

837 Health Care Claim: Professional

Functional Group ID=**HC**

Introduction:

This Draft Standard for Trial Use contains the format and establishes the data contents of the Health Care Claim Transaction Set (837) for use within the context of an Electronic Data Interchange (EDI) environment. This transaction set can be used to submit health care claim billing information, encounter information, or both, from providers of health care services to payers, either directly or via intermediary billers and claims clearinghouses. It can also be used to transmit health care claims and billing payment information between payers with different payment responsibilities where coordination of benefits is required or between payers and regulatory agencies to monitor the rendering, billing, and/or payment of health care services within a specific health care/insurance industry segment. For purposes of this standard, providers of health care products or services may include entities such as physicians, hospitals and other medical facilities or suppliers, dentists, and pharmacies, and entities providing medical information to meet regulatory requirements. The payer refers to a third party entity that pays claims or administers the insurance product or benefit or both. For example, a payer may be an insurance company, health maintenance organization (HMO), preferred provider organization (PPO), government agency (Medicare, Medicaid, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), etc.) or an entity such as a third party administrator (TPA) or third party organization (TPO) that may be contracted by one of those groups. A regulatory agency is an entity responsible, by law or rule, for administering and monitoring a statutory benefits program or a specific health care/insurance industry segment.

Notes:

X12N HIPAA Notes:

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.

This standard is also recommended for the submission of similar data within a pre-paid managed care context. Referred to as capitated encounters, this data usually does not result in a payment, though it is possible to submit a "mixed" claim that includes both pre-paid and request for payment services. This standard will allow for the submission of data from providers of health care products and services to a Managed Care Organization or other payer. This standard may also be used by payers to share data with plan sponsors, employers, regulatory entities and Community Health Information Networks.

This standard can, also, be used as a transaction set in support of the coordination of benefits claims process. Additional looped segments can be used within both the claim and service line levels to transfer each payer's adjudication information to subsequent payers.

ODJFS User Note:

When billing ODJFS in an EDI format, the following services must be submitted on the 837P:

Physician services provided by individual physician practices, physician group practices, hospice organizations, and ambulatory surgery centers;

Hospice services;

Ambulatory surgery center facility services;

clinic services provided by fee-for-service clinics (federally qualified health centers, rural health clinics and outpatient health facilities)

Home health services;

Waiver services;

Private duty nursing services;

Podiatry services;

Advanced practice nurse services;

Psychology services;

Physical therapy services;

Laboratory services;

Diagnostic facility services;
 Ambulance services;
 Ambulette services;
 Chiropracter services;
 Durable medical equipment services;
 Medical supply services;
 Vision, optometric, optician and eyewear services;
 Medicaid Schools Program

Encounter claims do not need to be sent in 837 format at this point in time.

For each element, in addition to the notes and examples provided by HIPAA, there will be ODJFS User Notes and/or ODJFS Application Notes. These notes will provide information about the rules used for processing claims.

The symbol N/U is used for Not Used elements throughout the document.

Heading:

Page No.	Pos. No.	Seg. ID	Name	HIPAA Usage	ODJFS Usage	Max.Use	Loop Repeat	Notes and Comments
9	002	ISA	Interchange Control Header	R	R	1		
12	003	GS	Functional Group Header	R	R	1		
14	005	ST	Transaction Set Header	R	R	1		
15	010	BHT	Beginning of Hierarchical Transaction	R	R	1		
17	015	REF	Transmission Type Identification	R	R	1		
LOOP ID - 1000A							1	
18	020	NM1	Submitter Name	R	R	1		n1
20	045	PER	Submitter EDI Contact Information	R	R	2		
LOOP ID - 1000B							1	
22	020	NM1	Receiver Name	R	R	1		

Detail:

Page No.	Pos. No.	Seg. ID	Name	HIPAA Usage	ODJFS Usage	Max.Use	Loop Repeat	Notes and Comments
LOOP ID - 2000A							>1	
24	001	HL	Billing/Pay-to Provider Hierarchical Level	R	R	1		n2
26	003	PRV	Billing/Pay-to Provider Specialty Information	S	S	1		
	010	CUR	Foreign Currency Information	S	Not Used	1		
LOOP ID - 2010AA							1	
28	015	NM1	Billing Provider Name	R	R	1		
31	025	N3	Billing Provider Address	R	R	1		
32	030	N4	Billing Provider City/State/ZIP Code	R	R	1		
33	035	REF	Billing Provider Secondary Identification	S	S	8		
	035	REF	Credit/Debit Card Billing Information	S	Not Used	8		
35	040	PER	Billing Provider Contact Information	S	S	2		
LOOP ID - 2010AB							1	
37	015	NM1	Pay-to Provider Name	S	S	1		
40	025	N3	Pay-to Provider Address	R	R	1		
41	030	N4	Pay-to Provider City/State/ZIP Code	R	R	1		
42	035	REF	Pay-to-Provider Secondary Identification	S	S	5		
LOOP ID - 2000B							>1	
44	001	HL	Subscriber Hierarchical Level	R	R	1		
46	005	SBR	Subscriber Information	R	R	1		

	007	PAT	Patient Information	S	Not Used	1	
			LOOP ID - 2010BA			1	
49	015	NM1	Subscriber Name	R	R	1	
51	025	N3	Subscriber Address	S	S	1	
52	030	N4	Subscriber City/State/ZIP Code	S	S	1	
53	032	DMG	Subscriber Demographic Information	S	S	1	
	035	REF	Subscriber Secondary Identification	S	Not Used	4	
	035	REF	Property and Casualty Claim Number	S	Not Used	1	
			LOOP ID - 2010BB			1	
54	015	NM1	Payer Name	R	R	1	
	025	N3	Payer Address	S	Not Used	1	
	030	N4	Payer City/State/ZIP Code	S	Not Used	1	n3
	035	REF	Payer Secondary Identification	S	Not Used	3	
			LOOP ID - 2010BC			1	
	015	NM1	Responsible Party Name	S	Not Used	1	
	025	N3	Responsible Party Address	R	Not Used	1	
	030	N4	Responsible Party City/State/ZIP Code	R	Not Used	1	
			LOOP ID - 2010BD			1	
	015	NM1	Credit/Debit Card Holder Name	S	Not Used	1	
	035	REF	Credit/Debit Card Information	S	Not Used	2	
			LOOP ID - 2300			100	
56	130	CLM	Claim Information	S	R	1	
61	135	DTP	Date - Initial Treatment	S	S	1	
	135	DTP	Date - Date Last Seen	S	Not Used	1	
62	135	DTP	Date - Onset of Current Illness/Symptom	S	S	1	
	135	DTP	Date - Acute Manifestation	S	Not Used	5	
63	135	DTP	Date - Similar Illness/Symptom Onset	S	S	10	
64	135	DTP	Date - Accident	S		10	
65	135	DTP	Date - Last Menstrual Period	S	S	1	
66	135	DTP	Date - Last X-ray	S	S	1	
67	135	DTP	Date - Hearing and Vision Prescription Date	S	S	1	
	135	DTP	Date - Disability Begin	S	Not Used	5	
	135	DTP	Date - Disability End	S	Not Used	5	
	135	DTP	Date - Last Worked	S	Not Used	1	
	135	DTP	Date - Authorized Return to Work	S	Not Used	1	
	135	DTP	Date - Admission	S	Not Used	1	
68	135	DTP	Date - Discharge	S	S	1	
	135	DTP	Date - Assumed and Relinquished Care Dates	S	Not Used	2	
	155	PWK	Claim Supplemental Information	S	Not Used	10	
	160	CN1	Contract Information	S	Not Used	1	
	175	AMT	Credit/Debit Card Maximum Amount	S	Not Used	1	
69	175	AMT	Patient Amount Paid	S	S	1	
	175	AMT	Total Purchased Service Amount	S	Not Used	1	
	180	REF	Service Authorization Exception Code	S	Not Used	1	
	180	REF	Mandatory Medicare (Section 4081) Crossover Indicator	S	Not Used	1	
	180	REF	Mammography Certification Number	S	Not Used	1	
70	180	REF	Prior Authorization or Referral Number	S	S	2	
71	180	REF	Original Reference Number (ICN/DCN)	S	S	1	
72	180	REF	Clinical Laboratory Improvement	S	S	3	

	180	REF	Amendment (CLIA) Number	S	Not Used	1
	180	REF	Repriced Claim Number	S	Not Used	1
	180	REF	Adjusted Repriced Claim Number	S	Not Used	1
	180	REF	Investigational Device Exemption Number	S	Not Used	1
	180	REF	Claim Identification Number for Clearing Houses and Other Transmission Intermediaries	S	Not Used	1
	180	REF	Ambulatory Patient Group (APG)	S	Not Used	4
73	180	REF	Medical Record Number	S	S	1
74	180	REF	Demonstration Project Identifier	S	S	1
	185	K3	File Information	S	Not Used	10
75	190	NTE	Claim Note	S	S	1
77	195	CR1	Ambulance Transport Information	S	S	1
80	200	CR2	Spinal Manipulation Service Information	S	S	1
83	220	CRC	Ambulance Certification	S	S	3
86	220	CRC	Patient Condition Information: Vision	S	S	3
	220	CRC	Homebound Indicator	S	Not Used	1
89	220	CRC	EPSDT Referral	S	S	1
92	231	HI	Health Care Diagnosis Code	S	S	1
	241	HCP	Claim Pricing/Repricing Information	S	Not Used	1
LOOP ID - 2305						6
96	242	CR7	Home Health Care Plan Information	S	S	1
97	243	HSD	Health Care Services Delivery	S	S	3
LOOP ID - 2310A						2
100	250	NM1	Referring Provider Name	S	S	1
	255	PRV	Referring Provider Specialty Information	S	Not Used	1
103	271	REF	Referring Provider Secondary Identification	S	S	5
LOOP ID - 2310B						1
105	250	NM1	Rendering Provider Name	S	S	1
108	255	PRV	Rendering Provider Specialty Information	S	S	1
109	271	REF	Rendering Provider Secondary Identification	S	S	5
LOOP ID - 2310C						1
	250	NM1	Purchased Service Provider Name	S	Not Used	1
	271	REF	Purchased Service Provider Secondary Identification	S	Not Used	5
LOOP ID - 2310D						1
	250	NM1	Service Facility Location	S	Not Used	1
	265	N3	Service Facility Location Address	R	Not Used	1
	270	N4	Service Facility Location City/State/ZIP	R	Not Used	1
	271	REF	Service Facility Location Secondary Identification	S	Not Used	5
LOOP ID - 2310E						1
	250	NM1	Supervising Provider Name	S	Not Used	1
	271	REF	Supervising Provider Secondary Identification	S	Not Used	5
LOOP ID - 2320						10
111	290	SBR	Other Subscriber Information	S	S	1
115	295	CAS	Claim Level Adjustments	S	S	5
120	300	AMT	Coordination of Benefits (COB) Payer Paid Amount	S	S	1
121	300	AMT	Coordination of Benefits (COB) Approved Amount	S	S	1
122	300	AMT	Coordination of Benefits (COB) Allowed Amount	S	S	1

123	300	AMT	Coordination of Benefits (COB) Patient Responsibility Amount	S	S	1
124	300	AMT	Coordination of Benefits (COB) Covered Amount	S	S	1
	300	AMT	Coordination of Benefits (COB) Discount Amount	S	Not Used	1
	300	AMT	Coordination of Benefits (COB) Per Day Limit Amount	S	Not Used	1
125	300	AMT	Coordination of Benefits (COB) Patient Paid Amount	S	S	1
	300	AMT	Coordination of Benefits (COB) Tax Amount	S	Not Used	1
	300	AMT	Coordination of Benefits (COB) Total Claim Before Taxes Amount	S	Not Used	1
126	305	DMG	Subscriber Demographic Information	S	S	1
127	310	OI	Other Insurance Coverage Information	R	R	1
129	320	MOA	Medicare Outpatient Adjudication Information	S	S	1
LOOP ID - 2330A						1
131	325	NM1	Other Subscriber Name	R	R	1
133	332	N3	Other Subscriber Address	S	S	1
134	340	N4	Other Subscriber City/State/ZIP Code	S	S	1
	355	REF	Other Subscriber Secondary Identification	S	Not Used	3
LOOP ID - 2330B						1
136	325	NM1	Other Payer Name	R	R	1
	345	PER	Other Payer Contact Information	S	Not Used	2
138	350	DTP	Claim Adjudication Date	S	S	1
	355	REF	Other Payer Secondary Identifier	S	Not Used	2
	355	REF	Other Payer Prior Authorization or Referral Number	S	Not Used	2
	355	REF	Other Payer Claim Adjustment Indicator	S	Not Used	2
LOOP ID - 2330C						1
139	325	NM1	Other Payer Patient Information	S	S	1
	355	REF	Other Payer Patient Identification	S	Not Used	3
LOOP ID - 2330D						2
	325	NM1	Other Payer Referring Provider	S	Not Used	1
	355	REF	Other Payer Referring Provider Identification	R	Not Used	3
LOOP ID - 2330E						1
	325	NM1	Other Payer Rendering Provider	S	Not Used	1
	355	REF	Other Payer Rendering Provider Secondary Identification	R	Not Used	3
LOOP ID - 2330F						1
	325	NM1	Other Payer Purchased Service Provider	S	Not Used	1
	355	REF	Other Payer Purchased Service Provider Identification	R	Not Used	3
LOOP ID - 2330G						1
	325	NM1	Other Payer Service Facility Location	S	Not Used	1
	355	REF	Other Payer Service Facility Location Identification	R	Not Used	3
LOOP ID - 2330H						1
	325	NM1	Other Payer Supervising Provider	S	Not Used	1
	355	REF	Other Payer Supervising Provider Identification	R	Not Used	3
LOOP ID - 2400						50
141	365	LX	Service Line	R	R	1
142	370	SV1	Professional Service	R	R	1
	400	SV5	Durable Medical Equipment Service	S	Not Used	1

	420	PWK	DMERC CMN Indicator	S	Not Used	1
147	425	CR1	Ambulance Transport Information	S	S	1
149	430	CR2	Spinal Manipulation Service Information	S	S	5
152	435	CR3	Durable Medical Equipment Certification	S	S	1
153	445	CR5	Home Oxygen Therapy Information	S	S	1
156	450	CRC	Ambulance Certification	S	S	3
159	450	CRC	Hospice Employee Indicator	S	S	1
161	450	CRC	DMERC Condition Indicator	S	S	2
164	455	DTP	Date - Service Date	R	R	1
	455	DTP	Date - Certification Revision Date	S	Not Used	1
	455	DTP	Date - Begin Therapy Date	S	Not Used	1
	455	DTP	Date - Last Certification Date	S	Not Used	1
	455	DTP	Date - Date Last Seen	S	Not Used	1
	455	DTP	Date - Test	S	Not Used	2
	455	DTP	Date - Oxygen Saturation/Arterial Blood Gas Test	S	Not Used	3
165	455	DTP	Date - Shipped	S	S	1
166	455	DTP	Date - Onset of Current Symptom/Illness	S	S	1
167	455	DTP	Date - Last X-ray	S	S	1
168	455	DTP	Date - Acute Manifestation	S	S	1
169	455	DTP	Date - Initial Treatment	S	S	1
	455	DTP	Date - Similar Illness/Symptom Onset	S	Not Used	1
	462	MEA	Test Result	S	Not Used	20
	465	CN1	Contract Information	S	Not Used	1
	470	REF	Repriced Line Item Reference Number	S	Not Used	1
	470	REF	Adjusted Repriced Line Item Reference Number	S	Not Used	1
170	470	REF	Prior Authorization or Referral Number	S	S	2
171	470	REF	Line Item Control Number	S	S	1
	470	REF	Mammography Certification Number	S	Not Used	1
172	470	REF	Clinical Laboratory Improvement Amendment (CLIA) Identification	S	S	1
173	470	REF	Referring Clinical Laboratory Improvement Amendment (CLIA) Facility Identification	S	S	1
	470	REF	Immunization Batch Number	S	Not Used	1
	470	REF	Ambulatory Patient Group (APG)	S	Not Used	4
	470	REF	Oxygen Flow Rate	S	Not Used	1
	470	REF	Universal Product Number (UPN)	S	Not Used	1
	475	AMT	Sales Tax Amount	S	Not Used	1
174	475	AMT	Approved Amount	S	S	1
	475	AMT	Postage Claimed Amount	S	Not Used	1
	480	K3	File Information	S	Not Used	10
	485	NTE	Line Note	S	Not Used	1
	488	PS1	Purchased Service Information	S	Not Used	1
	491	HSD	Health Care Services Delivery	S	Not Used	1
	492	HCP	Line Pricing/Repricing Information	S	Not Used	1
			LOOP ID - 2410			25
175	494	LIN	Drug Identification	S	S	1
	495	CTP	Drug Pricing	S	Not Used	1
	496	REF	Prescription Number	S	Not Used	1
			LOOP ID - 2420A			1
176	500	NM1	Rendering Provider Name	S	S	1
179	505	PRV	Rendering Provider Specialty Information	S	S	1

180	525	REF	Rendering Provider Secondary Identification	S	S	5		
LOOP ID - 2420B							1	
	500	NM1	Purchased Service Provider Name	S	Not Used	1		
	525	REF	Purchased Service Provider Secondary Identification	S	Not Used	5		
LOOP ID - 2420C							1	
	500	NM1	Service Facility Location	S	Not Used	1		
	514	N3	Service Facility Location Address	R	Not Used	1		
	520	N4	Service Facility Location City/State/ZIP	R	Not Used	1		
	525	REF	Service Facility Location Secondary Identification	S	Not Used	5		
LOOP ID - 2420D							1	
	500	NM1	Supervising Provider Name	S	Not Used	1		
	525	REF	Supervising Provider Secondary Identification	S	Not Used	5		
LOOP ID - 2420E							1	
	500	NM1	Ordering Provider Name	S	Not Used	1		
	514	N3	Ordering Provider Address	S	Not Used	1		
	520	N4	Ordering Provider City/State/ZIP Code	S	Not Used	1		
	525	REF	Ordering Provider Secondary Identification	S	Not Used	5		
	530	PER	Ordering Provider Contact Information	S	Not Used	1		
LOOP ID - 2420F							2	
182	500	NM1	Referring Provider Name	S	S	1		
185	505	PRV	Referring Provider Specialty Information	S	S	1		
186	525	REF	Referring Provider Secondary Identification	S	S	5		
LOOP ID - 2420G							4	
	500	NM1	Other Payer Prior Authorization or Referral Number	S	Not Used	1		
	525	REF	Other Payer Prior Authorization or Referral Number	R	Not Used	2		
LOOP ID - 2430							25	
188	540	SVD	Line Adjudication Information	S	S	1		
192	545	CAS	Line Adjustment	S	S	99		
198	550	DTP	Line Adjudication Date	R	R	1		
LOOP ID - 2440							5	
	551	LQ	Form Identification Code	S	Not Used	1		
	552	FRM	Supporting Documentation	R	Not Used	99		

Summary:

Page No.	Pos. No.	Seg. ID	Name	HIPAA Usage	ODJFS Usage	Max.Use	Loop Repeat	Notes and Comments
199	555	SE	Transaction Set Trailer	R	R	1		
200	565	GE	Functional Group Trailer	R	R	1		
201	575	IEA	Interchange Control Trailer	R	R	1		

Transaction Set Notes

1. 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. 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.

3. Loop 2310 contains information about the rendering, referring, or attending provider.

Segment: **ISA** Interchange Control Header
Position: 002
Loop:
Level: Heading
Usage: Optional (Must Use)
Max Use: 1
Purpose: To start and identify an interchange of zero or more functional groups and interchange-related control segments

Syntax Notes:
Semantic Notes:
Comments:
Notes:

X12N HIPAA Notes

The ISA is a fixed record length segment and all positions within each of the data elements must be filled. The first element separator defines the element separator to be used through the entire interchange. The segment terminator used after the ISA defines the segment terminator to be used throughout the entire interchange. Spaces in the example are represented by "." for clarity.

X12N HIPAA Example

```
ISA*00*.....*01*SECRET...*ZZ*SUBMITTERS.ID..*ZZ*RECEIVERS.ID...*93060
2*1253*U*00401*000000905*1*T*::~~
```

ODJFS User Note

ISA segment ODJFS User Note

```
ISA*00*.....*00*.....*ZZ*7.DIGIT.ID.....*ZZ*MMISODJFS.....*031016*1253*U*
00401*000000001*0*P*::~~
```

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
ISA01	I01	Authorization Information Qualifier	M ID 2/2	R
		Code to identify the type of information in the Authorization Information		
		00 No Authorization Information Present (No Meaningful Information in I02)		
		X12N HIPAA Notes:		
		ADVISED UNLESS SECURITY REQUIREMENTS MANDATE USE OF ADDITIONAL IDENTIFICATION INFORMATION.		
ISA02	I02	Authorization Information	M AN 10/10	R
		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)		
		ODJFS User Note:		
		This field should contain all spaces.		
ISA03	I03	Security Information Qualifier	M ID 2/2	R
		Code to identify the type of information in the Security Information		
		00 No Security Information Present (No Meaningful Information in I04)		
		X12N HIPAA Notes:		
		ADVISED UNLESS SECURITY REQUIREMENTS MANDATE USE OF PASSWORD DATA.		
ISA04	I04	Security Information	M AN 10/10	R
		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)		
		ODJFS User Note:		
		This field should contain all spaces.		
ISA05	I05	Interchange ID Qualifier	M ID 2/2	R
		Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified		
		X12N HIPAA Notes:		

		This ID qualifies the Sender in ISA06.		
		ZZ	Mutually Defined	
ISA06	I06	Interchange Sender ID	M AN 15/15	R
		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		
		ODJFS User Note:		
		This field should contain the 7-digit Medicaid Trading Partner ID assigned to the Sender of this file. Since this is a fixed-length field, it should be filled with spaces to meet the minimum length requirement of 15.		
ISA07	I05	Interchange ID Qualifier	M ID 2/2	R
		Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified		
		X12N HIPAA Notes:		
		This ID qualifies the Receiver in ISA08.		
		ZZ	Mutually Defined	
ISA08	I07	Interchange Receiver ID	M AN 15/15	R
		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		
		ODJFS User Note:		
		This field should contain the value MMISODJFS assigned to the Receiver of this file (Ohio Department of Job and Family Services). Since this is a fixed-length field, it should be filled with spaces to meet the minimum length requirement of 15.		
ISA09	I08	Interchange Date	M DT 6/6	R
		Date of the interchange		
		X12N HIPAA Notes:		
		The date format is YYMMDD.		
ISA10	I09	Interchange Time	M TM 4/4	R
		Time of the interchange		
		X12N HIPAA Notes:		
		The time format is HHMM.		
ISA11	I10	Interchange Control Standards Identifier	M ID 1/1	R
		Code to identify the agency responsible for the control standard used by the message that is enclosed by the interchange header and trailer		
		U	U.S. EDI Community of ASC X12, TDCC, and UCS	
ISA12	I11	Interchange Control Version Number	M ID 5/5	R
		This version number covers the interchange control segments		
		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	R
		A control number assigned by the interchange sender		
		X12N HIPAA Notes:		
		The Interchange Control Number, ISA13, must be identical to the associated Interchange Trailer IEA02.		
ISA14	I13	Acknowledgment Requested	M ID 1/1	R
		Code sent by the sender to request an interchange acknowledgment (TA1)		
		X12N HIPAA Notes:		
		See Section A.1.5.1 for interchange acknowledgment information.		
		ODJFS User Note:		
		ODJFS will return an acknowledgment segment (TA1) for the ISA if requested.		
		0	No Acknowledgment Requested	
		1	Interchange Acknowledgment Requested	
ISA15	I14	Usage Indicator	M ID 1/1	R
		Code to indicate whether data enclosed by this interchange envelope is test, production or		

information

P

Production Data

T

Test Data

ISA16

I15

Component Element Separator

M AN 1/1 R

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

Segment: **GS** Functional Group Header
Position: 003
Loop:
Level: Heading
Usage: Optional (Must Use)
Max Use: 1
Purpose: To indicate the beginning of a functional group and to provide control information
Syntax Notes:
Semantic Notes:

- 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: **X12N HIPAA Example**

GS*HC*SENDER CODE*RECEIVER CODE*19940331*0802*1*X*004010X098A1~

ODJFS User Note

GS*HC*MEDICAID ID*MMISODJFS*20080708*0802*1*X*004010X098A1~

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
GS01	479	Functional Identifier Code Code identifying a group of application related transaction sets HC Health Care Claim (837)	M ID 2/2	R
GS02	142	Application Sender's Code Code identifying party sending transmission; codes agreed to by trading partners X12N HIPAA Notes: Use this code to identify the unit sending the information. ODJFS User Note: This field should contain the 7-digit Medicaid Trading Partner ID assigned to the Sender of this file.	M AN 2/15	R
GS03	124	Application Receiver's Code Code identifying party receiving transmission; codes agreed to by trading partners X12N HIPAA Notes: Use this code to identify the unit receiving the information. ODJFS User Note: This field should contain the value MMISODJFS assigned to the Receiver of this file (Ohio Department of Job and Family Services).	M AN 2/15	R
GS04	373	Date Date expressed as CCYYMMDD X12N HIPAA Notes: Use this date for the functional group creation date.	M DT 8/8	R
GS05	337	Time 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) X12N HIPAA Notes: Use this time for the creation time. The recommended format is HHMM.	M TM 4/8	R
GS06	28	Group Control Number Assigned number originated and maintained by the sender	M N0 1/9	R
GS07	455	Responsible Agency Code Code used in conjunction with Data Element 480 to identify the issuer of the standard	M ID 1/2	R

GS08

480

Version / Release / Industry Identifier Code M AN 1/12 R

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

X12N HIPAA Notes:

004010X098A1 Draft Standards Approved for Publication by ASC X12 Procedures Review Board through October 1997, as published in the implementation guide.

When using the X12N Health Care Claim: Professional Implementation Guide, originally published May 2000 as 004010X098 and incorporating the changes identified in the Addenda, the value used in GS08 must be "004010X098A1".

004010X098A1

Version/Release/Industry Identifier Code

X12N HIPAA Notes:

Draft Standards Approved for Publication by ASC X12 Procedures Review Board through October 1997, as published in this implementation guide.
1091 When using the X12N Health Care Claim: Professional Implementation Guide, originally published May 2000 as 004010X098 and incorporating the changes identified in the Addenda, the value used in GS08 must be "004010X098A1".

Segment: **ST** Transaction Set Header
Position: 005
Loop:
Level: Heading
Usage: Mandatory
Max Use: 1
Purpose: To indicate the start of a transaction set and to assign a control number
Syntax Notes:
Semantic Notes: 1 The transaction set identifier (ST01) is used by the translation routines of the interchange partners to select the appropriate transaction set definition (e.g., 810 selects the Invoice Transaction Set).
Comments:
Notes: **X12N HIPAA Example**
 Example: ST*837*987654~

Data Element Summary

<u>Ref.</u>	<u>Data</u>	<u>Name</u>	<u>Base</u>	<u>User</u>
<u>Des.</u>	<u>Element</u>		<u>Attributes</u>	<u>Attributes</u>
ST01	143	Transaction Set Identifier Code Code uniquely identifying a Transaction Set X12N HIPAA Notes: The only valid value within this transaction set for ST01 is 837. INDUSTRY: Transaction Set Identifier Code 837 Health Care Claim	M ID 3/3	R
ST02	329	Transaction Set Control Number Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set X12N HIPAA Notes: 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. ALIAS: Transaction Set Control Number INDUSTRY: Transaction Set Control Number	M AN 4/9	R

Segment: **BHT** Beginning of Hierarchical Transaction
Position: 010
Loop:
Level: Heading
Usage: Mandatory
Max Use: 1
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

Syntax Notes:
Semantic Notes:

- 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.

Comments:
Notes: **X12N HIPAA Notes**
 The second example denotes the case where the entire transaction set contains ENCOUNTERS.
X12N HIPAA Example
 Example: BHT*0019*00*0123*19970618*0932*CH~
 BHT*0019*00*44445*19970213*0345*RP~

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
BHT01	1005	Hierarchical Structure Code Code indicating the hierarchical application structure of a transaction set that utilizes the HL segment to define the structure of the transaction set X12N HIPAA Notes: INDUSTRY: Hierarchical Structure Code 0019 Information Source, Subscriber, Dependent	M ID 4/4	R
BHT02	353	Transaction Set Purpose Code Code identifying purpose of transaction set X12N HIPAA Notes: BHT02 is intended to convey the electronic transmission status of the 837 batch contained in this ST-SE envelope. The terms "original" and "reissue" refer to the electronic transmission status of the 837 batch, not the billing status. ORIGINAL: Original transmissions are claims/encounters which have never been sent to the receiver. Generally nearly all transmissions to a payer entity (as the ultimate destination of the transaction) are original. REISSUE: In the case where a transmission was disrupted the receiver can request that the batch be sent again. Use "Reissue" when resending transmission batches that have been previously sent. ALIAS: Transaction Set Purpose Code NSF Reference: AA0-23.0 INDUSTRY: Transaction Set Purpose Code 00 Original 18 Reissue	M ID 2/2	R
BHT03	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	O AN 1/30	R

X12N HIPAA Notes:

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.

