REMITTANCE ADVICE DETAIL HEADING DESCRIPTIONS

FIRST LINE

PAT CONTROL NUMBER	PATIENT LNAME FIRST A	SER FROM PS	COVD	BDATE	WEIGHT	TOTAL CHARGES	DEDUCTIBLE	PENALTY	OUTLIER AMT	CONTRACT ADJ
MEMBER ID	GRP PRDC DRG C	SER THRU RM	NCVD	2TIER	W ASG1	COVERED CHGS	COINSURANCE	OTHER INS PAID	TRANSFER AMT	SUBR LIABILITY
CLAIM NUMBER ST	HCPC1 CA1 HCPC2 CA2	PREV DT CI	VERS	4TIER	P ASG2	NET ALLOWANCE	COPAY	NONCOVERED CHG	BASE PAYMENT	PAYMENT
PHO PPMI	AGC ARC TOB MSG			5TIER			OTHER ADJMT	WITHHOLD		INTEREST CALC
	RMK1 RMK2 RMK3									

Field Name	Definition
PAT CONTROL NUMBER Patient Control Number	The patient's unique alphanumeric account number assigned by the provider to facilitate retrieval of individual financial records and for posting of payment.
PATIENT LNAME Patient Last Name	Patient's last name
FIRST Patient First name	Patient's first name
A Accommodation Code 1	The primary accommodation used by the patient. Codes include: 1 Private 2 Semi-Private 3 Ward 4 Outpatient 5 Home Health 6 Nursery 7 Neonatal
SER FROM Service From Date	The beginning date of service for the entire period reflected by this bill. (MM-DD-YY)
PS Patient Status Code	A code indicating the patient's status as of the "Service thru Date." Commonly used status codes include: 01 = Discharged to home 02 = Transferred to short-term hospital 03 = Transferred to Medicare certified SNF 06 = Transferred to home with home care services 20 = Expired 30 = Still patient 61 = Transferred to hospital-based Medicare approved swing bed 62 = Transferred to an inpatient rehabilitation facility 63 = Transferred to a Medicare certified long-term care hospital
COVD Covered Days	The number of the billed inpatient days that are covered under the subscriber's benefit plan.
BDATE Patient Birth Date	The month and year in which the patient was born. (MM-YY)
WEIGHT DRG Weight	The total DRG weight that is assigned to the claim, **if applicable**. (*DRG = Diagnosis Related Group. This is a system of classifying inpatient stays into groups for the purpose of payment.*)
TOTAL CHARGES Total Charges	The total charges billed on the claim.
DEDUCTIBLE Deductible	The deductible amount to be paid by the subscriber.
PENALTY Penalty	The penalty amount that is either provider liability, subscriber responsibility, or both. (*See **P** on the **Third Line** for the indicator and explanation.*)
OUTLIER AMT Day or Cost Outlier	An additional payment made for a DRG case that has an extremely long length of stay (*day outlier*) or extremely high costs (*cost outlier*) which may qualify for a day or cost outlier payment.
CONTRACT ADJ Contractual Adjustment	Represents the difference between the provider's charge and the plan allowed amount (*differential*). The provider may not bill the subscriber for this amount (the member is "held harmless").

SECOND LINE

PAT CONTROL NUMBER	PATIENT LNAME FIRST A	SER FROM PS	COVD	BDATE	WEIGHT	TOTAL CHARGES	DEDUCTIBLE	PENALTY	OUTLIER AMT	CONTRACT ADJ
MEMBER ID	GRP PRDC DRG C	SER THRU RM	NCVD	2TIER	W ASG1	COVERED CHGS	COINSURANCE	OTHER INS PAID	TRANSFER AMT	SUBR LIABILITY
CLAIM NUMBER ST PHO PPMI	HCPC1 CA1 HCPC2 CA2 AGC ARC TOB MSG RMK1 RMK2 RMK3	PREV DT CI	VERS	4TIER 5TIER	P ASG2	NET ALLOWANCE	COPAY OTHER ADJMT	NONCOVERED CHG WITHHOLD	BASE PAYMENT	PAYMENT INTEREST CALC

