Standard Companion Guide
for the Vision Business Segment

Refers to the Implementation Guide Based on
ASC X12N/005010X221A1
Health Care Claim Payment/Advice
(835)

Companion Guide Version Number: 1.6

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Change Log

Version	Release date	Changes
1.0	3/28/11	Initial External Release Draft
1.1	6/22/11	Revised with process clarifications
1.2	09/30/15	VAS changes and Minnesota MUCG Updates
1.3	01/02/18	Added Minnesota MUCG website link
1.4	01/27/20	Annual review-No changes
1.5	04/01/21	Rebranding updates
1.6	02/11/25	Updated Minnesota MUCG website link

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Preface

This Companion Guide to the ASC X12N/005010X221A1 Health Care Claim Payment Advice (835) Implementation Guide, also known as Technical Report Type 3 (TR3), clarifies and specifies the data content when exchanging electronically with Spectera. Transmissions based on this companion guide, used in tandem with the specified ASC X12/005010X221A1 835 Implementation 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/005010X221A1 835 implementation Guide 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 Guides.

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1. INTRODUCTION

1.1. SCOPE

This guide is to be used by the Trading Partner for the development of the ASC X12/005010X221A1 835 transaction for the purpose of reporting claim payment information from Spectera.

1.2. OVERVIEW

This Companion Guide will replace the previous Spectera Companion Guide for Health Care Claim Payment/Advice release dated August, 2006.

This Spectera Health Care Claim Payment/Advice Companion Guide has been written to assist you in designing and implementing Claim Payment Advice transactions to meet Spectera processing standards. This Companion Guide must be used in conjunction with the Health Care Claim Payment/Advice (835) instructions as set forth by the ASC X12 Standards for Electronic Data Interchange Version 005010X221), April 2006, and the Errata (Version 005010X221A1), June 2010. The Spectera Companion Guide identifies key data elements from the transaction set that will be provided in the transaction. The recommendations made are to enable you to more effectively complete EDI transactions with Spectera.

Our companion guide complies with the Minnesota Statutes, section 62J.536. The Minnesota Uniform Companion Guides (MUCGs) are state companions to HIPAA Implementation Guides and provide instructions and information for the standard, electronic exchange of health care administrative transactions pursuant to Minnesota Statutes, section 62J.536.

AUC Minnesota Uniform Companion Guides - MN Dept. of Health

1.3. REFERENCE

For more information regarding the ASC Standards for Electronic Data Interchange (X12/005010X221A1) Health Care Claim Payment/Advice (835) and to purchase copies of these documents, consult the Washington Publishing Company web site at www.wpc-edi.com

1.4. ADDITIONAL INFORMATION

The American National Standards Institute (ANSI) is the coordinator and clearinghouse for information on national and international standards. In 1979 ANSI chartered the Accredited Standards Committee (ASC) X12 to develop uniform standards for electronic interchange of business transactions and eliminate the problem of non-standard electronic data

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communication. The objective of the ASC X12 committee is to develop standards to facilitate electronic interchange relating to all types of business transactions. The ANSI X12 standards is recognized by the United States as the standard for North America.

2. GETTING STARTED

2.1. WORKING WITH SPECTERA

Spectera contracted with OptumInsight for all electronic claim transactions.

- Providers who send us claims via OptumInsight can also enroll for 835 electronic remittance files.

  Setting up electronic remittances is easy! Simply contact your current clearinghouse or electronic billing partner and request transmission of your electronic remittances from Spectera through OptumInsight (formerly Ingenix).
  Our Payer ID is 00773.

  835 Remittance:
  Providers/Clearinghouse can enroll to receive 835 remittances by calling OptumInsight at 1-866-678-8646 (1-866-OPTUMGO), option 2

- Providers who are enrolled for electronic payments can also receive 835 remittances.

  The remittances are posted on the Optumfinancial website

  www.optumhealthfinancial.com.

3. CONTACT INFORMATION

3.1. EDI BUSINESS CONTACT

Clearinghouse
If you have questions related to 835 transactions submitted through a clearinghouse please contact your clearinghouse vendor.

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Providers

- If you have questions related to 835 transactions posted by OptumInsight please contact OptumInsight at 1-866-678-8646 (1-866-OPTUMGO), option 2

- If you have questions related to transactions posted on the Optumfinancial website please contact Optumfinancial at 877-620-6194, option 1 to get to an Optumfinancial representative.

