X12 Standards for Electronic Data Interchange
Technical Report Type 3

# Health Care Claim Payment Advice (835)

## Change Log : 005010 - 007030

MARCH 2019

PUBLIC REVIEW DRAFT

## Intellectual Property

X12 holds the copyright on the Standards and associated publications designed to facilitate implementation of the Standards. Users of all X12 publications should be aware of the permissible uses, as well as the limitations on such usage, as outlined here: http://store.x12.org/store/ip-use.

Copyright © 2019, X12, Format © 2019 Washington Publishing Company. Exclusively published by the Washington Publishing Company. No part of this publication may be distributed, posted, reproduced, stored in a retrieval system, or transmitted in any form or by any means without the prior written permission of the copyright owner.

All rights reserved.

## New Loops/Segments

For new loops, the change log will only reflect the new loop identifier and name and associated segments. For new segments added to existing loops, the change log will only reflect the segment name.

## Non-substantive Changes

Changes considered by the work group to be non-substantive in nature will not appear in the change log. This includes changes to correct typographical or grammatical errors, updated examples, reformatted text, updated industry names, and modifications to rules and notes either for consistency across TR3s or for proper textual construct that did not change the note's original intent.

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice<br>1.3 Implementation Limitations |
| Action | **Modify Chapter 1**<br>Section 1.3.1 Batch and Real-Time Usage 7030 content Paragraph 4 |
| CR 1037 | Incorporate real-time claim processing and adjudication information in the TR3. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice<br>1.4 Business Usage |
| Action | **Modify Chapter 1**<br>Section 1.4.2 Information Flows, paragraph 1 |
| CR 1265 | Allow for card payments (p-card, debit card, and credit card) within the 835 and related X12 transactions so remittance information can be conveyed electronically in these scenarios. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice<br>1.5 Business Terminology |
| Action | **Add Chapter 1**<br>Section 1.5 Business Terminology<br><br>New Term Added:<br>IISRC - Insurance industry Specific Remark Codes |
| CR 1234 | Create new external code list for industry specific remark codes that do not meet the criteria for CARCs or RARCs but are needed by their respective industries. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice<br>1.5 Business Terminology |
| Action | **Modify Chapter 1**<br>Section 1.5 Business Terminology |

| | |
|---|---|
| | Add: Real Time Adjudication |
| CR 1037 | Incorporate real-time claim processing and adjudication information in the TR3. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice<br>1.5 Business Terminology |
| Action | **Modify Chapter 1**<br>Section 1.5 Business Terminology, add:<br>Real Time Predetermination/Estimation |
| CR 1037 | Incorporate real-time claim processing and adjudication information in the TR3. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice<br>1.5 Business Terminology |
| Action | **Modify Chapter 1**<br>Section 1.5 Business Terminology<br>Add Self-Insured Plan |
| CR 1499 | Section 1.5 - Change term for existing definition of "Plan" to "Self-insured Plan". Add a more generic "Plan" definition describing all plans. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice<br>1.5 Business Terminology |
| Action | **Modify Chapter 1**<br>Section 1.5 Business Terminology<br><br>Add: Forced balancing |
| CR 1076 | Guidance to payers (front matter section) on how to handle out of balance situations, include info from Operating rules |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice<br>1.10 Data Overview |
| Action | **Modify Chapter 1**<br>Section 1.10.1.3 Electronic Funds Transfer - revise entire section |
| CR 1450 | 835 Front matter section 1.10.1.3 includes a table listing file formats for various stages of the payment process, and 2 notes to the table. This table needs to be reviewed based upon the new EFT requirements, and the NOTES included need to be revised as it is confusing having 2 separate notes. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice<br>1.10 Data Overview |
| Action | **Delete Chapter 1**<br>Section 1.10.2.4.2 Claim/Service Adjustment Information Segment, Bulleted List. |

| | |
|---|---|
| | - the entire claim submitted charge is being adjusted by this RAS segment<br><br>- and there are multiple adjustment reasons that are each applicable for the adjustment of that full amount in RAS01. |
| CR 1079 | Provide additional explanation related to the correct use of the RAS segment. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice<br>1.10 Data Overview |
| Action | **Modify Chapter 1**<br>Section 1.10.2.12 Balance Forward and section 1.10.2.17 Claim Overpayment Recovery - revise entire section |
| CR 1034 | Review front matter section 1.10.2.17 Overpayment Recovery and re-evaluate the directions for the industry. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice<br>1.10 Data Overview |
| Action | **Add Chapter 1**<br>Section 1.10.2.24 Data Integrity - Add new section |
| CR 1072 | Need to add to front matter section language that clarifies 835 must be compliant regardless of the source of the claim input.<br>Include guidance on what to do if receive invalid data on the claim, what to put in the 835 |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice<br>1.10 Data Overview |
| Action | **Modify Chapter 1**<br>Section 1.10.2.25 Real-Time Claim Processing - add new section |
| CR 1037 | Incorporate real-time claim processing and adjudication information in the TR3. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice<br>1.10 Data Overview |
| Action | **Modify Chapter 1**<br>Section 1.10.1.2.6 ERA with Payment by Card, add new section |
| CR 1265 | Allow for card payments (p-card, debit card, and credit card) within the 835 and related X12 transactions so remittance information can be conveyed electronically in these scenarios. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice<br>1.10 Data Overview |
| Action | **Modify Chapter 1**<br>Section 1.10.1.4 Card Payments in the 835 - add new section |
| CR 1265 | Allow for card payments (p-card, debit card, and credit card) within the 835 and related X12 transactions so remittance information can be conveyed |

| | |
|---|---|
| | electronically in these scenarios. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice<br>1.10 Data Overview |
| Action | **Modify Chapter 1**<br>Section 1.10.2.27 Claim Status Code Usage - add new section |
| CR 1035 | Please clarify what value to use for CLP02 when a payer denies the claim because they are not the primary payer and provide direction on how to report the priority of the payer based on the order they hold for the member's total insurance package. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice<br>1.10 Data Overview |
| Action | **Modify Chapter 1**<br>Section 1.10.2.26 Funds Not Available - add new section |
| CR 1070 | Payer has no money to pay the RA but has an 835 created. Need direction/rule on what to do with the 835.<br><br>Front matter section - giving guidance on how to handle the 835 in this situation.<br>Providers and payers across the industry need direction.<br>Providers tend to not post the 835 until the money has been received. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice<br>1.10 Data Overview |
| Action | **Modify Chapter 1**<br>1.10.2.21 835 Message Matching - add new section |
| CR 1153 | To clarify intended use. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice<br>1.10 Data Overview |
| Action | **Modify Chapter 1**<br>Section 1.10.2.13 Secondary Payment Reporting Considerations - revise entire section |
| CR 1096 | Update Section 1.10.2.13 Secondary Payment Reporting Considerations to clarify how amounts are reported for COB payments. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice<br>1.10 Data Overview |
| Action | **Modify Chapter 1**<br>Section 1.10.2.1.1 Service Line Balancing - revise entire section |
| CR 1103 | Front Matter section on balancing for professional claims - refine rules to report RAS ONLY at service level. Need stronger language to force professional claims to be service line only. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice<br>1.10 Data Overview |
| Action | **Modify Chapter 1**<br>1.10.2.1.2 Claim Balancing - last paragraph |
| CR 1461 | Need clarification to ensure understanding of the use of all existing Group Codes. It is not always completely clear when to use CO versus OA, for example, so descriptions need to be reviewed and clarified to eliminate confusion. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice<br>1.10 Data Overview |
| Action | **Modify Chapter 1**<br>Section 1.10.2.4.3 Claim Adjustment Reason Code (CARC) Usage - revise entire section |
| CR 1466 | Section 1.10.2.13 includes a definition of CARC 23 which does not match the currect CARC description. In addition, an update to that description has been proposed. The front matter section should be updated to reflect the correct CARC description. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice<br>1.10 Data Overview |
| Action | **Modify Chapter 1**<br>Section 1.10.2.4.4 Remark Codes - Revise entire section |
| CR 1466 | Section 1.10.2.13 includes a definition of CARC 23 which does not match the currect CARC description. In addition, an update to that description has been proposed. The front matter section should be updated to reflect the correct CARC description. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice<br>1.10 Data Overview |
| Action | **Modify Chapter 1**<br>1.10.2.6 Procedure Code Bundling and Unbundling, paragraph 4 |
| CR 1461 | Need clarification to ensure understanding of the use of all existing Group Codes. It is not always completely clear when to use CO versus OA, for example, so descriptions need to be reviewed and clarified to eliminate confusion. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice<br>1.10 Data Overview |
| Action | **Modify Chapter 1**<br>Section 1.10.2.6 Procedure Code Bundling and Unbundling, Bundling Example |
| CR 1091 | The Bundling section states to adjust off the non-paying service lines using the RAS segment, and the example shows the SVC reporting "0" paid units. But, |

| | |
|---|---|
| | the RAS segment instructions and example don't include usage of the RAS quantity. Since we have added instructions about the quantity usage at other places, shouldn't we include it here? From an implicit balancing perspective, we should be stating to use the RAS Adjustment Quantity with the OA*94 adjustment to reduce the units to zero for each of the services that aren't paying. Only the primary service line that includes the payment shows paying units and the others should balance out appropriately. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice<br>1.10 Data Overview |
| Action | **Modify Chapter 1**<br>1.10.2.7 Predetermination of Benefits Paragraph 1 - revise entire section |
| CR 1461 | Need clarification to ensure understanding of the use of all existing Group Codes. It is not always completely clear when to use CO versus OA, for example, so descriptions need to be reviewed and clarified to eliminate confusion. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice<br>1.10 Data Overview |
| Action | **Modify Chapter 1**<br>Section 1.10.2.10 Capitation and Related Payments or Adjustments paragraph 1 |
| CR 1427 | Wording should be reviewed and corrected in section 1.10.2.10 where there is a reference to the 271 transaction's Reassociation Key Segment, which doesn't exist. In a future guide this should be updated to point to the TRN - Information Source Trace number. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice<br>1.10 Data Overview |
| Action | **Modify Chapter 1**<br>Section 1.10.2.10 Capitation and Related Payments or Adjustments paragraph 4 |
| CR 1427 | Wording should be reviewed and corrected in section 1.10.2.10 where there is a reference to the 271 transaction's Reassociation Key Segment, which doesn't exist. In a future guide this should be updated to point to the TRN - Information Source Trace number. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice<br>1.10 Data Overview |
| Action | **Modify Chapter 1**<br>Section 1.10.2.15 PPOs, Networks and Contract Types, Paragraph 3 |
| CR 1461 | Need clarification to ensure understanding of the use of all existing Group Codes. It is not always completely clear when to use CO versus OA, for example, so descriptions need to be reviewed and clarified to eliminate |

confusion.

