Fallon Health

Health Care Payment Advice

835 Companion Guide

Refers to the ASC X12N 835 Technical Report Type 3 Guide (Version 005010X221A1)

Companion Guide Version Number: 1.6

January 2022

Disclosure Statement

The information in this document is subject to change. Changes will be posted via the Fallon Health websites located below

- Fallon Health Provider Portal containing documentation on transactions for providers is located at http://www.fchp.org/providers/provider-tools/electronic-data-submission.aspx

This notice is not a guarantee of claim payment. Coverage for all services is subject to member eligibility and all terms and conditions of the member's contract in effect as of the date of service. Deductible and out-of-pocket maximum amounts are subject to change.

PREFACE

This Companion Guide to the ASC X12N Implementation Guides adopted under HIPAA clarifies and specifies the data content when exchanging electronically with Fallon Health. Transmissions based on this companion guide, used in tandem with the X12N Technical Report Type 3 Guides, are compliant with both X12 syntax and those guides. This Companion Guide is intended to convey information that is within the framework of the ASC X12N Implementation Guides adopted for use under HIPAA. The Companion Guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the Implementation Technical Report Type 3 Guides.

Contents

1. INTRODUCTION

Scope

Providers, billing services and clearinghouses are advised to use the ASC X12N 835 (005010X221A1) Implementation Guide as a basis for their Health Care Claim Payment Advice. This companion document should be used to clarify the CORE Business rules for 835 data content requirements, connectivity, response time, and system availability, specifically for submissions through Fallon Health or clearinghouses. This document is intended for use with CAQH CORE compliant systems. For additional information on building a CORE compliant system go to http://www.caqh.org.

Overview

The Health Insurance Portability and Accountability Act–Administration Simplification (HIPAA-AS) requires Fallon Health and all other covered entities to comply with the electronic data interchange standards for health care as established by the Secretary of Health and Human Services.

This guide is designed to help those responsible for setting up electronic Health Care Claim Payment/Advice. Specifically, it documents and clarifies when conditional/situational data elements and segments must be used for reporting, and it identifies codes and data elements that do not apply to Fallon Health. This guide supplements (but does not contradict) requirements in the ASC X12N 835 (version 005010X221A1) implementation. This information should be given to the provider's business area to ensure that Health Care Claim Payment Advice transactions are interpreted correctly.

References

- The ASC X12N 835 (version 005010X221A1) Technical Report Type 3 guide for Health Care Claim Payment Advice has been established as the standard for Claim Payment transactions and is available at http://www.wpc-edi.com
  Fallon Health Provider Portal containing documentation on transactions for providers is located at http://www.fchp.org/providers/provider-tools/electronic-data-submission.aspx

2. GETTING STARTED

Working with Fallon Health

Fallon Health offers the 835 ERA transaction through PaySpan. Providers must contact PaySpan to receive an 835 and the paper RAS. If you are new to Payspan, please visit their website at ***www.payspanhealth.com*** and click "Register Now". You will need:

1.) Registration code and PIN (If you have not received these from PaySpan, click "Request a Registration Code" or call PaySpan at 1-877-331-7154, option 1.)

2.) Tax ID

3.) Bank routing and account number (found on your check).

If you are already registered with PaySpan but would like to add Fallon Health to your account, get your unique registration code on the PaySpan website: ***https://www.payspanhealth.com/RequestRegCode/***

Trading Partner Registration

Trading partner registration is not required with Fallon because the registration is completed with Payspan.

3. TESTING WITH THE PAYER

Due to Payspan providing the Health Care Claim Payment Advice/835 file, testing with Fallon Health is not applicable. Payspan does not actively test with providers.

4. CONNECTIVITY WITH THE PAYER/COMMUNICATIONS

Process Flows

Fallon Health's 835 files are available at www.payspanhealth.com. Providers must register to receive Fallon Health payment information. There is an option to have the 835 routed to a third party, such as: Affiliated Professional Services (APS), Athena, MedAssets, Relay Health, SSI Group, Trizetto Provider Services, Change Healthcare or Zirmed.

Confidentiality, Privacy and Security

Maintaining the confidentiality of personal health information continues to be one of Fallon Health's guiding principles. Fallon Health has a strict Confidentiality Policy with regard to safeguarding patient, employee, and health plan information. All staff is

required to be familiar with, and comply with, Fallon Health's policy on the Confidentiality of Member Personal and Clinical Information to ensure that all member information is treated in a confidential and respectful manner. The policy permits use or disclosure of members' medical or personal information only as necessary to conduct required business, care management, approved research or quality assurance or measurement activities, or when authorized to do so by a member or as required by law.

