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: 1.6
January 2020

This template is Copyright © 2010 by The Workgroup for Electronic Data Interchange (WEDI) and the Data Interchange Standards Association (DISA), on behalf of the Accredited Standards Committee (ASC) X12. All rights reserved. It may be freely redistributed in its entirety provided that this copyright notice is not removed. It may not be sold for profit or used in commercial documents without the written permission of the copyright holder. This document is provided “as is” without any express or implied warranty. Note that the copyright on the underlying ASC X12 Standards is held by DISA on behalf of ASC X12.

Express permission to use ASC X12 copyrighted materials has been granted.

2019 © Companion Guide copyright by California Department of Health Care Services

Preface

Companion Guides (CG's) 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 8

3.3 Premium Payment File Naming Conventions 8

3.4 820 Data Elements 8

4 TI Additional Information 13

4.1 Business Scenarios 13

4.2 Payer Specific Business Rules and Limitations 14

4.2.1 Individual Remittance/List Bill Type 820 14

4.2.2 Rate Adjustments 15

4.2.3 Net Eligibility Adjustments 18

4.2.4 Plan-Based Adjustments on List Bill Type 820 Transaction 22

4.3 Organizational Remittance/Summary Bill Type 23

4.3.1 Plan Based Payments and Adjustments 23

4.3.2 Summary Bill Type Example: 23

4.4 Payment Types 25

4.5 Adjustment Reason Codes 30

5 TI Change Summary 30

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 Guide 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
S = “segments” in the X12N implementation guide
D = “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 Enterprise Innovation Technology Services (EITS).

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_AAAAAAAAA.dat

Where:

YYYYMMDD is the date of the file creation.

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

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

Example:

DHCS820_PHP0987654-00_20130608_123456789.dat

3.4 820 Data Elements

Type	Loop ID	Reference	Name	Codes	Notes/Comments
S	ISA		Interchange Control Header		
D		ISA06	Interchange Sender ID		CALIFORNIA-DHCS
D		ISA08	Interchange Receiver ID		Receiver's Federal Tax ID + 6 spaces
D		ISA11	Repetition Separator		'+'

Type	Loop ID	Reference	Name	Codes	Notes/Comments
D		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.
D		ISA14	Acknowledge ment Requested	0	
D		ISA16	Component Element Separator		”:”
S	GS		Functional Group Header		
D		GS02	Application Sender's Code		Use this code to identify the unit sending the information. Valid Value: "CALIFORNIA-DHCS"
D		GS03	Application Receiver's Code		Receiver’s Federal Tax ID
S		BPR	Financial Information		
D		BPR01	Transaction Handling Code	I	Remittance Information Only
D		BPR02	Monetary Amount		This is the California State Controller’s Office Warrant Amount
D		BPR10	Origination Company Identifier		68-0317191 (DHCS Federal tax ID)
D		BPR16	Date		This is the California State Controller’s Office Warrant Date.
S	TRN		Re-association Trace Number		

Type	Loop ID	Reference	Name	Codes	Notes/Comments
D		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.
S	REF		Premium Receivers Identification Key		
D		REF01	Reference Identification Qualifier	14	
D	-	REF02	Reference Identification		DHCS Vendor Code of Receiver
S	1000B	N1	Premium Payer’s Name		
D		N102	Name		“California - Department of Health Care Services”
S	1000B	N3	Premium Payer's Address		
D		N301	Address Information		“1501 Capitol Ave”
S	1000B	N4	Premium Payer's City, State, Zip Code		
D		N401	City Name		“Sacramento”
D		N402	State or Province Code		“CA”
D		N403	Postal Code		“95814”
S	2000B	ENT	Individual Remittance		

Type	Loop ID	Reference	Name	Codes	Notes/Comments
D		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.

Type	Loop ID	Reference	Name	Codes	Notes/Comments
D		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.
S	2100B	NM1	Individual Name		
D		NM109	Identification Code		Medi-Cal CIN
S	2300B	RMR	Individual Premium Remittance Detail		
D		RMR01	Reference Identification Qualifier	IK	
D		RMR02	Reference Identification		Payment Set Number
D		RMR04	Monetary Amount		This is the amount being paid on this remittance item.