NSF Reference: AA0-05.0

INDUSTRY: Originator Application Transaction Identifier

BHT04 **373** **Date** **O** **DT 8/8** **R**

Date expressed as CCYYMMDD

X12N HIPAA Notes:

Identifies the date that the submitter created the file.

NSF Reference: AA0-15.0

INDUSTRY: Transaction Set Creation Date

BHT05 **337** **Time** **O** **TM 4/8** **R**

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)

X12N HIPAA Notes:

Use this time to identify the time of day that the submitter created the file.

NSF Reference: AA0-16.0

INDUSTRY: Transaction Set Creation Time

BHT06 **640** **Transaction Type Code** **O** **ID 2/2** **R**

Code specifying the type of transaction

X12N HIPAA Notes:

Although this element is required, submitters are not necessarily required to accurately batch claims and encounters at this level. Generally CH is used for claims and RP is used for encounters. However, if an ST-SE envelope contains both claims and encounters use CH. Some trading partner agreements may specify using only one code.

ALIAS: Claim or Encounter Indicator

INDUSTRY: Claim or Encounter Identifier

CH Chargeable

X12N HIPAA Notes:

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.

Segment: **REF** **Transmission Type Identification**
Position: 015
Loop:
Level: Heading
Usage: Optional (Must Use)
Max Use: 1
Purpose: To specify identifying information
Syntax Notes:
Semantic Notes: 1 REF04 contains data relating to the value cited in REF02.
Comments:
Notes: **X12N HIPAA Example**

Example: REF*87*004010X098D~

Data Element Summary

<u>Ref.</u>	<u>Data</u>	<u>Name</u>	<u>Base</u>	<u>User</u>
<u>Des.</u>	<u>Element</u>		<u>Attributes</u>	<u>Attributes</u>
REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification X12N HIPAA Notes: INDUSTRY: Reference Identification Qualifier 87 Functional Category An organization or groups of organizations with a common operational orientation such as Quality Control Engineering, etc	M ID 2/3	R
REF02	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier X12N HIPAA Notes: When piloting the transaction set, this value is 004010X098DA1. When sending the transaction set in a production mode, this value is 004010X098A1. INDUSTRY: Transmission Type Code ODJFS User Note: The value 004010X098DA1 is NOT USED in the ODJFS testing environment. Please use only the 004010X098A1 value in the REF02. (Omit the 'D') 004010X098A1 Production ID	O AN 1/30	R

Segment: **NM1** Submitter Name
Position: 020
Loop: 1000A Optional (Must Use)
Level: Heading
Usage: Optional (Must Use)
Max Use: 1
Purpose: To supply the full name of an individual or organizational entity
Syntax Notes: 1 If either NM108 or NM109 is present, then the other is required.
Semantic Notes: 1 NM102 qualifies NM103.
Comments:
Notes:

X12N HIPAA Notes

See Section 2.4, Loop ID-1000, Data Overview, for a detailed description about using Loop ID-1000. Ignore the Set Notes below.

Because this is a required segment, this is a required loop. See Appendix A for further details on ASC X12 syntax rules.

X12N HIPAA Example

Example: NM1*41*2*CRAMMER, DOLE, PALMER, AND
 JOHANSON*****46*W7933THU~

Data Element Summary

Ref. Des.	Data Element	Name	Base Attributes	User Attributes
NM101	98	Entity Identifier Code Code identifying an organizational entity, a physical location, property or an individual X12N HIPAA Notes: INDUSTRY: Entity Identifier Code 41 Submitter Entity transmitting transaction set	M ID 2/3	R
NM102	1065	Entity Type Qualifier Code qualifying the type of entity X12N HIPAA Notes: INDUSTRY: Entity Type Qualifier 1 Person 2 Non-Person Entity	M ID 1/1	R
NM103	1035	Name Last or Organization Name Individual last name or organizational name X12N HIPAA Notes: ALIAS: Submitter Name NSF Reference: AA0-06.0 INDUSTRY: Submitter Last or Organization Name	O AN 1/35	R
NM104	1036	Name First Individual first name X12N HIPAA Notes: Required if NM102=1 (person). ALIAS: Submitter Name INDUSTRY: Submitter First Name	O AN 1/25	S
NM105	1037	Name Middle Individual middle name or initial X12N HIPAA Notes: Required if NM102=1 and the middle name/initial of the person is known.	O AN 1/25	S

		ALIAS: Submitter Name			
		INDUSTRY: Submitter Middle Name			
NM106	1038	Name Prefix	O	AN 1/10	N/U
NM107	1039	Name Suffix	O	AN 1/10	N/U
NM108	66	Identification Code Qualifier	X	ID 1/2	R
		Code designating the system/method of code structure used for Identification Code (67)			
		X12N HIPAA Notes:			
		INDUSTRY: Identification Code Qualifier			
		46	Electronic Transmitter Identification Number (ETIN)		
			A unique number assigned to each transmitter and software developer		
			X12N HIPAA Notes:		
			Established by trading partner agreement.		
NM109	67	Identification Code	X	AN 2/80	R AN 7/7
		Code identifying a party or other code			
		X12N HIPAA Notes:			
		ALIAS: Submitter Primary Identification Number			
		NSF Reference: AA0-02.0, ZA0-02.0			
		INDUSTRY: Submitter Identifier			
		ODJFS User Note:			
		This is the seven-digit number ODJFS assigned to the Medicaid Trading Partner. Medicaid numbers assigned to identify healthcare providers (e.g. Physicians) are not valid.			
		Medicaid Trading Partners with a test status may only submit test EDI transactions. Medicaid Trading Partners with an active status may submit business transactions to ODJFS. A Medicaid Trading Partner is given an active status when they have passed the testing phase and have met all of the criteria specified by ODJFS.			

Segment: **PER** **Submitter EDI Contact Information**
Position: 045
Loop: 1000A Optional (Must Use)
Level: Heading
Usage: Optional (Must Use)
Max Use: 2
Purpose: To identify a person or office to whom administrative communications should be directed
Syntax Notes:

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

Semantic Notes:

Comments:

Notes:

X12N HIPAA Notes

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.

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.

There are 2 repetitions of the PER segment to allow for six possible combination of communication numbers including extensions.

X12N HIPAA Example

Example: PER*IC*JANE DOE*TE*900555555~

Data Element Summary

<u>Ref.</u> <u>Des.</u>	<u>Data</u> <u>Element</u>	<u>Name</u>	<u>Base</u> <u>Attributes</u>	<u>User</u> <u>Attributes</u>
PER01	366	Contact Function Code Code identifying the major duty or responsibility of the person or group named X12N HIPAA Notes: INDUSTRY: Contact Function Code IC Information Contact	M ID 2/2	R
PER02	93	Name Free-form name X12N HIPAA Notes: 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). NSF Reference: AA0-13.0 INDUSTRY: Submitter Contact Name	O AN 1/60	R
PER03	365	Communication Number Qualifier Code identifying the type of communication number X12N HIPAA Notes: INDUSTRY: Communication Number Qualifier ED Electronic Data Interchange Access Number EM Electronic Mail FX Facsimile TE Telephone	X ID 2/2	R
PER04	364	Communication Number	X AN 1/80	R

Complete communications number including country or area code when applicable

X12N HIPAA Notes:

NSF Reference: AA0-14.0

INDUSTRY: Communication Number

PER05 365 Communication Number Qualifier X ID 2/2 S

Code identifying the type of communication number

X12N HIPAA Notes:

Used at the discretion of the submitter.

INDUSTRY: Communication Number Qualifier

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

PER06 364 Communication Number X AN 1/80 S

Complete communications number including country or area code when applicable

X12N HIPAA Notes:

Used at the discretion of the submitter.

INDUSTRY: Communication Number

PER07 365 Communication Number Qualifier X ID 2/2 S

Code identifying the type of communication number

X12N HIPAA Notes:

Used at the discretion of the submitter.

INDUSTRY: Communication Number Qualifier

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

PER08 364 Communication Number X AN 1/80 S

Complete communications number including country or area code when applicable

X12N HIPAA Notes:

Used at the discretion of the submitter.

INDUSTRY: Communication Number

Segment: **NM1** Receiver Name
Position: 020
Loop: 1000B Optional (Must Use)
Level: Heading
Usage: Optional (Must Use)
Max Use: 1
Purpose: To supply the full name of an individual or organizational entity
Syntax Notes: 1 If either NM108 or NM109 is present, then the other is required.
Semantic Notes: 1 NM102 qualifies NM103.
Comments:
Notes:

X12N HIPAA Notes

Because this is a required segment, this is a required loop. See Appendix A for further details on ASC X12 syntax rules.

X12N HIPAA Example

Example: NM1*40*2*UNION MUTUAL OF OREGON*****46*11122333~

ODJFS User Note

ODJFS Example: NM1*40*2*OH DEPARTMENT OF JOB AND FAMILY SERVICES*****46*MMISODJFS~

Data Element Summary

<u>Ref.</u>	<u>Data</u>	<u>Name</u>	<u>Base</u>	<u>User</u>
<u>Des.</u>	<u>Element</u>		<u>Attributes</u>	<u>Attributes</u>
NM101	98	Entity Identifier Code Code identifying an organizational entity, a physical location, property or an individual X12N HIPAA Notes: INDUSTRY: Entity Identifier Code 40 Receiver Entity to accept transmission	M ID 2/3	R
NM102	1065	Entity Type Qualifier Code qualifying the type of entity X12N HIPAA Notes: INDUSTRY: Entity Type Qualifier 2 Non-Person Entity	M ID 1/1	R
NM103	1035	Name Last or Organization Name Individual last name or organizational name X12N HIPAA Notes: ALIAS: Receiver Name INDUSTRY: Receiver Name	O AN 1/35	R
NM104	1036	Name First	O AN 1/25	N/U
NM105	1037	Name Middle	O AN 1/25	N/U
NM106	1038	Name Prefix	O AN 1/10	N/U
NM107	1039	Name Suffix	O AN 1/10	N/U
NM108	66	Identification Code Qualifier Code designating the system/method of code structure used for Identification Code (67) X12N HIPAA Notes: INDUSTRY: Identification Code Qualifier 46 Electronic Transmitter Identification Number (ETIN) A unique number assigned to each transmitter and software developer	X ID 1/2	R
NM109	67	Identification Code Code identifying a party or other code X12N HIPAA Notes: ALIAS: Receiver Primary Identification Number	X AN 2/80	R AN 9/9

NSF Reference: AA0-17.0, ZA0-04.0

INDUSTRY: Receiver Primary Identifier

ODJFS User Note:

Receiver ID for ODJFS = MMISODJFS

Segment: **HL Billing/Pay-to Provider Hierarchical Level**
Position: 001
Loop: 2000A Mandatory
Level: Detail
Usage: Mandatory
Max Use: 1
Purpose: To identify dependencies among and the content of hierarchically related groups of data segments

Syntax Notes:

Semantic Notes:

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.
The HL segment defines a top-down/left-right ordered structure.
- 2 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.
- 3 HL02 identifies the hierarchical ID number of the HL segment to which the current HL segment is subordinate.
- 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:

X12N HIPAA Notes

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.

The NSF fields shown in Loop ID-2010AA and Loop ID-2010AB are intended to carry billing provider information, not billing service information. Refer to your NSF manual for proper use of these fields. If Loop 2010AA contains information on a billing service (rather than a billing provider), do not map the information in that loop to the NSF billing provider fields for Medicare claims.

The Billing/Pay-to Provider HL may contain information about the Pay-to Provider entity. If the Pay-to Provider entity is the same as the Billing Provider entity, then only use Loop ID-2010AA.

Because this is a required segment, this is a required loop. See Appendix A for further details on ASC X12 syntax rules.

Receiving trading partners may have system limitations regarding the size of the transmission they can receive. The developers of this implementation 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.

If the Billing or Pay-to Provider is also the Rendering Provider and Loop ID-2310B is not used, the Loop ID-2000 PRV must be used to indicate which entity (Billing or Pay-to) is the Rendering Provider.

X12N HIPAA Example

Example: HL*1**20*1~

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
HL01	628	Hierarchical ID Number A unique number assigned by the sender to identify a particular data segment in a hierarchical structure X12N HIPAA Notes: 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.	M AN 1/12	R
HL02	734	Hierarchical Parent ID Number	O AN 1/12	N/U
HL03	735	Hierarchical Level Code Code defining the characteristic of a level in a hierarchical structure X12N HIPAA Notes: INDUSTRY: Hierarchical Level Code 20 Information Source Identifies the payor, maintainer, or source of the information	M ID 1/2	R
HL04	736	Hierarchical Child Code Code indicating if there are hierarchical child data segments subordinate to the level being described X12N HIPAA Notes: INDUSTRY: Hierarchical Child Code 1 Additional Subordinate HL Data Segment in This Hierarchical Structure.	O ID 1/1	R

Segment: **PRV** Billing/Pay-to Provider Specialty Information
Position: 003
Loop: 2000A Mandatory
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To specify the identifying characteristics of a provider
Syntax Notes:
Semantic Notes:
Comments:
Notes:

X12N HIPAA Notes

Required when adjudication is known to be impacted by the provider taxonomy code and the Rendering Provider is the same entity as the Billing Provider and/or the Pay-to Provider. In these cases, the Rendering Provider is being identified at this level for all subsequent claims/encounters in this HL and Loop ID-2310B is not used.

This PRV is not used when the Billing or Pay-to Provider is a group and the individual Rendering Provider is in loop 2310B. The PRV segment is then coded with the Rendering Provider in loop 2310B.

PRV02 qualifies PRV03.

X12N HIPAA Example

Example: PRV*BI*ZZ*203BA050N~

ODJFS User Note

When the billing or pay-to provider is a professional group practice, the 2310B loop must be completed. Adjudication is not impacted by the taxonomy number.

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
PRV01	1221	Provider Code Code identifying the type of provider X12N HIPAA Notes: INDUSTRY: Provider Code ODJFS User Note: Enter "BI" if loop 2010AB or 2310B are not completed. Enter "PT" or "BI", (whichever is applicable) if both the 2010AA and 2010AB loops are submitted and the 2310B is not completed. BI Billing PT Pay-To	M ID 1/3	R
PRV02	128	Reference Identification Qualifier Code qualifying the Reference Identification X12N HIPAA Notes: ZZ is used to indicate the "Health Care Provider Taxonomy" code list (provider specialty code) which is available on the Washington Publishing Company web site: http://www.wpc-edi.com . This taxonomy is maintained by the Blue Cross Blue Shield Association and ASC X12N TG2 WG15. INDUSTRY: Reference Identification Qualifier ZZ Mutually Defined X12N HIPAA Notes: Health Care Provider Taxonomy Code list	M ID 2/3	R
PRV03	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier X12N HIPAA Notes:	M AN 1/30	R

ALIAS: Provider Specialty Code

Provider Specialty Code

NSF Reference: BA0-22.0

INDUSTRY: Provider Taxonomy Code

Segment: **NM1 Billing Provider Name**
Position: 015
Loop: 2010AA Optional (Must Use)
Level: Detail
Usage: Optional (Must Use)
Max Use: 1
Purpose: To supply the full name of an individual or organizational entity
Syntax Notes: 1 If either NM108 or NM109 is present, then the other is required.
Semantic Notes: 1 NM102 qualifies NM103.
Comments:
Notes:

X12N HIPAA Notes

Although the name of this loop/segment is "Billing Provider" the loop/segment really identifies the billing entity. The billing entity does not have to be a health care provider to use this loop. However, some payers do not accept claims from non-provider billing entities.

Because this is a required segment, this is a required loop. See Appendix A for further details on ASC X12 syntax rules.

X12N HIPAA Example

Example: NM1*85*2*CRAMMER, DOLE, PALMER, AND
JOHNANSE*****24*111223333~

ODJFS User Note

The provider information submitted in this loop should be for a Medicaid provider that provides covered Medicaid services. It should not be trading partner information.

When the 2010AA loop is submitted without the 2010AB loop the information in the 2010AA loop is used. When the 2010AA loop is submitted with the 2010AB loop then the information in the 2010AB loop is used.

For most providers billing on an 837P, the billing provider, pay to provider, and rendering provider are the same provider. For group professional practices the rendering provider is always different from the billing and/or pay-to provider so the 2310B loop must also be submitted.

The NPI for the following providers must be included in this segment: FFS Clinics, Hospice, Home Health Agencies, and Waiver Providers, Ambulatory Surgery Centers, FQHC's, RHC's, Individual Practitioners in solo (non-group) practice, professional Group practices, ambulance, pharmacies, durable medical equipment, medical supply (DME) providers, laboratories, Diagnostic facilities and Vision and eyewear providers.

The National Provider Identifier is mandated to be used on electronic claims on and after May 23, 2008. ODJFS will deny electronic claims that are missing an NPI in the billing loop on the 837 electronic claim transactions. Although the legacy ID is not required, ODJFS will continue to accept claims that contain both the NPI and legacy ID in the billing loop of the electronic claim until further notice. If it is included, a legacy ID will be validated. An invalid legacy ID will be rejected.

For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop with the EI or SY qualifier code.

Atypical providers should send their EIN or SSN in the NM1 segment and their Medicaid 7-digit legacy ID in the REF segment with an REF01 qualifier of ID.

NPI is required on all crossover claims submitted to ODJFS.

Data Element Summary

<u>Ref.</u> <u>Des.</u>	<u>Data</u> <u>Element</u>	<u>Name</u>	<u>Base</u> <u>Attributes</u>	<u>User</u> <u>Attributes</u>
----------------------------	-------------------------------	-------------	----------------------------------	----------------------------------

NM101	98	Entity Identifier Code	M	ID 2/3	R
Code identifying an organizational entity, a physical location, property or an individual					
X12N HIPAA Notes:					
INDUSTRY: Entity Identifier Code					
		85	Billing Provider		
X12N HIPAA Notes:					
Use this code to indicate billing provider, billing submitter, and encounter reporting entity.					
NM102	1065	Entity Type Qualifier	M	ID 1/1	R
Code qualifying the type of entity					
X12N HIPAA Notes:					
INDUSTRY: Entity Type Qualifier					
ODJFS User Note:					
When the billing provider is a group professional practice the 2310B loop must be completed.					
		1	Person		
		2	Non-Person Entity		
NM103	1035	Name Last or Organization Name	O	AN 1/35	R
Individual last name or organizational name					
X12N HIPAA Notes:					
ALIAS: Billing Provider Name					
NSF Reference: BA0-18.0 or BA0-19.0					
INDUSTRY: Billing Provider Last or Organizational Name					
NM104	1036	Name First	O	AN 1/25	S
Individual first name					
X12N HIPAA Notes:					
Required if NM102=1 (person).					
ALIAS: Billing Provider Name					
NSF Reference: BA0-20.0					
INDUSTRY: Billing Provider First Name					
NM105	1037	Name Middle	O	AN 1/25	S
Individual middle name or initial					
X12N HIPAA Notes:					
Required if NM102=1 and the middle name/initial of the person is known.					
ALIAS: Billing Provider Name					
NSF Reference: BA0-21.0					
INDUSTRY: Billing Provider Middle Name					
NM106	1038	Name Prefix	O	AN 1/10	N/U
NM107	1039	Name Suffix	O	AN 1/10	S
Suffix to individual name					
X12N HIPAA Notes:					
Required if known.					
ALIAS: Billing Provider Name					
INDUSTRY: Billing Provider Name Suffix					
NM108	66	Identification Code Qualifier	X	ID 1/2	R
Code designating the system/method of code structure used for Identification Code (67)					

X12N HIPAA Notes:

If "XX - NPI" is used, then either the Employer's Identification Number or the Social Security Number of the provider must be carried in the REF in this loop.

INDUSTRY: Identification Code Qualifier

- 24 Employer's Identification Number
- 34 Social Security Number
- XX Health Care Financing Administration National Provider Identifier

NM109

67

Identification Code

X AN 2/80 R

Code identifying a party or other code

X12N HIPAA Notes:

ALIAS: Billing Provider Primary Identification Number

NSF Reference: BA0-09.0, CA0-28.0, BA0-02.0, BA1-02.0, YA0-02.0, BA0-06.0, BA0-10.0, BA0-12.0, BA0-13.0, BA0-14.0, BA0-15.0, BA0-16.0, BA0-17.0, BA0-24.0, YA0-06.0

INDUSTRY: Billing Provider Identifier

ODJFS User Note:

For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop.

Atypical providers should send their EIN or SSN in the NM1 segment and their Medicaid 7-digit legacy ID in the REF segment with an REF01 qualifier of 1D.

Segment: N3 Billing Provider Address
Position: 025
Loop: 2010AA Optional (Must Use)
Level: Detail
Usage: Optional (Must Use)
Max Use: 1
Purpose: To specify the location of the named party
Syntax Notes:
Semantic Notes:
Comments:
Notes:

X12N HIPAA Example

Example: N3*225 MAIN STREET*BARKLEY BUILDING~

Data Element Summary

<u>Ref.</u>	<u>Data</u>	<u>Name</u>	<u>Base</u>	<u>User</u>
<u>Des.</u>	<u>Element</u>		<u>Attributes</u>	<u>Attributes</u>
N301	166	Address Information Address information X12N HIPAA Notes: ALIAS: Billing Provider Address 1 NSF Reference: BA1-07.0, BA1-13.0	M AN 1/55	R
N302	166	Address Information Address information X12N HIPAA Notes: Required if a second address line exists. ALIAS: Billing Provider Address 2 NSF Reference: BA1-08.0, BA1-14.0 INDUSTRY: Billing Provider Address Line	O AN 1/55	S

Segment: **N4 Billing Provider City/State/ZIP Code**
Position: 030
Loop: 2010AA Optional (Must Use)
Level: Detail
Usage: Optional (Must Use)
Max Use: 1
Purpose: To specify the geographic place of the named party
Syntax Notes:
Semantic Notes:
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: **X12N HIPAA Example**
Example: N4*CENTERVILLE*PA*17111~

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
N401	19	City Name Free-form text for city name X12N HIPAA Notes: ALIAS: Billing Provider's City NSF Reference: BA1-09.0, BA1-15.0 INDUSTRY: Billing Provider City Name	O AN 2/30	R
N402	156	State or Province Code Code (Standard State/Province) as defined by appropriate government agency X12N HIPAA Notes: ALIAS: Billing Provider's State NSF Reference: BA1-10.0, BA1-16.0 INDUSTRY: Billing Provider State or Province Code	O ID 2/2	R
N403	116	Postal Code Code defining international postal zone code excluding punctuation and blanks (zip code for United States) X12N HIPAA Notes: ALIAS: Billing Provider's Zip Code NSF Reference: BA1-11.0, BA1-17.0 INDUSTRY: Billing Provider Postal Zone or ZIP Code	O ID 3/15	R
N404	26	Country Code Code identifying the country X12N HIPAA Notes: Required if the address is out of the U.S. ALIAS: Billing Provider Country Code INDUSTRY: Country Code	O ID 2/3	S

Segment: **REF** Billing Provider Secondary Identification
Position: 035
Loop: 2010AA Optional (Must Use)
Level: Detail
Usage: Optional
Max Use: 8
Purpose: To specify identifying information
Syntax Notes:
Semantic Notes: 1 REF04 contains data relating to the value cited in REF02.
Comments:
Notes:

X12N HIPAA Notes

Required when a secondary identification number is necessary to identify the entity. The primary identification number should be carried in NM108/9 in this loop.

If the reason the number is being used in this REF can be met by the NPI, carried in the NM108/09 of this loop, then this REF is not used.

If "code XX - NPI" is used in the NM108/09 of this loop, then either the Employer's Identification Number or the Social Security Number of the provider must be carried in this REF. The number sent is the one which is used on the 1099. If additional numbers are needed the REF can be run up to 8 times.

X12N HIPAA Example

Example: REF*1G*98765~

ODJFS User Note

The National Provider Identifier is mandated to be used on electronic claims on and after May 23, 2008. ODJFS will deny electronic claims that are missing an NPI in the billing loop on the 837 electronic claim transactions. Although the legacy ID is not required, ODJFS will continue to accept claims that contain both the NPI and legacy ID in the billing loop of the electronic claim until further notice. If it is included, a legacy ID will be validated. An invalid legacy ID will be rejected.

For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop with the EI or SY qualifier code.

Atypical providers should send their EIN or SSN in the NM1 segment and their Medicaid 7-digit legacy ID in the REF segment with an REF01 qualifier of 1D.

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification	M ID 2/3	R
		X12N HIPAA Notes: INDUSTRY: Reference Identification Qualifier		
		1D Medicaid Provider Number		
		EI Employer's Identification Number		
		SY Social Security Number		
		X12N HIPAA Notes: The social security number may not be used for Medicare.		
REF02	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	O AN 1/30	R
		X12N HIPAA Notes: ALIAS: Billing Provider Secondary Identification Number		
		Corresponds to: BA0-09.0		

NSF Reference: CA0-28.0, BA0-02.0, BA1-02.0, YA0-06.0, BA0-06.0, BA0-10.0, BA0-12.0, BA0-13.0, BA0-14.0, BA0-15.0, BA0-16.0, BA0-17.0, BA0-24.0, BA0-08.0, YA0-02.0

INDUSTRY: Billing Provider Additional Identifier

ODJFS User Note:

For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop with the EI or SY qualifier code.

Atypical providers should send their EIN or SSN in the NM1 segment and their Medicaid 7-digit legacy ID in the REF segment with an REF01 qualifier of 1D.

Segment: **PER** Billing Provider Contact Information
Position: 040
Loop: 2010AA Optional (Must Use)
Level: Detail
Usage: Optional
Max Use: 2
Purpose: To identify a person or office to whom administrative communications should be directed
Syntax Notes:

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

Semantic Notes:

Comments:

Notes:

X12N HIPAA Notes

Required if this information is different that that contained in the Loop 1000A - Submitter PER segment.

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.

There are 2 repetitions of the PER segment to allow for six possible combination of communication numbers including extensions.

X12N HIPAA Example

Example: PER*IC*JIM*TE*8007775555~

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
PER01	366	Contact Function Code Code identifying the major duty or responsibility of the person or group named X12N HIPAA Notes: INDUSTRY: Contact Function Code IC Information Contact	M ID 2/2	R
PER02	93	Name Free-form name X12N HIPAA Notes: 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). INDUSTRY: Billing Provider Contact Name	O AN 1/60	R
PER03	365	Communication Number Qualifier Code identifying the type of communication number X12N HIPAA Notes: INDUSTRY: Communication Number Qualifier EM Electronic Mail FX Facsimile TE Telephone	X ID 2/2	R
PER04	364	Communication Number Complete communications number including country or area code when applicable X12N HIPAA Notes: NSF Reference: BA1-12.0, BA1-18.0	X AN 1/80	R

		INDUSTRY: Communication Number		
PER05	365	Communication Number Qualifier	X	ID 2/2 S
		Code identifying the type of communication number		
		X12N HIPAA Notes:		
		Used at the discretion of the billing provider.		
		INDUSTRY: Communication Number Qualifier		
		EM	Electronic Mail	
		EX	Telephone Extension	
		FX	Facsimile	
		TE	Telephone	
PER06	364	Communication Number	X	AN 1/80 S
		Complete communications number including country or area code when applicable		
		X12N HIPAA Notes:		
		Used at the discretion of the billing provider.		
		INDUSTRY: Communication Number		
PER07	365	Communication Number Qualifier	X	ID 2/2 S
		Code identifying the type of communication number		
		X12N HIPAA Notes:		
		Used at the discretion of the billing provider.		
		INDUSTRY: Communication Number Qualifier		
		EM	Electronic Mail	
		EX	Telephone Extension	
		FX	Facsimile	
		TE	Telephone	
PER08	364	Communication Number	X	AN 1/80 S
		Complete communications number including country or area code when applicable		
		X12N HIPAA Notes:		
		Used at the discretion of the billing provider.		
		INDUSTRY: Communication Number		

Segment: **NM1** Pay-to Provider Name
Position: 015
Loop: 2010AB Optional
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To supply the full name of an individual or organizational entity
Syntax Notes: 1 If either NM108 or NM109 is present, then the other is required.
Semantic Notes: 1 NM102 qualifies NM103.
Comments:
Notes:

X12N HIPAA Notes

Required if the Pay-to Provider is a different entity than the Billing Provider.

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.

X12N HIPAA Example

Example: NM1*87*1*CRAMMER*JOSEPH****XX*09876543~

ODJFS User Note

The provider information submitted in this loop should be for a Medicaid provider that provides covered Medicaid services. It should not be trading partner information.

When the 2010AA loop is submitted without the 2010AB loop the information in the 2010AA loop is used. When the 2010AA loop is submitted with the 2010AB loop then the information in the 2010AB loop is used.

For most providers billing on an 837P, the billing provider, pay to provider, and rendering provider are the same provider. For group professional practices the rendering provider is always different from the billing and/or pay-to provider so the 2310B loop must also be submitted.

The NPI for the following providers must be included in this segment: FFS Clinics, Hospice, Home Health Agencies, and Waiver Providers, Ambulatory Surgery Centers, FQHC's, RHC's, Individual Practitioners in solo (non-group) practice, professional Group practices, ambulance, pharmacies, durable medical equipment, medical supply (DME) providers, laboratories, Diagnostic facilities and Vision and eyewear providers.