To comply with internal policies as well as the provisions of the Health Insurance Portability and Accountability Act, 1996 (HIPAA), Fallon Health has outlined specific requirements applicable to the electronic exchange of Protected Health Information (PHI) including provisions for:

- Maintaining confidentiality of protected information
- Confidentiality safeguards
- Security standards
- Return or destruction of protected information
- Compliance with state and federal regulatory and statutory requirements
- Required disclosure
- Use of business associates

Due to its sensitivity, the use and disclosure of PHI is restricted, except in circumstances where permitted or required by law or where appropriate authorization for use or disclosure is obtained. Access to PHI is limited to those with a business need to know the information for treatment, payment, or health care operations, or as otherwise permitted or required by law.

Associates with a business need to handle PHI must be identified and granted appropriate access in accordance with their department-level policies and procedures. FallonHealth maintains policies and procedures for the HIPAA compliant transfer of protected health information to external health care partners. These provisions include secure file transfer, encryption, password protection, secure fax, and other measures, as indicated based on the nature of the data being transferred.

System Availability

Routine downtime is scheduled weekly from 6 PM to 11 PM on Thursdays and 8 AM to 12 PM on Sundays to support maintenance and enhancements for all EDI transactions. Non-routine downtime will be communicated via email at least one week in advance. Emergency unscheduled downtime will be communicated to trading partners via email within one hour following the determination that emergency downtime is needed.

5. CONTACT INFORMATION

EDI Customer Service & Technical Assistance

If you cannot find the answers to your questions within this Companion Guide, please use the contact information below to reach our EDI Support team.

Phone: 1-866-275-3247 (Option 6)
ail: edi.coordinator@fallonhealth.org
EDI Support is available Monday through Friday, 8:00 AM to 5:00 PM EST, excluding the following major holidays:

New Year's Day (1/1)
Presidents Day (3rd Monday in February)
Memorial Day (Last Monday in May)
Independence Day (7/4)
Labor Day (1st Monday in September)
Columbus Day (2nd Monday of October)
Thanksgiving Day (4th Thursday in November)
Day after Thanksgiving Day
Christmas Day (12/25)

Provider Service Number

Phone: 1-866-275-3247 (Option 4)
Email: AskFCHP@fallonhealth.org

Applicable Websites/ E-mail

This section contacts a list of useful websites and email addresses:

- Fallon Health website is www.fallonhealth.org
- PaySpan Health website is www.payspanhealth.com
- CORE website is www.caqh.org/CORE_overview.php
- CAQH website is www.caqh.org
- Washington Publishing Company is www.wpc-edi.com
- WEDI website is www.wedi.org
- EDI Coordinator email address is edi.coordinator@fallonhealth.org

6. Production EDI-835 File – Frequency

Production files will be sent on a weekly basis. Normally the 835 files are available by close of business on Wednesday (Thursday if a holiday week).

7. 835 Electronic Remittance Advice Specifications

General Notes

- An ANSI X12N 837 Health Care Claim is NOT required in order to receive ANSI X12N 835 Electronic Remittance Advice
- Provider must be registered with Payspan in order to receive the 835 file.

Transaction Specific Information

- Claims that have the same providers as the Pay-to Provider and the Rendering Provider will have the Rendering Providers listed on the claim. This is a change for the Hospital/UB04 claims.
- The date of service will be listed on the service line.
- Withhold amounts are listed at the line level as CAS*CO*104.
- CARC and RARC mapping has been enhanced to more accurately reflect the denial reasons. See Appendix B.
- There is only one ISA, GS segment per file. There may be one or more ST segments per file. Each ST segment corresponds to a payee/check number. The file is structured in the following hierarchy
    a. ISA
    b. GS
    c. ST*835*
    d. One check per payee number (BPR Segment) per insurance system
    e. NM Loop 1000B—Payee Identification Qualifier XX the National Provider Identifier
    f. Provider Loop 2000 – LX segment is used to indicate the start of a provider's claims.
    g. Loop 2000 —TS3 contains the National Provider Identifier for the subsequent group of claims.
    h. Provider's claim header (Loop 2100 CLP)
    i. One or more service lines with adjustment details. (Loop 2110 SVC)
    j. Additional claims and corresponding service lines for the provider
    Note: A provider's claims are grouped by product.
    k. Repeat loops for additional providers' claims and service lines
    l. SE*
    m. Repeat ST/SE loops for additional payee/checks for this submitter.

File Retrieval Methods

The Fallon Health gateway will be configured to automatically deliver the 835 file to PaySpan gateway. It is the receiver's responsibility to configure their PaySpan gateway in order to accept the 835 file. Please contact PaySpan representative to review your gateway software version and configuration.

