

California Department of Health Care Services

820 Transaction

Payroll Deducted and Other Group Premium Payment for Insurance Products (820)

Standard Companion Guide Transaction Information

Instructions related to Transactions based on ASC X12 Implementation Guides, version 005010

**Companion Guide Version Number: 1.4
September 2013**

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Preface

Companion Guides (CG) may contain two types of data, instructions for electronic communications with the publishing entity (Communications/Connectivity Instructions) and supplemental information for creating transactions for the publishing entity while ensuring compliance with the associated ASC X12 IG (Transaction Instructions). Either the Communications/Connectivity component or the Transaction Instruction component must be included in every CG. The components may be published as separate documents or as a single document.

The Communications/Connectivity component is included in the CG when the publishing entity wants to convey the information needed to commence and maintain communication exchange.

The Transaction Instruction component is included in the CG when the publishing entity wants to clarify the IG instructions for submission of specific electronic transactions. The Transaction Instruction component content is limited by ASCX12's copyrights and Fair Use statement.

Associated TR3s are available at <http://store.x12.org/store>.

Table of Contents

1	TI Introduction.....	5
1.1	Background.....	5
1.1.1	Overview of HIPAA Legislation	5
1.1.2	Compliance according to HIPAA	5
1.1.3	Compliance according to ASC X12	6
1.2	Intended Use.....	6
2	Included ASC X12 Implementation Guides.....	6
3	Instruction Tables	7
3.1	Transaction Availability.....	7
3.2	Transaction Components	7
3.3	Premium Payment File Naming Conventions	8
3.4	820 Data Elements.....	8
4	TI Additional Information	11
4.1	Business Scenarios.....	11
4.2	Payer Specific Business Rules and Limitations	12
4.2.1	Individual Remittance/List Bill Type 820	12
4.2.2	Rate Adjustments	13
4.2.3	Net Eligibility Adjustments	15
4.2.4	Plan-Based Adjustments on List Bill Type 820 Transaction	18
4.3	Organizational Remittance/Summary Bill Type.....	19
4.3.1	Plan Based Payments and Adjustments	19
4.3.2	Summary Bill Type Example:	19
4.4	Invoice Types.....	21
4.5	Adjustment Reason Codes.....	22
5	TI Change Summary	23

Transaction Instruction (TI)

1 TI Introduction

1.1 Background

1.1.1 Overview of HIPAA Legislation

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 carries provisions for administrative simplification. This requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. HIPAA directs the Secretary to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard HIPAA serves to:

- Create better access to health insurance
- Limit fraud and abuse
- Reduce administrative costs

1.1.2 Compliance according to HIPAA

The HIPAA regulations at 45 CFR 162.915 require that covered entities not enter into a trading partner agreement that would do any of the following:

- Change the definition, data condition, or use of a data element or segment in a standard.
- Add any data elements or segments to the maximum defined data set.
- 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).
- Change the meaning or intent of the standard’s implementation specification(s).

1.1.3 Compliance according to ASC X12

ASC X12 requirements include specific restrictions that prohibit trading partners from:

- Modifying any defining, explanatory, or clarifying content contained in the implementation guide.
- Modifying any requirement contained in the implementation guide.

1.2 Intended Use

The Transaction Instruction component of this companion guide must be used in conjunction with an associated ASC X12 Implementation Guide. The instructions in this companion guide are not intended to be stand-alone requirements documents. This companion guide conforms to all the requirements of any associated ASC X12 Implementation Guides and is in conformance with ASC X12's Fair Use and Copyright statements.

2 Included ASC X12 Implementation Guides

This table lists the X12N Implementation Guides for which specific transaction Instructions apply and which are included in Section 3 of this document.

Unique ID	Name
005010X218	Payroll Deducted and Other Group Premium Payment for Insurance Products (820)

3 Instruction Tables

These tables contain one or more rows for each segment for which a supplemental instruction is needed.

Legend
SHADED rows represent "segments" in the X12N implementation guide.
NON-SHADED rows represent "data elements" in the X12N implementation guide.

Only those elements that require specific explanation are included in these tables. The underlying TR3 document for this transaction is available at <http://store.x12.org>.

3.1 Transaction Availability

Premium payment data will be uploaded to a plan's designated Secure File Transfer Protocol (SFTP) "submission" folder administered by DHCS Information Technology Services Division (ITSD).

Each 820 file will be uploaded without being zipped.

