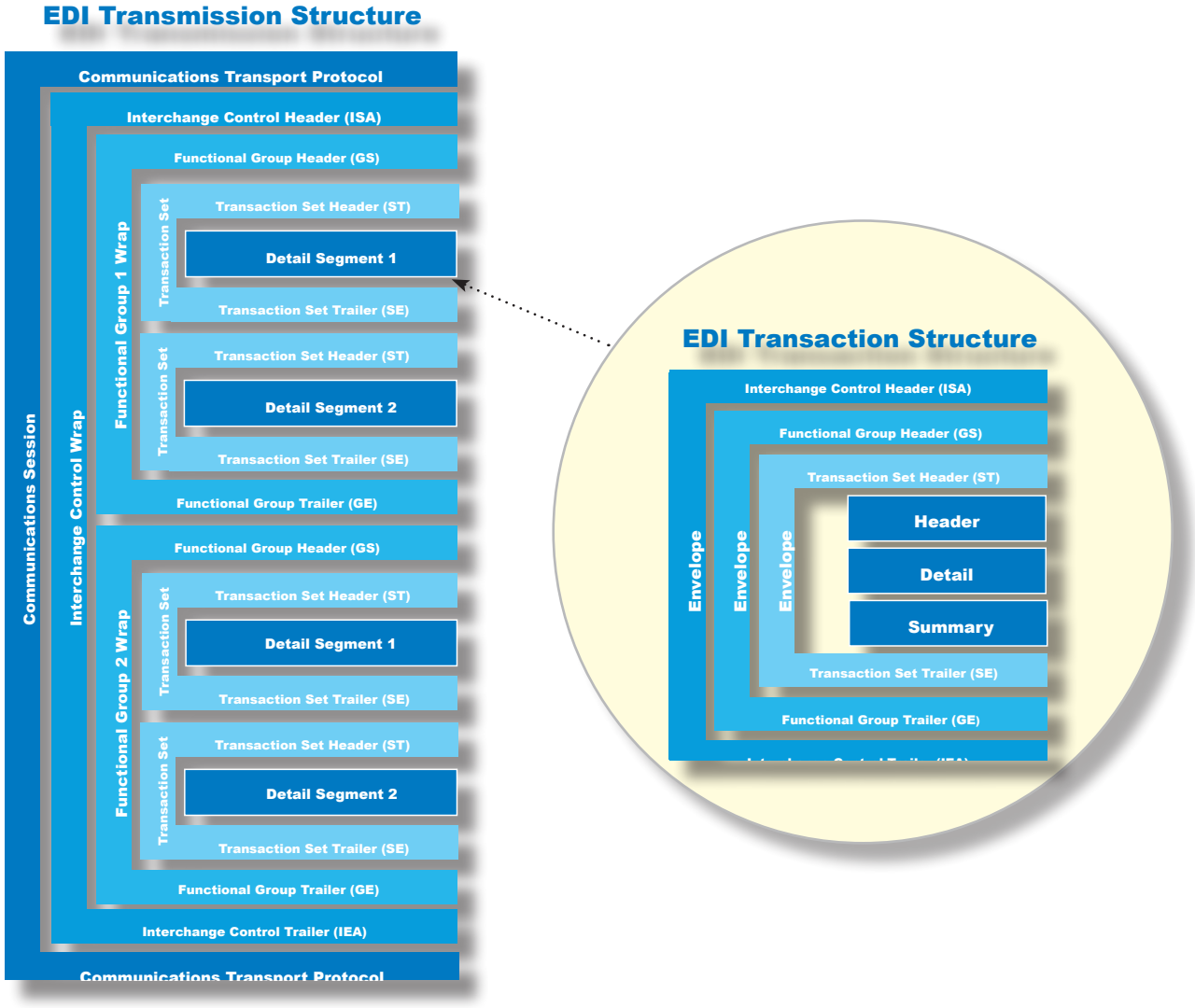
835 Health Care Claim Payment/Advice

Basic Instructions

This section provides information to help you prepare for the ANSI ASC X12 Health Care Claim Payment/Advice (835) transaction. The remaining sections of this appendix include tables that provide information about 835 segments and data elements that are used to efficiently process transactions through Anthem Blue Cross and Blue Shield, Connecticut, Maine, and New Hampshire (East Region) systems.

Use this companion document in conjunction with both the Transaction Set Implementation Guide "Health Care Claim Payment/Advice, 835, ASCX12N 835 (004010X091)," May 2000, and the subsequent Addenda (004010X091A1), October 2002, published by the Washington Publishing Co.



1 Registration Process - Remittances

The 835 Electronic Remittance Advice (ERA) provides information for the payee regarding claims in their final status, including information about the payee, the payer, the amount, and any payment identifying information.

All trading partners are eligible to receive the ERA but **require** prior registration with EDI Solutions, (800) 334-8262 for the necessary set up and instructions.

As part of the process, the Payment Advice/Remittance Registration Form must be completed. It is available from the EDI website (http://www.anthem.com/edi, Register, Registration Forms). Changes to the NPI, provider or tax identification numbers may affect the distribution of the 835 Payment/ Advice, therefore, providers should notify Anthem Provider Services and EDI Solutions when these types of changes do occur.

2 Electronic Funds Transfer (EFT)

In order to sign up for EFT, complete and submit the ERA/EFT Enrollment Form (available on EDI website, www.anthem.com/edi, Select Registration). The same form is used to submit any changes to your EFT set up.

3 Basic Format of the 835 File - Payment by NPI, Payee ID, Multiple Providers

Claim payments are made based on the NPI (or Payee ID) and Tax ID number. Depending on the provider reimbursement arrangement, multiple providers may be paid under the same NPI (or Payee ID) and Tax ID. Therefore, when a provider group requests an 835, by default all provider payments linked to the group NPI (or group Payee ID) will appear on the 835. Note that all registered NPIs will be returned on the 835.

The format of the 835 file will show multiple checks and/or payment information tied to the provider group or individual provider on a given day in one or multiple ERA files. Checks and/or payment information can be bundled and uniquely identified within the same 835 file.

Multiple checks and/or payment information within one 835 file may cause difficulty and require system changes for providers who directly download 835 files.

4 Paper Claims & Paper Remittance Advices

A compliant 835 Payment/Advice with required elements will be generated in response to all claim submissions regardless if they are submitted on paper or electronically in the 837 format. Anthem will continue to produce paper remittance advices along with electronic remittances advices for an undetermined period of time.

5 Delimiters

Anthem will use the delimiters as defined in the table below for all outbound transactions.

Delimiter	Character Name	Character
Data Element Separator	Asterisk	*
Sub-Element Separator	Bar	|
Segment Terminator	Tilde	~

6 Balancing

To ensure HIPAA compliance, editing is performed on the 835 transaction as it is routed through the Enterprise EDI Gateway/Clearinghouse. Successful outbound routing to the 835 trading partner depends on the balancing of the file where the total payment must agree with the remittance information detailing that payment.

