

ADDENDUM 16

PRMMIS 835 Companion Guide

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GOVERNMENT OF PUERTO RICO

Department of Health
Medicaid Program

HIPAA Transaction Standard Companion Guide

**Refers to the Technical Report Type 3 (TR3)
Implementation Guides
Based on Instructions Related to 835 Health Care Claim
Payment/Advice**

Companion Guide Version Number: 1.0

February 2019

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Preface

This companion guide to the v5010 ASC X12N Technical Report Type 3 (TR3), and associated errata and addenda, adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) clarifies and specifies the data content when exchanging transactions electronically with Puerto Rico Medicaid. Transmissions based on this companion guide, used in tandem with the TR3, also called 835 Health Care Claim Payment/Advice (835) ASC X12N (version 005010X221A1), are compliant with both ASC X12 syntax and those guides. This companion guide is intended to convey information that is within the framework of the ASC X12N TR3 adopted for use under HIPAA. This companion guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the TR3.

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1 INTRODUCTION

This section describes how TR3, also called 835 ASC X12N (005010X221A1), which was adopted under HIPAA, will be detailed with the use of a table. The table contains a Notes/Comments column for each segment that Puerto Rico Medicaid has additional information to provide over and above the information in the TR3. That information can do any of the following:

1. Limit the repeat of loops, or segments.
2. Limit the length of a simple data element.
3. Specify a sub-set of the implementation guide internal code listings.
4. Clarify the use of loops, segments, composite, and simple data elements.
5. Any other information tied directly to a loop, segment, composite, or simple data element pertinent to trading electronically with Puerto Rico Medicaid.

In addition to the row for each segment, one or more additional rows are used to describe Puerto Rico Medicaid's usage for composite and simple data elements and for any other information. Notes and comments should be placed at the deepest level of detail. For example, a note about a code value should be placed on a row specifically for that code value, not in a general note about the segment.

The following table specifies the columns and suggested use of the rows for the detailed description of the transaction set companion guides. The table contains a Notes/Comments column for each segment that Puerto Rico Medicaid has additional information to provide, over and above the information in the TR3. The following is just an example of the type of information that would be spelled out or elaborated on in Section 8: TRANSACTION-SPECIFIC INFORMATION.

| Page# | Loop ID | Reference | Name | Codes | Notes/Comments |
|-------|---------|-----------|---|----------------------------|--|
| 193 | 2100C | NM1 | Subscriber Name | | This type of row exists to indicate that a new segment has begun. It is shaded at 10 percent and notes or comments about the segment itself go in this cell. |
| 196 | 2100C | REF | Subscriber Additional Identification | | |
| 197 | 2100C | REF01 | Reference Identification Qualifier | 18 49 6P HJ N6 | These are the only codes transmitted by Puerto Rico Medicaid. |
| | | | Plan Network Identification Number | N6 | This type of row exists when a note for a particular code value is required. For example, this note may say that value "N6" is the default. Not populating the first three columns makes it clear that the code value belongs to the row immediately above it. |
| 218 | 2110C | EB | Subscriber Eligibility or Benefit Information | | |
| 231 | 2110C | EB13-1 | Product/Service ID Qualifier | AD | This row illustrates how to indicate a component data element in the Reference column and also how to specify that only one code value is applicable. |

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1.1 Scope

This companion guide is intended for trading partner use in conjunction with the TR3 HIPAA 5010 835 (referred to as 835 Health Care Claim Payment/Advice in the rest of this document) for the purpose of submitting Claim Payment/Advice requests electronically. This companion guide is not intended to replace the TR3. The TR3s define the national data standards, electronic format, and values for each data element within an electronic transaction. The purpose of this companion guide is to provide trading partners with a guide to communicate Puerto Rico Medicaid-specific information required to successfully exchange transactions electronically with Puerto Rico Medicaid. The instructions in this companion guide are not intended to be stand-alone requirements documents. This companion guide conforms to all the requirements of any associated ASC X12 implementation guide and is in conformance with ASC X12's copyrights and Fair Use statements.

The information contained in this companion guide applies to Puerto Rico Medicaid. These programs use Puerto Rico Medicaid for processing.

Refer to the companion guide first if there is a question about how Puerto Rico Medicaid processes a HIPAA transaction. For further information, contact pmmis_edt_support@dx.com. This guide is intended as a resource to assist trading partners (Managed Care Organizations – MCO and Platinos), with Puerto Rico Department of Health, in successfully conducting Electronic Data Interchange (EDI) of administrative health care transactions. This document does not provide detailed data specifications, which are published separately by the industry committees responsible for their creation and maintenance.

1.2 Overview

Puerto Rico Medicaid and all other covered entities are required by HIPAA to comply with the EDI standards for health care, as established by the Secretary of the federal Department of Health and Human Services (HHS). The Secretary of the HHS is required by HIPAA to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. The Health Insurance Portability and Accountability Act of 1996 directs the Secretary to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard.

The Health Insurance Portability and Accountability Act of 1996 serves to:

- Create better access to health insurance.
- Limit fraud and abuse.
- Reduce administrative costs.

This guide is designed to help those responsible for testing and setting up the 835 Health Care Claim Payment/Advice transactions. Specifically, it documents and clarifies when situational data elements and segments must be used for reporting, and identifies codes and data elements that do not apply to Puerto Rico Medicaid. This guide supplements (but does not contradict) requirements in the ASC X12N 835 (version 005010X221A1) implementation. This information should be given to the trading partner's business area to ensure that 835 Health Care Claim Payment/Advice transactions are interpreted correctly. This companion guide provides communications-related information a trading partner needs to obtain support, format the interchange control header (ISA) and functional group header (GS) envelopes, and exchange test and production transactions with Puerto Rico Medicaid.

This companion guide must be used in conjunction with the TR3 instructions. The companion guide is intended to assist trading partners in implementing electronic 835 Health Care Claim Payment/Advice transactions that meet Puerto Rico Medicaid processing standards by identifying pertinent structural and data-related requirements and recommendations.

1.3 References

For more information regarding the ASC X12 standards for EDI 835 (version 005010X221A1) and to purchase copies of the TR3 documents, consult the Washington Publishing Company Web site at <http://www.wpc-edi.com/>.

The implementation guide specifies in detail the required formats for transactions exchanged electronically with an insurance company, health care payer, or government agency. The implementation guide contains requirements for the use of specific segments and specific data elements within those segments and applies to all health care providers and their trading partners. It is critical that the trading partner's Information Technology (IT) staff, or software vendor, review this document in its entirety and follow the stated requirements to exchange HIPAA-compliant files with Puerto Rico Medicaid interChange.

Provider taxonomy code set can be obtained from www.wpc-edi.com/reference.

1.4 Additional Information

The American National Standards Institute (ANSI) is the coordinator for information on national and international standards. In 1979, ANSI chartered the ASC X12 to develop uniform standards for electronic interchange of business transactions and eliminate the problem of non-standard electronic data communication. The objective of the ASC X12 committee is to develop standards to facilitate electronic interchange relating to all types of business transactions. The ANSI X12 standard is recognized by the United States as the standard for North America. Electronic Data Interchange adoption has been proved to reduce the administrative burden on providers.