820 files will usually be made available in the second week of the month and these files will usually contain information on payments made the previous month.

Each 820 file corresponds to a single warrant (check), except in the circumstance when DHCS and the CA State Controller's Office have split a payment that exceeds \$99,999,999.99 into multiple warrants. If this has occurred, DHCS manually updates TRN02 to indicate the range of warrant numbers that the 820 file relates.

3.2 Transaction Components

Data element separator will be "**"

Segment terminator will be “~”

3.3 Premium Payment File Naming Conventions

Premium payment files will use the following naming convention:

DHCS820_VVVVVVVVVV-VV_YYYYMMDD_AAAAAAAAAA.dat

Where:

YYYYMMDD is the date of the file creation.

VVVVVVVVVV-VV is the DHCS vendor code that the payment was made to.

AAAAAAAAAA is the warrant number of the payment (nine digits).

Example:

DHCS820_PHP0987654-00_20130608_123456789.dat

3.4 820 Data Elements

Loop ID	Reference	Name	Codes	Notes/Comments
ISA		Interchange Control Header		
	ISA06	Interchange Sender ID		CALIFORNIA-DHCS
	ISA08	Interchange Receiver ID		Receiver's Federal Tax ID + 6 spaces
	ISA11	Repetition Separator		'+'
	ISA13	Interchange Control Number		The Interchange Control Number, ISA13, must be identical to the associated Interchange Trailer IEA02. Must be a positive unsigned number and must be identical to the value in IEA02.
	ISA14	Acknowledgement Requested	0	

	ISA16	Component Element Separator		":"
GS		Functional Group Header		
	GS02	Application Sender's Code		Use this code to identify the unit sending the information. Valid Value: "CALIFORNIA-DHCS"
	GS03	Application Receiver's Code		Receiver's Federal Tax ID
	BPR	Financial Information		
	BPR01	Transaction Handling Code	I	Remittance Information Only
	BPR02	Monetary Amount		This is the California State Controller's Office Warrant Amount
	BPR10	Origination Company Identifier		68-0317191 (DHCS Federal tax id)
	BPR16	Date		This is the California State Controller's Office Warrant Date.
TRN		Re-association Trace Number		
	TRN02	Reference Identification		State of California Warrant Number. NOTE – in some cases this field will be represented as a warrant number range. – two nine digit warrant numbers separated by a dash for example: 012345678-012345679.
REF		Premium Receivers Identification Key		
	REF01	Reference Identification Qualifier	14	
-	REF02	Reference Identification		DHCS Vendor Code of Receiver
1000B	N1	Premium Payer's Name		
	N102	Name		"California - Department of Health Care Services"
1000B	N3	Premium Payer's Address		
	N301	Address Information		" 1501 Capitol Ave"

1000B	N4	Premium Payer's City, State, Zip Code		
	N401	City Name		"Sacramento"
	N402	State or Province Code		"CA"
	N403	Postal Code		"95814"
2000B	ENT	Individual Remittance		
	ENT01	Assigned Number		Assigned incremental number beginning with "1". The X12 standard limits this field to six digits, but some Medi-Cal Managed Care Plans have more than 999,999 members. In the circumstances where a plan has over 1,000,000 members this field will be sent with a maximum length of seven digits to accommodate the size of the population. A modification to the standard has been requested.
	ENT04	Identification Code		This is the identification number of the party with which the individual remittance item is associated. Valid Values: 1. 999999999 is used as the filler value for beneficiary-level payments and adjustments. 2. The Vendor's 9-digit numeric Federal Tax ID (EIN) is used for Plan-level (Health Care Plan) payments and adjustments that are reflected on the Individual Remittance transaction. These include: Dental Withhold Adjustment, Recoupment Withhold Adjustment, Recoupment Release Adjustment, and Payment Error Adjustment.
2100B	NM1	Individual Name		
	NM109	Identification Code		Medi-Cal CIN
2300B	RMR	Individual Premium Remittance Detail		
	RMR01	Reference Identification Qualifier	IK	
	RMR02	Reference Identification		Invoice Number
	RMR04	Monetary Amount		This is the amount being paid on this remittance item.

