835 Health Care Claim Payment/Advice Companion Guide ANSI ASC X12N 835 (Version 4010A1)

State of Washington Department of Social & Health Services

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CNSI Project Manager		**DSHS Project Manager**
Date		**Date**

Disclaimer

This companion guide for the ANSI ASC X12N 835 transaction has been created for use in conjunction with the standard Implementation Guide It should not be considered a replacement for the Implementation Guide, but rather used as an additional source of information The companion guide contains data clarifications derived from specific business rules that apply exclusively to Medicaid processing for Washington State DSHS The guide also includes useful information about sending and receiving data to and from the ProviderOne system

Revision History

Documented revisions are maintained in this document through the use of the Revision History Table shown below all revisions made to this companion guide after the creation date are noted along with the date, page affected, and reason for the change

Revision Level	Date	Page	Description	Change Summary
WAMMIS-CG835-00-00-01	06/09/08		Initial Document	
WAMMIS-CG835-00-00-02	06/27/08		Comments from DSHS incorporated	
WAMMIS-CG-835-01-01	06/28/08		Final Delivery	
WAMMIS-CG-835-01-02	07/16/08		Re-Delivery of the Deliverable based on DSHS non-Acceptance and identification of deficiencies	
WAMMIS-CG-835-01-03	10/01/08		Re-Delivery of the Deliverable based on DSHS suggested changes to Trading Partners Testing Procedures verbiage	
WAMMIS-CG-835-01-04	04/21/09		Removal of “Payee Additional Identification” situational segment	
	10/30/09		Update screen shots for submitting claims and retrieving responses	Replaced screen shots and updated verbiage.
	11/4/09		Update TCN from 21 to 19 digits	Update documentation

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1 Introduction

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) includes requirements that national standards be established for electronic health care transactions, and national identifiers for providers, health plans, and employers. This requires Washington State Department of Social and Health Services (DSHS) to adopt standards to support the electronic exchange of administrative and financial health care transactions between covered entities (health care providers, health plans, and healthcare clearinghouses.

The intent of these standards is to improve the efficiency and effectiveness of the nation's health care system by encouraging widespread use of electronic data interchange standards in health care. The intent of the law is that all electronic transactions for which standards are specified must be conducted according to the standards. These standards were not imposed arbitrarily but were developed by processes that included significant public and private sector input.

1.1 Document Purpose

Companion Guides are used to clarify the exchange of information on HIPAA transactions between the DSHS ProviderOne system and its trading partners. DSHS defines trading partners as covered entities that either submit or retrieve HIPAA batch transactions to and from ProviderOne.

This Companion Guide provides information about the 835 Health Care Payment/Advice that is specific to DSHS and DSHS trading partners. This Companion Guide is intended for trading partner use in conjunction with the ANSI ASC X12N National Implementation Guide listed below. The ANSI ASC X12N Implementation Guides can be accessed at http://www.wpc-edi.com.

- ASC X12N 835 (004010X091)
- ASC X12N 835 (004010X091A1) (Addenda)

1.1.1 Intended Users

Companion Guides are intended for members of the technical staffs of trading partners who are responsible for electronic transaction/file exchanges.

1.1.2 Relationship to HIPAA Implementation Guides

Companion Guides are intended to supplement the HIPAA Implementation Guides for each of the HIPAA transactions. Rules for format, content, and field values can be found in the Implementation Guides. This Companion Guide describes the technical interface environment with DSHS, including connectivity requirements and protocols, and electronic interchange

procedures. This guide also provides specific information on data elements and the values required for transactions sent to or received from DSHS.

Companion Guides are intended to supplement rather than replace the standard Implementation Guide for each transaction set. The information in these documents is not intended to:

- Modify the definition, data condition, or use of any data element or segment in the standard Implementation Guides.
- Add any additional data elements or segments to the defined data set.
- Utilize any code or data values that are not valid in the standard Implementation Guides.
- Change the meaning or intent of any implementation specifications in the standard Implementation Guides.

1.2 Transmission Schedule

N/A

2 Technical Infrastructure and Procedures

2.1 Technical Environment

2.1.1 Communication Requirements

This section will describe how trading partners will receive 835 Transactions from DSHS using 2 methods:

- Secure File Transfer Protocol (SFTP)
- ProviderOne Web Portal

2.1.2 Testing Process

Completion of the testing process must occur prior to production electronic retrieval from ProviderOne. Testing is conducted to ensure the following for maintaining HIPAA guidelines:

1. Syntactical integrity: Testing of the EDI file for valid segments, segment order, element attributes, testing for numeric values in numeric data elements, validation of X12 or NCPDP syntax, and compliance with X12 and NCPDP rules.
2. Syntactical requirements: Testing for HIPAA Implementation Guide-specific syntax requirements, such as limits on repeat counts, used and not used qualifiers, codes, elements and segments. It will also include testing for HIPAA required or intra-segment situational data elements, testing for non-medical code sets as laid out in the Implementation Guide, and values and codes noted in the Implementation Guide via an X12 code list or table.

Additional testing may be required in the future to verify any changes made to the ProviderOne system. Changes to the ANSI formats may also require additional testing. Assistance is available throughout the testing process.

Trading Partner Testing Procedures

1. ProviderOne companion guides and trading partner enrollment package are available for download via the web at http://maa.dshs.wa.gov/dshshipaa
2. The Trading Partner completes the Trading Partner Agreement and submits the signed agreement to DSHS.