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice<br>1.10 Data Overview |
| Action | **Modify Chapter 1**<br>1.10.2.22 Billing Provider as Payee - revise entire section |
| CR 1074 | Section 1.10.2.22 Billing Provider as Payee, Review direction of NPI. Offer more direction, include information from operating rules as applicable. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice<br>1.10 Data Overview |
| Action | **Delete Chapter 1**<br>Section 1.10.2.8 Reversals and Corrections, Paragraph 8.<br><br>For the reversal, include any Supplemental Claim Information (AMT) segment iterations from the original claim payment that relate to interest (use code I) or prompt payment discount (use code D8). Negate the dollar amount reported on the original claim adjudication. These reversed interest and prompt payment discount entries must be included in the net interest and prompt payment discount payments in the PLB segment. Do not report any other Claim Information (AMT) segments in the reversal claim. See Section 1.10.2.9 - Interest and Prompt Payment Discounts, for additional information. |
| CR 1230 | Provide payers the ability to report the allowed amount for informational purposes for coordination of benefits. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice<br>1.10 Data Overview |
| Action | **Delete Chapter 1**<br>Section 1.10.2.8 Reversals and Corrections, Paragraph 9.<br><br>NOTE<br>The reversal does not contain any patient responsibility amount in CLP. |
| CR 1230 | Provide payers the ability to report the allowed amount for informational purposes for coordination of benefits. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice<br>1.10 Data Overview |
| Action | **Delete Chapter 1**<br>Section 1.10.2.8 Reversals and Corrections, Paragraph 10.<br><br>The corrected claim payment is provided as if it were the original payment. This must include any revised, non-zero, interest or prompt payment discount values in the Supplemental Claim Information (AMT) segment. |

| | |
|---|---|
| CR 1230 | Provide payers the ability to report the allowed amount for informational purposes for coordination of benefits. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice<br>1.10 Data Overview |
| Action | **Add Chapter 1**<br>Section 1.10.2.20 Retroactive Claim Adjustments |
| CR 644 | Add front matter section detailing the use of RARC codes that were created to be used for Retroactive Claim Adjustments. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice<br>1.10 Data Overview |
| Action | **Delete Chapter 1**<br>1.10.2.10 Capitation and Related Payments or Adjustments, bulleted item 2. |
| CR 1153 | To clarify intended use. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice<br>1.10 Data Overview |
| Action | **Modify Chapter 1**<br>1.10.3.1 835 Message Matching, paragraph 3. |
| CR 1153 | To clarify intended use. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice<br>1.10 Data Overview |
| Action | **Delete Chapter 1**<br>1.10.3.1 835 Message Matching, paragraph 5. |
| CR 1153 | To clarify intended use. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice<br>1.10 Data Overview |
| Action | **Modify Chapter 1**<br>1.10.3.1 835 Message Matching, paragraph 6. |
| CR 1153 | To clarify intended use. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0100<br>ST - Transaction Set Header |
| Action | **Modify Data Element Usage**<br>ST03 Change from Not Used to Required |
| CR 1338 | To promote consistency across all guides. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0200<br>BPR - Financial Information |

| | |
|---|---|
| Action | **Add Data Element Code Value**<br>BPR01 Add qualifier K (Reimbursement to Follow) with code note for use with Real-Time Adjudication. |
| CR 1564 | To enhance transaction functionality |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0200<br>BPR - Financial Information |
| Action | **Modify Data Element Code Note**<br>Header/BPR03 (Credit/Debit Flag Code)<br><br>C - Credit - Added instructions for card payments. |
| CR 1265 | Allow for card payments (p-card, debit card, and credit card) within the 835 and related X12 transactions so remittance information can be conveyed electronically in these scenarios. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0200<br>BPR - Financial Information |
| Action | **Modify Data Element Code Note**<br>Header/BPR03 (Credit/Debit Flag Code)<br><br>D - Debit - Added instructions for card payments. |
| CR 1265 | Allow for card payments (p-card, debit card, and credit card) within the 835 and related X12 transactions so remittance information can be conveyed electronically in these scenarios. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0200<br>BPR - Financial Information |
| Action | **Add Data Element Code Value**<br>Header/BPR04 (Payment Method Code)<br><br>CCC - Credit Card, with code notes. |
| CR 1265 | Allow for card payments (p-card, debit card, and credit card) within the 835 and related X12 transactions so remittance information can be conveyed electronically in these scenarios. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0200<br>BPR - Financial Information |
| Action | **Add Data Element Code Value**<br>Header/BPR04 (Payment Method Code)<br><br>DEB - Debit Card, with code notes. |
| CR 1265 | Allow for card payments (p-card, debit card, and credit card) within the 835 and related X12 transactions so remittance information can be conveyed electronically in these scenarios. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0200<br>BPR - Financial Information |
| Action | **Modify Data Element Code Note**<br>Header/BPR04 (Payment Method Code) BOP (Financial Institution Option) - Update note to clarify Third Party Processor actions needed. |
| CR 1458 | In BPR04, the notes for qualifiers ACH, BOP, and FWT all contain the following sentence: "When this code is used, see BPR05 through BPR15 for additional requirements." This sentence is not accurate in all cases - BPR05 is only allowed / required when BPR04 = ACH. In addition, this sentence is redundant, as each of the subsequent elements that are referenced contain notes indicating what is required. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0200<br>BPR - Financial Information |
| Action | **Modify Data Element Note**<br>Header BPR13<br><br>Modified data element note for clarity. |
| CR 1672 | Some data elements need to be revised for consistency and to clarify the workgroup's intent, including the names, usage, situational rules, Implementation/Industry names and data element notes. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0200<br>BPR - Financial Information |
| Action | **Modify Data Element Note**<br>Header BPR07<br><br>Modified data element note for clarity. |
| CR 1672 | Some data elements need to be revised for consistency and to clarify the workgroup's intent, including the names, usage, situational rules, Implementation/Industry names and data element notes. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0400<br>TRN - Reassociation Trace Number |
| Action | **Modify Segment Example**<br>TRN Segment Example<br><br>Modified TRN04 to match BPR11 of the BPR example. |
| CR 1671 | Some segments need to be revised for consistency and to clarify the workgroup's intent, including the usage, situational rules, TR3 Notes, and examples. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0400<br>TRN - Reassociation Trace Number |

| | |
|---|---|
| Action | **Modify Data Element Industry Name**<br>Header/TRN02 (Reference Identification)<br><br>Added information for card payments |
| CR 1265 | Allow for card payments (p-card, debit card, and credit card) within the 835 and related X12 transactions so remittance information can be conveyed electronically in these scenarios. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0400<br>TRN - Reassociation Trace Number |
| Action | **Add Data Element Note**<br>TRN02 - add note on size restriction |
| CR 1153 | To clarify intended use. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0400<br>TRN - Reassociation Trace Number |
| Action | **Modify Data Element Note**<br>Header/TRN02 (Reference Identification)<br><br>Added instructions for EFT, BOP, and card payments |
| CR 1265 | Allow for card payments (p-card, debit card, and credit card) within the 835 and related X12 transactions so remittance information can be conveyed electronically in these scenarios. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0400<br>TRN - Reassociation Trace Number |
| Action | **Modify Data Element Note**<br>Header TRN04<br><br>Modified data element note for clarity. |
| CR 1672 | Some data elements need to be revised for consistency and to clarify the workgroup's intent, including the names, usage, situational rules, Implementation/Industry names and data element notes. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0600<br>REF - Version Identification |
| Action | **Delete Segment**<br>Removed the REF- Version Identification from Table 1 - Header |
| CR 1045 | Remove the REF Version ID segment from Header loop since there is no longer a need for this information per the members of WG3. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0600<br>REF - Card Security Verification Code |

| | |
|---|---|
| Action | **Add Segment**<br>Header / REF (Card Security Verification Code) - Add segment as situational, with situational rule, and qualifier AFC (Verification Source Code) |
| CR 1265 | Allow for card payments (p-card, debit card, and credit card) within the 835 and related X12 transactions so remittance information can be conveyed electronically in these scenarios. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0700<br>DTM - Card Expiration Date |
| Action | **Add Segment**<br>Header / DTM (Card Expiration Date) - Add Segment, Segment Situational Rule, Data Element DTM01 qualifier 036 (Expiration) with note, and DTM02 note |
| CR 1265 | Allow for card payments (p-card, debit card, and credit card) within the 835 and related X12 transactions so remittance information can be conveyed electronically in these scenarios. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0800 \| 1000A<br>N1 - Payer Identification |
| Action | **Add Data Element Note**<br>Loop ID 1000A / N102 - Add Note reflecting the Operating Rule requirements |
| CR 1101 | N1 Payer Name - Name the provider knows the payer by, match the CCD+<br><br>NACHA Operating Rules update requires the Payer Name in the CCD+ file to be the name the provider will recognize, the name the provider knows the payer by. Name listed in the 835 should match this name. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0800 \| 1000A<br>N1 - Payer Identification |
| Action | **Modify Data Element Situational Rule**<br>N103 Identification Code Qualifier - Update note to reflect relationship to N104. |
| CR 1478 | A situational rule should not be duplicated on both the qualifying element and the element reporting the actual value (e.g., NM108 and NM109). Apply the situational rule on the element containing the value with the qualifying element required when the value is used. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 1200 \| 1000A<br>REF - Additional Payer Identification |
| Action | **Modify Segment Repeat**<br>Loop ID 1000A / REF (Additional Payer Identification)<br><br>Repeat changed from 4 to 3. |
| CR 1542 | Improve the consistency of the code value notes within and across the TR3s. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 1200 \| 1000A<br>REF - Additional Payer Identification |
| Action | **Modify Data Element Code Note**<br>Loop ID 1000A / REF01 (Reference Identification Qualifier)<br><br>2U (Payer Identification Number)<br>- removed references to specific payers, clarified use for legacy payer IDs |
| CR 1542 | Improve the consistency of the code value notes within and across the TR3s. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 1200 \| 1000A<br>REF - Additional Payer Identification |
| Action | **Delete Data Element Code Value**<br>Loop ID 1000A / REF01 (Reference Identification Qualifier)<br><br>EO (Submitter Identification Number) |
| CR 1542 | Improve the consistency of the code value notes within and across the TR3s. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 1200 \| 1000A<br>REF - Additional Payer Identification |
| Action | **Delete Data Element Code Note**<br>Loop ID 1000A / REF01 (Reference Identification Qualifier)<br><br>NF (National Association of Insurance Commissioners (NAIC) Code)<br><br>Removed: This is the preferred value when identifying the payer. |
| CR 1542 | Improve the consistency of the code value notes within and across the TR3s. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 1300 \| 1000A<br>PER - Payer Business Contact Information |
| Action | **Modify Segment Repeat**<br>Loop ID 1000A PER (Payer Business Contact) - Modified Segment Repeat from 1 to 2 |
| CR 132 | 1000A Payer Technical and Business Contact PER Segments need notes reflecting the relationship between PER02 and PER04. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 1300 \| 1000A<br>PER - Payer Business Contact Information |
| Action | **Modify Data Element Usage**<br>Loop ID 1000A / PER03, - Update PER03 to Required |
| CR 132 | 1000A Payer Technical and Business Contact PER Segments need notes reflecting the relationship between PER02 and PER04. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 1300 \| 1000A<br>PER - Payer Business Contact Information |

