HIPAA EDI Companion Guide

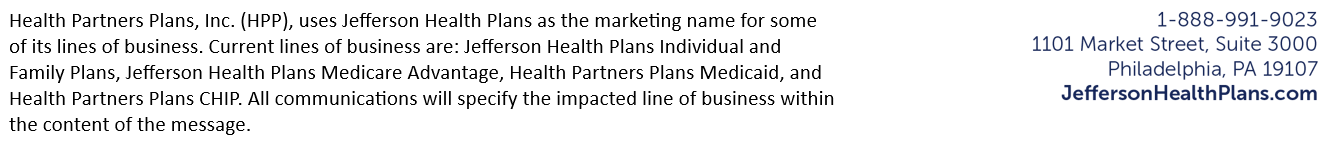
**for**

835 Electronic Remittance Advice

**ASC X12 Standards for Electronic Data Interchange Technical Report Type 3 (TR3)**

**Version 005010X221A1**

**Companion Guide Version: 2.0**



# Disclosure Statement

This document is intended to be a companion guide for use in conjunction with the ASC X12 Standards for Electronic Data Interchange Technical Report Type 3 (TR3 and Errata). The information in this document is provided for Jefferson Health Plans and its associated Trading Partners.

This document contains clarifications as permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Standard for Electronic Transactions. This document is not intended to convey information that exceeds the requirements or usages of data expressed in the ASC X12 Standards for Electronic Data Interchange Technical Report Type 3 (TR3 and Errata).

**This document is not intended, and should not be regarded, as a substitute for the ASC X12 Standards for Electronic Data Interchange Technical Report Type 3 (TR3 and Errata)**

Jefferson Health Plans may make improvements and/or changes to the information contained in this document without notice.

This document may be copied and distributed without direct permission from the author.

**Preface**

This companion guide is intended to convey information that is within the framework of the ASC X12N Technical Report Type 3 (TR3) adopted for use under HIPAA. This companion guide to the ASC X12 Standards for Electronic Data Interchange Technical Report Type 3 (TR3 and Errata) adopted under HIPAA will clarify and specify Jefferson Health Plans communication protocols, business rules and information applicable to the 835 Electronic Remittance Advice Transaction. Transmissions based on this companion guide, used in tandem with the X12N Technical Report Type 3 (TR3), are compliant with X12 syntax, those guides, and HIPAA.

# Table of Contents

[Disclosure Statement 2](#_bookmark0)

[Table of Contents 4](#_bookmark1)

[Document Control - Version History 5](#_bookmark2)

[Introduction 6](#_bookmark3)

[Scope 6](#_bookmark3)

[References 6](#_bookmark3)

[Contact information 7](#_bookmark4)

[EDI Customer Service and Technical Assistance 7](#_bookmark4)

[Non-EDI Customer Service and Assistance 7](#_bookmark4)

[Applicable Websites 7](#_bookmark4)

[835 Electronic Remittance Advice Specifications 9](#_bookmark5)

[General Notes. 9](#_bookmark5)

[Data Content and Specifications 9](#_bookmark5)

# Document Control - Version History

The following version history is provided to easily identify updates between Companion Guide versions. Each update is numbered. All corresponding areas of the document related to this update are also numbered.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **#** | **Version** | **Date** | **Author** | **Updates** |
| **1** | 1.0 | 10/11 | Operations Technical Support | * Initial version of 835 5010 Companion Guide Document. This version was also posted to the Jefferson Health Plans external website, |
| **2** | 2.0 | 11/18/13 | Claims Department | * Changed the Plan name and logo. * Providers now are enrolling with ECHO to receive their ERA/EFT. |
| **3** | 3.0 | 10/9/24 | Claims Department | * Updated naming and contact information |

# Introduction

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 is intended to provide better access to health insurance, limit fraud and abuse, and reduce administrative costs of the health care industry. The provisions for administrative simplification contained within HIPAA require the Secretary of the Department of Health and Human Services (HHS) to adopt standards to support the electronic exchange of administrative and financial health care transactions.

