



California Department of Health Care Services

Short Doyle/Medi-Cal Phase II

Companion Guide

ADP – 837P

Version: 1.3.4

Date: 01/15/09



Versioning, History

Version	Author	Date	Loop	Segment	Element	Change Made
1.3.1	Deepa Pochiraju	11/24/08	2310D	NM1 – Service Facility Location	NM101	Codes included to match the Imp. Guide default values.
1.3.1	Deepa Pochiraju	11/24/08	2420C	NM1 -Billing Provider Name	NM109	Codes included to match the Imp. Guide default values.
1.3.1	Deepa Pochiraju	11/24/08	2320	CAS -	CAS03	Changed the usage from ‘Situational’ to ‘Required’.
1.3.2	Deepa Pochiraju	11/25/08	1000A	NM1 – Submitter Name	NM108	Changed the valid value from ‘FI’ to ‘46’
1.3.3	Deepa Pochiraju	01/09/09	-	ISA – Interchange Control Header	ISA06	Updated the example at the segment level and also for the element.
1.3.3	Deepa Pochiraju	01/09/09	-	GS – Functional Group Header	GS02	Updated the example at the segment level and also for the element.
1.3.3	Deepa Pochiraju	01/09/09	2400	SV1 – Professional Service	-	Removed comments about SV113 and SV114.
1.3.4	Deepa Pochiraju	01/15/09	2000B	PAT – Patient Information	PAT09	Changed the notes for this element per CR 052.

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837

Health Care Claim: Professional

Functional Group=HC

Purpose: The purpose of this Companion Guide is to document any assumptions, conventions, or data issues that may be specific to ADP business processes when implementing the HIPAA ASC X12N Implementation Guides. This Companion Guide does NOT replace the Implementation Guides, nor does it attempt to amend any of the rules therein or impose any mandates on ADP trading partners. Readers of this Companion Guide should be acquainted with the Implementation Guides, their structure and content. Information contained in the HIPAA Implementation Guides has not been repeated here, although the Guides have been referenced when necessary.

The Companion Guide provides information necessary for trading partners to submit claims/encounters electronically to ADP for adjudication and processing through the Short-Doyle Medi-Cal (SD/MC) system. Included are data elements that are either required, or required in certain circumstances, to meet HIPAA validation and SD/MC processing requirements.

Not Defined:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Notes</u>	<u>Usage</u>
	ISA	Interchange Control Header	M	1			Required
	GS	Functional Group Header	M	1			Required

Heading:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Notes</u>	<u>Usage</u>
005	ST	Transaction Set Header	M	1			Required
010	BHT	Beginning of Hierarchical Transaction	M	1			Required
015	REF	Transmission Type Identification	O	1			Required

<u>LOOP ID - 1000A</u>					<u>Repeat</u>	<u>Notes</u>	
020	NM1	Submitter Name	O	1		N1/020	Required
045	PER	Submitter EDI Contact Information	O	2			Required

<u>LOOP ID - 1000B</u>					<u>Repeat</u>	<u>Notes</u>	
020	NM1	Receiver Name	O	1		N1/020	Required

Detail:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Notes</u>	<u>Usage</u>
<u>LOOP ID - 2000A</u>					<u>Repeat</u>		
001	HL	Billing/Pay-to Provider Hierarchical Level	M	1			Required

<u>LOOP ID - 2010AA</u>					<u>Repeat</u>	<u>Notes</u>	
015	NM1	Billing Provider Name	O	1		N2/015	Required
025	N3	Billing Provider Address	O	1			Required
030	N4	Billing Provider City/State/ZIP Code	O	1			Required
035	REF	Billing Provider Secondary Identification	O	8			Situational
040	PER	Billing Provider Contact Information	O	2			Situational

<u>LOOP ID - 2000B</u>					<u>Repeat</u>		
001	HL	Subscriber Hierarchical Level	M	1			Required

005	SBR	Subscriber Information	O	1		Required
007	PAT	Patient Information	O	1		Situational
LOOP ID - 2010BA					1	N2/015L
015	NM1	Subscriber Name	O	1		Required
025	N3	Subscriber Address	O	1		Required
030	N4	Subscriber City/State/ZIP Code	O	1		Required
032	DMG	Subscriber Demographic Information	O	1		Required
LOOP ID - 2010BB					1	N2/015L
015	NM1	Payer Name	O	1		Required
025	N3	Payer Address	O	1		Situational
030	N4	Payer City/State/ZIP Code	O	1		Situational
LOOP ID - 2300					100	
130	CLM	Claim Information	O	1		Required
135	DTP	Date - Onset of Current Illness/Symptom	O	1		Situational
135	DTP	Date - Admission	O	1		Situational
135	DTP	Date - Discharge	O	1		Situational
155	PWK	Claim Supplemental Information	O	10		Situational
175	AMT	Patient Amount Paid	O	1		Situational
180	REF	Original Reference Number (ICN/DCN)	O	1		Situational
180	REF	Medical Record Number	O	1		Situational
231	HI	Health Care Diagnosis Code	O	1		Situational
LOOP ID - 2310B					1	N2/250L
250	NM1	Rendering Provider Name	O	1		Situational
LOOP ID - 2310D					1	N2/250L
250	NM1	Service Facility Location	O	1		Situational
265	N3	Service Facility Location Address	O	1		Required
270	N4	Service Facility Location City/State/ZIP	O	1		Required
LOOP ID - 2320					10	N2/290L
290	SBR	Other Subscriber Information	O	1		Situational
295	CAS	Claim Level Adjustments	O	5		Situational
300	AMT	Coordination of Benefits (COB) Payer Paid Amount	O	1		Situational
300	AMT	Coordination of Benefits (COB) Allowed Amount	O	1		Situational
305	DMG	Subscriber Demographic Information	O	1		Situational
310	OI	Other Insurance Coverage Information	O	1		Required
LOOP ID - 2330A					1	N2/325L
325	NM1	Other Subscriber Name	O	1		Required
LOOP ID - 2330B					1	N2/325L
325	NM1	Other Payer Name	O	1		Required

350	DTP	Claim Adjudication Date	O	1		Situational
LOOP ID - 2400					50	N2/365L
365	LX	Service Line	O	1		Required
370	SV1	Professional Service	O	1		Required
455	DTP	Date - Service Date	O	1		Required
470	REF	Line Item Control Number	O	1		Situational
485	NTE	Line Note	O	1		Situational
LOOP ID - 2420A					1	N2/500L
500	NM1	Rendering Provider Name	O	1		Situational
LOOP ID - 2420C					1	N2/500L
500	NM1	Service Facility Location	O	1		Situational
514	N3	Service Facility Location Address	O	1		Required
520	N4	Service Facility Location City/State/ZIP	O	1		Required
LOOP ID - 2430					25	N2/540L
540	SVD	Line Adjudication Information	O	1		Situational
545	CAS	Line Adjustment	O	99		Situational
550	DTP	Line Adjudication Date	O	1		Required
555	SE	Transaction Set Trailer	M	1		Required

Not Defined:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Notes</u>	<u>Usage</u>
	GE	Functional Group Trailer	M	1			Required
	IEA	Interchange Control Trailer	M	1			Required

Notes:

- 1/020L Loop 1000 contains submitter and receiver information. If any intermediary receivers change or add data in any way, then they add an occurrence to the loop as a form of identification. The added loop occurrence must be the last occurrence of the loop.
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- 1/020 Loop 1000 contains submitter and receiver information. If any intermediary receivers change or add data in any way, then they add an occurrence to the loop as a form of identification. The added loop occurrence must be the last occurrence of the loop.
- 2/015L Loop 2010 contains information about entities that apply to all claims in loop 2300. For example, these entities may include billing provider, pay-to provider, insurer, primary administrator, contract holder, or claimant.
- 2/015 Loop 2010 contains information about entities that apply to all claims in loop 2300. For example, these entities may include billing provider, pay-to provider, insurer, primary administrator, contract holder, or claimant.
- 2/015L Loop 2010 contains information about entities that apply to all claims in loop 2300. For example, these entities may include billing provider, pay-to provider, insurer, primary administrator, contract holder, or claimant.
- 2/015 Loop 2010 contains information about entities that apply to all claims in loop 2300. For example, these entities may include billing provider, pay-to provider, insurer, primary administrator, contract holder, or claimant.
- 2/015L Loop 2010 contains information about entities that apply to all claims in loop 2300. For example, these entities may include billing provider, pay-to provider, insurer, primary administrator, contract holder, or

- claimant.
- 2/015 Loop 2010 contains information about entities that apply to all claims in loop 2300. For example, these entities may include billing provider, pay-to provider, insurer, primary administrator, contract holder, or claimant.
 - 2/250L Loop 2310 contains information about the rendering, referring, or attending provider.
 - 2/250 Loop 2310 contains information about the rendering, referring, or attending provider.
 - 2/250L Loop 2310 contains information about the rendering, referring, or attending provider.
 - 2/250 Loop 2310 contains information about the rendering, referring, or attending provider.
 - 2/290L Loop 2320 contains insurance information about: paying and other Insurance Carriers for that Subscriber, Subscriber of the Other Insurance Carriers, School or Employer Information for that Subscriber.
 - 2/290 Loop 2320 contains insurance information about: paying and other Insurance Carriers for that Subscriber, Subscriber of the Other Insurance Carriers, School or Employer Information for that Subscriber.
 - 2/325L Segments NM1-N4 contain name and address information of the insurance carriers referenced in loop 2320.
 - 2/325 Segments NM1-N4 contain name and address information of the insurance carriers referenced in loop 2320.
 - 2/325L Segments NM1-N4 contain name and address information of the insurance carriers referenced in loop 2320.
 - 2/325 Segments NM1-N4 contain name and address information of the insurance carriers referenced in loop 2320.
 - 2/365L Loop 2400 contains Service Line information.
 - 2/365 Loop 2400 contains Service Line information.
 - 2/500L Loop 2420 contains information about the rendering, referring, or attending provider on a service line level. These segments override the information in the claim - level segments if the entity identifier codes in each NM1 segment are the same.
 - 2/500 Loop 2420 contains information about the rendering, referring, or attending provider on a service line level. These segments override the information in the claim - level segments if the entity identifier codes in each NM1 segment are the same.
 - 2/500L Loop 2420 contains information about the rendering, referring, or attending provider on a service line level. These segments override the information in the claim - level segments if the entity identifier codes in each NM1 segment are the same.
 - 2/500 Loop 2420 contains information about the rendering, referring, or attending provider on a service line level. These segments override the information in the claim - level segments if the entity identifier codes in each NM1 segment are the same.
 - 2/540L SVD01 identifies the payer which adjudicated the corresponding service line and must match DE 67 in the NM109 position 325 for the payer.
 - 2/540 SVD01 identifies the payer which adjudicated the corresponding service line and must match DE 67 in the NM109 position 325 for the payer.

1. The 837 transaction is designed to transmit one or more claims for each billing provider. The hierarchy of the looping structure is billing provider, subscriber, patient, claim level, and claim service line level. Billing providers who sort claims using this hierarchy will use the 837 more efficiently because information that applies to all lower levels in the hierarchy will not have to be repeated within the transaction.

ISA Interchange Control Header

Pos:	Max: 1
Not Defined - Mandatory	
Loop: N/A	Elements: 16

User Option (Usage): Required

Purpose: To start and identify an interchange of zero or more functional groups and interchange-related control segments

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
ISA01	I01	Authorization Information Qualifier	M	ID	2/2	Required

Description: Code to identify the type of information in the Authorization Information

<u>Code</u>	<u>Name</u>
00	No Authorization Information Present (No Meaningful Information in I02) <i>ADVISED UNLESS SECURITY REQUIREMENTS MANDATE USE OF ADDITIONAL IDENTIFICATION.</i>

ISA02	I02	Authorization Information	M	AN	10/10	Required
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Description: Information used for additional identification or authorization of the interchange sender or the data in the interchange; the type of information is set by the Authorization Information Qualifier (I01)

Fixed Length
Valid Values: 10 Blanks

ISA03	I03	Security Information Qualifier	M	ID	2/2	Required
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Description: Code to identify the type of information in the Security Information

<u>Code</u>	<u>Name</u>
00	No Security Information Present (No Meaningful Information in I04) <i>ADVISED UNLESS SECURITY REQUIREMENTS MANDATE USE OF PASSWORD DATA.</i>

ISA04	I04	Security Information	M	AN	10/10	Required
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Description: This is used for identifying the security information about the interchange sender or the data in the interchange; the type of information is set by the Security Information Qualifier (I03)

Fixed Length
Valid Values: 10 Blanks

ISA05	I05	Interchange ID Qualifier	M	ID	2/2	Required
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Description: Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified
This ID qualifies the Sender in ISA06.

<u>Code</u>	<u>Name</u>
30	U.S. Federal Tax Identification Number

ISA06	I06	Interchange Sender ID	M	AN	15/15	Required
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Description: Identification code published by the sender for other parties to use as the receiver ID to route data to them; the sender always codes this value in the sender ID element

Valid Format:
County or Direct Contract Provider: 9 digit EIN established by Trading Partner agreement + 6 Spaces
Example: 956000928

ISA07	I05	Interchange ID Qualifier	M	ID	2/2	Required
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Description: Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified
This ID qualifies the Receiver in ISA08.

<u>Code</u>	<u>Name</u>
ZZ	Mutually Defined

ISA08	I07	Interchange Receiver ID	M	AN	15/15	Required
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Description: Identification code published by the receiver of the data; When sending, it is used by the sender as their sending ID, thus other parties sending to them will use this as a receiving ID to route data to them
This field has to be SDMCPHASETWOADP

ISA09	I08	Interchange Date	M	DT	6/6	Required
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Description: Date of the interchange
The date format is YYMMDD; The date on which the transaction file is created.

ISA10	I09	Interchange Time	M	TM	4/4	Required
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Description: Time of the interchange
The time format is HHMM; The time on which the transaction file is created.

ISA11	I10	Interchange Control Standards Identifier	M	ID	1/1	Required
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Description: Code to identify the agency responsible for the control standard used by the message that is enclosed by the interchange header and trailer
Valid Values:
U - U.S. EDI Community of ASC X12, TDCC, and UCS
All valid standard codes are used.

ISA12	I11	Interchange Control Version Number	M	ID	5/5	Required
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Description: Code specifying the version number of the interchange control segments

<u>Code</u>	<u>Name</u>
00401	Draft Standards for Trial Use Approved for Publication by ASC X12 Procedures Review Board through October 1997

ISA13	I12	Interchange Control Number	M	N0	9/9	Required
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Description: A control number assigned by the interchange sender
Created by the Sender and must have the same value as in the Interchange Trailer (IEA02). It must 9 numeric characters (e.g., 123456789).

ISA14	I13	Acknowledgment Requested	M	ID	1/1	Required
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Description: Code sent by the sender to request an interchange acknowledgment (TA1)

<u>Code</u>	<u>Name</u>
0	No Acknowledgment Requested

ISA15	I14	Usage Indicator	M	ID	1/1	Required
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Description: Code to indicate whether data enclosed by this interchange envelope is test, production or information

<u>Code</u>	<u>Name</u>
P	Production Data
T	Test Data

ISA16	I15	Component Element Separator	M		1/1	Required
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Description: Type is not applicable; the component element separator is a delimiter and not a data element; this field provides the delimiter used to separate component data elements

within a composite data structure; this value must be different than the data element separator and the segment terminator

The component element separator is a delimiter and not a data element. It is used with composite data elements such as CLM05.

Notes:

All positions within each data element in the ISA segment must be filled. Delimiters are specified in the Interchange Header Segment. Examples of the values are as follows:

** Asterisk Data Element Separator*

: Colon Sub element Separator

~ Tilde Segment Terminator

Example:

*ISA*00* *00* *30*956000928*

**ZZ*SDMCPHASETWOADP*030918*1659*U*00401*000000864*1*P*::~*

GS**Functional Group Header**

Pos:	Max: 1
Not Defined - Mandatory	
Loop: N/A	Elements: 8

User Option (Usage): Required

Purpose: To indicate the beginning of a functional group and to provide control information

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
GS01	479	Functional Identifier Code	M	ID	2/2	Required
Description: Code identifying a group of application related transaction sets						
		<u>Code</u>	<u>Name</u>			
		HC	Health Care Claim (837)			
GS02	142	Application Sender's Code	M	AN	2/15	Required
Description: Code identifying party sending transmission; codes agreed to by trading partners						
Alias: <i>Interchange Sender ID</i>						
Valid Format:						
<i>County or Direct Contract Provider: 9 digit EIN established by Trading Partner agreement</i>						
<i>Example: 956000928</i>						
GS03	124	Application Receiver's Code	M	AN	2/15	Required
Description: Code identifying party receiving transmission; codes agreed to by trading partners						
<i>Use this code to identify the unit receiving the information.</i>						
Valid Value: <i>SDMCPHASETWOADP</i>						
GS04	373	Date	M	DT	8/8	Required
Description: Date expressed as CCYYMMDD						
<i>Use this date for the functional group creation date.</i>						
<i>The recommended format is CCYYMMDD.</i>						
GS05	337	Time	M	TM	4/8	Required
Description: Time expressed in 24-hour clock time as follows: HHMM, or HHMMSS, or HHMMSSD, or HHMMSSDD, where H = hours (00-23), M = minutes (00-59), S = integer seconds (00-59) and DD = decimal seconds; decimal seconds are expressed as follows: D = tenths (0-9) and DD = hundredths (00-99)						
<i>Use this time for the creation time. The recommended format is HHMMSS.</i>						
GS06	28	Group Control Number	M	N0	1/9	Required
Description: Assigned number originated and maintained by the sender						
<i>Must match GE02. It has to be unique within ISA segment.</i>						
GS07	455	Responsible Agency Code	M	ID	1/2	Required
Description: Code identifying the issuer of the standard; this code is used in conjunction with Data Element 480						
		<u>Code</u>	<u>Name</u>			
		X	Accredited Standards Committee X12			
GS08	480	Version / Release / Industry Identifier Code	M	AN	1/12	Required
Description: Code indicating the version, release, subrelease, and industry identifier of the EDI standard being used, including the GS and GE segments; if code in DE455 in GS segment is X, then in DE 480 positions 1-3 are the version number; positions 4-6 are the						

release and subrelease, level of the version; and positions 7-12 are the industry or trade association identifiers (optionally assigned by user); if code in DE455 in GS segment is T, then other formats are allowed

<u>Code</u>	<u>Name</u>
004010X098 A1	Draft Standards Approved for Publication by ASC X12 Procedures Review Board through October 1997, as published in this implementation guide.

Semantics:

1. GS04 is the group date.
2. GS05 is the group time.
3. The data interchange control number GS06 in this header must be identical to the same data element in the associated functional group trailer, GE02.

Comments:

1. A functional group of related transaction sets, within the scope of X12 standards, consists of a collection of similar transaction sets enclosed by a functional group header and a functional group trailer.

Notes:

The functional group header used for the 837 is HC.

Example:

GS*HC*956000928*SDMCPHASETWOADP*20020606*105531*5*X*004010X098A1~

ST Transaction Set Header

Pos: 005	Max: 1
Heading - Mandatory	
Loop: N/A	Elements: 2

User Option (Usage): Required

Purpose: To indicate the start of a transaction set and to assign a control number

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
ST01	143	Transaction Set Identifier Code	M	ID	3/3	Required

Description: Code uniquely identifying a Transaction Set
The only valid value within this transaction set for ST01 is 837.

<u>Code</u>	<u>Name</u>
837	Health Care Claim
	REQUIRED

ST02	329	Transaction Set Control Number	M	AN	4/9	Required
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Description: Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set

Alias: *Transaction Set Control Number*

The Transaction Set Control Numbers in ST02 and SE02 must be identical. This unique number also aids in error resolution research. Submitters could begin sending transactions using the number 0001 in this element and increment from there. The number must be unique within a specific functional group (GS-GE) and interchange (ISA-IEA), but can repeat in other groups and interchanges.

Semantics:

1. The transaction set identifier (ST01) used by the translation routines of the interchange partners to select the appropriate transaction set definition (e.g., 810 selects the Invoice Transaction Set).