| | |
|---|---|
| Action | **Modify Data Element Usage**<br>Loop ID 1000A / PER04, - Update PER04 to Required |
| CR 132 | 1000A Payer Technical and Business Contact PER Segments need notes reflecting the relationship between PER02 and PER04. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 1300 \| 1000A<br>PER - Payer Business Contact Information |
| Action | **Modify Data Element Situational Rule**<br>Changed to "Required when PER03 is used and a contact communication number is to be transmitted. If not required by this implementation guide, do not send." |
| CR 132 | 1000A Payer Technical and Business Contact PER Segments need notes reflecting the relationship between PER02 and PER04. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 1300 \| 1000A<br>PER - Payer Technical Contact Information |
| Action | **Modify Segment Repeat**<br>Loop ID 1000A PER (Payer Technical Contact) - Modify Segment Repeat from >1 to 2 |
| CR 132 | 1000A Payer Technical and Business Contact PER Segments need notes reflecting the relationship between PER02 and PER04. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 1300 \| 1000A<br>PER - Payer Technical Contact Information |
| Action | **Add Segment Note**<br>Loop ID 1000A / PER (Payer Technical Contact Information) - Add Segment Note regarding format of telephone information. |
| CR 132 | 1000A Payer Technical and Business Contact PER Segments need notes reflecting the relationship between PER02 and PER04. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 1300 \| 1000A<br>PER - Payer Technical Contact Information |
| Action | **Modify Data Element Usage**<br>Loop ID 1000A / PER (Payer Technical Contact Information) PER03 - Update PER03 to Required |
| CR 132 | 1000A Payer Technical and Business Contact PER Segments need notes reflecting the relationship between PER02 and PER04. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 1300 \| 1000A<br>PER - Payer Technical Contact Information |
| Action | **Modify Data Element Usage**<br>Loop ID 1000A / PER (Payer Technical Contact Information) PER04 - Update PER04 to Required |

| | |
|---|---|
| CR 132 | 1000A Payer Technical and Business Contact PER Segments need notes reflecting the relationship between PER02 and PER04. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 1300 \| 1000A<br>PER - Payer Technical Contact Information |
| Action | **Delete Data Element Code Note**<br>Loop ID 1000A / PER03 (Communication Number Qualifier<br><br>TE (Telephone)<br><br>Removed: Recommended. |
| CR 1542 | Improve the consistency of the code value notes within and across the TR3s. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 1300 \| 1000A<br>PER - Payer Technical Contact Information |
| Action | **Modify Data Element Situational Rule**<br>Changed to "Required when PER03 is used and a contact communication number is to be transmitted. If not required by this implementation guide, do not send." |
| CR 132 | 1000A Payer Technical and Business Contact PER Segments need notes reflecting the relationship between PER02 and PER04. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 1300 \| 1000A<br>PER - Payer Website Contact Information |
| Action | **Modify Segment Name**<br>Loop ID 1000A PER - Payer Website Contact Information: Update Segment Name to include "Contact Information |
| CR 1367 | To enable the use of the PER segment for notification claims and payment determination methodology. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 1300 \| 1000A<br>PER - Payer Website Contact Information |
| Action | **Modify Segment Repeat**<br>Loop ID 1000A PER (Payer Website Contact Information) Modify Segment Repeat from 1 to 2 |
| CR 1367 | To enable the use of the PER segment for notification claims and payment determination methodology. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 1300 \| 1000A<br>PER - Payer Website Contact Information |
| Action | **Modify Segment Situational Rule**<br>Loop ID 1000A PER - Payer Website Contact Information: Update Segment Situational Rule to include relationships to REF segments. |

| | |
|---|---|
| CR 1367 | To enable the use of the PER segment for notification claims and payment determination methodology. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 1300 \| 1000A<br>PER - Payer Website Contact Information |
| Action | **Add Segment Note**<br>Loop ID 1000A PER (Payer Website Contact Information) Add Segment Notes |
| CR 1367 | To enable the use of the PER segment for notification claims and payment determination methodology. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0800 \| 1000B<br>N1 - Payee Identification |
| Action | **Modify Data Element Usage**<br>Loop ID 1000B N1 (Payee Identification) N103 - Update to Situational with Situational Rule update to reflect relationship to N104 |
| CR 1102 | Strengthen rule requiring Tax ID in the 835 when it is not the primary identifier of the payee. If the TIN is not the primary ID in the N1, there is still a need for TIN as Payee Additional Identifier for Tax reporting and 1099 processing because this is a financial transaction. The REF*TJ must be reported to include the TIN in the 835. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0800 \| 1000B<br>N1 - Payee Identification |
| Action | **Add Data Element Note**<br>Loop ID 1000B N1 (Payee Identification) N103 - Add Data Element Note referring to front matter section 1.10.2.22 |
| CR 1153 | To clarify intended use. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0800 \| 1000B<br>N1 - Payee Identification |
| Action | **Modify Data Element Code Value**<br>Loop ID 1000B N1 (Payee Identification) N103 - Remove code value FI. Code Value XX - Remove Note. Code Value XV Update note to include HPID and OEID. |
| CR 1102 | Strengthen rule requiring Tax ID in the 835 when it is not the primary identifier of the payee. If the TIN is not the primary ID in the N1, there is still a need for TIN as Payee Additional Identifier for Tax reporting and 1099 processing because this is a financial transaction. The REF*TJ must be reported to include the TIN in the 835. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0800 \| 1000B<br>N1 - Payee Identification |
| Action | **Modify Data Element Usage**<br>Loop ID 1000B N1 (Payee Identification) N104 - Update to Situational, Add situational rule |

CR 1102 Strengthen rule requiring Tax ID in the 835 when it is not the primary identifier of the payee. If the TIN is not the primary ID in the N1, there is still a need for TIN as Payee Additional Identifier for Tax reporting and 1099 processing because this is a financial transaction. The REF*TJ must be reported to include the TIN in the 835.

---

Location X322 | Health Care Claim Payment/Advice | 835 | 1000 | 1000B
N3 - Payee Address

Action **Modify Segment Situational Rule**
Loop ID 1000B N3 and N4 - Update Segment Situational Rule to add relationship to BPR and RDM

CR 684 1000B N4 segment (Payee City, State, Zip) - Change to Situational and require when a physical address is needed to communicate the payee address to the transaction receiver.

---

Location X322 | Health Care Claim Payment/Advice | 835 | 1100 | 1000B
N4 - Payee City, State, ZIP Code

Action **Modify Segment Situational Rule**
Loop ID 1000B N3 and N4 - Update Segment Situational Rule to add relationship to BPR and RDM

CR 684 1000B N4 segment (Payee City, State, Zip) - Change to Situational and require when a physical address is needed to communicate the payee address to the transaction receiver.

---

Location X322 | Health Care Claim Payment/Advice | 835 | 1200 | 1000B
REF - Payee Additional Identification

Action **Modify Segment Repeat**
Loop ID 1000B REF Payee Additional Identification update repeats to 3

CR 1205 Modify the repeat count to match the number of qualifiers available for use.

---

Location X322 | Health Care Claim Payment/Advice | 835 | 1200 | 1000B
REF - Payee Additional Identification

Action **Delete Data Element Code Value**
REF- Payee Additional Identification: Delete code TJ. Code TJ (Federal Taxpayer's Identification Number) is moved to the new REF - Payee Tax Identification Segment

CR 1102 Strengthen rule requiring Tax ID in the 835 when it is not the primary identifier of the payee. If the TIN is not the primary ID in the N1, there is still a need for TIN as Payee Additional Identifier for Tax reporting and 1099 processing because this is a financial transaction. The REF*TJ must be reported to include the TIN in the 835.

---

Location X322 | Health Care Claim Payment/Advice | 835 | 1400 | 1000B
RDM - Remittance Delivery Method

| | |
|---|---|
| Action | **Modify Segment Situational Rule**<br>Loop ID 1000B RDM Update Segment Situational Rule to remove requirement for payers to instruct banks |
| CR 1153 | To clarify intended use. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 1400 \| 1000B<br>RDM - Remittance Delivery Method |
| Action | **Modify Segment Note**<br>Loop ID 1000B RDM - Update Segment Note to reflect that both Payer and Payee must coordinate on remittance delivery |
| CR 1153 | To clarify intended use. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0050 \| 2000<br>TS3 - Provider Summary Information |
| Action | **Modify Segment Situational Rule**<br>TS3 - Modify Segment Situational Rule to remove requirement for Medicare Part A |
| CR 669 | Modify TS3 Segment Situational Rule to remove reference to Medicare as there are other situations where this segment is needed. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0050 \| 2000<br>TS3 - Provider Summary Information |
| Action | **Modify Data Element Note**<br>TS304 - Data Element Note updated to clarify definition of total number of claims |
| CR 1089 | TS3 Balancing. Clarify balancing within the TS3 (Provider Summary Information Segment). In the pharmacy industry it is typical to balance at this level especially in the chain arena.<br>Include: claim count, clarify how to count, especially regarding correction & reversals |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0050 \| 2000<br>TS3 - Provider Summary Information |
| Action | **Modify Data Element Note**<br>TS305 - Data Element Note updated to clarify definition of total reported charges |
| CR 1089 | TS3 Balancing. Clarify balancing within the TS3 (Provider Summary Information Segment). In the pharmacy industry it is typical to balance at this level especially in the chain arena.<br>Include: claim count, clarify how to count, especially regarding correction & reversals |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0070 \| 2000<br>TS2 - Provider Supplemental Summary Information |

