# 835 Health Care Claim Payment and Remittance Advice Companion Guide 004010 X091A1

**Version 1.3**

**March 1, 2008**

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# 1 INTRODUCTION

The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicaid and all other health insurance payers in the United States comply with the EDI standards for health care as established by the Secretary of Health Services. The ANSI X12N implementation guides have been established as the standards of compliance for claim transactions.

The following information is intended to serve only as a companion guide to the HIPAA ANSI X12N implementation guides. The use of this guide is solely for the purpose of clarification. The information describes specific requirements to be used for processing data. This companion guide supplements, but does not contradict any requirements in the X12N implementation guide. Additional companion guides/trading partner agreements will be developed for use with other HIPAA standards, as they become available.

Additional information on the *Final Rule for Standards for Electronic Transactions* can be found at http://aspe.hhs.gov/admnsimp/final/txfin00.htm. The HIPAA Implementation Guides can be accessed at http://www.wpc-edi.com/hipaa/HIPAA_40.asp.

## 1.1 Purpose

According to HIPAA regulations, the 835 Transaction Set can be used to make a payment, send an Explanation of Benefits (EOB) remittance advice, or make a payment and send an EOB remittance advice.

It is mandatory under HIPAA that the Agency for Health Care Administration (AHCA) be able to generate this transaction set to report on Payment and Remittance Information.

## 1.2 Special Considerations for 835 Transactions

1. **Subscriber, Insured = Recipient in the Florida Medicaid Eligibility Verification System:**

   The Florida Medicaid Eligibility Verification System does not allow for dependents to be enrolled under a primary subscriber, rather all enrollees/recipients are primary subscribers within each program or MCO (Managed Care Organization).

2. **Provider Identification = Agency for Health Care Administration Medicaid ID or NPI:**

   Value contained within the 1000B (Payee Identification) Loop sent on the 835, will contain either the NPI or Provider Tax ID. The Florida Medicaid Provider Number may be returned in the 1000B-REF02, where REF01=1D.

# 2 TRANSMISSION AND DATA RETRIEVAL METHODS

EDS supports several types of data transport depending upon the trading partner's need. Providers and their representatives can submit and receive data via: Web portal, Remote Access Server (RAS), and Value Added Network (VAN)/Switch Vendors for interactive transactions.

1. Web portal: Transaction files are uploaded/downloaded in the Trade Files menu on the secure Web portal.
2. Remote Access Server (RAS): This option is available to trading partners who do not have an existing Internet connection. The RAS server typically supports those who need a dial-up option. Once the RAS connection is established, transaction files are uploaded/ downloaded in the Trade Files menu on the secure Web portal.
3. Value Added Networks (VANs) or Switch Vendors: VANs or Switch Vendors typically support interactive transactions through a dedicated connection to the fiscal agent. VANs sign a contract with the State and have unique, VAN specific communication arrangements with the fiscal agent. A list of approved vendors is listed on the fiscal agent Web site.

Detailed information to assist with EDI related processes are available on the Provider Public Web site at: http://www.mymedicaid-florida.com.

Information available includes:

1. Remote Access Server connectivity instructions for submitters without an existing Internet connection.
2. Trading Partner Testing Procedures for all new trading partners, or trading partners adding a new transaction.
3. Web Upload/Download instructions for submitters uploading/downloading via the secure Web portal.

## 2.1 File/System Specifications

EDI will only accept Windows\PC\DOS formatted files.

EDI will allow upload and download of zipped or compressed files.

Note: Only one X12 transaction file is permitted in each “zipped” file.

EDI does not require any specific file extensions. This includes acceptance of files without an extension.

The Web portal is designed to support the following Internet browsers:

1. Internet Explorer, version 6 or later;
2. Firefox, version 1.5 or later; and
3. Opera, version 8.5 or later.

# 3 TRANSMISSION RESPONSES

For every transaction received, there is an expected response. The available responses are an Interchange Acknowledgement (TA1), a Functional Acknowledgement (997), and an Unsolicited Claim Status (277U).

Once a transaction is received, it will go through a ‘front end’ compliance check called a TA1. The TA1 Acknowledgement is a means of replying to an interchange or transmission that has

been sent. The TA1 verifies the envelopes only. The TA1 is a single segment and is unique in the sense that this single segment is transmitted without the GS/GE envelope structure. The TA1 segment provides the capability for the receiving trading partner to notify the sending trading partner of problems that were encountered in the interchange control structure.

