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Chapter 4:

835 – Claim Payment/Advice

Overview

The 835 Health Care Claim Payment/Advice provides detailed payment information about health care claims submitted to BCBSNC. The 835 Transaction may be returned for Professional and Institutional 837Claim electronic submissions, as well as HCFA 1500 and UB92 paper claim submissions.

835 Claim Payment/Advice Processing

Eligibility for the 835 Transaction

In order to receive an 835 Claim Payment/Advice, submitters of health care claims must:

- Be a participating provider*
- Complete and submit a BCBSNC Trading Partner Agreement to BCBSNC Electronic Solutions; **or** enter a contractual relationship with a clearinghouse or service bureau that has a BCBSNC Trading Partner Agreement in place to submit claims on the their behalf.
- Complete an 835 Electronic Connectivity Request form, available online at www.bcbsnc.com/providers/edi/hipaainfo.cfm . Complete the form and return to Electronic Solutions, per the instructions available at the same Web site location.

Contact information for Electronic Solutions, ECR forms, and online testing is available at www.bcbsnc.com/providers/edi.cfm .

*It is the policy of BCBSNC to issue an 835 only to a provider to whom we send direct payment.

835 Transactions for Blue Card Claims (Blue Exchange)

Blue Exchange, the application that coordinates the exchange of electronic transactions among Blue Cross and Blue Shield Association licensees around the country, will accommodate the interchange of 835 Transactions with out-of-state providers and payees for Medicare Crossovers **only**. Until such time as Blue Exchange is implemented for the 835 Transaction, any out-of-state provider who files a health care cross-over claim directly with BCBSNC must comply with eligibility requirements listed above in order to receive an 835 Claim Payment/Advice.

Frequency of Data Exchange

BCBSNC sends a nightly 835 Claims Payment/Advice batch transaction in response to all processed health care claims, except for State claims. For State claims, BCBSNC sends a weekly 835 Claims Payment/Advice. Submitters should be aware that the 835 Transaction is not a paired transaction to the 837 Health Care Claim. Batch transmissions of the 835 do not directly correlate to batch transmissions of the 837. Response time to any submitted claim can vary, depending upon the processing requirements of the individual claim sent.

Electronic Funds Transfer (EFT)

The BCBSNC 835 Transaction is for notification only and does not include Electronic Funds Transfers (EFT) to financial institutions. The EFT process that BCBSNC has had in place with its trading partners prior to HIPAA implementation remains in place. New trading partners who would like to implement EFT should contact BCBSNC Financial Services at 919 765-7678.

Interchange Envelope (ISA/IEA) Structuring

Effective September 2004, each Interchange Envelope (ISA/IEA) will contain all the remittances posted for an individual provider, with separate Transaction Sets (St/SE) within the Interchange containing that provider's remittances for a specific line of business. Trading partners will receive fewer Interchange Envelopes than in the past, as each Interchange will contain Transaction Sets for all lines of business posting for that day.

The electronic bulletin board, or mailbox batch ID for these files is **ED835R** or **CE835R**. This batch ID replaces previously used batch IDs of P O ED835M, P O ED835F, P O ED835S, and P O ED835L.

Claims Remittance Processing



Important Notices:

1. The 835 Transaction may be returned for any type of health care claim submitted; however, the level of detail in the remittance response differs, depending upon which type of claim initiated the 835. The 835 Remittance responding to an Institutional Claim (837 or UB92) reports at the Claim level of detail, rather than the Service Line level of detail. The 835 Response to a Professional Claim (837 or HCFA 1500) reports at the Service Line level.
2. BCBSNC generates electronic 835 Transactions only for claims that have a "paid" or "denied" record on file. Claims that are still in the adjudication process or that have been returned with error messages do not receive an 835 response. Electronic submitters wishing to verify receipt of an 837 submission should access their Claims Audit Report.
3. BCBSNC returns a paper remittance advice (Explanation of Payment [EOP] or Notice of Payment [NOP]) in addition to the electronic 835 Transaction for both paper claims and 837 electronic claims. If BCBSNC is unable to produce a HIPAA compliant 835 Claim PaymentAdvice, the payment is still recorded on the paper EOP/NOP.
4. A .PDF format of an EOP or NOP is available online, via the **Blue e** Remittance Inquiry transaction. Providers who have not registered for the free **Blue e** service can do so at www.bcbsnc.com/providers/edi/bluee.cfm.

Batch Matching and Claims Matching

Submitters should note that there is no batch matching between 837 Health Care Claims and 835 Remittances. Claims submitted via batch transactions might be split and regrouped in bundles that are inconsistent with the original batch received. Submitters must match specific claims with specific remittance advice received on the 835 Transaction by the Patient Control Number (Patient Account Number) from the Claims Payment Information Loop, CLP01. This control number matches the 837 Health Care Claim Element CLM01.

Bundling and Unbundling for Professional Services

As claims are processed, professional services reflected by procedure codes are bundled or unbundled according to BCBSNC business processes. Procedure codes are returned for

professional health care claims as processed, reflecting the BCBSNC payment record. The record may not necessarily reflect procedure codes submitted.

Reporting

The Manual Posting Identification Report will be distributed, when appropriate, to any trading partner receiving the 835 Remittance Advice transaction. This report identifies those health care claims remittances not listed in the 835 transaction due to failure to pass HIPAA Implementation Guide edits. These remittance records may not have been posted within the 835 for a variety of reasons, but the most common reason would be that an original paper claim was received and could not be transformed to a HIPAA-compliant electronic format. BCBSNC expects the claims remittances listed on this report to be a very small proportion of any provider's total remittances.

