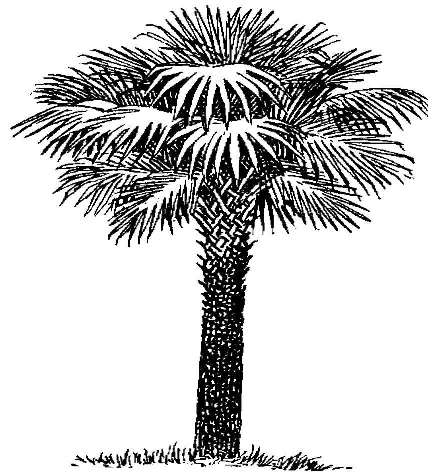
PGBA, LLC

Tricare Companion Document



835 Health Care Claim Payment/Advice – 005010X221A1

ANSI ASC X12N

Revised: April 2011

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Introduction

Note: Production files of the HIPAA implementation standard 835 Health Care Claim Payment Advice transactions will not be sent outbound prior to January 01, 2011.

This document is the property of PGBA, LLC and is for the use solely in your capacity as a Trading Partner of health care transactions with PGBA, LLC.

This document provides information related to specific elements with the ANSI ASC X12 835 transactions. It does not change the definition, data conditions, or use of the data elements or segments in a standard. Nor does it add data elements or segments to the maximum defined data set. It will not use any code or data elements that are marked "not used" in the standard's implementation specifications or are not in the standard's implementation specification(s), or change the meaning or intent of the HIPAA standards implementation specifications. (Refer to Standards for Electronic Transactions, *Federal Register, Vol. 75, No. 197, October 13, 2010*.

This document is intended solely for use as a companion to the Health Insurance Portability and Accountability Act (HIPAA) mandated ANSI ASC X12 Health Care Claim Payment Advice transaction set Implementation Guides (IG). Specific payer instructions contained in this document are provided for clarification purposes only. This document should be used in conjunction with the applicable HIPAA Implementation Guides published by Washington Publishing Company and the Blue Cross Blue Shield of SC EDI Gateway documentation.

The Final Rule adopting updated versions of the standards for electronic transactions was published in the Federal Register on January 16, 2009. The URL Link to the Federal Register is: http://www.access.gpo.gov. This final rule also adopts a transaction standard for Medicaid pharmacy subrogation. In addition, this final rule adopts two standards for billing retail pharmacy supplies and professional services, and clarifies who the "senders" and "receivers" are in the descriptions of certain transactions. The updated versions are available and can be downloaded through the Washington Publishing Company website at http://www.wpc-edi.com.

This document is incorporated by reference in the Trading Partner Agreement. All instructions were written as known at the time of publication and are subject to change. Changes will be communicated in future letters and on the TRICARE web site: www.mytricare.com.

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Appropriate steps must be taken before receiving production ANSI ASC X12N 835 transactions, such as testing, completion of an EDIG Trading Partner Agreement validation and demographic confirmation with our customer support staff. To begin the process, receive more information or ask questions, please contact the Tricare EDI Help Desk at 1-800-325-5920 (Menu Option 2).

ANSI ASC X12N 835 Health Care Claim (005010X221A1) – Reporting Instruction Clarifications

Overview

One 835 transaction set reflects a single payment advice or check. Multiple claims can be referenced within one 835. This document refers only to 835's for PGBA, LLC and their trading partners and does not reflect what other payers will return.

There are two formats, or views that are used to present the transaction sets in the National Electronic Data Interchange Implementation Guide edits. They are the implementation view and the standard view. The intent of the implementation view is to clarify the segments' purpose and use by restricting the view to display only those segments used with their assigned health care names. For this reason the implementation view of the transaction set is presented within this document.

The X12 835 Version 5010 remittance transaction is divided into three groups of segment sets, called tables:

Table 1 Header - contains general payment information, such as amount, payee, payer, trace number, and payment method.
Table 2 Detail - contains the Explanation Of Benefits (EOB) information related to adjudicated claims and services
Table 3 Summary - contains the Provider Level Adjustment Segment, PLB, which provides information, related to adjustments to the payment amount not specific to Table 2 claims. These adjustments can either increase or decrease the actual payment with respect to the Table 2 claim charges.