The National Provider Identifier is mandated to be used on electronic claims on and after May 23, 2008. ODJFS will deny electronic claims that are missing an NPI in the pay-to loop on the 837 electronic claim transactions. Although the legacy ID is not required, ODJFS will continue to accept claims that contain both the NPI and legacy ID in the billing loop of the electronic claim until further notice. If it is included, a legacy ID will be validated. An invalid legacy ID will be rejected.

For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop with the EI or SY qualifier code.

Atypical providers should send their EIN or SSN in the NM1 segment and their Medicaid 7-digit legacy ID in the REF segment with an REF01 qualifier of 1D.

NPI is required on all crossover claims submitted to ODJFS.

Data Element Summary

<u>Ref.</u>	<u>Data</u>	<u>Name</u>	<u>Base</u>	<u>User</u>
<u>Des.</u>	<u>Element</u>	<u>Entity Identifier Code</u>	<u>Attributes</u>	<u>Attributes</u>
NM101	98		M ID 2/3	R

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

X12N HIPAA Notes:

INDUSTRY: Entity Identifier Code

87 Pay-to Provider
NM102 1065 Entity Type Qualifier M ID 1/1 R

Code qualifying the type of entity

X12N HIPAA Notes:

INDUSTRY: Entity Type Qualifier

1 Person

X12N HIPAA Notes:

If Person is used and if the pay-to provider is the same person as the rendering provider, it is not necessary to use the Rendering Provider NM1 loop at the claim loop (Loop ID-2300).

2 Non-Person Entity

X12N HIPAA Notes:

If Non-Person Entity is used then the rendering provider NM1 loop (Loop ID-2310B) must be used when appropriate to identify the person who rendered the services.

NM103 1035 Name Last or Organization Name O AN 1/35 R

Individual last name or organizational name

X12N HIPAA Notes:

ALIAS: Pay-to Provider Last or Organizational Name

NSF Reference: BA0-18.0 or BA0-19.0

INDUSTRY: Pay-to Provider Last or Organizational Name

NM104 1036 Name First O AN 1/25 S

Individual first name

X12N HIPAA Notes:

Required if NM102=1 (person).

ALIAS: Pay-to Provider First Name

NSF Reference: BA0-20.0

INDUSTRY: Pay-to Provider First Name

NM105 1037 Name Middle O AN 1/25 S

Individual middle name or initial

X12N HIPAA Notes:

Required if NM102=1 and the middle name/initial of the person is known.

ALIAS: Pay-to Provider Middle Name

NSF Reference: BA0-21.0

INDUSTRY: Pay-to Provider Middle Name

NM106 1038 Name Prefix O AN 1/10 N/U

NM107 1039 Name Suffix O AN 1/10 S

Suffix to individual name

X12N HIPAA Notes:

Required if known.

ALIAS: Pay-to Provider Name Suffix

INDUSTRY: Pay-to Provider Name Suffix

NM108 66 Identification Code Qualifier X ID 1/2 R

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

X12N HIPAA Notes:

If "XX - NPI" is used, then either the Employer's Identification Number or the Social Security Number of the provider must be carried in the REF in this loop.

INDUSTRY: Identification Code Qualifier

24 Employer's Identification Number

34 Social Security Number

X12N HIPAA Notes:

The social security number may not be used for Medicare.

XX Health Care Financing Administration National Provider Identifier

NM109

67

Identification Code

X AN 2/80 R

Code identifying a party or other code

X12N HIPAA Notes:

ALIAS: Pay-to Provider Primary Identification Number

NSF Reference: BA0-09.0, CA0-28.0, BA0-02.0, BA1-02.0, YA0-02.0, BA0-06.0, BA0-10.0, BA0-12.0, BA0-13.0, BA0-14.0, BA0-15.0, BA0-16.0, BA0-17.0, BA0-24.0, YA0-06.0

INDUSTRY: Pay-to Provider Identifier

ODJFS User Note:

For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop with the EI or SY qualifier code.

Atypical providers should send their EIN or SSN in the NM1 segment and their Medicaid 7-digit legacy ID in the REF segment with an REF01 qualifier of 1D.

Segment: N3 Pay-to Provider Address
Position: 025
Loop: 2010AB Optional
Level: Detail
Usage: Optional (Must Use)
Max Use: 1
Purpose: To specify the location of the named party
Syntax Notes:
Semantic Notes:
Comments:
Notes: X12N HIPAA Example

Example: N3*225 MAIN STREET*BARKLEY BUILDING~

Data Element Summary

<u>Ref.</u>	<u>Data</u>	<u>Name</u>	<u>Base</u>	<u>User</u>
<u>Des.</u>	<u>Element</u>		<u>Attributes</u>	<u>Attributes</u>
N301	166	Address Information Address information X12N HIPAA Notes: ALIAS: Pay-to Provider Address 1 NSF Reference: BA1-13.0, BA1-07.0 INDUSTRY: Pay-to Provider Address Line	M AN 1/55	R
N302	166	Address Information Address information X12N HIPAA Notes: Required if a second address line exists. ALIAS: Pay-to Provider Address 2 NSF Reference: BA1-14.0, BA1-08.0 INDUSTRY: Pay-to Provider Address Line	O AN 1/55	S

Segment: N4 Pay-to Provider City/State/ZIP Code
Position: 030
Loop: 2010AB Optional
Level: Detail
Usage: Optional (Must Use)
Max Use: 1
Purpose: To specify the geographic place of the named party
Syntax Notes:
Semantic Notes:
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: **X12N HIPAA Example**
 Example: N4*CENTERVILLE*PA*17111~

Data Element Summary

<u>Ref.</u> <u>Des.</u>	<u>Data</u> <u>Element</u>	<u>Name</u>	<u>Base</u> <u>Attributes</u>	<u>User</u> <u>Attributes</u>
N401	19	City Name Free-form text for city name X12N HIPAA Notes: ALIAS: Pay-to Provider City Name NSF Reference: BA1-15.0, BA1-09.0 INDUSTRY: Pay-to Provider City Name	O AN 2/30	R
N402	156	State or Province Code Code (Standard State/Province) as defined by appropriate government agency X12N HIPAA Notes: ALIAS: Pay-to Provider State Code NSF Reference: BA1-16.0, BA1-10.0 INDUSTRY: Pay-to Provider State Code	O ID 2/2	R
N403	116	Postal Code Code defining international postal zone code excluding punctuation and blanks (zip code for United States) X12N HIPAA Notes: ALIAS: Pay-to Provider Zip Code NSF Reference: BA1-17.0, BA1-11.0 INDUSTRY: Pay-to Provider Postal Zone or ZIP Code	O ID 3/15	R
N404	26	Country Code Code identifying the country X12N HIPAA Notes: Required if the address is out of the U.S. ALIAS: Pay-to Provider Country Code INDUSTRY: Country Code	O ID 2/3	S

Segment: **REF** Pay-to-Provider Secondary Identification
Position: 035
Loop: 2010AB Optional
Level: Detail
Usage: Optional
Max Use: 5
Purpose: To specify identifying information
Syntax Notes:
Semantic Notes: 1 REF04 contains data relating to the value cited in REF02.
Comments:
Notes:

X12N HIPAA Notes

Required when a secondary identification number is necessary to identify the entity. The primary identification number should be carried in NM109 in this loop.

If "code XX - NPI" is used in the NM108/09 of this loop, then either the Employer's Identification Number or the Social Security Number of the provider must be carried in this REF. The number sent is the one which is used on the 1099. If additional numbers are needed the REF can be run up to 5 times.

X12N HIPAA Example

Example: REF*1G*98765~

ODJFS User Note

The National Provider Identifier is mandated to be used on electronic claims on and after May 23, 2008. ODJFS will deny electronic claims that are missing an NPI in the pay-to loop on the 837 electronic claim transactions. Although the legacy ID is not required, ODJFS will continue to accept claims that contain both the NPI and legacy ID in the billing loop of the electronic claim until further notice. If it is included, a legacy ID will be validated. An invalid legacy ID will be rejected.

For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop with the EI or SY qualifier code.

Atypical providers should send their EIN or SSN in the NM1 segment and their Medicaid 7-digit legacy ID in the REF segment with an REF01 qualifier of 1D.

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification	M ID 2/3	R
X12N HIPAA Notes:				
INDUSTRY: Reference Identification Qualifier				
		1D Medicaid Provider Number		
		EI Employer's Identification Number		
		SY Social Security Number		
X12N HIPAA Notes:				
The social security number may not be used for Medicare.				
REF02	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	O AN 1/30	R AN 7/7
X12N HIPAA Notes:				
ALIAS: Pay-to Provider Additional Identifier				
NSF Reference: BA0-09.0, CA0-28.0, BA0-02.0, BA1-02.0, YA0-02.0, BA0-06.0, BA0-10.0, BA0-12.0, BA0-13.0, BA0-14.0, BA0-15.0, BA0-16.0, BA0-17.0, BA0-24.0, YA0-06.0				

INDUSTRY: Pay-to Provider Identifier

ODJFS User Note:

For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop with the EI or SY qualifier code.

Atypical providers should send their EIN or SSN in the NM1 segment and their Medicaid 7-digit legacy ID in the REF segment with an REF01 qualifier of 1D.

Segment: **HL** **Subscriber Hierarchical Level**
Position: 001
Loop: 2000B Mandatory
Level: Detail
Usage: Mandatory
Max Use: 1
Purpose: To identify dependencies among and the content of hierarchically related groups of data segments

Syntax Notes:

Semantic Notes:

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.
The HL segment defines a top-down/left-right ordered structure.
- 2 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.
- 3 HL02 identifies the hierarchical ID number of the HL segment to which the current HL segment is subordinate.
- 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:

X12N HIPAA Notes

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.

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). In addition, information about the credit/debit card holder is placed in this HL (Loop ID-2010BD). The credit/debit card holder may or may not be the subscriber. See Appendix G, Credit/Debit Card Use, for a description of using Loop ID-2010BD.

Because this is a required segment, this is a required loop. See Appendix A for further details on ASC X12 syntax rules.

Receiving trading partners may have system limitations regarding the size of the transmission they can receive. The developers of this implementation 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 Subscriber Hierarchical Level loops, there is an implied maximum of 5000.

X12N HIPAA Example

Example: HL*2*1*22*1~

ODJFS User Note

For Ohio Medicaid, the "insured", "subscriber", and the "patient" are always the same person.

Data Element Summary

<u>Ref.</u>	<u>Data</u>	<u>Name</u>	<u>Base</u>	<u>User</u>
<u>Des.</u>	<u>Element</u>		<u>Attributes</u>	<u>Attributes</u>
HL01	628	Hierarchical ID Number	M AN 1/12	R

A unique number assigned by the sender to identify a particular data segment in a

hierarchical structure

X12N HIPAA Notes:

INDUSTRY: Hierarchical ID Number

HL02 734 Hierarchical Parent ID Number O AN 1/12 R

Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to

X12N HIPAA Notes:

INDUSTRY: Hierarchical Parent ID Number

HL03 735 Hierarchical Level Code M ID 1/2 R

Code defining the characteristic of a level in a hierarchical structure

X12N HIPAA Notes:

INDUSTRY: Hierarchical Level Code

22 Subscriber

Identifies the employee or group member who is covered for insurance and to whom, or on behalf of whom, the insurer agrees to pay benefits

HL04 736 Hierarchical Child Code O ID 1/1 R

Code indicating if there are hierarchical child data segments subordinate to the level being described

X12N HIPAA Notes:

The claim loop (Loop ID-2300) can be used both when HL04 has no subordinate levels (HL04 = 0) or when HL04 has subordinate levels indicated (HL04 = 1).

In the first case (HL04 = 0), the subscriber is the patient and there are no dependent claims. The second case (HL04 = 1) happens when claims/encounters for both the subscriber and a dependent of theirs are being sent under the same billing provider HL (e.g., a father and son are both involved in the same automobile accident and are treated by the same provider). In that case, the subscriber HL04 = 1 because there is a dependent to this subscriber, but the 2300 loop for the subscriber/patient (father) would begin after the subscriber HL. The dependent HL (son) would then be run and the 2300 loop for the dependent/patient would be run after that HL. HL04=1 would also be used when a claim/encounter for a only a dependent is being sent.

INDUSTRY: Hierarchical Child Code

0 No Subordinate HL Segment in This Hierarchical Structure.

Segment: **SBR** Subscriber Information
Position: 005
Loop: 2000B Mandatory
Level: Detail
Usage: Optional (Must Use)
Max Use: 1
Purpose: To record information specific to the primary insured and the insurance carrier for that insured

Syntax Notes:
Semantic Notes: 1 SBR02 specifies the relationship to the person insured.
 2 SBR03 is policy or group number.
 3 SBR04 is plan name.

Comments:
Notes: **X12N HIPAA Example**

Example: SBR*P**GRP01020102*****MB~

Data Element Summary

<u>Ref.</u>	<u>Data</u>	<u>Name</u>	<u>Base</u>	<u>User</u>
<u>Des.</u>	<u>Element</u>		<u>Attributes</u>	<u>Attributes</u>
SBR01	1138	Payer Responsibility Sequence Number Code	M ID 1/1	R

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

X12N HIPAA Notes:

ALIAS: Payer Responsibility Sequence Number Code

NSF Reference: DA1-02.0, DA0-02.0, DA2-02.0

INDUSTRY: Payer Responsibility Sequence Number Code

ODJFS User Note:

When there is other payer liability for this claim, ODJFS expects the SBR01 to be either "S" or "T". This condition includes an ODJFS supplemental payment to a Federally Qualified Health Clinic (FQHC) or Rural Health Clinic (RHC).

P	Primary
S	Secondary
T	Tertiary

X12N HIPAA Notes:

Use to indicate 'payer of last resort'.

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

Code indicating the relationship between two individuals or entities

X12N HIPAA Notes:

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.

ALIAS: Relationship Code

NSF Reference: DA0-17.0

INDUSTRY: Individual Relationship Code

ODJFS User Note:

Required because for Medicaid, the subscriber is always the same person as the patient.

18	Self
----	------

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

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

X12N HIPAA Notes:

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).

ALIAS: Group or Policy Number

NSF Reference: DA0-10.0

INDUSTRY: Insured Group or Policy Number

SBR04 93 Name O AN 1/60 S

Free-form name

X12N HIPAA Notes:

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

ALIAS: Group or Plan Name

NSF Reference: DA0-11.0

INDUSTRY: Insured Group Name

SBR05 1336 Insurance Type Code O ID 1/3 S

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

X12N HIPAA Notes:

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

ALIAS: Insurance type code

NSF Reference: DA0-06.0

INDUSTRY: Insurance Type Code

- 12 Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan
- 13 Medicare Secondary End-Stage Renal Disease Beneficiary in the 12 month coordination period with an employer's group health plan
- 14 Medicare Secondary, No-fault Insurance including Auto is Primary
- 15 Medicare Secondary Worker's Compensation
- 16 Medicare Secondary Public Health Service (PHS) or Other Federal Agency
- 41 Medicare Secondary Black Lung
- 42 Medicare Secondary Veteran's Administration
- 43 Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health Plan (LGHP)
- 47 Medicare Secondary, Other Liability Insurance is Primary

SBR06 1143 Coordination of Benefits Code O ID 1/1 N/U

Refer to 004010X098A1 Data Element Dictionary for acceptable code values.

SBR07 1073 Yes/No Condition or Response Code O ID 1/1 N/U

Refer to 004010X098A1 Data Element Dictionary for acceptable code values.

SBR08 584 Employment Status Code O ID 2/2 N/U

Refer to 004010X098A1 Data Element Dictionary for acceptable code values.

SBR09 1032 Claim Filing Indicator Code O ID 1/2 S

Code identifying type of claim

X12N HIPAA Notes:

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

ALIAS: Claim Filing Indicator Code

INDUSTRY: Claim Filing Indicator Code

ODJFS Application Notes:

Since Medicaid is the destination payer "MC" must be submitted.

MC

Medicaid

X12N HIPAA Notes:

CA0-23.0 (D), DA0-05.0 (D)

Segment: **NM1** Subscriber Name
Position: 015
Loop: 2010BA Optional (Must Use)
Level: Detail
Usage: Optional (Must Use)
Max Use: 1
Purpose: To supply the full name of an individual or organizational entity
Syntax Notes: 1 If either NM108 or NM109 is present, then the other is required.
Semantic Notes: 1 NM102 qualifies NM103.
Comments:
Notes:

X12N HIPAA Notes

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.

Because this is a required segment, this is a required loop. See Appendix A for further details on ASC X12 syntax rules.

X12N HIPAA Example

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

ODJFS User Note

No claim can be paid if the NM109 does not contain a valid 12-digit Medicaid recipient billing number or a Disability Assistance billing number.

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
NM101	98	Entity Identifier Code Code identifying an organizational entity, a physical location, property or an individual X12N HIPAA Notes: INDUSTRY: Entity Identifier Code	M ID 2/3	R
		IL Insured or Subscriber		
NM102	1065	Entity Type Qualifier Code qualifying the type of entity X12N HIPAA Notes: INDUSTRY: Entity Type Qualifier	M ID 1/1	R
		1 Person		
		2 Non-Person Entity		
NM103	1035	Name Last or Organization Name Individual last name or organizational name X12N HIPAA Notes: ALIAS: Subscriber Last Name NSF Reference: CA0-04.0, DA0-19.0 INDUSTRY: Subscriber Last Name	O AN 1/35	R
NM104	1036	Name First Individual first name X12N HIPAA Notes: Required if NM102=1 (person). ALIAS: Subscriber First Name NSF Reference: CA0-05.0, DA0-20.0 INDUSTRY: Subscriber First Name	O AN 1/25	S
NM105	1037	Name Middle Individual middle name or initial	O AN 1/25	S

X12N HIPAA Notes:

Required if NM102=1 and the middle name/initial of the person is known.

ALIAS: Subscriber Middle Name

NSF Reference: CA0-06.0, DA0-21.0

INDUSTRY: Subscriber Middle Name

NM106	1038	Name Prefix	O	AN 1/10	N/U
NM107	1039	Name Suffix	O	AN 1/10	N/U
NM108	66	Identification Code Qualifier	X	ID 1/2	R

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

X12N HIPAA Notes:

Required if NM102 = 1 (person)

INDUSTRY: Identification Code Qualifier

MI Member Identification Number

X12N HIPAA Notes:

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.

MI is also intended to be used in claims submitted to the Indian Health Service/Contract Health Services (IHS/CHS) Fiscal Intermediary for the purpose of reporting the Tribe Residency Code (Tribe County State).

In the event that a Social Security Number is also available on an IHS/CHS claim, put the SSN in REF02.

NM109	67	Identification Code	X	AN 2/80	R	AN 12/12
--------------	-----------	----------------------------	----------	----------------	----------	-----------------

Code identifying a party or other code

X12N HIPAA Notes:

Required if NM102 = 1 (person)

ALIAS: Subscriber Primary Identifier

NSF Reference: DA0-18.0, CA1-05.0, CA1-06.0

INDUSTRY: Subscriber Primary Identifier

ODJFS User Note:

12-digit Medicaid Recipient ID or the 12-digit Ohio Disability Assistance Billing number

Segment: N3 Subscriber Address
Position: 025
Loop: 2010BA Optional (Must Use)
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To specify the location of the named party
Syntax Notes:
Semantic Notes:
Comments:
Notes:

X12N HIPAA Notes

Required if the patient is the same person as the subscriber. (Required when Loop ID-2000B, SBR02=18 (self)).

X12N HIPAA Example

Example: N3*125 CITY AVENUE~

Data Element Summary

<u>Ref.</u>	<u>Data</u>	<u>Name</u>	<u>Base</u>	<u>User</u>
<u>Des.</u>	<u>Element</u>		<u>Attributes</u>	<u>Attributes</u>
N301	166	Address Information Address information X12N HIPAA Notes: ALIAS: Subscriber Address 1 NSF Reference: CA0-11.0, DA2-04.0	M AN 1/55	R
N302	166	Address Information Address information X12N HIPAA Notes: Required if a second address line exists. ALIAS: Subscriber Address 2 NSF Reference: CA0-12.0, DA2-05.0 INDUSTRY: Subscriber Address Line	O AN 1/55	S

Segment: N4 Subscriber City/State/ZIP Code
Position: 030
Loop: 2010BA Optional (Must Use)
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To specify the geographic place of the named party
Syntax Notes:
Semantic Notes:
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: **X12N HIPAA Notes**

Required if the patient is the same person as the subscriber. (Required when Loop ID-2000B, SBR02=18 (self)).

X12N HIPAA Example

Example: N4*CENTERVILLE*PA*17111~

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
N401	19	City Name Free-form text for city name X12N HIPAA Notes: ALIAS: Subscriber City Name NSF Reference: DA2-06.0, CA0-13.0 INDUSTRY: Subscriber City Name	O AN 2/30	R
N402	156	State or Province Code Code (Standard State/Province) as defined by appropriate government agency X12N HIPAA Notes: ALIAS: Subscriber State Code NSF Reference: CA0-14.0, DA2-07.0 INDUSTRY: Subscriber State Code	O ID 2/2	R
N403	116	Postal Code Code defining international postal zone code excluding punctuation and blanks (zip code for United States) X12N HIPAA Notes: ALIAS: Subscriber Zip Code NSF Reference: CA0-15.0, DA2-08.0 INDUSTRY: Subscriber Postal Zone or ZIP Code	O ID 3/15	R
N404	26	Country Code Code identifying the country X12N HIPAA Notes: Required if the address is out of the U.S. ALIAS: Subscriber Country Code INDUSTRY: Country Code	O ID 2/3	S

Segment: **DMG** **Subscriber Demographic Information**
Position: 032
Loop: 2010BA Optional (Must Use)
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To supply demographic information
Syntax Notes: 1 If either DMG01 or DMG02 is present, then the other is required.
Semantic Notes: 1 DMG02 is the date of birth.
Comments:
Notes:

X12N HIPAA Notes

Required if the patient is the same person as the subscriber. (Required when Loop ID-2000B, SBR02=18 (self)).

X12N HIPAA Example

Example: DMG*D8*19330706*M~

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
DMG01	1250	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format X12N HIPAA Notes: INDUSTRY: Date Time Period Format Qualifier D8 Date Expressed in Format CCYYMMDD	X ID 2/3	R
DMG02	1251	Date Time Period Expression of a date, a time, or range of dates, times or dates and times X12N HIPAA Notes: ALIAS: Patient Birth Date Date of Birth - Patient NSF Reference: CA0-08.0, DA0-24.0 INDUSTRY: Subscriber Birth Date	X AN 1/35	R
DMG03	1068	Gender Code Code indicating the sex of the individual X12N HIPAA Notes: ALIAS: Patient Gender Code Gender - Patient NSF Reference: CA0-09.0, DA0-23.0 INDUSTRY: Subscriber Gender Code F Female M Male U Unknown	O ID 1/1	R

Segment: **NM1** Payer Name
Position: 015
Loop: 2010BB Optional (Must Use)
Level: Detail
Usage: Optional (Must Use)
Max Use: 1
Purpose: To supply the full name of an individual or organizational entity
Syntax Notes: 1 If either NM108 or NM109 is present, then the other is required.
Semantic Notes: 1 NM102 qualifies NM103.
Comments:
Notes:

X12N HIPAA Notes

This is the destination payer.

Because this is a required segment, this is a required loop. See Appendix A for further details on ASC X12 syntax rules.

X12N HIPAA Example

Example: NM1*PR*2*UNION MUTUAL OF OREGON*****PI*11122333~

Data Element Summary

Ref. Des.	Data Element	Name	Base Attributes	User Attributes
NM101	98	Entity Identifier Code	M ID 2/3	R
		Code identifying an organizational entity, a physical location, property or an individual		
		X12N HIPAA Notes:		
		INDUSTRY: Entity Identifier Code		
		PR Payer		
NM102	1065	Entity Type Qualifier	M ID 1/1	R
		Code qualifying the type of entity		
		X12N HIPAA Notes:		
		INDUSTRY: Entity Type Qualifier		
		2 Non-Person Entity		
NM103	1035	Name Last or Organization Name	O AN 1/35	R
		Individual last name or organizational name		
		X12N HIPAA Notes:		
		ALIAS: Payer Name		
		NSF Reference: DA0-09.0		
		INDUSTRY: Payer Name		
NM104	1036	Name First	O AN 1/25	N/U
NM105	1037	Name Middle	O AN 1/25	N/U
NM106	1038	Name Prefix	O AN 1/10	N/U
NM107	1039	Name Suffix	O AN 1/10	N/U
NM108	66	Identification Code Qualifier	X ID 1/2	R
		Code designating the system/method of code structure used for Identification Code (67)		
		X12N HIPAA Notes:		
		INDUSTRY: Identification Code Qualifier		
		PI Payor Identification		
		XV Health Care Financing Administration National Payer Identification Number (PAYERID)		
NM109	67	Identification Code	X AN 2/80	R
		Code identifying a party or other code		
		X12N HIPAA Notes:		
		ALIAS: Payer Primary Identifier		

NSF Reference: DA0-07.0

INDUSTRY: Payer Identifier

ODJFS User Note:

ODJFS Payer ID = MMISODJFS

Segment: **CLM Claim Information**
Position: 130
Loop: 2300 Optional (Must Use)
Level: Detail
Usage: Optional (Must Use)
Max Use: 1
Purpose: To specify basic data about the claim
Syntax Notes:
Semantic Notes:

- 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.

Comments:

Notes: X12N HIPAA Notes

Because this is a required segment, this is a required loop. See Appendix A for further details on ASC X12 syntax rules.

The developers of this implementation guide recommend that trading partners limit the size of the transaction (ST-SE envelope) to a maximum of 5000 CLM segments. There is no recommended limit to the number of ST-SE transactions within a GS-GE or ISA-IEA. Willing trading partners can agree to set limits higher.

For purposes of this documentation, the claim detail information is presented only in the dependent level. Specific claim detail information can be given in either the subscriber or the dependent hierarchical level. Because of this the claim information is said to "float." Claim information is positioned in the same hierarchical level that describes its owner-participant, either the subscriber or the dependent. In other words, the claim information, loop 2300, is placed following loop 2010BD in the subscriber hierarchical level when the patient is the subscriber, or it is placed at the patient/dependent hierarchical level when the patient is the dependent of the subscriber as shown here. When the patient is the subscriber, loops 2000C and 2010CA are not sent. See 2.3.2.1, HL Segment, for details.

X12N HIPAA Example

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

Data Element Summary

<u>Ref.</u>	<u>Data</u>		<u>Base</u>	<u>User</u>
<u>Des.</u>	<u>Element</u>	<u>Name</u>	<u>Attributes</u>	<u>Attributes</u>
CLM01	1028	Claim Submitter's Identifier	M AN 1/38	R AN 1/20

Identifier used to track a claim from creation by the health care provider through payment

X12N HIPAA Notes:

The number that the submitter transmits in this position is echoed back to the submitter in the 835 and other transactions. This permits the submitter to use the value in this field as a key in the submitter's system to match the claim to the payment information returned in the 835 transaction. The two recommended identifiers are either the Patient Account Number or the Claim Number in the billing submitter's patient management system. The developers of this implementation guide strongly recommend that submitters use completely unique numbers for this field for each individual claim.

The maximum number of characters to be supported for this field is '20'. A provider may submit fewer characters depending upon their needs. However, the HIPAA maximum requirement to be supported by any responding system is '20'. Characters beyond 20 are not required to be stored nor returned by any 837-receiving system.

ALIAS: Patient Account Number

NSF Reference: CA0-03.0, CB0-03.0, DA0-03.0, DA1-03.0, DA2-03.0, EA0-03.0, EA1-

03.0, EA2-03.0, FA0-03.0, FB0-03.0, FB1-03.0, FB2-03.0, FD0-03.0, FE0-03.0, GA0-03.0, GC0-03.0, GX0-03.0, GX2-03.0, XA0-03.0, CA1-03.0, GU0-03.0, HA0-03.0

INDUSTRY: Patient Account Number

ODJFS Application Notes:

Returned on 835.

CLM02 782 Monetary Amount O R 1/10 R

Monetary amount

X12N HIPAA Notes:

For encounter transmissions, zero (0) may be a valid amount.

ALIAS: Total Submitted Charges

NSF Reference: XA0-12.0

INDUSTRY: Total Claim Charge Amount

ODJFS Application Notes:

Used for Claim Processing

ODJFS User Note:

Total claim charges must be equal to the sum of all line item charges. In addition, for TPL claims, total charges must balance against CAS and prior payments.

CLM03 1032 Claim Filing Indicator Code O ID 1/2 N/U

Refer to 004010X098A1 Data Element Dictionary for acceptable code values.

CLM04 1343 Non-Institutional Claim Type Code O ID 1/2 N/U

Refer to 004010X098A1 Data Element Dictionary for acceptable code values.

CLM05 C023 Health Care Service Location Information O R

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

X12N HIPAA Notes:

CLM05 applies to all service lines unless it is over written at the line level.

ALIAS: Place of Service Code

NSF Reference: FA0-07.0

C02301 1331 Facility Code Value M AN 1/2 R

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

X12N HIPAA Notes:

Use this element for codes identifying a place of service from code source 237. As a courtesy, the codes are listed below, however, the code list is thought to be complete at the time of publication of this implementation guideline. Since this list is subject to change, only codes contained in the document available from code source 237 are to be supported in this transaction and take precedence over any and all codes listed here.