The amounts reported in the file must balance at three different levels; the service line, the claim, and the transaction. When service payment information is provided, the submitted service charge (SVC02) minus the sum of all monetary adjustments (CAS segments) must equal the amount paid for the service line (SVC03). Similarly within the claim payment loop, the submitted charge for the claim (CLP03) minus the sum of all monetary adjustments (CAS segments) must equal the claim paid amount (CLP04). The total claim charge (CLP03) must balance the sum of the related service charges (SVC02), if applicable. *Monetary amounts in the AMT segments convey information only; they do not affect the financial balancing of the transaction.

Further balancing within the transaction ensures that the sum of all claim payments (CLP04) minus the sum of all provider level adjustments (PLB segments) equals the total payment amount (BPR02).

All balancing measures must be met in order for an 835 file to be delivered to the Gateway. Occasionally, balancing issues may delay the delivery of an 835 file. Delays are generally no later than 24 hours beyond the scheduled delivery.

7 Scheduling

The delivery of 835 files is coordinated with their corresponding check remit dates. Under normal operating conditions, the 835 file is available the next business day between the hours after 11am and 2pm, following the check remit date. For example, payment information for the check remit date Monday 7/12 will be available and posted in the 835 file on Tuesday 7/13.

Company closings or holidays may affect delivery of 835 files. Scheduling resumes when production begins on the next opening business day.

The following table provides the check remit dates for institutional and professional payments.

REMITTANCE ISSUE DATE						
		Monday	Tuesday	Wednesday	Thursday	Friday
System	**Line of Business**					
ACES	BCBS *CT*	Institutional	Institutional	Institutional	Institutional	Institutional Professional
	ME	Institutional	Institutional Professional	Institutional	Institutional	Institutional Professional
	NH	Institutional	Institutional	Institutional Professional	Institutional	Institutional Professional
FEP	Federal Employees' Program	Institutional Professional	Institutional Professional	Institutional Professional	Institutional Professional	Institutional Professional
NASCO	National Accounts					Institutional Professional

For National Accounts: 835 Files are generated during the week although no payment is made. Also, in some situations when the claims on the check are for plan 803, New York post-dates their checks two days after the cycle date. For example, claims on a file processed through the financial system on 9/14 will show check records date 9/16.

8 Claim Filing Indicator Code (Loop 2100 CLP06)

The **Claim Filing Indicator Code** is used to separately identify and manage the different product lines or contractual arrangements between the payer and the provider. It is the value that is submitted on the 837 claim (Loop 1000A SBR09), if applicable, or is provided as assigned or edited by the payer. The following table identifies the products of the East Region and their appropriate Claim Filing Indicator Code.

Plan Code - Product Name												
Loop 2100, CLP06 - Claim Filing Indicator Code (See 835 IG, Page 92)												
12 **- PPO Arrangements**												
	P-PAR	Century Preferred			**HMOCL**	HMO Choice 50+			**NHPBL**	Preferred Blue		
	STATE	State Preferred			**BLCHC**	BlueChoice Under 51			**NHBLD**	Blue Direct		
	PP2K	Century Preferred 2000			**BLCHL**	BlueChoice 50+			**NHINB**	Individual Blue		
	CPCMP	Century Preferred Comp			**H2CHC**	HMO Choice Under 51			**HMOCH**	HMO Choice Under 51		
	YALPA	Yale Preferred Access			**H2CHL**	HMO Choice 50+						
	URNP1	Century Preferred National (United)			**P2000**	Preferred Provider Plan (C2000 Ntwk)						
	ITS	Plan Code for ITS with prefix not noted in Plan Codes 13 and HM categories. (See Codes 13 and HM)										
		FEP (Federal Employee's Program)										
13 **- Point of Service POS**												
	POSP1	Bluecare Plus Option 1(Hi Option)			**HLTHC**	HealthChoice			**NHB2T**	BlueChoice 2 Tier		
	POSP2	Bluecare Plus Option 2 (Med Option)			**HCSTD**	HealthChoice Standard			**NHB3T**	BlueChoice 3 Tier		
	POSP3	Bluecare Plus Option 3 (Low Option)			**HCBSC**	HealthChoice Basic			**NHBCN**	BlueChoice New England		
	POS1	Bluecare POS Option 1 (Hi Option)			**MPCHC**	Maine Partners Choice (POS) Under 51						
	POS2	Bluecare POS Option 2 (Med Option)			**MPCHL**	Maine Partners Choice (POS) 51+						
	POS3	Bluecare POS Option 3 (Low Option)			**MP2CH**	Maine Partners Choice Under 51						
	PKSP1	Bluecare Plus Option 1 2000 (Hi Option)			**MP2CL**	Maine Partners Choice 51+						
	PKSP2	Bluecare Plus Option 2 2000 (Med Option)			**PKS1**	Bluecare Option 1 2000 (Hi Option)						
	PKSP3	Bluecare Plus Option 3 2000 (Low Option)			**PKS2**	Bluecare Option 2 2000 (Med Option)						
					PKS3	Bluecare Option 3 2000 (Low Option)						
	ITS	Plan Code for ITS with prefix CTP, HPP, MEP, MTP, NAP, NHP, or PVP.										
15 **- Indemnity Insurance**												
	NHMGA	Medigap A	**081**	BS-65 Plan 81	**08S**	State CarePlus	**C90**	Century 90				
	NHMGB	Medigap B	**082**	BS-65 Plan 82	**08P**	CarePlus (non-stat	**MT-90**	Modified Traditional				
	NHMBC	Medigap C	**083**	BS-65 Plan 83	**C9**	Century 90	**WRAP**	Wraparound				
	NHMGD	Medigap D	**08A**	Medigap Plan A	**C94**	Century 94	**HOSP**	Semi-private				
	NHMGF	Medigap F	**08B**	Medigap Plan B	**C96**	Century 96	**COMP**	Comprehensive				
	NHMGG	Medigap G	**08C**	Medigap Plan C	**C98**	Century 98	**COMPS**	Group Comprehensive				
	NHMGH	Medigap H	**08D**	Medigap Plan D	**C9D**	Century 9D	**SUPP**	Major Medical				
	NHMGJ	Medigap J	**08F**	Medigap Plan F	**C9T**	Century 9T	**SUPPS**	Major Medical				
	NHMC1	Medicomp I	**NHBCO**	Blue Cross only			**NHNGC**	Non-Group Comprehensive				
	NHMC2	Medicomp II	**NHGCP**	Group Comprehensive			**NHTMP**	Temporary Product				
	NHMC3	Medicomp III			**MDGPA**	Medigap A	**MDGPC**	Medigap C	**MDGPF**	Medigap F	**MDGPJ**	Medigap J
	NHCSM	BCBS Basic Major Medical			**MDGPB**	Medigap B	**MDGPE**	Medigap E	**MDGPI**	Medigap I		
	MPIST	Maine Partners Individual Standard					**FSMM**	Major Medical portion Full Service				
	MPIBA	Maine Partners Individual Basic					**FSMM2**	Major Medical 20-50	**FSMML**	Major Medical 51+		
	GCMPG	Group Companion Under 51 - Drug rider					**FSMMG**	Major Medical - Drug rider				
	GCMLG	Group Companion 51+ - Drug rider					**FSM2G**	Major Medical 20-50 Drug rider				
	GCOMP	Group Companion Under 51					**FSMLG**	Major Medical 51+ Drug rider				
	GCOML	Group Companion 51+					**CCARE**	CompCare Under 51				
	FSERV	Full Service Under 20					**CCARL**	CompCare 51+				
	FSV2+	Full Service 20-50					**CAREG**	CompCare Under 51 - Drug rider covg				
	FSERL	Full Service 51+					**CARLG**	CompCare 51+ - Drug rider covg.				
16 **- HMO Medicare Risk**												
	MR2K	MedBlue			**MRPOE**	MedBlue POS			**MRPOE**	MedBlue POE		
HM **- HMO**												
	SEP10	Bluecare Access 10			**INDST**	Individual HMO Standard						
	BRAD	Bradlees			**INDBA**	Individual HMO Basic						
	POEP1	Bluecare Plus POE Option1			**MPHMO**	Maine Partners HMO (lock-in) Under 51						
	POEP2	Bluecare Plus POE Option 2			**MPHML**	Maine Partners HMO (lock-in) 51+						
	POEP3	Bluecare Plus POE Option 3			**H2RER**	HMO Maine Under 51			**NHKID**	Healthy Kids		
	PKEP1	Bluecare Plus POE Option 1 2000			**H2REL**	HMO Maine 50+			**NHFRH**	Franklin Health		
	PKEP2	Bluecare Plus POE Option 2 2000			**MP2HM**	Maine Partners HMO Under 51			**MHLNK**	HealthLink		
	PKEP3	Bluecare Plus POE Option 3 2000			**MP2HL**	Maine Partners HMO 51+			**NHNCC**	North Country Cares		
	PKE1	Bluecare POE Option 1 2000			**NHHMO**	Mathew Thornton HMO						
	PKE2	Bluecare POE Option 2 2000			**NHHNE**	HMO Blue New England						
	PKE3	Bluecare POE Option 3 2000			**HMMEO**	HMO Maine (old) Under 51						
	HMRER	HMO Maine (rewrite) Under 51			**HMMEL**	HMO Maine (old) 51+						
	HMREL	HMO Maine (rewrite) 51+										
	ITS	Plan Code for ITS with prefix CTN, HPN, MEN, MTN, NAN, NHN, or PVN.										
MC **- Medicaid**												
	NHCAD	Medicaid (for NH only)										