| | |
|---|---|
| Action | **Modify Data Element Situational Rule**<br>TS201 - Modify situational rule to require based upon total noncovered day count instead of DRG amount. |
| CR 1153 | To clarify intended use. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0100 \| 2100<br>CLP - Claim Payment Information |
| Action | **Add Data Element Code Value**<br>Loop ID 2100 CLP (Claim Payment Information) CLP11-01 - Add DRG code values and notes explaining usage. |
| CR 1047 | The 835 needs to allow for greater length in the DRG code, in addition to multiple DRG lists (along with a way to differentiate which DRG methodology was used in adjudication). |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0100 \| 2100<br>CLP - Claim Payment Information |
| Action | **Modify Data Element Industry Name**<br>CLP01 - Change Industry Name to Provider's Assigned Claim Identifier |
| CR 123 | CLP01- revise the rule to be consistent with other TR3s and to require a unique ID. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0100 \| 2100<br>CLP - Claim Payment Information |
| Action | **Modify Data Element Note**<br>Loop ID 2100 CLP (Claim Payment Information) CLP01 Modify Note to clarify content of element and requirement to return what was submitted on the claim. |
| CR 1153 | To clarify intended use. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0100 \| 2100<br>CLP - Claim Payment Information |
| Action | **Delete Data Element Code Value**<br>4 Denied |
| CR 1469 | In 5010, the meaning of qualifier 4 was changed so that it no longer reflected an overall denial, but should only be used if the Patient/Subscriber is not recognized, and the claim was not forwarded to another payer. Many payers have not correctly modified their systems to reflect this change, and so claims returned with qualifier 4 cannot be accurately determined if the reason was "denial" or the correct reason of "patient/subscriber not recognized." It would be better to sunset qualifier 4 and introduce a new qualifier for the "patient / subscriber not recognized" reason so that the intention of the CLP02 is very clear. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0100 \| 2100<br>CLP - Claim Payment Information |

| | |
|---|---|
| Action | **Add Data Element Code Value**<br>CLP02 Add Code Value 35 Patient/Subscriber Not Recognized with notes. |
| CR 1469 | In 5010, the meaning of qualifier 4 was changed so that it no longer reflected an overall denial, but should only be used if the Patient/Subscriber is not recognized, and the claim was not forwarded to another payer. Many payers have not correctly modified their systems to reflect this change, and so claims returned with qualifier 4 cannot be accurately determined if the reason was "denial" or the correct reason of "patient/subscriber not recognized." It would be better to sunset qualifier 4 and introduce a new qualifier for the "patient / subscriber not recognized" reason so that the intention of the CLP02 is very clear. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0100 \| 2100<br>CLP - Claim Payment Information |
| Action | **Delete Data Element Code Value**<br>CLP02 Delete Code Value 22 Reversal of Previous Payment - replaced with new codes |
| CR 1044 | Need to include qualifiers in CLP02 for reversal and secondary claim, reversal and tertiary claim to reflect the priority of payer, which is currently lost in reversals. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0100 \| 2100<br>CLP - Claim Payment Information |
| Action | **Add Data Element Code Value**<br>Loop ID 2100 CLP (Claim Payment Information) CLP02 - Add Code Values 32, 33, and 34 - Reversal of Previous Payment for Primary, Secondary, and Tertiary Claim, along with Notes. |
| CR 1339 | The notes for each of the codes in CLP02 need to be consistent language. Some begin with 'Use this code..." and others begin with "Usage of this code...". Uniform wording will ensure consistent use of the codes by all implementers. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0100 \| 2100<br>CLP - Claim Payment Information |
| Action | **Modify Data Element Code Note**<br>Loop ID 2100 CLP (Claim Payment Information) CLP02 - Modify code notes for all qualifiers to clarify usage |
| CR 1035 | Please clarify what value to use for CLP02 when a payer denies the claim because they are not the primary payer and provide direction on how to report the priority of the payer based on the order they hold for the member's total insurance package. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0100 \| 2100<br>CLP - Claim Payment Information |

| | |
|---|---|
| Action | **Modify Data Element Situational Rule**<br>CLP05 Situational Rule update to clarify when patient responsibility must be reported. |
| CR 1600 | Values within the 835 should be validated based on other values internal to the same 835 when possible. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0100 \| 2100<br>CLP - Claim Payment Information |
| Action | **Modify Data Element Usage**<br>Loop ID 2100 CLP (Claim Payment Information) CLP06 (Claim Filing Indicator) change to Not Used. |
| CR 1032 | The Public Health Data Standards Consortium has developed and maintains an external code set for the Source of Payment Typology. This code source was developed to address the limitations and deficiencies in the existing X12 internal Claim Filing Indicator (Data Element 1032) code set.<br>The Source of Payment typology has already been added to the X12 standards for use in the claim standard. Including the additional detail of this value in the 835 is beneficial. In addition, CMS includes the Payer Typology as one of the required supplemental variables for quality e-measures (for the CMS 2014 Meaningful Use Clinical Quality Measures). Several states have adopted the Source of Payment Typology in their statewide hospital administrative data. Because it is used by CMS and in state requirements, it is necessary to include in the 835. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0100 \| 2100<br>CLP - Claim Payment Information |
| Action | **Modify Data Element Usage**<br>CLP11 - Update to situational, with situational rule updated to remove requirement for institutional claims |
| CR 1047 | The 835 needs to allow for greater length in the DRG code, in addition to multiple DRG lists (along with a way to differentiate which DRG methodology was used in adjudication). |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0100 \| 2100<br>CLP - Claim Payment Information |
| Action | **Add Data Element**<br>CLP15 - Add New Data Element Claim Exchange Rate as Situational, with situational rule and note. |
| CR 675 | To indicate the currency of the claim if it is different that the claim payment. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0100 \| 2100<br>CLP - Claim Payment Information |
| Action | **Add Data Element**<br>CLP16 - Add New Data Element Source of Payment Typology Code as Required with note. Usage of this element replaces CLP06. |

| | |
|---|---|
| CR 1032 | The Public Health Data Standards Consortium has developed and maintains an external code set for the Source of Payment Typology. This code source was developed to address the limitations and deficiencies in the existing X12 internal Claim Filing Indicator (Data Element 1032) code set.<br>The Source of Payment typology has already been added to the X12 standards for use in the claim standard. Including the additional detail of this value in the 835 is beneficial. In addition, CMS includes the Payer Typology as one of the required supplemental variables for quality e-measures (for the CMS 2014 Meaningful Use Clinical Quality Measures). Several states have adopted the Source of Payment Typology in their statewide hospital administrative data. Because it is used by CMS and in state requirements, it is necessary to include in the 835. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0100 \| 2100<br>CLP - Claim Payment Information |
| Action | **Add Data Element Code Note**<br>Loop ID 2100 CLP (Claim Payment Information) CLP02 - Add Data Element Code Note - 25 Predetermination Pricing Only - No Payment. |
| CR 1339 | The notes for each of the codes in CLP02 need to be consistent language. Some begin with 'Use this code..." and others begin with "Usage of this code...". Uniform wording will ensure consistent use of the codes by all implementers. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0100 \| 2100<br>CLP - Claim Payment Information |
| Action | **Add Data Element Code Note**<br>"Use for overpayment recovery electronic notification claim. See Section 1.10.2.17 option 3 for additional information." |
| CR 680 | |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0250 \| 2100<br>RAS - Claim Adjustment Information |
| Action | **Add Segment**<br>Delete Segment CAS.<br><br>Add Segment RAS - Claim Adjustment Information. The RAS segment is Situational, with situational rule and notes.<br><br>The RAS segment replaces the CAS segment for reporting adjustment codes and amounts, and also includes reporting remark codes associated to a CARC. |
| CR 105 | Inclusion of the RAS segment supports multiple CARCs for a single dollar amount and allows association of remark codes to a specific CARC. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0250 \| 2100<br>RAS - Claim Adjustment Information |
| Action | **Delete Data Element Code Value**<br>Loop ID 2100, Data Element RAS02 (Claim Adjustment Group Code)<br><br>All Code Values were moved to External Code Source 974: Claim Adjustment Group Codes. |
| CR 678 | 835 - Make Claim Adjustment Group Code an external list to support flexibility when new codes or revisions are needed to meet changing business or regulatory requirements. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0250 \| 2100<br>RAS - Claim Adjustment Information |
| Action | **Add Data Element Code Value**<br>Loop ID 2100/RAS03-02 (Code List Qualifier Code) RM - Insurance Industry Specific Remark Codes. New external code list to provide remark codes not in the Remittance Advice Remark Code list. |
| CR 1234 | Create new external code list for industry specific remark codes that do not meet the criteria for CARCs or RARCs but are needed by their respective industries. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0300 \| 2100<br>NM1 - Patient Name |
| Action | **Modify Data Element Situational Rule**<br>Loop ID 2100 NM1 (Patient Name) NM103 - Updated Situational Rule to include requirement for submission if on original claim. |
| CR 1153 | To clarify intended use. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0300 \| 2100<br>NM1 - Patient Name |
| Action | **Modify Data Element Situational Rule**<br>Loop ID 2100 NM1 (Patient Name) NM104 - Updated Situational Rule to require submission if on the original claim. |
| CR 1153 | To clarify intended use. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0300 \| 2100<br>NM1 - Patient Name |
| Action | **Modify Data Element Situational Rule**<br>Loop ID 2100 NM1 (Patient Name) NM105 - Updated Situational Rule to require submission if on the original claim. |
| CR 1153 | To clarify intended use. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0300 \| 2100<br>NM1 - Patient Name |