Notes:

This segment begins the transaction.

Example:

ST*837*0001~

BHT Beginning of Hierarchical Transaction

Pos: 010	Max: 1
Heading - Mandatory	
Loop: N/A	Elements: 6

User Option (Usage): Required

Purpose: To define the business hierarchical structure of the transaction set and identify the business application purpose and reference data, i.e., number, date, and time

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>				
BHT01	1005	Hierarchical Structure Code	M	ID	4/4	Required				
<p>Description: Code indicating the hierarchical application structure of a transaction set that utilizes the HL segment to define the structure of the transaction set</p> <table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>0019</td> <td>Information Source, Subscriber, Dependent</td> </tr> </tbody> </table>							<u>Code</u>	<u>Name</u>	0019	Information Source, Subscriber, Dependent
<u>Code</u>	<u>Name</u>									
0019	Information Source, Subscriber, Dependent									
BHT02	353	Transaction Set Purpose Code	M	ID	2/2	Required				
<p>Description: Code identifying purpose of transaction set Alias: <i>Transaction Set Purpose Code</i> <i>BHT02 is intended to convey the electronic transmission status of the 837 batch contained in this ST-SE envelope.</i></p> <table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>00</td> <td>Original</td> </tr> </tbody> </table>							<u>Code</u>	<u>Name</u>	00	Original
<u>Code</u>	<u>Name</u>									
00	Original									
BHT03	127	Reference Identification	O	AN	1/30	Required				
<p>Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier Industry: <i>Originator Application Transaction Identifier</i> <i>The inventory file number of the tape or transmission assigned by the submitter's system. This number operates as a batch control number. It may or may not be identical to the number carried in ST02.</i></p>										
BHT04	373	Date	O	DT	8/8	Required				
<p>Description: Date expressed as CCYYMMDD Industry: <i>Transaction Set Creation Date</i> <i>Identifies the date that the submitter created the file.</i> <i>This date will not be used to determine the age of the claim. The date received by the state will be compared to the service dates on the service lines to determine claim age.</i></p>										
BHT05	337	Time	O	TM	4/8	Required				
<p>Description: Time expressed in 24-hour clock time as follows: HHMM, or HHMMSS, or HHMMSSD, or HHMMSSDD, where H = hours (00-23), M = minutes (00-59), S = integer seconds (00-59) and DD = decimal seconds; decimal seconds are expressed as follows: D = tenths (0-9) and DD = hundredths (00-99) Industry: <i>Transaction Set Creation Time</i> <i>Use this time to identify the time of day that the submitter created the file.</i></p>										
BHT06	640	Transaction Type Code	O	ID	2/2	Required				
<p>Description: Code specifying the type of transaction Industry: <i>Claim or Encounter Identifier</i> <i>"CH" only value for claiming Medi-Cal.</i></p> <table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>CH</td> <td>Chargeable</td> </tr> </tbody> </table>							<u>Code</u>	<u>Name</u>	CH	Chargeable
<u>Code</u>	<u>Name</u>									
CH	Chargeable									

Use this code when the transaction contains only fee-for-service claims or claims with at least one chargeable line item. If it is not clear whether a transaction contains claims or encounters, or if the transaction contains a mix of claims and encounters, the developers of this implementation guide recommend using code CH.

Semantics:

1. BHT03 is the number assigned by the originator to identify the transaction within the originator's business application system.
2. BHT04 is the date the transaction was created within the business application system.
3. BHT05 is the time the transaction was created within the business application system.

Notes:

This segment provides the bill date of the claim submitted.

Example:

*BHT*0019*00*4144000001*20030416** CH~*

REF Transmission Type Identification

Pos: 015	Max: 1
Heading - Optional	
Loop: N/A	Elements: 2

User Option (Usage): Required

Purpose: To specify identifying information

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
REF01	128	Reference Identification Qualifier	M	ID	2/3	Required

Description: Code qualifying the Reference Identification

Code	Name
87	Functional Category

REF02	127	Reference Identification	C	AN	1/30	Required
-------	-----	--------------------------	---	----	------	----------

Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

Industry: *Transmission Type Code*

When sending the transaction set in a production mode, this value is 004010X098A1.

Test value should be 004010X098DA1 (this test value is also indicated in ISA15)

Syntax Rules:

1. R0203 - At least one of REF02 or REF03 is required.

Notes:

Transaction Type Identification

Example:

*REF*87*004010X098A1~*

Loop Submitter Name

Pos: 020	Repeat: 1
	Optional
Loop: 1000A	Elements: N/A

User Option (Usage): Required

Purpose: To supply the full name of an individual or organizational entity

Loop Summary:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Usage</u>
020	NM1	Submitter Name	O	1		Required
045	PER	Submitter EDI Contact Information	O	2		Required

NM1 Submitter Name

Pos: 020	Max: 1
Heading - Optional	
Loop: 1000A	Elements: 7

User Option (Usage): Required

Purpose: To supply the full name of an individual or organizational entity

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
NM101	98	Entity Identifier Code	M	ID	2/3	Required
		Description: Code identifying an organizational entity, a physical location, property or an individual				
		Code		Name		
		41		Submitter		
NM102	1065	Entity Type Qualifier	M	ID	1/1	Required
		Description: Code qualifying the type of entity				
		Code		Name		
		1		Person		
		2		Non-Person Entity		
NM103	1035	Name Last or Organization Name	O	AN	1/35	Required
		Description: Individual last name or organizational name				
		Industry: <i>Submitter Last Name or Organization Name Assigned to trading partner.</i>				
NM104	1036	Name First	O	AN	1/25	Situational
		Description: Individual first name				
		Industry: <i>Submitter First Name Required if NM102=1 (person).</i>				
NM105	1037	Name Middle	O	AN	1/25	Situational
		Description: Individual middle name or initial				
		Industry: <i>Submitter Middle Name Required if NM102=1 and the middle name/initial of the person is known.</i>				
NM108	66	Identification Code Qualifier	C	ID	1/2	Required
		Description: Code designating the system/method of code structure used for Identification Code (67)				
		Code		Name		
		46		Electronic Transmitter Identification Number (ETIN)		
		<i>Established by trading partner agreement.</i>				
NM109	67	Identification Code	C	AN	2/80	Required
		Description: Code identifying a party or other code				
		Industry: <i>Submitter Identifier County or Direct Contract Provider: 9 digit EIN established by Trading Partner agreement Example: 923456789</i>				

Syntax Rules:

1. P0809 - If either NM108 or NM109 is present, then the other is required.

Semantics:



1. NM102 qualifies NM103.

Notes:

This will be either a county or direct provider.

Example:

NM1*41*2*ORANGE COUNTY HEALTH CARE AGENCY*****46*30~

PER Submitter EDI Contact Information

Pos: 045	Max: 2
Heading - Optional	
Loop: 1000A	Elements: 8

User Option (Usage): Required

Purpose: To identify a person or office to whom administrative communications should be directed

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage												
PER01	366	Contact Function Code	M	ID	2/2	Required												
<p>Description: Code identifying the major duty or responsibility of the person or group named</p> <table border="1"> <thead> <tr> <th>Code</th> <th>Name</th> </tr> </thead> <tbody> <tr> <td>IC</td> <td>Information Contact</td> </tr> </tbody> </table>							Code	Name	IC	Information Contact								
Code	Name																	
IC	Information Contact																	
PER02	93	Name	O	AN	1/60	Required												
<p>Description: Free-form name Industry: <i>Submitter Contact Name</i> <i>Use this data element when the name of the individual to contact is not already defined or is different than the name within the prior name segment (e.g. N1 or NM1).</i> <i>Can use "Billing Department".</i></p>																		
PER03	365	Communication Number Qualifier	C	ID	2/2	Required												
<p>Description: Code identifying the type of communication number</p> <table border="1"> <thead> <tr> <th>Code</th> <th>Name</th> </tr> </thead> <tbody> <tr> <td>ED</td> <td>Electronic Data Interchange Access Number</td> </tr> <tr> <td>EM</td> <td>Electronic Mail</td> </tr> <tr> <td>EX</td> <td>Telephone Extension</td> </tr> <tr> <td>FX</td> <td>Facsimile</td> </tr> <tr> <td>TE</td> <td>Telephone</td> </tr> </tbody> </table>							Code	Name	ED	Electronic Data Interchange Access Number	EM	Electronic Mail	EX	Telephone Extension	FX	Facsimile	TE	Telephone
Code	Name																	
ED	Electronic Data Interchange Access Number																	
EM	Electronic Mail																	
EX	Telephone Extension																	
FX	Facsimile																	
TE	Telephone																	
PER04	364	Communication Number	C	AN	1/80	Required												
<p>Description: Complete communications number including country or area code when applicable <i>Submitters Communication Number</i> <i>999.999.9999</i></p>																		
PER05	365	Communication Number Qualifier	C	ID	2/2	Situational												
<p>Description: Code identifying the type of communication number <i>Used at the discretion of the submitter.</i></p> <table border="1"> <thead> <tr> <th>Code</th> <th>Name</th> </tr> </thead> <tbody> <tr> <td>ED</td> <td>Electronic Data Interchange Access Number</td> </tr> <tr> <td>EM</td> <td>Electronic Mail</td> </tr> <tr> <td>EX</td> <td>Telephone Extension</td> </tr> <tr> <td>FX</td> <td>Facsimile</td> </tr> <tr> <td>TE</td> <td>Telephone</td> </tr> </tbody> </table>							Code	Name	ED	Electronic Data Interchange Access Number	EM	Electronic Mail	EX	Telephone Extension	FX	Facsimile	TE	Telephone
Code	Name																	
ED	Electronic Data Interchange Access Number																	
EM	Electronic Mail																	
EX	Telephone Extension																	
FX	Facsimile																	
TE	Telephone																	
PER06	364	Communication Number	C	AN	1/80	Situational												
<p>Description: Complete communications number including country or area code when applicable <i>Used at the discretion of the submitter.</i></p>																		
PER07	365	Communication Number Qualifier	C	ID	2/2	Situational												

Description: Code identifying the type of communication number
Used at the discretion of the submitter.

Code	Name
ED	Electronic Data Interchange Access Number
EM	Electronic Mail
EX	Telephone Extension
FX	Facsimile
TE	Telephone

PER08 364 **Communication Number** C AN 1/80 Situational

Description: Complete communications number including country or area code when applicable
Used at the discretion of the submitter.

Syntax Rules:

1. P0304 - If either PER03 or PER04 is present, then the other is required.
2. P0506 - If either PER05 or PER06 is present, then the other is required.
3. P0708 - If either PER07 or PER08 is present, then the other is required.

Notes:

1. When the communication number represents a telephone number in the United States and other countries using the North American Dialing Plan (for voice, data, fax, etc.), the communication number should always include the area code and phone number using the format AAABBBCCCC where AAA is the area code, BBB is the telephone number prefix, and CCCC is the telephone number (e.g., (534) 224-2525 would be represented as 5342242525). The extension, when applicable, should be included in the communication number immediately after the telephone number.
2. The contact information in this segment should point to the person in the submitter organization who deals with data transmission issues. If data transmission problems arise, this is the person to contact in the submitter organization.
3. There are 2 repetitions of the PER segment to allow for six possible combination of communication numbers including extensions.

Example:

PER*IC*FERMIN*TE*1234567890*EM*abc@AAA.COM~

Loop Receiver Name

Pos: 020	Repeat: 1
	Optional
Loop: 1000B	Elements: N/A

User Option (Usage): Required

Purpose: To supply the full name of an individual or organizational entity

Loop Summary:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Usage</u>
020	NM1	Receiver Name	O	1		Required

NM1 Receiver Name

Pos: 020	Max: 1
Heading - Optional	
Loop: 1000B	Elements: 5

User Option (Usage): Required

Purpose: To supply the full name of an individual or organizational entity

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
NM101	98	Entity Identifier Code	M	ID	2/3	Required
Description: Code identifying an organizational entity, a physical location, property or an individual						
		<u>Code</u>	<u>Name</u>			
		40	Receiver			
NM102	1065	Entity Type Qualifier	M	ID	1/1	Required
Description: Code qualifying the type of entity						
		<u>Code</u>	<u>Name</u>			
		2	Non-Person Entity			
NM103	1035	Name Last or Organization Name	O	AN	1/35	Required
Description: Individual last name or organizational name						
Industry: Receiver Name						
<i>Enter ADP.</i>						
NM108	66	Identification Code Qualifier	C	ID	1/2	Required
Description: Code designating the system/method of code structure used for Identification Code (67)						
		<u>Code</u>	<u>Name</u>			
		46	Electronic Transmitter Identification Number (ETIN)			
NM109	67	Identification Code	C	AN	2/80	Required
Description: Code identifying a party or other code						
Industry: Receiver Primary Identifier						
<i>Use this value : SDMCPHASETWOADP</i>						

Syntax Rules:

1. P0809 - If either NM108 or NM109 is present, then the other is required.

Semantics:

1. NM102 qualifies NM103.

Notes:

This will be the Receiver of this Transaction.

Example:

*NM1*40*2*ADP*****46*SDMCPHASETWOADP*

Loop Billing/Pay-to Provider Hierarchical Level

Pos: 001	Repeat: >1
	Mandatory
Loop: 2000A	Elements: N/A

User Option (Usage): Required

Purpose: To identify dependencies among and the content of hierarchically related groups of data segments

Loop Summary:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Usage</u>
001	HL	Billing/Pay-to Provider Hierarchical Level	M	1		Required
015		Loop 2010AA	O		1	Required

HL**Billing/Pay-to Provider
Hierarchical Level**

Pos: 001	Max: 1
Detail - Mandatory	
Loop: 2000A	Elements: 3

User Option (Usage): Required**Purpose:** To identify dependencies among and the content of hierarchically related groups of data segments**Element Summary:**

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
HL01	628	Hierarchical ID Number	M	AN	1/12	Required
Description: A unique number assigned by the sender to identify a particular data segment in a hierarchical structure <i>Must begin with the number 1 and increment by one each time an HL is used.</i>						
HL03	735	Hierarchical Level Code	M	ID	1/2	Required
Description: Code defining the characteristic of a level in a hierarchical structure						
		<u>Code</u>	<u>Name</u>			
		20	Information Source			
HL04	736	Hierarchical Child Code	O	ID	1/1	Required
Description: Code indicating if there are hierarchical child data segments subordinate to the level being described						
		<u>Code</u>	<u>Name</u>			
		1	Additional Subordinate HL Data Segment in This Hierarchical Structure.			

Comments:

1. The HL segment is used to identify levels of detail information using a hierarchical structure, such as relating line-item data to shipment data, and packaging data to line-item data.
2. The HL segment defines a top-down/left-right ordered structure.
3. HL01 must begin with "1" and be incremented by one each time an HL is used in the transaction. Only numeric values are allowed in HL01.
4. HL03 indicates the context of the series of segments following the current HL segment up to the next occurrence of an HL segment in the transaction. For example, HL03 is used to indicate that subsequent segments in the HL loop form a logical grouping of data referring to shipment, order, or item-level information.
5. HL04 indicates whether or not there are subordinate (or child) HL segments related to the current HL segment.

Notes:

1. Use the Billing Provider HL to identify the original entity who submitted the electronic claim/encounter to the destination payer identified in Loop ID-2010BB. The billing provider entity may be a health care provider, a billing service, or some other representative of the provider.
2. Receiving trading partners may have system limitations regarding the size of the transmission they can receive. The developers of this guide recommend that trading partners limit the size of the transaction (ST-SE envelope) to a maximum of 5000 CLM segments. While the implementation guide sets no specific limit to the number of Billing/Pay-to Provider Hierarchical Level loops, there is an implied maximum of 5000.

Example:

HL*1**20*1~

Loop Billing Provider Name

Pos: 015	Repeat: 1
	Optional
Loop: 2010AA	Elements: N/A

User Option (Usage): Required

Purpose: To supply the full name of an individual or organizational entity

Loop Summary:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Usage</u>
015	NM1	Billing Provider Name	O	1		Required
025	N3	Billing Provider Address	O	1		Required
030	N4	Billing Provider City/State/ZIP Code	O	1		Required
035	REF	Billing Provider Secondary Identification	O	8		Situational
040	PER	Billing Provider Contact Information	O	2		Situational

Notes:

Although the name of this loop is "Billing Provider" the loop really identifies the billing entity.

NM1 Billing Provider Name

Pos: 015	Max: 1
Detail - Optional	
Loop: 2010AA	Elements: 8

User Option (Usage): Required

Purpose: To supply the full name of an individual or organizational entity

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
NM101	98	Entity Identifier Code	M	ID	2/3	Required
		Description: Code identifying an organizational entity, a physical location, property or an individual				
		Code		Name		
		85		Billing Provider		
		<i>Use this code to indicate billing provider.</i>				
NM102	1065	Entity Type Qualifier	M	ID	1/1	Required
		Description: Code qualifying the type of entity				
		Code		Name		
		1		Person		
		2		Non-Person Entity		
NM103	1035	Name Last or Organization Name	O	AN	1/35	Required
		Description: Individual last name or organizational name				
		Industry: Billing Provider Last or Organizational Name				
		<i>This will be passed to the 835 if Loop 2010AB is not used.</i>				
NM104	1036	Name First	O	AN	1/25	Situational
		Description: Individual first name				
		Industry: Billing Provider First Name				
		<i>Required if NM102=1 (person).</i>				
NM105	1037	Name Middle	O	AN	1/25	Situational
		Description: Individual middle name or initial				
		Industry: Billing Provider Middle Name				
		<i>Required if NM102=1 and the middle name/initial of the person is known.</i>				
NM107	1039	Name Suffix	O	AN	1/10	Situational
		Description: Suffix to individual name				
		Industry: Billing Provider Name Suffix				
		<i>Required if known.</i>				
NM108	66	Identification Code Qualifier	C	ID	1/2	Required
		Description: Code designating the system/method of code structure used for Identification Code (67)				
		<i>When "XX - NPI" is used, the Employer's Identification Number of the provider must be carried in the Billing Provider Secondary Identification segment in this loop.</i>				
		Code		Name		
		XX		Health Care Financing Administration National Provider Identifier		
NM109	67	Identification Code	C	AN	2/80	Required
		Description: Code identifying a party or other code				
		Industry: Billing Provider Identifier				

This must be a valid NPI.

ExternalCodeList

Name: 537

Description: Health Care Financing Administration National Provider Identifier

Syntax Rules:

1. P0809 - If either NM108 or NM109 is present, then the other is required.

Semantics:

1. NM102 qualifies NM103.

Notes:

This will either be a county or Direct Contract Provider. The NPI is reported in this segment, and the EIN/Tax ID must be reported in the REF segment.

Example:

NM1*85*2*YORK COUNTY HEALTH CARE AGY*****XX*1234567893~

N3**Billing Provider Address**

Pos: 025	Max: 1
Detail - Optional	
Loop: 2010AA	Elements: 2

User Option (Usage): Required

Purpose: To specify the location of the named party

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
N301	166	Address Information	M	AN	1/55	Required
		Description: Address information				
		Industry: <i>Billing Provider Address Line</i>				
N302	166	Address Information	O	AN	1/55	Situational
		Description: Address information				
		Industry: <i>Billing Provider Address Line</i>				
		<i>Required if a second address line exists.</i>				

Example:

N3*66 HURLBUT STREET~

N4

Billing Provider City/State/ZIP Code

Pos: 030	Max: 1
Detail - Optional	
Loop: 2010AA	Elements: 4

User Option (Usage): Required

Purpose: To specify the geographic place of the named party

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
N401	19	City Name	O	AN	2/30	Required
Description: Free-form text for city name						
Industry: <i>Billing Provider City Name</i>						
N402	156	State or Province Code	O	ID	2/2	Required
Description: Code (Standard State/Province) as defined by appropriate government agency						
Industry: <i>Billing Provider State or Province Code</i>						
ExternalCodeList						
Name: 22						
Description: States and Outlying Areas of the U.S.						
N403	116	Postal Code	O	ID	3/15	Required
Description: Code defining international postal zone code excluding punctuation and blanks (zip code for United States)						
Industry: <i>Billing Provider Postal Zone or ZIP Code</i>						
ExternalCodeList						
Name: 51						
Description: ZIP Code						
N404	26	Country Code	O	ID	2/3	Situational
Description: Code identifying the country						
Alias: <i>Billing Provider Country Code</i>						
<i>Required if the address is out of the U.S.</i>						
ExternalCodeList						
Name: 5						
Description: Countries, Currencies and Funds						

Syntax Rules:

1. C0605 - If N406 is present, then N405 is required.

Comments:

1. N402 is required only if city name (N401) is in the U.S. or Canada.

Example:

N4*PASADENA*CA*91104~

REF Billing Provider Secondary Identification

Pos: 035	Max: 8
Detail - Optional	
Loop: 2010AA	Elements: 2

User Option (Usage): Situational

Purpose: To specify identifying information

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
REF01	128	Reference Identification Qualifier	M	ID	2/3	Required

Description: Code qualifying the Reference Identification

Code	Name
EI	Employer's Identification Number

REF02	127	Reference Identification	C	AN	1/30	Required
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Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

Industry: *Billing Provider Additional Identifier*
This will be the Tax ID/ EIN of the Billing Provider.