Once the transaction has passed the 'front end' compliance check it then goes through a syntax compliance edit. This edit is to verify the compliance within the ANSI X12 syntax according to the HIPAA Implementation Guides. The transaction will receive a Functional Acknowledgement (997) to provide feedback on the transaction. The 997 functional acknowledgement contains accepted or rejected information. If the transaction contains any syntactical errors, the segments and elements in which the error occurred will be reported in a rejected acknowledgement. If the transaction contains no syntactical errors, a positive 997 response will be generated and the transaction is passed on for processing.

# 4 EDI SUPPORT

The EDS EDI Unit is available to support trading partners and providers that exchange transactions electronically. Support functions include:

1. Enrollment processing for trading partners requesting to submit transactions electronically;
2. Installation assistance and submission support for Provider Electronic Solutions (PES) software;
3. Provide assistance to billing agents, clearinghouses and software vendors;
4. Identifying and troubleshooting technical issues; and
5. Data Exchange help.

EDI staff is available Monday through Friday 8:00 a.m. to 5:00 p.m., EST by choosing option 3 when dialing:

1. Inside Florida: 1-800-289-7799;
2. Outside Florida: 1-800-955-7799; and
3. Local calls from Tallahassee area: 850-xxx-xxxx.

# 5 CONTROL SEGMENT DEFINITIONS FOR FLORIDA MEDICAID 835 TRANSACTION

Note the page numbers listed below in each of the tables represent the corresponding page number in the X12N 835 HIPAA Implementation Guide.

| X12N EDI Control Segments |
|---|
| ISA – Interchange Control Header Segment |
| IEA – Interchange Control Trailer Segment |

GS – Functional Group Header Segment
GE – Functional Group Trailer Segment
ST – Transaction Set Header
SE – Transaction Set Trailer
TA1 – Interchange Acknowledgement

## 5.1 ISA - Interchange Control Header Segment

Communications transport protocol interchange control header segment. This segment within the X12N implementation guide identifies the start of an interchange of zero or more functional groups and interchange-related control segments. This segment may be thought of traditionally as the file header record.

| **835 Health Care Claim Payment and Remittance Advice** | | | | |
|---|---|---|---|---|
| **Page** | **Loop** | **Segment** | **Data Element** | **Comments** |
| B.3 | N/A | ISA | ISA01 - Authorization Information Qualifier | '00' – No Authorization Information Present |
| B.3 | N/A | ISA | ISA02 - Authorization Information | [space fill] |
| B.4 | N/A | ISA | ISA03 - Security Information Qualifier | '00' – No Security Information Present |
| B.4 | N/A | ISA | ISA04 - Security Information | [space fill] |
| B.4 | N/A | ISA | ISA05 - Interchange ID Qualifier | 'ZZ' – Mutually Defined |
| B.4 | N/A | ISA | ISA06 - Interchange Sender ID | ‘77027’ left justified and space filled. Florida Medicaid Sender ID |
| B.4 | N/A | ISA | ISA07 - Interchange ID Qualifier | 'ZZ' – Mutually Defined |
| B.5 | N/A | ISA | ISA08 - Interchange Receiver ID | Trading Partner ID Supplied by Florida Medicaid |
| B.5 | N/A | ISA | ISA09 - Interchange Date | The date format is YYMMDD |

| 835 Health Care Claim Payment and Remittance Advice | | | | |
|---|---|---|---|---|
| **Page** | **Loop** | **Segment** | **Data Element** | **Comments** |
| B.5 | N/A | ISA | ISA10 - Interchange Time | The time format is HHMM |
| B.5 | N/A | ISA | ISA11 - Interchange Control Standards Identifier | 'U' – Interchange Control Standards Identifier |
| B.5 | N/A | ISA | ISA12 - Interchange Control Version Number | '00401' – Control Version Number |
| B.5 | N/A | ISA | ISA13 - Interchange Control Number | Interchange Unique Control Number |
| B.6 | N/A | ISA | ISA14 - Acknowledgment Requested | '1' – Acknowledgement Requested |
| B.6 | N/A | ISA | ISA15 - Usage Indicator | 'T' - Test Data<br>'P' - Production Data |
| B.6 | N/A | ISA | ISA16 - Component Element Separator | ':' – Component Element Separator |

## 5.2 IEA - Interchange Control Trailer

Communications transport protocol interchange control trailer segment. This segment within the X12N implementation guide defines the end of an interchange of zero or more functional groups and interchange-related control segments. This segment may be thought of traditionally as the file trailer record.

