October 12, 2017

To: Mr. Zach VanTrieste
InstaMed

Re: Formal Interpretation #227 – Use of NM1*74 on X12 835

Mr. VanTrieste,

This letter is in response to your Request for Interpretation (RFI) submitted on August 9th, 2017 to the X12 Interpretation Portal. This interpretation was prepared by X12N the Insurance Subcommittee and approved by X12J, the Technical Assessment Subcommittee and the X12 Procedures Review Board. The interpretation was developed and approved in conformance with the X12 Operations Manual (SD2).

Request
Please provide clarity on the use of NM1*74 (Corrected Patient/Insured) in X12 5010 835.

One of our clients, a commercial health plan, believes that NM1*74 (Corrected Patient/Insured Name) should be used any time they receive a claim in which the provider submitted the patient as the subscriber in error. When they generate their 835 file, they are including a NM1*QC segment (Patient) and NM1*74 segment (Corrected Subscriber). However, they are NOT including an NM1*IL segment in the 835.

Our position is that if a claim is received where the patient is listed as the subscriber in error, NM1*74 should not be used to communicate the subscriber and patient are in fact different. Instead, the payer should pass the receiver both NM1*IL (to communicate the actual subscriber) and NM1*QC (to communicate the actual patient) in their 835 transaction. The primary use case of NM1*74 appears to be when the Patient is the Subscriber and the adjudicated Name/ID are different than what was submitted on the claim.

Formal Interpretation
The 005010X221A1 TR3, 835 Loop 2100 NM1 - PATIENT NAME NM1*QC segment is required and “must provide the information from the original claim”. This data when sent in an electronic claim, will either be from the 837 Loop 2010BA (when the subscriber is also identified as the patient) or from the 837 Loop 2010CA (when the patient is a different person than the Insured).
The 835 Loop 2100 NM1 - INSURED NAME NM1*IL segment is “Required when the original claim reported the insured or subscriber (for example 837 2010BA loop Subscriber Name NM1 Segment) that is different from the patient. If not required by this implementation guide, do not send.” “This segment contains the same information as reported on the claim (for example 837 2010BA loop Subscriber Name NM1 Segment when the patient was reported in the 2010CA loop Patient Name NM1 Segment).” This means the 835 Loop 2100 NM1 - INSURED NAME NM1*IL segment will only be reported if both the 2010BA and 2010CA were reported in the submitted claim, thereby identifying the Patient and the Insured as different people/entities.

The NM1 - CORRECTED PATIENT/INSURED NAME NM1*74 segment is “Required when needed to provide corrected information about the patient or insured. If not required by this implementation guide, do not send.” For non-Medicare and non-Medicaid claim filings, this will always be the corrected insured information.

In the commercial insurance filed claim scenario you describe, the client's 835 reporting is correct. If the provider incorrectly reported the Insured as also being the Patient, then the only submitted data reported in the 835 would be the Loop 2100 NM1 - PATIENT NAME NM1 segment. The Loop 2100 NM1 - INSURED NAME NM1 Segment would not be reported as the Insured was not identified on the original claim as being different than the Patient, per the segment usage rule and note. The Corrected Patient/Insured’s Name NM1*74 segment would be reported to provide the corrected Insured’s information since this is a ‘non-Medicare or non-Medicaid' claim filing scenario.

Sincerely,

Gary Beatty
Chair, X12