



MINNESOTA DEPARTMENT OF HEALTH  
DIVISION OF HEALTH POLICY  
CENTER FOR HEALTH CARE PURCHASING IMPROVEMENT

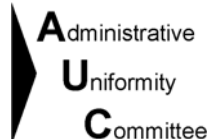
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# **Minnesota Uniform Companion Guide**

**For the Implementation of the**

# **Health Care Claim Payment And Remittance Advice Electronic Transaction (ANSI ASC X12 835)**

*Prepared In Consultation With  
Minnesota Administrative Uniformity Committee*



**OCTOBER, 2009  
VERSION 4.0**

**Disclaimer**

The following Minnesota Uniform Companion Guide is intended to serve as a companion document to the corresponding HIPAA Implementation Guide ANSI ASC X12N Electronic Transaction Standard (Version – 004010X091A1). The document further specifies the requirements to be used when preparing, submitting, receiving and processing electronic health care administrative data. The document supplements, but does not contradict, disagree, oppose, or otherwise modify the HIPAA Implementation Guide in a manner that will make its implementation by users to be out of compliance. Using this Companion Guide does not mean that a claim will be paid. It does not imply payment policies of payers or the benefits that have been purchased by the employer or subscriber.

**Statutory Authority**

Development, adoption and use of this companion guide is mandated for all group purchasers and health care providers under Minnesota Statutes, § 62J.536. The required use of this Minnesota Uniform Companion Guide was promulgated as a rule under Minnesota Statutes, § 62J.61.

**Document Changes**

The content of this companion guide is subject to change. The version, release and effective date of the document is included in the document, as well as a description of the process for handling future updates or changes.

**About the Minnesota Department of Health**

The Minnesota Department of Health is responsible for protecting, maintaining and improving the health of Minnesotans. The department operates programs in the areas of disease prevention and control, health promotion, community public health, environmental health, health care policy, and registration of health care providers. <http://www.health.state.mn.us/asa/index.html>

**About the Minnesota Administrative Uniformity Committee**

The Administrative Uniformity Committee (AUC) is a broad-based group representing Minnesota health care public and private payers, hospitals, health care providers and state agencies. The mission of the AUC is to develop agreement among Minnesota payers and providers on standardized administrative processes when implementation of the processes will reduce administrative costs. The AUC acts as a consulting body to various public and private entities, but does not formally report to any organization and is not a statutory committee. <http://www.health.state.mn.us/auc/index.html>

**Contact for Further Information on this Companion Guide**

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## TABLE OF CONTENTS

	<u>Page</u>
1.0 COMPANION GUIDE REVISION HISTORY	4
2.0 STATEMENT FROM THE MINNESOTA DEPARTMENT OF HEALTH	5
3.0 STATEMENT FROM THE MINNESOTA ADMINISTRATIVE UNIFORMITY COMMITTEE (MN-AUC)	7
4.0 INTRODUCTION AND OVERVIEW	8
4.1 PURPOSE AND OVERVIEW	8
4.2 INFORMATION ABOUT THE 835 HEALTH CARE CLAIM PAYMENT AND REMITTANCE ADVICE TRANSACTION	13
4.3 PROCESS FOR UPDATING COMPANION GUIDE DOCUMENT	15
4.4 MINNESOTA BEST PRACTICES FOR THE IMPLEMENTATION OF ELECTRONIC HEALTH CARE TRANSACTIONS	15
5.0 835 – HEALTH CARE CLAIM PAYMENT AND REMITTANCE ADVICE: COMPANION GUIDE TABLE	17
5.1 INTRODUCTION TO TABLE	17
5.2 COMPANION GUIDE TABLE	19
6.0 APPENDICES	30
APPENDIX A: TERMINOLOGY AND ACRONYMS	31
APPENDIX B: MINNESOTA CROSSWALK FOR THE CLAIM ADJUSTMENT REASON CODES (CARC), CLAIM ADJUSTMENT GROUP CODES, AND REMITTANCE ADVICE REMARK CODES (RARC)	35
APPENDIX C: WORKERS COMPENSATION REPORTING OF REASON FOR A DENIAL OR REDUCTION OF PAYMENT	50

## **1.0 Companion Guide Revision History**

Ver	Revision Date	Summary Changes
1.0	July 28, 2008	Version Released for Public Comment
2.0	November 3, 2008	Final Published Version for Implementation
3.0	June 8, 2009	Technical Changes – Version Released for Public Comments
4.0	October 12, 2009	Final Published Version for Implementation



*Protecting, maintaining and improving the health of all Minnesotans*

## **2.0 Statement from the Minnesota Department of Health**

### **Summary Notice of Adoption of Rules Regarding a Uniform, Standard Companion Guide for Health Care Claim Payment and Remittance Advice Electronic Transactions; Pursuant to Minnesota Statutes, Section 62J.536.**

**Adoption:** Notice is hereby given that the *Minnesota Uniform Companion Guide for the Implementation of the Health Care Claim Payment and Remittance Advice Electronic Transaction*, as proposed at *State of Minnesota State Register*, Volume 33, Number 4, page 218, July 28, 2008 (33 SR 218) is adopted with modifications.

**Companion Guide Available:** The *Minnesota Uniform Companion Guide for the Implementation of the Health Care Claim Payment and Remittance Advice Electronic Transaction*, as defined by the Commissioner of Health, is available on the World Wide Web at <http://www.health.state.mn.us/asa/rules.html> and at Minnesota's Bookstore at (651) 297-3000 or (800) 657-3757. The Minnesota's Bookstore TTY relay service phone number is (800) 627-3529. If you have any questions, please email [health.ASAGuides@state.mn.us](mailto:health.ASAGuides@state.mn.us).

The adopted rule differs from the rule proposed on July 28, 2008. A complete copy of the rule showing all of the changes in a strike/underline format is available at: <http://www.health.state.mn.us/asa/rules.html>. Interested parties may also obtain a printed copy of the rule showing all of the changes in a strike/underline format by contacting Mayumi Reuvers by phone at 651-201-5508 or by fax at 651-201-3574.

**Description and Statutory Reference:** This *Minnesota Uniform Companion Guide for the Implementation of the Health Care Claim Payment and Remittance Advice Electronic Transaction* is the single, uniform companion guide to the implementation guide described under the Code of Federal Regulations, title 45, part 162, to be used in health plan transactions pursuant to *Minnesota Statutes, Section 62J.536*. The statute requires that beginning December 15, 2009: all group purchasers must transmit to health care providers the health care claim payment and remittance advice information for the transaction described under Code of Federal Regulations, title 45, part 162, subpart P; and all health care providers must also accept from group purchasers the health care claim payment and remittance advice transaction as described under Code of Federal Regulations, title 45, part 162, subpart P.

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For directions to any of the MDH locations, call (651) 201-5000 \* An equal opportunity employer

*Minnesota Statutes, section 62J.536*, further requires that the transaction described above shall use a single, uniform companion guide to the implementation guide described under the Code of Federal Regulations, title 45, part 162. In addition, the statute requires all group purchasers and health care providers to exchange claims and eligibility information electronically using the transactions, companion guides, implementation guides, and timelines set forth in subdivision 1 of the statute. The statute requires the Commissioner of Health to promulgate rules pursuant to section 62J.61, at least 12 months prior to the timelines required in subdivision 1 of *Minnesota Statutes, section 62J.536*. Under *Minnesota Statutes, section 62J.61*, the Commissioner of Health is exempt from chapter 14, including section 14.386, in implementing sections 62J.50 to 62J.54, subdivision 3, and 62J.56 to 62J.59. This rule does **not** require electronic funds transfer (EFT).

**Development:** The Commissioner of Health developed this rule in consultation with the Minnesota Administrative Uniformity Committee (AUC) and its Explanation of Benefits (EOB) Technical Advisory Group (TAG). This rule was submitted for public comment in the *State Register*, Volume 33, Number 4, page 218, July 28, 2008. The comment period was from July 28, 2008 until August 26, 2008. The Minnesota Department of Health collected the public comments. Comments were received from 10 organizations and individuals. The Minnesota Department of Health consulted with the AUC EOB TAG in reviewing comments and making modifications to the rule proposed on July 28, 2008.

**Required Date of Compliance:** The required date of compliance is December 15, 2009.

Dated: November 3 2008

Sanne Magnan, M.D., Ph.D.  
Commissioner  
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### **3.0 Statement from the Minnesota Administrative Uniformity Committee (MN-AUC)**

**Administrative Uniformity Committee  
C/O Minnesota Department of Health  
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July 2008

The 2007 Minnesota Legislature amended the Minnesota Health Care Administrative Simplification Act (Minnesota Statutes, §62J.50 -§62J.61) by adding §62J.536, entitled *Uniform Electronic Transactions and Implementation Guide Standards*. This section requires all group purchasers and health care providers to electronically transmit and accept eligibility verification, claims and remittance advice transactions using a single uniform companion guide.

The Commissioner of Health is required to base the companion guides' billing, coding rules, and standards on the Medicare program and to consult with the Minnesota Administrative Uniformity Committee (AUC) in the development of the uniform companion guides.

The AUC is a broad-based group representing Minnesota health care public and private group purchasers, hospitals, physicians, other providers and State agencies. The goal of the AUC is to reduce administrative costs for both payers and providers by standardizing their administrative processes and requirements. The AUC is made up of a Strategic Steering Committee, an Operations Committee, and various Technical Advisory Groups (TAGs), and Work Groups.

Minnesota Statutes, §62J.536 builds upon Minnesota's already significant leadership in health care administrative simplification. The AUC is confident that the Minnesota approach will provide more efficient communication of administrative health care information between payers and providers throughout the state.

This Health Care Claim Payment and Remittance Advice Transaction Companion Guide was developed by the Explanation of Benefits/Remittance Advice TAG. Cross-reference work was done with all the health care claim workgroups for consistency. The TAG reviewed and considered the CMS payment documentation and recommended alternatives to it where Minnesota providers and payers deemed it appropriate. As part of its responsibility of consultation, the AUC Operations Committee presented recommendations for content of this Minnesota Companion Guide to the Commissioner of Health on July 8, 2008.

The AUC also recommended that this companion guide be reviewed and updated approximately every 12 months or more often if deemed necessary by the Commissioner of Health in consultation with the AUC.

The AUC will continue to work in partnership with the Commissioner of Health to improve the clarity and usefulness of the manual.

## **4.0 Introduction and Overview**

### **4.1 Purpose and Overview**

#### **4.1.1 Purpose**

The purpose of this Companion Guide is to clarify, supplement and further define specific data content requirements to be used in conjunction with the HIPAA 835 Health Care Claim Payment/ Advice Implementation Guide created for the electronic transaction standard mandated by the HIPAA regulations.

The terms "companion guide", "guide", "state companion guide" and "state guide" are used interchangeably throughout this document to refer to each single, uniform companion guide being created pursuant to Minnesota Statutes, § 62J.536.

#### **4.1.2 Applicability**

Effective December 15, 2009, all group purchasers licensed or doing business in Minnesota and health care providers providing services for a fee in Minnesota must exchange health care claim payment and remittance advice information electronically using the transaction, companion guide, implementation guide, and timelines required under Minnesota Statutes, section 62J.536. The only exceptions to the statutory requirements are as follow:

- The requirements do NOT apply to the exchange of electronic health care claim payment and remittance advice transactions with Medicare and other payers for Medicare products; and
- See section 4.1.2.1 Exceptions to Applicability below.