   Submit to: Provider Enrollment
   PO Box 45562
   Olympia, WA 98504-5562

For Questions call 1-800-562-3022 option 2, then option 5

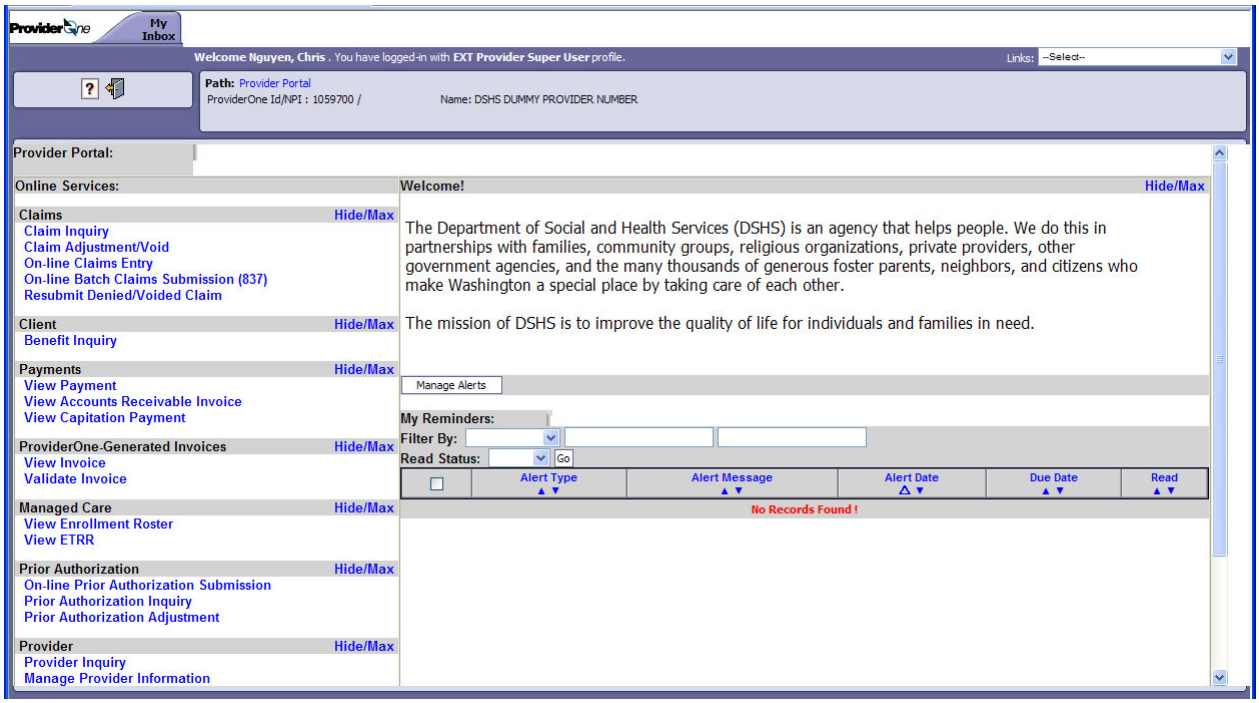
3. The trading partner is assigned a Submitter ID, Domain, Logon User ID and password.
4. ProviderOne system processes and validates all outbound HIPAA test files. It will be available for download via the ProviderOne web portal or Secure File Transfer Protocol (SFTP).
    - Web Portal URL: https://www.waproviderone.org/edi
    - SFTP URL: sftp://ftp.waproviderone.org/
5. The trading partner downloads the file from the ProviderOne web portal or Secure File Transfer Protocol (SFTP).
6. If the test file download is successful and the trading partner's system accepts the file for processing, the trading partner is approved for transaction download in the ProviderOne production environment.
7. If the test file download is unsuccessful, the trading partner should immediately call 1-800-562-3022 to report the failure. They will continue testing in the testing environment until a successful download is completed.

2.1.3 Who to contact for assistance

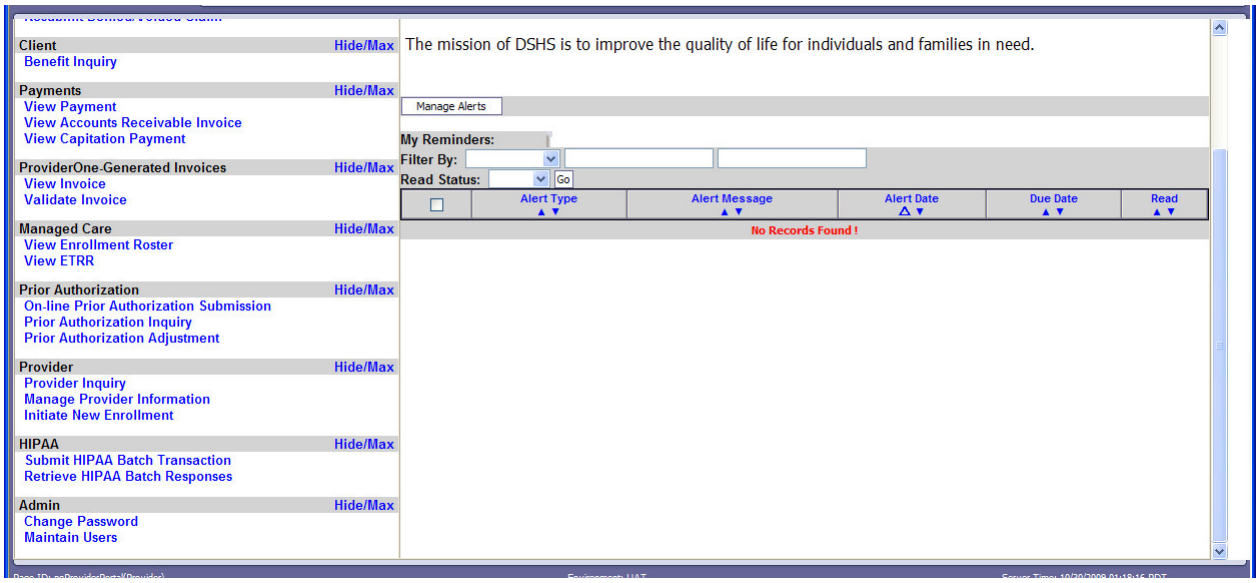
- Telephone Number: 1-800-562-3022
    - Select option 2
    - Select option 4
    - All calls result in the assignment of a Ticket Number for problem tracking
- Hours: 8:00 AM – 5:00 PM Pacific Standard Time, Monday through Friday
- Information required for initial call:
    - Topic of Call (setup, procedures, etc.)
    - Name of caller
    - Submitter ID Number
    - Organization of caller
    - Telephone number of caller
    - Nature of problem (connection, receipt status, etc.)
- Information required for follow up call(s):
    - Assigned Ticket Number

