



**ARIZONA HEALTH CARE
COST CONTAINMENT SYSTEM
(AHCCCS)**

**Companion Document
and
Transaction Specifications
for the HIPAA
835 Claims Remittance Advice Transaction**

**Version 2.0
April 2009**

Revision History

Date	Version	Description	Author
05/12/2003	1.0	Initial draft for posting to the AHCCCS Web Site	AHCCCS Information Services Division
07/18/2003	1.1	Draft document for posting to the AHCCCS Web Site for HIPAA Transaction and Code Set implementation	AHCCCS Information Services Division
09/09/2003	1.2	Draft with detail-level modifications for posting to the AHCCCS Web Site.	AHCCCS Information Services Division
12/05/2003	1.3	Draft for HIPAA Transaction and Code Set implementation	AHCCCS Information Services Division
03/04/2004	1.4	Final Companion Document for 835 Claims Remittance Advise Transaction implementation	AHCCCS Information Services Division
06/08/2004	1.5	Final Companion Document for 835 Claims Remittance Advise Transaction implementation	AHCCCS Information Services Division
08/20/2007	1.6	NPI Changes	AHCCCS Information Services Division
04/21/2009	2.0	Restructured Companion Document File Naming Convention Changes	AHCCCS Information Services Division

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1. Introduction

Companion Documents

Companion Documents are intended to supplement the standard HIPAA Implementation Guides and are technical in nature. They are intended for technical staff members who are responsible for electronic transaction/file exchanges. This document provides specific information related to the fields and values reported in the AHCCCS 835 transaction.

Disclaimer

This Companion Document is intended to be a technical document describing the specific technical and procedural requirements for interfaces between AHCCCS and its trading partners. It does not supersede either health plan contracts or the specific procedure manuals for various operational processes. If there are conflicts between this document and either the health plan contracts or operational procedure manuals, the contract or procedure manual will prevail.

Substantial effort has been taken to minimize conflicts or errors; however, AHCCCS, the AHCCCS Information Services Division, or its employees will not be liable or responsible for any errors or expenses resulting from the use of information in this document. If you believe there is an error in the document, please notify the AHCCCS Information Services Division immediately.

2. 835 Claim Remittance Advice Transaction

Claim Remittance Advice Transaction

AHCCCS creates an 835 Remittance Advice Transaction for its receivers on a weekly basis. They are created at the same time as claim payments. It serves as a detailed remittance advice that shows payments, adjustments, and denials for each claim submitted by providers that choose to receive the 835 transaction.

At times there are gaps between the AHCCCS adjudication codes and the codes on the 835 transaction. Because of this, AHCCCS creates a sequential Remittance Advice Supplemental File along with the 835 Transaction. The Supplemental File carries claim identification information and the original adjudication codes generated for each claim or service line by the adjudication system. The Supplemental File is described in detail in Section 5.1, Supplemental File.

3. Technical Infrastructure and Procedures

3.1 Technical Environment

Trading Partner Setup Authorized receivers of the 835 Claim Remittance Advice Transactions can download 835 Transactions from the AHCCCS server. To become an authorized trading partner, please visit our trading partner setup website at: <http://www.azahcccs.gov/HIPAA/Testing/Default.asp>.

Technical Assistance and Help The AHCCCS Information Services Division (ISD) Customer Support Center is the primary contact for all questions related to electronic transactions and data. The preferred method of contact is email. All inquiries result in Ticket Number assignment and problem tracking. The contact information is:

- **Email:** EDICustomerSupport@azahcccs.gov
 - **Telephone Number:** (602) 417-4451
 - **Hours:** 7:00 AM – 5:00 PM AZ Time, Monday through Friday
 - **Information required for initial inquiry:**
 - Customer Name
 - Organization Name
 - Customer Email Address
 - Customer Telephone Number
 - Health Plan ID/Provider ID/Submitter ID
 - Transaction ID Inquiring About
 - Applicable ISA/GS Control Numbers
 - Topic/Nature of Problem (setup, connectivity, etc.)
 - **Information required for follow up inquiry:**
 - Ticket Number assigned by the Customer Support Center
-

3.2 File Naming Conventions

File Naming Conventions

835 File

The file naming convention for the batch 835 file is:

AZD835-XXXXXX-XX-YYMMDD-HHMMSS.TXT

- AZ is the state, D is daily, 835 is the transaction number
- XXXXXX represents the legacy provider ID number
- XX is the location code
- YYMMDD is the payment date
- HHMMSS is the process time
- TXT is the file extension

Supplemental File

The supplemental file provides additional claim adjudication information not available within the 835 Transaction. This file is not required for determining the status of a claim, but it does provide additional detailed information that Providers may find helpful. Refer to Section 5.1, About 835 Supplemental File, for additional information.

