

Version 3.2

Utah State Dept. of Health
Division of Medicaid and Health Financing

835 REMITTANCE
COMPANION GUIDE

Utah Specific Transaction Instructions

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

The Health Insurance Portability and Accountability Act (HIPAA) require all health insurance payers in the United States to comply with the Electronic Data Interchange (EDI) standards for healthcare as established by the Secretary of Health and Human Services. The ANSI ASC X12N 835 Version 4010 implementation guide is the standard of compliance -- available at www.wpc-edi.com. The following supplemental information is specific to Utah Medicaid and serves as a companion guide to the implementation guide. Utah Medicaid Provider Manuals are available at <http://www.health.utah.gov/medicaid/manuals/directory.php?p=Medicaid%20Provider%20Manuals/>.

Electronic Claims:

1. Telephone number for Medicaid EDI Customer Support is 801-538-6155 or 800-662-9651 option 3, option 5, option 2. Hours of operation are Monday through Friday 8 am to noon and 1 pm to 5 pm, with the exception of Thursday when Medicaid will begin taking calls from 11 am to noon and 1 pm to 5 pm.
2. AccessNow, telephone automated system for member eligibility, is available from 6 am to 12 midnight Monday through Saturday and 12 noon to 12 midnight on Sundays.
3. Medicaid companion guides are available at <https://health.utah.gov/hipaa/guides.htm>.
4. All EDI must pass through the Utah Health Information Network (UHIN), an independent, not-for-profit, value added network serving all payers in Utah. Contact UHIN at www.uhin.org or call 801-466-7705 x200. UHIN will assign a Trading Partner Number (TPN) for EDI.
5. Use your TPN and your National Provider Identifier (NPI), atypical providers use the Medicaid 12-digit Contract Number, to complete the online EDI Enrollment Form at <https://mmcs.health.utah.gov/hcfeenroll2/index.jsp>. The TPN in the 835 field of the EDI Enrollment will receive the 835 electronic remittance advice.
6. 835s are available for pickup (download) by noon on the first business day of each week. They will remain available for pickup for one month.

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7. Electronic claims received before the end of business on Thursday, and paper claims received before the end of business on Monday, usually adjudicate that weekend. Transactions that miss the adjudication cycle will process the following weekend.
8. When Medicaid splits an 837 healthcare claim, the provider is notified through the 277 Front End Acknowledgment. The 835 will report line level information relating to each individual claim (split claim). A provider may receive multiple 835 responses to a single 837. NOTE: Claims held in suspense will not appear on the 835.
9. Medicaid requires Electronic Funds Transfer (EFT) and providers should register by using the form at <http://health.utah.gov/medicaid/pdfs/EFTapril2005.pdf>. EFT is independent from EDI.
10. Adjustments in any CAS segment decrease the payment when the adjustment amount is positive, and increases the payment when the adjustment amount is negative. For an 835 transaction to balance the sum of all submitted charges minus the sum of all provider adjustments must equal the total payment amount.
11. When using UHINT 2.5, Easy Print is software that can be used to view the 835 file, download the software from http://www.cms.gov/AccessToDataApplication/02_medicareremiteasyprint.asp. It is a Medicare Product so the Medicare name is on the remittance. Click on Medicare Remit Easy Print - Version 2.7. Follow the steps to install. After the download process an icon will be on desktop; click on the Icon, click IMPORT, follow the path to where the UHINT 2.5 downloaded the 835 file, click on the file and it will view in Easy Print. To find the path to the 835 files; open UHINT 2.5, click on Preference, click on General Maintenance, click on Directories. The path is listed under File Downloads.

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

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Page	Loop	Segment	Data Element	Values / Comments
50		BPR16	Date	Warrant issue date or date money is available to the payee.
53		TRN02	Check or EFT Trace Number	Warrant or EFT number
53		TRN03	Payer Identifier	Tax ID preceded by a "1"
62	1000A	N101	Entity Identifier Code	"PR" – Payer
63	1000A	N102	Name	"Utah Dept of Health"
70	1000A	PER01	Contact Function Code	"CX" – Payer's claim office
70	1000A	PER03	Communication Number Qualifier	"TE" – telephone
70	1000A	PER04	Communication Number	"8015386155"
72	1000B	N101	Entity Identifier Code	"PE" – Payee
73	1000B	N102	Name	Payee Name (Provider)
73	1000B	N103	Identification Code Qualifier	"FI" – EIN (atypical only) "XX" – NPI (non atypical)
73	1000B	N104	Identification Code	EIN (atypical only) NPI (non atypical)
77	1000B	REF01	Reference Identification Qualifier	"ID" – Medicaid Contract Number (atypical only) "TJ" – Tax ID (non atypical)
78	1000B	REF02	Additional Payee Identifier	The 12-digit identifier assigned by Medicaid. (atypical only) Tax ID (non atypical)
79	2000	LX01	Assigned Number	Assigned number unique to this particular line.
80	2000	TS3	Provider Summary Information	TS301-305 will only be returned when the 835 is reported based on NPI
81	2000	TS301	Provider Identifier	Provider Number
81	2000	TS302	Facility Code Value	Facility Type Code
81	2000	TS303	Fiscal Period Date	CCYYMMDD
81	2000	TS304	Total Claim Count	Total number of claims
82	2000	TS305	Total Claim Charge Amount	Total reported charges
89	2100	CLP01	Patient Control Number	Assigned by the provider on the original 837.
90	2100	CLP02	Claim Status Code	"1" – Processed as primary "2" – Processed as secondary "3" – Processed as tertiary "4" – Denied "22" – Reversal of previous payment
91	2100	CLP03	Total Claim Charge Amount	Total submitted charges for this claim
91	2100	CLP04	Claim Payment Amount	Total paid for the claim