Minnesota Statutes, Section 62J.03, Subd. 6 defines group purchaser as follows:

"Group purchaser" means a person or organization that purchases health care services on behalf of an identified group of persons, regardless of whether the cost of coverage or services is paid for by the purchaser or by the persons receiving coverage or services, as further defined in rules adopted by the commissioner. "Group purchaser" includes, but is not limited to, community integrated service networks; health insurance companies, health maintenance organizations, nonprofit health service plan corporations, and other health plan companies; employee health plans offered by self-insured employers; trusts established in a collective bargaining agreement under the federal Labor-Management Relations Act of 1947, United States Code, title 29, section 141, et seq.; the Minnesota Comprehensive Health Association; group health coverage offered by fraternal organizations, professional associations, or other organizations; state and federal health care programs; state and local public employee health plans; workers' compensation plans; and the medical component of automobile insurance coverage.

Minnesota Statutes, Section 62J.03, Subd. 8 defines provider or health care provider as follows:

"Provider" or "health care provider" means a person or organization other than a nursing home that provides health care or medical care services within Minnesota for a fee and is eligible for reimbursement under the medical assistance program under chapter 256B. For purposes of this subdivision, "for a fee" includes traditional fee-for-service arrangements, capitation arrangements, and any other arrangement in which a provider receives compensation for providing health care services or has the authority to directly bill a group purchaser, health carrier, or individual for providing health care services. For purposes of this subdivision, "eligible for reimbursement under the medical assistance program" means that the provider's services would be reimbursed by the medical assistance program if the services were provided to medical assistance enrollees and the provider sought reimbursement, or that the services would be eligible for reimbursement under medical assistance except that those services are characterized as experimental, cosmetic, or voluntary.

Minnesota Statutes, Section 62J.536, Subd. 3 defines "health care provider" to also include licensed nursing homes, licensed boarding care homes, and licensed home care providers.

As described in the beginning of this section, this Minnesota uniform Companion Guide applies to all health care claim payment and remittance advice transactions transmitted or received electronically after December 15, 2009 that use the transaction standard and corresponding implementation guide described under Code of Federal Regulations, title 45, part 162, subpart P - the ANSI ASC X12N 835, herein referred to as "Reference HIPAA Implementation Guide". The Code of Federal Regulations, title 45, part 162, subpart P specifies that the standard for dental, professional, institutional and retail pharmacy health care claim payment and remittance advice is the ASC X12N 835. The Companion Guide applies ONLY to the purposes identified and described in the HIPAA Implementation Guide for which the health care claim payment and remittance advice transaction is used.

The Companion Guide may be adopted voluntarily by trading partners prior to December 15, 2009.

Entities conducting (i.e., submitting or receiving) health care claim payment and remittance advice transactions electronically via direct data entry system (i.e., Internet-based interactive applications) must also comply with the data content requirements established in this Companion Guide.

This Companion Guide contains the maximum data set of values allowed to be submitted or received by health care providers and group purchasers when conducting a health care claim payment and remittance advice transaction. No other Data Element values will be allowed to be used in connection with this transaction.

Consistent with Minnesota Statutes, § 62J.536, no additions or modifications may be made to this Companion Guide by group purchasers or health care providers through their own companion guides or by establishing other requirements.

#### 4.1.2.1 Exceptions to Applicability

Chapter 305, section 7, of 2008 Minnesota Laws (to be codified as Minnesota Statutes, section 62J.536, subd. 4) authorizes the Commissioner of Health to exempt group purchasers not covered by HIPAA (group purchasers not covered under United States Code, title 42, sections 1320d to 1320d-8) from one or more of the requirements to exchange information electronically as required by Minnesota Statutes, § 62J.536 if the Commissioner determines that:

- i. a transaction is incapable of exchanging data that is currently being exchanged on paper and is necessary to accomplish the purpose of the transaction; or
- ii. another national electronic transaction standard would be more appropriate and effective to accomplish the purpose of the transaction.

If group purchasers are exempt from one or more of the requirements, providers shall also be exempt from exchanging those transactions with the group purchaser.

**The Commissioner has determined that the criteria above are not met and that all health care providers and group purchasers are required to comply with these rules for the standard, electronic exchange of health care claim payment/remittance advice. No exception to these rules has been granted.**

#### 4.1.3 Scope

This Companion Guide covers all the required and situational Loops, Segments and Data Elements contained in the Reference HIPAA Implementation Guide.

This Companion Guide does NOT include any of the Loops, Segments or Data Elements defined as NOT USED in the Reference HIPAA Implementation Guide. Consistent with the HIPAA requirements and implementation guide instructions, the NOT USED Loops, Segments and Data Elements are not permitted to be submitted or received when conducting this transaction.

This Companion Guide excludes any of the EDI transmission instructions, generally defined in trading partner agreement documents. The Interchange Control Header (ISA) and Trailer (IEA), and the Functional Group Header (GS) and Trailer (GE) are not covered by this Companion Guide. The specifications of these Loops, Segments and Data Elements are generally defined in trading partner agreement documents.

#### 4.1.4 Reference HIPAA Implementation Guide

The Reference HIPAA Implementation Guide for this Companion Guide is the ANSI ASC X12N 835 Implementation Guide Version – 004010X091A1 (Copyright © 2000, Data Interchange Standards Association on behalf of ASC X12. Format © 2000, Washington Publishing Company. All Rights Reserved). A copy of the full Reference HIPAA

Implementation Guide can be obtained from the Washington Publishing Company at <http://www.wpc-edi.com>.

#### **4.1.5 Key Terminology Used in This Companion Guide**

This Companion Guide treats the required and situational Loops, Segments and Data Elements included in the Reference HIPAA Implementation Guide as described in the following sections.

##### **4.1.5.1 Required Loops, Segments and Data Elements**

In some instances, the values and conditions defined in the HIPAA Implementation Guide for required Loops, Segments and Data Elements are further clarified by the Companion Guide. Such further clarifications are appropriately noted in the Companion Guide table included in Section 5.

Under no circumstance does the Companion Guide add new or different values to those defined in the Reference HIPAA Implementation Guide.

##### **4.1.5.2 Situational Loops, Segments and Data Elements**

The Companion Guide further defines or refines the conditions and values of Situational Loops, Segments and Data Elements to one of the following three possibilities:

- Required, with further definition of condition and/or values: This means that in Minnesota, providers do consider and need this data for proper posting of the transaction and that the Loop, Segment and Data Element will be REQUIRED for ALL values further defined in the Minnesota Companion Guide.
- Situational, with or without further definition of condition: This means that the Loop, Segment or Data Element will retain in the Minnesota Companion Guide the original Situational classification given in the HIPAA Implementation Guide, and that the Minnesota Companion Guide will follow either:
  - The exact same conditions and values defined in the HIPAA Implementation Guide (because the conditions and values are close-ended, unambiguous, and straight-forward); or
  - A set of further refined conditions and values applicable to that Situational Loop, Segment or Data Element
- Not Considered for Processing: see next section.

##### **4.1.5.3 Segments and Data Elements Classified as Not Considered for Processing (NCFP)**

Required and Situational Segments and Data Elements may also be classified in the Minnesota Companion Guide as “Not Considered for

Processing". This means that receivers of this transaction in Minnesota do not consider these Segments or Data Elements necessary for posting of the transaction for services covered under this companion guide.

With respect to these NCFP Segments and Data Elements, the interpretation of this classification will be as follows:

- If the Segment or Data Element is REQUIRED by the HIPAA Implementation Guide and the Minnesota Usage in the table included in Section 5 of this Companion Guide is "NCFP," then the Segment or Data Element must be sent by the sender and received by the receiver (to meet HIPAA requirements) but the receiver may ignore it for posting.
- If the Segment or Data Element is SITUATIONAL in the HIPAA Implementation Guide and the Minnesota Usage in the table included in Section 5 of this Companion Guide is "NCFP," then the Segment or Data Element:
  - Will not be required by a receiver
  - May be submitted by a sender
  - Will be accepted by a receiver
  - May be ignored by the receiver for posting
  - The receiver will not reject transaction if sender submits this element

It is important to note that the parameters of Situational elements on Implementation Guides are generally written in a manner that creates a "requirement" for the element to be used (if such conditions are met).

Please refer to the disclaimer in the front matter of this guide.

#### **4.1.6 Addressing Code Set Issues in the Companion Guide**

Code sets utilized in HIPAA electronic transactions are classified as:

- Internal Transaction Codes (included and defined inside the Implementation Guides). The Companion Guide may define a set of values that are identical to or a subset of the values permitted in the Reference HIPAA Implementation Guide. Within the Companion Guide there are situations where only a subset of values is permitted. As business needs change, additional codes may be defined and made available for use as a best practice. Please refer to Section 4.4 for information on AUC Best Practices.
  - Minnesota group purchasers and providers have agreed upon usage for Claim Adjustment Group Codes.

- External Code Sets (referenced by Implementation Guides, defined and maintained by external bodies) including:
  - Non-Medical External Code Sets (such as Taxonomy Codes, Claims Adjustment Reason Codes, Remark Codes, etc) These values are effective based upon transaction date;
  - Medical External Code Sets (such as ICD-9, HCPCS). These values are effective based upon service date.

This Companion Guide does not redefine existing external code sets used in the transactions. Rather, the Companion Guide may identify a subset of external codes or clarify usage for specific Loops, Segments and Data Elements of the transaction.

Minnesota group purchasers and providers have agreed upon usage for Claim Adjustment Reason Codes (CARC), and Remittance Advice Remark codes (RARC). Please refer to Appendix B for the detailed crosswalk.

#### **4.1.7 Trading Partner Agreements**

This Companion Guide is not intended to replace trading partner agreements that define other transaction parameters (such as EDI transmission parameters or transaction header information).

Trading partner agreements may NOT add to or modify the requirements established by this Companion Guide.

### **4.2 Information About the 835 Health Care Claim Payment and Remittance Advice Transaction**

#### **4.2.1 Business Terminology**

For purposes of this Companion Guide, the following terms have the meaning given to them in this section.

##### **Adjustment**

Within the scope of this guide and the 835, the term “adjustment” refers to increases and/or reductions from the billed amount to the amount remitted. Adjustment does not refer to changing or correcting a previous adjudication of a claim.

##### **Claim Submitter’s Identifier**

The Claim Submitter’s Identifier reported in the claim within the 837 is returned in the 835 transaction for tracking purposes. The Claim Submitter’s Identifier is located in the 837 in CLM01, and for the NCPDP claims, return the Prescription number from 402-D2. These values are returned in CLP01 of the 835.

#### **4.2.2 Correlating Provider Information from Claim Transaction to 835 Claim Payment and Remittance Advice Transaction**

The 835 transaction identifies two primary provider types. These are the payee and the servicing/rendering provider. The payee is reported once in each 835 transaction in loop 1000B.

If no other agreement exists between the provider and group purchaser:

- The 835 payee corresponds to the 837 pay-to provider or the NCPDP service provider ID.
- If the pay-to provider loop was not sent then payee corresponds to the billing provider loop.
- For providers who participate with the group purchaser and are required to complete enrollment forms as part of the contracting process, the payment address submitted on the claim transaction may not be the address where payment is ultimately sent for the claim. The group purchaser in this case may use the payment address from the enrollment form or within the contract rather than the address that is submitted in the 2010AB loop of an electronic claim. The contracted provider must request address changes to the group purchaser records according to the instructions within the provider contract.
- When a pay-to provider loop is sent in addition to billing provider loop, the payment should be sent to the pay-to loop address, unless the group purchaser utilizes an enrollment form or a contract.