Syntax Rules:

1. R0203 - At least one of REF02 or REF03 is required.

Semantics:

1. REF04 contains data relating to the value cited in REF02.

Notes:

The Tax ID/ EIN is reported here.

Example:

*REF*EI*940000068~*

PER Billing Provider Contact Information

Pos: 040	Max: 2
Detail - Optional	
Loop: 2010AA	Elements: 8

User Option (Usage): Situational

Purpose: To identify a person or office to whom administrative communications should be directed

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
PER01	366	Contact Function Code	M	ID	2/2	Required
Description: Code identifying the major duty or responsibility of the person or group named						
		Code	Name			
		IC	Information Contact			
PER02	93	Name	O	AN	1/60	Required
Description: Free-form name						
Industry: Billing Provider Contact Name						
Use this data element when the name of the individual to contact is not already defined or is different than the name within the prior name segment (e.g. N1 or NM1).						
PER03	365	Communication Number Qualifier	C	ID	2/2	Required
Description: Code identifying the type of communication number						
		Code	Name			
		EM	Electronic Mail			
		FX	Facsimile			
		TE	Telephone			
PER04	364	Communication Number	C	AN	1/80	Required
Description: Complete communications number including country or area code when applicable						
NSF Reference: BA1-12.0, BA1-18.0						
PER05	365	Communication Number Qualifier	C	ID	2/2	Situational
Description: Code identifying the type of communication number						
Used at the discretion of the billing provider.						
		Code	Name			
		EM	Electronic Mail			
		EX	Telephone Extension			
		FX	Facsimile			
		TE	Telephone			
PER06	364	Communication Number	C	AN	1/80	Situational
Description: Complete communications number including country or area code when applicable						
Used at the discretion of the billing provider.						
PER07	365	Communication Number Qualifier	C	ID	2/2	Situational
Description: Code identifying the type of communication number						
Used at the discretion of the billing provider.						
		Code	Name			
		EM	Electronic Mail			
		EX	Telephone Extension			

FX Facsimile
TE Telephone

PER08 364 **Communication Number** C AN 1/80 Situational

Description: Complete communications number including country or area code when applicable

Used at the discretion of the billing provider.

Syntax Rules:

1. P0304 - If either PER03 or PER04 is present, then the other is required.
2. P0506 - If either PER05 or PER06 is present, then the other is required.
3. P0708 - If either PER07 or PER08 is present, then the other is required.

Notes:

1. Required if this information is different that that contained in the Loop 1000A - Submitter PER segment.
2. When the communication number represents a telephone number in the United States and other countries using the North American Dialing Plan (for voice, data, fax, etc.), the communication number should always include the area code and phone number using the format AAABBBCCCC where AAA is the area code, BBB is the telephone number prefix, and CCCC is the telephone number (e.g., (534) 224-2525 would be represented as 5342242525). The extension, when applicable, should be included in the communication number immediately after the telephone number.
3. There are 2 repetitions of the PER segment to allow for six possible combination of communication numbers including extensions.

Example:

PER*IC*JIM*TE*8007775555~

Loop Subscriber Hierarchical Level

Pos: 001	Repeat: >1
	Mandatory
Loop: 200B	Elements: N/A

User Option (Usage): Required

Purpose: To identify dependencies among and the content of hierarchically related groups of data segments

Loop Summary:

Pos	Id	Segment Name	Req	Max Use	Repeat	Usage
001	HL	Subscriber Hierarchical Level	M	1		Required
005	SBR	Subscriber Information	O	1		Required
007	PAT	Patient Information	O	1		Situational
015		Loop 2010BA	O		1	Required
015		Loop 2010BB	O		1	Required
130		Loop 2300	O		100	Required

Comments:

1. The HL segment is used to identify levels of detail information using a hierarchical structure, such as relating line-item data to shipment data, and packaging data to line-item data.
2. The HL segment defines a top-down/left-right ordered structure.
3. HL01 shall contain a unique alphanumeric number for each occurrence of the HL segment in the transaction set. For example, HL01 could be used to indicate the number of occurrences of the HL segment, in which case the value of HL01 would be "1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction.
4. HL02 identifies the hierarchical ID number of the HL segment to which the current HL segment is subordinate.
5. HL03 indicates the context of the series of segments following the current HL segment up to the next occurrence of an HL segment in the transaction. For example, HL03 is used to indicate that subsequent segments in the HL loop form a logical grouping of data referring to shipment, order, or item-level information.
6. HL04 indicates whether or not there are subordinate (or child) HL segments related to the current HL segment.

Notes:

1. If the insured and the patient are the same person, use this HL to identify the insured/patient, skip the subsequent (PATIENT) HL, and proceed directly to Loop ID-2300.
2. The Subscriber HL contains information about the person who is listed as the subscriber/insured for the destination payer entity (Loop ID-2010BA). The Subscriber HL contains information identifying the subscriber (Loop ID-2010BA), his or her insurance (Loop ID-2010BB), and responsible party (Loop ID-2010BC).
3. Because this is a required segment, this is a required loop. See Appendix A for further details on ASC X12 syntax rules.

Example:

HL*2*1*22*1~

HL

Subscriber Hierarchical Level

Pos: 001	Max: 1
Detail - Mandatory	
Loop: 2000B	Elements: 4

User Option (Usage): Required**Purpose:** To identify dependencies among and the content of hierarchically related groups of data segments**Element Summary:**

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
HL01	628	Hierarchical ID Number	M	AN	1/12	Required
Description: A unique number assigned by the sender to identify a particular data segment in a hierarchical structure <i>Increment by one for each HL segment in transaction.</i>						
HL02	734	Hierarchical Parent ID Number	O	AN	1/12	Required
Description: Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to <i>Use the HL01 value of the Billing/Pay-to Provider in 2000A.</i>						
HL03	735	Hierarchical Level Code	M	ID	1/2	Required
Description: Code defining the characteristic of a level in a hierarchical structure						
		<u>Code</u>	<u>Name</u>			
		22	Subscriber			
HL04	736	Hierarchical Child Code	O	ID	1/1	Required
Description: Code indicating if there are hierarchical child data segments subordinate to the level being described <i>The subscriber is always the patient for ADP.</i>						
		<u>Code</u>	<u>Name</u>			
		0	No Subordinate HL Segment in This Hierarchical Structure.			

Comments:

1. The HL segment is used to identify levels of detail information using a hierarchical structure, such as relating line-item data to shipment data, and packaging data to line-item data.
2. The HL segment defines a top-down/left-right ordered structure.
3. HL01 shall contain a unique alphanumeric number for each occurrence of the HL segment in the transaction set. For example, HL01 could be used to indicate the number of occurrences of the HL segment, in which case the value of HL01 would be "1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction.
4. HL02 identifies the hierarchical ID number of the HL segment to which the current HL segment is subordinate.
5. HL03 indicates the context of the series of segments following the current HL segment up to the next occurrence of an HL segment in the transaction. For example, HL03 is used to indicate that subsequent segments in the HL loop form a logical grouping of data referring to shipment, order, or item-level information.
6. HL04 indicates whether or not there are subordinate (or child) HL segments related to the current HL segment.

Example:

HL*2*1*22*1~

SBR Subscriber Information

Pos: 005	Max: 1
Detail - Optional	
Loop: 2000B	Elements: 6

User Option (Usage): Required

Purpose: To record information specific to the primary insured and the insurance carrier for that insured

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
SBR01	1138	Payer Responsibility Sequence Number Code	M	ID	1/1	Required

Description: Code identifying the insurance carrier's level of responsibility for a payment of a claim

Alias: *Payer Responsibility Sequence Number Code*

COB - Do not use "S" or "T" unless COB information is included on the claim.

Code	Name
P	Primary
S	Secondary
T	Tertiary

Use to indicate 'payer of last resort'.

SBR02	1069	Individual Relationship Code	O	ID	2/2	Situational
-------	------	-------------------------------------	---	----	-----	-------------

Description: Code indicating the relationship between two individuals or entities

Alias: *Relationship Code*

Required when the subscriber is the same person as the patient. If the subscriber is not the same person as the patient, do not use this element.

Code	Name
18	Self

SBR03	127	Reference Identification	O	AN	1/30	Situational
-------	-----	---------------------------------	---	----	------	-------------

Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

Industry: *Insured Group or Policy Number*

This data element is not used in Drug Medi-Cal.

SBR04	93	Name	O	AN	1/60	Situational
-------	----	-------------	---	----	------	-------------

Description: Free-form name

Industry: *Insured Group Name*

Required if the subscriber's payer identification includes a Group or Plan Name.

This data element is not used in Drug Medi-Cal.

SBR05	1336	Insurance Type Code	O	ID	1/3	Situational
-------	------	----------------------------	---	----	-----	-------------

Description: Code identifying the type of insurance policy within a specific insurance program

Alias: *Insurance type code*

Required when the destination payer (Loop 2010BB) is Medicare and Medicare is not the primary payer (SBR01 equals "S" or "T").

This data element is not used in Drug Medi-Cal.

SBR09	1032	Claim Filing Indicator Code	O	ID	1/2	Situational
-------	------	------------------------------------	---	----	-----	-------------

Description: Code identifying type of claim

Alias: *Claim Filing Indicator Code*

Required prior to mandated used of PlanID. Not used after PlanID is mandated. Use 'MC' for Drug Medi-Cal.

<u>Code</u>	<u>Name</u>
MC	Medicaid

Semantics:

1. SBR02 specifies the relationship to the person insured.
2. SBR03 is policy or group number.
3. SBR04 is plan name.
4. SBR07 is destination payer code. A "Y" value indicates the payer is the destination payer; an "N" value indicates the payer is not the destination payer.

Example:

*SBR*P*18*****MC~*

PAT Patient Information

Pos: 007	Max: 1
Detail - Optional	
Loop: 200B	Elements: 5

User Option (Usage): Situational

Purpose: To supply patient information

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
PAT05	1250	Date Time Period Format Qualifier	C	ID	2/3	Situational

Description: Code indicating the date format, time format, or date and time format
Required if patient is known to be deceased and the date of death is available to the provider billing system.

Code	Name
D8	Date Expressed in Format CCYYMMDD

PAT06	1251	Date Time Period	C	AN	1/35	Situational
-------	------	------------------	---	----	------	-------------

Description: Expression of a date, a time, or range of dates, times or dates and times
Industry: *Insured Individual Death Date*
Required if patient is known to be deceased and the date of death is available to the provider billing system.

PAT07	355	Unit or Basis for Measurement Code	C	ID	2/2	Situational
-------	-----	------------------------------------	---	----	-----	-------------

Description: Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken
Required when PAT08 is used.

Code	Name
01	Actual Pounds

PAT08	81	Weight	C	R	1/10	Situational
-------	----	--------	---	---	------	-------------

Description: Numeric value of weight
Industry: *Patient Weight*
Not used in Drug Medi-Cal.

PAT09	1073	Yes/No Condition or Response Code	O	ID	1/1	Situational
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Description: Code indicating a Yes or No condition or response
Industry: *Pregnancy Indicator*
The pregnancy indicator is required where the client is known to the provider to be either pregnant or postpartum as defined in 22 CCR § 51341.1(b)(18). The indicator will be used for statistical purposes, and for adjudicating claims for which the client's perinatal eligibility is relevant. The "Y" code indicates that the patient is pregnant. If PAT09 is not used it means the patient is not pregnant.

Code	Name
Y	Yes

Syntax Rules:

1. P0506 - If either PAT05 or PAT06 is present, then the other is required.
2. P0708 - If either PAT07 or PAT08 is present, then the other is required.

Semantics:

1. PAT06 is the date of death.
2. PAT08 is the patient's weight.
3. PAT09 indicates whether the patient is pregnant or not pregnant. Code "Y" indicates the patient is pregnant;



code "N" indicates the patient is not pregnant.

Notes:

1. Required if the subscriber is the same person as the patient (Loop ID-2000B SBR02=18), and information in this PAT segment (date of death, and/or patient weight) is necessary to file the claim/encounter (see PAT05, 06, 07, and 08).

Example:

PAT*****D8*19970314*01*146~

Loop Subscriber Name

Pos: 015	Repeat: 1
	Optional
Loop: 2010BA	Elements: N/A

User Option (Usage): Required

Purpose: To supply the full name of an individual or organizational entity

Loop Summary:

Pos	Id	Segment Name	Req	Max Use	Repeat	Usage
015	NM1	Subscriber Name	O	1		Required
025	N3	Subscriber Address	O	1		Required
030	N4	Subscriber City/State/ZIP Code	O	1		Required
032	DMG	Subscriber Demographic Information	O	1		Required

Semantics:

1. NM102 qualifies NM103.

Comments:

- 1.

Notes:

1. In worker's compensation or other property and casualty claims, the "subscriber" may be a non-person entity (i.e., the employer). However, this varies by state.
2. Because this is a required segment, this is a required loop. See Appendix A for further details on ASC X12 syntax rules.

Example:

NM1*IL*1*DOE*JOHN*T**JR*MI*123456~

NM1 Subscriber Name

Pos: 015	Max: 1
Detail - Optional	
Loop: 2010BA	Elements: 8

User Option (Usage): Required

Purpose: To supply the full name of an individual or organizational entity

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
NM101	98	Entity Identifier Code	M	ID	2/3	Required
		Description: Code identifying an organizational entity, a physical location, property or an individual				
		Code		Name		
		IL		Insured or Subscriber		
NM102	1065	Entity Type Qualifier	M	ID	1/1	Required
		Description: Code qualifying the type of entity <i>For Drug Medi-Cal use "1" = Person.</i>				
		Code		Name		
		1		Person		
NM103	1035	Name Last or Organization Name	O	AN	1/35	Required
		Description: Individual last name or organizational name Industry: <i>Subscriber Last Name</i>				
NM104	1036	Name First	O	AN	1/25	Required
		Description: Individual first name Industry: <i>Subscriber First Name</i> <i>Required if NM102=1 (person).</i>				
NM105	1037	Name Middle	O	AN	1/25	Situational
		Description: Individual middle name or initial Industry: <i>Subscriber Middle Name</i> <i>Required if NM102=1 and the middle name/initial of the person is known. Blank if not known.</i>				
NM107	1039	Name Suffix	O	AN	1/10	Situational
		Description: Suffix to individual name Industry: <i>Subscriber Name Suffix</i> <i>Required if known.</i> <i>Examples: I, II, III, IV, Jr, Sr</i>				
NM108	66	Identification Code Qualifier	C	ID	1/2	Situational
		Description: Code designating the system/method of code structure used for Identification Code (67) <i>Required if NM102 = 1 (person)</i>				
		Code		Name		
		MI		Member Identification Number		
		<i>The code MI is intended to be the subscriber's identification number as assigned by the payer. For Drug Medi-Cal use the Client Index Number.</i>				
NM109	67	Identification Code	C	AN	2/80	Situational
		Description: Code identifying a party or other code				

Industry: *Subscriber Primary Identifier*

Required if the Subscriber is the patient. If the subscriber is not the patient, use if known. For Drug Medi-Cal the subscriber is always the same person as the patient.

*CIN Example: 98630052A
(98630052A)*

Syntax Rules:

1. P0809 - If either NM108 or NM109 is present, then the other is required.

Semantics:

1. NM102 qualifies NM103.

Notes:

This segment identifies the subscriber and must include the Subscriber Identification Number.

Example:

*NM1*IL*1*DOE* JOHN****MI*196009244900334~*

N3

Subscriber Address

Pos: 025	Max: 1
Detail - Optional	
Loop: 2010BA	Elements: 2

User Option (Usage): Required

Purpose: To specify the location of the named party

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
N301	166	Address Information	M	AN	1/55	Required

Description: Address information
Industry: *Subscriber Address Line*
"HOMELESS" may be used if appropriate.

N302	166	Address Information	O	AN	1/55	Situational
------	-----	---------------------	---	----	------	-------------

Description: Address information
Industry: *Subscriber Address Line*
Required if a second address line exists. In case of Homeless subscribers, this field can be omitted or be populated with the provider's address.

Notes:

1. Required if the patient is the same person as the subscriber. (Required when Loop ID-2000B, SBR02=18 (self)). This is required due to situational guide notes, but not used in SD/MC.

Example:

N3*250 E WASHINGTON BLVD~

N4**Subscriber City/State/ZIP Code**

Pos: 030	Max: 1
Detail - Optional	
Loop: 2010BA	Elements: 4

User Option (Usage): Required

Purpose: To specify the geographic place of the named party

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
N401	19	City Name	O	AN	2/30	Required
Description: Free-form text for city name Industry: <i>Subscriber City Name</i> <i>If unknown or in case of Homeless subscribers, use the provider's city.</i>						
N402	156	State or Province Code	O	ID	2/2	Required
Description: Code (Standard State/Province) as defined by appropriate government agency Industry: <i>Subscriber State Code</i> <u>ExternalCodeList</u> Name: 22 Description: States and Outlying Areas of the U.S.						
N403	116	Postal Code	O	ID	3/15	Required
Description: Code defining international postal zone code excluding punctuation and blanks (zip code for United States) Industry: <i>Subscriber Postal Zone or ZIP Code</i> <i>If unknown or in case of Homeless subscribers, use the provider's postal code.</i> <u>ExternalCodeList</u> Name: 51 Description: ZIP Code						
N404	26	Country Code	O	ID	2/3	Situational
Description: Code identifying the country Alias: <i>Subscriber Country Code</i> <i>Required if the address is out of the U.S.</i> <u>ExternalCodeList</u> Name: 5 Description: Countries, Currencies and Funds						

Comments:

1. A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location.
2. N402 is required only if city name (N401) is in the U.S. or Canada.

Notes:

1. Required if the patient is the same person as the subscriber. (Required when Loop ID-2000B, SBR02=18 (self)). This is required due to situational guide notes, but not used in SD/MC.

Example:

N4*CENTERVILLE*PA*17111~

DMG Subscriber Demographic Information

Pos: 032	Max: 1
Detail - Optional	
Loop: 2010BA	Elements: 3

User Option (Usage): Required

Purpose: To supply demographic information

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
DMG01	1250	Date Time Period Format Qualifier	C	ID	2/3	Required

Description: Code indicating the date format, time format, or date and time format

Code	Name
D8	Date Expressed in Format CCYYMMDD

DMG02	1251	Date Time Period	C	AN	1/35	Required
-------	------	------------------	---	----	------	----------

Description: Expression of a date, a time, or range of dates, times or dates and times

Industry: *Subscriber Birth Date*

DMG03	1068	Gender Code	O	ID	1/1	Required
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Description: Code indicating the sex of the individual

Industry: *Subscriber Gender Code*

Alias: *Gender - Patient*

Code	Name
F	Female
M	Male
U	Unknown

Syntax Rules:

1. P0102 - If either DMG01 or DMG02 is present, then the other is required.

Semantics:

1. DMG02 is the date of birth.

Notes:

1. Required if the patient is the same person as the subscriber. (Required when Loop ID-2000B, SBR02=18 (self)). This segment identifies the Subscriber Demographic Information.

