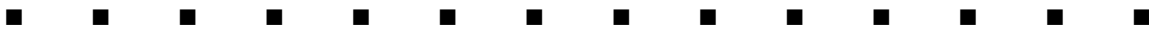




# HIPAA 835 Companion Document



*For use with the  
ASC X12N 835(004010X091) and (004010X091A1)  
Health Care Claim Payment/Advice Transaction Set  
Implementation Guide and Addenda*

*And the National Provider Identification*

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# Table of Contents

Introduction .....	5
Audience.....	5
Document Purpose.....	5
General Transaction Information .....	6
Getting Started .....	6
Key Points.....	6
Tufts Health Plan Specifications/Requirements.....	8
Special Considerations .....	11
Connecting to Tufts Health Plan .....	12
Setup Process .....	12
Security Statement .....	12
Contact Information.....	13
General HIPAA Questions.....	13
835 Transaction Questions .....	13
Appendix A: Tufts Health Plan 835 EDI Set-up Form.....	14
Appendix B: Tufts Health Plan 835 Transaction Enveloping Specifications.....	15
OUTBOUND Transaction .....	15
Appendix C: Tufts Health Plan's 835 Standard Group Codes for Commercial (HMO, POS, and PPO) and Tufts Health Plan Medicare Preferred Products .....	17



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## Introduction

Tufts Health Plan (Tufts HP) will offer a Health Insurance Portability and Accountability Act of 1996 (HIPAA) Health Care Claim Payment/Advice Transaction that allows providers to receive claim remittance information electronically. The ASC X12N 835(004010X091) and (004010X091A1) Health Care Claim Payment/Advice Transaction Set Implementation Guide and Addenda has been established as the standard for claim remittance transaction compliance.

### Audience

This document is designed to aid both technical and business areas. It contains Tufts Health Plan specifications of the transaction, contact information, and helpful hints.

### Document Purpose

This companion document serves as a Tufts HP-specific guide to the *835 Health Care Claim Payment/Advice Transaction Set Implementation Guide*. This document supplements, but does not contradict, any requirements in the *835 Transaction Set Implementation Guide*.

The primary focus of the document is to clarify how specific Segments and Data Elements will appear on your Tufts HP 835 Claim Payment/Advice Transaction. This document contains the following sections:

**General Transaction Information** explains the initial steps you will need to take to implement ASC X12N 835 transactions. It also contains key points to remember regarding 835 transactions.

**Tufts Health Plan Specifications/Requirements** provides Tufts HP-specific information to be used in addition to the required segments and data elements in the *835 Implementation Guide*.

**Special Considerations** describes certain conditionally required Segments and Data Elements that may not be reported on the 835 transaction as submitted.

**Connecting to Tufts Health Plan** explains how to connect to Tufts HP and receive your 835 transactions. It also contains a security statement.

**Appendix A: Tufts Health Plan 835 EDI Set-up Form** for requesting the receipt of the 835 transaction.

**Appendix B: Tufts Health Plan 835 Transaction Enveloping Specifications** contains general enveloping information for this transaction.

**Appendix C: HIPAA Claim Adjustment Group Code - ARC Relationship** outlines Tufts Health Plan's usage of the HIPAA Claim Adjustment Group Codes and their relationship - to our adjustments.

This document will be subject to revisions as new versions of the *835 Health Care Claim Payment/Advice Transaction Set Implementation Guide* are released.

## General Transaction Information

### Getting Started

For a valid transaction, please refer to the *National Electronic Data Interchange Transaction Set Implementation Guide & Addenda: Health Care Claim Payment/Advice ASC X12N 835 (004010X091) & (004010X091A1)*. This transaction guide can be ordered from the Washington Publishing Company's website at [www.wpc-edi.com](http://www.wpc-edi.com).

Please note Tufts HP is not responsible for any software utilized by the receiver for the ASC X12N 835 transaction.

For questions relating to the Tufts HP 835 Claim Payment/Advice Transaction, please contact the Tufts HP EDI Operations Department at 888-880-8699 x4042 or email your questions to [EDI\\_Operations@Tufts-Health.com](mailto:EDI_Operations@Tufts-Health.com).