2.2 Retrieve batches via Web Interface

Once logged into the ProviderOne Portal, the following options will be viewable to the user:

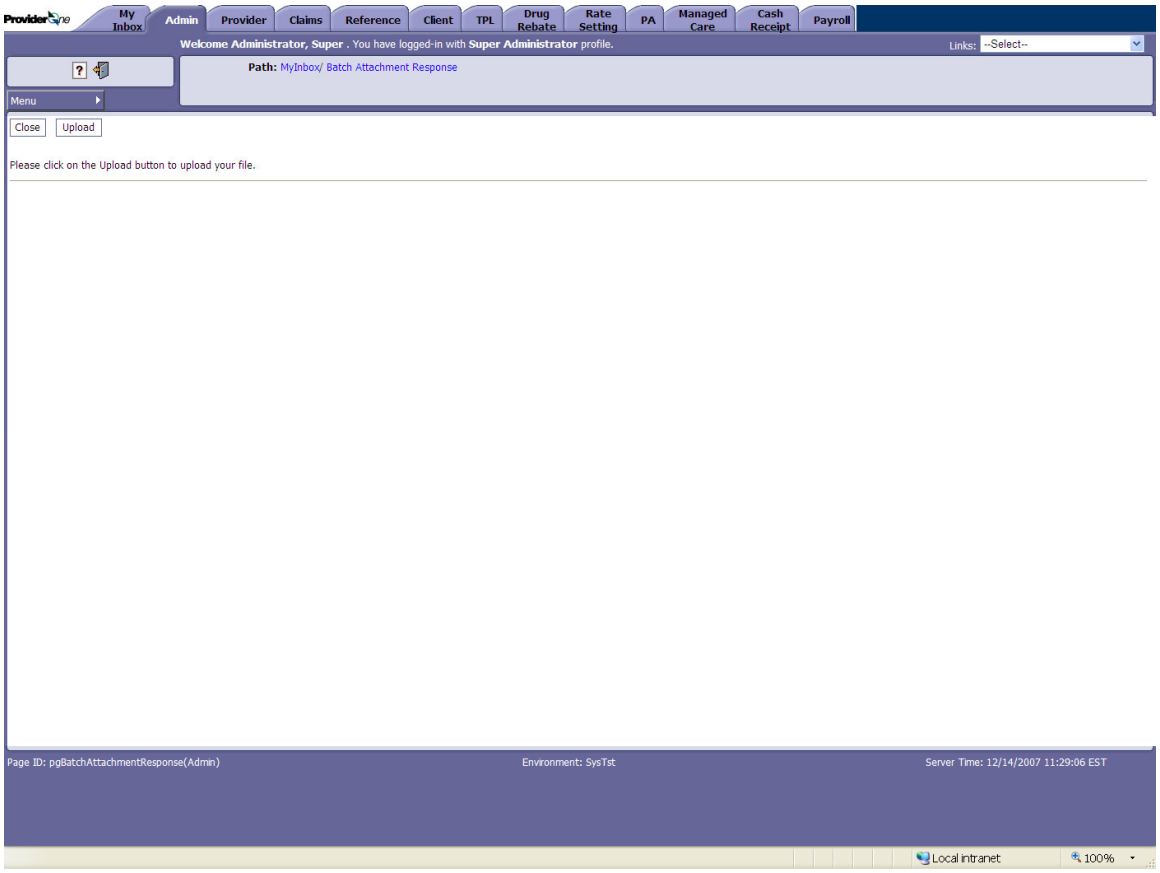


Scroll down to the next page of options and click on the HIPAA option to manage the HIPAA transactions.