9 Definition of Adjustment

Anthem (East Region) recognizes the word "adjustment" differently under HIPAA.

CURRENT - The term "adjustment" refers to a previously adjudicated claim in need of a correction	**HIPAA** - The term "adjustment" is any change (reduction or additional) that the payer has made either to the originally submitted charge or to the units related to the claim or service(s).
For example: **Payment** is made in the amount of $20.00. Examination has shown that the Payment was made in error. The **Amount Paid** should have been $18.00. The **Adjustment** is -$2.00 and requires a reduction of $2.00 from the original payment.	For example: The **Charge** is $100.00. The **Allowed Amount** is $80.00. The **Amount Paid** is $70.00. The Reductions of $20.00 and $10.00 are known as **Adjustments**, respectively.

10 Claim Adjustment Group Code

The Claim Adjustment and Service Adjustment Segments (CAS) provide the reasons, amounts, and quantities of any adjustments that the payer made either to the original submitted charge or to the units related to the claim or service(s). Specifically, the **Claim Adjustment Group Code** (CAS01) categorizes the adjustment reason codes contained in a particular CAS and are evaluated according to the following order:

1. **Patient Responsibility** (PR) — indicates the amount adjusted in CAS segment is the patient's responsibility.
2. **Contractual Obligations** (CO) — indicates the amount adjusted in CAS segment is not the patient's responsibility due to a contractual obligation between the provider and the payer.
3. **Payer Initiated Reductions** (PI) — indicates the amount adjusted in CAS segment is not the patient's responsibility, without a supporting contract between the provider and the payer.
4. **Correction and Reversals** (CR) — indicates the claim is the reversal of a previously reported claim or claim payment.
5. **Other Adjustments** (OA) — indicates the amount adjusted does not fall in any of the above categories.

11 Claim Adjustment Reason Codes and Remittance Advice Remark Codes

A claim adjustment reason code (CAS segment) is used to communicate that an adjustment was made at the claim/service line, and provides the reason for why the payment differs from what was billed. The adjustment reason code list is available on the internet (http://www.wpc-edi.com/codes, select Claim Adjustment Reason Codes) and reviewed by the Claim Adjustment Status Code maintenance committee three times a year.

A claim remittance advice remark code (LQ segment) provides supplemental explanation for an adjustment already described by an adjustment reason code. Previously, the remittance remark code list was created and supported for Medicare only, but now it is appropriate for use by all payers. The remark code list is available on the internet (http://www.wpc-edi.com/codes, select Remittance Advice Remark Codes) and reviewed by the Remittance Advice Code Maintenance Committee whose members represent various components from CMS.

It is important to continue referring to the code lists maintained by the committees. Updated code lists are published tri-annually at the end of March, July, and November.

The use of HIPAA standards has imposed a limitation on what detailed explanation is reported on the 835 Payment/Advice. It has been determined that proprietary disposition codes may not map one-for-one to a standard HIPAA claim adjustment reason and/or remittance advice remark code.

12 Corrections and Reversals (CR)

A reversal of a previously reported claim or claim payment is reported by using the data elements CLP02 (22 - reversal of previous payment) and CAS01 (CR - corrections and reversals). The corrected data is then resent as if it were the original payment.

The following are 835 examples of an adjustment and a void:

	ORIGINAL CLAIM	REVERSAL	CORRECTION
ADJUSTMENT	CLP*12345*1*115*79.2*25*HM*ABCDEF1200~ NM1*QC*1*DOE*JOHN****MI*ABC0000A12345~ NM1*82*1*KAHN*****BS*01Z11111ZZ01~ SVC*HC:92014*115*79.2**1~ DTM*472*20040812~ CAS*CO*104*10.8~ CAS*PR*3*25~ AMT*B6*115~	**CLP***12345***22***-115*-79.2***HM*ABCDEF1201~ NM1*QC*1*DOE*JOHN****MI*ABC0000A12345~ NM1*74*1******C*0000A31802~ NM1*82*1*KAHN*****BS*01Z11111ZZ01~ SVC*HC:92014*-115*-79.2**1~ DTM*472*20040812~ **CAS*CR***104*-10.8**3*-25 AMT*B6*-115~	CLP*12345*1*150*100.62*25*HM*ABCDEF1202~ NM1*QC*1*DOE*JOHN****MI*ABC0000A12345~ NM1*82*1*KAHN*****BS*01Z11111ZZ01~ SVC*HC:92014*150*100.62**1~ DTM*472*20040812~ CAS*CO*42*10.67**104*13.71~ CAS*PR*3*25~ AMT*B6*139.33~
VOID	CLP*54321*1*255*64.59*25*HM*FEDCBA3200~ NM1*QC*1*SMITH*JOHN****MI*CBA0000012345~ NM1*IL*1*SMITH*JANE****MI*CBA0000012345~ NM1*82*1*MORRISON*****BS*01Z22222ZZ01~ SVC*HC:92012*80*48.4**1~ DTM*472*20040801~ CAS*CO*104*6.6~ CAS*PR*3*25~ AMT*B6*80~ SVC*HC:76514*115*16.19**1~ DTM*472*20040801~ CAS*CO*42*96.61**104*2.2~ AMT*B6*18.39~ SVC*HC:99058*60*0**1~ DTM*472*20040801~ CAS*CO*97*60~	**CLP***54321***22***-255*-64.59***HM* FEDCBA3201~ NM1*QC*1*SMITH*JOHN****MI* CBA0000012345~ NM1*IL*1*SMITH*JANE****MI* CBA0000012345~ NM1*74*1******C*0000041053~ NM1*82*1*MORRISON*****BS*01Z22222ZZ01~ SVC*HC:92012*-80*-48.4**1~ DTM*472*20040801~ **CAS*CR***104*-6.6**3*-25~ AMT*B6*-80~ SVC*HC:76514*-115*-16.19**1~ DTM*472*20040801~ **CAS*CR***42*-96.61**104*-2.2~ AMT*B6*-18.39~ SVC*HC:99058*-60*0**1~ DTM*472*20040801~ **CAS*CR***97*-60~	CLP*543210*1*255*0**HM* FEDCBA3202~ NM1*QC*1*SMITH*JOHN****MI* CBA0000012345~ NM1*IL*1*SMITH*JANE****MI* CBA0000012345~ NM1*82*1*MORRISON*****BS*01Z22222ZZ01~ SVC*HC:92012*80*0**1~ DTM*472*20040801~ CAS*OA*[adjustment reason code]*80~ SVC*HC:76514*115*0**1~ DTM*472*20040801~ CAS*OA*[adjustment reason code]*115~ SVC*HC:99058*60*0**1~ DTM*472*20040801~ CAS*OA*[adjustment reason code]*60~

13 Home Plan Payments for Non-Par Providers (PER)

In cases when the Home Plan flips payment direction from "home-pay-subscriber" to "home-pay-provider", the electronic remittance(s) will be generated by the East Region and sent to the non-par provider, if registered to receive the 835. Anthem as the Host Plan will not make any payments for non-par provider claims as they are sent to their appropriate Home Plan for payments.

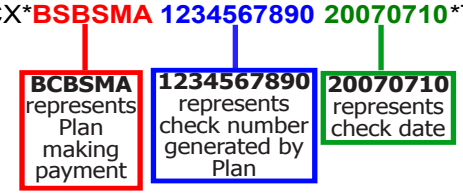
Refer to Loop 1000A PER segment for details.

Example of Host Plan Payment - from BCBS of Massachusetts

BPR*I*60*C*CHK**********20070710~
TRN*1*NO CHECK ISSUED181332120000088*1020494919~
DTM*405*20070726~
N1*PR*MATTHEW THORTON HEALTH PLAN, INC.~
N3*3000 GOFFS FALL ROAD~
N4*MANCHESTER*NH*03111~
PER*CX*BSBSMA 1234567890 20070710*TE*8003348262~

BPR segment, BPR02 Check amount of **$60** from BCBSMA paid to provider

TRN segment, TRN02 **NO CHECK ISSUED** indicates check not issued from Anthem



In cases when the claim is rejected, no check number and no check date will be available for Anthem to populate in the PER segment. Instead, the default values will be reported:

Check Number = '**DEFAULT**' and
Check Date = "**20491231**".

14 Procedure Code Bundling

Actual services performed and reported for a claim payment can be represented by a different group of procedure codes. Bundling occurs when two or more reported procedures are going to be paid under only one procedure code.

The originally submitted procedures are reported with the procedures paying on the bundled procedure code, and the original submitted code referenced. The bundled service line is adjusted up by an amount equal to the sum of the other line charges.

Original Claim

Billed with CPT 36415, 99000, and **84443**.

Second Billed Claim

Billed with CPT 80061, **85025**, and **80053**.

Result of Bundling

CLP*00000000000000000000*1*104*81.07*9*13*71210A2100~
NM1*QC*1*SMITH*JOHN****MI*ABC0000123456~
NM1*82*1*CARLSON*****BS*01P000000ME01~
SVC*HC|80061*54*36.07**1~
DTM*472*20050726~
CAS*CO*42*13.93~
CAS*PR*2*4~
AMT*B6*40.07~
SVC*HC|**80050***20*45**1*HC|**85025**~ — From the second billed claim, CPT **85025** is bundled under CPT 80050
DTM*472*20050726~
CAS*OA*94*-30~
CAS*PR*2*5~
AMT*B6*50~
SVC*HC|**80050***10*0**1*HC|**80053**~ — From the second billed claim, CPT **80053** is bundled under CPT 80050
DTM*472*20050726~
CAS*CO*97*10~
LQ*HE*M15~
SVC*HC|**80050***20*0**1*HC|**84443**~ — From the original claim in history, CPT **84443** is bundled under CPT 80050
DTM*472*20050726~
CAS*CO*97*20~
CLP*00000000000000000000*22*-46*-24.87**13*7121002101~
NM1*QC*1*SMITH*JOHN****MI*ABC0000123456~
NM1*82*1*CARLSON*****BS*01P000000ME01~
SVC*HC|36415*-15*0**1~
DTM*472*20050726~
CAS*CR*97*-15~
LQ*HE*N19~
SVC*HC|99000*-11*-6.87**1~
DTM*472*20050726~
CAS*CR*2*-.76**42*-3.37~
AMT*B6*-7.63~
SVC*HC|84443*-20*-18**1~
DTM*472*20050726~
CAS*CR*2*-2~
AMT*B6*-20~
CLP*00000000000000000000*1*46*6.87*.76*13*7121002102~
NM1*QC*1*SMITH*JOHN****MI*ABC0000123456~ — Adjustment of the original claim in history
NM1*82*1*CARLSON*****BS*01P000000ME01~
SVC*HC|36415*15*0**1~
DTM*472*20050726~
CAS*CO*97*15~
LQ*HE*N19~
SVC*HC|99000*11*6.87**1~
DTM*472*20050726~
CAS*CO*42*3.37~
CAS*PR*2*.76~
AMT*B6*7.63~
SVC*HC|84443*20*0**1~
DTM*472*20050726~
CAS*CO*97*20~

15 Coordination of Benefits - Primary and Secondary Payments (CLP02)

Primary and Secondary processing is indicated by using the claim status code (1 - Processed as Primary, 2 - Processed as Secondary). Secondary payments are based on individual business contracts, each of which presents unique payment scenarios.