These transactions primarily occur between health care providers and health insurance plans or clearinghouses. HIPAA directs the Secretary of HHS to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard.

## Scope

This companion guide explains the procedures and requirements necessary for

Trading Partners of Jefferson Health Plans to transmit the following HIPAA standard transactions:

* 835 Electronic Remittance Advice (835)

This companion guide is intended to convey information that is within the framework of the ASC X12N Technical Report Type 3 (TR3) adopted for use under HIPAA. Transmissions based on this companion guide, used in tandem with the X12N Technical Report Type 3 (TR3), are compliant with X12 syntax, those guides, and HIPAA.

## References

Additional information on the HIPAA Final Rule for Standards for Electronic Transmissions and the endorsed Implementation Guides can be found at:

* [httpp://www.cms.gov/hipaa/hipaa2](https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/HIPAA-ACA/HIPAAAdministrativeSimplificationandACAFAQs.html) (HIPAA Administrative Simplification)
* [http://www.wpc-edi.com](http://www.wpc-edi.com/) (Washington Publishing Company)

# Contact information

**EDI Claims Customer Service and Technical Assistance**

Electronic Data Interchange (EDI) customer service and technical assistance requests focus solely on the generation, processing, and/or transmission of a HIPAA standard transaction. EDI customer service and technical assistance requests will not focus on transaction results such as claim payment and remittance results.

Please contact Jefferson Health Plans EDI Department at [EDI@jeffersonhealthplans.com](mailto:EDI@jeffersonhealthplans.com) for technical assistance.

## Non-EDI Customer Service and Assistance

Non-EDI customer service and assistance requests focus solely on transaction results such as claim payment and remittance advice, member maintenance, or member eligibility. Non-EDI customer service and assistance requests will not focus on the generation, processing, and/or transmission of a HIPAA standard transaction.

Please contact Jefferson Health Plans Provider Services at 1-888-991-9023 for non-EDI customer service and assistance.

**Getting Started**

* 1. Communicate your plans by:
     1. Download the funding agreement
  2. Formalize agreements and authorizations
     1. Review and sign the funding agreement
     2. Provide all required information and according to the funding agreement.

# 835 Electronic Remittance Advice Specifications

## General Notes

* An ANSI X12N 837 Health Care Claim is NOT required in order to receive ANSI X12N 835 Electronic Remittance Advice.
* Transaction files are provided via a secure FTP site.
* Transaction files are posted to an FTP site for your retrieval on a weekly basis.
* Transaction delimiters will be as follows:
  + Data Element = \*
  + Segment = ~
  + Component/Sub-element = : (colon)
* Jefferson Health Plans will use all standard code sets within the 835 transaction.
* Jefferson Health Plans trading partner ID is 445562154, with a qualifier of “mutually defined” (ZZ).