Type	Loop ID	Reference	Name	Codes	Notes/Comments
D		RMR05	Monetary Amount		Any difference between the RMR05 and the RMR04 would be explained by the ADX at loop 2320B.
S	2300B	REF	Reference Information		Multiple instances of this segment are provided
D		REF01	Reference Identification Qualifier	18,ZZ	Organizational Reference Identification Qualifier
D		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 Payment Type – see section 4.4 for a full listing of all available Payment Types.
S	2300B	DTM	Individual Coverage Period		
D		DTM01	Date/Time Qualifier	582,AAG	Date Time Qualifier
D		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

Payment types (refer to the list of Payment 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/Payment types: Dental Withhold Release, Cal MediConnect Quality Withhold Release, 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 Payment Set 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 Payment Set Number (ascending).

Within the 2300B Loop, the RMR02 element indicates the Payment Set Number. Element RMR04 indicates the Payment Set 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 Payment 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 Payment 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 “Payment Set 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 Payment Set 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			
		January	February	March	**Totals**
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**

<u>**820 Transaction**</u>

BPR: Warrant Amount $5

TRN: Warrant #12345

REF: Vendor Code HN3000

ENT: Beneficiary CIN 123456789

MARCH RMR02: Payment Set #03

RMR04: $3.00 (payment amount, i.e. rate difference)

REF02: Aid Code 3N

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

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

FEBRUARY RMR02: Payment Set 03

RMR04: $1.00 (payment amount, i.e. rate difference)

RMR05: $3.00 (billed amount)

REF02: Aid Code 3N

REF02 (2nd iteration): Payment 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: Payment Set 03

RMR04: $1.00 (payment amount, i.e. rate difference)

RMR05: $3.00 (billed amount)

REF02: Aid Code 3N

REF02 (2nd iteration): Payment 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 payment set number pertaining to the beneficiary. The HCP Code, Aid Code, Payment 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.

<table>
<tr><th colspan="6">List Bill Type 820 TXN - Net Eligibility Adjustment Example</th></tr>
<tr><td colspan="2"></td><td colspan="3">Eligibility per Service Month</td><td></td></tr>
<tr><td colspan="2">Payment Set #: 1903150147000P
HCP 300, Medi-Cal Only</td><td>January</td><td>February</td><td>March</td><td>Totals</td></tr>
<tr><td rowspan="7">Payment Month</td><td>January</td><td>$2 (7X)</td><td></td><td></td><td rowspan="3"></td></tr>
<tr><td>February</td><td>$2 (7X)</td><td>$2 (7X)</td><td></td></tr>
<tr><td>March</td><td>$0 (7X)</td><td>$3(3N)</td><td>$3 (3N)</td></tr>
<tr><td>Retro Rate Adj.</td><td></td><td></td><td></td><td>$0</td></tr>
<tr><td>Net Eligibility Adj.</td><td>($2)</td><td>$1</td><td></td><td>($1)</td></tr>
<tr><td colspan="4">Current Month Capitation $3</td><td>$3</td></tr>
<tr><td colspan="4">Total Paid March Medi-Cal Only</td><td>$2</td></tr>
</table>

<table>
<tr><th colspan="7">List Bill Type 820 TXN - Net Eligibility Adjustment Example</th></tr>
<tr><td colspan="2"></td><td colspan="3">Eligibility per Service Month</td><td></td></tr>
<tr><td colspan="2">Payment Set #: 1903150148000P
HCP 300, Medicare Part D</td><td>January</td><td>February</td><td>March</td><td>Totals</td></tr>
<tr><td rowspan="7">Payment Month</td><td>January</td><td></td><td></td><td></td><td rowspan="3"></td></tr>
<tr><td>February</td><td></td><td></td><td></td></tr>
<tr><td>March</td><td>$4 (7X)</td><td></td><td></td></tr>
<tr><td>Retro Rate Adj.</td><td></td><td></td><td></td><td>$0</td></tr>
<tr><td>Net Eligibility Adj.</td><td></td><td></td><td></td><td>$0</td></tr>
<tr><td colspan="4">Current Month
Capitation</td><td>$4</td></tr>
<tr><td colspan="4">Total Paid March Medicare Part D</td><td>$4</td></tr>
</table>