Field Name	Definition
MEMBER ID Agreement Number	The unique subscriber identifier assigned by Highmark which is used for claims processing and payment.
GRP Member Group Number	The subscriber's insurance group number under which the patient is covered.
PRDC Product ID Code	The code used to identify the product type. Product type will be either: Indemnity, Managed Care, or Medicare Advantage. INDEMNITY: 100 = Indemnity Plan 363; 150 = Indemnity Plan 378 MANAGED CARE: 231 = Direct Blue Plan 363; 300 = PPO Plan 363; 280 = Direct Blue Plan 378; 350 = PPO Plan 378; 400 = HMO MEDICARE ADVANTAGE: 110 = Highmark PFFS; 310 = Freedom Blue PPO; 410 = Security Blue HMO Plan Code 363 = Western Region; Plan Code 378 = Central Region
DRG DRG Code	The Diagnosis Related Group (DRG) code, **if applicable**.
C Accommodation Code 2	The second accommodation used by the patient, **if applicable**.
SER THRU Service Thru Date	The ending service date of the entire period reflected by the bill. (MM-DD-YY)
RM Reimbursement Method Code	Indicates the contractual reimbursement methodology used to pay the claim.
NCVD Non-covered Days	The number of days billed that are not covered under the subscriber's benefit plan.
2TIER Tier Code 1 and Code 2	First and second tier to which a claim may be assigned, **if applicable**. *('Tiers' were developed for some reimbursement methodologies to divide cases into classifications based on intensity of services.)*
W Weight Adjustment Code	The code used to describe the type of weight adjustment. Codes include: O = Day Outlier; C = Cost Outlier; T = Transfer.
ASG1 PIRC Code	Point Integrated Rehabilitation Category (PIRC) code assigned, **if applicable**. *(PIRC is a rehabilitation classification based on diagnosis and patient age.)*
COVERED CHGS Covered Charges Amount	The total charges minus the non-covered charges.
COINSURANCE Member Coinsurance Amount	The coinsurance amount to be paid by the subscriber.
OTHER INS PAID Other Insurance Paid Amount	The amount paid by another insurance carrier. Includes reduction(s) taken by the current payer as a result of the other payer(s) payment or contractual adjustment(s).
TRANSFER AMT Transfer Amount	Pro-rated payment for Diagnosis Related Group (DRG) cases qualifying as transfer cases. To qualify for transfer payment, there **must** be: (1) a discharge status of 02, 03, 04, or 05 on the claim; **and** (2) the claim length of stay must be less than the DRG Geometric Length of Stay.
SUBR LIABILITY Member Liability Amount	The amount due from the subscriber. This represents the sum of non-covered charges, deductible, coinsurance, copayment, and penalty (subscriber liability) amounts.

THIRD LINE

PAT CONTROL NUMBER	PATIENT LNAME	FIRST A	SER FROM	PS	COVD	BDATE	WEIGHT	TOTAL CHARGES	DEDUCTIBLE	PENALTY	OUTLIER AMT	CONTRACT ADJ
MEMBER ID	GRP	PRDC	DRG	C	SER THRU	RM	NCVD	3TIER	W ASG1	COVERED CHGS	COINSURANCE	OTHER INS PAID	TRANSFER AMT	SUBR LIABILITY
CLAIM NUMBER	ST	HCPC1 CA1 HCPC2	CA2		PREV DT	CI	VERS	4TIER	P ASG2	NET ALLOWANCE	COPAY	NONCOVERED CHG	BASE PAYMENT	PAYMENT
PHO	PPMI	AGC ARC TOB	MSG					5TIER			OTHER ADJMT	WITHHOLD		INTEREST CALC
		RMK1 RMK2	RMK3											

Field Name	Definition
CLAIM NUMBER Claim Number	The number assigned by Highmark as a claim identifier.
ST Provider Site Number	A number which identifies the site location of a facility where services are performed.
HCPC1 HCPCS Code 1	The first HCPCS Code for which payment is made.
CA1 Category Code 1	**NOT IN USE**
HCPC2 HCPCS Code 2	The second HCPCS code for which payment is made.
CA2 Category Code 2	**NOT IN USE**
PREV DT Previous Date Paid	The date of the previous remittance advice on which the claim was paid. (MM-DD-YY)
CI Contractual Indicator	Indicator that shows the claim was paid with a contractual amount based on the provider agreement. If **Y**, the claim was paid with a contractual amount. If **blank**, the claim was not paid with a contractual amount.
VERS Software Payment Methodology Version	Indicates the Outpatient or Inpatient Grouper Version Number utilized in processing.
4TIER Tier Code 3 and Tier Code 4	Third and fourth tiers to which a claim may be assigned under any of the tier payment methodologies, **if applicable**.
P Member Penalty/Provider Liability Indicator	This indicator tells the provider whether the dollar amount in the PENALTY field (on first line) is a provider liability (which is not billable to the subscriber) or a subscriber penalty. In some rare cases, the amount can be the combination of both the subscriber penalty *and* provider liability. (The provider liabilities are not included in the Subscriber Liability field on the second line.) Indicators in use for this field include: **P** = Provider; **S** = Subscriber; **B** = Both
ASG2	**NOT IN USE**
NET ALLOWANCE Net Allowance Amount	Allowed charges minus any deductibles, copayment, coinsurance, penalty (subscriber liability), and any other insurance payments.
COPAY Member Copay Amount	Copayment amount to be paid by the subscriber.
NONCOVERED CHG Non-Covered Charge Amount	The total of charges not covered by the subscriber's benefit plan.
BASE PAYMENT Base Payment Amount	The payment for a claim excluding day or cost outlier payments; DRG weight times the unit price (not adjusted for outliers).
PAYMENT Payment Amount	The amount paid on the claim.