## Data Content and Specifications

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Loop** | **Segment / Element** | **Description** | **Element Length** | **Mapping Comments** |
| **Interchange** |  | **Interchange Control Loop** |  | **Required** |
|  | ISA | Interchange Control Segment |  |  |
|  | ISA01 | Authorization Information Qualifier | 2/2 | "00" No Authorization Information Present |
|  | ISA02 | Authorization Information | 10/10 | Leave Blank |
|  | ISA03 | Security Information Qualifier | 2/2 | "00" No security Information Present |
|  | ISA04 | Security Information | 10/10 | Leave Blank |
|  | ISA05 | Interchange Sender ID Qualifier | 2/2 | "ZZ" Mutually Defined |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Segment / Element** | **Description** | **Element Length** | **Mapping Comments** |
|  | ISA06 | Interchange Sender ID | 15/15 | "445562154 " |
|  | ISA07 | Interchange Receiver ID Qualifier | 2/2 | Your Receiver ID Qualifier as per Trading Partner Agreement document |
|  | ISA08 | Interchange Receiver ID | 15/15 | Your Receiver ID as per Trading Partner Agreement document |
|  | ISA09 | Interchange Date | 6/6 | Date of interchange. Date format is YYMMDD |
|  | ISA10 | Interchange Time | 4/4 | Time of interchange. Time format is HHMM |
|  | ISA11 | Interchange Control Standards Identifier | 1/1 | "^" |
|  | ISA12 | Interchange Control Version Number | 5/5 | “00501” ANSI Version number that covers the Interchange Control  Segment. |
|  | ISA13 | Interchange Control Number | 9/9 | Interchange Control Number. Must = IEA02 |
|  | ISA14 | Acknowledgement Requested | 1/1 | "0" No Acknowledgement Requested "1" Acknowledgement Requested |
|  | ISA15 | Usage Indicator | 1/1 | "P" Production Data "T" Test Data |
|  | ISA16 | Component element Separator | 1/1 | ":" Delimiter used to separate Components (colon) |
| Functional Group |  | Functional Group Loop |  | Required |
|  | GS | Functional Group Header |  | Required |
|  | GS01 | Functional Identifier Code | 2/2 | “HP” = Health Care Claim Payment Advice |
|  | GS02 | Application Sender Code | 2/15 | "445562154" |
|  | GS03 | Application Receiver ID | 2/15 | Receiver ID specified in your Jefferson Health Plans Agreement |
|  | GS04 | Date | 8/8 | Date Expressed in CCYYMMDD format |
|  | GS05 | Time | 4/4 | Time in HHMMSS format |
|  | GS06 | Group Control Number | 1/9 | Functional Group Control Number. Value must equal GE02 |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Loop** | **Segment / Element** | **Description** | **Element Length** | **Mapping Comments** |
|  | GS07 | Responsible Agency Code | 1/2 | "X" Accredited Standards Committee X12 |
|  | GS08 | Version/Release/Industry Identifier | 1/12 | "005010X221A1" |
| 0000 |  | Transaction Set Loop |  | Required will contain one or more transactions |
|  | ST | Transaction Set Header |  | Required |
|  | ST01 | Transaction Set Identifier Code | 3/3 | "835" |
|  | ST02 | Transaction Set Control Number | 4/9 | Transaction Set Control Number. Must equal SE02 |
| 0000 | BPR | Financial Information |  | Required |
|  | BPR01 | Transaction Handling Code | 1/2 | “I” = Remittance Information Only  This is the only value being used by Jefferson Health Plans at this time. |
|  | BPR02 | Monetary Amount | 1/18 | Total Actual Provider Payment Amount |
|  | BPR03 | Credit/Debit Flag | 1/1 | "C" = Credit  This is the only value being used by Jefferson Health Plans at this time. |
|  | BPR04 | PAYMENT METHOD CODE | 3/3 | "CHK" = Check  This is the only value being used by Jefferson Health Plans at this time. |
|  | BPR05 | PAYMENT FORMAT CODE | 1/10 | Not used at this time |
|  | BPR06 | (DFI) ID NUMBER QUALIFIER | 2/2 | Not used at this time |