The 835 claim servicing/rendering provider corresponds to the 837P and 837D claim rendering provider or the NCPDP service provider. The claim servicing/rendering provider may be reported once for each 835 claim in loop 2100/NM1 (NM101=82). The servicing/rendering provider is only required when different from the payee.

The 835 line rendering provider identifier corresponds to the 837P and 837D service line rendering provider. The line rendering provider identifier may also be reported once for each 835 service line in loop 2110/REF (REF01=HPI). The line rendering provider identifier is only required when different from the claim servicing/rendering provider. Only providers eligible for an NPI can be sent at the line level. Atypical provider numbers cannot be sent back at the line level based on the available qualifiers in the 835 implementation guide.

#### **4.2.3 Relationship and Importance of Accurate and Balanced 835s for 837 COB Situations**

It is imperative that 835 transactions balance, contain accurate information, and utilize active CARC, RARC or NCPDP reject codes. After the receipt and posting of the 835 payment and/or adjustment data, this data must be used in 837 Coordination of Benefits (COB) situations. When submitting COB claims to secondary/ tertiary payers, the provider needs to populate the appropriate 837 segments with the prior payer's payment and/or adjustment

data. If this data is inaccurate, or does not balance, then the subsequent 835 payment and remittance advice from the secondary/tertiary payer may be delayed, or inaccurate.

#### **4.2.3.1 Using Inactive CARC and RARC**

Inactive CARC and RARC can only be used in derivative business messages (messages where the code is being reported from the original business message). For example, a CARC with a Stop date of 02/01/2007 would not be able to be used by a health plan in a CAS segment in a claim payment/remittance advice transaction (835) dated after 02/01/2007 as part of an original claim adjudication (CLP02 values like "1", "2", "3" or "19"). The code would still be able to be used after 02/01/2007 in derivative transactions, as long as the original usage was prior to 02/01/2007. Derivative transactions include: secondary or tertiary claims (837) from the provider or health plan to a secondary or tertiary health plan, an 835 from the original health plan to the provider as a reversal of the original adjudication (CLP02 value "22"). The deactivated code is usable in these derivative transactions because they are reporting on the valid usage (pre-deactivation) of the code in a previously generated 835 transaction.

#### **4.2.4 Minnesota Requirements for Compliance**

This section contains general Minnesota requirements for compliance applicable to this transaction.

##### **4.2.4.1 Formatting Requirements**

**Segments Reporting Multiple Values From Same Code Set:** Some segments have multiple elements that contain values from the same code set. When it is necessary to report multiple values, they must be populated sequentially within the segment; gaps between data elements are not allowed.

#### **4.3 Process for Updating Companion Guide Document**

The process for updating Minnesota Uniform Companion Guide documents, including submitting and collecting change requests, reviewing and evaluating requests and making recommendations, adopting and publishing a new version of the guide is available from the Minnesota Department of Health's website at <http://www.health.state.mn.us/asa/index.html>

#### **4.4 Minnesota Best Practices for the Implementation of Electronic Health Care Transactions**

The Minnesota Administrative Uniformity Committee (MN AUC) is continuously working on the identification of Best Practices for the implementation of administrative transactions and processes. Although they are not required as part

of this Companion Guide, they are helpful in aiding group purchasers and providers in implementing these transactions.

Please visit the MN-AUC website at <http://www.health.state.mn.us/auc/index.html> for more information about Best Practices for implementing electronic health care transactions in Minnesota.

## **5.0 835 – Health Care Claim Payment and Remittance Advice** **- Companion Guide Table -**

### **5.1 Introduction to Table**

All the information related to the way this Companion Guide classifies and defines required and situational Data Elements is presented in a table format in the next sections. The table is organized by Loops and Segments, to make it easier to review and locate.

The table includes the following:

- ALL of the Loops, Segments and Data Elements that are classified as REQUIRED by the HIPAA Implementation Guide (except as noted in Section “Compressing Data Element Rows into Segment Rows” below)
- ALL of the Loops, Segments and Data Elements that are classified as SITUATIONAL by the HIPAA Implementation Guide (except as noted in Section “Compressing Data Element Rows into Segment Rows” below)

The table DOES NOT include any of the Loops, Segments or Data Elements classified as NOT USED by the HIPAA Implementation Guide

The table is organized into the following columns:

- Segment Information: The ID, NAME, USAGE and MIN/MAX Values given to the Segment on the HIPAA Implementation Guide
- Data Element Information: The ID, NAME, USAGE, MIN/MAX and IG Coding Values given to each Data Element on the HIPAA Implementation Guide
- Minnesota Information:
  - Minnesota Usage - The only permitted values are:
    - “R” for Required
    - “S” for Situational
    - “NCFP” for Not Considered for Processing
  - Values, Definition and Notes: The specific values and other notes applicable to the Segment/Data Element required to be followed in Minnesota. If Minnesota values have been limited to a subset of values, additional HIPAA compliant values will be considered NCFP.
  - MN Usage Same as HIPAA IGs: If checked, it means that the Minnesota Companion Guide conditions, values and notes for the Segment or Data Element are identical to the conditions, values and notes from the HIPAA Implementation Guide

#### **5.1.1 Compressing Data Element Rows into Segment Rows**

In preparing the companion guides, some “compression” or “collapsing” of Data Element rows into Segment rows has been done to simplify the size and content of the document. This compression or collapsing was done as follows: If the “Minnesota Usage” classification of a Segment and its Data Elements are ALL IDENTICAL with the HIPAA IG, then the Data

Element rows for that Segment are NOT included in these tables and only the Segment-level row is presented.

### 5.1.2 Relationship Between Condition Given to Segments and Data Elements in HIPAA IGs and the Minnesota Usage Classification Given in the Companion Guide

A summary of the seven (7) scenarios that could occur in the companion guide when relating the following three elements are presented in the table below:

1. The condition that a Loop, Segment and Data Element has in the original HIPAA Implementation Guide (Required or Situational)
2. The “Minnesota Usage” as defined by the companion guide development teams (Required; Situational; Not Considered for Processing)
3. Whether the Minnesota Usage/Notes are identical to the HIPAA Implementation Guide

**Table 1**  
**Seven Specific Minnesota Companion Guide Scenarios for Minnesota-defined Usage of Loops, Segments and Data Elements**

Condition of Loop/ Segment/Data Element from HIPAA Implementation Guide	Minnesota Usage Classification Companion Guide	Minnesota Notes about Usage
1. Required	Required	Same as HIPAA Implementation Guide
2. Required	Required	Further clarifies the HIPAA Implementation Guide
3. Required	NCFP (Not Considered for Processing)	Same as HIPAA Implementation Guide
4. Situational	Required	Further defines the requirements from the HIPAA Implementation Guide
5. Situational	Situational	Same as HIPAA Implementation Guide
6. Situational	Situational	Further refines the requirements from the HIPAA Implementation Guide
7. Situational	NCFP (Not Considered for Processing)	Same as HIPAA Implementation Guide

## 5.2 Companion Guide Table

Transaction: 835 – Health Care Claim Payment and Remittance Advice							
SEGMENT (Gray-Shaded Rows) -- DATA ELEMENT (Non-shaded Rows)					Minnesota Information		MN Usage Same as HIPAA IGs
ID	Name	Usage	Min/Max	IG Values	Usage	Values, Definition and Notes	
<b>ST - Transaction Set Header (Loop Repeat: 1)</b>							
<b>ST</b>	<b>TRANSACTION SET HEADER</b>	R	1		R		X
<b>BPR</b>	<b>FINANCIAL INFORMATION</b>	R	1		R		X
BPR01	Transaction Handling Code	R	1-2	C, D, H, I, P, U, X	R	C, H, or I	
BPR02	Monetary Amount	R	1-18		R		X
BPR03	Credit/Debit Flag Code	R	1-1	C, D	R	C	
BPR04	Payment Method Code	R	3-3	ACH, BOP, CHK, FWT, NON	R	ACH, CHK, FWT, NON	
BPR05	Payment Format Code	S	1-17	CCP, CTX	S		X
BPR06	(DFI) ID Number Qualifier	S	2-2	01, 04	S		X
BPR07	(DFI) Identification Number	S	3-12	(Sender's DFI)	S		X
BPR08	Account Number Qualifier	S	1-3	DA	S		X
BPR09	Account Number	S	1-35		S		X
BPR10	Originating Company Identifier	S	10-10		S		X
BPR11	Originating Company Supplemental Code	S	9-9		S		X
BPR12	(DFI) ID Number Qualifier	S	2-2	01,04	S		X
BPR13	(DFI) Identification Number	S	3-12	(Receiver or Provider Bank ID Number)	S		X
BPR14	Account Number Qualifier	S	1-3	DA, SG	S		X
BPR15	Account Number	S	1-35		S		X
BPR16	Date	R	8-8	CCYYMMDD	R		X
<b>TRN</b>	<b>REASSOCIATION TRACE NUMBER</b>	R	1		R		X
<b>CUR</b>	<b>FOREIGN CURRENCY INFORMATION</b>	S	1		NCFP		X

Transaction: 835 – Health Care Claim Payment and Remittance Advice							
SEGMENT (Gray-Shaded Rows) -- DATA ELEMENT (Non-shaded Rows)				Minnesota Information			MN Usage Same as HIPAA IGs
ID	Name	Usage	Min/Max	IG Values	Usage	Values, Definition and Notes	
REF	RECEIVER IDENTIFICATION	S	1		S		X
REF	VERSION IDENTIFICATION	S	1		NCFP		X
DTM	PRODUCTION DATE	S	1		S		X
Loop ID – 1000A Payer Identification (Loop Repeat: 1)							
N1	PAYER IDENTIFICATION	R	1		R		X
N3	PAYER ADDRESS	R	1		R		X
N4	PAYER CITY, STATE, ZIP CODE	R	1		R		X
REF	ADDITIONAL PAYER IDENTIFICATION	S	4		S		X
PER	PAYER CONTACT INFORMATION	S	1		S		X
Loop ID – 1000B Payee Identification (Loop Repeat: 1)							
N1	PAYEE IDENTIFICATION	R	1		R		X
N3	PAYEE ADDRESS	S	1		S		X
N4	PAYEE CITY, STATE, ZIP CODE	S	1		S		X
REF	PAYEE ADDITIONAL IDENTIFICATION	S	>1		S		X
REF01	Reference Identification Qualifier	R	2-3	0B, 1A, 1B, 1C, 1D, 1E, 1F, 1G, 1H, D3, G2, N5, PQ, TJ	R	D3, G2, PQ, TJ G2 identifies the submitted Atypical provider PQ identifies the Payer assigned Payee identifier	
REF02	Reference Identification	R	1-30		R		X
Loop ID – 2000 Header Number (Loop Repeat: >1)							
LX	HEADER NUMBER	S	1		S		X
TS3	PROVIDER SUMMARY INFORMATION	S	1		S		X
TS2	PROVIDER SUPPLEMENTAL SUMMARY INFORMATION	S	1		NCFP		X
Loop ID – 2100 Claim Payment Information (Loop Repeat: >1)							