Example:

DMG*D8*19540506*M~

Loop Payer Name

Pos: 015	Repeat: 1
	Optional
Loop: 2010BB	Elements: N/A

User Option (Usage): Required

Purpose: To supply the full name of an individual or organizational entity

Loop Summary:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Usage</u>
015	NM1	Payer Name	O	1		Required
025	N3	Payer Address	O	1		Situational
030	N4	Payer City/State/ZIP Code	O	1		Situational

Semantics:

1. NM102 qualifies NM103.

Notes:

1. This is the destination payer.
2. Because this is a required segment, this is a required loop. See Appendix A for further details on ASC X12 syntax rules.

Example:

NM1*PR*2*UNION MUTUAL OF OREGON*****PI*1122333~

NM1 Payer Name

Pos: 015	Max: 1
Detail - Optional	
Loop: 2010BB	Elements: 5

User Option (Usage): Required

Purpose: To supply the full name of an individual or organizational entity

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
NM101	98	Entity Identifier Code	M	ID	2/3	Required

Description: Code identifying an organizational entity, a physical location, property or an individual

Code	Name
PR	Payer

NM102	1065	Entity Type Qualifier	M	ID	1/1	Required
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Description: Code qualifying the type of entity

Code	Name
2	Non-Person Entity

NM103	1035	Name Last or Organization Name	O	AN	1/35	Required
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Description: Individual last name or organizational name

Industry: Payer Name

Use "ADP" only.

NM108	66	Identification Code Qualifier	C	ID	1/2	Required
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Description: Code designating the system/method of code structure used for Identification Code (67)

Code	Name
PI	Payor Identification

NM109	67	Identification Code	C	AN	2/80	Required
-------	----	---------------------	---	----	------	----------

Description: Code identifying a party or other code

Industry: Payer Identifier

Alias: Payer Primary Identifier

Enter the Program Code here

20 - ADP, Non-Perinatal Services

25 - ADP, Perinatal Services

ExternalCodeList

Name: 540

Description: Health Care Financing Administration National PlanID

Syntax Rules:

1. P0809 - If either NM108 or NM109 is present, then the other is required.

Semantics:

1. NM102 qualifies NM103.

Notes:

This segment identifies the payer and must include the Payer Identification Number.

Example:



NM1*PR*2*ADP*****PI*951234567~

N3 Payer Address

Pos: 025	Max: 1
Detail - Optional	
Loop: 2010BB	Elements: 2

User Option (Usage): Situational

Purpose: To specify the location of the named party

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
N301	166	Address Information	M	AN	1/55	Required
Description: Address information Industry: Payer Address Line Alias: Payer Address 1						
N302	166	Address Information	O	AN	1/55	Situational
Description: Address information Industry: Payer Address Line Alias: Payer Address 2 <i>Required if a second address line exists.</i>						

Notes:

1. Payer Address is required when the submitter intends for the claim to be printed on paper at the next EDI location (e.g., a clearinghouse).

Example:

N3*225 MAIN STREET*BARKLEY BUILDING~

N4 Payer City/State/ZIP Code

Pos: 030	Max: 1
Detail - Optional	
Loop: 2010BB	Elements: 4

User Option (Usage): Situational

Purpose: To specify the geographic place of the named party

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
N401	19	City Name	O	AN	2/30	Required
Description: Free-form text for city name Industry: <i>Payer City Name</i>						
N402	156	State or Province Code	O	ID	2/2	Required
Description: Code (Standard State/Province) as defined by appropriate government agency Industry: <i>Payer State Code</i>						
ExternalCodeList						
Name: 22						
Description: States and Outlying Areas of the U.S.						
N403	116	Postal Code	O	ID	3/15	Required
Description: Code defining international postal zone code excluding punctuation and blanks (zip code for United States) Industry: <i>Payer Postal Zone or ZIP Code</i> Alias: <i>Payer Zip Code</i>						
ExternalCodeList						
Name: 51						
Description: ZIP Code						
N404	26	Country Code	O	ID	2/3	Situational
Description: Code identifying the country Alias: <i>Payer Country Code</i> <i>Required if the address is out of the U.S.</i>						
ExternalCodeList						
Name: 5						
Description: Countries, Currencies and Funds						

Syntax Rules:

1. C0605 - If N406 is present, then N405 is required.

Comments:

1. A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location.
2. N402 is required only if city name (N401) is in the U.S. or Canada.

Notes:

1. *Payer Address is required when the submitter intends for the claim to be printed on paper at the next EDI location (e.g., a clearinghouse).*

Example:

N4*CENTERVILLE*PA*17111~

Loop Claim Information

Pos: 130	Repeat: 100
Optional	
Loop: 2300	Elements: N/A

User Option (Usage): Required

Purpose: To specify basic data about the claim

Loop Summary:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Usage</u>
130	CLM	Claim Information	O	1		Required
135	DTP	Date - Onset of Current Illness/Symptom	O	1		Situational
135	DTP	Date - Admission	O	1		Situational
135	DTP	Date - Discharge	O	1		Situational
155	PWK	Claim Supplemental Information	O	10		Situational
175	AMT	Patient Amount Paid	O	1		Situational
180	REF	Original Reference Number (ICN/DCN)	O	1		Situational
180	REF	Medical Record Number	O	1		Situational
231	HI	Health Care Diagnosis Code	O	1		Situational
250		Loop 2310B	O		1	Situational
250		Loop 2310D	O		1	Situational
290		Loop 2320	O		10	Situational
365		Loop 2400	O		50	Required

Semantics:

1. CLM02 is the total amount of all submitted charges of service segments for this claim.
2. CLM06 is provider signature on file indicator. A "Y" value indicates the provider signature is on file; an "N" value indicates the provider signature is not on file.
3. CLM08 is assignment of benefits indicator. A "Y" value indicates insured or authorized person authorizes benefits to be assigned to the provider; an "N" value indicates benefits have not been assigned to the provider.

Notes:

1. Because this is a required segment, this is a required loop. See Appendix A for further details on ASC X12 syntax rules.
3. For purposes of this documentation, the claim detail information is presented only in the subscriber level. For Drug Medi-Cal, the subscriber is always the same person as the patient. When the patient is the subscriber, loops 2000C and 2010CA are not sent. See 2.3.2.1, HL Segment, for details.

Example:

CLM*A37YH556*500***11::1*Y*A*Y*Y*C~

CLM Claim Information

Pos: 130	Max: 1
Detail - Optional	
Loop: 2300	Elements: 9

User Option (Usage): Required

Purpose: To specify basic data about the claim

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
CLM01	1028	Claim Submitter's Identifier	M	AN	1/38	Required
<p>Description: Identifier used to track a claim from creation by the health care provider through payment</p> <p>Industry: <i>Patient Account Number</i> <i>From 837P Guide "Patient account number" or claim number is echoed back on the 835 - recommend unique numbers for each individual claim. Used to match the claim with the payment information on the 835. CLM01 on 837 ties to CLP01 on the 835.</i></p>						
CLM02	782	Monetary Amount	O	R	1/18	Required
<p>Description: Monetary amount</p> <p>Industry: <i>Total Claim Charge Amount</i></p>						
CLM05	C023	Health Care Service Location Information	O	Comp		Required
<p>Description: To provide information that identifies the place of service or the type of bill related to the location at which a health care service was rendered</p> <p>Alias: <i>Place of Service Code</i> <i>CLM05 applies to all service lines unless it is over written at the line level.</i></p>						
CLM05-01	1331	Facility Code Value	M	AN	1/2	Required
<p>Description: Code identifying the type of facility where services were performed; the first and second positions of the Uniform Bill Type code or the Place of Service code from the Electronic Media Claims National Standard Format</p> <p>Industry: <i>Facility Type Code</i> <i>Used in SD/MC if service line POS not used. Check the Service Code Crosswalk for specific codes that may be necessary depending on the services rendered. Otherwise, any valid code may be used.</i></p> <p>ExternalCodeList Name: 237 Description: Place of Service from Health Care Financing Administration Claim Form</p>						
CLM05-03	1325	Claim Frequency Type Code	O	ID	1/1	Required
<p>Description: Code specifying the frequency of the claim; this is the third position of the Uniform Billing Claim Form Bill Type</p> <p>Industry: <i>Claim Frequency Code</i> <i>Valid Values:</i> <i>1 - Original</i> <i>7 - Replacement</i> <i>8 - Void</i></p> <p>ExternalCodeList Name: 235 Description: Claim Frequency Type Code</p>						
CLM06	1073	Yes/No Condition or Response Code	O	ID	1/1	Required
<p>Description: Code indicating a Yes or No condition or response</p> <p>Industry: <i>Provider or Supplier Signature Indicator</i></p>						

Always use "Y" unless ADP instructions indicate otherwise. Need signature on file at county for authority to bill to SD/MC.

<u>Code</u>	<u>Name</u>
N	No
Y	Yes

CLM07	1359	Provider Accept Assignment Code	O	ID	1/1	Required
-------	------	----------------------------------------	---	----	-----	----------

Description: Code indicating whether the provider accepts assignment
Industry: Medicare Assignment Code
 In the absence of COB information (Loop2320), a value of "C" (Not Assigned) equals "H" (Non- Medicare certified provider) in SD/MC.
All valid standard codes are used.

CLM08	1073	Yes/No Condition or Response Code	O	ID	1/1	Required
-------	------	------------------------------------------	---	----	-----	----------

Description: Code indicating a Yes or No condition or response
Industry: Benefits Assignment Certification Indicator
Alias: Assignment of Benefits Indicator
 Always use "Y" unless ADP instructions indicate otherwise.

<u>Code</u>	<u>Name</u>
N	No
Y	Yes

CLM09	1363	Release of Information Code	O	ID	1/1	Required
-------	------	------------------------------------	---	----	-----	----------

Description: Code indicating whether the provider has on file a signed statement by the patient authorizing the release of medical data to other organizations
Alias: Release of Information Code

<u>Code</u>	<u>Name</u>
I	Informed Consent to Release Medical Information for Conditions or Diagnoses Regulated by Federal Statutes
Y	Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim

CLM10	1351	Patient Signature Source Code	O	ID	1/1	Situational
-------	------	--------------------------------------	---	----	-----	-------------

Description: Code indicating how the patient or subscriber authorization signatures were obtained and how they are being retained by the provider
Alias: Patient Signature Source Code
 As recommended by federal Office of Civil Rights.
All valid standard codes are used.

CLM20	1514	Delay Reason Code	O	ID	1/2	Situational
-------	------	--------------------------	---	----	-----	-------------

Description: Code indicating the reason why a request was delayed
Alias: Delay Reason Code
 Only required if explanation for the late claim submission is needed.

<u>Code</u>	<u>Name</u>
1	Proof of Eligibility Unknown or Unavailable
2	Litigation
4	Delay in Certifying Provider
7	Third Party Processing Delay
8	Delay in Eligibility Determination
10	Administration Delay in the Prior Approval Process
11	Other

Semantics:

1. CLM02 is the total amount of all submitted charges of service segments for this claim.
2. CLM06 is provider signature on file indicator. A "Y" value indicates the provider signature is on file; an "N" value



indicates the provider signature is not on file.

3. CLM08 is assignment of benefits indicator. A "Y" value indicates insured or authorized person authorizes benefits to be assigned to the provider; an "N" value indicates benefits have not been assigned to the provider.

Notes:

This loop should be subordinate to Loop 2000B for Drug Medi-Cal.

Example:

CLM*1887*2361.58***55::1*Y*A*Y*Y*B*****1~

DTP Date - Onset of Current Illness/Symptom

Pos: 135	Max: 1
Detail - Optional	
Loop: 2300	Elements: 3

User Option (Usage): Situational

Purpose: To specify any or all of a date, a time, or a time period

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
DTP01	374	Date/Time Qualifier	M	ID	3/3	Required

Description: Code specifying type of date or time, or both date and time

Industry: *Date Time Qualifier*

Code	Name
431	Onset of Current Symptoms or Illness

DTP02	1250	Date Time Period Format Qualifier	M	ID	2/3	Required
-------	------	-----------------------------------	---	----	-----	----------

Description: Code indicating the date format, time format, or date and time format

Code	Name
D8	Date Expressed in Format CCYYMMDD

DTP03	1251	Date Time Period	M	AN	1/35	Required
-------	------	------------------	---	----	------	----------

Description: Expression of a date, a time, or range of dates, times or dates and times

Industry: *Onset of Current Illness or Injury Date*

Semantics:

1. DTP02 is the date or time or period format that will appear in DTP03.

Notes:

1. Dates in Loop ID-2300 apply to all service lines within Loop ID-2400 unless a DTP segment occurs in Loop ID-2400 with the same value in DTP01. In that case, the DTP in Loop ID-2400 overrides the DTP in Loop ID-2300 for that service line only.
2. Required when information is available and if different than the date of service. If not used, claim/service date is assumed to be the date of onset of illness/symptoms.

Example:

DTP*431*D8*19970115~

DTP Date - Admission

Pos: 135	Max: 1
Detail - Optional	
Loop: 2300	Elements: 3

User Option (Usage): Situational

Purpose: To specify any or all of a date, a time, or a time period

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
DTP01	374	Date/Time Qualifier	M	ID	3/3	Required

Description: Code specifying type of date or time, or both date and time

Industry: *Date Time Qualifier*

Code	Name
435	Admission

DTP02	1250	Date Time Period Format Qualifier	M	ID	2/3	Required
-------	------	-----------------------------------	---	----	-----	----------

Description: Code indicating the date format, time format, or date and time format

Code	Name
D8	Date Expressed in Format CCYYMMDD

DTP03	1251	Date Time Period	M	AN	1/35	Required
-------	------	------------------	---	----	------	----------

Description: Expression of a date, a time, or range of dates, times or dates and times

Industry: *Related Hospitalization Admission Date*

Semantics:

1. DTP02 is the date or time or period format that will appear in DTP03.

Notes:

ADP - Required for hospitals only

Example:

*DTP*435*D8*20030915~*

DTP Date - Discharge

Pos: 135	Max: 1
Detail - Optional	
Loop: 2300	Elements: 3

User Option (Usage): Situational

Purpose: To specify any or all of a date, a time, or a time period

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
DTP01	374	Date/Time Qualifier	M	ID	3/3	Required

Description: Code specifying type of date or time, or both date and time

Industry: *Date Time Qualifier*

Code	Name
096	Discharge

DTP02	1250	Date Time Period Format Qualifier	M	ID	2/3	Required
-------	------	-----------------------------------	---	----	-----	----------

Description: Code indicating the date format, time format, or date and time format

Code	Name
D8	Date Expressed in Format CCYYMMDD

DTP03	1251	Date Time Period	M	AN	1/35	Required
-------	------	------------------	---	----	------	----------

Description: Expression of a date, a time, or range of dates, times or dates and times

Industry: *Related Hospitalization Discharge Date*

Semantics:

1. DTP02 is the date or time or period format that will appear in DTP03.

Notes:

ADP - Required for hospitals only. Populate only on the last claim for the encounter

Example:

*DTP*096*D8*20030915~*

PWK Claim Supplemental Information

Pos: 155	Max: 10
Detail - Optional	
Loop: 2300	Elements: 4

User Option (Usage): Situational

Purpose: To identify the type or transmission or both of paperwork or supporting information

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage												
PWK01	755	Report Type Code	M	ID	2/2	Required												
<p>Description: Code indicating the title or contents of a document, report or supporting item Industry: Attachment Report Type Code</p> <table border="1"> <thead> <tr> <th>Code</th> <th>Name</th> </tr> </thead> <tbody> <tr> <td>OZ</td> <td>Support Data for Claim</td> </tr> </tbody> </table>							Code	Name	OZ	Support Data for Claim								
Code	Name																	
OZ	Support Data for Claim																	
PWK02	756	Report Transmission Code	O	ID	1/2	Required												
<p>Description: Code defining timing, transmission method or format by which reports are to be sent Industry: Attachment Transmission Code</p> <table border="1"> <thead> <tr> <th>Code</th> <th>Name</th> </tr> </thead> <tbody> <tr> <td>AA</td> <td>Available on Request at Provider Site <i>This means that the paperwork is not being sent with the claim at this time. Instead, it is available to the payer (or appropriate entity) at their request.</i></td> </tr> <tr> <td>BM</td> <td>By Mail</td> </tr> <tr> <td>EL</td> <td>Electronically Only <i>Use to indicate that attachment is being transmitted in a separate X12 functional group.</i></td> </tr> <tr> <td>EM</td> <td>E-Mail</td> </tr> <tr> <td>FX</td> <td>By Fax</td> </tr> </tbody> </table>							Code	Name	AA	Available on Request at Provider Site <i>This means that the paperwork is not being sent with the claim at this time. Instead, it is available to the payer (or appropriate entity) at their request.</i>	BM	By Mail	EL	Electronically Only <i>Use to indicate that attachment is being transmitted in a separate X12 functional group.</i>	EM	E-Mail	FX	By Fax
Code	Name																	
AA	Available on Request at Provider Site <i>This means that the paperwork is not being sent with the claim at this time. Instead, it is available to the payer (or appropriate entity) at their request.</i>																	
BM	By Mail																	
EL	Electronically Only <i>Use to indicate that attachment is being transmitted in a separate X12 functional group.</i>																	
EM	E-Mail																	
FX	By Fax																	
PWK05	66	Identification Code Qualifier	C	ID	1/2	Situational												
<p>Description: Code designating the system/method of code structure used for Identification Code (67) Required if PWK02 = "BM", "EL", "EM" or "FX".</p> <table border="1"> <thead> <tr> <th>Code</th> <th>Name</th> </tr> </thead> <tbody> <tr> <td>AC</td> <td>Attachment Control Number</td> </tr> </tbody> </table>							Code	Name	AC	Attachment Control Number								
Code	Name																	
AC	Attachment Control Number																	
PWK06	67	Identification Code	C	AN	2/80	Situational												
<p>Description: Code identifying a party or other code Industry: Attachment Control Number Required if PWK02 = "BM", "EL", "EM" or "FX".</p>																		

Syntax Rules:

1. P0506 - If either PWK05 or PWK06 is present, then the other is required.

Comments:

1. PWK05 and PWK06 may be used to identify the addressee by a code number.
2. PWK07 may be used to indicate special information to be shown on the specified report.
3. PWK08 may be used to indicate action pertaining to a report.

Notes:



1. The PWK segment is required if there is paper documentation supporting this claim. The PWK segment should not be used if the information related to the claim is being sent within the 837 ST-SE envelope.
2. The PWK segment is required to identify attachments that are sent electronically (PWK02 = EL) but are transmitted in another functional group (e.g., 275) rather than by paper. PWK06 is used to identify the attached electronic documentation. The number in PWK06 would be carried in the TRN of the electronic attachment.
3. The PWK segment can be used to identify paperwork that is being held at the provider's office and is available upon request by the payer (or appropriate entity), but that is not being sent with the claim. Use code AA in PWK02 to convey this specific use of the PWK segment. See code note under PWK02, code AA.

Example:

PWK*OB*BM***AC*DMN0012~

AMT Patient Amount Paid

Pos: 175	Max: 1
Detail - Optional	
Loop: 2300	Elements: 2

User Option (Usage): Situational

Purpose: To indicate the total monetary amount

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
AMT01	522	Amount Qualifier Code	M	ID	1/3	Required

Description: Code to qualify amount
Medi-Cal share of cost (SOC)

<u>Code</u>	<u>Name</u>
F5	Patient Amount Paid

AMT02	782	Monetary Amount	M	R	1/18	Required
-------	-----	-----------------	---	---	------	----------

Description: Monetary amount
Industry: Patient Amount Paid
Medi-Cal share of cost (SOC). This will be placed on the 835 if provided.

Notes:

1. Required when patient has made payment specifically toward this claim.
2. Patient Amount Paid refers to the sum of all amounts paid on the claim by the patient or his/her representative(s).

