



HIPAA Transaction  
Standard Companion Guide  
835 – Health Care Claim Payment Advice

**Refers to the Implementation Guides  
Based on X12 version 004010 Addendum  
Companion Guide Version Number: 1.1  
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## Disclaimer Statement

The Health Insurance Portability and Accountability Act (HIPAA), sections 160 and 162, requires that health care providers, health plans, and health care clearing houses comply with the EDI standards for health care. The HIPAA implementation specifications for ASC X12N standards may be obtained through the Washington Publishing Company on the Internet at <http://www.wpc-edi.com>. The complete Implementation Guide is a combination of both the version 4010 and the 4010 addenda as adopted for use under the HIPAA regulation. The combined version is referred in this document as the X12N 4010A1.

**The purpose of this companion guide is solely to supplement the HIPAA ASC X12N standards, to provide clarification to the ASC X12N standards, and should not be interpreted as a contract, amendment to a contract or an addendum to a contract. In any instance where this companion guide differs from the HIPAA ASC X12N Implementation Guides, the HIPAA ASC X12N standards shall govern.**

**Substantial effort has been taken to minimize errors; however, APEX Benefits Services, its agents, employees, directors and shareholders shall not be liable or responsible for any errors, omissions or expenses resulting from the use of the information in this document.**

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# 1 Introduction

## 1.1 Overview

This Companion Guide identifies unique information processing or adjudication needs specific to APEX Benefits Services in its implementation of the 835 Health Care Claim Payment Advice and should be used in conjunction with the *HIPAA 835 Implementation Guide*. Throughout this document, “APEX” represents APEX Benefits Services. This companion guide contains three categories of information:

- General information applicable to the processing of claims and business edits performed by APEX.
- The transaction table outlining specific requests for data format or content within the transaction, or describing APEX handling of specific data types.
- Additional information containing a sample scenario and frequently asked questions (FAQ).

All claims (paper and electronic) will be reported on the 835 if a provider/submitter chooses to receive the 835.

While APEX accepts all ASCX12 compliant transactions, the HIPAA Implementation Guides allow for some discretion in applying the regulations to existing business practices. Understanding APEX business practices may expedite claims processing for trading partners as they exchange EDI transactions with APEX.

## 1.2 EDI Registration

All Trading Partners must complete the EDI registration process before sending any transactions to APEX. This process is detailed separately in the Communication Companion Guide and on the APEX Website.

**Prior to submitting claims electronically, all providers must complete an EDI Registration Form. A Trading Partner Agreement may also be required.**

**Furthermore, all providers are required to file a change in registration with APEX when the following occurs:**

- Changes in Clearinghouse, Billing Service, Software Vendor or any Vendor handling the provider's electronic data information
- Change in address
- Change or addition of your Tax Identification Number (TIN)
- Change in name

## 1.3 Testing Prior to Production

All Trading Partners must complete transaction testing prior to submission of transactions in production. This process is detailed separately in the Communication Companion Guide and on the APEX Website.

**Prior to submitting production claims electronically, all providers or their designated vendor must complete successful transaction testing. Providers must maintain a successful level of transaction submission to remain in production.**

## 2 Eligibility

In order to receive an 835 Health Care Claim Payment Advice, submitters of health care claims must complete the following:

- Have an APEX Rendering Network Provider Identification (RNPI) number that has been assigned by APEX.
- Complete and submit a Trading Partner Agreement to APEX or enter into a contractual agreement with a clearinghouse or billing service that has a Trading Partner Agreement with us that allows them to submit claims on your behalf.
- Complete APEX EDI Registration Form along with the 835 Registration Form.
- Complete testing requirements with APEX.

## 3 Data Exchange Frequency

New files may be available each business day by noon eastern standard time.

## 4 Electronic Funds Transfer (EFT)

The APEX 835 Transaction is for notification only and does not include Electronic Funds Transfer (EFT) to financial institutions. Trading Partners who would like to implement EFT should contact the Finance Department at (330) 996-8461.

## 5 Claim Remittance Processing

Notes that are important to claims processing are as follows:

- 835 Transactions are only generated for claims that have a “paid” or “denied” status. Claims still in the adjudication process or returned with an error messages do not receive an 835 response.
- If a provider who receives an electronic remittance and also submits **claims on paper**, APEX will generate a format compliant 835 Health Care Claim Payment Advice transaction with required elements. However, the content of the resulting 835 will not be as complete as an 835 resulting from an electronic 837 Claim transaction.
- APEX will continue to produce paper remittance advices along with electronic remittance advices for an undetermined period of time for both paper and 837 electronic claims.

## 6 Claims/Batch Matching

Please note that there is not batch matching between 837 Health Care Claims and 835 Health Care Claim Payment Advice.