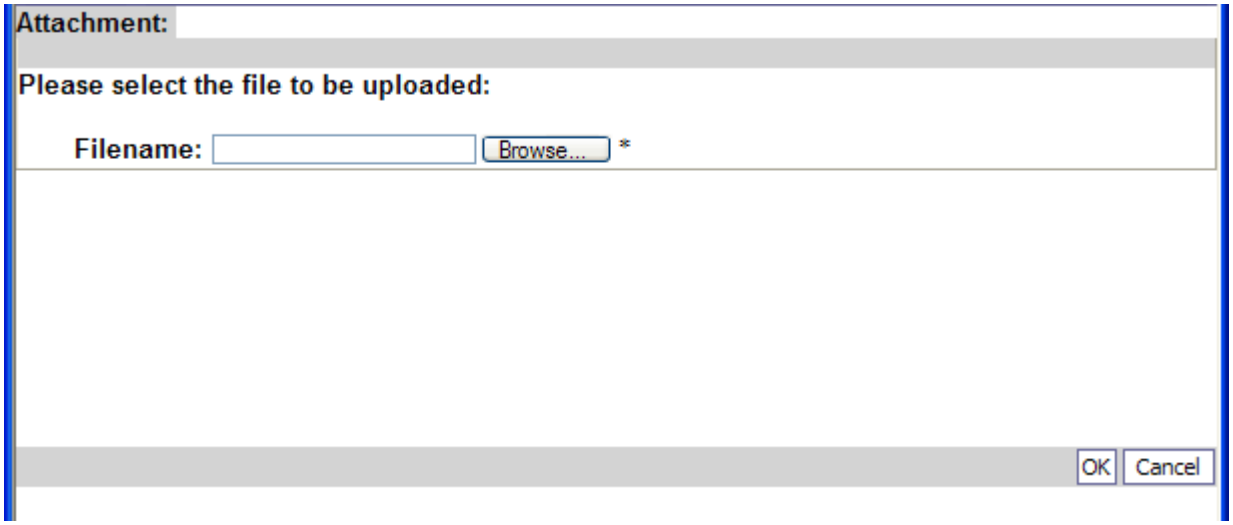


In order to upload a file, the following steps are followed:

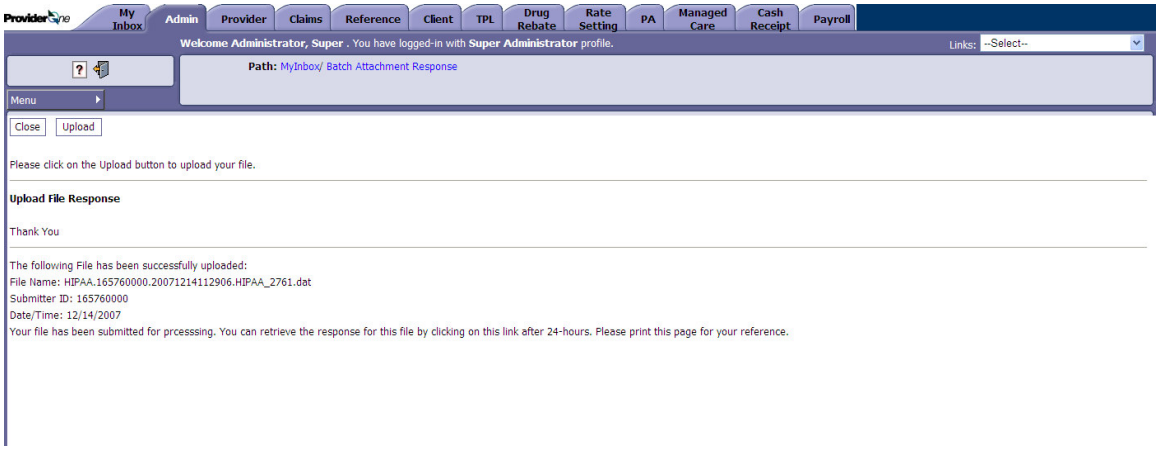
Click on the Upload button to upload a HIPAA file



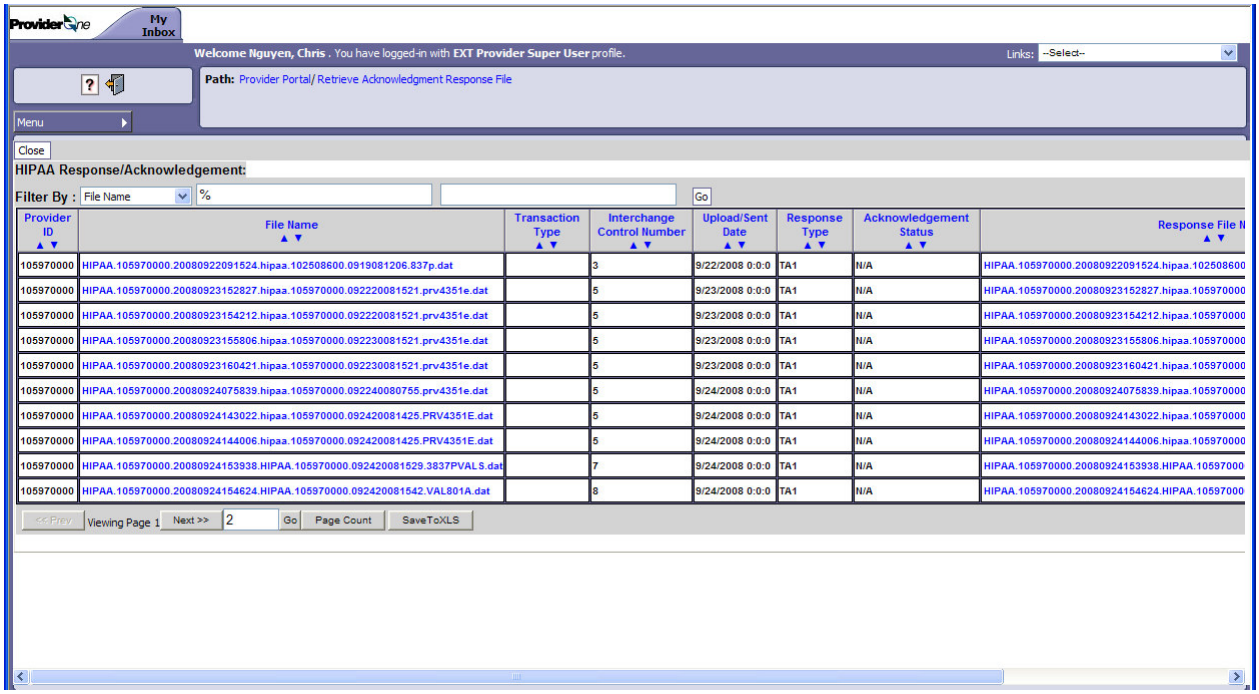
On file upload page click on the Browse button to attach HIPAA file from local file system. After selecting the file from the local file system, press OK to start the upload.