Example:

AMT*F5*152.45~

REF Original Reference Number (ICN/DCN)

Pos: 180	Max: 1
Detail - Optional	
Loop: 2300	Elements: 2

User Option (Usage): Situational

Purpose: To specify identifying information

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
REF01	128	Reference Identification Qualifier	M	ID	2/3	Required

Description: Code qualifying the Reference Identification

Code	Name
F8	Original Reference Number

REF02	127	Reference Identification	C	AN	1/30	Required
-------	-----	--------------------------	---	----	------	----------

Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

Industry: Claim Original Reference Number

Syntax Rules:

1. R0203 - At least one of REF02 or REF03 is required.

Semantics:

1. REF04 contains data relating to the value cited in REF02.

Notes:

1. Required when CLM05-3 (Claim Submission Reason Code) = "6", "7", or "8" and the payer has assigned a payer number to the claim. The resubmission number is assigned to a previously submitted claim/encounter by the destination payer or receiver.
2. This segment can be used for the payer assigned Original Document Control Number/Internal Control Number (DCN/ICN) assigned to this claim by the payer identified in the 2010BB loop of this claim. This number would be received from a payer in a case where the payer had received the original claim and, for whatever reason, had (1) asked the provider to resubmit the claim and (2) had given the provider the payer's claim identification number. In this case the payer is expecting the provider to give them back their (the payer's) claim number so that the payer can match it in their adjudication system. By matching this number in the adjudication system, the payer knows this is not a duplicate claim. This information is specific to the destination payer reported in the 2010BB loop. If other payers have a similar number, report that information in the 2330 loop which holds that payer's information.
3. Payer Claim Control Number provided here is used for processing Voids and Replacements in SD/MC.

Example:

REF*F8*R555588~

REF Medical Record Number

Pos: 180	Max: 1
Detail - Optional	
Loop: 2300	Elements: 2

User Option (Usage): Situational

Purpose: To specify identifying information

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
REF01	128	Reference Identification Qualifier	M	ID	2/3	Required

Description: Code qualifying the Reference Identification

Code

Name

Code	Name
EA	Medical Record Identification Number

REF02	127	Reference Identification	C	AN	1/30	Required
-------	-----	--------------------------	---	----	------	----------

Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

Industry: Medical Record Number

Put County Patient Medical Record here.

Chart #

Match to CSI

Used for audits

Syntax Rules:

1. R0203 - At least one of REF02 or REF03 is required.

Notes:

This segment identifies the patient's Medical Record Number.

Example:

*REF*EA*7251A001~*

HI**Health Care Diagnosis Code**

Pos: 231	Max: 1
Detail - Optional	
Loop: 2300	Elements: 8

User Option (Usage): Situational**Purpose:** To supply information related to the delivery of health care**Element Summary:**

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>				
HI01	C022	Health Care Code Information	M	Comp		Required				
Description: To send health care codes and their associated dates, amounts and quantities Alias: <i>Principal Diagnosis</i> <i>The diagnosis listed in this element is assumed to be the principal diagnosis.</i>										
HI01-01	1270	Code List Qualifier Code	M	ID	1/3	Required				
Description: Code identifying a specific industry code list Industry: <i>Diagnosis Type Code</i>										
<table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>BK</td> <td>Principal Diagnosis ICD-9 Codes</td> </tr> </tbody> </table> CODE SOURCE: <i>131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure</i>							<u>Code</u>	<u>Name</u>	BK	Principal Diagnosis ICD-9 Codes
<u>Code</u>	<u>Name</u>									
BK	Principal Diagnosis ICD-9 Codes									
HI01-02	1271	Industry Code	M	AN	1/30	Required				
Description: Code indicating a code from a specific industry code list Industry: <i>Diagnosis Code</i> <i>According to ICD-9 codes.</i> <i>Refer to Appendix for a list of ICD-9 codes used by ADP.</i>										
ExternalCodeList Name: 131D Description: International Classification of Diseases Clinical Mod (ICD-9-CM) Diagnosis										
HI02	C022	Health Care Code Information	O	Comp		Situational				
Description: To send health care codes and their associated dates, amounts and quantities Alias: <i>Diagnosis</i> <i>Required if needed to report an additional diagnoses and if the preceding HI data elements have been used to report other diagnoses.</i>										
HI02-01	1270	Code List Qualifier Code	M	ID	1/3	Required				
Description: Code identifying a specific industry code list Industry: <i>Diagnosis Type Code</i>										
<table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>BF</td> <td>Diagnosis ICD-9 Codes</td> </tr> </tbody> </table> CODE SOURCE: <i>131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure</i>							<u>Code</u>	<u>Name</u>	BF	Diagnosis ICD-9 Codes
<u>Code</u>	<u>Name</u>									
BF	Diagnosis ICD-9 Codes									
HI02-02	1271	Industry Code	M	AN	1/30	Required				
Description: Code indicating a code from a specific industry code list Industry: <i>Diagnosis Code</i> <i>According to ICD-9 codes.</i>										

ExternalCodeList

Name: 131D

Description: International Classification of Diseases Clinical Mod (ICD-9-CM) Diagnosis

HI03 C022 **Health Care Code Information** O Comp Situational

Description: To send health care codes and their associated dates, amounts and quantities

Alias: *Diagnosis*

Required if needed to report an additional diagnoses and if the preceding HI data elements have been used to report other diagnoses.

HI03-01 1270 **Code List Qualifier Code** M ID 1/3 Required

Description: Code identifying a specific industry code list

Industry: *Diagnosis Type Code*

Code

Name

BF Diagnosis

ICD-9 Codes

CODE SOURCE:

131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure

HI03-02 1271 **Industry Code** M AN 1/30 Required

Description: Code indicating a code from a specific industry code list

Industry: *Diagnosis Code*

According to ICD-9 codes.

ExternalCodeList

Name: 131D

Description: International Classification of Diseases Clinical Mod (ICD-9-CM) Diagnosis

HI04 C022 **Health Care Code Information** O Comp Situational

Description: To send health care codes and their associated dates, amounts and quantities

Alias: *Diagnosis*

Required if needed to report an additional diagnoses and if the preceding HI data elements have been used to report other diagnoses.

HI04-01 1270 **Code List Qualifier Code** M ID 1/3 Required

Description: Code identifying a specific industry code list

Industry: *Diagnosis Type Code*

Code

Name

BF Diagnosis

ICD-9 Codes

CODE SOURCE:

131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure

HI04-02 1271 **Industry Code** M AN 1/30 Required

Description: Code indicating a code from a specific industry code list

Industry: *Diagnosis Code*

According to ICD-9 codes.

ExternalCodeList

Name: 131D

Description: International Classification of Diseases Clinical Mod (ICD-9-CM) Diagnosis

HI05 C022 **Health Care Code Information** O Comp Situational

Description: To send health care codes and their associated dates, amounts and quantities



		Alias: <i>Diagnosis</i> <i>Required if needed to report an additional diagnoses and if the preceding HI data elements have been used to report other diagnoses.</i>				
HI05-01	1270	Code List Qualifier Code	M	ID	1/3	Required
		Description: Code identifying a specific industry code list Industry: <i>Diagnosis Type Code</i>				
		Code	Name			
		BF	Diagnosis <i>ICD-9 Codes</i>			
		CODE SOURCE: <i>131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure</i>				
HI05-02	1271	Industry Code	M	AN	1/30	Required
		Description: Code indicating a code from a specific industry code list Industry: <i>Diagnosis Code</i> <i>According to ICD-9 codes.</i>				
		ExternalCodeList Name: 131D Description: International Classification of Diseases Clinical Mod (ICD-9-CM) Diagnosis				
HI06	C022	Health Care Code Information	O	Comp		Situational
		Description: To send health care codes and their associated dates, amounts and quantities Alias: <i>Diagnosis</i> <i>Required if needed to report an additional diagnoses and if the preceding HI data elements have been used to report other diagnoses.</i>				
HI06-01	1270	Code List Qualifier Code	M	ID	1/3	Required
		Description: Code identifying a specific industry code list Industry: <i>Diagnosis Type Code</i>				
		Code	Name			
		BF	Diagnosis <i>ICD-9 Codes</i>			
		CODE SOURCE: <i>131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure</i>				
HI06-02	1271	Industry Code	M	AN	1/30	Required
		Description: Code indicating a code from a specific industry code list Industry: <i>Diagnosis Code</i> <i>According to ICD-9 codes.</i>				
		ExternalCodeList Name: 131D Description: International Classification of Diseases Clinical Mod (ICD-9-CM) Diagnosis				
HI07	C022	Health Care Code Information	O	Comp		Situational
		Description: To send health care codes and their associated dates, amounts and quantities Alias: <i>Diagnosis</i> <i>Required if needed to report an additional diagnoses and if the preceding HI data elements have been used to report other diagnoses.</i>				
HI07-01	1270	Code List Qualifier Code	M	ID	1/3	Required
		Description: Code identifying a specific industry code list Industry: <i>Diagnosis Type Code</i>				

<u>Code</u>	<u>Name</u>
BF	Diagnosis <i>ICD-9 Codes</i> CODE SOURCE: <i>131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure</i>
HI07-02	1271 Industry Code M AN 1/30 Required Description: Code indicating a code from a specific industry code list Industry: <i>Diagnosis Code According to ICD-9 codes.</i> ExternalCodeList Name: 131D Description: International Classification of Diseases Clinical Mod (ICD-9-CM) Diagnosis
HI08	C022 Health Care Code Information O Comp Situational Description: To send health care codes and their associated dates, amounts and quantities Alias: <i>Diagnosis</i> <i>Required if needed to report an additional diagnoses and if the preceding HI data elements have been used to report other diagnoses.</i>
HI08-01	1270 Code List Qualifier Code M ID 1/3 Required Description: Code identifying a specific industry code list Industry: <i>Diagnosis Type Code</i>
	Code Name BF Diagnosis <i>ICD-9 Codes</i> CODE SOURCE: <i>131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure</i>
HI08-02	1271 Industry Code M AN 1/30 Required Description: Code indicating a code from a specific industry code list Industry: <i>Diagnosis Code According to ICD-9 codes.</i> ExternalCodeList Name: 131D Description: International Classification of Diseases Clinical Mod (ICD-9-CM) Diagnosis

Notes:

This is required on all claims. Do not send decimal points. The actual diagnosis pulled for a specific service will depend on the diagnosis pointer in SV107.

Example:

*HI*BK:30030~*

Loop Rendering Provider Name

Pos: 250	Repeat: 1
	Optional
Loop: 2310B	Elements: N/A

User Option (Usage): Situational

Purpose: To supply the full name of an individual or organizational entity

Loop Summary:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Usage</u>
250	NM1	Rendering Provider Name	O	1		Situational

Semantics:

1. NM102 qualifies NM103.

Notes:

1. Information in Loop ID-2310 applies to the entire claim unless overridden on a service line by the presence of Loop ID-2420 with the same value in NM101.
2. Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment.
3. Required when the Rendering Provider NM1 information is different than that carried in the Billing Provider NM1 in the 2010AA loops respectively.
4. Used for all types of rendering providers. The Rendering Provider is the person or company (laboratory or other facility) who rendered the care. In the case where a substitute provider (locum tenans) was used, that person should be entered here.

Example:

NM1*82*1*BEATTY*GARY*C**SR*XX*12345678~

NM1 Rendering Provider Name

Pos: 250	Max: 1
Detail - Optional	
Loop: 2310B	Elements: 8

User Option (Usage): Situational

Purpose: To supply the full name of an individual or organizational entity

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
NM101	98	Entity Identifier Code	M	ID	2/3	Required
<p>Description: Code identifying an organizational entity, a physical location, property or an individual <i>The entity identifier in NM101 applies to all segments in this Loop ID-2310.</i></p>						
		<u>Code</u>	<u>Name</u>			
		82	Rendering Provider			
NM102	1065	Entity Type Qualifier	M	ID	1/1	Required
<p>Description: Code qualifying the type of entity <i>1= individual for procedure codes H0004 and H0005; 1 = individual or 2 = group for optional segment reporting</i></p>						
		<u>Code</u>	<u>Name</u>			
		1	Person			
		2	Non-Person Entity			
NM103	1035	Name Last or Organization Name	O	AN	1/35	Required
<p>Description: Individual last name or organizational name Alias: <i>Rendering Provider Last Name Counselor's Last Name</i></p>						
NM104	1036	Name First	O	AN	1/25	Situational
<p>Description: Individual first name Alias: <i>Counselor's First Name Required if NM102=1 (person).</i></p>						
NM105	1037	Name Middle	O	AN	1/25	Situational
<p>Description: Individual middle name or initial Industry: <i>Rendering Provider Middle Name Required if NM102=1 and the middle name/initial of the person is known.</i></p>						
NM107	1039	Name Suffix	O	AN	1/10	Situational
<p>Description: Suffix to individual name Industry: <i>Rendering Provider Name Suffix Required if known.</i></p>						
NM108	66	Identification Code Qualifier	C	ID	1/2	Required
<p>Description: Code designating the system/method of code structure used for Identification Code (67)</p>						
		<u>Code</u>	<u>Name</u>			
		XX	Health Care Financing Administration National Provider Identifier			
NM109	67	Identification Code	C	AN	2/80	Required
<p>Description: Code identifying a party or other code Industry: <i>Rendering Provider Identifier</i></p>						

Must be a valid Type 1 or 2 NPI identifying the rendering provider.

ExternalCodeList**Name:** 537**Description:** Health Care Financing Administration National Provider Identifier**Syntax Rules:**

1. P0809 - If either NM108 or NM109 is present, then the other is required.

Semantics:

1. NM102 qualifies NM103.

Notes:

This segment is required for counseling services billed with Procedure Codes H0004 and H0005. The counselor name and NPI should be reported here. This segment is optional for services billed for other procedure codes.. If there are multiple counselors or individuals providing service, populate loop 2420A as appropriate.

Example:

NM1*82*1*FEELGOOD*PHIL****XX*1234567893~

Loop Service Facility Location

Pos: 250	Repeat: 1
	Optional
Loop: 2310D	Elements: N/A

User Option (Usage): Situational

Purpose: To supply the full name of an individual or organizational entity

Loop Summary:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Usage</u>
250	NM1	Service Facility Location	O	1		Situational
265	N3	Service Facility Location Address	O	1		Required
270	N4	Service Facility Location City/State/ZIP	O	1		Required

Semantics:

1. NM102 qualifies NM103.

Notes:

1. Information in Loop ID-2310 applies to the entire claim unless overridden on a service line by the presence of Loop ID-2420 with the same value in NM101.
2. Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment.
3. This loop is required when the location of health care service is different than that carried in the 2010AA (Billing Provider) loop.
4. The purpose of this loop is to identify specifically where the service was rendered. In cases where it was rendered at the patient's home, do not use this loop. In that case, the place of service code in CLM05- 1 should indicate that the service occurred in the patient's home.

Example:

NM1*TL*2*A-OK MOBILE CLINIC*****24*1122333~

NM1 Service Facility Location

Pos: 250	Max: 1
Detail - Optional	
Loop: 2310D	Elements: 5

User Option (Usage): Situational

Purpose: To supply the full name of an individual or organizational entity

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
NM101	98	Entity Identifier Code	M	ID	2/3	Required

Description: Code identifying an organizational entity, a physical location, property or an individual

Code	Name
77	Service Location
FA	Facility
LI	Independent Lab
TL	Testing Laboratory

Use when other codes in this element do not apply.

NM102	1065	Entity Type Qualifier	M	ID	1/1	Required
-------	------	-----------------------	---	----	-----	----------

Description: Code qualifying the type of entity

Code	Name
2	Non-Person Entity

NM103	1035	Name Last or Organization Name	O	AN	1/35	Situational
-------	------	--------------------------------	---	----	------	-------------

Description: Individual last name or organizational name

Industry: *Laboratory or Facility Name*

Required except when service was rendered in the patient's home.

NM108	66	Identification Code Qualifier	C	ID	1/2	Situational
-------	----	-------------------------------	---	----	-----	-------------

Description: Code designating the system/method of code structure used for Identification Code (67)

Required for Drug Medi-Cal to report NPI.

Code	Name
XX	Health Care Financing Administration National Provider Identifier

NM109	67	Identification Code	C	AN	2/80	Situational
-------	----	---------------------	---	----	------	-------------

Description: Code identifying a party or other code

Industry: *Laboratory or Facility Primary Identifier*

Must be a valid NPI identifying the service facility location.

ExternalCodeList

Name: 537

Description: Health Care Financing Administration National Provider Identifier

Syntax Rules:

1. P0809 - If either NM108 or NM109 is present, then the other is required.

Semantics:

1. NM102 qualifies NM103.

Notes:



The purpose of this loop is to identify specifically where the service was rendered, if rendered in a location different than that carried in the 2010AA (Billing Provider) loop. The provider identifier from this loop will be used in the Short-Doyle claim system, unless the loop is not used or there are multiple provider codes for the claim. Multiple provider codes should be reflected in loop 2420C as appropriate.

Example:

NM1*FA*2*A-OK CLINIC*****XX*1234567893~

N3**Service Facility Location
Address**

Pos: 265	Max: 1
Detail - Optional	
Loop: 2310D	Elements: 2

User Option (Usage): Required

Purpose: To specify the location of the named party

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
N301	166	Address Information	M	AN	1/55	Required
		Description: Address information				
		Industry: <i>Laboratory or Facility Address Line</i>				
N302	166	Address Information	O	AN	1/55	Situational
		Description: Address information				
		Industry: <i>Laboratory or Facility Address Line</i>				
		<i>Required if a second address line exists.</i>				

Notes:

1. If service facility location is in an area where there are no street addresses, enter a description of where the service was rendered (e.g., "crossroad of State Road 34 and 45" or "Exit near Mile marker 265 on Interstate 80".)

Example:

N3*123 MAIN STREET~

N4

Service Facility Location City/State/ZIP

Pos: 270	Max: 1
Detail - Optional	
Loop: 2310D	Elements: 4

User Option (Usage): Required

Purpose: To specify the geographic place of the named party

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
N401	19	City Name	O	AN	2/30	Required
<p>Description: Free-form text for city name Industry: <i>Laboratory or Facility City Name</i></p>						
N402	156	State or Province Code	O	ID	2/2	Required
<p>Description: Code (Standard State/Province) as defined by appropriate government agency Industry: <i>Laboratory or Facility State or Province Code</i></p> <p>ExternalCodeList Name: 22 Description: States and Outlying Areas of the U.S.</p>						
N403	116	Postal Code	O	ID	3/15	Required
<p>Description: Code defining international postal zone code excluding punctuation and blanks (zip code for United States) Industry: <i>Laboratory or Facility Postal Zone or ZIP Code</i></p> <p>ExternalCodeList Name: 51 Description: ZIP Code</p>						
N404	26	Country Code	O	ID	2/3	Situational
<p>Description: Code identifying the country Alias: <i>Laboratory/Facility Country Code</i> <i>Required if the address is out of the U.S.</i></p> <p>ExternalCodeList Name: 5 Description: Countries, Currencies and Funds</p>						

Comments:

1. A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location.
2. N402 is required only if city name (N401) is in the U.S. or Canada.

Notes:

1. If service facility location is in an area where there are no street addresses, enter the name of the nearest town, state and zip of where the service was rendered.

Example:

N4*ANY TOWN*TX*75123~

Loop Other Subscriber Information

Pos: 290	Repeat: 10
Optional	
Loop: 2320	Elements: N/A

User Option (Usage): Situational

Purpose: To record information specific to the primary insured and the insurance carrier for that insured

Loop Summary:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Usage</u>
290	SBR	Other Subscriber Information	O	1		Situational
295	CAS	Claim Level Adjustments	O	5		Situational
300	AMT	Coordination of Benefits (COB) Payer Paid Amount	O	1		Situational
300	AMT	Coordination of Benefits (COB) Allowed Amount	O	1		Situational
305	DMG	Subscriber Demographic Information	O	1		Situational
310	OI	Other Insurance Coverage Information	O	1		Required
325		Loop 2330A	O		1	Required
325		Loop 2330B	O		1	Required

Semantics:

1. SBR02 specifies the relationship to the person insured.
2. SBR03 is policy or group number.
3. SBR04 is plan name.
4. SBR07 is destination payer code. A "Y" value indicates the payer is the destination payer; an "N" value indicates the payer is not the destination payer.