The intended audience for this document is the technical and operational staff responsible for generating, receiving, and reviewing electronic health care transactions.

National Provider Identifier

As a result of HIPAA, the federal HHS adopted a standard identifier for health care providers. The Final Rule, published by the HHS, adopted the National Provider Identifier (NPI) as the standard identifier.

The NPI replaces all payer-specific identification numbers (e.g., Medicaid provider numbers) on nationally recognized electronic transactions (also known as standard transactions); therefore, all health care providers are required to obtain an NPI to identify themselves on these transactions. The NPI is required in standard transactions.

Puerto Rico Medicaid requires all health care providers to submit their NPI on electronic transactions.

Acceptable Characters

The HIPAA transactions must not contain any carriage returns, nor line feeds; the data must be received in one, continuous stream. Puerto Rico Medicaid accepts the extended character set. Uppercase characters are recommended.

Acknowledgements

PRMMIS will accept 999 Implementation Acknowledgement transactions from trading partners after they have downloaded their 835 Health Care Claim Payment/Advice transaction. If you return an acknowledgement file after downloading your 835 X12, we request that you name your file using the 835 X12 file's name and make the extension ".ACK".

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Example:

You receive the following X12:

3627_3623_#####_@@_SFTP_ERA835_201900131.X12

Acknowledgement file you upload to SFTP:

3627_3623_#####_@@_SFTP_ERA835_201900131.ACK

– Trading Partner ID

@@@ – Trading Partner Short Name

File/System Specifications

EDI only accepts Windows/PC/DOS formatted files. Any file transmitted to EDI must be named in accordance to standard file naming conventions, including a valid three-character file extension.

The following standards should be used:

- To avoid accidentally overwriting files, do not send multiple files with the same name on the same day.
- File Names should not be longer than 45 characters – the first 20 characters will be used to identify the file through PRMMIS.
- File Names should not contain spaces or special characters.
- File Names should contain a file extension, such as .dat or .txt.
- Zip files utilizing WinZip are allowed, but a zip file should contain only one X12 file.
- Zip files must contain the extension .zip (not case sensitive).



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2 GETTING STARTED

2.1 Testing Overview

Submitters are responsible for the preservation, privacy, and security of data in their possession. While using production data that contains Personal Health Information (PHI) to conduct testing, the data must be guarded and disposed of appropriately.



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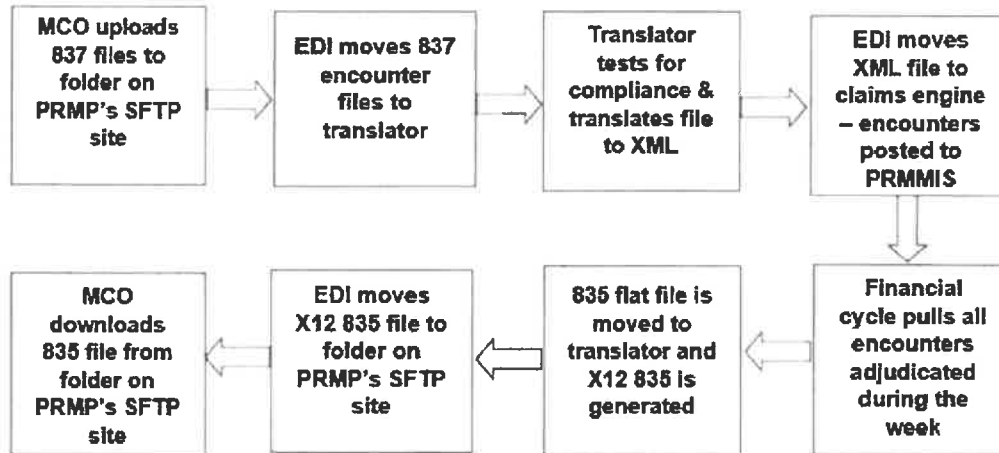
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3 CONNECTIVITY WITH PUERTO RICO MEDICAID / COMMUNICATIONS

This section describes the process for downloading HIPAA 835 Health Care Claim Payment/Advice transactions, along with various security requirements and exceptions to handling procedures.

3.1 Process Flows

Retrieval of Puerto Rico Medicaid's 835 Health Care Claim Payment/Advice via MCO's folder on Puerto Rico Medicaid Program (PRMP) Secure File Transfer Protocol (SFTP) site.



3.2 Transmission Administrative Procedures

Puerto Rico Medicaid is available only to authorized users. Submitters are required to be Puerto Rico Medicaid trading partners.

3.3 Re-transmission Procedure

In the event of an interrupted communications session, the trading partner only has to reconnect and initiate their file transfer as they normally would.

3.4 Batch

Trading partners can submit all batch transactions to Puerto Rico Medicaid and download acknowledgements and response files. Access is free; however, the user must have their own internet connection to access the PRMP SFTP site.

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4 CONTACT INFORMATION

Refer to this companion guide with your questions, then use the contact information below for questions not answered by this guide.

4.1 Electronic Data Interchange Helpdesk

If you have questions related to Puerto Rico Medicaid Program's 835 Health Care Claim Payment/Advice, contact the EDI Helpdesk by email at prmmis_edi_support@dx.com or by telephone 1-833-209-8326.

4.2 Applicable Web Sites

Additional information is available on the following Web sites:

- The current list of Claim Status Category Codes: <http://www.wpc-edi.com/reference>
- The current list of Claim Status Codes: <http://www.wpc-edi.com/reference/>
- Accredited Standards Committee X12 develops and maintains standards for inter-industry electronic interchange of business transactions: www.x12.org.
- Accredited Standards Committee X12N develops and maintains X12 EDI and XML standards, standards interpretations and guidelines as they relate to all aspects of insurance and insurance-related business processes: www.x12.org.
- American Hospital Association (AHA) Central Office on *International Classification of Diseases, Tenth Revision, Clinical Modification* (ICD-10-CM) is a resource for the ICD-10-CM codes used in medical transcription, billing, and for Level I Healthcare Common Procedure Coding System (HCPCS) procedure codes: www.ahacentraloffice.org.
- American Medical Association (AMA) is a resource for the *Current Procedural Terminology* 4th Edition codes (CPT-4). The AMA copyrights the CPT codes: www.ama-assn.org.
- Centers for Medicare and Medicaid Services (CMS) is the unit within the HHS that administers the Medicare and Medicaid programs. The CMS provides the Electronic Health Care Transactions and Code Sets Model Compliance Plan at <https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/Code-Sets/index.html>.
- The CMS is the resource for information related to HCPCS procedure codes: www.cms.hhs.gov/HCPCSReleaseCodeSets/.
- As a multi-phase initiative of CAQH, CORE is a committee of more than 100 industry leaders who help create and promulgate a set of voluntary business rules focused on improving physician and hospital access to electronic patient insurance information at or before the time of care: www.caqh.org/CORE_overview.php.
- The CAQH is a nonprofit alliance of health plans and trade associations, working to simplify health care administration through industry collaboration on public-private initiatives. Through two initiatives — CORE and Universal Provider Datasource (UPD) — CAQH aims to reduce administrative burden for providers and health plans: www.caqh.org.
- Designated Standard Maintenance Organizations (DSMO) is a resource for information about the standard-setting organizations and transaction change request system: www.hipaa-dsmo.org.
- Health Level Seven (HL7) is one of several ANSI-accredited Standards Development Organizations (SDOs) and is responsible for clinical and administrative data standards: www.hl7.org.
- Healthcare Information and Management Systems (HIMSS) is an organization exclusively focused on providing global leadership for the optimal use of IT and management systems for the betterment of health care: www.himss.org.
- National Committee on Vital and Health Statistics (NCVHS) was established by Congress to serve as an advisory body to the HHS on health data, statistics and national health information policy; for more information, refer to: www.ncvhs.hhs.gov.