Data Content and Specifications

Segment / Element	Description	ID	Min-Max	R \ N \ S	Loop	Loop repeat	Values (Code - Definition)
ISA	**Interchange Control Segment**			**R**	**Header**	**1**	
ISA01	Authorization Information Qualifier	ID	2/2	R	Header		“00” No Authorization Information Present
ISA02	Authorization Information	AN	10/10	R	Header		Leave Blank
ISA03	Security Information Qualifier	ID	2/2	R	Header		“00” No security Infornrntion Present
ISA04	Security Information	AN	10/10	R	Header		Leave Blank
ISA05	Interchange Sender ID Qualifier	ID	2/2	R	Header		“ZZ” Mutually Defined
ISA06	Interchange Sender ID	AN	15/15	R	Header		FCHP
ISA07	Interchange Receiver ID Qualifier	ID	2/2	R	Header		Your Receiver ID Qualifier as per Trading Partner Agreement document
ISA08	Interchange Receiver ID	AN	15/15	R	Header		Your Receiver ID as per Trading Partner Agreement document
ISA09	Interchange Date	DT	6/6	R	Header		Date of interchange. Date format is YYMMDD
ISA10	Interchange Time	TM	4/4	R	Header		Time of interchange. Time format is HHMM
ISA11	Interchange Control Standards Identifier		1/1	R	Header		"^"
ISA12	Interchange Control Version Number	ID	5/5	R	Header		"00501" ANSI Version number that covers the Interchange Control Segment.
ISA13	Interchange Control Number	N0	9/9	R	Header		Interchange Control Number - Unique number sent by FCHP. Must = IEAO2
ISA14	Acknowledgement Requested	ID	1/1	R	Header		"0" No Acknowledgement Requested "1" Acknowledgement Requested
ISA15	Usage Indicator	ID	1/1	R	Header		"P" Production Data "T" Test Data
ISA16	Component element Separator		1/1	R	Header		":" Delimiter used to separate Components (colon)
GS	**Functional Group Header**			**R**	**Header**	**1**	
GS01	Functional Identifier Code	ID	2/2	R	Header		“HP” = Health Care Claim Payment Advice
GS02	Application Sender Code	AN	2/15	R	Header		If you are receiving production 835 files in the 4010A1 format, this value will be the same in your 5010 file
GS03	Application Receiver ID	AN	2/15	R	Header		Receiver ID specified in your Health Partners Agreement
GS04	Date	DT	8/8	R	Header		Date Expressed in CCYYMMDD format
GS05	Time	TM	4/4	R	Header		Time in HHMM format
GS06	Group Control Number	N0	1/9	R	Header		Functional Group Control Number. Value must equal GE02

GS07	Responsible Agency Code	ID	1/2	R	Header		"X" Accredited Standards Committee X12
GS08	Version/Release/Industry Identifier	AN	1/12	R	Header		"005010X221A1"
ST	**Transaction Set Header**			**R**	**Header**	**1**	**Required – will contain one or more transactions**
ST01	Transaction Set Identifier Code	ID	3/3	R	Header		"835"
ST02	Transaction Set Control Number	AN	4/9	R	Header		Transaction Set Control Number. Must equal SE02
BPR	**Financial Information**			**R**		**1**	
BPR01	Transaction Handling Code	ID	1/2	R			"I" = Remittance Information Only "H" = Notification Only
BPR02	Monetary Amount	R	1/18	R			Total Actual Provider Payment Amount
BPR03	Credit/Debit Flag	ID	1/1	R			"C" = Credit
BPR04	PAYMENT METHOD CODE	ID	3/3	R			"CHK" = Check / "NON" -Check only. Set to NON if check amount is $0.00
BPR05	PAYMENT FORMAT CODE	ID	1/10	S			Not used at this time
BPR06	(DFI) ID NUMBER QUALIFIER	ID	2/2	S			Not used at this time
BPR07	(DFI) IDENTIFICATION NUMBER	AN	3/12	S			Not used at this time
BPR08	Account Number Qualifier	ID	1/3	S			Not used at this time
BPR09	Sender Bank Account Number	AN	1/35	S			Not used at this time
BPR10	ORIGINATING COMPANY IDENTIFIER	AN	10/10	S			Not used at this time
BPR11	Originating Company Supplemental Code	AN	9/9	S			Not used at this time
BPR12	DFI Identification Number Qualifier	ID	2/2	S			Not used at this time
BPR13	Receiver or Provider Bank ID Number	AN	3/12	S			Not used at this time
BPR14	ACCOUNT NUMBER QUALIFIER	ID	1/3	S			Not used at this time
BPR15	Receiver or Provider ACCOUNT NUMBER	AN	1/35	S			Not used at this time
BPR16	Check Issue or EFT Effective Date	DT	8/8	S			Check Issuance Date in CCYYMMDD Format
TRN	**Reassociation Trace Number**			**R**		**1**	
TRN01	Trace Type Code	ID	1/2	R			"1" = Current Transaction Trace Numbers
TRN02	REFERENCE IDENTIFICATION	AN	1/50	R			Check Number
TRN03	ORIGINATING COMPANY IDENTIFIER	AN	10/10	R			Employer Identification number, prefixed a "1"
TRN04	Originating Company Supplemental Code	AN	1/50	S			Not used at this time
CUR	**Foreign Currency Information**			**S**		**1**	**Segment not used at this time**
REF	**Receiver Identification**			**S**		**1**	**Situational (When Receiver is different than Payee)**
REF01	Receiver Identification Number	ID	2/3	R			"EV" = Receiver Identification Number Qualifier
REF02	Receiver REFERENCE IDENTIFICATION	AN	1/50	R			Receiver Identification Number
REF	**Version Identification**			**S**		**1**	
DTM	**Production Date**			**S**		**1**	
	Payer Identification Loop				**1000A**		
N1	**Payer Identification**			**R**		**1**	**Required**
N101	Payer Identifier Code	ID	2/3	R	1000A		"PR" Payer
N102	Payer NAME	AN	1/60	R	1000A		"FCHP" "FHLAC" "FHLACASO"