AZS835-XXXXXX-XX-YYMMDD-HHMMSS.TXT

- AZ is the state, S is supplemental, 835 is the transaction number
 - XXXXXX represents the legacy provider ID number
 - XX is the location code
 - YYMMDD is the payment date
 - HHMMSS is the process time
 - TXT is the file extension
-

4. Transaction Specifications

Overview

The purpose of these Transaction Specifications is to identify the data elements used in the 835 Claims Remittance Advice Transaction so that providers and other entities that receive 835 Transactions from AHCCCS will be able to understand and process transaction data.

Transaction Specifications provide how individual data elements are populated by AHCCCS, including the ISA/IEA and GS/GE envelopes.

Code Sets

There are three HIPAA code sets that describe the results of claim adjudication: Adjustment Group Code, Adjustment Reason Code, and Remark Code. Adjustment Group and Adjustment Reason Codes explain the differences between Charged Amounts and Paid Amounts at both claim and service line levels. For the 835, adjustments are variations between Charged and Paid Amounts that result from claim adjudication.

High level Adjustment Group Codes and more specific Adjustment Reason Code are associated with an adjustment amount on the 835 Transaction. Remark Codes have no direct relationship to dollar amounts, although many Remark Codes explain why a claim or service line is denied.

Adjustment code combinations are based on two factors. The first factor is the status categories that are assigned by the adjudication system:

- Original Paid Claims or Service Lines
- Replacement Claims
- Voided Claims
- Denied Claims or Service Lines

The second factor in adjustment code assignment is the reason for the adjustment. The following adjustment types (in addition to provider level adjustments that are not claim specific) are accommodated:

- Share of Cost Amount paid by the patient
- Amount paid by other health care carriers
- Pricing adjustments – reductions in Payment Amounts from Charged Amounts due to AHCCCS Allowed Amounts in payment

See the following table for a breakdown.

Status Category	Adjustment Type	835 Adjustment Group	835 Adjustment Reason
Original or Replacement	Share of Cost	“PR” – Patient Responsibility	“2” – Coinsurance Amount
Original or Replacement	Other Carrier	“OA” – Other Adjustment	“23” – Payment adjusted because charges have been paid by another payer.
Original or Replacement	Pricing	“CO” – Contractual Obligation	“45” - Contractual Adjustment
Void	Share of Cost	“CR” – Correction and Reversals	“2” – Coinsurance Amount
Void	Other Carrier	“CR” – Correction and Reversals	“23” – Payment adjusted because charges have been paid by another payer.
Void	Pricing	“CR” – Correction and Reversals	“45” - Contractual Adjustment
Denial	Pricing	“CO” – Contractual Obligation	“A1” – Claim denied charges

Inpatient institutional claims with tier-based pricing are priced and adjusted at the claim header level. All other claims are priced and adjusted by service line.

**Transaction
Specifications
Table**

Definitions of table columns follow:

Loop ID

The Implementation Guide's identifier for a data loop within a transaction. The outer envelopes (ISA/IEA and GS/GE segments) do not have loops and are always labeled "NA".

Segment ID

The Implementation Guide's identifier for a data segment within a loop.

Element ID

The Implementation Guide's identifier for a data element within a segment.

Element Name

A data element name as shown in the Implementation Guide. When the industry name differs from the Data Element Dictionary name, the more descriptive industry name is used.

Element Definition/Length

How the data element is defined in the Implementation Guide. For ISA and IEA Segments only, fields are of fixed lengths and are present whether or not they are populated. For this reason, field lengths are provided in this column after element definitions.

Valid Values

The valid values from the Implementation Guide that are used by AHCCCS.

Definition/Format

Definitions of valid values used by AHCCCS and additional information about AHCCCS data element requirements.