Transaction: 835 – Health Care Claim Payment and Remittance Advice							
SEGMENT (Gray-Shaded Rows) -- DATA ELEMENT (Non-shaded Rows)				Minnesota Information		MN Usage Same as HIPAA IGs	
ID	Name	Usage	Min/Max	IG Values	Usage		Values, Definition and Notes
<b>CLP</b>	<b>CLAIM PAYMENT INFORMATION</b>	<b>R</b>	<b>1</b>		<b>R</b>		<b>X</b>
CLP01	Claim Submitter's Identifier	R	1-38		R	Value returned on the 835 for the Patient control number is limited to 20 characters per 837.	
CLP02	Claim Status Code	R	1-2	1, 2, 3, 4, 5, 10, 13, 15, 16, 17, 19, 20, 21, 22, 23, 25, 27	R	1, 2, 3, 4, 19, 20, 21, 22, 25 "4" - The entire claim has been denied Claims that are denied may or may not be considered for reprocessing	
CLP03	Monetary Amount	R	1-18		R		X
CLP04	Monetary Amount	R	1-18		R		X
CLP05	Monetary Amount	S	1-18		S		X
CLP06	Claim Filing Indicator Code	R	1-2	12,13,14,15,16,AM,CH, DS,HM,LM,MA, MB,MC,OF,TV,VA,WC	R		X
CLP07	Reference Identification	S	1-30		S		X
CLP08	Facility Code Value	S	1-2		S	.	X
CLP09	Claim Frequency Type Code	S	1-1		S	.	X
CLP11	Diagnosis Related Group (DRG) Code	S	1-2		S		X
CLP12	Quantity	S	1-15		S		X
CLP13	Percent	S	1-10		S		X
<b>CAS</b>	<b>CLAIM ADJUSTMENT</b>	<b>S</b>	<b>99</b>		<b>S</b>		<b>X</b>
<b>NM1</b>	<b>PATIENT NAME</b>	<b>R</b>	<b>1</b>		<b>R</b>		<b>X</b>
NM101	Entity Identifier Code	R	2-3	QC	R		X
NM102	Entity Type Qualifier	R	1-1	1	R		X
NM103	Name Last or Organization Name	R	1-35		R		X
NM104	Name First	R	1-25		R		X
NM105	Name Middle	S	1-25		S		X
NM107	Name Suffix	S	1-10		S		X
NM108	Identification Code Qualifier	S	1-2	34, HN, II, MI, MR	S		X

Transaction: 835 – Health Care Claim Payment and Remittance Advice							
SEGMENT (Gray-Shaded Rows) -- DATA ELEMENT (Non-shaded Rows)					Minnesota Information		MN Usage Same as HIPAA IGs
ID	Name	Usage	Min/Max	IG Values	Usage	Values, Definition and Notes	
NM109	Identification Code	S	2-80		S	This is the patient's member ID. If there is a unique ID to identify the patient, it must be entered in NM109 of the patient name segment. If there is not a unique ID for the patient then the NM108 and NM109 elements of the patient loop are not populated.	
<b>NM1</b>	<b>INSURED NAME</b>	<b>S</b>	<b>1</b>		<b>S</b>		<b>X</b>
NM101	Entity Identifier Code	R	2-3	IL	R		X
NM102	Entity Type Qualifier	R	1-1	1, 2	R	1, 2. An example for value "2" would be Worker's Compensation where the employer is the insured.	
NM103	Name Last or Organization Name	S	1-35		S		X
NM104	Name First	S	1-25		S		X
NM105	Name Middle	S	1-25		S	.	X
NM107	Name Suffix	S	1-10		S	.	X
NM108	Identification Code Qualifier	R	1-2	34, HN, MI	R		X
NM109	Identification Code	R	2-80		R		X
<b>NM1</b>	<b>CORRECTED PATIENT/INSURED NAME</b>	<b>S</b>	<b>1</b>		<b>S</b>		<b>X</b>
<b>NM1</b>	<b>SERVICE PROVIDER NAME</b>	<b>S</b>	<b>1</b>		<b>S</b>	This loop does not apply to 837 Institutional Claims.	
NM101	Entity Identifier Code	R	2-3	82	R		X
NM102	Entity Type Qualifier	R	1-1	1, 2	R		X
NM103	Name Last or Organization Name	S	1-35		S		X
NM104	Name First	S	1-25		S		X
NM105	Name Middle	S	1-25		S		X
NM107	Name Suffix	S	1-10		S		X
NM108	Identification Code Qualifier	R	1-2	BD, BS, FI, MC, PC, SL, UP, XX	R	FI, PC, and XX	
NM109	Identification Code	R	2-80		R		X
<b>NM1</b>	<b>CROSSOVER CARRIER NAME</b>	<b>S</b>	<b>1</b>		<b>S</b>		<b>X</b>

Transaction: 835 – Health Care Claim Payment and Remittance Advice							
SEGMENT (Gray-Shaded Rows) -- DATA ELEMENT (Non-shaded Rows)					Minnesota Information		MN Usage Same as HIPAA IGs
ID	Name	Usage	Min/Max	IG Values	Usage	Values, Definition and Notes	
<b>NM1</b>	<b>CORRECTED PRIORITY PAYER NAME</b>	<b>S</b>	<b>2</b>		<b>S</b>		<b>X</b>
NM101	Entity Identifier Code	R	2-3	PR	R		X
NM102	Entity Type Qualifier	R	1-1	2	R		X
NM103	Name Last or Organization Name	R	1-35		R		X
NM108	Identification Code Qualifier	R	1-2	AD, FI, NI, PI, PP, XV	R		X
NM109	Identification Code	R	2-80		R	Corrected Priority Payer Identification Number. If ID is unavailable, use qualifier PI in NM108 and send payer name in NM109.	
<b>MIA</b>	<b>INPATIENT ADJUDICATION INFORMATION</b>	<b>S</b>	<b>1</b>		<b>S</b>	Use when an inpatient claim remittance remark code applies to this claim  If you are using a claim level CARC that indicates a remark code must be sent - then a remark code is required	
MIA01	Quantity	R	1-15		R		X
MIA02	Quantity	S	1-15		NCFP		X
MIA03	Quantity	S	1-15		NCFP		X
MIA04	Monetary Amount	S	1-18		NCFP		X
MIA05	Reference Identification	S	1-30		S		X
MIA06	Monetary Amount	S	1-18		S		X
MIA07	Monetary Amount	S	1-18		NCFP		X
MIA08	Monetary Amount	S	1-18		NCFP		X
MIA09	Monetary Amount	S	1-18		NCFP		X
MIA10	Monetary Amount	S	1-18		NCFP		X
MIA11	Monetary Amount	S	1-18		NCFP		X
MIA12	Monetary Amount	S	1-18		NCFP		X
MIA13	Monetary Amount	S	1-18		NCFP		X
MIA14	Monetary Amount	S	1-18		NCFP		X
MIA15	Quantity	S	1-15		NCFP		X
MIA16	Monetary Amount	S	1-18		NCFP		X
MIA17	Monetary Amount	S	1-18		NCFP		X
MIA18	Monetary Amount	S	1-18		NCFP		X
MIA19	Monetary Amount	S	1-18		NCFP		X

Transaction: 835 – Health Care Claim Payment and Remittance Advice							
SEGMENT (Gray-Shaded Rows) -- DATA ELEMENT (Non-shaded Rows)				Minnesota Information		MN Usage Same as HIPAA IGs	
ID	Name	Usage	Min/Max	IG Values	Usage		Values, Definition and Notes
MIA20	Reference Identification	S	1-30		S		X
MIA21	Reference Identification	S	1-30		S		X
MIA22	Reference Identification	S	1-30		S		X
MIA23	Reference Identification	S	1-30		S		X
MIA24	Monetary Amount	S	1-18		NCFP		X
<b>MOA</b>	<b>OUTPATIENT ADJUDICATION INFORMATION</b>	<b>S</b>	<b>1</b>		<b>S</b>	Use when an outpatient claim remittance remark code applies to this claim  If you are using a claim level CARC that indicates a remark code must be sent - then a remark code is required	
MOA01	Percent	S	1-10		NCFP		X
MOA02	Monetary Amount	S	1-18		NCFP		X
MOA03	Reference Identification	S	1-30		S		X
MOA04	Reference Identification	S	1-30		S		X
MOA05	Reference Identification	S	1-30		S		X
MOA06	Reference Identification	S	1-30		S		X
MOA07	Reference Identification	S	1-30		S		X
MOA08	Monetary Amount	S	1-18		NCFP		X
MOA09	Monetary Amount	S	1-18		NCFP		X
<b>REF</b>	<b>OTHER CLAIM RELATED IDENTIFICATION</b>	<b>S</b>	<b>5</b>		<b>S</b>		<b>X</b>
<b>REF</b>	<b>RENDERING PROVIDER IDENTIFICATION</b>	<b>S</b>	<b>10</b>		<b>NCFP</b>		<b>X</b>
<b>DTM</b>	<b>CLAIM DATE</b>	<b>S</b>	<b>1</b>		<b>S</b>		<b>X</b>
<b>PER</b>	<b>CLAIM CONTACT INFORMATION</b>	<b>S</b>	<b>3</b>		<b>S</b>	Required for Workers' Compensation, Auto and Property and Casualty payments.	
<b>AMT</b>	<b>CLAIM SUPPLEMENTAL INFORMATION</b>	<b>S</b>	<b>14</b>		<b>S</b>		<b>X</b>
AMT01	Amount Qualifier Code	R	1-3	AU, D8, DY, F5, I, NL, T, T2, ZK, ZL, ZM, ZN, ZO, ZZ	R	AU,F5, I, T, D8	

Transaction: 835 – Health Care Claim Payment and Remittance Advice							
SEGMENT (Gray-Shaded Rows) -- DATA ELEMENT (Non-shaded Rows)					Minnesota Information		MN Usage Same as HIPAA IGs
ID	Name	Usage	Min/Max	IG Values	Usage	Values, Definition and Notes	
AMT02	Monetary Amount	R	1-18		R		X
QTY	CLAIM SUPPLEMENTAL INFORMATION QUANTITY	S	15		S		X
Loop ID – 2110 Service Payment Information (Loop Repeat: 999)							
SVC	SERVICE PAYMENT INFORMATION	S	1		S		X
SVC01	COMPOSITE MEDICAL PROCEDURE IDENTIFIER	R			R		X
SVC01-1	Product/Service ID Qualifier	R	2-2	AD, ER, HC, ID, IV, N4, NU, RB, ZZ	R	AD, ER, HC, ID, IV, N4, NU, ZZ	
SVC01-2	Product/Service ID	R	1-48		R		X
SVC01-3	Procedure Modifier	S	2-2		S		X
SVC01-4	Procedure Modifier	S	2-2		S		X
SVC01-5	Procedure Modifier	S	2-2		S		X
SVC01-6	Procedure Modifier	S	2-2		S		X
SVC01-7	Description	S	1-80		NCFP		X
SVC02	Monetary Amount	R	1-18		R		X
SVC03	Monetary Amount	R	1-18		R		X
SVC04	Product/Service ID	S	1-48		S		X
SVC05	Quantity	S	1-15		S		X
SVC06	COMPOSITE MEDICAL PROCEDURE IDENTIFIER	S			S		X
SVC06-1	Product/Service ID Qualifier	R	2-2	AD, ER, HC, ID, IV, N4, NU, RB, ZZ	R	AD, ER, HC, ID, IV, N4, NU, ZZ	
SVC06-2	Product/Service ID	R	1-48		R		X
SVC06-3	Procedure Modifier	S	2-2		S		X
SVC06-4	Procedure Modifier	S	2-2		S		X
SVC06-5	Procedure Modifier	S	2-2		S		X
SVC06-6	Procedure Modifier	S	2-2		S		X