N103	Identification Code Qualifier	ID	1/2	S	1000A		Not required at this time
N104	Payer Identification Code	AN	1/80	S	1000A		Not required at this time
N3	**Payer Address**			**R**		**1**	**Required**
N301	Payer Address Line	AN	1/55	R	1000A		"PO Box 15121"
N302	Payer Address Line	AN	1/55	S	1000A		
N4	**Payer City, State, Zip Code**			**R**		**1**	**Required**
N401	Payer City Name	AN	2/30	R	1000A		"WORCESTER"
N402	Payer State Code	ID	2/2	S	1000A		"MA"
N403	Payer Postal Zone or Zip Code	ID	3/15	S	1000A		"01615"
REF	**Additional Payer Identification**			**S**		**4**	**Segment not used at this time**
PER	**Payer Contact Information**			**S**		**1**	**Situational**
PER01	Contact Function Code	ID	2/2	R	1000A		"CX" = Payers Claim Office
PER02	Payer Contact Name	AN	1/60	S	1000A		"Claim Department"
PER03	Communication Number Qualifier	ID	2/2	S	1000A		"TE" = Telephone
PER04	Payer Contact Communication Number	AN	1/256	S	1000A		"8008685200"
PER	**Payer Technical Contact Information**			**R**		**>1**	**Required**
PER01	Contact Function Code	ID	2/2	R	1000A		"BL"
PER02	Payer Technical Contact Name	AN	1/60	S	1000A		"FCHP" "FHLAC" "FHLACASO"
PER03	Communication Number Qualifier	ID	2/2	S	1000A		"TE" = Telephone
PER04	Payer Contact Communication Number	AN	1/256	S	1000A		"8008685200"
PER05	Payer Contact Communication Number	ID	2/2	S	1000A		
PER06	Payer Technical Contact Communication	AN	1/256	S	1000A		
PER	**Payer Web Site**			**S**		**1**	**Situational**
PER01	Contact Function Code	ID	2/2	R	1000A		"IC" = Information Contact
PER02	Name	AN	1/60	NU	1000A		Not used at this time
PER03	Communication Number Qualifier	ID	1/256	R	1000A		"UR" = Uniform Resource Locator (URL)
PER04	Communication Number	AN	1/256	R	1000A		"www.healthpart.com"
	Payee Identification Loop			**R**	**1000B**		**Required**
N1	**Payee Identification**			**R**		**1**	**Required**
N101	Payer Identifier Code	ID	2/3	R	1000B		"PE" = Payee
N102	Payee Name	AN	1/60	R	1000B		Payee Name Provided
N103	Payee Identification Code Qualifier	ID	1/2	R	1000B		"XX" = National Provider Identifier "FI" = Federal Taxpayers's Identification Number (when NPI not mandated)
N104	Payee Identification Code	AN	2/80	R	1000B		Corresponding Identifier
N3	**Payee Address**			**S**		**1**	**Situational (when needed to inform Receiver of Payee Address)**
N301	Payee Address Line	AN	1/55	R	1000B		Payee Address Information provided to Health Partners
N302	Payee Address Line	AN	1/55	S	1000B		Payee Address Information, if second line needed
N4	**Payee City, State, Zip Code**			**R**		**1**	**Situational (when needed to inform Receiver)**
N401	Payee City Name	AN	1/30	R	1000B		Payee City Name provided