3.2. APPLICABLE WEBSITES / E-MAIL

Please visit the following web sites for more details:
General HIPAA Information – http://aspe.hhs.gov/admnsimp/
FAQ's about Transactions – http://aspe.hhs.gov/admnsimp/faqtx.htm
FAQ's about Code Sets – http://aspe.hhs.gov/admnsimp/faqcode.htm
Educational Materials & White Papers – http://wedi.org/

4. CONTROL SEGMENTS / ENVELOPES

4.1. ISA-IEA

Transactions transmitted during a session or as a batch are identified by an interchange header segment (ISA) and trailer segment (IEA) which form the envelope enclosing the transmission. Each ISA marks the beginning of the transmission (batch) and provides sender and receiver identification.

Spectera uses the following delimiters on your 835 file

Data Element: The first element separator following the ISA will define what Data Element Delimiter is used throughout the entire transaction. **The Data Element Delimiter is an asterisk (*).**

Segment: The last position in the ISA will define what Segment Element Delimiter is used throughout the entire transaction. **The Segment Delimiter is a tilde (~).**

Component-Element: Element ISA16 will define what Component-Element Delimiter is used throughout the entire transaction. **The Component-Element Delimiter is a colon (:).**

4.2. GS-GE

EDI transactions of a similar nature and destined for one trading partner may be gathered into a functional group, identified by a functional group header segment (GS) and a functional group trailer segment (GE). Each GS segment marks the beginning of a functional group. There can be many functional groups within an interchange envelope.

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4.3. ST-SE

The beginning of each individual transaction is identified using a transaction set header segment (ST). The end of every transaction is marked by a transaction set trailer segment (SE).

5. PAYER SPECIFIC BUSINESS RULES ANDLIMITATIONS

Claim Overpayment Recovery
Claim Overpayment Recovery occurs when Spectera identifies that a prior processed claim was over paid. To recoup the overpayment UNET Business will follow the steps outlined in method three provided in section 1.10.2.17 (Claim Overpayment Recovery) of the ASC X12 005010X221A1 835 implementation guide.

835 Enrollments
The 835 transaction enrollment registration will be done at the Federal Tax Identification Number level.

6. TRADING PARTNER AGREEMENTS

This section contains general information concerning Trading Partner Agreements (TPA).

6.1. TRADING PARTNERS

An EDI Trading Partner is defined as any Spectera customer (provider, billing service, software vendor, employer group, financial institution, etc.) that transmits to, or receives electronic data from Spectera via OptumInsight.

Payers have EDI Trading Partner Agreements that accompany the standard implementation guide to ensure the integrity of the electronic transaction process. The Trading Partner Agreement is related to the electronic exchange of information. The agreement is an entity or a part of a larger agreement, between each party to the agreement.

7. TRANSACTION SPECIFICINFORMATION

Spectera has put together the following grid to assist you in designing and programming the information we would provide in 835 transactions. This Companion Guide is meant to illustrate the data provided by Spectera for successful posting of Health Care Claim Payment/Advice transactions. The table contains a row for each segment that Spectera has something additional, over and above, the information in the IG. That information can:

1. Limit the repeat of loops or segments
2. Limit the length of a simple data element
3. Specify a subset of the IG internal code listings
4. Clarify the use of loops, segments, composite and simple data elements

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5. Provide any other information tied directly to a loop, segment, composite or simple data element pertinent to trading electronically with Spectera

All segments, data elements, and codes supported in the ASC X12N/005010X221A1 835 Implementation Guide are acceptable; however, all data may not be used in the processing of this transaction by Spectera for an 835 transaction.

LOOP	SEGMENT	NAME	VALUE	NOTES
	ISA	Interchange Control Header		CAM can produce one file per Payee, or one file for all Payees. To instruct CAM to produce one File for all Payees (instead of the default of one file per Payee), insert a record for the Bank/Checking Account (set PAYEE_ID to zero) as follows: INSERT INTO [UserDB].[dbo].[CAM_835_CONTROL_DATA] VALUES(1, '9600129432', 0, 'MULTIPLE_PAYEES_PER_FILE', '1')
	ISA01	Authorization Information Qualifier	00	00 - No authorization information present.
	ISA02	Authorization Information	10 spaces	
	ISA03	Security Information Qualifier	00	
	ISA04	Security Information	10 spaces	
	ISA05	Security Information	zz	zz - Mutually Defined
	ISA06	Interchange Sender ID		UserDB.CAM_835_CONTROL_DATA with FIELD_NAME of "INTERCHANGE_SENDER_ID"
	ISA07	Interchange ID Qualifier	zz	zz - Mutually Defined
	ISA08	Interchange Receiver ID		UserDB.CAM_835_CONTROL_DATA with FIELD_NAME of "INTERCHANGE_RECEIVER_ID"
	ISA09	Interchange Date		Date expressed as YYMMDD
	ISA10	Interchange Time		Time expressed as HHMM
	ISA11	Repetition Separator	/¥	
	ISA12	Interchange Control Version Number	00501	
	ISA13	Interchange Control Number	yMMddHHmm	