The following illustrate examples of primary and secondary institutional and professional payments.

835 Coordination of Benefits (COB)		
Current 835	**Future 835 (Dec 2007)**	**Comments**
Professional Claim Payment - Claim Paid as Secondary (CLP02 '2') Medicare Carveout		
CLP*ABC321*2*85*0*8.77*12*CLM4~ **SVC***HC|99999*85*0**1~ CAS***CO*** **42** * 76.23 ~ CAS***PR*** **1** * 80 ** **A2** * -71.23~	**CLP***ABC321*2*85*0*8.77*12*CLM4~ **SVC***HC|99999*85*0**1~ CAS***OA*** **23*** 76.23~ CAS***PR*** **96** *8.77~ **LQ***HE* **N130**~	Member's deductible not met. Replace **CO*42, PR*1** & **PR*A2** with **OA*23**, and **PR*96** & LQ****N130** *Contractual Obligation* **23** Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments. *Patient Responsibility* **96** Non-covered charge(s). **N130** Alert: Consult plan benefit documents for information about restrictions for this service.
Professional Claim Payment - Claim Paid as Secondary (CLP02 '2') Medicare Crossover		
CLP*ABC123*2*410*73.45**15*CLM5~ **SVC***HC|Q3025*360*69.09**3~ CAS***OA*** **23** * 276.38 ** **A2** * 14.53~ **AMT***B6*69.09 **SVC***HC|90772*50*4.36**1~ CAS***OA*** **23** * 17.42 ** **A2** * 28.22~ **AMT***B6*4.36	**CLP***ABC123*2*410*73.45**15*CLM5~ **SVC***HC|Q3025*360*69.09**3~ CAS***OA*** **23** * 290.91~ **AMT***B6*69.09 **SVC***HC|90772*50*4.36**1~ CAS***OA*** **23** * 45.64~ **AMT***B6*4.36	Payment made to provider. Replace **OA*23** & **OA*A2** with **OA*23** *Other Adjustment* **23** Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments.
Professional Claim Payment - Claim Paid as Secondary (CLP02 '2') Commercial		
SVC*NU|120***705*****11.22****1~ CAS***CO*** **131** * 458.61~ CAS***OA*** **A2*** 235.17~ **AMT***B6*246.39 **SVC***NU|0940***128.7*****2.07****1~ CAS***CO*** **131** * 83.08 CAS***OA*** **A2** * 43.55~ **AMT***B6*45.62	**SVC***NU|120*705*11.22**1~ CAS***OA*** **23*** 693.78~ **AMT***B6*11.22 **SVC***NU|0940*128.7*2.07**1~ CAS***OA*** **23** * 126.63~ **AMT***B6*2.07	Payment made to provider. Replace **CO*131** & **OA*A2** with **OA*23** *Other Adjustment* **23** Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments

835 Coordination of Benefits (COB)		
Current 835	**Future 835 (Dec 2007)**	**Comments**
Institutional Claim Payment - Claim Paid as Primary (CLP02 '1')		
CLP*ABC1*1*385*153.62*176.44*12*CLM1~ **SVC***HC|97110*154*105.62*0420*2~ CAS***CO*** **131** * 21.98~ CAS***PR*** **2** * 26.4 ~ **AMT***B6*132.02~ **SVC***HC|97535*231*48*0430*3~ CAS***CO*** **131** * 32.96~ CAS***PR*** **2** * 39.6 ****A2*** 110.44 ~ **AMT***B6*198.04~	**CLP***ABC1*1*385*153.62*176.44*12*CLM1~ **SVC***HC|97110*154*105.62*0420*2~ CAS***CO*** **131** * 21.98~ CAS***PR*** **2** * 26.4 ~ **AMT***B6*132.02~ **SVC***HC|97535*231*48*0430*3~ CAS***CO*** **131** * 32.96~ CAS***PR*** **2** * 39.6 ****119*** 110.44 **AMT***B6*198.04~	Member reaches benefit maximum. Replace **PR*****A2** with **PR*****119** **119** Benefit maximum for this time period or occurrence has been reached.
CLP*ABC*1*2667*1979.09*519.89*12*CLM2~ **SVC***HC|97110*2667*1979.09*0420*2~ CAS***CO*** **131** * 168.02~ CAS***PR*** **2** * 219.89 ** **A2** * 300~ **AMT***B6*2498.98~	**CLP***ABC*1*2667*1979.09*519.89*12*CLM2~ **SVC***HC|97110*2667*1979.09*0420*2~ CAS***CO*** **131** * 168.02~ CAS***PR*** **2** * 219.89 ** **197** * 300~ **AMT***B6*2498.98~	No prior authorization. Replace **PR*****A2** with **PR*****197** **197** Payment adjusted for absence of precertification/ authorization.
Institutional Claim Payment - Claim Paid as Secondary (CLP02 '2') Medicare Crossover		
SVC*HC|80051*710.1*26.71***0301***1~ CAS***CO*** **131** * 471.42~ CAS***OA*** **A2** * 211.97~ AMT*B6*238.68~	**SVC***HC|80051*113.59*26.71***0301***1~ CAS***OA*** **94** * - 596.51 ~ CAS***OA*** **23** * 683.39~ AMT*B6*238.68~ **SVC***HC|82247*35.62*0***0301***1~ CAS***CO*** **97** *35.62~ **SVC***HC|82248*35.64*0***0301***1~ CAS***CO*** **97** *35.64~ **SVC***HC|82550*43*0***0301***1~ CAS***CO*** **97** *43~ **SVC***HC|82552*74.83*0***0301***1~ CAS***CO*** **97** *74.83~ **SVC***HC|82565*32.6*0***0301***1~ CAS***CO*** **97** *32.6~ **SVC***HC|82947*28.05*0***0301***1~ CAS***CO*** **97** *28.05~ **SVC***HC|83605*66*0***0301***1~ CAS***CO*** **97** *66~ **SVC***HC|83690*62.21*0***0301***1~ CAS***CO*** **97** *62.21~ **SVC***HC|84075*33*0***0301***1~ CAS***CO*** **97** *33~ **SVC***HC|84450*36.4*0***0301***1~ CAS***CO*** **97** *36.4~ **SVC***HC|84460*36.4*0***0301***1~ CAS***CO*** **97** *36.4~ **SVC***HC|84484*84.26*0***0301***1~ CAS***CO*** **97** *84.26~ **SVC***HC|84520*28.5*0***0301***1~ CAS***CO*** **97** *28.5~	All originally submitted lines will be reported – with first line containing payment and remaining lines inclusive. Replace **CO*****131** and **OA*****A2** with **OA*****94**, **OA*****23**, **CO*****97**. *Other Adjustment* **94** Processed in Excess of charges. **23** Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments *Contractual Obligation* **97** Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated

835 Health Care Claim Payment/Advice – Header

The 835 Payment/Advice Header contains general payment information, such as Amount, Payee, Payer, Trace Number and Payment method. The following table explains the header segments and data elements that require specific information for East Region processing.