Notes:

1. Required if other payers are known to potentially be involved in paying on this claim.
2. Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 syntax rules.
3. All information contained in the 2320 Loop applies only to the payer who is identified in the 2330B Loop of this iteration of the 2320 Loop. It is specific only to that payer. If information on additional payers is needed to be carried, run the 2320 Loop again with it's respective 2330 Loops.
See Section 1.4.4 for more information on handling COB.
4. See Section 1.4.5 Crosswalking COB Data Elements for more information on handling COB in the 837.

Example:

SBR*S*01*GR00786**MC****OF~

SBR Other Subscriber Information

Pos: 290	Max: 1
Detail - Optional	
Loop: 2320	Elements: 6

User Option (Usage): Situational

Purpose: To record information specific to the primary insured and the insurance carrier for that insured

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
SBR01	1138	Payer Responsibility Sequence Number Code	M	ID	1/1	Required

Description: Code identifying the insurance carrier's level of responsibility for a payment of a claim

Alias: *Payer responsibility sequence number code*

Code	Name
P	Primary
S	Secondary
T	Tertiary

SBR02	1069	Individual Relationship Code	O	ID	2/2	Required
-------	------	-------------------------------------	---	----	-----	----------

Description: Code indicating the relationship between two individuals or entities

Alias: *Individual relationship code*

Code	Name
18	Self

SBR03	127	Reference Identification	O	AN	1/30	Situational
-------	-----	---------------------------------	---	----	------	-------------

Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

Industry: *Insured Group or Policy Number*

Required if the subscriber's payer identification includes Group or Plan Number. This data element is intended to carry the subscriber's Group Number, not the number that uniquely identifies the subscriber (Subscriber ID, Loop 2010BA-NM109).

SBR04	93	Name	O	AN	1/60	Situational
-------	----	-------------	---	----	------	-------------

Description: Free-form name

Industry: *Other Insured Group Name*

Required if the subscriber's payer identification includes a Group or Plan Name.

SBR05	1336	Insurance Type Code	O	ID	1/3	Required
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Description: Code identifying the type of insurance policy within a specific insurance program

Alias: *Insurance type code*

Code	Name
AP	Auto Insurance Policy
C1	Commercial
CP	Medicare Conditionally Primary
GP	Group Policy
HM	Health Maintenance Organization (HMO)
IP	Individual Policy
LD	Long Term Policy
LT	Litigation
MB	Medicare Part B

MC	Medicaid
MI	Medigap Part B
MP	Medicare Primary
OT	Other
PP	Personal Payment (Cash - No Insurance)
SP	Supplemental Policy

SBR09 1032 **Claim Filing Indicator Code** O ID 1/2 Situational

Description: Code identifying type of claim

Alias: *Claim filing indicator code*

Required prior to mandated used of PlanID. Not used after PlanID is mandated.

Code	Name
10	Central Certification
11	Other Non-Federal Programs
12	Preferred Provider Organization (PPO)
13	Point of Service (POS)
14	Exclusive Provider Organization (EPO)
15	Indemnity Insurance
16	Health Maintenance Organization (HMO) Medicare Risk
AM	Automobile Medical
BL	Blue Cross/Blue Shield
CH	Champus
CI	Commercial Insurance Co.
DS	Disability
HM	Health Maintenance Organization
LI	Liability
LM	Liability Medical
MB	Medicare Part B
OF	Other Federal Program
TV	Title V
VA	Veteran Administration Plan
	<i>Refers to Veterans Affairs Plan.</i>
WC	Workers' Compensation Health Claim
ZZ	Mutually Defined
	<i>Unknown</i>

Semantics:

1. SBR02 specifies the relationship to the person insured.

Notes:

Only use for COB situations, including indication of Medicare or Other Health Coverage denial.

Example:

*SBR*P*18***MB****MB~*

CAS Claim Level Adjustments

Pos: 295	Max: 5
Detail - Optional	
Loop: 2320	Elements: 19

User Option (Usage): Situational

Purpose: To supply adjustment reason codes and amounts as needed for an entire claim or for a particular service within the claim being paid

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
CAS01	1033	Claim Adjustment Group Code	M	ID	1/2	Required

Description: Code identifying the general category of payment adjustment

Alias: Claim Adjustment Group Code

Code	Name
CO	Contractual Obligations
CR	Correction and Reversals
OA	Other adjustments
PI	Payor Initiated Reductions
PR	Patient Responsibility

CAS02	1034	Claim Adjustment Reason Code	M	ID	1/5	Required
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Description: Code identifying the detailed reason the adjustment was made

Industry: Adjustment Reason Code

ExternalCodeList

Name: 139

Description: Claim Adjustment Reason Code

CAS03	782	Monetary Amount	M	R	1/18	Required
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Description: Monetary amount

Industry: Adjustment Amount

CAS04	380	Quantity	O	R	1/15	Situational
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Description: Numeric value of quantity

Industry: Adjustment Quantity

Use as needed to show payer adjustment.

CAS05	1034	Claim Adjustment Reason Code	C	ID	1/5	Situational
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Description: Code identifying the detailed reason the adjustment was made

Industry: Adjustment Reason Code

Use as needed to show payer adjustment.

ExternalCodeList

Name: 139

Description: Claim Adjustment Reason Code

CAS06	782	Monetary Amount	C	R	1/18	Situational
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Description: Monetary amount

Industry: Adjustment Amount

Use as needed to show payer adjustment.

CAS07	380	Quantity	C	R	1/15	Situational
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Description: Numeric value of quantity

Industry: Adjustment Quantity

Use as needed to show payer adjustment.

CAS08	1034	Claim Adjustment Reason Code	C	ID	1/5	Situational
Description: Code identifying the detailed reason the adjustment was made Industry: <i>Adjustment Reason Code</i> <i>Use as needed to show payer adjustment.</i>						
ExternalCodeList						
Name: 139						
Description: Claim Adjustment Reason Code						
CAS09	782	Monetary Amount	C	R	1/18	Situational
Description: Monetary amount Industry: <i>Adjustment Amount</i> <i>Use as needed to show payer adjustment.</i>						
CAS10	380	Quantity	C	R	1/15	Situational
Description: Numeric value of quantity Industry: <i>Adjustment Quantity</i> <i>Use as needed to show payer adjustment.</i>						
CAS11	1034	Claim Adjustment Reason Code	C	ID	1/5	Situational
Description: Code identifying the detailed reason the adjustment was made Industry: <i>Adjustment Reason Code</i> <i>Use as needed to show payer adjustment.</i>						
ExternalCodeList						
Name: 139						
Description: Claim Adjustment Reason Code						
CAS12	782	Monetary Amount	C	R	1/18	Situational
Description: Monetary amount Industry: <i>Adjustment Amount</i> <i>Use as needed to show payer adjustment.</i>						
CAS13	380	Quantity	C	R	1/15	Situational
Description: Numeric value of quantity Industry: <i>Adjustment Quantity</i> <i>Use as needed to show payer adjustment.</i>						
CAS14	1034	Claim Adjustment Reason Code	C	ID	1/5	Situational
Description: Code identifying the detailed reason the adjustment was made Industry: <i>Adjustment Reason Code</i> <i>Use as needed to show payer adjustment.</i>						
ExternalCodeList						
Name: 139						
Description: Claim Adjustment Reason Code						
CAS15	782	Monetary Amount	C	R	1/18	Situational
Description: Monetary amount Industry: <i>Adjustment Amount</i> <i>Use as needed to show payer adjustment.</i>						
CAS16	380	Quantity	C	R	1/15	Situational
Description: Numeric value of quantity Industry: <i>Adjustment Quantity</i> <i>Use as needed to show payer adjustment.</i>						
CAS17	1034	Claim Adjustment Reason Code	C	ID	1/5	Situational

Description: Code identifying the detailed reason the adjustment was made

Industry: *Adjustment Reason Code*

Use as needed to show payer adjustment.

ExternalCodeList

Name: 139

Description: Claim Adjustment Reason Code

CAS18	782	Monetary Amount	C	R	1/18	Situational
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Description: Monetary amount

Industry: *Adjustment Amount*

Use as needed to show payer adjustment.

CAS19	380	Quantity	C	R	1/15	Situational
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Description: Numeric value of quantity

Industry: *Adjustment Quantity*

Use as needed to show payer adjustment.

Syntax Rules:

1. L050607 - If CAS05 is present, then at least one of CAS06 or CAS07 is required.
2. C0605 - If CAS06 is present, then CAS05 is required.
3. C0705 - If CAS07 is present, then CAS05 is required.
4. L080910 - If CAS08 is present, then at least one of CAS09 or CAS10 is required.
5. C0908 - If CAS09 is present, then CAS08 is required.
6. C1008 - If CAS10 is present, then CAS08 is required.
7. L111213 - If CAS11 is present, then at least one of CAS12 or CAS13 is required.
8. C1211 - If CAS12 is present, then CAS11 is required.
9. C1311 - If CAS13 is present, then CAS11 is required.
10. L141516 - If CAS14 is present, then at least one of CAS15 or CAS16 is required.
11. C1514 - If CAS15 is present, then CAS14 is required.
12. C1614 - If CAS16 is present, then CAS14 is required.
13. L171819 - If CAS17 is present, then at least one of CAS18 or CAS19 is required.
14. C1817 - If CAS18 is present, then CAS17 is required.
15. C1917 - If CAS19 is present, then CAS17 is required.

Semantics:

1. CAS03 is the amount of adjustment.
2. CAS04 is the units of service being adjusted.
3. CAS06 is the amount of the adjustment.
4. CAS07 is the units of service being adjusted.
5. CAS09 is the amount of the adjustment.
6. CAS10 is the units of service being adjusted.
7. CAS12 is the amount of the adjustment.
8. CAS13 is the units of service being adjusted.
9. CAS15 is the amount of the adjustment.
10. CAS16 is the units of service being adjusted.
11. CAS18 is the amount of the adjustment.
12. CAS19 is the units of service being adjusted.

Comments:

1. Adjustment information is intended to help the provider balance the remittance information. Adjustment amounts should fully explain the difference between submitted charges and the amount paid.
2. When the submitted charges are paid in full, the value for CAS03 should be zero.

Notes:



1. Submitters should use this CAS segment to report prior payers' claim level adjustments that cause the amount paid to differ from the amount originally charged.
2. Only one Group Code is allowed per CAS. If it is necessary to send more than one Group Code at the claim level, repeat the CAS segment again.
3. Codes and associated amounts should come from 835s (Remittance Advice) received on the claim. If no previous payments have been made, omit this segment.
4. Required if claim has been adjudicated by payer identified in this loop and has claim level adjustment information.
5. To locate the claim adjustment group codes (CAS01) and claim adjustment reason codes (CAS02, 05, 08, 11, 14, and 17) see the Washington Publishing Company web site: <http://www.wpc-edi.com>. Follow the buttons to Code Lists - Claim Adjustment Reason Codes.

Example:

CAS*PR*1*7.93~
CAS*OA*93*15.06~

AMT Coordination of Benefits (COB) Payer Paid Amount

Pos: 300	Max: 1
Detail - Optional	
Loop: 2320	Elements: 2

User Option (Usage): Situational

Purpose: To indicate the total monetary amount

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
AMT01	522	Amount Qualifier Code	M	ID	1/3	Required

Description: Code to qualify amount

Code	Name
D	Payor Amount Paid

AMT02	782	Monetary Amount	M	R	1/18	Required
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Description: Monetary amount

Industry: Payer Paid Amount

Submitters - Crosswalk from CLP04 in 835 when doing COB. This will only be used if line level COB payment information is not available. This segment is required to pass HIPAA validation if doing COB. For non-covered services use zero (0) to satisfy the requirements.

Notes:

Required if claim has been adjudicated by the payer identified in this loop. It is acceptable to show "0" amount paid.

Example:

AMT*D*152.45~

AMT Coordination of Benefits (COB) Allowed Amount

Pos: 300	Max: 1
Detail - Optional	
Loop: 2320	Elements: 2

User Option (Usage): Situational

Purpose: To indicate the total monetary amount

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
AMT01	522	Amount Qualifier Code	M	ID	1/3	Required

Description: Code to qualify amount

Code	Name
B6	Allowed - Actual

AMT02	782	Monetary Amount	M	R	1/18	Required
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Description: Monetary amount

Industry: Allowed Amount

If the value is equivalent to zero, and Medicare is indicated in the COB data, this equals "N" Crossover Indicator value in SD/MC.

Notes:

- Used primarily in payer-to-payer COB situations by the payer who is sending this claim to another payer. Providers (in a provider-to-payer COB situation) do not usually complete this information but may do so if the information is available.
- The allowed amount equals the amount for the total claim that was allowed by the payer sending this 837 to another payer.
Only used to identify situations where a Medicare recipient is receiving services from a Medicare provider that are denied or not covered by Medicare.

Example:

AMT*B6*519.21~

DMG Subscriber Demographic Information

Pos: 305	Max: 1
Detail - Optional	
Loop: 2320	Elements: 3

User Option (Usage): Situational

Purpose: To supply demographic information

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
DMG01	1250	Date Time Period Format Qualifier	C	ID	2/3	Required

Description: Code indicating the date format, time format, or date and time format

Code	Name
D8	Date Expressed in Format CCYYMMDD

DMG02	1251	Date Time Period	C	AN	1/35	Required
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Description: Expression of a date, a time, or range of dates, times or dates and times

Industry: *Other Insured Birth Date*

DMG03	1068	Gender Code	O	ID	1/1	Required
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Description: Code indicating the sex of the individual

Industry: *Other Insured Gender Code*

Code	Name
F	Female
M	Male
U	Unknown

Syntax Rules:

1. P0102 - If either DMG01 or DMG02 is present, then the other is required.

Semantics:

1. DMG02 is the date of birth.
2. DMG07 is the country of citizenship.
3. DMG09 is the age in years.

Notes:

1. Required when 2330A NM102 = 1 (person).
This segment identifies the Subscriber Demographic Information.

Example:

DMG*D8*19671105*F~

OI Other Insurance Coverage Information

Pos: 310	Max: 1
Detail - Optional	
Loop: 2320	Elements: 3

User Option (Usage): Required

Purpose: To specify information associated with other health insurance coverage

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
OI03	1073	Yes/No Condition or Response Code	O	ID	1/1	Required

Description: Code indicating a Yes or No condition or response

Industry: *Benefits Assignment Certification Indicator*

This is a crosswalk from CLM08 when doing COB.

Code	Name
N	No
Y	Yes

OI04	1351	Patient Signature Source Code	O	ID	1/1	Situational
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Description: Code indicating how the patient or subscriber authorization signatures were obtained and how they are being retained by the provider

Alias: *Patient Signature Source Code*

Required except in cases where "N" is used in OI06.

This is a crosswalk from CLM10 when doing COB.

All valid standard codes are used.

OI06	1363	Release of Information Code	O	ID	1/1	Required
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Description: Code indicating whether the provider has on file a signed statement by the patient authorizing the release of medical data to other organizations

Alias: *Release of Information Code*

This is a crosswalk from CLM09 when doing COB.

All valid standard codes are used.

Semantics:

- OI03 is the assignment of benefits indicator. A "Y" value indicates insured or authorized person authorizes benefits to be assigned to the provider; an "N" value indicates benefits have not been assigned to the provider.

Notes:

- All information contained in the OI segment applies only to the payer who is identified in the 2330B loop of this iteration of the 2320 loop. It is specific only to that payer.

Example:

OI***Y*B**Y~

Loop Other Subscriber Name

Pos: 325	Repeat: 1
	Optional
Loop: 2330A	Elements: N/A

User Option (Usage): Required

Purpose: To supply the full name of an individual or organizational entity

Loop Summary:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Usage</u>
325	NM1	Other Subscriber Name	O	1		Required

Semantics:

1. NM102 qualifies NM103.

Notes:

1. Submitters are required to send information on all known other subscribers in Loop ID-2330.
2. This 2330 loop is required when Loop ID-2320 - Other Subscriber Information is used. Otherwise, this loop is not used.

Example:

NM1*IL*1*DOE*JOHN*T**JR*MI*123456~

NM1 Other Subscriber Name

Pos: 325	Max: 1
Detail - Optional	
Loop: 2330A	Elements: 8

User Option (Usage): Required

Purpose: To supply the full name of an individual or organizational entity

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
NM101	98	Entity Identifier Code	M	ID	2/3	Required
		Description: Code identifying an organizational entity, a physical location, property or an individual				
		<u>Code</u>		<u>Name</u>		
		IL		Insured or Subscriber		
NM102	1065	Entity Type Qualifier	M	ID	1/1	Required
		Description: Code qualifying the type of entity				
		<u>Code</u>		<u>Name</u>		
		1		Person		
NM103	1035	Name Last or Organization Name	O	AN	1/35	Required
		Description: Individual last name or organizational name				
		Industry: <i>Other Insured Last Name</i>				
NM104	1036	Name First	O	AN	1/25	Situational
		Description: Individual first name				
		Industry: <i>Other Insured First Name</i>				
		<i>Required if NM102=1 (person).</i>				
NM105	1037	Name Middle	O	AN	1/25	Situational
		Description: Individual middle name or initial				
		Industry: <i>Other Insured Middle Name</i>				
		<i>Required if NM102=1 and the middle name/initial of the person is known.</i>				
NM107	1039	Name Suffix	O	AN	1/10	Situational
		Description: Suffix to individual name				
		Industry: <i>Other Insured Name Suffix</i>				
		<i>Required if known.</i>				
		<i>Examples: I, II, III, IV, Jr, Sr</i>				
NM108	66	Identification Code Qualifier	C	ID	1/2	Required
		Description: Code designating the system/method of code structure used for Identification Code (67)				
		<u>Code</u>		<u>Name</u>		
		MI		Member Identification Number		
		<i>The code MI is intended to be the subscriber's identification number as assigned by the payer. Payers use different terminology to convey the same number. Therefore the 837 Professional Workgroup recommends using MI - Member Identification Number to convey the following terms: Insured's ID, Subscriber's ID, Health Insurance Claim Number (HIC), etc.</i>				
NM109	67	Identification Code	C	AN	2/80	Required
		Description: Code identifying a party or other code				

Industry: *Other Insured Identifier*

Syntax Rules:

1. P0809 - If either NM108 or NM109 is present, then the other is required.

Semantics:

1. NM102 qualifies NM103.

Notes:

This segment identifies Other Subscriber Information in the Claim.

Example:

NM1*IL*1*DOE*JOHN*T**JR*MI*123456~

Loop Other Payer Name

Pos: 325	Repeat: 1
	Optional
Loop: 2330B	Elements: N/A

User Option (Usage): Required

Purpose: To supply the full name of an individual or organizational entity

Loop Summary:

Pos	Id	Segment Name	Req	Max Use	Repeat	Usage
325	NM1	Other Payer Name	O	1		Required
350	DTP	Claim Adjudication Date	O	1		Situational

Semantics:

1. NM102 qualifies NM103.

Comments:

1. NM110 and NM111 further define the type of entity in NM101.

Notes:

1. Submitters are required to send all known information on other payers in this Loop ID-2330.
2. This 2330 loop is required when Loop ID-2320 - Other Subscriber Information is used. Otherwise, this loop is not used.

Example:

NM1*PR*2*UNION MUTUAL OF OREGON*****PI*1122333~

NM1 Other Payer Name

Pos: 325	Max: 1
Detail - Optional	
Loop: 2330B	Elements: 5

User Option (Usage): Required

Purpose: To supply the full name of an individual or organizational entity

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
NM101	98	Entity Identifier Code	M	ID	2/3	Required

Description: Code identifying an organizational entity, a physical location, property or an individual

Code	Name
PR	Payer

NM102	1065	Entity Type Qualifier	M	ID	1/1	Required
-------	------	-----------------------	---	----	-----	----------

Description: Code qualifying the type of entity

Code	Name
2	Non-Person Entity

NM103	1035	Name Last or Organization Name	O	AN	1/35	Required
-------	------	--------------------------------	---	----	------	----------

Description: Individual last name or organizational name

Industry: Other Payer Last or Organization Name

Valid Values: MEDI-CAL

NM108	66	Identification Code Qualifier	C	ID	1/2	Required
-------	----	-------------------------------	---	----	-----	----------

Description: Code designating the system/method of code structure used for Identification Code (67)

Code	Name
PI	Payor Identification

NM109	67	Identification Code	C	AN	2/80	Required
-------	----	---------------------	---	----	------	----------

Description: Code identifying a party or other code

Industry: Other Payer Primary Identifier

This number must be identical to SVD01 (Loop ID-2430) for COB.