- 03 School
- 11 Office
- 12 Home
- 21 Inpatient Hospital
- 22 Outpatient Hospital
- 23 Emergency Room - Hospital
- 24 Ambulatory Surgical Center
- 25 Birthing Center
- 26 Military Treatment Facility
- 31 Skilled Nursing Facility
- 32 Nursing Facility
- 33 Custodial Care Facility
- 34 Hospice
- 41 Ambulance - Land

- 42 Ambulance - Air or Water
- 51 Inpatient Psychiatric Facility
- 52 Psychiatric Facility Partial Hospitalization
- 53 Community Mental Health Center
- 54 Intermediate Care Facility/Mentally Retarded
- 55 Residential Substance Abuse Treatment Facility
- 56 Psychiatric Residential Treatment Center
- 50 Federally Qualified Health Center
- 60 Mass Immunization Center
- 61 Comprehensive Inpatient Rehabilitation Facility
- 62 Comprehensive Outpatient Rehabilitation Facility
- 65 End Stage Renal Disease Treatment Facility
- 71 State or Local Public Health Clinic
- 72 Rural Health Clinic
- 81 Independent Laboratory
- 99 Other Unlisted Facility

ALIAS: Facility Type Code

INDUSTRY: Facility Type Code

ODJFS Application Notes:

Used for Claim Processing

C02302 1332 Facility Code Qualifier O ID 1/2 N/U

Refer to 004010X098A1 Data Element Dictionary for acceptable code values.

C02303 1325 Claim Frequency Type Code O ID 1/1 R

Code specifying the frequency of the claim; this is the third position of the Uniform Billing Claim Form Bill Type

X12N HIPAA Notes:

Industry: Claim Frequency Code

ODJFS Application Notes:

Used for Claim Processing

CLM06 1073 Yes/No Condition or Response Code O ID 1/1 R

Code indicating a Yes or No condition or response

X12N HIPAA Notes:

ALIAS: Provider Signature on File

NSF Reference: EA0-37.0

INDUSTRY: Provider or Supplier Signature Indicator

- N No
- Y Yes

CLM07 1359 Provider Accept Assignment Code O ID 1/1 R

Code indicating whether the provider accepts assignment

X12N HIPAA Notes:

CLM07 indicates whether the provider accepts Medicare assignment.

The NSF mapping to FA0-59.0 occurs only in payer-to-payer COB situations.

ALIAS: Medicare Assignment Code

NSF Reference: EA0-36.0, FA0-59.0

INDUSTRY: Medicare Assignment Code

- A Assigned
- B Assignment Accepted on Clinical Lab Services Only
- C Not Assigned
- P Patient Refuses to Assign Benefits

CLM08	1073	Yes/No Condition or Response Code	O	ID 1/1	R
Code indicating a Yes or No condition or response					
X12N HIPAA Notes:					
ALIAS: Assignment of Benefits Indicator					
NSF Reference: DA0-15.0					
INDUSTRY: Benefits Assignment Certification Indicator					
N No					
Y Yes					
CLM09	1363	Release of Information Code	O	ID 1/1	R
Code indicating whether the provider has on file a signed statement by the patient authorizing the release of medical data to other organizations					
X12N HIPAA Notes:					
ALIAS: Release of Information Code					
NSF Reference: EA0-13.0					
INDUSTRY: Release of Information Code					
A Appropriate Release of Information on File at Health Care Service Provider or at Utilization Review Organization					
I Informed Consent to Release Medical Information for Conditions or Diagnoses Regulated by Federal Statutes					
M The Provider has Limited or Restricted Ability to Release Data Related to a Claim					
N No, Provider is Not Allowed to Release Data					
O On file at Payor or at Plan Sponsor					
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	N/U
B Signed signature authorization form or forms for both HCFA-1500 Claim Form block 12 and block 13 are on file					
C Signed HCFA-1500 Claim Form on file					
M Signed signature authorization form for HCFA-1500 Claim Form block 13 on file					
P Signature generated by provider because the patient was not physically present for services					
S Signed signature authorization form for HCFA-1500 Claim Form block 12 on file					
CLM11	C024	Related Causes Information	O		S
To identify one or more related causes and associated state or country information					
X12N HIPAA Notes:					
CLM11-1, CLM11-2, or CLM11-3 are required when the condition being reported is accident or employment related. If CLM11-1, CLM11-2, or CLM11-3 equals AP, then map Yes to EA0-09.0.					
If DTP - Date of Accident (DTP01=439) is used, then CLM11 is required.					
ALIAS: Accident/Employment/Related Causes					
C02401	1362	Related-Causes Code	M	ID 2/3	R
Code identifying an accompanying cause of an illness, injury or an accident					
Business Rules:					
Variable Name:2300CLM1101Accident					
X12N HIPAA Notes:					
NSF Reference: EA0-05.0 - Auto Accident or Other Accident, EA0-04.0 - Employment, EA0-09.0 - Responsibility Indicator					

INDUSTRY: Related Causes Code

ODJFS Application Notes:

Used in Claim Processing

AA Auto Accident
AP Another Party Responsible
EM Employment
OA Other Accident

C02402 1362 Related-Causes Code O ID 2/3 S

Code identifying an accompanying cause of an illness, injury or an accident

Business Rules:

Variable Name:2300CLM1102Accident

X12N HIPAA Notes:

Used if more than one code applies.

NSF Reference: EA0-05.0 - Auto Accident or Other Accident, EA0-04.0 - Employment, EA0-09.0 - Responsibility Indicator

INDUSTRY: Related Causes Code

AA Auto Accident
AP Another Party Responsible
EM Employment
OA Other Accident

C02403 1362 Related-Causes Code O ID 2/3 S

Code identifying an accompanying cause of an illness, injury or an accident

Business Rules:

Variable Name:2300CLM1103Accident

X12N HIPAA Notes:

Used if more than one code applies.

NSF Reference: EA0-05.0 - Auto Accident or Other Accident, EA0-04.0 - Employment, EA0-09.0 - Responsibility Indicator

INDUSTRY: Related Causes Code

AA Auto Accident
AP Another Party Responsible
EM Employment
OA Other Accident

C02404 156 State or Province Code O ID 2/2 S

Code (Standard State/Province) as defined by appropriate government agency

X12N HIPAA Notes:

Required if CLM11-1, -2, or -3 = AA to identify the state in which the automobile accident occurred. Use state postal code (CA = California, UT = Utah, etc).

NSF Reference: EA0-10.0

INDUSTRY: Auto Accident State or Province Code

C02405 26 Country Code O ID 2/3 S

Code identifying the country

X12N HIPAA Notes:

Required if the automobile accident occurred out of the United States to identify the country in which the accident occurred.

INDUSTRY: Country Code

Segment: **DTP** Date - Initial Treatment
Position: 135
Loop: 2300 Optional (Must Use)
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To specify any or all of a date, a time, or a time period
Syntax Notes:
Semantic Notes: 1 DTP02 is the date or time or period format that will appear in DTP03.
Comments:
Notes:

X12N HIPAA Notes

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.

Required on all claims involving spinal manipulation for Medicare Part B.

X12N HIPAA Example

Example: DTP*454*D8*19970115~

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
DTP01	374	Date/Time Qualifier	M ID 3/3	R
		Code specifying type of date or time, or both date and time		
		X12N HIPAA Notes:		
		INDUSTRY: Date Time Qualifier		
		454 Initial Treatment		
		Date medical treatment first began		
DTP02	1250	Date Time Period Format Qualifier	M ID 2/3	R
		Code indicating the date format, time format, or date and time format		
		X12N HIPAA Notes:		
		INDUSTRY: Date Time Period Format Qualifier		
		D8 Date Expressed in Format CCYYMMDD		
DTP03	1251	Date Time Period	M AN 1/35	R
		Expression of a date, a time, or range of dates, times or dates and times		
		X12N HIPAA Notes:		
		NSF Reference: GC0-05.0		
		INDUSTRY: Initial Treatment Date		

Segment: **DTP** Date - Onset of Current Illness/Symptom
Position: 135
Loop: 2300 Optional (Must Use)
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To specify any or all of a date, a time, or a time period
Syntax Notes:
Semantic Notes: 1 DTP02 is the date or time or period format that will appear in DTP03.
Comments:
Notes:

X12N HIPAA Notes

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.

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.

X12N HIPAA Example

Example: DTP*431*D8*19970115~

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
DTP01	374	Date/Time Qualifier Code specifying type of date or time, or both date and time X12N HIPAA Notes: INDUSTRY: Date Time Qualifier 431 Onset of Current Symptoms or Illness Date first symptoms appeared	M ID 3/3	R
DTP02	1250	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format X12N HIPAA Notes: INDUSTRY: Date Time Period Format Qualifier ODJFS User Note: ODJFS does not accept date ranges. D8 Date Expressed in Format CCYYMMDD	M ID 2/3	R
DTP03	1251	Date Time Period Expression of a date, a time, or range of dates, times or dates and times X12N HIPAA Notes: NSF Reference: EA0-07.0 INDUSTRY: Onset of Current Illness or Injury Date	M AN 1/35	R

Segment: **DTP** Date - Similar Illness/Symptom Onset
Position: 135
Loop: 2300 Optional (Must Use)
Level: Detail
Usage: Optional
Max Use: 10
Purpose: To specify any or all of a date, a time, or a time period
Syntax Notes:
Semantic Notes: 1 DTP02 is the date or time or period format that will appear in DTP03.
Comments:
Notes:

X12N HIPAA Notes

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.

Required when claim involves services to a patient experiencing symptoms similar or identical to previously reported symptoms.

X12N HIPAA Example

Example: DTP*438*D8*19970115~

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
DTP01	374	Date/Time Qualifier Code specifying type of date or time, or both date and time X12N HIPAA Notes: INDUSTRY: Date Time Qualifier 438 Onset of Similar Symptoms or Illness Date symptoms related to current illness first appeared	M ID 3/3	R
DTP02	1250	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format X12N HIPAA Notes: INDUSTRY: Date Time Period Format Qualifier ODJFS User Note: ODJFS does not accept date ranges. D8 Date Expressed in Format CCYYMMDD	M ID 2/3	R
DTP03	1251	Date Time Period Expression of a date, a time, or range of dates, times or dates and times X12N HIPAA Notes: NSF Reference: EA0-16.0 INDUSTRY: Similar Illness or Symptom Date	M AN 1/35	R

Segment: **DTP** Date - Accident
Position: 135
Loop: 2300 Optional (Must Use)
Level: Detail
Usage: Optional (Dependent)
Max Use: 10
Purpose: To specify any or all of a date, a time, or a time period
Syntax Notes:
Semantic Notes: 1 DTP02 is the date or time or period format that will appear in DTP03.
Comments:
Business Rules:

1. If 2300CLM1101Accident EQ 'AA', then set Usage to 'Must Use'
2. If 2300CLM1102Accident EQ 'AA', then set Usage to 'Must Use'
3. If 2300CLM1103Accident EQ 'AA', then set Usage to 'Must Use'

Notes:

X12N HIPAA Notes

Required if CLM11-1, CLM11-2, or CLM11-3 = AA, AB, AP or OA.

X12N HIPAA Example

Example: DTP*439*D8*19970114~

Data Element Summary

<u>Ref.</u> <u>Des.</u>	<u>Data</u> <u>Element</u>	<u>Name</u>	<u>Base</u> <u>Attributes</u>	<u>User</u> <u>Attributes</u>
DTP01	374	Date/Time Qualifier Code specifying type of date or time, or both date and time X12N HIPAA Notes: INDUSTRY: Date Time Qualifier 439 Accident Date mishap occurred	O ID 3/3	S
DTP02	1250	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format X12N HIPAA Notes: INDUSTRY: Date Time Period Format Qualifier ODJFS User Note: ODJFS does not accept date ranges. D8 Date Expressed in Format CCYYMMDD	M ID 2/3	R
DTP03	1251	Date Time Period Expression of a date, a time, or range of dates, times or dates and times X12N HIPAA Notes: NSF Reference: EA0-07.0 - Accident Date, EA0-11.0 Accident Hour (no minutes) INDUSTRY: Accident Date	O AN 1/35	S

Segment: **DTP** Date - Last Menstrual Period
Position: 135
Loop: 2300 Optional (Must Use)
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To specify any or all of a date, a time, or a time period
Syntax Notes:
Semantic Notes: 1 DTP02 is the date or time or period format that will appear in DTP03.
Comments:
Notes:

X12N HIPAA Notes

Required when claim involves pregnancy.

X12N HIPAA Example

Example: DTP*484*D8*19961113~

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
DTP01	374	Date/Time Qualifier Code specifying type of date or time, or both date and time X12N HIPAA Notes: INDUSTRY: Date Time Qualifier	M ID 3/3	R
		484 Last Menstrual Period		
DTP02	1250	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format X12N HIPAA Notes: INDUSTRY: Date Time Period Format Qualifier ODJFS User Note: ODJFS does not accept date ranges.	M ID 2/3	R
		D8 Date Expressed in Format CCYYMMDD		
DTP03	1251	Date Time Period Expression of a date, a time, or range of dates, times or dates and times X12N HIPAA Notes: NSF Reference: EA0-07.0 INDUSTRY: Last Menstrual Period Date	M AN 1/35	R

Segment: **DTP** Date - Last X-ray
Position: 135
Loop: 2300 Optional (Must Use)
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To specify any or all of a date, a time, or a time period
Syntax Notes:
Semantic Notes: 1 DTP02 is the date or time or period format that will appear in DTP03.
Comments:
Notes:

X12N HIPAA Notes

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.

Required when claim involves spinal manipulation if an x-ray was taken.

X12N HIPAA Example

Example: DTP*455*D8*19970114~

Data Element Summary

<u>Ref.</u> <u>Des.</u>	<u>Data</u> <u>Element</u>	<u>Name</u>	<u>Base</u> <u>Attributes</u>	<u>User</u> <u>Attributes</u>
DTP01	374	Date/Time Qualifier Code specifying type of date or time, or both date and time X12N HIPAA Notes: INDUSTRY: Date Time Qualifier 455 Last X-Ray Date of the most recent x-ray	M ID 3/3	R
DTP02	1250	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format X12N HIPAA Notes: INDUSTRY: Date Time Period Format Qualifier ODJFS User Note: ODJFS does not accept date ranges. D8 Date Expressed in Format CCYYMMDD	M ID 2/3	R
DTP03	1251	Date Time Period Expression of a date, a time, or range of dates, times or dates and times X12N HIPAA Notes: NSF Reference: GC0-06.0 INDUSTRY: Last X-Ray Date	M AN 1/35	R

Segment: **DTP** Date - Hearing and Vision Prescription Date
Position: 135
Loop: 2300 Optional (Must Use)
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To specify any or all of a date, a time, or a time period
Syntax Notes:
Semantic Notes: 1 DTP02 is the date or time or period format that will appear in DTP03.
Comments:
Notes:

X12N HIPAA Notes

Required on claims where a prescription has been written for hearing devices or vision frames and lenses and it is being billed on this claim.

ODJFS Application Notes

Used for Claim Processing

X12N HIPAA Example

Example: DTP*471*D8*19970115~

ODJFS User Note

Date the eyeglass vendor receives order.
This segment is used exclusively by eyeglass vendors.

Data Element Summary

<u>Ref.</u>	<u>Data</u>	<u>Name</u>	<u>Base</u>	<u>User</u>
<u>Des.</u>	<u>Element</u>		<u>Attributes</u>	<u>Attributes</u>
DTP01	374	Date/Time Qualifier Code specifying type of date or time, or both date and time X12N HIPAA Notes: INDUSTRY: Date Time Qualifier 471 Prescription Date on which prescription was written	M ID 3/3	R
DTP02	1250	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format X12N HIPAA Notes: INDUSTRY: Date Time Period Format Qualifier ODJFS User Note: ODJFS does not accept date ranges. D8 Date Expressed in Format CCYYMMDD	M ID 2/3	R
DTP03	1251	Date Time Period Expression of a date, a time, or range of dates, times or dates and times X12N HIPAA Notes: INDUSTRY: Prescription Date	M AN 1/35	R

Segment: **DTP** Date - Discharge
Position: 135
Loop: 2300 Optional (Must Use)
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To specify any or all of a date, a time, or a time period
Syntax Notes:
Semantic Notes: 1 DTP02 is the date or time or period format that will appear in DTP03.
Comments:
Notes:

X12N HIPAA Notes

Required for inpatient claims when the patient was discharged from the facility and the discharge date is known.

X12N HIPAA Example

Example: DTP*096*D8*19970115~

ODJFS User Note

Required for Home Health and Private Duty Nursing Providers when billing services provided as a result of a post-hospital stay.

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
DTP01	374	Date/Time Qualifier Code specifying type of date or time, or both date and time X12N HIPAA Notes: INDUSTRY: Date Time Qualifier 096 Discharge	M ID 3/3	R
DTP02	1250	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format X12N HIPAA Notes: INDUSTRY: Date Time Period Format Qualifier D8 Date Expressed in Format CCYYMMDD	M ID 2/3	R
DTP03	1251	Date Time Period Expression of a date, a time, or range of dates, times or dates and times X12N HIPAA Notes: NSF Reference: GA0-22.0 (for Ambulance Claims only), EA0-29.0 INDUSTRY: Related Hospitalization Discharge Date	M AN 1/35	R

Segment: **AMT Patient Amount Paid**
Position: 175
Loop: 2300 Optional (Must Use)
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To indicate the total monetary amount
Syntax Notes:
Semantic Notes:
Comments:
Notes:

X12N HIPAA Notes

Required when patient has made payment specifically toward this claim.

Patient Amount Paid refers to the sum of all amounts paid on the claim by the patient or his/her representative(s).

X12N HIPAA Example

Example: AMT*F5*152.45~

ODJFS User Note

At this time, Patient Paid Amount should be zero.

Data Element Summary

<u>Ref.</u> <u>Des.</u>	<u>Data</u> <u>Element</u>	<u>Name</u>	<u>Base</u> <u>Attributes</u>	<u>User</u> <u>Attributes</u>
AMT01	522	Amount Qualifier Code Code to qualify amount	M ID 1/3	R
		X12N HIPAA Notes:		
		INDUSTRY: Amount Qualifier Code		
		F5 Patient Amount Paid Monetary amount value already paid by one receiving medical care		
AMT02	782	Monetary Amount Monetary amount	M R 1/10	R
		X12N HIPAA Notes:		
		NSF Reference: XA0-19.0		
		INDUSTRY: Patient Amount Paid		

Segment: **REF** Prior Authorization or Referral Number
Position: 180
Loop: 2300 Optional (Must Use)
Level: Detail
Usage: Optional
Max Use: 2
Purpose: To specify identifying information
Syntax Notes:
Semantic Notes: 1 REF04 contains data relating to the value cited in REF02.
Comments:
Notes:

X12N HIPAA Notes

Numbers at this position apply to the entire claim unless they are overridden in the REF segment in Loop ID-2400. A reference identification is considered to be overridden if the value in REF01 is the same in both the Loop ID-2300 REF segment and the Loop ID-2400 REF segment. In that case, the Loop ID-2400 REF applies only to that specific line.

Required where services on this claim were preauthorized or where a referral is involved. Generally, preauthorization/referral numbers are those numbers assigned by the payer/UMO to authorize a service prior to its being performed. The UMO (Utilization Management Organization) is generally the entity empowered to make a decision regarding the outcome of a health services review or the owner of information. The referral or prior authorization number carried in this REF is specific to the destination payer reported in the 2010BB loop. If other payers have similar numbers for this claim, report that information in the 2330 loop REF which holds that payer's information.

X12N HIPAA Example

Example: REF*G1*13579~

ODJFS User Note

For ODJFS only certain procedure codes require prior authorization. See Ohio Medicaid Handbooks for services requiring prior authorization.

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification X12N HIPAA Notes: INDUSTRY: Reference Identification Qualifier ODJFS User Note: ODJFS only uses G1 in Claims Processing. G1 Prior Authorization Number An authorization number acquired prior to the submission of a claim	M ID 2/3	R
REF02	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier X12N HIPAA Notes: NSF Reference: DA0-14.0 INDUSTRY: Prior Authorization or Referral Number ODJFS User Note: Use the prior authorization number issued by ODJFS.	O AN 1/30	R

Segment: **REF** Original Reference Number (ICN/DCN)
Position: 180
Loop: 2300 Optional (Must Use)
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To specify identifying information
Syntax Notes:
Semantic Notes: 1 REF04 contains data relating to the value cited in REF02.
Comments:
Notes:

X12N HIPAA Notes

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.

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.

ODJFS Application Notes

Used for Claim Processing

X12N HIPAA Example

Example: REF*F8*R555588~

ODJFS User Note

Use this REF segment when submitting a reversal/correction to the original claim.

The value is the unique 17-digit transaction control number (TCN) assigned by Medicaid to the original claim. The format of this 17-digit TCN should not include any spaces or hyphens.

Data Element Summary

<u>Ref.</u>	<u>Data</u>	<u>Name</u>	<u>Base</u>	<u>User</u>
<u>Des.</u>	<u>Element</u>		<u>Attributes</u>	<u>Attributes</u>
REF01	128	Reference Identification Qualifier	M ID 2/3	R
		Code qualifying the Reference Identification		
		X12N HIPAA Notes:		
		INDUSTRY: Reference Identification Qualifier		
		F8 Original Reference Number		
REF02	127	Reference Identification	O AN 1/30	R
		Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier		
		X12N HIPAA Notes:		
		ALIAS: Claim Original Reference Number (ICN/DCN)		
		NSF Reference: EA0-47.0, INDUSTRY: Claim Original Reference Number		
		ODJFS User Note:		
		The value is the unique 17-digit transaction control number (TCN) assigned by Medicaid to the original claim. The format of this 17-digit TCN should not include any spaces or hyphens.		

Segment: **REF** Clinical Laboratory Improvement Amendment (CLIA) Number
Position: 180
Loop: 2300 Optional (Must Use)
Level: Detail
Usage: Optional
Max Use: 3
Purpose: To specify identifying information
Syntax Notes:
Semantic Notes: 1 REF04 contains data relating to the value cited in REF02.
Comments:
Notes:

X12N HIPAA Notes

Required on Medicare and Medicaid claims for any laboratory performing tests covered by the CLIA Act.

If a CLIA number is indicated at the line level (Loop ID-2400) in addition to the claim level (Loop ID-2300), that would indicate an exception to the CLIA number at the claim level for that individual line.

In cases where this claim contains both in-house and outsourced laboratory services: For laboratory services performed by the billing or rendering provider the CLIA number is reported here for laboratory services which were outsourced, report that CLIA number at the 2400 loop.

X12N HIPAA Example

Example: REF*X4*12D4567890~

ODJFS User Note

Under Ohio Medicaid, only the provider performing the test can bill for the service.

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification X12N HIPAA Notes: INDUSTRY: Reference Identification Qualifier	M ID 2/3	R
		X4 Clinical Laboratory Improvement Amendment Number		
REF02	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier X12N HIPAA Notes: NSF Reference: FA0-34.0 INDUSTRY: Clinical Laboratory Improvement Amendment Number	O AN 1/30	R

Segment: **REF** Medical Record Number
Position: 180
Loop: 2300 Optional (Must Use)
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To specify identifying information
Syntax Notes:
Semantic Notes: 1 REF04 contains data relating to the value cited in REF02.
Comments:
Notes:

X12N HIPAA Notes

Used at discretion of submitter.

X12N HIPAA Example

Example: REF*EA*44444TH56~

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification	M ID 2/3	R
X12N HIPAA Notes:				
INDUSTRY: Reference Identification Qualifier				
		EA Medical Record Identification Number A unique number assigned to each patient by the provider of service (hospital) to assist in retrieval of medical records		
REF02	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	O AN 1/30	R
X12N HIPAA Notes:				
INDUSTRY: Medical Record Number				

Segment: **REF** **Demonstration Project Identifier**
Position: 180
Loop: 2300 Optional (Must Use)
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To specify identifying information
Syntax Notes:
Semantic Notes: 1 REF04 contains data relating to the value cited in REF02.
Comments:
Notes:

X12N HIPAA Notes

Required on claims/encounters where a demonstration project is being billed/reported. 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.

X12N HIPAA Example

Example: REF*P4*THJ1222~

ODJFS User Note

At this time ODJFS does not have programs with demonstration project identifiers.

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification	M ID 2/3	R
		X12N HIPAA Notes: INDUSTRY: Reference Identification Qualifier		
		P4 Project Code		
REF02	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	O AN 1/30	R
		X12N HIPAA Notes: NSF Reference: EA0-43.0		
		INDUSTRY: Demonstration Project Identifier		

Segment: **NTE** Claim Note
Position: 190
Loop: 2300 Optional (Must Use)
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To transmit information in a free-form format, if necessary, for comment or special instruction

Syntax Notes:
Semantic Notes:
Comments:

1 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: X12N HIPAA Notes

Information in the NTE segment in Loop ID-2300 applies to the entire claim unless overridden by information in the NTE segment in Loop ID-2400. Information is considered to be overridden when the value in NTE01 in Loop ID-2400 is the same as the value in NTE01 in Loop ID-2300.

The developers of this implementation guide discourage using narrative information within the 837. Trading partners who require narrative information with claims are encouraged to codify that information within the ASC X12 environment.

Required when: (1) State regulations mandate information not identified elsewhere within the claim set or (2) in the opinion of the provider, the information is needed to substantiate the medical treatment and is not supported elsewhere within the claim data set.

X12N HIPAA Example

Example: NTE*ADD*SURGERY WAS UNUSUALLY LONG BECAUSE [FILL IN REASON]~

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
NTE01	363	Note Reference Code	O ID 3/3	R

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

X12N HIPAA Notes:

INDUSTRY: Note Reference Code

ADD Additional Information

CER Certification Narrative

Any notes associated with the certification involved

NTE02	352	Description	M AN 1/80	R
-------	-----	-------------	-----------	---

A free-form description to clarify the related data elements and their content

X12N HIPAA Notes:

NSF Reference: HA0-05.0

INDUSTRY: Claim Note Text

ODJFS User Note:

When a Medicaid co-payment exclusion applies, the 10 character code (see Application Value List below) must be the first item listed in the NTE02. There must always be a single space between the word COPAY and the four character exclusion code.

ODJFS Example: NTE*ADD*COPAY PREG~

When a Medicaid Schools Program claim is submitted, the value in NTE01 must be CER; the 10 character code (see Application Value List below) must be the first item listed in the NTE02. There must always be a single space between the word ATTEST and the three character certification code.

ODJFS Example: NTE*CER*ATTEST NAY~

ODJFS Example: NTE*CER*ATTEST YES~

Application Value List:

ATTEST NAY

ATTEST YES

COPAY EMER (Emergency)

COPAY HSPC (Hospice)

COPAY PREG (Pregnancy)

Segment: **CR1** Ambulance Transport Information
Position: 195
Loop: 2300 Optional (Must Use)
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To supply information related to the ambulance service rendered to a patient
Syntax Notes: 1 If either CR101 or CR102 is present, then the other is required.
 2 If either CR105 or CR106 is present, then the other is required.
Semantic Notes: 1 CR102 is the weight of the patient at time of transport.
 2 CR106 is the distance traveled during transport.
Comments:
Notes:

X12N HIPAA Notes

The CR1 segment in Loop ID-2300 applies to the entire claim unless an exception is reported in the CR1 segment in Loop ID-2400.

Required on all claims involving ambulance services.

ODJFS Application Notes

Required by HIPAA for Ambulance Transportation claims.

X12N HIPAA Example

Example: CR1*LB*140*I*A*DH*12****UNCONSCIOUS~

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
CR101	355	Unit or Basis for Measurement Code Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken X12N HIPAA Notes: Required if needed to justify extra ambulance services. INDUSTRY: Unit or Basis for Measurement Code LB Pound	X ID 2/2	S
CR102	81	Weight Numeric value of weight X12N HIPAA Notes: Required if needed to justify extra ambulance services. ALIAS: Patient Weight NSF Reference: GA0-05.0 INDUSTRY: Patient Weight	X R 1/10	S
CR103	1316	Ambulance Transport Code Code indicating the type of ambulance transport X12N HIPAA Notes: ALIAS: Ambulance Transport Code NSF Reference: GA0-07.0 INDUSTRY: Ambulance Transport Code I Initial Trip R Return Trip T Transfer Trip Ambulance from one facility to another ODJFS User Note:	O ID 1/1	R

			Use if ambulance is needed to transport from one facility to another facility			
		X	Round Trip			
CR104	1317	Ambulance Transport Reason Code		O	ID 1/1	R
		Code indicating the reason for ambulance transport				
		X12N HIPAA Notes:				
		ALIAS: Ambulance Transport Reason Code				
		NSF Reference: GA0-15.0				
		INDUSTRY: Ambulance Transport Reason Code				
		A	Patient was transported to nearest facility for care of symptoms, complaints, or both			
			X12N HIPAA Notes:			
			Can be used to indicate that the patient was transferred to a residential facility.			
		B	Patient was transported for the benefit of a preferred physician			
		C	Patient was transported for the nearness of family members			
		D	Patient was transported for the care of a specialist or for availability of specialized equipment			
		E	Patient Transferred to Rehabilitation Facility			
CR105	355	Unit or Basis for Measurement Code		X	ID 2/2	R
		Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken				
		X12N HIPAA Notes:				
		INDUSTRY: Unit or Basis for Measurement Code				
		DH	Miles			
CR106	380	Quantity		X	R 1/15	R
		Numeric value of quantity				
		X12N HIPAA Notes:				
		NSF crosswalk to FA0-50.0 is used only in Medicare payer-to-payer COB situations.				
		ALIAS: Transport Distance				
		NSF Reference: GA0-17.0, FA0-50.0				
		INDUSTRY: Transport Distance				
CR107	166	Address Information		O	AN 1/55	S
		Address information				
CR108	166	Address Information		O	AN 1/55	S
		Address information				
CR109	352	Description		O	AN 1/80	S
		A free-form description to clarify the related data elements and their content				
		X12N HIPAA Notes:				
		Required if CR103 (Ambulance Transport Code) = "X - Round Trip"; otherwise not used.				
		ALIAS: Round Trip Purpose Description				
		NSF Reference: GA0-20.0				
		INDUSTRY: Round Trip Purpose Description				
CR110	352	Description		O	AN 1/80	S
		A free-form description to clarify the related data elements and their content				
		X12N HIPAA Notes:				
		Required if needed to justify usage of stretcher.				