This report should assist BCBSNC trading partners and health care providers in reconciling their billing systems if they have been using only the 835 Remittance for reconciliation of accounts. Providers should manually post the remittances listed in the Manual Posting Identification Report to their internal systems, cross-referencing with their Notice of Payment (NOP) or Explanation of Payment (EOP) for complete claims remittance information.

Remittance information on this report is Claim payment information and does not include line item detail. The detail of the report includes the Claim ID, Patient Account Number, Subscriber ID, Patient Name, Service Start and End Date, Charge Amount, Paid Amount, Contracted Charges, Disallowed Amount, Deductible Amount, Co-payment Amount, Co-Insurance Amount and Remark/Denial codes from the payment record that is reported on the paper notification.

A sample of the [Manual Posting Identification Report](#) is at the end of this chapter. The report provides the number of claims remitted and total money value of the remittances sent within the 835 transaction, as well as totals for those claims remittances listed on the report.

Trading partners can find their Manual Posting Identification Report by looking in their mailboxes for one of the following batch IDs:

P O ED835M Posting Report
P O CE835M Posting Report

Business Processes

835 Mapping from 837

Any mapping issues particular to BCBSNC business rules are identified on the [835 Data Element Table](#) contained in this chapter.

Identification Codes and Numbers

In creating the 835 Transaction, BCBSNC uses the standard medical and non-medical codes sets prescribed in Appendix C of the 835 Implementation Guide. Discretionary identifiers within the 835 Transaction are listed below, with explanations of BCBSNC usage for those identifiers.

Provider Identifier

The 835 Transaction returns the National Provider Identifier (NPI) in1000B, Payee ID, N104, the BCBSNC Provider Identifier (1000B, Payee Additional ID, REF02 – where REF01=PQ), and the Payee's Tax ID in a subsequent iteration of the1000B, Payee Additional ID, REF02 (where REF01=TJ). Once full compliance of NPI use is mandated by Centers for Medicare and Medicaid Services (CMS), the BCBSNC Provider Identifier will no longer be sent.

Subscriber Identifier

The Subscriber Identifier returned on the 835 Claim Payment/Advice is the Membership ID as it appears within the BCBSNC system. If this identifier differs from that which was submitted on the health care claim, assume that the identifier returned on the 835 transaction is correct.

Payer Claim Control Number

The Claims Identifier is the BCBSNC generated number for tracking the claim. This identifier is returned on the 835 in the 2100 Loop, CLP07. Receivers of the 835 are advised to use their patient account numbers (Patient Control Number CLP01) and dates of service, in conjunction with the CLP07 value, to match submitted claims with remittances. Submitters should note that HCFA 1500 and UB92 paper claims do not contain the patient account number; for these claims, the CLP01 defaults to zero.

If the claim is for a Blue Card Subscriber and handled through Blue Exchange, the CLP07 value consists of the Payer Claim Control Number (first 11 digits) and the SCCF number (subsequent 15 digits). Submitters should use all 27 digits when making customer support inquiries about claims.

Payment Identifier

The Payment Identifier is contained in the Version Identification REF02. When making customer support inquiries about payment received via an 835, use the Re-association Trace Number (TRN02) and the Version Identification (REF02) to identify the record.

Adjustment Group and Reason Codes

The 835 Transaction Standard limits the content of the Claim and Service Adjustment Group and Adjustment Reason Code Elements (CAS01 and CAS02*) to those codes listed in Washington Publishing Company's (WPC) Health Care Claim Adjustment Reason Code Guide (see **Appendix A** of the *BCBSNC Companion Guide to EDI Transactions*, online at www.bcbsnc.com/providers/edi/hipaainfo.cfm for the complete code list).

*Note that for Institutional Claims, the CAS Elements are reporting at the claim level and appear in the 2100 Loop. For Professional Health Care Claims the CAS Elements are reporting at the service line level and appear in the 2110 Loop.

Remittance Remarks Codes

The HIPAA 835 transaction provides the ability for a payer to further describe details of reimbursement results through the use of Remittance Remark Codes. There are three locations within the 835 transaction where Remittance Remark codes can be placed.

- Two locations within the 2100 Loop, the MIA and MOA segments on the Claim Payment Information loop, allow up to 5 different Remittance Remark Codes for each claim. The MIA segment is used to pass Remittance Remark codes for an inpatient institutional claim and the MOA segment is used for an outpatient institutional claim.
- The LQ segment on the Service Payment Information loop (2110) is used to send up to 99 different Remittance Remark Codes for each 'line' on a claim. Since we only report 'line' level details for Professional claims, this segment would only be used to record Remittance Remarks for BCBSNC professional claims.

During the original design of the 835 transactions, it was decided BCBSNC would only report Claim Adjustment Reason Codes (CARC). Since that time, internal management and our external trading partners have requested we add Remittance Remark codes to the 835 transactions.

In response to these requests, 835 transactions from BCBSNC will begin displaying Remittance Remarks Codes for Claim Adjustment Reason Codes (CARC) that require additional clarification. 835 transactions with payment dates after July 17, 2006 display the Remittance Remarks Codes.

