Geisinger Health Plan

Companion Guide for the 835 Health Care Claim Payment Advice

Refers to the Implementation Guides

Based on X12 version 005010X221A1

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Disclosure Statement

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Preface

This is a Companion Guide to the v5010 ASC X12N Implementation Guides and associated errata are adopted under the Health Insurance Portability and Accountability Act (HIPAA). It should be used when interacting with Geisinger Health Plan (GHP). This document describes the data element requirements of GHP's trading partners for submission of EDI HIPAA compliant transactions. Transmissions based on this companion guide, used in tandem with the v5010 ASC X12N Implementation Guides, are compliant with both ASC X12 syntax and those guides. This guide is not meant to replace HIPAA's Implementation Guides but should be used in conjunction with them.

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EDITOR'S NOTE

This companion guides follows the CORE v5010 Master Companion Guide Template.

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1. INTRODUCTION

In an effort to reduce the administrative costs of health care across the nation, the Health Insurance Portability and Accountability Act (HIPAA) were passed in 1996. This legislation requires that health insurance payers in the United States comply with the electronic data interchange (EDI) standards for health care, established by the Secretary of Health and Human Services (HHS). For the health care industry to achieve the potential administrative cost savings with EDI, standard transactions and code sets have been developed and need to be implemented consistently by all organizations involved in the electronic exchange of data. The ANSI X12N 835 Health Care Claim Payment Advice transaction implementation guides provide the standardized data requirements to be implemented for all health care claims electronic submissions.

HIPAA does not require that a provider submit health care claims electronically. Providers may continue to submit paper claims and receive a paper remittance advice. However, if the provider elects to conduct business electronically, HIPAA does mandate the use of the standard transactions and code sets.

The following table specifies the columns and suggested use of the rows:

HIPAA IG Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments Required/Situational Repeat
	Table 1 - Header					
68		ST	Transaction Set Header			R 1
69		BPR	Financial Information			R 1
77		TRN	Reassociation Trace Number			R 1
79		CUR	Foreign Currency Information			S 1
82		REF	Receiver Identification			S 1
84		REF	Version Identification			S 1
85		DTM	Production Date			S 1
	Loop 1000A Payer Identification					**1**
87		N1	Payer Identification			R 1
89		N3	Payer Address			R 1
90		N4	Payer City/State/Zip Code			R 1
92		REF	Additional Payer Identification			S 4
94		PER	Payer Business Contact Information			S 1

97		PER	Payer Technical Contact Information			R >1
100		PER	Payer WEB Site			S 1
	Loop 1000B Payee Identification					**1**
102		N1	Payee Identification			R 1
104		N3	Payee Address			S 1
105		N4	Payee City/State/Zip Code			R 1
107		REF	Payee Additional Identification			S >1
109		RDM	Remittance Delivery Method			S 1
	Table 2 Detail - Loop 2000 Header Number					**>1**
111		LX	Header Number			S 1
112		TS3	Provider Summary Information			S 1
117		TS2	Provider Supplemental Summary Info			S 1
	Loop 2010 Claim Payment Information					**>1**
123		CLP	Claim Payment Information			R 1
129		CAS	Claim Adjustment			S 99
137		NM1	Patient Name			R 1
140		NM1	Insured Name			S 1
143		NM1	Corrected Patient/Insured Name			S 1
146		NM1	Service Provider Name			S 1
150		NM1	Crossover Carrier Name			S 1
153		NM1	Corrected Priority Payer Name			S 1
156		NM1	Other Subscriber Name			S 1

159		MIA	Inpatient Adjudication Information			S 1
166		MOA	Outpatient Adjudication Information			S 1
169		REF	Other Claim Related Identification			S 5
171		REF	Rendering Provider Identification			S 10
173		DTM	Statement From or To Date			S 2
175		DTM	Coverage Expiration Date			S 1
177		DTM	Claim Received Date			S 1
179		PER	Claim Contact Information			S 2
182		AMT	Claim Supplemental Information			S 13
184		QTY	Claim Supplemental Information Quantity			S 14
	Loop 2110 Service Payment Information					**999**
186		SVC	Service Payment Information			S 1
194		DTM	Service Date			S 2
196		CAS	Service Adjustment			S 99
204		REF	Service Identification			S 8
206		REF	Line Item Control Number			S 1
207		REF	Rendering Provider Information			S 10
209		REF	Health Care Policy Identification			S 5
211		AMT	Service Supplemental Amount			S 9
213		QTY	Service Supplemental Quantity			S 6
215		LQ	Health Care Remark Codes			S 99
	Table 3 Summary					

217		PLB	Provider Adjustment			S	>1
228		SE	Transaction Set Trailer			R	1

Scope

This Companion Guide explains the procedures necessary for trading partners of the Health Plan to transmit Electronic Data Interchange (EDI) for the 835 Health Care Claim Payment Advice transactions. This Companion Guide is not intended to replace, contradict or exceed the X12N Implementation Guides; rather it is intended to be used in conjunction with them.

