



## Forum Companion Document

For use with ANSI ASC X12N  
Health Care Claim Payment/Advice  
Implementation Guide

# Health Care Claim Payment/Advice 835

ANSI ASC X12N 835 (004010X091A1)

## “Health Plan Specific Data Requirements & Coding Scenarios”

*Version:  
November 28, 2005*

## **Introduction**

This document is intended to be used by programmers who are developing or modifying the HIPAA 835 transaction for a Provider Organization. It identifies data segments, loops and elements . . .

- where additional clarification may be beneficial, and/or
- where participating health plans have specific data requirements or conventions that need to be implemented

This document should be used in conjunction with the HIPAA Implementation Guide, which can be accessed at [www.wpc-edi.com/hipaa/HIPAA\\_40.asp](http://www.wpc-edi.com/hipaa/HIPAA_40.asp).

This document has three sections:

1. Data Requirements – Variations by Health Plan: This section is designed to be used by programmers when initially developing or modifying an existing 835 transaction for a new health plan trading partner. It highlights those data elements whose values are most likely to vary by health plan and provides information about health-plan specific values.
2. Scenarios: This section is also designed to be used by programmers during initial development of the 835 transaction. It provides samples of how to code different variations of the 835 transaction.
3. Commonly Used Group Codes and Reason Codes: This section is also designed to be used by programmers during initial development of the 835 transaction. It identifies the Group Codes and Reason Codes that are commonly used by the participating health plans, along with variations by health plan.

**THIS DOCUMENT ONLY APPLIES WHEN PROVIDERS ARE EXCHANGING INFORMATION DIRECTLY WITH A HEALTH PLAN. CLEARINGHOUSES MAY HAVE OTHER OR DIFFERENT REQUIREMENTS**

# **Data Requirements – Variations by Health Plan**

**Standard Envelop Information: ISA & GS**

| I.G. Page | LOOP     | SEGMENT    | DATA ELEMENT | NAME                                     | FCHA (TPA)   | GHC          | Premera      | Regence      | Asuris       |
|-----------|----------|------------|--------------|--|--|--------------|--------------|--------------|--------------|
| Append B  | Envelope | <b>ISA</b> | 01           | Authorization Information Qualifier      | <b>00</b>  |              |              |              |              |
|           | Envelope | ISA        | 03           | Security Information Qualifier           | <b>00</b>  |              |              |              |              |
|           | Envelope | ISA        | 05           | Interchange ID Qualifier                 | <b>ZZ</b>  |              |              |              |              |
|           | Envelope | ISA        | 06           | Interchange Sender ID                    | Contact FCHA   | OPNM or GHNM | Contact Plan | Contact Plan | Contact Plan |
|           | Envelope | ISA        | 07           | Interchange ID Qualifier                 | <b>ZZ</b>  |              |              |              |              |
|           | Envelope | ISA        | 08           | Interchange Receiver ID                  | Provide to FCHA  | TIN          | Contact Plan | Contact Plan | Contact Plan |
|           | Envelope | ISA        | 11           | Interchange Control Standards Identifier | <b>U</b>   |              |              |              |              |
|           | Envelope | ISA        | 12           | Interchange Control Version Number       | <b>00401</b>   |              |              |              |              |
|           | Envelope | ISA        | 13           | Interchange Control Number               | A value assigned by provider which must be identical to number used in IEA02 |              |              |              |              |
|           | Envelope | ISA        | 14           | Acknowledgement Requested                | Would prefer a 0 (zero), file will be acknowledged using a 997 transaction   |              |              |              |              |
|           | Envelope | <b>GS</b>  | 02           | Application Sender Code                  | Contact FCHA   | OPNM or GHNM | Contact Plan | Contact Plan | Contact Plan |
|           | Envelope | GS         | 03           | Application Receiver Code                | Provide to FCHA  | TIN          | Contact Plan | Contact Plan | Contact Plan |

**835 Claims Payment/Advice: Transaction-Specific Information**

| I.G. Page | LOOP   | SEGMENT | DATA ELEMENT | NAME   | Health Plans  |  |   |  |   |
|-----------|--|---------|--------------|--|---|--|---|--|---|
|           |  |         |              |  | FCHA (TPA)  | GHC  | Premera   | Regence  | Asuris  |
| 49        | <b>Header Financial Information</b>          | BPR     | 11           | Originating Company Supplemental Code<br><br>Note: This number must match TRN04<br><br>Comment: In those cases when health plans have more than one product line, providers would like health plans to use this data element to identify the product line against which this claim is being processed. | Used for EFT and defined by FCHA and Depository Financial Institution | N.A.   | This number represents the PREMERA internal source system from which the 835 was built. | N/A  | N/A   |
| 63        | <b>1000A Payer Identification</b>            | N1      | 02           | Payer Name   | Contact FCHA  | Group Health   | Premera   | Regence BlueShield, RegenceCare, Regence BlueShield - FEP      | Asuris Northwest Health                               |
| 77        | <b>1000B Payee Additional Identification</b> | REF     | 01           | Reference Identification Qualifier   | Not Applicable  | G2   | PQ  | PQ   | PQ  |
| 77        | <b>Payee Additional Identification</b>       | REF     | 02           | Reference Identification   | Not Used  | GHC assigned provider number                         | Premera assigned provider number  | Regence assigned provider number                               | Asuris assigned provider number                       |
| 92        | <b>2100 Claim Payment Information</b>        | CLP     | 06           | Claim Filing Indicator Code<br><br>Comment: Providers would like health plans to use this field to indicate the type of product against which the claim is being paid.   | FCHA only has HM type products. Will always return an                 | GHC only has HM type products. Will always return an | Premera will indicate the type of product using: HM, MC, OF,                            | Regence will indicate the type of product using:HM, 12, 13,15, | Asuris will indicate the type of product using:12, 15 |

| I.G. Page | LOOP           | SEGMENT | DATA ELEMENT                                 | NAME   | Health Plans  |          |         |         |        |
|-----------|----------------|---------|--|--|---|----------|---------|---------|--------|
|           |                |         |  |  | FCHA (TPA)  | GHC      | Premera | Regence | Asuris |
|           |                |         |  | The contents of the field will reflect the health plan's 'system platform' that generated the check, rather than the specific product.   | HM - HMO  | HM - HMO | 12, 15  | 16      |        |
| 162       | <b>Summary</b> | PLB     | 03-2<br>05-2<br>07-2<br>09-2<br>11-2<br>13-2 | Provider Adjustment Identifier<br><br>Comment: Ideally, the PLB will only be used to report interest on claims, balance forward, and overpayment recovery. When the PLB segment is used, providers would like health plans to put as much information in the segment as possible so that the provider can identify the appropriate patient account. Providers request that the provider supplied trace number be included in second part of the composite field, e.g. PLB03-2. | See the Companion Document titled 'Posting From & Troubleshooting the Transaction'<br>- Item #8 under Helpful Hints for Posting from the 835 Transaction<br>- Answers to Common Questions |          |         |         |        |

# Sample 835 Scenarios

The coding of each scenario represents ONE possible implementation of the 835 transaction.  
Many other alternative and compliant implementation are also possible.

**835 Scenario #1**

(837-Professional Claim: Scenario #3)

Patient is Subscriber, Paid Fee-for-Service, with an Interest payment --not processed within 30 Days

Scope: A Provider is submitting a professional claim to the primary payer for an office visit that is accident related.

**Billing Provider:**

Billing Inc.  
45 Ocean Blvd  
Seattle, WA  
TIN - 91-20202020  
Payor A Provider ID #WI 1234

Health Plan -- Payor A  
Worldwide Insurance  
2020 1<sup>st</sup> Ave  
Seattle, WA 98112  
ID # - 91-1234567  
EDI # WI911234567

Pay to Provider  
Medical Associates  
Payor A Provider ID # MA1234  
TIN 91-99999577

Rendering Provider  
Marcus Welby, M.D.  
SSN - 886027777  
Payor A Provider ID # MWB7777

Subscriber & Patient:  
Fred Flintstone  
666 Bedrock Lane  
Quarryville, WA 98666  
Sex - M DOB 11/1/50  
SSN - 555-20-2020  
Employer - CSI, Inc.  
Payor A Member ID # - WW2020-01

Office Visit - 99213  
DOS - 1/1/02  
Units - 1  
Charge - \$95.00  
Onset of Illness: 12/20/01  
Backpain: DX 724.4  
Total Charge - \$95.00  
Accident Remarks: 'ACC - Pt fell at work on 12/20/01'

Patient Account #PF64532

Payor A Interest - \$.20  
Payor A Payment Amount - \$95.20

Coding . . .