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LOOP	SEGMENT	NAME	VALUE	NOTES
	ISA14	Acknowledgement Requested	0	0 - No Interchange Acknowledgement Requested We have set the Acknowledgement indicate that we are NOT requesting an electronic acknowledgement (TA1 or 997).
	ISA15	Usage Indicator	P	P - Production Data The Usage Indicator (ISA15) has been hard-coded to Production ('P') vs. Test ('T').
	ISA16	Component Element Separator	:	Colon :
	Segment Terminator	Segment Terminator		
	(Data Element Separator)	(Data Element Separator)	*	
	GS	Functional Group Header		
	GS01	Functional Identifier Code	HP	HP - Health Care Claim Payment / Advice
	GS02	Application Send's Code		UserDB.CAM_835_CONTROL_DATA with FIELD_NAME of "APPLICATION_SENDERS_CODE"
	GS03	Application Rec'sCode		UserDB.CAM_835_CONTROL_DATA with FIELD_NAME of "APPLICATION_RECEIVERS_CODE"
	GS04	Date		Date (CCYYMMDD)
	GS05	Time		Time (HHMM)
	GS06	Group Control Number		Starts at 1 and increments with each new Group
	GS07	Responsible Agency Code	X	
	GS08	Version / Release Industry Identifier Code	005010X221A1	
	ST	Transaction Set Header		
	ST01	Transaction Set Identifier Code	835	835 - Health Care Claim Payment / Advice

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LOOP	SEGMENT	NAME	VALUE	NOTES
	ST02	Transaction Set Control Number		Starts at "0001" and increments with each new Transaction Set
	BPR	Payment Order/Remittance Advice		
	BPR01 H	Transaction	C, D, I, P,	C- Payment & Remit Advice D=Payment Only I - Remit Advice Only
		Handling Code		P - Prenotification of Future Transfers H - Notification Only
	BPR02 Amount	Monetary		Total amount of the check (PAYMENT_CYCLE_PAYEES.CHECK_ AMOUNT)
	BPR03	Credit / Debit Flag Code	C	C- Credit
	BPR04 Code	Payment Method	BOP, BPR04, CHK, UserDB ACH, forAllPayees, NON	BOP - Financial Institution Option CHK - Check ACH -Automated Clearing House (ACH) NON - Non-Payments If Transaction Handle Code (BPR01)is "I" then thisis"CHK" (paper check), otherwise it is"ACH" or "BOP". Note that the following segments BPR05 through BPR15 are only present when this segment is"ACH" or "BOP". If BPR02 is<=0 this segmentshould be "NON". To Send BOP instead ofACH in add the following entry to the table (PAYEE_ID of zero orindividualPAYEE_ ID to use at the Payeelevel): INSERT INTO [UserDB].[dbo].[CAM_835_CONTROL_DATA] VALUES(1, '9600129432', 0, 'PAYMENT_METHOD_CODE', 'BOP')
	BPR05 CCP	Payment Format Code		CCP - Cash Concentration / Disbursement plus Addenda (CCD+) (ACH)

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LOOP	SEGMENT	NAME	VALUE	NOTES
	BPR08	Account Number Qualifier	DA	DA - Demand Deposit
	BPR09	Account Number		PAYMENT_CYCLES.CHECKING_ ACCOUNT
	BPR10	Originating Company Identifier		"1" and PROCESSORS.TAX_ID
	BPR11	Originating Company Supplemental Code		Not Used
	BPR12	DFI ID Number Qualifier	01	01 - ABA transit routing number including check digits (9 digits)
	BPR13	DFI ID Number		PAYEE_EFT_DETAIL.ACH_ ROUTING_NUMBER
	BPR14	Account Number Qualifier	DA, SG	DA - Demand Deposit SG- Savings When PAYEE_EFT_DETAIL.EFT_ ACCOUNT_TYPE = 1 then this is "DA" (Checking), otherwise "SG" (Savings)
	BPR15	Account Number		PAYEE_EFT_DETAIL.EFT_ACCOUNT_ NUMBER
	BPR16	Date		Post date of check (CCYYMMDD). Retrieved from PAYMENT_ CYCLES.PAY_DATE.
	TRN	Reassociation Trace Number		
	TRN01	Trace Type Code	1	1 - Current Transaction Trace Numbers
	TRN02	Reference Identification		If PAYEES.ECHECK_CODE = 1 then the PAYMENT_CYCLE_ PAYEES.CHECK_NUMBERis used. (Note: If the check amount is $0 or negative, then a check number > 9000000000 will be used). If ECHECK_CODE indicates EFT or 835 then a fixed length 15 digit zero (left) padded number is used representing PAYMENT_CYCLE_ID + PAYEE_I D (this formula is used by the EFT process to generate the EFT Trace Number for each payment).
	TRN03	Originating Company Identifier		"1" and PROCESSORS.TAX_ID