	RMR05	Monetary Amount		Any difference between the RMR05 and the RMR04 would be explained by the ADX at loop 2320B.
2300B	REF	Reference Information		Multiple instances of this segment are provided
	REF01	Reference Identification Qualifier	18,ZZ	Organizational Reference Identification Qualifier
	REF02	Reference Identification		For REF*18 – REF02 will contain the HCP. Two instances of REF*ZZ will be provided. In the first instance of REF*ZZ REF02 will contain the Aid Code. The second instance of REF*ZZ REF02 will contain the Invoice Type – see section 4.4 for a full listing of all available Invoice Types.
2300B	DTM	Individual Coverage Period		
	DTM01	Date/Time Qualifier	582,AAG	Date Time Qualifier
	DTM06	Date Time Period		Month of service - date range

4 TI Additional Information

4.1 Business Scenarios

The 820 Transaction may be structured in either one of two ways. The first 820 transaction type is the Individual Remittance/List Bill Type, which provides remittance information associated with a list bill payment. This transaction type is used for the beneficiary-level invoice types (refer to the list of Invoice Types in Section 4.4) generated by the 820 Phase 2 System. On the Individual Remittance/List Bill Type 820 Transaction, the payment and/or adjustment amounts are reported for each individual beneficiary, using the Beneficiary CIN as the unique identifier.

The second 820 transaction type is the Organizational Remittance/Summary Bill Type, which is used to provide remittance information associated with a summary bill payment. Specifically, the Summary Bill Type Transaction is used to report Plan-Based payments, which have no association with individual beneficiaries. These payments are reported at the Plan or Organizational level, using the HCP Code as the unique identifier. There are

three Plan Based payment/invoice types: Dental Withhold Release, Savings Sharing Disbursement, and Other Plan Based Payment/Adjustment.

4.2 Payer Specific Business Rules and Limitations

4.2.1 Individual Remittance/List Bill Type 820

The Individual Remittance/List Bill Type 820 Transaction is used for the majority of the 820 Phase 2 payments, since MMCD Capitation payments and HIPP/BCCTP Premium Payments are calculated at the Beneficiary level. Adjustments and Net Eligibility Adjustments are reflected on the 820 TXN, according to the standards of the Implementation guide. In order to pass SNIP validations, the payment amounts, adjustment amounts and total warrant amount must balance properly.

At the Transaction level, the BPR02 Loop indicates the total Warrant Amount for the Vendor. Loop 2100B, NM109 is repeated for each Beneficiary CIN associated with the Warrant. Within each 2100B Loop, the 2300B Loop is repeated for each Service Month and/or Invoice Number for which a payment and/or adjustment was made for that beneficiary. The order of the 2100B Loop listing is by CIN (ascending). For each CIN listed, the 2300B Loop is ordered first according to Month of Service (descending), then by Invoice Number (ascending).

Within the 2300B Loop, the RMR02 element indicates the Invoice Number. Element RMR04 indicates the Invoice Amount for a Beneficiary for the Service Month indicated in DTM02. Element RMR05 indicates the Billed Amount (i.e. Current Rate) based on the Service Month, Aid Code, HCP and Invoice Type. The sum of all RMR04 elements must equal the total Warrant Amount for the Vendor in BPR02.

The REF segment is repeated for each of the following data elements as mutually defined between DHCS and the Trading Partners: HCP Code, Aid Code, and Invoice Type. The DTM Segment indicates the Service Month for each payment or adjustment amount.

The ADX Segment reflects the Rate Adjustment Amount and Reason Code. The ADX Segment may only be used when RMR04 “Invoice Amount” is not equal to RMR 05 “Billed Amount.” The Adjustment Amount in ADX01 must equal the difference between RMR04 and RMR05 in order to balance the 2300B Loop and pass SNIP validation.

The example adjustment scenarios below illustrate the adjustment balancing structure.

4.2.2 Rate Adjustments

Retroactive Rate Adjustments are reflected on the Individual Remittance/List Bill Type 820 Transaction by using RMR05 in Loop 2300B, along with the ADX Segment in Loop 2320B. RMR05 indicates the full current rate amount, ADX01 indicates the adjustment amount to subtract the rate previously paid, and RMR04 indicates the rate difference (i.e. the rate adjustment amount paid for the beneficiary for the invoice number listed in 2300B, RMR02).

Rate Adjustment Example

Current service month is March 2009. Retroactive Rate Adjustment is made for January and February 2009. Note: No change in Eligibility (HCP status, Aid Code or Medi-Cal status).