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: Payment Set #03

RMR04: $3.00 (payment amount)

REF02: HCP 300

REF02: Aid Code 3N

REF02: Payment Type= Capitation Medi-Cal Only

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

FEBRUARY (3N) RMR02: Payment Set 03

RMR04: $3.00 (payment amount)

REF02: HCP 300

REF02: Aid Code 3N

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

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

FEBRUARY (7X) RMR02: Payment Set 03

RMR04: -$2.00 (payment amount)

REF02: HCP 300

REF02: Aid Code 7X

REF02: Payment Type= Capitation Medi-Cal Only

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

JANUARY MEDI-CAL RMR02: Payment Set 03

RMR04: -$2.00 (payment amount)

REF02: HCP 300

REF02: Aid Code 7X

REF02: Payment Type= Capitation Medi-Cal Only

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

JANUARY MEDICARE D

RMR02: Payment Set 04

RMR04: $4.00 (payment amount)

REF02: HCP 300

REF02: Aid Code 7X

REF02: Payment 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: 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 payment sets 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 Payment set number, payment or adjustment amount, HCP Code, Aid Code, Payment 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 payment sets 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: Payment Set 001
RMR04: -$2,000.00 (payment amount)

REF02: HCP 300

REF02: Payment Type= Savings Sharing Disbursement

DTM: 7/1/08-12/31/08 (service month range)

MARCH RMR02: Payment Set 002

RMR04: $1,000.00 (payment amount)

REF02: HCP 300

REF02: Payment Type= Dental Withhold Release

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

MARCH RMR02: Payment Set 003

RMR04: $4,000.00 (payment amount)

REF02: HCP 300

REF02: Payment Type= Other Plan Based Payment/Adjustment

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

4.4 Payment Types

The 820 Phase 2 System generates 120 Payment types, which are listed in the table below. For Individual Remittance/List Bill Type Transactions, the name of the Payment type is listed in the REF02 Segment of Loop 2300B. For Organizational Remittance/Summary Bill Type Transactions, the name of the Payment type is listed in the REF02 Segment of Loop 2300A.

820 Phase 2 CAPMAN Managed Care Payment Types	
#	**Payment Type**
1	Primary Capitation Medi-Cal Only
2	Primary Capitation Dual
3	Healthy Families Capitation Medi-Cal Only
4	Healthy Families Capitation Dual
5	HYDE
6	HYDE Healthy Families
7	AIDS Medi-Cal Only
8	AIDS Dual
9	Agnews Medi-Cal Only
10	Agnews Dual
11	Craig/Bonta Medi-Cal Only
12	Craig/Bonta Dual
13	Maternity
14	Lanterman Medi-Cal Only
15	Lanterman Dual
16	Lanterman Healthy Families Medi-Cal Only
17	Lanterman Healthy Families Dual
18	CBAS Medi-Cal Only
19	CBAS Dual
20	CBAS Healthy Families Medi-Cal Only
21	CBAS Healthy Families Dual
22	Dental Withhold Release - Primary
23	Dental Withhold Release - Healthy Families
24	Savings Sharing
25	Other Plan Based Primary
26	Other Plan Based Hyde
27	HQAF Primary Medi-Cal Only
28	HQAF Primary Dual
29	HQAF Healthy Families Medi-Cal Only

