



Minnesota Department of Health (MDH) Rule

Minnesota Uniform Companion Guide (MUCG) Version 14.0 for the Implementation of the X12/005010X221A1 Health Care Claim Payment Advice (835)

Adopted as a rule on August 12, 2019

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1. Overview

This is version 14.0 of the Minnesota Uniform Companion Guide (MUCG) for the Implementation of the X12/005010X221A1 Health Care Claim Payment Advice (835). It was adopted into rule pursuant to [Minnesota Statutes, section 62J.61](#) on August 12, 2019, and supersedes all previous versions. This version 14.0 remains in force until superseded by a subsequent version that has been adopted into rule.

1.1. How to obtain a copy of this document

This document is available at no charge on the [Minnesota Uniform Companion Guides webpage](#) (<https://www.health.state.mn.us/facilities/ehealth/auc/guides/index.html>).

1.2. Applicable statutes and requirements

[Minnesota Statutes, section 62J.536](#) (<https://www.revisor.mn.gov/statutes/cite/62J.536>) requires [health care providers](#) (<https://www.revisor.mn.gov/statutes/cite/62J.03>), [group purchasers](#) (payers) (<https://www.revisor.mn.gov/statutes/cite/62J.03>), and [clearinghouses](#) (<https://www.revisor.mn.gov/statutes/cite/62J.51>) to exchange certain health care business (administrative) transactions electronically. These exchanges must comply with the specifications of a single uniform “companion guide” adopted into rule by the Commissioner of Health in consultation with a large, voluntary external stakeholder advisory organization, the [Minnesota Administrative Uniformity Committee \(AUC\)](#) (<https://www.health.state.mn.us/facilities/ehealth/auc/index.html>). The state’s companion guide rules are promulgated and adopted pursuant to [Minnesota Statutes, section 62J.61](#) (<https://www.revisor.mn.gov/statutes/cite/62J.61>). Other state statutes also reference MS §62J.536.

Note: Compliance with a companion guide rule adopted pursuant to MS §62J.536 does not mean that a health care claim will be paid, nor does it imply payment policies of payers, or the benefits that have been purchased by the employer or subscriber.

Additional information regarding Minnesota’s requirements for the standard, electronic exchange of health care administrative transactions, including relevant rules, examples of entities that are subject to MS §62J.536, Frequently Asked Questions (FAQs) and other information, is available on the [MDH Administrative Simplification Act webpage](#) (<https://www.health.state.mn.us/facilities/ehealth/asa/index.html>).

1.3. This document:

- Describes the proposed data content and other transaction specific information to be used with the [X12/005010X221A1 Health Care Claim Payment Advice \(835\)](#), hereinafter referred to as 005010X221A1, by entities subject to Minnesota Statutes, section 62J.536;
- Supplements, but does not otherwise modify the 005010X221A1 in a manner that will make its implementation by users to be out of compliance.
- Must be used in conjunction with all applicable Minnesota and federal regulations, including [45 CFR Parts 160, 162, and 164](#) (HIPAA Administrative Simplification, including adopted federal operating rules) and related X12N and retail pharmacy specifications ([X12](#) and [NCPDP](#) implementation specifications);
- Must be appropriately incorporated by reference and/or the relevant transaction information must be displayed in any companion guides provided by entities subject to MS §62J.536. In particular, the applicable information in this document must be appropriately incorporated by reference and/or displayed in companion guides of entities subject to MS §62J.536, so as to also meet any applicable requirements of [CFR 45 § 162.1603](#).
- Was prepared by the [Minnesota Department of Health \(MDH\)](#) (<https://www.health.state.mn.us>) with the assistance of the Minnesota Administrative Uniformity Committee (AUC).

1.4. Reference for this document

The X12 reference for this document is the X12/005010X221A1 Health Care Claim Payment Advice (835) (Copyright © 2008, Data Interchange Standards Association on behalf of X12. Format © 2008, ASC X12. All Rights Reserved), hereinafter described below as 005010X221A1. A copy of the full 005010X221A1 can be obtained from the [X12 store](#) (<http://store.x12.org/store/>).

[Placeholder: Express permission to use X12 copyrighted materials within this document has been granted.]

