

Subject:	Final 820 Business Requirements
820 Transaction:	Payroll Deducted and Other Group Premium Payment for Insurance products (Replaces the Prepaid Health Plan Capitation-RA File)
JAD Session	On August 17, 2004, DHS hosted a JAD Session for Prepaid Health Plan (PHP) representatives. Minutes of the JAD session are attached reflecting the attendees and discussions during the meeting.
820 Business Purpose	DHS will use the 820 Transaction to relay remittance detail information associated with health care premium (capitation) payments. <ol style="list-style-type: none"> 1. The choice of which type of detail, Organization Summary Remittance Detail or Individual Remittance Detail depends on the contract type. 2. Individual Remittance Detail should only be sent for those contractors that require individual remittance information in order to properly apply the premium payments.
Business Requirement Decision #1:	See the attached Business Decision reflecting the DHS Remittance Payment process. DHS will send payment and remittance information separately and will support sending remittance information at the individual detail level vs. the summary level.
Business Requirement Decision #2:	See the attached Business Decision reflecting the DHS Remittance Payment process: DHS will deposit the 820 Transaction into the PHP Mailbox located on a Secure File Transfer Protocol (SFTP) site. PHPs will receive an EFT or check for payment and a separate 820 transaction containing Individual Remittance Detail information. PHPs who have not established the EFT process will continue to receive a check and the 820 Transaction.

820 Crosswalk	<p>The JAD participants reviewed the DHS Initial 820 Crosswalk; a spreadsheet which maps data in the current proprietary Remittance Advice to the location where the same data will be carried in the 820 Transaction. Decisions made by the group are described below:</p> <p>Review of the 820 Crosswalk identified one potential data element gap for: Remittance Advice Number. The 820 Transaction does not have a clear data element for the RA Number. The 820 does provide a check/EFT trace number.</p>
Business Requirement Decision #3:	<p>The check number or EFT trace number is sufficient to meet PHP business requirements. DHS will not send the Remittance Advice number.</p>
JAD Action Item	<p>The PHPs assigned an ACTION ITEM to the HIPAA Project Office: Determine if the following data can be placed in the 820 Transaction:</p> <ul style="list-style-type: none"> a) PERC Code b) Rate Group Code c) 4 digit plan ID d) County Code (aka FIPS)
DHS Answer	<p>Upon preliminary review DHS anticipates accommodating the inclusion of the four requested data elements in the 820 Transaction. The final determination of inclusion and location will be established during the development and design phase.</p>
Business Requirement Decision #4:	<p>The Final 820 Crosswalk is accepted by the JAD participants with the addition of these data elements to be reported in the 820 Transaction:</p> <ul style="list-style-type: none"> a) PERC Code b) Rate Group Code c) 4 digit plan ID d) County Code (aka FIPS)
Attachments:	<p>August 17, 2004 Minutes The 820 Purpose and Business Overview Remittance Advice Business Decision 820 Final Crosswalk 820 Adjustment Reason Code Table</p>

Approval:

Patricia Krewson

Print

Signature

09/01/2004

Date

National Electronic Data Interchange Transaction Set Implementation Guide

Payroll Deducted and Other Group Premium Payment for Insurance Products 820 - Purpose and Business Overview

1.1 Document Purpose

The Payroll Deducted and Other Group Premium Payment for Insurance Products Implementation Guide (IG) provides standardized data requirements and content to all users of the ANSI ASC X12 Premium Payment Order/Remittance Advice (820) Transaction Set for the purpose of reporting payroll deducted and other group premiums. This Implementation Guide is designed to assist those sending premium payments to an insurance company, health care organization or government agency receiving premium payments using the 820-transaction set.