Transaction: 835 – Health Care Claim Payment and Remittance Advice							
SEGMENT (Gray-Shaded Rows) -- DATA ELEMENT (Non-shaded Rows)					Minnesota Information		MN Usage Same as HIPAA IGs
ID	Name	Usage	Min/Max	IG Values	Usage	Values, Definition and Notes	
SVC06-7	Description	S	1-80		NCFP		X
SVC07	Quantity	S	1-15		S		X
DTM	SERVICE DATE	S	3		S	<p>Required when claim level Statement From or Through Dates are not supplied or the service dates are not the same as reported at the claim level. If not required by this companion guide, may be provided at sender's discretion, but cannot be required by the receiver.</p> <p>1. Dates at the service line level apply only to the service line where they appear.</p> <p>2. If used for inpatient claims and no service date was provided on the claim, then report the through date from the claim level.</p> <p>3. When claim dates are not provided, service dates are required for every service line.</p> <p>4. When claim dates are provided, service dates are not required, but if used they override the claim dates for individual service lines.</p> <p>5. For retail pharmacy claims, the service date is equivalent to the prescription filled date.</p>	
CAS	SERVICE ADJUSTMENT	S	99		S		X
REF	SERVICE IDENTIFICATION	S	7		S		X
REF	RENDERING PROVIDER INFORMATION	S	10		S		X

Transaction: 835 – Health Care Claim Payment and Remittance Advice							
SEGMENT (Gray-Shaded Rows) -- DATA ELEMENT (Non-shaded Rows)					Minnesota Information		MN Usage Same as HIPAA IGs
ID	Name	Usage	Min/Max	IG Values	Usage	Values, Definition and Notes	
REF01	Reference Identification Qualifier	R	2-3	1A, 1B, 1C, 1D, 1G, 1H, 1J, HPI, SY, TJ	R	HPI	
REF02	Reference Identification	R	1-30		R		X
AMT	<b>SERVICE SUPPLEMENTAL AMOUNT</b>	S	12		S	For use by Workers' Compensation, Auto and Property and Casualty payments. NCFP for other group purchasers.	
AMT01	Amount Qualifier Code	R	1-3	B6, DY, KH, NE, T, T2, ZK, ZL, ZM, ZN, ZO	R	B6, KH, T, T2	
AMT02	Monetary Amount	R	1-18		R		X
QTY	<b>SERVICE SUPPLEMENTAL QUANTITY</b>	S	6		NCFP		X
LQ	<b>HEALTH CARE REMARK CODES</b>	S	1		S	If using a service level CARC that indicates a RARC or NCPDP reject code must be sent - then a RARC or NCPDP reject code is required	
<b>Summary</b>							
PLB	<b>PROVIDER ADJUSTMENT</b>	S	>1		S		X
PLB01	Reference Identification	R	1-30		R	When the provider is a covered health care provider under the National Provider (NPI) regulation, this must be the NPI assigned to the provider.	X
PLB02	Date	R	8-8	CCYYMMDD	R		X
PLB03	ADJUSTMENT IDENTIFIER	R			R		X
PLB03-1	Adjustment Reason Code	R	2-2	50, 51, 72, 90, AH, AM, AP, B2, B3, BD, BN, C5, CR, CS, CT, CV, CW, DM, E3, FB, FC, GO, IP, IR, IS, J1, L3, L6, LE, LS, OA, OB, PI, PL, RA, RE, SL, TL, WO, WU, ZZ	R		X
PLB03-2	Reference Identification	S	1-30		S		X
PLB04	Monetary Amount	R	1-18		R		X
PLB05	ADJUSTMENT IDENTIFIER	S			S		X

Transaction: 835 – Health Care Claim Payment and Remittance Advice							
SEGMENT (Gray-Shaded Rows) -- DATA ELEMENT (Non-shaded Rows)					Minnesota Information		MN Usage Same as HIPAA IGs
ID	Name	Usage	Min/Max	IG Values	Usage	Values, Definition and Notes	
PLB05-1	Adjustment Reason Code	R	2-2	50, 51, 72, 90, AH, AM, AP, B2, B3, BD, BN, C5, CR, CS, CT, CV, CW, DM, E3, FB, FC, GO, IP, IR, IS, J1, L3, L6, LE, LS, OA, OB, PI, PL, RA, RE, SL, TL, WO, WU, ZZ	R		X
PLB05-2	Reference Identification	S	1-30		S		X
PLB06	Monetary Amount	S	1-18		S		X
PLB07	ADJUSTMENT IDENTIFIER	S			S		X
PLB07-1	Adjustment Reason Code	R	2-2	50, 51, 72, 90, AH, AM, AP, B2, B3, BD, BN, C5, CR, CS, CT, CV, CW, DM, E3, FB, FC, GO, IP, IR, IS, J1, L3, L6, LE, LS, OA, OB, PI, PL, RA, RE, SL, TL, WO, WU, ZZ	R		X
PLB07-2	Reference Identification	S	1-30		S		X
PLB08	Monetary Amount	S	1-18		S		X
PLB09	ADJUSTMENT IDENTIFIER	S			S		X
PLB09-1	Adjustment Reason Code	R	2-2	50, 51, 72, 90, AH, AM, AP, B2, B3, BD, BN, C5, CR, CS, CT, CV, CW, DM, E3, FB, FC, GO, IP, IR, IS, J1, L3, L6, LE, LS, OA, OB, PI, PL, RA, RE, SL, TL, WO, WU, ZZ	R		X
PLB09-2	Reference Identification	S	1-30		S		X
PLB10	Monetary Amount	S	1-18		S		X
PLB11	ADJUSTMENT IDENTIFIER	S			S		X
PLB11-1	Adjustment Reason Code	R	2-2	50, 51, 72, 90, AH, AM, AP, B2, B3, BD, BN, C5, CR, CS, CT, CV, CW, DM, E3, FB, FC, GO, IP, IR, IS, J1, L3, L6, LE, LS, OA, OB, PI, PL, RA, RE, SL, TL, WO, WU, ZZ	R		X
PLB11-2	Reference Identification	S	1-30		S		X
PLB12	Monetary Amount	S	1-18		S		X
PLB13	ADJUSTMENT IDENTIFIER	S			S		X
PLB13-1	Adjustment Reason Code	R	2-2	50, 51, 72, 90, AH, AM, AP, B2, B3, BD, BN, C5, CR, CS, CT, CV, CW, DM, E3, FB, FC, GO, IP, IR, IS, J1, L3, L6, LE, LS, OA, OB, PI, PL, RA, RE, SL, TL, WO, WU, ZZ	R		X
PLB13-	Reference	S	1-30		S		X

Transaction: 835 – Health Care Claim Payment and Remittance Advice							
SEGMENT <i>(Gray-Shaded Rows)</i> -- DATA ELEMENT <i>(Non-shaded Rows)</i>					Minnesota Information		MN Usage Same as HIPAA IGs
ID	Name	Usage	Min/Max	IG Values	Usage	Values, Definition and Notes	
2	Identification						
PLB14	Monetary Amount	S	1-18		S		X
SE	<b>TRANSACTION SET TRAILER</b>	R	1		R		X

## **6.0 Appendices**

### **List of Appendices:**

- **Appendix A: Terminology and Acronyms**
- **Appendix B: Minnesota Crosswalk for the Claim Adjustment Reason Codes (CARC), Claim Adjustment Group Codes, and Remittance Advice Remark Codes (RARC)**
- **Appendix C: Workers Compensation Reporting of Reason for a Denial or Reduction of Payment**

## Appendix A

### Terminology and Acronyms

- **835** - X12 Transaction Set contains the format and establishes the data content of the Health Care Claim Payment/Advice Transaction Set (835) for use within the context of the Electronic Data Interchange (EDI) environment.
- **Adjudication** - Adjudication is the process of determining benefits applicable to a claim. This may result in payment, denial, pending or suspension for additional information.
- **ASC** - Accredited Standard Committee. A standards development organization accredited by the American National Standards Institute. (See X12N below).
- **Atypical provider** - Providers who do not meet the federal definition of a "health care provider" under HIPAA (45 CFR 160.103) and are not eligible to receive a National Provider Identifier (NPI) under HIPAA (45 CFR Part 162) are atypical providers. Examples of atypical providers include approved day treatment centers, children's residential services, clearinghouses, billing intermediaries, day training and habilitation, health care case coordinators, home and community based services, personal care provider organizations and individual PCAs, non-medical transportation, and waived services.
- **CARC** - Claim Adjustment Reason Code - Standard codes and messages that detail the reason why an adjustment was made to a health care claim payment.
- **CCP or CCD+** - Cash Concentration/Disbursement plus Addenda.
- **CDHP** - Consumer Driven (or Directed) Health Plan - Consumer Driven Health Plans (CDHPs) use both education and technology to help members ("consumers") determine how their health plan dollars should be spent.
- **CFO** - Chief Financial Officer.
- **COB** - Coordination of Benefits - The coordination of the payment of health care claims between payers. This can occur when there is more than one payer who has financial responsibility for health services being rendered.
- **Covered Health Care Provider** - 45 CFR § Subtitle A 160.103 Definitions Covered health care provider means a health care provider that meets the definition at paragraph (3) of the definition of "covered entity" at § 160.103 of this subchapter.
- **CTX** - Corporate Trade Exchange.
- **DDE** - The "direct data entry" process, using dumb terminals or computer browser screens, where the data is directly keyed by a health care provider into a health plan's computer, would not have to use the format portion of the standard, but the data content must conform. As noted in the HIPAA Final Rule, DDE is a transmission

mode in which use of the format portion of the standard is inappropriate. However, the transaction must conform to the data content portion of the standard.

- **DFI** - Depository Financial Institution.
- **EFT** - Electronic Funds Transfer.
- **EOB** - Explanation of Benefits – explanation of payer’s adjudication that is sent to the patient.
- **ERA** - Electronic Remittance Advice (also referred to as an 835) – explanation of payer’s adjudication that is sent to the provider.
- **FDN** - Funds Deposit Notification.
- **FSA** - Flexible Spending Account.
- **FTE** - Full Time Employee.
- **GC** - Group Code.
- **HCPCS Level I** - Level I of the HCPCS is comprised of Current Procedural Terminology (CPT-4), a numeric coding system maintained by the American Medical Association (AMA). The CPT-4 is a uniform coding system consisting of descriptive terms and identifying codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals. These health care professionals use the CPT-4 to identify services and procedures for which they bill public or private health insurance programs. Level I of the HCPCS, the CPT-4 codes, does not include codes needed to separately report medical items or services that are regularly billed by suppliers other than physicians.

Issues related to the application of Level I HCPCS codes (CPT-4) for physicians will be referred to the AMA.

- **HCPCS Level II** - Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT-4 codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office. Because Medicare and other insurers cover a variety of services, supplies, and equipment that are not identified by CPT-4 codes, the level II HCPCS codes were established for submitting claims for these items.
- **High Deductible Health Plans (HDHP)** - HDHP provides both a comprehensive coverage for high-cost medical events and a tax-advantaged way to help build savings for future medical expenses. The HDHP has greater flexibility and discretion over how health care benefits will be used.
- **Health Care** - 45 CFR § Subtitle A 160.103 Definitions *Health care* means care, services, or supplies related to the health of an individual. *Health care* includes, but is not limited to, the following:

(1) Preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling, service, assessment, or procedure with respect to the physical or mental condition, or functional status, of an individual or that affects the structure or function of the body; and

(2) Sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription.