| 835 Health Care Claim Payment and Remittance Advice | | | | |
|---|---|---|---|---|
| **Page** | **Loop** | **Segment** | **Data Element** | **Comments** |
| B.7 | N/A | IEA | IEA01 - Number of Included Functional Groups | Number of included Functional Groups |
| B.7 | N/A | IEA | IEA02 - Interchange Control Number | Must be identical to the value in ISA13. |

## 5.3 GS – Functional Group Header

Communications transport protocol functional group header segment. This segment within the X12N implementation guide indicates the beginning of a functional group and provides control information concerning the batch of transactions. This segment may be thought of traditionally as the batch header record.

| 835 Health Care Claim Payment and Remittance Advice | | | | |
|---|---|---|---|---|
| **Page** | **Loop** | **Segment** | **Data Element** | **Comments** |
| B.8 | N/A | GS | GS01 - Functional ID Code | 'HP' – Health Care Claim Payment/Advice (835) |
| B.8 | N/A | GS | GS02 - Application Sender's Code | This will be equal to the value in ISA06. |
| B.8 | N/A | GS | GS03 - Application Receiver's Code | This will be equal to the value in ISA08. |
| B.8 | N/A | GS | GS04 - Date | The date format is CCYYMMDD. |
| B.8 | N/A | GS | GS05 – Time | The time format is HHMM. |
| B.9 | N/A | GS | GS06 - Group Control Number | Group Control Number |
| B.9 | N/A | GS | GS07 - Responsible Agency Code | 'X' – Responsible Agency Code |
| B.9 | N/A | GS | GS08 - Version/ Release/ Industry ID Code | '004010X091A1' – Version/ Release/ Industry Identifier Code |

## 5.4 GE – Functional Group Trailer

Communications transport protocol functional group trailer segment. This segment within the X12N implementation guide indicates the end of a functional group and provides control information concerning the batch of transactions. This segment may be thought of traditionally as the batch trailer record.

| 835 Health Care Claim Payment and Remittance Advice | | | | |
|---|---|---|---|---|
| **Page** | **Loop** | **Segment** | **Data Element** | **Comments** |
| B.10 | N/A | GE | GE01 – Number of Transaction Sets Included | Number of included Transaction Sets |
| B.10 | N/A | GE | GE02 – Group Control Number | Must be identical to the value in GS06 |

## 5.5 ST – Transaction Set Header

Communications transport protocol transaction set header segment. This segment within the X12N implementation guide indicates the start of the transaction set and assigns a control number to the transaction. This segment may be thought of traditionally as the claim header record.

| 835 Health Care Claim Payment and Remittance Advice | | | | |
|---|---|---|---|---|
| **Page** | **Loop** | **Segment** | **Data Element** | **Comments** |
| 43 | N/A | ST | ST01 – Transaction Set Identifier Code | '835' – Health Care Claim Payment/Advice |
| 43 | N/A | ST | ST02 – Transaction Set Control Number | Transaction Control Number |

## 5.6 SE – Transaction Set Trailer

Communications transport protocol transaction set trailer. This segment within the X12N implementation guide indicates the end of the transaction set and provides the count of transmitted segments (including the beginning (ST) and ending (SE) segments). This segment may be thought of traditionally as the claim trailer record.

| 835 Health Care Claim Payment and Remittance Advice | | | | |
|---|---|---|---|---|
| **Page** | **Loop** | **Segment** | **Data Element** | **Comments** |
| 173 | N/A | SE | SE01 – Number of Included Segments | Total number of segments included in Transaction Set including ST and SE. |
| 173 | N/A | SE | SE02 – Transaction Set Control Number | Must be identical to the value in ST02. |

## 5.7 Valid Delimiters

The delimiters documented below will be used for Florida Medicaid, unless otherwise requested by a trading partner.

| Definition | ASCII | Decimal | Hexadecimal |
|---|---|---|---|
| Segment Separator | ~ | 126 | 7E |
| Element Separator | * | 42 | 2A |
| Compound Element Separator | : | 58 | 3A |