| | |
|---|---|
| Action | **Modify Data Element Situational Rule**<br>Loop ID 2100 NM1 (Patient Name) NM107 - Updated Situational Rule to require submission if on the original claim. |
| CR 1153 | To clarify intended use. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0300 \| 2100<br>NM1 - Patient Name |
| Action | **Modify Data Element Situational Rule**<br>Loop ID 2100 NM1 (Patient Name) NM109 - Updated Situational Rule to require submission if on the original claim. |
| CR 1153 | To clarify intended use. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0300 \| 2100<br>NM1 - Patient Name |
| Action | **Modify Data Element Situational Rule**<br>Loop ID 2100/NM108 (Identification Code Qualifier) - Update note to reflect relationship to NM109 |
| CR 1478 | A situational rule should not be duplicated on both the qualifying element and the element reporting the actual value (e.g., NM108 and NM109). Apply the situational rule on the element containing the value with the qualifying element required when the value is used. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0300 \| 2100<br>NM1 - Subscriber Name |
| Action | **Modify Segment Name**<br>Loop ID 2100 NM1 Modify Segment Name from "Insured" to "Subscriber". |
| CR 1153 | To clarify intended use. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0300 \| 2100<br>NM1 - Subscriber Name |
| Action | **Modify Segment Note**<br>NM1 Subscriber Name - Modify Segment Note to clarify that corrected information is not reported in this segment. |
| CR 1081 | NM1 Note, review NM1 Subscriber TR3 note to confirm this is accurate for how the 837 now works w/ patient and subscriber |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0300 \| 2100<br>NM1 - Subscriber Name |
| Action | **Modify Segment Note**<br>NM1 Subscriber Name - Modify Segment Note to require that this report the information submitted on the original claim. |
| CR 1081 | NM1 Note, review NM1 Subscriber TR3 note to confirm this is accurate for how the 837 now works w/ patient and subscriber |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0300 \| 2100<br>NM1 - Subscriber Name |
| Action | **Modify Data Element Situational Rule**<br>Loop ID 2100 NM1 (Subscriber Name) NM103 - Updated Situational Rule to require submission if on the original claim. |
| CR 1153 | To clarify intended use. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0300 \| 2100<br>NM1 - Subscriber Name |
| Action | **Modify Data Element Situational Rule**<br>Loop ID 2100 NM1 (Subscriber Name) NM104 - Updated Situational Rule to require submission if on the original claim. |
| CR 1153 | To clarify intended use. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0300 \| 2100<br>NM1 - Subscriber Name |
| Action | **Modify Data Element Situational Rule**<br>Loop ID 2100 NM1 (Subscriber Name) NM105 - Updated Situational Rule to require submission if on the original claim. |
| CR 1153 | To clarify intended use. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0300 \| 2100<br>NM1 - Subscriber Name |
| Action | **Modify Data Element Situational Rule**<br>Loop ID 2100 NM1 (Subscriber Name) NM107 - Updated Situational Rule to require submission if on the original claim. |
| CR 1153 | To clarify intended use. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0300 \| 2100<br>NM1 - Subscriber Name |
| Action | **Modify Data Element Usage**<br>Loop ID 2100 NM1 (Subscriber Name) NM108 - Update to Situational with Situational Rule to reflect relationship to NM109 |
| CR 1153 | To clarify intended use. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0300 \| 2100<br>NM1 - Subscriber Name |
| Action | **Modify Data Element Usage**<br>Loop ID 2100 NM1 (Subscriber Name) NM109 - Updated to Situational with Situational Rule to require submission if on the original claim. |
| CR 1153 | To clarify intended use. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0300 \| 2100<br>NM1 - Corrected Patient/Subscriber Name |

| | |
|---|---|
| Action | **Modify Segment Name**<br>NM1 Corrected Patient / Subscriber Name - Change Segment Name and other instances of "Insured" to "Subscriber" |
| CR 1082 | Corrected Patient / Insured Segment - Update to coordinate with changes to the 837 regarding insured versus subscriber. Also need to include patient correction ability and ability to report corrected patient information when the payer's information differs from the submitted claim. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0300 \| 2100<br>NM1 - Corrected Patient/Subscriber Name |
| Action | **Modify Segment Repeat**<br>Modify Segment Repeat from 1 to 2. |
| CR 630 | Support reporting of the adjudicated patient name when it is different from the submitted patient name. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0300 \| 2100<br>NM1 - Corrected Patient/Subscriber Name |
| Action | **Modify Segment Situational Rule**<br>NM1 Corrected Patient / Subscriber Name - Modify Segment Situational Rule to include relationship to information submitted on the claim. |
| CR 629 | Support reporting of the adjudicated patient name when it is different from the submitted patient name. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0300 \| 2100<br>NM1 - Corrected Patient/Subscriber Name |
| Action | **Add Segment Note**<br>NM1 Corrected Patient / Subscriber Name - Add note requiring information from the payer's system. |
| CR 629 | Support reporting of the adjudicated patient name when it is different from the submitted patient name. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0300 \| 2100<br>NM1 - Corrected Patient/Subscriber Name |
| Action | **Delete Segment Note**<br>Remove Note #1 |
| CR 1082 | Corrected Patient / Insured Segment - Update to coordinate with changes to the 837 regarding insured versus subscriber. Also need to include patient correction ability and ability to report corrected patient information when the payer's information differs from the submitted claim. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0300 \| 2100<br>NM1 - Corrected Patient/Subscriber Name |
| Action | **Modify Data Element Code Value**<br>NM101 - Remove code 74 (Corrected Insured). Add codes COP (Corrected |

| | |
|---|---|
| | Patient) and COS ( Corrected Subscriber). |
| CR 1082 | Corrected Patient / Insured Segment - Update to coordinate with changes to the 837 regarding insured versus subscriber. Also need to include patient correction ability and ability to report corrected patient information when the payer's information differs from the submitted claim. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0300 \| 2100<br>NM1 - Corrected Patient/Subscriber Name |
| Action | **Modify Data Element Situational Rule**<br>Loop ID 2100 NM1 (Corrected Patient / Subscriber Name) NM103 (Last Name) - changed requirement to include only when adjudicated is different than what was submitted on the claim. |
| CR 1082 | Corrected Patient / Insured Segment - Update to coordinate with changes to the 837 regarding insured versus subscriber. Also need to include patient correction ability and ability to report corrected patient information when the payer's information differs from the submitted claim. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0300 \| 2100<br>NM1 - Corrected Patient/Subscriber Name |
| Action | **Modify Data Element Situational Rule**<br>Loop ID 2100 NM1 (Corrected Patient / Subscriber Name) NM104 - Update Situational Rule to require when information differs from that submitted on the original claim. |
| CR 1082 | Corrected Patient / Insured Segment - Update to coordinate with changes to the 837 regarding insured versus subscriber. Also need to include patient correction ability and ability to report corrected patient information when the payer's information differs from the submitted claim. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0300 \| 2100<br>NM1 - Corrected Patient/Subscriber Name |
| Action | **Modify Data Element Situational Rule**<br>Loop ID 2100 NM1 (Corrected Patient / Subscriber Name) NM105 - Update to require submission when different than what was submitted on the claim. |
| CR 1082 | Corrected Patient / Insured Segment - Update to coordinate with changes to the 837 regarding insured versus subscriber. Also need to include patient correction ability and ability to report corrected patient information when the payer's information differs from the submitted claim. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0300 \| 2100<br>NM1 - Corrected Patient/Subscriber Name |
| Action | **Modify Data Element Situational Rule**<br>Loop ID 2100 NM1 (Corrected Patient / Subscriber Name) NM107 - Update Situational Rule to require when information differs from that submitted on the claim. |

| | |
|---|---|
| CR 1082 | Corrected Patient / Insured Segment - Update to coordinate with changes to the 837 regarding insured versus subscriber. Also need to include patient correction ability and ability to report corrected patient information when the payer's information differs from the submitted claim. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0300 \| 2100<br>NM1 - Corrected Patient/Subscriber Name |
| Action | **Modify Data Element Code Value**<br>NM108 - Corrected Patient / Subscriber Name - Remove code C (Insured's Changed Unique Identification Number). Add code IN (Changed Unique Identification Number). |
| CR 1082 | Corrected Patient / Insured Segment - Update to coordinate with changes to the 837 regarding insured versus subscriber. Also need to include patient correction ability and ability to report corrected patient information when the payer's information differs from the submitted claim. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0300 \| 2100<br>NM1 - Service Provider Name |
| Action | **Modify Segment Situational Rule**<br>Loop ID 2100, NM1 Segment (Rendering Provider Name)<br><br>Changed Situational Rule and other instances of Rendering Provider to Service Provider. |
| CR 1135 | Ensure consistency between the NUCC rendering provider definition & TR3 instructions. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0300 \| 2100<br>NM1 - Service Provider Name |
| Action | **Modify Data Element Code Value**<br>Loop ID 2100, NM101 (Entity Identifier Code)<br><br>Remove code 82 (Rendering Provider). Add code SJ (Service Provider). |
| CR 1135 | Ensure consistency between the NUCC rendering provider definition & TR3 instructions. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0300 \| 2100<br>NM1 - Service Provider Name |
| Action | **Delete Segment Note**<br>This segment provides information about the rendering provider. An identification number is provided in NM109. |
| CR 1181 | For consistency across TR3's, Recommend Changing the name of the Location Identification 2100 REF to Additional Rendering Provider Identification Number (Currently the Location Identification segment) include both the LU and A6 to carry the payer assigned identifiers; increase the repeat |

| | |
|---|---|
| | to '2'. The Code LU and A6 should be consistent with the notes in the claim. This would result in removing the 'SV' qualifier from the NM108 for Rendering Provider and change from required to situational - this is consistent with the way the 837. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0300 \| 2100<br>NM1 - Service Provider Name |
| Action | **Modify Data Element Usage**<br>NM1 Service Provider Name NM108 - Change element from Required to Situational and modify situational rule to clarify NPI requirements |
| CR 1181 | For consistency across TR3's, Recommend Changing the name of the Location Identification 2100 REF to Additional Rendering Provider Identification Number (Currently the Location Identification segment) include both the LU and A6 to carry the payer assigned identifiers; increase the repeat to '2'. The Code LU and A6 should be consistent with the notes in the claim. This would result in removing the 'SV' qualifier from the NM108 for Rendering Provider and change from required to situational - this is consistent with the way the 837. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0300 \| 2100<br>NM1 - Service Provider Name |
| Action | **Delete Data Element Code Value**<br>NM1 Service Provider Name NM108 - Delete all code values except XX (Standard Unique Health Identifier for Health Care Providers (NPI)). |
| CR 1366 | Align with NPI Rule. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0300 \| 2100<br>NM1 - Service Provider Name |
| Action | **Modify Data Element Usage**<br>Loop ID 2100 NM1 Service Provider Name NM109 - Change element from Required to Situational and modify situational rule to clarify NPI requirements. |
| CR 1181 | For consistency across TR3's, Recommend Changing the name of the Location Identification 2100 REF to Additional Rendering Provider Identification Number (Currently the Location Identification segment) include both the LU and A6 to carry the payer assigned identifiers; increase the repeat to '2'. The Code LU and A6 should be consistent with the notes in the claim. This would result in removing the 'SV' qualifier from the NM108 for Rendering Provider and change from required to situational - this is consistent with the way the 837. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0300 \| 2100<br>NM1 - Crossover Carrier Name |
| Action | **Modify Segment Repeat**<br>Revise Segment Repeat from 1 to 10 |