ALIAS: Stretcher Purpose Description

NSF Reference: GA0-21.0

INDUSTRY: Stretcher Purpose Description

Segment: **CR2 Spinal Manipulation Service Information**
Position: 200
Loop: 2300 Optional (Must Use)
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To supply information related to the chiropractic service rendered to a patient
Syntax Notes:
Semantic Notes:
Comments:
Notes:

X12N HIPAA Notes

CR2 segment in Loop ID-2300 applies to the entire claim unless overridden by the presence of a CR2 segment in Loop ID-2400.

Required on chiropractic claims involving spinal manipulation and known to impact payer's adjudication process.

ODJFS Application Notes

Required by HIPAA for Chiropractic claims.

X12N HIPAA Example

Example: CR2*****M****Y~

Data Element Summary

<u>Ref.</u>	<u>Data</u>		<u>Base</u>	<u>User</u>
<u>Des.</u>	<u>Element</u>	<u>Name</u>	<u>Attributes</u>	<u>Attributes</u>
CR201	609	Count	O N0 1/9	N/U
CR202	380	Quantity	O R 1/15	N/U
CR203	1367	Subluxation Level Code	O ID 2/3	N/U
		C1		Cervical 1
		C2		Cervical 2
		C3		Cervical 3
		C4		Cervical 4
		C5		Cervical 5
		C6		Cervical 6
		C7		Cervical 7
		CO		Coccyx
		IL		Ilium
		L1		Lumbar 1
		L2		Lumbar 2
		L3		Lumbar 3
		L4		Lumbar 4
		L5		Lumbar 5
		OC		Occiput
		SA		Sacrum
		T1		Thoracic 1
		T10		Thoracic 10
		T11		Thoracic 11
		T12		Thoracic 12
		T2		Thoracic 2
		T3		Thoracic 3
		T4		Thoracic 4
		T5		Thoracic 5
		T6		Thoracic 6
		T7		Thoracic 7

		T8	Thoracic 8			
		T9	Thoracic 9			
CR204	1367	Subluxation Level Code		O	ID 2/3	N/U
		C1	Cervical 1			
		C2	Cervical 2			
		C3	Cervical 3			
		C4	Cervical 4			
		C5	Cervical 5			
		C6	Cervical 6			
		C7	Cervical 7			
		CO	Coccyx			
		IL	Ilium			
		L1	Lumbar 1			
		L2	Lumbar 2			
		L3	Lumbar 3			
		L4	Lumbar 4			
		L5	Lumbar 5			
		OC	Occiput			
		SA	Sacrum			
		T1	Thoracic 1			
		T10	Thoracic 10			
		T11	Thoracic 11			
		T12	Thoracic 12			
		T2	Thoracic 2			
		T3	Thoracic 3			
		T4	Thoracic 4			
		T5	Thoracic 5			
		T6	Thoracic 6			
		T7	Thoracic 7			
		T8	Thoracic 8			
		T9	Thoracic 9			
CR205	355	Unit or Basis for Measurement Code		O	ID 2/2	N/U
		DA	Days			
		MO	Months			
		WK	Week			
		YR	Years			
CR206	380	Quantity		O	R 1/15	N/U
CR207	380	Quantity		O	R 1/15	N/U
CR208	1342	Nature of Condition Code		O	ID 1/1	R

Code indicating the nature of a patient's condition

X12N HIPAA Notes:

ALIAS: Nature of Condition Code. Spinal Manipulation

NSF Reference: GC0-11.0

INDUSTRY: Patient Condition Code

- A Acute Condition
A disease of rapid onset, severe symptoms, and brief duration
- C Chronic Condition
A disease of long duration involving very slow changes; such a disease is often of gradual onset; the term does not imply anything about the severity of the disease

D	Non-acute
E	Non-Life Threatening
F	Routine
G	Symptomatic
M	Acute Manifestation of a Chronic Condition
	A disease of long duration interrupted by a rapid onset of severe symptoms of brief duration

Segment: **CRC** Ambulance Certification
Position: 220
Loop: 2300 Optional (Must Use)
Level: Detail
Usage: Optional
Max Use: 3
Purpose: To supply information on conditions
Syntax Notes:
Semantic Notes:

- 1 CRC01 qualifies CRC03 through CRC07.
- 2 CRC02 is a Certification Condition Code applies indicator. A "Y" value indicates the condition codes in CRC03 through CRC07 apply; an "N" value indicates the condition codes in CRC03 through CRC07 do not apply.

Comments:
Notes:

X12N HIPAA Notes

The CRC segment in Loop ID-2300 applies to the entire claim unless overridden by a CRC segment at the service line level in Loop ID-2400 with the same value in CRC01.

Required on ambulance claims/encounters, i.e. when CR1 segment is used.

ODJFS Application Notes

Required by HIPAA for Ambulance Certification claims.

X12N HIPAA Example

Example: CRC*07*Y*01~

Data Element Summary

<u>Ref.</u>	<u>Data</u>	<u>Name</u>	<u>Base</u>	<u>User</u>
<u>Des.</u>	<u>Element</u>	<u>Code Category</u>	<u>Attributes</u>	<u>Attributes</u>
CRC01	1136	Specifies the situation or category to which the code applies X12N HIPAA Notes: INDUSTRY: Code Category 07 Ambulance Certification	M ID 2/2	R
CRC02	1073	Yes/No Condition or Response Code Code indicating a Yes or No condition or response X12N HIPAA Notes: ALIAS: Certification Condition Code Applies Indicator INDUSTRY: Certification Condition Indicator N No Y Yes	M ID 1/1	R
CRC03	1321	Condition Indicator Code indicating a condition X12N HIPAA Notes: The codes for CRC03 also can be used for CRC04 through CRC07. ALIAS: Condition Indicator INDUSTRY: Condition Code 01 Patient was admitted to a hospital X12N HIPAA Notes: GA0-06.0 02 Patient was bed confined before the ambulance service X12N HIPAA Notes: GA0-08.0 03 Patient was bed confined after the ambulance service X12N HIPAA Notes:	M ID 2/2	R

- 02 Patient was bed confined before the ambulance service
- 03 Patient was bed confined after the ambulance service
- 04 Patient was moved by stretcher
- 05 Patient was unconscious or in shock
- 06 Patient was transported in an emergency situation
- 07 Patient had to be physically restrained
- 08 Patient had visible hemorrhaging
- 09 Ambulance service was medically necessary
- 60 Transportation Was To the Nearest Facility

CRC06 1321 Condition Indicator O ID 2/2 S

Code indicating a condition

X12N HIPAA Notes:

Required if additional condition codes are needed.

Use the codes listed in CRC03.

ALIAS: Condition Indicator

INDUSTRY: Condition Code

- 01 Patient was admitted to a hospital
- 02 Patient was bed confined before the ambulance service
- 03 Patient was bed confined after the ambulance service
- 04 Patient was moved by stretcher
- 05 Patient was unconscious or in shock
- 06 Patient was transported in an emergency situation
- 07 Patient had to be physically restrained
- 08 Patient had visible hemorrhaging
- 09 Ambulance service was medically necessary
- 60 Transportation Was To the Nearest Facility

CRC07 1321 Condition Indicator O ID 2/2 S

Code indicating a condition

X12N HIPAA Notes:

Required if additional condition codes are needed.

Use the codes listed in CRC03.

ALIAS: Condition Indicator

INDUSTRY: Condition Code

- 01 Patient was admitted to a hospital
- 02 Patient was bed confined before the ambulance service
- 03 Patient was bed confined after the ambulance service
- 04 Patient was moved by stretcher
- 05 Patient was unconscious or in shock
- 06 Patient was transported in an emergency situation
- 07 Patient had to be physically restrained
- 08 Patient had visible hemorrhaging
- 09 Ambulance service was medically necessary
- 60 Transportation Was To the Nearest Facility

Segment: **CRC Patient Condition Information: Vision**
Position: 220
Loop: 2300 Optional (Must Use)
Level: Detail
Usage: Optional
Max Use: 3
Purpose: To supply information on conditions
Syntax Notes:
Semantic Notes:

- 1 CRC01 qualifies CRC03 through CRC07.
- 2 CRC02 is a Certification Condition Code applies indicator. A "Y" value indicates the condition codes in CRC03 through CRC07 apply; an "N" value indicates the condition codes in CRC03 through CRC07 do not apply.

Comments:
Notes:

X12N HIPAA Notes

Required on vision claims/encounters involving replacement lenses or frames when this information is known to impact reimbursement.

ODJFS Application Notes

Required by HIPAA for Vision claims.

X12N HIPAA Example

Example: CRC*E1*Y*L1~

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
CRC01	1136	Code Category Specifies the situation or category to which the code applies X12N HIPAA Notes: INDUSTRY: Code Category E1 Spectacle Lenses ODJFS User Note: Valid value for Vision Claims/Encounters. E2 Contact Lenses ODJFS User Note: Valid value for Vision Claims/Encounters. E3 Spectacle Frames ODJFS User Note: Valid value for Vision Claims/Encounters.	M ID 2/2	R
CRC02	1073	Yes/No Condition or Response Code Code indicating a Yes or No condition or response X12N HIPAA Notes: ALIAS: Certification Condition Code Applies Indicator INDUSTRY: Certification Condition Indicator N No Y Yes	M ID 1/1	R
CRC03	1321	Condition Indicator Code indicating a condition X12N HIPAA Notes: ALIAS: Condition Indicator INDUSTRY: Condition Code L1 General Standard of 20 Degree or .5 Diopter Sphere or Cylinder Change Met L2 Replacement Due to Loss or Theft L3 Replacement Due to Breakage or Damage	M ID 2/2	R

		L4	Replacement Due to Patient Preference			
		L5	Replacement Due to Medical Reason			
CRC04	1321	Condition Indicator		O	ID 2/2	S
		Code indicating a condition				
		X12N HIPAA Notes:				
		Use codes listed in CRC03.				
		Required if additional condition codes are needed.				
		INDUSTRY: Condition Code				
		L1	General Standard of 20 Degree or .5 Diopter Sphere or Cylinder Change Met			
		L2	Replacement Due to Loss or Theft			
		L3	Replacement Due to Breakage or Damage			
		L4	Replacement Due to Patient Preference			
		L5	Replacement Due to Medical Reason			
CRC05	1321	Condition Indicator		O	ID 2/2	S
		Code indicating a condition				
		X12N HIPAA Notes:				
		Use codes listed in CRC03.				
		Required if additional condition codes are needed.				
		INDUSTRY: Condition Code				
		L1	General Standard of 20 Degree or .5 Diopter Sphere or Cylinder Change Met			
		L2	Replacement Due to Loss or Theft			
		L3	Replacement Due to Breakage or Damage			
		L4	Replacement Due to Patient Preference			
		L5	Replacement Due to Medical Reason			
CRC06	1321	Condition Indicator		O	ID 2/2	S
		Code indicating a condition				
		X12N HIPAA Notes:				
		Use codes listed in CRC03.				
		Required if additional condition codes are needed.				
		INDUSTRY: Condition Code				
		L1	General Standard of 20 Degree or .5 Diopter Sphere or Cylinder Change Met			
		L2	Replacement Due to Loss or Theft			
		L3	Replacement Due to Breakage or Damage			
		L4	Replacement Due to Patient Preference			
		L5	Replacement Due to Medical Reason			
CRC07	1321	Condition Indicator		O	ID 2/2	S
		Code indicating a condition				
		X12N HIPAA Notes:				
		Use codes listed in CRC03.				
		Required if additional condition codes are needed.				
		INDUSTRY: Condition Code				
		L1	General Standard of 20 Degree or .5 Diopter Sphere or Cylinder Change Met			
		L2	Replacement Due to Loss or Theft			
		L3	Replacement Due to Breakage or Damage			

L4	Replacement Due to Patient Preference
L5	Replacement Due to Medical Reason

Segment: **CRC** EPSDT Referral
Position: 220
Loop: 2300 Optional (Must Use)
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To supply information on conditions
Syntax Notes:
Semantic Notes:

- 1 CRC01 qualifies CRC03 through CRC07.
- 2 CRC02 is a Certification Condition Code applies indicator. A "Y" value indicates the condition codes in CRC03 through CRC07 apply; an "N" value indicates the condition codes in CRC03 through CRC07 do not apply.

Comments:
Notes:

X12N HIPAA Notes

Required on Early & Periodic Screening, Diagnosis, and Treatment (EPSDT) claims/encounters.

ODJFS Application Notes

Required by HIPAA for EPSDT claims. Used for Federal Reporting requirements.

X12N HIPAA Example

Example: CRC*ZZ*Y*ST~

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
CRC01	1136	Code Category	M ID 2/2	R
		Specifies the situation or category to which the code applies		
		X12N HIPAA Notes:		
		Specifies the situation or category to which the code applies		
		ZZ Mutually Defined		
		X12N HIPAA Notes:		
		Mutally Defined		
		EPSDT Screening referral information.		
CRC02	1073	Yes/No Condition or Response Code	M ID 1/1	R
		Code indicating a Yes or No condition or response		
		X12N HIPAA Notes:		
		Industry: Certification Condition Indicator		
		Alias: Certification Condition Code Applies Indicator		
		Was an EPSDT referral given to the patient?		
		N No		
		X12N HIPAA Notes:		
		If no, then choose "NU" in CRC03 indicating no referral given.		
		Y Yes		
		X12N HIPAA Notes:		
		Yes		
CRC03	1321	Condition Indicator	M ID 2/2	R
		Code indicating a condition		
		X12N HIPAA Notes:		
		Use codes listed in CRC03.		
		Required if additional condition codes are needed		
		AV Available - Not Used		
		X12N HIPAA Notes:		
		Available - Not Used		
		Patient refused referral.		

		NU	Not Used X12N HIPAA Notes: Not Used This condition indicator must be used when the submitter answers "N" in CRC02.
		S2	Under Treatment X12N HIPAA Notes: Under Treatment Patient is currently under treatment for referred diagnostic or corrective health problem.
		ST	New Services Requested X12N HIPAA Notes: New Services Requested Referral to another provider for diagnostic or corrective treatment/scheduled for another appointment with screening provider for diagnostic or corrective treatment for at least one health problem identified during an initial or periodic screening service (not including dental referrals).
CRC04	1321	Condition Indicator	O ID 2/2 S
			Code indicating a condition X12N HIPAA Notes: Use codes listed in CRC03. Required if additional condition codes are needed.
		AV	Available - Not Used X12N HIPAA Notes: Available - Not Used Patient refused referral.
		NU	Not Used X12N HIPAA Notes: Not Used This conditioner indicator must be used when the submitter answers "N" in CRC02.
		S2	Under Treatment X12N HIPAA Notes: Under Treatment Patient is currently under treatment for referred diagnostic or corrective health problem.
		ST	New Services Requested X12N HIPAA Notes: New Services Requested Referral to another provider for diagnostic or corrective treatment/scheduled for another appointment with screening provider for diagnostic or corrective treatment for at least one health problem identified during an initial or periodic screening service (not including dental referrals).
CRC05	1321	Condition Indicator	O ID 2/2 S
			Code indicating a condition X12N HIPAA Notes: Use codes listed in CRC03. Required if additional condition codes are needed.
		AV	Available - Not Used X12N HIPAA Notes: Available - Not Used Patient refused referral.
		NU	Not Used X12N HIPAA Notes:

S2	<p>Not Used This conditioner indicator must be used when the submitter answers "N" in CRC02.</p> <p>Under Treatment</p> <p>X12N HIPAA Notes:</p>
ST	<p>Under Treatment Patient is currently under treatment for referred diagnostic or corrective health problem.</p> <p>New Services Requested</p> <p>X12N HIPAA Notes:</p>
	<p>New Services Requested Referral to another provider for diagnostic or corrective treatment/scheduled for another appointment with screening provider for diagnostic or corrective treatment for at least one health problem identified during an initial or periodic screening service (not including dental referrals).</p>

Segment: **HI** Health Care Diagnosis Code
Position: 231
Loop: 2300 Optional (Must Use)
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To supply information related to the delivery of health care
Syntax Notes:

- 1 If either C02203 or C02204 is present, then the other is required.
- 2 If either C02203 or C02204 is present, then the other is required.
- 3 If either C02203 or C02204 is present, then the other is required.
- 4 If either C02203 or C02204 is present, then the other is required.
- 5 If either C02203 or C02204 is present, then the other is required.
- 6 If either C02203 or C02204 is present, then the other is required.
- 7 If either C02203 or C02204 is present, then the other is required.
- 8 If either C02203 or C02204 is present, then the other is required.
- 9 If either C02203 or C02204 is present, then the other is required.
- 10 If either C02203 or C02204 is present, then the other is required.
- 11 If either C02203 or C02204 is present, then the other is required.
- 12 If either C02203 or C02204 is present, then the other is required.

Semantic Notes:

Comments:

Notes:

X12N HIPAA Notes

Required on all claims/encounters except claims for which there are no diagnoses (e.g., taxi claims).

Do not transmit the decimal points in the diagnosis codes. The decimal point is assumed.

X12N HIPAA Example

Example: HI*BK:8901*BF:87200*BF:5559~

ODJFS User Note

Used for claim processing except for laboratory, diagnostic facilities, portable x-ray, and waiver claims.

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
HI01	C022	Health Care Code Information To send health care codes and their associated dates, amounts and quantities X12N HIPAA Notes: With a few exceptions, it is not recommended to put E codes in HI01. E codes may be put in any other HI element using BF as the qualifier. The diagnosis listed in this element is assumed to be the principal diagnosis. ALIAS: Principal Diagnosis	M	R
C02201	1270	Code List Qualifier Code Code identifying a specific industry code list X12N HIPAA Notes: INDUSTRY: Diagnosis Type Code BK Principal Diagnosis X12N HIPAA Notes: ICD-9 Codes	M ID 1/3	R
C02202	1271	Industry Code Code indicating a code from a specific industry code list X12N HIPAA Notes: NSF Reference: EA0-32.0, GX0-31.0, GU0-12.0 INDUSTRY: Diagnosis Code	M AN 1/30	R

HI02	C022	Health Care Code Information	O	S
		To send health care codes and their associated dates, amounts and quantities		
		X12N HIPAA Notes:		
		Refer to HI01-1(C022-01) and HI01-3(C022-03) for C022-01 and C022-03.		
		Required if needed to report an additional diagnoses and if the preceeding HI data elements have been used to report other diagnoses.		
		ALIAS: Diagnosis		
C02201	1270	Code List Qualifier Code	M ID 1/3	R
		Code identifying a specific industry code list		
		X12N HIPAA Notes:		
		INDUSTRY: Diagnosis Type Code		
		BF Diagnosis		
		X12N HIPAA Notes:		
		ICD-9 Codes		
C02202	1271	Industry Code	M AN 1/30	R
		Code indicating a code from a specific industry code list		
		X12N HIPAA Notes:		
		NSF Reference: EA0-33.0, GX0-32.0, GU0-13.0		
		INDUSTRY: Diagnosis Code		
HI03	C022	Health Care Code Information	O	S
		To send health care codes and their associated dates, amounts and quantities		
		X12N HIPAA Notes:		
		Refer to HI01-1(C022-01) and HI01-3(C022-03) for C022-01 and C022-03.		
		Required if needed to report an additional diagnoses and if the preceeding HI data elements have been used to report other diagnoses.		
		ALIAS: Diagnosis		
C02201	1270	Code List Qualifier Code	M ID 1/3	R
		Code identifying a specific industry code list		
		X12N HIPAA Notes:		
		INDUSTRY: Diagnosis Type Code		
		BF Diagnosis		
		X12N HIPAA Notes:		
		ICD-9 Codes		
C02202	1271	Industry Code	M AN 1/30	R
		Code indicating a code from a specific industry code list		
		X12N HIPAA Notes:		
		NSF Reference: EA0-34.0, GX0-33.0, GU0-14.0		
		INDUSTRY: Diagnosis Code		
HI04	C022	Health Care Code Information	O	S
		To send health care codes and their associated dates, amounts and quantities		
		X12N HIPAA Notes:		
		Refer to HI01-1(C022-01) and HI01-3(C022-03) for C022-01 and C022-03.		
		Required if needed to report an additional diagnoses and if the preceeding HI data elements have been used to report other diagnoses.		
		ALIAS: Diagnosis		
C02201	1270	Code List Qualifier Code	M ID 1/3	R
		Code identifying a specific industry code list		

X12N HIPAA Notes:

INDUSTRY: Diagnosis Type Code

BF Diagnosis

X12N HIPAA Notes:

ICD-9 Codes

C02202 1271 Industry Code M AN 1/30 R

Code indicating a code from a specific industry code list

X12N HIPAA Notes:

NSF Reference: EA0-35.0, GX0-34.0, GU0-15.0

INDUSTRY: Diagnosis Code

HI05 C022 Health Care Code Information O S

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

X12N HIPAA Notes:

Refer to HI01-1(C022-01) and HI01-3(C022-03) for C022-01 and C022-03.

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

ALIAS: Diagnosis

C02201 1270 Code List Qualifier Code M ID 1/3 R

Code identifying a specific industry code list

X12N HIPAA Notes:

INDUSTRY: Diagnosis Type Code

BF Diagnosis

X12N HIPAA Notes:

ICD-9 Codes

C02202 1271 Industry Code M AN 1/30 R

Code indicating a code from a specific industry code list

X12N HIPAA Notes:

INDUSTRY: Diagnosis Code

HI06 C022 Health Care Code Information O S

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

X12N HIPAA Notes:

Refer to HI01-1(C022-01) and HI01-3(C022-03) for C022-01 and C022-03.

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

ALIAS: Diagnosis

C02201 1270 Code List Qualifier Code M ID 1/3 R

Code identifying a specific industry code list

X12N HIPAA Notes:

INDUSTRY: Diagnosis Type Code

BF Diagnosis

X12N HIPAA Notes:

ICD-9 Codes

C02202 1271 Industry Code M AN 1/30 R

Code indicating a code from a specific industry code list

X12N HIPAA Notes:

INDUSTRY: Diagnosis Code

HI07 C022 Health Care Code Information O S

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

X12N HIPAA Notes:

Refer to HI01-1(C022-01) and HI01-3(C022-03) for C022-01 and C022-03.

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

ALIAS: Diagnosis

C02201 1270 Code List Qualifier Code M ID 1/3 R

Code identifying a specific industry code list

X12N HIPAA Notes:

INDUSTRY: Diagnosis Type Code

BF Diagnosis

X12N HIPAA Notes:

ICD-9 Codes

C02202 1271 Industry Code M AN 1/30 R

Code indicating a code from a specific industry code list

X12N HIPAA Notes:

INDUSTRY: Diagnosis Code

HI08 C022 Health Care Code Information O S

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

X12N HIPAA Notes:

Refer to HI01-1(C022-01) and HI01-3(C022-03) for C022-01 and C022-03.

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

ALIAS: Diagnosis

C02201 1270 Code List Qualifier Code M ID 1/3 R

Code identifying a specific industry code list

X12N HIPAA Notes:

INDUSTRY: Diagnosis Type Code

BF Diagnosis

X12N HIPAA Notes:

ICD-9 Codes

C02202 1271 Industry Code M AN 1/30 R

Code indicating a code from a specific industry code list

X12N HIPAA Notes:

INDUSTRY: Diagnosis Code

Segment: **CR7 Home Health Care Plan Information**
Position: 242
Loop: 2305 Optional
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To supply information related to the home health care plan of treatment and services
Syntax Notes:
Semantic Notes:

- 1 CR702 is the total visits on this bill rendered prior to the recertification "to" date.
- 2 CR703 is the total visits projected during this certification period.

Comments:
Notes:

X12N HIPAA Notes

Required on home health claims/encounters that involve billing/reporting home health visits.

X12N HIPAA Example

Example: CR7*PT*4*12~

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
CR701	921	Discipline Type Code Code indicating disciplines ordered by a physician X12N HIPAA Notes: ALIAS: Discipline type code INDUSTRY: Discipline Type Code AI Home Health Aide MS Medical Social Worker OT Occupational Therapy PT Physical Therapy SN Skilled Nursing ST Speech Therapy	M ID 2/2	R
CR702	1470	Number A generic number X12N HIPAA Notes: ALIAS: Total visits rendered, home health INDUSTRY: Total Visits Rendered Count	M N0 1/9	R
CR703	1470	Number A generic number X12N HIPAA Notes: ALIAS: Total visits projected, home health INDUSTRY: Certification Period Projected Visit Count	M N0 1/9	R

Segment: **HSD** Health Care Services Delivery
Position: 243
Loop: 2305 Optional
Level: Detail
Usage: Optional
Max Use: 3
Purpose: To specify the delivery pattern of health care services
Syntax Notes: 1 If either HSD01 or HSD02 is present, then the other is required.
 2 If HSD06 is present, then HSD05 is required.
Semantic Notes:
Comments:
Notes:

X12N HIPAA Notes

Required on claims/encounters billing/reporting home health visits where further detail is necessary to clearly substantiate medical treatment.

The HSD segment is used to specify the delivery pattern of the health care services. This is how it is used: HSD01 qualifies HSD02: If the value in HSD02=1 and the value in HSD01=VS (Visits), this means "one visit". Between HSD02 and HSD03 verbally insert a "per every." HSD03 qualifies HSD04: If the value in HSD04=3 and the value in HSD03=DA (Day), this means "three days." Between HSD04 and HSD05 verbally insert a "for." HSD05 qualifies HSD06: If the value in HSD06=21 and the value in HSD05=7 (Days), this means "21 days." The total message reads:

HSD*VS*1*DA*3*7*21~

= "One visit per every three days for 21 days."

Another similar data string of HSD*VS*2*DA*4*7*20~

= Two visits per every four days for 20 days.

An alternate way to use HSD is to employ HSD07 and/or HSD08. A data string of HSD*VS*1*****SX*D~

means "1 visit on Wednesday and Thursday morning."

X12N HIPAA Example

Example: HSD*VS*1*DA*1*7*10~

(This indicates "1 visit every (per) 1 day (daily) for 10 days")

HSD*VS*1*DA****W~

(This indicates "1 visit per day whenever necessary")

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
HSD01	673	Quantity Qualifier Code specifying the type of quantity X12N HIPAA Notes: Required if the order/prescription for the service contains the data. INDUSTRY: Visits VS Visits	X ID 2/2	S
HSD02	380	Quantity Numeric value of quantity X12N HIPAA Notes: Required if the order/prescription for the service contains the data. INDUSTRY: Number of Visits	X R 1/15	S
HSD03	355	Unit or Basis for Measurement Code Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken X12N HIPAA Notes: Required if the order/prescription for the service contains the data.	O ID 2/2	S

ALIAS: Modulus, Unit

INDUSTRY: Frequency Period

DA Days

MO Months

X12N HIPAA Notes:

Month

Q1 Quarter (Time)

WK Week

HSD04 1167 Sample Selection Modulus O R 1/6 S

To specify the sampling frequency in terms of a modulus of the Unit of Measure, e.g., every fifth bag, every 1.5 minutes

X12N HIPAA Notes:

Required if the order/prescription for the service contains the data.

ALIAS: Modulus, Amount

INDUSTRY: Frequency Count

HSD05 615 Time Period Qualifier X ID 1/2 S

Code defining periods

X12N HIPAA Notes:

Required if the order/prescription for the service contains the data.

INDUSTRY: Duration of Visits Units

7 Day

35 Week

HSD06 616 Number of Periods O N0 1/3 S

Total number of periods

X12N HIPAA Notes:

Required if the order/prescription for the service contains the data.

INDUSTRY: Duration of Visits, Number of Units

HSD07 678 Ship/Delivery or Calendar Pattern Code O ID 1/2 S

Code which specifies the routine shipments, deliveries, or calendar pattern

X12N HIPAA Notes:

Required if the order/prescription for the service contains the data.