List Bill Type 820 TXN - Rate Adjustment Example					
		Rate per Service Month			Totals
		January	February	March	
Payment Month	January	\$2			
	February	\$2	\$2		
	March	\$3	\$3	\$3	
	Retro Rate Adj.	\$1	\$1		\$2
	Current Month Capitation			\$3	\$3
	Total Paid in March				\$5

820 Transaction

BPR: Warrant Amount \$5
 TRN: Warrant #12345
 REF: Vendor Code HN3000

ENT: Beneficiary CIN 123456789

MARCH RMR02: Inv03
 RMR04: \$3.00 (payment amount, i.e. rate difference)
 REF02: Aid Code 3N
 REF02 (2nd iteration): Invoice Type= Capitation Medi-Cal Only
 DTM: 3/1/09-3/31/09 (current service month)

FEBRUARY RMR02: Inv03
 RMR04: \$1.00 (payment amount, i.e. rate difference)
 RMR05: \$3.00 (billed amount)
 REF02: Aid Code 3N
 REF02 (2nd iteration): Invoice Type= Capitation Medi-Cal Only
 DTM: 2/1/09-2/28/09 (prior service month 1)
 ADX 01: -\$2.00 (Adjustment Amount for previous payment)
 ADX 02: Rate Adjustment Reason Code

Rate Adjustment Balancing	
Calculation	RMR04= RMR05 + sum (ADX)
Example	\$1= \$3 + (- \$2)

JANUARY RMR02: Inv03
 RMR04: \$1.00 (payment amount, i.e. rate difference)
 RMR05: \$3.00 (billed amount)
 REF02: Aid Code 3N
 REF02 (2nd iteration): Invoice Type= Capitation Medi-Cal Only
 DTM: 1/1/09-1/31/09 (prior service month 2)
 ADX 01: -\$2.00 (Adjustment Amount for previous payment)
 ADX 02: Rate Adjustment Reason Code

Rate Adjustment Balancing	
Calculation	RMR04= RMR05 + sum (ADX)
Example	\$1= \$3 + (-\$2)

4.2.3 Net Eligibility Adjustments

The RMR segment in Loop 2300B is repeated for a beneficiary for each service month and invoice number pertaining to the beneficiary. The HCP Code, Aid Code, Invoice Type and Service Month are indicated for each payment or adjustment amount. If there is a change in the Aid Code or Medi-Cal eligibility status (Medi-Cal Only vs. Medicare Part D), the RMR segment is repeated so that the payment or adjustment amount is associated with the correct Aid Code and Medi-Cal eligibility status. If there is a change in the Health Care Plan (HCP), the positive and negative net eligibility amounts will also be reflected for each HCP in separate RMR segments; However if the payments/adjustments pertain to separate warrants or different vendors, the amounts appear on separate 820 Transactions.

Net Eligibility Example

In March (payment month), the enrollment file indicates that the Beneficiary was actually eligible for Medicare Part D in January, which was previously paid using the Medi-Cal Only rate. In addition, the March enrollment file indicates that for February the beneficiary’s Aid Code was actually 3N, which was previously paid based on Aid Code 7X.

List Bill Type 820 TXN - Net Eligibility Adjustment Example					
		Eligibility per Service Month			
Invoice #: Inv03		January	February	March	Totals
HCP 300, Medi-Cal Only					
Payment Month	January	\$2 (7X)			
	February	\$2 (7X)	\$2 (7X)		
	March	\$0 (7X)	\$3(3N)	(3N)	\$3
	Retro Rate Adj.				\$0
	Net Eligibility Adj.	(\$2)	\$1		(\$1)
	Current Month Capitation			\$3	\$3
	Total Paid March Medi-Cal Only				\$2

List Bill Type 820 TXN - Net Eligibility Adjustment Example					
		Eligibility per Service Month			
Invoice #: Inv04 HCP 300, Medicare Part D		January	February	March	Totals
Payment Month	January				
	February				
	March	\$4 (7X)			
	Retro Rate Adj.				\$0
	Net Eligibility Adj.				\$0
	Current Month Capitation				\$4
	Total Paid March Medicare Part D				\$4

820 Transaction:

BPR: Warrant Amount \$6.00 (3 + 3 – 2 + 0 – 2 + 4)

TRN: Warrant #12345

REF: Vendor Code HN300

ENT: Beneficiary CIN 123456789

MARCH

RMR02: Inv03

RMR04: \$3.00 (payment amount)

REF02: HCP 300

REF02: Aid Code 3N

REF02: Invoice Type= Capitation Medi-Cal Only

DTM: 3/1/09-3/31/09 (current service month)