|  | BPR07 | (DFI) IDENTIFICATION NUMBER | 3/12 | Not used at this time |
|  | BPR08 | Account Number Qualifier | 1/3 | Not used at this time |
|  | BPR09 | Sender Bank Account Number | 1/35 | Not used at this time |
|  | BPR010 | ORIGINATING COMPANY IDENTIFIER | 10/10 | Not used at this time |
|  | BPR11 | Originating Company Supplemental Code | 9/9 | Not used at this time |
|  | BPR12 | DFI Identification Number Qualifier | 2/2 | Not used at this time |
|  | BPR013 | Receiver or Provider Bank ID Number | 3/12 | Not used at this time |
|  | BPR014 | ACCOUNT NUMBER QUALIFIER | 1/3 | Not used at this time |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Segment / Element** | **Description** | **Element Length** | **Mapping Comments** |
|  | BPR015 | Receiver or Provider ACCOUNT NUMBER | 1/35 | Not used at this time |
|  | BPR016 | Check Issue or EFT Effective Date | 8/8 | Check Issuance Date in CCYYMMDD Format |
|  | TRN | Reassociation Trace Number |  | Required |
|  | TRN01 | Trace Type Code | 1/2 | "1" = Current Transaction Trace Numbers |
|  | TRN02 | REFERENCE IDENTIFICATION | 1/50 | Check Number |
|  | TRN03 | ORIGINATING COMPANY IDENTIFIER | 10/10 | Employer Identification number, prefixed a "1" |
|  | TRN04 | Originating Company Supplemental Code | 1/50 | Not used at this time |
|  | CUR | Foreign Currency Information |  | Segment not used at this time |
| 0000 | REF | Receiver Identification |  | Situational (When Receiver is different than Payee) |
|  | REF01 | Receiver Identification Number | 2/3 | "EV" = Receiver Identification Number |
|  | REF02 | Receiver REFERENCE IDENTIFICATION | 1/50 | Receiver Identification Number |
|  | REF | Version Identification |  | Segment not used at this time |
|  | DTM | Production Date |  | Segment not used at this time |
| 1000A |  | Payer Identification Loop |  | Required |
|  | N1 | Payer Identification |  | Required |
|  | N101 | Payer Identifier Code | 2/3 | "PR" Payer |
|  | N102 | Payer NAME | 1/60 | “Jefferson Health Plans of Philadelphia” |
|  | N103 | Identification Code Qualifier | 1/2 | Not required at this time |
|  | N104 | Payer Identification Code | 1/80 | Not required at this time |
|  | N3 | Payer Address |  | Required |
|  | N301 | Payer Address Line | 1/55 | "901 Market St" |
|  | N302 | Payer Address Line | 1/55 | “Suite 500” |
|  | N4 | Payer City, State, Zip Code |  | Required |
|  | N401 | Payer City Name | 2/30 | "Philadelphia" |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Loop** | **Segment / Element** | **Description** | **Element Length** | **Mapping Comments** |
|  | N402 | Payer State Code | 2/2 | "PA" |
|  | N403 | Payer Postal Zone or Zip Code | 3/15 | "19107" |
|  | REF | Additional Payer Identification |  | Segment not used at this time |
|  | PER | Payer Contact Information |  |  |
|  | PER01 | Contact Function Code | 2/2 | “CX” = Payers Claim Office |
|  | PER02 | Payer Contact Name | 1/60 | “Claim Department” |
|  | PER03 | Communication Number Qualifier | 2/2 | “TE” = Telephone |
|  | PER04 | Payer Contact Communication Number | 1/256 | “2159914350” |
|  | PER | Payer Technical Contact Information |  | Required |
|  | PER01 | Contact Function Code | 2/2 | “BL” |
|  | PER02 | Payer Technical Contact Name | 1/60 | “EDI Support” |
|  | PER03 | Communication Number Qualifier | 2/2 | “TE” = Telephone |
|  | PER04 | Payer Contact Communication Number | 1/256 | “2159914290” |
|  | PER05 | Payer Contact Communication Number | 2/2 | “EM” = Electronic Mail |
|  | PER06 | Payer Technical Contact Communication | 1/256 | [“EDI@HEALTHPART.COM](mailto:EDI@HEALTHPART.COM)” |
|  | PER | Payer Web Site |  |  |
|  | PER01 | Contact Function Code | 2/2 | “IC” = Information Contact |
|  | PER02 | Name | 1/60 | Not used at this time |