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ISA INTERCHANGE CONTROL SPECIFICATIONS						
Loop ID	Seg ID	Element ID	Element Name	Element Definition/Length	Valid Values	Definition/Format
ISA INTERCHANGE HEADER						
NA	ISA	ISA01	AUTHORIZATION INFORMATION QUALIFIER	Code to identify the type of information in the Authorization Information Element/2 Characters	00	No Authorization Information Present
NA	ISA	ISA02	AUTHORIZATION INFORMATION	Information used for additional identification or authorization of the interchange sender or the data in the interchange; the type of information is set by the Authorization Information Qualifier/10 characters		Leave field blank – not used by AHCCCS
NA	ISA	ISA03	SECURITY INFORMATION QUALIFIER	Code to identify the type of information in the Security Information/2 characters	00	No Security Information present
NA	ISA	ISA04	SECURITY INFORMATION	This field is used for identifying the security information about the interchange sender and the data in the interchange; the type of information is set by the Security Information Qualifier/10 characters		Leave field blank – not used by AHCCCS.
NA	ISA	ISA05	INTERCHANGE ID QUALIFIER	Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified/2 characters	ZZ	Mutually Defined
NA	ISA	ISA06	INTERCHANGE SENDER ID	Identification code published by the sender for other parties to use as the receiver ID to route data to them; the sender always codes this value in the sender ID element/15 characters		“AHCCCS” followed by the nine-digit AHCCCS Federal Tax ID number (866004791).
NA	ISA	ISA07	INTERCHANGE ID QUALIFIER	Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified/2 characters	ZZ	Mutually Defined
NA	ISA	ISA08	INTERCHANGE RECEIVER ID	Identification code published by the receiver of the data; When sending, it is used by the sender as their sending ID, thus other parties sending to them will use this as a receiving ID to route data to them/15 characters		The six-digit AHCCCS Provider ID
NA	ISA	ISA09	INTERCHANGE DATE	Date of the interchange/6 characters		The Interchange Date in YYMMDD format
NA	ISA	ISA10	INTERCHANGE TIME	Time of the interchange/4 characters		The Interchange Time in HHMM format
NA	ISA	ISA11	INTERCHANGE CONTROL STANDARDS IDENTIFIER	Code to identify the agency responsible for the control standard used by the message that is enclosed by the interchange header and trailer/1 character	U	U.S. EDI Community of ASC X12, TDCC, and UCS

ISA INTERCHANGE CONTROL SPECIFICATIONS						
Loop ID	Seg ID	Element ID	Element Name	Element Definition/Length	Valid Values	Definition/Format
NA	ISA	ISA12	INTERCHANGE CONTROL VERSION NUMBER	This version number covers the interchange control segments/5 characters	00401	Draft Standards for Trial Use Approved for Publication by ASC X12 Procedure Review Board through October 1997.
NA	ISA	ISA13	INTERCHANGE CONTROL NUMBER	A control number assigned by the interchange sender/9 characters		The Interchange Control Number. ISA13 must be identical to the control number in associated Interchange Trailer field IEA02.
NA	ISA	ISA14	ACKNOWLEDGEMENT REQUESTED	Code sent by the sender to request an Interchange Acknowledgement (TA1)/1 character	0	No Acknowledgement Requested AHCCCS does not request or expect TA1 Interchange Acknowledgement Segments from its trading partners.
NA	ISA	ISA15	USAGE INDICATOR	Code to indicate whether data enclosed is test, production or information/1 character	P T	Production Data Test Data
NA	ISA	ISA16	COMPONENT ELEMENT SEPARATOR	The delimiter value used to separate components of composite data elements/1 character		Delimiter values, by definition, cannot be used as data, even within free-form messages. The following separator or delimiter values are used by AHCCCS on outgoing transactions: Segment Delimiter - "~" (tilde – hexadecimal value X"7E") Element Delimiter - "{" (left rounded bracket – hexadecimal value X"7B") Composite Component Delimiter (ISA16) - " " (pipe – hexadecimal value X"7C") These values are used because they are not likely to occur within transaction data.