# 6 COMPANION GUIDE FOR THE 835 TRANSACTION

| 835 Health Care Claim Payment and Remittance Advice | | | | |
|---|---|---|---|---|
| **Page** | **Loop** | **Segment** | **Data Element** | **Comments** |
| 45-46 | N/A | BPR | BPR01 - Transaction Handling Code | 'I' – Remittance Information Only<br>'H' – Notification Only |
| 46 | N/A | BPR | BPR02 - Monetary Amount (Total Actual Provider Payment Amount) | Check Amount - Total payment amount for paid and denied claims will always contain the correct total payment amount for the week. |
| 46 | N/A | BPR | BPR03 - Credit/Debit Flag | 'C' - Credit |
| 46-47 | N/A | BPR | BPR04 - Payment Method Code | 'ACH' – Automated Clearing House<br>'CHK' – Check<br>'NON' – Non-Payment Data |
| 50 | N/A | BPR | BPR16 - Date (Check Issue or EFT Effective Date) | Cycle Date |
| 52 | N/A | TRN | TRN01 - Trace Type Code | '1' – Current Transaction Trace No. |
| 53 | N/A | TRN | TRN02 - Reference Identification (Check or EFT Trace Number) | Check Number OR<br>Internal Trace Number (The RA number will be moved to the payment number when the paid amount is zero.) |

| 835 Health Care Claim Payment and Remittance Advice | | | | |
|---|---|---|---|---|
| **Page** | **Loop** | **Segment** | **Data Element** | **Comments** |
| 53 | N/A | TRN | TRN03 - Originating Company Identifier (Payer Identifier) | '593452939' - Florida Medicaid Tax ID |
| 57 | N/A | REF | REF01 - Reference Identification Qualifier | 'EV' – Receiver Identification Number |
| 57 | N/A | REF | REF02 - Reference Identification | Florida Medicaid Receiver ID (if different than Florida Medicaid Provider ID) |
| 61 | N/A | DTM | DTM02 - Date (Production Date) | Cycle Date |
| 63 | 1000A | N1 | N102 - Name (Payer Name) | 'STATE OF FLORIDA MEDICAID' |
| 64 | 1000A | N3 | N301 - Address Information | 'SUITE 100' |
| 65 | 1000A | N4 | N401 - City Name | 'TALLAHASSEE' |
| 65 | 1000A | N4 | N402 - State or Province Code | 'FL' |
| 65 | 1000A | N4 | N403 - Postal Code | '323093574' |
| 73 | 1000B | N1 | N103 - Identification Code Qualifier | 'FI' – Federal Taxpayer's Identification Number<br>'XX' – Health Care Financing Administration National Provider Identifier |
| 73 | 1000B | N1 | N104 - Identification Code | If NM108='FI' - Federal Tax ID<br>If NM108='XX' - NPI |
| 77-78 | 1000B | REF | REF01 - Reference Identification Qualifier | '1D' – Medicaid Provider Number<br>'TJ' – Federal Tax ID |
| 78 | 1000B | REF | REF02 - Reference Identification (Additional Payee Identifier) | If REF01='1D' – Florida Medicaid Provider Number<br>If REF01='TJ' – Provider Tax ID |

| 835 Health Care Claim Payment and Remittance Advice | | | | |
|---|---|---|---|---|
| **Page** | **Loop** | **Segment** | **Data Element** | **Comments** |
| 89 | 2100 | CLP | CLP01 - Claim Submitter's Identifier (Patient Control Number) | Patient Account Number |
| 90 | 2100 | CLP | CLP02 - Claim Status Code | '1' – Processed as Primary (Regular Medicaid Claims)<br>'2' – Processed as Secondary (Medicare Crossover Claims<br>'4' – All Denied (Regular & Crossover) |
| 92 | 2100 | CLP | CLP06 - Claim Filing Indicator Code | 'MC' - Medicaid |
| 93 | 2100 | CLP | CLP11 - Diagnosis Related Group (DRG) Code | Institutional claims only |
| 93 | 2100 | CLP | CLP12 - Quantity (Diagnosis Related Group (DRG) Weight) | The diagnosis-related group (DRG) weight – Institutional claims only |
| 97-100 | 2100 | CAS | CAS02, CAS05, CAS08, CAS11, CAS14, CAS17 - Claim Adjustment Reason Code | Adjustment Code can be found on http://www.wpc-edi.com |
| 97-100 | 2100 | CAS | CAS03, CAS06, CAS09, CAS12, CAS15, CAS18 - Monetary Amount (Adjustment Amount) | Displays the Adjustment (cutback) Amount.<br>The X12N 835 will contain information regarding the difference between the submitted charge, (Loop 2100 Segment CLP03) and the approved payment amount, (Loop 2100 Segment (CLP04).<br>For example: If a provider bills $750.00 for a procedure that allows a maximum of $500.00, $250.00 will be reported as a cutback amount. |
| 102 | 2100 | NM1 | NM101 - Entity Identifier Code | 'QC' - Patient |