FEBRUARY (3N)

RMR02: Inv03

RMR04: \$3.00 (payment amount)

REF02: HCP 300

REF02: Aid Code 3N

REF02 (2nd iteration): Invoice Type= Capitation Medi-Cal Only

DTM: 2/1/09-2/28/09 (prior service month 1)

FEBRUARY (7X)

RMR02: Inv03

RMR04: -\$2.00 (payment amount)

REF02: HCP 300

REF02: Aid Code 7X

REF02: Invoice Type= Capitation Medi-Cal Only

DTM: 2/1/09-2/28/09 (prior service month 1)

JANUARY MEDI-CAL RMR02: Inv03

RMR04: -\$2.00 (payment amount)

REF02: HCP 300

REF02: Aid Code 7X

REF02: Invoice Type= Capitation Medi-Cal Only

DTM: 1/1/09-1/31/09 (prior service month 2)

JANUARY MEDICARE D

RMR02: Inv04

RMR04: \$4.00 (payment amount)

REF02: HCP 300

REF02: Aid Code 7X

REF02: Invoice Type= Capitation Medi-Care Part D

DTM: 1/1/09-1/31/09 (prior service month 2)

4.2.4 Plan-Based Adjustments on List Bill Type 820 Transaction

There are three types of plan-based (HCP) adjustments that may appear on the List Bill Type 820 Transaction. These include Dental Withhold Adjustments, Recoupment Adjustments (withholds and releases), and Payment Error Reconciliation Adjustments. These adjustments are not associated with Individual Beneficiaries. However, since they are included on the beneficiary-level capitation invoices and are paid by the same warrant, they must appear on the same List Bill Type 820 Transaction in order for the Transaction to balance and pass SNIP validations. On the List Bill Type 820 Transaction, when the adjustment is plan-based, the required 2000B ENT segment is populated with the Vendor's Federal Tax ID in lieu of the 'Dummy ID' (999999999) which is used when payments are associated with a beneficiary. In addition, the 2100B loop, which is normally populated with the Beneficiary's name and CIN, is left null when a plan-based adjustment appears on a List Bill Type Transaction. The invoice number, payment or adjustment amount, HCP Code, Aid Code, Invoice Type, and service dates are populated in the 2300B Loop. The REF segment that is normally used to indicate a Beneficiary's Aid Code, is used to indicate the Plan-Based Adjustment Type.

4.3 Organizational Remittance/Summary Bill Type

4.3.1 Plan Based Payments and Adjustments

As mentioned in section 4.1 above, there are three payment types for which the Organizational Remittance/Summary Bill Type 820 Transaction is used: Savings Sharing Disbursement, Dental Withhold Release, and Other Plan Based Payment/Adjustment. The example below illustrates how each of these payment types will be reflected on the 820 Transaction.

4.3.2 Summary Bill Type Example:

Plan-based payment/adjustment type = Savings Sharing Disbursement
Payment / Adjustment amount = -\$2,000.00

Plan-based payment/adjustment type = Dental Withhold Release
Payment / Adjustment amount = \$1,000.00

Plan-based payment/adjustment type = Other Plan Based
Payment/Adjustment
Payment / Adjustment amount = \$4,000.00

HCP Code = 300

Next available supplemental invoice is for March 09.

820 Transaction:

BPR: Warrant Amount \$3,000.00

TRN: Warrant #12345

REF: Vendor Code HN300

ENT: Vendor FTIN 123456789

MARCH RMR02: Inv001
 RMR04: -\$2,000.00 (payment amount)
 REF02: HCP 300
 REF02: Invoice Type= Savings Sharing Disbursement
 DTM: 7/1/08-12/31/08 (service month range)

MARCH RMR02: Inv002
RMR04: \$1,000.00 (payment amount)
REF02: HCP 300
REF02: Invoice Type= Dental Withhold Release
DTM: 1/1/09-1/31/09 (a prior service month)

MARCH RMR02: Inv003
RMR04: \$4,000.00 (payment amount)
REF02: HCP 300
REF02: Invoice Type= Other Plan Based
Payment/Adjustment
DTM: 3/1/09-3/31/09 (current service month)

4.4 Invoice Types

The 820 Phase 2 System generates 40 invoice types, which are listed in the table below. For Individual Remittance/List Bill Type Transactions, the name of the invoice type is listed in the REF02 Segment of Loop 2300B. For Organizational Remittance/Summary Bill Type Transactions, the name of the invoice type is listed in the REF02 Segment of Loop 2300A.