| | |
|---|---|
| CR 1043 | Need to report the Crossover NM1 segment with multiple occurrences. Also need to report more Corrected Priority Payers. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0300 \| 2100<br>NM1 - Crossover Carrier Name |
| Action | **Add Segment Note**<br>TR3 Note:<br>2. When the claim is transferred to more than 1 carrier, use this segment to report all crossover names and reference numbers. |
| CR 1043 | Need to report the Crossover NM1 segment with multiple occurrences. Also need to report more Corrected Priority Payers. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0300 \| 2100<br>NM1 - Corrected Priority Payer Name |
| Action | **Delete Segment**<br>Delete Segment Loop ID 2100, NM1 Corrected Priority Payer Name. Move to 2105 Loop N1 Segment to allow multiple iterations and association with Subscriber NM1." |
| CR 1043 | Need to report the Crossover NM1 segment with multiple occurrences. Also need to report more Corrected Priority Payers. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0300 \| 2100<br>NM1 - Other Subscriber Name |
| Action | **Delete Segment**<br>Delete Segment Loop ID 2100, NM1 Other Subscriber Name. Move to 2105 Loop NM1 Segment to allow multiple iterations and association with Corrected Priority Payer N1." |
| CR 1043 | Need to report the Crossover NM1 segment with multiple occurrences. Also need to report more Corrected Priority Payers. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0330 \| 2100<br>MIA - Inpatient Adjudication Information |
| Action | **Modify Segment Situational Rule**<br>Modify Loop ID 2100/ MIA Segment Situational Rule to remove reference to Remark Code list. |
| CR 1234 | Create new external code list for industry specific remark codes that do not meet the criteria for CARCs or RARCs but are needed by their respective industries. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0330 \| 2100<br>MIA - Inpatient Adjudication Information |
| Action | **Delete Segment Note**<br>Loop ID 2100/MIA Segment<br><br>When used outside of the Medicare and Medicaid community only MIA01, 05, |

| | |
|---|---|
| | 20, 21, 22 and 23 may be used. |
| CR 1234 | Create new external code list for industry specific remark codes that do not meet the criteria for CARCs or RARCs but are needed by their respective industries. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0330 \| 2100<br>MIA - Inpatient Adjudication Information |
| Action | **Modify Data Element Usage**<br>Modify all Loop ID 2100/MIA segment Remark Code elements (MIA05, MIA20, MIA21, MIA22, MIA23) to Not Used. Remark Codes are now reported in either a RAS Segment (when associated with a CARC) or an LQ Segment. |
| CR 1234 | Create new external code list for industry specific remark codes that do not meet the criteria for CARCs or RARCs but are needed by their respective industries. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0350 \| 2100<br>MOA - Outpatient Adjudication Information |
| Action | **Modify Segment Situational Rule**<br>Loop ID 2100/MOA Segment (Outpatient Adjudication Information)<br><br>Modify Loop ID 2100/ MOA Segment Situational Rule to remove reference to Remark Code list. |
| CR 1234 | Create new external code list for industry specific remark codes that do not meet the criteria for CARCs or RARCs but are needed by their respective industries. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0350 \| 2100<br>MOA - Outpatient Adjudication Information |
| Action | **Modify Data Element Industry Name**<br>Modify all Loop ID 2100/MOA segment Remark Code elements (MOA03 through MOA07) to Not Used. Remark Codes are now reported in either a RAS Segment (when associated with a CARC) or an LQ Segment. |
| CR 1234 | Create new external code list for industry specific remark codes that do not meet the criteria for CARCs or RARCs but are needed by their respective industries. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0400 \| 2100<br>REF - Other Claim Related Identification |
| Action | **Add Segment**<br>Add Segment 2100 REF Original Payer Claim Control Number |
| CR 1153 | To clarify intended use. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0400 \| 2100<br>REF - Other Claim Related Identification |

| | |
|---|---|
| Action | **Modify Segment Situational Rule**<br>Loop ID 2100 REF - Other Claim Related Information - Modify Segment Situational Rule to include additional situations when segment is required. |
| CR 1153 | To clarify intended use. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0400 \| 2100<br>REF - Other Claim Related Identification |
| Action | **Add Data Element Code Value**<br>Loop ID 2100 / REF (Other Claim Related Information)<br><br>Add Data Element Code Values OX (Statement Number), M7 (Medical Assistance Category), 5N (Citation or Statute), and Y4 (Agency Claim Number) and notes. |
| CR 1153 | To clarify intended use. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0400 \| 2100<br>REF - Other Claim Related Identification |
| Action | **Delete Data Element Code Value**<br>Loop ID 2100 REF - Other Claim Related Identification - Delete Data Element Code Values G3, G1 and BB. See new REF (Claim Authorization Information). |
| CR 1086 | Clarify use of Authorization Numbers in the 835. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0400 \| 2100<br>REF - Other Claim Related Identification |
| Action | **Delete Data Element Code Value**<br>G3 Predetermination of Benefits Identification Number |
| CR 1086 | Clarify use of Authorization Numbers in the 835. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0400 \| 2100<br>REF - Other Claim Related Identification |
| Action | **Delete Data Element Code Note**<br>Loop ID 2100 / REF01 (Reference Identification Qualifier)<br><br>1L (Group or Policy Number)<br><br>Removed: Use this code when conveying the Group Number in REF02. |
| CR 1542 | Improve the consistency of the code value notes within and across the TR3s. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0400 \| 2100<br>REF - Other Claim Related Identification |
| Action | **Delete Data Element Code Value**<br>Loop ID 2100 / REF01 (Reference Identification Qualifier)<br><br>F8 (Original Reference Number) |

| | |
|---|---|
| | Delete Data Element Code Value F8 (Original Reference Number). This Code Value was moved to a new unique REF (Original Payer Claim Control Number). |
| CR 1542 | Improve the consistency of the code value notes within and across the TR3s. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0400 \| 2100<br>REF - Other Claim Related Identification |
| Action | **Delete Data Element Code Note**<br>Loop ID 2100 / REF01 (Reference Identification Qualifier)<br><br>IG (Insurance Policy Number)<br><br>Removed: Use this code when conveying the Policy Number in REF02. |
| CR 1542 | Improve the consistency of the code value notes within and across the TR3s. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0400 \| 2100<br>REF - Other Claim Related Identification |
| Action | **Delete Data Element Code Value**<br>Loop ID 2100 REF Additional Claim Identification, remove qualifiers A6, 1W, and SY. |
| CR 1001 | Need to revisit the Social Security Number qualifier in this REF as there is not way to determine who the SSN belongs to. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0400 \| 2100<br>REF - Other Claim Related Identification |
| Action | **Delete Data Element Code Value**<br>1W - Member Identification Number |
| CR 1153 | To clarify intended use. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0400 \| 2100<br>REF - Other Claim Related Identification |
| Action | **Delete Data Element Code Value**<br>A6 - Provider Identifier |
| CR 1153 | To clarify intended use. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0400 \| 2100<br>REF - Other Claim Related Identification |
| Action | **Delete Data Element Code Value**<br>CE - Class of Contract Code |
| CR 1153 | To clarify intended use. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0400 \| 2100<br>REF - Class of Contract Code |

| | |
|---|---|
| Action | **Add Segment**<br>Add new unique REF segment (Class of Contract Code) as situational, with situational rule, qualifier CE and notes. |
| CR 1404 | To enable identification of plan information for the payee on the 835 |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0400 \| 2100<br>REF - Service Provider Secondary Identification |
| Action | **Modify Segment Name**<br>Modify Segment Name to "Rendering Provider Secondary Identification", include code values LU and A6 with notes. |
| CR 1181 | For consistency across TR3's, Recommend Changing the name of the Location Identification 2100 REF to Additional Rendering Provider Identification Number (Currently the Location Identification segment) include both the LU and A6 to carry the payer assigned identifiers; increase the repeat to '2'. The Code LU and A6 should be consistent with the notes in the claim. This would result in removing the 'SV' qualifier from the NM108 for Rendering Provider and change from required to situational - this is consistent with the way the 837. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0400 \| 2100<br>REF - Payment Determination Methodology |
| Action | **Add Segment**<br>Add Segment REF - Payment Determination Methodology as situational including situational rule, code values 9V, AFT, APC, and notes. |
| CR 1405 | To allow the reporting of the methodology used to derive the allowed amount used for adjudication. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0400 \| 2100<br>REF - Original Claim Information |
| Action | **Add Segment**<br>Add Segment Loop ID 2100 REF - Original Claim Information as required. This new required REF will provide information on the type of claim (professional, institutional inpatient, etc) as well as the claim submission method (electronic, paper, etc.). |
| CR 1042 | Need the 835 to report the type of claim submitted / initiated by the provider so a transaction that includes all type of claims can be split by a provider and processed by different A/R systems. Include type of claims and paper forms. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0500 \| 2100<br>DTM - Statement Dates |
| Action | **Modify Segment Name**<br>Statement Dates |
| CR 1185 | For consistency across TR3s, The Segment Name and Situational Rule on the DTM should be the Statement From AND To Date vs. From OR To since both |

| | |
|---|---|
| | dates are allowed. This segment needs to be aligned with the claim - professional claim has service dates only at the service level and the institutional has statement date only at the claim level. Use the same qualifiers and elements so that payers can return what is received in the claim.<br><br>The Situational Note needs to be modified to "Required when the "Service Date" is not supplied in 2100 DTM..." to align with the name of the Segment. If the above request is implemented then this note should align with the new name. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0500 \| 2100<br>DTM - Statement Dates |
| Action | **Modify Segment Situational Rule**<br>Loop ID 2100 DTM Statement Dates Update Segment Situational Rule to include exclusion of Predetermination Claims. |
| CR 1153 | To clarify intended use. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0500 \| 2100<br>DTM - Statement Dates |
| Action | **Modify Segment Note**<br>Loop ID 2100 DTM Statement Dates - Modify Segment Note for Predetermination Claims to remove requirement for default date. No dates are sent for Predetermination Claims. |
| CR 1153 | To clarify intended use. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0500 \| 2100<br>DTM - Claim Received Date |
| Action | **Modify Segment Situational Rule**<br>Loop ID 2100 DTM Claim Received Date - Modify Segment Situational Rule to include pharmacy requirements. |
| CR 649 | Revise the Claim Received Date DTM Segment situational rule to require it when state or federal regulations or the provider contract mandate interest or prompt payment discounts based upon claim receipt date or clean claim date. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0500 \| 2100<br>DTM - Clean Claim Date |
| Action | **Add Segment**<br>Add Segment Loop ID 2100 DTM (Clean Claim Date) as Situational, with Situational Rule and notes |
| CR 649 | Revise the Claim Received Date DTM Segment situational rule to require it when state or federal regulations or the provider contract mandate interest or prompt payment discounts based upon claim receipt date or clean claim date. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0500 \| 2100<br>DTM - Corrected Accident Date |