Although the remittance information in Tables 2 and 3 are not always provided, the intention of this business use of the 835-remittance transaction is for payers to provide some claim or provider-specific information along with the payment information. The following table contains the segments provided by PGBA, LLC for an 835 X12 ERA:

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Table 1 - Header

SEG. ID	NAME	USAGE	REPEAT
ST	Transaction Set Header	Required	1
BPR	Financial Information	Required	1
TRN	Re-association Trace Number	Required	1
REF	Version Identification	Situational	1
REF	Receiver Identification	Situational	1
DTM	Production Date	Situational	1
LOOP ID – 1000A PAYER IDENTIFICATION			**1**
N1	Payer Identification	Required	1
N3	Payer Address	Required	1
N4	Payer City, State, ZIP Code	Required	1
PER	Payer Contact Information	Situational	1
PER	Payer Technical Contact Information	Required	1
LOOP ID – 1000B PAYEE IDENTIFICATION			**1**
N1	Payee Identification	Required	1
N3	Payee Address	Situational	1
N4	Payee City, State, ZIP Code	Situational	1

Table 2 Detail

SEG. ID	NAME	USAGE	REPEAT
LOOP ID - 2000 HEADER NUMBER			**>1**
LX	Header Number	Situational	1
LOOP ID - 2100 CLAIM PAYMENT INFORMATION			**>1**
CLP	Claim Payment Information	Required	1
NM1	Patient Name	Required	1
NM1	Insured Name	Situational	1
NM1	Service Provider Name	Situational	1
NM1	Crossover Carrier Name	Situational	1
MIA	Inpatient Adjudication Information	Situational	1

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MOA	Outpatient Adjudication Information	Situational	1
REF	Other Claim Related Identification	Situational	5
REF	Rendering Provider Identification	Situational	10
DTM	Claim Date	Situational	4
PER	Claim Contact Information	Situational	3
AMT	Claim Supplemental Information	Situational	14
QTY	Claim Supplemental Quantity	Situational	15
LOOP ID – 2110 SERVICE PAYMENT INFORMATION			**999**
SVC	Service Payment Information	Situational	1
DTM	Service Date	Situational	3
CAS	Service Adjustment	Situational	99
REF	Service Identification	Situational	7
REF	Rendering Provider Information	Situational	10
AMT	Service Supplemental Amount	Situational	12
QTY	Service Supplemental Quantity	Situational	6
LQ	Health Care Remark Codes	Situational	99

Table 3 – Summary

SEG. ID	**NAME**	**USAGE**	**REPEAT**
PLB	Provider Adjustment	Situational	>1
SE	Transaction Set Trailer	Required	1

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835 Balancing

Three levels of balancing occur within the 835 transaction:

- **Service Level Balancing** – Claim Adjustment Segments (CAS) can be generated at either the service level or claim level but not both. PGBA, LLC Claim Adjustment Segments (CAS) will be generated only at the service level. For each claim line, the submitted service charge (SVC02 segment) minus all of the monetary adjustments (CAS03, 06, 09, 12, 15, and 18 segments) must equal the amount paid (SVC03).
- **Transaction Set Balancing** – Balancing must occur within each Claim Payment loop so that the submitted charges for the claim minus the sum of all monetary adjustments equals the claim paid amount. Because all Claim Adjustment Segments (CAS) will be generated at the service level, claim level balancing requires that the total charge submitted for the claim (CLP03 segment) minus the sum of the service level adjustment segments (CAS03, 06, 09, 12, 15, and 18 segments) equal the amount paid for the claim (CLP04 segment).
- **Claim Level Balancing** – Balancing must also occur within a transaction, defined as all segments included within a set of ST and SE segments. Provider level adjustments (PLB segments) are used to report remittance information that is not specific to the claims or services. PLB segments reflect increases or reductions to the amount remitted. Transaction balancing requires the sum of all claim payments (CLP04 segments) minus the sum of all provider level adjustments (PLB04, 06, 08, 10, 12, and 14 segments) equal the total payment amount (BPR02 segment).

Adjustments within the 835, through use of the Claim Adjustment and Service Adjustment Segments (CAS) or Provider Adjustment Segments (PLB) decrease the payment when the adjustment amount is positive, and increase the payment when the adjustment amount is negative.