1.1.1 Trading Partner Agreements

It is appropriate and prudent for payers to have trading partner agreements that go with the standard Implementation Guides. This is because there are 2 levels of scrutiny that all electronic transactions must go through. First is standards compliance. These requirements MUST be completely described in the Implementation Guides for the standards, and NOT modified by specific trading partners. Second is the specific processing, or adjudication, of the transactions in each trading partner's individual system. Since this will vary from site to site (e.g., payer to payer), additional documentation, which gives information regarding the processing, or adjudication, will prove helpful to each site's trading partners (e.g., providers), and will simplify implementation. **It is important that these trading partner agreements NOT:**

1. **Modify the**
 - a. **Definition,**
 - b. **Condition, or**
 - c. **Use of a data element or segment in the standard Implementation Guide**
2. **Add any additional data elements or segments to this Implementation Guide**
3. **Utilize any code or data values which are not valid in this Implementation Guide**
4. **Change the meaning or intent of this Implementation Guide**

These types of companion documents should exist solely for the purpose of clarification, and should not be required for acceptance of a transaction as valid.

1.1.2 HIPAA Role in Implementation Guides

The Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191 - known as HIPAA) includes provisions for Administrative Simplification, which require the Secretary of Department of Health and Human Services 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.
- Detailed Implementation Guides for each standard must be available at the time of the adoption of HIPAA standards so that health plans, providers, clearinghouses, and software vendors can ready their information systems and application software for compliance with the standards.
- Consistent usage of the standards, including loops, segments, data elements, etc., across all guides is mandatory to support the Secretary's commitment to standardization.

This Implementation Guide has been developed for use as the HIPAA Implementation Guide for Premium Payments as well as non HIPAA functions.

Should the Secretary adopt the X12 Payroll Deducted and Other Group Premium Payment for Insurance Products (820) transaction as an industry standard, this Implementation Guide describes the consistent industry usage called for by HIPAA.

If adopted under HIPAA, the Payroll Deducted and Other Group Premium Payment for Insurance Products (820) transaction cannot be implemented for HIPAA except as described in this Implementation Guide.

HIPAA specific usage is identified in this guide by notes at specific segments and data elements.

The general business function applicable under HIPAA compliance falls into 2 categories.

1. **The first is the use of an Electronic Funds Transfer (EFT)** with remittance information being carried through the ACH system.
 - a. The remittance information is detailed in section 2.2.2.1 (Organization Summary Remittance Detail) and 2.2.2.2 (Individual Remittance).
 - b. The choice of which type of detail, Organization Summary Remittance Detail or Individual Remittance Detail depends on your contract type.
 - c. Individual Remittance Detail should only be sent for those contractors that require individual remittance information in order to properly apply the premium payments.
2. **The second function applicable under HIPAA is the use of an EFT or a check to make the payment with a separate remittance advice** containing either Organization Summary Remittance Detail or Individual Remittance Detail information.
 - a. In this case, the movement of the remittance is via an 820 transaction that is communicated outside of the banking networks.
 - b. The choice of which type of detail again depends on your contract type.

1.3 Business Usage and Definition Companies and government agencies that offer employees group life, health, and disability insurance can use a subset of the 820 to provide remittance detail associated with the premium payments. The premium being remitted can be associated with health care, individual life, disability, and/or property and casualty contracts. The 820 can be used in the following ways:

- Initiate an electronic payment that includes the remittance detail needed by the premium receiver to properly apply the payment.
- Initiate a payment without the remittance detail, and send the remittance detail separately to the premium receiver. The payment can be an electronic payment or a paper check.

1.4 Information Flows

The 820 transaction can perform multiple functions:

1. An 820 can be sent to a bank to move money only.
2. An 820 can be sent to a bank to move money as well as detailed or summary remittance information.

An 820 can be sent directly to a payee to move detailed or summary remittance information. Each function changes the actual content of the transaction slightly.

2 Data Overview

2.1 Overall Data Architecture NOTE See Appendix A, ASC X12 Nomenclature, to review the transaction set structure, including descriptions of segments, data elements, levels, and loops.

2.1.1 The Reporting Process The 820 can be used by premium remitters to report premium payment remittance information, as well as premium payment to a premium receiver.