Overview

The first part of this Companion Guide explains its purpose and the trading partner's role working with the Health Plan. It also provides important information on the communication process and detailed Health Plan contact information.

References

This Companion Guide should be used in conjunction with the Implementation Guides, which can be obtained from the Washington Publishing Company on their web site at http://www.wpc-edi.com/

Additional Information

The following websites has additional information:
Workgroup for Electronic Data Interchange (WEDI) – http://www.wedi.org
United States Department of Health and Human Services (DHHS) – http://aspe.hhs.gov/admnsimp/
Centers for Medicare and Medicaid Services (CMS) – http://www.cms.hhs.gov/HIPAAGenInfo/
Designated Standard Maintenance Organizations (DSMO) – http://www.hipaa-dsmo.org/
National Council of Prescription Drug Programs (NCPDP) – http://www.ncpdp.org/
National Uniform Billing Committee (NUBC) – http://www.nubc.org/
Accredited Standards Committee (ASC X12) – http://www.x12.org/

2. GETTING STARTED

Working with Geisinger Health Plan

The Geisinger Health Plan EDI Customer Service is available to assist with this process Monday – Friday, from 8:00 AM to 5:00 PM Eastern time. Potential Trading Partners must contact GHP customer assistance help desk to initiate the registration process.

Please refer to Section 5 of this Companion Guide for contact information.

Trading Partner Registration

To request electronic Explanation of Payment (835), please to to the website…

http://www.thehealthplan.com/providers_us/eeop.cfm

…and complete the applicable registration form and Letter of Authorization (if using a clearinghouse).

Certification and Testing Overview

The Workgroup for Electronic Data Interchange (WEDI) and the Strategic National Implementation Process (SNIP) have recommended seven types of HIPAA compliance testing, these are:

1. Integrity Testing – This is testing the basic syntax and integrity of the EDI transmission to include: valid segments, segment order, element attributes, numeric values in numeric data elements, X12 syntax and compliance with X12 rules.

2. Requirement Testing – This is testing for HIPAA Implementation Guide specific syntax such as repeat counts, qualifiers, codes, elements and segments. Also testing for required or intra-segment situational data elements and non-medical code sets whose values are noted in the guide via a code list or table.

3. Balance Testing – This is testing the transaction for balanced totals, financial balancing of claims or remittance advice and balancing of summary fields.

4. Situational Testing – This is testing of inter-segment situations and validation of situational fields based on rules in the Implementation Guide.

5. External Code Set Testing – This is testing of external code sets and tables specified within the Implementation Guide. This testing not only validates the code value but also verifies that the usage is appropriate for the particular transaction.

6. Product Type or Line of Service Testing – This is testing that the segments and elements required for certain health care services are present and formatted correctly. This type of testing only applies to a trading partner candidate that conducts the specific line of business or product type.

7. Implementation Guide-Specific Trading Partners Testing – This is testing of HIPAA requirements that pertain to specific trading partners such as Medicare, Medicaid and Indian Health. Compliance testing with these payer specific requirements is not required from all trading partners. If the trading partner intends to exchange transactions with one of these special payers, this type of testing is required.