### Key Points

- To receive an 835 transaction from Tufts HP, a receiver must be set up to do so. Refer to **Setup Process** section.
- The Tufts HP 835 Claim Payment/Advice Transaction contains paid and denied claim data on both electronic and paper claims for the HMO, POS, PPO and Tufts Health Plan Medicare Preferred products.
- The Tufts HP 835 Transaction will contain Remittance Information only. Tufts HP does not conduct Electronic Fund Transfers at this time.
- The Tufts HP will not be creating an 835 transaction for settlement and capitation checks.
- The Tufts HP 835 Transaction is available to receivers for the HMO, POS, PPO and Medicare Preferred products on a weekly basis. *All files are deleted after 7 days.*
- The selection of claims for the 835 transactions is based on the pay date. For new receivers requesting Tufts HP 835 Claim Payment/Advice Transactions, the 835 transaction will be created for the first check run following the receiver's go-live date for 835 transaction. No previous 835 transactions will be created.
- Existing receivers of the 835 Transaction can request a previous 835 transaction set, available for pickup again, for up to 8 weeks by contacting EDI Operations.
- Tufts HP paper Statements of Account (SOA) for HMO, POS, PPO and Medicare Preferred have not changed; therefore there will be differences between the paper SOAs and 835 Transactions. However, the payment amounts should always be the same between the related paper SOA and 835 Transaction. Due to HIPAA regulations, Tufts HP specific Message, Reason and Adjustment Codes, found on your paper SOA, cannot be sent on the 835 Transaction. These Tufts HP specific codes have been translated to HIPAA compliant codes for the 835 Transaction. It is important to note that your paper SOA will continue to reflect Tufts HP specific codes, whereas your 835 Transaction will reflect the new HIPAA codes.
- Tufts HP will continue with its current policy for paper claim corrections for HMO, POS, PPO and Medicare Preferred. A copy of your paper SOA and necessary documentation must be submitted with paper claim corrections. Do not send a paper copy of the Tufts HP 835 Transaction in place of the SOA.

- All Loops, Segments and Data Elements required and conditionally required by the 835 Transaction Set Implementation Guide will generally be sent if the original claim was submitted via an 837 Transaction. However, some Segments & Data Elements conditionally required will not be sent back on the 835 when:
  - a.) The original claim was submitted on paper,
  - b.) Claim required intervention for processing. For detailed information on this subject, please refer to the Tufts HP **Special Considerations** section of this document.
- The 835 Implementation Guide requires payers to categorize financial adjustments to claims into HIPAA Claim Adjustment Group Codes. Refer to the implementation guide for information and descriptions of these Adjustment Group Codes. Please note two instances below regarding the HIPAA Group Code "Contractual Obligation" (CO).
  - Contractual Obligation (CO) group code used when:
    - Financial adjustments to a claim because of Provider billing issues (i.e. Provider did not follow appropriate billing guidelines).
    - Waived co-payments will be categorized under the HIPAA Group Code "Contractual Obligation" (CO) not "Patient Responsibility" (PR).
  - Contractual Obligation (CO) group code **not** used for:
    - Correction & Reversals. Refer to your paper SOA for further details/ instructions for resubmitting your claim.
    - Patient Responsibility. If any portion of the co-payment is the responsibility of the patient, it will be up to the Provider to determine the amount due.
- **If a claim is submitted on paper without a National Provider Identifier (NPI), and no NPI is on file for that provider, no 835 will be generated.**
- **If a claim was submitted prior to the NPI Implementation and did not contain an NPI, but adjudicated after the implementation date, an 835 may not be generated.**

## Tufts Health Plan Specifications/Requirements

In addition to the required segments and data elements in the 835 Implementation Guide, the following grid documents Tufts HP specific information.

*Usage Key: R = Required, S = Situational*

Loop	Segment ID	Segment	Data Element ID	Data Element	Usage	Comments
N/A	BPR	Financial Information	BPR01	Transaction Handling Code	R	Qualifier will always equal "I" (Remittance Information Only).
			BPR04	Payment Method Code	R	Qualifier will either be "CHK" (check) or "NON" (Non-Payment Data).
N/A	TRN	Re-association Trace Number	TRN02	Check or EFT Trace Number	R	The Tufts HP check number will always be sent in this field.
N/A	REF	Receiver Identification			S	This segment will only be used if the Submitter ID # does not equal the Payee ID #. If the ID #'s do not equal, the Submitter ID # will be sent in REF02 (Receiver Identifier).
N/A	REF	Version Identification			S	Tufts HP will always send this segment.
1000B	N1	Payee Identification	N103	Payee Identification Qualifier	R	National Provider Identifier (NPI) is mandated for use by the HIPAA regulations. A qualifier of "XX" will be used.
1000B	N1	Payee Identification	N104	Payee Identification Code	R	National Provider Identifier (NPI) is mandated for use by the HIPAA regulations.
2000	LX	Header Number			S	Tufts HP will always send this segment.
2100	CLP	Claim Payment Information	CLP06	Claim Filing Indicator Code	R	This element will contain the HIPAA Claim Filing Indicator Code corresponding to the general Tufts HP Product name (i.e. "HM" for HMO, "13" for POS, "12" for PPO, "16" for Medicare Preferred).
			CLP07	Payer Claim Control Number	S	Tufts HP will always send this data element containing the claim number assigned by the payer.
2100	CAS	Claim Adjustment			S	In instances when financial adjustments occur at the Claim level this segment will be used. However, most financial adjustments will occur at the CAS Service Adjustment Segment.
2100	NM1	Corrected Patient/Insured Name			S	When possible, Tufts HP will only correct Member ID #s if they were submitted incorrectly on the 837 claims. This segment will act