ISA\*00\* \*00\* \*ZZ\*911234567 \*ZZ\*9120202020  
\*020419\*1203\*U\*00401\*000000001\*0\*P\*:  
GS\*HP\*911234567\*9120202020\*20020419\*1203\*1\*X\*004010X091A1  
ST\*835\*0001

-----  
BPR\*I\*95.20\*C\*CHK\*\*\*\*\*20020419  
TRN\*1\*87654321\*1911234567  
N1\*PR\*WORLDWIDE INSURANCE  
N3\*2020 1ST AVE  
N4\*SEATTLE\*WA\*98112  
N1\*PE\*MEDICAL ASSOCIATES\*FI\*919999577  
N3\*1234 MAIN ST  
N4\*ANY CITY\*WA\*98101  
LX\*1  
CLP\*PF64532\*1\*95.00\*95.00\*\*HM\*0204502276\*11  
NM1\*QC\*1\*FLINTSTONE\*FRED\*\*\*\*MI\*WW202001  
NM1\*82\*1\*WELBY\*MARCUS\*\*\*\*PC\*MWB7777  
DTM\*232\*20020101  
AMT\*I\*.20  
SVC\*HC:99213\*95.00\*95.00\*\*1  
PLB\*MWB7777\*20021231\*L6\*-.20  
SE\*18\*0001  
GE\*1\*1  
IEA\*1\*000000001

**835 Scenario #2,**

(Sample 837-Professional Claim: Information for Scenario #1 &amp; #2)

Patient is not Subscriber, Paid as Secondary

Scope: A provider is submitting a professional claim to the Secondary payer (Payor B) for an office visit and lab work

## Billing Provider:

Billing Inc.  
45 Ocean Blvd  
Seattle, WA  
TIN - 91-20202020  
Payor A Provider ID #WI 1234  
Payor B Provider ID # WHS5678

## Health Plan -- (Payor A)

Worldwide Insurance  
2020 1<sup>st</sup> Ave  
Seattle, WA 98112  
ID # - 91-1234567  
EDI # WI911234567

## Health Plan – (Payor B)

Washington Health Services  
234 2<sup>nd</sup> Ave  
Seattle, Wa 98112  
ID # 91-5779491  
EDI # WHS915779491

## Pay to Provider

Medical Associates  
Payor A Provider ID # MA1234  
Payor B Provider ID # JB5686  
TIN -91-99999577

## Rendering Provider

Marcus Welby, M.D.  
SSN - 886027777  
Payor A Provider ID # MWB7777  
Payor B Provider ID # YT5555

## Subscriber for Payor A:

Fred Flintstone  
666 Bedrock Lane  
Quarryville, WA 98666  
Sex - M DOB 11/1/50  
SSN - 555-20-2020  
Employer - CSI, Inc.  
Payor A Member ID # - WW2020-01

## Subscriber for Payor B:

Wilma Flintstone  
666 Bedrock Lane  
Quarryville, WA 98666  
SEX - F DOB 10/01/52  
SSN - 444-50-5050  
Employer - WIZYWIG, Inc.  
Payor B Member ID # WF55550

## Patient:

Pebbles Flintstone  
666 Bedrock Lane  
Quarryville, WA 98666  
Sex F DOB 12/1/72  
SSN - 000-20-3333  
Relationship to Fred: Daughter  
Relationship to Wilma: Stepdaughter  
Payor A Member ID # - WW2020-03  
Payor B Member ID # - WF5555002

## Date of Service - 12/1/01

Office Visit = 99213  
DX – 724.3  
Charge 85.00  
Payor A Allowed - \$50  
Payor A Paid - \$40  
Payor B Allowed - \$50

## Date of Service 12/1/01

Lab – G0001

Patient Account #PF55520

DX – 724.3  
 Charge \$10.00  
 Payor A Allowed - \$5.00  
 Payor A Paid - \$3.00  
 Payor B Allowed - \$10

Payor B Copay - \$15  
 Payor B Paid - \$2

Total Charges - \$95.00

Coding . . .

ISA\*00\* \*00\* \*ZZ\*915779491 \*ZZ\*9120202020  
 \*020419\*1203\*U\*00401\*000000002\*0\*P\*:  
 GS\*HP\*915779491\*9120202020\*20020419\*1203\*1\*X\*004010X091A1  
 ST\*835\*0001  
 BPR\*I\*12.00\*C\*CHK\*\*\*\*\*20020419  
 TRN\*1\*87654321\*1915779491  
 N1\*PR\*WASHINGTON HEALTH SERVICES  
 N3\*234 2ND AVE  
 N4\*SEATTLE\*WA\*98112  
 N1\*PE\*MEDICAL ASSOCIATES\*FI\*919999577  
 N3\*1234 MAIN ST  
 N4\*ANY CITY\*WA\*98101  
 LX\*1  
 CLP\*PF55520\*2\*95.00\*12.00\*15.00\*HM\*0204502277\*11  
 CAS\*PR\*2\*15  
 NM1\*QC\*1\*FLINTSTONE\*PEBBLES\*\*\*\*MI\*WF5555002  
 NM1\*IL\*1\*FLINTSTONE\*WILMA\*\*\*\*MI\*WF55550  
 NM1\*82\*1\*WELBY\*MARCUS\*\*\*\*PC\*YT5555  
 SVC\*HC:99213\*85.00\*22.00\*\*1  
 DTM\*472\*20011201  
 CAS\*CO\*42\*23  
 CAS\*OA\*23\*40  
 SVC\*HC:G0001\*10.00\*5.00\*\*1  
 DTM\*472\*20011201  
 CAS\*CO\*42\*2  
 CAS\*OA\*23\*3  
 SE\*24\*0001  
 GE\*1\*1  
 IEA\*1\*000000002

**835 Scenario #3**

(837-Institutional Claim: Scenario #3)

Patient is not the Subscriber, Paid as Secondary

Scope: A hospital is submitting an institutional claim to the **secondary payer** for a hospital visit and related services.

## Billing Provider:

General Hospital  
404 2<sup>nd</sup> Ave  
Seattle, WA 98112  
TIN: 91-7777666

## Health Plan -- (Payor A)

Worldwide Insurance  
2020 1<sup>st</sup> Ave  
Seattle, WA 98112  
ID # - 91-1234567  
EDI # WI911234567

## Health Plan – (Payor B)

Washington Health Services  
234 2<sup>nd</sup> Ave  
Seattle, Wa 98112  
ID # 91-5779491  
EDI # WHS915779491

## Pay to Provider

General Hospital  
404 2<sup>nd</sup> Ave  
Seattle, WA 98112  
TIN: 91-7777666

## Attending Provider

Marcus Welby, M.D.  
SSN - 886027777  
Payor A Provider ID # MWB7777  
Payor B Provider ID # YT5555

## Subscriber for Payor A:

Fred Flintstone  
666 Bedrock Lane  
Quarryville, WA 98666  
Sex - M DOB 11/1/50  
SSN - 555-20-2020  
Employer - CSI, Inc.  
Payor A Member ID # - WW2020-01

## Subscriber for Payor B:

Wilma Flintstone  
666 Bedrock Lane  
Quarryville, WA 98666  
SEX - F DOB 10/01/52  
SSN - 444-50-5050  
Employer - WIZYWIG, Inc.  
Payor B Member ID # WF55550

## Patient:

Pebbles Flintstone  
666 Bedrock Lane  
Quarryville, WA 98666  
Sex F DOB 12/1/72  
SSN - 000-20-3333  
Relationship to Fred: Daughter  
Relationship to Wilma: Stepdaughter  
Payor A Member ID - WW2020-03  
Payor B Member ID - WF5555002

Admit Date/Time: 11/15/01 – 3pm  
Discharge Date/Time: 11/17/01 – 5pm  
Authorization #: 888990  
Room & Board – Revenue Code 120 -  
\$1670.00 – Two days  
Pharmacy – Rev Code 250 - \$667.00  
Anesthesia Code 01810 – \$375 – 1 unit  
Delivery Room – 720 \$1000.00  
Total Charge - \$3712.00

Patient Account # FF559872032  
 Med Record #: 310628838

Baby's Birthweight: 3712

Principal Diagnosis: 654.21  
 Admit Dx: 659.61  
 Diag 3: 648.91  
 Diag 4: V27.0

ICD9 Procedure Code: 74.1 – Principal  
 ICD9 Procedure Code: 72.79

Admint Type – 04  
 Admit Source – 01  
 Patient Discharge Status – 01  
 Bill Type - 131

Payor A Allowed - \$1800.00  
 Payor A Paid – \$1000.00  
 Payor B Allowed - \$1800.00  
 Payor B Copay - \$200.00  
 Payor B Paid - \$600.00

Coding . . .