- The NCPDP is the standards and codes development organization for pharmacy; for more information, refer to: www.ncdp.org.
- National Uniform Billing Committee (NUBC) is affiliated with the AHA and develops standards for institutional claims, which can be found at: www.nubc.org.
- National Uniform Claim Committee (NUCC) is affiliated with the AMA. It develops and maintains a standardized data set for use by the non-institutional health care organizations to transmit claims and encounter information. The NUCC maintains the national provider taxonomy at: www.nucc.org.
- Office for Civil Rights (OCR) is the office within the federal HHS responsible for enforcing the Privacy Rule under HIPAA, which can be found at: www.hhs.gov/ocr/hipaa.
- The federal HHS is a resource for the Notice of Proposed Rule Making, rules, and other information about HIPAA, which can be found at: www.aspe.hhs.gov/admsimp.
- Washington Publishing Company (WPC) is a resource for HIPAA-required transaction implementation guides and code sets, which can be found at: www.wpc-edi.com/.
- The WEDI is a workgroup dedicated to improving health care through electronic commerce, which includes the Strategic National Implementation Process (SNIP) for complying with the administrative-simplification provisions of HIPAA: www.wedi.org.
- The registry for the NPI is the National Plan and Provider Enumeration System (NPPES), at: <https://nppes.cms.hhs.gov/NPPES/Welcome.do>.
- Implementation guides and non-medical code sets are at: store.x12.org/.
- The HIPAA statute, Final Rules, and related Notices of Proposed Rulemaking (NPRMS) are available at: <https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/Code-Sets/index.html> or aspe.hhs.gov/datacncl/admsim.shtml.
- Information from CMS about *International Classification of Diseases, 10th Revision* (ICD-10) codes can be found at: <https://www.cms.gov/ICD10/>.
- Quarterly updates to the HCPCS code set are available from CMS at: www.cms.hhs.gov/HCPCSReleaseCodeSets/.
Note: CPT-4, or Level 1 HCPCS, is maintained and licensed by the AMA and is available for purchase in various hardcopy and softcopy formats from a variety of vendors.
- The CMS online manuals system and Internet only manuals (IOM) system, including transmittals and program memoranda, can be found at: www.cms.hhs.gov/Manuals/.
- Place of service codes are listed in the Medicare Claims Processing Manual and are maintained by CMS, which are available online at: www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf.



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5 CONTROL SEGMENTS / ENVELOPES

5.1 ISA – Interchange Control Header

This section describes Puerto Rico Medicaid's use of the ISA. It includes a description of expected sender and receiver codes, authorization information, and delimiters.

To promote efficient, accurate electronic transaction processing, note the following Puerto Rico Medicaid specifications:

- Each trading partner is assigned a six-digit trading partner ID.
- All dates are in the CCYYMMDD format.
- All date/times are in the CCYYMMDDHHMM format.
- Payer ID can be found in all companion guides.
- Only one interchange (ISA/IEA) loop and one functional (GS/GE) loop is allowed per file.

Transactions transmitted are identified by an ISA and trailer segment (IEA) which form the envelope enclosing the transmission. The ISA marks the beginning of the transmission (batch) and provides sender and receiver identification. The table below shows the fields that Puerto Rico Medicaid will be sending.

The ISA data segment is a fixed length record and all fields must be supplied. Fields that are not populated with actual data must be filled in with spaces.

Note: Puerto Rico Department of Health sends files with one ISA/IEA loop per file.

| TR3 Page # | Loop ID | Reference | Name | Codes | Notes/Comments |
|---------------|---------|-----------|-------------------------------------|--------|---|
| C.3 | None | ISA | Interchange Control Header | | The ISA is a fixed-length record with fixed-length elements. |
| C.4 | | ISA01 | Authorization Information Qualifier | 00 | No authorization information present. |
| C.4 | | ISA02 | Authorization Information | | [space fill] |
| C.4 | | ISA03 | Security Information Qualifier | 00 | No security information present. |
| C.4 | | ISA04 | Security Information | | [space fill] |
| C.4 | | ISA05 | Interchange ID (Sender) Qualifier | ZZ | |
| C.4 | | ISA06 | Interchange Sender ID | PRMMIS | "PRMMIS" – left-justified and space-filled |
| C.5 | | ISA07 | Interchange ID (Receiver) Qualifier | ZZ | |
| C.5 | | ISA08 | Interchange Receiver ID | | Trading Partner ID supplied by Puerto Rico Medicaid, left-justified and space-filled. |
| C.5 | | ISA09 | Interchange Date | | The date format is YYMMDD. |
| C.5 | | ISA10 | Interchange Time | | The time format is HHMM. |
| C.5 | | ISA11 | Repetition Separator | ^ | A Caret "^" will be sent. |
| C.5 | | ISA12 | Interchange Control Version Number | 00501 | 00501 = Control Version Number |
| C.5 | | ISA13 | Interchange Control Number | | The interchange control number assigned in ISA13 will be identical to the value in IEA02. |

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| TR3 Page # | Loop ID | Reference | Name | Codes | Notes/Comments |
|---------------|---------|-----------|-----------------------------|-------|--|
| C.6 | | ISA14 | Acknowledgement Requested | 0 | No interchange acknowledgment requested (TA1). |
| C.6 | | ISA15 | Usage Identifier | T & P | Code indicating whether the data enclosed is production or test. |
| | | | Production Data | T | File submitted to PRMMIS test environment. |
| | | | Production Data | P | File submitted to PRMMIS production environment. |
| C.6 | | ISA16 | Component Element Separator | : | A colon ":" will be sent. |

5.2 IEA – Interchange Control Header

Communications transport protocol interchange control trailer segment. This segment within the X12N implementation guide defines the end of an interchange of zero or more functional groups and interchange-related control segments. This segment may be thought of traditionally as the file trailer record.

| TR3 Page # | Loop ID | Reference | Name | Codes | Notes/Comments |
|---------------|---------|-----------|--------------------------------------|-------|--|
| C.10 | None | IEA | Interchange Control Trailer | | |
| C.10 | | IEA01 | Number of Included Functional Groups | | Number of included Functional Groups. |
| C.10 | | IEA02 | Interchange Control Number | | Must be identical to the value in ISA13. |

5.3 GS – Functional Group Header

This section describes Puerto Rico Medicaid's use of the functional group control segments. It includes a description of expected application sender and receiver codes.