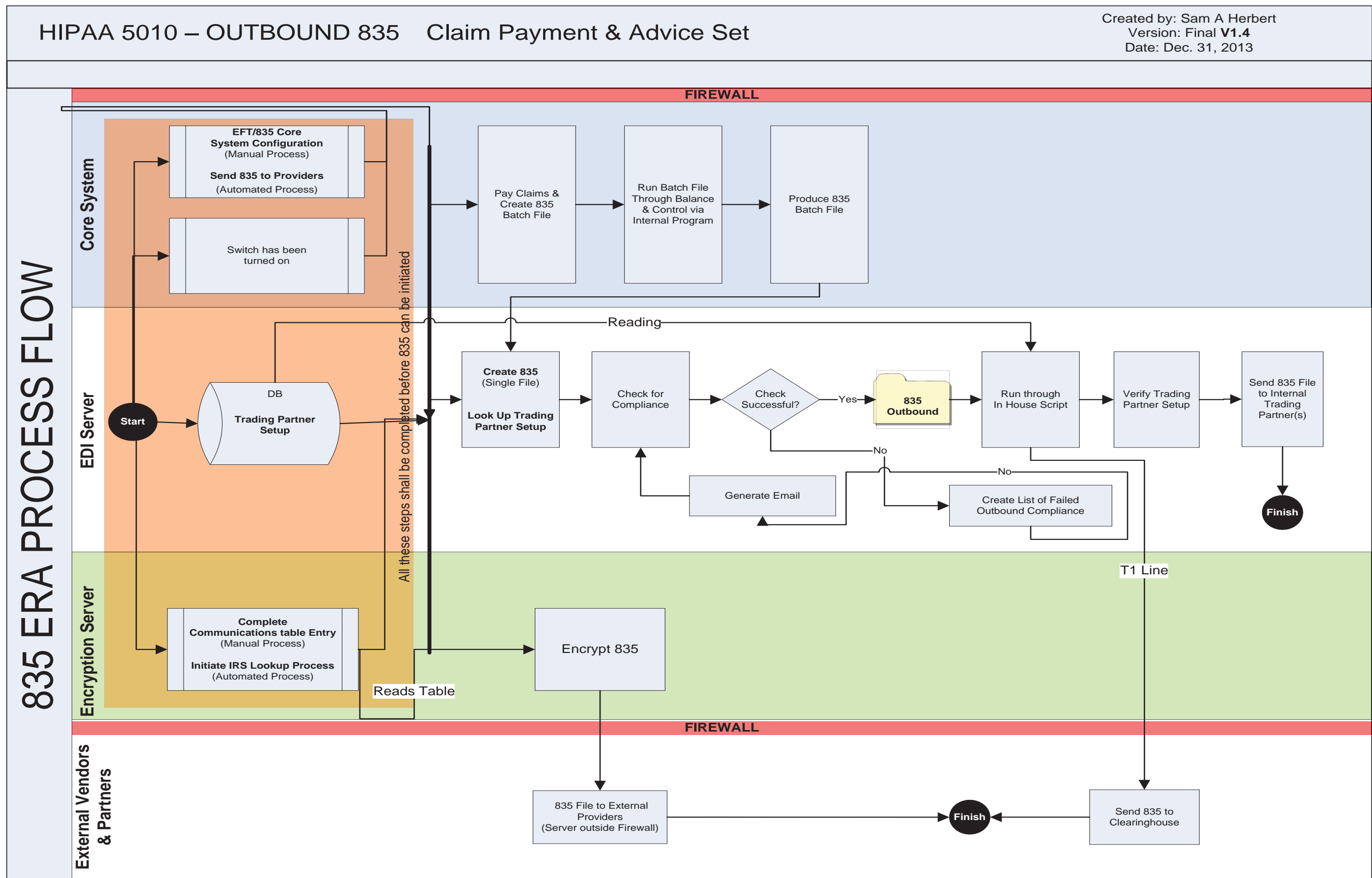
3. TESTING WITH GEISINGER HEALTH PLAN

After registering with Geisinger Health Plan (as described in Section 2), you will be configured internally in the GHP EDI system. If you requested a direct set-up (no clearinghouse), our connectivity team will be in contact with you to exchange information needed for the connection set-up. If you are receiving your 835's via a clearinghouse, you will be responsible for assuring you are configured at the clearinghouse. After the set-ups are complete you may begin receiving 835 transactions. If you are transitioning from paper to the 835 there will be an overlap period in which you will receive both the 835 and paper to allow you to verify that you can successfully process the 835 prior to moving exclusively to the electronic transmission.

4. CONNECTIVITY WITH GEISINGER HEALTH PLAN/COMMUNICATIONS

835 ERA Process Flow

The following describes the detailed 835 ERA Process Flow:



Transmission Administrative Procedures

Providers will need to register with the health plan in order to receive the 835 transaction. (Please see the Trading Partner Registration section above for information regarding that process.)

Re-Transmission Procedures

If you receive your 835 via a clearinghouse, please contact your clearinghouse if you are seeking a re-transmission of an 835. If your clearinghouse feels it is necessary to contact Geisinger Health Plan in regard to this request, please us the contact information detailed in Section 5 of this document.

Communication Protocol Specifications

GHP will follow the communication protocols as required in the CAQH Core Connectivity Rule for all new trading partners.

Passwords

The GHPIT Communications team will communicate password needs as necessary pending the information obtained during Trading Partner Registration (Section 2 of this document).

5. CONTACT INFORMATION

EDI Customer Service

PRODUCTION ISSUES ONLY:

- CALL GHS HELPDESK
  - Telephone: 1-800-272-8092
  - Weekdays 8:00 am – 5:00 pm Eastern Time
  - Please be prepared with the following information:
    - Your Organization
    - Your Contact Information
    - Issue specifics
  - Please indicate your trouble ticket should be assigned to the GHP-EDI assignment group.
- SUBMIT VIA EMAIL
  - helpdesk@geisinger.edu
  - Please include the following information in your email:
    - Your Organization
    - Your Contact Information
    - Issue specifics
  - Please indicate your trouble ticket should be assigned to the GHP-EDI assignment group.