1.5. Best practices for the implementation of electronic health care transactions

The AUC develops and publicizes best practices for the implementation of health care administrative transactions and processes. While use of the best practices is not required per statute, their use is strongly encouraged to aid in meeting the state's health care administrative data exchange requirements, and to provide the greatest benefits of health care administrative simplification. Please visit the [AUC best practices webpage](#) (<https://www.health.state.mn.us/facilities/ehealth/auc/bestpractices/index.html>) for more information about best practices for implementing electronic health care administrative transactions in Minnesota.

1.6. Contact for further information

Minnesota Department of Health

Division of Health Policy

[Office of Health Information Technology](#)

P.O. Box 64882

St. Paul, Minnesota 55164-0882

Phone: (651) 201-3570

Fax: (651) 201-3830

Email: health.ASAGuides@state.mn.us

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2. Transaction specific instructions and information to be used with the 005010X221A1

The remainder of this document, including Appendices A-E, provides transaction-specific information to be used in conjunction with the 005010X221A1.

2.1. Naming conventions and business terminology

2.1.1. Naming conventions for brevity

For purposes of brevity, this Companion Guide references several standard health care transactions as follows:

- X12/005010X221A1 Health Care Claim Payment/Advice (835), is referred to in the subsequent sub-sections as “005010X221A1”, “835,” “the 835,” or “the 835 transaction.”
- X12/005010X222A1 Health Care Claim: Professional (837), X12/005010X223A2 Health Care Claim: Institutional (837) and X12/005010X224A2 Health Care Claim: Dental (837), are referred to in the subsequent sub-sections collectively as “837,” or “the 837.”
- The 005010X222A1 is referred to as “837P” and the 005010X224A2 is referred to as “837D.”

2.1.2. Business Terminology and related instructions

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

2.1.2.1. Adjustment

As defined in the 005010X221A1 TR3 (Implementation Guide), “the term adjustment refers to changes to the amount paid on a claim, service or remittance advice versus the original submitted charge/bill. Adjustment does not refer to changing or correcting a previous adjudication of a claim.”¹

2.1.2.2. 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 005010X221A1.

¹ Accredited Standards Committee X12, Insurance Subcommittee, X12N.
"1.5 Business Terminology"
Health Care Claim Payment/Advice (835), 005010X221A1.
X12 Incorporated, June 2010.
<<http://www.x12.org>>. 4.

2.1.2.3. Payee

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 billing provider or the NCPDP service provider ID.

2.1.2.4. Payment Address

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.

2.1.2.5. Pay-to provider loop

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 (payer) utilizes an enrollment form or a contract.

2.1.2.6. Servicing/rendering provider

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=G2 or HPI). The line rendering provider identifier is only required when different from the claim servicing/rendering provider.

2.2. 835 transactions must be accurate, balanced

835 transactions must balance, contain accurate information, and utilize active CARC, RARC or NCPDP reject codes except as noted below in section 2.2.1. 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 populates 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.

See Appendix C for detailed COB examples.

2.2.1. 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 02/01/2019 would not be available for use by a payer in a CAS segment in a claim payment/advice transaction (835) dated after 02/01/2019 as part of an original claim adjudication (CLP02 values such as “1”, “2”, “3” or “19”). The code may be used after 02/01/2019 in derivative transactions, as long as the original usage was prior to 02/01/2019. Derivative transactions include: secondary or tertiary claims (837) from the provider or payer to a secondary or tertiary payer, or an 835 from the original payer to the provider as a reversal of the original adjudication (i.e., CLP02 value “22”). The deactivated code may be used in these derivative transactions because they are reporting on the valid usage (pre-deactivation) of the code in a previously generated 835 transaction.

2.3. Formatting requirements

2.3.1. Segments Reporting Multiple Values from Same Code Set

Some segments [e.g., “Claims Adjustment” (CAS) and “Provider Level Adjustment” (PLB)] 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.

2.4. Transaction information for specific loops, segments, and elements

The following table contains information needed to implement the 005010X221A1 Health Care Claim Payment Advice (835). It contains a row for each segment for which there is additional information over and above the information in the 005010X221A1. The table shows the relevant loop and corresponding segment(s) with the additional information. In instances in which the additional information is at the data element level, the relevant loop, segment, and data element are shown.