- **HIPAA** - The Federal Health Insurance Portability and Accountability Act.
- **HIPAA Standard Transaction** - HIPAA Standard transaction means a transaction that complies with the applicable standard adopted under 45 CFR Parts 160 and 162 Health Insurance Reform: Standards for Electronic Transactions; Announcement of Designated Standard Maintenance Organizations; Final Rule and Notice.
- **HIR** - HIPAA Interpretation Request. Interpretations of the ASC X12N Implementation Guides named as HIPAA standards. They are published on the "Portal" at <http://www.X12n.org>.
- **HRA** - Health Reimbursement Account - An employer funded account that reimburses employees for qualified medical expenses.
- **HSA** - Health Savings Account - A tax-exempt account created exclusively to pay for qualified medical expenses of the account holder/employee and their dependents.
- **ID** – Identifier.
- **Implementation Guide (IG)** - This is a document that provides the information required for the implementation of HIPAA Standard Transactions. These guides are maintained by the ASC X12N (Insurance) workgroup. The version of the implementation guides that were mandated for HIPAA transactions is 004010A1.
- **MSA** - Medical Savings Account.
- **NAIC** - National Association of Insurance Commissioners.
- **NACHA Transaction** - National Automated Clearinghouse Association, which is a non-profit trade association that promulgates rules and operating guidelines for electronic payments.
- **NCPDP Reject/Payment Codes**: The National Council for Prescription Drug Programs Reject/Payment Codes comprise a listing of NCPDP payment and reject reason codes, the explanation of the code and the field number in error (if rejected).
- **NPI** - National Provider Identifier.
- **NPRM** - Notice of Proposed Rule Making.
- **Order of Responsibility** - The order of responsibility is the determination of which payers has primary, secondary, and tertiary status for claim payment responsibility.

Destination vs. non-destination is independent of the order of payment responsibility.

- **Payer ID/Plan ID** - An identification number that represents a health insurer. Most HIPAA documents use Plan ID to mean the same as Payer ID.
- **Primary Payer** - The payer responsible for the initial adjudication of a claim based on predefined "order of responsibility" rules. The primary payer adjudicates a claim without regard to the fact that the same claim will be adjudicated by other payers.
- **PLB** - Provider Level Adjustment.
- **RA** – Paper Remittance Advice – a common term used by the health care community that typically refers to a paper document containing the results of the adjudication/payment process sent from the payer to the provider. This term occasionally is also used for the electronic remittance.
- **RARC** - Remittance Advice Remark Code. These codes represent non-financial information critical to understanding the adjudication of a health insurance claim.
- **Secondary Payer** - The payer responsible for a claim that has been previously adjudicated by a primary payer. A secondary payer will base its claim payment decisions upon the amount that has not been paid by the primary payer and has been categorized as "patient responsibility."
- **TIN** - Tax Identification Number (SSN, EIN, ITIN).
- **U Modifiers** These are codes defined and used by states to modify procedures identified in Medicaid claims.
- **X12** - The Accredited Standards Committee (ASC) X12 to develop uniform standards for inter-industry electronic exchange of business transactions-electronic data interchange (EDI).
- **X12N** - The Accredited Standards Committee's Insurance Subcommittee responsible for the creation of the 835 Technical Report Type 3 (TR3) (also known as implementation guide) for the health care industry.

## **Appendix B**

### **Minnesota Crosswalk for the Claim Adjustment Reason Codes (CARC), Claim Adjustment Group Codes, and Remittance Advice Remark Codes (RARC)**

The Minnesota Crosswalk below lists the Claim Adjustment Reason Codes (CARCs), Claim Adjustment Group Codes, and Remittance Advice Remark Codes (RARCs) for use by group purchasers and providers. As noted below, national organizations are responsible for maintenance of CARCs and RARCs and periodically add, delete, or make other changes to these codes. This Guide and Appendix incorporate by reference any changes adopted by national organizations with responsibilities for these codes.

- Claim Adjustment Reason Codes are updated (additions, deletions, changes) three times/year by the ANSI X12 Health Care Claim Adjustment Reason Code/Health Care Claim Status Code Committee. These updates are published by Washington Publishing Company at <http://www.wpc-edi.com>.
- Remittance Advice Remark Codes are maintained by CMS. Updates to the Remark Codes (additions, changes, deletions) are published by Washington Publishing Company (see website above).

In addition, pharmacy transactions may also require additional codes, and pharmacy may use the CARC and RARC codes in Appendix B, Minnesota Crosswalk, and the payment/reject codes maintained by the National Council of Prescription Drug Plans (NCPDP) as needed and appropriate. (NCPDP payment/reject codes – see <http://www.ncdp.org> for more information).

#### **CLAIM ADJUSTMENT REASON CODES**

- The Minnesota Crosswalk contains all codes active as of 07/01/2009.
- The Claim Adjustment Reason Codes can only be used in conjunction with the Claim Adjustment Group Code value(s) specified on the crosswalk with the exception of CR (see Claim Adjustment Group Codes).

#### **CLAIM ADJUSTMENT GROUP CODES**

- Only the Claim Adjustment Group Codes listed in the Minnesota Crosswalk are permitted for use. The Minnesota Crosswalk further clarifies the Claim Adjustment Group Codes as follows:

CO (Contractual Obligations)- Used when the amount adjusted is not the patient's responsibility under any circumstances due to either a contractual obligation between the provider and the payer or a regulatory requirement.

CR (Correction and Reversal)- Usage matches 004010X091A1 for correction and reversals. Code "CR" – Correction and Reversal is not included in the Crosswalk. When processing a Reversal of Previous Payment (CLP02 = "22"), code "CR" is permitted with all Claim Adjustment Reason Codes.

OA (Other Adjustments)- Used for showing the impact of prior payments from other payers, bundling, predeterminations, or when no other group code applies.

PI (Payer Initiated Reductions)- Used when, in the payer's opinion, the adjusted amount is not the responsibility of the patient and there is no supporting contract between the provider and the payer.

PR (Patient Responsibility)- Used for patient financial responsibility amounts that include, but are not limited to, co-pay, coinsurance, deductible, spenddown, non-covered services, and exhausted benefits.

- NOTE: When the Minnesota Crosswalk indicates both PR and CO (outside of 16, 96, 125, 148, and A1), CO is used for participating provider adjudication/provider payments and PR is used for non-participating provider adjudication. For 16, 96, 125, 148, and A1, responsibility is determined by the RARC.

#### **REMARK CODES**

- RARCs are not required and should only be used as appropriate to clarify adjudication. However, RARCs are required for certain CARCs; please refer to CARC definitions. Group purchasers must not use RARCs for CARCs that do not have a RARC associated with them, except for "alert" RARCs.
- RARCs that are "alerts" and not associated with an adjustment are not included in the Minnesota Crosswalk, but are permitted for use under the HIPAA IG.

#### **USE OF INACTIVE CARCs AND RARCs**

- Group purchasers and providers must not use inactive codes, except as defined in Section 4.2.3.1.

<b>TABLE B.1</b> <b>Minnesota Crosswalk for</b> <b>Claim Adjustment Reason Codes (CARC), Claim Adjustment Group Codes</b> <b>and Remittance Advice Remark Codes (RARC)</b>		
<b>Claim Adjustment Reason Code (CARC)</b>	<b>Claim Adjustment Group Code</b>	<b>Remittance Advice Remark Code (RARC)</b>
1	PR	MA118
2	PR	MA118
3	PR	N/A
4	CO/OA	M118, MA66, MA67, N20, N56, N129
5	CO	M21, M77, M97, MA66, N34, N93, N163, N428
6	PR/CO	M37, M82, M89, MA66, N2, N22, N10, N30, N59, N129
7	CO	MA39, MA66, N22
8	CO	N95, MA66, N121
9	CO	M37, M76, M82, M89, MA63, MA65, N129
10	CO	M64, M76, MA39, MA63, MA65
11	PR/CO	M51, M76, M122, MA63, MA65, N59
12	CO	M76, MA63, MA65
13	CO	M30, MA31, N330
14	CO	N/A
15	PR/CO	N54, M62, N45, N188

**TABLE B.1**  
**Minnesota Crosswalk for**  
**Claim Adjustment Reason Codes (CARC), Claim Adjustment Group Codes**  
**and Remittance Advice Remark Codes (RARC)**

Claim Adjustment Reason Code (CARC)	Claim Adjustment Group Code	Remittance Advice Remark Code (RARC)
16	PR/CO/PI/OA	M19, M20, M21, M22, M23, M24, M29, M30, M31, M42, M44, M45, M46, M47, M49, M50, M51, M52, M53, M54, M56, M59, M60, M62, M64, M67, M76, M77, M79, M80, M99, M119, M122, M123, M124, M125, M126, M127, M129, M130, M131, M132, M135, M136, M141, M142, MA04, MA27, MA30, MA31, MA32, MA33, MA34, MA35, MA36, MA37, MA39, MA40, MA41, MA42, MA43, MA48, MA50, MA53, MA58, MA60, MA61, MA63, MA65, MA66, MA69, MA70, MA71, MA75, MA76, MA81, MA88, MA89, MA90, MA92, MA97, MA99, MA100, MA109, MA110, MA111, MA112, MA113, MA114, MA115, MA116, MA120, MA121, MA122, MA128, MA130, MA134, N3, N4, N8, N24, N26, N27, N29, N30, N31, N32, N33, N37, N40, N42, N46, N50, N53, N55, N57, N58, N59, N63, N72, N75, N76, N77, N78, N80, N81, N102, N108, N146, N147, N148, N150, N152, N153, N170, N175, N178, N179, N188, N190, N203, N207, N208, N209, N213, N214, N221, N223, N247, N248, N249, N250, N251, N252, N253, N254, N255, N256, N257, N258, N259, N260, N261, N262, N263, N264, N265, N266, N267, N268, N269, N270, N271, N272, N273, N274, N275, N276, N277, N278, N279, N280, N282, N284, N285, N286, N287, N288, N289, N290, N281, N283, N291, N292, N293, N294, N295, N296, N297, N298, N299, N300, N301, N302, N303, N304, N305, N306, N307, N308, N309, N310, N311, N312, N313, N314, N315, N316, N317, N318, N319, N320, N321, N322, N323, N324, N325, N326, N327, N328, N329, N330, N331, N332, N333, N334, N335, N336, N337, N338, N339, N340, N341, N342, N343, N344, N346, N350, N359, N375, N378, N371, N382, N388, N391, N393, N395, N398, N401, N403, N434, N439, N443, N445, N451, N453, N455, N457, N459, N461, N463, N465, N467, N471, N473, N475, N477, N479, N481, N483, N485, N487, N489, N491, N493, N495, N497, N499, N501, N503
18	PR/CO/PI	M86, N111
19	PR/CO/OA	N/A
20	PR/CO/OA	M118, MA04
21	PR/CO/OA	N/A
22	PR/CO/PI/OA	MA04, MA15, MA64, MA67, MA92, N4, N8, N9, N23, N36, N185, N193, N196, N219, N376, N418
23	PR/CO/PI/OA	M41, M49, N23
24	CO	M118, N30, N59, N216

**TABLE B.1**  
**Minnesota Crosswalk for**  
**Claim Adjustment Reason Codes (CARC), Claim Adjustment Group Codes**  
**and Remittance Advice Remark Codes (RARC)**