Service detail will be reported in the 835 for all institutional claims or any time payment adjustments are related to specific line items from the original submitted claim. If any service detail is reported in the claim payment, all services for the claim payment will be reported.

All reductions are documented at the service level. They are also used to differentiate between the units that were reported and the actual units that were used to adjudicate the claim/service. The adjustment group is also indicated. The nature of the adjustment is identified by a standard list of adjustment reason codes published by the Washington Publishing Company (www.wpc-edi.com).

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Provider level adjustments include remittance information that is not specific to the claim(s)/service(s) contained in the prior level of the 835 transaction. These provide for reporting increases or reductions to the amount remitted. Reference numbers are used for further identification and reconciliation.

The total payment will agree with the remittance detailing that payment.

Maximums/Limitations

The 835 will not be issued for less than zero dollars.

Control / Reference Numbers

If reported in the claim, the line item control number will be returned in the electronic remittance file. When not reported in the claim, the original service line number will be returned as the line item control number.

Claim and Service Level Information

- A Claim Status Code is used to identify the status of the entire claim as assigned by the payer. Possible status codes describe the following conditions: processed as primary, processed as secondary, processed as tertiary, denied, reversal of previous payment, predetermination pricing only, processed as primary, secondary or tertiary and forwarded to additional payer(s) and not our claim, forwarded to additional payer(s).
- Patient Responsibility Amount will balance to supporting claim/service level adjustments.
- DRG Related Group Code and Weight will be present when adjudication considered the DRG.
- Corrected insured name or identification number is provided when available.

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Bundling and Unbundling

Procedure code bundling or unbundling occurs when a payer believes that the actual services performed and reported for a claim payment can be represented by a different group of procedure codes. Grouping usually results in a lower payment from the payer. Bundling occurs when two or more reported procedures are going to be paid under only one procedure code. Unbundling occurs when one submitted procedure code is to be paid and reported back as two or more procedure codes. PGBA, LLC only performs the bundling process utilizing software from an outside vendor. No unbundling is performed by PGBA, LLC.

When bundling occurs, **all** of the originally submitted procedures will be reported back to the payee in the remittance advice. This reporting of the originally submitted procedures will be limited to HIPAA claims, i.e. claims received electronically in the X12 837 format. All non-HIPAA claims will be reported on the X12 835 as they were adjudicated.

Claim/Service Adjustments

- For 835's coming from other payers, the Service Adjustment Segments may provide the reasons, amounts and quantities of any adjustments that the payer made to the original submitted charge.
- For 835's coming from PGBA, LLC, only Service Adjustment Segments will provide the reasons, amounts and quantities of any adjustments that the payer made either to the original submitted charge or to the units related to the claim or service(s). Service adjustments will not be repeated at the claim level.
- The summation of the adjustments at the claim and service levels is the total adjustment for the entire claim.
- A standardized list of claim adjustment reason codes is used in the Claim Adjustment and Service Adjustment Segments. These codes provide the 'explanation' for the positive or negative financial adjustments specific to particular claims or services that are referenced in the transmitted 835.
- A Claim Adjustment Group Code categorizes the adjustment reason codes that are contained in a particular adjustment segment. Up to six different adjustments related to a particular Claim Adjustment Group may be reported per segment.

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Claim Interest and Prompt Payment Discounts

Payer-provider level interest and prompt payment discounts refer to adjustments that specific payer and provider contractual agreements require. Such adjustments are financially independent from the formula for determining benefit payments and are reported at the provider adjustment level. This information will also be provided in an amount segment at the claim level without affecting balancing.

Provider Withholds

If a provider declines the option of returning monies owed, PBGA, LLC or one of its trading partners would then withhold payment up to the amount in a future check with a "Withhold" message in the PLB segment. Payment will not be negative. The payment amount reflected in the remittance advice will be adjusted to $0. If there is an additional balance owed to PGBA, LLC or one of its trading partners, this amount will be moved forward into the next payment cycle. If the amount owed is less than the amount scheduled to be paid, a manual check will be issued for the balance along with a letter of explanation to the provider.