N402	Payee State Code	ID	2/2	S	1000B		Payee State Name provided
N403	Payee Postal Zone or Zip Code	ID	1/15	s	1000B		Payee Zip Code provided
REF	**Payee Additional Identification**			**S**		**>1**	**Situational (When additional identification is needed)**
REF01	Additional Payee Identification Qualifier	ID	2/3	R	1000B		"PQ" = Payee Identification
REF02	Reference Identification Code	AN	1/30	R	1000B		Health Partners Legacy Number
REF01	Additional Payee Identification Qualifier	AN	2/3	NU	1000B		"TJ" = Federal Taxpayer Identification Number
REF02	Reference Identification Code		1/30	NU	1000B		Federal Taxpayer Identification Number
	Header Number Loop				**2000**	**>1**	**Situational (Required when claim or service level information follows)**
LX	**Header Number**			**S**		**1**	**Situational (required for 2000 Header Number Loop)**
LX01	Claim Sequence Number	N0	1/6	R			Transaction Sequence Number
TS3	**Provider Summary Information**			**S**		**1**	**Segment not used at this time**
TS2	**Provider supplemental Summary Information**			**S**		**1**	**Segment not used at this time**
	Claim Payment Information Loop				**2100**	**>1**	**Required**
CLP	**Claim payment Information**			**R**	**2100**	**1**	**Required**
CLP01	Patient Control Number	AN	1/38	R	2100		Patient account number as submitted on the claim
CLP02	Claim Status Code	ID	1/2	R	2100		Claim Status. See page 124 of HIPAA TR3 for valid codes
CLP03	Total Claim Charge Amount	R	1/18	R	2100		Total Claim Charge Amount (not reflecting any potential interest).
CLP04	Total Claim Payment Amount	R	1/18	R	2100		Claim Payment Amount
CLP05	Patient Responsibility Amount	R	1/18	S	2100		Patient Responsibility Amount
CLP06	Claim Filing Indicator Code	ID	1/2	R	2100		"HM" = Health Maintenance Organization
CLP07	Payer Claim Control Number	AN	1/50	R	2100		FCHP Claim Control Number
CLP08	Facility Type Code	AN	1/2	S	2100		from original claim
CLP09	Claim Frequency Code	ID	1/1	S	2100		from original claim
CLP10	Patient Status Code	ID	---		2100		***Not used for HIPAA***
CLP11	Diagnosis Related Group (DRG) Code	ID	1/4	S	2100		Code Source 229. Institutional claims only.
CLP12	DRG Weight	R	1/15	S	2100		Diagnosis Related Group (DRG) weight
CLP13	PERCENT - Discharge Fraction	R	1/10	S	2100		Not used at this time
CAS	**Claim Adjustment**			**S**	**2100**	**99**	**FCHP supplies the Claim Adjustment (CAS segment) sometimes at the header level as well as the claim line level. This is dependent on how the claim processes in our core system**
CAS01	Claim Adjustment Group Code	ID	1/2	R	2100		Health Partners Supports the following Adjustment Group Codes: "CO" Contractual Obligations "OA" Other Adjustments "PI" Payor Initiated Reductions "PR" Patient Responsibility
CAS02	Adjustment Reason Code	ID	1/5	R	2100		Code Source 139: Claim Adjustment Reason Code
CAS03	Adjustment Amount	R	1/18	R	2100		Claim Level Adjustment Amount
CAS04	QUANTITY	R	1/15	S	2100		Provided only when unit quantity is being adjusted
CAS05 – CAS19	(Repeat of reason code, amount, and quantity sequence five times)	ID		S	2100		Not used at this time, only one adjustment is reported on a give CAS segment, and each adjustment is on a separate CAS segment.
NM1	**Patient Name**			**R**	**2100**	**1**	**Required**
NM101	Patient Identifier Code	ID	2/3	R	2100		"QC" = Patient

