

X12N/005010X221A1 Health Care Claim Payment/Advice (835) Questions and Answers

Version 2.0

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1. PURPOSE OF THIS DOCUMENT

This document provides a consolidated reference point for questions that have been posed based on the review and implementation of the *X12N/005010X221A1 Health Care Claim Payment/Advice (835)*.

As members reviewed the documents, questions arose which were not specifically addressed in the guides or could be clarified further. Initial questions were addressed in the Work Group 45 External Standards Assessment and Implementation Guidance meetings. The WG45 834/835 FAQ Task Group reviews additional questions received regarding the 835 and will draft and may publish responses to new issues needing to be addressed when applicable to pharmacy and related transactions.

Disclaimer:

This Reference Guide must be used in conjunction with the *X12N/005010X221A1 Health Care Claim Payment/Advice (835)*. This document does not supersede the *X12N/005010X221A1*. Implementers should also consult the CAQH CORE Operating Rules for the *X12N/005010X221A1 Health Care Claim Payment/Advice (835)* located at <https://www.caqh.org/core/operating-rules>.

2. X12N/005010X221A1 HEALTH CARE CLAIM PAYMENT/ADVICE (835) FREQUENTLY ASKED QUESTIONS

2.1 REPORTING OF THE PRESCRIPTION FILL NUMBER

Question: Would you please clarify the appropriate reporting of the prescription refill number in the Claim Payment Information (CLP) Segment?

Response: If the prescription number and other information in the claim will not uniquely identify the service without providing the refill number, per trading partner agreement, the payer may include both in the Claim Submitter's Identifier (CLP01) by reporting the prescription number and the characters "FILL" followed by the refill number including the leading zero (0). Example: CLP01 = 12345FILL03.

2.2 INVALID NDC NUMBERS

Question: If a batch or paper claim includes an invalid NDC, what should be returned on the 835 in the Product/Service ID (SVC01-2) field?

Response: If a reject has already been reported to the pharmacy in a NCPDP Telecommunication Standard or Batch Standard response, NCPDP recommends the rejects not be reported on the 835.

An invalid NDC, UPC, HCPCS or other value for a valid identifier type cannot be reported on the 835 in the Product/Service ID (SVC01-2) field. The payer would need to inform the pharmacy provider of this rejection however determined by trading partner agreements.

2.3 PRESCRIPTION/SERVICE REFERENCE NUMBER

Question: As of the NCPDP Telecommunication Standard Version D.0, the Prescription/Service Reference Number is defined as a 12-byte numeric reference number in the Prescription/Service Reference Number (402-D2) field. Per the implementation guide, this field can be submitted with or without leading zeros. How should the prescription number be provided in Claim Submitter's Identifier (CLP01) field when less than 12 significant numeric characters are sent from the pharmacy?

Response: Prescription/Service Reference Number (402-D2) is a numeric field, and per the NCPDP Telecommunication Implementation Guide, non-header numeric fields may be submitted with or without leading zeros. It is up to the pharmacy provider to determine if leading zeros are sent in a claim request transaction. According to the 835 transaction, the Claim Submitter's Identifier (CLP01) must be identical to the value submitted in the NCPDP Telecommunication field Prescription/Service Reference Number (402-D2) field on the claim unless otherwise stated in trading partner agreement.

2.4 X12N/005010X221A1 Health Care Claim Payment/Advice (835) FILE MATCHING AND REASSOCIATION

2.4.1 Question: Is it true that one 835 transaction set, reflective of a single payment, must correspond to and equal a single check or a single electronic funds transfer (EFT) payment?

Response: Yes, see Sections 1.10.1.1 (Payment) and 1.10.2.1.3 (Transaction Balancing) in the 835 for details.

2.4.2 Question: If an 835 file for one 835 transaction set does not balance to a single check or a single EFT payment, is it considered noncompliant per the 835 standard?

Response: NCPDP does not make determinations regarding compliance on behalf of X12. See Sections 1.10.1.4 (Remittance) and 1.10.2.1 (Balancing) in the 835. Also see the WEDI Transaction and Certification White Paper for recommendations for compliance testing which may be found at the following link: <https://www.wedi.org/2010/03/10/transaction-compliance-and-certification/>

2.4.3 Question: Does a single BPR02 (Total Actual Provider Payment Amount) always have to equal a single check or a single EFT payment?

Response: Yes, BPR02 must equal a single payment if the amount is greater than 0. If BPR02 is equal to 0, no check or EFT must be issued. See Section 1.10.2.1 (Balancing) in the X12N/005010X221A1 Health Care Claim Payment/Advice (835).

2.4.4 Question: Is it acceptable for an 835 that contains a single BPR02 (Total Actual Provider Payment Amount) to equate to multiple checks or multiple EFT payments?

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Response: No, each BPR02 must have a single payment. See Section 1.10.1.1 (Payment) and 1.10.2.2 (Remittance Tracking) in the *X12N/005010X221A1 Health Care Claim Payment/Advice (835)*.