Reversals and Corrections

Reversals and corrections will be handled by reversing the original claim payment and re-sending the corrected data. Reversing the original payment restores the patient accounting system to the pre-posting balance for this patient. Next, the payer sends the corrected claim payment to the provider for posting to the account. This gives providers the ability to control the accuracy and integrity of their receivable systems. TRICARE adjustments should appear as two separate claims on the X12 835 ERA. Reversing the original claim payment is accomplished using code 22 (reversal of previous payment) in CLP02 and the appropriate adjustments. All original charge, payment, and adjustment amounts are negated. The corrected claim payment is then provided as if it were the original payment.

Note: *This process does NOT apply to TRICARE credit adjustments. Credit adjustments will be reported at the provider level (PLB segment).*

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Claim Splitting by Payers

When the adjudication system requirements result in the services submitted within one claim being split into multiple claims, the payer will retain and return basic original claim information in each of the adjudicated claims. The original Claim Submitter's Identifier and line item control numbers will be returned. In addition, the MIA/MOA segments will be returned with a Remark Code of MA15 (Your Claim has been separated to expedite handling. You will receive a separate notice for the other services reported).

835 Interchange Envelope and Functional Group Structure

Trading partners should follow the Interchange Control Structure (ICS), Functional Group Structure (GS), Interchange Acknowledgment (TA1), and Functional Acknowledgement (999) guidelines for HIPAA that are located in the HIPAA Implementation Guides in Appendix A and B. Trading Partners should also follow the basic character set guidelines as set forth in the implementation guide. The interchange cannot contain non-HIPAA version functional groups for unique instructions for transmitting to PGBA, LLC EDIG refer to the ***GPNet Technical Communications User's Manual.***

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Data Clarification for the 835 Health Care Claim Payment Advice (005010X221A1) Transaction Set

Loop	Seg Pos	Data Element	Req or Sit	Segment/ Element	Instruction	Industry/Element Name	Attributes	IG Page No.
Header	202		R	BPR	Financial Information, always provided. BPR contains mandatory information, even when it is not being used to move funds electronically.	Beginning Segment for Payment Order/Remittance Advice	M	69
		305	R	BPR01	PGBA, LLC will only send the following codes: **I** **Remittance Information Only Identification Number.** **H** **Notification Only**	Transaction Handling Code	M ID 1/2	70
		478	R	BPR03	PGBA, LLC will only send the following codes: **C** **Credit**	Total Actual Provider Payment Amount Monetary Amount	M ID 1/1	71
		591	R	BPR04	Used to identify the method used to move the payment. Must use: **ACH** Automated Clearing House (used for electronic funds transfer) **CHK** Check (payment made via check) **NON** **Non-payment Data**	Payment Method Code	M ID 3/3	72

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Loop	Seg Pos	Data Element	Req or Sit	Segment/ Element	Instruction	Industry/Element Name	Attributes	IG Page No.
		912	S	BPR05	Required and used only when BPR04 equals ACH. Must use: **CCP Cash Concentration/ Disbursement plus Addenda (CCD+) (ACH)** ***Note:*** *Only provided if electronic funds transfer.*	Payment Format Code	O ID 1/10	72
		506	S	BPR06	Required if BPR04 (Payment Method Code) equals ACH, BOP, or FWT. Not used if BPR04 equals CHK (Check). Must use: **01 ABA Transit Routing Number** (including check digits (9 digits))	Depository Financial Institution (DFI Identification Number Qualifier (DFI) ID Number Qualifier	X ID 2/2	73
		506	S	BPR12	Identifies the type of identification number of Depository Financial Institution (DFI). Required when BPR04 equals ACH, BOP, or FWT. Not used if BPR04 equals CHK (Check). Must use: **01 ABA Transit Routing Number (including check digits (9 digits))**	Depository Financial Institution (DFI) Identification Number Qualifier	X ID 2/2	75
		127	R	REF02	Identifies the transaction receiver. Must use: Clearing house or billing service (trading partner) Mailbox ID.	Receiver Identification		82