ExternalCodeList

Name: 540

Description: Health Care Financing Administration National PlanID

Syntax Rules:

1. P0809 - If either NM108 or NM109 is present, then the other is required.
2. C1110 - If NM111 is present, then NM110 is required.

Semantics:

1. NM102 qualifies NM103.

Comments:

1. NM110 and NM111 further define the type of entity in NM101.

Notes:

This segment identifies Other Payer Information in the Claim.

Example:

*NM1*PR*2*MEDI-CAL*****PI*951234567~*

DTP Claim Adjudication Date

Pos: 350	Max: 1
Detail - Optional	
Loop: 2330B	Elements: 3

User Option (Usage): Situational

Purpose: To specify any or all of a date, a time, or a time period

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
DTP01	374	Date/Time Qualifier	M	ID	3/3	Required

Description: Code specifying type of date or time, or both date and time

Industry: *Date Time Qualifier*

Code	Name
573	Date Claim Paid

DTP02	1250	Date Time Period Format Qualifier	M	ID	2/3	Required
-------	------	-----------------------------------	---	----	-----	----------

Description: Code indicating the date format, time format, or date and time format

Code	Name
D8	Date Expressed in Format CCYYMMDD

DTP03	1251	Date Time Period	M	AN	1/35	Required
-------	------	------------------	---	----	------	----------

Description: Expression of a date, a time, or range of dates, times or dates and times

Industry: *Adjudication or Payment Date*

Semantics:

1. DTP02 is the date or time or period format that will appear in DTP03.

Notes:

1. This segment is required when the payer identified in this iteration of the 2330 loop has previously adjudicated the claim and Loop-ID 2430 (Line Adjudication Information) is not used. This segment is used to specify a time period.

Example:

*DTP*573*D8*19980314~*

Loop Service Line

Pos: 365	Repeat: 50
Optional	
Loop: 2400	Elements: N/A

User Option (Usage): Required

Purpose: To reference a line number in a transaction set

Loop Summary:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Usage</u>
365	LX	Service Line	O	1		Required
370	SV1	Professional Service	O	1		Required
455	DTP	Date - Service Date	O	1		Required
470	REF	Line Item Control Number	O	1		Situational
485	NTE	Line Note	O	1		Situational
500		Loop 2420A	O		1	Situational
500		Loop 2420C	O		1	Situational
540		Loop 2430	O		25	Situational

Notes:

1. The Service Line LX segment begins with 1 and is incremented by one for each additional service line of a claim. The LX functions as a line counter.
2. The datum in the LX is not usually returned in the 835 (Remittance Advice) transaction. LX01 may be used as a line item control number by the payer in the 835 if a line item control number has not been submitted on the service line. See that REF for more information. LX01 is used to indicate bundling/unbundling in SVC06. See Section 1.4.3 for more information on bundling and unbundling.
3. Because this is a required segment, this is a required loop. See Appendix A for further details on ASC X12 syntax rules.

Example:

LX*1~

LX**Service Line**

Pos: 365	Max: 1
Detail - Optional	
Loop: 2400	Elements: 1

User Option (Usage): Required**Purpose:** To reference a line number in a transaction set**Element Summary:**

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
LX01	554	Assigned Number	M	NO	1/6	Required

Description: Number assigned for differentiation within a transaction set**Alias:** *Line Counter**Start with 1 and increment by 1 for each service line on the claim.***Notes:***This segment identifies Service Lines in a Claim.***Example:***LX*1~*

SV1 Professional Service

Pos: 370	Max: 1
Detail - Optional	
Loop: 2400	Elements: 8

User Option (Usage): Required

Purpose: To specify the claim service detail for a Health Care professional

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>				
SV101	C003	Composite Medical Procedure Identifier	M	Comp		Required				
<p>Description: To identify a medical procedure by its standardized codes and applicable modifiers</p> <p>Alias: <i>Procedure identifier</i></p>										
SV101-01	235	Product/Service ID Qualifier	M	ID	2/2	Required				
<p>Description: Code identifying the type/source of the descriptive number used in Product/Service ID (234)</p> <p>Industry: <i>Product or Service ID Qualifier</i></p> <table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>HC</td> <td>Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes</td> </tr> </tbody> </table> <p>CODE SOURCE: <i>130: Health Care Financing Administration Common Procedural Coding System</i></p>							<u>Code</u>	<u>Name</u>	HC	Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes
<u>Code</u>	<u>Name</u>									
HC	Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes									
SV101-02	234	Product/Service ID	M	AN	1/48	Required				
<p>Description: Identifying number for a product or service</p> <p>Industry: <i>Procedure Code</i></p> <p>ExternalCodeList Name: 130 Description: Health Care Financing Administration Common Procedural Coding System</p>										
SV101-03	1339	Procedure Modifier	O	AN	2/2	Situational				
<p>Description: This identifies special circumstances related to the performance of the service, as defined by trading partners</p> <p>Alias: <i>Procedure Modifier 1</i> <i>Duplicate Payment Override may be indicated here if needed.</i></p> <p>ExternalCodeList Name: 130 Description: Health Care Financing Administration Common Procedural Coding System</p>										
SV101-04	1339	Procedure Modifier	O	AN	2/2	Situational				
<p>Description: This identifies special circumstances related to the performance of the service, as defined by trading partners</p> <p>Alias: <i>Procedure Modifier 2</i> <i>Duplicate Payment Override may be indicated here if needed.</i></p> <p>ExternalCodeList Name: 130 Description: Health Care Financing Administration Common Procedural Coding System</p>										
SV101-05	1339	Procedure Modifier	O	AN	2/2	Situational				
<p>Description: This identifies special circumstances related to the performance of the service, as defined by trading partners</p>										

Alias: Procedure Modifier 3

Duplicate Payment Override may be indicated here if needed.

ExternalCodeList

Name: 130

Description: Health Care Financing Administration Common Procedural Coding System

SV101-06	1339	Procedure Modifier	O	AN	2/2	Situational
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Description: This identifies special circumstances related to the performance of the service, as defined by trading partners

Alias: Procedure Modifier 4

Duplicate Payment Override may be indicated here if needed.

ExternalCodeList

Name: 130

Description: Health Care Financing Administration Common Procedural Coding System

SV102	782	Monetary Amount	O	R	1/18	Required
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Description: Monetary amount

Industry: Line Item Charge Amount

Alias: Submitted charge amount

SV103	355	Unit or Basis for Measurement Code	C	ID	2/2	Required
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Description: Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken

<u>Code</u>	<u>Name</u>
UN	Unit

SV104	380	Quantity	C	R	1/15	Required
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Description: Numeric value of quantity

Industry: Service Unit Count

Alias: Units or Minutes

If the value is reduced during adjudication, this value will be passed to SVC07 on the 835.

SV105	1331	Facility Code Value	O	AN	1/2	Situational
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Description: Code identifying the type of facility where services were performed; the first and second positions of the Uniform Bill Type code.

Industry: Place of Service Code

Only required if the Place of Service differs from the value provided in CLM05-1. Use specific Service codes that may be necessary depending on the services rendered. Otherwise, use the most appropriate code available.

SV107	C004	Composite Diagnosis Code Pointer	O	Comp		Situational
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Description: To identify one or more diagnosis code pointers

Alias: Diagnosis Code Pointer

Required if HI segment in Loop ID-2300 is used.

SV107-01	1328	Diagnosis Code Pointer	M	N0	1/2	Required
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Description: A pointer to the claim diagnosis code in the order of importance to this service
This value determines which diagnosis code provided in Loop 2300 will be used for processing. If only one diagnosis is submitted, this value should be "1".

SV107-02	1328	Diagnosis Code Pointer	O	N0	1/2	Situational
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Description: A pointer to the claim diagnosis code in the order of importance to this service
Use this pointer for the second diagnosis code pointer.

Required if the service relates to that specific diagnosis and is needed to substantiate the medical treatment. Acceptable values are 1 through 8, inclusive.

SV107-03	1328	Diagnosis Code Pointer	O	N0	1/2	Situational
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		Description: A pointer to the claim diagnosis code in the order of importance to this service <i>Use this pointer for the third diagnosis code pointer. Required if the service relates to that specific diagnosis and is needed to substantiate the medical treatment. Acceptable values are 1 through 8, inclusive.</i>				
SV107-04	1328	Diagnosis Code Pointer	O	N0	1/2	Situational
		Description: A pointer to the claim diagnosis code in the order of importance to this service <i>Use this pointer for the fourth diagnosis code pointer. Required if the service relates to that specific diagnosis and is needed to substantiate the medical treatment. Acceptable values are 1 through 8, inclusive.</i>				
SV109	1073	Yes/No Condition or Response Code	O	ID	1/1	Situational
		Description: Code indicating a Yes or No condition or response Industry: <i>Emergency Indicator</i> <i>Required when the service is known to be an emergency by the provider. Emergency definition: The patient requires immediate medical intervention as a result of severe, life threatening, or potentially disabling conditions.</i>				
		Code	Name			
		Y	Yes			
SV111	1073	Yes/No Condition or Response Code	O	ID	1/1	Situational
		Description: Code indicating a Yes or No condition or response Industry: <i>EPSDT Indicator</i> <i>Required if Medicaid services are the result of a screening referral.</i>				
		Code	Name			
		Y	Yes			

Syntax Rules:

1. P0304 - If either SV103 or SV104 is present, then the other is required.

Semantics:

1. SV102 is the submitted charge amount.
2. SV105 is the place of service.
3. SV108 is the independent lab charges.
4. SV109 is the emergency-related indicator; a "Y" value indicates service provided was emergency related; an "N" value indicates service provided was not emergency related.
5. SV111 is early and periodic screen for diagnosis and treatment of children (EPSDT) involvement; a "Y" value indicates EPSDT involvement; an "N" value indicates no EPSDT involvement.

Notes:

This segment specifies claim service detail.

Example:

SV1*HC:H0019*2361.58*UN*31*55**1~

DTP Date - Service Date

Pos: 455	Max: 1
Detail - Optional	
Loop: 2400	Elements: 3

User Option (Usage): Required

Purpose: To specify any or all of a date, a time, or a time period

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
DTP01	374	Date/Time Qualifier	M	ID	3/3	Required

Description: Code specifying type of date or time, or both date and time

Industry: *Date Time Qualifier*

Code	Name
472	Service

Use RD8 in DTP02 to indicate begin/end or from/to dates.

DTP02	1250	Date Time Period Format Qualifier	M	ID	2/3	Required
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Description: Code indicating the date format, time format, or date and time format

Code	Name
D8	Date Expressed in Format CCYYMMDD

RD8	Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD
-----	------------------------------------------------------

Use RD8 if it is necessary to indicate begin/end dates. Date range indicates drug duration for which the supply of drug be will used by the patient. The difference in dates, including both the begin and end dates, are the days supply of the drug.

Example: 20000101 - 20000107 (1/1/00 to 1/7/00) is used for a 7 day supply where the first day of the drug used by the patient is 1/1/00. In the event a drug is administered on less than a daily basis (e.g., every other day) the date range would include the entire period during which the drug was supplied, including the last day the drug was used. Example: 20000101 - 20000108 (1/1/00 to 1/8/00) is used for an 8 days supply where the prescription is written for Q48 (every 48 hours), four doses of the drug are dispensed and the first dose is used on 1/1/00.

DTP03	1251	Date Time Period	M	AN	1/35	Required
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Description: Expression of a date, a time, or range of dates, times or dates and times

Industry: *Service Date*

The Service Month and Year for all the service lines must be the same. The transaction set is rejected if there are claims/services from more than one service period.

Valid values: With D8: 20030314; with RD8: 20030314-20030322

Semantics:

1. DTP02 is the date or time or period format that will appear in DTP03.

Notes:

1. The total number of DTP segments in the 2400 loop cannot exceed 15.
2. In cases where a drug is being billed on a service line, the Date of Service DTP may be used to indicate the range of dates through which the drug will be used by the patient. Use RD8 for this purpose.
3. In cases where a drug is being billed on a service line, the Date of Service DTP is used to indicate the date the prescription was written (or otherwise communicated by the prescriber if not written).

This segment is used to specify a time period.

Example:

*DTP*472*RD8*19970607-19970608~*



REF Line Item Control Number

Pos: 470	Max: 1
Detail - Optional	
Loop: 2400	Elements: 2

User Option (Usage): Situational

Purpose: To specify identifying information

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
REF01	128	Reference Identification Qualifier	M	ID	2/3	Required

Description: Code qualifying the Reference Identification

Code	Name
6R	Provider Control Number

REF02	127	Reference Identification	C	AN	1/30	Required
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Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

Industry: *Line Item Control Number*

Unique claim ID across all service lines. All 30 characters will be passed through to 835.

Syntax Rules:

1. R0203 - At least one of REF02 or REF03 is required.

Semantics:

1. REF04 contains data relating to the value cited in REF02.

Notes:

1. Required if it is necessary to send a line control or inventory number. Providers are **STRONGLY** encouraged to routinely send a unique line item control number on all service lines, particularly if the provider automatically posts their remittance advice. Submitting a unique line item control number gives providers the capability to automatically post by service line. The line item control number should be unique within a patient control number (CLM01). Payers are required to return this number in the remittance advice transaction (835) if the providers sends it to them in the 837.

This Segment is the Provider Control Number.

Example:

REF*6R*31063~

NTE Line Note

Pos: 485	Max: 1
Detail - Optional	
Loop: 2400	Elements: 2

User Option (Usage): Situational

Purpose: To transmit information in a free-form format, if necessary, for comment or special instruction

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
NTE01	363	Note Reference Code	O	ID	3/3	Required

Description: Code identifying the functional area or purpose for which the note applies

<u>Code</u>	<u>Name</u>
ADD	Additional Information
DCP	Goals, Rehabilitation Potential, or Discharge Plans
PMT	Payment
TPO	Third Party Organization Notes

NTE02	352	Description	M	AN	1/80	Required
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Description: A free-form description to clarify the related data elements and their content

Industry: Line Note Text

Used only with the Procedure Code H0047.

Valid Values: 1 = LAAM, 2 = Naltrexone

Comments:

- The NTE segment permits free-form information/data which, under ANSI X12 standard implementations, is not machine processable. The use of the NTE segment should therefore be avoided, if at all possible, in an automated environment.

Notes:

1. Required if submitter used a "not otherwise classified" (NOC) procedure code on this service line (use ADD in NTE01). Otherwise, use at providers discretion.

For use with ADP codes for LAAM and Naltrexone only.

Example:

NTE*DCP*PATIENT GOAL TO BE OFF OXYGEN BY END OF MONTH~

Loop Rendering Provider Name

Pos: 500	Repeat: 1
	Optional
Loop: 2420A	Elements: N/A

User Option (Usage): Situational

Purpose: To supply the full name of an individual or organizational entity

Loop Summary:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Usage</u>
500	NM1	Rendering Provider Name	O	1		Situational

Semantics:

1. NM102 qualifies NM103.

Notes:

1. Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment.
2. Required if the Rendering Provider NM1 information is different than that carried in the 2310B (claim) loop, or if the Rendering provider information is carried at the Billing/Pay-to Provider loop level (2010AA) and this particular service line has a different Rendering Provider that what is given in the 2010AA loop. The identifying payer-specific numbers are those that belong to the destination payer identified in loop 2010BB.
3. Used for all types of rendering providers. The Rendering Provider is the person or company (laboratory or other facility) who rendered the care. In the case where a substitute provider (locum tenans) was used, that person should be entered here.

Example:

NM1*82*1*SMITH*JUNE*L***XX*87654321~

NM1 Rendering Provider Name

Pos: 500	Max: 1
Detail - Optional	
Loop: 2420A	Elements: 8

User Option (Usage): Situational

Purpose: To supply the full name of an individual or organizational entity

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
NM101	98	Entity Identifier Code	M	ID	2/3	Required
<p>Description: Code identifying an organizational entity, a physical location, property or an individual <i>The entity identifier in NM101 applies to all segments in this iteration of Loop ID-2420.</i></p>						
		<u>Code</u>	<u>Name</u>			
		82	Rendering Provider			
NM102	1065	Entity Type Qualifier	M	ID	1/1	Required
<p>Description: Code qualifying the type of entity</p>						
		<u>Code</u>	<u>Name</u>			
		1	Person			
NM103	1035	Name Last or Organization Name	O	AN	1/35	Required
<p>Description: Individual last name or organizational name Industry: <i>Rendering Provider Last or Organization Name</i></p>						
NM104	1036	Name First	O	AN	1/25	Situational
<p>Description: Individual first name Industry: <i>Rendering Provider First Name</i> <i>Required if NM102=1 (person).</i></p>						
NM105	1037	Name Middle	O	AN	1/25	Situational
<p>Description: Individual middle name or initial Industry: <i>Rendering Provider Middle Name</i> <i>Required if NM102=1 and the middle name/initial of the person is known.</i></p>						
NM107	1039	Name Suffix	O	AN	1/10	Situational
<p>Description: Suffix to individual name Alias: <i>Rendering Provider Generation</i> <i>Required if known.</i></p>						
NM108	66	Identification Code Qualifier	C	ID	1/2	Required
<p>Description: Code designating the system/method of code structure used for Identification Code (67)</p>						
		<u>Code</u>	<u>Name</u>			
		XX	Health Care Financing Administration National Provider Identifier			
NM109	67	Identification Code	C	AN	2/80	Required
<p>Description: Code identifying a party or other code Industry: <i>Rendering Provider Identifier</i> <i>Must be a valid Type 1 NPI identifying the rendering provider.</i></p>						
ExternalCodeList						
Name: 537						

Description: Health Care Financing Administration National Provider Identifier

Syntax Rules:

1. P0809 - If either NM108 or NM109 is present, then the other is required.

Semantics:

1. NM102 qualifies NM103.

Notes:

Use this loop if there are multiple counselors or other professionals rendering service.

Example:

NM1*82*1*SMITH*JUNE*L***XX*1234567893~

Loop Service Facility Location

Pos: 500	Repeat: 1
Optional	
Loop: 2420C	Elements: N/A

User Option (Usage): Situational

Purpose: To supply the full name of an individual or organizational entity

Loop Summary:

Pos	Id	Segment Name	Req	Max Use	Repeat	Usage
500	NM1	Service Facility Location	O	1		Situational
514	N3	Service Facility Location Address	O	1		Required
520	N4	Service Facility Location City/State/ZIP	O	1		Required

Semantics:

1. NM102 qualifies NM103.

Notes:

1. Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 syntax rules.
2. Required when the location of health care service for this service line is different than that carried in the 2010AA (Billing Provider) or 2310D Service Facility Location loops. All payer-specific identifying numbers belong to the destination payer identified in the 2010BB loop.

Example:

NM1*TL*2*A-OK MOBILE CLINIC*****24*1122333~

NM1 Service Facility Location

Pos: 500	Max: 1
Detail - Optional	
Loop: 2420C	Elements: 5

User Option (Usage): Situational

Purpose: To supply the full name of an individual or organizational entity

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
NM101	98	Entity Identifier Code	M	ID	2/3	Required

Description: Code identifying an organizational entity, a physical location, property or an individual

The entity identifier in NM101 applies to all segments in this iteration of Loop ID-2420.

Code	Name
77	Service Location
FA	Facility
LI	Independent Lab
TL	Testing Laboratory

Use when other codes in this element do not apply.

NM102	1065	Entity Type Qualifier	M	ID	1/1	Required
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Description: Code qualifying the type of entity

Code	Name
2	Non-Person Entity

NM103	1035	Name Last or Organization Name	O	AN	1/35	Situational
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Description: Individual last name or organizational name

Alias: *Service Facility Location Name*

Required except when service was rendered in the patient's home.