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LOOP	SEGMENT	NAME	VALUE	NOTES
	TRN04	Originating Company Supplemental Identifier		A 5 digit ID may be entered for UserDB.CAM_835_CONTROL_DATA with FIELD_NAME of "ORIGINATING_COMPANY_ SUPPLEMENTAL_ID". All values are left padded with 4 zeros to make a 9 digit number.
	CUR	Foreign Currency Information		Not Used
	REF	Receiver Identification		
	REF01	Receiver Identification Qualifier	EV	EV - Reciever Identification Number
	REF02	Receiver Identification		UserDB.CAM_835_CONTROL_DATA with FIELD_NAME of " RECEIVER_ ID_NUMBER"
	REF	Version Identification		
	REF01	Version Identification Qualifier	F2	F2 - Version Code-Local
	REF02	Version Identification		"Version" from the application's web.config file (appSettings section)
	DTM	Production Date		
	DTM01	Date/Time Qualifier	405	405 - Production
	DTM02	Date		Post date of check (CCYYMMDD). Retrieved from PAYMENT_ CYCLES.PAY_DATE.
1000A	N1	Payer Identification		
1000A	N101	Entity Identifier Code	PR	PR - Payer
1000A	N102	Name		NAMEfromPROCESSORStable
1000A	N103	Identification Code Qualifier		Not Used
1000A	N104	Identification Code		Not Used
1000A	N3	Payer Address		From PROCESSOR_CONTACTS table for Contact Type4
1000A	N301	Address		ADDRESS1
1000A	N302	Address		ADDRESS2 if not empty

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LOOP	SEGMENT	NAME	VALUE	NOTES
1000A	N4	Payer City, State, zip Code		
1000A	N401	City Name		CITY
1000A	N402	State or Province Code		STATE
1000A	N403	Postal Code		zIP (+ zIP 4 if not empty)
1000A	REF	Additional Payer Identification		
1000A	REF01	Originating Company Supplemental Identification		A 5 digit ID may be entered for UserDB.CAM_835_CONTROL_DATA with FIELD_NAME of "ORIGINATING_COMPANY_ SUPPLEMENTAL_ID".
1000A	PER	Payer Business Contact Information		
1000A	PER01	Contact Function Code	CX	CX- If a PROCESSOR_CONTACT_ TYPE of Provider Services (1) is defined then this segment will be included (in addition to BL - Technical Department).
1000A	PER02	Name		PROCESSOR_ CONTACTS.CONTACT_NAME if not blank
1000A	PER03	Co mmunicatio n Nu mber Qualifier	FX	FX - Payer's fax number
1000A	PER04	Co mmunication Nu mber		PROCESSOR_CONTACTS.FAX_ PHONE if not blank
1000A	PER05	Co mmunicatio n Nu mber Qualifier	TE	TE - Payer's telephone number
1000A	PER06	Co mmunication Nu mber		PROCESSOR_CONTACTS.VOICE_ PHONE if not blank
1000A	PER07	Co mmunicatio n Nu mber Qualifier	EX	EX - Payer's telephone number extension
1000A	PER08	Co mmunication Nu mber		PROCESSOR_CONTACTS .VOICE_ PHONE_EXTENSION if not blank
1000A	PER	Payer Technical Contact Information		
1000A	PER01	Contact Function Code	BL	BL - Technical Department

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LOOP	SEGMENT	NAME	VALUE	NOTES
1000A	PER02	Name		PROCESSOR_ CONTACTS.CONTACT_NAME if not blank
1000A	PER03	Co mmunicatio n Nu mber Qualifier	FX	FX - Payer's fax number
1000A	PER04	Co mmunication Nu mber		PROCESSOR_CONTACTS.FAX_ PHONE if not blank
1000A	PER05	Co mmunicatio n Nu mber Qualifier	TE	TE - Payer's telephone number
1000A	PER06	Co mmunication Nu mber		PROCESSOR_CONTACTS.VOICE_ PHONE if not blank
1000A	PER07	Co mmunicatio n Nu mber Qualifier	EX	EX - Payer's telephone number extension
1000A	PER08	Co mmunication Nu mber		PROCESSOR_CONTACTS .VOICE_ PHONE_EXTENSION if not blank
1000B	N1	Payee Name		
1000B	N101	Entity Identifier Code	PE	PE- Payee
1000B	N102	Name		Payee name(required when N104 does not contain the NPI)
1000B	N103	Identification Code Qualifier	FI, XX	FI - Federal Taxpayer's Identification Number XX- NPI Qualifier for ID Code (required when N104 does not contain the NPI)
1000B	N104	Identification Code		Payee tax ID or NPI
1000B	N3	Payee Address		
1000B	N301	Address Information		Address 1
1000B	N302	Address Information		Address 2 if not empty
1000B	N4	Payee City, State, zip Code		
1000B	N401	City		City
1000B	N402	State		State
1000B	N403	Postal Code		zip (+ zip4 if not empty)
1000B	N404	Country Code		Not Used