2.4.1. Transaction information table for specific loops, segments, and elements of the 005010X221A1 (835)

Loop Name	Segment Name	Data Element Name (if applicable)	Value Definition and Notes
ST Transaction Set Header	BPR Financial Information	BPR04 Payment Method Code	ACH, CHK, FWT, NON

Loop Name	Segment Name	Data Element Name (if applicable)	Value Definition and Notes
1000B Payee Identification	REF Payee Additional Identification	REF01 Reference Identification Qualifier	D3, PQ, TJ PQ identifies the Payer assigned Payee identifier
2100 Claim Payment Information	CLP Claim Payment Information	CLP06 Claim Filing Indicator Code	ZZ may be used by pharmacy payers to identify Medicare retroactive Low Income Subsidy (LIS) adjustment of pharmacy claims using the 005010X221A1 with their long term care (LTC) business partners. Otherwise, ZZ is not an appropriate code because this document does not support the use of a mutually defined qualifier.
2100 Claim Payment Information	NM1 Insured Name	NM102 Entity Type Qualifier	1, 2. An example for value "2" would be Worker's Compensation where the employer is the insured.
2100 Claim Payment Information	NM1 Service Provider Name	NM108 Identification Code Qualifier	FI, PC, and XX
2100 Claim Payment Information	REF Other claim related identification	REF02 Reference Identification	See Appendix D for instructions for reporting Medicaid "PMAP" codes.
2100 Claim Payment Information	PER Claim Contact Information		Required for Workers' Compensation, Auto and Property and Casualty payments.
2110 Service Payment Information	REF Rendering Provider Information	REF01 Reference Identification Qualifier	G2, HPI
2110 Service Payment Information	AMT Service Supplemental Amount	AMT01 Amount Qualifier Code	B6, KH, T, T2

List of Appendices

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- B. Workers Compensation Reporting of Reason for a Denial or Reduction of Payment
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- D. Prepaid Medical Assistance Program (PMAP) Program Codes for Medicaid Remittances
- E. Reporting All Patients Refined Diagnosis Related Groups (APR-DRG)

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Appendix A -- Requirements and instructions for CARC, RARC, and CAGC use

This appendix lists Claim Adjustment Reason Codes (CARC), Claim Adjustment Group Codes (CAGC), and Remittance Advice Remark Codes (RARC) for use by group purchasers and providers subject to Minnesota Statutes, section 62J.536 as follows below.

As noted below, national organizations are responsible for maintenance of CARC and RARC 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.

- CARC are updated (additions, deletions, changes) three times/year by the Joint Claim Adjustment Reason/Health Care Claim Status Reason Code Maintenance Committee. These updates are published by [Washington Publishing Company](http://www.wpc-edi.com/reference) (<http://www.wpc-edi.com/reference>).
- RARC are maintained by the federal Centers for Medicare & Medicaid Services (CMS) and updates (additions, changes, deletions) are published by [Washington Publishing Company](http://www.wpc-edi.com/reference) (<http://www.wpc-edi.com/reference>).
- CAQH-CORE maintains and regularly updates the "[CORE-required Code Combinations for CORE-defined Business Scenarios for CAQH CORE 360 Rule](https://www.caqh.org/core/caqh-core-phase-iii-rules)" (<https://www.caqh.org/core/caqh-core-phase-iii-rules>). The document describes a minimum set of CORE-defined Claim Adjustment/Denial Business Scenarios and a maximum set of CORE-required CARC/RARC/CAGC and CARC/NCPDP Reject Code/CAGC combinations to convey detailed information about payment adjustments or denials.

A.1 When CAQH-CORE business scenarios apply

If the applicable business scenario is described in the "[CORE-required Code Combinations for CORE-defined Business Scenarios for the Phase III CORE 360](https://www.caqh.org/core/caqh-core-phase-iii-rules)" use the applicable CARC, RARC, and CAGC in the CORE requirements.