GS FUNCTIONAL GROUP SPECIFICATIONS						
Loop ID	Seg ID	Element ID	Element Name	Element Definition/Length	Valid Value	Definition/Format
NA	GS	GS01	FUNCTIONAL IDENTIFIER CODE	Code identifying a group of application related transaction sets	HP	Health Care Claim Payment/Advice (835)
NA	GS	GS02	APPLICATION SENDER'S CODE	Code identifying party sending transmission; codes agreed to by trading partners		AHCCCS repeats the Sender Identifier used in the ISA Segment.
NA	GS	GS03	APPLICATION RECEIVER'S CODE	Codes identifying party receiving transmission. Codes agreed to by trading partners		State Identifier (AZ=Arizona) plus the 6 digit AHCCCS Provider ID.
NA	GS	GS04	DATE	Date expressed as CCYYMMDD		The functional group creation date
NA	GS	GS05	TIME	Time on a 24-hour clock in HHMM format.		The functional group creation time
NA	GS	GS06	GROUP CONTROL NUMBER	Assigned number originated and maintained by the sender		A control number for the functional group of transactions
NA	GS	GS07	RESPONSIBLE AGENCY CODE	Code used in conjunction with Element GS08 to identify the issuer of the standard	X	Accredited Standards Committee X12
NA	GS	GS08	VERSION/RELEASE/INDUSTRY IDENTIFIER CODE	Code that identifies the version of the transaction(s) in the functional group		004010X091A1 AHCCCS uses Addenda versions of all HIPAA Transactions. This Version Number incorporates the final Addenda.

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835 CLAIMS REMITTANCE ADVICE TRANSACTION SPECIFICATIONS						
Loop ID	Seg ID	Element ID	Element Name	Element Definition	Valid Values	Definition/Format
N/A	BPR	BPR01	Transaction Handling Code	This code designates whether and how the money and remittance information will be processed	I	Remittance Information Only
N/A	BPR	BPR02	Total Actual Provider Amount	The total payment for this batch or transaction		The Total Payment Amount on the 835 Transaction. This is the amount of the weekly check or electronic transfer to the billing provider from an AHCCCS funding source (Acute, LTC, or KidsCare). If the Total Payment Amount on an 835 Transaction is negative due to a preponderance of payment recoveries, zero appears in this element. Positive and negative amounts are available at the institutional claim or professional/dental service line level.
N/A	BPR	BPR10	Originating Company Identifier	A unique identifier designating the company originating the transaction	1866004 791	The AHCCCS Federal Tax ID Number preceded by the number "1". For the organization originating the transaction. Used when BPR04 is "ACH" or "FWT".
N/A	TRN	TRN03	Originating Company Identifier	A unique identifier designating the company originating the transaction	1866004 791	The AHCCCS Federal Tax ID Number preceded by the number "1". For the organization originating the transaction.
N/A	TRN	TRN04	Reference Identification	Originating company supplemental code	AHCCCS	AHCCCS will appear in the payment NACHA CCD+ ACH format, addenda record type 7, Payment-Related Information data element.
1000A	N1	N101	Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	PR	Payer
1000A	N1	N102	Payer Name	Name identifying the organization remitting the payment	AHCCCS	Name of organization making the payment

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835 CLAIMS REMITTANCE ADVICE TRANSACTION SPECIFICATIONS						
Loop ID	Seg ID	Element ID	Element Name	Element Definition	Valid Values	Definition/Format
1000A	N3	N301	Payer Address Line	Address line for the payer's address		AHCCCS Street Address Line 1 ("701 E. Jefferson")
1000A	N4	N401	Payer City Name	The city name of the payer's address		AHCCCS City ("Phoenix")
1000A	N4	N402	Payer State Code	State postal code of the payer's address		AHCCCS State Code ("AZ")
1000A	N4	N403	Payer Postal Zone or ZIP Code	The postal zone code of the payer's address		AHCCCS Zip Code ("85034")
1000A	PER	PER01	Contact Function Code	Code identifying the major duty or responsibility of the person or group named.	CX	Payers Claim Office
1000A	PER	PER02	Payer Contact Name	Free-form name	IN STATE	
1000A	PER	PER03	Communication Number Qualifier	Code identifying the type of communication number.	TE	Telephone
1000A	PER	PER04	Payer Contact Communication Number	Complete communications number including country or area code when applicable.	6024177 670	The contact local telephone number for AHCCCS.
1000A	PER	PER05	Communication Number Qualifier	Code identifying the type of communication number.	TE	Telephone
1000A	PER	PER06	Payer Contact Communication Number	Complete communications number including country or area code when applicable.	8007947 670	The contact 800 telephone number for AHCCCS.
1000B	N1	N101	Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	PE	Payee
1000B	N1	N102	Information Receiver Last or Organization Name	The name of the organization or last name of the individual that expects to receive information or is receiving information		Receiver Name
1000B	N1	N103	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	FI XX	The payee's Federal Taxpayer's ID Number National Provider ID
1000B	N1	N104	Payee Identifier	Number identifying the organization receiving the payment		National Provider ID will appear in this field or Payee's Tax ID for atypical providers.
1000B	N3	N301	Payee Address Line	The payee's address line		Payee's Street Address Line 1
1000B	N3	N302	Payee Address Line	The payee's address line		Payee's Street Address Line 2