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LOOP	SEGMENT	NAME	VALUE	NOTES
1000B	REF	Payee Additional Identification		Situational. Use only if Payee NPI was sent in N104 and Tax ID is known.
1000B	REF01	Reference Identification Qualifier	TJ	TJ- Federal Taxpayer's Identification Number
1000B	REF02	Additional Payee Identifier		
2000	LX	Header Number		LX before each provider and before each product
2000	LX01	Assigned Number		Increments by 1 starting at 1
2000	TS3	Provider Summary Information		
2000	TS301	Reference Identification		Provider ID
2000	TS302	Facility Type Code		Using '11 for Medical and Dental, '21' for Facilities. Only one of these can exist in a Payment Cycle for a Provider, based on PAYEE.CLAIM_ TYPE
2000	TS303	Date		Set to the last day of the year -ex. 20101231, since this is specified when Provider fiscal years are not tracked.
2000	TS304	Quantity		Total number of claims for this Provider in this cycle.
2000	TS305	Monetary Amount		Total sum of billed amount for all services on all claims. For Facility claims, this amount is the sum of the CHMF.TOTAL_BILLED_ AMOUNTs.
2000	TS306	Monetary Amount		Medicare Use Only
2000	TS307	Monetary Amount		Medicare Use Only
2000	TS308	Monetary Amount		Medicare Use Only
2000	TS309	Monetary Amount		Medicare Use Only
2000	TS310	Monetary Amount		Medicare Use Only
2000	TS311	Monetary Amount		Medicare Use Only
2000	TS312	Monetary Amount		Medicare Use Only
2000	TS313	Monetary Amount		Medicare Use Only

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LOOP	SEGMENT	NAME	VALUE	NOTES
2000	TS314	Monetary Amount		Medicare Use Only
2000	TS315	Monetary Amount		Medicare Use Only
2000	TS316	Monetary Amount		Medicare Use Only
2000	TS317	Monetary Amount		Medicare Use Only
2000	TS318	Monetary Amount		Medicare Use Only
2000	TS319	Monetary Amount		Medicare Use Only
2000	TS320	Monetary Amount		Medicare Use Only
2000	TS321	Monetary Amount		Medicare Use Only
2000	TS322	Monetary Amount		Medicare Use Only
2000	TS323	Quantity		Medicare Use Only
2000	TS324	Monetary Amount		Medicare Use Only
2000	TS2	Transaction Supplemental Statistics		Not Used
2100	CLP	Claim Level Data		
2100	CLP01	Claim Submitter's Identifier		OFFICE_REF_NUMBER (or PATIENT_CONTROL_NUMBER for facility claims). If Patient Account Nu mber has a * it will be removed, a will be replaced with a -.
2100	CLP02	Claim Status Code	1, 2, 4, 22	1 - Pay as Primary 2 - Pay as Secondary 4 - Denied 22 - Adjusted claim
2100	CLP03	Monetary Amount		Total billed amount of all services on all claims.
2100	CLP04	Monetary Amount		Total claim paid amou nt for all services on all claims.
2100	CLP05	Monetary Amount		Total Patient Pay Applied Amount for all services on all claims
2100	CLP06	Claim Filing Indicator Code		Product Code for PPO, HMO, Indemnity, etc. Must be setup in UserDB as value for field name CLAIM_FILING_ INDICATOR_CODE

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LOOP	SEGMENT	NAME	VALUE	NOTES
2100	CLP07	Reference Identification		ENCOUNTER_ID is used to facilitate communications regarding claim
2100	CLP08	Facility Code		Facility Code Value - which is actuallyTOB_FACILITYand TOB_ CLASSIFICATION For facility claims only.
2100	CLP09	Claim Frequency Type Code		TOB_FREQUENCY For facility claims only.
2100	CLP10	Patient Status Code		Not Used
2100	CLP11	DRGCode		DRGValue For facility claims only.
2100	CLP12	Quantity		Not Used
2100	CLP13	DischargeFraction		Not Used
2100	CAS	Claim Adjustment		This segment does not need to be sent because adjustments to claims will always be at the service level
2100	NM1	Patient Name		
2100	NM101	Entity Identifier Code	QC	QC - Patient
2100	NM102	Entity Type Qualifier	1	1 - Person
2100	NM103	Name Last or Organization Name		Patient Last name from Claim
2100	NM104	Name First		Patient First Name from Claim
2100	NM105	Name Middle		Patient Middle initial from claim
2100	NM106	Name Prefix		Not Used
2100	NM107	Name Suffix		Not Used
2100	NM108	Identification Code Qualifier	MI	MI - Member Identification Number
2100	NM109	Identification Code		Member IDisthe SUBSCRIBER_ID + "" + MEMBER_ID from the claim
2100	NM1	Insured Name		This is always provided based on Insured Enrollee ID on the claim
2100	NM101	Entity Identifier Code	IL	IL - Insured or Subscriber