A.2 If CORE scenarios do not apply, use CAGC "PR" and specified RARC for CARC 227

If the CORE scenarios in section A.1 above do not apply, use the CAGC "PR" and the RARC for CARC 227 listed in the [Supplement to be used with Appendix A, Section A.2 of the Minnesota Uniform Companion Guide \(MUCG\) v14.0 for the Implementation of the X12/005010X221A1 Health Care Claim Payment Advice \(835\)](#).

A.3 Creation of new business scenarios

If the business scenario is not described by the choices in section A.1 or A.2 above, group purchasers may create new scenarios that do not conflict with those above, and may use applicable, appropriate code combinations, consistent with the above referenced CORE requirements in section A.1. Group purchasers should [submit new scenarios to CAQH CORE](https://www.caqh.org/core/ongoing-maintenance-core-code-combinations-caqh-core-360-rule) (<https://www.caqh.org/core/ongoing-maintenance-core-code-combinations-caqh-core-360-rule>) for consideration in an updated CORE rule.

A.4 Property and Casualty

For Property and Casualty lines of business ONLY, RARC N202 may be used with any CARC. For all other payers, RARC N202 may only be used as prescribed in this Appendix A.

A.5 Worker's Compensation

For workers' compensation, see Appendix B.

A.6 Pharmacy Transactions

Pharmacy transactions may also require additional codes, and pharmacy may use the code combinations described above 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.)

Appendix B -- Workers' compensation reporting of reason for a denial or reduction of payment

B.1 Scope

The Minnesota Uniform Companion Guide and this Appendix do not modify any requirement in the workers' compensation statutes and rules governing the legal basis for denial or reduction of payment or the notice that must be given to the injured employee and the health care provider about payment or denial of medical charges or treatment.

This appendix applies only to remittance advices for workers' compensation claims to meet specific Minnesota workers' compensation jurisdictional requirements in [Minnesota Statutes, section 176.135, subd. 6](https://www.revisor.mn.gov/statutes/cite/176.135) (<https://www.revisor.mn.gov/statutes/cite/176.135>) and [Minnesota Rules 5221.0600](https://www.revisor.mn.gov/rules/5221.0600) (<https://www.revisor.mn.gov/rules/5221.0600>).

B.2 Enumerated Code List

For purposes of this Appendix, an enumerated code list describes the basis for adjustment or denial of a workers' compensation medical bill or charge. Each enumerated code identifies the applicable Minnesota rule, part, and subpart or, if no rule applies, the applicable Minnesota statute or other legal basis for the adjustment or denial. An enumerated code must be used in addition to the applicable CARC/RARC code as described in section B.3.

Examples:

- Code 176.136 S 1a (a) means Minnesota Statutes, section 176.136, subdivision 1a, paragraph (a).
- Code 5221.4035 S 5 D means Minnesota Rules, Part 5221.4035, subpart 5, item D.

Web Site URL:

The Minnesota Department of Labor and Industry (Department) maintains a web site URL that has links to the text of the statutes and rules used by workers' compensation payers as a basis to reduce or deny a charge. The URL address that must be referred to in loop 1000A segment PER is the URL of the [website that is maintained by the Minnesota Department of Labor and Industry](http://www.dli.mn.gov) (www.dli.mn.gov). The URL website is required anytime a charge is reduced or denied.

Example: PER*IC**UR* www.dli.mn.gov~

B.3 Instructions for using CARC/RARCs:

Items 1 to 11 describe how the Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) must be used at the claim or line level.