820 Phase 2 CAPMAN Managed Care Invoice Types		
#	Invoice Type	Transaction Type
1	Primary Capitation Medi-Cal Only	Individual Remittance
2	Primary Capitation Dual	Individual Remittance
3	Healthy Families Capitation Medi-Cal Only	Individual Remittance
4	Healthy Families Capitation Dual	Individual Remittance
5	HYDE	Individual Remittance
6	HYDE Healthy Families	Individual Remittance
7	AIDS Medi-Cal Only	Individual Remittance
8	AIDS Dual	Individual Remittance
9	Agnews Medi-Cal Only	Individual Remittance
10	Agnews Dual	Individual Remittance
11	Craig/Bonta Medi-Cal Only	Individual Remittance
12	Craig/Bonta Dual	Individual Remittance
13	Maternity	Individual Remittance
14	Lanterman Medi-Cal Only	Individual Remittance
15	Lanterman Dual	Individual Remittance
16	Lanterman Healthy Families Medi-Cal Only	Individual Remittance
17	Lanterman Healthy Families Dual	Individual Remittance
18	CBAS Medi-Cal Only	Individual Remittance
19	CBAS Dual	Individual Remittance
20	CBAS Healthy Families Medi-Cal Only	Individual Remittance
21	CBAS Healthy Families Dual	Individual Remittance
22	Dental Withhold Release - Primary	Organizational Remittance

820 Phase 2 CAPMAN Managed Care Invoice Types		
#	Invoice Type	Transaction Type
23	Dental Withhold Release - Healthy Families	Organizational Remittance
24	Savings Sharing	Organizational Remittance
25	Other Plan Based Primary	Organizational Remittance
26	Other Plan Based Hyde	Organizational Remittance
27	HQAF Primary Medi-Cal Only	Individual Remittance
28	HQAF Primary Dual	Individual Remittance
29	HQAF Healthy Families Medi-Cal Only	Individual Remittance
30	HQAF Healthy Families Dual	Individual Remittance
31	HQAF AIDS Medi-Cal Only	Individual Remittance
32	HQAF AIDS Dual	Individual Remittance
33	HQAF Agnews Medi-Cal Only	Individual Remittance
34	HQAF Agnews Dual	Individual Remittance
35	HQAF Craig/Bonta Medi-Cal Only	Individual Remittance
36	HQAF Craig/Bonta Dual	Individual Remittance
37	HQAF Lanterman Medi-Cal Only	Individual Remittance
38	HQAF Lanterman Dual	Individual Remittance
39	HQAF Lanterman Healthy Families Medi-Cal Only	Individual Remittance
40	HQAF Lanterman Healthy Families Dual	Individual Remittance

4.5 Adjustment Reason Codes

When the ADX Segment is used on the 820 Transaction to balance a rate adjustment, an Adjustment Reason Code is required in the ADX02 Element. Because the ADX Segment is used only for retroactive rate adjustments, which are all beneficiary level payments, the usage of the ADX segment applies only to the List Bill Type 820 Transaction (and not the Summary Bill Type 820 Transaction). The 820 Transaction uses the following two HIPAA-Compliant Rate Adjustment Reason Codes from the Implementation Guide's External Code List: 52 - Credit for Overpayment (for a negative rate adjustment) and 53 - Credit for Underpayment (for a positive rate adjustment).

Adjustment Type	Adjustment Reason Code and Description
Overpayment (Negative Retroactive Rate Adjustment)	52 - Credit for Overpayment
Underpayment (Positive Retroactive Rate Adjustment)	53 - Remittance for Previous Underpayment

5 TI Change Summary

Version History

Version	Date	Updates/Comments
0.9	02/08/2013	Initial creation of draft in X12/WEDI format.
1.0	02/08/2013	Updates per internal review.
1.1	02/20/2013	Updated invoice types table: removed 'Dental' and 'Dental HF' invoice types; removed asterisks (note not relevant for 820 Transaction); added column for 'Transaction Type'. Fixed minor formatting issues.
1.2	04/25/2013	Submitted to X12 for review.
1.3	06/24/2013	Expand file name to include the full warrant number, add more description to section 3. 1.3a – corrected GS03 value definition to remove indication of adding spaces after the Tax ID.
1.4	09/25/2013	Corrections per X12