Tufts Health Plan Specifications/Requirements

Loop	Segment ID	Segment	Data Element ID	Data Element	Usage	Comments
						as a flag to make you aware that the Member ID you submitted was incorrect. This segment will not be sent for Medicare Preferred.
2100	NM1	Rendering Provider Identification	N108	Identification Code Qualifier	S	National Provider Identifier (NPI) is mandated for use by the HIPAA regulations. A qualifier of "XX" will be used.
2100	NM1	Rendering Provider Identification	N109	Rendering Provider Identifier	S	The 10 digit National Provider Identifier (NPI) is mandated for use by the HIPAA regulations.
2100	DTM	Claim Date			S	This segment will be used only when Claim Statement Period Start & Claim Statement Period End Dates appear on institutional claims. Service dates will be reflected in the Service Payment Information Loop.
2110	SVC	Service Payment Information	SVC01-2	Procedure Code	R	Please note that there will be instances when SVC01-2 will carry "00000" when an Invalid Procedure Code was submitted on a claim.
			SVC05	Units of Service Paid Count	S	Please note that Anesthesia Units submitted as minutes on the 837 claim will be converted from minutes to number of units. SVC05 will reflect the converted units. When possible, SVC07 will reflect the original minutes submitted. SVC07 will not be sent for Medicare Preferred.
			SVC06	Composite Medical Procedure Identifier	S	This composite data element will be sent whenever the adjudicated procedure code provided in SVC01 is different from any portion of the procedure code from the submitted 837 claim. (i.e. revenue code, procedure code or modifiers) SVC06 will not be sent for Medicare Preferred.
2110	DTM	Service Date			S	In most instances this service level DTM segment will be sent for service lines even if claim dates have already been provided at the claim level DTM segment. Medicare Preferred will send start and end dates if submitted and start date <> end date.
2110	CAS	Service Adjustment			S	This segment will always be sent if there is a difference between the billed amount and paid amount at the service line.

Tufts Health Plan Specifications/Requirements

Loop	Segment ID	Segment	Data Element ID	Data Element	Usage	Comments
2110	REF	Service Identification			S	This segment will contain the line item control number (REF02) <u>or</u> the line item sequence number (LX01) submitted on the 837 claim. If neither number was submitted, this segment will not be sent. This segment will not be sent for Medicare Preferred.
2110	AMT	Service Supplemental Amount			S	This AMT segment will be sent if the SVC Service Payment Information Segment is sent. The claim service line Allowed Amount will be reflected in AMT02 and will not be sent in this segment if the value is zero.

## Special Considerations

This section identifies 835 data that will not be sent by Tufts HP for HMO, POS, PPO and Medicare Preferred claims submitted on paper.

All Loops, Segments and Data Elements required and conditionally required by the 835 Transaction Set Implementation Guide will generally be sent if the original claim was submitted via an 837 Transaction.

However, some conditionally required Segments and Data Elements *will not* be sent back on the 835 when:

- a.) The original claim was submitted on paper, or
- b.) Claim required intervention for processing. These segments and data elements are illustrated below:

Loop	Segment ID	Segment	Data Element ID	Data Element	Usage	Comments
2100	CLP	Claim Payment Information	CLP08	Facility Type Code	S	
			CLP09	Claim Frequency Code	S	
2100	NM1	Corrected Patient/ Insured Name			S	
2100	REF	Rendering Provider Identification			S	
2110	SVC	Service Payment Information	SVC04	National Uniform Billing Committee Revenue Code	S	
			SVC06	Composite Medical Procedure Identifier	S	This composite field includes SVC06-1 through SVC06-6. This field will only be sent for Code Review Bundling, otherwise it will not be sent for paper claims or claims submitted prior to HIPAA implementation.
			SVC07	Original Units of Service Count	S	This field will only be sent for Code Review Bundling, otherwise it will not be sent for paper claims or claims submitted prior to HIPAA implementation.
2110	REF	Service Identification			S	

## Connecting to Tufts Health Plan

### Setup Process

Providers interested in receiving 835 electronic remittance advice should contact EDI Operations at Tufts HP via email or telephone to request setup. Please refer to the “*Contact Information*” section for details. The setup form for EDI setup can be found in Appendix A.