NM102	Entity Type Qualifier	ID	1/1	R	2100		"1" = Person
NM103	Patient Last Name	AN	1/60	S	2100		
NM104	Patient First Name	AN	1/35	S	2100		
NM105	Patient Middle Initial	AN	1/25	S	2100		
NM106	Name Prefix				***		*** Element not used for HIPAA
NM!07	Patient Name Suffix	AN	1/10	S	2100		Not used at this time
NM108	Identification Code Qualifier	ID	1/2	S	2100		"34" / "MI" = Member Identification Number (other values reserved for future use)
NM109	Patient Member Number	AN	2/80	S	2100		Corresponding Patient Identifier
NM1	**Insured Name**			**S**	**2100**	**1**	**Segment not used at this time**
NM101	Entity Identifier Code	ID	2/3	R	2100	1	"IL" = Insured or Subscriber
NM102	Entity Type Qualifier	ID	1/1	R	2100	1	"1" = Person
NM103	Subscriber Last Name	AN	1/60	S	2100	1	
NM104	Subscriber First Name	AN	1/35	S	2100	1	
NM105	Subscriber Middle Name or Initial	AN	1/25	S	2100	1	
NM106	Identification Code Qualifier	AN	1/10	NU	2100	1	
NM107	Subscriber Identifier	AN	1/10	S	2100	1	
NM108	Identification Code Qualifier	ID	1/2	R	2100	1	"34" / "MI" = Member Identification Number (other values reserved for future use)
NM109	Patient Member Number	AN	2/80	R	2100	1	Generally the member's id number from their FCHP ID card is returned here
NM1	**Corrected Patient/Insured Name**			**S**		**1**	**Segment not used at this time**
NM1	**Service Provider Name**			**S**	**2100**	**1**	**Situational (Required when different than Payee**
NM101	Entity Identifier Code	ID	2/3	R	2100		"82" Rendering Provider
NM102	Entity Type Qualifier	ID	1/1	R	2100		"1" = Person
NM103	Rendering Provider Last or Organization Name	AN	1/60	S	2100		Not used at this time
NM104	Rendering Provider First Name	AN	1/35	S	2100		Not used at this time
NM105	Rendering Provider Middle Name	AN	1/25	S	2100		Not used at this time
NM106	Name Prefix				***		*** Element not used for HIPAA
NM107	Rendering Provider Name Suffix	AN	1/10	S	2100		Not used at this time
NM108	Rendering Provider Identification Code Qualifier	ID	1/2	R	2100		"XX" = National Provider Identifier
NM109	Rendering Provider Identifier	AN	2/80	R	2100		National Provider Identifier Number Provided
NM1	**Crossover Carrier Name**			**S**		**1**	**Segment not used at this time**
NM1	**Corrected Priority Payer Name**			**S**		**1**	**Segment not used at this time**
MIA	**Inpatient Adjudication Information**			**S**		**1**	**Segment not used at this time**
MOA	**Outpatient Adjudication Information**			**S**		**1**	**Segment not used at this time**
MOA1	Percentage as Decimal	R	1/10	S	2100	1	
MOA2	Monetary Amount	R	1/18	S	2100	1	
MOA3	Claim Payment Remark Code	AN	1/50	S	2100	1	FCHP supplies Remark Codes sometimes at the header level as well as the claim line level. This is dependent on how the claim processes in our core system
MOA4	Reference Identification	AN	1/50	S	2100	1	
MOA5	Reference Identification	AN	1/50	S	2100	1	

REF							**Segment not used at this time**
REF	**Rendering Provider Identification**			**S**		**10**	**Segment not used at this time**
DTM	**Statement From or To Date**			**S**		**2**	**Segment not used at this time**
DTM	**Coverage Expiration Date**			**S**	**2100**	**1**	**Situational (Required due to expiration of coverage)**
DTM01	Date Time Qualifier	ID	3/3	R	2100		"036" = Expiration
DTM02	Expiration Date	DT	8/8	R	2100		
DTM	**Claim Received Date**			**S**	**2100**	**1**	**Situational**
DTM01	Date Time Qualifier	ID	3/3	R	2100		"050" = Received
DTM02	Received Date	DT	8/8	R	2100		
PER	**Claim Contact Information**			**S**		**2**	**Not used at this time**
AMT	**Claim Supplemental Information**			**S**	**2100**	**13**	**Situational (Informational only, not used for balancing)**
AMT01	Amount Qualifier Code	ID	1/3	R	2100		Allowed Values: "D8" = Discount Amount "I" = Interest "T" Tax
AMT02	Claim Supplemental Information Amount	R	1/18	R	2100		Corresponding Amont
QTY	**Claim Supplemental Information Quantity**						**Segment not used at this time**
2110	**Service Payment Information**					**2110**	**Situational**
SVC	**Service Payment Information**			**S**	**2110**	**1**	**Situational (Expected to be sent under most circumstances)**
SVC01-1	Service Type Code	ID	2/2	R	2110		See HIPAA 835 Technical Report Type 3, pg. 187-188 for supported codes
SVC01-2	Service Code	AN	1/48	R	2110		Procedure Code
SVC01-3	PROCEDURE MODIFIER 1	AN	2/2	S	2110		Payer will be reporting up to 4 procedure Modifiers
SVC01-4	PROCEDURE MODIFIER 2	AN	2/2	S	2110		
SVC01-5	PROCEDURE MODIFIER 3	AN	2/2	S	2110		
SVC01-6	PROCEDURE MODIFIER 4	AN	2/2	S	2110		
SVC01-7	Procedure Code Description	AN	1/80		2110		Sub-element not used at this time
SVC02	Monetary Amount	R	1/18	R	2110		Submitted Line Item Service Charge Amount
SVC03	Monetary Amount	R	1/18	R	2110		Line Item Provider Payment Amount
SVC04	NUBC Revenue Code	AN	1/48	S	2110		Not used at this time
SVC05	Units of Service Paid Count	R	1/15	S	2110		If not present, the value is assumed to be 1
SVC06-1	PRODUCT/SERVICE ID QUALIFIER	ID	2/2	R	2110		Provided if procedure code in SVC01 is different from procedure code submitted; see pg. 191 of the HIPAA Technical Report Type 3
SVC06-2	Procedure Code	AN	1/48	R	2110		Provided if procedure code in SVC01 is different from procedure code submitted
SVC06-3	Procedure Modifier 1	AN	2/2	S	2110		Sub-Element not used at this time
SVC06-4	Procedure Modifier 2	AN	2/2	S	2110		Sub-Element not used at this time
SVC06-5	Procedure Modifier 3	AN	2/2	S	2110		Sub-Element not used at this time
SVC06-6	Procedure Modifier 4	AN	2/2	S	2110		Sub-Element not used at this time
SVC06-7	Procedure Code Description	AN	1/80	S	2110		Sub-Element not used at this time
SVC07	Original Units of Service Count	R	1/15	S	2110		Only provided when paid unit is different from submitted units