NON-PRODUCTION ISSUES & GENERIC QUESTIONS/REQUESTS:

- SUBMIT VIA EMAIL
  - ghpedi@geisinger.edu

EDI Technical Assistance

For on-line EDI information pertaining to GHP, including the Health Plan's companion guides, please access www.thehealthplan.com and click HIPAA at the bottom of the page.

For industry information on EDI not specific to GHP, please see the websites listed under Additional Information in Section 1 of this companion guide.

For assistance with current transactions or any other issues, please use the E-Help Desk contact information listed above, under EDI Customer Service.

Provider Service Number

Providers needing GHP service outside of EDI transactions should please use the applicable contact information listed on the website www.thehealthplan.com.

Applicable Websites/E-Mail

Websites

- Geisinger Health Plan – http://www.thehealthplan.com
- CAQH Core - http://www.caqh.org/
- Workgroup for Electronic Data Interchange (WEDI) – http://www.wedi.org
- United States Department of Health and Human Services (DHHS) – http://aspe.hhs.gov/admnsimp/
- Designated Standard Maintenance Organizations (DSMO) – http://www.hipaa-dsmo.org/
- National Council of Prescription Drug Programs (NCPDP) – http://www.ncpdp.org/
- National Uniform Billing Committee (NUBC) – http://www.nubc.org/
- Accredited Standards Committee (ASC X12) – http://www.x12.org/

Email

- EDI Customer Service – please see the "EDI Customer Service" section of this document for applicable contact information
- CAQH Core - core@caqh.org
-

6. CONTROL SEGMENTS/ENVELOPES

ISA-IEA

Table 6A describes the values within the ISA Headers and IEA Trailers on the 835 transaction.

Table 6A – 270 ISA/IEA Segment Rules

Reference	X12 Element Name	Max Length	271 Notes/Values
ISA01	Authorization Information Qualifier	2	“00”
ISA02	Authorization Information	10	(blank)
ISA03	Security Information Qualifier	2	“00”
ISA04	Security Information	10	“00” left-justified blank-filled
ISA05	Interchange ID Qualifier	2	“ZZ”
ISA06	Interchange Sender ID	15	“75273” left-justified blank-filled
ISA07	Interchange ID Qualifier	2	“ZZ”
ISA08	Interchange Receiver ID	15	Must be Trading Partner Submitter ID assigned by GHP
ISA09	Interchange date	6	YYMMDD format
ISA10	Interchange Time	4	HHMM format
ISA11	Repetition Separator	1	“<” (less-than sign)
ISA12	Interchange Control Version Number	5	“00501”
ISA13	Interchange Control No	9	Must match with IEA02
ISA14	Acknowledgment Requested	1	GHP will not return the TA1 acknowledgement receipt of a real time transaction unless an error is found.

Reference	X12 Element Name	Max Length	271 Notes
ISA15	Usage indicator	1	“P” = production, “T” = test
ISA16	Component Element Separator	1	“:” (colon)
IEA01	Number of Included Functional Groups	5	Count of GS-GE Functional Group
IEA02	Interchange Control Number	9	A control number assigned by the interchange sender. This value matches that in ISA13

GS-GE

Table 6B describes the values within the GS/GE loop structure on the 835 transaction.

Table 6B – 270 GS/GE Segment Rules

Reference	X12 Element Name	Max Length	271 Notes/Values
GS01	Functional Identifier Code	2	"HP"
GS02	Application Sender's Code	15	"75273"
GS03	Application Receiver's Code	15	Must be Trading Partner ID, similar value to ISA08
GS04	Date	8	CCYYMMDD format
GS05	Time	8	HHMM format followed by "0000"
GS06	Group Control Number	9	"1"
GS07	Responsible Agency Code	2	"X"
GS08	Version/Release/Industry Identifier Code		"005010X221A1"
GE01	Number of Transaction Sets Included	6	Count of ST-SE in the Transaction
GE02	Group Control Number	9	"1"

ST-SE

Table 6C describes the values within the ST/SE loop structure on the 835 transaction. .

Table 6C – 270 ST/SE Segment Rules

Reference	X12 Element Name	Max Length	271 Notes/Values
ST01	Transaction Set Identifier Code	3	"835"
ST02	Transaction Set Control No	9	This number is assigned by GHP and must match the value in the corresponding SE 02 segment. This number must be sequentially incremented with each transaction.

ST03	Implementation Convention reference	35	"005010X279A1"
SE01	Number of Included Segments	10	Segment count between ST-SE
SE02	Transaction Set Control Number	9	This number is assigned by GHP and should match the value in the corresponding ST02 segment.