Important Note for Medicare Crossover Claims

If the claim was crossed over, the payment advice/EOMB should have Remark Code MA 18 printed on it, which states; "The claim information is also being forwarded to the patient's supplemental insurer. Send any questions regarding supplemental benefits to them."

The remark code and message may differ if the contractor does not use the ANSI X12 835 payment advice. If the claim was crossed over, do not file for the Medicare supplemental benefits. The Medicare supplemental insurer will automatically pay you if you accepted Medicare assignment. Otherwise, the member will be paid and you will need to bill the member.

Special Handling

In the event that an electronic 835 Remittance Advice cannot be generated from an adjudicated health care claim, only a paper NOP or EOP is generated. Submitters are advised that the turn-around time for a paper remittance advice is generally longer than that of an electronically generated 835 transaction.

Corrections and Reversals

The HIPAA 4010A-1 835 Implementation Guide provides guidance on reporting Reversals and Corrections on the electronic remittance advice. These situations are where a Provider submits an original claim and later submits a corrected claim or where a liability error is recognized by the payer and reprocessing is required to rectify the payment.

Historically, BCBSNC has required providers to submit professional claim corrections and reversals in paper format. Going forward, BCBSNC is expecting that providers will begin to submit these transactions, for all claim types, in 837 format.

The HIPAA 4010A-1 837 I & P Implementation Guides define what values claim submitters must use to signal to payers that the inbound 837 contains a reversal or correction to a claim that has previously been submitted for processing (Health Care Claim Implementation Guides: Professional p.173, Institutional p.159). For both the 4010A-1 version of Professional and Institutional 837 claims:

2300 CLM05-3 (Claim Frequency Code) must contain a value from the National UB Data Element Specification Type List Type of Bill Position 3. Values supported for corrections and reversals are:

- 5 = "Late Charges Only" Claim
- 7 = Replacement of Prior Claim
- 8 = Void/Cancel of Prior Claim

Claims processed under New Blue and FEP will generate an 835 transaction showing the claim reversal and a separate transaction showing the corrected claim.

Claims processed under the Traditional and State Health Plan lines of business will generate a single 835 transaction showing the net difference between the original and corrected transactions.

Inquiries

The following section provides guidelines for making successful inquiries about 835 Remittances or Payment Advice.

File Transmission Inquiries

For inquiries about file transmission or file errors, contact the eSolutions HelpDesk (see the Introduction to the BCBSNC Companion Guide or www.bcbsnc.com/providers/edi for EDI contact information. Callers should reference the following 835 data elements when making inquiries about specific remittance files or transmissions:

835 Data Element ID	835 Segment Name	IG Location of Element
TRN02	Reassociation Trace Number	Page 52
REF02	Version Identification	Page 58 (for a list of version identifiers used by BCBSNC, see the Data Element Table below, page 6.)
DTM02	Production Date	Page 60

Remittance Amount Inquiries

For inquiries about the total on the remittance/advice or receipt of a NOP/EOP, contact BCBSNC Financial Services at 919 765-7678. For inquiries regarding specific claim payment, contact the proper area of BCBSNC business by using the telephone number on the subscriber's identification card. Callers should reference the following 835 data elements when making inquiries about specific claim remittances:

835 Data Element ID	835 Segment Name	IG Location of Element
NM103	Patient Name (Last)	Page 102
NM109	Patient Name (Patient ID)	Page 103

State Plan Inquiries

For Inquiries about claims remittances for State Employees Health Plan, contact 1-800-422-4658.

835 Data Element Table

The following Data Element Table defines some of the specific BCBSNC business rules applicable to the 835 Remittance.

Transaction: 835 Health Care Claim Payment/Advice					
Loop ID	Segment Type	Segment Designator	Element ID	Data Element	BCBSNC Business Rules
	BPR	Financial Information (p. 44)			
			01	Transaction Handling Code	BCBSNC uses only value I, Remittance Information.
			02	Monetary Amount	This value reflects the total monetary amount of claims remitted electronically. On a paper remittance (NOP or EOP), this value equals the total check amount.
			04	Payment Method Code	BCBSNC returns one of two possible values: ACH (electronic funds transfer) or CHK (check).
			15	Account Number	If payment method is 'ACH' then populate with the payee's account number
			16	Date	If payment method is 'CHK', then populate with the check date. If the payment method is 'ACH' populate with the check date + 2 days
	TRN	Re-association Trace Number (p. 52)			
			02	Reference identification	When making inquiries about the 835, use the TRN02 and the REF02 for Version Identification to identify the record.
	REF	Version Identification (p. 58)			
			02	Reference identification	<p>The following identifiers are used:</p> <ul style="list-style-type: none"> • LCLA438D (Traditional) • SLCA435WS1 (State Employees) • SLCA435WS2 (State Employees) • SLCA435WS3 (State Employees) • BEBFAA053D (Blue Products) • CLMA278DF1 (Federal Employees Plan) • CLMA283DF2 (Federal Employees Plan) • CLMA003DF3 (Federal Employees Plan) • PCLA635D (Medpoint PPO) <p>These numbers are helpful in problem resolution when contacting Customer Support regarding an 835.</p>
	DTM	Production Date (p 60)			
			02	Date	This value reflects the payment system run date.