NM108	66	Identification Code Qualifier	C	ID	1/2	Situational
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Description: Code designating the system/method of code structure used for Identification Code (67)

Code	Name
XX	Health Care Financing Administration National Provider Identifier

NM109	67	Identification Code	C	AN	2/80	Situational
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Description: Code identifying a party or other code

Industry: *Laboratory or Facility Primary Identifier*

Must be a valid NPI identifying the Service Facility Location.

ExternalCodeList

Name: 537

Description: Health Care Financing Administration National Provider Identifier

Syntax Rules:

1. P0809 - If either NM108 or NM109 is present, then the other is required.

Semantics:

1. NM102 qualifies NM103.

Notes:



Required when the location of health care services for this service line is different than carried in the 210AA (Billing Provider) or 2310D (Service Facility Location) loops. If this loop is populated, the provider identifier from this loop will be used in the Short-Doyle claim system.

Example:

NM1* TL*2*A-OK MOBILE CLINIC*****XX*1234567893~

N3**Service Facility Location
Address**

Pos: 514	Max: 1
Detail - Optional	
Loop: 2420C	Elements: 2

User Option (Usage): Required

Purpose: To specify the location of the named party

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
N301	166	Address Information	M	AN	1/55	Required
Description: Address information						
Alias: <i>Service Facility Location Address 1</i>						
N302	166	Address Information	O	AN	1/55	Situational
Description: Address information						
Alias: <i>Service Facility Location Address 2</i>						
<i>Required if a second address line exists.</i>						

Notes:

1. If service facility location is in an area where there are no street addresses, enter a description of where the service was rendered (e.g., "crossroad of State Road 34 and 45" or "Exit near Mile marker 265 on Interstate 80".)

Example:

N3*66 HURLBUT STREET~

N4

Service Facility Location City/State/ZIP

Pos: 520	Max: 1
Detail - Optional	
Loop: 2420C	Elements: 4

User Option (Usage): Required

Purpose: To specify the geographic place of the named party

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
N401	19	City Name	O	AN	2/30	Required
<p>Description: Free-form text for city name Industry: <i>Laboratory or Facility City Name</i></p>						
N402	156	State or Province Code	O	ID	2/2	Required
<p>Description: Code (Standard State/Province) as defined by appropriate government agency Industry: <i>Laboratory or Facility State or Province Code</i></p> <p>ExternalCodeList Name: 22 Description: States and Outlying Areas of the U.S.</p>						
N403	116	Postal Code	O	ID	3/15	Required
<p>Description: Code defining international postal zone code excluding punctuation and blanks (zip code for United States) Industry: <i>Laboratory or Facility Postal Zone or ZIP Code</i></p> <p>ExternalCodeList Name: 51 Description: ZIP Code</p>						
N404	26	Country Code	O	ID	2/3	Situational
<p>Description: Code identifying the country Alias: <i>Service Facility Location Country Code</i> <i>Required if the address is out of the U.S.</i></p> <p>ExternalCodeList Name: 5 Description: Countries, Currencies and Funds</p>						

Syntax Rules:

1. C0605 - If N406 is present, then N405 is required.

Comments:

1. A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location.
2. N402 is required only if city name (N401) is in the U.S. or Canada.

Notes:

1. If service facility location is in an area where there are no street addresses, enter the name of the nearest town, state and zip of where the service was rendered.

Example:

N4*PASADENA*CA*91104~

Loop Line Adjudication Information

Pos: 540	Repeat: 25
Optional	
Loop: 2430	Elements: N/A

User Option (Usage): Situational

Purpose: To convey service line adjudication information for coordination of benefits between the initial payers of a health care claim and all subsequent payers

Loop Summary:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Usage</u>
540	SVD	Line Adjudication Information	O	1		Situational
545	CAS	Line Adjustment	O	99		Situational
550	DTP	Line Adjudication Date	O	1		Required

Semantics:

1. SVD01 is the payer identification code.
2. SVD02 is the amount paid for this service line.
3. SVD04 is the revenue code.
4. SVD05 is the paid units of service.

Comments:

1. SVD03 represents the medical procedure code upon which adjudication of this service line was based. This may be different than the submitted medical procedure code.
2. SVD06 is only used for bundling of service lines. It references the LX Assigned Number of the service line into which this service line was bundled.

Notes:

1. To show unbundled lines: If, in the original claim, line 3 is unbundled into (for examples) 2 additional lines, then the SVD for line 3 is used 3 times: once for the original adjustment to line 3 and then two more times for the additional unbundled lines. If a line item control number (REF01 = 6R) exists for the line, that number may be used in SVD06 instead of the LX number when a line is unbundled.
2. Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 syntax rules.
3. Required if claim has been previously adjudicated by payer identified in Loop 2330B and service line has adjustments applied to it.

Example:

SVD*43*55*HC:84550**3~

SVD Line Adjudication Information

Pos: 540	Max: 1
Detail - Optional	
Loop: 2430	Elements: 5

User Option (Usage): Situational

Purpose: To convey service line adjudication information for coordination of benefits between the initial payers of a health care claim and all subsequent payers

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
SVD01	67	Identification Code	M	AN	2/80	Required

Description: Code identifying a party or other code

Industry: *Other Payer Primary Identifier*

This number should match NM109 in Loop ID-2330B identifying Other Payer.

SVD02	782	Monetary Amount	M	R	1/18	Required
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Description: Monetary amount

Industry: *Service Line Paid Amount*

Zero "0" is an acceptable value for this element.

This is the primary value that will be used if available.

SVD03	C003	Composite Medical Procedure Identifier	O	Comp		Required
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Description: To identify a medical procedure by its standardized codes and applicable modifiers

Alias: *Procedure identifier*

This element contains the procedure code that was used to pay this service line. It crosswalks from SVC01 in the 835 transmission.

SVD03-01	235	Product/Service ID Qualifier	M	ID	2/2	Required
----------	-----	-------------------------------------	---	----	-----	----------

Description: Code identifying the type/source of the descriptive number used in Product/Service ID (234)

Industry: *Product or Service ID Qualifier*

Code

HC

Name

Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes

CODE SOURCE:

130: Health Care Financing Administration Common Procedural Coding System

SVD03-02	234	Product/Service ID	M	AN	1/48	Required
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Description: Identifying number for a product or service

Industry: *Procedure Code*

ExternalCodeList

Name: 130

Description: Health Care Financing Administration Common Procedural Coding System

SVD03-03	1339	Procedure Modifier	O	AN	2/2	Situational
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Description: This identifies special circumstances related to the performance of the service, as defined by trading partners

Alias: *Procedure Modifier 1*

Use this modifier for the first procedure code modifier.

Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.

ExternalCodeList**Name:** 130**Description:** Health Care Financing Administration Common Procedural Coding SystemSVD03-04 1339 **Procedure Modifier** O AN 2/2 Situational**Description:** This identifies special circumstances related to the performance of the service, as defined by trading partners**Alias:** *Procedure Modifier 2**Use this modifier for the second procedure code modifier.**Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.***ExternalCodeList****Name:** 130**Description:** Health Care Financing Administration Common Procedural Coding SystemSVD03-05 1339 **Procedure Modifier** O AN 2/2 Situational**Description:** This identifies special circumstances related to the performance of the service, as defined by trading partners**Alias:** *Procedure Modifier 3**Use this modifier for the third procedure code modifier.**Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.***ExternalCodeList****Name:** 130**Description:** Health Care Financing Administration Common Procedural Coding SystemSVD03-06 1339 **Procedure Modifier** O AN 2/2 Situational**Description:** This identifies special circumstances related to the performance of the service, as defined by trading partners**Alias:** *Procedure Modifier 4**Use this modifier for the fourth procedure code modifier.**Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.***ExternalCodeList****Name:** 130**Description:** Health Care Financing Administration Common Procedural Coding SystemSVD03-07 352 **Description** O AN 1/80 Situational**Description:** A free-form description to clarify the related data elements and their content**Industry:** *Procedure Code Description**Required if SVC01-7 was returned in the 835 transaction.*SVD05 380 **Quantity** O R 1/15 Required**Description:** Numeric value of quantity**Industry:** *Paid Service Unit Count**Crosswalk from SVC05 in 835 or, if not present in 835, use original billed units.*SVD06 554 **Assigned Number** O NO 1/6 Situational**Description:** Number assigned for differentiation within a transaction set**Industry:** *Bundled Line Number**Use the LX from this transaction which points to the bundled line.**Required if payer bundled this service line.***Semantics:**

1. SVD01 is the payer identification code.

2. SVD02 is the amount paid for this service line.
3. SVD04 is the revenue code.
4. SVD05 is the paid units of service.

Comments:

1. SVD03 represents the medical procedure code upon which adjudication of this service line was based. This may be different than the submitted medical procedure code.
2. SVD06 is only used for bundling of service lines. It references the LX Assigned Number of the service line into which this service line was bundled.

Notes:

This is the primary value that will be used for Medicare/Other Health Coverage amount if available.

Example:

*SVD*43*55*HC: 90829**3~*

CAS Line Adjustment

Pos: 545	Max: 99
Detail - Optional	
Loop: 2430	Elements: 19

User Option (Usage): Situational

Purpose: To supply adjustment reason codes and amounts as needed for an entire claim or for a particular service within the claim being paid

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
CAS01	1033	Claim Adjustment Group Code	M	ID	1/2	Required

Description: Code identifying the general category of payment adjustment

Alias: Adjustment Group Code

Code	Name
CO	Contractual Obligations
CR	Correction and Reversals
OA	Other adjustments
PI	Payor Initiated Reductions
PR	Patient Responsibility

CAS02	1034	Claim Adjustment Reason Code	M	ID	1/5	Required
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Description: Code identifying the detailed reason the adjustment was made

Industry: Adjustment Reason Code

Use the Claim Adjustment Reason Code list (See Appendix C).

ExternalCodeList

Name: 139

Description: Claim Adjustment Reason Code

CAS03	782	Monetary Amount	M	R	1/18	Required
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Description: Monetary amount

Industry: Adjustment Amount

Use this amount for the adjustment amount.

CAS04	380	Quantity	O	R	1/15	Situational
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Description: Numeric value of quantity

Industry: Adjustment Quantity

Use this quantity for the units of service being adjusted.

Use as needed to show payer adjustment.

CAS05	1034	Claim Adjustment Reason Code	C	ID	1/5	Situational
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Description: Code identifying the detailed reason the adjustment was made

Industry: Adjustment Reason Code

Use as needed to show payer adjustment.

Use the Claim Adjustment Reason Code list (See Appendix C).

ExternalCodeList

Name: 139

Description: Claim Adjustment Reason Code

CAS06	782	Monetary Amount	C	R	1/18	Situational
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Description: Monetary amount

Industry: Adjustment Amount

Use this amount for the adjustment amount.

Use as needed to show payer adjustment.

CAS07	380	Quantity	C	R	1/15	Situational
Description: Numeric value of quantity Industry: <i>Adjustment Quantity</i> <i>Use this quantity for the units of service being adjusted.</i> <i>Use as needed to show payer adjustment.</i>						
CAS08	1034	Claim Adjustment Reason Code	C	ID	1/5	Situational
Description: Code identifying the detailed reason the adjustment was made Industry: <i>Adjustment Reason Code</i> <i>Use as needed to show payer adjustment.</i> <i>Use the Claim Adjustment Reason Code list (See Appendix C).</i>						
ExternalCodeList						
Name: 139						
Description: Claim Adjustment Reason Code						
CAS09	782	Monetary Amount	C	R	1/18	Situational
Description: Monetary amount Industry: <i>Adjustment Amount</i> <i>Use this amount for the adjustment amount.</i> <i>Use as needed to show payer adjustment.</i>						
CAS10	380	Quantity	C	R	1/15	Situational
Description: Numeric value of quantity Industry: <i>Adjustment Quantity</i> <i>Use this quantity for the units of service being adjusted.</i> <i>Use as needed to show payer adjustment.</i>						
CAS11	1034	Claim Adjustment Reason Code	C	ID	1/5	Situational
Description: Code identifying the detailed reason the adjustment was made Industry: <i>Adjustment Reason Code</i> <i>Use as needed to show payer adjustment.</i> <i>Use the Claim Adjustment Reason Code list (See Appendix C).</i>						
ExternalCodeList						
Name: 139						
Description: Claim Adjustment Reason Code						
CAS12	782	Monetary Amount	C	R	1/18	Situational
Description: Monetary amount Industry: <i>Adjustment Amount</i> <i>Use this amount for the adjustment amount.</i> <i>Use as needed to show payer adjustment.</i>						
CAS13	380	Quantity	C	R	1/15	Situational
Description: Numeric value of quantity Industry: <i>Adjustment Quantity</i> <i>Use this quantity for the units of service being adjusted.</i> <i>Use as needed to show payer adjustment.</i>						
CAS14	1034	Claim Adjustment Reason Code	C	ID	1/5	Situational
Description: Code identifying the detailed reason the adjustment was made Industry: <i>Adjustment Reason Code</i> <i>Use as needed to show payer adjustment.</i> <i>Use the Claim Adjustment Reason Code list (See Appendix C).</i>						
ExternalCodeList						
Name: 139						
Description: Claim Adjustment Reason Code						

CAS15	782	Monetary Amount	C	R	1/18	Situational
Description: Monetary amount Industry: <i>Adjustment Amount</i> <i>Use this amount for the adjustment amount.</i> <i>Use as needed to show payer adjustment.</i>						
CAS16	380	Quantity	C	R	1/15	Situational
Description: Numeric value of quantity Industry: <i>Adjustment Quantity</i> <i>Use this quantity for the units of service being adjusted.</i> <i>Use as needed to show payer adjustment.</i>						
CAS17	1034	Claim Adjustment Reason Code	C	ID	1/5	Situational
Description: Code identifying the detailed reason the adjustment was made Industry: <i>Adjustment Reason Code</i> <i>Use as needed to show payer adjustment.</i> <i>Use the Claim Adjustment Reason Code list (See Appendix C).</i>						
ExternalCodeList						
Name: 139						
Description: Claim Adjustment Reason Code						
CAS18	782	Monetary Amount	C	R	1/18	Situational
Description: Monetary amount Industry: <i>Adjustment Amount</i> <i>Use this amount for the adjustment amount.</i> <i>Use as needed to show payer adjustment.</i>						
CAS19	380	Quantity	C	R	1/15	Situational
Description: Numeric value of quantity Industry: <i>Adjustment Quantity</i> <i>Use this quantity for the units of service being adjusted.</i> <i>Use as needed to show payer adjustment.</i>						

Syntax Rules:

1. L050607 - If CAS05 is present, then at least one of CAS06 or CAS07 is required.
2. C0605 - If CAS06 is present, then CAS05 is required.
3. C0705 - If CAS07 is present, then CAS05 is required.
4. L080910 - If CAS08 is present, then at least one of CAS09 or CAS10 is required.
5. C0908 - If CAS09 is present, then CAS08 is required.
6. C1008 - If CAS10 is present, then CAS08 is required.
7. L111213 - If CAS11 is present, then at least one of CAS12 or CAS13 is required.
8. C1211 - If CAS12 is present, then CAS11 is required.
9. C1311 - If CAS13 is present, then CAS11 is required.
10. L141516 - If CAS14 is present, then at least one of CAS15 or CAS16 is required.
11. C1514 - If CAS15 is present, then CAS14 is required.
12. C1614 - If CAS16 is present, then CAS14 is required.
13. L171819 - If CAS17 is present, then at least one of CAS18 or CAS19 is required.
14. C1817 - If CAS18 is present, then CAS17 is required.
15. C1917 - If CAS19 is present, then CAS17 is required.

Semantics:

1. CAS03 is the amount of adjustment.
2. CAS04 is the units of service being adjusted.
3. CAS06 is the amount of the adjustment.

4. CAS07 is the units of service being adjusted.
5. CAS09 is the amount of the adjustment.
6. CAS10 is the units of service being adjusted.
7. CAS12 is the amount of the adjustment.
8. CAS13 is the units of service being adjusted.
9. CAS15 is the amount of the adjustment.
10. CAS16 is the units of service being adjusted.
11. CAS18 is the amount of the adjustment.
12. CAS19 is the units of service being adjusted.

Comments:

1. Adjustment information is intended to help the provider balance the remittance information. Adjustment amounts should fully explain the difference between submitted charges and the amount paid.
2. When the submitted charges are paid in full, the value for CAS03 should be zero.

Notes:

1. Required if the payer identified in Loop 2330B made line level adjustments which caused the amount paid to differ from the amount originally charged.
2. Mapping CAS information into a flat file format may involve reading specific Claim Adjustment Reason Codes and then mapping the subsequent Monetary Amount and/or Quantity elements to specific fields in the flat file.
3. The Claim Adjustment Reason codes are located on the Washington Publishing Company web site <http://www.wpc-edi.com>.

PR(Patient Responsibility)

Example:

CAS*PR*1*7.93~
CAS*OA*93*15.06~

DTP Line Adjudication Date

Pos: 550	Max: 1
Detail - Optional	
Loop: 2430	Elements: 3

User Option (Usage): Required

Purpose: To specify any or all of a date, a time, or a time period

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
DTP01	374	Date/Time Qualifier	M	ID	3/3	Required

Description: Code specifying type of date or time, or both date and time

Industry: *Date Time Qualifier*

<u>Code</u>	<u>Name</u>
573	Date Claim Paid

DTP02	1250	Date Time Period Format Qualifier	M	ID	2/3	Required
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Description: Code indicating the date format, time format, or date and time format

<u>Code</u>	<u>Name</u>
D8	Date Expressed in Format CCYYMMDD

DTP03	1251	Date Time Period	M	AN	1/35	Required
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Description: Expression of a date, a time, or range of dates, times or dates and times

Industry: *Adjudication or Payment Date*

Semantics:

1. DTP02 is the date or time or period format that will appear in DTP03.

Example:

*DTP*573*D8*20030314~*

SE Transaction Set Trailer

Pos: 555	Max: 1
Detail - Mandatory	
Loop: N/A	Elements: 2

User Option (Usage): Required

Purpose: To indicate the end of the transaction set and provide the count of the transmitted segments (including the beginning (ST) and ending (SE) segments)

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
SE01	96	Number of Included Segments	M	N0	1/10	Required

Description: Total number of segments included in a transaction set including ST and SE segments

Industry: *Transaction Segment Count*

Alias: *Segment Count*

SE02	329	Transaction Set Control Number	M	AN	4/9	Required
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Description: Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set

Alias: *Transaction Set Control Number*

The Transaction Set Control Numbers in ST02 and SE02 must be identical. The Transaction Set Control Number is assigned by the originator and must be unique within a functional group (GS-GE) and interchange (ISA-IEA). This unique number also aids in error resolution research.

Comments:

- SE is the last segment of each transaction set.

Notes:

Transaction Set Trailer Counts

Example:

*SE*34*0001~*

GE Functional Group Trailer

Pos:	Max: 1
Not Defined - Mandatory	
Loop: N/A	Elements: 2

User Option (Usage): Required

Purpose: To indicate the end of a functional group and to provide control information

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
GE01	97	Number of Transaction Sets Included	M	NO	1/6	Required
Description: Total number of transaction sets included in the functional group or interchange (transmission) group terminated by the trailer containing this data element						
GE02	28	Group Control Number	M	NO	1/9	Required
Description: Assigned number originated and maintained by the sender <i>Same as GS06</i>						

Semantics:

1. The data interchange control number GE02 in this trailer must be identical to the same data element in the associated functional group header, GS06.

Comments:

1. The use of identical data interchange control numbers in the associated functional group header and trailer is designed to maximize functional group integrity. The control number is the same as that used in the corresponding header.

Example:

GE*5*399876323~

IEA Interchange Control Trailer

Pos:	Max: 1
Not Defined - Mandatory	
Loop: N/A	Elements: 2

User Option (Usage): Required

Purpose: To define the end of an interchange of zero or more functional groups and interchange-related control segments

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
IEA01	I16	Number of Included Functional Groups	M	N0	1/5	Required
Description: A count of the number of functional groups included in an interchange <i>Number of functional groups included in this interchange envelope.</i>						
IEA02	I12	Interchange Control Number	M	N0	9/9	Required
Description: A control number assigned by the interchange sender <i>Should be same as ISA13.</i>						

Example:

IEA*5*399876323~