1. Use CARC P2 to deny payment on the basis that primary liability for the injury or illness being treated is denied.

2. Use CARC P4 to deny payment on the basis that the treatment is due to a prior workers' compensation injury that is the liability of a previous workers' compensation carrier.
3. Use CARC 219 to deny payment on the basis that the treatment or service is for a condition not related to the admitted workers' compensation injury.
4. Use CARC P12, along with any other applicable RARC, 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](https://www.revisor.mn.gov/statutes/cite/176.136) (<https://www.revisor.mn.gov/statutes/cite/176.136>) and [Minnesota Rules, parts 5221.4005 to 5221.4070](https://www.revisor.mn.gov/rules/5221) (<https://www.revisor.mn.gov/rules/5221>).
5. Use CARC P13 to adjust a charge to 85% of the provider's usual and customary charge according to [Minn. Stat. § 176.136, subd. 1b\(b\)](https://www.revisor.mn.gov/statutes/cite/176.136) (<https://www.revisor.mn.gov/statutes/cite/176.136>) and [Minnesota Rules 5221.0500, subp. 2 \(B\) \(1\)](https://www.revisor.mn.gov/rules/5221.0500) (<https://www.revisor.mn.gov/rules/5221.0500>).
6. Use CARC P13 to adjust a charge to 85% of the prevailing charges for similar treatment according to [Minn. Stat. § 176.136, subd. 1b\(b\)](https://www.revisor.mn.gov/statutes/cite/176.136) (<https://www.revisor.mn.gov/statutes/cite/176.136>) and [Minnesota Rules 5221.0500, subp. 2 \(B\) \(2\)](https://www.revisor.mn.gov/rules/5221.0500) (<https://www.revisor.mn.gov/rules/5221.0500>).
7. Use CARC 50, 56, or 152, 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; or is not consistent with Minnesota workers' compensation treatment parameters ([Minnesota Rules 5221.6010 to 5221.6600](https://www.revisor.mn.gov/rules/5221) (<https://www.revisor.mn.gov/rules/5221>)).
8. Use CARC 96 and RARC N381 to adjust a charge based on a contractual reimbursement agreement between the provider and payer.
9. To adjust a charge based on a statute or rule for reasons other than those described in items 1 to 8, use any CARC that includes this language:

"Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF), if present" and remittance advice remark code that best describes the adjustment." (Claim adjustment reason codes with this language are listed in section 5.2.5 of this Appendix B.)

If there is no CARC that accurately describes the adjustment and includes the quoted language, use CARC P13.
10. **If an entire bill is denied at the claim level**, use the Insurance Policy Number Segment (Loop 2100) Other Claim Related Information REF. Use the qualifier 'IG' for bills that are adjusted at the claim level.

Example (a):

CARC P2 is used when an entire bill is denied on the basis that primary liability for the injury or illness being treated is denied per [Minnesota Statute 176.135 subdivision 6 \(1\)](https://www.revisor.mn.gov/statutes/cite/176.135) (<https://www.revisor.mn.gov/statutes/cite/176.135>).

- In REF 01, use qualifier IG
- In REF 02 specify the appropriate code for the applicable statute, followed by the URL for the website that is maintained by the [Minnesota Department of Labor and Industry](http://www.dli.mn.gov) to describe enumerated codes: www.dli.mn.gov.

Example (a) in X12 syntax: REF*IG*176.135 S 6 (1) www.dli.mn.gov.

11. **If a bill is reduced at the line level**, use the Healthcare Policy Identification Segment (Loop 2110) to specify the appropriate code for the most specific statute and subdivision or rule part and subpart supporting the adjustment.

Example (b):

CARC P12 is used when a line item of a bill is reduced based solely on the maximum fee in the Minnesota workers compensation medical fee schedule rule per [Minnesota Statute 176.136 subdivision 1a \(1\)](http://www.revisor.mn.gov/statutes/cite/176.136) (<https://www.revisor.mn.gov/statutes/cite/176.136>) and [Minnesota Rule 5221.4020, subpart 1b, item A \(1\)](http://www.revisor.mn.gov/rules/5221.4020) (<https://www.revisor.mn.gov/rules/5221.4020>).

- In REF01, use qualifier OK
- In REF02, specify the appropriate code for the applicable statute, rule or law.

Example (b) in X12 syntax: REF*OK*176.136 S 1a (1); 5221.4020 S1b A (1)~

Example (c):

CARC P12 is used and a line item of a bill is reduced based on the Minnesota workers compensation medical fee schedule multiple procedure rule per Minnesota Statute 176.136 subdivision 1a (a) and Minnesota Rule 5221.4035, subpart 5, item D.

