
Minnesota Standards for the Use of the
Uniform Paper Explanation of Benefits
and
Uniform Paper Remittance Advice Report

August 1, 2007

As defined by the Commissioner of Health

Uniform Paper Explanation of Benefits
and
Uniform Paper Remittance Advice Report

Second Edition



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Protecting, maintaining and improving the health of all Minnesotans

Minnesota Department of Health

Division of Health Policy

Notice of Adoption of Rules Regarding a Manual of Minnesota Standards for the Use of the Uniform Paper Explanation of Benefits and Uniform Paper Remittance Advice Report as defined by the Commissioner of Health; per *Minnesota Statutes*, section 62J.581

Adoption: Notice is hereby given that the *Minnesota Standards for the Use of the Uniform Paper Explanation of Benefits and Uniform Paper Remittance Advice Report*, as proposed at *State Register*, Volume 31, Number 39, page 1338, March 26, 2007, (31 SR 1338) is adopted with the modifications set out at the end of this Notice.

Manual Available: The *Minnesota Standards for the Use of the Uniform Paper Explanation of Benefits and Uniform Paper Remittance Advice Report*, as defined by the Commissioner of Health, is available on the World Wide Web at <http://www.health.state.mn.us/auc/index.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 e-mail auc@health.state.mn.us.

Description and Statutory Reference: This *Minnesota Standards for the Use of the Uniform Paper Explanation of Benefits and Uniform Paper Remittance Advice Report* manual is a description of the conventions of use for the paper Remittance Advice Report and the paper Explanation of Benefits document. *Minnesota Statutes*, section 62J.581, outlines the standards for the Minnesota uniform health care reimbursement documents. The statute requires all group purchasers, as defined in *Minnesota Statutes*, section 62J.51, to provide a uniform remittance advice report to providers when a claim is adjudicated. The statute also requires group purchasers to provide a uniform explanation of benefits document to patients when the document is provided. 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. Because the Commissioner of Health has determined that it is unduly cumbersome to publish the entire text of the proposed rules, the Commissioner of Health is publishing this notice of the adopted rule with the modifications to the proposed rule.

Development: The Administrative Uniformity Committee (AUC) and its subcommittee on Explanation of Benefits and Remittance Advice Notice developed this rule. This rule was submitted for public comment in the *State Register*, Volume 31, Number 39, page 1338, March 26, 2007. The comment period was from March 26, 2007 until April 27, 2007. The Minnesota Department of Health collected the public comments. Thirteen comments were received. The AUC subcommittee on Explanation of Benefits and Remittance Advice Notice reviewed the comments and made modifications to the rule as listed following this notice.

Required Date of Compliance: The required date of compliance is August 1, 2007.

Dated: June 4, 2007

A handwritten signature in cursive script, reading "Dianne M. Mandernach", is written over a horizontal line.

Dianne M. Mandernach
Commissioner

* P.O. Box 64975 * Saint Paul, Minnesota 55164-0975 *

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Modifications:

The rule is adopted with the following modifications from the version proposed in the *State Register*, Volume 31, Number 39, page 1338, March 26, 2007:

Outside cover
~~June 30, 2007~~ August 1, 2007

Inside Cover
~~June 30, 2007~~ August 1, 2007

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Appendix D- 62J Statutes, sections 62J.50 – 62J.61 131- ~~146~~ 145

Appendix E-G 147- ~~149~~ 148

Page 1
~~June 30, 2007~~ June 4, 2007
Providers and payers must comply with these rules by ~~June 30, 2007~~ August 1, 2007.

Page 5
The required date of compliance is ~~June 30, 2007~~ August 1, 2007.

Page 21
Under “Definition of Claim Splitting:” In addition, with the implementation of the 5010 Technical Report payers must identify each claim as being part of a split claim by utilizing the Remittance Advice Remark Code MA15 (“Your claim has been separated to expedite handling. However, we strongly encourage the use of the Remittance Advice Remarks Code to communicate the splitting of a claim. You will receive a separate notice for the other services reported.”) on each of the adjudicated (split) claims.

Page 22
Under “Secondary Payment Reporting Considerations:”
~~For instance, when reporting an adjustment for a post operative visit service that is being denied because the payment was included in the payment for the surgery, the claim adjustments and the submitted product/service code fields must work together to report the complete message. This situation is similar to procedure code bundling, except that one of the submitted services is the adjudicated procedure code. The claim adjustment field will report an adjustment code of 97 (payment is included in the allowance for another service/procedure). But, this information is not adequate without reporting the surgery procedure code in the Adjudicated Product/Service Code field as well as the post operative procedure code in the Product/Service Code field.~~
This ability to report an adjudicated and submitted procedure code must always be implemented to:

- ~~Report changes in coding by the payer.~~

- ~~Report adjudication decisions based upon a service other than what was submitted by the provider for this line.~~

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Under “Splitting Line Requirements:”

- ~~Return~~ The 5010 Implementation Technical Report requires payers to return the line item control number from the original line on all split lines. If no line item control number was received, use the original line item sequence as the line item control number. However, we strongly encourage payers to return the line item control number prior to the implementation of the 5010 Technical Report.
- With the implementation of the 5010 Technical Report, payers must report N123 (This is a split service and represents a portion of the units from the originally submitted service.) in the Remark Code field (R-3M). However, we strongly encourage the use of the N123 to communicate the splitting of a line.

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~~June 30, 2007~~ August 1, 2007

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~~June 30, 2007~~ August 1, 2007

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~~Definition: This~~ The “Minnesota Standards for the Use of the Uniform Paper Explanation of Benefits and Uniform Paper Remittance Advice Report” manual published in 2005 required this data element is situational. This should be sent if applicable to the claim. Please note that effective with the 2007 manual, this is now an optional data element. Please reference page 117 for a list of optional data elements.

Page 87

~~Usage: This data element is situational. This is required when the rendering provider name is different from the payee name in R1-E. R2J (Rendering Provider Name) is required when R2K (Rendering Provider ID) is used.~~

Page 88

~~Definition: This is the payer assigned ID number, or the National Provider Identifier (NPI) when available, of the provider who performed the service. This provider ID pertains to the entire claim unless overridden at the line level by R-3C (Rendering Provider ID). This is required when the rendering provider ID is different from the payee ID in R-1G (Payee ID). It is not required if the rendering provider ID is identified on all claim lines in R-3C.~~

~~Usage: This data element is situational. It is required when the rendering provider is different than the payee (billing/pay to provider). This data element will contain the National Provider Identifier of the rendering provider. If the provider does not meet the definition of a health care provider, a payer assigned identifier for atypical providers will be sent. This section is intended for professional and dental claims only.~~

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: 2310B – Rendering Provider Name	Position: NM109	Segment: NM1 – Rendering Provider Name
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: 2310A – Attending Provider Name	Position: NM109	Segment: NM1 – Attending Provider Name
ANSI ASC X12-837 Version 4010A1 Dental	Loop: 2310B – Rendering Provider Name	Position: NM109	Segment: NM1 – Rendering Provider Name
ANSI ASC X12-835 Version 4010A1	Loop: 2100 – Claim Payment Information	Position: NM109	Segment: NM1 – Service Provider Name

Page 100

Usage: This data element is situational. This is required if available and different from R2K (Rendering Provider ID). This data element will contain the National Provider Identifier of the rendering provider. ~~If the provider does not meet the definition of a health care provider, a payer assigned identifier~~ This element cannot be used for atypical providers will be sent.

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: 2420A – Rendering Provider Name	Position: NM109	Segment: NM1 – Rendering Provider Name
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: 2420A – Attending Provider Name	Position: NM109	Segment: NM1 – Attending Provider Name
ANSI ASC X12-837 Version 4010A1 Dental	Loop: 2420A – Rendering Provider Name	Position: NM109	Segment: NM1 – Rendering Provider Name
ANSI ASC X12-835 Version 4010A1	Loop: 2110 – Service Payment Information	Position: REF02	Segment: REF – Rendering Provider Information

Definition: This is the Claim Adjustment Reason Code that explains the adjustment amount at the line level.

The following segments and/or data elements are situational. The use of these fields is allowed in the 835 implementation guide and on the paper remittance advice. These data elements are not included or required on the template.

- Foreign Currency Segment (CUR)
- Receiver ID Information Segment (REF)
- Provider Summary Information (TS3)
- Facility Type Code Data Element (CLP08)
- Claim Frequency Code Data Element (CLP09)
- Payee Address, City, State and Zip Code Segments (N3 and N4)
- Payee Additional Identification (REF)
- Insured Name Segment (NM1)
- Corrected Patient/Insured Name Segment (NM1). Note: Use of this segment is strongly suggested when the patient name is incorrect.
- Crossover Carrier Name Segment(NM1)
- Corrected Priority Payer Name Segment (NM1)
- Inpatient Adjudication Information Segment (MIA)
- Outpatient Adjudication Information Segment (MOA)
- Other Claim Related Identification (REF) Note: Some values in this segment are included in the template. Values considered optional include Member, Identification Number, Repriced Claim Reference Number, Adjusted Repriced Claim Reference Number, Employee Identification Number, Original Reference Number, Prior Authorization Number (Authorization Number is used), Predetermination of Benefits Identification Number, Insurance Policy Number, and Social Security Number.
- Authorization/Reference Number (R-2E) Claim Section
- Claim Contact Information Segment (PER)
- Claim Supplemental Information Segment (AMT)

D. Minnesota Statutes, sections 62J.50 – 62J.61 131- ~~146~~ 145

E. National Claim Adjustment Reason Codes Web Site Address~~147~~ 146

F. Remark Code Web Site Address~~148~~ 147

Throughout the entire Manual: The “Draft” watermark has been removed; Double spacing after sentences have been removed and replaced by single spacing; Formatting and punctuation changes have been made to improve readability.

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June 4, 2007

Providers and payers must comply with these rules by August 1, 2007.

Effective January 1, 1996, Minnesota providers are required to use uniform billing formats for medical, allied health, hospital and dental bills. Payers are required to accept these forms for claim payment purposes.

Minnesota Statutes section 62J.581, part of the Health Care Administrative Uniformity Act of MinnesotaCare legislation, requires payers to use the uniform paper EOB and remittance advice report.

To help payers complete the Uniform Paper EOB and Remit, the Administrative Uniformity Committee (AUC), a committee consisting of public and private payers and providers, has developed a user manual. Using the criteria outlined in the manuals will improve consistency in data and will help reduce health care costs.

The "Minnesota Standards for Use of the Uniform Paper EOB and Remittance Advice Report" manual will be available from Minnesota's Bookstore at (651) 297-3000 or (800) 657-3706. Updates will be available as often as required by changes in the claim form or billing practices; updates will seek to reduce variation in billing practices over time. The AUC will continue to work to improve the clarity and usefulness of the manual.

Questions?

- Questions about specific patients and their insurance claims should be directed to the payer of the claim.
- Questions, comments and recommendations for clarification or updates to the manual may be directed in writing to:

The Administrative Uniformity Committee
In care of: Minnesota Department of Health
Division of Health Policy
P.O. Box 64882, St. Paul, MN 55164-0882

Allina Hospitals and Clinics ◊ American Association of Healthcare Administrative Management ◊ Blue Cross Blue Shield of MN ◊ CentraCare Health System ◊ Children's Hospitals and Clinics ◊ Delta Dental Plan of MN ◊ Fairview Hospital and Health Care Services ◊ HealthEast ◊ HealthPartners – Health Plan ◊ HealthPartners – Medical Group and Regions Hospital ◊ Hennepin County Medical Center ◊ Hennepin Faculty Associates ◊ Mayo Clinic ◊ Medica Health Plan ◊ Metropolitan Health Plan ◊ MN Dental Association ◊ MN Department of Health ◊ MN Department of Human Services ◊ MN Department of Labor and Industry ◊ MN Hospital Association ◊ MN Medical Association ◊ MN Medical Group Management Association ◊ MN Pharmacists Association ◊ MN Uniform Billing Committee ◊ Noridian Administrative Services, L.L.C. - Medicare Part A ◊ Park Nicollet Health Services ◊ PreferredOne ◊ PrimeWest Health System ◊ St. Mary's/Duluth Clinic Health System ◊ UCare MN ◊ University of Minnesota Physicians ◊ Wisconsin Physician Services – Medicare Part B

Visit our website at: <http://www.health.state.mn.us/auc/index.html>

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Foreword

History:

The HealthCare Administrative Simplification Act (ASA) of 1994 offers health care providers and payers the opportunity to raise consumer awareness and strengthen customer satisfaction by implementing a set of administrative standards and simplified procedures throughout the industry. By developing consistent industry guidelines we not only help our customers, but we also eliminate much of the administrative burden associated with maintaining various billing practices and systems.

This manual has been developed by the Health Care Administrative Uniformity Committee (AUC) and the Explanation of Benefits/Remittance of Advice - Technical Advisory Group (EOB/Remit TAG) to help carry out the specifications of the HealthCare Administrative Simplification Act (ASA) of 1994. The AUC and its technical advisory group (TAG), consisting of representatives from providers, payers, professional associations, and consumers, have helped develop this implementation guide to further assist in the standardization effort. To remain in compliance with Minnesota State law, providers and payers are required to adopt all the conventions addressed in this manual.

Information on Electronic Remittance: The June 2007 edition of this manual is developed based upon the ANSI ASC X12 004010X091 A1 version of the Health Care Claim Payment/Advice 835 transaction mandated by the Administrative Simplification Act of 1996.

The manual for the ANSI ASC X12 004010X091 A1 transaction and the current list of Adjustment Reason Codes can be viewed at: www.wpc-edi.com.

Intent: The purpose of the remittance advice portion of the manual is to identify the minimum data set that must be included on a remittance advice as well as categorize the available data elements in the 835. Items that are situational need to be sent if the condition in the notes of the 835 transaction are met.

There are additional data elements in the 835 that have not been included in this template. These data elements are listed at the end of the remittance advice section of the manual.

Continuing Issues: This guide will be updated to remain current with State and Federal legislation and regulation. This is to be used in conjunction with other state and federal requirements for this type of document e.g. review, appeal, fraud abuse statements, etc.

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To remain in compliance with Minnesota state law, providers and payers doing business in the state of Minnesota are required to adopt all the conventions addressed in this manual. The required date of compliance is August 1, 2007. For background information please see page 3.

How to Use this Manual

Each page of the manual refers to a specific data element listed on the explanation of benefits document (EOB) and the remittance advice report (REMIT). The user should note that the term “field” may be used interchangeably with the term “data element.” Example layouts are attached for illustrative purposes, which include an alphanumeric reference for the EOB and the REMIT.

Title: The name which identifies the data element. It will identify whether or not a standard label is required.

Abbreviation: The designated abbreviation for the data element. The abbreviation may be used in lieu of the title.

Definition: This is the explanation of the data element. Definitions given are for illustrative purposes, but may not apply in all situations.

Usage: Indicates whether the data element is required or situational. Further explanation for proper use of the data element may also be provided in this section.

Example: This is a simple example of the data to be presented. Examples given are for illustrative purposes, and may not describe all situations.

Electronic

Concordance: The electronic concordance is a reference to the location of the data within the corresponding 837 claim transaction and the 835 remittance transaction and accompanying implementation guides.

General Characteristics

- The Minnesota Health Care Uniform explanation of benefits and remittance advice shall be provided as a paper document conforming to the data specifications in this manual.
- The templates on pages 29, 63, 65, 66, 121 and 123 are included in this rule for illustrative purposes only and not intended to be part of the requirement. Data content requirements and nomenclature are defined with each data element in the rule.
- The Minnesota Health Care Uniform explanation of benefits and remittance advice must include the data elements specified in this manual printed on standard 8.5 x 11-inch paper. The individual payer may determine the layout, portrait, or landscape.
- The EOB and REMIT must be numbered sequentially for the entire document.
- To ensure the documents can be scanned and are readable, care should be taken in selecting ink color, font size, and paper color.
- Avoid usage of special characters in all of the fields.

See page 9 for how to submit updates and suggestions for improvement to this manual

Definitions

835: the transaction ID for the X12 electronic health care claim payment/advice transaction used to support reimbursement processing for health care products and services.

Automated Clearing House (ACH): An electronic banking network operating system that processes credit and debit batch transactions known as ACH transactions. ACH credit and debit transfers include direct-deposit payments, insurance premiums, and mortgage loans. The ACH is governed by the Electronic Payments Association, previously known as the National Automated Clearing House Association (NACHA). See also Electronic Funds Transfer (EFT).

Accredited Standards Committees (ASC): committees responsible for developing standards

Adjustments: all types of adjudication, repricing or processing decisions applied to a claim for reimbursement that affect the amount of payment. Adjustments must be uniformly coded using the national claim adjustment reason codes.

American National Standards Institute (ANSI): a voluntary organization that approves standards developed by accredited standards committees. ANSI represents the United States on all international standards organization (ISO) committees.

Electronic Funds Transfer (EFT): the electronic mechanism that payers use to instruct one Depository Financial Institution (DFI) to move money from one account to another account within the same or at another DFI. The information required for the funds transfer is communicated electronically. May also be known as an ACH transaction. See also Automated Clearing House (ACH).

Explanation of Benefits (EOB): a statement sent to the recipient of services and/or their representatives showing how their claims were adjudicated.

Provider Organization: the organization identified by a distinct name such as a clinic, hospital or provider group, which provides health care services and bills group purchasers for those services. More than one provider organization may share the same federal tax identification number.

Remittance Advice (RA): a statement sent to providers and/or their representatives showing how their claims were adjudicated.

X12N: accredited standards committee that develops standards for electronic data interchange (EDI). "N" represents the Insurance subcommittee section of X12. See www.x12.org for more information on X12.

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Errors and Comments:

This manual was developed by the Minnesota Administrative Uniformity Committee and the Explanation of Benefits/Remittance of Advice - Technical Advisory Group (EOB/Remit TAG). It was reviewed for Minnesota business functionality by Minnesota payers, providers, and vendors.

However, you may find apparent errors, or business needs which the guide does not address. We encourage you to report these issues to the Minnesota Administrative Uniformity Committee using the format below. When possible, members of the Minnesota Administrative Uniformity Committee will take substantive issues forward to the appropriate state or national remittance related committee.

Date of manual: _____

Data Element Name: _____

Data Element Number (i.e. E-A1): _____

Narrative description of error or comment:

Optional:

Name: _____

Organization: _____

Address: _____

Phone: _____

Email: _____

Report errors to: **Minnesota Administrative Uniformity Committee**
In care of: Minnesota Department of Health
Division of Health Policy
Center for Data Initiatives
P.O. Box 64882, St. Paul, MN 55164-0882
auc@health.state.mn.us
Fax: 651-201-5179

Thank you. We appreciate your bringing these issues to our attention.

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Overview

Remittance Data Overview

Payment

Within this manual, “payee” refers to the actual providers and/or their agents. Likewise, “payer” refers not only to the actual payer but to any third party agent as well. The RA document contains information about the payee, the payer, amounts, and any identifying information related to the payment. Payment is made by electronic funds transfer, wire transfer, or check with each RA document receiving separate payment.

Remittance (RA)

The RA document provides detailed payment information relative to a health care claim(s) and, if applicable, describes why the total original charges have not been paid in full. This RA information is provided as “justification” for the payment, as well as input to the payee’s patient accounting system/accounts receivable (A/R) and general ledger applications.

The RA document consists of several separate levels. Sections R-1A to R-1K provide header information related to the entire RA and is required at the top of each page of the RA. Sections R-2A to R-2T provide information relating to one entire claim. Sections R-3A to R-3O provide line item detail information. Sections R-4A to R-4C contain the Provider Adjustment information. This section reports increases or decreases to the amount remitted and are not related to a specific claim.

Balancing

Amounts reported in the RA document, if present, **MUST** balance at three different levels—service line, the claim, and total RA. Adjustments within the RA, through use of Provider, Claim, or Service level adjustments **DECREASE** the payment when the adjustment amount is **POSITIVE**, and **INCREASE** the payment when the adjustment amount is **NEGATIVE**.

Service Line Balancing

Although the service payment information is situational, it is **REQUIRED** for all professional claims or any time payment adjustments are related to specific line items from the original submitted claim. When used, the submitted service charge minus the sum of all monetary adjustments must equal the amount paid for this service line.

Amount 1 - Amount 2 = Amount 3

Where:

Amount 1 — reported in the “Charge” (R-3I) field— is the submitted charge for this service.

Amount 2 — reported in the “Adjustment Amount” (R-3J) is the monetary adjustment amount applied to this service.

Amount 3 — reported in the “Payment Amount” (R-3N), is the paid amount for this service.

NOTES:

All services for the claim being adjudicated must be reported. This may be a subset of the original claim services when claims are split. See Claim Splitting Section, for the requirements when splitting claims.

Claim Balancing

Balancing must occur at the claim level so that the submitted charges for the claim minus the sum of all monetary adjustments equals the claim paid amount.

When the Service Payment Information is not present, the following formula applies:

$$\text{Amount 4} - \text{Amount 5} = \text{Amount 6}$$

Where:

Amount 4 — sent in the “Charge” (R-2P) field— is the submitted charge for this claim.