## **7 Bundling/Unbundling**

As claims are processed, professional services reflected by procedure codes are bundled or unbundled utilizing APEX business processes. Procedure codes are returned for professional health care claims as processed reflecting APEX payment record. This does not necessarily reflect procedure codes submitted.

## **8 Identification Codes and Numbers**

APEX uses the standard medical and non-medical code sets indicated in Appendix C of the 835 Payment Advice/Remittance Implementation Guide.

### **8.1 Provider Identifiers**

APEX requires that all submitters use the Rendering Network Provider Identification (RNPI) number assigned to the provider by APEX.

The RNPI number submitted on the 837 Health Care Claim Transaction will be the number returned on the 835 Health Care Claim Payment Advice.

### **8.2 Subscriber Identifiers**

The Subscriber Identifier returned on the 835 Claim Payment Advice is the membership identifier that appears within the APEX system which could be different than what was submitted on the 837 Health Care Claims transaction. If this identifier differs from that which was submitted, assume the returned identifier on the 835 transactions is correct.

### **8.3 Payer Claim Control Number**

The Payer Claim Control Number (Payer Patient Control Number in the 2100 loop, CLP07) is the 12-digit claim number assigned to each claim by APEX. Receivers of the 835 Health Care Claim Payment Advice should use their Patient Control Number (Patient Control Number CLP01) and dates of service, in conjunction with the CLP07 value to match claims with remittances. If the Patient Control Number is submitted on paper claims, then this number will be returned on the 835 Health Care Claim Payment Advice. If there is no Patient Control Number on the paper claim, then the value of "0" will be returned.

### **8.4 Adjustment Group and Reason Codes**

For claim adjustment reason code use code source 139 and for Health Care Remark Codes, use source code 411.

### **8.5 Remarks Codes**

We will be returning the HIPAA Standard Remarks Codes (Loop2110, segment LQ02) along with our current Explanation Codes (Loop 2110, segment REF02).

## **9 Special Handling**

In the event that we are unable to produce an 835 Health Care Claim Payment Advice electronically, APEX will generate a paper Explanation of Payment (EOP).

## **10 Inquiries**

For inquiries concerning the EFT (Electronic Funds Transfer) please contact our Finance Department at (330) 996-8461. All other inquiries should contact: APEX Provider Services Unit at (330) 996-8400 or 1-800-996-8401.

## **11 835 Data Element Table**

### 11.1 835 Health Care Claim Payment/Advice – Header

The 835 Transaction Set Header contains general information about the claim payment, such as Payee, Amount, Payer, Payment method, and Trace Number. The following table explains the header segments and data elements that require specific information for APEX processing.

Table 1 - 835 Claim Payment / Advice - Header					
Envelope/Section Label	Segment	Description	Value Options for APEX	Value Options from IG	IG page
<b>Transaction Set Header</b>					
Financial Information	BPR01	Transaction Handling Code	I, C, D,	I - Remittance information only, C-Payment Accompanies Remittance Advice, D- Make payment only	45-46
Financial Information	BPR03	Credit / Debit Flag Code	C	C - Credit	46
Financial Information	BPR04	Payment Method Code	ACH, CHK	ACH - Automated Clearing House      CHK - Check	46-47
Financial Information	BPR05	Payment Format Code	CCP	CCP - Cash Concentration / Disbursement plus Addenda	47
Financial Information	BPR06	DFI ID Number Qualifier	01	01 - ABA Transit Routing Number Including Check Digit (9 digits)	48
Financial Information	BPR07	Sender DFI ID Number	Sender DFI ID	Represents Summa Insurance Company/ Summa Health Network/ APEX Bank Number	48
Financial Information	BPR09	Sender Bank Account Number	Sender Bank Account Number	Represents Summa Insurance Company/ Summa Health Network/ APEX Bank Account Number	49
Financial Information	BPR12	DFI ID Number Qualifier	01	01 - ABA Transit Routing Number Including Check Digit (9 digits)	49
Financial Information	BPR13	Receiver DFI ID Number	Receiver DFI ID	Represents Receiver / Provider's Bank Number	50
Financial Information	BPR15	Receiver Bank Account Number	Receiver Bank Account Number	Represents Receiver / Provider's Bank Account Number	50
Financial Information	BPR16	Check Issue or EFT Effective Date	Date	Represent the Check Issue Date or EFT Effective Date	50
Re-association Trace Number	TRN02	Check or EFT Trace Number	Check Number, Advice Number	Check Number - If the Provider Receives a Paper Check. Advice Number - If the Provider Receives an EFT	53
Re-association Trace Number	TRN03	Payer Identifier	34196	APEX Payer Identification Number	53
Receiver Identification	REF01	Reference Identification Qualifier	EV	EV - Receiver ID Number	57
Receiver Identification	REF02	Receiver Identifier	Receiver's EDI Sender ID Number	Represents the Receiver's EDI Sender ID Number Assigned by APEX	57
<b>LOOP ID - 1000B Payee Identification</b>					
Payee Identification	N103	Identification Code Qualifier	FI	FI - Federal Tax Identification Number	73
Payee Identification	N104	Payee Identification Code	Provider's Fed. Tax ID Number	Represents the Provider's Federal Tax ID Number	73

## 11.2 835 Health Care Claim Payment /Advice – Detail

The 835 Payment Advice detail level contains the explanations of benefits and charges paid, reduced, or denied related to the adjudicated claims and services. The Claim Payment and Service Patient Information are contained in Loops 2100 and 2110 in the following table. The table also explains the situational segments and data elements that require specific information for APEX Processing.