Once the file is uploaded to the ProviderOne system success/failure message is displayed on the screen along with transmission details.



Select Retrieve Acknowledgement/Response option from the HIPAA screen to retrieve Acknowledgements/Responses (TA1, 997, 271, 277, 820, 834, 835, or 277U) as shown below:



*Note: Filter by the File Name and then use the wildcard '%' to see received transactions. The data can be sorted by clicking on the up or down arrows.

2.3 Set-up, Directory, and File Naming Convention

2.3.1 SFTP Set-up

Trading partners can contact 1-800-562-3022 for information on establishing connections through the FTP server. Upon completion of set-up, they will receive additional instructions on FTP usage.

2.3.2 SFTP Directory Naming Convention

There would be two categories of folders under Trading Partner's SFPT folders:

1. **TEST – Trading Partners should submit and receive their test files under this root folder**
2. **PROD – Trading Partners should submit and receive their production files under this root folder**

Following folder will be available under TEST/PROD folder within SFTP root of the Trading Partner:

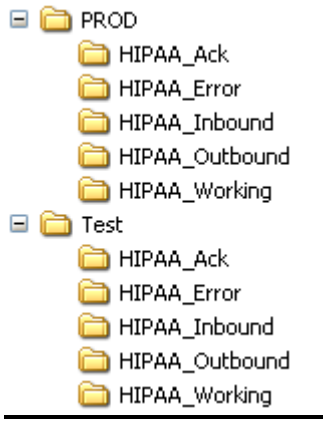
'HIPAA_Inbound' - This folder should be used to drop the Inbound files that needs to be submitted to DSHS

'HIPAA_Ack' - Trading partner should look for acknowledgements to the files submitted in this folder. TA1, 997 and custom error report will be available for all the files submitted by the Trading Partner

'HIPAA_Outbound' – X12 outbound transactions generated by DSHS will be available in this folder

'HIPAA_Error' – Any inbound file that is not HIPAA compliant or is not recognized by ProviderOne will be moved to this folder

Folder structure will appear as:



2.3.3 File Naming Convention

The HIPAA Subsystem Package is responsible for assisting ProviderOne activities related to Electronic Transfer and processing of Health Care and Health Encounter Data, with a few exceptions or limitations.

HIPAA files are named:

For Outbound transactions:

HIPAA.<TPId>.<datetimestamp>.<TxID>.O.<out>

Example of file name: HIPAA.16576000000000.12262007211315.835.O.out

- <TPId> is the Trading Partner Id
- <datetimestamp> is the Date timestamp
- <TxID> is the Transaction Id.

2.4 Transaction Standards

2.4.1 General Information

HIPAA standards are specified in the Implementation Guide for each mandated transaction and modified by authorized Addenda. Currently, the 835 transaction has one Addendum. This Addendum has been adopted as final and is incorporated into DSHS requirements.

An overview of requirements specific to each transaction can be found in the 835 Implementation Guide. Implementation Guides contain information related to:

- Format and content of interchanges and functional groups
- Format and content of the header, detailer and trailer segments specific to the transaction
- Code sets and values authorized for use in the transaction
- Allowed exceptions to specific transaction requirements

Transmission sizes are limited based on two factors:

- Number of Segments/Records allowed by HIPAA standards
- DSHS file transfer limitations

HIPAA standards for the maximum file size of each transaction set are specified in the 835 Implementation Guide. The 835 Implementation Guide recommends a limit of 10,000 CLP Claim Payment Segments in 2100 Claim Payment Information Loop. ProviderOne may exceed the recommended limit of 10,000 CLP (Claim Payment Information) segments per ST-SE envelope in order to maintain the balancing requirement within 835.

DSHS has no size limitations for postings to its FTP Server.

2.4.2 Data Format

Delimiters

The ProviderOne will use the following delimiters on outbound transactions:

- Data element separator, Asterisk, (*)
- Sub-element Separator, Vertical Bar, (:)
- Segment Terminator, Tilde, (~)

Dates

The following rules apply to any dates in the 835 transaction:

- For the 835 transaction, all dates will be formatted according to Year 2000 compliance, CCYYMMDD, except for the ISA09 element where the date format is YYMMDD.

- The only value acceptable for "CC" (century) is 20. The exception to this rule is for any of the Date of Birth values.

- Time is in military time format, 1 to 24 to indicate hours and 00 to 59 to indicate minutes and/or seconds. ISA10 and GS05 elements are formatted HHMM (ie 2115 defines the time of 9:15 p.m).

- No spaces or character delimiters should be used in presenting dates or times.