DTM	**Service Start Date**			**S**	**2110**	**2**	**Situational (if claim date is absent or different from Service Line date)**
DTM01	Date Time Qualifier	ID	3/3	R	2110		"150" = Service Period Start Date
DTM02	Service Date	DT	8/8	R	2110		Service Start Date in CCYYMMDD Format
DTM	**Service End Date**			**S**		**2**	**Situational (if claim date is absent or different from Service Line date)**
DTM01	Date Time Qualifier	ID	3/3	R	2110		"151" = Service Period End Date
DTM02	Service End Date	DT	8/8	R	2110		Service End Date in CCYYMMDD Format
DTM	**Service Date**			**S**	**2110**	**2**	**Situational (if claim date is absent or different from Service Line date)**
DTM01	Date Time Qualifier	ID	3/3	R	2110		"472" = Service Date
DTM02	Service Date	DT	8/8	R	2110		Service Date in CCYYMMDD Format to indicate a single day service
CAS	**Service Adjustment**			**S**	**2110**	**99**	**Situational (to account for difference in amount paid for this service)**
CAS01	Claim Adjustment Group Code	ID	1/2	R	2110		Health Partners uses the following Adjustment Group Codes: "CO" Contractual Obligations "OA" Other Adjustments "PI" Payor Initiated Reductions "PR" Patient Responsibility
CAS02	Adjustment Reason Code	ID	1/5	R	2110		Code Source 139: Claim Adjustment Reason Code
CAS03	Adjustment Amount	R	1/18	R	2110		Service Level Adjustment Amount; negative number increases amount, positive decreases
CAS04	Adjustment Quantity	R	1/15	S	2110		Provided only when unit quantity is being adjusted; negative number increases amount, positive decreases
CAS05- CAS19	(Repeat of reason code, amount, and quantity sequence five times)						Not used at this time
REF	**Service Identification**			**S**	**2110**	**8**	**Situational (provider reference numbers specific to this service)**
REF01	Reference Identification Qualifier	ID	2/3	R	2110		Refer to HIPAA Technical Report Type 3 pg. 204 for supported code values.
REF02	Provider Identifier	AN	1/50	R	2110		Provider Identifier
REF	**Line Item Control Number**			**S**	**2110**	**1**	**Situational**
REF01	Reference Identification Qualifier	ID	2/3	R	2110		“6R” = Provider Control Number
REF02	Reference Identification	AN	1/50	R	2110		Line Item Control Number
REF	**Rendering Provider Information**			**S**	**2100**	**10**	**Situational (to identify provider specific to this service)**
REF01	Reference Identification Number	ID	2/3	R	2100		“HPI” = National Provider Identifier "TJ" = Federal Taxpayers Identification Number (other supported values as needed)
REF02	Rendering Provider Federal ID	AN	1/50	R	2100		Corresponding identifier
AMT	**Service Supplemental Amount**			**S**	**2110**	**9**	**Situation (Informational only, not used for balancing)**
AMT01	Amount Qualifier Code	ID	1/3	R	2110		Refer to HIPAA Technical Report Type 3 pg. 211-212 for supported codes
AMT02	Service Line Allowed Amount	R	1/18	R	2110		Corresponding Amount (Service Line Allowed Amount)
QTY	**Service Supplemental Quantity**			**S**		**6**	**Segment not used at this time**
LQ	**Health Care Remark Code**			**S**	**2110**	**99**	**Situational (Informational remarks only)**
LQ01	Service Line Remittance Remark Code 1	ID	1/3	R	2110		"HE" Claim Payment Remark Codes