820 Phase 2 CAPMAN Managed Care Payment Types	
#	Payment Type
30	HQAF Healthy Families Dual
31	HQAF AIDS Medi-Cal Only
32	HQAF AIDS Dual
33	HQAF Agnews Medi-Cal Only
34	HQAF Agnews Dual
35	HQAF Craig/Bonta Medi-Cal Only
36	HQAF Craig/Bonta Dual
37	HQAF Lanterman Medi-Cal Only
38	HQAF Lanterman Dual
39	HQAF Lanterman Healthy Families Medi-Cal Only
40	HQAF Lanterman Healthy Families Dual
41	IHSS Primary Capitation Medi-Cal Only
42	MSSP Primary Capitation Medi-Cal Only
43	GEMT Medi-Cal Only
44	PHDP Medi-Cal Only
45	IHSS Primary Capitation Dual
46	MSSP Primary Capitation Dual
47	GEMT Dual
48	PHDP Dual
49	IHSS AIDS Medi-Cal Only
50	IHSS AIDS Dual
51	MSSP AIDS Medi-Cal Only
52	MSSP AIDS Dual
53	GEMT AIDS Medi-Cal Only
54	GEMT AIDS Dual
55	PHDP AIDS Medi-Cal Only
56	PHDP AIDS Dual
57	AIDS Healthy Families Medi-Cal Only
58	AIDS Healthy Families Dual
59	HQAF AIDS Healthy Families Medi-Cal Only
60	HQAF AIDS Healthy Families Dual
61	IHSS Agnews Medi-Cal Only
62	IHSS Agnews Dual
63	MSSP Agnews Medi-Cal Only
64	MSSP Agnews Dual
65	GEMT Agnews Medi-Cal Only
66	GEMT Agnews Dual
67	PHDP Agnews Medi-Cal Only
68	PHDP Agnews Dual
69	Agnews Healthy Families Medi-Cal Only

820 Phase 2 CAPMAN Managed Care Payment Types	
#	Payment Type
70	Agnews Healthy Families Dual
71	HQAF Agnews Healthy Families Medi-Cal Only
72	HQAF Agnews Healthy Families Dual
73	IHSS Craig/Bonta Medi-Cal Only
74	IHSS Craig/Bonta Dual
75	MSSP Craig/Bonta Medi-Cal Only
76	MSSP Craig/Bonta Dual
77	GEMT Craig/Bonta Medi-Cal Only
78	PHDP Craig/Bonta Medi-Cal Only
79	PHDP Craig/Bonta Dual
80	Maternity Healthy Families
81	IHSS Lanterman Medi-Cal Only
82	IHSS Lanterman Dual
83	MSSP Lanterman Medi-Cal Only
84	MSSP Lanterman Dual
85	GEMT Lanterman Medi-Cal Only
86	GEMT Lanterman Dual
87	PHDP Lanterman Medi-Cal Only
88	PHDP Lanterman Dual
89	HCBS High
90	IHSS HCBS High
91	MSSP HCBS High
92	HCBS Low
93	IHSS HCBS Low
94	MSSP HCBS Low
95	Hepatitis C non-340B Medi-Cal Only
96	Hepatitis C non-340B Dual
97	Hepatitis C 340B Medi-Cal Only
98	Hepatitis C 340B Dual
99	Behavioral Health Treatment Medi-Cal Only
100	Behavioral Health Treatment Dual
101	American Indian Health Service Medi-Cal Only
102	American Indian Health Service Dual
103	Whole Child Model Medi-Cal Only
104	Whole Child Model Dual
105	HQAF Whole Child Model Medi-Cal Only
106	HQAF Whole Child Model Dual
107	IHSS Whole Child Model Medi-Cal Only
108	IHSS Whole Child Model Dual
109	MSSP Whole Child Model Medi-Cal Only