ALIAS: Pattern Code

INDUSTRY: Ship, Delivery or Calendar Pattern Code

- 1 1st Week of the Month
- 2 2nd Week of the Month
- 3 3rd Week of the Month
- 4 4th Week of the Month
- 5 5th Week of the Month
- 6 1st & 3rd Weeks of the Month
- 7 2nd & 4th Weeks of the Month
- A Monday through Friday
- B Monday through Saturday
- C Monday through Sunday
- D Monday
- E Tuesday
- F Wednesday
- G Thursday

H	Friday
J	Saturday
K	Sunday
L	Monday through Thursday
N	As Directed
O	Daily Mon. through Fri.
S	Once Anytime Mon. through Fri.
SA	Sunday, Monday, Thursday, Friday, Saturday
SB	Tuesday through Saturday
SC	Sunday, Wednesday, Thursday, Friday, Saturday
SD	Monday, Wednesday, Thursday, Friday, Saturday
SG	Tuesday through Friday
SL	Monday, Tuesday and Thursday
SP	Monday, Tuesday and Friday
SX	Wednesday and Thursday
SY	Monday, Wednesday and Thursday
SZ	Tuesday, Thursday and Friday
W	Whenever Necessary

HSD08 679 Ship/Delivery Pattern Time Code O ID 1/1 S

Code which specifies the time for routine shipments or deliveries

X12N HIPAA Notes:

Required if the order/prescription for the service contains the data.

ALIAS: Time Code

INDUSTRY: Delivery Pattern Time Code

D	A.M.
E	P.M.
F	As Directed

Segment: **NM1** Referring Provider Name
Position: 250
Loop: 2310A Optional
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To supply the full name of an individual or organizational entity
Syntax Notes: 1 If either NM108 or NM109 is present, then the other is required.
Semantic Notes: 1 NM102 qualifies NM103.
Comments:
Notes:

X12N HIPAA Notes

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.

When there is only one referral on the claim, use code "DN - Referring Provider". When more than one referral exists and there is a requirement to report the additional referral, use code DN in the first iteration of this loop to indicate the referral received by the rendering provider on this claim. Use code "P3 - Primary Care Provider" in the second iteration of the loop to indicate the initial referral from the primary care provider or whatever provider wrote the initial referral for this patient's episode of care being billed/reported in this transaction.

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.

Required if claim involved a referral.

When reporting the provider who ordered services such as diagnostic and lab utilize the 2310A loop at the claim level. For ordered services such as DMERC utilize the 2420E Loop at the line level.

X12N HIPAA Example

Example: NM1*DN*1*WELBY*MARCUS*W**JR*34*444332222~

ODJFS User Note

ODJFS requires a referring provider number for claims for individuals enrolled in the PACT program when the rendering provider is not the designated PACT provider. This segment must also be completed for all physician consultation codes and pathology and clinical laboratory consultation codes.

The National Provider Identifier is mandated to be used on electronic claims on and after May 23, 2008. The referring provider loop is situational, depending on the claim type. If the loop is present in the 837, ODJFS will deny any claims that do not include the NPI in the loop. Although the legacy ID is not required, ODJFS will continue to accept claims that contain both the NPI and legacy ID in the referring provider loop of the electronic claim until further notice. If it is included, a legacy ID will be validated. An invalid legacy ID will be rejected.

The 9111115 value is no longer an ODJFS acceptable value. Do not use 9111115 in this field.

If the referring entity or provider is required to be identified and does not furnish an NPI, the billing provider must first attempt to obtain that NPI by directly contacting the referring entity or provider. If the attempt is not successful, the billing provider may use the NPI Registry (<https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do>) to obtain the referring entity or provider's NPI to enter it on the claim.

For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop.

Atypical providers should send their EIN or SSN in the NM1 segment and their Medicaid 7-digit legacy ID in the REF segment with an REF01 qualifier of 1D.

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
NM101	98	Entity Identifier Code Code identifying an organizational entity, a physical location, property or an individual X12N HIPAA Notes: The entity identifier in NM101 applies to all segments in this Loop ID-2310. INDUSTRY: Entity Identifier Code DN Referring Provider X12N HIPAA Notes: Use on first iteration of this loop. Use if loop is used only once. P3 Primary Care Provider Physician that is selected by the insured to provide medical care X12N HIPAA Notes: Use only if loop is used twice. Use only on second iteration of this loop.	M ID 2/3	R
NM102	1065	Entity Type Qualifier Code qualifying the type of entity X12N HIPAA Notes: INDUSTRY: Entity Type Qualifier 1 Person 2 Non-Person Entity	M ID 1/1	R
NM103	1035	Name Last or Organization Name Individual last name or organizational name X12N HIPAA Notes: ALIAS: Referring Provider Last Name NSF Reference: EA0-24.0 INDUSTRY: Referring Provider Last Name	O AN 1/35	R
NM104	1036	Name First Individual first name X12N HIPAA Notes: Required if NM102=1 (person). ALIAS: Referring Provider First Name NSF Reference: EA0-25.0 INDUSTRY: Referring Provider First Name	O AN 1/25	S
NM105	1037	Name Middle Individual middle name or initial X12N HIPAA Notes: Required if NM102=1 and the middle name/initial of the person is known. ALIAS: Referring Provider Middle Name NSF Reference: EA0-26.0 INDUSTRY: Referring Provider Middle Name	O AN 1/25	S
NM106	1038	Name Prefix	O AN 1/10	N/U

NM107	1039	Name Suffix Suffix to individual name X12N HIPAA Notes: Required if known. ALIAS: Referring Provider Generation INDUSTRY: Referring Provider Name Suffix	O AN 1/10 S
NM108	66	Identification Code Qualifier Code designating the system/method of code structure used for Identification Code (67) X12N HIPAA Notes: Required if Employer's Identification/Social Security number (Tax ID) or National Provider Identifier is known. INDUSTRY: Identification Code Qualifier 24 Employer's Identification Number 34 Social Security Number XX Health Care Financing Administration National Provider Identifier	X ID 1/2 S
NM109	67	Identification Code Code identifying a party or other code X12N HIPAA Notes: Required if Employer's Identification/Social Security number (Tax ID) or National Provider Identifier is known. ALIAS: Referring Provider Primary Identifier NSF Reference: EA0-20.0 INDUSTRY: Referring Provider Identifier ODJFS User Note: If the referring entity or provider is required to be identified and does not furnish an NPI, the billing provider must first attempt to obtain that NPI by directly contacting the referring entity or provider. If the attempt is not successful, the billing provider may use the NPI Registry (https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do) to obtain the referring entity or provider's NPI to enter it on the claim. The 9111115 value is no longer an ODJFS acceptable value. Do not use 9111115 in this field. For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop. Atypical providers should send their EIN or SSN in the NM1 segment and their Medicaid 7-digit legacy ID in the REF segment with an REF01 qualifier of 1D.	X AN 2/80 S

Segment: **REF** Referring Provider Secondary Identification
Position: 271
Loop: 2310A Optional
Level: Detail
Usage: Optional
Max Use: 5
Purpose: To specify identifying information
Syntax Notes:
Semantic Notes: 1 REF04 contains data relating to the value cited in REF02.
Comments:
Notes:

X12N HIPAA Notes

Required if NM108/09 in this loop is not used or if a secondary number is necessary to identify the provider. Until the NPI is mandated for use, this REF may be required if necessary to adjudicate the claim.

X12N HIPAA Example

Example: REF*1D*A12345~

ODJFS User Note

ODJFS requires a referring provider number for claims for individuals enrolled in the PACT program when the rendering provider is not the designated PACT provider. This segment must also be completed for all physician consultation codes and pathology and clinical laboratory consultation codes.

The 9111115 value is no longer an acceptable value. Do not use 9111115 in this field.

For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop with the EI or SY qualifier code.

Atypical providers should send their EIN or SSN in the NM1 segment and their Medicaid 7-digit legacy ID in the REF segment with an REF01 qualifier of 1D.

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification X12N HIPAA Notes: INDUSTRY: Reference Identification Qualifier 1D Medicaid Provider Number EI Employer's Identification Number SY Social Security Number X12N HIPAA Notes: The social security number may not be used for Medicare.	M ID 2/3	R
REF02	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier X12N HIPAA Notes: ALIAS: Referring Provider Secondary Identifier NSF Reference: EA0-20.0 INDUSTRY: Referring Provider Secondary Identifier ODJFS User Note: The 9111115 value is no longer an acceptable value. Do not use 9111115 in this field. For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the	O AN 1/30	R AN 7/7

NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop with the EI or SY qualifier code.

Atypical providers should send their EIN or SSN in the NM1 segment and their Medicaid 7-digit legacy ID in the REF segment with an REF01 qualifier of 1D.

Segment: **NM1** Rendering Provider Name
Position: 250
Loop: 2310B Optional
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To supply the full name of an individual or organizational entity
Syntax Notes: 1 If either NM108 or NM109 is present, then the other is required.
Semantic Notes: 1 NM102 qualifies NM103.
Comments:
Notes:

X12N HIPAA Notes

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.

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.

Required when the Rendering Provider NM1 information is different than that carried in either the Billing Provider NM1 or the Pay-to Provider NM1 in the 2010AA/AB loops respectively.

Used for all types of rendering providers including laboratories. The Rendering Provider is the person or company (laboratory or other facility) who rendered the care. In the case where a substitute provider (locum tenens) was used, that person should be entered here.

X12N HIPAA Example

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

ODJFS User Note

The 2310B Rendering Provider loop is always required when the NPI in the 2010AA and/or 2010AB loops is for a professional group practice. Professional group practices enrolled under the Ohio Medicaid program include provider types physician group, osteopath group, dentist group, Advanced Practice nurse (APN) group, optometrist group, podiatrist group, Chiropractor group, mechanotherapist group, physical therapist group, psychologist group, chiromechanotherapist group.

This loop is also required when a hospice organization or an Ambulatory Surgery Center (ASC) is seeking payment for physician or APN professional services. No rendering provider loop should be submitted for hospice per diem payments or ASC facility payments.

No other 837P transactions (e.g., Clinics, FQHCs, RHCs, OHFs, Ambulatory Surgery Centers, Laboratories) require the rendering provider loop. If the REF02 of the 2310B is completed for other 837P transactions, the provider number must match the numbers submitted in the 2010AA and/or 2010AB loops to assure claims will pay correctly.

The National Provider Identifier is mandated to be used on electronic claims on and after May 23, 2008. ODJFS will deny electronic claims that are missing an NPI in the rendering provider field, if required on a claim. Although the Medicaid legacy ID is not required, ODJFS will continue to accept claims that contain both NPI and the Medicaid legacy ID in the rendering provider field. If it is included, a legacy ID will be validated. An invalid legacy ID will be rejected

For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop with the EI or SY qualifier code.

A claim that contains an NPI that does not pass check digit validation WILL DENY.

Atypical providers should send their EIN or SSN in the NM1 segment.

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
NM101	98	Entity Identifier Code Code identifying an organizational entity, a physical location, property or an individual X12N HIPAA Notes: The entity identifier in NM101 applies to all segments in this Loop ID-2310. INDUSTRY: Entity Identifier Code 82 Rendering Provider	M ID 2/3	R
NM102	1065	Entity Type Qualifier Code qualifying the type of entity X12N HIPAA Notes: INDUSTRY: Entity Type Qualifier 1 Person 2 Non-Person Entity	M ID 1/1	R
NM103	1035	Name Last or Organization Name Individual last name or organizational name X12N HIPAA Notes: ALIAS: Rendering Provider Last Name NSF Reference: FB1-14.0 INDUSTRY: Rendering Provider Last or Organization Name	O AN 1/35	R
NM104	1036	Name First Individual first name X12N HIPAA Notes: Required if NM102=1 (person). ALIAS: Rendering Provider First Name NSF Reference: FB1-15.0 INDUSTRY: Rendering Provider First Name	O AN 1/25	S
NM105	1037	Name Middle Individual middle name or initial X12N HIPAA Notes: Required if NM102=1 and the middle name/initial of the person is known. ALIAS: Rendering Provider Middle Name NSF Reference: FB1-16.0 INDUSTRY: Rendering Provider Middle Name	O AN 1/25	S
NM106	1038	Name Prefix	O AN 1/10	N/U
NM107	1039	Name Suffix Suffix to individual name X12N HIPAA Notes: Required if known. ALIAS: Rendering Provider Generation INDUSTRY: Rendering Provider Name Suffix	O AN 1/10	S
NM108	66	Identification Code Qualifier Code designating the system/method of code structure used for Identification Code (67)	X ID 1/2	R

X12N HIPAA Notes:

FA0-57.0 crosswalk is only used in Medicare COB payer-to-payer claims.

NSF Reference: FA0-57.0

INDUSTRY: Identification Code Qualifier

- 24 Employer's Identification Number
- 34 Social Security Number
- XX Health Care Financing Administration National Provider Identifier

NM109

67

Identification Code

X AN 2/80 R

Code identifying a party or other code

X12N HIPAA Notes:

FA0-58.0 crosswalk is only used in Medicare COB payer-to-payer claims.

ALIAS: Rendering Provider Primary Identifier

NSF Reference: FA0-23.0, FA0-58.0

INDUSTRY: Rendering Provider Identifier

ODJFS User Note:

For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop with the EI or SY qualifier code.

A claim that contains an NPI that does not pass check digit validation WILL DENY.

Atypical providers should send their EIN or SSN in the NM1 segment.

Segment: **PRV** **Rendering Provider Specialty Information**
Position: 255
Loop: 2310B Optional
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To specify the identifying characteristics of a provider
Syntax Notes:
Semantic Notes:
Comments:
Notes:

X12N HIPAA Notes

The PRV segment in Loop ID-2310 applies to the entire claim unless overridden on the service line level by the presence of a PRV segment with the same value in PRV01.

PRV02 qualifies PRV03.

Required when adjudication is known to be impacted by provider taxonomy code.

X12N HIPAA Example

Example: PRV*PE*ZZ*203BA0200N~

ODJFS User Note

ODJFS does not require provider taxonomy codes.

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
PRV01	1221	Provider Code Code identifying the type of provider X12N HIPAA Notes: INDUSTRY: Provider Code PE Performing	M ID 1/3	R
PRV02	128	Reference Identification Qualifier Code qualifying the Reference Identification X12N HIPAA Notes: ZZ is used to indicate the "Health Care Provider Taxonomy" code list (provider specialty code) which is available on the Washington Publishing Company web site: http://www.wpc-edi.com . This taxonomy is maintained by the Blue Cross Blue Shield Association and ASC X12N TG2 WG15. INDUSTRY: Reference Identification Qualifier ZZ Mutually Defined X12N HIPAA Notes: Health Care Provider Taxonomy Code list	M ID 2/3	R
PRV03	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier X12N HIPAA Notes: ALIAS: Provider Specialty Code NSF Reference: FA0-37.0 INDUSTRY: Provider Taxonomy Code ODJFS User Note: This field should contain the Taxonomy Code.	M AN 1/30	R

Segment: **REF** Rendering Provider Secondary Identification
Position: 271
Loop: 2310B Optional
Level: Detail
Usage: Optional
Max Use: 5
Purpose: To specify identifying information
Syntax Notes:
Semantic Notes: 1 REF04 contains data relating to the value cited in REF02.
Comments:
Notes:

X12N HIPAA Notes

Required when a secondary identification number is necessary to identify the entity. The primary identification number should be carried in NM109 in this loop.

X12N HIPAA Example

Example: REF*1D*A12345~

ODJFS User Note

The 2310B Rendering Provider loop is always required when the NPI in the 2010AA and/or 2010AB loops is for a professional group practice. Professional group practices enrolled under the Ohio Medicaid program include provider types physician group, osteopath group, dentist group, Advanced Practice nurse (APN) group, optometrist group, podiatrist group, Chiropractor group, mechanotherapist group, physical therapist group, psychologist group, chiro-mechanotherapist group.

Also required for payment of physician or APN professional services submitted by hospices or ASCs. Do not submit a rendering provider number for hospice per diem payments or ASC facility payments.

No other 837P transactions require a rendering provider number. If the REF02 of the 2310B is completed for other 837P transactions, the provider number must match the numbers submitted in the 2010AA and/or 2010AB loops to assure claims will pay correctly.

The National Provider Identifier is mandated to be used on electronic claims on and after May 23, 2008. ODJFS will deny electronic claims that are missing an NPI in the rendering provider field, if required on a claim. Although the Medicaid legacy ID is not required, ODJFS will continue to accept claims that contain both NPI and the Medicaid legacy ID in the rendering provider field. If it is included, a legacy ID will be validated. An invalid legacy ID will be rejected.

For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop with the EI or SY qualifier code.

A claim that contains an NPI that does not pass check digit validation WILL DENY.

Atypical providers should send their EIN or SSN in the NM1 segment.

Data Element Summary

<u>Ref.</u>	<u>Data</u>	<u>Name</u>	<u>Base</u>	<u>User</u>
<u>Des.</u>	<u>Element</u>		<u>Attributes</u>	<u>Attributes</u>
REF01	128	Reference Identification Qualifier	M ID 2/3	R
		Code qualifying the Reference Identification		
		X12N HIPAA Notes:		
		NSF Reference: FA0-57.0		
		INDUSTRY: Reference Identification Qualifier		
		1D Medicaid Provider Number		
		EI Employer's Identification Number		

SY Social Security Number

X12N HIPAA Notes:

The social security number may not be used for Medicare.

REF02

127

Reference Identification

O AN 1/30 R AN 7/7

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

X12N HIPAA Notes:

ALIAS: Rendering Provider Secondary Identifier

NSF Reference: FA0-58.0

INDUSTRY: Rendering Provider Secondary Identifier

ODJFS User Note:

For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop with the EI or SY qualifier code.

A claim that contains an NPI that does not pass check digit validation WILL DENY.

Atypical providers should send their EIN or SSN in the NM1 segment.

Segment: **SBR** Other Subscriber Information
Position: 290
Loop: 2320 Optional
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To record information specific to the primary insured and the insurance carrier for that insured

Syntax Notes:
Semantic Notes: 1 SBR02 specifies the relationship to the person insured.
 2 SBR03 is policy or group number.
 3 SBR04 is plan name.

Comments:
Notes: **X12N HIPAA Notes**

Required if other payers are known to potentially be involved in paying on this claim.

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.

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.

See Section 1.4.5 Crosswalking COB Data Elements for more information on handling COB in the 837.

X12N HIPAA Example

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

ODJFS User Note

Required whenever an individual is also covered by Medicare part A, B, or C and/or is covered under another third party payer.

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
SBR01	1138	Payer Responsibility Sequence Number Code Code identifying the insurance carrier's level of responsibility for a payment of a claim X12N HIPAA Notes: ALIAS: Payer responsibility sequence number code NSF Reference: DA0-02.0, DA1-02.0, DA2-02.0 INDUSTRY: Payer Responsibility Sequence Number Code P Primary S Secondary T Tertiary	M ID 1/1	R
SBR02	1069	Individual Relationship Code Code indicating the relationship between two individuals or entities X12N HIPAA Notes: ALIAS: Individual relationship code NSF Reference: DA0-17.0 INDUSTRY: Individual Relationship Code 01 Spouse	O ID 2/2	R

04	Grandfather or Grandmother
05	Grandson or Granddaughter
07	Nephew or Niece
10	Foster Child
15	Ward
17	Stepson or Stepdaughter
18	Self
19	Child
	Dependent between the ages of 0 and 19; age qualifications may vary depending on policy
20	Employee
21	Unknown
22	Handicapped Dependent
23	Sponsored Dependent
	Dependents between the ages of 19 and 25 not attending school; age qualifications may vary depending on policy
24	Dependent of a Minor Dependent
	A child not legally of age who has been granted adult status
29	Significant Other
32	Mother
33	Father
36	Emancipated Minor
	A person who has been judged by a court of competent jurisdiction to be allowed to act in his or her own interest; no adult is legally responsible for this minor; this may be declared as a result of marriage
39	Organ Donor
	Individual receiving medical service in order to donate organs for a transplant
40	Cadaver Donor
	Deceased individual donating body to be used for research or transplants
41	Injured Plaintiff
43	Child Where Insured Has No Financial Responsibility
	Child is covered by the insured but the insured is not the legal guardian
53	Life Partner
G8	Other Relationship

SBR03 **127** **Reference Identification** **O AN 1/30 S**
Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

X12N HIPAA Notes:
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).
ALIAS: Group or Policy Number
NSF Reference: DA0-10.0
INDUSTRY: Insured Group or Policy Number

SBR04 **93** **Name** **O AN 1/60 S**
Free-form name

X12N HIPAA Notes:
Required if the subscriber's payer identification includes a Group or Plan Name.

ALIAS: Group or Plan Name
 NSF Reference: DA0-11.0
 INDUSTRY: Other Insured Group Name

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

X12N HIPAA Notes:
 ALIAS: Insurance type code
 NSF Reference: DA0-06.0
 INDUSTRY: Insurance Type Code

- AP Auto Insurance Policy
- C1 Commercial
- CP Medicare Conditionally Primary
- GP Group Policy
 Two or more people who are part of complete unit who enter into an insurance contract with an insurance company
- HM Health Maintenance Organization (HMO)
- IP Individual Policy
- LD Long Term Policy
- LT Litigation
- MB Medicare Part B
- MC Medicaid
 Program of health care services made available to medically indigent and other needy persons, regardless of age, under terms of a 1965 amendment to the U.S. Social Security Act
- MI Medigap Part B
 Health insurance policy intended to cover the non-covered portion of expenses eligible for Medicare Part B reimbursement which must be paid by a Medicare beneficiary for health care services and/or supplies received
- MP Medicare Primary
 Medicare has the primary responsibility to pay for health care services and/or supplies received by a covered beneficiary (a person entitled to Medicare benefits)
- OT Other
- PP Personal Payment (Cash - No Insurance)
- SP Supplemental Policy
 An insurance policy intended to cover non-covered charges of another insurance policy

SBR06 1143 Coordination of Benefits Code O ID 1/1 N/U
 Refer to 004010X098A1 Data Element Dictionary for acceptable code values.

SBR07 1073 Yes/No Condition or Response Code O ID 1/1 N/U
 Refer to 004010X098A1 Data Element Dictionary for acceptable code values.

SBR08 584 Employment Status Code O ID 2/2 N/U
 Refer to 004010X098A1 Data Element Dictionary for acceptable code values.

SBR09 1032 Claim Filing Indicator Code O ID 1/2 S
 Code identifying type of claim

X12N HIPAA Notes:
 Required prior to mandated used of PlanID. Not used after PlanID is mandated.
 ALIAS: Claim filing indicator code

NSF Reference: DA0-05.0

INDUSTRY: Claim Filing Indicator Code

ODJFS User Note:

Required on all Part B and Part C Crossover claims. Must submit MB for Part B and 16 for Part C.

09	Self-pay
10	Central Certification
	X12N HIPAA Notes:
	CA0-23.0 (K), DA0-05.0 (K)
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
	X12N HIPAA Notes:
	Refers to Veterans Affairs Plan.
WC	Workers' Compensation Health Claim

Segment: **CAS** Claim Level Adjustments

Position: 295

Loop: 2320 Optional

Level: Detail

Usage: Optional

Max Use: 5

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

- Syntax Notes:**
- 1 If CAS05 is present, then at least one of CAS06 or CAS07 is required.
 - 2 If CAS06 is present, then CAS05 is required.
 - 3 If CAS07 is present, then CAS05 is required.
 - 4 If CAS08 is present, then at least one of CAS09 or CAS10 is required.
 - 5 If CAS09 is present, then CAS08 is required.
 - 6 If CAS10 is present, then CAS08 is required.
 - 7 If CAS11 is present, then at least one of CAS12 or CAS13 is required.
 - 8 If CAS12 is present, then CAS11 is required.
 - 9 If CAS13 is present, then CAS11 is required.
 - 10 If CAS14 is present, then at least one of CAS15 or CAS16 is required.
 - 11 If CAS15 is present, then CAS14 is required.
 - 12 If CAS16 is present, then CAS14 is required.
 - 13 If CAS17 is present, then at least one of CAS18 or CAS19 is required.
 - 14 If CAS18 is present, then CAS17 is required.
 - 15 If CAS19 is present, then CAS17 is required.

- Semantic Notes:**
- 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: **X12N HIPAA Notes**

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.

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.

Codes and associated amounts should come from 835s (Remittance Advice) received on the claim. If no previous payments have been made, omit this segment.

Required if claim has been adjudicated by payer identified in this loop and has claim level adjustment information.

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.

There several NSF fields which are not directly crosswalked from the 837 to NSF, particularly with respect to payer-to-payer COB situations. Below is a list of some of these NSF fields and some suggestions regarding how to handle them in the 837.

Provider Adjustment Amt (DA3-25.0). This would equal the sum of all the adjustment amounts in CAS03, 06, 09, 12, 15, and 18 at both the claim and the line level. See the 835 for how to balance the CAS adjustments against the total billed amount.

Beneficiary liability amount (FA0-53.0) This amount would equal the sum of all the adjustment amounts in CAS03, 06, 09, 12, 15, and 18 at both the claim and the line level when CAS01 = PR (patient responsibility).

Amount paid to Provider (DA1-33.0). This would be calculated through the use of the CAS codes. Please see the detail on the codes and the discussion of how to use them in the 835 implementation guide.

Balance bill limit charge (FA0-54.0). This would equal any CAS adjustment where CAS01=CO and one of the adjustment reason code elements equaled "45".

Beneficiary Adjustment Amt (DA3-26.0) Amount paid to beneficiary (DA1-30.0)). The amount paid to the beneficiary is indicated by the use of CAS code "100 - Payment made to patient/insured/responsible party."

Original Paid Amount (DA3-28.0): The original paid amount can be calculated from the original COB claim by subtracting all claim adjustments carried in the claim and line level CAS from the original billed amount.

ODJFS Application Notes

All Claim Adjustment Reason codes and Monetary Amounts and Quantity submitted will be used in claims processing.

X12N HIPAA Example

Example: CAS*PR*1*7.93~

CAS*OA*93*15.06~

ODJFS User Note

All Medicare Part A, Medicare Part B, Medicare Part C, and all TPL claims submitted to ODJFS must contain, at a minimum, the CAS codes and associated monetary amounts issued by the payer who adjudicated the claim immediately prior to submitting the claim to ODJFS. The sum of the CAS code monetary amounts (2320 and 2430 loops) and the payer paid amount must balance to equal the total billed charges.

ODJFS requires the claim to be adjudicated by all other payers prior to submitting the claim.