The premium remitter can be:

- An employer-operated internal department or an outside agency, which performs payroll processing on behalf of an employer.
- A government agency paying health care premiums.
- An Employer paying group premiums.

The premium receiver can be either

- an insurance company,
- a government agency, or
- a health care organization.

The 820 can be sent from the premium remitter to the premium receiver either directly, through a VAN, or through a financial institution using an ACH Network to facilitate both the remittance and dollars movement.

Subject:	Remittance Payment Process Business Decision – 820 Transaction
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Issue: An 820 - Payroll Deducted and Other Group Premium Payment for Insurance Products can be sent directly to a payee to move detailed or summary remittance information. Each function changes the actual content of the transaction slightly.
Question: Should Oregon Medicaid return detailed or summary information?

Background: Historically, OMAP has returned summary information on the Remittance Advice (RA). OMAP developed the current RA to be an integral part of Capitation payment analysis and reconciliation for the Prepaid Health Plans (PHP).
Currently all Capitation payment funds are disbursed by check. OMAP has established the Electronic Funds Transfer (EFT) functionality for receipt of Capitation Payments effective October 1, 2004 for all PHPs. It is OMAP's understanding that all PHPs will take advantage of this option.

Decision: OMAP has determined returning detailed information in the 820 Transaction rather than summary information would allow Prepaid Health Plans a more efficient and effective analysis of Capitation information and more closely match what is currently returned in the RA for financial reconciliation. To facilitate this process OMAP will:

- Develop a crosswalk of information between the current RA and the 820 to include those data elements that are allowed by HIPAA standards for review by the Prepaid Health Plans. Any data elements in the current RA that cannot be cross-walked will be eliminated.
- Finalize a crosswalk document after collaboration with all stakeholders for final approval. OMAP will maintain this crosswalk and supply stakeholders with any revised documents.
- Develop a crosswalk between the current RA Explanation of Benefit information and the Adjustment Reason Codes returned in the ADX segment. OMAP will maintain this crosswalk and supply stakeholders with any revised documents.
- Incorporate into DHS' Companion Guides and associated crosswalks any future changes by the federal regulatory agency to the Implementation Guide.

To maintain the DHS Mailbox process, DHS will deposit the 820 Transaction into the Prepaid Health Plan's (PHP) Mailbox located on a Secure File Transfer Protocol (SFTP) site.

The 820 HIPAA standards allow two categories related to the distribution of funds and payment information: 1) EFT with remittance information being carried through the Automated Clearinghouse (ACH) or 2) check or EFT with a separate remittance advice.

OMAP Decision: PHPs will receive an EFT or check for payment and a separate remittance advice containing Individual Remittance Detail information. PHPs who have not established the EFT process will continue to receive a check and the 820 Transaction.