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835 CLAIMS REMITTANCE ADVICE TRANSACTION SPECIFICATIONS						
Loop ID	Seg ID	Element ID	Element Name	Element Definition	Valid Values	Definition/Format
1000B	N4	N401	Payee City Name	The City Name of the payee's address		Payee's City
1000B	N4	N402	Payee State Code	The State Postal Code of the payee's address		Payee's State
1000B	N4	N403	Payee Postal Zone or ZIP Code	The Zip Code of the payee's address		Payee's Zip Code
1000B	REF	REF01	Reference Identification Qualifier	Code qualifying the Reference Identification	TJ	Federal Taxpayer ID Number Qualifier
1000B	REF	REF02	Additional Payee Identifier	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier		Federal Taxpayer ID Number of the provider, or 6 digit AHCCCS Provider ID of atypical providers
2000	TS3	TS301	Provider Identifier	Number assigned by the payer, regulatory authority, or other authorized body or agency to identify the provider		Atypical Service Providers The AHCCCS ID and Location Code of the provider. Health Care Service Providers The National Provider Identifier (NPI).
2000	TS3	TS302	Facility Type Code	Code identifying the type of facility where services were performed; the first and second positions of the Uniform Bill Type code or the Place of Service code from the Electronic Media Claims National Standard Format	99	AHCCCS uses Location Code "99" (Other Unlisted Facility) to populate this required field. Location Codes that more truly indicate where the service was performed appear at the claim level.
2000	TS3	TS303	Fiscal Period Date	Last day of provider's fiscal year		December 31 of the current year in CCYY1231 format. All claims reported for a provider will always fall within the same fiscal period.
2000	TS3	TS304	Total Claim Count	Total number of claims in this 2000 Loop		The number of paid and denied claims reported for the service provider in Element TS301. Pended claims and claims not yet processed are not included in the 835 Transaction.
2000	TS3	TS305	Total Claim Charge Amount	The sum of all charges included within this 2000 Loop		The total charges for all paid and denied claims reported for the service provider in Element TS301.

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835 CLAIMS REMITTANCE ADVICE TRANSACTION SPECIFICATIONS						
Loop ID	Seg ID	Element ID	Element Name	Element Definition	Valid Values	Definition/Format
2100	CLP	CLP02	Claim Status Code	Code specifying the status of a claim submitted by the provider to the payer for processing	1 2 3 4 22	<p>Processed as Primary (Original Paid and Replacement Claims)</p> <p>Processed as Secondary</p> <p>Processed as Tertiary</p> <p>Denied</p> <p>Reversal of Previous Payment (Void Claims and the void component of Replacement Claims)</p> <p>These are the Claim Status Code values used by AHCCCS on 835 Transactions. "Processed as Primary" indicates a normal payment.</p> <p>For claim reversals, two claims appear, one to void the original (CLP02 = "22") and the other to create a new replacement claim (CLP02 = "1, 2 or 3").</p>
2100	CLP	CLP03	Total Claim Charge Amount	The sum of all charges included within this claim		The Total Charged Amount for the claim. This amount includes Share of Cost payments by the patient and amounts paid by other carriers prior to AHCCCS.
2100	CLP	CLP04	Claim Payment Amount	Net provider reimbursement amount for this claim (includes all payments to the provider)		The amount AHCCCS would have paid prior to any discounts or interest.
2100	CLP	CLP05	Patient Responsibility Amount	The amount determined to be the patient's responsibility for payment		<p>The Share of Cost Amount paid by the recipient.</p> <p>If a Share of Cost Amount is paid by a patient, it is included in the provider's Charged Amount and shown on the claim level CAS Segment.</p>
2100	CLP	CLP06	Claim Filing Indicator Code	Code identifying type of claim or expected adjudication process	MC	Medicaid