Amount 5 — sent in the “Adjustment Amount” (R-2Q) is the monetary adjustment amount applied to this claim.

Amount 6 — sent in the “Claim Payment Amount” (R-2T), is the paid amount for this claim.

NOTES:

The difference between balancing with or without the Service Payment Information is the inclusion or exclusion of the Claim Adjustment (R2Q) or Service Adjustment (R3J) monetary amounts.

When the Service Payment Information loop is present, adjustments are reported in either the Claim Adjustment (R2Q) or the Service Adjustment (R3J) Segment, but the same adjustment is not reported in both locations.

For example, if a \$100 deductible adjustment is taken at the service level, do not repeat that deductible at the claim level. It is preferred that the adjustment be shown at the service level when possible. When specific service detail is presented, the claim level balancing includes balancing the total claim charge (R-2P) to the sum of the related service charges. Service lines that are not finalized must be adjusted using a Claim Adjustment Group (R3K) code of 'OA' (Other Adjustment), a Claim Adjustment Reason code of 133 (This service is suspended pending further review) and the full dollar amount for the service in Adjustment Amount (R3J). When finalized, the claim must be reported using the instructions found in the Reversal and Correction section.

Remittance Balancing

Within the transaction, the sum of all payments minus the sum of all provider level adjustments equals the Payment Amount (R1I).

$$\text{Amount 10} - \text{Amount 11} = \text{Amount 12}$$

Where:

Amount 10 — the sum of all payments totaled in R-2P for the R-2T amounts — is the total of all claim payments included in this transaction.

Amount 11 — the sum of Provider Adjustment Amounts (R4C) reported in the Provider Adjustment Section — is the provider level adjustment made to the payment amounts.

Amount 12 — reported in the Payment Amount (R1I)— is the total payment amount of this RA.

NOTES:

A **POSITIVE** amount in Provider Adjustment Amount (R4C) indicates a **DECREASE** in the payment amount. A **NEGATIVE** amount in Provider Adjustment Amount (R4C) indicates an **INCREASE** in the payment amount.

Remittance Tracking

The Check/EFT Trace Number (R1H) contains the Trace Number for the transaction. The Trace Number is used to associate payments and remittances. It must be a unique number for this business purpose between the payer and the payee.

This will be:

- For check payments, it is the check number.
- For Electronic Funds Transfer (EFT) payments, it is the unique number assigned by the payer to identify this EFT.
- For non-payment RA it is a unique number generated by the payment originator as that RA's identification number (e.g., a control number).

NOTES:

Due to the need for RA tracking, there is a one to one relationship between any specific Remittance document and the related payment mechanism (check or EFT). One RA must only relate to a single payment mechanism and one payment mechanism must only relate to a single Remittance. The only exception is a non-payment, where there is no associated payment mechanism.

Claim Adjustment and Service Adjustment Segment Theory

The Claim Adjustment and Service Adjustment fields provide the reasons, amounts, and quantities of any adjustments that the payer made either to the original submitted charge or to the units related to the claim or service(s). The summation of the adjustments at the claim and service levels is the total adjustment for the entire claim. Service level adjustments are not repeated at the claim level.

A standardized list of claim adjustment reason codes is used in the Group Code (R2R and R3K) and Adjustment Reason Code (R2S and R3L) for both claim and service level adjustments. These codes provide the “explanation” for the positive or negative financial adjustments specific to particular claims or services that are referenced in the Remittance. Other financial adjustments can be expressed in the Provider Adjustment section.

The Blue Cross Blue Shield Association created a committee of payer and provider representatives to maintain the list of Adjustment Reason Codes. The list can be viewed at http://www.wpc-edi.com/ClaimAdjustment_40.asp; Maintenance requests may be handled from this site also.

The Group Code (R2R or R3K) categorizes the adjustment reason codes that are contained in a particular Adjustment Amount field.

The Claim Adjustment Group Codes are evaluated according to the following order:

1. Is the amount adjusted the patient's responsibility?

Use code **PR - Patient Responsibility**.

2. Is the amount adjusted not the patient's responsibility under any circumstances due to either a contractual obligation between the provider and the payer or a regulatory requirement?

Use code **CO - Contractual Obligation**.

An example of a contractual obligation might be a Participating Provider Agreement.

3. In the payer's opinion, is the amount in this segment not the responsibility of the patient, without a supporting contract between the provider and the payer?

Use code **PI - Payer Initiated**. **This code is NOT recommended for use.**

4. Is this claim the reversal of a previously reported claim or claim payment?

Use code **CR - Correction and Reversals**.

5. If no other category is appropriate:

Use code **OA - Other Adjustment**.

Avoid the Other Adjustment Group Code (OA) for financial adjustments, except when doing predetermination of benefits.

NOTES:

Only use the Adjustment Segment if needed.

At either level — the claim or the service— multiple adjustments can be made.

Adjustments do not get reported in a remittance in any specific order. The order for determining the applicable group code is not intended to require reporting the groups in that order.

Institutional-Specific Use

Within the institutional environment, certain circumstances require special handling.

Although it is customary in the non-institutional and outpatient environment to provide adjustments and full service line detail with the remittance advice, this situation is unusual for inpatient claims. There are circumstances when there is a need to provide service-specific adjustments, but it is not desirable to provide all service information. When working with room rate adjustments, administrative days, or non-covered days, it may be appropriate to provide these adjustments at the claim level and not provide service level detail. Claim Adjustment Reason Code 78, Non-covered Days/Room Charge Adjustment, is used in the Claim Adjustment Reason Code (R-2S) field to report an adjustment in the room rate or in the number of days covered. The associated adjustment amount provides the total dollar adjustment related to reductions in the number of covered days and the per day rate. The associated adjustment quantity is used to report the actual number of non-covered days.

Procedure Code Bundling and Unbundling

Procedure code bundling or unbundling occurs when a **payer** believes that the actual services performed and reported for a payment should be reported as a different group of procedure codes. Grouping usually results in a lower payment from the payer. Bundling occurs when two or more reported procedures are going to be reported as only one procedure code. Unbundling occurs when one submitted procedure code is to be reported as two or more different procedure codes. Unbundling results in an increase in the units of service for the claim.

Splitting of a service line with multiple units of service into multiple service lines and maintaining the same total units of service is not unbundling. See the section on “Service Line Splitting” (p.23) for additional information.

When bundling or unbundling occurs, the information must be reported back to the payee accurately to facilitate automatic entry into a patient accounting/accounts receivable system. In the interest of standardization, payers are to report bundling or unbundling in a consistent manner. When bundling, report all of the originally submitted procedures in the remittance advice. Report all procedures as paying on the changed (bundled) procedure code, and reference the original submitted code R-3G. The bundled service line must be adjusted up by an amount equal to the sum of the other line charges. This is reported as a service level adjustment with a group code OA (Other Adjustments) and a reason code of 94 (Processed in Excess of Charges) with a negative dollar amount. From that point, apply all normal adjustments to derive the reimbursement amount. Report the other procedure or procedures as originally submitted, with an adjudicated code of the bundled procedure code and a Claim Adjustment Reason Code of 97 (payment is included in the allowance for the basic service) and an adjustment amount equal to the submitted charge. The Adjustment Group is either CO (Contractual Obligation) or PI (Payer Initiated) depending on the provider/payer relationship.

Bundling Example

This is an example of a Preferred Provider Organization (PPO) claim.

- ❑ This example leaves out all of information not necessary to bundling.
- ❑ The provider submits procedure code ‘A’ and ‘B’ for \$100.00 each to the payer. The procedures were provided on the same date.
- ❑ The payers adjudication system reviews the submitted procedures and identifies that procedure ‘C’ covers the services rendered by the provider on that single date of service.
- ❑ The patient has a \$10.00 deductible.

Line Item Control Number R3A	Dates of Service R3B		Rendering Provider ID R3C	Rev Code R3D	Adjudicated Product/Service Code R3E	Modifier(s) R3F	Submitted Product/Service Code R3G	Units R3H	Charge R3I	Adjustment Amount R3J	Group Code R3K	Claim Adjustment Reason Code R3L	Remark Code R3M	Payment Amount R3N	Adjustment Quantity R3O
	From	To													
1	1/1/07				C		A	1	100.00	10.00	PR	1			
										-100.00	OA	94		190.00	
2	1/1/07				C		B	1	100.00	100.00	CO	97		0	
									200.00	10.00				190.00	

Unbundling

When unbundling, report the original service as the first of the new services with the original submitted charge in 'Charge' (R-3I) field. Use the following lines for the other new services. For these other services, report the submitted charge as zero dollars (\$0.00) in this field. As in bundling, the adjustment amount field is used in conjunction with the 'Group Code' and 'Claim Adjustment Reason Code' fields to increase the submitted charge from \$0.00 to the allowed amount for each procedure. Report the original procedure code in each line of the remittance. Balancing must be maintained for all services.

Unbundling Example

- ❑ The provider submits a claim for \$200.00 for service 'A'.
- ❑ The payer unbundled this into 2 services 'B' and 'C' each with an allowed amount of \$80.00
- ❑ There is a \$10.00 deductible due.

Line Item Control Number R3A	Dates of Service R3B		Rendering Provider ID R3C	Rev Code R3D	Ajudicated Product/Service Code R3E	Modifier(s) R3F	Submitted Product/Service Code R3G	Units R3H	Charge R3I	Adjustment Amount R3J	Group Code R3K	Claim Adjustment Reason Code R3L	Remark Code R3M	Payment Amount R3N	Adjustment Quantity R3O
	From	To													
1	1/1/07				B		A	1	200.00	120.00	CO	45			
										10.00	PR	1		70.00	
1	1/1/07				C		A		0	-100.00	OA	94			
										20.00	CO	45		80.00	
									200.00	50.00				150.00	

Partial Unbundling

Partial unbundling may occur when a bundled panel of services, such as a lab panel or a surgical panel, is billed under a single HCPCS assigned to that panel, and a denial or reduction is made related to only one or some of the services in that panel. For example, two lab panels may include the same lab test. The full amount would be payable for the first panel, but a lesser amount may be due for the second panel due to the overlap. Rather than totally unbundle the panels to be able to report detail on individual services within the panel, it is possible to partially unbundle to highlight only the individual service being adjusted. If this is done, however, you must report the regular allowed and payable amounts for the panel, then use a negative payment with the single adjusted service to offset for that reduction and to link that individual service to the HCPCS for the affected panel. The allowed amount for the single unbundled adjusted service in the panel must be reported as 0 when there is partial unbundling. This results in an increase in the units of service for the claim. Splitting of a service line with multiple units of service into multiple service lines and maintaining the same total units of service is not unbundling.

Partial Unbundling Example (Two lab panels billed and one test repeated in each):

Line Item Control Number R3A	Dates of Service R3B		Rendering Provider ID R3C	Rev Code R3D	Adjudicated Product/Service Code R3E	Modifier(s) R3F	Submitted Product/Service Code R3G	Units R3H	Charge R3I	Adjustment Amount R3J	Group Code R3K	Claim Adjustment Reason Code R3L	Remark Code R3M	Payment Amount R3N	Adjustment Quantity R3O
	From	To													
1	1/1/07				80049			1	42.00					42.00	
2	1/1/07				80054			1	30.00					30.00	
2	1/1/07				82435		80054	0	0	6.00	CO	18		-6.00	
									72.00	6.00				66.00	

NOTES:

When following Unbundling or Partial Unbundling procedures, payers are required to return all service lines related to a single submitted service line on the same claim. The claim splitting process specified cannot be applied to the parts of an unbundled submitted service.

Predetermination of Benefits

A Remittance Advice also may contain information about future remittances that are to be paid when specified services are completed. The future payment is expressed as an adjustment – please use the Claim Adjustment Group code of OA, “other adjustment,” and a Claim Adjustment Reason Code of 101, “predetermination, anticipated payment upon completion of services.”

A predetermination must balance within a transaction set in the same way that claim payments must balance. Because the payment amount is actually zero now, adjustments must be adequate to reduce the claim balance to zero. Effectively, a predetermination is informational only and can be contained in an RA that pays other claims.

Reversals and Corrections

When a claim is paid in error, the method for correcting it is to reverse the original claim payment and resends the corrected data. This helps the providers control the accuracy and integrity of their receivable systems.

Example

In the original Preferred Provider Organization (PPO) payment, the reported charges were as follows:

- Submitted charges \$100.00
- Adjustments
- Disallowed amount \$20.00
- Coinsurance \$16.00
- Deductible \$24.00
- Payment amount \$40.00

Original Payment

Line Item Control Number R3A	Dates of Service R3B		Rendering Provider ID R3C	Rev Code R3D	Adjudicated Product/Service Code R3E	Modifier(s) R3F	Submitted Product/Service Code R3G	Units R3H	Charge R3I	Adjustment Amount R3J	Group Code R3K	Claim Adjustment Reason Code R3L	Remark Code R3M	Payment Amount R3N	Adjustment Quantity R3O
	From	To													
1	1/1/07				A			1	100.00	20.00	CO	45			
										16.00	PR	2			
										24.00	PR	1		40.00	
									100.00	60.00					40.00

The payer found an error in the original claim adjudication that requires a correction. In this case, the disallowed amount should have been \$40.00 instead of the original \$20.00. The co-insurance amount should have been \$12.00 instead of \$16.00, and the deductible amount did remain the same.

Reversal Method

Reverse the original payment, restoring the patient accounting system to the preposting balance for this patient. Then, the payer sends the corrected claim payment to the provider for posting to the account.

Reversal Payment

Line Item Control Number R3A	Dates of Service R3B		Rendering Provider ID R3C	Rev Code R3D	Adjudicated Product/Service Code R3E	Modifier(s) R3F	Submitted Product/Service Code R3G	Units R3H	Charge R3I	Adjustment Amount R3J	Group Code R3K	Claim Adjustment Reason Code R3L	Remark Code R3M	Payment Amount R3N	Adjustment Quantity R3O
	From	To													
1	1/1/07				A			1	-100.00	-20.00	CR	45			
										-16.00	CR	2			
										-24.00	CR	1		-40.00	

Corrected Payment

1	1/01/07				A			1	100.00	40.00	CO	45			
										12.00	PR	2			
										24.00	PR	1		24.00	
									0.00	16.00				-16.00	

NOTES

Caution: while the payment amount (R3P) for this claim can be zero or less, the reversal must not cause the total payment for this Remittance (R1I) to become negative.

Provider Level Adjustments

Provider level adjustments are not related to a specific claim but to the total payment amount of the Remittance. Convey these types of financial adjustments in the Provider Adjustment field. Such adjustments are financially independent from the formula for determining benefit payments on behalf of the beneficiary receiving care. Consequently, providers must be able to post these types of adjustments to the general ledger rather than to the patient's account receivable.

The nature of the financial adjustments conveyed on the Provider Adjustment page is identified in Provider Adjustment Code (R-4A). The payments can either increase — reported as a **negative** number — or decrease — reported as a **positive** number — the payment amount (R-1I).

The valid code values for Provider adjustments are located in Appendix H. It should be noted that Medicare A and Medicare B both have exceptions to this list.

Capitation and Related Payments or Adjustments

The RA is used to provide financial notification of capitation payments from a Managed Care Organization (MCO) to a capitated care provider. The RA does not contain the capitation details or the membership roster. Use an associated Eligibility and Benefits Notification Transaction Set (271) to communicate these details.

Capitation payments may be included with the claims payment information in a single RA or they may be passed alone. In either case, the existing balancing process for the RA applies. Capitation payments and adjustments are reported in the R-4A, B and C fields. See provider level adjustment section for element specifics.

For identification and explanation purposes, use the following codes in the R-4A element to define Capitation amounts:

- **AM - Applied to Borrowers Account**
Loan Repayment is a repayment to the MCO of monies previously paid to the capitated provider for purchasing equipment. The repayment amount is deducted from the usual periodic payment that the provider would otherwise receive from the MCO.
- **BN - Bonus**
Bonus Payment is an additional payment made to a primary care physician or other capitated provider at a set time agreed upon by both parties, usually to recognize performance above usual standards. The bonus payment may be based upon utilization parameters, quality measurements, membership services performed, or other factors.
- **CR - Capitation Interest**
Interest payments represent a percentage payment in excess of the usual amount, paid to the capitated provider as a result of a late payment by the MCO or as a result of funds previously withheld.

- **CT - Capitation Payment**
Capitation Payment is a set dollar amount paid to the primary care physician or other capitated provider selected by the member for the provision of services agreed upon by the provider and the MCO. The dollar amount may be based upon a member's age, sex, specific plan under which the member is enrolled, benefit limitations, or other predetermined factors. The payment is made at periodic set times generally defined in the contractual arrangement between the provider and the MCO.
- **E3 - Withholding**
Withholding is a set dollar amount or percentage of the capitation payment deducted per the contractual agreement between the provider and the MCO. This amount may be returned to the provider at a later date, usually as a result of meeting specific performance requirements defined in the agreement.
- **FC - Fund Allocation**
Fund Allocation is a methodology used to distribute payments made to the primary care or other capitated provider from funds designated for allocation. Funds may be prepaid amounts where deductions are withdrawn over a set period as services are provided.
- **IP - Incentive Premium Payments**
Incentive Premium Payments are additional payments made to a capitated provider to acknowledge high quality services or to provide additional services that are not routinely considered as capitated services by the MCO. This payment also may be used as a financial incentive to sign new providers to the managed care network.
- **L3 - Penalty**
A Penalty is a deduction made in the financial payment to the capitated provider as a result of non-fulfillment of a requirement stipulated in the contractual agreement between the provider and the MCO. Generally, the actual sum forfeited is defined in the agreement.
- **RA - Retro-Activity Adjustment**
Retro-activity payments, adjustments, and notification are given to the capitated provider for an enrolled member who had selected or changed a capitation provider for a time period before the current payment period. This adjustment usually occurs because of late notification from an employer and/or member after the set cutoff time for a capitation payment/notification. This adjustment may result in a payment deduction to the provider in circumstances where the member disenrolled or was terminated from coverage under the MCO during a previous payment period.
- **TL - Third Party Liability**
Third Party Liability indicates that another entity is liable for the payment of health care expenses. The capitation payment may be reduced for the reported time period as a result of the payment from the other responsible party.

Definition of Claim Splitting

A claim submitted to a payer may, due to a payer's adjudication system requirements, have service line(s) separated from the original claim. The commonly used term for this process is 'splitting the claim'. Each portion of a claim that has been split has a separate claim control number, assigned by the payer and the sum of the service line(s) charge submitted on each split claim becomes the split claim total charge.

An example of this type of processing is a multi-line claim that contains a service line, which requires further information to finalize. By splitting the pending service line to a separate claim, the payer can then adjudicate the remainder of the claim/service lines submitted. Once the split claim is finalized, the adjudication information for the split claim will be returned to the provider.

To assist the provider in reconciling their patient accounts, the payer must retain and return basic original claim information in each of the adjudicated claims. The original claim submitter's identifier must be returned on all split claim. The provider's original submitted line item control number from the claim must be returned. If the original claim did not contain a specific line item control number for the service lines, the line item sequence number from the original claim must be used instead.

In addition, with the implementation of the 5010 Technical Report payers must identify each claim as being part of a split claim by utilizing the Remittance Advice Remark Code MA15 ("Your claim has been separated to expedite handling. However, we strongly encourage the use of the Remittance Advice Remarks Code to communicate the splitting of a claim. You will receive a separate notice for the other services reported.") on each of the adjudicated (split) claims.

Balance Forward Processing

A common practice within Health Care claim processing is the review and re-adjudication of claims. This practice sometimes results in additional payments to the provider. Other times it results in a reduction in the payment amount. While the reversal and correction process identifies the process for reporting these changes, one aspect has been left out. Since the RA is a financial transaction and not just a report, the payment amount can not be negative. The question then arises, what do you do when refunds from reversals and corrections exceed the payments for new claims, resulting in a net negative payment?

The answer is Balance Forward Processing. The Provider Adjustment segment's ability to report adjustments not related to a specific claim also allows for a balance forward adjustment. This capability allows a payer to move the negative balance from the current RA transaction into a future transaction.

The business objectives are:

- Increase the net for the current RA to \$0.00.
- Add the previous balance into a future RA transaction.
- Identify to the provider what has happened.
- Identify a reference number for reconciliation of the balance forward process.

Moving a negative balance out of the current RA, when a net negative payment is detected in a RA is corrected by adding a balance forwarding adjustment in the Provider Adjustment Section of the RA. The reference number in the Provider Adjustment Section will contain the same number as the trace number of the current transaction. This reference number will facilitate tracking by the provider. The dollar amount in the PLB will be the same as the current, negative, balance. Since the balancing section, specifies that the transaction balance is the claim payment total minus the provider level adjustments, the transaction payment amount will now be \$0.00.

Secondary Payment Reporting Considerations

Many patients are covered by more than one health benefit payer. In multi-payer situations, a hierarchy is established as to which plan is primary, secondary, or tertiary as applicable for payment of a patient's health care expenses. Secondary and tertiary payers are frequently referred to as "secondary" payers. Most secondary payers adjust their payments so that the total payments, primary and secondary, do not exceed the billed charges for covered services.