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LOOP	SEGMENT	NAME	VALUE	NOTES
2100	NM102	Entity Type Qualifier	1	Person
2100	NM103	Name Last or Organization Name		Insured's last name from ENROLLEES
2100	NM104	Name First		Insured's first name from ENROLLEES
2100	NM105	Name Middle		Insured's middle initial from ENROLLEES
2100	NM106	Name Prefix		Not Used
2100	NM107	Name Suffix		Not Used
2100	NM108	Identification Code Qualifier	MI	MI - Member Identification Number
2100	NM108	Identification Code		Insured's Member ID is the SUBSCRIBER_ID +" " + MEMBER_ID from ELIGIBILITY, based on Claim DOS. If not Eligible, then last active ELIGIBILITY record isused
2100 2100	NM1 NM1	Corrected Patient/Insured Name Service Provider Name		Not Used. Thissegment is only included when the Rendering Provider is not the Payee. The Enterprise System deduces this by attempting to match the SSN to the Tax ID, as well as looking for an NPI match
2100	NM101	Entity Identifier Code	82	82 - Rendering Provider
2100	NM102	Entity Type Qualifier	1	1 - Person Always indicate a person even if a facility
2100	NM103	Name Last or Organization Name		Servicing provider last name
2100	NM104	Name First		Servicingproviderfirstname
2100	NM105	Name Middle		Servicingprovidermiddleinit ial
2100	NM106	Name Prefix		Not Used
2100	NM107	Name Suffix		Not Used
2100	NM108	Identification Code Qualifier	FI, XX	FI-FederalTaxpayer's Identification Number (Provider's SSN) XX-NPI

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LOOP	SEGMENT	NAME	VALUE	NOTES
2100	NM109	Identification Code		The IRS number or NPI for the provider
2100	DTM	Claim Received Date		
2100	DTM01	Date Time Qualifier	050	050 - Received
2100	DTM02	Date		Date expressed as CCYYMMDD
2100	NM1	Crossover Carrier Name		Not Used
2100	NM1	Corrected Priority Payer Name		Not Used
2100	MIA	Medicare Inpatient Adjudication		Not Used
2100	MOA	Medicare Outpatient Adjudication		Not Used
2100	REF	Other Claim Related Information		Usethis segmenttoreference values stored in "Other Information" fields.
2100	REF01	Reference Identification Code	CE	CE - Class of Contract Code
2100	REF02	Reference Identification	1, 2, 3	1 - CLAIMS_HEADER.ELIG_OTHER_INFO1 2 - CLAIMS_HEADER.ELIG_OTHER_INFO2 3 - CLAIMS_HEADER.ELIG_OTHER_INFO3 Optional. Must be setup in UserDB as value for field name CONTRACT_CODE.
2100	REF	Rendering Provider Identification		Not Used
2100	DTM	Statement From Date		Not Used
2100	PER	Claim Contact Information		Not Used
2100	AMT	Claim Supplemental Information		Optional segment that displays the SUM(BILLED_AMOUNT) for Valid (SERVICE_STATUS = 1) servicesif greater than zero.
2100	AMT01	Amount Qualifier Code		AU

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LOOP	SEGMENT	NAME	VALUE	NOTES
2100	AMT02	Monetary Amount		Covered Charges
2100 2110	QTY SVC	Claim Supplemental Quantity Information Service Information		Not Used
2110	SVC01	Composite Medical Procedure Identifier		
2110	SVC01-1	Product/Service ID Qualifier		Our internal CODE_TYPESare mapped as follows: CASE SH.CODE_TYPE -- map our code types to the ANSIequivalents WHEN 1 THEN'AD' WHEN 2 THEN'HC' WHEN 4 THEN 'NU' WHEN 6 THEN 'ID' WHEN 9 THEN 'ND' WHEN 12 THEN 'NU' ELSE 'HC' END AS PROCEDURE_CODE_TYPE
2110	SVC01-2	Product/Service ID		PROCEDURE_CODE
2110	SVC01-3	Procedure Modifier		Modifi er 1 if supplied
2110	SVC01-4	Procedure Modifier		Modifi er 2 if supplied
2110	SVC01-5	Procedure Modifier		Modifi er 3 if supplied
2110	SVC01-6	Procedure Modifier		Modifi er 4 if supplied
2110	SVC01-7	Description		Not Used
2110	SVC02	Monetary Amount		BILLED_AMOUNT
2110	SVC03	Monetary Amount		PAID_AMOUNT
2110	SVC04	Product/Service ID		Not Used
2110	SVC05	Quantity		QUANTITY_AUTHORIzED
2110	SVC06-1	Product/Service ID Qualifier		Not Used
2110	SVC06-2	Product/Service ID		Not Used
2110	SVC06-3	Procedure Modifier		Not Used
2110	SVC06-4	Procedure Modifier		Not Used