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835 CLAIMS REMITTANCE ADVICE TRANSACTION SPECIFICATIONS						
Loop ID	Seg ID	Element ID	Element Name	Element Definition	Valid Values	Definition/Format
2100	CLP	CLP07	Payer Claim Control Number	A number assigned by the payer to identify a claim The number is usually referred to as an Internal Control Number (ICN), Claim Control Number (CCN) or a Document Control Number (DCN)	00 - 99	The 14-character Claim Reference Number (CRN) assigned by AHCCCS. At the claim level, the last two digits of the CRN are zeros.
2100	CLP	CLP08	Facility Type Code	Code identifying the type of facility where services were performed; the first and second positions of the Uniform Bill Type code or the Place of Service code from the Electronic Media Claims National Standard Format		For Professional and Dental Claims, CLP08 is the Place of Service. Since the adjudication system maintains Place of Service at the line rather than the claim level, CLP08 is the Place of Service from the initial line. For Institutional Claims, CLP08 consists of the first and second characters of the Type Bill Code.
2100	CLP	CLP09	Claim Frequency Code	Code specifying the frequency of the claim This is the third position of the Uniform Billing Claim Form Bill Type		CLP09 Claim Frequency Code values of "7" (Replacement) and "8" (Void) indicate claims that perform these functions. All other valid Claim Frequency values are for original claims.
2100	NM1	NM101	Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	QC	Patient
2100	NM1	NM102	Entity Type Qualifier	Code qualifying the type of entity	1	Person
2100	NM1	NM103	Patient Last Name	The last name of the individual to whom the services were provided		The patient's Last Name as submitted on the claim.
2100	NM1	NM104	Patient First Name	The first name of the individual to whom the services were provided		The patient's First Name as submitted on the claim.
2100	NM1	NM105	Patient Middle Name	The middle name of the individual to whom the services were provided		If present, the patient's Middle Name or Middle Initial as submitted on the claim.
2100	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	MR	Medicaid Recipient Identification Number
2100	NM1	NM109	Patient Identifier	Patient identification code		The recipient's nine-character AHCCCS ID.
2100	NM1	NM101	Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	74	Corrected Insured

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835 CLAIMS REMITTANCE ADVICE TRANSACTION SPECIFICATIONS						
Loop ID	Seg ID	Element ID	Element Name	Element Definition	Valid Values	Definition/Format
2100	NM1	NM102	Entity Type Qualifier	Code qualifying the type of entity	1	Person
2100	NM1	NM103	Corrected Patient or Insured Last Name	Corrected last name of the patient or insured		The recipient's Last Name as known to AHCCCS.
2100	NM1	NM104	Corrected Patient or Insured First Name	Corrected first name of the patient or insured		The recipient's First Name as known to AHCCCS.
2100	NM1	NM105	Corrected Patient or Insured Middle Name	Corrected middle name of the patient or insured		If present, the recipient's Middle Initial as known to AHCCCS.
2100	NM1	NM101	Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	82	Rendering Provider
2100	NM1	NM102	Entity Type Qualifier	Code qualifying the type of entity	2	Non-Person Entity
2100	NM1	NM103	Rendering Provider Last or Organization Name	The last name or organization of the provider who performed the service		The full name of the service provider. This is how the Provider Name appears in the adjudication system.
2100	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	XX	National Provider ID Qualifier
2100	NM1	NM109	Rendering Provider Identifier	The identifier assigned by the payer to the provider who performed the service		National Provider ID
2100	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	F8	Original Reference Number AHCCCS uses this REF Segment to show the AHCCCS CRN of a claim being replaced or voided.
2100	REF	REF02	Other Claim Related Identifier	Code identifying other claim related reference numbers		The 14 character Claim Reference Number (CRN) of the claim being replaced or voided when the Claim Frequency Code (CLP09) has a value of "7" (Replacement) or "8" (Void).

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835 CLAIMS REMITTANCE ADVICE TRANSACTION SPECIFICATIONS						
Loop ID	Seg ID	Element ID	Element Name	Element Definition	Valid Values	Definition/Format
2100	AMT	AMT01	Amount Qualifier Code	Code to qualify amount	I D8 AU F5	<p>Interest (an additional amount paid by AHCCCS to the provider due to late claim payment)</p> <p>Discount Amount (a reduction in the amount paid by AHCCCS to the provider due to a prompt pay discount in the provider's contract)</p> <p>Coverage Amount (the AHCCCS Allowed Amount)</p> <p>Patient Amount Paid (a Share of Cost Amount)</p> <p>An Allowed Amount is present for every claim. Other amounts are reported on separate AMT Segments when they are present.</p> <p>Amounts in this segment are independent of amounts in CAS Segments and are not referenced for internal balancing. They do, however, contribute to differences between Charged and Paid Amount reported in the CAS Segment. When this happens, the same Amount appears in both places.</p>
2100	AMT	AMT02	Claim Supplemental Information Amount	Amount of supplemental information values associated with the claim		The positive or negative dollar amount described by the qualifier in AMT01.