Each health plan defines when that plan is primary, secondary, or tertiary for a covered individual. Each payer's plan also generally defines its calculation methodology to determine its payment for services when another payer is primary. The calculation methodology often includes adjustments when the primary allows a higher or lower payment amount for a service than the secondary, if the primary's plan does not cover one or more services on a multi-service claim, if the amounts of deductible or coinsurance differ under the plans, or for other variables. To eliminate a possible disincentive for enrollment in more than one plan, some payers do not consider the full amount of the primary's payment when calculating their secondary payment.

From the perspective of the secondary payer, the impact of the primary's payment is a reduction in their payment amount. This "impact" may be up to the actual amount of the primary payment. Report the "impact" primary payment in the correct claim or service level claim adjustment elements with reason code 23 (Claim adjusted because charges have been paid by another payer as part of coordination of benefits) with a group code of "OA" (Other Adjustment). It is essential that any secondary payer report in the remittance advice only the primary amount that has actually impacted their secondary or tertiary payment. In many cases, this "impact" primary payment is less than the actual primary payment. When this happens, reporting the "actual" primary payment would prevent the transaction from balancing.

Service Line Issues

The Remittance Advice (remit) provides two locations for service line procedure information. The Adjudicated Product/Service Code field always contains the coding for the procedure used in adjudication. The Submitted Product/Service Code field contains the original procedure code submitted by the provider when it is different than the code in Adjudicated Product/Service Code. Use of both of these locations is necessary to maximize administrative simplification benefits.

Service Line Splitting

During the adjudication process there may be times when a service line needs to be split. This section explains and shows examples of how service line splitting must be reported in the remit. This section also differentiates between Service Line Splitting and Unbundling of a service line.

Line splitting reported in the Remit may only be a result of a business issue. Line splitting, as a result of an adjudication system limitation (technical issue), must be recombined prior to reporting in the Remit. To help clarify this, examples of both types of issues are given below.

Business issues:

There may be times when a service line may need to be split by the payer for business reasons. Examples when service line splitting is necessary include, but are not limited to:

- The date of service range crosses a change in coverage
- Some units process under one adjudicated procedure code and others process under a different adjudicated code
- Some units process under one benefit rate and others process under a different benefit rate.

Technical Issues (System Limitations):

Technical limitations are another reason for line splitting within the adjudication system. For example, the adjudication system only handles 2 place positions for units of service therefore 101 units submitted would be split into 99 units and 2 units respectively. In some payer systems there are limitations on date ranges, forcing lines to be split to separate units by date. This is not to say that the claims system can not split lines, but they must be recombined on the remittance.

Characteristics of Line Splitting versus Unbundling:

Line Splitting:

- A submitted service line would be split into multiple lines.
- Adjudicated Procedure code may or may not be the same as the submitted procedure code across split service lines.
- The sum of the split line units must equal the total submitted units from the original service line.

Unbundling:

- A submitted service line is reported as more than one Adjudicated Product/Service Code.
- The adjudicated procedure code in the R-3G segment will always be different than the submitted procedure code. Note: an exception to this is partial unbundling.
- The sum of the unbundled units of service is greater than the total submitted units from the original service line.

NOTE

When both line splitting and unbundling are required, the payer must first apply the splitting logic, and then the unbundling logic.

Splitting Line Requirements:

When reporting split service lines in the Remit you must:

- Retain the original submitted procedure code
- Sum of split lines units of service must equal the original submitted units of service with each split line.
- Allocate the submitted charge proportionately by units of service across the split lines. The sum of the split lines submitted charges must equal the original submitted line charge.
- The 5010 Implementation Technical Report requires payers to return the line item control number from the original line on all split lines. If no line item control number was received, use the original line item sequence as the line item control number. However, we strongly encourage payers to return the line item control number prior to the implementation of the 5010 Technical Report.
- With the implementation of the 5010 Technical Report, payers must report N123 (This is a split service and represents a portion of the units from the originally submitted service.) in the Remark Code field (R-3M). However, we strongly encourage the use of the N123 to communicate the splitting of a line.

Line Splitting across Claims:

An example of Service line splitting:

A claim with 5 revenue lines, the lines are split on to two claims, where two of the lines will remain on the original claim, two will be moved to the new claim and the last line will be split between the two claims based on periods of service. Thus, there is no procedure code change and the units remain the same, just split between two claims. It is possible to have an original claim with split lines that are also split to separate claims. For example, a business reason for splitting a claim is when service line dates of service cross the dates of service of a benefit plan. Another example for splitting the claim is when some lines are going to be further reviewed and other lines are ready to be paid. Additionally these two situations can result in split lines across split claims. Criteria for split claims and split lines must be maintained in this situation. These are:

- Claim submitters identifications must be returned on all split claims.
- The amount on each claim becomes the split claim total charge.
- The original submitted line item control number or (when not present) the line item sequence number from the claim must be returned.
- Remark codes at the service level and claim level are required in this situation.

PPO Networks and Contract Types

Many payers may encounter a situation where a particular provider has contracted with several different Preferred Provider Organizations, contract types or networks (PPO's) offered by that payer. This section explains how to communicate to a provider which contract applies to a particular claim. When adjusting the claim for the PPO discount, the amount of the adjustment is reported in the Adjustment Amount segment (R-2Q or R-3J) using CO, contractual obligation in the Group Code fields (R-2R or R-3K), an appropriate adjustment reason code (R-2S or R-3L) and amount (R-2Q or R-3J). The name or identifier of the PPO is reported in Contract Header (R-2H).

Claim Overpayment Recovery

While all health plans strive for accurate adjudication, occasionally errors are detected, sometimes through an appeal process, that result in changes to either the amount paid or the allocation of responsibility for unpaid balances. When the payment increases or the responsibility (contractual obligation versus patient responsibility) changes without a change in payment the Reversal and Correction section of this manual describes the necessary steps. However, when the review results in a reduction of the claim payment amount, the business gets more complicated in how to accomplish an overpayment recovery. Basically, there are three business approaches to claim overpayment recovery. The health plan should specify its methodology for claim overpayment recovery in either a trading partner agreement or a provider contract.

- 1.** A health plan may choose to immediately recoup the overpayment within the current remittance advice. When this is the business model, the reversal and corrections section describes the necessary steps.
- 2.** A health plan may choose to not immediately recoup the funds and use a manual reporting process to the provider. This process involves sending a letter identifying the claim, the changes to the adjudication, the balance due to the health plan and a statement identifying how long (or if) the provider has to remit that balance. This document must contain a financial control number (FCN) for tracking purposes. Upon receipt of the letter, the provider must manually update the accounts receivable system to record the changes to the claim payment and issue a refund to the health plan.

If the provider chooses (or is instructed) not to remit the overpayment by the established deadline, then the health plan will recoup the funds in a future remit. This is accomplished using the Provider Adjustment section of the RA, and NOT the reversal and correction procedure. Reversal and correction is not appropriate since the provider has already been notified with the necessary information to update their system. The Provider Adjustment code WO (Overpayment Recovery) is used to identify the recovery.

- 3.** The health plan may use a combination of methods 1 and 2 for overpayment recovery. The reversal and correction process would provide the claim specific information. Within the same RA, a provider adjustment segment is then used to return the funds to the provider and NOT reduce the current payment. This is effectively delaying the recovery of funds within the RA. The FCN reported would be the health plan's internal control number for the claim involved in the recovery. The external agreement identifying how the health plan is doing overpayment recovery would specify the time period within which the provider may send the payment or that the provider may not send the payment.

WO (Overpayment Recovery) is used with a negative dollar amount to eliminate the financial impact of the reversal and correction from the current RA. When the payment is received from the provider, or the health plan recoups the funds, the process identified in option 2 is followed to report the payment or recoup the funds, as appropriate.

Example: The health plan re-adjudicates a claim (number 837483) resulting in an overpayment recovery of \$37.50 from provider number 1234. The reversal and correction are reported in the RA with a Provider Adjustment Segment to reverse the current financial impact.

The provider remits the balance before the deadline identified in the agreement with the health plan. The next RA reconciles the payment with the previous receivable using the PLB segment.

Reporting Encounters in the Remittance Advice (RA)

The health plan should specify its methodology for reporting encounters in either a trading partner agreement or a provider contract. Encounters (services covered under a capitation agreement between the payer and the provider) present special challenges in the RA. To be an encounter for RA purposes, both the payer and provider must agree that the claim and/or service are an encounter. The payer identifies this through adjudication. The provider identifies this to the payer by the charge on the claim and/or service. A service that the provider believes is an encounter was submitted with a charge of \$0.00. An encounter claim would have all services and the claim with a charge of \$0.00.

Minnesota Standards for the Use of the
Uniform Paper Explanation of Benefits Document
and
Uniform Paper Remittance Advice Report

August 1, 2007

As defined by the Commissioner of Health

Part I
Uniform Paper Explanation of Benefits

Second Edition



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Explanation of Benefits

This is not a bill

E-A1 PLAN INC. E-A2 P.O. Box 22556 Any town, MN 99999					E-A3 Contact: Customer Service E-A4 2597 First Ave Any Town, MN 99999-9999 E-A5 (800) 123-4567 or (123) 123-4567 Fax (555) 555-1234 Email@email.com						
E-B1 Subscriber Name					Jane Doe						
E-B2 Patient Name					John Doe						
E-B3 Patient ID					ABC12345						
E-B4 Group/Policy					11111-1111						
E-C1 Claim Number					80036000000						
E-C2 EOB Date					10/16/2007						
E-C3 Provider					ABC Hospital						
E-C4 Patient Control Number					7232145611475						
E-D1 Dates of Service	E-D2 Description	E-D3 Charges	E-D4 Provider Responsibility Amount	E-D5 Allowed Amount	E-D6 Patient Non-covered Amount	E-D7 Deductible Amount	E-D8 Co-pay Amount	E-D9 Co-insurance Amount	E-D10 Paid Amount	E-D11 Amount You Owe	E-D12 Notes ID
From To											
10/01/07 10/02/07	Lab	250.00	130.00	120.00	7.00	60.00	0.00	0.00	53.00	67.00	1
10/02/07	Lab	85.00	0.00	0.00	85.00	0.00	0.00	0.00	0.00	85.00	2
10/02/07	Office	90.00	65.00	25.00	0.00	0.00	0.00	13.00	12.00	13.00	
10/02/07	X-ray	100.00	83.00	17.00	0.00	0.00	10.00	0.00	7.00	10.00	
		525.00							72.00	175.00	
E – E1 Notes						E-F1 Total Charges			525.00		
1 Charges exceed maximum allowed under your benefits. 2 Claim/service denied because the payer has deemed the procedure or treatment experimental or investigational.						E-F2 Total Benefit Amount			72.00		
						E-F3 Total Amount Paid by Other Insurance			0.00		
						E-F4 Total Amount You Owe			175.00		

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E-A1 Report Header Section – Group Purchaser or Payer Name

Title: No standard label is required for this data element/field.

Definition: This is the name that identifies the payer. This data element is required at the top of each page of a multi-page remittance.

Usage: This data element is required on all explanation of benefits.

Example: Plan Inc.

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: 2010BB – Payer Name	Position: NM103	Segment: NM1 – Payer Name
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: 2010BC – Payer Name	Position: NM103	Segment: NM1 – Payer Name
ANSI ASC X12-837 Version 4010A1 Dental	Loop: 2010BB – Payer Name	Position: NM103	Segment: NM1 – Payer Name
ANSI ASC X12-835 Version 4010A1	Loop: 1000A – Payer Identification	Position: N102	Segment: N1 – Payer Identification

E-A2 Report Header Section -- Payer Address

Title: No standard label is required for this element.

Definition: This is the complete mailing address of the payer.

Usage: This data element is required on all explanation of benefits.

Example: P.O. Box 22556
Anytown, MN 99999

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: 2010BB - Payer Name	Position: N301 N302 N401 N402 N403	Segment: N3 – Payer Address N4 – Payer City/State/Zip
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: 2010BC – Payer Name	Position: N301 N302 N401 N402 N403	Segment: N3 – Payer Address N4 – Payer City/State/Zip
ANSI ASC X12-837 Version 4010A1 Dental	Loop: 2010 BB – Payer Name	Position: N301 N302 N401 N402 N403	Segment: N3 – Payer Address N4 – Payer City/State/Zip
ANSI ASC X12-835 Version 4010A1	Loop: 1000A – Payer Identification	Position: N301 N401 N402 N403	Segment: N3 – Payer Address N4 – Payer City/State/Zip

E-A3 Report Header Section – Payer’s Contact Name

Title: The standard label required for this data element is “Contact.”

Abbreviation: None

Definition: This is the name of the entity or person that the patient is to contact regarding questions on the Explanation of Benefits document.

Usage: This data element is required on all explanation of benefits.

Example: Customer Service

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Dental	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-835 Version 4010A1	Loop: 1000A - Payer Identification	Position: PER02	Segment: PER - Payer Contact Information

E-A4 Report Header Section – Payer’s Contact Address

Title: No standard label is required for this element.

Abbreviation: None

Definition: This is the payer’s address for any written correspondence from the patient.

Usage: This data element is situational. The data element is required if different from the payer’s general business address.

Example: 2597 First Ave
Anytown, MN 99999

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Dental	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-835 Version 4010A1	Loop: N/A	Position: N/A	Segment: N/A

E-A5 Report Header Section - Payer's Contact Information

Title: No standard label is required for this data element. If a fax number is provided use the standard label of "Fax."

Abbreviation: None

Definition: This is the local and / or toll free telephone number, fax, TDD/TTY or email address to contact the payer.

Usage: This data element is required on all explanation of benefits.

Example: (800) 123-4567 and (555) 123-4567
 Fax (555) 555-1234
Email@email.com

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Dental	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-835 Version 4010A1	Loop: 1000A - Payer Identification	Position: If PER03 (or PER05) = TE, then PER04 (or PER06) is the telephone number = EM, then PER04 (or PER06) is the email address = FX , then PER04 (or PER06) is the fax number	Segment: PER - Payer Contact Information

E-B1 Patient Section – Subscriber Name

Title: The standard label required for this data element is “Subscriber Name.”

Abbreviation: Subscriber

Definition: This is the name that identifies the policyholder, member, subscriber, or enrollee.

Usage: This data element is situational. It is required only if the subscriber is different from the patient.

Example: Jane Doe

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: 2010BA – Subscriber Name	Position: NM103 NM104 NM105	Segment: NM1 – Subscriber Name
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: 2010BA – Subscriber Name	Position: NM103 NM104 NM105	Segment: NM1 – Subscriber Name
ANSI ASC X12-837 Version 4010A1 Dental	Loop: 2010BA – Subscriber Name	Position: NM103 NM104 NM105	Segment: NM1 – Subscriber Name
ANSI ASC X12-835 Version 4010A1	Loop: 2100 – Claim Payment Information	Position: If NM101=IL, then NM103 NM104 NM105	Segment: NM1 – Insured Name

E-B2 Patient Section – Patient Name

Title: The standard label required for this data element is “Patient Name.”

Abbreviation: Patient

Definition: This is the name that identifies the patient.

Usage: This data element is required on all explanation of benefits.

Example: John Doe

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: 2010CA – Patient Name (if subscriber is patient) – 2010BA – Subscriber Name)	Position: NM103 NM104 NM105	Segment: NM1 – Patient Name (NM1 – Subscriber Name)
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: 2010CA – Patient Name (if subscriber is patient) – 2010BA – Subscriber Name)	Position: NM103 NM104 NM105	Segment: NM1 – Patient Name (NM1 – Subscriber Name)
ANSI ASC X12-837 Version 4010A1 Dental	Loop: 2010CA – Patient Name (if subscriber is patient) – 2010BA – Subscriber Name)	Position: NM103 NM104 NM105	Segment: NM1 – Patient Name (NM1 – Subscriber Name)
ANSI ASC X12-835 Version 4010A1	Loop: 2100 – Claim Payment Information	Position: NM103 NM104 NM105	Segment: NM1 – Patient Name

E-B3 Patient Section – Patient ID

Title: The standard label required for this data element is “Patient ID.”

Abbreviation: None

Definition: This is the payer assigned patient identifier that uniquely distinguishes the patient in the payer’s system. If the payer does not use patient identifiers this element is not required.

Usage: This data element is situational.

Example: ABC12345

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: 2010CA – Patient Name (if subscriber is patient) – 2010BA – Subscriber Name)	Position: NM109	Segment: NM1 – Patient Name (NM1 – Subscriber Name)
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: 2010CA – Patient Name (if subscriber is patient) – 2010BA – Subscriber Name)	Position: NM109	Segment: NM1 – Patient Name (NM1 – Subscriber Name)
ANSI ASC X12-837 Version 4010A1 Dental	Loop: 2010CA – Patient Name (if subscriber is patient) – 2010BA – Subscriber Name)	Position: NM109	Segment: NM1 – Patient Name (NM1 – Subscriber Name)
ANSI ASC X12-835 Version 4010A1	Loop: 2100 – Claim Payment Information	Position: NM109	Segment: NM1 – Patient Name

E-B4 Patient Section – Group/Policy

Title: The standard label required for this data element is “Group/Policy.”

Abbreviation: None

Definition: This is the payer assigned group number, policy number, plan number or name that uniquely distinguishes the patient’s coverage in the payer’s system.

Usage: This data element is situational. If the payer does not use this identifier this element is not required. This field may be used to report the case number.

Example: 11111111

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: 2000B – Subscriber Hierarchical Level	Position: SBR03	Segment: SBR – Subscriber Information
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: 2000B – Subscriber Hierarchical Level	Position: SBR03	Segment: SBR – Subscriber Information
ANSI ASC X12-837 Version 4010A1 Dental	Loop: 2000B – Subscriber Hierarchical Level	Position: SBR03	Segment: SBR – Subscriber Information
ANSI ASC X12-835 Version 4010A1	Loop: 2100 – Claim Payment Information	Position: If REF01 = 1L then REF02	Segment: REF – Other Claim Related Identification

E-C1 Claim Section –Claim Number

Title: The standard label required for this data element is “Claim Number.”

Abbreviation: Claim # (or “Claim Nbr”)

Definition: This is the identifier assigned by the payer to uniquely identify each patient claim as adjudicated. Some payers may refer to this internally as a DCN or ICN.

Usage: This data element is situational. This is required if created by the payer.

Example: 80036000000

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Dental	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-835 Version 4010A1	Loop: 2100 – Claim Payment Information	Position: CLP07	Segment: CLP – Claim Payment Information

E-C2 Claim Section – EOB Date

Title: No standard label is required for this data element.

Definition: This is the date that identifies the resolution of the claim. Its interpretation may include but is not limited to the claim process date, the print date or the payment issuance date.

Usage: This data element is required on all explanation of benefits.

Example: MMDDCCYY
10162004

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Dental	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-835 Version 4010A1	Loop: Header	Position: BPR16	Segment: BPR – Financial Information

E-C3 Claim Section - Provider

Title: The standard label required for this data element is “Provider.”

Abbreviation: None

Definition: This is the individual or provider name, entity, or organization that provided these services.

Usage: This data element is required on all explanation of benefits.

Example: ABC Hospital

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: 2010AB – Pay-to Provider Name (if blank – 2010AA – Billing Provider Name)	Position: NM103	Segment: NM1 – Pay-to Provider Name (NM1 – Billing Provider Name)
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: 2010AB – Pay-to Provider Name (if blank – 2010AA – Billing Provider Name) Billing Provider Name)	Position: NM103	Segment: NM1 – Pay-to Provider Name (NM1 – Billing Provider Name)
ANSI ASC X12-837 Version 4010A1 Dental	Loop: 2010AB – Pay-to Provider Name (if blank – 2010AA – Billing Provider Name)	Position: NM103	Segment: NM1 – Pay-to Provider Name (NM1 – Billing Provider Name)
ANSI ASC X12-835 Version 4010A1	Loop: 1000B – Payee Identification	Position: N102	Segment: N1 – Payee Identification

E-C4 Claim Section – Patient Control Number

Title: The standard label required for this data element is “Patient Control Number.”

Abbreviation: Pat Ctrl # (or “Pat Ctrl Nbr”)

Definition: This is the provider assigned identifier used to track a claim from creation through adjudication.

Usage: This data element is optional. Use at payers discretion.

Example: 7232145611475

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: 2300 – Claim Information	Position: CLM01	Segment: CLM – Claim Information
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: 2300 – Claim Information	Position: CLM01	Segment: CLM – Claim Information
ANSI ASC X12-837 Version 4010A1 Dental	Loop: 2300 – Claim Information	Position: CLM01	Segment: CLM – Claim Information
ANSI ASC X12-835 Version 4010A1	Loop: 2100 – Claim Payment Information	Position: CLP01	Segment: CLP – Claim Payment Information

E-D1 Line Item Section – Date(s) of Service

Title: The standard label required for this data element is “Date(s) of Service.”

Abbreviation: Date(s) or Svc Date(s)

Definition: This is the date of service or range of service dates for each line item or service grouping being reported. “From” date is always required. “To” date is required if submitted on the claim.