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Loop	Seg Pos	Data Element	Req or Sit	Segment/ Element	Instruction	Industry/Element Name	Attributes	IG Page No.
1000A		93	S	N102	Required if the National Plan ID is not transmitted in N104 (Payer Identifier). Must equal: **PGBA, LLC**	Payer Name Name	X AN 1/60	87
1000A		166	R	N301	Must equal (first address line): **Tricare Claims Administrator**	Payer Address Line Address Information	M AN 1/55	89
1000A	120		O	REF	***Under most circumstances, this segment is not sent.*** Use this REF segment whenever additional payer identification numbers are required. The ID numbers in the TRN and N1 segments should be used before using the REF segment.	Additional Payer Identification	O	92
1000A		128	R	REF01	Code used to qualify the additional payer identification numbers. Must use: **2U Payer Identification Number**.	Reference Identification Qualifier	M ID 2/3	92
1000A		93	S	PER02	**Required when there is a business contact area that would apply to this remittance and all the claims. If not required by this implementation guide.** Must equal: **Tricare Claims Administration**	Payer Business Contact Name Name	O AN 1/60	94-95

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Loop	Seg Pos	Data Element	Req or Sit	Segment/ Element	Instruction	Industry/Element Name	Attributes	IG Page No.
1000A		365	S	PER03	Code identifying the type of business communication number. Must equal: **TE Telephone Number**	Business Contact Number Communication Number Qualifier	X ID 2/2	95
1000A		364	S	PER04	PGBA, LLC Website, required if a contact communications number is to be transmitted. Complete communications number including country or area code when applicable. Must equal: **Differs depending on contract region.**	Payer Business Contact Communication Number Communication Number	X AN 1/80	95
1000A		366	R	PER01	Code identifier for the technical contact. Must equal: BL Technical Department	Payer Technical Contact Contact Function Code		97
1000A		93	S	PER02	Technical contact name. Must equal: TRICARE ELECTRONIC CLAIMS SERVICE CENTER	Payer Technical Contact Contact Name		98
1000A		365	S	PER03	Technical communication number qualifier. Must equal: TE Telephone	Payer Technical Contact Communication Number Qualifier		98
1000A		364	S	PER04	Technical contact number. Must equal: **1-800-325-5920**	Payer Technical Contact Communication Number		98

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Loop	Seg Pos	Data Element	Req or Sit	Segment/ Element	Instruction	Industry/Element Name	Attributes	IG Page No.
1000B		66	R	N103	Required when N104 does not contain the National Provider Identifier. Must equal: **FI Federal Taxpayer's Identification Number** **XX National Provider Identifier** ***Note:*** *For individual providers as payees, use this number to represent the Social Security Number.*	Identification Code Qualifier	X ID 1/2	103
2100		1029	R	CLP02	Identifies the status of an entire claim as assigned by the payer, claim review organization or re-pricing organization. The following codes are sent: **1 Processed as Primary** **2 Processed as Secondary** **3 Processed as Tertiary**	Claim Status Code	M ID 1/2	124
2100		1032	R	CLP06	Code identifying the type of claim. For many providers to electronically post the 835 remittance data to their patient accounting systems with human intervention, a unique, provider-specific insurance plan code is needed. Must use: **CH CHAMPUS**	Claim Filing Indicator Code	O ID 1/2	92
2100	99		S	CAS	This segment is not used or provided; adjustments are reported at the service level.	Claim Adjustment Claim Payment Information		129

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Loop	Seg Pos	Data Element	Req or Sit	Segment/ Element	Instruction	Industry/Element Name	Attributes	IG Page No.
2100		66	S	NM108	Required if the patient ID is known or was reported on the health care claim. Used for identification code and under most circumstances, this element should be sent. Should be same as MI if patient is the subscriber. Must use: **HN Health Insurance Claim (HIC) Number** ***Note:*** *If either NM108 or NM109 is present, then the other is required*	Patient Name Identification Code Qualifier Patient Control Number	X ID 1/2	139
2100		1065	R	NM102	Code qualifying the type of entity. Must use: **1 Person**	Insured Name Entity Type Qualifier	M ID 1/1	141
2100		65	R	NM108	Used for identification code of the subscriber. Under most circumstances, this element should be sent. Must use: **MI Member Identification** ***Note:*** *If either NM108 or NM109 is present, then the other is required.*	Insured Name Identification Code Qualifier Subscriber ID	X ID 1/2	142