Claim Adjustment Reason Code (CARC)	Claim Adjustment Group Code	Remittance Advice Remark Code (RARC)
26	PR	N52, N128
27	PR/CO	MA47, MA56, N52
29	PR/CO/PI	MA67, MA91, N30
31	PR/CO	MA39, MA61, N30, N59, N216, N329, N382
32	PR/OA	N30, N179
33	PR	N/A
34	PR	N/A
35	PR	N/A
38	PR/CO	M118, N450
39	PR/CO	M118
40	PR	MA46, N391, N392
44	CO	N/A
45	PR/CO	M7, M27, M86, M118, MA01, MA15, MA67, MA125, N1, N14, N18, N23, N162, N187, N193, N381, N447, N449,
49	PR/CO	N/A
50	PR/CO	M25, M118
51	PR/CO	M118
53	PR/CO	N/A
54	PR/CO	M118
55	PR/CO	N/A
56	PR/CO	M118
58	PR/CO	N/A
59	CO	M118, N59

<b>TABLE B.1</b> <b>Minnesota Crosswalk for</b> <b>Claim Adjustment Reason Codes (CARC), Claim Adjustment Group Codes</b> <b>and Remittance Advice Remark Codes (RARC)</b>		
Claim Adjustment Reason Code (CARC)	Claim Adjustment Group Code	Remittance Advice Remark Code (RARC)
60	CO	N20
61	CO	M62, N59
66	PR	N/A
69	CO	N/A
70	CO	N199
74	CO	N/A
75	CO	N/A
76	CO	N/A
78	PR/CO	N/A
85	PR	N/A
87	PI/OA	N/A
89	PR/CO	M118
90	CO/PI/OA	N/A
91	CO/PI/OA	N/A
94	PR/CO/OA	N/A
95	PR/CO	M7, M8, M10, M16, M18, M36, M39, M40, M42, M55, M102, M113, M114, M117, M138, M139, MA09, MA14, MA25, MA94, MA96, MA123, N32, N33, N36, N42, N59, N71, N78, N86, N98, N141, N143, N151, N176, N182, N217, N357, N381, N400
96	PR/CO/OA	M15, M20, M50, M66, M80, M84, M85, M86, M90, M99, N14, N19, N20, N28, N30, N59, N129, N130, N156, N157, N171, N356, N357, N372, N383, N441, N519
97	PR/CO/PI/OA	M2, M15, M80, M86, M118, M144, N19, N20, N22, N59, N365, N390
100	PR/CO	MA07
101	PR/CO/OA	N/A
102	PR/CO	N/A

<b>TABLE B.1                      Minnesota Crosswalk for                      Claim Adjustment Reason Codes (CARC), Claim Adjustment Group Codes                      and Remittance Advice Remark Codes (RARC)</b>		
<b>Claim                      Adjustment                      Reason Code                      (CARC)</b>	<b>Claim Adjustment                      Group Code</b>	<b>Remittance Advice Remark Code (RARC)</b>
103	CO	N/A
104	CO	N/A
105	PR/CO/PI	N/A
106	CO	N143
107	PR/CO	N2
108	PR/CO	M7, M70, M118, N370
109	PR/CO/OA	M11, M118, MA101, N104, N106, N143, N193, N216, N418
110	CO	M52, M59
111	CO	N/A
112	PR/CO	M118
114	CO	M61, M102, M118
115	CO	N/A
116	CO	N/A
117	PR/CO	N130
118	CO	M83
119	PR/CO/OA	M7, M38, M83, M86, M90, MA67, N117, N357, N362, N435
121	CO	N/A
122	CO	N/A

<b>TABLE B.1</b> <b>Minnesota Crosswalk for</b> <b>Claim Adjustment Reason Codes (CARC), Claim Adjustment Group Codes</b> <b>and Remittance Advice Remark Codes (RARC)</b>		
<b>Claim Adjustment Reason Code (CARC)</b>	<b>Claim Adjustment Group Code</b>	<b>Remittance Advice Remark Code (RARC)</b>
125	PR/CO/PI/OA	M19, M20, M21, M22, M23, M24, M29, M30, M31, M42, M44, M45, M46, M47, M49, M50, M51, M52, M53, M54, M56, M59, M60, M62, M64, M66, M67, M76, M77, M79, M80, M81, M99, M117, M119, M122, M123, M124, M125, M126, M129, M135, MA27, MA30, MA31, MA32, MA33, MA34, MA35, MA36, MA37, MA39, MA40, MA41, MA42, MA43, MA48, MA58, MA60, MA61, MA63, MA65, MA66, MA67, MA70, MA71, MA75, MA76, MA81, MA88, MA89, MA90, MA92, MA100, MA109, MA110, MA111, MA113, MA114, MA115, MA116, MA120, MA121, MA122, MA130, MA134, N2, N3, N4, N8, N26, N27, N29, N30, N31, N32, N33, N34, N37, N39, N42, N46, N50, N53, N55, N56, N57, N58, N59, N61, N62, N63, N64, N65, N72, N75, N77, N78, N79, N80, N81, N93, N94, N102, N146, N148, N150, N152, N153, N170, N175, N179, N186, N188, N190, N203, N206, N207, N208, N209, N213, N214, N247, N248, N249, N250, N251, N252, N253, N254, N255, N256, N257, N258, N259, N260, N261, N262, N263, N264, N265, N266, N267, N268, N269, N270, N271, N272, N273, N274, N275, N276, N277, N278, N279, N280, N282, N284, N285, N286, N287, N288, N289, N290, N281, N292, N293, N294, N295, N296, N297, N298, N299, N300, N301, N302, N303, N304, N305, N306, N307, N308, N309, N310, N311, N312, N313, N314, N315, N316, N317, N318, N319, N320, N321, N322, N323, N324, N325, N326, N327, N328, N329, N330, N331, N332, N333, N334, N335, N336, N337, N338, N339, N340, N341, N342, N343, N344, N346, N350, N359, N365, N375, N377, N378, N371, N382, N390, N434, N440, N443, N446, N452, N454, N456, N458, N460, N462, N464, N466, N468, N471, N474, N476, N478, N480, N482, N484, N486, N488, N490, N494, N496, N498, N500, N502, N504, N519
128	PR/CO	N/A
129	CO	N142, N152, N384, N400
130	CO/PI	N400
131	CO	N432
132	CO	N/A
133	CO/PI/OA	M118
134	CO	N428
135	CO	N/A
136	OA	N/A

<b>TABLE B.1</b> <b>Minnesota Crosswalk for</b> <b>Claim Adjustment Reason Codes (CARC), Claim Adjustment Group Codes</b> <b>and Remittance Advice Remark Codes (RARC)</b>		
<b>Claim Adjustment Reason Code (CARC)</b>	<b>Claim Adjustment Group Code</b>	<b>Remittance Advice Remark Code (RARC)</b>
137	CO/OA	N/A
138	PR/CO	MA91
139	CO	N/A
140	PR/CO/PI	N48
141	PR	N/A
142	PR	N/A
143	OA	N/A
144	CO/PI/OA	N/A
146	CO	M76, MA65, MA66
147	PR	MA12, N144, N153, N182, N381
148	PR/CO/PI	M19, M23, M29, M30, M31, M42, M60, M62, M64, M67, M76, M80, M99, M119, M123, M124, M125, M129, M130, M131, M132, M135, M136, M141, M142, MA50, MA53, MA63, MA65, MA66, MA70, MA71, MA75, MA76, MA81, MA97, MA100, MA111, MA112, MA120, MA121, MA122, MA128, MA134, N3, N27, N32, N33, N37, N40, N42, N46, N50, N53, N55, N57, N59, N65, N72, N75, N76, N77, N78, N80, N102, N146, N150, N170, N175, N178, N186, N188, N190, N203, N214, N221, N222, N223, N224, N225, N226, N227, N228, N229, N230, N231, N233, N234, N235, N236, N238, N239, N240, N241, N242, N243, N244, N247, N248, N249, N250, N251, N252, N253, N254, N261, N262, N263, N264, N265, N266, N267, N268, N269, N270, N271, N283, N284, N288, N289, N305, N306, N308, N309, N310, N311, N312, N313, N314, N315, N316, N317, N318, N319, N320, N321, N322, N323, N324, N325, N326, N328, N330, N331, N332, N333, N334, N335, N336, N339, N341, N342, N343, N344, N346, N378, N388, N391, N392, N393, N394, N395, N396, N398, N399, N401, N402, N403, N404, N434, N443, N445, N446, N451, N452, N453, N454, N455, N456, N457, N458, N459, N460, N461, N462, N463, N464, N465, N466, N467, N468, N471, N473, N474, N475, N476, N477, N478, N481, N482, N483, N484, N485, N486, N487, N488, N489, N490, N491, N493, N494, N495, N496, N497, N498, N499, N500, N501, N502, N503, N504
149	PR	N117, N130

<b>TABLE B.1                      Minnesota Crosswalk for                      Claim Adjustment Reason Codes (CARC), Claim Adjustment Group Codes                      and Remittance Advice Remark Codes (RARC)</b>		
<b>Claim                      Adjustment                      Reason Code                      (CARC)</b>	<b>Claim Adjustment                      Group Code</b>	<b>Remittance Advice Remark Code (RARC)</b>
150	PR/CO	M25, M26, M118, N59, N163, N180, N188
151	PR/CO	N362, M44, M53, M69, M86, MA109, N19, N29, N123, N200, N362, N430
152	PR/CO	N/A
153	PR/CO	M123, N378
154	PR/CO	N378
155	PR/CO	M118
157	PR	N193, N376
158	PR	N176
159	PR	N193
160	PR	N59, N167, N356, N425
161	CO	M73, M74
162	PR/CO	N246, N369
163	PR/CO	M60, M69, N29, N102, N358, N439, N445, N451, N453, N455, N457, N459, N461, N463, N465, N467, N471, N473, N475, N477, N479, N481, N483, N485, N487, N489, N491, N493, N495, N497, N499, N501, N503
164	PR/CO	MA54, N102, N385
165	PR/CO	N45, N54, N130, N335
166	PR/CO	N/A
167	PR/CO	N130
168	PR	N10, N138, N139, N140
169	PR	M51, N156
170	PR/CO	N32, N59, N95, N384
171	PR/CO	M13, M18, MA101, N67, N95, N121

**TABLE B.1**  
**Minnesota Crosswalk for**  
**Claim Adjustment Reason Codes (CARC), Claim Adjustment Group Codes**  
**and Remittance Advice Remark Codes (RARC)**

Claim Adjustment Reason Code (CARC)	Claim Adjustment Group Code	Remittance Advice Remark Code (RARC)
172	PR/CO	M13, N95
173	CO	M42, N95
174	CO	N/A
175	CO	N319, N349, N378, N388, N389
176	CO	N349, N378, N388, N389
177	PR	N30, N196, N375
178	PR/CO	N59
179	PR/CO	N/A
180	PR/CO	N/A
181	CO	N/A
182	CO	N/A
183	PR/CO	N55, N285, N286
184	PR/CO	N264, N265, N450
185	PR/CO	N32, N289, N290, N450
186	CO	M25, M26, M103, M105, N188
187	PR	N/A
188	CO	M61, M102, MA50
189	CO	N/A
190	CO	MA101, N106, N107
191	PR	M118
192	NCFP	N/A
193	CO	MA01, MA02, MA44, MA46, MA91, N83, N136, N210, N211
194	PR/CO	N/A

**TABLE B.1**  
**Minnesota Crosswalk for**  
**Claim Adjustment Reason Codes (CARC), Claim Adjustment Group Codes**  
**and Remittance Advice Remark Codes (RARC)**