|  | PER03 | Communication Number Qualifier | 1/256 | “UR” = Uniform Resource Locator (URL) |
|  | PER04 | Communication Number | 1/256 | [“www.healthpart.com](http://www.healthpart.com/)” |
| 1000B |  | Payee Identification Loop |  | Required |
|  | N1 | Payee Identification |  | Required |
|  | N101 | Payer Identifier Code | 2/3 | "PE" = Payee |
|  | N102 | Payee Name | 1/60 | Payee Name Provided |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Loop** | **Segment / Element** | **Description** | **Element Length** | **Mapping Comments** |
|  | N103 | Payee Identification Code Qualifier | 1/2 | "XX" = National Provider Identifier  “FI” = Federal Taxpayers’s Identification Number (when NPI not mandated) |
|  | N104 | Payee Identification Code | 2/80 | Corresponding Identifier |
|  | N3 | Payee Address |  | Situational (when needed to inform Receiver of Payee Address) |
|  | N301 | Payee Address Line | 1/55 | Payee Address Information provided to Jefferson Health Plans |
|  | N302 | Payee Address Line | 1/55 | Payee Address Information, if second line needed |
|  | N4 | Payee City, State, Zip Code |  | Situational (when needed to inform Receiver) |
|  | N401 | Payee City Name | 1/30 | Payee City Name provided |
|  | N402 | Payee State Code | 2/2 | Payee State Name provided |
|  | N403 | Payee Postal Zone or Zip Code | 1/15 | Payee Zip Code provided |
|  | REF | Payee Additional Identification |  | Situational (When additional identification is needed) |
|  | REF01 | Additional Payee Identification Qualifier | 2/3 | “PQ” = Payee Identification |
|  | REF02 | Reference Identification Code | 1/30 | Jefferson Health Legacy Number |
|  | REF01 | Additional Payee Identification Qualifier | 2/3 | “TJ” = Federal Taxpayer Identification Number |
|  | REF02 | Reference Identification Code | 1/30 | Federal Taxpayer Identification Number |
| 2000 |  | Header Number Loop |  | Situational (Required when claim or service level information follows) |
|  | LX | Header Number |  | Situational (required for 2000 Header Number Loop) |
|  | LX01 | Claim Sequence Number | 1/6 | Transaction Sequence Number |
|  | TS3 | Provider Summary Information |  | Segment not used at this time |
|  | TS2 | Provider supplemental Summary Information |  | Segment not used at this time |
| 2100 |  | Claim Payment Information Loop |  | Required |
|  | CLP | Claim payment Information |  | Required |
|  | CLP01 | Patient Control Number | 1/38 | Claim Submitter’s Identifier |
|  | CLP02 | Claim Status Code | 1/2 | Claim Status. See page 124 of HIPAA TR3 for valid codes |
|  | CLP03 | Total Claim Charge Amount | 1/18 | Total Claim Charge Amount (not reflecting any potential interest). |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Loop** | **Segment / Element** | **Description** | **Element Length** | **Mapping Comments** |
|  | CLP04 | Total Claim Payment Amount | 1/18 | Claim Payment Amount |
|  | CLP05 | Patient Responsibility Amount | 1/18 | Patient Responsibility Amount |
|  | CLP06 | Claim Filing Indicator Code | 1/2 | "HM" = Health Maintenance Organization |
|  | CLP07 | Payer Claim Control Number | 1/50 | Payer Claim Control Number |
|  | CLP08 | Facility Type Code | 1/2 | from original claim |
|  | CLP09 | Claim Frequency Code | 1/1 | from original claim |
|  | CLP10 | Patient Status Code | --- | \*\*\*Not used for HIPAA\*\*\* |
|  | CLP11 | Diagnosis Related Group (DRG) Code | 1/4 | Code Source 229. Institutional claims only. |
|  | CLP12 | DRG Weight | 1/15 | Diagnosis Related Group (DRG) weight |
|  | CLP13 | PERCENT - Discharge Fraction | 1/10 | Not used at this time |
|  | CAS | Claim Adjustment |  | Situational (to report claim level adjustments affecting amount paid) |