- Dates that are logically invalid (e.g. 20071301) are rejected.

Field Length

HIPAA regulations specify field lengths for all of the data elements of the 835 Health Care Claim Payment/Advice transaction. For some of these data elements, ProviderOne processes fewer characters than the maximum allowed. The Transaction Specifications in section 3 display the ProviderOne field lengths.

Phone Numbers

Phone numbers are presented as contiguous number strings, without dashes or parenthesis markers. For example, the phone number (800) 555-1212 should be presented as 8005551212. Area codes should always be included.

2.4.3 Data Interchange Conventions

When transmitting 835 Transactions to Trading Partners DSHS follows standards developed by the Accredited Standards Committee (ASC) of the American National Standards Institute (ANSI). These standards involve Interchange (ISA/IEA) and Functional Group (GS/GE) Segments or “outer envelopes”. All 835 Transactions are enclosed in transmission level ISA/IEA envelopes and, within transmissions, functional group level GS/GE envelopes. The segments and data elements used in outer envelopes are documented in Appendix B1 of the 835 Implementation Guide. Specific information on how individual data elements are populated by DSHS on ISA/IEA and GS/GE envelopes are shown in the table beginning later in this section.

The ISA/IEA Interchange Envelope, unlike most ASC X12 data structures has fixed field length. The entire data length of the data element should be considered and padded with spaces if the data element length is less than the field length.

Example of ISA with the entire data length with padded spaces:

ISA*00* *00* *ZZ*123456789 *ZZ*77045
*040303*1300*U*00401*000001001*1*T*:~

DSHS transmits 835 Transaction files with a single ISA/IEA and GS/GE envelope. 835 Transaction contains all the claims within one ST-SE segment within the same GS/GE envelope.

2.4.4 Acknowledgement Procedures

N/A

2.4.5 Rejected Transmissions and Transactions

DSHS will validate all 835 transactions up to HIPAA validation levels 1 and 2. If a receiver that rejects any part of a transmission, they must reject the entire transmission. Data on rejected 835 transmissions should not be used to update Trading Partner databases. DSHS transmits 835 Transactions within single functional groups, and in single ST-SE Segments.

3 Transaction Specifications

Page	Loop	Segment	Data Element	Element Name	Comments
Interchange Control Header					
App B	Envelope	ISA	01	Authorization Information Qualifier	Receive 00
App B	Envelope	ISA	02	Authorization Information	Receive 10 Spaces
App B	Envelope	ISA	03	Security Information Qualifier	Receive 00
App B	Envelope	ISA	04	Security Information	Receive 10 Spaces
App B	Envelope	ISA	05	Interchange ID Qualifier	Receive ZZ
App B	Envelope	ISA	06	Interchange Sender ID	Receive 77045 followed by 10 Spaces
App B	Envelope	ISA	07	Interchange ID Qualifier	Receive ZZ
App B	Envelope	ISA	08	Interchange Receiver ID	Receive the 9 Digit ProviderOne ID followed by 6 Spaces
App B	Envelope	ISA	09	Interchange Date	Receive System Date Format - YYMMDD
App B	Envelope	ISA	10	Interchange Time	Receive System Time Format - HHMM
App B	Envelope	ISA	11	Interchange Control Standards Identifier	Receive U

Page	Loop	Segment	Data Element	Element Name	Comments
App B	Envelope	ISA	12	Interchange Control Version Number	Receive 00401
App B	Envelope	ISA	13	Interchange Control Number	Receive the Interchange Control Number Note ISA13 = IEA02
App B	Envelope	ISA	14	Acknowledgment Requested	Receive 0
App B	Envelope	ISA	15	Usage Indicator	Receive P in Production Mode and T in Test Mode
App B	Envelope	ISA	16	Component Element Separator	Receive Value - :
Functional Group Header					
App B	Envelope	GS	01	Functional Identifier Code	Receive HP
App B	Envelope	GS	02	Application Sender's Code	Receive 77045
App B	Envelope	GS	03	Application Receiver's Code	Receive the 9 Digit ProviderOne ID
App B	Envelope	GS	04	Date	Receive System Date Format - CCYYMMDD
App B	Envelope	GS	05	Time	Receive System Time Format = HHMM
App B	Envelope	GS	06	Group Control Number	Receive the Group Control Number Note GS06 = GE02
App B	Envelope	GS	07	Responsible Agency Code	Receive X

Page	Loop	Segment	Data Element	Element Name	Comments
App B	Envelope	GS	08	Version / Release / Industry Identifier Code	Receive 004010X091A1
Transaction Set Header					
43	Header	ST	01	Transaction Set Identifier Code	Receive 835
43	Header	ST	02	Transaction Set Control Number	Receive the Group Control Number Note ST02 = SE02
Financial Information					
45	Header	BPR	01	Transaction Handling Code	Receive I or H
46	Header	BPR	02	Monetary Amount	Receive Check/EFT Amount
46	Header	BPR	03	Credit/Debit Flag Code	Receive C
46	Header	BPR	04	Payment Method Code	Receive NON , ACH , or CHK
47	Header	BPR	05	Payment Format Code	Receive CCP if BPR04 = ACH
48	Header	BPR	06	(DFI) ID Number Qualifier	Receive 01 if BPR04 = ACH
48	Header	BPR	07	(DFI) Identification Number	Receive Sender DFI Identifier if BPR04 = ACH
48	Header	BPR	08	Account Number Qualifier	Receive DA if BPR04 = ACH
49	Header	BPR	09	Account Number	Receive Sender Bank Account Number if BPR04 = ACH
49	Header	BPR	10	Originating Company Identifier	Receive 10 digit Payer Identifier
49	Header	BPR	11	Originating Company Supplemental Code	Receive WA DSHS

