

**American National Standard Institute X12N 835
Health Care Claim Payment/Advice, Version 004010X091A1,
Wisconsin Physicians Service Insurance Corp.
TRICARE Companion Document**

The Electronic Remittance Advice (ERA) is an electronic version of the Standard Provider Remittance (SPR) and contains the same information on claim payment, deductible, and co-insurance. As soon as your WPS TRICARE claims finalize, we generate your ERA and post it into the appropriate mailbox on our Bulletin Board System. The ERA can also be retrieved from our Secure-EDI website. Depending on your software program, your ERA can be a secure and reliable alternative to manually posting claim adjudication information to an accounts receivable software program.

If you are planning to enroll in ERA in the future, below are some important facts you need to know about X12N 835 V4010A1.

Conducting ANSI ASC X12N 835 V4010 Testing:

We have the ability to conduct compatibility testing for version 4010A1 with Vendors, Billing Services, Clearinghouses and Practitioners. In order to conduct testing, you must contact our office. Once you are satisfied with your testing or are ready to be placed into production for V4010A1, you will need to notify our office. Testing is not required.

Claim Types:

Professional claims will provide remittance information at the service line level.

Institutional outpatient claims will provide remittance information at the service line level.

Institutional inpatient claims will provide remittance information at the claim level only.

Rendering Provider Identification:

Professional claims: The TRICARE Provider Number for the group will be reported at the claim level in loop 2100, REF segment, qualifier 1H. The TRICARE Provider Number for the rendering individual will also be reported at the line level in loop 2110, REF segment, qualifier 1H.

Institutional claims: The TRICARE Provider Number will be reported at the claim level in loop 2100, REF segment, qualifier 1H.

Reason and Remark Codes:

Reason Codes are maintained by the Blue Cross Blue Shield Association in the Joint Claim Adjustment/Claim Status Reason Code Maintenance Committee, and Remark Codes are maintained by the Centers for Medicare and Medicaid Services (CMS). Reason and Remark Codes are updated quarterly and are available at <http://www.wpc-edi.com>.

Corrections and Reversals:

The 835 4010 Implementation Guide outlines the approved method of adjustment processing. Adjustments to previously adjudicated claims, under HIPAA, must be performed utilizing the "correction and reversal" process. When a claim is adjusted the initial claim is completely reversed and then corrected with a complete adjustment claim.

Provider Adjustments:

If a claim was adjudicated prior to the provider being identified for electronic remittance and that claim is subsequently adjusted to result in an additional payment, the additional payment will be reported in the PLB segment using reason code "CS", Adjustment. The reference number will reflect the original claim number, and the patient's account number if reported. If the provider reports a check lost, stolen, damaged, etc. which results in a reissue of the payment to the same provider, the payment will be reflected in the PLB segment using reason code "CS", Adjustment, and the reference number will reflect the original check number.

Please call us at 800-782-2680 to discuss any questions or concerns you may have.