- In REF01, use qualifier OK
- In REF02, specify the appropriate code for the applicable statute, rule or law

Example (c) in X12 syntax: REF*OK*176.136 S 1a (a); 5221.4035 S 5 D~

B.4 Allowed CARC Codes

ONLY CARC with the language: “Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present” are allowed to be used in Minnesota workers’ compensation transactions. At the time this document was published, CARC codes with this language include:

4, 5, 6, 7, 8, 9, 10, 11, 12, 16, 40, 49, 50, 51, 54, 55, 56, 58, 59, 61, 96, 97, 107, 108, 152, 167, 170, 171, 172, 179, 183, 184, 185, 219, 222, 231, B7, B8, B15, P2, P4, P6, P8, P12, P13 and P14.

Note: CARC are updated (additions, deletions, changes) three times/year by the ANSI X12N Health Care Claim Adjustment Reason Code/Health Care Claim Status Code Committee. These updates are published by [Washington Publishing Company](http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes) (<http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes>). This Guide and Appendix incorporate by reference any CARC changes as updated and published by WPC.

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Appendix C -- Coordination of Benefits (COB) Examples

Purpose and use of this appendix

Note: The following examples are provided as a general reference for group purchasers (payers) and providers and are not intended as an exhaustive guide to meet HIPAA or Minnesota requirements. These examples are not to be interpreted as the only scenarios associated with a particular requirement, and are not intended to be all-inclusive.

Group purchasers and providers must look within their own particular application systems to see if any other scenarios may fit the requirements. These examples typically include only the minimum required data; however, in some cases, additional data may be required to be reported by group purchasers, as defined by benefit designs or this Minnesota Uniform Companion Guide.

Section C.2 below provides four examples of an ASC X12/005010X221A1 Health Care Claim Payment/Advice (835) used for COB, including three examples with a secondary payer and one with tertiary payer.

C.1 COB Example 1

Secondary group purchaser allows less than the primary group purchaser

The claim total is \$2500.00, and the primary group purchaser (payer) allows \$1800.00 based on the contract with the provider (noted in B6 segment). The \$700.00 disallowance is sent in the 005010X221A1 transaction with the CO-45 CARC code. The primary group purchaser pays \$1300.00 on the allowed amount, and leaves \$500.00 as the patient's responsibility (PR).

CLP*id*1*2500*1300*500*...

SVC*HC:proc*2500*1300*...

CAS*CO*45*700~

CAS*PR*1*500~

AMT*B6*1800~

When the secondary group purchaser considers the \$2500.00 claim, the payment and disallowed amounts from the primary group purchaser (\$2000.00 total) are sent in the 005010X221A1 transaction with the OA-23 CARC code. The secondary group purchaser would allow \$1450.00 on the \$2500.00 claim, as noted in the B6 segment. This \$1450.00 is deducted from the \$1800.00 already allowed, so the secondary group purchaser disallows an additional \$350.00 and sends that amount in the 005010X221A1 transaction with the CO-45 CARC code. This \$350.00 is deducted from the \$500.00 patient responsibility (PR) left by the primary group purchaser. The secondary group purchaser pays \$100.00 on the claim, and leaves \$50.00 as patient responsibility (PR). The secondary payment is based on a lower allowed amount than the primary payment. The submitted charge is \$2,500.

CLP*id*2*2500*100*50*...
SVC*HC:proc*2500*100*...
CAS*OA*23*2000~
CAS*PR*3*50~
CAS*CO*45*350~
AMT*B6*1450~

C.2 COB Example 2

Secondary group purchaser allows more than primary group purchaser

The claim total is \$2500.00, and the primary group purchaser allows \$1450.00 based on the contract with the provider (noted in B6 segment). The \$1050.00 disallowance is sent in the 005010X221A1 transaction with the CO-45 CARC code. The primary group purchaser pays \$1300.00 on the allowed amount, and leaves \$150.00 as the patient's responsibility (PR).

CLP*id*1*2500*1300*150*...
SVC*HC:proc*2500*1300*...
CAS*CO*45*1050~
CAS*PR*1*150~ AMT*B6*1450~

When the secondary group purchaser considers the \$2500.00 claim, the payment and disallowed amounts from the primary group purchaser (\$2350.00 total) are sent in the 005010X221A1 transaction with the OA-23 CARC code. The secondary group purchaser would allow \$1800.00 on the \$2500.00 claim, as noted in the B6 segment. Since the secondary group purchaser would allow more than the primary allowed on this claim, there is no additional contract adjustment (CARC transaction). The secondary group purchaser pays \$100.00 on the claim, and leaves \$50.00 as patient responsibility (PR).