ISA\*00\* \*00\* \*ZZ\*915779491 \*ZZ\*91777666  
 \*020419\*1203\*U\*00401\*000000003\*0\*P\*:  
 GS\*HP\*915779491\*91777666\*20020419\*1203\*1\*X\*004010X091A1  
 ST\*835\*0001  
 BPR\*I\*600.00\*C\*CHK\*\*\*\*\*20020419  
 TRN\*1\*87654321\*1915779491  
 N1\*PR\*WASHINGTON HEALTH SERVICES  
 N3\*234 2ND AVE  
 N4\*SEATTLE\*WA\*98112  
 N1\*PE\*GENERAL HOSPITAL\*FI\*91777666  
 N3\*404 2ND AVE  
 N4\*SEATTLE\*WA\*98112  
 LX\*1  
 CLP\*FF559872032\*2\*3712.00\*600.00\*200.00\*HM\*0204502277\*11\*1  
 CAS\*OA\*23\*1000.00  
 CAS\*PR\*3\*200.00  
 NM1\*QC\*1\*FLINTSTONE\*PEBBLES\*\*\*\*MI\*WF5555002  
 NM1\*IL\*1\*FLINTSTONE\*WILMA\*\*\*\*MI\*WF55550  
 NM1\*82\*1\*WELBY\*MARCUS\*\*\*\*PC\*YT5555  
 DTM\*232\*20011115  
 DTM\*233\*20011117  
 SVC\*NU:120\*1670.00\*1800.00\*\*2

CAS\*CO\*42\*-130.00  
SVC\*NU:250\*667.00\*0\*\*1  
CAS\*CO\*42\*667.00  
SVC\*NU:01810\*375.00\*0  
CAS\*CO\*42\*375.00  
SVC\*NU:720\*1000.00\*0  
CAS\*CO\*42\*1000.00  
SE\*27\*0001  
GE\*1\*1  
IEA\*1\*000000003

**835 Scenario #4**

Patient is Subscriber, Overpayment Offset

Scope: A previously submitted claim was paid at \$50.00 when it should have been paid at \$30.00. The \$20.00 overpayment is being assessed against a current claim of \$50.00, which has an allowed amount of \$30.00. The check amount for this Remittance will be \$10.00.

Health Plan – Payor B  
 Washington Health Services  
 234 2<sup>nd</sup> Ave  
 Seattle, Wa 98112  
 ID # 91-5779491  
 EDI # WHS915779491

Pay to Provider  
 Dr. Joyce Brothers  
 1234 Ocean Blvd.  
 Seaway, WA 98102  
 SSN - 88-9090901

Rendering Provider  
 Dr. Joyce Brothers  
 1234 Ocean Blvd.  
 Seaway, WA 98102  
 SSN - 88-9090901

Subscriber & Patient  
 Wilma Flintstone  
 666 Bedrock Lane  
 Quarryville, WA 98666  
 SEX - F DOB 10/01/52  
 SSN - 444-50-5050  
 Employer - WIZYWIG, Inc.  
 Payor B Member ID # WF55550

Previously Paid Claim:  
 Mental Health Visit -  
 CPT 90804  
 DX: 300.00  
 DOS 12/1/01  
 Charge: \$50.00  
 Supervising Provider: Dr. Ben Casey  
 1010 6<sup>th</sup> Ave  
 Seattle, WA 98101  
 TIN – 91-8889099

Patient Account #PF55679

Allowed Amount: \$30.00  
 Paid Amount: \$50.00

Submitted Claim:  
**Mental Health Visit -**  
 CPT 90804  
 DX: 300.00  
 DOS 12/5/01  
 Charge - \$50.00  
 Supervising Provider: Dr. Ben Kildare  
 5050 6<sup>th</sup> Ave  
 Tukwila, WA 98107  
 TIN: 91-5559099

Allowed Amount: \$30.00  
Paid Amount: \$30.00

Net Check Amount: \$10.00

Coding . . .

The prior payment of \$50 for the 12-01 visit was reversed, a payment of \$30 for the 12-01 was posted and a payment of \$30 on the 12-05 visit was posted. The net check amount will be \$10.00.

ISA\*00\* \*00\* \*ZZ\*915779491 \*ZZ\*9120202020  
\*020419\*1203\*U\*00401\*000000004\*0\*P\*:  
GS\*HP\*915779491\*889090901\*20020419\*1203\*1\*X\*004010X091A1  
ST\*835\*0001  
BPR\*1\*10.00\*C\*CHK\*\*\*\*\*20020419  
TRN\*1\*87654321\*1915779491  
N1\*PR\*WASHINGTON HEALTH SERVICES  
N3\*234 2ND AVE  
N4\*SEATTLE\*WA\*98112  
N1\*PE\*DR. JOYCE BROTHERS\*FI\*889090901  
N3\*1234 OCEAN BLVD  
N4\*SEAWAY\*WA\*98102  
LX\*1  
CLP\*PF55679\*22\*-50.00\*-50.00\*\*HM\*0204500003000  
NM1\*QC\*1\*FLINTSTONE\*WILMA\*\*\*\*MI\*WF55550  
SVC\*HC:90804\*-50.00\*-50.00\*\*1  
DTM\*472\*20011201  
CLP\*PF55679\*1\*50.00\*30.00\*\*HM\*0204500003001  
NM1\*QC\*1\*FLINTSTONE\*WILMA\*\*\*\*MI\*WF55550  
SVC\*HC:90804\*50.00\*30.00\*\*1  
DTM\*472\*20011201  
CAS\*CO\*45\*20.00  
CLP\*PF55679\*1\*50.00\*30.00\*\*HM\*0204500004000  
NM1\*QC\*1\*FLINTSTONE\*WILMA\*\*\*\*MI\*WF55550  
SVC\*HC:90804\*50.00\*30.00\*\*1  
DTM\*472\*20011205  
CAS\*CO\*45\*20.00  
SE\*25\*0001  
GE\*1\*1  
IEA\*1\*000000004

**835 Scenario #5**

(Sample 837-Institutional Claim: Scenario #2)

Patient is not the Subscriber, Split ER visit from Lab, Pay Fee-for-Service on both as two entries on the same 835

Scope: A hospital emergency room is submitting an institutional claim to the **primary** payer for an accident related ER visit.

## Sender of Transaction

General Hospital  
404 2<sup>nd</sup> Ave  
Seattle, WA 98112  
TIN: 91-7777666

## Billing Provider:

General Hospital  
404 2<sup>nd</sup> Ave  
Seattle, WA 98112  
TIN: 91-7777666

## Health Plan -- (Payor A)

Worldwide Insurance  
2020 1<sup>st</sup> Ave  
Seattle, WA 98112  
ID # - 91-1234567  
EDI # WI911234567

## Health Plan – (Payor B)

Washington Health Services  
234 2<sup>nd</sup> Ave  
Seattle, Wa 98112  
ID # 91-5779491  
EDI # WHS915779491

## Pay to Provider

General Hospital  
404 2<sup>nd</sup> Ave  
Seattle, WA 98112  
TIN: 91-7777666  
Payor A Provider ID# - 360  
Payor B Provider ID# - 1294

## Attending Provider

Marcus Welby, M.D.  
SSN - 886027777  
Payor A Provider ID # MWB7777  
Payor B Provider ID# YT5555

## Subscriber for Payor A:

Fred Flintstone  
666 Bedrock Lane  
Quarryville, WA 98666  
Sex - M DOB 11/1/50  
SSN - 555-20-2020  
Employer - CSI, Inc.  
Payor A Member ID # - WW2020-01