**Contractor/OMAP
Approval Date:**

August 17, 2004

Approval

Patricia Krewson
Print Name

/s/ Patricia Krewson
Signature

820 CROSSWALK FOR AUG. 2004 JAD Sessions

		PHP Spreadsheet - (Provided by LIPA)				820 Implementation Guide				DHS Comments
Line Num.		DHS Name	Pos	Len	Plan Description	Segment and Axial Pos	Page	Assoc. Qual.	HIPAA Industry Name	
Claim Header (WDBMM075) Record										
1	Used to identify record (Header or Detail)	PROV-GRP-CODE	1	3	Provider Group Code					Used internally by DHS for sorting purposes
2		NMBR-ID-PROV	4	6	PHP Number	REF02	49	14	Premium Receiver Reference Identifier	PHP six-digit number
3		FILLER	10	13	Filler					Not applicable
4		NMBR-REMIT-ADV	23	8	Remittance Advice Number					The Check Number (TRN02 'Check or EFT Trace Number' will replace this field
5		FORM-TYPE-CODE	31	2	Format Type Code '03' for professional					Not applicable
6		RA-REC-TYPE-CODE	33	1	Record Type Code 2=Header					Not applicable
7		NAME-RECIP-COMPL	34	25	Recipient Name	NM104-07	89	1	Individual Last/First/Middle Name	Recipient Full Name will be parsed to appropriate HIPAA Data Elements
8		NMBR-PER-PRIM-ID	59	8	Recipient Prime Number	ENT04	87	EI	Receiver's Individual Identifier	Recipient Prime Number + PERC Code +Rate Group Code + 4 digit Plan Code + FIPS Code
9		NMBR-PAT-ACCT	67	12	Patient Acct Number					Not maintained in DHS files
10		DATE-CLM	79	8	Claim Date					Not applicable
11		DATE-PAY	87	8	Payment Date	BPR16	41		Check Issue or EFT Effective Date	Payment Date
12		AMT-CLM-BILL-TOT	95	7	Total Billed Amount	BPR02	37	I	Total Premium Payment Amount	'Total Billed Amount' and 'Provider Paid Total Amount' (line 16) will be mapped to the same HIPAA Data Element
13		FLAG-DEB-CR	102	1	Debit Credit Flag					Not Applicable. Negative money amounts in HIPAA carry a negative sign with the monetary amount
14		AMT-OTHR-INS-PAY	103	7	Other Ins. Payment Amount					Not applicable
15		FLAG-DEB-CR	110	1	Debit Credit Flag					Not Applicable. Negative money amounts in HIPAA carry a negative sign with the monetary amount
16		AMT-PAID-PROV-TOT	111	7	Provider Paid Total Amount	BPR02	37	I	Total Premium Payment Amount	'Total Billed Amount' (line 12) and 'Provider Paid Total Amount' will be mapped to the same HIPAA Data Element

820 CROSSWALK FOR AUG. 2004 JAD Sessions

		PHP Spreadsheet - (Provided by LIPA)				820 Implementation Guide				DHS Comments
Line Num.		DHS Name	Pos	Len	Plan Description	Segment and Axial Pos	Page	Assoc. Qual.	HIPAA Industry Name	
17		FLAG-DEB-CR	118	1	Debit Credit Flag					Not Applicable. Negative money amounts in HIPAA carry a negative sign with the monetary amount
18		EXP-BEN-CODE	119	2	Explanation of Benefits Code	ADX02	97		Adjustment Reason Code	Will be shown at Individual reporting level (line 37). HIPAA Adj. Reason Codes (HARC) are limited to those shown on page 97. Please see the DHS "820 Adjustment Reason Code Table".
		Claim Detail (WDBMM077)								
19	Used to identify record (Header or Detail)	PROV-GRP-CODE	1	3	Provider Group Code	N104	57	EQ	Receiver Identifier	Used internally by DHS for sorting purposes
20		NMBR-ID-PROV	4	6	PHP Number	REF02	49	14	Premium Receiver Reference Identifier	Six-digit Plan Number
21		NMBR-CLM-INT-CT-ENT	10	13	Claim ICN	RMR02	92	IK	Insurance Remittance Reference Number	ICN Number
22		NMBR-REMIT-ADV	23	8	Remittance Advice Number					PHP Decision: The check number or EFT trace number is sufficient to meet PHP business requirements. DHS will not send the Remittance Advice number. Possible placement in REF02 where REF01 = 2F Consolidated Invoice Number (see page 48 of IG)
23		FORM-TYPE-CODE	31	2	Format Type Code '03' for professional					Not applicable
24		RA-REC-TYPE-CODE	33	1	Record Type Code 1=detail					Not applicable
25		DATE-PROC-SERV-BEG	34	8	Beginning Date	DTM05	95	RD8	Date Coverage; expressed as part of a range (CCYYMMDD-CCYYMMDD)	Example: Beginning date of June 1, 2004 and Ending date of Aug. 31, 2004 (20040601-20040831)
26		DATE-PROC-SERV-END	42	8	Ending Date	DTM05	95	RD8	Date Coverage; expressed as part of a range (CCYYMMDD-CCYYMMDD)	Example: Beginning date of June 1, 2004 and Ending date of Aug. 31, 2004 (20040601- 20040831)
27		TYPE-SERV-CODE	50	1	Type of Service Coding					Not applicable
28		SERV-PROC-CODE	51	5	Service Procedure Code					Not applicable