LQ02	Service Line Remittance Remark Code 2	AN	1/30	R	2110		Remark Code
	Transaction Set Loop (Summary)			**00 00**			**Required**
PLB	**Provider Adjustment**			**S**		**>1**	**Situational (for adjustments not specific to a claim or service)**
PLB01	Provider Identifier	AN	1/50	R			
PLB02	Fiscal Period Date	DT	8/8	R			Last day of provider's fiscal year in CCYYMMDD format; if not known, December 31 of current year.
PLB03-1	PROVIDER ADJUSTMENT REASON CODE	ID	2/2	R			Refer to HIPAA Technical Report Type Values pg. 219-222 for supported Code
PLB03-2	Provider Adjustment Identifier	AN	1/50	S			Sub-Element not used
PLB04	Provider Adjustment Amount	R	1/18	R			
PLB05 – PLB14	(Repeat of adjustment identifier and amount sequence five more times)						Not used at this time, only one adjustment is reported on a PLB segment
SE	**Transaction Set Trailer**			**R**		**0001**	**Required**
SE01	Number Of Included Segments	N0	1/10	R			Transaction Segment Count
SE02	Transaction Set Control Number	AN	4/9	R			Transaction Set Control Number
Functional Group	**Functional Group Loop (End)**				**Trailer**		**Required**
GE	**Functional Group Trailer**				**Trailer**		**Required**
GE01	Number of Transaction Sets Included	N0	1/6	R	Trailer		Number of Transactions Sets included in the Functional Group
GE02	Group Control Number	N0	1/9	R	Trailer		Functional Group control number must equal the value in GS06
Interchange	**Interchange Control Loop (End)**				**Trailer**		**Required**
IEA	**Interchange Control Trailer**				**Trailer**		**Required**
IEA01	Number of Included Functional Groups	N0	1/5	R	Trailer		A count of the number of Functional Groups (GS-GE) in the interchange
IEA02	Interchange Control Number	N0	9/9	R	Trailer		A control number that must equal the value in ISA 13

8. ACKNOWLEDGEMENTS AND/OR REPORTS

The 835 Healthcare Claim Payment Advice transaction files are generated once a week and advise/report on claims that are in their finalized status (paid, denied, reversed, etc.). Once generated, the 835 file(s) can be downloaded via PaySpan site.

Appendix A—frequently asked questions

Q: What is claim payment turnaround time for EDI claims?

A: In most cases, payment will be received within three weeks of date of submission.

Q: Does Fallon offer electronic notification of claims received and claims denied for each file received electronically?

A: Fallon will send the standard ANSI X12 999 acknowledgement to all trading partners. Please contact the EDI Coordinators for testing of the HIPAA compliant 276 / 277 Health Care Claim Status Request and Response transaction set.

Q: Does Fallon offer real-time eligibility and claim status?

A: Fallon offers real-time eligibility and claim status. Fallon also offers a Web-based eligibility tool that allows providers to verify eligibility. Claims metric reports for a rolling 12-week period are also available to contracted providers via the Web. Contact an EDI Coordinator at 866-ASK-FCHP (866-275-3247) option 6 or e-mail Edi.Coordinator@fchp.org for assistance.

Appendix B—CARC and RARC

The Adjustment Reason Codes for the remittance advice can be found at
http://www.x12.org/codes/claim-adjustment-reason-codes/

The Remittance Remark Codes for the remittance advice can be found at
http://www.wpc-edi.com/reference/codelists/healthcare/remittance-advice-remark-codes/

Appendix C – Revision History

Revision Number	Date	Section	Notes
1.0	9/1/11	Full document	Initial draft
1.1	6/1/12	Full document	Update
1.2	3/15/16	Full document	Update with Payspan
1.3	10/29/17	Full document	Review and Update
1.4	05/14/2018	Section 4	Updated the Maintenance information.
1.5	08/17/2018	Disclosure	Updated the link to Fallon Health provider portal.
1.6	01/14/2022	Section 4	Updated the Maintenance information.