## Subscriber for Payor B:

Wilma Flintstone  
666 Bedrock Lane  
Quarryville, WA 98666  
SEX - F DOB 10/01/52  
SSN - 444-50-5050  
Employer - WIZYWIG, Inc.  
Payor B Member ID # WF55550

## Patient:

Pebbles Flintstone  
666 Bedrock Lane  
Quarryville, WA 98666  
Sex F DOB 12/1/72  
SSN - 000-20-3333  
Relationship to Fred: Daughter

## Date of Service – 11/01/01

Primary and Admitting Diag: 789.07  
Place of Service: Emergency Room  
Hospital (23)  
Accident Remarks: Fell out of car  
11/01/01  
Source Code: 07

Relationship to Wilma: Stepdaughter  
 Payor A Member ID - WW2020-03  
 Payor B Member ID - WF5555002

Patient Account # FF555672020  
 Med Record #: 310628838

Admit Type: 03  
 Condition Code: 09  
 Occurrence Code: 11  
 Occurrence Date: 11/01/01  
 Bill Type: 131

Services:  
 Lab – Revenue Code - 301 - \$350.00  
 Drug Detail – Rev 650 - \$ 124.00

Payor A Paid: \$474.00

ER Room – Rev 450 - \$500.00  
 CPT Code - 99283

Payor A Paid: \$500.00

Total Charges: \$974.00

Coding . . .

ISA\*00\* \*00\* \*ZZ\*911234567 \*ZZ\*917777666  
 \*020419\*1203\*U\*00401\*000000005\*0\*P\*:  
 GS\*HP\*911234567\*917777666\*20020419\*1203\*1\*X\*004010X091A1  
 ST\*835\*0001  
 BPR\*1\*974.00\*C\*CHK\*\*\*\*\*20020419  
 TRN\*1\*12345678\*1911234567  
 N1\*PR\*WORLDWIDE INSURANCE  
 N3\*2020 1ST AVE  
 N4\*SEATTLE\*WA\*98112  
 N1\*PE\*GENERAL HOSPITAL\*FI\*917777666  
 N3\*404 2ND AVE  
 N4\*SEATTLE\*WA\*98112  
 LX\*1  
 CLP\*FF555672020\*1\*474.00\*474.00\*\*HM\*0204502222000\*13\*1  
 NM1\*QC\*1\*FLINTSTONE\*PEBBLES\*\*\*\*MI\*WW202003  
 NM1\*IL\*1\*FLINTSTONE\*FRED\*\*\*\*MI\*WW202001  
 NM1\*82\*1\*WELBY\*MARCUS\*\*\*\*FI\*886027777  
 DTM\*232\*20011101  
 SVC\*NU:301\*350.00\*350.00\*\*1  
 SVC\*NU:650\*124.00\*124.00\*\*1  
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 NM1\*QC\*1\*FLINTSTONE\*PEBBLES\*\*\*\*MI\*WW202003  
 NM1\*IL\*1\*FLINTSTONE\*FRED\*\*\*\*MI\*WW202001  
 NM1\*82\*1\*WELBY\*MARCUS\*\*\*\*FI\*886027777  
 DTM\*232\*20011101  
 SVC\*HC:99283\*500.00\*500.00\*450\*1  
 SE\*24\*0001

GE\*1\*1  
IEA\*1\*000000005

**835 Scenario #6**

Patient is Subscriber, Payor bundled services

Scope: A Lab is submitting professional claim to the primary payer for services.

**Billing Provider**

Dinolab  
404 2<sup>nd</sup> Ave  
Seattle, WA 98112  
TIN: 91-7777666

**Health Plan - Payor A**

Worldwide Insurance  
2020 1<sup>st</sup> Ave  
Seattle, WA 98112  
ID # - 91-1234567  
EDI # WI911234567

**Pay to Provider**

Dinolab  
404 2<sup>nd</sup> Ave  
Seattle, WA 98112  
TIN: 91-7777666

**Referring Provider**

Marcus Welby, M.D.  
SSN - 886027777  
Payor A Provider ID # MWB7777  
Payor B Provider ID # YT5555

**Subscriber & Patient:**

Fred Flintstone  
666 Bedrock Lane  
Quarryville, WA 98666  
Sex - M DOB 11/1/50  
SSN - 555-20-2020  
Employer - CSI, Inc.  
Payor A Member ID # - WW2020-01

Date of Service: 12/5/01

Place of Service: Laboratory (81)

Principal Diagnosis: 275.42

**Submitted Services:**

80053 Medibolic Panel, Charge \$60  
85025 Hemogram, Charge \$30  
84443 TSH, Charge \$35

Patient Account # FF555202020

Total Charges Submitted - \$125

**Bundled Service:**

80050 General Health Panel, Charge  
\$100

Payor A Paid - \$100.00

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 Coding . . .

ISA\*00\*           \*00\*           \*ZZ\*911234567   \*ZZ\*917777666  
 \*020419\*1203\*U\*00401\*000000006\*0\*P\*:  
 GS\*HP\*911234567\*917777666\*20020419\*1203\*1\*X\*004010X091A1  
 ST\*835\*0001  
 BPR\*1\*100.00\*C\*CHK\*\*\*\*\*20020419  
 TRN\*1\*87654321\*1911234567  
 N1\*PR\*WORLDWIDE INSURANCE  
 N3\*2020 1ST AVE  
 N4\*SEATTLE\*WA\*98112  
 N1\*PE\*DINOLAB\*FI\*917777666  
 N3\*404 2ND AVE  
 N4\*SEATTLE\*WA\*98112  
 LX\*1  
 CLP\*FF555202020\*1\*125.00\*100.00\*\*HM\*0204503333\*11\*1  
 NM1\*QC\*1\*FLINTSTONE\*FRED\*\*\*\*MI\*WW202001  
 DTM\*232\*20010501  
 SVC\*HC:80050\*60.00\*100.00\*\*1\*HC:80053  
 CAS\*OA\*94\*-65.00  
 CAS\*CO\*45\*25.00  
 SVC\*HC:80050\*30.00\*0\*\*1\*HC:85025  
 CAS\*CO\*97\*30.00  
 SVC\*HC:80050\*35.00\*0\*\*1\*HC:84443  
 CAS\*CO\*97\*35.00  
 SE\*21\*0001  
 GE\*1\*1  
 IEA\*1\*000000006

**835 Scenario #7**

Patient is Subscriber, All Services denied

Scope: A Lab is submitting an institutional claim to the primary payer for services.

**Billing Provider**

Tyro Hospital Lab  
501 9<sup>th</sup> Ave  
Seattle, WA 98112  
TIN: 91-7777666

**Health Plan - Payor A**

Worldwide Insurance  
2020 1<sup>st</sup> Ave  
Seattle, WA 98112  
ID # - 91-1234567  
EDI # WI911234567

**Pay to Provider**

Dinolab  
404 2<sup>nd</sup> Ave  
Seattle, WA 98112  
TIN: 91-7777666

**Referring Provider**

Marcus Welby, M.D.  
SSN - 886027777  
Payor A Provider ID # MWB7777  
Payor B Provider ID # YT5555

**Subscriber & Patient:**

Fred Flintstone  
666 Bedrock Lane  
Quarryville, WA 98666  
Sex - M DOB 11/1/50  
SSN - 555-20-2020  
Employer - CSI, Inc.  
Payor A Member ID # - WW2020-01

Date of Service: 12/5/01

Principal Diagnosis: 275.42

Bill type = 111

**Submitted Services:**

80053 Medibolic Panel, Charge \$60  
85025 Hemogram, Charge \$30  
84443 TSH, Charge \$35

Patient Account # FF555202020

Total Charges Submitted - \$125

**Adjustment Reason Code:**

PR27 – Coverage Terminated

**Remarks Code**

M10

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Coding . . .