Transaction: 835 Health Care Claim Payment/Advice					
Loop ID	Segment Type	Segment Designator	Element ID	Data Element	BCBSNC Business Rules
1000A	PER	Payer Contact Information (p. 70)			
			02	Name	The Payer Contact Name reflects the name in BCBSNC systems and not necessarily that which came in on the 837 or paper claim.
			04	Communication Number	The Payer Contact Phone Number reflects the name in BCBSNC systems and not necessarily that which came in on the 837 or paper claim.
1000B	N1	Payee identification (p. 72)			
			02	Name	Payee Name from BCBSNC internal systems
			03	Identification Code Qualifier	XX
			04	Identification Code	Your National Provider ID number is returned.
	N3	Payee Address (p. 74)			
			01	Address Information	Payee Address 1 from BCBSNC internal systems
			02	Address Information	Payee Address 2 from BCBSNC internal systems
	N4	Payee City/State/Zip Code (p. 75)			
			01	City Name	Payee City from BCBSNC internal systems
			02	State or Province Code	Payee State Code from BCBSNC internal systems
			03	Postal Code	Payee Zip Code from BCBSNC internal systems
	REF	Additional Payee Identification (p. 77)			
			01	Reference Identification Qualifier	A value of TJ (Federal Tax ID) is returned.
			02	Payee Identification	The REF02 value is your Federal Tax ID.
2100	CLP	Claim Payment Information (p. 89)			
			01	Claim submitter's Identifier	This data element references the "Patient Control/Account Number" submitted on either the 837 Institutional or the 837 Professional (Loop 2300 CLM01); if this value has not been submitted on a paper claim, the default value is "0".
			02	Claim Status Code	BCBSNC uses only the following code values: <ul style="list-style-type: none"> • 1 (Processed as Primary) • 2 (Processed as Secondary) • 3 (Processed as Tertiary) • 4 (Denied)

Transaction: 835 Health Care Claim Payment/Advice					
Loop ID	Segment Type	Segment Designator	Element ID	Data Element	BCBSNC Business Rules
					<ul style="list-style-type: none"> 22 (Reversal of Previous Payment).
			03	Monetary Amount (Total Charge)	This value reflects the Claim Charge Amount.
			04	Monetary Amount (Claim Payment)	This value reflects the Claim Paid Amount..
			05	Monetary Amount (Patient Response)	This value reflects the Claim Patient Responsibility Amount
			07	Reference Identification	Use CLP07 when making inquiries regarding claim payment.
			08	Facility Code Value	This value is returned only if used in adjudication. (Institutional Only)
			09	Claim Frequency Type Code	This value is returned only if used in adjudication. (Institutional Only)
2100	CAS	Claim Adjustment (p 95)			
				Entire Segment	Institutional only segment
			01	Claim Adjustment Group Code	<ul style="list-style-type: none"> CO=Contractual Obligation CR=Correction and Reversals OA=Other Adjustments PI=Payor Initiated Reductions PR=Patient Responsibility
			02	Claim Adjustment Reason Code	BCBSNC uses the standard Claim Adjustment Reason Codes as listed in Appendix A of the Companion Guide; however, the paper NOP/EOP still use the BCBSNC proprietary reason codes.
			03	Monetary Amount	Dollar amount of the adjustment. Negative numbers indicate payment increases. Positive numbers indicate payment reductions.
			04	Quantity	Claim adjustment reason code mapped in the source system.
	NM1	Patient Name (p. 101)			
			03-5	Name	BCBNC returns the patient name as it appears in the system.
			09	Identification Code	Member's identification number.
2100	NM1	Insured Name (p. 105)			
			03-5	Name	BCBNC returns the insured name as it appears in the system.
			09	Identification Code	Member's identification number.
	NM1	Corrected Patient/Insured Name			

Transaction: 835 Health Care Claim Payment/Advice					
Loop ID	Segment Type	Segment Designator	Element ID	Data Element	BCBSNC Business Rules
				Whole Segment	Not used by BCBSNC
	DTM	Claim Date (p. 130)			
			01	Date/Time Qualifier	<ul style="list-style-type: none"> 050=Received Date 232=Start Service Date 233=End Service Date if different from Start Service Date
			02	Date	Claim received date, Claim start date, Claim end date
	AMT	Claim Supplemental Information (p 135)			
			01	Amount Qualifier Code	BCBSNC uses only a value of "I" (Interest) for this qualifier.
			02	Monetary Amount	Claim interest amount at the claim level.
2110	SVC	Service Payment Information (p. 139)			
				Entire Segment	For Professional Claims only
			01-1	Product/Service ID Qualifier	BCBSNC utilizes only the following codes: <ul style="list-style-type: none"> AD, for Dental Claims HC, for Professional Claims No Service Line information is returned for Institutional Claims.
			01-2	Product/Service Identifier	The code used for adjudication is reported in this data element.
	CAS	Claim Adjustment (p. 148)			
				Entire Segment	Professional only segment.
			01	Claim Adjustment Group Code	<ul style="list-style-type: none"> CO=Contractual Obligation CR=Correction and Reversals OA=Other Adjustments PI=Payor Initiated Reductions PR=Patient Responsibility
			02	Claim Adjustment Reason Code	BCBSNC uses the standard Claim Adjustment Reason Codes as listed in Appendix A of the Companion Guide; however, the paper NOP/EOP still use the BCBSNC proprietary reason codes.
			03	Monetary Amount	Dollar amount of the adjustment. Negative numbers indicate payment increases. Positive numbers indicate payment reductions.
			04	Quantity	Claim adjustment reason code mapped in the source system.
2110	LQ	Health Care Remarks Code (p.161)			