The table below shows the fields that Puerto Rico Medicaid will be sending.

| TR3 Page # | Loop ID | Reference | Name | Codes | Notes/Comments |
|---------------|---------|-----------|-----------------------------|--------|---|
| C.7 | None | GS | Functional Group Header | | |
| C.7 | | GS01 | Functional ID Code | HP | "HP" – Health Care Claim Payment/Advice (835) |
| C.7 | | GS02 | Application Sender's Code | PRMMIS | "PRMMIS" will be sent. |
| C.7 | | GS03 | Application Receiver's Code | | Trading partner's six-digit numeric identification number assigned by Puerto Rico Medicaid. |
| C.7 | | GS04 | Date | | The date format is CCYYMMDD. |
| C.8 | | GS05 | Time | | The time format is HHMM. |
| C.8 | | GS06 | Group Control Number | | Group Control Number – Must be identical to GE02. |

| TR3 Page # | Loop ID | Reference | Name | Codes | Notes/Comments |
|---------------|---------|-----------|---|--------------|--|
| C.8 | | GS07 | Responsible Agency Code | X | "X" – Responsible Agency Code |
| C.8 | | GS08 | Version/ Release/Industry Identifier Code | 005010X221A1 | Version / Release / Industry Identifier Code |

5.4 GE – Functional Group Trailer

The table below shows the fields that Puerto Rico Medicaid will be sending.

| TR3 Page # | Loop ID | Reference | Name | Codes | Notes/Comments |
|---------------|---------|-----------|-------------------------------------|-------|---|
| C.9 | None | GE | Functional Group Trailer | | |
| C.9 | | GE01 | Number of Transaction Sets Included | | Total number of transaction sets. |
| C.9 | | GE02 | Group Control Number | | Must be identical to the value in GS06. |

5.5 File Delimiters

Puerto Rico Medicaid uses the following delimiters in the 835 file:

- **Data Element:** Byte 4 in the ISA segment defines the data element separator to be used throughout the entire transaction. The data element delimiter is an asterisk (*).
- **Repetition Separator:** ISA11 defines the repetition separator to be used throughout the entire transaction. The repetition separator is a caret (^).
- **Component-Element:** ISA16 defines the component element delimiter to be used throughout the entire transaction. The component-element delimiter is a colon (:).
- **Data Segment:** Byte 106 of the ISA segment defines the segment terminator used throughout the entire transaction. The data segment delimiter is a tilde (~).

These characters (* : ~ ^) are not present within the data content of the transaction sets.

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6 PUERTO RICO MEDICAID-SPECIFIC BUSINESS RULES AND LIMITATIONS

6.1 Trading Partner Identification Number

In Phase Two of the Puerto Rico Department of Health's implementation of PRMMIS, the EDI team will create any needed Trading Partner Profiles.

6.2 Terminology

The term "subscriber" will be used as a generic term throughout the companion guide.

6.3 Notes on 835 Claim Payment/Advice

Puerto Rico Medicaid posts for download an 835 Health Care Claim Payment/Advice batch transaction upon release of a financial cycle. The financial cycle covers seven days.

Pharmacy claims are not reported in the 835 Health Care Claim Payment/Advice.

Puerto Rico Medicaid generates electronic 835 Health Care Claim Payment/Advice transactions only for claims/encounters that have a "paid", "denied", or "suspended" status on file. Trading partners wishing to verify receipt of an 837 submission should access their 999 Acknowledgement (and HTML file if the file had compliance errors). Encounter claims in a suspended status will only appear the first time on the 835 Health Care Claim Payment/Advice transaction when it is processed within a PRMMIS claim location.

The 835 Health Care Claim Payment/Advice transaction is for notification only and does not include payment of funds, such as checks or Electronic Funds Transfers (EFT) to financial institutions.

The 835 files will be available for retrieval for 30 days. If an 835 file is needed after 30 days, contact the EDI Helpdesk via e-mail using prmmis_edi_support@dx.com. The 835 file will be available for a maximum of 90 days.

6.4 Scheduled Maintenance

Puerto Rico Medicaid schedules regular maintenance every Sunday from 02:00 a.m. to 06:00 a.m. Atlantic Time (during daylight savings time Atlantic Time is the same as Eastern Time).

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7 ACKNOWLEDGEMENTS AND/OR REPORTS

7.1 Report Inventory

There are no acknowledgement reports at this time.

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8 TRANSACTION-SPECIFIC INFORMATION

This section describes how ASC X12N implementation guides adopted under HIPAA will be detailed with the use of a table. The tables contain a row for each segment that Puerto Rico Medicaid has something additional, over and above, the information in the implementation guides. That information can:

1. Limit the repeat of loops or segments.
2. Limit the length of a simple data element.
3. Specify a sub-set of the implementation guide's internal code listings.
4. Clarify the use of loops, segments, composite, and simple data elements.
5. Any other information tied directly to a loop, segment, composite, or simple data element pertinent to trading electronically with Puerto Rico Medicaid.

In addition to the row for each segment, one or more additional rows are used to describe Puerto Rico Medicaid's usage for composite and simple data elements and for any other information. Notes and comments will be placed at the deepest level of detail. For example, a note about a code value will be placed on a row specifically for that code value, not in a general note about the segment.

The following table specifies the columns and suggested use of the rows for the detailed description of the transaction set companion guides. The table contains a Notes/Comments column for each segment that Puerto Rico Medicaid has additional information to provide, over and above the information in the TR3.

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| TR3 Page # | Loop ID | Reference | Name | Codes | Notes/Comments |
|---------------|---------|-----------|--|-------|---|
| 69 | | BPR | Financial Information | | |
| 70 | | BPR01 | Financial Information | H | "H" – Notification only, no payment |
| 71 | | BPR02 | Total Actual Provider Payment Amount | | This field will always be zero. |
| 71 | | BPR03 | Credit or Debit Flag Code | C | This field will contain "C" to indicate credit. |
| 72 | | BPR04 | Payment Method | NON | "NON" – Non-payment data will be sent. <i>Note:</i> Information only and no dollars are to be moved. |
| 72 | | BPR05 | Payment Format Code | | Because BPR04 is equal to "NON" this will not be sent. |
| 72 | | BPR06 | Depository Financial Institution (DFI) Identification Number Qualifier | | Because BPR04 is equal to "NON" this will not be sent. |
| 73 | | BPR07 | Sender DFI Identifier | | Because BPR04 is equal to "NON" this will not be sent. |
| 74 | | BPR08 | Account Number Qualifier | | Because BPR04 is equal to "NON" this will not be sent. |
| 74 | | BPR09 | Sender Bank Account Number | | Because BPR04 is equal to "NON" this will not be sent. |
| 74 | | BPR10 | Payer Identifier | | Because BPR04 is equal to "NON" this will not be sent. |