2.4.5 Question: Is it acceptable for an 835 to have multiple BPR02s (Total Actual Provider Payment Amount) that equate to a single check or a single EFT payment?

Response: No, see Sections 1.10.1.1 (Payment) and 1.10.2.2 (Remittance Tracking) in the *X12N/005010X221A1 Health Care Claim Payment/Advice (835)*.

2.5 X12N/005010X221A1 Health Care Claim Payment/Advice (835) FILE CREATION AND FILE RECREATION

2.5.1 Question: Are there any timing requirements for payers generating the 835? Should the 835 be delivered to the pharmacy provider at the same time the check or EFT is issued?

Response: There are no requirements in the 835 addressing timing requirements. At this time, any timing requirements would be between trading partners or in accordance with state or federal regulations.

2.5.2 Question: If a file is found to be noncompliant, are there any time requirements for a corrected (recreated) 835 to be generated?

Response: There are no requirements in the 835 addressing timing requirements. At this time, any timing requirements would be between trading partners or in accordance with state or federal regulations. NCPDP does not make determinations regarding compliant use of other SDOs' standards.

2.6 TRANSACTION LEVEL BALANCING, CLAIM LEVEL FILE BALANCING AND PLBS

2.6.1 Question: For a given 835 within each Claim Payment loop (CLP), does the Total Claim Charge Amount (CLP03) minus the sum of all monetary adjustments (CAS03, 06, 09, 12, 15 and 18) have to equal the Claim Paid Amount (CLP04)?

Response: Yes, but the pharmacy industry does not support the Claim Adjustment Segment (CAS) being reported at the CLP loop; it is supported at the Service Payment Information (SVC) loop. See Section 1.10.2.1.3 (Transaction Balancing) in the *X12N/005010X221A1 Health Care Claim Payment/Advice (835)*.

2.6.2 Question: Within an 835 does the sum of all Claim Payment Amounts (CLP04) minus the sum of all Provider Level Adjustments (PLB04, 06, 08, 10, 12 and 14) always have to equal the Total Actual Provider Payment Amount (BPR02)?

Response: Yes, see Section 1.10.2.1.3 (Transaction Balancing) in the *X12N/005010X221A1 Health Care Claim Payment/Advice (835)*.

2.6.3 Question: Is it acceptable to have a situation where the Total Actual Provider Payment Amount (BPR02) is equal to zero, to not contain any claim detail and have a PLB04, 06, 08, 10, 12 or 14 that is either greater or less than zero?

Response: Yes, when adjustments are only being made at the pharmacy provider level it is acceptable. Then the claim detail is not required, but the sum of the Provider Adjustment (PLB) must also be equal to zero. See Section 1.10.2.1.3 (Transaction Balancing) in the *X12N/005010X221A1 Health Care Claim Payment/Advice (835)*.

2.6.4 Question: Is it correct for payers to send PLBs that are not specific to a particular pharmacy provider and do not contain enough information for the pharmacy provider to tie it back to an entity within their pharmacy receivables system?

Response: Yes, the PLB Segment contains identifiers and rules for usage. See Section 2.4 (835 Segment Detail) in the *X12N/005010X221A1 Health Care Claim Payment/Advice (835)* PLB segment for specific requirements. In some cases, as in balance forward processing, the 835 transaction is specific where the Adjustment Reason Code (PLB03-1) has a reference number contained in the Provider Adjustment Identifier (PLB03-2).

2.7 *X12N/005010X221A1 Health Care Claim Payment/Advice (835)* BALANCING CERTIFICATION

Question: Should payers be required to perform 835 validations or certifications for claim level balancing to ensure files meet 835 standards prior to distributing files to their respective trading partners?

Response: NCPDP does not make determinations regarding the compliant use of other SDOs' standards. See Section 1.10.2 (Data Use by Business Use) in the *X12N/005010X221A1 Health Care Claim Payment/Advice (835)* for guidance as to what can be produced and determined compliant within the standard. The interpretation and application of this guidance may need to be reviewed by trading partners' legal counsels.

2.8 VOIDED CHECKS

Question: How should voided check scenarios be addressed if a check is voided by the payer after the 835 has been created and made available or sent to the pharmacy provider?

Response: If a check is voided by a payer after the 835 has been created, see Section 1.10.2.3.1 (Lost and Reissued Payments) in the *X12N/005010X221A1 Health Care Claim Payment/Advice (835)* for guidance.

2.9 TAKE BACKS

Question: How should take back scenarios be addressed if a check is voided by the payer after the 835 has been created and made available or sent to the pharmacy provider?

Response: If a check is voided by a payer after the 835 has been created, see Section 1.10.2.3.1 (Lost and Reissued Payments) in the *X12N/005010X221A1 Health Care Claim Payment/Advice (835)* for guidance.

2.10 CLAIM STATUS CODE

Question: When a supplemental claim is paid on an 835, should the 835 reflect the order of the payers billed?