Transaction: 835 Health Care Claim Payment/Advice					
Loop ID	Segment Type	Segment Designator	Element ID	Data Element	BCBSNC Business Rules
			02	Industry code	BCBSNC does not report the Claim Payment Remark Codes or the RX codes; however, the paper NOP/EOP still uses the BCBSNC proprietary reason codes.
	PLB	Provider Adjustment (p. 164)			
				Entire Segment	Payee level Adjustments
			03-1	Adjustment Reason Code	BCBSNC uses only the following values: <ul style="list-style-type: none"> • 72=Authorized Return, used for Refund • L6=Interest Owed, used for Total Interest Paid • WO=Overpayment Recovery, used for Voucher Deduct
			03-2	Reference Identification	If the payment method is qualified by "ACH" (see BPR04, p. 44), this element reflects the EFT batch number; If the payment is qualified by 'CHK', this element reflects the check number.
			04	Monetary Amount	Dollar amount of the adjustment. Negative numbers indicate payment increases. Positive numbers indicate payment reductions.

835 Transaction Samples

Sample 1 – 835 Remittance for Unbundling Professional Claim

Scenario

This scenario depicts the use of the ANSI ASC X12 835 in a Professional Health Care environment. In this scenario, one provider is involved with one unbundling claim.

The following assumptions pertain:

- The Receiver is XYZ Regional Healthcare Corporation
- Their Tax ID 987654321
- Their mailing address is PO Box XYZ, Charlotte, NC 28234
- Check number is 02790758
- Check date is 01/08/2002; Check amount is \$0.00

Claim:

- Claim total charge is \$2100.00
- Claim paid amount is \$1922.86, paid as primary indemnity coverage.
- Patient account number is 20030964A52
- Claim number is 94151100100 (all 11 digits of our claim number)
- Claim receiver date is 01/03/2002
- Subscriber and patient is Mary Dough – Member ID is YPB123456789001
- Patient Responsibility is \$142.54

Claim Line 1:

- Health Service Code is 59409
- Line charge is \$1210.00
- Line Paid Amount is \$1057.86
- Date of Service is 12/31/2001
- Denied CO (Contractual Obligation) amount is \$34.50
- Denide reason code is 42 (charges exceed our fee schedule or maximum allowable amount)
- Denied PR (Patient Responsibility) amount is \$117.54
- Denied Reason code is 2 (copayment)
- Allowed amount is \$1175.40

Claim Line 2:

- Health Service Code is 59430
- Line charge is \$148.00
- Line paid amount is \$123.00
- Date of Service is 12/31/01
- Denied PR (patient responsibility) amount \$25.00
- Denial reason 3 (coinsurance)
- Allowed amount \$148.00

Claim Line 3:

- Health Service Code is 59426
- Line charge \$742.00
- Line paid amount \$742.00
- Date of Service is 12/31/01

- Allowed Amount is \$742.00

Data String Example

This is an example of the actual data string that would be transmitted in the 835 Payment/Advice. The data is presented in an unwrapped format, with carriage returns separating each Segment.

```
ST*835*1234~
BPR*I*1922.86*C*CHK*****20020108~
TRN*1*02790758*560894904~
REF*F2*LCLA438D~
DTM*405*20020104~
N1*PR*BLUE CROSS AND BLUE SHIELD OF NORTH CAROLINA~
N3*P O BOX 2291~
N4*DURHAM*NC*27702~
PER*CX*TE*1-800-555-4844~
N1*PE*XYZ HEALTHCARE CORPORATION*XX*0987654321~
N3*P O BOX XYZ~
N4*CHARLOTTE*NC*28234~
REF*PQ*0275W~
REF*TJ*123456789~
CLP*200200964A52*1*2100*1922.86*142.54*15*94151100100~
NM1*QC*1*Dough*Mary****MI* YPB123456789001~
DTM*50*20020103~
SVC*HC:59409*****1210*1057.86**1*HC*59400~
DTM*472*20011231~
CAS*CO*42*34.6~
CAS*PR*2*117.54~
REF*6R*01~
AMT*B6*1175.4~
SVC*HC:59430*****148*123**1~
DTM*472*20011231~
CAS*PR*3*25~
REF*6R*01~
AMT*B6*148~
SVC*HC:59426*****742*742**1~
DTM*472*20011231~
REF*6R*01~
AMT*B6*742~
SE*33*1234~
```

File Map – 835 Remittance for Unbundled Professional Health Claim

File Map – 835 Remittance for Unbundled Professional Health Claim									
Loop ID	Segments	Elements							
1	Transaction Set Header	ST	ST01	ST02					
			835	1234~					
1	Financial Information	BPR	BPR01	BPR02	BPR03	BPR04	BPR05	BPR06	BPR07
			I	1922.86	C	CHK			
	Financial Information - CONTINUED		BPR09	BPR10	BPR11	BPR12	BPR13	BPR14	BPR16
									20020108~
1	Reassociation Trace Number	TRN	TRN01	TRN02	TRN03				
			1	02790758	560894904				
1	Version Identification	REF	REF01	REF02					
			F2	LCLA438D~					
1	Production Date	DTM	DTM01	DTM02					
			405 (Payment run date)	20020104~					
1	1000A Payer Identification	N1	N101	N102					
			PR	BLUE CROSS AND BLUE SHIELD OF NORTH CAROLINA~					
1	1000A Payer Address	N3	N301						
				P O BOX 2291~					
1	1000A Payer City, State, Zip Code	N4	N401	N402	N403				
			DURHAM	NC	27702~				
1	1000A Payer Contact Information	PER	PER01	PER02	PER03	PER04			
			CX		TE	1-800-555-4844~			
1	1000B Payee Identification	N1	N101	N102	N103	N104			