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Page	Loop	Segment	Data Element	Values / Comments
91	2100	CLP05	Patient Responsibility Amount	Co-pay, co-insurance assigned to patient.
92	2100	CLP06	Claim Filing Indicator Code	“MC” – Medicaid
93	2100	CLP07	Payer Claim Control Number	Transaction Control Number (TCN) assigned by Medicaid.
93	2100	CLP11	Diagnosis Related Group (DRG) Code	Related to Institutional claims only.
97	2100	CAS01	Claim Adjustment Group Code	“CO” – Contractual Obligations “CR” – Correction and Reversals “OA” – Other adjustments “PR” – Patient Responsibility
97	2100	CAS02	Adjustment Reason Code	HIPAA Code List www.wpc-edi.com
97	2100	CAS03	Adjustment Amount	Monetary amount of adjustment
102	2100	NM101	Entity Identifier Code	“QC” – Patient
103	2100	NM102	Entity Type Qualifier	“1” – Person
103	2100	NM103	Patient Last Name	Patient’s last name
103	2100	NM104	Patient First Name	Patient’s first name
103	2100	NM108	Identification Code Qualifier	“MI” – Patient ID number
104	2100	NM109	Patient Identifier	Patient ID
108	2100	NM1	Corrected patient / Insured name	NM101-109 will only be returned when Medicaid corrects the name on the 837
108	2100	NM101	Entity Identifier Code	“74” – Corrected Insured
109	2100	NM102	Entity Type Qualifier	“1” – Person
109	2100	NM103	Last Name	Corrected patient last name
109	2100	NM104	First Name	Corrected patient first name
109	2100	NM108	Identification Code Qualifier	“C” – Corrected Patient ID
109	2100	NM109	Identification Code	Corrected Patient ID
118	2100	MIA	Inpatient Adjudication Information	Used for claim level remark codes
120-122	2100	MIA05, MIA20 thru MIA23	Remark Code	HIPAA Code List www.wpc-edi.com
123	2100	MOA	Outpatient Adjudication Information	Used for claim level remark codes
124-125	2100	MOA03 thru MOA07	Remark Code	HIPAA Code List www.wpc-edi.com
126	2100	REF01	Reference Identification Qualifier	“CE” – Name of Plan “F8” – Original Ref Number

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Page	Loop	Segment	Data Element	Values / Comments
127	2100	REF02	Other Claim Related Identifier	Medicaid Crossover, Traditional Medicaid, etc. Original TCN Number
131	2100	DTM01	Date Time Qualifier	“232” – Start date “233” – End date When omitted start and end date are the same.
131	2100	DTM02	Claim Date	Date (CCYYMMDD)
139	2110	SVC01	Service Payment Information	Procedure/Rev codes information used in the adjudication process
140	2110	SVC01-1	Product or Service ID Qualifier	“HC” – HCPCS “NU” – Rev codes “N4” – NDC
141	2110	SVC01-2	Procedure Code	Code for product or service
141	2110	SVC01-3 thru SVC01-6	Procedure Modifier	Procedure code modifier(s)
142	2110	SVC02	Line Item Charge Amount	Submitted service charge amount
142	2110	SVC03	Line Item Provider Payment Amount	Service amount paid
142	2110	SVC04	Product/Service ID	Rev code when used in addition to HCPCS code.
142	2110	SVC05	Quantity	Units of service paid
142	2110	SVC06-1 thru SVC06-7	Composite Medical Procedure Identifier	Used to report the submitted code when different from the code adjudicated in SVC01.
145	2110	SVC07	Quantity	Used to report units of service when different from the units adjudicated in SVC05
147	2110	DTM01	Date Time Qualifier	“150” – Start date “151” – End date
147	2110	DTM02	Service Date	Date (CCYYMMDD)
150	2110	CAS01	Claim Adjustment Group Code (line level)	“CO” – Contractual Obligations “CR” – Correction and Reversals “OA” – Other adjustments “PR” – Patient Responsibility
150-153	2110	CAS02 thru CAS17	Adjustment Reason Codes	HIPAA Code List www.wpc-edi.com
150-153	2110	CAS03 thru CAS18	Adjustment Amount (line level)	Monetary amount of adjustment
154	2110	REF01	Reference Identification Qualifier	“6R” – Provider Control Number

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Page	Loop	Segment	Data Element	Values / Comments
155	2110	REF02	Provider Identifier	Provider assigned number unique to this line in the 837.
156	2110	REF01	Reference Identification Qualifier	“HPI” – NPI
157	2110	REF02	Rendering Provider Identifier	NPI of Rendering Provider
158	2110	AMT	Amount Qualifier Code	“B6” – Allowed - Actual
159	2110	AMT	Monetary Amount	Monetary Amount
162	2110	LQ01	Code List Qualifier Code	“HE” – Claim payment remark code
163	2110	LQ02	Industry Code	HIPAA Code List www.wpc-edi.com
164		PLB	Provider Adjustment	Allows adjustments that are NOT specific to a particular claim. (Gross Adjustment)
165		PLB01	Provider Identifier	Provider number assigned by payer.
165		PLB02	Fiscal Period Date	December 31 of the current year.
165		PLB03-1	Adjustment Reason Code	HIPAA Code List Available in Implementation Guide Pages 165-170
170		PLB03-2	Provider Adjustment Identifier	TCN assigned by Medicaid.
170		PLB04	Provider Adjustment Amount	Adjustment amount. Negative amount is money owed to Medicaid. Positive amount is money paid to Provider.