820 Phase 2 CAPMAN Managed Care Payment Types	
#	Payment Type
110	MSSP Whole Child Model Dual
111	GEMT Whole Child Model Medi-Cal Only
112	GEMT Whole Child Model Dual
113	PHDP Whole Child Model Medi-Cal Only
114	PHDP Whole Child Model Dual
115	Health Homes Program - SMI Medi-Cal Only
116	Health Homes Program - SMI Dual
117	Health Homes Program - PHYS SUD Medi-Cal Only
118	Health Homes Program - PHYS SUD Dual
119	CMC Quality Withhold Release
120	GEMT Craig/Bonta Dual
121	IHSS SCHIP Primary Capitation Medi-Cal Only
122	MSSP SCHIP Primary Capitation Medi-Cal Only
123	GEMT SCHIP Medi-Cal Only
124	PHDP SCHIP Medi-Cal Only
125	IHSS SCHIP Primary Capitation Dual
126	MSSP SCHIP Primary Capitation Dual
127	GEMT SCHIP Dual
128	PHDP SCHIP Dual
129	Primary SCHIP Capitation Medi-Cal Only
130	Primary SCHIP Capitation Dual
131	HQAF SCHIP Primary Medi-Cal Only
132	HQAF SCHIP Primary Dual
133	Hyde SCHIP
134	AIDS SCHIP Medi-Cal Only
135	AIDS SCHIP Dual
136	HQAF AIDS SCHIP Medi-Cal Only
137	HQAF AIDS SCHIP Dual
138	IHSS AIDS SCHIP Medi-Cal Only
139	IHSS AIDS SCHIP Dual
140	MSSP SCHIP AIDS Medi-Cal Only
141	MSSP SCHIP AIDS Dual
142	GEMT SCHIP AIDS Medi-Cal Only
143	GEMT AIDS SCHIP Dual
144	PHDP AIDS SCHIP Medi-Cal Only
145	PHDP AIDS SCHIP Dual
146	Agnews SCHIP Medi-Cal Only
147	Agnews SCHIP Dual
148	HQAF Agnews SCHIP Medi-Cal Only
149	HQAF Agnews SCHIP Dual

820 Phase 2 CAPMAN Managed Care Payment Types	
#	Payment Type
150	IHSS Agnews SCHIP Medi-Cal Only
151	IHSS Agnews SCHIP Dual
152	MSSP Agnews SCHIP Medi-Cal Only
153	MSSP Agnews SCHIP Dual
154	GEMT Agnews SCHIP Medi-Cal Only
155	GEMT Agnews SCHIP Dual
156	PHDP Agnews SCHIP Medi-Cal Only
157	PHDP Agnews SCHIP Dual
158	Maternity SCHIP
159	HCBS High SCHIP
160	IHSS HCBS High SCHIP
161	MSSP HCBS High SCHIP
162	HCBS Low SCHIP
163	IHSS HCBS Low SCHIP
164	MSSP HCBS Low SCHIP
165	Hepatitis C non-340B SCHIP Medi-Cal Only
166	Hepatitis C non-340B SCHIP Dual
167	Hepatitis C 340B SCHIP Medi-Cal Only
168	Hepatitis C 340B SCHIP Dual
169	Behavioral Health Treatment SCHIP Medi-Cal Only
170	Behavioral Health Treatment SCHIP Dual
171	American Indian Health Service SCHIP Medi-Cal Only
172	American Indian Health Service SCHIP Dual
173	Whole Child Model SCHIP Medi-Cal Only
174	Whole Child Model SCHIP Dual
175	HQAF Whole Child Model SCHIP Medi-Cal Only
176	HQAF Whole Child Model SCHIP Dual
177	IHSS Whole Child Model SCHIP Medi-Cal Only
178	IHSS Whole Child Model SCHIP Dual
179	MSSP Whole Child Model SCHIP Medi-Cal Only
180	MSSP Whole Child Model SCHIP Dual
181	GEMT Whole Child Model SCHIP Medi-Cal Only
182	GEMT Whole Child Model SCHIP Dual
183	PHDP Whole Child Model SCHIP Medi-Cal Only
184	PHDP Whole Child Model SCHIP Dual
185	Dental Withhold Release - SCHIP

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 Payment types table: removed 'Dental' and 'Dental HF' Payment 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.

Version	Date	Updates/Comments
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
1.5	05/30/2019	Updated Section 4.1 Cal MediConnect Withhold Release added to the Business Scenario. Updated Invoice Type to Payment Type Updated Invoice Number with Payment Set Number Updated Section 4.4 80 New Payment Types are added.
1.6	01/09/2020	Updated Section 4.4 Added 65 New SCHIP Payment Type Updated Section 3.4 820 data elements added column “Type” S= Segments, D= Data Elements