File Map – 835 Remittance for Unbundled Professional Health Claim										
Loop ID	Segments	Elements								
			PE	XYZ HEALTHCARE CORPORATION	XX	0987654321~				
1	1000B	Payee Address	N3	N301						
				P O BOX XYZ~						
1	1000B	Payee City/State/zip	N4	N401	N402	N403				
				Charlotte	NC	28234~				
1	1000B	Additional Payee Identification	REF	REF01	REF02					
				PQ	0275W~					
1	1000B	Additional Payee Identification	REF	REF01	REF02					
				TJ	123456789~					
1	2100	Claim Payment Information	CLP	CLP01 (Pat Control #)	CLP02 (Claim Status Cd)	CLP03 (Claim Charge)	CLP04 (Claim Pmt)	CLP05 (Pat Resp)	CLP06 (LOB Indemnity)	CLP07 (CIm ID SCCF)
				200200964A52	1	2100	1922.86	142.54	15	94151100100~
1	2100	Patient Name	NM1	NM101	NM102	NM103	NM104	NM108	NM109	
				QC	1	Dough	Mary	MI	YPB123456789001	
1	2100	Claim Date	DTM	DTM01	DTM02					
				50	20020103~					
1	2110	Service information	SVC	SVC01-1 (Product Identifier)	SVC01-2 (Code)	SVC02 (Line Charge Amount)	SVC03 (Line Paid Amount)	SVC04 (Revenue Code)	SVC05 (Paid Units of Service)	
				HC	59409	1210	1057.86		1	
		Service information CONTINUED		SVC06-1 (Product Identifier)	SVC06-2 (Code)					
				HC	59400~					
1	2110	Service Date	DTM	DTM01	DTM02					
				472	20011231~					

File Map – 835 Remittance for Unbundled Professional Health Claim										
Loop ID	Segments	Elements								
1	2110	Service Adjustment	CAS	CAS01	CAS02	CAS03				
				CO	42(CHARGES EXCEED OUR FEE SCHEDULE OR MAXIMUM ALLOWED AMOUNT)	34.6~				
1	2110	Service Adjustment	CAS	CAS01	CAS02	CAS03				
				PR	2(COPAYMENT)	117.54~				
1	2110	Service Identification	REF	REF01	REF02					
				6R	01~					
1	2110	Service Supplemental Information (Allowed amount)	AMT	AMT01	AMT02					
				B6	1175.4~					
1	2110	Service information	SVC	SVC01-1 (Product Identifier)	SVC01-2 (Code)	SVC02 (Line Charge Amount)	SVC03 (Line Paid Amount)	SVC04 (Revenue Code)	SVC05 (Paid Units of Service)	
				HC	59430	148	123		1~	
1	2110	Service Date	DTM	DTM01	DTM02					
				472	20011231~					
1	2110	Service Adjustment	CAS	CAS01	CAS02	CAS03				
				PR	3(COINSURANCE)	25~				
1	2110	Service Identification	REF	REF01	REF02					
				6R	01~					
1	2110	Service Supplemental Information (Allowed amount)	AMT	AMT01	AMT02					
				B6	148~					
1	2110	Service information	SVC	SVC01-1 (Product Identifier)	SVC01-2 (Code)	SVC02 (Line Charge Amount)	SVC03 (Line Paid Amount)	SVC04 (Revenue Code)	SVC05 (Paid Units of Service)	
				HC	59426	742	742		1~	

File Map – 835 Remittance for Unbundled Professional Health Claim										
	Loop ID	Segments		Elements						
1	2110	Service Date	DTM	DTM01	DTM02					
				472	20011231~					
1	2110	Service Identification	REF	REF01	REF02					
				6R	01~					
1	2110	Service Supplemental Information (Allowed amount)	AMT	AMT01	AMT02					
				B6	742~					
1		Transaction Set Trailer	SE	SE01	SE02					
32				32	1234~					

Sample 2 - 835 Remittance for Institutional Claim (Diagnosis Related Group (DRG) Rate Greater Than Actual Charge)

Scenario

This scenario depicts the use of the ANSI ASCX12 835 in an Institutional Health Care environment. In this scenario, an inpatient claim has a DRG rate greater than charge.

The following assumptions pertain:

- The receiver is provider Acme University Health System, Tax ID number 1234567890
Mailing Address – PO Box AAA1, Durham, NC 27701-6508
- Check Number 70408535
- Check dates 20020323
- Total check amount \$15,096.46

Claim data:

- Total charge is \$3,740.60
- Claim paid amount, paid as primary is \$5,451.04
- Subscriber and patient is Roger Rabbit, Member ID is RUN123456789

Reported on NOP and Payment Record:

- Charge amount is \$3,740.60
- Case Rate \$3490.00
- Paid \$5451.04
- Payment adjustment due to contract obligation - CO (contractual obligation)
\$-1710.44/drg exceeds charge.