FOURTH LINE

PAT CONTROL NUMBER MEMBER ID CLAIM NUMBER ST	PATIENT LNAME FIRST A GRP PRDC DRG C HCPC1 CA1 HCPC2 CA2	SER FROM PS SER THRU RM PREV DT CI	COVD NCVD VERS	BDATE 2TIER 4TIER	WEIGHT W ASG1 P ASG2	TOTAL CHARGES COVERED CHGS NET ALLOWANCE	DEDUCTIBLE COINSURANCE COPAY	PENALTY OTHER INS PAID NONCOVERED CHG	OUTLIER AMT TRANSFER AMT BASE PAYMENT	CONTRACT ADJ SUBR LIABILITY PAYMENT
PHO PPMI	AGC ARC TOB MSG			5TIER			OTHER ADJMT	WITHHOLD		INTEREST CALC
	RMK1 RMK2 RMK3									

Field Name	Definition
PHO	**NOT IN USE**
PPMI	**NOT IN USE**
AGC ANSI Group Code	These two-character codes indicate the type of rejection and the financial liability for the adjusted amount. Available codes include: CO = Contractual Obligation PR = Patient Responsibility CR = Correction and Reversal PI = Payer Initiated Reductions OA = Other Adjustment **NOTE:** Present *only* on claims that are totally rejected.
ARC ANSI Reason Code	These three-character codes provide information as to why the claim was rejected. To access the most up-to-date code list, visit **X12.org**. **NOTE:** Present *only* on claims that are totally rejected.
TOB Type of Bill	Indicates the type and frequency of the bill from the institution.
MSG Message Indicator	An **A** will appear in this field indicating if the member's group has an Administrative Services Only (ASO) contract with Highmark.
5TIER Tier Code 5	A pricing tier that indicates an elevated level of care, **if applicable**.
OTHER ADJMT Other Adjustment Amount	Represents the dollar amount on the claim that is neither the provider nor the subscriber's liability. This amount is not billable to the subscriber.
WITHHOLD Managed Care Withhold Amount	**NOT IN USE**
BLANK SPACE *between* WITHHOLD *and* INTEREST CALC Limit Adjustment Amount	The amount added to or subtracted from the payment amount to account for extenuating circumstances will be populated here, **if applicable**.
INTEREST CALC Interest Amount	Represents the Interest Penalty amount paid on the claim as a result of the claim not being paid in a timely manner.

FIFTH LINE

PAT CONTROL NUMBER MEMBER ID CLAIM NUMBER ST PHO PPMI	PATIENT LNAME FIRST A GRP PRDC DRG C HCPC1 CA1 HCPC2 CA2 AGC ARC TOB MSG	SER FROM PS SER THRU RM PREV DT CI	COVD NCVD VERS	BDATE 2TIER 4TIER 5TIER	WEIGHT W ASG1 P ASG2	TOTAL CHARGES COVERED CHGS NET ALLOWANCE	DEDUCTIBLE COINSURANCE COPAY OTHER ADJMT	PENALTY OTHER INS PAID NONCOVERED CHG WITHHOLD	OUTLIER AMT TRANSFER AMT BASE PAYMENT	CONTRACT ADJ SUBR LIABILITY PAYMENT INTEREST CALC
	RMK1 RMK2 RMK3									

Field Name	Definition
RMK1	**For BlueCard Claims ONLY:** Remark Code **N524** will be populated here when a claim is processed per the BlueCard Default Claims Process. This is the result of a national initiative among Blue Cross and Blue Shield companies to address claim processing delays. The N524 remark code indicates the claim was paid as a one-time exception at 100 percent of allowance due to a specific processing delay.
RMK2	**NOT IN USE**
RMK3	**NOT IN USE**