CLP*id*2*2500*100*50*...
SVC*HC:proc*2500*100*...
CAS*OA*23*2350~
CAS*PR*3*50~
AMT*B6*1800~

C.3 COB Example 3

Primary group purchaser allows full claim amount, secondary group purchaser does not

The claim total is \$2500.00, and that amount is fully allowed by the group purchaser as noted in the B6 segment. There is no contractual adjustment, but \$1200.00 is assigned as patient responsibility (PR). The primary payment is \$1300.00.

CLP*id*1*2500*1300*1200*...

SVC*HC:proc*2500*1300*...

CAS*PR*1*1200~

AMT*B6*2500~

When the secondary group purchaser considers the \$2500.00 claim, the payment amount from the primary group purchaser (\$1300.00) is sent in the 005010X221A1 transaction with the OA-23 CARC code. The secondary group purchaser allows \$1800.00 as noted in the B6 segment, which is less than the primary allowed. As a result, the secondary group purchaser applies a \$700.00 contract adjustment and sends this amount in the 005010X221A1 transaction as a CO-45 CARC code. The \$700.00 is deducted from the \$1200.00 patient responsibility from the primary group purchaser's consideration, leaving \$500.00. The secondary group purchaser pays \$450.00 on the claim, leaving \$50.00 as patient responsibility (PR).

CLP*id*2*2500*450*50*...

SVC*HC:proc*2500*450*...

CAS*OA*23*1300~

CAS*PR*3*50~

CAS*CO*45*700~

AMT*B6*1800~

C.4 COB Example 4

Tertiary Billing

When billing Tertiary, use all applicable COB loops for each payer. This requires repeating certain COB loops and allows the sender to communicate the dollar amounts for each payer in a separate loop.

C.4.1 COB Loops

Loop ID-2320 contains the following:

- Claim level adjustments
- Other subscriber demographics
- Payment amounts
- Other payer information
- Assignment of benefits indicator
- Patient signature indicator

Loop ID – 2330

- Other Subscriber Information
- Other Payer Information
- Loop ID-2430 contains the following:
 - ID of the payer who adjudicated the service line
 - Amount paid for the service line
 - Procedure code upon which adjudication of the service line was based – this code may be different than the submitted procedure code. (This procedure code also can be used for unbundling or bundling service lines.)
- Paid units of service
- Service line level adjustments
- Adjudication date

C.4.2 Examples

Example – Sending the Claim to the Third Destination Payer:

- **2000B/2010BB Third payer**
 - 2000B – Subscriber
 - SBR01 = T
 - 2010BB – Payer Name
 - NM103 = Destination Payer Name
- **2320/2330 Primary payer**
 - 2320 – Other Subscriber – Claim Level COB
 - SBR01 = P
 - CAS* segments
 - CAS claim level amounts are cross-walked from the primary payer’s 835
 - 2330A – Other Subscriber
 - NM1* = Other Subscriber Name
 - 2330B – Other Payer
 - NM1* = Previous Payer Name

- **2430 Primary payer**
 2430 – Line Adjudication – Line Level COB
 CAS* segments
 CAS line level amounts are cross-walked from the primary payer’s 835 or paper RA
 DTP03 = Payment or Adjudication Date
- **2320/2330 Secondary payer (repeat 2320/2330 loops as needed for additional payers.)**
 2320 – Other Subscriber – Claim Level COB
 SBR01 = S
 CAS* segments
 CAS claim level amounts are cross-walked from the primary payer’s 835 or paper RA.

 2330A – Other Subscriber
 NM1* = Other Subscriber Name

 2330B – Other Payer
 NM1* = Previous Payer Name
- **2430 Secondary payer**
 2430 – Line Adjudication – Line Level COB
 CAS* segments
 CAS line level amounts are cross-walked from the primary payer’s 835 or paper RA
 DTP03 = Payment or Adjudication Date

 Repeat as necessary up to a maximum of 10 times. Any one claim can report a total of 11 payers (10 carried at the COB level and 1 carried up at the top 2010BB loop)

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Appendix D -- Prepaid Medical Assistance Program (PMAP) Program Codes for Medicaid Remittances

Group purchasers (payers) that report Medicaid claims in the 835 electronic remittance include the two-digit PMAP code with the claim. This code is used by providers when reporting encounters to the state.