Data String Example

This is an example of the actual data string that would be transmitted in the 835 Payment/Advice. The data is presented in an unwrapped format, with carriage returns separating each Segment.

```
ST*835*1234~
BPR*I*15096.46*C*CHK*****20020323~
TRN*1*70408535*15714001~
REF*F2*slca435w~
DTM*405*20020323~
N1*PR*NC TEACHERS' & STATE EMPLOYEES' HEALTH PLAN & HEALTH CHOICE~
N3*P O BOX 30025~
N4*DURHAM*NC*27702~
PER*CX**TE*18002144844~
N1*PE*ACME UNIV HLTH SYS INC*XX*1234567890~
N3*P O BOX AAA1~
N4*DURHAM*NC*27701~
REF*PQ*0003R~
REF*TJ*123456789~
CLP*474623UB001CW0321*1*3740.6*5451.04**15*8020900000*11*1**397*0.7309~
CAS*CO*94*-1710.44~
NM1*QC*1*Rabbit*Roger*B***MI* RUN123456789~
MIA*0*****89.05*****173.29**374.98~
REF*EA*CW0321~
```

DTM*50*20020318~
AMT*AU*5451.04~
DTM*232*20020307~
DTM*233*20020310~
SE*21*1234~

File Map – 835 Remittance for Institutional Claim (DRG Rate Greater Than Actual Charge)

File Map – 835 Remittance for Institutional Claim (DRG Rate Greater Than Actual Charge)													
Loop ID	Segment Name	ID	Elements										
1	Transaction Set Header	ST	ST01	ST02									
			835	1234~									
1	Financial Information	BPR	BPR01	BPR02 (check amount)	BPR03	BPR04	BPR05	BPR06	BPR07	BPR08			
			I	15096.46	C	CHK							
	Financial Information - CONTINUED		BPR09	BPR10	BPR11	BPR12	BPR13	BPR14	BPR15	BPR16			
										20020323~			
1	Reassociation Trace Number	TRN	TRN01	TRN02	TRN03								
			1	70408535	15714001~								
1	Version Identification	REF	REF01	REF02									
			F2	SLCA435W~									
1	Production Date	DTM	DTM01	DTM02									
			405 (Payment run date)	20020323~									
1	1000A	Payer Identification	N1	N101	N102								
				PR	NC TEACHERS' & STATE EMPLOYEES' HEALTH PLAN & HEALTH CHOICE~								
1	1000A	Payer Address	N3	N301									
				P O BOX 30025~									
1	1000A	Payer City, State, Zip Code	N4	N401	N402	N403							
				DURHAM	NC	27702~							
1	1000A	Payer Contact Information	PER	PER01	PER02	PER03	PER04						

File Map – 835 Remittance for Institutional Claim (DRG Rate Greater Than Actual Charge)														
Loop ID	Segment Name	ID	Elements											
				CX		TE	1-800-214-4844~							
1	1000B	Payee Identification	N1	N101	N102	N103	N104							
				PE	ACME UNIV HLTH SYS INC	XX	123456789 0~							
1	1000B	Payee Address	N3	N301										
				P O BOX AAA1~										
1	1000B	Payee City/State/zip	N4	N401	N402	N403								
				DURHAM	NC	27701-1737~								
1	1000B	Additional Payee Identification	REF	REF01	REF02									
				PQ	0003R~									
1	1000B	Additional Payee Identification	REF	REF01	REF02									
				TJ	123456789~									
1	2100	Claim Payment Information	CLP	CLP01 (Pat Control #)	CLP02 (Claim Status Cd)	CLP03 (Claim Charge)	CLP04 (Claimm Pmt)	CLP05 (Pat Resp)	CLP06 (LOB Indemnity)	CLP07 (Clim ID SCCF)	CLP08 (Clim Fam Type Cd)	CLP09 (Clim Freq Cd)	CLP11 (DRG Code)	CLP12 (DRG Wt)
				474623UB001C W0321	1	3740.6	5451.04		15	8020900 0000	11	1	397	0.7309~
1	2100	Claim Adjustment	CAS	CAS01	CAS02	CAS03								
				CO	94	-1710.44~								
1	2100	Patient Name	NM1	NM101	NM102	NM103 (Last Name)	NM104 (First Name)	NM105 (M Initial)	NM106	NM107	NM108	NM109 (Subscriber ID)		
				QC	1	Rabbit	Roger	B			MI	RUN123456 789~		

File Map – 835 Remittance for Institutional Claim (DRG Rate Greater Than Actual Charge)														
Loop ID	Segment Name	ID	Elements											
1	2100	Inpatient Adjudication Information	MIA	MIA01 (Default = 0 if segment is used)	MIA02	MIA03	MIA04	MIA05	MIA06 (Dir Med Factor)	MIA07	MIA10	MIA11 (Disp Shr Factor)	MIA12	MIA13 (Indir MED ED/Ind Med Factor)
				0					89.05			173.29		374.98~
1	2100	Other Claim Related Identification	REF	REF01	REF02									
				EA	CW0321~									
1	2100	Claim Date	DTM	DTM01	DTM02									
				50 (Receive date)	20020318~									
	2100	Claim Supplemental Information	AMT	AMT01	AMT02									
				AU	5451.04~									
1	2100	Claim Date	DTM	DTM01	DTM02									
		(Start Service)		232	20020307~									
1	2100	Claim Date	DTM	DTM01	DTM02									
		(End Service)		233	20020310~									
1		Transaction Set Trailer	SE	SE01	SE02									
21				21	1234~									