GE FUNCTIONAL GROUP SPECIFICATIONS						
NA	GE	GE01	NUMBER OF TRANSACTION SETS INCLUDED	The number of transactions in the functional group ended by this trailer segment		
NA	GE	GE02	GROUP CONTROL NUMBER	Assigned number originated and maintained by the sender		This number must match the control number in GS06.
IEA INTERCHANGE SPECIFICATIONS						
NA	IEA	IEA01	NUMBER OF INCLUDED FUNCTIONAL GROUPS	A count of the number of functional groups included in an interchange/5 characters		The number of functional groups of transactions in the interchange.
NA	IEA	IEA02	INTERCHANGE CONTROL NUMBER	A control number assigned by the interchange sender/9 characters		A control number identical to the header-level Interchange Control Number in ISA13.

5. Supplemental File

Supplemental File Summary

A basic purpose of all claim remittance advices, including the 835 Transaction, is to communicate to claim submitters the reasons why billed services are paid or denied. Both the current paper RA used by AHCCCS and the electronic 835 RA Transaction have many adjudication code values and messages that serve this purpose.

Frequently, however, HIPAA offers no reasonable translation for detailed AHCCCS Pricing, Edit, and Reason Codes. For this reason, AHCCCS has created an 835 Remittance Advice Supplemental File to accompany each 835 Transaction. The Supplemental File supplies all of the claim or service line pricing and adjudication codes that are generated by the adjudication system prior to translation and that are included on paper RAs. The file is available to 835 receivers that request it.

In terms of claim level and line level information, the Supplemental File follows the structure of the AHCCCS 835 Transaction. Claims are defined as multi-line invoices for institutional claims and single services for professional and dental claims.

Institutional claims have only claim header data on the Supplemental File because that is the level at which adjudication messages are generated by the adjudication system. This is the case even when the 835 includes line level pricing and adjustment data for outpatient institutional claims and inpatient claims paid on a cost-to-charge basis. Professional and dental claims have both header and line data on the Supplemental File.

The 835 Supplemental File is a fixed-length sequential file with 197 byte records. It has four record types:

- A single Header Record with identification information on the payer and billing provider
- Multiple Claim Report Records with Patient Account Numbers, AHCCCS Claim Reference Numbers (CRN's), and adjudication system codes within each Comment Type
- A single Processing Notes Record with the adjudication code descriptions for all adjudication codes generated for claims submitted by a billing provider
- A single Trailer Record with a control count

A single Header and Trailer Record appear at the beginning and end of each Supplemental File. A Claim Report Record appears for each institutional invoice or professional/dental service. A Processing Notes Record is created for each billing provider. It provides messages associated with the adjudication codes on the billing provider's Claim Report Records.

Data element level information on the 835 Supplemental File appears in the remainder of this section.

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835 SUPPLEMENTAL FILE SPECIFICATIONS				
Record Type	Field Name	Field Description	Field Length/ Usage	Comments
HEADER RECORD – 1 record per 835 Transaction				
Header	Record Type	A code for one of the four Record Types on the 835 Supplemental File	2/AN	“HR” = Header Record
Header	File Name	A descriptive name for the file	35/AN	“REMITTANCE ADVICE SUPPLEMENTAL FILE”
Header	Payer Name	The name of the claim payer	50/AN	“ARIZONA”
Header	Payer’s Tax ID	The Federal Tax ID of the claim payer	20/AN	“866004791”
Header	Billing Provider ID	The AHCCCS Identification Number assigned to the Billing Provider	8/AN	
Header	Billing Provider Name	The name of the Billing Provider	25/AN	The full name of the billing provider with intervening spaces between name components
Header	Billing Provider Tax ID	The Federal Tax ID of the Billing Provider	20/AN	
Header	Filler		37/AN	Filled with spaces
CLAIM REPORT RECORD – 1 or more records per 835 Transaction				
Claim Report	Record Type	A code for one of the four Record Types on the 835 Supplemental File	2/AN	“S1” = Claim Report Record
Claim Report	Patient Account Number	The claim submitter’s ID Number for the patient	20/AN	
Claim Report	AHCCCS Claim Number	The Claim Reference Number (CRN) or Service Line Reference Number assigned by AHCCCS	14/AN	For institutional claims reported at the claim level, the final two characters are zeros. For professional and dental service lines, the final two characters carry the Line Number with a value of more than zero.
Claim Report	Recipient ID	The AHCCCS ID Number for the recipient	10/AN	The nine-character AHCCCS Recipient ID
Claim Report	Claim Status Code	The claim or line level status code	1/AN	For institutional claims, this Status Code is always at the claim level. For professional and dental claims, it is at the service line level without an equivalent claim level code on the 835. Valid values are: <ul style="list-style-type: none"> • “1” = Paid • “2” = Adjusted • “3” = Voided • “4” = Denied
Claim Report	Claim Status Date	The date on which the adjudication system Status Code from which the Claim Status Code is derived was assigned.	8/AN	Format is CCYYMMDD.