| | |
|---|---|
| Action | **Add Segment**<br>Add Segment Loop ID 2100 DTM (Corrected Accident Date) as Situational, with Situational Rule and notes. |
| CR 661 | Add information for Accident Date, including the date the mishap occurred. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0500 \| 2100<br>DTM - Corrected Onset of Current Symptoms or Illness Date |
| Action | **Add Segment**<br>Add Segment Loop ID 2100 DTM (Corrected Onset of Current Symptoms or Illness Date) as Situational, with Situational Rule and notes. |
| CR 660 | Add information for Onset of Current Symptoms or Illness, including corrected date of onset of current symptoms or illness. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0600 \| 2100<br>PER - Claim Contact Information |
| Action | **Modify Data Element Situational Rule**<br>PER06 - Modify Data Element Situational Rule to include relationship with PER05. |
| CR 1154 | For consistency across all TR3s. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0600 \| 2100<br>PER - Entity Self-Insured Plan / Jurisdiction Contact |
| Action | **Add Segment**<br>Add Segment Loop ID 2100 PER - Entity Self-Insured Plan / Jurisdictional Contact as situational, with situational rule and notes. |
| CR 1498 | The term "self-insured" is used in various places throughout the TR3, but is spelled inconsistently, sometimes capitalized, sometimes with a hyphen, other times without. Need to make this term consistent throughout the TR3. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0600 \| 2100<br>PER - Entity Self-Insured Plan / Jurisdiction Contact |
| Action | **Modify Data Element Situational Rule**<br>PER06 - Modify Data Element Situational Rule to include relationship with PER05. |
| CR 1154 | For consistency across all TR3s. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0600 \| 2100<br>PER - Workers' Compensation Payer Website |
| Action | **Add Segment**<br>Add Segment Loop ID 2100 PER - Worker's Compensation Payer Website as situational, with situational rule and notes. |
| CR 1138 | Payers have different levels of security. There is a need to direct providers to the best location needed to supply information, which sometimes may be within a secure site. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0600 \| 2100<br>PER - Workers' Compensation Payer Website |
| Action | **Modify Data Element Situational Rule**<br>PER06 - Modify Data Element Situational Rule to include relationship with PER05. |
| CR 1154 | For consistency across all TR3s. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0600 \| 2100<br>AMT - Claim Allowed Amount |
| Action | **Add Segment**<br>Loop ID 2100 AMT Claim Allowed Amount - Add new Required Segment AMT - Claim Allowed Amount with notes. |
| CR 1230 | Provide payers the ability to report the allowed amount for informational purposes for coordination of benefits. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0620 \| 2100<br>AMT - Claim Supplemental Information |
| Action | **Modify Segment Repeat**<br>changed from 13 to 12. |
| CR 1205 | Modify the repeat count to match the number of qualifiers available for use. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0620 \| 2100<br>AMT - Claim Supplemental Information |
| Action | **Add Segment Note**<br>"Supplemental information reported at the Service level (2110 loop) AMT Segment are not repeated at the claim level (2100 loop) AMT Segment." |
| CR 1153 | To clarify intended use. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0620 \| 2100<br>AMT - Claim Supplemental Information |
| Action | **Delete Data Element Code Value**<br>T2 Total Claim Before Taxes |
| CR 1139 | It is unclear what should go into the AMT*T2 money amount field, whether the original amount or adjudicated amount. Based on the confusion that exists in the industry between use of the T qualifier vs T2 qualifier (and the fact that no one seems to be using T2), it was determined the best solution is to remove T2 to eliminate confusion. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0620 \| 2100<br>AMT - Claim Supplemental Information |
| Action | **Modify Data Element Code Note**<br>Loop ID 2100, AMT Segment (Claim Supplemental Informaiton), Data Element AMT01 (Amount Qualifier Code) |

| | |
|---|---|
| | AU (Coverage Amount)<br><br>Modify Data Element Code Note to differentiate this amount from the Allowed Amount. The Allowed Amount now appears in a new unique AMT segment. |
| CR 1230 | Provide payers the ability to report the allowed amount for informational purposes for coordination of benefits. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0640 \| 2100<br>QTY - Claim Supplemental Information Quantity |
| Action | **Add Data Element Code Note**<br>Loop ID 2100 / QTY01 (Quantity Qualifier)<br><br>PS (Prescription)<br><br>Add Code Note to clarify usage. |
| CR 1542 | Improve the consistency of the code value notes within and across the TR3s. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0640 \| 2100<br>QTY - Claim Supplemental Information Quantity |
| Action | **Add Data Element Code Note**<br>Loop ID 2100 / QTY01 (Quantity Qualifier)<br><br>VS (Visits)<br><br>Add Code Note to clarify usage. |
| CR 1542 | Improve the consistency of the code value notes within and across the TR3s. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0660 \| 2100<br>LQ - Health Care Remark Codes |
| Action | **Add Segment**<br>Loop ID 2100 LQ Segment -Health Care Remark Codes<br><br>Add new Segment as Situational, with Situational Rule and Notes. This new segment will convey all remark codes that are not associated with a specific CARC appearing in a RAS segment. |
| CR 1234 | Create new external code list for industry specific remark codes that do not meet the criteria for CARCs or RARCs but are needed by their respective industries. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0670 \| 2105<br>N1 - Corrected Priority Payer Name |
| Action | **Add Segment**<br>New Loop 2105, N1 - Corrected Priority Payer Name Segment<br><br>Situational Rule: Required when the current payer believes that another payer |

| | |
|---|---|
| | has priority for making a payment and the claim is not being automatically transferred to that payer. If not required by this implementation guide, do not send. |
| CR 1043 | Need to report the Crossover NM1 segment with multiple occurrences. Also need to report more Corrected Priority Payers. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0670 \| 2105<br>N1 - Corrected Priority Payer Name |
| Action | **Modify Data Element Situational Rule**<br>N103 Identification Code Qualifier - Update note to reflect relationship to N104. |
| CR 1478 | A situational rule should not be duplicated on both the qualifying element and the element reporting the actual value (e.g., NM108 and NM109). Apply the situational rule on the element containing the value with the qualifying element required when the value is used. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0675 \| 2105<br>NM1 - Other Subscriber Name |
| Action | **Add Segment**<br>New Loop 2105, NM1 - Other Subscriber Name<br><br>Situational Rule: Required when a corrected priority payer has been identified in this iteration of Loop 2105 N1 Corrected Priority Payer Name Segment AND the name or ID of the other subscriber for this payer is known. If not required by this implementation guide, do not send. |
| CR 1043 | Need to report the Crossover NM1 segment with multiple occurrences. Also need to report more Corrected Priority Payers. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0700 \| 2110<br>SVC - Service Payment Information |
| Action | **Add Data Element Note**<br>SVC06-02 through SVC06-06 and SVC06-09 through SVC06-12 are intended to convey the originally submitted service, and are not intended to be validated when the qualifier in SVC06-01 is RA. |
| CR 685 | Clarify what should be reported in SVC01 and SVC06 when invalid procedure / service codes come in on the claim (e.g. paper). How should the original bad code be reported in the 835 to show what came in versus what was adjudicated? |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0700 \| 2110<br>SVC - Service Payment Information |
| Action | **Add Data Element Note**<br>SVC01-02 through SVC01-06 and SVC01-09 through SVC01-12 are intended to convey the adjudicated service, and are not intended to be validated when the qualifier in SVC01-01 is RA. |

| | |
|---|---|
| CR 685 | Clarify what should be reported in SVC01 and SVC06 when invalid procedure / service codes come in on the claim (e.g. paper). How should the original bad code be reported in the 835 to show what came in versus what was adjudicated? |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0700 \| 2110<br>SVC - Service Payment Information |
| Action | **Modify Segment Situational Rule**<br>Loop 2110 SVC update Situational Rule to clearly identify when SVC required |
| CR 1449 | RFI 1950 and others have requested clarification on the situational rule associated with the 2110 SVC segment in the 835. Because we continue to receive requests for clarification on when the SVC segment is required, we need to reword the situational rule to make it clear when the segment is required. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0700 \| 2110<br>SVC - Service Payment Information |
| Action | **Delete Data Element Code Value**<br>Loop ID 2110, SVC01-01 (Product/Service ID Qualifier)<br><br>WK - Advanced Billing Concepts (ABC) Codes<br>N6 - National Health Related Item Code in 4-6 Format |
| CR 749 | Remove support for Advanced Billing Concept Codes (ABC) across the TR3s as HHS has discontinued the associated pilot project. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0700 \| 2110<br>SVC - Service Payment Information |
| Action | **Add Data Element Code Value**<br>Loop ID 2110 SVC01-01 Add new Data Element Code Value RA (Return Code) for use when an invalid code was submitted on the claim and used for adjudication. This would acknowledge that the code indicated was invalid and can't be validated. |
| CR 685 | Clarify what should be reported in SVC01 and SVC06 when invalid procedure / service codes come in on the claim (e.g. paper). How should the original bad code be reported in the 835 to show what came in versus what was adjudicated? |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0700 \| 2110<br>SVC - Service Payment Information |
| Action | **Add Data Element Code Value**<br>Loop ID 2110 / SVC01-01 (Product/Service ID Qualifier)<br><br>Add Data Element Code Value ZZ (Mutually Defined) for use when reporting the Device Identifier of the Unique Device Identifier. |