EDI Operations will coordinate the appropriate process to set up an electronic data interchange. This includes completing File Exchange Request Form and the enveloping requirements.

Using data from the above forms, EDI Operations will set up a username and password for new receivers. Current 837 Submitters will use their current username/password setups to receive the 835 Transaction. Upon completion of the setup, EDI Operations will schedule a conference call with the provider to confirm the details.

### Security Statement

The HIPAA Security regulations were finalized recently. The final regulations outline standards for the security of individual health information used by health plans, health care clearinghouses and health care providers. Tufts Health Plan has taken reasonable and appropriate steps to be compliant with the Security Rule.

## Contact Information

The following sections provide contact information for any questions regarding HIPAA, 835 transactions, EDI and/or documentation.

### General HIPAA Questions

If you have any general HIPAA questions, please access the Tufts Health Plan HIPAA website. To access the site:

Go to <http://www.tuftshealthplan.com/providers>

Select the **Electronic Services** link.

### 835 Transaction Questions

The following table provides specific contact information by department and responsibility.

For Questions Regarding...	Contact	Phone Number	Email Address
EDI Claims and/or Remittance	EDI Operations	(888) 880-8699 x4042 Fax: 617-923-5555	<a href="mailto:EDI_Operations@tufts-health.com">EDI_Operations@tufts-health.com</a>
HMO, POS or PPO Claim Information	Provider Services	(888) 884-2404 (Fax: 617-972-9452)	
Tufts Health Plan Medicare Preferred Claim Information	Customer Service	(800) 279-9022 Fax: 617-972-9487	

## Appendix A: Tufts Health Plan EDI Set-up Form

Type of practice:       Solo  Group       Billing Service       Hospital/Facility  
 Type of account:               New               Existing (indicate changes below)  
 Type of claim billed:               837I (Institutional)       837P (professional)  
 Additional Transaction Type:       835               270  276               278

**Contact for solo, group, billing service client(s), hospital/facility**

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_  
 Office contact: \_\_\_\_\_ Practice Tax ID: \_\_\_\_\_  
 Telephone: ( ) \_\_\_\_\_ - \_\_\_\_\_ Fax: ( ) \_\_\_\_\_ - \_\_\_\_\_  
 E-Mail Address \_\_\_\_\_  
 Practice Management System Vendor \_\_\_\_\_  
 Vendor Contact Name \_\_\_\_\_ ( ) \_\_\_\_\_ - \_\_\_\_\_

**Payment Information**

Name of payee: \_\_\_\_\_ National Provider ID: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_  
 Payee tax ID: \_\_\_\_\_

**Provider Information**

Name of Provider	National Provider ID

Please contact EDI Operations (888-880-8699 x4042) if you have any questions regarding this form. EDI Operations will contact you after this information is verified to initiate electronic transactions.

Completed forms can be sent to [EDI\\_Operations@tufts-health.com](mailto:EDI_Operations@tufts-health.com) or faxed to 617-923-5555.

## Appendix B: Tufts Health Plan 835 Transaction Enveloping Specifications

### OUTBOUND Transaction

<b>Trading Partner1 (SENDER)</b>	170558746
<b>Trading Partner2 (RECEIVER)</b>	<receiver ID>#
<b>APRF (Application Reference)</b>	835
<b>Segment Terminator</b>	LF (line feed)
<b>Element Separator</b>	* (asterisk)