Table 2 - 835 Claim Payment / Advice - Detail					
Envelope/Section Label	Segment	Description	Value Options for APEX	Value Options for IG	IG page
<b>LOOP ID - 2100 Claims Payment Information</b>					
Claim Payment Information	CLP01	Patient Control Number	Patient Control number (UB92) Patient Account Number (HCFA)	For electronic claims, this field will contain the value received in CLM01 on the inbound 837. For paper claims, this field will contain the value received in block 26 on the HCFA and block 3 on the UB92 claim forms. If the patient control number was not present on the inbound claim, a zero will appear here	89
Claim Payment Information	CLP02	Claim Status Code	One of the following values : 1 - Primary 2 - Secondary	One of the following values will be displayed: 1 - Claim processed as Primary 2 - Claim processed as Secondary	90/91
Claim Payment Information	CLP06	Claim Filing Indicator Code	One of the following values: 12 - PPO 13 - POS 14 - EPO 15 - Indemnity 16- HMO Medicare Risk HM - HMO	One of the following values will be displayed: 12 - Preferred Provider Org. (PPO) 13 - Point of Service (POS) 14 - Exclusive Provider Org. (EPO) 15 - Indemnity Insurance * 16 - HMO Medicare Risk HM - HMO * The value of 15 may include Traditional plans	92
Claim Payment Information	CLP07	Payer Claim Control Number	APEX Claim Number	Represents the claim number assigned by APEX	93
Patient Name	NM108	Identification Code Qualifier	MI	MI - Member Identification Number	103
Patient Name	NM109	Patient Identifier	APEX member number plus 2 digit suffix	Represents the Member Identification Number	104
Insured Name	NM108	Identification Code Qualifier	MI *This segment is only used when the patient is not the subscriber	MI - Member Identification Number	107

**Table 2 - 835 Claim Payment / Advice – Detail (continued)**

Envelope/Section Label	Segment	Description	Value Options for APEX	Value Options for IG	IG page
<b>LOOP ID - 2100 Claims Payment Information</b>					
Insured Name	NM109	Patient Identifier	APEX Subscriber's number *This segment is only used when the patient is not the subscriber	Represents the Member Identification Number	107
Service Provider Name	NM108	Identification Code Qualifier	FI	FI - Federal Tax Identification	113
Service Provider Name	NM109	Identification Code	Rendering Network Provider Identification (RNPI) number	Represents the Provider ID	113
Claim Date	DTM01	Date / Time Qualifier	One of the following values: 232,233	232- Claim Statement Period Start 233 - Claim statement Period End	131
Claim Date	DTM02	Date	Date specified by the code used in DTM01	Date specified by the code used in DTM01	131
<b>LOOP ID - 2110 Service Payment Information</b>					
Service Payment Information	SVC01-1	Product or Service ID Qualifier	One of the following values: AD HC NU	This value qualifies the values in SVC06-2 through SVC06-6. AD - American Dental Association Codes HC - Health Care Financing Administration Common Procedural Coding System Codes (HCPCS) NU - National Uniform Billing Committee Codes (NUBC) UB92 codes	140
Service Payment Information	SVC01-2	Product or Service ID	Procedure Code	If charges are re-bundled, the adjudicated code will be reflected as opposed to the original submitted code.	141

**Table 2 - 835 Claim Payment / Advice – Detail (continued)**

Envelope/Section Label	Segment	Description	Value Options for APEX	Value Options for IG	IG page
<b>LOOP ID - 2110 Service Payment Information</b>					
Service Payment Information	SVC06	Composite Medical Procedure Identifier	See SVC06-1 through SVC06-7	Data elements SVC06-1 through SVC06-6 are included as applicable in the following circumstances: The adjudicated procedure code in SVC01 is different from the submitted procedure code on the original claim. - As needed to reference originally submitted procedures on a re-bundled claim - As needed to reference a APEX Medical Policy change.	142-144
Service Date	DTM01	Date/Time Qualifier	One of the following values: 150, 151 or 472	150- Service Period Start 151- Service Period End 472 - Service	147
Service Date	DTM02	Date	Service date	Service date	147
Claims Adjustments	CAS02	Claims Adjustments Reason Code	Claims Adjustments Reason Code	See the appendix section for the Adjustment Reason Codes. It documents the Adjustment Reason Codes as of publication date of this document.	150
Service Identification	REF01	Reference Identification Qualifier	E9	E9 - Attachment Code	154-155
Service Identification	REF02	Reference Identification	EX codes attached to the service line without the description of the EX code	This represents Apex's internal explanation code that is shown on the paper EOP.	155
Health Care Remarks Code	LQ01	Code List Qualifier Code	HE	HE - Claim Payment Remark Code	162
Health Care Remarks Code	LQ02	Remark Code	See Source 411 pg. C.9, referenced in the 835 IG. Source 530 for prescription drugs, pg. C.9 in 835 IG.	The 835 may include up to five codes per line.	163