Usage: This data element is required on all explanation of benefits.

Example: MMDDCCYY

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: 2400 – Service Line	Position: DTP03	Segment: DTP – Date – Service Date
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: 2400 – Service Line Number	Position: DTP03	Segment: DTP – Service Line Date (if blank – DTP – Assessment Date)
ANSI ASC X12-837 Version 4010A1 Dental	Loop: 2400 – Line Counter	Position: DTP03	Segment: DTP – Date - Service
ANSI ASC X12-835 Version 4010A1	Loop: 2110 – Service Payment Information	Position: DTM02	Segment: DTM – Service Date

E-D2 Line Item Section – Service Description

Title: The standard label required for this data element is “Description.”

Abbreviation: Desc

Definition: This is the description for each adjudicated line item or service grouping as determined by the payer.

Usage: This data element is required on all explanation of benefits.

Example: Lab

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Dental	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-835 Version 4010A1	Loop: 2110 – Service Payment Information	Position: SVC06-7	Segment: SVC – Service Payment Information

E-D3 Line Item Section – Charges

Title: The standard label required for this data element is “Charges.”

Abbreviation: Chgs

Definition: This is the provider billed amount or the sum of provider billed amounts being reported by the payer.

Usage: This data element is required on all explanation of benefits.

Example: 250.00

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: 2400 – Service Line	Position: SV102	Segment: SV1 – Professional Service
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: 2400 – Service Line Number	Position: SV203	Segment: SV2 – Institutional Service Line
ANSI ASC X12-837 Version 4010A1 Dental	Loop: 2400 – Line Counter	Position: SV302	Segment: SV3 – Dental Service
ANSI ASC X12-835 Version 4010A1	Loop: 2110 – Service Payment Information	Position: SVC02	Segment: SVC – Service Payment Information

E-D4 Line Item Section – Provider Responsibility Amount

Title: The standard label required for this data element is “Provider Responsibility Amount.”

Abbreviation: Prov Resp

Definition: This is the non-covered amount corresponding to each adjudicated line item or service grouping for which the provider will be responsible.

Usage: This data element is situational.

Example: 130.00

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Dental	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-835 Version 4010A1	Loop: 2100 – Service Payment Information	Position: If CAS01 = PR, then the total of CAS03, CAS06, CAS09, CAS12, CAS15, and CAS18 for that line.	Segment: CAS – Service Adjustment

E-D5 Line Item Section – Allowed Amount

Title: The standard label required for this data element is “Allowed Amount.”

Abbreviation: Allowed

Definition: This is the amount considered for reimbursement corresponding to each adjudicated line item or service grouping.

Usage: This data element is situational.

Example: 120.00

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Dental	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-835 Version 4010A1	Loop: 2110 – Service Payment Information	Position: If AMT01 = B6, then AMT02	Segment: AMT – Service Supplemental Amount

E-D6 Line Item Section – Patient Non-Covered Amount

Title: The standard label required for this data element is “Patient Non-covered Amount.”

Abbreviation: Pat Non-covered

Definition: This is the non-covered amount corresponding to each adjudicated line item or service grouping for which the patient will be responsible.

Usage: This data element is situational.

Example: 7.00

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Dental	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-835 Version 4010A1	Loop: 2100 – Service Payment Information	Position: If CAS01 = PR and CAS02 is NOT=, then the total of CAS03, CAS06, CAS09, CAS12, CAS15, and CAS18	Segment: CAS – Service Adjustment

E-D7 Line Item Section - Deductible Amount

Title: The standard label required for this data element is “Deductible Amount or Deductible/Spend Down Amount or Spend Down Amount.”

Abbreviation: Deductible or Deductible/Spend Down or Spend Down.

Definition: This is the deductible amount corresponding to each adjudicated line or service grouping for which the patient will be responsible.

Usage: This data element is situational. This field may be used to report spend down amount.

Example: 60.00

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Dental	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-835 Version 4010A1	Loop: 2100 – Service Payment Information	Position: If CAS01 = PR and CAS02 = 1, then the total of CAS03, CAS06, CAS09, CAS12, CAS15, and CAS18	Segment: CAS – Service Adjustment

E-D8 Line Item Section - Co-pay Amount

Title: The standard label required for this data element is “Co-pay Amount.”

Abbreviation: Co-pay

Definition: This is the co-pay amount corresponding to each adjudicated line or service grouping for which the patient will be responsible.

Usage: This data element is situational.

Example: 0.00

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Dental	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-835 Version 4010A1	Loop: 2100 – Service Payment Information	Position: If CAS01 = PR and CAS02 = 3, then the total of CAS03, CAS06, CAS09, CAS12, CAS15, and CAS18	Segment: CAS – Service Adjustment

E-D9 Line Item Section - Co-insurance Amount

Title: The standard label required for this data element is “Co-insurance Amount.”

Abbreviation: Coinsurance

Definition: This is the coinsurance amount corresponding to each adjudicated line or service grouping for which the patient will be responsible.

Usage: This data element is situational.

Example: 0.00

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Dental	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-835 Version 4010A1	Loop: 2100 – Service Payment Information	Position: If CAS01 = PR and CAS02 = 2, then the total of CAS03, CAS06, CAS09, CAS12, CAS15, and CAS18	Segment: CAS – Service Adjustment

E-D10 Line Item Section - Paid Amount

Title: The standard label required for this data element is “Paid Amount.”

Abbreviation: Paid

Definition: This is the benefit amount corresponding to each adjudicated line or service grouping as determined by the payer.

Usage: This data element is situational. The value of zero is acceptable.

Example: 63.00

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Dental	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-835 Version 4010A1	Loop: 2110 – Service Payment Information	Position: SVC03	Segment: SVC – Service Payment Information

E-D11 Line Item Section – Amount You Owe

Title: The standard label required for this data element is “Amount You Owe.”

Abbreviation: You Owe

Definition: This is the patient responsibility amount corresponding to each adjudicated line or service grouping as determined by the payer.

Usage: This data element is required on all explanation of benefits. The value of zero is acceptable.

Example: 67.00

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Dental	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-835 Version 4010A1	Loop: 2100 – Claim Payment Information	Position: If CAS01 = PR, then it is the total of CAS03, CAS06, CAS09, CAS12, CAS15, and CAS18 for a line.	Segment: CAS- Claim Adjustment Information.

E-D12 Line Item Section – Notes ID

Title: The standard label required for this data element is “Notes ID.”

Abbreviation: None

Definition: This is the indicator to correlate explanations in E-E1 to the appropriate adjudicated line.

Usage: This data element is situational. Payer may use standard claim adjustment reason code descriptions or internal proprietary descriptions.

Example: 1

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Dental	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-835 Version 4010A1	Loop: N/A	Position: N/A	Segment: N/A

E-E1 Miscellaneous Text Message Section - Notes

Title: The standard label required for this data element is “Notes.”

Abbreviation: None

Definition: This is the text message further explaining adjudication.

Usage: This data element is situational. This must be included to describe patient non-covered amounts or if any “Notes” indicator is used in E-D12. Payer may use standard claim adjustment reason code descriptions or internal proprietary descriptions.

Example: Charges exceed your fee schedule or maximum allowable amount.
Claim/service denied because the procedure or treatment has been deemed experimental or investigational by the payer.

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Dental	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-835 Version 4010A1	Loop: 2110 – Service Payment Information	Position: Must have a conversion table for the values of CAS02, CAS05, CAS08, CAS11, CAS14, and CAS17	Segment: CAS – Service Adjustment

E-F1 Summary - Total Charges

Title: The standard label required for this data element is “Total Charges.”

Abbreviation: Tot Chgs

Definition: This is the sum of the Charges (E-D3).

Usage: This data elements is optional. Use at payers discretion.

Example: 525.00

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: 2300 - Claim Information	Position: CLM02	Segment: CLM – Claim Information
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: 2300 – Claim Information	Position: CLM02	Segment: CLM – Claim Information
ANSI ASC X12-837 Version 4010A1 Dental	Loop: 2300 – Claim Information	Position: CLM02	Segment: CLM – Claim Information
ANSI ASC X12-835 Version 4010A1	Loop: 2100 – Claim Payment Information	Position: CLP03	Segment: CLP – Claim Payment Information

E-F2 Summary - Total Benefit Amount

Title: The standard label required for this data element is “Total Benefit Amount.”

Abbreviation: Tot Benefit

Definition: This is the sum of the benefit amount (E-D10).

Usage: This data elements is optional. Use at payers discretion.

Example: 115.00

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Dental	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-835 Version 4010A1	Loop: 2100 – Claim Payment Information	Position: CLP04	Segment: CLP – Claim Payment Information

E-F3 Summary - Total Amount Paid by Other Insurance

Title: The standard label required for this data element is “Total Amount Paid by Other Insurance.”

Abbreviation: Pd by Other Ins

Definition: This is the actual total amount paid by other payer(s). If there are no other payer(s) that have made payment, this sum should be zero or blank.

Usage: This data element is optional. Use at payers discretion.

Example: 0.00

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: 2320 – Other Subscriber Information	Position: If AMT01 = D, then AMT02	Segment: AMT – COB Payer Paid Amount
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: 2320 – Other Subscriber Information	Position: If AMT01 = C4, then AMT02	Segment: AMT – Payer Prior Payment
ANSI ASC X12-837 Version 4010A1 Dental	Loop: 2320 – Other Subscriber Information	Position: If AMT01 = D, then AMT02	Segment: AMT – COB Payer Paid Amount
ANSI ASC X12-835 Version 4010A1	Loop: 2100 – Claim Payment Information	Position: If CAS01 = OA and CAS02 = B13 or 23, then it is the total of CAS03, CAS06, CAS09, CAS12, CAS15, and CAS18	Segment: CAS – Service Adjustment

E-F4 Footer Section - Total Amount You Owe

Title: The standard label required for this data element is “Total Amount You Owe.”

Abbreviation: Tot You Owe

Definition: This is the total of “Amount You Owe” (E-D11).

Usage: This data element is required on all explanation of benefits. If there is no patient liability, a zero should be entered.

Example: 163.00

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Dental	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-835 Version 4010A1	Loop: 2110 – Service Payment Information	Position: CLP05	Segment: CLP–Claim Payment Information

Minnesota Standards for the Use of the
Uniform Paper Explanation of Benefits Document
and
Uniform Paper Remittance Advice Report

August 1, 2007

As defined by the Commissioner of Health

Part II
Uniform Paper Remittance Advice Report

Second Edition



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Remittance Document- Header Section

(Payer Name) R1A				Payee Name R1E				
(Payer Address) R1B				Payee Tax ID R1F				
				NPI/Payee ID R1G				
(Payer Contact Information) R1C				Check/EFT Trace Number R1H				
				Payment Amount R1I				
Contact R1D				Check/EFT Date R1J				
				Production End Cycle Date R1K				
(No label is required. Data element name is listed for illustrative purpose only)								

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Remittance Advice –Claim and Line Section

(Name) R-1A															
Check/EFT Trace Number R-1H															
Check/EFT Date R-1J															
Patient Control Number R-2A					Medical Record Number R-2I										
Patient Name R-2B					Rendering Provider Name R-2J										
Patient ID R-2C					Rendering Provider ID R-2K										
Payer Claim Number R-2D					Claim Date R-2L										
Auth/Ref Number R-2E					DRG R-2M										
Group/Policy R-2F					DRG Weight R-2N										
Patient Responsibility R-2G					Discharge Fraction R-2O										
Contract Header R-2H															
Claim Charge Amount R-2P			Claim Adj. Amt. R-2Q		Group Code R-2R		Claim Adj. Reason Code R-2S		Payment Amount R-2T						
Line Item Control Number R-3A	Dates of Service R-3B		Rendering Provider ID R-3C	Revenue Code R-3D	Adj Product/Service Code R-3E	Modifier(s) R-3F	Submitted Product/Service Code R-3G	Units R-3H	Charge R-3I	Adjustment Amount R-3J	Group Code R-3K	Claim Adjustment Reason Code R-3L	Remark Code R-3M	Payment Amount R-3N	Adjustment Quantity R-3O
	From	To													

Remittance Advice- Provider Adjustment Section

Provider Adjustment Code R4A	Provider Adjustment Identifier R4B	Provider Adjustment Amount R4C

R-1A Report Header Section – Group Purchaser or Payer Name

Title: No standard label is required for this data element.

Definition: This is the name that identifies the payer. This data element is required at the top of each page of a multi-page remittance.

Usage: This data element is required on all remittance advices until the National Plan ID is available.

Example: Plan Inc.

Electronic concordance:

ANSI ASC X12-837 Version 004010A1 Professional	Loop: 2010BB - Payer Name	Position: NM103	Segment: NM1 - Payer Name
ANSI ASC X12-837 Version 004010A1 Institutional	Loop: 2010BC - Payer Name	Position: NM103	Segment: NM1 - Payer Name
ANSI ASC X12-837 Version 004010A1 Dental	Loop: 2010BB - Payer Name	Position: NM103	Segment: NM1 - Payer Name
ANSI ASC X12-835 Version 4010A1	Loop: 1000A – Payer Identification	Position: N102	Segment: N1 – Payer Identification

R-1B Report Header Section – Payer Address

Title: No standard label is required for this data element

Definition: This is the complete mailing address of the payer.

Usage: This data element is required on all remittance advices.

Example: P.O. Box 22556, Anytown, MN 99999

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: 2010BB – Payer Name	Position: N301 N302 N401 N402 N403	Segment: N3 – Payer Address N4 – Payer City/State/Zip
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: 2010BC – Payer Name	Position: N301 N302 N401 N402 N403	Segment: N3 – Payer Address N4 – Payer City/State/Zip
ANSI ASC X12-837 Version 4010A1 Dental	Loop: 2010BB – Payer Name	Position: N301 N302 N401 N402 N403	Segment: N3 – Payer Address N4 – Payer City/State/Zip
ANSI ASC X12-835 Version 4010A1	Loop: 1000A – Payer Identification	Position: N301 N302 N401 N402 N403	Segment: N3 – Payer Address N4 – Payer City/State/Zip

R-1C Report Header Section – Payer Contact Information

Title: No standard label is required for this data element. If a fax number is provided, use the standard label of “Fax.”

Definition: This is the local and /or toll free telephone number, fax and e-mail address that identifies the payer.

Usage: This data element is situational. This should be provided if it is unclear who to contact at the payer.

Example: 1-800-123-4567 or (123) 123-4567
email@email.com
 Fax: (123) 231-7654

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Dental	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-835 Version 4010A1	Loop: 1000A – Payer Identification	Position: If PER03 (or PER05) = TE, then PER04 (or PER06) is the phone number = EM, then PER04 (or PER06) is the email address = FX, then PER04 (or PER06) is the fax number	Segment: PER- Payer Contact Information

R-1D Report Header Section – Payer Contact Name

Title: The standard label required for this data element is “Contact.”

Abbreviation: None

Definition: This is the name of the entity or person that the provider is to contact regarding questions on the remittance advice.

Usage: This data element is situational. This should be provided if it is unclear who to contact at the payer.

Example: Customer Service

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Dental	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-835 Version 4010A1	Loop: 1000A – Payer Identification	Position: PER02	Segment: PER – Payer Contact Information

R-1E Report Header Section – Payee Name

Title: The standard label required for this data element is “Payee Name.”

Abbreviation: Payee

Definition: The name identifying the payee organization to whom payment is directed.

Usage: This data element is required on all remittance advices. When the National Provider Identifier is required, this data element is optional.

Example: River Road Clinic

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: 2010AB – Pay-to Provider Name (if blank – 2010AA – Billing Provider Name)	Position: NM103	Segment: NM1 – Pay-to Provider Name (NM1 – Billing Provider Name)
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: 2010AB – Pay-to Provider Name (if blank – 2010AA – Billing Provider Name)	Position: NM103	Segment: NM1 – Pay-to Provider Name (NM1 – Billing Provider Name)
ANSI ASC X12-837 Version 4010A1 Dental	Loop: 2010AB – Pay-to Provider Name (if blank – 2010AA – Billing Provider Name)	Position: NM103	Segment: NM1 – Pay-to Provider Name (NM1 – Billing Provider Name)
ANSI ASC X12-835 Version 4010A1	Loop: 1000B – Payee Identification	Position: N102	Segment: N1 – Payee Identification

R-1F Report Header Section – Payee Tax ID

Title: The standard label required for this data element is “Payee Tax ID.”

Abbreviation: None

Definition: This is the provider organization federal tax identification number or social security number.

Usage: This data element is required on all remittance advices. When the National Provider Identifier is required, this data element is optional.

Example: 123456789

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: 2010AB – Pay-to Provider Name (if blank – 2010AA – Billing Provider Name)	Position: NM109	Segment: NM1 – Pay-to Provider Name (NM1 – Billing Provider Name)
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: 2010AB – Pay-to Provider Name (if blank – 2010AA – Billing Provider Name)	Position: NM109	Segment: NM1 – Pay-to Provider Name (NM1 – Billing Provider Name)
ANSI ASC X12-837 Version 4010A1 Dental	Loop: 2010AB – Pay-to Provider Name (if blank – 2010AA – Billing Provider Name)	Position: NM109	Segment: NM1 – Pay-to Provider Name (NM1 – Billing Provider Name)
ANSI ASC X12-835 Version 4010A1	Loop: 1000B – Payee Identification	Position: If N103 = FI, then N104	Segment: N1 – Payee Identification

R-1G Report Header Section – Payee ID

Title: The standard label required for this data element is “Payee ID.”

Abbreviation: None

Definition: This is the National Provider Identifier (NPI) or the payer assigned payee ID.

Usage: This data element is situational. Use at discretion of payer. This data element will contain the National Provider Identifier. If the provider does not meet the definition of a health care provider, a payer assigned identifier for atypical providers will be sent. When the National Provider Identifier is required, this data element is required and no longer situational.

Example: 1234SA

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: 2010AB – Pay-to Provider Name (if blank – 2010AA – Billing Provider Name)	Position: REF02	Segment: REF – Pay-to Provider Secondary Identification (REF – Billing Provider Secondary Identification)
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: 2010AB – Pay-to Provider Name (if blank – 2010AA – Billing Provider Name)	Position: REF02	Segment: REF – Pay-to Provider Secondary Identification (REF – Billing Provider Secondary Identification)
ANSI ASC X12-837 Version 4010A1 Dental	Loop: 2010AB – Pay-to Provider Name (if blank – 2010AA – Billing Provider Name)	Position: REF02	Segment: REF – Pay-to Provider Secondary Identification (REF – Billing Provider Secondary Identification)
ANSI ASC X12-835 Version 4010A1	Loop: 1000B – Payee Identification	Position: REF02 (The number represented depends on the qualifier value in REF01,or N104 when N103 is equal to “XX.”)	Segment: REF – Payee Additional Information or N1- Payee Identification.

R-1H Report Header Section – Check/EFT Trace Number

Title: The standard label required for this data element is “Check/EFT Trace Number.”

Abbreviation: Check/EFT.

Definition: This is the check, warrant, draft or electronic funds transfer number associated with the remittance advice report. This data element is required at the top of each page of a multi-page remittance. If there is no check or EFT sent to the provider, we recommend that you utilize a date time stamp with unique trailing number.

Usage: This data element is required on all remittance advices.

Example: 78912345

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Dental	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-835 Version 4010A1	Loop: Header	Position: TRN02	Segment: TRN – Reassociation Trace Number

R-1I Report Header Section – Payment Amount

Title: The standard label required for this data element is “Payment Amount.”

Abbreviation: Payment

Definition: This is the total amount of the payment as it corresponds to the entire remittance advice.

Usage: This data element is required on all remittance advices.

Example: 10495.00

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Dental	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-835 Version 4010A1	Loop: Header	Position: BPR02	Segment: BPR – Financial Information

R-1J Report Header Section – Check Date

Title: The standard label required for this data element is “Check/EFT Date.”

Abbreviation: Check/EFT Dt

Definition: This is the check, warrant, draft or electronic funds transfer date associated with the remittance advice. This data element is required at the top of each page of a multi-page remittance.

Usage: This data element is required on all remittance advices.

Example: 10152004

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Dental	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-835 Version 4010A1	Loop: Header	Position: BPR16	Segment: BPR – Financial Information

R-1K Report Header Section – Production End Cycle Date

Title: The standard label required for this data element is “Production End Cycle Date.”

Abbreviation: Prod Date

Definition: This is the last date the payer adjudicated the claims appearing on this remittance advice. This is required only if it is different than the check/EFT date (R-1J).

Usage: This data element is situational. The production date is required when the adjudication cutoff date is different than the remittance date.

Example: 10012004

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Dental	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-835 Version 4010A1	Loop: Header	Position: DTM02	Segment: DTM – Production Date

R-2A Claim Section – Patient Control Number

Title: The standard label required for this data element is “Patient Control Number.”

Abbreviation: Pat Ctrl # (or “Pat Ctrl Nbr”)

Definition: This is the provider assigned identifier used to track a claim from creation through payment.

