ADDENDUM 16

PRMMIS 835 Companion Guide

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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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Disclosure Statement

Companion guides may contain two types of data, instructions for electronic communications with the publishing entity (communications/connectivity instructions) and supplemental information for creating transactions for the publishing entity while ensuring compliance with the associated ASC X12 implementation guide (transaction instructions). Either the communications/connectivity component or the transaction instruction component must be included in every companion guide. The components may be published as separate documents or as a single document.

The communications/connectivity component is included in the companion guide when the publishing entity wants to convey the information needed to commence and maintain communication exchange.

The transaction instruction component is included in the companion guide when the publishing entity wants to clarify the implementation guide instructions for submission of specific electronic transactions. The transaction instruction component content is limited by ASC X12's copyrights and Fair Use statement.

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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.

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 prmmis_edi_support@dxc.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".

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 accidently 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).

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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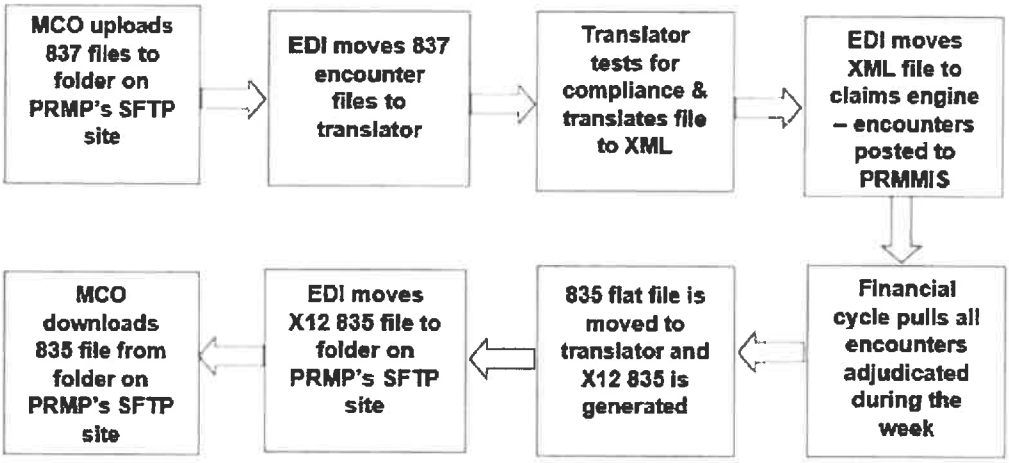
3 CONNECTIVITY WITH PUERTO RICO MEDICAID / COMMUNICATIONS

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@dxc.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.ncpdp.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/admnsimp.
- 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/adminsim.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 of 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.

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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@dxc.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.

005010X221A1 — 835 Health Care Claim Payment / Advice

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. *Note*: 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.

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_support@dxc.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_support@dxc.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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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	

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TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
			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	
			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.

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. *Note*: 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	ADMINISTRACION DE SEGUROS DE SALUD
			Healthcare Common Procedure Coding System (HCPCS) codes.	HC	23 - 00044
			National Drug Code (NDC) in 5-4-2 format.	N4	Contrato Número
			National Uniform Billing Committee (NUBC) UB92 codes.	NU	

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	ADMINISTRACION DE SEGUROS DE SALUD
			ADA codes	AD	
			HCPCS codes	HC	23 - 00044
			NDC in 5-4-2 format	N4	
191	2110	SVC06-2	Procedure Code		Contrato Número
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.

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	ADMINISTRACION DE SEGUROS DE SALUD
			Other adjustments	OA	
			Payor Initiated Reductions	PI	23 - 00044 H
			Patient Responsibility	PR	Contrato Número
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.

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 31st 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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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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