| 835 Health Care Claim Payment and Remittance Advice | | | | |
|---|---|---|---|---|
| **Page** | **Loop** | **Segment** | **Data Element** | **Comments** |
| 103 | 2100 | NM1 | NM103 - Name Last or Organization Name | Recipient last name as stored on Florida Medicaid file. If recipient not found on file, the value will be the recipient last name submitted on claim. |
| 103 | 2100 | NM1 | NM104 - Name First | Recipient first name as stored on Florida Medicaid file. If recipient not found on file, the value will be the recipient first name submitted on claim. |
| 103 | 2100 | NM1 | NM108 - Identification Code Qualifier | 'MR' – Medicaid Recipient Identification Number |
| 104 | 2100 | NM1 | NM109 - Identification Code | Florida Recipient 10-digit Medicaid ID |
| 112 | 2100 | NM1 | NM101 - Entity Identifier Code | '82' – Rendering Provider |
| 113 | 2100 | NM1 | NM108 - Identification Code Qualifier | 'MC' – Medicaid Provider Number<br>'XX' – Health Care Financing Administration National Provider Identifier |
| 113 | 2100 | NM1 | NM109 - Identification Code (Rendering Provider Identifier) | If NM108='MC' - Florida Medicaid Provider Number<br><br>If NM108='XX' - NPI |
| 116 | 2100 | NM1 | NM101 - Entity Identifier Code | 'PR' – Payer |
| 117 | 2100 | NM1 | NM108 - Identification Code Qualifier | 'PI' – Payer Identification |
| 117 | 2100 | NM1 | NM109 - Identification Code (Corrected Priority Payer Identification Number) | TPL Carrier Code |
| 119 | 2100 | MIA | MIA01 - Quantity (Covered Days or Visits Count) | Default to '0' – Institutional only |

| 835 Health Care Claim Payment and Remittance Advice | | | | |
|---|---|---|---|---|
| **Page** | **Loop** | **Segment** | **Data Element** | **Comments** |
| 120 | 2100 | MIA | MIA04 - Monetary Amount (Claim DRG Amount) | Use this monetary amount for the DRG dollar amount. – Institutional only |
| 120 | 2100 | MIA | MIA05 - Reference Identification (Remark Code) | HIPAA Remark Code for Inpatient and Institutional Regular and Crossover claims. Remark Codes can be found on http://www.wpc-edi.com |
| 122 | 2100 | MIA | MIA20 - Reference Identification (Remark Code) | HIPAA Remark Code for Inpatient and Institutional Regular and Crossover claims (2) |
| 124 | 2100 | MOA | MOA03 - Reference Identification (Remark Code) | HIPAA Remark Code for Outpatient/Professional Crossover claims. Remark Codes can be found on http://www.wpc-edi.com |
| 124 | 2100 | MOA | MOA04 - Reference Identification (Remark Code) | HIPAA Remark Code for Outpatient/Professional Crossover claims (2) |
| 126-127 | 2100 | REF | REF01 - Reference Identification Code | 'EA' – Medical Record ID Number |
| 127 | 2100 | REF | REF02 - Reference Identification (Other Claim Related Identifier) | Medical Record ID Number as submitted on claim. |
| 126-127 | 2100 | REF | REF01 - Reference Identification Code | 'SY' –SSN |
| 127 | 2100 | REF | REF02 - Reference Identification (Other Claim Related Identifier) | Recipient SSN |
| 126-127 | 2100 | REF | REF01 - Reference Identification Code | '9C' – Adjusted Repriced Claim Reference |
| 127 | 2100 | REF | REF02 - Reference Identification (Other Claim Related Identifier) | Adjusted ICN |
| 126-127 | 2100 | REF | REF01 - Reference Identification Code | 'F8' – Original Reference Number |