|  | CAS01 | Claim Adjustment Group Code | 1/2 | Jefferson Health Plans Supports the following Adjustment Group Codes: "CO" Contractual Obligations  "OA" Other Adjustments  "PI" Payor Initiated Reductions "PR" Patient Responsibility |
|  | CAS02 | Adjustment Reason Code | 1/5 | Code Source 139: Claim Adjustment Reason Code |
|  | CAS03 | Adjustment Amount | 1/18 | Claim Level Adjustment Amount |
|  | CAS04 | QUANTITY | 1/15 | Provided only when unit quantity is being adjusted |
|  | CAS05 –  CAS19 | (Repeat of reason code, amount, and quantity  sequence five times) |  | Not used at this time, only one adjustment is reported on a give CAS  segment, and each adjustment is on a separate CAS segment. |
|  | NM1 | Patient Name |  | Required |
|  | NM101 | Patient Identifier Code | 2/3 | "QC" = Patient |
|  | NM102 | Entity Type Qualifier | 1/1 | "1" = Person |
|  | NM103 | Patient Last Name | 1/60 |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Loop** | **Segment / Element** | **Description** | **Element Length** | **Mapping Comments** |
|  | NM104 | Patient First Name | 1/35 |  |
|  | NM105 | Patient Middle Initial | 1/25 |  |
|  | NM106 | Name Prefix |  | \*\*\* Element not used for HIPAA \*\*\* |
|  | NM!07 | Patient Name Suffix | 1/10 | Not used at this time |
|  | NM108 | Identification Code Qualifier | 1/2 | "MI" = Member Identification Number (other values reserved for future use) |
|  | NM109 | Patient Member Number | 2/80 | Corresponding Patient Identifier |
|  | NM1 | Insured Name |  | Segment not used at this time |
|  | NM1 | Corrected Patient/Insured Name |  | Segment not used at this time |
|  | NM1 | Service Provider Name |  | Situational (Required when different than Payee |
|  | NM101 | Entity Identifier Code | 2/3 | "82" Rendering Provider |
|  | NM102 | Entity Type Qualifier | 1/1 | "1" = Person  "2" = Entity |
|  | NM103 | Rendering Provider Last or Organization Name | 1/60 | Not used at this time |
|  | NM104 | Rendering Provider First Name | 1/35 | Not used at this time |
|  | NM105 | Rendering Provider Middle Name | 1/25 | Not used at this time |
|  | NM106 | Name Prefix |  | \*\*\* Element not used for HIPAA \*\*\* |
|  | NM107 | Rendering Provider Name Suffix | 1/10 | Not used at this time |
|  | NM108 | Rendering Provider Identification Code Qualifier | 1/2 | "XX" = National Provider Identifier |
|  | NM109 | Rendering Provider Identifier | 2/80 | National Provider Identifier Number Provided |
|  | NM1 | Crossover Carrier Name |  | Segment not used at this time |
|  | NM1 | Corrected Priority Payer Name |  | Segment not used at this time |
|  | MIA | Inpatient Adjudication Information |  | Segment not used at this time |
|  | MOA | Outpatient Adjudication Information |  | Segment not used at this time |
|  | REF | Other Claim Related Identification |  | Segment not used at this time |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Loop** | **Segment / Element** | **Description** | **Element Length** | **Mapping Comments** |
|  | REF | Rendering Provider Identification |  | Segment not used at this time |
|  | DTM | Statement From or To Date |  | Segment not used at this time |
|  | DTM | Coverage Expiration Date |  | Situational (Required due to expiration of coverage) |
|  | DTM01 | Date Time Qualifier | 3/3 | “036” = Expiration |
|  | DTM02 | Expiration Date | 8/8 |  |
|  | DTM | Claim Received Date |  | Situational |
|  | DTM01 | Date Time Qualifier | 3/3 | “050” = Received |
|  |  | Received Date | 8/8 |  |
|  | PER | Claim Contact Information |  | Not used at this time |
|  | AMT | Claim Supplemental Information |  | Situational (Informational only, not used for balancing) |
| DTM02 | AMT01 | Amount Qualifier Code | 1/3 | Allowed Values:  "D8" = Discount Amount "I" = Interest  "T" Tax |