Page	Loop	Segment	Data Element	Element Name	Comments
49	Header	BPR	12	(DFI) ID Number Qualifier	Receive 01 if BPR04 = ACH
50	Header	BPR	13	(DFI) Identification Number	Receive Provider DFI number if BPR04 = ACH
50	Header	BPR	14	Account Number Qualifier	Receive Provider Account Number Qualifier DA = Demand Deposit SG = Saving if BPR04 = ACH
50	Header	BPR	15	Account Number	Receive Provider Bank Account Number if BPR04 = ACH
50	Header	BPR	16	Date	Check Issue or EFT Effective Date
Reassociation Trace Number					
52	Header	TRN	01	Trace Type Code	Receive 1
53	Header	TRN	02	Reference Identification	Receive Check or EFT Trace Number
53	Header	TRN	03	Originating Company Identifier	Receive 10 digit Payer Identifier
53	Header	TRN	04	Reference Identification	Receive WA DSHS
Receiver Identification NOTE: This segment will be used only when the receiver of the transaction is other than the payee (e.g., Clearing House or billing service ID)					
57	Header	REF	01	Reference Identification Qualifier	Receive EV
57	Header	REF	02	Reference Identification	Receive the 9 Digit ProviderOne ID
Production Date					

Page	Loop	Segment	Data Element	Element Name	Comments
60	Header	DTM	01	Date/Time Qualifier	Receive 405
61	Header	DTM	02	Date	Receive Date of Production or Payment
Payer Identification					
62	1000A	N1	01	Entity Identifier Code	Receive PR
63	1000A	N1	02	Name	Receive WA State DSHS
63	1000A	N1	03	Identification Code Qualifier	Receive XV
63	1000A	N1	04	Identification Code	Receive Payer Identifier 916001088.
Payer Address					
64	1000A	N3	01	Address Information	Receive WA State DSHS
64	1000A	N3	02	Address Information	Receive PO BOX 45500
Payer City, State, ZIP Code					
65	1000A	N4	01	City Name	Receive Olympia
65	1000A	N4	02	State or Province Code	Receive WA
65	1000A	N4	03	Postal Code	Receive 98504
Payer Contact Information					
70	1000A	PER	01	Contact Function Code	Receive CX
70	1000A	PER	02	Name	Receive WA State DSHS Provider Relations
70	1000A	PER	03	Communication Number Qualifier	Receive TE

Page	Loop	Segment	Data Element	Element Name	Comments
70	1000A	PER	04	Communication Number	Receive 8005623022
Payee Identification					
72	1000B	N1	01	Entity Identifier Code	Receive PE
73	1000B	N1	02	Name	Receive Payee Name
73	1000B	N1	03	Identification Code Qualifier	Receive the following: FI - for non healthcare providers XX - for healthcare providers
73	1000B	N1	04	Identification Code	Federal Taxpayer Identification Number if N103 = FI Provider NPI if N103 = XX
Payee Address					
74	1000B	N3	01	Address Information	Receive Payee Address1 (if available)
74	1000B	N3	02	Address Information	Receive Payee Address2 (if available)
Payee City, State, ZIP Code					
75	1000B	N4	01	City Name	Receive Payee City (if available)
75	1000B	N4	02	State or Province Code	Receive Payee State Code (if available)
76	1000B	N4	03	Postal Code	Receive Payee Zip Code (if available)
Header Number					

Page	Loop	Segment	Data Element	Element Name	Comments
79	2000	LX	01	Assigned Number	Receive Remittance Advice (RA) Number (Last six digits only)
Claim Payment Information					
89	2100	CLP	01	Claim Submitter's Identifier	Receive Patient Control Number If the patient control number (CLM01) is not present on the claim, this field is populated with 0
90	2100	CLP	02	Claim Status Code	Receive one of the following codes 1 - Processed as Primary 2 - Processed as Secondary 3 - Processed as Tertiary 4 - Denied 22 - Reversal of Previous Payment
91	2100	CLP	03	Monetary Amount	Receive Total Claim Charge Amount
91	2100	CLP	04	Monetary Amount	Receive Claim Payment Amount
91	2100	CLP	05	Monetary Amount	Receive Patient Responsibility Amount if submitted on claim
92	2100	CLP	06	Claim Filing Indicator Code	Receive MC
93	2100	CLP	07	Reference Identification	Receive 19 digit DSHS Transaction Control Number (TCN)

Page	Loop	Segment	Data Element	Element Name	Comments
93	2100	CLP	08	Facility Code Value	Receive Facility Type Code (CLM05-1, Whenever there is a change in Submitted Facility Type & Adjudicated Facility Type)
93	2100	CLP	09	Claim Frequency Type Code	Receive Claim Frequency Type Code (CLM05-2, Only for Instituitional Claims)
Claim Adjustment					
97	2100	CAS	01	Claim Adjustment Group Code	Receive appropriate code
97	2100	CAS	02	Claim Adjustment Reason Code	Claim Adjustment Reason Code
97	2100	CAS	03	Monetary Amount	Claim Adjustment Amount
98	2100	CAS	04	Quantity	Claim Adjustment Quantity
Patient Name					
102	2100	NM1	01	Entity Identifier Code	Receive QC
103	2100	NM1	02	Entity Type Qualifier	Receive 1
103	2100	NM1	03	Name Last or Organization Name	Receive Patient's Last Name
103	2100	NM1	04	Name First	Receive Patient's First Name
103	2100	NM1	05	Name Middle	Receive Patient's Middle Initial if available
103	2100	NM1	08	Identification Code Qualifier	Receive MR
104	2100	NM1	09	Identification Code	Receive ProviderOne Client ID submitted on claim