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
CAS01	1033	Claim Adjustment Group Code Code identifying the general category of payment adjustment	M ID 1/2	R
X12N HIPAA Notes:				
ALIAS: Claim Adjustment Group Code				
INDUSTRY: Claim Adjustment Group Code				
		CO Contractual Obligations		
		CR Correction and Reversals		
		OA Other adjustments		
		PI Payor Initiated Reductions		
		PR Patient Responsibility		
CAS02	1034	Claim Adjustment Reason Code Code identifying the detailed reason the adjustment was made	M ID 1/5	R
X12N HIPAA Notes:				
ALIAS: Adjustment Reason Code - Claim Level				
NSF Reference: DA3-04.0, DA3-06.0, DA3-08.0, DA3-10.0, DA3-12.0, DA3-14.0, DA3-16.0, DA1-16.0, DA1-30.0				
INDUSTRY: Adjustment Reason Code				

CAS03	782	Monetary Amount Monetary amount X12N HIPAA Notes: ALIAS: Adjusted Amount - Claim Level NSF Reference: DA1-09.0, DA1-10.0, DA1-11.0, DA1-12.0, DA1-13.0, DA3-05.0, DA3-07.0, DA3-09.0, DA3-11.0, DA3-13.0, DA3-15.0, DA3-17.0, DA1-30.0, DA1-33.0, DA3-25.0, DA3-26.0 INDUSTRY: Adjustment Amount	M	R 1/10	R
CAS04	380	Quantity Numeric value of quantity X12N HIPAA Notes: Use as needed to show payer adjustment. ALIAS: Adjusted Units - Claim Level INDUSTRY: Adjustment Quantity	O	R 1/15	S
CAS05	1034	Claim Adjustment Reason Code Code identifying the detailed reason the adjustment was made X12N HIPAA Notes: Use as needed to show payer adjustment. ALIAS: Adjustment Reason Code - Claim Level NSF Reference: DA3-04.0, DA3-06.0, DA3-08.0, DA3-10.0, DA3-12.0, DA3-14.0, DA3-16.0, DA1-17.0, DA1-30.0 INDUSTRY: Adjustment Reason Code	X	ID 1/5	S
CAS06	782	Monetary Amount Monetary amount X12N HIPAA Notes: Use as needed to show payer adjustment. ALIAS: Adjusted Amount - Claim Level NSF Reference: DA3-05.0, DA3-07.0, DA3-09.0, DA3-11.0, DA3-13.0, DA3-15.0, DA3-17.0, DA1-30.0, DA1-33.0, DA3-25.0, DA3-26.0 INDUSTRY: Adjustment Amount	X	R 1/10	S
CAS07	380	Quantity Numeric value of quantity X12N HIPAA Notes: Use as needed to show payer adjustment. ALIAS: Adjusted Units - Claim Level INDUSTRY: Adjustment Quantity	X	R 1/15	S
CAS08	1034	Claim Adjustment Reason Code Code identifying the detailed reason the adjustment was made X12N HIPAA Notes: Use as needed to show payer adjustment. ALIAS: Adjustment Reason Code - Claim Level NSF Reference: DA3-04.0, DA3-06.0, DA3-08.0, DA3-10.0, DA3-12.0, DA3-14.0, DA3-16.0, DA1-30.0, DA1-18.0	X	ID 1/5	S

CAS09	782	INDUSTRY: Adjustment Reason Code			
		Monetary Amount	X	R 1/10	S
		Monetary amount			
		X12N HIPAA Notes: Use as needed to show payer adjustment. ALIAS: Adjusted Amount - Claim Level NSF Reference: DA3-05.0, DA3-07.0, DA3-09.0, DA3-11.0, DA3-13.0, DA3-15.0, DA3-17.0, DA1-30.0, DA1-33.0, DA3-25.0, DA3-26.0			
CAS10	380	INDUSTRY: Adjustment Amount			
		Quantity	X	R 1/15	S
		Numeric value of quantity			
		X12N HIPAA Notes: Use as needed to show payer adjustment. ALIAS: Adjusted Units - Claim Level			
CAS11	1034	INDUSTRY: Adjustment Quantity			
		Claim Adjustment Reason Code	X	ID 1/5	S
		Code identifying the detailed reason the adjustment was made			
		X12N HIPAA Notes: Use as needed to show payer adjustment. ALIAS: Adjustment Reason Code - Claim Level NSF Reference: DA3-04.0, DA3-06.0, DA3-08.0, DA3-10.0, DA3-12.0, DA3-14.0, DA3-16.0, DA1-30.0			
CAS12	782	INDUSTRY: Adjustment Reason Code			
		Monetary Amount	X	R 1/10	S
		Monetary amount			
		X12N HIPAA Notes: Use as needed to show payer adjustment. ALIAS: Adjusted Amount - Claim Level NSF Reference: DA3-05.0, DA3-07.0, DA3-09.0, DA3-11.0, DA3-13.0, DA3-15.0, DA3-17.0, DA1-30.0, DA1-33.0, DA3-25.0, DA3-26.0			
CAS13	380	INDUSTRY: Adjustment Amount			
		Quantity	X	R 1/15	S
		Numeric value of quantity			
		X12N HIPAA Notes: Use as needed to show payer adjustment. ALIAS: Adjusted Units - Claim Level			
CAS14	1034	INDUSTRY: Adjustment Quantity			
		Claim Adjustment Reason Code	X	ID 1/5	S
		Code identifying the detailed reason the adjustment was made			
		X12N HIPAA Notes: Use as needed to show payer adjustment. ALIAS: Adjustment Reason Code - Claim Level NSF Reference: DA3-04.0, DA3-06.0, DA3-08.0, DA3-10.0, DA3-12.0, DA3-14.0, DA3-			

		16.0, DA1-30.0			
CAS15	782	<p>INDUSTRY: Adjustment Reason Code</p> <p>Monetary Amount X R 1/10 S</p> <p>Monetary amount</p> <p>X12N HIPAA Notes:</p> <p>Use as needed to show payer adjustment.</p> <p>ALIAS: Adjusted Amount - Claim Level</p> <p>NSF Reference: DA3-05.0, DA3-07.0, DA3-09.0, DA3-11.0, DA3-13.0, DA3-15.0, DA3-17.0, DA1-30.0, DA1-33.0, DA3-25.0, DA3-26.0</p>			
CAS16	380	<p>INDUSTRY: Adjustment Amount</p> <p>Quantity X R 1/15 S</p> <p>Numeric value of quantity</p> <p>X12N HIPAA Notes:</p> <p>Use as needed to show payer adjustment.</p> <p>ALIAS: Adjusted Units - Claim Level</p>			
CAS17	1034	<p>INDUSTRY: Adjustment Quantity</p> <p>Claim Adjustment Reason Code X ID 1/5 S</p> <p>Code identifying the detailed reason the adjustment was made</p> <p>X12N HIPAA Notes:</p> <p>Use as needed to show payer adjustment.</p> <p>ALIAS: Adjustment Reason Code - Claim Level</p> <p>NSF Reference: DA3-04.0, DA3-06.0, DA3-08.0, DA3-10.0, DA3-12.0, DA3-14.0, DA3-16.0, DA1-30.0</p>			
CAS18	782	<p>INDUSTRY: Adjustment Reason Code</p> <p>Monetary Amount X R 1/10 S</p> <p>Monetary amount</p> <p>X12N HIPAA Notes:</p> <p>Use as needed to show payer adjustment.</p> <p>ALIAS: Adjusted Amount - Claim Level</p> <p>NSF Reference: DA3-05.0, DA3-07.0, DA3-09.0, DA3-11.0, DA3-13.0, DA3-15.0, DA3-17.0, DA1-30.0, DA1-33.0, DA3-25.0, DA3-26.0</p>			
CAS19	380	<p>INDUSTRY: Adjustment Amount</p> <p>Quantity X R 1/15 S</p> <p>Numeric value of quantity</p> <p>X12N HIPAA Notes:</p> <p>Use as needed to show payer adjustment.</p> <p>ALIAS: Adjusted Units - Claim Level</p> <p>INDUSTRY: Adjustment Quantity</p>			

Segment: **AMT** Coordination of Benefits (COB) Payer Paid Amount
Position: 300
Loop: 2320 Optional
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To indicate the total monetary amount
Syntax Notes:
Semantic Notes:
Comments:
Notes:

X12N HIPAA Notes

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

ODJFS Application Notes

Required on all COB Claims.

X12N HIPAA Example

Example: AMT*D*411~

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
AMT01	522	Amount Qualifier Code Code to qualify amount	M ID 1/3	R
		X12N HIPAA Notes: INDUSTRY: Amount Qualifier Code		
		D Payor Amount Paid		
AMT02	782	Monetary Amount Monetary amount	M R 1/10	R
		X12N HIPAA Notes: This is a crosswalk from CLP04 in 835 when doing COB. INDUSTRY: Payer Paid Amount		

Segment: **AMT** Coordination of Benefits (COB) Approved Amount
Position: 300
Loop: 2320 Optional
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To indicate the total monetary amount
Syntax Notes:
Semantic Notes:
Comments:
Notes:

X12N HIPAA 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 approved amount equals the amount for the total claim that was approved by the payer sending this 837 to another payer.

X12N HIPAA Example

Example: AMT*AAE*500.35~

ODJFS User Note

All COB Claims (Medicare Part A, B, or C Crossover and TPL Claims) must have either an AMT01 of AAE or B6 and a coinciding monetary amount in AMT02. Crosswalk the AMT02 amount from the 835 CLP from the other payer(s). In cases when claims are not adjudicated by the other payer (e.g., when payment is under a capitation payment arrangement), the monetary amount may be zero.

Data Element Summary

<u>Ref.</u>	<u>Data</u>	<u>Name</u>	<u>Base</u>	<u>User</u>
<u>Des.</u>	<u>Element</u>	<u>Amount Qualifier Code</u>	<u>Attributes</u>	<u>Attributes</u>
AMT01	522	Amount Qualifier Code Code to qualify amount X12N HIPAA Notes: INDUSTRY: Amount Qualifier Code	M ID 1/3	R
AMT02	782	Monetary Amount Monetary amount X12N HIPAA Notes: NSF Reference: DA1-37.0 INDUSTRY: Approved Amount ODJFS Application Notes: Used for Claim Processing	M R 1/10	R

Segment: **AMT** Coordination of Benefits (COB) Allowed Amount
Position: 300
Loop: 2320 Optional
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To indicate the total monetary amount
Syntax Notes:
Semantic Notes:
Comments:
Notes:

X12N HIPAA 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.

X12N HIPAA Example

Example: AMT*B6*519.21~

ODJFS User Note

All COB Claims (Medicare Part A, B, or C Crossover and TPL Claims) must have either an AMT01 of AAE or B6 and a coinciding monetary amount in AMT02. Crosswalk the AMT02 amount from the 835 CLP from the other payer(s). In cases when claims are not adjudicated by the other payer (e.g., when payment is under a capitation payment arrangement), the monetary amount may be zero.

Data Element Summary

<u>Ref.</u>	<u>Data</u>	<u>Name</u>	<u>Base</u>	<u>User</u>
<u>Des.</u>	<u>Element</u>	<u>Name</u>	<u>Attributes</u>	<u>Attributes</u>
AMT01	522	Amount Qualifier Code Code to qualify amount X12N HIPAA Notes: INDUSTRY: Amount Qualifier Code B6 Allowed - Actual Amount considered for payment under the provisions of the contract	M ID 1/3	R
AMT02	782	Monetary Amount Monetary amount X12N HIPAA Notes: INDUSTRY: Allowed Amount	M R 1/10	R

Segment: **AMT** Coordination of Benefits (COB) Patient Responsibility Amount
Position: 300
Loop: 2320 Optional
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To indicate the total monetary amount
Syntax Notes:
Semantic Notes:
Comments:
Notes:

X12N HIPAA Notes

Required if patient is responsible for payment according to another payer's adjudication. This is the amount of money which is the responsibility of the patient according to the payer identified in this loop (2330B NM1).

X12N HIPAA Example

Example: AMT*F2*15~

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
AMT01	522	Amount Qualifier Code Code to qualify amount	M ID 1/3	R
		X12N HIPAA Notes:		
		INDUSTRY: Amount Qualifier Code		
		F2 Patient Responsibility - Actual		
		Calculated value one receiving medical care is obliged to pay		
AMT02	782	Monetary Amount Monetary amount	M R 1/10	R
		X12N HIPAA Notes:		
		This is a crosswalk from CLP05 in 835 when doing COB.		
		INDUSTRY: Other Payer Patient Responsibility Amount		

Segment: **AMT** Coordination of Benefits (COB) Covered Amount
Position: 300
Loop: 2320 Optional
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To indicate the total monetary amount
Syntax Notes:
Semantic Notes:
Comments:
Notes:

X12N HIPAA 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 covered amount equals the amount for the total claim that was covered by the payer sending this 837 to another payer.

X12N HIPAA Example

Example: AMT*AU*50~

Data Element Summary

<u>Ref.</u> <u>Des.</u>	<u>Data</u> <u>Element</u>	<u>Name</u>	<u>Base</u> <u>Attributes</u>	<u>User</u> <u>Attributes</u>
AMT01	522	Amount Qualifier Code Code to qualify amount X12N HIPAA Notes: INDUSTRY: Amount Qualifier Code	M ID 1/3	R
		AU Coverage Amount The dollar amount of property coverage provided by a specific policy contract		
AMT02	782	Monetary Amount Monetary amount X12N HIPAA Notes: This is a crosswalk from AMT in 835 (Loop CLP, position 062) when AMT01 = AU. INDUSTRY: Other Payer Covered Amount	M R 1/10	R

Segment: **AMT** Coordination of Benefits (COB) Patient Paid Amount
Position: 300
Loop: 2320 Optional
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To indicate the total monetary amount
Syntax Notes:
Semantic Notes:
Comments:
Notes:

X12N HIPAA Notes

Required if claim has been adjudicated by the payer identified in this loop and if this information was included in the remittance advice reporting those adjudication results.

The amount carried in this segment is the total amount of money paid by the payer to the patient (rather than to the provider) on this claim.

X12N HIPAA Example

Example: AMT*F5*152.45~

ODJFS User Note

At this time, Patient Paid Amount should be zero.

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
AMT01	522	Amount Qualifier Code Code to qualify amount	M ID 1/3	R
		X12N HIPAA Notes:		
		INDUSTRY: Amount Qualifier Code		
		F5 Patient Amount Paid Monetary amount value already paid by one receiving medical care		
AMT02	782	Monetary Amount Monetary amount	M R 1/10	R
		X12N HIPAA Notes:		
		This is a crosswalk from AMT in 835 (Loop CLP, position 062) when AMT01 = F5.		
		INDUSTRY: Other Payer Patient Paid Amount		

Segment: **DMG** Subscriber Demographic Information
Position: 305
Loop: 2320 Optional
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To supply demographic information
Syntax Notes: 1 If either DMG01 or DMG02 is present, then the other is required.
Semantic Notes: 1 DMG02 is the date of birth.
Comments:
Notes:

X12N HIPAA Notes

Required when 2330A NM102 = 1 (person).

See Section 1.4.5 Crosswalking COB Data Elements for more information on handling COB in the 837.

X12N HIPAA Example

Example: DMG*D8*19671105*F~

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
DMG01	1250	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format X12N HIPAA Notes: INDUSTRY: Date Time Period Format Qualifier	X ID 2/3	R
		D8 Date Expressed in Format CCYYMMDD		
DMG02	1251	Date Time Period Expression of a date, a time, or range of dates, times or dates and times X12N HIPAA Notes: ALIAS: Date of Birth - Subscriber NSF Reference: DA0-24.0	X AN 1/35	R
		INDUSTRY: Other Insured Birth Date		
DMG03	1068	Gender Code Code indicating the sex of the individual X12N HIPAA Notes: ALIAS: Gender - Subscriber NSF Reference: DA0-23.0 INDUSTRY: Other Insured Gender Code	O ID 1/1	R
		F Female		
		M Male		
		U Unknown		

Segment: **OI Other Insurance Coverage Information**
Position: 310
Loop: 2320 Optional
Level: Detail
Usage: Optional (Must Use)
Max Use: 1
Purpose: To specify information associated with other health insurance coverage
Syntax Notes:
Semantic Notes: 1 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.

Comments:
Notes:

X12N HIPAA 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.

See Section 1.4.5 Crosswalking COB Data Elements for more information on handling COB in the 837.

X12N HIPAA Example

Example: OI***Y*B**Y~

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
OI01	1032	Claim Filing Indicator Code Refer to 004010X098A1 Data Element Dictionary for acceptable code values.	O ID 1/2	N/U
OI02	1383	Claim Submission Reason Code Refer to 004010X098A1 Data Element Dictionary for acceptable code values.	O ID 2/2	N/U
OI03	1073	Yes/No Condition or Response Code Code indicating a Yes or No condition or response X12N HIPAA Notes: This is a crosswalk from CLM08 when doing COB. ALIAS: Assignment of Benefits Indicator NSF Reference: DA0-15.0 INDUSTRY: Benefits Assignment Certification Indicator N No Y Yes	O ID 1/1	R
OI04	1351	Patient Signature Source Code Code indicating how the patient or subscriber authorization signatures were obtained and how they are being retained by the provider X12N HIPAA Notes: Required except in cases where "N" is used in OI06. This is a crosswalk from CLM10 when doing COB. ALIAS: Patient Signature Source Code NSF Reference: DA0-16.0 INDUSTRY: Patient Signature Source Code B Signed signature authorization form or forms for both HCFA-1500 Claim Form block 12 and block 13 are on file C Signed HCFA-1500 Claim Form on file M Signed signature authorization form for HCFA-1500 Claim Form	O ID 1/1	S

Segment: **MOA Medicare Outpatient Adjudication Information**
Position: 320
Loop: 2320 Optional
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To convey claim-level data related to the adjudication of Medicare claims not related to an inpatient setting

Syntax Notes:
Semantic Notes:

- 1 MOA01 is the reimbursement rate.
- 2 MOA02 is the claim Health Care Financing Administration Common Procedural Coding System (HCPCS) payable amount.
- 3 MOA03 is the Claim Payment Remark Code. See Code Source 411.
- 4 MOA04 is the Claim Payment Remark Code. See Code Source 411.
- 5 MOA05 is the Claim Payment Remark Code. See Code Source 411.
- 6 MOA06 is the Claim Payment Remark Code. See Code Source 411.
- 7 MOA07 is the Claim Payment Remark Code. See Code Source 411.
- 8 MOA08 is the End Stage Renal Disease (ESRD) payment amount.
- 9 MOA09 is the professional component amount billed but not payable.

Comments:
Notes:

X12N HIPAA Notes

Required if returned in the electronic remittance advice (835).

X12N HIPAA Example

Example: MOA***A4~

Data Element Summary

<u>Ref.</u>	<u>Data</u>	<u>Name</u>	<u>Base</u>	<u>User</u>
<u>Des.</u>	<u>Element</u>		<u>Attributes</u>	<u>Attributes</u>
MOA01	954	Percent Percentage expressed as a decimal X12N HIPAA Notes: Required if returned in the electronic remittance advice (835). ALIAS: Outpatient Reimbursement Rate INDUSTRY: Reimbursement Rate	O R 1/10	S
MOA02	782	Monetary Amount Monetary amount X12N HIPAA Notes: Required if returned in the electronic remittance advice (835). ALIAS: HCPCS Payable Amount INDUSTRY: HCPCS Payable Amount	O R 1/10	S
MOA03	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier X12N HIPAA Notes: Required if returned in the electronic remittance advice (835). ALIAS: Remarks Code NSF Reference: DA3-18.0, DA3-19.0, DA3-20.0, DA3-21.0, DA3-22.0 INDUSTRY: Remark Code	O AN 1/30	S
MOA04	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	O AN 1/30	S

Segment: **NM1** Other Subscriber Name
Position: 325
Loop: 2330A Optional (Must Use)
Level: Detail
Usage: Optional (Must Use)
Max Use: 1
Purpose: To supply the full name of an individual or organizational entity
Syntax Notes: 1 If either NM108 or NM109 is present, then the other is required.
Semantic Notes: 1 NM102 qualifies NM103.
Comments:
Notes:

X12N HIPAA Notes

Submitters are required to send information on all known other subscribers in Loop ID-2330.

This 2330 loop is required when Loop ID-2320 - Other Subscriber Information is used. Otherwise, this loop is not used.

See Section 1.4.5 Crosswalking COB Data Elements for more information on handling COB in the 837.

X12N HIPAA Example

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

ODJFS User Note

A value of '8' will be placed in the Other Source Indicator when Provider Type is 05 or 12 and AMT01=D and the AMT02 Monetary amount is greater than zero.

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
NM101	98	Entity Identifier Code Code identifying an organizational entity, a physical location, property or an individual X12N HIPAA Notes: INDUSTRY: Entity Identifier Code IL Insured or Subscriber	M ID 2/3	R
NM102	1065	Entity Type Qualifier Code qualifying the type of entity X12N HIPAA Notes: INDUSTRY: Entity Type Qualifier 1 Person 2 Non-Person Entity	M ID 1/1	R
NM103	1035	Name Last or Organization Name Individual last name or organizational name X12N HIPAA Notes: ALIAS: Subscriber Last Name NSF Reference: DA0-19.0 INDUSTRY: Other Insured Last Name	O AN 1/35	R
NM104	1036	Name First Individual first name X12N HIPAA Notes: Required if NM102=1 (person). ALIAS: Subscriber First Name NSF Reference: DA0-20.0	O AN 1/25	S

		INDUSTRY: Other Insured First Name			
NM105	1037	Name Middle	O	AN 1/25	S
		Individual middle name or initial			
		X12N HIPAA Notes:			
		Required if NM102=1 and the middle name/initial of the person is known.			
		ALIAS: Subscriber Middle Name			
		NSF Reference: DA0-21.0			
		INDUSTRY: Other Insured Middle Name			
NM106	1038	Name Prefix	O	AN 1/10	N/U
NM107	1039	Name Suffix	O	AN 1/10	N/U
NM108	66	Identification Code Qualifier	X	ID 1/2	R
		Code designating the system/method of code structure used for Identification Code (67)			
		X12N HIPAA Notes:			
		INDUSTRY: Identification Code Qualifier			
		MI		Member Identification Number	
				X12N HIPAA Notes:	
				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.	
		ZZ		Mutually Defined	
				X12N HIPAA Notes:	
				The value 'ZZ', when used in this data element shall be defined as "HIPAA Individual Identifier" once this identifier has been adopted. Under the Health Insurance Portability and Accountability Act of 1996, the Secretary of the Department of Health and Human Services must adopt a standard individual identifier for use in this transaction.	
NM109	67	Identification Code	X	AN 2/80	R
		Code identifying a party or other code			
		X12N HIPAA Notes:			
		ALIAS: Other Subscriber Primary Identifier			
		NSF Reference: DA0-18.0			
		INDUSTRY: Other Insured Identifier			

Segment: N3 Other Subscriber Address
Position: 332
Loop: 2330A Optional (Must Use)
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To specify the location of the named party
Syntax Notes:
Semantic Notes:
Comments:
Notes:

X12N HIPAA Notes

Required when information is available.

See Section 1.4.5 Crosswalking COB Data Elements for more information on handling COB in the 837.

X12N HIPAA Example

Example: N3*4320 WASHINGTON ST*SUITE 100~

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
N301	166	Address Information Address information X12N HIPAA Notes: ALIAS: Subscriber Address 1 NSF Reference: DA2-04.0	M AN 1/55	R
N302	166	Address Information Address information X12N HIPAA Notes: Required if a second address line exists. ALIAS: Subscriber Address 2 NSF Reference: DA2-05.0 INDUSTRY: Other Insured Address Line	O AN 1/55	S

Segment: N4 Other Subscriber City/State/ZIP Code
Position: 340
Loop: 2330A Optional (Must Use)
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To specify the geographic place of the named party
Syntax Notes:
Semantic Notes:
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: X12N HIPAA Notes

Required when information is available.

See Section 1.4.5 Crosswalking COB Data Elements for more information on handling COB in the 837.

X12N HIPAA Example

Example: N4*PALISADES*OR*23119~

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
N401	19	City Name Free-form text for city name X12N HIPAA Notes: Required when information is available. ALIAS: Subscriber City Name NSF Reference: DA2-06.0 INDUSTRY: Other Insured City Name	O AN 2/30	S
N402	156	State or Province Code Code (Standard State/Province) as defined by appropriate government agency X12N HIPAA Notes: Required when information is available. ALIAS: Subscriber State Code NSF Reference: DA2-07.0 INDUSTRY: Other Insured State Code	O ID 2/2	S
N403	116	Postal Code Code defining international postal zone code excluding punctuation and blanks (zip code for United States) X12N HIPAA Notes: Required when information is available. ALIAS: Subscriber Zip Code NSF Reference: DA2-08.0 INDUSTRY: Other Insured Postal Zone or ZIP Code	O ID 3/15	S
N404	26	Country Code Code identifying the country X12N HIPAA Notes:	O ID 2/3	S

Required if the address is out of the U.S.

ALIAS: Subscriber Country Code

INDUSTRY: Country Code

Segment: **NM1** Other Payer Name
Position: 325
Loop: 2330B Optional (Must Use)
Level: Detail
Usage: Optional (Must Use)
Max Use: 1
Purpose: To supply the full name of an individual or organizational entity
Syntax Notes: 1 If either NM108 or NM109 is present, then the other is required.
Semantic Notes: 1 NM102 qualifies NM103.
Comments:
Notes:

X12N HIPAA Notes

Submitters are required to send all known information on other payers in this Loop ID-2330.

This 2330 loop is required when Loop ID-2320 - Other Subscriber Information is used. Otherwise, this loop is not used.

See Section 1.4.5 Crosswalking COB Data Elements for more information on handling COB in the 837.

X12N HIPAA Example

Example: NM1*PR*2*UNION MUTUAL OF OREGON*****PI*11122333~

ODJFS User Note

Special Note for FQHC/RHC supplemental payments.

FQHC/RHC: PI (Payer information) must be submitted on all Federally Qualified Health Center/Rural Health Center (FQHC/RHC) transactions seeking supplemental payments from ODJFS for services rendered to Medicaid Managed Care enrollees. The Medicaid provider number assigned to the Medicaid Managed Care Organization for the subscriber/patient (i.e., Medicaid managed care enrollee) must be submitted in the NM109 of the 2330B loop.

Special Note for Medicare Part C (i.e. Medicare Managed Care plan) Crossover Claims.

The primary identifier for the Medicare Managed Care Organization (MCO) or a Medicare Health Maintenance Organization (HMO) for the subscriber/patient (i.e., Medicare Managed Care enrollee) must be submitted for a Medicaid cost sharing payment to be made.

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
NM101	98	Entity Identifier Code	M ID 2/3	R
		Code identifying an organizational entity, a physical location, property or an individual		
		X12N HIPAA Notes:		
		INDUSTRY: Entity Identifier Code		
		PR Payer		
NM102	1065	Entity Type Qualifier	M ID 1/1	R
		Code qualifying the type of entity		
		X12N HIPAA Notes:		
		INDUSTRY: Entity Type Qualifier		
		2 Non-Person Entity		
NM103	1035	Name Last or Organization Name	O AN 1/35	R
		Individual last name or organizational name		
		X12N HIPAA Notes:		
		ALIAS: Payer Name		
		NSF Reference: DA0-09.0		

		INDUSTRY: Other Payer Last or Organization Name		
NM104	1036	Name First	O AN 1/25	N/U
NM105	1037	Name Middle	O AN 1/25	N/U
NM106	1038	Name Prefix	O AN 1/10	N/U
NM107	1039	Name Suffix	O AN 1/10	N/U
NM108	66	Identification Code Qualifier	X ID 1/2	R
		Code designating the system/method of code structure used for Identification Code (67)		
		X12N HIPAA Notes:		
		INDUSTRY: Identification Code Qualifier		
		ODJFS User Note:		
		PI (Payer information) must be submitted on all Federally Qualified Health Center/Rural Health Center (FQHC/RHC) transactions seeking supplemental payments from ODJFS for services rendered to Medicaid Managed Care enrollees.		
		PI	Payor Identification	
		XV	Health Care Financing Administration National Payer Identification Number (PAYERID)	
NM109	67	Identification Code	X AN 2/80	R
		Code identifying a party or other code		
		X12N HIPAA Notes:		
		This number must be identical to SVD01 (Loop ID-2430) for COB.		
		ALIAS: Other Payer Primary Identification Number		
		NSF Reference: DA0-07.0		
		INDUSTRY: Other Payer Primary Identifier		
		ODJFS Application Notes:		
		PI (Payer Identification) is used for Federally Qualified Health Center/Rural Health Center (FQHC/RHC) Medicaid Provider Number.		
		ODJFS User Note:		
		Special Note for FQHC/RHC supplemental payments.		
		FQHC/RHC: PI (Payer information) must be submitted on all Federally Qualified Health Center/Rural Health Center (FQHC/RHC) transactions seeking supplemental payments from ODJFS for services rendered to Medicaid Managed Care enrollees. The Medicaid provider number assigned to the Medicaid Managed Care Organization for the subscriber/patient (i.e., Medicaid managed care enrollee) must be submitted in the NM109 of the 2330B loop.		
		Special Note for Medicare Part C (i.e. Medicare Managed Care plan) Crossover Claims.		
		The primary identifier for the Medicare Managed Care Organization (MCO) or a Medicare Health Maintenance Organization (HMO) for the subscriber/patient (i.e., Medicare Managed Care enrollee) must be submitted for a Medicaid cost sharing payment to be made.		

Segment: **DTP** Claim Adjudication Date
Position: 350
Loop: 2330B Optional (Must Use)
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To specify any or all of a date, a time, or a time period
Syntax Notes:
Semantic Notes: 1 DTP02 is the date or time or period format that will appear in DTP03.
Comments:
Notes:

X12N HIPAA Notes

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.

ODJFS Application Notes

Used for Claim Processing

X12N HIPAA Example

Example: DTP*573*D8*19980314~

ODJFS User Note

Required on all Coordination of Benefit (COB) claims when the COB exception applies or when the payer identified in this iteration of the 2330 loop has a capitation arrangement with the provider; the date may be no later than 180 days from the date of service.

Data Element Summary

<u>Ref.</u> <u>Des.</u>	<u>Data</u> <u>Element</u>	<u>Name</u>	<u>Base</u> <u>Attributes</u>	<u>User</u> <u>Attributes</u>
DTP01	374	Date/Time Qualifier Code specifying type of date or time, or both date and time X12N HIPAA Notes: INDUSTRY: Date Time Qualifier	M ID 3/3	R
		573 Date Claim Paid		
DTP02	1250	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format X12N HIPAA Notes: INDUSTRY: Date Time Period Format Qualifier	M ID 2/3	R
		D8 Date Expressed in Format CCYYMMDD		
DTP03	1251	Date Time Period Expression of a date, a time, or range of dates, times or dates and times X12N HIPAA Notes: NSF Reference: DA1-27.0 INDUSTRY: Adjudication or Payment Date	M AN 1/35	R

Segment: **NM1 Other Payer Patient Information**
Position: 325
Loop: 2330C Optional
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To supply the full name of an individual or organizational entity
Syntax Notes: 1 If either NM108 or NM109 is present, then the other is required.
Semantic Notes: 1 NM102 qualifies NM103.
Comments:
Notes:

X12N HIPAA Notes

Required when it is necessary, in COB situations, to send one or more payer-specific patient identification numbers. The patient identification number(s) carried in this iteration of the 2330 loop are those patient ID's which belong to non-destination (COB) payers. The patient ID(s) for the destination payer are carried in the 2010CA loop NM1 and REF segments. See Section 1.4.5 Crosswalking COB Data Elements for more information on handling non-destination payer patient identifiers and other COB elements.

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.

X12N HIPAA Example

Example: NM1*QC*1*****MI*6677U801~

ODJFS User Note

Medicaid billing number for the patient is required in the NM109 when submitting a claim to Medicare or any other primary insurance carrier and the individual is also enrolled in the Medicaid program. In this situation Medicaid is the non-destination payer.