7. GEISINGER HEALTH PLAN EDI BUSINESS RULES/LIMITATIONS

- Geisinger Health Plan expects to receive 999 Acknowledgments for the outbound 835's per CAQH CORE Phase III Operating Rules.
- A provider is not required to receive 835's from Geisinger Health Plan in order to engage GHP with the EFT transaction.
- A provider is not required engage in the EFT transaction with Geisinger Health Plan in order to receive the 835 transaction.

8. ACKNOWLEDGEMENTS AND/OR REPORTS

Report Inventory

GHP supports the following response transactions and acknowledgements to the 835 Transaction:

- 999 Functional Acknowledgement

9. TRADING PARTNER AGREEMENTS

- Depending in the information collected during the registration process, a trading partner agreement may be necessary before establishing connectivity. This requirement would most likely be the result of a request for a direct connection. If an agreement is needed, the Connectivity Team will work with the provider to facilitate this need.

- A trading partner agreement must not override the specifications in ASC X12N/005010X221 HIPAA implementation guide if a transmission is reported in GS08 to be a product of ASC X12N/005010X221 implementation guide.

10. TRANSACTION SPECIFIC INFORMATION

835 TRANSACTION

The following table specifies the columns and suggested use of the rows:

HIPAA IG Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments Required/Situation Repeat
	Table 1 - Header					
68		ST	Transaction Set Header			R 1
69		BPR	Financial Information			R 1
77		TRN	Reassociation Trace Number			R 1
79		CUR	Foreign Currency Information			Not used by GHP
82		REF	Receiver Identification			S 1
84		REF	Version Identification			S 1
85		DTM	Production Date			S 1
	Loop 1000A Payer Identification					**1**
87		N1	Payer Identification			R 1
89		N3	Payer Address			R 1
90		N4	Payer City/State/Zip Code			R 1
92		REF	Additional Payer Identification			S 4
94		PER	Payer Business Contact Information			S 1
97		PER	Payer Technical Contact Information			R >1
100		PER	Payer WEB Site			S 1
	Loop 1000B Payee Identification					**1**
102		N1	Payee Identification			R 1

104		N3	Payee Address			S 1
105		N4	Payee City/State/Zip Code			R 1
107		REF	Payee Additional Identification			S >1
109		RDM	Remittance Delivery Method			Not used by GHP
	Table 2 Detail - Loop 2000 Header Number					**>1**
111		LX	Header Number			S 1
112		TS3	Provider Summary Information			Not used by GHP
117		TS2	Provider Supplemental Summary Info			Not used by GHP
	Loop 2010 Claim Payment Information					**>1**
123		CLP	Claim Payment Information			R 1
129		CAS	Claim Adjustment			S 99
137		NM1	Patient Name			R 1
140		NM1	Insured Name			S 1
143		NM1	Corrected Patient/Insured Name			Not used by GHP
146		NM1	Service Provider Name			S 1
150		NM1	Crossover Carrier Name			S 1
153		NM1	Corrected Priority Payer Name			Not used by GHP
156		NM1	Other Subscriber Name			S 1
159		MIA	Inpatient Adjudication Information			Not used by GHP
166		MOA	Outpatient Adjudication Information			Not used by GHP
169		REF	Other Claim Related Identification			Not used by GHP
171		REF	Rendering Provider Identification			S 10

173		DTM	Statement From or To Date			S 2
175		DTM	Coverage Expiration Date			S 1
177		DTM	Claim Received Date			S 1
179		PER	Claim Contact Information			S 2
182		AMT	Claim Supplemental Information			Not used by GHP
184		QTY	Claim Supplemental Information Quantity			Not used by GHP
	Loop 2110 Service Payment Information					**999**
186		SVC	Service Payment Information			S 1
194		DTM	Service Date			S 2
196		CAS	Service Adjustment			S 99
204		REF	Service Identification			S 8
206		REF	Line Item Control Number			S 1
207		REF	Rendering Provider Information			S 10
209		REF	Health Care Policy Identification			S 5
211		AMT	Service Supplemental Amount			Not used by GHP
213		QTY	Service Supplemental Quantity			Not used by GHP
215		LQ	Health Care Remark Codes			S 99
	Table 3 Summary					
217		PLB	Provider Adjustment			S >1 Not by G
228		SE	Transaction Set Trailer			R 1

EFT TRANSACTION

Please note a provider is not required to engage in the EFT transaction with Geisinger Health Plan in order to receive the 835 transaction. Should a provider utilize the EFT transaction, the CAQH Core Phase III rules governing this transaction must be followed.