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| TR3 Page # | Loop ID | Reference | Name | Codes | Notes/Comments |
|---------------|---------|-----------|--|-------|---|
| 74 | | BPR11 | Originating Company Supplemental Code | | Because BPR04 is equal to "NON" this will not be sent. |
| 75 | | BPR12 | Depository Financial Institution (DFI) Identification Number Qualifier | | Because BPR04 is equal to "NON" this will not be sent. |
| 75 | | BPR13 | Receiver or Provider Bank ID Number | | Because BPR04 is equal to "NON" this will not be sent. |
| 76 | | BPR14 | Account Number Qualifier | | Because BPR04 is equal to "NON" this will not be sent. |
| 76 | | BPR15 | Receiver or Provider Account Number | | Because BPR04 is equal to "NON" this will not be sent. |
| 76 | | BPR16 | Check Issue or EFT Effective Date | | Because BPR04 is equal to "NON" this will be the date the 835 was created. |
| 77 | | TRN | Reassociation Trace Number | | Uniquely identify this transaction set and to aid in reassociating payments and remittances that have been separated. |
| 77 | | TRN01 | Trace Type Code | 1 | "1" – Current Transaction Trace Numbers |
| 77 | | TRN02 | Check or EFT Trace number | | Because BPR04 is equal to "NON" this will be a unique remittance advice identification number. |
| 78 | | TRN03 | Payer Identification | | This field contains the value "1" followed by the Puerto Rico Medicaid federal Tax Identification Number (TIN). |
| 79 | | CUR | Foreign Currency Information | | This segment does not meet the situational requirements to be sent by Puerto Rico Medicaid. |
| 82 | | REF | Receiver Identification | | |
| 82 | | REF01 | Reference Identification Qualifier | EV | "EV" – Receiver Identification Number |
| 82 | | REF02 | Receiver Identifier | | This field will contain the Provider's Medicaid ID. |
| 84 | | REF | Version Identification | | This segment does not meet the situational requirements to be sent by Puerto Rico Medicaid. |
| 85 | | DTM | Production Date | | |
| 85 | | DTM01 | Date Time Qualifier | 405 | "405" – Production |
| 86 | | DTM02 | Production Date | | Reports the end date for the adjudication production cycle for encounters included in this 835. |
| 87 | 1000A | N1 | Payer Identification | | |
| 87 | 1000A | N101 | Entity Identifier Code | PR | "PR" – Payer |
| 87 | 1000A | N102 | Payer Name | PRMP | This field will contain "PRMP" for Puerto Rico Medicaid Program. |

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| TR3 Page # | Loop ID | Reference | Name | Codes | Notes/Comments |
|---------------|---------|-----------|---------------------------------------|---|---|
| 89 | 1000A | N3 | Payer Address | | |
| 89 | 1000A | N301 | Payer Address Line | P.O. Box 195661 | This field will contain the address of the payer. |
| 90 | 1000A | N4 | Payer City, State, ZIP Code | | |
| 90 | 1000A | N401 | Payer City Name | San Juan | This field will contain the city of the payer. |
| 91 | 1000A | N402 | Payer State Code | PR | State of the payer. |
| 91 | 1000A | N403 | Postal Zone or ZIP Code | 009195661 | ZIP code of the payer. |
| 92 | 1000A | REF | Additional Payer Identification | | This segment does not meet the situational requirements to be sent by Puerto Rico Medicaid. |
| 94 | 1000A | PER | Payer Business Contact | | |
| 95 | 1000A | PER01 | Contact Function Code | CX | "CX" – Payers Claim Office |
| 95 | 1000A | PER02 | Payer Technical Contact Name | PRMMIS EDI Helpdesk prmmis_edi_sup port@dx.com | |
| 95 | 1000A | PER03 | Communication Number Qualifier | TE | "TE" – Telephone |
| 95 | 1000A | PER04 | Payer Contact Communication Number | 8332098326 | Telephone number for PRMMIS EDI Helpdesk |
| 97 | 1000A | PER | Payer Technical Contact | | This segment will contain EDI Helpdesk information as the Technical Contact. |
| 97 | 1000A | PER01 | Contact Function Code | BL | "BL" – Technical Department |
| 98 | 1000A | PER02 | Payer Technical Contact Name | PRMMIS EDI Helpdesk prmmis_edi_sup port@dx.com | |
| 98 | 1000A | PER03 | Communication Number Qualifier | TE | "TE" – Telephone |
| 98 | 1000A | PER04 | Payer Contact Communication Number | 8332098326 | Telephone number for PRMMIS EDI Helpdesk |
| 100 | 1000A | PER | Payer Web Site | | This segment does not meet the situational requirements to be sent by Puerto Rico Medicaid. |
| 102 | 1000B | N1 | Payee Identification | | |
| 103 | 1000B | N101 | Entity Identifier Code | PE | "PE" – Payee |

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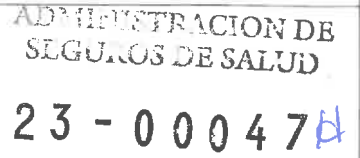
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| TR3 Page # | Loop ID | Reference | Name | Codes | Notes/Comments |
|---------------|---------|-----------|---|------------------------|---|
| 103 | 1000B | N102 | Payee Name | | |
| 103 | 1000B | N103 | Identification Code Qualifier | FI XX | |
| | | | Federal TIN | FI | |
| | | | National Provider Identifier (NPI) | XX | |
| 103 | 1000B | N104 | Payee Identification Code | | This field contains the billing provider's NPI when N103 contains the value "XX". This is the billing provider's Federal TIN when N103 contains the value "FI". |
| 104 | 1000B | N3 | Payee Address | | Since only encounters are being reported in the 835 this segment does not meet the situational requirements to be sent by Puerto Rico Medicaid. |
| 105 | 1000B | N4 | Payee City, State, ZIP | | Since only encounters are being reported in the 835 this segment does not meet the situational requirements to be sent by Puerto Rico Medicaid. |
| 107 | 1000B | REF | Payee Additional Identification | | Since only encounters are being reported in the 835 this segment does not meet the situational requirements to be sent by Puerto Rico Medicaid. |
| 109 | 1000B | RDM | Remittance Delivery Method | | Since only encounters are being reported in the 835 this segment does not meet the situational requirements to be sent by Puerto Rico Medicaid. |
| 111 | 2000 | LX | Header Number | | |
| 111 | 2000 | LX01 | Assigned Number | | "1" for first encounter loop within ST. Add +1 for each encounter loop. |
| 112 | 2000 | TS3 | Provider Summary Information | | This segment does not meet the situational requirements to be sent by Puerto Rico Medicaid. |
| 117 | 2000 | TS2 | Provider Supplemental Summary | | This segment does not meet the situational requirements to be sent by Puerto Rico Medicaid. |
| 123 | 2100 | CLP | Claim Payment Information | | |
| 123 | 2100 | CLP01 | Patient Control Number | | The information that was in the encounter's CLM01 field will be put in this field. |
| 124 | 2100 | CLP02 | Claim Status Code | 1 2 3 4 22 |  |
| | | | Paid claim with Medicaid as the primary payer on the claim. | 1 | Contrato Número |