Response: Anytime a Coordination of Benefit (COB) segment is used in payment calculation, the Claim Status Code in the 835 should not default to Processed as Primary and should reflect the order of the payers billed as indicated by the Other Payer Coverage Type (338-5C) field in the Telecommunication Standard claim request. For more than three payers, consult the trading partner agreement.

2.11 PHARMACY PROVIDER INITIATED PAYMENT TO PAYER

Question: In the following scenarios how should receipt of a payment from a pharmacy provider be reported on an 835?

Scenario 1: A pharmacy provider sends monies due to a payer including details of the claim(s), and the claim(s) have previously been reported on an 835.

Response: It is assumed the payer and pharmacy provider have discussed this situation, and the monies due to the payer were previously reported on an 835. The pharmacy provider sends the payer a check resulting in an 835 created by the payer where no CLP detail is reported but the PLB segment reports as shown in Section 1.10.2.17 (*Claim Overpayment and Recovery, Number 2*) in the X12N/005010X221A1 Health Care Claim Payment/Advice (835).

Scenario 2: A pharmacy provider sends monies due to a payer that includes details of the claim(s), and the claim(s) have not previously been reported on an 835.

Response: The monies must be reported as shown in Section 1.10.2.17 (*Claim Overpayment and Recovery, Number 3*) in the X12N/005010X221A1 Health Care Claim Payment/Advice (835).

Scenario 3: When a pharmacy provider sends monies due to a payer but the monies due are not equal to the claim(s) detail provided by the payer.

Response: The payment must not be reported on an 835 until such a time as the payer and pharmacy provider agree with the details of the payment. Once the details are determined, the payer must follow either scenario 1 or 2, as described above.

Scenario 4: When a pharmacy provider sends monies to a payer and no claim(s) detail is provided.

Response: It is recommended that the 835 not report the check received. If the detail can be determined, the payer must follow scenario 1 or 2, as described above. If no detail can be determined, then it is up to the trading partners as to if or how the monies are reported on an 835.

2.12 NETWORK REIMBURSEMENT ID (545-2F)

Question: When the Network Reimbursement ID (545-2F) is returned in a claim response to define the line of business under which a claim was paid, where could I expect to find the Network Reimbursement ID in the 835 Remittance?

Response: The Network Reimbursement ID (545-2F) returned in the claim response could be translated into an REF Segment in the 2100 loop of 835 with a qualifier of 'CE' (Class of Contract Code). The REF segment would be populated as follows:

- REF01 = CE (Class of Contract Code)
- REF02 = Value contained in the Network Reimbursement ID (545-2F)

For example, if the Network Reimbursement ID (545-2F) is 12345, it would be reflected in the 835 as **REF*CE*12345~**.

See the [NCPDP Pharmacy Reference Guide to the X12N/005010X221 Health Care Claim Payment/Advice \(835\)](#) for additional information.

3. MODIFICATIONS TO THIS DOCUMENT

3.1 VERSION 1.1– JUNE 2013

- Added Questions 3.10 and 3.11

3.2 VERSION 1.2 – MARCH 2017

- Editorial updates to remove slashed zeros (Ø) and replace with zero (0). Also updated the NCPDP logo and X12 name change from ASC X12 to X12.

3.3 VERSION 1.3 – AUGUST 2018

- Added Question 3.12

3.4 VERSION 2.0 – JANUARY 2024

- Removed references to the X12N/005010X220A1 Benefit Enrollment and Maintenance (834) Frequently Asked Questions throughout the document and title.
- Updated instances of Telecommunication Standard VD.0 and Batch Standard V1.2 to have no specific version referenced unless version number required for a specific scenario.
- Created header/footer in place of manually entered text at the top and bottom of each page.
- Replaced “provider” with “pharmacy provider” where applicable throughout for clarity.
- Replaced “non-compliant” with “noncompliant” throughout.
- Updated copyright verbiage.
- Updated the name of WG45 removing “Harmonization”.
- Corrected various formatting, grammatical and punctuation errors and spelled out acronyms throughout.
- Standardized references to the *X12N/005010X221A1 Health Care Claim Payment/Advice (835)* as 835.
- Updated the Purpose of This Document section to align with task group scope.
- Section 2.1: Simplified question and added, “per trading partner agreement” to the response.
- Section 2.2: Removed unnecessary statement from the question and clarified the response is regarding paper claims.
- Section 2.3: Removed “and above” from the question and added, “...unless otherwise stated in trading partner agreement” in the response.
- Section 2.4, 2.5 and 2.6: Added subsection for each question.
- Section 2.4.2: Corrected URL.
- Section 2.5.2: Added compliance disclaimer.
- Section 2.6.3: Simplified the question.
- Section 2.6.4: Added section number for PLB segment information.
- Section 2.10: Simplifies question, clarified response for up to three payers. Referred reader to trading partner agreement for more than three payers.
- Section 2.11: Labeled each number as a scenario within the question. Updated “Option” to “Number” in scenarios 1 and 2 to correspond to 835 implementation guide. Updated response to scenario 1 clarifying the 835 is created by the payer.