APPENDICES

1. Implementation Checklist

1) ERA Enrollment Form Completed
2) EFT Enrollment Form Completed (if applicable)
3) Trading Partner Agreement Completed (if applicable)
4) Test FTP Set-up and Testing Completed
5) Production FTP Set-up

2. Business Scenarios

Business Scenario 1

Dollars and data are being sent together through the banking system to pay Medicare Part A institutional claims. This scenario depicts the use of the ANSI ASC X12 835 in a governmental institutional environment. The electronic transmission of funds request and the remittance detail are contained within this single 835. In this scenario, one or more Depository Financial Institutions is involved in transferring information from the sender to the receiver.

Assumptions

The following assumptions pertain to scenario one:

• The dollars move using the ACH network from the Bank of Payorea, ABA# 999999992, and account number 123456 to the Bank of No Return, ABA# 999988880, and checking account number 98765. The money moves on September 13, 2002.

• The Insurance Company of Timbucktu, Federal tax ID # 512345678 and Medicare Intermediary ID# 999, is paying Regional Hope Hospital, National Provider Number 6543210903. This is for one inpatient and one outpatient claim.

• For the inpatient claim, the patient's name is Sam O. Jones. The Health Insurance Claim Number is 666-66-6666A. The Claim Submitter's Identifier is 666123. The date of the hospitalization was August 16, 2002 to August 24, 2002.Total charges reported are $211,366.97. Paid amount is $138,018.40. There is no patient responsibility. Contractual adjustment is $73,348.57. No service line detail is provided.

• For the outpatient claim, the patient's name is Liz E. Border, Health Insurance Claim Number 996-66-9999B.The Claim Submitter's Identifier is 777777.The date of service is May 12, 2002. Total charges reported are $15,000. Paid amount is $11,980.33. Contractual adjustment is $3,019.67. There is no service line information.

• There is a Capital Pass Through Amount (CV) payment to the provider for $1.27.

Transmission

```
ST*835*1234~
BPR*C*150000*C*ACH*CTX*01*999999992*DA*123456*1512345678**01*999988880*DA*987
65*20020913~
TRN*1*12345*1512345678~
DTM*405*20020916~
N1*PR*INSURANCE COMPANY OF TIMBUCKTU~
N3*1 MAIN STREET~
N4*TIMBUCKTU*AK*89111~
REF*2U*999~
N1*PE*REGIONAL HOPE HOSPITAL*XX*6543210903~
LX*110212~
TS3*6543210903*11*20021231*1*211366.97****138018.4**73348.57~
TS2*2178.45*1919.71**56.82*197.69*4.23~
CLP*666123*1*211366.97*138018.4**MA*1999999444444*11*1~
CAS*CO*45*73348.57~
NM1*QC*1*JONES*SAM*O***HN*666666666A~
MIA*0***138018.4~
DTM*232*20020816~
DTM*233*20020824~
QTY*CA*8~
LX*130212~
TS3*6543210909*13*19961231*1*15000****11980.33**3019.67~
```

```
CLP*777777*1*15000*11980.33**MB*1999999444445*13*1~
CAS*CO*45*3019.67~
NM1*QC*1*BORDER*LIZ*E***HN*996669999B~
MOA***MA02~
DTM*232*20020512~
PLB*6543210903*20021231*CV:CP*-1.27~
SE*28*1234~
```

Business Scenario 2

Dollars and data are sent separately. Scenario 2 depicts the use of the 835 in a managed care environment. The funds are moved separately from the remittance detail. In this scenario, the funds are sent by EFT to the provider's account, and the remittance data is transmitted directly to the provider.

Assumptions
The following assumptions pertain to scenario two:
• The dollars move from the Hudson River Bank, ABA# 888999777, account number 24681012 to the Amazon Bank, ABA# 111333555, checking account number 144444 using the ACH network. The money moves on March 16, 2002.

The insurance company, Rushmore Life, Federal Tax ID # 935665544, is paying ACME Medical Center, Nation Provider ID 5544667733 ;& Federal Tax ID # 777667755, a total of $945.00. Rushmore Life and ACME Medical Center have an agreement that a certain portion of their payments will be withheld for future use as specified in their managed medical contract.

• The first patient's name is William Budd, patient number 5554555444 and member ID # 33344555510.Total reported charges are $800.00. Amount paid is $450.00. Patient responsibility is $300.00. Contractual adjustment (for withhold amount) is $50.00. The service code for the procedure performed is CPT code 99211. The service start date is March 1, 2002. The service end date is March 4, 2002.

• The second patient's name is Susan Settle, patient number 8765432112 and member ID # 44455666610. Total reported charges are $1200.00. Amount paid is $495.00. Patient responsibility is $600.00. Contractual adjustment is $50.00. Contractual adjustment (for withhold amount) was $55.00. The procedure code for the service performed is CPT code 93555. The service start date is March 10, 2002. The service end date is March 12, 2002.