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		PHP Spreadsheet - (Provided by LIPA)				820 Implementation Guide				DHS Comments
Line Num.		DHS Name	Pos	Len	Plan Description	Segment and Axial Pos	Page	Assoc. Qual.	HIPAA Industry Name	
29		NMBR-TTH-ID	56	2	Tooth Number Identifier					Not applicable
30		QUAN-SERV-UNIT	58	3	Units of Service					Not applicable
31		AMT-CLM-BILL-DET	61	7	Billed Amount	RMR05	93		Billed Premium Amount	Billed Amount
32		FLAG-DEB-CR	68	1	Debit Credit Flag					Not Applicable. Negative money amounts in HIPAA carry a negative sign with the monetary amount
33		AMT-OTHR-INS-PAY	69	7	Other Ins. Payment Amount					Not applicable
34		FLAG-DEB-CR	76	1	Debit Credit Flag					Not Applicable. Negative money amounts in HIPAA carry a negative sign with the monetary amount
35		AMT-PAID-PROV-DET	77	7	Provider Paid Amount	RMR04	93		Detail Premium Payment Amount	Shown at Individual level
36		FLAG-DEB-CR	84	1	Debit Credit Flag					Not Applicable. Negative money amounts in HIPAA carry a negative sign with the monetary amount
37		EXP-BEN-CODE	85	15	Explanation of Benefits Code	ADX02	97		Adjustment Reason Code	Adj. Reason Codes limited to those shown on page 97 of the 820 Implementation Guide
38		NMBR-ID-PROV-PER	100	6	Performing Provider ID	N104	57	EQ	Receiver Identifier	Not applicable
39						ADX01	96		Adjustment Amount	New with HIPAA. Information is provided when there is a difference between the Billed Amount and the Paid Amount
40						TRN02	43		Check for EFT Trace Number	New with HIPAA; PHP Decision: Use instead of Remittance Advice Number
1. Tan or shaded rows indicate a proposed PHP data field mapping to the HIPAA 820 Implementation Guide data element.										
2. Non shaded rows indicate no proposed match between the PHP data fields and HIPAA IG 820 data elements.										
3. Rows 39 and 40 are new elements										

820 ADJUSTMENT REASON CODE TABLE
Draft for 820 Payroll Deducted/Premium Payment for Insurance Products Codes

820 HIPAA ADJUSTMENT REASON CODES			
The most appropriate, active HIPAA Adjustment Reason Code to report OHP Member status. OMAP will crosswalk the HARC			
HIPAA Code	HARC Description	DHS RA messages	DHS RA Message Number
20	Balance Due Declined. Used when the entire balance due is being disputed.		N/A
52	Credit for Previous Overpayment	Adjustment resulted in reduced payment. Accounts receivable set-up for remainder.	78
53	Remittance for Previous Underpayment	N/A	N/A
AA	Prepaid Benefit or Advances	Capitation payment/case management fee for clients enrolled in a Prepaid Health Plan, Physician Care Organization or with a Primacy Care Physician.	525
AX	Person No Longer Employed. This adjustment should never be used as a substitute for a termination notice using the 834 transaction.	N/A	N/A
H1	Information Forthcoming. Detailed information related to the adjustment will be provided through a separate mechanism.	N/A	N/A
H6	Partial Payment Remitted. Used when the payer does not have sufficient funds to remit the full balance.	N/A	N/A
IA	Invoice Amount Does Not Match Account Analysis Statement. Used when the invoice does not match the expectation for number or number/type of members and charges.	Disregard this adjustment which was processed to correct our records only, no action is required on your part.	82
J3	Promised Adjustment Not Received. Used when an adjustment promised by the payee for a previous invoice has not been reflected on the current invoice.	N/A	N/A