Usage: This data element is required on all remittance advices. If a patient control number was not submitted on the claim, enter the number zero.

Example: 723214561AZB

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: 2300 – Claim Information	Position: CLM01	Segment: CLM – Claim Information
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: 2300 – Claim Information	Position: CLM01	Segment: CLM – Claim Information
ANSI ASC X12-837 Version 4010A1 Dental	Loop: 2300 – Claim Information	Position: CLM01	Segment: CLM – Claim Information
ANSI ASC X12-835 Version 4010A1	Loop: 2100 – Claim Payment Information	Position: CLP01	Segment: CLP – Claim Payment Information

R-2B Claim Section – Patient Name

Title: The standard label required for this data element is “Patient Name.”

Abbreviation: Patient

Definition: This is the name that identifies the patient.

Usage: This data element is required. It is recommended that the patient claims be listed in alphabetical order by last name.

Example: Doe, Jane A (Last Name, First Name Middle Initial)

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: 2010CA – Patient Name (if blank – 2010BA – Subscriber Name)	Position: NM103 NM104 NM105	Segment: NM1 – Patient Name (NM1 – Subscriber Name)
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: 2010CA – Patient Name (if blank – 2010BA – Subscriber Name)	Position: NM103 NM104 NM105	Segment: NM1 – Patient Name (NM1 – Subscriber Name)
ANSI ASC X12-837 Version 4010A1 Dental	Loop: 2010CA – Patient Name (if blank – 2010BA – Subscriber Name)	Position: NM103 NM104 NM105	Segment: NM1 – Patient Name (NM1 – Subscriber Name)
ANSI ASC X12-835 Version 4010A1	Loop: 2100 – Claim Payment Information	Position: NM103 NM104 NM105	Segment: NM1 – Patient Name

R-2C Claim Section – Patient ID

Title: The standard label required for this data element is “Patient ID.”

Abbreviation: None

Definition: This is the payer assigned identifier that uniquely distinguishes the patient in the payer’s system.

Usage: This data element is situational. This is required if known or was sent on the claim.

Example: 99999999

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: 2010CA – Patient Name (if blank – 2010BA – Subscriber Name)	Position: NM109	Segment: NM1 – Patient Name (NM1 – Subscriber Name)
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: 2010CA – Patient Name (if blank – 2010BA – Subscriber Name)	Position: NM109	Segment: NM1 – Patient Name (NM1 – Subscriber Name)
ANSI ASC X12-837 Version 4010A1 Dental	Loop: 2010CA – Patient Name (if blank – 2010BA – Subscriber Name)	Position: NM109	Segment: NM1 – Patient Name (NM1 – Subscriber Name)
ANSI ASC X12-835 Version 4010A1	Loop: 2100 – Claim Payment Information	Position: NM109	Segment: NM1 – Patient Name

R-2D Claim Section –Claim Number

Title: The standard label required for this data element is “Claim Number.”

Abbreviation: Clm # (or “Clm Nbr”)

Definition: This is the identifier assigned by the payer to uniquely identify each patient claim as adjudicated.

Usage: This is a situational data element. This is required unless not created by the payer.

Example: 2043650045678

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Dental	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-835 Version 4010A1	Loop: 2100 – Claim Payment Information	Position: CLP07	Segment: CLP – Claim Payment Information

R-2E Claim Section – Auth/Ref Number

Title: The standard label required for this data element is “Auth/Ref Number.”

Abbreviation: Auth/Ref # (or “Auth/Ref Nbr”)

Definition: This is the prior authorization, treatment authorization code, or referral number.

Usage: The “Minnesota Standards for the Use of the Uniform Paper Explanation of Benefits and Uniform Paper Remittance Advice Report” manual published in 2005 required this data element. Please note that effective with the 2007 manual, this is now an optional data element. Please reference page 117 for a list of optional data elements.

Example: 4356734

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Dental	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-835 Version 4010A1	Loop: 2100 – Claim Payment Information	Position: If REF01 = BB, then REF02; or REF01 = G1, then REF02	Segment: REF – Other Claim Related Identification

R-2F Claim Section – Group/Policy

Title: The standard label required for this data element is “Group/Policy.”

Abbreviation: Grp

Definition: This is the patient’s group/policy number and/or plan name.

Usage: This data element is situational.

Example: Z1234

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: 2000B – Subscriber Hierarchical Level	Position: SBR03	Segment: SBR – Subscriber Information
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: 2000B – Subscriber Hierarchical Level	Position: SBR03	Segment: SBR – Subscriber Information
ANSI ASC X12-837 Version 4010A1 DentalA1	Loop: 2000B – Subscriber Hierarchical Level	Position: SBR03	Segment: SBR – Subscriber Information
ANSI ASC X12-835 Version 4010A1	Loop: 2100 – Claim Payment Information	Position: If REF01 = 1L then REF02	Segment: REF – Other Claim Related Identification

R-2G Claim Section – Patient Responsibility

Title: The standard label required for this data element is “Patient Responsibility.”

Abbreviation: Pat Resp

Definition: This is the total patient responsibility amount for the reported claim.

Usage: This data element is situational. This should be sent if it is applicable to the claim.

Example: 10.00

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Dental	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-835 Version 4010A1	Loop: 2100 – Claim Payment Information	Position: CLP05	Segment: CLP – Claim Payment Information

R-2H Claim Section – Contract Header

Title: The standard label required for this data element is “Contract Header.”

Abbreviation: Contract

Definition: The contract that was used between the payer and provider to determine payment on this section of claims.

Usage: This data element is situational. This is used to describe the PPO network utilized by the payer or the product/program, and should be sent if it is applicable to the claim.

Examples: Beech Street Network, Preferred One Network, MA (Medicaid), GA (Medicaid), Medical Supplemental, etc.

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Dental	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-835 Version 4010A1	Loop: 2100 – Claim Payment Information	Position: If REF01= CE then REF02	Segment: REF – Other Claim Related Identification

R-2I Claim Section – Medical Record Number

Title: The standard label required for this data element is “Medical Record Number.”

Abbreviation: Med Rec # (or “Med Rec Nbr”)

Definition: This is the provider-assigned medical record identification number.

Usage: This data element is situational. If this information is submitted on the claim, the payer is required to return the information.

Example: 987654321456789

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: 2300 – Claim Information	Position: REF02	Segment: REF – Medical Record Number
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: 2300 – Claim Information	Position: REF02	Segment: REF – Medical Record Number
ANSI ASC X12-837 Version 4010A1 Dental	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-835 Version 4010A1	Loop: 2100 – Claim Payment Information	Position: If REF01 = EA then REF02	Segment: REF – Other Claim Related Identification

R-2J Claim Section – Rendering Provider Name

Title: The standard label required for this data element is “Rendering Provider Name.”

Abbreviation: Rend Prov

Definition: This is the name of the provider who performed the service. This provider name pertains to the entire claim unless overridden by a different provider number at the line level in R3C (Rendering Provider ID).

Usage: This data element is situational.

Example: Health, Robert

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: 2310B – Rendering Provider Name	Position: NM103 NM104 NM105	Segment: NM1 – Rendering Provider Name
ANSI ASC X12-837 Version 4010A1 Institutional			
ANSI ASC X12-837 Version 4010A1 Dental	Loop: 2310B – Rendering Provider Name	Position: NM103 NM104 NM105	Segment: NM1 – Rendering Provider Name
ANSI ASC X12-835 Version 4010A1	Loop: 2100 – Claim Payment Information	Position: NM103 NM104 NM105	Segment: NM1 – Service Provider Name

R-2K Claim Section – Rendering Provider ID

Title: The standard label required for this data element is “Rendering Provider ID.”

Abbreviation: Rend Prov ID

Definition: This is the payer assigned ID number, or the National Provider Identifier (NPI) when available, of the provider who performed the service. This provider ID pertains to the entire claim unless overridden at the line level by R-3C (Rendering Provider ID).

Usage: This data element is situational. It is required when the rendering provider is different than the payee (billing/pay to provider). This data element will contain the National Provider Identifier of the rendering provider. If the provider does not meet the definition of a health care provider, a payer assigned identifier for atypical providers will be sent. This section is intended for professional and dental claims only.

Example: 77789456

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: 2310B – Rendering Provider Name	Position: NM109	Segment: NM1 – Rendering Provider Name
ANSI ASC X12-837 Version 4010A1 Dental	Loop: 2310B – Rendering Provider Name	Position: NM109	Segment: NM1 – Rendering Provider Name
ANSI ASC X12-835 Version 4010A1	Loop: 2100 – Claim Payment Information	Position: NM109	Segment: NM1 – Service Provider Name

R-2L Claim Section – Statement From and To Date

Title: The standard label required for this data element is “Claim Date.”

Abbreviation: Claim Dt

Definition: This is the date(s) pertaining to the entire claim.

Usage: This data element is situational. Required if applicable to the claim. Dates are required at the claim level and/or service line level.

Example: 10152004 10162004

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: 2300 – Claim Information	Position: DTP03	Segment: DTP – Statement Dates
ANSI ASC X12-837 Version 4010A1 Dental	Loop: 2300 – Claim Information	Position: DTP03	Segment: DTP – Date – Service
ANSI ASC X12-835 Version 4010A1	Loop: 2100 – Claim Payment Information	Position: DTM02	Segment: DTM- Claim Date

R-2M Claim Section – Diagnosis Related Group Code

Title: The standard label required for this data element is “DRG.”

Abbreviation: None

Definition: This is the diagnosis related group based on a patient’s illness, diseases, and medical problems.

Usage: This data element is situational. This only pertains to institutional claims and is required when adjudication considers the DRG weight.

Example: 5

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: 2300 – Claim Information	Position: HI01-2	Segment: HI – Diagnosis Related Group (DRG) Information
ANSI ASC X12-837 Version 4010A1 Dental	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-835 Version 4010A1	Loop: 2100 – Claim Payment Information	Position: CLP11	Segment: CLP - Claim Payment Information

R-2N Claim Section – Diagnosis Related Group Weight

Title: The standard label required for this data element is “DRG Weight.”

Abbreviation: DRG Wght

Definition: This is the DRG weight for the claim.

Usage: This data element is situational. This only pertains to institutional claims and is required when adjudication considers the DRG weight.

Example: 3

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Dental	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-835 Version 4010A1	Loop: 2100 – Claim Payment Information	Position: CLP12	Segment: CLP – Claim Payment Information

R-20 Claim Section – Discharge Fraction

Title: The standard label required for this data element is “Discharge Fraction.”

Abbreviation: Discharge % (or “Dis Frac”)

Definition: This is the Discharge Fraction for the claim.

Usage: This data element is situational. This only pertains to institutional claims and is required when this value is considered during adjudication.

Example: 6

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Dental	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-835 Version 4010A1	Loop: 2100 – Claim Payment Information	Position: CLP13	Segment: CLP – Claim Payment Information

R-2P Claim Section – Claim Charge Amount

Title: The standard label required for this data element is “Claim Charge Amount.”

Abbreviation: Clm Chg (or “Charge”)

Definition: The monetary amount for the submitted charges for this claim.

Usage: This data element is required.

Example: 45.00

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Dental	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-835 Version 4010A1	Loop: 2100 – Claim Payment Information	Position: CLP03	Segment: CLP – Claim Payment Information

R-2Q Claim Section – Claim Adjustment Amount

Title: The standard label required for this data element is “Claim Adjustment Amount.”

Abbreviation: Clm Adj Amt

Definition: The claim level adjustment amount for the associated reason code.

Usage: This data element is situational. This is required if the claim is not paid in full and an adjustment was made at the claim level. If multiple adjustments apply additional segments should be used for reporting. Whenever an adjustment amount is used, a corresponding Claim Adjustment Group Code (R-2R) and the Claim Adjustment Reason Code (R-2S) are required

Example: 5.00

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Dental	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-835 Version 4010A1	Loop: 2100 – Claim Payment Information	Position: CAS03, CAS06, CAS09, CAS12, CAS15, CAS18	Segment: CAS – Claim Adjustment

R-2R Claim Section – Group Code

Title: The standard label required for this data element is “Group Code.”

Abbreviation: Grp Cd

Definition: This is the Claim Adjustment Group Code that identifies the general category of payment adjustment.

Usage: This data element is situational. This is required if the claim is not paid in full and an adjustment was made at the claim level. If multiple group codes apply additional rows should be used for reporting. Whenever Group Code is used, a corresponding Claim Adjustment Reason Code (R-2S) and Adjustment Amount (R-2Q) are required.

Example: CO
PR
CR
OA
PI

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Dental	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-835 Version 4010A1	Loop: 2100 – Claim Payment Information	Position: CAS01	Segment: CAS – Claim Adjustment

R-2S Claim Section – Claim Adjustment Reason Code

Title: The standard label required for this data element is “Claim Adjustment Reason Code.”

Abbreviation: Clm Adj Rsn Cd

Definition: This is the code that defines the Adjustment Amount in R2Q.

Usage: This data element is situational. This is required if the claim is not paid in full and adjustment was made at the claim level.

Example: 50
100
96
22

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Dental	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-835 Version 4010A1	Loop: 2100	Position: CAS02, CAS05, CAS08, CAS11, CAS14, CAS17	Segment: Claim Adjustment

R-2T Claim Section – Claim Payment Amount

Title: The standard label required for this data element is “Claim Payment Amount.”

Abbreviation: Clm Payment

Definition: This is the total payment amount corresponding to the charges adjudicated on a claim.

Usage: This data element is required.

Example: 40.00

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Dental	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-835 Version 4010A1	Loop: 2100	Position: CLP04	Segment: CLP-Claim Payment Information

R-3A Line Item Section – Line Item Control Number

Title: The standard label required for this data element is “Line Item Control Number.”

Abbreviation: Line Ctrl # (or “Line Ctrl Nbr”)

Definition: This is the identifier assigned by the submitter/provider to identify a line item.

Usage: This data element is situational. If this was sent on the claim, it must be returned on the remittance advice.

Example: 27DO
3

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: 2400 – Service Line	Position: REF02	Segment: REF – Line Item Control Number
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Dental	Loop: 2400 – Line Counter	Position: REF02	Segment: REF – Line Item Control Number
ANSI ASC X12-835 Version 4010A1	Loop: 2110 – Service Payment Information	Position: If REF01 = 6R then REF02	Segment: REF – Service Identification

R-3B Line Item Section – Dates of Service

Title: The standard label required for this data element is “Dates of Service.”

Abbreviation: DOS

Definition: This is the date of service or range of service dates for each line item. If used, “From” date is always required. “To” date required if submitted on the claim.

Usage: This data element is situational. It is required at the claim level or at the service level or can be entered at both levels.

Example: 10012004 10022004

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: 2400 – Service Line	Position: DTP03	Segment: DTP – Date – Service Date
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: 2400 – Service Line	Position: DTP03	Segment: DTP – Service Line Date (if blank – DTP – Assessment Date)
ANSI ASC X12-837 Version 4010A1 Dental	Loop: 2400 – Line Counter	Position: DTP03	Segment: DTP – Date - Service
ANSI ASC X12-835 Version 4010A1	Loop: 2110 – Service Payment Information	Position: DTM02	Segment: DTM – Service Date

R-3C Line Item Section – Rendering Provider ID

Title: The standard label required for this data element is “Rendering Provider ID.”

Abbreviation: Rend Prov ID

Definition: This is the National Provider Identifier (NPI) or payer assigned ID number of the provider who performed the service.

Usage: This data element is situational. This is required if available and different from R2K (Rendering Provider ID). This data element will contain the National Provider Identifier of the rendering provider. This element cannot be used for atypical providers.

Example: 789456123

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: 2420A – Rendering Provider Name	Position: NM109	Segment: NM1 – Rendering Provider Name
ANSI ASC X12-837 Version 4010A1 Dental	Loop: 2420A – Rendering Provider Name	Position: NM109	Segment: NM1 – Rendering Provider Name
ANSI ASC X12-835 Version 4010A1	Loop: 2110 – Service Payment Information	Position: REF02	Segment: REF – Rendering Provider Information

R-3D Line Item Section – Revenue Code

Title: The standard label required for this data element is “Revenue Code.”

Abbreviation: Rev

Definition: This code identifies a specific accommodation and/or ancillary service or billing calculation.

Usage: This data element is situational. This should be sent if applicable to the line item. This data element is required if R-3E is not used.

Example: 0320

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: 2400 – Service Line Number	Position: SV201	Segment: SV2 – Institutional Service Line
ANSI ASC X12-837 Version 4010A1 Dental	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-835 Version 4010A1	Loop: 2110	Position: SVC01-2 or SVC04	Segment: SVC

R-3E Line Item Section – Adjudicated Product/Service Code

Title: The standard label required for this data element is “Adjudicated Product/Service Code.”

Abbreviation: Adj Prod/Svc

Definition: This data element is used to identify medical procedures or products. This includes CPT/HCPCS codes, CDT codes, National Drug Codes, and Home Infusion EDI Coalition (HIEC) Codes.

Usage: This data element is situational. This data element is required if R-3D is not used.

Example: 99213

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: 2400 – Service Line	Position: SV101-2	Segment: SV1 – Professional Service
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: 2400 – Service Line Number	Position: SV202-2	Segment: SV2 – Institutional Service Line
ANSI ASC X12-837 Version 4010A1 Dental	Loop: 2400 – Line Counter	Position: SV301-2	Segment: SV3 – Dental Service
ANSI ASC X12-835 Version 4010A1	Loop: 2110 – Service Payment Information	Position: SVC01-2	Segment: SVC – Service Payment Information

R-3F Line Item Section – Modifiers

Title: The standard label required for this data element is “Modifiers.”

Abbreviation: Mod

Definition: This code identifies special circumstances related to the performance of the service.

Usage: This data element is situational. This should be sent if applicable to the service.

Example: 22

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: 2400 – Service Line	Position: SV101-3 SV101-4 SV101-5 SV101-6	Segment: SV1 – Professional Service
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: 2400 – Service Line Number	Position: SV202-3 SV202-4 SV202-5 SV202-6	Segment: SV2 – Institutional Service Line
ANSI ASC X12-837 Version 4010A1 Dental	Loop: 2400 – Line Counter	Position: SV301-3 SV301-4 SV301-5 SV301-6	Segment: SV3 – Dental Service
ANSI ASC X12-835 Version 4010A1	Loop: 2110 – Service Payment Information	Position: SVC01-3, SVC01-4, SVC01-5, SVC01-6	Segment: SVC – Service Payment Information

R-3G Line Item Section – Submitted Product/Service Code/Modifiers

Title: The standard label required for this data element is “Submitted Product/Service Code/Modifiers.”

Abbreviation: Sub Prod/Svc/Mod

Definition: Product/service code(s), revenue codes and modifiers for each line item as submitted by the payer, using a correct coding initiative. The submitted product/service code is entered in this field while the new code is entered in R-3D, R-3E (Service/Product Code) and or R-3F.

Usage: This data element is situational. This is required if the billed procedure has been changed.

Example: 99214

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Dental	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-835 Version 4010A1	Loop: 2110 – Service Payment Information	Position: SVC06-2 SVC06-3,4,5,6	Segment: SVC – Service Payment Information

R-3H Line Item Section – Units

Title: The standard label required for this data element is “Units.”

Abbreviation: # (or “Nbr”)

Definition: This is the number of the adjudicated units of service.

Usage: This data element is situational. If not present, the value is assumed to be one.

Example: 2

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional			
ANSI ASC X12-837 Version 4010A1 Institutional			
ANSI ASC X12-837 Version 4010A1 Dental			
ANSI ASC X12-835 Version 4010A1	Loop: 2110 – Service Payment Information	Position: SVC05	Segment: SVC – Service Payment Information

R-3I Line Item Section – Provider Charge or Billed Amount

Title: The standard label required for this data element is “Charge.”

Abbreviation: Chg

Definition: Provider charge/billed amount corresponding to the Product/Service Code (R-3E) or Revenue Code (R-3D) for each line item as submitted

Usage: This data element is situational. Required if line item detail is submitted.

Example: 45.00

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: 2400 – Service Line	Position: SV102	Segment: SV1 – Professional Service
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: 2400 – Service Line Number	Position: SV203	Segment: SV2 – Institutional Service Line
ANSI ASC X12-837 Version 4010A1 Dental	Loop: 2400 – Line Counter	Position: SV302	Segment: SV3 – Dental Service
ANSI ASC X12-835 Version 4010A1	Loop: 2110 – Service Payment Information	Position: SVC02	Segment: SVC – Service Payment Information

R-3J Line Item Section – Adjustment Amount

Title: The standard label required for this data element is “Adjustment Amount.”

Abbreviation: Adj Amt

Definition: The claim level adjustment amount for the associated reason code.

Usage: This data element is situational. This is required if the line charge is not paid in full and the adjustment was at the service line level. If multiple adjustments apply to a single service line, additional rows should be used for reporting. Whenever an adjustment amount is used, a corresponding Claim Adjustment Group Code (R-3K) and a Claim Adjustment Reason Code (R-3L) are required

Example: 5.00

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Dental	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-835 Version 4010A1	Loop: 2110 – Service Payment Information	Position: CAS03, CAS06, CAS09, CA12, CAS15, CAS18	Segment: CAS – Service Adjustment

R-3K Line Item Section – Claim Adjustment Group Code

Title: The standard label required for this data element is “Group Code.”