Transmission

```
ST*835*112233~
BPR*I*945*C*ACH*CCP*01*888999777*DA*24681012*1935665544**01*111333555*DA*1444
44*20020316~
TRN*1*71700666555*1935665544~
DTM*405*20020314~
N1*PR*RUSHMORE LIFE~
N3*10 SOUTH AVENUE~
N4*RAPID CITY*SD*55111~
N1*PE*ACME MEDICAL CENTER*XX*5544667733~
REF*TJ*777667755~
LX*1~
CLP*5554555444*1*800*450*300*12*94060555410000~
CAS*CO*A2*50~
NM1*QC*1*BUDD*WILLIAM****MI*33344555510~
SVC*HC:99211*800*500~
DTM*150*20020301~
```

```
DTM*151*20020304~
CAS*PR*1*300~
CLP*8765432112*1*1200*495*600*12*9407779923000~
CAS*CO*A2*55~
NM1*QC*1*SETTLE*SUSAN****MI*44455666610~
SVC*HC:93555*1200*550~
DTM*150*20020310~
DTM*151*20020312~
CAS*PR*1*600~
CAS*CO*45*50~
SE*25*112233~
```

Business Scenario 3

Regardless of which COB methodology is used to derive a subsequent payment, the following examples provide illustrations of how to report secondary or tertiary payments back to the provider that will facilitate auto-posting.
Considerations used in each example:
1. What was the primary payer’s payment?
2. What is the amount, after COB that the patient is responsible to pay for the service?
3. What was the impact of the primary payer’s handling of the claim (payment and contractual adjustments) upon the current payer’s benefit determination?
4. What amount, if any, does the provider still need to write-off (contractual obligations)?

Assumptions

In the first claim, YTDAW (Your Tax Dollars at Work) payer receives the claim as secondary with a submitted charge of $10323.64. The primary payer (Old World Insurance, a Medicare carrier) allowed $8441.31 of the total submitted charges. A deductible of $912.00 and a contractual adjustment of $1882.33 were applied. The primary payer paid $7529.31 of the submitted charges.

YTDAW, as the secondary payer, is only required to pay the deductible based on the coverage of this contract. After the $912.00 payment is made, the patient, William Peter Townsend does not have a balance due for this provider.

In the second claim, YTDAW payer received a claim as secondary for Angi Baki with a submitted charge of $751.50 for two services rendered. The primary payer (Patients United Health) allowed for one service but denied the other as a non-covered procedure. The amount charged for the covered procedure was $166.50 and $150.00 was allowed. The primary payer paid $120.00 with $30.00 coinsurance due and a contractual adjustment of $16.50. The charge for the non-covered service was $585.00; therefore, the total patient responsibility was $615.00.

YTDAW as the secondary payer allowed $650.00 for the total submitted charges. The secondary payer allowed $150.00 for one service and $500.00 for the other service. The patient owed a deductible of $150.00 and YTDAW paid $310.00 for this claim. The impact of the primary payer’s payment upon the secondary payment is $136.50 (the $16.50 contractual adjustment plus their $120.00 payment). After reviewing all of the adjustments, the provider still has an $85.00 contractual adjustment based on YTDAW’s fee schedule with this provider.

Transmission

```
ST*835*0001~
BPR*I*1222*C*CHK************20050412~
TRN*1*0012524965*1559123456~
REF*EV*030240928~
DTM*405*20050412~
N1*PR*YOUR TAX DOLLARS AT WORK~
```

```
N3*481A00 DEER RUN ROAD~
N4*WEST PALM BCH*FL*11114~
N1*PE*ACME MEDICAL CENTER*FI*599944521~
N3*PO BOX 863382~
N4*ORLANDO*FL*55115~
REF*PQ*10488~
LX*1~
CLP*L0004828311*2*10323.64*912**12*05090256390*11*1~
CAS*OA*23*9411.64~
NM1*QC*1*TOWNSEND*WILLIAM*P***MI*XXX123456789~
NM1*82*2*ACME MEDICAL CENTER*****BD*987~
DTM*232*20050303~
DTM*233*20050304~
AMT*AU*912~
LX*2~
CLP*0001000053*2*751.50*310*220*12*50630626430~
NM1*QC*1*BAKI*ANGI****MI*456789123~
NM1*82*2*SMITH JONES PA*****BS*34426~
DTM*232*20050106~
DTM*233*20050106~
SVC*HC>12345>26*166.5*30**1~
DTM*472*20050106~
CAS*OA*23*136.50~
REF*1B*43285~
AMT*AU*150~
SVC*HC>66543>26*585*280*220*1~
DTM*472*20050106~
CAS*PR*1*150**2*70~
CAS*CO*42*85~
REF*1B*43285~
AMT*AU*500~
SE*38*0001~
```

Assumptions

This is an example of a tertiary payment. The patient, Ellis E. Island, has three insurance companies. The total charge for his claim is $1766.50. The primary payer allowed $1600.00 and applied a contractual adjustment of $166.50 as part of the provider's fee schedule. The allowed amount was paid at 80% after a $500.00 deductible was applied. The primary payer paid $880.00.

