	2110	SVC04	Product/Service ID	Rev code when used in addition to HCPCS code.
142	2110	SVC05	Quantity	Units of service paid
142	2110	SVC06-1 thru SVC06-7	Composite Medical Procedure Identifier	Used to report the submitted code when different from the code adjudicated in SVC01.
145	2110	SVC07	Quantity	Used to report units of service when different from the units adjudicated in SVC05
147	2110	DTM01	Date Time Qualifier	“150” – Start date “151” – End date
147	2110	DTM02	Service Date	Date (CCYYMMDD)
150	2110	CAS01	Claim Adjustment Group Code (line level)	“CO” – Contractual Obligations “CR” – Correction and Reversals “OA” – Other adjustments “PR” – Patient Responsibility
150	2110	CAS02	Adjustment Reason Code	HIPAA Code List www.wpc-edi.com
150	2110	CAS03	Adjustment Amount (line level)	Monetary amount of adjustment
154	2110	REF01	Reference Identification Qualifier	“6R” – Provider Control Number
155	2110	REF02	Provider Identifier	Provider assigned number unique to this line in the 837.
156	2110	REF01	Reference Identification Qualifier	“1D” – Medicaid Provider Number Not used after May 22, 2007, unless provider type is atypical.

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157	2110	REF02	Rendering Provider Identifier	12-digit identifier assigned by Medicaid Not used after May 22, 2007, unless provider type is atypical.
162	2110	LQ01	Code List Qualifier Code	“HE” – Claim payment remark code
163	2110	LQ02	Industry Code	HIPAA Code List www.wpc-edi.com
164		PLB	Provider Adjustment	Allows adjustments that are NOT specific to a particular claim.
165		PLB01	Provider Identifier	Provider number assigned by payer.
165		PLB02	Fiscal Period Date	December 31 of the current year.
165		PLB03-1	Adjustment Reason Code	“CS” – Adjustment HIPAA Code List www.wpc-edi.com
170		PLB03-2	Provider Adjustment Identifier	TCN assigned by Medicaid.
170		PLB04	Provider Adjustment Amount	Adjustment amount