ISA\*00\*           \*00\*           \*ZZ\*911234567   \*ZZ\*917777666  
\*020419\*1203\*U\*00401\*000000007\*0\*P\*:  
GS\*HP\*911234567\*917777666\*20020419\*1203\*1\*X\*004010X091A1  
ST\*835\*0001  
BPR\*H\*0\*C\*NON\*\*\*\*\*20020419  
TRN\*1\*87654321\*1911234567  
N1\*PR\*WORLDWIDE INSURANCE  
N3\*2020 1ST AVE  
N4\*SEATTLE\*WA\*98112  
N1\*PE\*TYRO HOSPITAL LAB\*FI\*917777666  
N3\*501 9TH AVE  
N4\*SEATTLE\*WA\*98112  
LX\*1  
CLP\*FF555202020\*1\*125.00\*0\*\*HM\*0204503333\*11\*1  
NM1\*QC\*1\*FLINTSTONE\*FRED\*\*\*\*MI\*WW202001  
DTM\*232\*20010501  
SVC\*HC:80053\*60.00\*0\*300\*1  
CAS\*PR\*27\*60.00  
LQ\*HE\*M10  
SVC\*HC:85025\*30.00\*0\*300\*1  
CAS\*PR\*27\*30.00  
LQ\*HE\*M10  
SVC\*HC:84443\*35.00\*0\*300\*1  
CAS\*PR\*27\*35.00  
LQ\*HE\*M10  
SE\*23\*0001  
GE\*1\*1  
IEA\*1\*000000007

# 835 Coding Tables

## Claim Adjustment Codes

The following lists present valid values for Claim Adjustment Group Codes and Claim Adjustment Reason Codes (Code Source 139). Claim Adjustment Reason Codes (CAS02 Pg #97 in the IG) are grouped into three categories:

- Codes Commonly Used by Washington State Commercial Health Plans
- Codes Rarely Used by Washington State Commercial Health Plans
- Inactive Codes

Each of the commonly used Reason Codes is associated with a Claim Adjustment Group Code (CAS01 Pg #97 in the IG). In most cases, one Reason Code is associated with one Group Code. However, there are cases where a Reason Code is associated with multiple Group Codes, e.g. Reason Code 17 is associated with Group Codes PR and PI. This happens because of the possibility of different circumstances behind the use of the Reason Code. In the above example, some of the circumstances will allow for the patient to be billed (thus a PR) and others may not (thus a PI). The valid values for Group Codes are:

- **CO - Contractual Obligations**  
This group code should be used when a contractual agreement between the payer and payee, or a regulatory requirement, resulted in an adjustment. Generally, these adjustments are considered a write off for the provider and are not billed to the patient.
- **CR - Corrections and Reversals**  
This group code should be used for correcting a prior claim. It applies when there is a change to a previously adjudicated claim. When correcting a prior claim, CLP02 (claim status code) needs to be 22. See ASC X12N Health Care Claim Payment/Advice Implementation Guide (835) section 2.2.8 for complete information about corrections and reversals.
- **OA - Other Adjustments**  
This group code should be used when no other group code applies to the adjustment.
- **PI - Payer Initiated Reductions**  
This group code should be used when, in the opinion of the payer, the adjustment is not the responsibility of the patient, but there is no supporting contract between the provider and the payer (i.e., medical review or professional review organization adjustments).  
  
The provider will need to determine whether these are adjustments that must be written off or can billed to the patient.
- **PR - Patient Responsibility**  
This group should be used when the adjustment represents an amount that should be billed to the patient or insured. This group would typically be used for deductible and copay adjustments.

The order for evaluating which Group Code to use:

1. Is the amount adjusted in this segment 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.

4. Is this claim the reversal of a previously reported claim or claim payment, indicated by Claim Status Code = 22, Reversal of Previous Payment?

Use code CR - Correction and Reversals.

Note: When CLP02 = '22' (Claim Status Code Pg #90 in the IG is Reversal of Previous Payment), CAS01 must always be CR.

5. If no other category is appropriate, do the following:

Use code OA - Other Adjustment.

Avoid use of the Other Adjustment Group Code (OA) whenever possible.

Codes **COMMONLY** Used by Washington State Commercial Health Plans:

| Group Code    | Reason Code | Description   | Note               | FCHA | GHC | Premera | Regence |
|---------------|-------------|---|--------------------|------|-----|---------|---------|
| PR            | <b>1</b>    | Deductible Amount   |                    | X    | X   | X       | X       |
| PR            | <b>2</b>    | Coinsurance Amount  |                    | X    | X   | X       | X       |
| PR            | <b>3</b>    | Co-payment Amount   |                    | X    | X   | X       | X       |
| CO,<br>PR, PI | <b>4</b>    | The procedure code is inconsistent with the modifier used or a required modifier is missing.  |                    |      | X   |         | X       |
| CO,<br>PR, PI | <b>5</b>    | The procedure code/bill type is inconsistent with the place of service.   |                    |      | X   | X       | X       |
| PI            | <b>6</b>    | The procedure/revenue code is inconsistent with the patient's age.  | Changed as of 6/02 |      | X   | X       |         |
| PI            | <b>7</b>    | The procedure/revenue code is inconsistent with the patient's gender.   | Changed as of 6/02 |      | X   | X       |         |
| PI            | <b>8</b>    | The procedure code is inconsistent with the provider type/specialty (taxonomy).   | Changed as of 6/02 |      |     | X       |         |
| PI            | <b>9</b>    | The diagnosis is inconsistent with the patient's age.   |                    |      | X   | X       |         |
| PI            | <b>10</b>   | The diagnosis is inconsistent with the patient's gender.  | Changed as of 2/00 |      | X   |         |         |
| PI,CO,<br>PR  | <b>11</b>   | The diagnosis is inconsistent with the procedure.   |                    |      | X   | X       | X       |
| PI,CO,<br>PR  | <b>13</b>   | The date of death precedes the date of service.   |                    |      |     | X       | X       |
| PI,CO,<br>PR  | <b>15</b>   | Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.                          | Changed as of 2/01 |      | X   |         |         |
| PI,CO,<br>PR  | <b>16</b>   | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | Changed as of 2/02 | X    | X   | X       | X       |
| PR,           | <b>17</b>   | Payment adjusted because  | Changed            | X    | X   | X       | X       |

| <b>Group Code</b> | <b>Reason Code</b> | <b>Description</b>  | <b>Note</b>        | <b>FCHA</b> | <b>GHC</b> | <b>Premera</b> | <b>Regence</b> |
|-------------------|--------------------|---|--------------------|-------------|------------|----------------|----------------|
| PI,CO             |                    | requested information was not provided or was insufficient/incomplete. Additional information is supplied using the remittance advice remarks codes whenever appropriate. | as of 2/02         |             |            |                |                |
| PI,CO, PR         | <b>18</b>          | Duplicate claim/service.  |                    | X           | X          | X              | X              |
| PR,CO ,PR         | <b>19</b>          | Claim denied because this is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.   |                    |             | X          | X              | X              |
| PR,CO             | <b>20</b>          | Claim denied because this injury/illness is covered by the liability carrier.   |                    | X           | X          | X              | X              |
| PI,PR, CO         | <b>22</b>          | Payment adjusted because this care may be covered by another payer per coordination of benefits.  | Changed as of 2/01 | X           | X          | X              | X              |
| PI,CO, PR         | <b>23</b>          | Payment adjusted because charges have been paid by another payer.   | Changed as of 2/01 | X           | X          | X              | X              |
| CO,PR             | <b>24</b>          | Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.   | Changed as of 6/00 |             |            | X              | X              |
| PR,CO             | <b>26</b>          | Expenses incurred prior to coverage.  |                    |             | X          | X              | X              |
| PR,CO             | <b>27</b>          | Expenses incurred after coverage terminated.  |                    | X           | X          | X              | X              |
| PI,PR, CO         | <b>29</b>          | The time limit for filing has expired.  |                    | X           | X          | X              | X              |
| PR,CO             | <b>30</b>          | Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.  | Changed as of 2/01 |             | X          | X              | X              |
| PI,CO, PR         | <b>31</b>          | Claim denied as patient cannot be identified as our insured.  |                    | X           | X          | X              | X              |
| PR,CO             | <b>32</b>          | Our records indicate that this dependent is not an eligible dependent as defined.   |                    | X           |            | X              | X              |