### 11.3 835 Health Care Claim Payment/Advice – Summary

The summary level contains the Provider Level Adjustment Segment and provides information related to adjustments to the payment amount not specific to the Detail level. The adjustments can either increase or decrease the actual payment.

The following table also explains the situational segments and data elements that require specific information for APEX Processing.

Table 3 - 835 Claim Payment / Advice - Summary				
Envelope/Section Label	Segment	Description	Value Options for APEX	Value Options for IG
Provider Level Adjustment	PLB01	Provider Identifier	Payee ID Number	Represents the Payee ID Number assigned by APEX.

## 12 835 Claim Payment/Advice Transaction Sample

### 12.1 Claim Payment Advice Scenario

On September 2, 2003, Jonathan Doe was experiencing pain in his leg and ankle. He was taken to Healthy Hospital for an x-ray of his foot and ankle. The hospital submitted the bill to their clearinghouse. On September 18, 2003, the clearinghouse transmitted a claim to APEX in the 837I file format, for \$583.70. On September 25, 2003, APEX issued a check for \$171.55 to Healthy Hospital for their services.

#### Claim Information

**Payment:** \$175.11

**Check Date:** 9/25/2003

**Facility Billed Amount:** \$583.70

**Check #:** 97CF0000000411

**Facility TIN:** 123456789

**Claim Production run date:** 9/18/2003

**Payer Name:** APEX Benefits Services

**Payer Address:** 10 North Main Street, Akron, OH 44309

**Facility:** Healthy Hospital

**Facility Rendering Network Provider Identification (RNPI) Number:** 123456789A

**Patient:** Jonathan Doe

**Patient ID:** 98765432103

**Patient Account #:** 330866922

**Date of Service:** 9/2/2003

**CPT Codes:** 73610, 73630

**Revenue Codes:** 320

**Adjustment:** \$408.59 due to a contractual obligation

**Provider System Control #:** 030620T03109

## 12.2 Claim Payment /Advice Example ANSI X 12

ST\*835\*3207~  
BPR\*I\*175.11\*C\*CHK\*\*\*\*\*20030925~  
TRN\*1\*97CF000000411\*1123456789~  
DTM\*405\*20030918~  
N1\*PR\*APEX BENEFITS SERVICES~  
N3\*10 NORTH MAIN STREET~  
N4\*AKRON\*OH\*44309~  
N1\*PE\*HEALTHY HOSPITAL\*FI\*123456789~  
REF\*G2\*123456789A~  
LX\*1~  
CLP\*330866922\*1\*583.7\*175.11\*\*13~  
NM1\*QC\*1\*DOE\*JONATHAN\*\*\*\*MI\*98765432103~  
DTM\*232\*20030902~  
DTM\*233\*20030902~  
SVC\*HC:73610\*297.40\*89.22\*320\*1~  
CAS\*CO\*42\*208.18~  
REF\*E9\*PA~  
REF\*6R\*030620T03109~  
SVC\*HC:73630\*286.30\*85.89\*320\*1~  
CAS\*CO\*42\*200.41~  
REF\*E9\*PA~  
REF\*6R\*030620T03109~  
SE\*22\*3207~

## 13 Frequently Asked Questions – FAQ

**1. What is Electronic Data Interchange?**

Electronic Data Interchange (EDI) allows providers to submit claims, retrieve remittance advices and retrieve claim file acknowledgements from their computer system via modem and phone lines to the insurance carrier or clearinghouse.

**2. Can I receive my payment and Explanation of Payment Electronically?**

APEX has not set a date as to when this will be available.

**3. Do you send data on all claims or just paid claims?**

We send data on all paid and denied claims. Data is not returned on electronic claims rejected at time of submission or claims in process in our system.

**4. Do you deposit the money directly into provider bank account or do you issue a check?**

We can handle multiple ways of issuing your payment. You will need to select the method that you wish to receive at the time of registration.

**5. Do you send paper Explanation of Payment along with the electronic version?**

If you wish we will send both paper and electronic payment advice for up to a four week period. After that time the paper will only be upon request.