### OUTBOUND Transaction – ISA (Interchange Control Header Segment)

Elements	Size	Name	Input Data	Remarks
ISA-01	2	Authorization Information Qualifier	<b>00</b>	00 - No Authorization Information Present.
ISA-02	10	Authorization Information	<spaces>	Additional data identification
ISA-03	2	Security Information Qualifier	<b>00</b>	00 - No Security Information Present.
ISA-04	10	Security Information	<spaces>	<a href="#">Security Information</a>
ISA-05	2	Interchange ID Qualifier/Tufts HP Qualifier (Sender)	<b>01</b>	01 - DUNS (Dun & Bradstreet)
ISA-06	15	Interchange Sender ID/Tufts HP ID (Sender)	<b>170558746</b>	Tufts HP DUNS number
ISA-07	2	Interchange ID Qualifier/ Trading Partner Qualifier (Receiver)	<receiver qualifiers>#	Receiver Qualifiers 01, 14, 20, 27, 28, 29, 30, 33, or ZZ
ISA-08	15	Interchange Receiver ID/Trading Partner ID (Receiver)	<receiver ID>#	Receiver ID (Assigned by Tufts HP)
ISA-09	6	Interchange Date	<b>YYMMDD</b>	[Enter the date using the format YYMMDD; for example, January 1, 2003 would be entered as <b>030101</b> ]
ISA-10	4	Interchange Time	<b>HHMM</b>	[Enter the time using the format HHMM; for example, 1:30 PM would be entered as <b>1330</b> ]
ISA-11	1	Interchange Control Standards ID	<b>U</b>	U.S. EDI Community of ASC X12, TDCC, and UCS

Appendix B: Tufts Health Plan 835 Transaction Enveloping Specifications

Elements	Size	Name	Input Data	Remarks
ISA-12	5	Interchange Control Version Number	<b>00401</b>	Draft Standards for Trial Use Approved for Publication by ASC X12 Procedures Review Board through October 1997
ISA-13	9	Interchange Control Number	<auto generated>	Assigned and maintained by the interchange sender, must be identical to the associated Interchange Trailer, IEA-02.
ISA-14	1	Acknowledgement Requested	<b>0</b>	0 - No Acknowledgment Requested.
ISA-15	1	Usage Indicator	<b>P</b>	P- Production Data
ISA-16	1	Component Element Separator	~	[Enter a separator character, for example ~ or *]

**OUTBOUND Transaction – GS (Functional Group Header Segment)**

To indicate the beginning of a functional group and to provide control information.

Elements	Size	Name	Input Data	Remarks
GS-01	2	Functional Identifier Code	<b>HP</b>	HP - Health Care Claim Payment/Advice (835)
GS -02	2/15	Application Sender's Code	<b>170558746</b>	
GS -03	2/15	Application Receiver's Code	<receiver ID>#	Receiver ID (Assigned by Tufts HP)
GS -04	8	Date	<b>CCYYMMDD</b>	[Enter the date using the format CCYYMMDD; for example, January 1, 2003 would be entered as <b>20030101</b> ]
GS -05	4/8	Time	<b>HHMM</b>	[Enter the time using the format HHMM; for example, 1:30 PM would be entered as <b>1330</b> ]
GS -06	1/9	Group Control Number	<auto generated>	Assigned and maintained by the sender, must be identical to the associated functional group trailer, GE-02.
GS -07	1/2	Responsible Agency Code	<b>X</b>	X - Accredited Standards Committee X12
GS -08	1/12	Version/Release/Industry Identifier Code	<b>004010X091A1</b>	Draft Standards Approved for Publication by ASC X12 Procedures Review Board through October 1997, as published in this implementation guide.

## Appendix C: Tufts Health Plan’s 835 Standard Group Codes for Commercial (HMO, POS, and PPO) and Tufts Health Plan Medicare Preferred Products

This document outlines Tufts Health Plan’s usage of the HIPAA Claim Adjustment Group Codes and their relationship - to our adjustments. It also shows the corresponding HIPAA Standard Adjustment Reason Codes (ARC) that will be reported on the 835 Transaction for that adjustment type. In some cases, the adjustment type may correspond to multiple ARC. In conjunction with the HIPAA Claim Adjustment Group Codes and the ARC, Tufts Health Plan utilizes HIPAA Claim Status Codes. The Commercial Product uses 1, 2, 3, 4, and 22; Medicare Preferred uses 1, 2, 4, and 22 to report the adjudicated financial transaction.