Abbreviation: Grp Cd

Definition: This is the Claim Adjustment Group Code that identifies the general category of payment adjustment.

Usage: This data element is situational. This is required if the claim is not paid in full and the adjustment was at the line level. If multiple group codes apply to a single service line, additional rows should be used for reporting. Whenever an adjustment amount is used, a corresponding Claim Adjustment Group Code (R-3K) and a Claim Adjustment Reason Code (R-3L) are required.

Example: CO
PR
CR
OA

Electronic concordance:

ANSI ASC X12-837 Version 4010A Professional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Dental	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-835 Version 4010A1	Loop: 2110 – Service Payment Information	Position: CAS01	Segment: CAS – Service Adjustment

R-3L Line Item Section – Claim Adjustment Reason Code

Title: The standard label required for this data element is “Claim Adjustment Reason Code.”

Abbreviation: Clm Adj Rsn Cd

Definition: This is the Claim Adjustment Reason Code that explains the adjustment amount at the line level.

Usage: This data element is situational. It is required when the claim is not paid in full and the adjustment was made at the line level. If multiple adjustment reason codes apply to a single service line, additional rows should be used for reporting. Whenever an adjustment reason code is used, a corresponding Claim Adjustment Group Code (R-3K) and the Claim Adjustment Amount (R-3L) are required.

Example: 42

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Dental	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-835 Version 4010A1	Loop: 2110 – Service Payment Information	Position: CAS02, CAS05, CAS08, CAS11, CAS14, CAS18	Segment: CAS – Service Adjustment

R-3M Line Item Section – Remittance Advice Remark Code

Title: The standard label required for this data element is “Remark Code.”

Abbreviation: Remark

Definition: This is a code used to relay informational messages that cannot be expressed with a claim adjustment reason code alone. Multiple remark codes may apply to a line. For retail pharmacy transactions, this code is used for NCPDP rejections codes (LQ02 when LQ01=RX in ANSI ASC X12-835).

Usage: This data element is situational, unless required by the claim adjustment reason code list. This list is located at www.wpc-edi.com. We encourage the use of this code set beyond the items required by the claim adjustment reason code list.

Example: N59

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Dental	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-835 Version 4010A1	Loop: 2110 – Service Payment Information	Position: LQ02	Segment: LQ – Health Care Remark Codes

R-3N Line Item Section – Payment Amount

Title: The standard label required for this data element is “Payment Amount.”

Abbreviation: Payment

Definition: This is the payment amount corresponding to the adjudicated service line.

Usage: This data element is situational. It is required when claim is adjudicated at the service line level.

Example: 40.00

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Dental	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-835 Version 4010A1	Loop: 2110 – Service Payment Information	Position: SVC03	Segment: SVC – Service Payment Information

R-30 Line Item Section – Adjustment Quantity

Title: The standard label required for this data element is “Adjustment Quantity.”

Abbreviation: Adj Qty

Definition: This/these is/are the unit(s) of service being adjusted.

Usage: This data element is situational. It is used when units are being adjusted.

Example: 1

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Dental	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-835 Version 4010A1	Loop: 2110 – Service Payment Information	Position: CAS04, CAS07, CAS10, CAS13, CAS16, CAS19	Segment: CAS – Service Adjustment

R-4A Provider Adjustment – Adjustment Reason Code

Title: The standard label required for this data element is “Provider Adjustment Code.”

Abbreviation: Prov Adj Cd

Definition: This is the reason for the provider adjustments that are not specific to a particular claim or service. Multiple adjustments may apply to the payment.

Usage: This data element is situational. Required when payment (R-1I) is not equal to the sum of all claim payment amount (R-2T).

Example: WU

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Dental	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-835 Version 4010A1	Loop: Trailer	Position: PLB03-1	Segment: PLB – Provider Adjustment

R-4B Provider Adjustment – Provider Adjustment Identifier

Title: The standard label required for this data element is “Provider Adjustment Identifier.”

Abbreviation: Prov Adj ID

Definition: This data element allows payers to report any internally assigned reference identifier for the related adjustment. Medicare intermediaries must enter the applicable Medicare code.

Usage: This data element is situational. Use at discretion of payer.

Example: 203560047824

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Dental	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-835 Version 4010A1	Loop: Trailer	Position: PLB03-2	Segment: PLB – Provider Adjustment

R-4C Provider Adjustment – Provider Adjustment Amount

Title: The standard label required for this data element is “Provider Adjustment Amount.”

Abbreviation: Prov Adj Amt

Definition: This is the monetary amount of the provider adjustment.

Usage: This data element is situational. Use at discretion of payer.

Example: -25.00

Electronic concordance:

ANSI ASC X12-837 Version 4010A1 Professional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Institutional	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-837 Version 4010A1 Dental	Loop: N/A	Position: N/A	Segment: N/A
ANSI ASC X12-835 Version 4010A1	Loop: Trailer	Position: PLB04	Segment: PLB – Provider Adjustment

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The following segments and/or data elements are situational. The use of these fields is allowed in the 835 implementation guide and on the paper remittance advice. These data elements are not included or required on the template.

- Foreign Currency Segment (CUR)
- Receiver ID Information Segment (REF)
- Provider Summary Information (TS3)
- Facility Type Code Data Element (CLP08)
- Claim Frequency Code Data Element (CLP09)
- Payee Address, City, State and Zip Code Segments (N3 and N4)
- Payee Additional Identification (REF)
- Insured Name Segment (NM1)
- Corrected Patient/Insured Name Segment (NM1). Note: Use of this segment is strongly suggested when the patient name is incorrect.
- Crossover Carrier Name Segment(NM1)
- Corrected Priority Payer Name Segment (NM1)
- Inpatient Adjudication Information Segment (MIA)
- Outpatient Adjudication Information Segment (MOA)
- Other Claim Related Identification (REF) Note: Some values in this segment are included in the template. Values considered optional include Member, Identification Number, Repriced Claim Reference Number, Adjusted Repriced Claim Reference Number, Employee Identification Number, Original Reference Number, Prior Authorization Number (Authorization Number is used), Predetermination of Benefits Identification Number, Insurance Policy Number, and Social Security Number.
- Authorization/Reference Number (R-2E) Claim Section
- Claim Contact Information Segment (PER)
- Claim Supplemental Information Segment (AMT)
- Claim Supplemental Information Quantity Segment (QTY)
- Procedure Modifier (SVC06-3 to SVC06-6): These fields may be used when the adjudicated procedure code is different than the submitted procedure code and modifiers were submitted on the claim. The submitted service procedure moves to SVC06-2 while corresponding modifiers moved to SVC06-3 to SVC06-6 as needed.
- Procedure Code Description Data Element (SVC01-7)
- Original Units of Service Count Data Element (SVC07)
- Service Identification (REF) Note: Some values in this segment are included in the template. Values considered optional include Ambulatory Patient Group (AGG) Number, Attachment Code, Prior Authorization Number, Predetermination of Benefits Identification Number, Location Number, and Rate code Number.
- Service Supplemental Amount Segment (AMT)
- Service Supplemental Quantity Segment (QTY)
- NCPDP Reject/Payment Codes (LQ02 when LQ01=RX)

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Appendix A- Sample EOB

Explanation of Benefits

This is not a bill

E-A1 PLAN INC.
E-A2 P.O. Box 22556
 Any town, MN 99999

E-A3 Contact: Customer Service
E-A4 2597 First Ave
 Any Town, MN 99999-9999
E-A5 (800) 123-4567 or (123) 123-4567
 Fax (555) 555-1234
Email@email.com

E-B1 Subscriber Name	Jane Doe
E-B2 Patient Name	John Doe
E-B3 Patient ID	ABC12345
E-B4 Group/Policy	11111-1111
E-C1 Claim Number	80036000000
E-C2 EOB Date	10/16/2007
E-C3 Provider	ABC Hospital
E-C4 Patient Control Number	7232145611475

E-D1 Dates of Service	E-D2 Description	E-D3 Charges	E-D4 Provider Liability Amount	E-D5 Allowed Amount	E-D6 Patient Non-covered Amount	E-D7 Deductible Amount	E-D8 Co-pay Amount	E-D9 Co-insurance Amount	E-D10 Paid Amount	E-D11 Amount You Owe	E-D12 Notes
From	To										
10/01/04	10/02/04	250.00	130.00	120.00	7.00	60.00	0.00	0.00	63.00	67.00	
10/02/07		85.00	0.00	0.00	85.00	0.00	0.00	0.00	0.00	85.00	
10/02/07		90.00	65.00	25.00	0.00	0.00	0.00	13.00	52.00	13.00	
10/02/07		100.00	83.00	17.00	0.00	23.00	10.00	0.00	0.00	83.00	
		525.00							115.00	248.00	

<p style="text-align: center;">E – E1 Notes</p> <p>1 Charges exceed your fee schedule or maximum allowable amount.</p> <p>2 Claim/service denied because the payer has deemed the procedure or treatment experimental or investigational.</p>	E-F1 Total Charges	525.00
	E-F2 Total Benefit Amount	115.00
	E-F3 Total Amount Paid by Other Insurance	0.00
	E-F4 Total Amount You Owe	248.00

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Appendix B – Sample Remit

(Payer Name) R-1A															
Check/EFT Trace Number R-1H															
Check/EFT Date R-1J															
Patient Control Number R-2A				Medical Record Number R-2I											
Patient Name R-2B				Rendering Provider Name R-2J											
Patient ID R-2C				Rendering Provider ID R-2K											
Payer Claim Number R-2D				Claim Date R-2L											
Auth/Ref Number R-2E				DRG R-2M											
Group/Policy R-2F				DRG Weight R-2N											
Patient Responsibility R-2G				Discharge Fraction R-2O											
Contract Header R-2H															
Claim Charge Amount R-2P		Claim Adj. Amount R-2Q	Group Code R-2R	Claim Adj. Reason Code R-2S	Payment Amount R-2T										
Line Item Control Number R-3A	Dates of Service R-3B		Rendering Provider ID R-3C	Revenue Code R-3D	Adj Product/Service Code R-3E	Modifier(s) R-3F	Submitted Product/Service Code R-3G	Units R-3H	Charge R-3I	Adjustment Amount R-3J	Group Code R-3K	Claim Adjustment Reason Code R-3L	Remark Code R-3M	Payment Amount R-3N	Adjustment Quantity R-3O
	From	To													

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Appendix C – Administrative Uniformity Committee - Mission Statement, History and Governing Principles (Updated, March 2007)

1. Mission: To develop agreement among Minnesota payers and providers on standardized administrative processes when implementation of the processes will reduce administrative costs.
2. History: The Administrative Uniformity Committee (AUC) is a broad-based group representing Minnesota health care public and private payers, hospitals, physicians, other providers and State agencies. The impetus for its establishment came from the Minnesota Council of Health Plans, whose member plans committed in 1991 to standardize their administrative processes and requirements with the goal of reducing administrative costs for both payers and providers. Recognizing that costs can be reduced effectively only if all major stakeholders are involved, the Council's committee sought the endorsement and active participation of other payers, state agencies, and representatives of key provider groups. By mid-1992, virtually all groups contacted had offered their enthusiastic support and had named representatives to the committee. The expanded AUC agreed that the initial priority was to respond to the MinnesotaCare health care reform mandates. Although the AUC originally reported to the Minnesota Council of Health Plans, the AUC is an independent entity with whom the Commissioner of the Minnesota Department of Health (MDH) is required to consult for purposes of M.S. §62J.50 to 62J.61. The AUC may also from time to time act as a consulting body to other public and private entities.
3. Purpose and Objectives:
 - 3.1 To develop agreement among Minnesota medical and dental payers and providers regarding uniform billing forms, uniform claims procedures, unique identifiers, and uniform electronic billing procedures;
 - 3.2 To participate actively in the implementation of standardization plans enacted as part of health care reform. It is understood that implementation will be a multi-year process;
 - 3.3 To function as a consulting body on matters related to the AUC's mission statement;
 - 3.4 To continue research into new issues that may lead to enhanced administrative uniformity and bring issues and recommendations to private industry and/or governmental entities;
 - 3.5 To undertake educational efforts and facilitate the members' understanding about how the different stakeholders address specific administrative simplification issues.

4. Membership:

- 4.1 Criteria: In order to be considered for membership in the AUC, an individual must represent a stakeholder as defined in this paragraph. A stakeholder must: (1) be a Minnesota broad-based health care provider, association, society, payer, or governmental organization; and, (2) be capable of implementing recommendations and decisions of the AUC. Each stakeholder will be entitled only to one vote, even if represented by more than one member at any given meeting unless the organization is both a payer and provider in which case the organization would have two votes. Membership of provider associations will be evaluated on a case-by-case basis taking into account size, geographic representation, speciality and so forth.
- 4.2 Roster: The members and liaison groups of the AUC shall be those persons or organizations listed on the AUC roster. The MDH staff shall be responsible for maintaining the roster and keeping it up-to-date.
- 4.3 New member approval: Organizations that wish to be AUC members must qualify as a stakeholder as defined in paragraph 4.1 and request membership in writing to the AUC. The request will be presented to the AUC at the next scheduled meeting and voted on at the following meeting. New members and stakeholders may be subject to approval by a two-thirds majority vote of stakeholders represented at a meeting.

5. AUC Structure:

- 5.1 The AUC is made up of three committees: a Strategic Steering Committee, an Executive Committee and an Operations Committee.
- 5.1.1 The AUC Strategic Steering Committee will be comprised of executives from voting member organizations and members of the Governor's Health Care Cabinet. The AUC Strategic Steering Committee will provide strategic direction and establish priorities for the work of the AUC. The members of this committee will provide the necessary resources to support the work of the AUC and ensure implementation of AUC solutions within their organizations.
- 5.1.2 The AUC Executive Committee will deliver the strategic direction from the AUC Strategic Steering Committee to the AUC Operations Committee. The AUC Executive Committee will bring issues and recommendations from the AUC Operations Committee to the Strategic Steering Committee. The AUC Executive Committee will be in charge of planning all AUC Strategic Steering Committee meetings, agendas, and all communications with the Strategic Steering Committee. The AUC Executive Committee shall be responsible for developing and circulating AUC Operations meeting agendas. AUC members may submit agenda items to the chair a reasonable amount of time in advance of the meeting.
- 5.1.3 The AUC Operations Committee will define all strategies and new uniformity opportunities. The AUC Operations Committee will approve all Technical Advisory Group (TAG) work products.

5.2 AUC Executive Committee:

- 5.2.1 The AUC Executive Committee members shall be comprised of the following voting members: the current AUC Chair, the current co-chair, the immediate past chair; 1 Association representative, and the chairs from the three Executive Technical Actions Groups (TAGs). Membership also includes a non-voting representative from the Minnesota Department of Health. The role of the AUC Executive Committee is to ensure efficient and effective communication between the AUC Operations Committee, AUC TAGs and AUC Strategic Steering Committee.
- 5.2.2 The AUC Executive Committee will review the need for new Operations TAGs and prepare a recommendation for the AUC Operations Committee. The AUC Executive Committee will evaluate the effectiveness of all TAGs.
- 5.2.3 The AUC Executive Committee will have three Executive TAGs – Membership, Communications and Marketing, and Policy and Procedures – that report to the Executive Committee. Each of these Executive TAGs will have a chair and a co-chair. Each chair will serve as a member of the AUC Executive Committee and will have a one-year term. Each co-chair will become the chair of the respective Executive TAG at the end of the chair’s term. Once the co-chair becomes the Chair of the Executive TAG, the new chair now serves on the AUC Executive Committee. To the extent possible, the chair and co-chair positions shall rotate representation from the payer and provider sector of the industry. The Chairs of the Executive TAGs must be members of the AUC Operations Committee.
- 5.2.4 The Membership Executive TAG is responsible for issues related to AUC membership. This Executive TAG will develop a job description for AUC members. This Executive TAG will review the membership of all TAGs to ensure all AUC member organizations are represented on the TAGs as needed. The TAG will review member attendance and make recommendations to the AUC Executive Committee. The Membership Executive TAG will work with the Policy and Procedures TAG. This TAG will have 5-6 members.
- 5.2.5 The Communications and Marketing Executive TAG is responsible for all AUC communications and marketing. This Executive TAG will be responsible for the AUC website, AUC newsletters and updates, and news releases. The membership for this TAG will be business and communications experts from AUC member organizations. This TAG will have 10-12 members.
- 5.2.6 The Policy and Procedures Executive TAG is responsible for the development of all AUC policies and procedures. This Executive TAG will develop documentation for AUC by-laws, chair rotation duties and rules, standard TAG documentation and reports for the AUC, policies and procedures related to legislation and issue development. This TAG will have 5-6 members.

5.2.7 AUC Executive Committee meetings will be open to the public.

5.3 AUC Operations Committee:

5.3.1 The AUC Operations will annually elect a chair and co-chair. Nominees for the chair and co-chair positions must come from the voting membership. It is the intent of the committee to rotate the chair position between representatives from payer and provider organizations. AUC Operations members making nominations should consider this before the nomination is made. At the end of the chair's one-year-term, the co-chair will automatically be elected chair for the coming year. The chair, in conjunction with the MDH staff, shall be responsible for maintaining the AUC Operations meeting schedule and membership roster. The chair shall also be responsible for chairing AUC Operations meetings. The co-chair will be responsible for chairing those meetings, which the chair cannot attend, and it is the chair's responsibility to coordinate with the chair-elect to ensure that at least one of them is present at each meeting. The chair and co-chair will serve on the AUC Executive Committee.

5.3.2 Members must commit to participate actively in the AUC by attending Operations meetings, or sending an alternate. It is the member's responsibility to arrange for an alternate to represent him or her at meetings, which the member cannot attend. Non-voting stakeholders may serve as an alternate member. If a member is scheduled to take minutes and cannot do so, it is the member's responsibility to arrange in advance for their alternate or another AUC member to take minutes. It is the member's responsibility to notify the AUC chair of the change.

5.3.3 Failure to attend or send an alternate to three AUC Operations meetings in one year shall be grounds for revoking the membership of a stakeholder organization or an individual representative.

5.3.4 Any stakeholder, whether voting or non-voting, may make a motion or bring forth a proposal to the committee during the meeting.

5.4 Operations Meeting/Agenda

5.4.1 Unless the members agree otherwise, the AUC Operations Committee's standing meetings shall be from 1:00 to 4:00 p.m. on the second Tuesday of every month. If the second Tuesday follows a holiday, then the AUC will meet on the third Tuesday.

5.4.2 All AUC Operations Meetings will be open to the public.

5.4.3 At the outset of each meeting, the chair shall ask the members if the agenda should be supplemented or otherwise changed.

5.4.4 The last item of business for each meeting will be to confirm the time and location of the next meeting, to confirm who will be responsible for taking the minutes, and to set, to the extent possible, the agenda for the next meeting.

- 5.5 AUC Operations Technical Action Groups (TAGs):
- 5.5.1 The AUC Operations Committee may from time to time establish one or more subgroups, which are called Operations Technical Action Groups (TAGs).
 - 5.5.2 Unless otherwise determined by the AUC, membership in an Operations TAG shall be open both to (1) AUC members or representatives of the member organization that can implement the Operations TAG's recommendations or decisions and (2) those who can offer technical expertise to the Operations TAG. Only AUC members may vote, and each member organization shall be limited to one vote, regardless of how many of its representatives are in attendance at any particular meeting. New Operations TAG members may be subject to approval by the AUC. Every AUC member organization should participate on at least one Operations TAG.
 - 5.5.3 The Operations TAG members shall elect co-chairs for the Operations TAG at the first meeting. One Operations TAG Co-Chair should represent a payer organization and the other co-chair should represent a provider organization, if possible. One of the co-chairs should be an AUC-Operations member. If a TAG co-chair is not able to continue to serve in this role, the Operations TAG membership shall elect a new co-chair representing the same sector of the industry. The Operations TAG Co-Chairs shall be responsible to coordinate, communicate and project manage work, meetings and other activities for the Operations TAG. Operations TAG Co-Chairs shall also be responsible for presenting, or arranging for another Operations TAG member to present periodic Operations TAG reports to the AUC Operations Committee on the dates designated by the AUC Operations Committee. Operations TAG co-chairs can decide to set up additional workgroups as needed to accomplish the work of the Operations TAG. Terms of the Operations TAG co-chairs will be 1 year or the project term., whichever is less.
 - 5.5.4 Operations TAG members must commit to participate actively in their Operations TAG by attending meetings, or sending an alternate. It is each TAG member's responsibility to arrange for an alternate to represent him or her at meetings which the Operations TAG member cannot attend. The MDH staff shall be responsible for circulating the minutes to the Operations TAG members.
 - 5.5.5 All AUC Operations TAG meetings will be open to the public.