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Loop	Seg Pos	Data Element	Req or Sit	Segment/ Element	Instruction	Industry/Element Name	Attributes	IG Page No.
2100		66	R	N108	Code designating the system/method of code structure used for Identification Code (67). Code is provided, if submitted. Must equal: **FI Federal Taxpayer's Identification Number** **XX National Provider Identifier**	Service Provider Name Identification Code Qualifier	X ID 1/2	148
2100		128	R	REF01	Code qualifying the Reference ID. It is provided, if available. Must equal: **EA Medical Record Identification Number**	Other Claim Related Id Reference Identification Qualifier	M ID 2/3	169
2100		374	R	DTM01	Code specifying type of date. **232 - Claim period start date** **233 – Claim period end date**	Date Time Qualifier Statement Date	M ID 3/3	174

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Loop	Seg Pos	Data Element	Req or Sit	Segment/ Element	Instruction	Industry/Element Name	Attributes	IG Page No.
2100				DTM01	Coverage Expiration Date - when payment denied due to expiration of coverage. If not required by this guide, do not send. DEERS does not maintain the history needed to determine expiration of coverage. When the patient is not eligible for coverage, the situational segment DTM - Coverage Expiration Date on Loop 2100 will not be sent.	Date Time Qualifier Coverage Expiration Date		175
2100		522	R	AMT01	Code to qualify the amount and is provided in certain situations. PGBA, LLC valid codes: **F5 Patient Amount Paid (Use to report the amount the patient has already paid.)** **I Interest**	Amount Qualifier Code	M ID 1/3	182-183
2100		673	R	QTY01	Specifies the type of quantity and is provided in certain situations. Must use: **OU Outlier Days**	Quantity Qualifier	M ID 2/2	184-185
2110		C003	R	SVC01	Use the adjudicated Medical Procedure Code. Identifies a medical procedure by its standardized code and modifiers.	Composite Medical Procedure Identifier	O	186

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Loop	Seg Pos	Data Element	Req or Sit	Segment/ Element	Instruction	Industry/Element Name	Attributes	IG Page No.
2110		235	R	SVC01 - 1	Identifies the type/source of the descriptive number used in Product/Service ID and is provided if available. Must equal: **HC HCPCS Codes (Professional)** **HP Health Insurance Prospective Payment System (HIPPS) Skilled Nursing Facility Rate Code** **N4 National Drug Code 5-4-2** **NU (NUBC) UB92 Codes**	Product or Service ID Qualifier Product/Service ID Qualifier	M ID 2/2	187-188
2110		235		SVC 06 - 1	Qualifies the values in SVC06 – 2 through SVC06 – 6. It is provided if available. Must equal: **HC HCPCS Codes (Professional)** **HP Health Insurance Prospective Payment System (HIPPS) Skilled Nursing Facility Rate Code** **N4 National Drug Code 5-4-2** **NU (NUBC) UB92 Codes**	Product or Service ID Qualifier Product/Service ID Qualifier	M ID 2/2	191
2110		128	S	REF01	**Provided when related service specific reference identifiers were used in the process of adjudicating this service.** **APC Ambulatory Payment Classification**	Service Identification Reference Identification Qualifier		204

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Loop	Seg Pos	Data Element	Req or Sit	Segment/ Element	Instruction	Industry/Element Name	Attributes	IG Page No.
2110		128	R	REF01	Qualifies the Reference Identification and is provided, if submitted Must equal: **6R** **Provider Control Number (Line item control number in Loop 2400, REF01 (used in 837 Professional) if submitted on the 837 this must be returned on the remittance.)**	Line Item Control Number Reference Identification Qualifier	M ID 2/3	206
2110		522	R	AMT01	Code to qualify amount and is provided in certain situations, if available. Must equal: **Allowed - Actual**	Amount Qualifier Code	M ID 1/3	211
2110		1270	R	LQ01	Code identifying a specific industry code list. Must use: **HE** **Claim Payment Remark Codes (code source 411: Remittance Remark Codes)**	Code List Qualifier Code	O ID 1/3	215