Page	Loop	Segment	Data Element	Element Name	Comments
Service Provider Name					
112	2100	NM1	01	Entity Identifier Code	Receive 82
112	2100	NM1	02	Entity Type Qualifier	Receive appropriate code
112	2100	NM1	03	Name Last or Organization Name	Receive Rendering Provider's Last or Organization Name
112	2100	NM1	04	Name First	Receive if NM102 = 1

113	2100	NM1	08	Identification Code Qualifier	Receive the following MC - Non-healthcare Providers XX - Healthcare providers
113	2100	NM1	09	Identification Code	ProviderOne ID if NM108 = MC NPI if NM108 = XX
Other Claim Related Identification					
126	2100	REF	01	Reference Identification Qualifier	EA - Medical Record Identification Number F8 - Original Reference Number G1 - Prior Authorization Number
127	2100	REF	02	Reference Identification	Medical Record Number if REF01- EA, Original Reference Number REF01- F8 Prior Authorization Number if REF01- G1,
Claim Date					
131	2100	DTM	01	Date/Time Qualifier	Receive 232, 233
131	2100	DTM	02	Date	Claim Statement Period Start if DTM01 - 232 Claim Statement Period End if DTM01 - 232

Claim Supplemental Information					
135	2100	AMT	01	Amount Qualifier Code	AU - Coverage Amount F5 - Patient Paid Amount T - Tax
136	2100	AMT	02	Monetary Amount	Coverage Amount if AMT01 - AU, Patient Paid Amount if AMT01 - F5, Tax if AMT01 - T
Service Payment Information					
140	2110	SVC	01-1	Product/Service ID Qualifier	AD - American Dental Association Codes HC - HCPCS Codes N4 - National Drug Code in 5-4-2 Format NU - NUBC UB92 Codes
141	2110	SVC	01-2	Product/Service ID	Receive appropriate code depends on SVC-01
141	2110	SVC	01-3	Procedure Modifier	Receive procedure modifier if submitted on claim line
141	2110	SVC	01-4	Procedure Modifier	Receive procedure modifier if submitted on claim line
141	2110	SVC	01-5	Procedure Modifier	Receive procedure modifier if submitted on claim line
141	2110	SVC	01-6	Procedure Modifier	Receive procedure modifier if submitted on claim line

142	2110	SVC	02	Monetary Amount	Receive Line Item Charged Amount
142	2110	SVC	03	Monetary Amount	Receive Line Item Paid Amount
142	2110	SVC	04	Product/Service ID	If applicable, Receive Revenue Code
142	2110	SVC	05	Quantity	Receive Paid Units of Service
142	2110	SVC	07	Quantity	Receive Billed Units of Service. This will be reported when there is difference between Paid and Billed Units
Service Date					
147	2110	DTM	01	Date/Time Qualifier	150 - Service Period Start 151 - Service Period End 472 - Service
147	2110	DTM	02	Date	Receive Claim Line Date
Service Adjustment					
150	2110	CAS	01	Claim Adjustment Group Code	Receive appropriate code
150	2110	CAS	02	Claim Adjustment Reason Code	Receive Claim Line Adjustment Reason Code
150	2110	CAS	03	Monetary Amount	Receive Claim Line Adjustment Amount
150	2110	CAS	04	Quantity	Receive Claim Line Adjustment Quantity
Service Identification					

154	2110	REF	01	Reference Identification Qualifier	6R - Provider Control Number G1 - Prior Authorization Number
155	2110	REF	02	Reference Identification	Receive appropriate identifier depends on REF-01
Rendering Provider Information					
156	2110	REF	01	Reference Identification Qualifier	1D - Non healthcare providers HPI - Healthcare providers
157	2110	REF	02	Reference Identification	ProviderOne ID if REF01 = 1D NPI if REF01 = HPI
Health Care Remark Codes					
162	2110	LQ	01	Code List Qualifier Code	Receive HE - Claim Payment Remark Codes
163	2110	LQ	02	Industry Code	Receive Remittance Remark Code
Provider Adjustment					
165	Summary	PLB	01	Reference Identification	Receive NPI or ProviderOne ID
165	Summary	PLB	02	Date	Date format in CCYYMMDD
165	Summary	PLB	03-1	Adjustment Reason Code	Receive Adjustment Reason Code

170	Summary	PLB	03-2	Reference Identification	Receive Reference Identification
170	Summary	PLB	04	Monetary Amount	Receive Provider Adjustment Amount
Transaction Set Trailer					
173	Trailer	SE	01	Number of Included Segments	Total Number of Segments in Transaction set
173	Trailer	SE	02	Transaction Set Control Number	Must be identical to ST02
Functional Group Trailer					
App B	Trailer	GE	01	Number of Transaction Sets Included	Total Number of Transaction sets
App B	Trailer	GE	02	Group Control Number	Must be identical to GS06
Interchange Control Trailer					
App B	Trailer	IEA	01	Number of Included Functional Groups	Total Number of Functional Groups
App B	Trailer	IEA	02	Interchange Control Number	Must be identical to ISA13