| <b>Group Code</b> | <b>Reason Code</b> | <b>Description</b>  | <b>Note</b>         | <b>FCHA</b> | <b>GHC</b> | <b>Premera</b> | <b>Regence</b> |
|-------------------|--------------------|---|---------------------|-------------|------------|----------------|----------------|
| PR                | <b>33</b>          | Claim denied. Insured has no dependent coverage.  |                     | X           |            |                |                |
| PR                | <b>34</b>          | Claim denied. Insured has no coverage for newborns.   |                     |             |            | X              |                |
| PR                | <b>35</b>          | Lifetime benefit maximum has been reached.  | Changed as of 10/02 | X           | X          | X              | X              |
| PR, PI, CO        | <b>38</b>          | Services not provided or authorized by designated (network/primary care) providers.   | Changed as of 06/03 | X           | X          | X              | X              |
| PR, PI, CO        | <b>39</b>          | Services denied at the time authorization/pre-certification was requested.  |                     |             |            | X              | X              |
| PR, CO            | <b>40</b>          | Charges do not meet qualifications for emergent/urgent care.  |                     | X           |            | X              | X              |
| CO, PR            | <b>42</b>          | Charges exceed our fee schedule or maximum allowable amount.  |                     | X           | X          | X              | X              |
| PI, PR, CO        | <b>47</b>          | This (these) diagnosis(es) is (are) not covered, missing, or are invalid.   | Changed as of 6/00  | X           | X          | X              | X              |
| PI                | <b>49</b>          | These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam. |                     |             |            | X              |                |
| PR, CO            | <b>50</b>          | These are non-covered services because this is not deemed a 'medical necessity' by the payer.                                 |                     | X           |            | X              | X              |
| PR, CO            | <b>51</b>          | These are non-covered services because this is a pre-existing condition   |                     |             | X          | X              | X              |
| PI, CO, PR        | <b>52</b>          | The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.             | Changed as of 10/98 | X           | X          | X              | X              |
| PR, CO            | <b>53</b>          | Services by an immediate relative or a member of the same household are not covered.  |                     | X           |            | X              | X              |
| PI, PR, CO        | <b>54</b>          | Multiple physicians/assistants are not covered  |                     |             | X          | X              | X              |

| Group Code | Reason Code | Description   | Note  | FCHA | GHC | Premera | Regence |
|------------|-------------|---|---|------|-----|---------|---------|
|            |             | in this case.   |   |      |     |         |         |
| PR, PI, CO | 55          | Claim/service denied because procedure/treatment is deemed experimental/investigational by the payer.   |   |      |     | X       | X       |
| PI, PR, CO | 57          | Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply. | Inactive for 004050. Split into codes 150, 151, 152, 153 and 154. |      | X   |         | X       |
| PI, CO, PR | 58          | Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.   | Changed as of 2/01  | X    | X   | X       | X       |
| PI, CO, PR | 59          | Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules.  | Changed as of 6/00  |      | X   | X       | X       |
| PI, CO, PR | 61          | Charges adjusted as penalty for failure to obtain second surgical opinion.  | Changed as of 6/00  |      |     | X       | X       |
| PR, PI, CO | 62          | Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.  | Changed as of 2/01  | X    | X   | X       | X       |
| PR, CO     | 70          | Cost outlier - Adjustment to compensate for additional costs.   | Changed as of 6/01  | X    |     |         | X       |
| PR, PI     | 78          | Non-Covered days/Room charge adjustment.  |   |      | X   | X       |         |
| OA         | 85          | Interest amount.  |   |      | X   |         |         |
| OA         | 87          | Transfer amount.  |   |      | X   | X       |         |
| CO         | 94          | Processed in Excess of charges.   |   |      | X   |         |         |
| PR, CO     | 96          | Non-covered charge(s).  |   | X    | X   | X       | X       |
| PI, CO, PR | 97          | Payment is included in the allowance for another service/procedure.   | Changed as of 2/99  | X    | X   | X       | X       |
| PR, PI     | 100         | Payment made to patient/insured/responsible   |   |      |     | X       |         |

| Group Code       | Reason Code | Description   | Note  | FCHA | GHC | Premera | Regence |
|------------------|-------------|---|---|------|-----|---------|---------|
|                  |             | party.  |   |      |     |         |         |
| OA               | <b>102</b>  | Major Medical Adjustment.   |   |      |     | X       |         |
| PI,<br>CO,<br>PR | <b>107</b>  | Claim/service denied because the related or qualifying claim/service was not previously paid or identified on this claim.                                 | Changed as of 6/03                            |      | X   | X       | X       |
| PI,<br>CO,<br>PR | <b>109</b>  | Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.  |   |      | X   | X       | X       |
| PI               | <b>110</b>  | Billing date predates service date.   |   |      | X   | X       |         |
| PI               | <b>111</b>  | Not covered unless the provider accepts assignment.   |   |      | X   |         |         |
| PI               | <b>112</b>  | Payment adjusted as not furnished directly to the patient and/or not documented.  | Changed as of 2/01                            |      |     | X       |         |
| PI,<br>CO,<br>PR | <b>116</b>  | Payment denied. The advance indemnification notice signed by the patient did not comply with requirements.  | Changed as of 2/01                            |      | X   |         |         |
| PI               | <b>117</b>  | Payment adjusted because transportation is only covered to the closest facility that can provide the necessary care.                                      | Changed as of 2/01                            |      |     | X       |         |
| PR ,<br>CO       | <b>119</b>  | Benefit maximum for this time period or occurrence has been reached.  | Changed as of 2/04                            |      |     | X       | X       |
| PI,<br>CO,<br>PR | <b>120</b>  | Patient is covered by a managed care plan.  | Inactive for 004030, since 6/99. Use code 24. |      | X   |         |         |
| PI,<br>CO,<br>PR | <b>125</b>  | Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. | Changed as of 2/02                            | X    |     | X       | X       |
| PI               | <b>128</b>  | Newborn's services are covered in the mother's  | New as of 2/97                                |      |     | X       |         |

| Group Code | Reason Code | Description  | Note  | FCHA | GHC | Premera | Regence |
|------------|-------------|--|---|------|-----|---------|---------|
|            |             | Allowance.   |   |      |     |         |         |
| CO         | <b>131</b>  | Claim specific negotiated discount.  | New as of 2/97  | X    | X   |         |         |
| CO, PR     | <b>133</b>  | The disposition of this claim/service is pending further review.   | Changed as of 10/99   |      |     | X       |         |
| PI         | <b>135</b>  | Claim denied. Interim bills cannot be processed.   | New as of 10/98   | X    | X   | X       |         |
| CO         | <b>138</b>  | Claim/service denied. Appeal procedures not followed or time limits not met.                               | New as of 6/99  |      |     | X       |         |
| PI         | <b>140</b>  | Patient/Insured health identification number and name do not match.  | New as of 6/99  |      |     | X       |         |
| CO, PR     | <b>150</b>  | Payment adjusted because the payer deems the information submitted does not support this level of service. | New as of 10/02   |      |     |         | X       |
| CO, PR     | <b>151</b>  | Payment adjusted because the payer deems the information submitted does not support this many services.    | New as of 10/02   |      |     |         | X       |
| OA         | <b>A0</b>   | Patient refund amount.   |   |      |     | X       |         |
| CO,PR      | <b>A1</b>   | Claim denied Charges   |   |      | X   |         | X       |
| CO, PR     | <b>A2</b>   | Contractual adjustment.  | Inactive for version 004060. Use Code 45 with Group Code 'CO' or use another appropriate specific adjustment code | X    |     | X       | X       |
| PI         | <b>A6</b>   | Prior hospitalization or 30 day transfer requirement not met.  |   |      |     | X       |         |
| PI, PR,    | <b>B5</b>   | Payment adjusted because   | Changed   |      |     | X       | X       |

| Group Code | Reason Code | Description  | Note                | FCHA | GHC | Premera | Regence |
|------------|-------------|--|---------------------|------|-----|---------|---------|
| CO         |             | coverage/program guidelines were not met or were exceeded.   | as of 2/01          |      |     |         |         |
| PI         | <b>B6</b>   | This payment is adjusted when performed/billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty.                      | Changed as of 2/01  |      | X   | X       |         |
| PI, CO, PR | <b>B7</b>   | This provider was not certified/eligible to be paid for this procedure/service on this date of service.  | Changed as of 10/98 |      |     | X       | X       |
| PI, PR, CO | <b>B8</b>   | Claim/service not covered/reduced because alternative services were available, and should have been utilized.  |                     |      |     | X       | X       |
| PI         | <b>B9</b>   | Services not covered because the patient is enrolled in a Hospice.   |                     |      | X   |         |         |
| CO, PR     | <b>B10</b>  | Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test. |                     |      | X   |         | X       |
| PI, CO, PR | <b>B11</b>  | The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.  |                     | X    | X   | X       | X       |
| CO, PR     | <b>B13</b>  | Previously paid. Payment for this claim/service may have been provided in a previous payment.  |                     | X    | X   | X       | X       |
| PR, PI     | <b>B14</b>  | Payment denied because only one visit or consultation per physician per day is covered.  | Changed as of 2/01  |      | X   | X       |         |
| PI, CO, PR | <b>B15</b>  | Payment adjusted because this procedure/service is not paid separately.  | Changed as of 2/01  | X    | X   | X       | X       |
| PI, CO,    | <b>B18</b>  | Payment denied because this procedure  | Changed as of       | X    | X   | X       | X       |