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Appendix D – Minnesota Statutes 2006, Chapter 62J.50 - 62J.61

Administrative Simplification Provisions of 2006 Minnesota Statutes, Chapter 62J

Editor's Notes:

This excerpt of Minnesota Statutes includes only the administrative simplification provisions of *Minnesota Statutes, sections 62J.50 to 62J.61*, the Administrative Simplification Act (ASA). The official 2006 version of chapter 62J was obtained from the Revisor of Statutes Web site.

MINNESOTA STATUTES 2006, CHAPTER 62J HEALTH CARE COST CONTAINMENT

HEALTH CARE ADMINISTRATIVE SIMPLIFICATION ACT OF 1994

62J.50	Citation and purpose.	62J.57	Minnesota center for health care electronic data interchange.
62J.51	Definitions.	62J.58	Implementation of standard transaction sets.
62J.52	Establishment of uniform billing forms.	62J.581	Standards for Minnesota uniform health care reimbursement documents.
62J.53	Acceptance of uniform billing forms by group purchasers.	62J.59	Implementation of NCPDP telecommunications standard for pharmacy claims.
62J.535	Uniform billing requirements for claim transactions.	62J.60	Standards for the Minnesota uniform health care identification card.
62J.54	Identification and implementation of unique identifiers.	62J.61	Rulemaking; implementation.
62J.55	Privacy of unique identifiers.		
62J.56	Implementation of electronic data interchange standards.		

HEALTH CARE ADMINISTRATIVE SIMPLIFICATION ACT OF 1994

62J.50 Citation and purpose.

Subdivision 1. **Citation.** Sections 62J.50 to [62J.61](#) may be cited as the Minnesota Health Care Administrative Simplification Act of 1994.

Subd. 2. **Purpose.** The legislature finds that significant savings throughout the health care industry can be accomplished by implementing a set of administrative standards and simplified procedures and by setting forward a plan toward the use of electronic methods of data interchange. The legislature finds that initial steps have been taken at the national level by the federal Health Care Financing Administration in its implementation of nationally accepted electronic transaction sets for its Medicare program. The legislature further recognizes the work done by the workgroup for electronic data interchange and the American National Standards Institute and its accredited standards committee X12, at the national level, and the Minnesota administrative uniformity committee, a statewide, voluntary, public-private group representing payers, hospitals, state programs, physicians, and other health care providers in their work toward administrative simplification in the health care industry.

HIST: 1994 c 625 art 9 s 1

62J.51 Definitions.

Subdivision 1. **Scope.** For purposes of sections [62J.50](#) to [62J.61](#), the following definitions apply.

Subd. 2. **ANSI.** "ANSI" means the American National Standards Institute.

Subd. 3. **ASC X12.** "ASC X12" means the American National Standards Institute committee X12.

Subd. 3a. **Card issuer.** "Card issuer" means the group purchaser who is responsible for printing and distributing identification cards to members or insureds.

Subd. 4. **Category I industry participants.** "Category I industry participants" means the following: group purchasers, providers, and other health care organizations doing business in Minnesota including public and private payers; hospitals; claims clearinghouses; third-party administrators; billing service bureaus; value added networks; self-insured plans and employers with more than 100 employees; clinic laboratories; durable medical equipment suppliers with a volume of at least 50,000 claims or encounters per year; and group practices with 20 or more physicians.

Subd. 5. **Category II industry participants.** "Category II industry participants" means all group purchasers and providers doing business in Minnesota not classified as category I industry participants.

Subd. 6. **Claim payment/advice transaction set (ANSI ASC X12 835).** "Claim payment/advice transaction set (ANSI ASC X12 835)" means the electronic transaction format developed and approved for implementation in October 1991, and used for electronic remittance advice and electronic funds transfer.

Subd. 6a. **Claim status transaction set (ANSI ASC X12 276/277).** "Claim status transaction set (ANSI ASC X12 276/277)" means the transaction format developed and approved for implementation in December 1993 and used by providers to request and receive information on the status of a health care claim or encounter that has been submitted to a group purchaser.

Subd. 6b. **Claim submission address.** "Claim submission address" means the address to which the group purchaser requires health care providers, members, or insureds to send health care claims for processing.

Subd. 6c. **Claim submission number.** "Claim submission number" means the unique identification number to identify group purchasers as described in section [62J.54](#), with its suffix identifying the claim submission address.

Subd. 7. **Claim submission transaction set (ANSI ASC X12 837).** "Claim submission transaction set (ANSI ASC X12 837)" means the electronic transaction format developed and approved for implementation in October 1992, and used to submit all health care claims information.

Subd. 8. **EDI or electronic data interchange.** "EDI" or "electronic data interchange" means the computer application to computer application exchange of information using nationally accepted standard formats.

Subd. 9. **Eligibility transaction set (ANSI ASC X12 270/271).** "Eligibility transaction set (ANSI ASC X12 270/271)" means the transaction format developed and approved for implementation in February 1993, and used by providers to request and receive coverage information on the member or insured.

Subd. 10. **Enrollment transaction set (ANSI ASC X12 834).** "Enrollment transaction set (ANSI ASC X12 834)" means the electronic transaction format developed and approved for implementation in February 1992, and used to transmit enrollment and benefit information from the employer to the payer for the purpose of enrolling in a benefit plan.

Subd. 11. **Group purchaser.** "Group purchaser" has the meaning given in section [62J.03](#), subdivision 6.

Subd. 12. **ISO.** "ISO" means the International Standardization Organization.

Subd. 13. **NCPDP.** "NCPDP" means the National Council for Prescription Drug Programs, Inc.

Subd. 14. **NCPDP telecommunication standard format 3.2.** "NCPDP telecommunication standard format 3.2" means the recommended transaction sets for claims transactions adopted by the membership of NCPDP in 1992.

Subd. 15. **NCPDP tape billing and payment format 2.0.** "NCPDP tape billing and payment format 2.0" means the recommended transaction standards for batch processing claims adopted by the membership of the NCPDP in 1993.

Subd. 16. **Provider.** "Provider" or "health care provider" has the meaning given in section [62J.03](#), subdivision 8.

Subd. 17. **Uniform billing form CMS 1450.** "Uniform billing form CMS 1450" means the uniform billing form known as the CMS 1450 or UB92, developed by the National Uniform Billing Committee in 1992 and approved for implementation in October 1993, and any subsequent amendments to the form.

Subd. 18. **Uniform billing form CMS 1500.** "Uniform billing form CMS 1500" means the 1990 version of the health insurance claim form, CMS 1500, developed by the National Uniform Claim and any subsequent amendments to the form.

Subd. 19. **Uniform dental billing form.** "Uniform dental billing form" means the most current version of the uniform dental claim form developed by the American Dental Association.

Subd. 19a. **Uniform explanation of benefits document.** "Uniform explanation of benefits document" means the document associated with and explaining the details of a group purchaser's claim adjudication for services rendered, which is sent to a patient.

Subd. 19b. **Uniform remittance advice report.** "Uniform remittance advice report" means the document associated with and explaining the details of a group purchaser's claim adjudication for services rendered, which is sent to a provider.

Subd. 20. **Uniform pharmacy billing form.** "Uniform pharmacy billing form" means the National Council for Prescription Drug Programs/universal claim form (NCPDP/UCF).

Subd. 21. **WEDI.** "WEDI" means the National Workgroup for Electronic Data Interchange report issued in October 1993.

HIST: 1994 c 625 art 9 s 2; 1996 c 440 art 1 s 22-25; 2000 c 460 s 2,3; 2002 c 307 art 2 s 3; 2002 c 330 s 19; 2005 c 106 s 1,2

62J.52 Establishment of uniform billing forms.

Subdivision 1. **Uniform billing form CMS 1450.** (a) On and after January 1, 1996, all institutional inpatient hospital services, ancillary services, institutionally owned or operated outpatient services rendered by providers in Minnesota, and institutional or noninstitutional home health services that are not being billed using an equivalent electronic billing format, must be billed using the uniform billing form CMS 1450, except as provided in subdivision 5.

(b) The instructions and definitions for the use of the uniform billing form CMS 1450 shall be in accordance with the uniform billing form manual specified by the commissioner. In promulgating these instructions, the commissioner may utilize the manual developed by the National Uniform Billing Committee, as adopted and finalized by the Minnesota uniform billing committee.

(c) Services to be billed using the uniform billing form CMS 1450 include: institutional inpatient hospital services and distinct units in the hospital such as psychiatric unit services, physical therapy unit services, swing bed (SNF) services, inpatient state psychiatric hospital services, inpatient skilled nursing facility services, home health services (Medicare part A), and hospice services; ancillary services, where benefits are exhausted or patient has no Medicare part A, from hospitals, state psychiatric hospitals, skilled nursing facilities, and home health (Medicare part B); institutional owned or operated outpatient services such as waived services, hospital outpatient services, including ambulatory surgical center services, hospital referred laboratory services, hospital-based ambulance services, and other hospital outpatient services, skilled nursing facilities, home health, freestanding renal dialysis centers,

comprehensive outpatient rehabilitation facilities (CORF), outpatient rehabilitation facilities (ORF), rural health clinics, and community mental health centers; home health services such as home health intravenous therapy providers, waived services, personal care attendants, and hospice; and any other health care provider certified by the Medicare program to use this form.

(d) On and after January 1, 1996, a mother and newborn child must be billed separately, and must not be combined on one claim form.

Subd. 2. Uniform billing form CMS 1500.

(a) On and after January 1, 1996, all noninstitutional health care services rendered by providers in Minnesota except dental or pharmacy providers, that are not currently being billed using an equivalent electronic billing format, must be billed using the health insurance claim form CMS 1500, except as provided in subdivision 5.

(b) The instructions and definitions for the use of the uniform billing form CMS 1500 shall be in accordance with the manual developed by the administrative uniformity committee entitled standards for the use of the CMS 1500 form, dated February 1994, as further defined by the commissioner.

(c) Services to be billed using the uniform billing form CMS 1500 include physician services and supplies, durable medical equipment, noninstitutional ambulance services, independent ancillary services including occupational therapy, physical therapy, speech therapy and audiology, home infusion therapy, podiatry services, optometry services, mental health licensed professional services, substance abuse licensed professional services, nursing practitioner professional services, certified registered nurse anesthetists, chiropractors, physician assistants, laboratories, medical suppliers, and other health care providers such as day activity centers and freestanding ambulatory surgical centers.

Subd. 3. Uniform dental billing form.

(a) On and after January 1, 1996, all dental services provided by dental care providers in Minnesota, that are not currently being billed using an equivalent electronic billing format, shall be billed using the American Dental Association uniform dental billing form.

(b) The instructions and definitions for the use of the uniform dental billing form shall be in accordance with the manual developed by the administrative uniformity committee dated February 1994, and as amended or further defined by the commissioner.

Subd. 4. Uniform pharmacy billing form.

(a) On and after January 1, 1996, all pharmacy services provided by pharmacists in Minnesota that are not currently being billed using an equivalent electronic billing format shall be billed using the NCPDP/universal claim form, except as provided in subdivision 5.

(b) The instructions and definitions for the use of the uniform claim form shall be in accordance with instructions specified by the commissioner of health, except as provided in subdivision 5.

Subd. 5. State and federal health care programs.

(a) Skilled nursing facilities and ICF/MR services billed to state and federal health care programs administered by the department of human services shall use the form designated by the department of human services.

(b) On and after July 1, 1996, state and federal health care programs administered by the department of human services shall accept the CMS 1450 for community mental health center services and shall accept the CMS 1500 for freestanding ambulatory surgical center services.

(c) State and federal health care programs administered by the department of human services shall be authorized to use the forms designated by the department of human services for pharmacy services.

(d) State and federal health care programs administered by the department of human services shall accept the form designated by the department of human services, and the CMS 1500 for supplies,

medical supplies, or durable medical equipment. Health care providers may choose which form to submit.

(e) Personal care attendant and waived services billed on a fee-for-service basis directly to state and federal health care programs administered by the department of human services shall use either the CMS 1450 or the CMS 1500 form, as designated by the department of human services.

HIST: 1994 c 625 art 9 s 3; 2000 c 460 s 4-6; 1Sp 2003 c 14 art 7 s 14, 15; 2005 c 106 s 3-5

62J.53 Acceptance of uniform billing forms by group purchasers.

On and after January 1, 1996, all category I and II group purchasers in Minnesota shall accept the uniform billing forms prescribed under section [62J.52](#) as the only nonelectronic billing forms used for payment processing purposes.

HIST: 1994 c 625 art 9 s 4

62J.535 Uniform billing requirements for claim transactions.

Subdivision 1. Repealed, 2002 c 307 art 2 s 9; 2002 c 330 s 35

Subd. 1a. **Electronic claim transactions.** Group purchasers, including government programs, not defined as covered entities under United States Code, title 42, sections 1320d to 1320d-8, as amended from time to time, and the regulations promulgated under those sections, that voluntarily agree with providers to accept electronic claim transactions, must accept them in the ANSI X12N 837 standard electronic format as established by federal law. Nothing in this section requires acceptance of electronic claim transactions by entities not covered under United States Code, title 42, sections 1320d to 1320d-8, as amended from time to time, and the regulations promulgated under those sections. Notwithstanding the above, nothing in this section or other state law prohibits group purchasers not defined as covered entities under United States Code, title 42, sections 1320d to 1320d-8, as amended from time to time, and the regulations promulgated under those sections, from requiring, as authorized by Minnesota law or rule, additional information associated with a claim submitted by a provider.

Subd. 1b. **Paper claim transactions.** All group purchasers that accept paper claim transactions must accept, and health care providers submitting paper claim transactions must submit, these transactions with use of the applicable medical and nonmedical data code sets specified in the federal electronic claim transaction standards adopted under United States Code, title 42, sections 1320d to 1320d-8, as amended from time to time, and the regulations promulgated under those sections. The paper claim transaction must also be conducted using the uniform billing forms as specified in section [62J.52](#) and the identifiers specified in section [62J.54](#), on and after the compliance date required by law. Notwithstanding the above, nothing in this section or other state law prohibits group purchasers not defined as covered entities under United States Code, title 42, sections 1320d to 1320d-8, as amended from time to time, and the regulations promulgated under those sections, from requiring, as authorized by Minnesota law or rule, additional information associated with a claim submitted by a provider.

Subd. 2. **Compliance.** Subdivision 1a is effective concurrent with the date of required compliance for covered entities established under United States Code, title 42, sections 1320d to 1320d-8, as amended from time to time.

HIST: 1999 c 245 art 2 s 8; 2000 c 483 s 16; 2000 c 488 art 11 s 1; 2002 c 307 art 2 s 4-6,8; 2002 c 330 s 20-22,33

62J.54 Identification and implementation of unique identifiers.

Subdivision 1. **Unique identification number for health care provider organizations.** (a) Not later than 24 months after the date on which a national provider identifier is made effective under

United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments), all group purchasers and any health care provider organization that meets the definition of a health care provider under United States Code, title 42, sections 1320d to 1320d-8, as amended, and regulations adopted thereunder shall use a national provider identifier to identify health care provider organizations in Minnesota, according to this section, except as provided in paragraph (b).

(b) Small health plans, as defined by the federal Secretary of Health and Human Services under United States Code, title 42, section 1320d-4 (1996 and subsequent amendments), shall use a national provider identifier to identify health provider organizations no later than 36 months after the date on which a national provider identifier is made effective under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments).

(c) The national provider identifier for health care providers established by the federal Secretary of Health and Human Services under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments), shall be used as the unique identification number for health care provider organizations in Minnesota under this section.

(d) All health care provider organizations in Minnesota that are eligible to obtain a national provider identifier according to United States Code, title 42, sections 1320d to 1320d-8, as amended, and regulations adopted thereunder shall obtain a national provider identifier from the federal Secretary of Health and Human Services using the process prescribed by the Secretary.

(e) Only the national provider identifier shall be used to identify health care provider organizations when submitting and receiving paper and electronic claims and remittance advice notices, and in conjunction with other data collection and reporting functions.

(f) Health care provider organizations in Minnesota shall make available their national provider identifier to other health care providers when required to be included in the administrative transactions regulated by United States Code, title 42, sections 1320d to 1320d-8, as amended, and regulations adopted thereunder.

(g) The commissioner of health may contract with the federal Secretary of Health and Human Services or the Secretary's agent to implement this subdivision.

Subd. 2. Unique identification number for individual health care providers.

(a) Not later than 24 months after the date on which a national provider identifier is made effective under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments), all group purchasers in Minnesota and any individual health care provider that meets the definition of a health care provider under United States Codes, title 42, sections 1320d to 1320d-8, as amended regulations adopted thereunder shall use the national provider identifier to identify an individual health care provider in Minnesota, according to this section, except as provided in paragraph (b).

(b) Small health plans, as defined by the federal Secretary of Health and Human Services under United States Code, title 42, section 1320d-4 (1996 and subsequent amendments), shall use the national provider identifier to identify an individual health care provider no later than 36 months after the date on which a national provider identifier for health care providers is made effective under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments).

(c) The national provider identifier for health care providers established by the federal Secretary of Health and Human Services under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments), shall be used as the unique identification number for individual health care providers.

(d) All individual health care providers in Minnesota that are eligible to obtain a national provider identifier according to United States Code, title 42, sections 1320d to 1320d-8, as amended, and regulations adopted thereunder shall obtain a national provider identifier from the federal Secretary of Health and Human Services using the process prescribed by the Secretary.

(e) Only the national provider identifier shall be used to identify individual health care providers when submitting and receiving paper and electronic claims and remittance advice notices, and in conjunction with other data collection and reporting functions.

(f) Individual health care providers in Minnesota shall make available their national provider identifier to other health care providers when required to be included in the administrative transactions regulated by United State Code, title 42, sections 1320d to 1320d-8, as amended, and regulations adopted thereunder.

(g) The commissioner of health may contract with the federal Secretary of Health and Human Services or the Secretary's agent to implement this subdivision.

Subd. 3. Unique identification number for group purchasers.

(a) Not later than 24 months after the date on which a unique health identifier for employers and health plans is adopted or established under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments), all group purchasers and health care providers in Minnesota shall use a unique identification number to identify group purchasers, except as provided in paragraph (b).

(b) Small health plans, as defined by the federal Secretary of Health and Human Services under United States Code, title 42, section 1320d-4 (1996 and subsequent amendments), shall use a unique identification number to identify group purchasers no later than 36 months after the date on which a unique health identifier for employers and health plans is adopted or established under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments).

(c) The unique health identifier for health plans and employers adopted or established by the federal Secretary of Health and Human Services under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments), shall be used as the unique identification number for group purchasers.

(d) Group purchasers shall obtain a unique health identifier from the federal Secretary of Health and Human Services using the process prescribed by the Secretary.

(e) The unique group purchaser identifier, as described in this section, shall be used for purposes of submitting and receiving claims, and in conjunction with other data collection and reporting functions.

(f) The commissioner of health may contract with the federal Secretary of Health and Human Services or the Secretary's agent to implement this subdivision.

Subd. 4. Unique patient identification number.

(a) Not later than 24 months after the date on which a unique health identifier for individuals is adopted or established under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments), all group purchasers and health care providers in Minnesota shall use a unique identification number to identify each patient who receives health care services in Minnesota, except as provided in paragraph (b).

(b) Small health plans, as defined by the federal Secretary of Health and Human Services under United States Code, title 42, section 1320d-4 (1996 and subsequent amendments), shall use a unique identification number to identify each patient who receives health care services in Minnesota no later than 36 months after the date on which a unique health identifier for individuals is adopted or established under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments).

(c) The unique health identifier for individuals adopted or established by the federal Secretary of Health and Human Services under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments), shall be used as the unique patient identification number, except as provided in paragraphs (e) and (f).

(d) The unique patient identification number shall be used by group purchasers and health care providers for purposes of submitting and receiving claims, and in conjunction with other data collection and reporting functions.

(e) Within the limits of available appropriations, the commissioner shall develop a proposal for an alternate numbering system for patients who do not have or refuse to provide their social security numbers, if:

(1) a unique health identifier for individuals is adopted or established under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments);

(2) the unique health identifier is the social security number of the patient;

(3) there is no federal alternate numbering system for patients who do not have or refuse to provide their social security numbers; and

(4) federal law or the federal Secretary of Health and Human Services explicitly allows a state to develop an alternate numbering system for patients who do not have or refuse to provide their social security numbers.

(f) If an alternate numbering system is developed under paragraph (e), patients who use numbers issued by the alternate numbering system are not required to provide their social security numbers and group purchasers or providers may not demand the social security numbers of patients who provide numbers issued by the alternate numbering system. If an alternate numbering system is developed under paragraph (e), group purchasers and health care providers shall establish procedures to notify patients that they can elect not to have their social security number used as the unique patient identifier.

(g) The commissioner of health may contract with the federal Secretary of Health and Human Services or the Secretary's agent to implement this subdivision.

HIST: 1994 c 625 art 9 s 5; 1995 c 234 art 5 s 17; 1996 c 440 art 1 s 26-28; 1997 c 228 s 2; 1Sp1997 c 5 s 16; 2005 c 106 s 6,7

62J.55 Privacy of unique identifiers.