The secondary payer also allowed $1600.00 for the total submitted charge of $1766.50. The secondary payer calculated their payment as primary to determine the difference in paying primary versus secondary. After evaluating the primary payment of $880.00, the secondary payer paid $310.00. The impact of the primary payer's payment upon the secondary payment is $1046.50 (their contractual adjustment of $166.50 plus their $880.00 payment).

YTDAW as the tertiary payer allowed $1700.00 of the submitted $1766.50 charge. The tertiary payer also calculated their payment as primary and determined that the total amount that could be paid was $1377.50. After evaluating the primary and secondary payments and adjustments, YTDAW paid $187.50. The impact of the primary and secondary payer's payments upon the tertiary payment is $1356.580 (primary amount

of $1046.50 and secondary amount of $310.00). Therefore, total remaining patient balance for the provider is $222.50.

Transmission

```
ST*835*0001~
BPR*I*187.50*C*CHK************20050412~
TRN*1*0012524879*1559123456~
REF*EV*030240928~
DTM*405*20050412~
N1*PR*YOUR TAX DOLLARS AT WORK~
N3*481A00 DEER RUN ROAD~
N4*WEST PALM BCH*FL*11114~
N1*PE*ACME MEDICAL CENTER*FI*599944521~
N3*PO BOX 863382~
N4*ORLANDO*FL*55115~
REF*PQ*10488~
LX*1~
CLP*0001000054*3*1766.5*187.50**12*50580155533~
NM1*QC*1*ISLAND*ELLIS*E****MI*789123456~
NM1*82*2*JONES JONES ASSOCIATES*****BS*AB34U~
DTM*232*20050120~
SVC*HC*24599*1766.5*187.50**1~
DTM*472*20050120~
CAS*OA*23*1579~
REF*1B*44280~
AMT*AU*1700~
SE*38*0001~
```

Assumptions

In this claim, the primary payer received a claim for $541.00. They allowed $400 and paid $375.00 of the submitted charges. The primary payer applied $141.00 as a contractual adjustment that was part of the provider's fee schedule. The patient, Raymond Burck owed a co-pay of $25.00.

YTDAW as the secondary payer allowed $550.00 for the service submitted. This amount is $9.00 more than charged. The secondary payer paid $34.00.The impact of the primary payer's payment on the secondary payer is $516.00 ($141.00 contractual adjustment and $375.00 payment).

Transmission

```
ST*835*0001~
BPR*I*34.00*C*CHK************20050318~
TRN*1*0063158ABC*1566339911~
REF*EV*030240928~
DTM*405*20050318~
N1*PR*YOUR TAX DOLLARS AT WORK~
N3*481A00 DEER RUN ROAD~
N4*WEST PALM BCH*FL*11114~
N1*PE*ATONEWITHHEALTH*FI*3UR334563~
N3*3501 JOHNSON STREET~
N4*SUNSHINE*FL*12345~
REF*PQ*11861~
LX*1~
```

```
CLP*0001000055*2*541*34**12*50650619501~
NM1*QC*1*BURCK*RAYMOND*W***MI*987654321~
NM1*82*2*PROFESSIONAL TEST 1*****BS*34426~
DTM*232*20050202~
DTM*233*20050202~
SVC*HC>55669*541*34**1~
DTM*472*20050202~
CAS*OA*23*516~
CAS*OA*94*-9~
REF*1B*44280~
AMT*AU*550~
SE*38*0001~
```

3. Transmission Examples

Please look for examples in the Business Scenarios explained above.

4. Frequently Asked Questions

1. How does GHP support, monitor, and communicate expected and unexpected connectivity outages?

Both expected an unexpected downtimes are communicated via email, using the technical contacts obtained from the trading partner during initial setup and updated on a yearly basis

2. What are the main differences between an 835 and a 999?

999 is an acknowledgement transaction that indicates if a 835 file was accepted or rejected. 999's do not contain any remittance information.

3. What is the proper procedure for working with Geisinger Health Plan should an expected 835 or EFT transaction be late or missing?

If you are missing an expected ERA or EFT from Geisinger Health Plan, please contact our EDI department by using to Production Issues contact information in Section 5 of this document.

5. Change Summary

Date of Change	Change Description
10/24/2011	Creation of version 1.0
12/31/2013	Modified per CORE v5010 Master Companion Guide Template