835 Health Care Claim Payment/Advice—Header				
IG	**Segment**	**Reference Designator(s)**	**Value**	**Definitions and Notes Specific to East Region**
P.44	**BPR** Financial Information	**BPR01** Transaction Handling Code	***I*** ***H***	I - Remittance Information Only H - Notification only
		BPR02 Total Actual Provider Payment Amount	***(Total Actual Prov Payment Amount)***	Amount must be equal to or greater than zero.
		BPR03 Credit/Debit Flag Code	***C***	C - Credit to the provider's account
		BPR04 Payment Method Code	***ACH*** ***CHK*** ***NON***	ACH - Automated Clearing House CHK - Check NON - Non-Payment Data
	Does not apply to National Accounts, SPA, and BS65 payments	**BPR05** Payment Format Code	***CCP***	CCP - Cash Concentration/Disbursement plus Addenda
		BPR06 Depository Financial Institution (DFI) ID Number Qualifier	***01***	01 - ABA Transit Routing Number
		BPR07 (DFI) ID Number	***(Sender DFI Identifier)***	Represents Anthem's Bank number.
		BPR09 Account Number	***(Sender Bank Account No.)***	Represents Anthem's Bank Account number.
		BPR12 (DFI) ID Number Qualifier	***01***	01 - ABA Transit Routing Number *ABA is not to be confused with Anthem Benefit Administrators.
		BPR13 (DFI) ID Number	***(Receiver DFI Identifier)***	Represents Receiver/Provider's Bank number.
		BPR15 Account Number	***(Receiver Bank Account No.)***	Represents Receiver/Provider's Bank Account number.
		BPR16 Check Issue or EFT Effective Date	***(Check Issue Date)***	▪ Date when check was created. ▪ National Accounts: Cycle date used when check is not created.
TRN segment provides Trace No. to reassociate dollars (payment) to remittance data (835).				
P.52	**TRN** Reassociation Trace Number	**TRN02** Trace Code Type	***(Check or EFT Trace Number)***	Represents the Check Number or Trace Number.
		TRN03 Originating Company Identifier	***(Payer Identifier)***	▪ Format: Prefix of '1' followed by Federal Tax ID Number (company code). ▪ National Accounts: Prefix of '1' followed by plan specific number.
P.57	**REF** Receiver Identification	**REF02** Reference ID Qualifier	***EV***	EV - Receiver ID Number
		REF02 Reference Identification	***FEP***	Represents payments for FEP claims.
P.60	**DTM** Production Date	**DTM01** Date Time Qualifier	***405***	405 - Production
		DTM02 Production Date	***(CCYYMMDD)***	Scheduled remittance run date.

835 Health Care Claim Payment/Advice—Header				
IG	**Segment**	**Reference Designator(s)**	**Value**	**Definitions and Notes Specific to East Region**
Loop ID 1000A—Payer Identification				
P.62	**N1** Payer Identification	**N102** Payer Name	***ANTHEM BCBS OF CT, ANTHEM HEALTH & LIFE INSURANCE CO. OF NY, ANTHEM BCBS OF MAINE MAINE PARTNER'S HEALTH PLAN, INC ANTHEM BCBS HEALTH PLANS OF NH MATHEW THORTON HEALTH PLAN, INC ANTHEM BLUE CROSS AND BLUE SHIELDCT ANTHEM BLUE CROSS AND BLUE SHIELDME ANTHEM BLUE CROSS AND BLUE SHIELDNH ANTHEM BCBS OF CONNECTICUT - FEP ANTHEM BCBS OF MAINE - FEP ANTHEM BCBS OF NEW HAMPSHIRE - FEP***	
P.67	**REF** Additional Payer Identification	***REF segment applies to National Accounts only.***		
		REF01 Reference ID Qualifier	***2U***	2U - Payer Identification Number
		REF02 Reference Identification	***560 680 770***	Represents Plan Code in Northeast Region 560 - Connecticut, 680 - Maine, 770 - New Hampshire
P.69	**PER** Payer Contact Infoprmation	***PER segment applies to BCBS and FEP only.***		
		PER02 Name	***(Payer Contact Name)***	*NOTE - For Home Plan Payments, Plan Code precedes Check number and date: **BCBSMA [CheckNo.] [Check Date]** For rejected claims, default values used: **BCBSMA [DEFAULT] [20491231]**
		PER04 Communication Number	***(Payer Contact Communication Number)***	Contact Phone Number.
Loop ID 1000B—Payee Identification				
P.72	**N1** Payee Identification	**N102** Name	***(Payee Name)***	Represents the Pay-to Provider.
		N103 ID Code Qualifier	***XX FI***	XX - National Provider Identifier FI - Federal Taxpayer's Identification number
		N104 Identification Code	***(Payee Identification Code)***	• NPI ('XX') for Non-Exempt providers • Tax ID ('FI') for Exempt providers
P.77	**REF** Payee Additional Identification	**REF01** Reference ID Qualifier	***TJ PQ***	TJ - Federal Taxpayer's Identification number PQ - Payee Identification
		REF02 Reference Identification	***(Additional Payee Identifier)***	• Tax ID ('TJ') for Non-Exempt providers • Payee ID ('PQ') for Exempt providers

835 Health Care Claim Payment/Advice – Detail

The 835 Payment/Advice Detail level contains the explanations of benefits/charges paid, reduced or denied, related to the adjudicated claims and services. The following table identifies the situational segments and data elements, and specific values of the required segments and data elements, in these Loops that are used for East Region processing.

835 Health Care Claim Payment/Advice—Detail				
IG	**Segment**	**Reference Designator(s)**	**Value**	**Definitions and Notes Specific to East Region**
Loop ID 2000—Header Number				
P.79	**LX** Header Number	**LX01** Assigned Number	***(Assigned Number)***	Precedes each series of claim level and service level segments.
Loop ID 2100—Claim Payment Information				
P.89	**CLP** Claim Payment Information	**CLP01** Claim Submitter's Identifier	***(Patient Control Number)***	▪ Value populated from 837 CLM01. ▪ '0' or 'X', if control number not available.
		CLP06 Claim Filing Ind Code	***(See Basic Instructions)***	Indicator code for Plan Code. Refer to Basic Instructions for value.
		CLP07 Ref Identification	***(Payer Claim Control Number)***	For corrections on subsequent 837s. National Accounts: ICN# and Activated Plan.
		CLP08 Facility Code Value	***(Facility Type Code)***	First two positions represent uniform billing type code.
		CLP09 Claim Freq Type Code	***(Claim Frequency Code)***	Third position of Bill Type Code populated on CLM05-2 of 837I.
P.95	**CAS** Claim Adjustment	**CAS02,5,8,11,14,17** Claim Adjustment Reason Code	***(Adjustment Reason Code)***	Adjustments reported when the amount paid differs from the amount originally charged.
		CAS03,6,9,12,15,18 Monetary Amount	***(Adjustment Amount)***	
		CAS04,7,10,13,16,19 Quantity	***(Adjustment Quantity)***	*Adjustment Quantity does not apply to National Accounts.
P.102	**NM1** Patient Name	**NM101** Entity ID Code	***QC***	QC - Patient
		NM108, (NM109) ID Code Qualifier, (Code)	***MI*** ***(Patient ID)***	MI - Member Identification Number Membership Number assigned by Anthem.
P.105	**NM1** Insured Name	**NM101** Entity ID Code	***IL***	IL - Insured or Subscriber
		NM108, (NM109) ID Code Qualifier, (Code)	***MI*** ***(Subscriber ID)***	MI - Member Identification Number Membership Number assigned by Anthem.
P.108	**NM1** Corrected Patient / Insured Name	**NM101** Entity ID Code	***74***	74 - Corrected Insured
		NM109 Identification Code	***(Corrected Insured Identification Number)***	When member has primary & secondary ID numbers under Anthem, the original submitted contract number will be populated with the primary ID number.
P.111	**NM1** Service Provider Name	**NM101** Entity ID Code	***82***	82 - Rendering Provider
		NM108 ID Code Qualifier	***XX*** ***FI***	XX - National Provider Identifier FI - Federal Taxpayer's Identification No.
		NM109 Identification Code	***(Rendering Provider Identifier)***	• NPI ('XX') for Non-Exempt providers • Tax ID ('FI') for Exempt providers