|  | AMT02 | Claim Supplemental Information Amount | 1/18 | Corresponding Amont |
|  | QTY | Claim Supplemental Information Quantity |  | Segment not used at this time |
| 2110 |  | Service Payment Information |  | Situational |
|  | SVC | Service Payment Information |  | Situational (Expected to be sent under most circumstances) |
|  | SVC01-1 | Service Type Code | 2/2 | See HIPAA 835 Technical Report Type 3, pg. 187-188 for supported codes |
|  | SVC01-2 | Service Code | 1/48 | Procedure Code |
|  | SVC01-3 | PROCEDURE MODIFIER 1 | 2/2 | Payer will be reporting up to 4 procedure Modifiers |
|  | SVC01-4 | PROCEDURE MODIFIER 2 | 2/2 |  |
|  | SVC01-5 | PROCEDURE MODIFIER 3 | 2/2 |  |
|  | SVC01-6 | PROCEDURE MODIFIER 4 | 2/2 |  |
|  | SVC01-7 | Procedure Code Description | 1/80 | Sub-element not used at this time |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Loop** | **Segment / Element** | **Description** | **Element Length** | **Mapping Comments** |
|  | SVC02 | Monetary Amount | 1/18 | Submitted Line Item Service Charge Amount |
|  | SVC03 | Monetary Amount | 1/18 | Line Item Provider Payment Amount |
|  | SVC04 | NUBC Revenue Code | 1/48 | Not used at this time |
|  | SVC05 | Units of Service Paid Count | 1/15 | If not present, the value is assumed to be 1 |
|  | SVC06-1 | PRODUCT/SERVICE ID QUALIFIER | 2/2 | Provided if procedure code in SVC01 is different from procedure code  submitted; see pg. 191 of the HIPAA Technical Report Type 3 |
|  | SVC06-2 | Procedure Code | 1/48 | Provided if procedure code in SVC01 is different from procedure code  submitted |
|  | SVC06-3 | Procedure Modifier 1 | 2/2 | Sub-Element not used at this time |
|  | SVC06-4 | Procedure Modifier 2 | 2/2 | Sub-Element not used at this time |
|  | SVC06-5 | Procedure Modifier 3 | 2/2 | Sub-Element not used at this time |
|  | SVC06-6 | Procedure Modifier 4 | 2/2 | Sub-Element not used at this time |
|  | SVC06-7 | Procedure Code Description | 1/80 | Sub-Element not used at this time |
|  | SVC07 | Original Units of Service Count | 1/15 | Only provided when paid unit is different from submitted units |
|  | DTM | Service Start Date |  | Situational (if claim date is absent or different from Service Line date) |
|  | DTM01 | Date Time Qualifier | 3/3 | "150" = Service Period Start Date |
|  | DTM02 | Service Date | 8/8 | Service Start Date in CCYYMMDD Format |
|  | DTM | Service End Date |  | Situational (if claim date is absent or different from Service Line date) |
|  | DTM01 | Date Time Qualifier | 3/3 | "151" = Service Period End Date |
|  | DTM02 | Service End Date | 8/8 | Service End Date in CCYYMMDD Format |
|  | DTM | Service Date |  | Situational (if claim date is absent or different from Service Line date) |
|  | DTM01 | Date Time Qualifier | 3/3 | "472" = Service Date |
|  | DTM02 | Service Date | 8/8 | Service Date in CCYYMMDD Format to indicate a single day service |
|  | CAS | Service Adjustment |  | Situational (to account for difference in amount paid for this service) |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Loop** | **Segment / Element** | **Description** | **Element Length** | **Mapping Comments** |
|  | CAS01 | Claim Adjustment Group Code | 1/2 | Jefferson Health Plans uses the following Adjustment Group Codes: "CO" Contractual Obligations  "OA" Other Adjustments  "PI" Payor Initiated Reductions "PR" Patient Responsibility |
|  | CAS02 | Adjustment Reason Code | 1/5 | Code Source 139: Claim Adjustment Reason Code |
|  | CAS03 | Adjustment Amount | 1/18 | Service Level Adjustment Amount; negative number increases amount, positive decreases |
|  | CAS04 | Adjustment Quantity | 1/15 | Provided only when unit quantity is being adjusted; negative number  increases amount, positive decreases |