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|---------------|---------|-----------|---|----------------------|---|
| | | | Paid claim with Medicaid as the secondary payer on the claim. | 2 | |
| | | | Paid claim with Medicaid as tertiary or greater payer. | 3 | |
| | | | Denied claim. | 4 | |
| | | | Reversal of a previous claim. | 22 | |
| 125 | 2100 | CLP03 | Total Claim Charge Amount | | This is the billed amount (CLM02) from the original encounter. The amount can be positive, zero or negative. An example of a situation with a negative charge is a reversal encounter. |
| 125 | 2100 | CLP04 | Claim Payment Amount | | This is the amount paid by the payer. The amount can be positive, zero or negative. An example of a situation with a negative charge is a reversal encounter. |
| 125 | 2100 | CLP05 | Patient Responsibility Amount | | This is the sum of the member's total cost share responsibility, which may include copayment, deductible, spend down, coinsurance cutback, member liability, and nursing home personal needs allowance. |
| 126 | 2100 | CLP06 | Claim Filing Indicator Code | MC | "MC" – Encounter Processed by Medicaid |
| 127 | 2100 | CLP07 | Payer Claim Control Number | | Payer's internal control number. |
| 127 | 2100 | CLP08 | Facility Type Code | | Uniform Bill Type Code for Institutional Services or the Place of Service Codes for Professional or Dental Services. |
| 127 | 2100 | CLP09 | Claim Frequency Code | | Frequency from Encounter. |
| 128 | 2100 | CLP11 | Diagnosis Related Group (DRG) Code | | If the institutional encounter was adjudicated using a DRG. |
| 128 | 2100 | CLP12 | Diagnosis Related Group (DRG) Weight | | The adjudicated DRG Weight for an institutional encounter. |
| 129 | 2100 | CAS | Claim Adjustment | | |
| 131 | 2100 | CAS01 | Claim Adjustment Group Code | CO OA PI PR | |
| | | | Contractual Obligations | CO |  ADMINISTRACION DE SEGUROS DE SALUD 23 - 00047H Contrato Número |
| | | | Other adjustments | OA | |
| | | | Payor Initiated Reductions | PI | |
| | | | Patient Responsibility | PR | |

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| TR3 Page # | Loop ID | Reference | Name | Codes | Notes/Comments |
|---------------|---------|--|----------------------------------|-------|--|
| 131 | 2100 | CAS02 CAS05 CAS08 CAS11 CAS14 CAS17 | Adjustment Reason Code | | Adjustment Reason Codes can be found on http://www.wpc-edi.com |
| 132 | 2100 | CAS03 CAS05 CAS09 CAS12 CAS15 CAS18 | Adjustment Amount | | |
| 137 | 2100 | NM1 | Patient Name | | This is the member's information as submitted on the original encounter |
| 137 | 2100 | NM101 | Identification Code Qualifier | QC | "QC" – Patient |
| 138 | 2100 | NM102 | Entity Type Qualifier | 1 | "1" – Person |
| 138 | 2100 | NM103 | Patient Last Name | | This is the Member's last name as submitted on encounter. |
| 138 | 2100 | NM104 | Patient First Name | | This is the Member's first name as submitted on encounter. |
| 138 | 2100 | NM105 | Patient Middle Initial | | This is the Member's middle initial as submitted on encounter. |
| 139 | 2100 | NM108 | Identification Code Qualifier | MR | "MR" – Medicaid Recipient Identification Number |
| 139 | 2100 | NM109 | Patient Identifier | | This is the member's Puerto Rico Medicaid member ID as submitted on the encounter. |
| 140 | 2100 | NM1 | Insured Name | | Puerto Rico Medicaid does not meet the situational rule to require this segment. |
| 143 | 2100 | NM1 | Corrected Patient/Insured Name | | Provides corrected information about the Member as submitted in the encounter – if member was found on file. |
| 143 | 2100 | NM101 | Identification Code Qualifier | 74 | "74" – Corrected Insured |
| 144 | 2100 | NM102 | Entity Type Qualifier | 1 | "1" – Person |
| 144 | 2100 | NM103 | Corrected Patient Last Name | | Member's last name as stored on Puerto Rico Medicaid file – if different from value submitted. |
| 144 | 2100 | NM104 | Corrected Patient First Name | | Member's first name as stored on Puerto Rico Medicaid file – if different from value submitted. |
| 144 | 2100 | NM105 | Corrected Patient Middle Initial | | Member's middle initial as stored on Puerto Rico Medicaid file – if different from value submitted. |

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| TR3 Page # | Loop ID | Reference | Name | Codes | Notes/Comments |
|---------------|---------|-----------|--|----------|---|
| 144 | 2100 | NM107 | Corrected Patient Name Suffix | | Member's name suffix as stored on Puerto Rico Medicaid file – if different from value submitted. |
| 145 | 2100 | NM108 | Identification Code Qualifier | C | "C" – Corrected Medicaid Recipient Identification Number |
| 145 | 2100 | NM109 | Corrected Insured Identification Indicator | | Corrected member's Puerto Rico Medicaid member ID as stored on Puerto Rico Medicaid file – if different from value submitted. |
| 146 | 2100 | NM1 | Service Provider Name | | Puerto Rico Medicaid meets the situational rule to require this segment. |
| 147 | 2100 | NM101 | Identification Code Qualifier | 82 | "82" – Rendering Provider |
| 147 | 2100 | NM102 | Entity Type Qualifier | 1 2 | |
| | | | Person | 1 | |
| | | | Non-Person Entity | 2 | |
| 147 | 2100 | NM103 | Rendering Provider Last Name | | |
| 147 | 2100 | NM104 | Rendering Provider First Name | | |
| 148 | 2100 | NM105 | Rendering Provider Middle Initial | | |
| 148 | 2100 | NM108 | Identification Code Qualifier | XX MC | |
| | | | National Provider Identifier (NPI) | XX | |
| | | | Puerto Rico Medicaid provider number. | MC | |
| 149 | 2100 | NM109 | Rendering Provider Identifier | | This field will contain the rendering provider's NPI when NM108 equals "XX" or eight or nine-digit Puerto Rico Medicaid number for atypical providers when NM108 equals "MC". |
| 150 | 2100 | NM1 | Crossover Carrier Name | | Since this is specific to COBA, Puerto Rico Medicaid does not meet the situational rule to require this segment. |
| 153 | 2100 | NM1 | Corrected Priority Payer Name | | Puerto Rico Medicaid does not meet the situational rule to require this segment. |
| 156 | 2100 | NM1 | Other Subscriber Name | | Puerto Rico Medicaid does not meet the situational rule to require this segment. |
| 159 | 2100 | MIA | Inpatient Adjudication Information | | On Medicare Institutional encounters only. |
| 160 | 2100 | MIA01 | Covered Days or Visits Count | | Always zero. |