835 Health Care Claim Payment/Advice—Detail				
IG	**Segment**	**Reference Designator(s)**	**Value**	**Definitions and Notes Specific to East Region**
Loop ID 2100—Claim Payment Information (cont'd)				
P.116	**NM1** Corrected Priority Payer Name	***NM1 segment does not apply to National Accounts.***		
		NM108, (NM109) ID Code Qualifier, (Code)	***PI*** ***(Corrected Priority Payer ID No.)***	PI - Payor Identification Payor Identification
P.130	**DTM** Claim Date	**DTM01** Date/Time Qualifier	***050***	050 - Received
		DTM02 Claim Date	***(Claim Date)***	Represents the date the claim was received by Anthem.
P.136	**AMT** Claim Supplemental Information	***AMT segment conveys information only. It does not affect financial balancing.***		
		AMT01 Amount Qualifier Code	***AU*** ***I***	AU - Coverage Amount (for National Accounts) I - Interest
		AMT02 Monetary Amount	***(Claim Supplemental Amt)***	Represents the specific amount associated to the claim.
Loop ID 2110—Service Payment Information				
P.139	**SVC** Service Payment Information	**SVC01-1** Product Service ID Qualifier	***HC*** - HCPCS Codes ***ID*** - ICD-9-CM - Procedure ***N4*** - National Drug Code in 5-4-2 Format ***NU*** - National Uniform Billing Committee (NUBC) UB92 Code NU: 1st position of procedure code is Z or Y; or 1st position of procedure code is Z & type of service is R. (for National Accounts) ID: 1st position of procedure code is S. (for National Accounts)	
P.146	**DTM** Service Date	**DTM02** Date	***(Service Date)***	Format CCYYMMDD
P.148	**CAS** Service Adjustment	**CAS02,5,8,11,14,17** Clm Adj Reason Code	***(Adjustment Reason Code)***	Represents adjustments at service line level.
		CAS03,6,9,12,15,18 Monetary Amount	***(Adjustment Amount)***	
		CAS04,7,10,13,16,19 Quantity	***(Adjustment Quantity)***	*Adjustment Quantity does not apply to National Accounts.
P.154	**REF** Service Identification	**REF01** Reference ID Qualifier	***6R***	6R - Provider Control Number
		REF02 Reference Identification	***(Provider Identifier)***	Line Item Control No. on 837 or Line Counter No. (for National Accounts).
P.158	**AMT** Service Supplemental Amount	***AMT segment conveys information only. It does not affect financial balancing.***		
		AMT01 Amount Qualifier Code	***B6***	B6 - Allowed - Actual
		AMT02 Monetary Amount	***(Service Supplemental Amt)***	Represents the Anthem Allowed Amount for the service.
P.162	**LQ** Health Care Remark Codes	**LQ01** Code List Qualifier Code	***HE***	HE - Claim Payment Remark Codes
		LQ02 Industry Code	***(Remark Code)***	Claim Payment Remark Code BC/BS: NCPDP Code referenced for Prescription Drug Program

835 Health Care Claim Payment/Advice – Summary

The 835 Payment/Advice Summary level contains the Provider level adjustments, which provides information related to adjustments to the payment amount not specific to the claims in the 835 Payment/Advice Detail level. The following table identifies the situational segments and data elements, and specific values of the required segments and data elements, in these Loops that are used for East Region processing.

835 Health Care Claim Payment/Advice—Summary				
IG	**Segment**	**Reference Designator(s)**	**Value**	**Definitions and Notes Specific to East Region**
P.164	**PLB** Provider Adjustment	**PLB01** Reference Identification	***(Provider Identifier)***	Pay-to Provider Number National Accounts: Same value as Loop 1000B, REF02 (Claim Header Provider Number)
		PLB03-1 Adjustment Reason Code	***72*** ***FB*** ***IR*** ***L6*** ***PI***	72 - Authorized Return FB - Forwarding Balance IR - Internal Revenue Service Withholding L6 - Interest Owed (not applicable to National Accounts) PI - Periodic Interim Payment (not applicable to National Accounts)

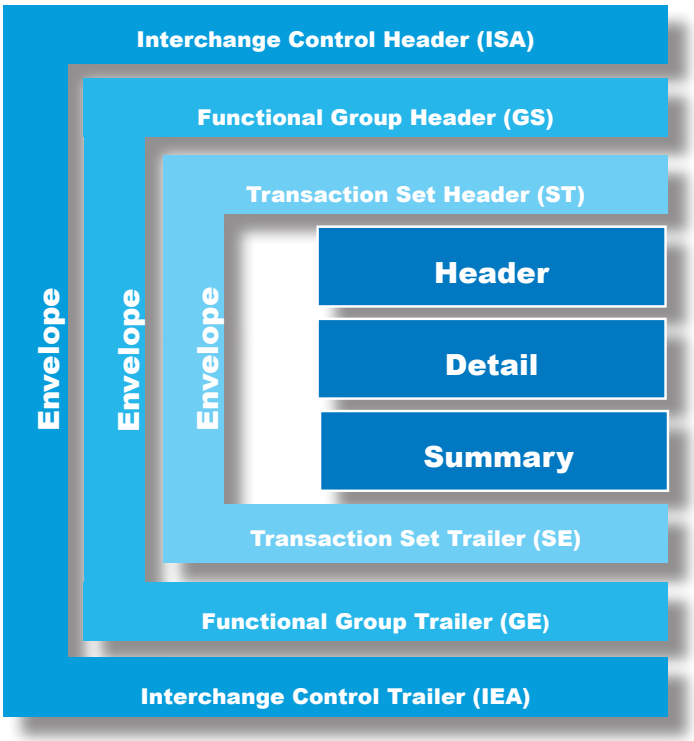
Enveloping

This section explains EDI enveloping of the 835 Payment/Advice transaction that will help you when receiving responses from Anthem (East Region).