Link to the table of major program codes under “MHCP Member Eligibility” on the Minnesota Department of Human Services (DHS) [“Health Care Programs and Services Overview” webpage](https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_008922#P23_1322) (https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_008922#P23_1322).

Use the loop 2100 Class of Contract REF segment to report the applicable PMAP code for the patient. Use the following format:

REF*CE*PMAP XX~ where XX is the PMAP code. (Use capital letters PMAP, followed by a space, followed by the 2-character PMAP code).

*Note: Only one REF*CE segment is allowed per claim. Do not use the REF*CE segment to report the PMAP code if a REF*CE segment is already used to report other Class of Contract information for a claim.*

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Appendix E -- Reporting All Patients Refined Diagnosis Related Groups (APR- DRG)

Follow the general guidelines in the X12 "[RFI # 2166: Reporting APR-DRG on 5010 835](#)" on the X12 website or as otherwise maintained by X12 and the instructions and examples below. (Note: At the time of publication of this rule, the X12 response to RFI #2166 was located at <http://rfi.x12.org/Request/Details/2166?stateViewModel=WPC.RFI.Models.ViewModels.RequestViewModel>.)

E.1 Instructions

In the 2100 Loop, Other Claim Related Identification, set REF01 to CE ("class of contract"). In REF02, list the applicable class of contract (such as a program or product name), followed by 5 spaces and then the abbreviation "APRDRG=" and then the applicable APRDRG number.

E.2 Examples

The examples below were submitted by the Minnesota Department of Human Services (DHS). The first example shows the reporting of the APR-DRG along with the PMAP code. The second example shows just the reporting of the PMAP code. Other group purchasers may substitute their own "class of contract code" designation (such as the applicable product name or other contract category) for "PMAP MA" shown below.

E.2.1 Example for payers reporting both the PMAP code and the APR-DRG

```
CLP*CR19394TEST2*2*23346.99*0**MC*21628000400000000*11*0**159
CAS*CO*A1*23346.99
NM1*QC*1*DOE*JANE****MR*999999999
MIA*0****MA32*****M53*MA33
REF*CE*PMAP MA   APRDRG=54011 (see note below in section E.2.2 re formatting)
REF*1L*U
REF*EA*0853682
DTM*233*20150801
DTM*050*20161006
AMT*AU*11235.78
```

E.2.2 Formatting when the APR-DRG is reported

In the fifth line of the example above, REF*CE*PMAP MA APRDRG=54011, use 5 spaces between "MA" and "APRDRG=54011." In the same line, the class of contract code (APRDRG=) and the APRDRG number (54011) together cannot exceed 50 characters.

E.2.3 Interpretation of APR-DRG

APR-DRGs are reported with five digits. The first three digits are used to report the “base DRG.” The fourth digit is used to report the “severity of illness” and the fifth digit is used to report the “risk of mortality.

In the example above, the APRDRG is 54011, to be interpreted as follows:

- 54011: The first three digits (540) are used to report the base DRG.
- 54011: The fourth digit (1) is used to report the severity of illness.
- 54011: The fifth digit (1) is used to report the risk of mortality.

E.2.4 Example for payers reporting the PMAP code only (Non-inpatient claim or payer is not using the APR-DRG payment methodology)

CLP*CR19394TEST2*2*23346.99*0**MC*21628000400000000*11*0**159
CAS*CO*A1*23346.99
NM1*QC*1*DOE*JOHN****MR*99999999
MIA*0****MA32*****M53*MA33
REF*CE*PMAP MA
REF*1L*U
REF*EA*0853682
DTM*232*20150731
DTM*233*20150801
DTM*050*20161006
AMT*AU*11235.7

Minnesota Department of Health (MDH) Rule

Minnesota Uniform Companion Guide (MUCG) Version 14.0 for the Implementation of the ASC X12/005010X221A1 Health Care Claim Payment Advice (835)

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