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| TR3 Page # | Loop ID | Reference | Name | Codes | Notes/Comments |
|---------------|---------|-----------|---|----------------|---|
| 161 | 2100 | MIA05 | Claim Payment Remark Code | | HIPAA Remark Code for Inpatient and Institutional Regular and Crossover encounters. Remark Codes can be found on http://www.wpc-edi.com . |
| 164 | 2100 | MIA20 | Claim Payment Remark Code | | HIPAA Remark Code for Inpatient and Institutional Regular and Crossover claims. Remark Codes can be found on http://www.wpc-edi.com . |
| 165 | 2100 | MIA21 | Claim Payment Remark Code | | |
| 165 | 2100 | MIA22 | Claim Payment Remark Code | | |
| 165 | 2100 | MIA23 | Claim Payment Remark Code | | |
| 166 | 2100 | MOA | Outpatient Adjudication Information | | Puerto Rico Medicaid meets the situational rule to require this segment. |
| 167 | 2100 | MOA03 | Claim Payment Remark Code | | HIPAA Remark Code for Outpatient/ Professional Crossover claims. Remark Codes can be found on http://www.wpc-edi.com . |
| 167 | 2100 | MOA04 | Claim Payment Remark Code | | HIPAA Remark Code for Outpatient/ Professional Crossover claims. |
| 167 | 2100 | MOA05 | Claim Payment Remark Code | | |
| 168 | 2100 | MOA06 | Claim Payment Remark Code | | |
| 168 | 2100 | MOA07 | Claim Payment Remark Code | | |
| 169 | 2100 | REF | Other Claim Related Identification | | This segment will populate if Medical Record Number (MRN), Social Security Number (SSN), or Original Reference Number (TCN) is known. |
| 169 | 2100 | REF01 | Reference Identification Qualifier | EA SY F8 | |
| | | | The next element is the MRN. | EA | Medical Record ID Number as submitted on encounter. |
| | | | The next element is the SSN. | SY | Member's SSN. |
| | | | The next element is the adjustment ICN. | F8 | Original Reference Number (TCN). |
| 171 | 2100 | REF | Rendering Provider Identification | | This segment will populate if a Puerto Rico Medicaid provider number was submitted on the encounter's detail line. |
| 171 | 2100 | REF01 | Reference Identification Qualifier | 1D | Indicates that the next element is the rendering provider's Medicaid ID. |

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| TR3 Page # | Loop ID | Reference | Name | Codes | Notes/Comments |
|---------------|---------|-----------|--|----------------------|---|
| 173 | 2100 | DTM | Statement From or To Date | | If the "Statement From or To Dates" are not supplied at the service (2110 loop) level then this segment will be present in the 835. <i>Note:</i> If invalid date received on original encounter, value will be default date of "19000101". |
| 174 | 2100 | DTM01 | Date Time Qualifier | 232 233 | |
| | | | Claim Statement Period Start | 232 | |
| | | | Claim Statement Period End | 233 | If the start date is conveyed without a subsequent end date, the end date is assumed to be the same as the start date. |
| 175 | 2100 | DTM | Coverage Expiration Date | | Returned when payment is denied because of the expiration of coverage. |
| 175 | 2100 | DTM01 | Date Time Qualifier | 036 | "036" – Expiration |
| 175 | 2100 | DTM02 | Date | | Recipient's last year and month of eligibility. |
| 177 | 2100 | DTM | Claim Received Date | | This segment does not meet the situational requirements to be sent by Puerto Rico Medicaid. |
| 179 | 2100 | PER | Claim Contact Information | | This segment does not meet the situational requirements to be sent by Puerto Rico Medicaid. |
| 182 | 2100 | AMT | Amount Qualifier Code | | This segment does not meet the situational requirements to be sent by Puerto Rico Medicaid. |
| 184 | 2100 | QTY | Claim Supplemental Information Quantity | | This segment does not meet the situational requirements to be sent by Puerto Rico Medicaid. |
| 186 | 2110 | SVC | Service Payment Information | | |
| 187 | 2110 | SVC01-1 | Product or Service ID Qualifier | AD HC N4 NU | |
| | | | American Dental Association (ADA) codes. | AD | <div>ADMINISTRACION DE SEGUROS DE SALUD</div> <div>23 - 000474</div> <div>Contrato Número</div> |
| | | | Healthcare Common Procedure Coding System (HCPCS) codes. | HC | |
| | | | National Drug Code (NDC) in 5-4-2 format. | N4 | |
| | | | National Uniform Billing Committee (NUBC) UB92 codes. | NU | |

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| TR3 Page # | Loop ID | Reference | Name | Codes | Notes/Comments |
|---------------|---------|-----------|--|-------------------|--|
| 188 | 2110 | SVC01-2 | Adjudicated Procedure Code | | The adjudicated procedure code or revenue code as identified by the qualifier in SVC01-1. |
| 188 | 2110 | SVC01-3 | Procedure Modifier | | Up to four (4) Procedure Code Modifiers per Detail (SVC01-3 thru SVC01-6). |
| 189 | 2110 | SVC02 | Line Item Charge Amount | | This is the billed amount from the encounter unless the line has been split for processing. |
| 190 | 2110 | SVC03 | Line Item Provider Payment Amount | | Amount "paid" during adjudication. |
| 190 | 2110 | SVC04 | National Uniform Billing Committee Revenue | | If an NUBC revenue code was considered during adjudication in addition to a procedure code, this element will be used. |
| 190 | 2110 | SVC05 | Units of Service Paid Count | | When the paid units of service are not equal to one. |
| 191 | 2110 | SVC06-1 | Product or Service ID Qualifier | AD HC N4 | |
| | | | ADA codes | AD | |
| | | | HCPCS codes | HC | |
| | | | NDC in 5-4-2 format | N4 | |
| 191 | 2110 | SVC06-2 | Procedure Code | | |
| 191 | 2110 | SVC06-3 | Procedure Modifier | | Up to four (4) Procedure Code Modifiers per Detail (SVC06-3 thru SVC06-6). |
| 193 | 2110 | SVC06-7 | Procedure Code Description | | When a description was received on the original service for a not otherwise classified procedure code. |
| 193 | 2110 | SVC07 | Original Units of Service Count | | When the paid units of service provided in SVC05 is different from the submitted units of service from the original encounter. |
| 194 | 2110 | DTM | Service Date | | Puerto Rico Medicaid meets the situational rule to require this segment. |
| 195 | 2110 | DTM01 | Date Time Qualifier | 150 151 472 | |
| | | | Service Period Start | 150 | Required for reporting the beginning of multi-day services. |
| | | | Service Period End | 151 | Required for reporting the end of multi-day services. |
| | | | Service | 472 | Required to indicate a single day service. |