Sample – Manual Posting Identification Report

ED835R01

Blue Cross and Blue Shield of North Carolina
Manual Posting Identification Report

08/12/04

Page 1 of 1

Transaction Receiver: 123456789
Payee ID: 1234567890 (NPI)
BATCH Level Information:

1 System	2 Check Number	3 Check Date	4 835 Claims	5 835 Totals	6 Non 835 Claims	7 Non 835 Totals
BEBFAA053D	00001076582	2004-01-13	1465	235,545.60	3	244.44

Claim ID	Patient Account	ID Number	Patient Name/ Service ST Service END	Charge Amount	Paid Amount
0112180313165	333202044A520	YPH11111111103	SMITH, BETTY 08-02-2004 08-02-2004	85.00	52.06
65.00	20.00	0.00	20.00	0.00	E21
0112180313167	333202037A520	YPH22222222203	DOE, JOHN 08-02-2004 08-02-2004	173.00	123.03
143.00	50.00	0.00	20.00	0.00	
0112180313216	333202115A520	YPP33333333301	JONES, JASON 08-02-2004 08-02-2004	101.00	69.35
70.00	31.00	0.00	30.00	0.00	

1 The **System** identifier is the 835 transaction's REF02 Version Identification Number. It is used as an identifier for a line of business. The following identifiers are used:

- LCLA438D (Traditional)
- SLCA435WS1 (State Employees)
- SLCA435WS2 (State Employees)
- SLCA435WS3 (State Employees)
- BEBFAA053D (Blue Products)
- CLMA278DF1 (Federal Employees Plan)
- CLMA283DF2 (Federal Employees Plan)
- CLMA003DF3 (Federal Employees Plan)
- PCLA635D (Medpoint PPO)

2 Our remittance **Check Number** is also the 835 transaction's TRN02 value – the Re-association Trace Number.

3 **Check Date** can be found on the remittance check and coincides with the BPR16 (Financial Information).

4 **835 Claims** indicates the number of remittances contained in the 835 Transaction Set ; this value does not include the remittances listed in the Manual Posting Identification Report.

5 **835 Totals** indicates the total dollar amount of the remittances contained in the referenced 835 Transaction Set.

6 **Non 835 Claims** indicates the claims remittances not included in the 835 Transaction Set but referenced in the Manual Posting Identification Report.

7 **Non 835 Totals** indicates the total dollar amount of the remittances contained in the Manual Posting Identification Report.

Claims information for sample purposes only.

Document Change Log

The following change log identifies changes that have been made from version 1.0 of *Chapter 4: 835 Health Care Claim Payment/Advice*

Chapter Section	Date of Change	Page Number	Change Description
Eligibility for the 835 Transaction	June 2004	2	Removed third bullet allowing providers to use the 837 ECR form to request 835 connectivity; removed second paragraph.
Corrections and Reversals	June 2004	5	Added this section.
Remittance Amount Inquiries	June 2004	5	Removed reference to the REF02 Version Identification from the table.
835 Data Element Table	June 2004	6	<ul style="list-style-type: none"> Added line of business identification to the Version Identifiers cited (REF02) Removal of D3 qualifier and references to D3 for 1000B, REF01 and 02 Removal of references to NCPDP claims for 2100 CLP01 Removal of references to 2110, REF01 (Service Identification)
Reporting	August 2004	4	A new section was added to define the <i>Manual Posting Identification Report</i> .
Manual Posting Identification Report Sample	August 2004	23	A new section was added to present a sample of the <i>Manual Posting Identification Report</i> .
Interchange Envelope Structuring	August 2004	3	A new section was added to identify changes in transaction set bundling within the interchange envelope.
Remarks Codes	April 2006	5	Added information about remarks codes used for Medicare Crossover claims – creation of version 4.
835 Data Element Table	October 2006	9	Changes in loop/segment/elements used to accommodate requirements for transmitting the NPI (National Provider Identifier).
File Sample	October 2006	14,19	Changes in loop/segment/elements used to accommodate requirements for transmitting the NPI (National Provider Identifier).
Both File Map guides	October 2006	16, 21	Changes in loop/segment/elements used to accommodate requirements for transmitting the NPI (National Provider Identifier).
Global	October 2006		Name change from EDI Services to Electronic Solutions.
Claims Remittance Processing	January 2007	3	Added notice about the availability of pdf format NOP and EOP
Eligibility for the 835 Transaction	May 2007	1	Added requirement that only participating providers may be issued an 835.
Global	May 2008		Removal of references to BCBSNC Proprietary Provider Identifier.

Bundling and Unbundling for Professional Services	May 2008	3 and 4	Updated Bundling and Unbundling Guidelines.
Sample 1 – 835 Remittance for Unbundling Professional Claim	May 2008	13-17	Example 1 to reflect Thomas Line Level changes to be implemented 04/08.
Bundling and Unbundling for Professional Services	May 2009	4	Added the sentence: The record may not necessarily reflect procedure codes submitted.
Provider Identifier	May 2009	4	Added the sentence: Once full compliance of NPI use is mandated by Centers for Medicare and Medicaid Services (CMS), the BCBSNC Provider Identifier will no longer be sent.
835 Data Element table	May 2009	7	Removed Data Element ID REF02