| <b>Group Code</b> | <b>Reason Code</b> | <b>Description</b>   | <b>Note</b>        | <b><u>FCHA</u></b> | <b><u>GHC</u></b> | <b><u>Premera</u></b> | <b><u>Regence</u></b> |
|-------------------|--------------------|--|--------------------|--------------------|-------------------|-----------------------|-----------------------|
| PR                |                    | code/modifier was invalid on the date of service or claim submission.                            | 2/01               |                    |                   |                       |                       |
| PI,<br>CO,<br>PR  | <b>B20</b>         | Payment adjusted because procedure/service was partially or fully furnished by another provider. | Changed as of 2/01 |                    |                   | X                     | X                     |
| PI                | <b>B22</b>         | This payment is adjusted based on the diagnosis.   | Changed as of 2/01 |                    |                   | X                     |                       |

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**Codes SOMETIMES Used by Washington State Commercial Health Plans:**

| <b>Group Code</b> | <b>Reason Code</b> | <b>Description</b>  | <b>Note</b>          |
|-------------------|--------------------|---|----------------------|
|                   | <b>12</b>          | The diagnosis is inconsistent with the provider type.   |                      |
|                   | <b>14</b>          | The date of birth follows the date of service.  |                      |
|                   |                    |   |                      |
|                   | <b>21</b>          | Claim denied because this injury/illness is the liability of the no-fault carrier.                          |                      |
|                   | <b>25</b>          | Payment denied. Your Stop loss deductible has not been met.   |                      |
|                   | <b>43</b>          | Gramm-Rudman reduction.   |                      |
|                   | <b>44</b>          | Prompt-pay discount.  |                      |
|                   | <b>45</b>          | Charges exceed your contracted/ legislated fee arrangement.   |                      |
|                   | <b>56</b>          | Claim/service denied because procedure/treatment has not been deemed 'proven to be effective' by the payer. |                      |
|                   | <b>60</b>          | Charges for outpatient services with this proximity to inpatient services are not covered.                  |                      |
|                   | <b>66</b>          | Blood Deductible.   |                      |
|                   | <b>69</b>          | Day outlier amount.   |                      |
|                   | <b>74</b>          | Indirect Medical Education Adjustment.  |                      |
|                   | <b>75</b>          | Direct Medical Education Adjustment.  |                      |
|                   | <b>76</b>          | Disproportionate Share Adjustment.  |                      |
|                   | <b>88</b>          | Adjustment amount represents collection against receivable created in prior overpayment.                    | Inactive for 004050. |
|                   | <b>89</b>          | Professional fees removed from charges.   |                      |
|                   | <b>90</b>          | Ingredient cost adjustment.   |                      |
|                   | <b>91</b>          | Dispensing fee adjustment.  |                      |
|                   | <b>95</b>          | Benefits adjusted. Plan procedures not followed.  |                      |
|                   | <b>101</b>         | Predetermination: anticipated payment upon  | Changed as of        |

| <b>Group Code</b> | <b>Reason Code</b> | <b>Description</b>   | <b>Note</b>  |
|-------------------|--------------------|--|--|
|                   |                    | completion of services or claim adjudication.  | 2/99   |
|                   | <b>103</b>         | Provider promotional discount (e.g., Senior citizen discount).   | Changed as of 6/01   |
|                   | <b>104</b>         | Managed care withholding.  |  |
|                   | <b>105</b>         | Tax withholding.   |  |
|                   | <b>106</b>         | Patient payment option/election not in effect.   |  |
|                   | <b>108</b>         | Payment adjusted because rent/purchase guidelines were not met.  | Changed as of 6/02   |
|                   | <b>113</b>         | Payment denied because service/procedure was provided outside the United States or as a result of war. | Changed as of 2/01   |
|                   | <b>114</b>         | Procedure/product not approved by the Food and Drug Administration.                                    |  |
|                   | <b>115</b>         | Payment adjusted as procedure postponed or canceled.   | Changed as of 2/01   |
|                   | <b>118</b>         | Charges reduced for ESRD network support.  |  |
|                   | <b>121</b>         | Indemnification adjustment.  |  |
|                   | <b>122</b>         | Psychiatric reduction.   |  |
|                   | <b>123</b>         | Payer refund due to overpayment.   | Inactive for 004030, since 6/99. Refer to implementation guide for proper handling of reversals. |
|                   | <b>124</b>         | Payer refund amount - not our patient.   | Inactive for 004030, since 6/99. Refer to implementation guide for                               |

| <b>Group Code</b> | <b>Reason Code</b> | <b>Description</b>  | <b>Note</b>                   |
|-------------------|--------------------|---|-------------------------------|
|                   |                    |   | proper handling of reversals. |
|                   | <b>126</b>         | Deductible -- Major Medical   | New as of 2/97                |
|                   | <b>127</b>         | Coinsurance -- Major Medical  | New as of 2/97                |
|                   | <b>129</b>         | Payment denied - Prior processing information appears incorrect.                              | Changed as of 2/01            |
|                   | <b>130</b>         | Claim submission fee.   | Changed as of 6/01            |
|                   | <b>132</b>         | Prearranged demonstration project adjustment.   | New as of 2/97                |
|                   | <b>134</b>         | Technical fees removed from charges.  | New as of 10/98               |
|                   | <b>136</b>         | Claim Adjusted. Plan procedures of a prior payer were not followed.                           | Changed as of 6/00            |
|                   | <b>137</b>         | Payment/Reduction for Regulatory Surcharges, Assessments, Allowances or Health Related Taxes. | New as of 2/99                |
|                   | <b>139</b>         | Contracted funding agreement - Subscriber is employed by the provider of services.            | New as of 6/99                |
|                   | <b>141</b>         | Claim adjustment because the claim spans eligible and ineligible periods of coverage.         | Changed as of 6/00            |
|                   | <b>142</b>         | Claim adjusted by the monthly Medicaid patient liability amount.                              | New as of 6/00                |
|                   | <b>143</b>         | Portion of payment deferred.  | New as of 2/01                |
|                   | <b>144</b>         | Incentive adjustment, e.g. preferred product/service.   | New as of 6/01                |
|                   | <b>145</b>         | Premium payment withholding   | New as of 6/02                |
|                   | <b>146</b>         | Payment denied because the diagnosis was invalid for the date(s) of service reported.         | New as of 6/02                |
|                   | <b>147</b>         | Provider contracted/negotiated rate   | New as of 6/02                |

| <b>Group Code</b> | <b>Reason Code</b> | <b>Description</b>   | <b>Note</b>     |
|-------------------|--------------------|--|-----------------|
|                   |                    | expired or not on file.  |                 |
|                   | <b>148</b>         | Claim/service rejected at this time because information from another provider was not provided or was insufficient/incomplete. | New as of 6/02  |
|                   | <b>149</b>         | Lifetime benefit maximum has been reached for this service/benefit category.   | New as of 10/02 |
|                   | <b>152</b>         | Payment adjusted because the payer deems the information submitted does not support this length of service.                    | New as of 10/02 |
|                   | <b>153</b>         | Payment adjusted because the payer deems the information submitted does not support this dosage.                               | New as of 10/02 |
|                   | <b>154</b>         | Payment adjusted because the payer deems the information submitted does not support this day's supply.                         | New as of 10/02 |
|                   | <b>155</b>         | This claim is denied because the patient refused the service/procedure   | New as of 6/03  |
|                   | <b>156</b>         | Flexible spending account payments   | New as of 9/03  |
|                   | <b>157</b>         | Payment denied/reduced because service/procedure was provided as a result of an act of war.                                    | New as of 9/03  |
|                   | <b>158</b>         | Payment denied/reduced because the service/procedure was provided outside of the United States                                 | New as of 9/03  |
|                   | <b>159</b>         | Payment denied/reduced because the service/procedure was provided as a result of terrorism                                     | New as of 9/03  |
|                   | <b>160</b>         | Payment denied/reduced because injury/illness was the result of an activity that is a benefit exclusion                        | New as of 9/03  |
|                   | <b>161</b>         | Provider performance bonus   | New as of 2/04  |