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| TR3 Page # | Loop ID | Reference | Name | Codes | Notes/Comments |
|------------------|---------|--|------------------------------------|----------------------|--|
| 195 | 2110 | DTM02 | Service Date | | |
| 196 | 2110 | CAS | Service Adjustment | | |
| 198 | 2110 | CAS01 | Claim Adjustment Group Code | CO OA PI PR | |
| | | | Contractual Obligations | CO | |
| | | | Other adjustments | OA | |
| | | | Payor Initiated Reductions | PI | |
| | | | Patient Responsibility | PR | |
| 198 To 201 | 2100 | CAS02 CAS05 CAS08 CAS11 CAS14 CAS17 | Adjustment Reason Code | | To report a non-zero adjustment applied at the service level. Adjustment Reason Codes can be found on http://www.wpc-edi.com |
| 199 To 201 | 2110 | CAS03 CAS05 CAS09 CAS12 CAS15 CAS18 | Adjustment Amount | | A negative amount increases the payment, and a positive amount decreases the payment contained in SVC03 and CLP04. |
| 204 | 2110 | REF | Service Identification | | This segment does not meet the situational requirements to be sent by Puerto Rico Medicaid. |
| 206 | 2110 | REF | Line Item Control Number | | When a Line Item Control Number was received on the original encounter. |
| 206 | 2110 | REF01 | Reference Identification Qualifier | 6R | This field will contain "6R", indicating that the next element is the provider control number/line item control number submitted on the 837. |
| 207 | 2110 | REF | Rendering Provider Information | | When the rendering provider for this service is different than the rendering provider applicable at the header level. |
| 207 | 2110 | REF01 | Reference Identification Qualifier | 1D HPI | This field will contain "1D", indicating that the next element is the provider's eight or nine-digit Puerto Rico Medicaid provider number or this field will contain "HPI" indicating that the next element is the provider's NPI. |

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| TR3 Page # | Loop ID | Reference | Name | Codes | Notes/Comments |
|---------------|---------|-----------|---|----------|---|
| | | | Medicaid Provider Number | 1D | |
| | | | Centers for Medicare and Medicaid Services National Provider Identifier | HPI | |
| 209 | 2110 | REF | Healthcare Policy Identification | | This segment does not meet the situational requirements to be sent by Puerto Rico Medicaid. |
| 211 | 2110 | AMT | Service Supplemental Amount | | |
| 211 | 2110 | AMT01 | Amount Qualifier Code | B6 | "B6" – Allowed – Actual Note: Allowed amount is the amount the payer deems payable prior to considering patient responsibility. |
| 213 | 2110 | QTY | Service Supplemental Quantity | | This segment does not meet the situational requirements to be sent by Puerto Rico Medicaid. |
| 215 | 2110 | LQ | Health Care Remark Codes | | Puerto Rico Medicaid meets the situational rule to require this segment. |
| 215 | 2110 | LQ01 | Code List Qualifier Code | HE RX | |
| | | | Claim Payment Remark Codes | HE | |
| | | | National Council for Prescription Drug Programs Reject/Payment Codes | RX | |
| 216 | 2110 | LQ02 | Remark Code | | Remark Codes, if needed, to communicate additional information about the denial or adjustment of a claim or service line that cannot be thoroughly explained by a Claim Adjustment Reason Code. Remark Codes can be found on http://www.wpc-edi.com |
| 217 | 2110 | PLB | Provider Adjustment | | This segment may not meet the situational requirements to be sent by Puerto Rico Medicaid. |
| 218 | 2110 | PLB01 | Provider Identifier | | |
| 218 | 2110 | PLB02 | Fiscal Period Date | | This is the last day of the provider's fiscal year. If the end of the provider's fiscal year is not known by the payer, use December 31 st of the current year. |

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| TR3 Page # | Loop ID | Reference | Name | Codes | Notes/Comments |
|---------------|---------|--|-------------------------|--|---|
| 219 | 2110 | PLB03-1 PLB05-1 PLB07-1 PLB09-1 PLB11-1 PLB13-1 | Adjustment Reason Code | 50 51 72 90 AH AM AP B2 B3 BD BN C5 CR CS CT CV CW DM E3 FB FC GO HM IP IR IS J1 L3 L6 LE LS OA OB PI PL RA RE SL TL WO WU | Code indicating reason for debit or credit memo or adjustment to invoice, debit or credit memo, or payment. |
| | | | Late Charge | 50 | |
| | | | Interest Penalty Charge | 51 | |
| | | | Authorized Return | 72 | |
| | | | Early Payment Allowance | 90 | |

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Puerto Rico Department of Health — 835 Health Care Claim Payment/Advice Companion Guide

| TR3 Page # | Loop ID | Reference | Name | Codes | Notes/Comments |
|---------------|---------|-----------|---------------------------------|-------|--|
| | | | Origination Fee | AH | |
| | | | Applied to Borrower's Account | AM | |
| | | | Acceleration of Benefits | AP | |
| | | | Rebate | B2 | |
| | | | Recovery Allowance | B3 | |
| | | | Bad Debt Adjustment | BD | |
| | | | Bonus | BN | |
| | | | Temporary Allowance | C5 | |
| | | | Capitation Interest | CR | |
| | | | Adjustment | CS | |
| | | | Capitation Payment | CT | |
| | | | Capital Passthru | CV | |
| | | | Certified Registered Nurse | CW | |
| | | | Anesthetist Passthru | DM | |
| | | | Direct Medical Education | E3 | |
| | | | Passthru | FB | |
| | | | Withholding | FC | |
| | | | Forwarding Balance | GO | |
| | | | Fund Allocation | HM | |
| | | | Graduate Medical Education | IP | |
| | | | Passthru | IR | |
| | | | Hemophilia Clotting Factor | IS | |
| | | | Supplement | J1 | |
| | | | Incentive Premium Payment | L3 | |
| | | | Internal Revenue Service | L6 | |
| | | | Withholding | LE | |
| | | | Interim Settlement | LS | Disproportionate share adjustment, indirect medical education passthrough, nonphysician passthrough, passthrough lump sum adjustment, or other passthrough amount. |
| | | | Nonreimbursable | J1 | |
| | | | Penalty | L3 | |
| | | | Interest Owed | L6 | |
| | | | Levy | LE | |
| | | | Lump Sum | LS | |
| | | | Organ Acquisition Passthru | OA | |
| | | | Offset for Affiliated Providers | OB | |

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| TR3 Page # | Loop ID | Reference | Name | Codes | Notes/Comments |
|---------------|---------|--|--------------------------------|-------|--|
| | | | Periodic Interim Payment | PI | |
| | | | Payment Final | PL | |
| | | | Retro-activity Adjustment | RA | |
| | | | Return on Equity | RE | |
| | | | Student Loan Repayment | SL | |
| | | | Third Party Liability | TL | |
| | | | Overpayment Recovery | WO | |
| | | | Unspecified Recovery | WU | |
| 222 | 2110 | PLB03-2 PLB05-2 PLB07-2 PLB09-2 PLB11-2 PLB13-2 | Provider Adjustment Identifier | | When a control, account or tracking number applies to this adjustment. |
| 223 | 2110 | PLB04 PLB06 PLB08 PLB10 PLB12 PLB14 | Provider Adjustment Amount | | This is the adjustment amount for the preceding adjustment reason. |

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APPENDICES

Change Summary

Version 1.0 Revision Log
Companion Guide: 835 Health Care Claim Payment/Advice
Approved by:

Name: _____ Designation: _____ Date: _____

| Loop ID | Page(s) Revised | Reference | Name | Codes | Text Revised |
|---------|--------------------|-----------|------|-------|--------------------|
| | | | | | Initial Submission |

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