Claim Adjustment Reason Code (CARC)	Claim Adjustment Group Code	Remittance Advice Remark Code (RARC)
195	NCFP	N/A
197	PR/CO	M62, MA67, N473
198	PR/CO	N54
199	CO	N/A
200	PR	N/A
201	PR	N/A
202	PR	MA20,N180
203	PR/CO/PI	N/A
204	PR/CO	N129, N130, N216, N356, N383, N429, N441
205	PR/CO	N/A
206	CO	N/A
207	CO	N/A
208	CO	N516
209	OA	N/A
210	PR/CO	N/A
211	CO	N/A
212	NCFP	N/A
213	CO	N/A
214	CO/OA	N/A
215	CO	N68
216	CO/PI	N10, N421
217	CO	N/A
218	NCFP	N/A

<b>TABLE B.1</b> <b>Minnesota Crosswalk for</b> <b>Claim Adjustment Reason Codes (CARC), Claim Adjustment Group Codes</b> <b>and Remittance Advice Remark Codes (RARC)</b>		
<b>Claim Adjustment Reason Code (CARC)</b>	<b>Claim Adjustment Group Code</b>	<b>Remittance Advice Remark Code (RARC)</b>
219	CO	M118
220	CO	M118
221	CO	M118
222	CO	N/A
223	CO/PR/OA	N/A
224	OA	N/A
225	NCFP	
226	CO/PI	M19, M20, M21, M22, M23, M24, M29, M30, M31, M42, M44, M45, M46, M47, M49, M50, M51, M52, M53, M54, M56, M59, M60, M62, M64, M67, M76, M77, M79, M99, M119, M122, M123, M124, M125, M126, M127, M129, M130, M131, M132, M135, M136, M141, M142, MA04, MA27, MA30, MA31, MA32, MA33, MA34, MA35, MA36, MA37, MA39, MA40, MA41, MA42, MA43, MA48, MA50, MA58, MA60, MA61, MA63, MA65, MA66, MA70, MA71, MA75, MA76, MA81, MA88, MA89, MA90, MA92, MA100, MA109, MA110, MA111, MA113, MA114, MA115, MA116, MA120, MA121, MA122, MA130, MA134, N3, N4, N8, N26, N27, N29, N31, N33, N37, N40, N42, N46, N50, N53, N57, N58, N72, N75, N77, N78, N80, N81, N102, N146, N148, N150, N153, N154, N170, N175, N178, N190, N203, N207, N208, N209, N213, N214, N221, N223, N225, N247, N248, N249, N250, N251, N252, N253, N254, N255, N256, N257, N258, N259, N260, N261, N262, N263, N264, N265, N266, N267, N268, N269, N270, N271, N272, N273, N274, N275, N276, N277, N278, N279, N280, N282, N284, N285, N286, N287, N288, N289, N290, N281, N292, N293, N294, N295, N296, N297, N298, N299, N300, N301, N302, N303, N304, N305, N306, N307, N308, N309, N310, N311, N312, N313, N314, N315, N316, N317, N318, N319, N320, N321, N322, N323, N324, N325, N326, N327, N328, N329, N330, N331, N332, N333, N334, N335, N336, N337, N338, N339, N340, N341, N342, N343, N344, N346, N350, N359, N375, N378, N382, N439, N443, N445, N451, N453, N455, N457, N459, N461, N463, N465, N467, N471, N473, N475, N477, N479, N481, N483, N485, N487, N489, N491, N493, N495, N497, N499, N501, N503
227	PR	MA04, N4, N179
228	PR/CO	MA04, N4, N8, N58, N272, N273, N274, N275, N276, N277, N278

<b>TABLE B.1</b> <b>Minnesota Crosswalk for</b> <b>Claim Adjustment Reason Codes (CARC), Claim Adjustment Group Codes</b> <b>and Remittance Advice Remark Codes (RARC)</b>		
<b>Claim Adjustment Reason Code (CARC)</b>	<b>Claim Adjustment Group Code</b>	<b>Remittance Advice Remark Code (RARC)</b>
229	NCFP	N/A
230	NCFP	N.A
231	CO/PR	N/A
A0	PR/OA	M26, MA10, MA59, MA72, MA77
A1	PR/CO/OA	M16, M20, M38, M54, M62, M64, M67, M86, M115, M118, M139, MA91, N1, N2, N8, N35, N54, N59, N94, N102, N109, N124, N125, N142, N159, N181, N202, N206, N350, N380, N434, N439, N441, N443, N445, N448, N451, N453, N455, N457, N459, N461, N463, N465, N467, N471, N473, N475, N477, N479, N481, N483, N485, N487, N489, N491, N493, N495, N497, N499, N501, N503, N507
A5	CO	N/A
A6	CO	N/A
A7	CO	N/A
A8	CO	N/A
B1	PR/CO	M118
B4	CO	N/A
B5	PR/CO	M3, M13, M62, M75, M86, M90, M118, M135, M144, MA22, MA67, N2, N20, N43, N59, N117, N130, N357
B7	CO	M118, M143, MA12, MA120, N95, N132, N290, N425
B8	PR/CO	N/A
B9	PR/CO	N/A
B10	CO/PI	N/A
B11	PR/CO/OA	N/A
B12	CO	M118
B13	PR/CO	M118, N59, N218
B14	PR/CO	N/A

<b>TABLE B.1</b> <b>Minnesota Crosswalk for</b> <b>Claim Adjustment Reason Codes (CARC), Claim Adjustment Group Codes</b> <b>and Remittance Advice Remark Codes (RARC)</b>		
<b>Claim Adjustment Reason Code (CARC)</b>	<b>Claim Adjustment Group Code</b>	<b>Remittance Advice Remark Code (RARC)</b>
<b>B15</b>	PR/CO/OA	M15, M20, M80, M144, MA109, N19, N20, N56, N122, N130, N390
<b>B16</b>	CO	M13, MA122, N22, N113, N130, N357, N366, N375
<b>B20</b>	CO	MA67, N347, N472
<b>B22</b>	PR/CO	M64, M76, MA63, MA65, N10, N314, N337, N472
<b>B23</b>	CO	N/A
<b>W1</b>	CO	M118

## **Appendix C**

### **Workers Compensation Reporting of Reason for a Denial or Reduction of Payment**

1. Use reason code 191 to deny payment on the basis that primary liability for the injury or illness being treated is denied. For each charge that is adjusted on this basis, use the Service Identification Loops (2110 loops) with qualifier RB in REF01. In REF02, explain the basis for the adjustment of the charge and cite any applicable statute or rule supporting the adjustment. (See item 8 below for examples of how to use the 2110 loops).
2. Use Reason code 51 or 167 to deny payment on the basis that the treatment or service is for a condition not related to the admitted workers' compensation injury. For each charge that is adjusted on this basis, use the Service Identification Loops (2110 loops) with qualifier RB in REF01. In REF02 explain the basis for the adjustment of the charge and cite any applicable statute or rule supporting the adjustment.
3. Use reason code 45 to adjust a charge to 85% of the provider's usual and customary charge according to Minn. Stat. § 176.136, subd. 1b(b) and Minn. R. 5221.0500, subp. 2 (B) (1). For each charge that is adjusted on this basis, use the Service Identification Loops (2110 loops) with qualifier RB in REF01. In REF02 explain that the charge is reduced to 85% of the provider's usual and customary charge and cite Minn. Stat. § 176.136, subd. 1b (b) and Minn. Rules, part 5221.0500, subp. 2.
4. Use reason code 45 and remark code N246 to adjust a charge to 85% of the prevailing charges for similar treatment according to Minn. Stat. § 176.136, subd. 1b(b) and Minn. R. 5221.0500, subp. 2 (B) (2). For each charge that is adjusted on this basis, use the Service Identification Loops (2110 loops) with qualifier RB in REF01. In REF02 explain that the charge is reduced to 85% of the prevailing charge and cite Minn. Stat. § 176.136, subd. 1b(b) and Minn. Rules, part 5221.0500, subp. 2.
5. Use reason code W1, along with any other applicable reason and remark codes, to adjust a charge based on the maximum fee allowed under the workers' compensation relative value fee schedule according to Minn. Stat. § 176.136, subd. 1a and Minnesota Rules, parts 5221.4010 to 5221.4070. For each charge that is adjusted on this basis, use the Service Identification Loops (2110 loops) with qualifier RB in REF01. In REF02 explain the basis for the adjustment of the charge and cite the applicable statute or rule supporting the adjustment.
6. Use reason codes 50, 56, 150, 151, 152, 153, or 154, as applicable, to adjust a charge on the basis that the service, article or supply is not reasonable and necessary to cure or relieve the effects of the injury or illness. For each charge that is adjusted on this basis:
  - If there is an applicable treatment parameter rule in Minn. Rules, parts 5221.6010 to 5221.8900, use the Service Identification Loops (2110 loops) with qualifier RB in REF01. In REF02 explain the basis for the adjustment of the charge, cite any applicable treatment parameter rule supporting the adjustment, and add the following language: "Departures may be allowed. See M.R. 5221.6050 subp 8"

- If there is no applicable treatment parameter rule, use the Service Identification Loops (2110 loops) with qualifier RB in REF01. In REF02 explain the basis for the adjustment of the charge and cite any applicable statute or other rule supporting the adjustment.

7. To adjust a charge based on a statute or rule for reasons other than those described in items 1 to 6, use the reason and remark code that best describes the adjustment. If there is no reason code that accurately describes the adjustment, use reason code A1. For each charge that is adjusted, use the Service Identification Loops (2110 loops) with qualifier RB in REF01. In REF02 explain the basis for the adjustment of the charge and cite any applicable statute or rule supporting the adjustment.

8. Use the Service Identification Loops (2110 loops) to explain the basis for the adjustment of a charge and cite the applicable statute or rule supporting the adjustment as follows:

- In REF01, use qualifier RB
- Of the seven occurrences in REF02, use the first occurrence for the line control number.
- Use the second occurrence to provide the applicable workers' compensation statutory or rule citation in the following format:
  - Cite Minnesota Statutes § 176.135, subd. 1b as "M.S. 176.136 subd 1b"
  - Cite Minnesota Rules, part 5221.0500, subp. 2 (B) as "M.R. 5221.0500 subp 2 B"
- Use up to five additional occurrences (of 30 characters each) to describe in short narrative form the basis for the adjustment.

For example, to adjust a charge because the service or supply for the charge is not paid separately from the facility fee under Minnesota Rules, part 5221.4033, subpart 1a:

- Use the second occurrence to provide the applicable rule citation:  
"M.R. 5221.4033 subp 1a"
- Use the remaining five occurrences to describe the basis for the adjustment in narrative format: For example, the narrative could say:  
"There is no separate payment for this service. Payment is included in facility fee."

9. If there is not enough space in the Service Identification Loops (2110 loops) to describe the basis for any adjustment, report the adjustment with the most accurate reason code, add remark code M118 and notify the provider and the employee by letter. The letter must:

- Explain the basis for denial;
- Include a citation to any statute or rule that supports the denial or reduction of the charge;
- List the patient control number of the applicable bill (CLM01 from the 837 and CLP01 from the 835); and
- Be mailed within 30 calendar days after receiving the bill and the appropriate record as provided in Minn. Stat. § 176.135, subd. 6 and 7 and Minn. R. 5221.0700, subpart 2.

10. On all 835 transactions, use the 30 character jurisdictional field in the Other Claim Related Identification REF segment in loop 2100. Use qualifier CE in REF01. In REF02 state:

“For work comp see MN835 Guide.”

**NOTE:** This guide does not modify any requirement in the workers’ compensation statutes and rules governing the legal bases for denial or reduction of payment or the notice that must be given to the injured employee about payment or denial of medical charges or treatment.