835 SUPPLEMENTAL FILE SPECIFICATIONS				
Record Type	Field Name	Field Description	Field Length/Usage	Comments
Claim Report	Comment Type	An AHCCCS code for the type of comment in the Comment Text field.	2/AN	Code values correspond to the four Comment Type descriptions identified below.
Claim Report	Comment Text	A field defined separately for each type of Comment generated by the adjudication system.	140/AN	<p>A description of the adjudication system Comment Type appears at the beginning of each comment. Comment Types identified by descriptions are:</p> <ul style="list-style-type: none"> • PRICE EXPL – An explanation of the pricing methodology used to price the claim or service line. For example, “APD” for Ancillary Per Discharge Rate on an inpatient claim. • REASON CDS – Claim Reason or Edit/Result Codes generated by the adjudication system to explain denials and payment cut-backs. For example “H129.2” for Primary Diagnosis Code is Invalid for Recipient Age. • TIER DATA – The pricing tier or tiers at which an inpatient claim is paid. For example “SUR” for Surgery Tier. • COMMENTS – Additional comments entered by reviewers. For example, “OUTLIER REQUESTED, NOT QUALIFIED”. <p>Descriptions of all codes used on an 835 Transaction appear in the Processing Notes Record.</p> <p>Layout for the comment text field follows:</p>

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835 SUPPLEMENTAL FILE SPECIFICATIONS				
Record Type	Field Name	Field Description	Field Length/ Usage	Comments
				<p>NOTE: The Comment Text field contains different formats, depending on the Comment Type.</p> <p>Comment Type 'A': There are three different formats for this type: (1) Price Explanation Code 3 characters 10 Occurrences of X(14) Price Explanation Reason 2 characters Filler 9 characters</p> <p>(2) Price Explanation Ind. 1 character 10 Occurrences of X(14) Price Explanation Rate 3 characters Filler 10 characters</p> <p>(3) Filler 1 character 10 Occurrences of X(14) Price Expl. Type Ind. 1 character Price Explanation Type 3 characters Filler 9 characters</p> <p>Comment Type 'R': There is one format for this type: (1) Reason Code 6 characters 17 Occurrences of X(8) Filler 2 characters</p> <p>Comment Type 'T': There is one format for this type: (1) Tier 1 5 characters 1 Occurrence of X(140) Filler 51 characters Reason 1 5 characters Filler 8 characters Tier 2 3 characters Filler 53 characters Reason 2 5 characters Filler 10 characters</p> <p>Comment Type 'X': Used to indicate free form. There is no format for this type.</p>
PROCESSING NOTES RECORD – 1 record per 835 Transaction				
Notes	Record Type	A code for one of the Record Types on the 835 Supplemental File	2/AN	"S2" = Processing Notes Record
Notes	Processing Note Code	An AHCCCS Adjudication Code that appears in the Comment Text Field on Claim Records.	6/AN	A claim or service line adjudication code that appears in the Comment Text field of a Claim Report Record for a billing provider.
Notes	Processing Note Description	The message associated with the AHCCCS Adjudication Code.	140/AN	A description of the claim or service line adjudication code. Code values generated for all claims for a billing provider are unduplicated.
Notes	Filler		49	

835 SUPPLEMENTAL FILE SPECIFICATIONS				
Record Type	Field Name	Field Description	Field Length/ Usage	Comments
TRAILER RECORD – 1 record per 835 Transaction				
Trailer	Record Type	A code for one of the Record Types on the 835 Supplemental File	2/AN	“TR” = Trailer Record
Trailer	Trailer Record Count	The number of records in the 835 Supplemental File, including the Header and Trailer Records.	9/N	
Trailer	Filler		186	