EDI envelopes control and track communications between you and Anthem (East Region). One envelope may contain many transaction sets grouped into functional groups. The envelope includes the following components:

- Interchange Control Header (ISA)
- Functional Group Header (GS)
- Functional Group Trailer (GE)
- Interchange Control Trailer (IEA)

835 EDI Transaction Structure



835 Envelope Control Segments – Outbound

1 835 Health Care Claim Payment/Advice Interchange Control Header (ISA)

The ISA segment is the beginning, outermost envelope of the interchange control structure. Containing authorization and security information, it clearly identifies the Sender, Receiver, Date, Time, and Interchange Control Number. Use the following table to supplement the 835 Implementation Guide. The table provides information that is specific to Anthem. This information does not modify the 835 Implementation Guide.

835 Health Care Claim Payment / Advice Interchange Control Header (ISA)			
Segment	**Reference Designator(s)**	**Value**	**Definitions and Notes Specific to Anthem**
ISA Interchange Control Header	**ISA01** Auth Information	***00***	00 - No Authorization Information Present
	ISA02 Authorization Information	***(10 Spaces)***	
	ISA03 Security Info Qualifier	***00***	00 - No Security Information Present
	ISA04 Security Information	***(10 Spaces)***	
	ISA05 Interchange ID Qualifier	***ZZ***	ZZ - Mutually Defined
	ISA06 Interchange Sender ID	***ANTHEM SRFACETS***	ANTHEM - represents payer generating 835 SRFACETS - SRFACETS MA PFFS
	ISA07 Interchange ID Qualifier	***ZZ***	ZZ - Mutually Defined
	ISA08 Interchange Receiver ID	***(Receiver ID)***	EDI Assigned Receiver ID representing the 835 receiver.
	ISA09 Interchange Date	***(YYMMDD)***	Valid date in YYMMDD format.
	ISA10 Interchange Time	***(HHMM)***	Valid time in HHMM format.
	ISA11 Interchange Control Standards Identifier	***U***	U - U.S. EDI Community of ASC X12, TDCC, and UCS
	ISA12 Interchange Control Version Number	***00401***	00401 - Draft Standards for Trial Used Approved for Publication by ASC X12 Procedures Review Board through October 1997
	ISA13 Interchange Control Number	***(Assigned by Sender)***	▪ Format - 9 position numeric. ▪ Unique value greater than zero, not used in previous HIPAA transaction within 30 calendar day period. ▪ Right-justified, filled with leading zeroes. ▪ Identical to value in IEA02.
	ISA14 Acknowledgment Requested	***0***	0 - No Acknowledgment Requested
	ISA15 Usage Indicator	***P, T***	Submitter ID must be approved to receive production data. P - Production Data; T - Test Data
	ISA16 Component Element Separator	***|***	Vertical Bar (|) will be sent as the Component Element Separator.

2 835 Health Care Claim Payment/Advice Functional Group Header (GS)

The GS segment identifies the collection of transaction sets that are included within the functional group. More specifically, the GS segment identifies the functional control group, sender, receiver, date, time, group control number and version/release/industry code for the transaction sets. Use the following table to supplement the 835 Implementation Guide. The table provides information that is specific to Anthem (East Region). This information does not modify the 835 Implementation Guide.

835 Health Care Claim Payment / Advice Functional Group Header (GS)			
Segment	**Reference Designator(s)**	**Value**	**Definitions and Notes Specific to East Region**
GS Functional Group Header	**GS01** Functional Identifier Code	***HP***	HP - Health Care Claim Payment / Advice (835)
	GS02 Application Sender's Code	***ANTHEMCT*** ***ANTHEMME*** ***ANTHEMNH*** ***ANTHEMFCS*** ***NASCO*** ***20012*** ***SRFACETS***	Routing from: ANTHEMCT - CT BCBS Plan ANTHEMME - ME BCBS Plan ANTHEMNH - NH BCBS Plan ANTHEMFCS - Federal Employee's Program (FEP) NASCO - National Accounts 20012 - Machigonne Benefits SRFACETS - SRFACETS MA PFFS
	GS03 Application Receiver's Code	***(Receiver ID)***	EDI Assigned Receiver ID representing the 835 receiver.
	GS04 Date	***(CCYYMMDD)***	Valid date in CCYYMMDD format.
	GS05 Time	***(HHMM)***	Valid time in HHMM format.
	GS06 Group Control Number	***(Assigned by Sender)***	▪ Format - 1-9 position numeric. ▪ Unique value greater than zero, not used in previous HIPAA transaction within 30 calendar day period. ▪ Right-justified, filled with leading zeroes. ▪ Identifical to value in GE02.
	GS07 Responsible Agency Code	***X***	X - Accredited Standards Committee X12
	GS08 Version / Release / Industry Identifier Code	***004010X091A1***	Operationally used to identify the 835 Health Care Claim Payment / Advice transaction.

3 835 Health Care Claim Payment/Advice Functional Group Trailer (GE)

The GE segment indicates the end of the functional group and provides control information. Use the following table to supplement the 835 Implementation Guide. The table provides information that is specific to Anthem (East Region). This information does not modify the 835 Implementation Guide.

835 Health Care Claim Payment / Advice Functional Group Trailer (GE)			
Segment	**Reference Designator(s)**	**Value**	**Definitions and Notes Specific to Anthem**
GE Functional Group Trailer	**GE01** Number of Transaction Sets Included	***(Total Number of Transaction Sets in Functional Group or Transmission)***	▪ Format - 1-6 positions, numeric. ▪ Left-justified with no trailing zeroes or spaces.
	GE02 Group Control Number	***(Control Number)***	▪ Format - 1-9 positions, numeric. ▪ Left-justified with no trailing zeroes or spaces. ▪ Identical to GS06.

4 835 Health Care Claim Payment/Advice Interchange Control Trailer (IEA)

The IEA segment is the ending, outermost level of the interchange control structure. It indicates and verifies the number of functional groups included within the interchange and the interchange control number (the same number indicated in the ISA segment). Use the following table to supplement the 835 Implementation Guide. The table provides information that is specific to Anthem (East Region). This information does not modify the 835 Implementation Guide.

835 Health Care Claim Payment / Advice Interchange Control Trailer (IEA)			
Segment	**Reference Designator(s)**	**Value**	**Definitions and Notes Specific to Anthem**
IEA Interchange Control Trailer	**IEA01** Number of Included Functional Groups	***(Number of Functional Groups GS/GE Pairs in Interchange)***	▪ Format - 1-5 positions, numeric. ▪ Left-justified with no trailing zeroes.
	IEA02 Interchange Control Number	***(Control Number)***	▪ Format - Fixed length 9 positions, numeric. ▪ Unique value greater than zero. ▪ Identical to ISA13.