(a) When the unique identifiers specified in section [62J.54](#) are used for data collection purposes, the identifiers must be encrypted, as required in section [62J.321](#), subdivision 1. Encryption must follow encryption standards set by the National Bureau of Standards and approved by the American National Standards Institute as ANSIX3. 92-1982/R 1987 to protect the confidentiality of the data. Social security numbers must not be maintained in unencrypted form in the database, and the data must never be released in a form that would allow for the identification of individuals. The encryption algorithm and hardware used must not use clipper chip technology.

(b) Providers and group purchasers shall treat medical records, including the social security number if it is used as a unique patient identifier, in accordance with section [144.335](#). The social security number may be disclosed by providers and group purchasers to the commissioner as necessary to allow performance of those duties set forth in section [144.05](#).

HIST: 1994 c 625 art 9 s 6; 1995 c 234 art 5 s 18

62J.56 Implementation of electronic data interchange standards.

Subdivision 1. **General provisions.** (a) The legislature finds that there is a need to advance the use of electronic methods of data interchange among all health care participants in the state in order to achieve significant administrative cost savings. The legislature also finds that in order to advance the use

of health care electronic data interchange in a cost-effective manner, the state needs to implement electronic data interchange standards that are nationally accepted, widely recognized, and available for immediate use. The legislature intends to set forth a plan for a systematic phase in of uniform health care electronic data interchange standards in all segments of the health care industry.

(b) The commissioner of health, with the advice of the Minnesota health data institute and the Minnesota administrative uniformity committee, shall administer the implementation of and monitor compliance with, electronic data interchange standards of health care participants, according to the plan provided in this section.

(c) The commissioner may grant exemptions to category I and II industry participants from the requirements to implement some or all of the provisions in this section if the commissioner determines that the cost of compliance would place the organization in financial distress, or if the commissioner determines that appropriate technology is not available to the organization.

Subd. 2. Identification of core transaction sets.

(a) All category I and II industry participants in Minnesota shall comply with the standards developed by the ANSI ASC X12 for the following core transaction sets, according to the implementation plan outlined for each transaction set.

- (1) ANSI ASC X12 835 health care claim payment/advice transaction set.
- (2) ANSI ASC X12 837 health care claim transaction set.
- (3) ANSI ASC X12 834 health care enrollment transaction set.
- (4) ANSI ASC X12 270/271 health care eligibility transaction set.
- (5) ANSI ASC X12 276/277 health care claims status request/notification transaction set.

(b) The commissioner, with the advice of the Minnesota health data institute and the Minnesota administrative uniformity committee, and in coordination with federal efforts, may approve the use of new ASC X12 standards, or new versions of existing standards, as they become available, or other nationally recognized standards, where appropriate ASC X12 standards are not available for use. These alternative standards may be used during a transition period while ASC X12 standards are developed.

Subd. 3. Implementation guides.

(a) The commissioner, with the advice of the Minnesota administrative uniformity committee, and the Minnesota center for health care electronic data interchange shall review and recommend the use of guides to implement the core transaction sets. Implementation guides must contain the background and technical information required to allow health care participants to implement the transaction set in the most cost-effective way.

(b) The commissioner shall promote the development of implementation guides among health care participants for those business transaction types for which implementation guides are not available, to allow providers and group purchasers to implement electronic data interchange. In promoting the development of these implementation guides, the commissioner shall review the work done by the American Hospital Association through the national Uniform Billing Committee and its state representative organization; the American Medical Association through the uniform claim task force; the American Dental Association; the National Council of Prescription Drug Programs; and the Workgroup for Electronic Data Interchange.

HIST: 1994 c 625 art 9 s 7; 1996 c 440 art 1 s 29

62J.57 Minnesota center for health care electronic data interchange.

(a) It is the intention of the legislature to support, to the extent of funds appropriated for that purpose, the creation of the Minnesota center for health care electronic data interchange as a broad-based effort of public and private organizations representing group purchasers, health care providers,

and government programs to advance the use of health care electronic data interchange in the state. The center shall attempt to obtain private sector funding to supplement legislative appropriations, and shall become self-supporting by the end of the second year.

(b) The Minnesota center for health care electronic data interchange shall facilitate the statewide implementation of electronic data interchange standards in the health care industry by:

- (1) coordinating and ensuring the availability of quality electronic data interchange education and training in the state;
- (2) developing an extensive, cohesive health care electronic data interchange education curriculum;
- (3) developing a communications and marketing plan to publicize electronic data interchange education activities, and the products and services available to support the implementation of electronic data interchange in the state;
- (4) administering a resource center that will serve as a clearinghouse for information relative to electronic data interchange, including the development and maintenance of a health care constituents database, health care directory and resource library, and a health care communications network through the use of electronic bulletin board services and other network communications applications; and
- (5) providing technical assistance in the development of implementation guides, and in other issues including legislative, legal, and confidentiality requirements.

HIST: 1994 c 625 art 9 s 8

62J.58 Implementation of standard transaction sets.

Subdivision 1. **Claims payment.** Six months from the date the commissioner formally recommends the use of guides to implement core transaction sets pursuant to section [62J.56](#), subdivision 3, all category I industry participants and all category II industry participants, except pharmacists, shall be able to submit or accept, as appropriate, the ANSI ASC X12 835 health care claim payment/advice transaction set (draft standard for trial use version/release 3051) for electronic submission of payment information to health care providers.

Subd. 2. **Claims submission.** Six months from the date the commissioner formally recommends the use of guides to implement core transaction sets pursuant to section [62J.56](#), subdivision 3, all category I and category II industry participants, except pharmacists, shall be able to accept or submit, as appropriate, the ANSI ASC X12 837 health care claim transaction set (draft standard for trial use version/release 3051) for the electronic transfer of health care claim information.

Subd. 2a. **Claim status information.** Six months from the date the commissioner formally recommends the use of guides to implement core transaction sets under section [62J.56](#), subdivision 3, all category I and II industry participants, excluding pharmacists, may accept or submit the ANSI ASC X12 276/277 health care claim status transaction set (draft standard for trial use version/release 3051) for the electronic transfer of health care claim status information.

Subd. 3. **Enrollment information.** Six months from the date the commissioner formally recommends the use of guides to implement core transaction sets pursuant to section [62J.56](#), subdivision 3, all category I and category II industry participants, excluding pharmacists, shall be able to accept or submit, as appropriate, the ANSI ASC X12 834 health care enrollment transaction set (draft standard for trial use version/release 3051) for the electronic transfer of enrollment and health benefit information.

Subd. 4. **Eligibility information.** Six months from the date the commissioner formally recommends the use of guides to implement core transaction sets pursuant to section [62J.56](#), subdivision 3, all category I and category II industry participants, except pharmacists, shall be able to accept or

submit, as appropriate, the ANSI ASC X12 270/271 health care eligibility transaction set (draft standard for trial use version/release 3051) for the electronic transfer of health benefit eligibility information.

Subd. 5. **Applicability.** This section does not require a group purchaser, health care provider, or employer to use electronic data interchange or to have the capability to do so. This section applies only to the extent that a group purchaser, health care provider, or employer chooses to use electronic data interchange.

HIST: 1994 c 625 art 9 s 9; 1995 c 234 art 5 s 19; 1996 c 440 art 1 s 30

62J.581 Standards for Minnesota uniform health care reimbursement documents.

Subdivision 1. **Minnesota uniform remittance advice report.** (a) All group purchasers shall provide a uniform remittance advice report to health care providers when a claim is adjudicated. The uniform remittance advice report shall comply with the standards prescribed in this section.

(b) Notwithstanding paragraph (a), this section does not apply to group purchasers not included as covered entities under United States Code, title 42, sections 1320d to 1320d-8, as amended from time to time, and the regulations promulgated under those sections.

Subd. 2. **Minnesota uniform explanation of benefits document.**

(a) All group purchasers shall provide a uniform explanation of benefits document to health care patients when an explanation of benefits document is provided as otherwise required or permitted by law. The uniform explanation of benefits document shall comply with the standards prescribed in this section.

(b) Notwithstanding paragraph (a), this section does not apply to group purchasers not included as covered entities under United States Code, title 42, sections 1320d to 1320d-8, as amended from time to time, and the regulations promulgated under those sections.

Subd. 3. **Scope.** For purposes of sections [62J.50](#) to [62J.61](#), the uniform remittance advice report and the uniform explanation of benefits document format specified in subdivision 4 shall apply to all health care services delivered by a health care provider or health care provider organization in Minnesota, regardless of the location of the payer. Health care services not paid on an individual claims basis, such as capitated payments, are not included in this section. A health plan company is excluded from the requirements in subdivisions 1 and 2 if they comply with section [62A.01](#), subdivisions 2 and 3.

Subd. 4. **Specifications.** The uniform remittance advice report and the uniform explanation of benefits document shall be provided by use of a paper document conforming to the specifications in this section or by use of the ANSI X12N 835 standard electronic format as established under United States Code, title 42, sections 1320d to 1320d-8, and as amended from time to time for the remittance advice. The commissioner, after consulting with the administrative uniformity committee, shall specify the data elements and definitions for the uniform remittance advice report and the uniform explanation of benefits document. The commissioner and the administrative uniformity committee must consult with the Minnesota Dental Association and Delta Dental Plan of Minnesota before requiring under this section the use of a paper document for the uniform explanation of benefits document or the uniform remittance advice report for dental care services.

Subd. 5. **Effective date.** The requirements in subdivisions 1 and 2 are effective June 30, 2007. The requirements in subdivisions 1 and 2 apply regardless of when the health care service was provided to the patient.

HIST: 2000 c 460 s 7; 2002 c 307 art 2 s 7; 2002 c 330 s 23; 2005 c 106 s 8

62J.59 IMPLEMENTATION OF NCPDP TELECOMMUNICATIONS STANDARD FOR PHARMACY CLAIMS.

(a) Beginning January 1, 1996, all category I and II pharmacists licensed in this state shall accept the NCPDP telecommunication standard format 3.2 or the NCPDP tape billing and payment format 2.0 for the electronic submission of claims as appropriate.

(b) Beginning January 1, 1996, all category I and category II group purchasers in this state shall use the NCPDP telecommunication standard format 3.2 or NCPDP tape billing and payment format 2.0 for electronic submission of payment information to pharmacists.

HIST: 1994 c 625 art 9 s 10

62J.60 Standards for the Minnesota uniform health care identification card.

Subdivision 1. **Minnesota uniform health care identification card.** All individuals with health care coverage shall be issued Minnesota uniform health care identification cards by group purchasers as of January 1, 1998, unless the requirements of section [62A.01](#), subdivisions 2 and 3, are met. If a health benefit plan issued by a group purchaser provides coverage for prescription drugs, the group purchaser shall include uniform prescription drug information on the uniform health care identification card issued to its enrollees on or after July 1, 2003. Nothing in this section requires a group purchaser to issue a separate card containing uniform prescription drug information, provided that the Minnesota uniform health care identification card can accommodate the information necessary to process prescription drug claims as required by this section. The Minnesota uniform health care identification cards shall comply with the standards prescribed in this section.

Subd. 1a. **Definition; health benefit plan.** For purposes of this section, "health benefit plan" means a policy, contract, or certificate offered, sold, issued, or renewed by a group purchaser for the coverage of medical and hospital benefits. A health benefit plan does not include coverage that is:

- (1) limited to disability or income protection coverage;
 - (2) automobile or homeowners medical payment coverage;
 - (3) liability insurance or supplemental to liability insurance;
 - (4) accident-only coverage;
 - (5) credit accident and health insurance issued under chapter 62B;
 - (6) designed solely to provide dental or vision care;
 - (7) designed solely to provide coverage for a specified disease or illness;
 - (8) coverage under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance;
- or
- (9) hospital income or indemnity.

Subd. 2. General characteristics.

(a) The Minnesota uniform health care identification card must be a preprinted card constructed of plastic, paper, or any other medium that conforms with ANSI and ISO 7810 physical characteristics standards. The card dimensions must also conform to ANSI and ISO 7810 physical characteristics standard. The use of a signature panel is optional. The uniform prescription drug information contained on the card must conform with the format adopted by the NCPDP and, except as provided in subdivision 3, paragraph (a), clause (2), must include all of the fields required to submit a claim in conformance with the most recent pharmacy identification card implementation guide produced by the NCPDP. All information required to submit a prescription drug claim, exclusive of information provided on a prescription that is required by law, must be included on the card in a clear, readable, and understandable manner. If a health benefit plan requires a conditional or situational field, as defined by

the NCPDP, the conditional or situational field must conform to the most recent pharmacy information card implementation guide produced by the NCPDP.

(b) The Minnesota uniform health care identification card must have an essential information window on the front side with the following data elements: card issuer name, electronic transaction routing information, card issuer identification number, cardholder (insured) identification number, and cardholder (insured) identification name. No optional data may be interspersed between these data elements.

(c) Standardized labels are required next to human readable data elements.

Subd. 2a. **Issuance.** A new Minnesota uniform health care identification card must be issued to individuals upon enrollment. Except for the medical assistance, general assistance medical care, and MinnesotaCare programs, a new card must be issued upon any change in an individual's health care coverage that impacts the content or format of the data included on the card or no later than 24 months after adoption of any change in the NCPDP implementation guide or successor document that affects the content or format of the data included on the card. Anytime that a card is issued upon enrollment or replaced by the medical assistance, general assistance medical care, or MinnesotaCare program, the card must conform to the adopted NCPDP standards in effect and to the implementation guide in use at the time of issuance. Newly issued cards must conform to the adopted NCPDP standards in effect at the time of issuance and to the implementation guide in use at the time of issuance. Stickers or other methodologies may be used to update cards temporarily.

Subd. 3. **Human readable data elements.** (a) The following are the minimum human readable data elements that must be present on the front side of the Minnesota uniform health care identification card:

- (1) card issuer name or logo, which is the name or logo that identifies the card issuer. The card issuer name or logo may be located at the top of the card. No standard label is required for this data element;
- (2) complete electronic transaction routing information including, at a minimum, the international identification number. The standardized label of this data element is "RxBIN." Processor control numbers and group numbers are required if needed to electronically process a prescription drug claim. The standardized label for the processor control numbers data element is "RxPCN" and the standardized label for the group numbers data element is "RxGrp," except that if the group number data element is a universal element to be used by all health care providers, the standardized label may be "Grp." To conserve vertical space on the card, the international identification number and the processor control number may be printed on the same line;
- (3) cardholder (insured) identification number, which is the unique identification number of the individual card holder established and defined under this section. The standardized label for the data element is "ID";
- (4) cardholder (insured) identification name, which is the name of the individual card holder. The identification name must be formatted as follows: first name, space, optional middle initial, space, last name, optional space and name suffix. The standardized label for this data element is "Name";
- (5) care type, which is the description of the group purchaser's plan product under which the beneficiary is covered. The description shall include the health plan company name and the plan or product name. The standardized label for this data element is "Care Type";

- (6) service type, which is the description of coverage provided such as hospital, dental, vision, prescription, or mental health.; and
- (7) provider/clinic name, which is the name of the primary care clinic the card holder is assigned to by the health plan company. The standard label for this field is "PCP." This information is mandatory only if the health plan company assigns a specific primary care provider to the card holder.

(b) The following human readable data elements shall be present on the back side of the Minnesota uniform health care identification card. These elements must be left justified, and no optional data elements may be interspersed between them:

- (1) claims submission names and addresses, which are the names and addresses of the entity or entities to which claims should be submitted. If different destinations are required for different types of claims, this must be labeled;
- (2) telephone numbers and names that pharmacies and other health care providers may call for assistance. These telephone numbers and names are required on the back side of the card only if one of the contacts listed in clause (3) cannot provide pharmacies or other providers with assistance or with the telephone numbers and names of contacts for assistance; and
- (3) telephone numbers and names; which are the telephone numbers and names of the following contacts with a standardized label describing the service function as applicable:
 - (i) eligibility and benefit information;
 - (ii) utilization review;
 - (iii) precertification; or
 - (iv) customer services.

(c) The following human readable data elements are mandatory on the back side of the Minnesota uniform health care identification card for health maintenance organizations:

- (1) emergency care authorization telephone number or instruction on how to receive authorization for emergency care. There is no standard label required for this information; and
- (2) one of the following:
 - (i) telephone number to call to appeal to or file a complaint with the commissioner of health; or
 - (ii) for persons enrolled under section [256B.69](#), [256D.03](#), or [256L.12](#), the telephone number to call to file a complaint with the ombudsperson designated by the commissioner of human services under section [256B.69](#) and the address to appeal to the commissioner of human services. There is no standard label required for this information.

(d) All human readable data elements not required under paragraphs (a) to (c) are optional and may be used at the issuer's discretion.

Subd. 4. **Machine readable data content.** The Minnesota uniform health care identification card may be machine readable or nonmachine readable. If the card is machine readable, the card must contain a magnetic stripe that conforms to ANSI and ISO standards for Tracks 1.

Subd. 5. **Annual reporting.** As part of an annual filing made with the commissioner of health or commerce on or after January 1, 2003, a group purchaser shall certify compliance with this section and shall submit to the commissioner of health or commerce a copy of the Minnesota uniform health care identification card used by the group purchaser.

HIST: 1994 c 625 art 9 s 11; 1996 c 440 art 1 s 31,32; 1997 c 205 s 17; 1997 c 225 art 2 s 62; 2000 c 460 s 8; 2001 c 110 s 1; 2006 c 255 s 22,23

62J.61 RULEMAKING; IMPLEMENTATION.

Subdivision 1. **Exemption.** 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.

Subd. 2. **Procedure.** (a) The commissioner shall publish proposed rules in the State Register or, if the commissioner determines that publishing the text of the proposed rules would be unduly cumbersome, shall publish notice of the proposed rules that contains a detailed description of the rules along with a statement that a free copy of the entire set of rules is available upon request to the agency.

(b) Interested parties have 30 days to comment on the proposed rules. After the commissioner has considered all comments, the commissioner shall publish notice in the State Register that the rules have been adopted 30 days before they are to take effect.

(c) If the adopted rules are the same as the proposed rules, the notice shall state that the rules have been adopted as proposed and shall cite the prior publication. If the adopted rules differ from the proposed rules, the portions of the adopted rules which differ from the proposed rules shall be included in the notice of adoption together with a citation to the prior State Register that contained the notice of the proposed rules.

(d) The commissioner may use rulemaking to implement sections 62J.54, subdivision 4, 62J.55, and 62J.60.

Subd. 3. **Restrictions.** The commissioner shall not adopt any rules requiring patients to provide their social security numbers unless and until federal laws are modified to allow or require such action nor shall the commissioner adopt rules which allow medical records, claims, or other treatment or clinical data to be included on the health care identification card, except as specifically provided in this chapter.

Subd. 4. **Patient privacy.** The commissioner shall seek comments from the ethics and confidentiality committee of the Minnesota health data institute and the department of administration, public information policy analysis division, before adopting or publishing final rules relating to issues of patient privacy and medical records.

Subd. 5. **Biennial review of rulemaking procedures and rules.** The commissioner shall biennially seek comments from affected parties about the effectiveness of and continued need for the rulemaking procedures set out in subdivision 2 and about the quality and effectiveness of rules adopted using these procedures. The commissioner shall seek comments by holding a meeting and by publishing a notice in the State Register that contains the date, time, and location of the meeting and a statement that invites oral or written comments. The notice must be published at least 30 days before the meeting date. The commissioner shall write a report summarizing the comments and shall submit the report to the Minnesota health data institute and to the Minnesota administrative uniformity committee by January 15 of every even-numbered year.

HIST: 1994 c 625 art 9 s 12; 1997 c 187 art 4 s 3; 1998 c 254 art 1 s 14

Appendix E – National Claim Adjustment Reason Codes Web Site Address

<http://www.wpc-edi.com/codes/claimadjustment>

Appendix F – Remittance Advice Remark Code Web Site Address

<http://www.wpc-edi.com/codes/remittanceadvice>

Appendix G – Provider Adjustment Code List – PLB Segment

50 Late Charge
51 Interest Penalty Charge
72 Authorized Return
90 Early Payment Allowance
AA Receivable Today (see "CS")
AP Acceleration of Benefits
AW Accelerated Withholdings
B2 Rebate
B3 Recovery Allowance
BD Bad Debt Allowance
BN Bonus
C5 Temporary Allowance TS
CR Capitation Interest
CS Adjustment
CT Capitation Payment
CV Capital Passthru
CW Certified Registered Nurse Anesthetist Passthru
DM Direct Medical Education Passthru
E3 Withholding
FB Forwarding Balance
FC Fund Allocation
GO Graduate Medical Education Passthru
IP Incentive Premium Payment
IR Internal Revenue Service Withholding
IS Interim Settlement
J1 Nonreimbursable
L3 Penalty
L6 Interest Owed
LE Levy
LS Lump Sum
OA Organ Acquisition Passthru
OB Offset for Affiliated Providers
PI Periodic Interim Payment
PL Payment Final
RA Retro-activity Adjustment
RE Return on Equity
SL Student Loan Repayment
TL Third Party Liability
WO Overpayment Recovery
WU Unspecified Recovery
ZZ Mutually Defined