| 835 Health Care Claim Payment and Remittance Advice | | | | |
|---|---|---|---|---|
| **Page** | **Loop** | **Segment** | **Data Element** | **Comments** |
| 127 | 2100 | REF | REF02 - Reference Identification (Other Claim Related Identifier) | Duplicate ICN |
| 131 | 2100 | DTM | DTM01 - Date/Time Qualifier | '232' – Claim Statement Period Start<br>'233' – Claim Statement Period End |
| 131 | 2100 | DTM | DTM02 - Claim Date | If DTM01='232' value will contain Start Date.<br>If DTM01='233' value will contain End Date<br>If Invalid date received on original claim, value will contain default date of 19000101. |
| 137 | 2100 | QTY | QTY01 – Quantity Qualifier | 'CA' – Covered (Actual) |
| 138 | 2100 | QTY | QTY02 – Quantity | Covered Days<br>Institutional only |
| 140-141 | 2110 | SVC | SVC01-1 - Product/Service ID Qualifier | 'AD' – American Dental Association Codes<br>'HC' – Health Care Financing Administration<br>Common Procedural Coding System<br>'N4' – National Drug Code (NDC)<br>'NU' – National Uniform Billing Committee (NUBC) UB92 |
| 141 | 2110 | SVC | SVC01-3 to SVC01-6 | Up to four (4) Procedure Code Modifiers per Detail. |
| 143 | 2110 | SVC | SVC06-1 - Product/Service ID Qualifier | Used if adjudicated procedure code provided in SVC01 is different from the submitted procedure code in the original claim. |

| 835 Health Care Claim Payment and Remittance Advice | | | | |
|---|---|---|---|---|
| **Page** | **Loop** | **Segment** | **Data Element** | **Comments** |
| | | | | 'AD' – American Dental Association Codes<br>'HC' – Health Care Financing Administration<br>Common Procedural Coding System<br>'N4' – National Drug Code (NDC)<br>'NU' – National Uniform Billing Committee (NUBC) UB92 |
| 144 | 2110 | SVC | SVC06-2 - Product/Service ID (Procedure Code) | Reports original code billed on claim. |
| 144 | 2110 | SVC | SVC06-3 to SVC06-6 | Up to four (4) Procedure Code Modifiers per Detail. |
| 145 | 2110 | SVC | SVC07 - Quantity (Original Units of Service Count) | Units of Service are reported here if different than the original billed units. |
| 150-153 | 2110 | CAS | CAS02, CAS05, CAS08, CAS11, CAS14, CAS17 - Claim Adjustment Reason Code | Adjustment Code can be found on http://www.wpc-edi.com |
| 150-153 | 2110 | CAS | CAS03, CAS06, CAS09, CAS12, CAS15, CAS18 - Monetary Amount (Adjustment Amount) | Difference between the line billed charge and line Medicaid paid amount |
| 154 | 2110 | REF | REF01 - Reference Identification Qualifier | '6R' – Provider Control Number |
| 155 | 2110 | REF | REF02 - Reference Identification | Original Line Item Control Number from 837-claim line |
| 156-157 | 2110 | REF | REF01 - Reference Identification Qualifier | '1D' – Medicaid Provider Number<br>'HPI' - NPI |
| 155 | 2110 | REF | REF02 - Reference Identification | If REF01='1D' – Florida Medicaid Provider Number |

| 835 Health Care Claim Payment and Remittance Advice | | | | |
|---|---|---|---|---|
| **Page** | **Loop** | **Segment** | **Data Element** | **Comments** |
| | | | | If REF01='HPI' – NPI |
| 158 | 2110 | AMT | AMT01 - Amount Qualifier Code | 'B6' – Allowed Actual |
| 162 | 2110 | LQ | LQ01 - Code List Qualifier Code | 'HE' – Claim Payment Remark Codes |
| 163 | 2110 | LQ | LQ02 - Industry Code (Remark Code) | Remark Codes if needed to communicate additional information about the denial or adjustment of a claim or service line that cannot be thoroughly explained by a Claim Adjustment Reason Code.<br>Remark Codes can be found on http://www.wpc-edi.com |
| 165 | Summary | PLB | PLB01 - Reference Identification (Provider Identifier) | Florida Medicaid Provider Number or NPI |
| 165 | Summary | PLB | PLB02 - Date (Fiscal Period Date) | Accounts Receivable Financial Cost Settlement Fiscal Year End Date or Set-up date for A/R transaction. For a Negative Net Payment Amount this field contains the Remittance Date. |
| 170 – 172 | Summary | PLB | PLB04, PLB06, PLB08, PLB10, PLB12, and PLB14. Monetary Amount (Provider Adjustment Amount) | The monetary amount for the adjustment to the preceding adjustment code. Amount of increase/decrease OR amount received/recouped OR Negative Net Payment Amount.<br>Note: As required for HIPAA compliance, only amounts that affect the remittance check amount will be reported in the PLB segment. |

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