| <b>Group Code</b> | <b>Reason Code</b> | <b>Description</b>   | <b>Note</b>        |
|-------------------|--------------------|--|--------------------|
|                   | <b>162</b>         | State-mandated Requirement for Property and Casualty, see Claim Payment Remarks Code for specific explanation.   | New as of 2/04     |
|                   | <b>163</b>         | Claim/Service adjusted because the attachment referenced on the claim was not received   | New as of 6/04     |
|                   | <b>164</b>         | Claim/Service adjusted because the attachment referenced on the claim was not received in a timely fashion.  | New as of 6/04     |
|                   | <b>A4</b>          | Medicare Claim PPS Capital Day Outlier Amount.   |                    |
|                   | <b>A5</b>          | Medicare Claim PPS Capital Cost Outlier Amount.  |                    |
|                   | <b>A7</b>          | Presumptive Payment Adjustment   |                    |
|                   | <b>A8</b>          | Claim denied; ungroupable DRG  |                    |
|                   | <b>B1</b>          | Non-covered visits.  |                    |
|                   | <b>B4</b>          | Late filing penalty.   |                    |
|                   | <b>B12</b>         | Services not documented in patients' medical records.  |                    |
|                   | <b>B16</b>         | Payment adjusted because 'New Patient' qualifications were not met.  | Changed as of 2/01 |
|                   | <b>B17</b>         | Payment adjusted because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current. | Changed as of 2/01 |
|                   | <b>B23</b>         | Payment denied because this provider has failed an aspect of a proficiency testing program.  | Changed as of 2/01 |
|                   | <b>W1</b>          | Workers Compensation State Fee Schedule Adjustment   | New as of 2/00     |

**Inactive Codes:**

| <b>Group Code</b> | <b>Reason Code</b> | <b>Description</b>  | <b>Note</b>  |
|-------------------|--------------------|---|--|
|                   | <b>28</b>          | Coverage not in effect at the time the service was provided.          | Inactive for 004010, since 6/98. Redundant to codes 26&27. |
|                   | <b>36</b>          | Balance does not exceed co-payment amount.                            | Inactive for 003040  |
|                   | <b>37</b>          | Balance does not exceed deductible.                                   | Inactive for 003040  |
|                   | <b>41</b>          | Discount agreed to in Preferred Provider contract.                    | Inactive for 003040  |
|                   | <b>46</b>          | This (these) service(s) is (are) not covered.                         | Inactive for 004010, since 6/00. Use code 96.              |
|                   | <b>48</b>          | This (these) procedure(s) is (are) not covered.                       | Inactive for 004010, since 6/00. Use code 96.              |
|                   | <b>63</b>          | Correction to a prior claim.  | Inactive for 003040  |
|                   | <b>64</b>          | Denial reversed per Medical Review.                                   | Inactive for 003040  |
|                   | <b>65</b>          | Procedure code was incorrect. This payment reflects the correct code. | Inactive for 003040  |
|                   | <b>67</b>          | Lifetime reserve days. (Handled in QTY, QTY01=LA)                     | Inactive for 003040  |
|                   | <b>68</b>          | DRG weight. (Handled in CLP12)  | Inactive for 003040  |
|                   | <b>72</b>          | Coinsurance day. (Handled in QTY, QTY01=CD)                           | Inactive for 003040  |
|                   | <b>73</b>          | Administrative days.  | Inactive for 003050  |
|                   | <b>77</b>          | Covered days. (Handled in QTY, QTY01=CA)                              | Inactive for 003040  |
|                   | <b>79</b>          | Cost Report days. (Handled in MIA15)                                  | Inactive for 003050  |
|                   | <b>80</b>          | Outlier days. (Handled in QTY, QTY01=OU)                              | Inactive for 003050  |
|                   | <b>81</b>          | Discharges.   | Inactive for   |

| Group Code | Reason Code | Description   | Note   |
|------------|-------------|---|--|
|            |             |   | 003040   |
|            | <b>82</b>   | PIP days.   | Inactive for 003040  |
|            | <b>83</b>   | Total visits.   | Inactive for 003040  |
|            | <b>84</b>   | Capital Adjustment.<br>(Handled in MIA)   | Inactive for 003050  |
|            | <b>86</b>   | Statutory Adjustment.   | Inactive for 004010,<br>since 6/98.<br>Duplicative<br>of code 45.                              |
|            | <b>92</b>   | Claim Paid in full.   | Inactive for 003040  |
|            | <b>93</b>   | No Claim level Adjustments.   | Inactive for 004010,<br>since 2/99.<br>In 004010,<br>CAS at the<br>claim level<br>is optional. |
|            | <b>98</b>   | The hospital must file the Medicare claim for this inpatient non-physician service.             | Inactive for 003040  |
|            | <b>99</b>   | Medicare Secondary Payer Adjustment Amount.   | Inactive for 003040  |
|            | <b>A3</b>   | Medicare Secondary Payer liability met.   | Inactive for 004010,<br>since 6/98.  |
|            | <b>B2</b>   | Covered visits.   | Inactive for 003040  |
|            | <b>B3</b>   | Covered charges.  | Inactive for 003040  |
|            | <b>B19</b>  | Claim/service adjusted because of the finding of a Review Organization.                         | Inactive for 003070  |
|            | <b>B21</b>  | The charges were reduced because the service/care was partially furnished by another physician. | Inactive for 003040  |
|            | <b>D1</b>   | Claim/service denied. Level of subluxation is missing or inadequate.                            | Inactive for 004010,<br>since 2/99.<br>Use code<br>16 and<br>remark<br>codes if                |

| Group Code | Reason Code | Description  | Note  |
|------------|-------------|--|---|
|            |             |  | necessary.  |
|            | <b>D2</b>   | Claim lacks the name, strength, or dosage of the drug furnished.   | Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary. |
|            | <b>D3</b>   | Claim/service denied because information to indicate if the patient owns the equipment that requires the part or supply was missing. | Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary. |
|            | <b>D4</b>   | Claim/service does not indicate the period of time for which this will be needed.  | Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary. |
|            | <b>D5</b>   | Claim/service denied. Claim lacks individual lab codes included in the test.   | Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary. |
|            | <b>D6</b>   | Claim/service denied. Claim did not include patient's medical record for the service.  | Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary. |
|            | <b>D7</b>   | Claim/service denied. Claim lacks date of patient's most recent physician visit.   | Inactive for 004010, since 2/99. Use code 16 and remark codes if            |

| Group Code | Reason Code | Description   | Note  |
|------------|-------------|---|---|
|            |             |   | necessary.  |
|            | <b>D8</b>   | Claim/service denied. Claim lacks indicator that `x-ray is available for review.'   | Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary. |
|            | <b>D9</b>   | Claim/service denied. Claim lacks invoice or statement certifying the actual cost of the lens, less discounts or the type of intraocular lens used. | Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary. |
|            | <b>D10</b>  | Claim/service denied. Completed physician financial relationship form not on file.  | Inactive for 003070, since 8/97. Use code 17.                               |
|            | <b>D11</b>  | Claim lacks completed pacemaker registration form.  | Inactive for 003070, since 8/97. Use code 17.                               |
|            | <b>D12</b>  | Claim/service denied. Claim does not identify who performed the purchased diagnostic test or the amount you were charged for the test.              | Inactive for 003070, since 8/97. Use code 17.                               |
|            | <b>D13</b>  | Claim/service denied. Performed by a facility/supplier in which the ordering/referring physician has a financial interest.                          | Inactive for 003070, since 8/97. Use code 17.                               |
|            | <b>D14</b>  | Claim lacks indication that plan of treatment is on file.   | Inactive for 003070, since 8/97. Use code 17.                               |
|            | <b>D15</b>  | Claim lacks indication that service was supervised or evaluated by a physician.   | Inactive for 003070, since 8/97. Use code 17.                               |