HIPAA CLAIM ADJUSTMENT GROUP CODE	ADJUSTMENT TYPES	HIPAA STANDARD ADJUSTMENT REASON CODE USED BY COMMERCIAL PRODUCTS	HIPAA STANDARD ADJUSTMENT REASON CODE USED BY MEDICARE PREFERRED
<b>CO = Contractual Obligation</b> The amount is not the patient’s responsibility under any circumstances due to either a contractual obligation between the provider and the payer or a regulatory requirement.	<ul style="list-style-type: none"> <li>Difference billed and allowed</li> </ul>	Multiple ARC	Multiple ARC
	<ul style="list-style-type: none"> <li>Provider liability as indicated in the provider contact to include but not limited to:</li> </ul>	Multiple ARC	Multiple ARC
	<ul style="list-style-type: none"> <li>- Filing Limit</li> </ul>	29: The time limit for filing has expired.	29: The time limit for filing has expired.
	<ul style="list-style-type: none"> <li>- Duplicates</li> </ul>	Multiple ARC	18: Duplicate claim/service
	<ul style="list-style-type: none"> <li>- Billing Errors</li> </ul>	Multiple ARC	Multiple ARC
	<ul style="list-style-type: none"> <li>- Capitation</li> </ul>	24: Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.	24: Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan
	<ul style="list-style-type: none"> <li>- Waiver Co-pay</li> </ul>	139: Contracted funding agreement. The provider of services employs subscriber.	Not Applicable
	<ul style="list-style-type: none"> <li>- Bundled</li> </ul>	See OA	94: Processed in Excess of charges.
	<ul style="list-style-type: none"> <li>- Unbundling</li> </ul>	97: Payment is included in the allowance for another service/procedure.	97: Payment is included in the allowance for another service/procedure
	<ul style="list-style-type: none"> <li>- Retention/Withhold</li> </ul>	104: Managed care withholding.	104: Managed care withholding.

Appendix C: Tufts Health Plan's 835 Standard Group Codes for Commercial (HMO, POS, and PPO) and Tufts Health Plan Medicare Preferred Products

HIPAA CLAIM ADJUSTMENT GROUP CODE	ADJUSTMENT TYPES	HIPAA STANDARD ADJUSTMENT REASON CODE USED BY COMMERCIAL PRODUCTS	HIPAA STANDARD ADJUSTMENT REASON CODE USED BY MEDICARE PREFERRED
	- Other Carrier Amount	Not Applicable	23: Payment adjusted because charges have been paid by another payer.
<b>PI = Payer Initiated</b> In the payer's opinion, this amount is not the responsibility of the patient without a supporting contract between the provider and payer.	Submit Claim to another payer/vendor	109: Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.	Multiple ARC
	Group Coverage End-dated	109: Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.	Multiple ARC
	Non-contracting Providers	Multiple ARC	Multiple ARC
	- Difference billed and allowed	Multiple ARC	Multiple ARC
	- Provider liability including but not limited to:	Multiple ARC	Multiple ARC
	- Duplicates	Multiple ARC	18: Duplicate claim/service
	- Billing Errors	Multiple ARC	Multiple ARC
	- Capitation	Multiple ARC	Not applicable
	- Bundled	See OA	94: Processed in Excess of charges.
	- Unbundling	97: Payment is included in the allowance for another service/procedure	97: Payment is included in the allowance for another service/procedure
	- Other Carrier Amount	Not Applicable	23: Payment adjusted because charges have been paid by another payer.
<b>PR = Patient Responsibility</b> Is the amount adjusted that is the patient's responsibility.	• Deductible	1: Deductible Amount	1: Deductible Amount
	• Coinsurance	2: Coinsurance amount	Not Applicable
	• Co-pay	3: Co-payment Amount	3: Co-payment Amount

Appendix C: Tufts Health Plan's 835 Standard Group Codes for Commercial (HMO, POS, and PPO) and Tufts Health Plan Medicare Preferred Products

HIPAA CLAIM ADJUSTMENT GROUP CODE	ADJUSTMENT TYPES	HIPAA STANDARD ADJUSTMENT REASON CODE USED BY COMMERCIAL PRODUCTS	HIPAA STANDARD ADJUSTMENT REASON CODE USED BY MEDICARE PREFERRED
	• Eligibility	27: Expenses incurred after coverage terminated	Multiple ARC
	• Non-covered services	96: Non-Covered charges(s)	Multiple ARC
	• Benefit Maximums	119: Benefit maximum for this time period has been reached.	119: Benefit maximum for this time period has been reached.
	• Other member responsibility adjustments	Multiple ARC	Multiple ARC
CR = Correction & Reversals <b>This is the reversal of a previously reported or claim payment.</b>	• Claim Reversal	Multiple ARC	17: Payment adjusted because requested information was not provided or was insufficient/incomplete.
OA = Other Adjustment <b>Use this value if no other category is appropriate.</b>	• First Bundled Line	94: Processed in excess of charges.	See CO and PI