| | |
|---|---|
| CR 1548 | Provide the ability to report the device identifier (DI) of the Unique Device Identifier (UDI) for pharmacy services. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0700 \| 2110<br>SVC - Service Payment Information |
| Action | **Modify Data Element Code Note**<br>HC (Healthcare Common Procedure Coding System (HCPCS) Code changed to:<br><br>Use when reporting HCPCS or CPT codes. AMA's CPT codes are level 1 HCPCS codes. |
| CR 1750 | Modify service procedure qualifier code notes for correct structure and clarity based on 7030 public comments. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0700 \| 2110<br>SVC - Service Payment Information |
| Action | **Modify Data Element Usage**<br>Loop ID 2110 / SVC05 (Units of Service Paid Count)<br><br>Modify Data Element Usage to Required so Units will always be sent. Note is removed as no longer needed. |
| CR 1092 | Ensure consistency with the 837 COB information regarding paid units of service. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0700 \| 2110<br>SVC - Service Payment Information |
| Action | **Modify Data Element Situational Rule**<br>Loop ID 2110 SVC (Service Payment Information) SVC06 (Submitted Procedure Code Information) - Update Situational Rule to include requirement for reporting for differences in modifiers in addition to procedure code. |
| CR 1153 | To clarify intended use. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0700 \| 2110<br>SVC - Service Payment Information |
| Action | **Add Data Element Code Value**<br>Loop ID 2110 SVC06-01 Add new Data Element Code Value RA (Return Code) for use when an invalid code was submitted on the claim and used for adjudication. This would acknowledge that the code indicated was invalid and can't be validated. |
| CR 685 | Clarify what should be reported in SVC01 and SVC06 when invalid procedure / service codes come in on the claim (e.g. paper). How should the original bad code be reported in the 835 to show what came in versus what was adjudicated? |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0700 \| 2110<br>SVC - Service Payment Information |
| Action | **Add Data Element Code Value**<br>Loop ID 2110 / SVC06-01 (Product/Service ID Qualifier)<br><br>ZZ (Mutually Defined) |
| CR 1548 | Provide the ability to report the device identifier (DI) of the Unique Device Identifier (UDI) for pharmacy services. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0700 \| 2110<br>SVC - Service Payment Information |
| Action | **Delete Data Element Code Value**<br>Loop ID 2110 / SVC06-01 (Product/Service ID Qualifier)<br><br>WK - Advanced Billing Concepts (ABC) Codes |
| CR 1548 | Provide the ability to report the device identifier (DI) of the Unique Device Identifier (UDI) for pharmacy services. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0700 \| 2110<br>SVC - Service Payment Information |
| Action | **Delete Data Element Code Value**<br>IV - Home Infusion EDI Coalition (HIEC) Product/Service Code |
| CR 1379 | For consistency across all guides. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0800 \| 2110<br>DTM - Service Date |
| Action | **Modify Segment Note**<br>Loop ID 2100 DTM Statement Dates - Modify Segment Note for Predetermination Claims to remove requirement for default date. No dates are sent for Predetermination Claims. |
| CR 1153 | To clarify intended use. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0800 \| 2110<br>DTM - Service Date |
| Action | **Modify Data Element Code Note**<br>Loop ID 2110 / DTM01 (Date/Time Qualifier)<br><br>150 (Service Period Start)<br><br>Modify Data Element Code Note to include relationship with Code 151. |
| CR 1542 | Improve the consistency of the code value notes within and across the TR3s. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0800 \| 2110<br>DTM - Service Date |

| | |
|---|---|
| Action | **Modify Data Element Code Note**<br>Loop ID 2100 / DTM (Date/Time Qualifier)<br><br>151 (Service Period End)<br><br>Modify Data Element Code Note to include relationship with Code 150. |
| CR 1542 | Improve the consistency of the code value notes within and across the TR3s. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0800 \| 2110<br>DTM - Service Date |
| Action | **Modify Data Element Code Note**<br>Loop ID 2110 / DTM01 (Date/Time Qualifier)<br><br>472 (Service)<br><br>Modify Data Element Code Note to include relationship with other DTMs. |
| CR 1542 | Improve the consistency of the code value notes within and across the TR3s. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0950 \| 2110<br>RAS - Service Adjustment Information |
| Action | **Delete Data Element Code Value**<br>Loop ID 2100, Data Element RAS02 (Claim Adjustment Group Code)<br><br>All Code Values were moved to External Code Source 974: Claim Adjustment Group Codes. |
| CR 678 | 835 - Make Claim Adjustment Group Code an external list to support flexibility when new codes or revisions are needed to meet changing business or regulatory requirements. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0950 \| 2110<br>RAS - Service Adjustment Information |
| Action | **Add Data Element Code Value**<br>Loop ID 2110/RAS03-02 (Code List Qualifier Code)<br><br>RM - Insurance Industry Specific Remark Codes<br><br>New external code list to provide remark codes not in the Remittance Advice Remark Code list. |
| CR 1234 | Create new external code list for industry specific remark codes that do not meet the criteria for CARCs or RARCs but are needed by their respective industries. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 1000 \| 2110<br>REF - Service Identification |

| | |
|---|---|
| Action | **Modify Segment Repeat**<br>Loop ID 2110 REF Service Identification - Modify Segment Repeat to 2. |
| CR 1153 | To clarify intended use. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 1000 \| 2110<br>REF - Service Identification |
| Action | **Modify Segment Situational Rule**<br>Loop ID 2110 REF Service Identification - Modify Segment Situational Rule to clarify requirements for not only use in the service line adjudication, but also as a result of the service line adjudication. |
| CR 1153 | To clarify intended use. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 1000 \| 2110<br>REF - Service Identification |
| Action | **Modify Data Element Code Value**<br>Loop ID 2110 REF (Service Identification) Update Code Values to include only E9 and LU. Other code values removed. |
| CR 1379 | For consistency across all guides. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 1000 \| 2110<br>REF - Service Identification |
| Action | **Delete Data Element Code Value**<br>Loop ID 2110 REF Service Identification - Delete Data Element Code Values G1 and BB, these codes moved to new unique REF - Service Authorization Number |
| CR 1086 | Clarify use of Authorization Numbers in the 835. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 1000 \| 2110<br>REF - Service Identification |
| Action | **Add Data Element Code Note**<br>E9 - Attachment Code<br><br>Use when an Attachment Control Number was assigned by the provider. |
| CR 1085 | REF01 - Service Identification.<br>Provide usage for the code values of E9 Adjustment Code and G3 Predetermination of Benefits Identification Number. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 1000 \| 2110<br>REF - Service Identification |
| Action | **Delete Data Element Code Value**<br>G3 Predetermination of Benefits Identification Number |
| CR 1086 | Clarify use of Authorization Numbers in the 835. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 1000 \| 2110<br>REF - Service Identification |
| Action | **Delete Data Element Code Value**<br>1S - Ambulatory Patient Group (APG) Number |
| CR 1379 | For consistency across all guides. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 1000 \| 2110<br>REF - Service Identification |
| Action | **Delete Data Element Code Value**<br>RB - Rate code number |
| CR 1379 | For consistency across all guides. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 1000 \| 2110<br>REF - Service Identification |
| Action | **Delete Data Element Code Value**<br>APC - Ambulatory Payment Classification |
| CR 1379 | For consistency across all guides. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 1000 \| 2110<br>REF - Service Identification |
| Action | **Delete Data Element Code Value**<br>BB - Authorization Number |
| CR 1379 | For consistency across all guides. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 1000 \| 2110<br>REF - Payment Determination Methodology |
| Action | **Add Segment**<br>Add Segment Loop ID 2110 REF - Payment Determination Methodology as situational, with situational rule, qualifiers, and code notes. |
| CR 1086 | Clarify use of Authorization Numbers in the 835. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 1000 \| 2110<br>REF - Service Provider Information |
| Action | **Modify Data Element Code Value**<br>Loop ID 2110 REF (Rendering Provider Information) - Modify Code Values to include only A6 and HPI with notes. Remove payer-specific code values. |
| CR 1379 | For consistency across all guides. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 1000 \| 2110<br>REF - HealthCare Policy Identification |
| Action | **Add Segment Note**<br>Loop ID 2110 REF Healthcare Policy Identification - Add Segment Note regarding procedure to use during reversals. |

| | |
|---|---|
| CR 1153 | To clarify intended use. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 1000 \| 2110<br>REF - HealthCare Policy Identification |
| Action | **Modify Segment Note**<br>Loop iD 2110 REF Healthcare Policy Identification - Modify Segment Note to clarify relationship with PER segments. |
| CR 1138 | Payers have different levels of security. There is a need to direct providers to the best location needed to supply information, which sometimes may be within a secure site. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 1100 \| 2110<br>AMT - Service Allowed Amount |
| Action | **Add Segment**<br>Add new Required Segment Loop ID 2110 / AMT - Service Allowed Amount with notes. |
| CR 1230 | Provide payers the ability to report the allowed amount for informational purposes for coordination of benefits. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 1100 \| 2110<br>AMT - Service Supplemental Amount |
| Action | **Add Segment Note**<br>Loop ID 2110 AMT Service Supplemental Amount - Add Segment Note clarifying that amounts reported at the claim level are not repeated at the service level. |
| CR 1153 | To clarify intended use. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 1100 \| 2110<br>AMT - Service Supplemental Amount |
| Action | **Delete Data Element Code Value**<br>Delete Data Element Code Value Loop ID 2110, AMT01 B6 (Allowed Actual). Code Value moved to new unique required REF (Service Allowed Amount) |
| CR 1230 | Provide payers the ability to report the allowed amount for informational purposes for coordination of benefits. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 1100 \| 2110<br>AMT - Service Supplemental Amount |
| Action | **Delete Data Element Code Value**<br>T2 Total Claim Before Taxes |
| CR 1139 | It is unclear what should go into the AMT*T2 money amount field, whether the original amount or adjudicated amount. Based on the confusion that exists in the industry between use of the T qualifier vs T2 qualifier (and the fact that no one seems to be using T2), it was determined the best solution is to remove T2 to eliminate confusion. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 1200 \| 2110<br>QTY - Service Supplemental Quantity |
| Action | **Modify Segment Repeat**<br>Loop ID 2110 QTY Service Supplemental Quantity - Modify Segment Repeat from 6 to 5. |
| CR 1154 | For consistency across all TR3s. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 1300 \| 2110<br>LQ - Health Care Remark Codes |
| Action | **Add Data Element Code Value**<br>Loop ID 2110/LQ01 (Code List Qualifier Code)<br><br>RM - Insurance Industry Specific Remark Codes<br><br>Update LQ to include use of new external code list for Insurance Industry Specific Remark Codes |
| CR 1234 | Create new external code list for industry specific remark codes that do not meet the criteria for CARCs or RARCs but are needed by their respective industries. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 1400 \| 2110<br>TOO - Tooth Information |
| Action | **Add Segment**<br>Add Segment Loop ID 2110 TOO Segment (Tooth Information) as situational, with situational rule, code values, and notes. |
| CR 1040 | DM was process and is available for next version.<br>The TOO segment should be added to the 835 for the purpose of a dental payment indicating the tooth number and surface that was adjudicated. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0100<br>PLB - Provider Adjustment |
| Action | **Modify Data Element Note**<br>Modify Data Element PLB03-01 to use external code list for Provider Adjustment Codes |
| CR 1039 | 835 - Make Provider Adjustment Codes an external list as there are situations where additional Claim Adjustment Group Codes are needed to meet changing business or regulatory requirements. Making this list external will allow more flexibility in meeting those needs. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0100<br>PLB - Provider Adjustment |
| Action | **Modify Data Element Note**<br>Modify Data Element note PLB03-02 to clarify use of Reference Identifier. |
| CR 1153 | To clarify intended use. |

| | |
|---|---|
| Location | X322 \| Health Care Claim Payment/Advice \| 835 \| 0200<br>SE - Transaction Set Trailer |
| Action | **Modify Data Element Note**<br>Transaction Set Trailer, Data Element SE02 (Transaction Set Control Number)<br><br>Changed to "The Transaction Set Control Numbers in ST02 and SE02 must be identical. The number is assigned by the originator and must be unique within a functional group (GS-GE). For example, start with the number 0001 and increment from there. The number also aids in error resolution research." |
| CR 999 | Revise the ST02 notes across the TR3's to make them consistent. |