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Loop	Seg Pos	Data Element	Req or Sit	Segment/ Element	Instruction	Industry/Element Name	Attributes	IG Page No.
2110		426	R	PLB03 – 1, PLB05 – 1, PLB07 – 1, PLB09 – 1, PLB11 – 1, PLB13 – 1	Provided only if a provider level adjustment. It indicates the reason for a debit or credit memo or adjustment to invoice, debit or credit memo, or payment. Must equal: **IR Internal Revenue Service Withholdings** **L6 Interest Owed (Used for the interest paid on claims in the 835. Supports the related adjustments where AMT01 is equal to I (Interest).** **WO Overpayment Recovery (Used for the recovery of previous overpayment. See IG Guide for information about balancing against a provider refund.)** **72 Authorized Return This is the provider refund adjustment.** **CS Adjustment.**	Adjustment Reason Code	M ID 2/2	219-222

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EDIG Glossary of Terms

ANSI X12 835 V5010
HIPAA standardized ANSI X12 transaction format approved January 16, 2009. The 835 transactions are for Healthcare Payment and Advices.

Data Segment
Corresponds to a record in data processing terminology and consist of logically related fields (data elements). These records and elements are structured in a defined sequence (defined by X12). Each segment begins with a segment identifier and one or more related data elements that are preceded by a data element separator and ends with a segment terminator.

Data Element
Relates to a field in data processing terminology and are assigned an individual reference number. Each element has a name, description, type, minimum length and maximum length. The length of an element is the number of character positions used, except as noted for numeric, decimal and binary elements. Data Element types are:

Nn	Numeric	Implied number of decimal positions and for this representation Nn; the N indicates numeric and n is the number of decimal positions to the right of the implied decimal point. Used when the position of the decimal within the data is permanently fixed and will not be transmitted with the data
R	Decimal Real Number	Used for numeric values that have a varying number of decimal positions. For negative values, the leading (-) minus sign is used. Absence of a sign indicates a positive value. The (+) plus sign should not be transmitted.
ID	Identifier	Always contains a value from a predefined list of codes.
AN	Alphanumeric string	Sequence of any characters from a basic or extended character set.
DT	Date	States the standard date in either YYMMDD or CCYYMMDD. CC (first two digits of calendar year), YY (last two digits of calendar year), MM (month 01 – 12), DD (day in the month 01 – 31)
TM	Time	The ISO standard time HHMMSSd, 24-hour clock. HH (Hour 00 - 23), MM (minute 00 – 59), SS (second 00 – 59), d (decimal seconds)

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Delimiter
A character used to separate two data elements (or sub-elements) or to end a segment. They are specified in the interchange header segment (ISA). Once specified in the ISA, they should not be used in the data elsewhere other than as a separator or terminator.

EDI
An acronym for Electronic Data Interchange.

EDIG
An acronym for Electronic Data Interchange Gateway.

Electronic Data Interchange
The application-to-application transfer of key business information transacted in a standard format using a computer-to-computer communications link. There are typically 6 components used in order to do EDI. They are: an EDI file, a trading partner agreement, an application file/form, translator (mapper), communications and value-added service provider.

HCFA
An acronym for Health Care Finance Adminstration.

Implementation Guides
Documents that provide standardized data requirements and content permitting the specification of consistent implementation of a standard transaction set. HIPAA implementation guides are published by the Washington Publishing Company on their web site: www.wpc-edi.com.

Interface
The connection point that two systems pass data.

Loops
Loops are groups of semantically related segments. Data segment loops may be unbounded or bounded.

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Routing
Separation of data based on specific criteria for subsequent transfer to an internal or external system.

Trading Partners
Entities that exchange electronic data files. Agreements are sometimes made between the partners to define the parameters of the data exchange and simplify the implementation process.

Translation Software
Commercial computer software that with input instructions converts a standard format to an application format and vise-versa.
Most translation software products also compliance check standard format files and automatically create interchange/functional acknowledgements to identify receipt of translation status of a file. Some products also offer translation capability from any format to any format.

X12 Transaction Set
A transactions set is considered one business document which is composed of a transactions et header control segment, one or more data segments, and a transaction set trailer control segment. For example, one 837- transaction set is equivalent to one claim file.

X12N
An Accredited Standards Committee (ASC) commissioned by the American National Standards Institute (ANSI) to develop standard for Electronic Data Interchange (EDI). While X12 indicates EDI, the N identifies the Insurance Subcommittee that is responsible for developing EDIO standards for the insurance industry. There is a special health care task group within this subcommittee responsible for the development of health care insurance transactions.

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