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LOOP	SEGMENT	NAME	VALUE	NOTES
2110	SVC06-5	Procedure Modifier		Not Used
2110	SVC06-6	Procedure Modifier		Not Used
2110	SVC06-7	Description		Not Used
2110	SVC07	Quantity		QUANTITY_BILLED
2110	DTM	Service Date		
2110	DTM01	Date/Time	472	472 - Service
2110	DTM02	Date		Servicedate(CCYYMMDD)
2110	CAS	Service Adjustment		Service Line Adjustments
2110	CAS01	Claim Adjustment Group Code	PR, CO, PI, OA	PR - Patient Responsibility CO - Contractual Obligations PI - Payer Initiat ed Reductions OA- Exceptions or Denials
2110	CAS02	Claim Adjustment Reason Code	See note	PR: 2 - Coinsurance CO: 24 - Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan. 45- Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. PI: 24 - Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan. 45- Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. OA: ANSI_ADJUSTMENT_REASON_ CODE from EXCEPTION_CODES (for exceptions) or REASON_ CODES (for denials)
2110	CAS03	Monetary Amount		
2110	CAS04			Not Used
2110	CAS05			Not Used

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LOOP	SEGMENT	NAME	VALUE	NOTES
2110	CAS06			Not Used
2110	CAS07			Not Used
2110	CAS08			Not Used
2110	CAS09			Not Used
2110	CAS10			Not Used
2110	CAS11			Not Used
2110	CAS12			Not Used
2110	CAS13			Not Used
2110	CAS14			Not Used
2110	CAS15			Not Used
2110	CAS16			Not Used
2110	CAS17			Not Used
2110	CAS18			Not Used
2110	CAS19			Not Used
2110	REF	Service Identification		
2110	REF01	Reference Identification Qualifier	BB	BB - Authorization Number
2110	REF02	Reference Identification		Authorization Nu mber
2110	REF	Line Item Control Number		
2110	REF01	Reference Identification Qualifier	6R	6R - Provider Control Number
2110	REF02	Reference Identification		LINE_ITEM_CONTROL_NUMBER
2110	REF	Rendering Provider Information		Not Used
2110	AMT	Service Supplemental Amount		This segment conveys the allowed amount for valid services
	AMT01	Amount Qualifier Code	B6	B6 - Allowed Amount

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LOOP	SEGMENT	NAME	VALUE	NOTES
	AMT02	Monetary Amount		Decimal elements will be limited to a maximum of 10 characters including reported or implied places for cents.
2110	QTY	Service Supplemental Quantity		Not Used
2110	LQ	Health Care Remark Codes		
	LQ01	Code List Qualifier Code	HE	HE - Claim Payment Remark Codes
	LQ02	Industry Code		RemittanceAdviceRemark Codes are used to provide additional explanation for an adjustment already described by a Claim AdjustmentReason Code.
	PLB	Provider Adjustment		
	PLB01	Reference Identification		ADDITIONAL COMPENSATION, CAPITATION,CAPITATION ADJUSTMENTS (retro terminations), CAPITATION ADJUSTMENTS (retro adds) PAYEE_ID +'P'+PROVIDER_ID OR PAYEE_ID + 'L' + LOCATION_ID OR PAYEE_ID+'F'+FACILITY_ID PAYEE ADJUSTMENTS PAYEE_ID
	PLB02	Date		PAYMENT_CYCLES.PAY_DATE
	PLB03 - 1	AdjustmentReason Code		ADDITIONAL COMPENSATION CASE ADDITIONAL_ COMPENSATION.COMPENSATION_ TYPE WHEN 1 THEN 'PI' WHEN 2 THEN '90' WHEN 3 THEN 'BN' ELSE 'zz' END CAPITATION 'CT' CAPITATION ADJUSTMENTS (retro terminations), CAPITATION ADJUSTMENTS(retro adds) 'RA' PAYEEADJUSTMENTS ADJUSTMENT_CODES.ANSI_ ADJUSTMENT_REASON_CODE