|  | CAS05-  CAS19 | (Repeat of reason code, amount, and quantity  sequence five times) |  | Not used at this time |
|  | REF | Service Identification |  | Situational (provider reference numbers specific to this service) |
|  | REF01 | Reference Identification Qualifier | 2/3 | Refer to HIPAA Technical Report Type 3 pg. 204 for supported code values. |
|  | REF02 | Provider Identifier | 1/50 | Provider Identifier |
|  | REF | Line Item Control Number |  | Situational |
|  | REF01 | Reference Identification Qualifier | 2/3 | “6R” = Provider Control Number |
|  | REF02 | Reference Identification | 1/50 | Line Item Control Number |
|  | REF | Rendering Provider Information |  | Situational (to identify provider specific to this service) |
|  | REF01 | Reference Identification Number | 2/3 | “HPI” = National Provider Identifier  "TJ" = Federal Taxpayers Identification Number (other supported values as needed) |
|  | REF02 | Rendering Provider Federal ID | 1/50 | Corresponding identifier |
|  | AMT | Service Supplemental Amount |  | Situation (Informational only, not used for balancing) |
|  | AMT01 | Amount Qualifier Code | 1/3 | Refer to HIPAA Technical Report Type 3 pg. 211-212 for supported codes |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Loop** | **Segment / Element** | **Description** | **Element Length** | **Mapping Comments** |
|  | AMT02 | Service Line Allowed Amount | 1/18 | Corresponding Amount (Service Line Allowed Amount) |
|  | QTY | Service Supplemental Quantity |  | Segment not used at this time |
|  | LQ | Health Care Remark Code |  | Situational (Informational remarks only) |
|  | LQ01 | Service Line Remittance Remark Code 1 | 1/3 | "HE" Claim Payment Remark Codes |
|  | LQ02 | Service Line Remittance Remark Code 2 | 1/30 | Remark Code |
| 0000 |  | Transaction Set Loop (Summary) |  | Required |
|  | PLB | Provider Adjustment |  | Situational (for adjustments not specific to a claim or service) |
|  | PLB01 | Provider Identifier | 1/50 |  |
|  | PLB02 | Fiscal Period Date | 8/8 | Last day of provider’s fiscal year in CCYYMMDD format; if not known, December 31 of current year. |
|  | PLB03-1 | PROVIDER ADJUSTMENT REASON CODE | 2/2 | Refer to HIPAA Technical Report Type pg. 219-222 for supported Code Values |
|  | PLB03-2 | Provider Adjustment Identifier | 1/50 | Sub-Element not used |
|  | PLB04 | Provider Adjustment Amount | 1/18 |  |
|  | PLB05 –  PLB14 | (Repeat of adjustment identifier and amount  sequence five more times) |  | Not used at this time, only one adjustment is reported on a PLB segment |
|  | SE | Transaction Set Trailer |  | Required |
|  | SE01 | Number Of Included Segments | 1/10 | Transaction Segment Count |
|  | SE02 | Transaction Set Control Number | 4/9 | Transaction Set Control Number |
| Functional  Group |  | Functional Group Loop (End) |  | Required |
|  | GE | Functional Group Trailer |  | Required |
|  | GE01 | Number of Transaction Sets Included | 1/6 | Number of Transactions Sets included in the Functional Group |
|  | GE02 | Group Control Number | 1/9 | Functional Group control number must equal the value in GS06 |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Loop** | **Segment / Element** | **Description** | **Element Length** | **Mapping Comments** |
| Interchange |  | Interchange Control Loop (End) |  | Required |
|  | IEA | Interchange Control Trailer |  | Required |
|  | IEA01 | Number of Included Functional Groups | 1/5 | A count of the number of Functional Groups (GS-GE) in the interchange |
|  | IEA02 | Interchange Control Number | 9/9 | A control number that must equal the value in ISA 13 |

## \* If the National Provider Identification Number is not included on the claim then a default of all 8’s will be generated in this field