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LOOP	SEGMENT	NAME	VALUE	NOTES
	PLB03 - 2	Reference Identification		ADDITIONAL COMPENSATION 'Additional Compensation' CAPITATION 'Capitation' CAPITATION ADJUSTMENTS (retro terminations) 'Capitation Adjustment - Terms' CAPITATION ADJUSTMENTS (retro adds) 'Capitation Adjustment - Adds' PAYEE ADJUSTMENTS 'Payee Adjustment'
	PLB04	Monetary Amount		(negative)
	PLB05-1	Adjustment Reason Code		Not Used
	PLB05 - 2	Reference Identification		Not Used
	PLB06	Monetary Amount		Not Used
	PLB07 - 1	Adjustment Reason Code		Not Used
	PLB07 - 2	Reference Identification		Not Used
	PLB08	Monetary Amount		Not Used
	PLB09-1	Adjustment Reason Code		Not Used
	PLB09-2	Reference Identification		Not Used
	PLB10	Monetary Amount		Not Used
	PLB11 - 1	Adjustment Reason Code		Not Used
	PLB11 - 2	Reference Identification		Not Used
	PLB12	Monetary Amount		Not Used
	PLB13 - 1	Adjustment Reason Code		Not Used
	PLB13 - 2	Reference Identification		Not Used
	PLB14	Monetary Amount		Not Used
	SE	Transaction Set Trailer		

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LOOP	SEGMENT	NAME	VALUE	NOTES
	SE01	Number of Included Segments		Total segment count including ST/SE segments.
	SE02	Transaction Set Control Number		Starts at "0001" and increments with each new Transaction Set
	GE	Functional Group Trailer		
	GE01	Number of Transaction Sets Included		Total count of Transaction Sets
	GE02	Group Control Number		Starts at 1 and increments with each new Group
	IEA	Interchange Control Number		
	IEA01	Number of Included Functional Groups		Total count of Groups
	IEA02	Interchange Control Number	yMMddHHmm	

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8. APPENDICES

8.1. IMPLEMENTATION CHECKLIST

The following provides high level check lists for the connectivity set up process:

Trading Partner contacts OptumInsight
(Type of connection is determined)
Trading Partner Agreement/Contract is signed
Trading Partner Connection is established
(Routing ID is assigned, passwords identified, and connection is set up)
Trading Partner submits 835 Enrollment form
(Includes the health care professional Taxid's to be set up)
835 Enrollment is completed
Trading Partner may utilize the 835 files for Testing but is not required.
(835 files will be actual production files for the health care provider's Federal Taxpayer ID unless testing the conversion to ASC X12/005010X221A1).

8.2. FREQUENTLY ASKED QUESTIONS

1. What is HIPAA?

It is the acronym for the **H**ealth **I**nsurance **P**ortability & **A**ccountability **A**ct of 1996, Public Law 104-191. HIPAA is intended to improve the efficiency of the healthcare system by standardizing the electronic transmission of health information.

2. Who do the HIPAA standards apply to?

Health plans, health care providers, health care clearinghouses, employee benefits plans, dental & plans, public health authorities, life insurers, billing agencies, information system vendors are all considered covered entities. (Spectera is a covered entity.)

3. Does this Companion Guide apply to all Spectera Specialty Benefits payers?

No. The changes will apply to commercial and government business for **Spectera** using payer ID 00773.

4. How does Spectera support, monitor, and communicate expected and unexpected connectivity outages?

Our systems do have planned outages. For the most part, transactions will be queued during those outages. We will send an email communication for scheduled and unplanned outages.

5. If enrolled to receive the 835 transaction will the paper PRA (Provider Remittance Advice) still be mailed to the provider?

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835 enrollments will not impact the delivery of the PRA. The PRA delivery is impacted by enrollment in EPS for those transactions where payment is made electronically. PRA's for EPS transactions can be still viewed on www.spectera.com and will not be mailed.

6. Does Spectera provide HRA (Health Reserve Account) or HSA (Health Savings Account) claim payments in the 835transactions?

No. Payments from HRA/HSA accounts are not reported in the 835 transaction.

***7. Does this companion guide apply to all Spectera Payers*?**

No. This companion guide will apply to Spectera Vision business using payer code 00773.

8. Why are the claim adjustment reason codes different than the adjustment codes on the PRA?

The adjustment codes reported in the 835 transaction are from the National Claim Adjustment Reason Code list. In most instances the Spectera proprietary adjustment codes are reported on the PRA.

9. If a claim is closed for additional information will the closed claim be reported in the 835?

No. Spectera only reports claims that are paid or denied are reported in the 835.

10. Does enrollment to receive the 835 transaction impact the payment cycle?

No, the generation of the 835 transaction will mirror the current payment cycle for the physician or health care professional.

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