This loop is also required when Medicaid is the destination payer for claims for individuals who are also covered under Medicare (A,B,or C) or other third party plans. In this situation the HIC number for a Medicare covered individual or the patient's plan ID for the third party plan must be submitted.

Data Element Summary

<u>Ref.</u>	<u>Data</u>	<u>Name</u>	<u>Base</u>	<u>User</u>
<u>Des.</u>	<u>Element</u>		<u>Attributes</u>	<u>Attributes</u>
NM101	98	Entity Identifier Code	M ID 2/3	R
		Code identifying an organizational entity, a physical location, property or an individual		
		X12N HIPAA Notes:		
		INDUSTRY: Entity Identifier Code		
		QC Patient		
		Individual receiving medical care		
NM102	1065	Entity Type Qualifier	M ID 1/1	R
		Code qualifying the type of entity		
		X12N HIPAA Notes:		
		INDUSTRY: Entity Type Qualifier		
		1 Person		
NM103	1035	Name Last or Organization Name	O AN 1/35	N/U
NM104	1036	Name First	O AN 1/25	N/U
NM105	1037	Name Middle	O AN 1/25	N/U
NM106	1038	Name Prefix	O AN 1/10	N/U
NM107	1039	Name Suffix	O AN 1/10	N/U
NM108	66	Identification Code Qualifier	X ID 1/2	R
		Code designating the system/method of code structure used for Identification Code (67)		

X12N HIPAA Notes:

INDUSTRY: Identification Code Qualifier

MI Member Identification Number

X12N HIPAA Notes:

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.

NM109 67 Identification Code X AN 2/80 R AN 1/12

Code identifying a party or other code

X12N HIPAA Notes:

ALIAS: Patient's Other Payer Primary Identification Number

INDUSTRY: Other Payer Patient Primary Identifier

ODJFS User Note:

Medicaid billing number for the patient is required in the NM109 when submitting a claim to Medicare or any other primary insurance carrier and the individual is also enrolled in the Medicaid program. In this situation Medicaid is the non-destination payer.

This loop is also required when Medicaid is the destination payer for claims for individuals who are also covered under Medicare (A,B,or C) or other third party plans. In this situation the HIC number for a Medicare covered individual or the patient's plan ID for the third party plan must be submitted.

Segment: **LX** Service Line
Position: 365
Loop: 2400 Optional (Must Use)
Level: Detail
Usage: Optional (Must Use)
Max Use: 1
Purpose: To reference a line number in a transaction set
Syntax Notes:
Semantic Notes:
Comments:
Notes:

X12N HIPAA Notes

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.

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.

Because this is a required segment, this is a required loop. See Appendix A for further details on ASC X12 syntax rules.

X12N HIPAA Example

Example: LX*1~

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
LX01	554	Assigned Number	M N0 1/6	R

Number assigned for differentiation within a transaction set

X12N HIPAA Notes:

The service line number incremented by 1 for each service line.

ALIAS: Line Counter

NSF Reference: FA0-02.0, FB0-02.0, FB1-02.0, GA0-02.0, GC0-02.0, GX0-02.0, GX2-02.0, HA0-02.0, FB2-02.0, GU0-02.0

INDUSTRY: Assigned Number

Segment: **SV1 Professional Service**
Position: 370
Loop: 2400 Optional (Must Use)
Level: Detail
Usage: Optional (Must Use)
Max Use: 1
Purpose: To specify the claim service detail for a Health Care professional
Syntax Notes: 1 If either SV103 or SV104 is present, then the other is required.
Semantic Notes: 1 SV102 is the submitted charge amount.
 2 SV105 is the place of service.
 3 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.
 4 SV112 is the family planning involvement indicator. A "Y" value indicates family planning services involvement; an "N" value indicates no family planning services involvement.

Comments:
Notes: **X12N HIPAA Example**
 Example: SV1*HC:99211:25*12.25*UN*1*11**1:2:3**N~

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
SV101	C003	Composite Medical Procedure Identifier To identify a medical procedure by its standardized codes and applicable modifiers X12N HIPAA Notes: ALIAS: Procedure identifier	M	R
C00301	235	Product/Service ID Qualifier Code identifying the type/source of the descriptive number used in Product/Service ID (234) X12N HIPAA Notes: INDUSTRY: Product or Service ID Qualifier The NDC number is used for reporting prescribed drugs and biologics when required by government regulation, or as deemed by the provider to enhance claim reporting/adjudication processes. The NDC number is reported in the LIN segment of Loop ID-2410 only.	M ID 2/2	R
C00302	234	Product/Service ID Identifying number for a product or service X12N HIPAA Notes: NSF Reference: FA0-09.0, FB0-15.0, GU0-07.0 INDUSTRY: Procedure Code ODJFS User Note: For the Medicaid Schools Program (MSP), the service code for Targeted Case Management, T1017, cannot be billed on the same claim as any other MSP service code. If T1017 is billed on the same claim as another MSP service code, the claim will be denied	M AN 1/48	R

C00303	1339	<p>and the provider will have to resubmit the services on separate claims.</p> <p>Procedure Modifier O AN 2/2 S</p> <p>This identifies special circumstances related to the performance of the service, as defined by trading partners</p> <p>X12N HIPAA Notes:</p> <p>Use this modifier for the first procedure code modifier.</p> <p>Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.</p> <p>ALIAS: Procedure Modifier 1</p> <p>NSF Reference: FA0-10.0, GU0-08.0</p> <p>INDUSTRY: Procedure Modifier</p>
C00304	1339	<p>Procedure Modifier O AN 2/2 S</p> <p>This identifies special circumstances related to the performance of the service, as defined by trading partners</p> <p>X12N HIPAA Notes:</p> <p>Use this modifier for the second procedure code modifier.</p> <p>Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.</p> <p>ALIAS: Procedure Modifier 2</p> <p>NSF Reference: FA0-11.0</p> <p>INDUSTRY: Procedure Modifier</p>
C00305	1339	<p>Procedure Modifier O AN 2/2 S</p> <p>This identifies special circumstances related to the performance of the service, as defined by trading partners</p> <p>X12N HIPAA Notes:</p> <p>Use this modifier for the third procedure code modifier.</p> <p>Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.</p> <p>ALIAS: Procedure Modifier 3</p> <p>NSF Reference: FA0-12.0</p> <p>INDUSTRY: Procedure Modifier</p>
C00306	1339	<p>Procedure Modifier O AN 2/2 S</p> <p>This identifies special circumstances related to the performance of the service, as defined by trading partners</p> <p>X12N HIPAA Notes:</p> <p>Use this modifier for the fourth procedure code modifier.</p> <p>Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.</p> <p>ALIAS: Procedure Modifier 4</p> <p>NSF Reference: FA0-36.0</p>

SV102	782	<p>INDUSTRY: Procedure Modifier</p> <p>Monetary Amount O R 1/10 R</p> <p>Monetary amount</p> <p>X12N HIPAA Notes:</p> <p>For encounter transmissions, zero (0) may be a valid amount.</p> <p>ALIAS: Submitted charge amount</p> <p>NSF Reference: FA0-13.0</p>																
SV103	355	<p>INDUSTRY: Line Item Charge Amount</p> <p>Unit or Basis for Measurement Code X ID 2/2 R</p> <p>Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken</p> <p>X12N HIPAA Notes:</p> <p>FA0-50.0 is only used in Medicare COB payer-to-payer situations.</p> <p>NSF Reference: FA0-50.0</p> <p>INDUSTRY: Unit or Basis for Measurement Code</p> <table border="0" style="width: 100%;"> <tr> <td style="width: 150px;">MJ</td> <td>Minutes</td> </tr> <tr> <td></td> <td>X12N HIPAA Notes:</td> </tr> <tr> <td></td> <td>Required for Anesthesia claims.</td> </tr> <tr> <td></td> <td>ODJFS User Note:</td> </tr> <tr> <td></td> <td>"MJ" may only be used for anesthesia claims.</td> </tr> <tr> <td>UN</td> <td>Unit</td> </tr> <tr> <td></td> <td>ODJFS User Note:</td> </tr> <tr> <td></td> <td>"UN" must be used for all claims except anesthesia claims.</td> </tr> </table>	MJ	Minutes		X12N HIPAA Notes:		Required for Anesthesia claims.		ODJFS User Note:		"MJ" may only be used for anesthesia claims.	UN	Unit		ODJFS User Note:		"UN" must be used for all claims except anesthesia claims.
MJ	Minutes																	
	X12N HIPAA Notes:																	
	Required for Anesthesia claims.																	
	ODJFS User Note:																	
	"MJ" may only be used for anesthesia claims.																	
UN	Unit																	
	ODJFS User Note:																	
	"UN" must be used for all claims except anesthesia claims.																	
SV104	380	<p>Quantity X R 1/15 R</p> <p>Numeric value of quantity</p> <p>X12N HIPAA Notes:</p> <p>Note: If a decimal is needed to report units, include it in this element, e.g., "15.6".</p> <p>ALIAS: Units or Minutes</p> <p>NSF Reference: FA0-18.0, FA0-19.0, FB0-16.0</p> <p>INDUSTRY: Service Unit Count</p> <p>ODJFS User Note:</p> <p>For many codes only a unit of "1" is allowed.</p> <p>Anesthesia services, drug codes and codes defined as each nerve, each 15 minutes, each digit, etc, may come in as multiple units unless otherwise indicated in the Ohio Medicaid Handbook.</p> <p>Special Note for Home Health, private duty nursing, nursing and daily living, personal care, or attendant care providers: Each unit entered in this element denotes fifteen minutes. The number of units submitted may not exceed the length of a visit. Each visit must be separated in a separate service line loop.</p>																
SV105	1331	<p>Facility Code Value O AN 1/2 S</p> <p>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>X12N HIPAA Notes:</p> <p>Required if value is different than value carried in CLM05-1 in Loop ID-2300.</p>																

Use this element for codes identifying a place of service from code source 237. As a courtesy, the codes are listed below, however, the code list is thought to be complete at the time of publication of this implementation guideline. Since this list is subject to change, only codes contained in the document available from code source 237 are to be supported in this transaction and take precedence over any and all codes listed here.

- 03 School
- 11 Office
- 12 Home
- 21 Inpatient Hospital
- 22 Outpatient Hospital
- 23 Emergency Room - Hospital
- 24 Ambulatory Surgical Center
- 25 Birthing Center
- 26 Military Treatment Facility
- 31 Skilled Nursing Facility
- 32 Nursing Facility
- 33 Custodial Care Facility
- 34 Hospice
- 41 Ambulance - Land
- 42 Ambulance - Air or Water
- 50 Federally Qualified Health Center
- 51 Inpatient Psychiatric Facility
- 52 Psychiatric Facility Partial Hospitalization
- 53 Community Mental Health Center
- 54 Intermediate Care Facility/Mentally Retarded
- 55 Residential Substance Abuse Treatment Facility
- 56 Psychiatric Residential Treatment Center
- 60 Mass Immunization Center
- 61 Comprehensive Inpatient Rehabilitation Facility
- 62 Comprehensive Outpatient Rehabilitation Facility
- 65 End Stage Renal Disease Treatment Facility
- 71 State or Local Public Health Clinic
- 72 Rural Health Clinic
- 81 Independent Laboratory
- 99 Other Unlisted Facility

ALIAS: Place of Service Code

NSF Reference: FA0-07.0, GU0-05.0

INDUSTRY: Place of Service Code

SV106	1365	Service Type Code	O	ID 1/2	N/U
		Refer to 004010X098A1 Data Element Dictionary for acceptable code values.			
SV107	C004	Composite Diagnosis Code Pointer	O		N/ U
SV108	782	Monetary Amount	O	R 1/10	N/U
SV109	1073	Yes/No Condition or Response Code	O	ID 1/1	S

Code indicating a Yes or No condition or response

X12N HIPAA Notes:

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.

ALIAS: Emergency Indicator

NSF Reference: FA0-20.0

INDUSTRY: Emergency Indicator

		Y	Yes			
SV110	1340	Multiple Procedure Code		O	ID 1/2	S
		Code indicating proper adjudication and payment determination in cases involving multiple surgical procedures during the same surgical session Refer to 004010X098A1 Data Element Dictionary for acceptable code values.				
SV111	1073	Yes/No Condition or Response Code		O	ID 1/1	S
		Code indicating a Yes or No condition or response				
		X12N HIPAA Notes:				
		Required if Medicaid services are the result of a screening referral.				
		ALIAS: EPSDT Indicator				
		NSF Reference: FB0-22.0				
		INDUSTRY: EPSDT Indicator				
		ODJFS User Note:				
		Required if Medicaid services are the result of a screening referral. Used in claims processing. Must be completed for all referrals made under the EPSDT program.				
		Y	Yes			
SV112	1073	Yes/No Condition or Response Code		O	ID 1/1	S
		Code indicating a Yes or No condition or response				
		X12N HIPAA Notes:				
		Required if applicable for Medicaid claims.				
		ALIAS: Family Planning Indicator				
		NSF Reference: FB0-23.0				
		INDUSTRY: Family Planning Indicator				
		ODJFS User Note:				
		Must be completed on all family planning related procedures.				
		Y	Yes			
SV113	1364	Review Code		O	ID 1/2	N/U
		Refer to 004010X098A1 Data Element Dictionary for acceptable code values.				
SV114	1341	National or Local Assigned Review Value		O	AN 1/2	N/U
SV115	1327	Copay Status Code		O	ID 1/1	S
		Code indicating whether or not co-payment requirements were met on a line by line basis				
		X12N HIPAA Notes:				
		Required if patient was exempt from co-pay.				
		ALIAS: Co-Pay Waiver				
		NSF Reference: FB0-21.0				
		INDUSTRY: Co-Pay Status Code				
		ODJFS Application Notes:				
		Reserved for future use if copayment policy is implemented. At the present time Medicaid has no copayments for services billed on the 837.				
		ODJFS User Note:				
		Code identifying extenuating circumstances or justifications that might assist any review of the medical necessity for this service.				
		0	Copay exempt			
			No copayment is required of patient for this service			

Segment: **CR1** Ambulance Transport Information
Position: 425
Loop: 2400 Optional (Must Use)
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To supply information related to the ambulance service rendered to a patient
Syntax Notes: 1 If either CR101 or CR102 is present, then the other is required.
 2 If either CR105 or CR106 is present, then the other is required.
Semantic Notes: 1 CR102 is the weight of the patient at time of transport.
 2 CR106 is the distance traveled during transport.
Comments:
Notes:

X12N HIPAA Notes

Required on all ambulance claims if the information is different than in the CR1 at the claim level (Loop ID-2300).

ODJFS Application Notes

Under HIPAA, required for Ambulance Transportation claims.

X12N HIPAA Example

Example: CR1*LB*140*I*A*DH*12****UNCONSCIOUS~

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
CR101	355	Unit or Basis for Measurement Code Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken X12N HIPAA Notes: Required if CR102 is present. INDUSTRY: Unit or Basis for Measurement Code LB Pound	X ID 2/2	S
CR102	81	Weight Numeric value of weight X12N HIPAA Notes: Required if it is necessary to justify the medical necessity of the level of ambulance services. ALIAS: Patient Weight NSF Reference: GA0-05.0 INDUSTRY: Patient Weight	X R 1/10	S
CR103	1316	Ambulance Transport Code Code indicating the type of ambulance transport X12N HIPAA Notes: ALIAS: Ambulance transport code NSF Reference: GA0-07.0 INDUSTRY: Ambulance Transport Code I Initial Trip R Return Trip T Transfer Trip Ambulance from one facility to another X Round Trip	O ID 1/1	R
CR104	1317	Ambulance Transport Reason Code	O ID 1/1	R

Code indicating the reason for ambulance transport

X12N HIPAA Notes:

ALIAS: Ambulance Transport Reason Code

NSF Reference: GA0-15.0

INDUSTRY: Ambulance Transport Reason Code

- A Patient was transported to nearest facility for care of symptoms, complaints, or both
- B Patient was transported for the benefit of a preferred physician
- C Patient was transported for the nearness of family members
- D Patient was transported for the care of a specialist or for availability of specialized equipment
- E Patient Transferred to Rehabilitation Facility

CR105 355 Unit or Basis for Measurement Code X ID 2/2 R

Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken

X12N HIPAA Notes:

INDUSTRY: Unit or Basis for Measurement Code

- DH Miles

CR106 380 Quantity X R 1/15 R

Numeric value of quantity

X12N HIPAA Notes:

NSF crosswalk to FA0-50.0 is used only in Medicare payer-to-payer COB situations.

ALIAS: Transport Distance

NSF Reference: GA0-17.0, FA0-50.0

INDUSTRY: Transport Distance

Segment: **CR2 Spinal Manipulation Service Information**
Position: 430
Loop: 2400 Optional (Must Use)
Level: Detail
Usage: Optional
Max Use: 5
Purpose: To supply information related to the chiropractic service rendered to a patient
Syntax Notes:
Semantic Notes:
Comments:
Notes:

X12N HIPAA Notes

Required on chiropractic claims involving spinal manipulation and known to impact payer's adjudication process.

ODJFS Application Notes

Required for Chiropractic claims.

X12N HIPAA Example

Example: CR*****M****Y~

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
CR201	609	Count	O N0 1/9	N/U
CR202	380	Quantity	O R 1/15	N/U
CR203	1367	Subluxation Level Code	O ID 2/3	N/U
		C1		Cervical 1
		C2		Cervical 2
		C3		Cervical 3
		C4		Cervical 4
		C5		Cervical 5
		C6		Cervical 6
		C7		Cervical 7
		CO		Coccyx
		IL		Ilium
		L1		Lumbar 1
		L2		Lumbar 2
		L3		Lumbar 3
		L4		Lumbar 4
		L5		Lumbar 5
		OC		Occiput
		SA		Sacrum
		T1		Thoracic 1
		T10		Thoracic 10
		T11		Thoracic 11
		T12		Thoracic 12
		T2		Thoracic 2
		T3		Thoracic 3
		T4		Thoracic 4
		T5		Thoracic 5
		T6		Thoracic 6
		T7		Thoracic 7
		T8		Thoracic 8
		T9		Thoracic 9
CR204	1367	Subluxation Level Code	O ID 2/3	N/U

C1	Cervical 1
C2	Cervical 2
C3	Cervical 3
C4	Cervical 4
C5	Cervical 5
C6	Cervical 6
C7	Cervical 7
CO	Coccyx
IL	Ilium
L1	Lumbar 1
L2	Lumbar 2
L3	Lumbar 3
L4	Lumbar 4
L5	Lumbar 5
OC	Occiput
SA	Sacrum
T1	Thoracic 1
T10	Thoracic 10
T11	Thoracic 11
T12	Thoracic 12
T2	Thoracic 2
T3	Thoracic 3
T4	Thoracic 4
T5	Thoracic 5
T6	Thoracic 6
T7	Thoracic 7
T8	Thoracic 8
T9	Thoracic 9

CR205	355	Unit or Basis for Measurement Code	O	ID 2/2	N/U
		DA			
		MO			
		WK			
		YR			
CR206	380	Quantity	O	R 1/15	N/U
CR207	380	Quantity	O	R 1/15	N/U
CR208	1342	Nature of Condition Code	O	ID 1/1	R

Code indicating the nature of a patient's condition

X12N HIPAA Notes:

ALIAS: Nature of Condition Code. Spinal Manipulation

NSF Reference: GC0-11.0

INDUSTRY: Patient Condition Code

A	Acute Condition
	A disease of rapid onset, severe symptoms, and brief duration
C	Chronic Condition
	A disease of long duration involving very slow changes; such a disease is often of gradual onset; the term does not imply anything about the severity of the disease
D	Non-acute
E	Non-Life Threatening
F	Routine

G Symptomatic
M Acute Manifestation of a Chronic Condition
A disease of long duration interrupted by a rapid onset of severe symptoms of brief duration

Segment: **CR3 Durable Medical Equipment Certification**
Position: 435
Loop: 2400 Optional (Must Use)
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To supply information regarding a physician's certification for durable medical equipment

Syntax Notes: 1 If either CR302 or CR303 is present, then the other is required.
Semantic Notes: 1 CR302 and CR303 specify the time period covered by this certification.
 2 CR305 is the prognosis of the patient.

Comments:
Notes: **X12N HIPAA Notes**

Required if it is necessary to include supporting documentation in an electronic form for Medicare DMERC claims for which the provider is required to obtain a certificate of medical necessity (CMN) from the physician.

ODJFS Application Notes

Required for DME claims.

X12N HIPAA Example

Example: CR3*I*MO*6~

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
CR301	1322	Certification Type Code Code indicating the type of certification X12N HIPAA Notes: NSF Reference: GU0-04.0 INDUSTRY: Certification Type Code I Initial R Renewal S Revised	O ID 1/1	R
CR302	355	Unit or Basis for Measurement Code Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken X12N HIPAA Notes: INDUSTRY: Unit or Basis for Measurement Code MO Months	X ID 2/2	R
CR303	380	Quantity Numeric value of quantity X12N HIPAA Notes: Length of time DME equipment is needed. ALIAS: DME Duration NSF Reference: GU0-21.0 INDUSTRY: Durable Medical Equipment Duration	X R 1/15	R

Segment: **CR5** Home Oxygen Therapy Information
Position: 445
Loop: 2400 Optional (Must Use)
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To supply information regarding certification of medical necessity for home oxygen therapy

Syntax Notes:
Semantic Notes: 1 CR502 is the number of months covered by this certification.
 2 CR510 is the arterial blood gas.
 3 CR511 is the oxygen saturation.

Comments:
Notes:

X12N HIPAA Notes

Required on all initial, renewal, and revision home oxygen therapy claims.

ODJFS Application Notes

Required for Home Oxygen Therapy claims.

X12N HIPAA Example

Example: CR5*I*6*****56**R*1~

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
CR501	1322	Certification Type Code Code indicating the type of certification X12N HIPAA Notes: ALIAS: Certification Type Code. Oxygen Therapy NSF Reference: GX0-04.0 INDUSTRY: Certification Type Code I Initial R Renewal S Revised	O ID 1/1	R
CR502	380	Quantity Numeric value of quantity X12N HIPAA Notes: ALIAS: Certification Period, Home Oxygen Therapy NSF Reference: GX0-06.0 INDUSTRY: Treatment Period Count	O R 1/15	R
CR503	1348	Oxygen Equipment Type Code Refer to 004010X098A1 Data Element Dictionary for acceptable code values.	O ID 1/1	N/U
CR504	1348	Oxygen Equipment Type Code Refer to 004010X098A1 Data Element Dictionary for acceptable code values.	O ID 1/1	N/U
CR505	352	Description	O AN 1/80	N/U
CR506	380	Quantity	O R 1/15	N/U
CR507	380	Quantity	O R 1/15	N/U
CR508	380	Quantity	O R 1/15	N/U
CR509	352	Description	O AN 1/80	N/U
CR510	380	Quantity Numeric value of quantity X12N HIPAA Notes: Either CR510 or CR511 is required.	O R 1/15	S

		Required on claims which report arterial blood gas.		
		ALIAS: Arterial Blood Gas		
		NSF Reference: GX0-22.0		
		INDUSTRY: Arterial Blood Gas Quantity		
CR511	380	Quantity	O R 1/15	S
		Numeric value of quantity		
		X12N HIPAA Notes:		
		Either CR510 or CR511 is required.		
		Required on claims which report oxygen saturation quantity.		
		ALIAS: Oxygen Saturation		
		NSF Reference: GX0-23.0		
		INDUSTRY: Oxygen Saturation Quantity		
CR512	1349	Oxygen Test Condition Code	O ID 1/1	R
		Code indicating the conditions under which a patient was tested		
		X12N HIPAA Notes:		
		ALIAS: Oxygen test condition code		
		NSF Reference: GX0-26.0		
		INDUSTRY: Oxygen Test Condition Code		
		E Exercising		
		R At rest on room air		
		S Sleeping		
CR513	1350	Oxygen Test Findings Code	O ID 1/1	S
		Code indicating the findings of oxygen tests performed on a patient		
		X12N HIPAA Notes:		
		Required if patient's arterial PO ₂ is greater than 55 mmHg and less than 60 mmHg, or oxygen saturation is greater than 88%. Use CR513, CR514, or CR515 as appropriate.		
		ALIAS: Oxygen test finding code		
		NSF Reference: GX0-27.0		
		INDUSTRY: Oxygen Test Findings Code		
		1 Dependent edema suggesting congestive heart failure		
CR514	1350	Oxygen Test Findings Code	O ID 1/1	S
		Code indicating the findings of oxygen tests performed on a patient		
		X12N HIPAA Notes:		
		Required if patient's arterial PO ₂ is greater than 55 mmHg and less than 60 mmHg, or oxygen saturation is greater than 88%. Use CR513, CR514, or CR515 as appropriate.		
		ALIAS: Oxygen test finding code		
		NSF Reference: GX0-27.0		
		INDUSTRY: Oxygen Test Findings Code		
		2 "P" Pulmonale on Electrocardiogram (EKG)		
CR515	1350	Oxygen Test Findings Code	O ID 1/1	S
		Code indicating the findings of oxygen tests performed on a patient		

X12N HIPAA Notes:

Required if patient's arterial PO₂ is greater than 55 mmHg and less than 60 mmHg, or oxygen saturation is greater than 88%. Use CR513, CR514, or CR515 as appropriate.

ALIAS: Oxygen test finding code

NSF Reference: GX0-27.0

INDUSTRY: Oxygen Test Findings Code

3 Erythrocythemia with a hematocrit greater than 56 percent

Segment: **CRC** Ambulance Certification
Position: 450
Loop: 2400 Optional (Must Use)
Level: Detail
Usage: Optional
Max Use: 3
Purpose: To supply information on conditions
Syntax Notes:
Semantic Notes:

- 1 CRC01 qualifies CRC03 through CRC07.
- 2 CRC02 is a Certification Condition Code applies indicator. A "Y" value indicates the condition codes in CRC03 through CRC07 apply; an "N" value indicates the condition codes in CRC03 through CRC07 do not apply.

Comments:
Notes:

X12N HIPAA Notes

The maximum number of CRC segments which can occur per 2400 loop is 3. Submitters are free to mix and match the three types of service line level CRC segments shown in this implementation guide to meet their billing/reporting needs but no more than a total of 3 CRC segments per 2400 loop are allowed.

Required on all service lines which bill/report ambulance services if the information is different when CRC01=07 in Loop ID-2300.

ODJFS Application Notes

Required by HIPAA for Ambulance Certification claims.

X12N HIPAA Example

Example: CRC*07*Y*08~

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
CRC01	1136	Code Category Specifies the situation or category to which the code applies X12N HIPAA Notes: INDUSTRY: Code Category 07 Ambulance Certification	M ID 2/2	R
CRC02	1073	Yes/No Condition or Response Code Code indicating a Yes or No condition or response X12N HIPAA Notes: ALIAS: Certification Condition Code, Ambulance Certification INDUSTRY: Certification Condition Indicator N No Y Yes	M ID 1/1	R
CRC03	1321	Condition Indicator Code indicating a condition X12N HIPAA Notes: The codes for CRC03 also can be used for CRC04 through CRC07. ALIAS: Condition Indicator INDUSTRY: Condition Code 01 Patient was admitted to a hospital X12N HIPAA Notes: GA0-06.0 02 Patient was bed confined before the ambulance service X12N HIPAA Notes:	M ID 2/2	R

	GA0-08.0
03	Patient was bed confined after the ambulance service X12N HIPAA Notes:
	GA0-09.0
04	Patient was moved by stretcher X12N HIPAA Notes:
	GA0-10.0
05	Patient was unconscious or in shock X12N HIPAA Notes:
	GA0-11.0
06	Patient was transported in an emergency situation X12N HIPAA Notes:
	GA0-12.0
07	Patient had to be physically restrained X12N HIPAA Notes:
	GA0-13.0
08	Patient had visible hemorrhaging X12N HIPAA Notes:
	GA0-14.0
09	Ambulance service was medically necessary X12N HIPAA Notes:
	GA0-16.0
60	Transportation Was To the Nearest Facility X12N HIPAA Notes:
	GA0-24.0

CRC04 **1321** **Condition Indicator** **O** **ID 2/2** **S**

Code indicating a condition

X12N HIPAA Notes:

Required if additional condition codes are needed.

Use the codes listed in CRC03.

ALIAS: Condition Indicator

INDUSTRY: Condition Code

01	Patient was admitted to a hospital
02	Patient was bed confined before the ambulance service
03	Patient was bed confined after the ambulance service
04	Patient was moved by stretcher
05	Patient was unconscious or in shock
06	Patient was transported in an emergency situation
07	Patient had to be physically restrained
08	Patient had visible hemorrhaging
09	Ambulance service was medically necessary
60	Transportation Was To the Nearest Facility

CRC05 **1321** **Condition Indicator** **O** **ID 2/2** **S**

Code indicating a condition

X12N HIPAA Notes:

Required if additional condition codes are needed.

Use the codes listed in CRC03.

ALIAS: Condition Indicator

INDUSTRY: Condition Code

- 01 Patient was admitted to a hospital
- 02 Patient was bed confined before the ambulance service
- 03 Patient was bed confined after the ambulance service
- 04 Patient was moved by stretcher
- 05 Patient was unconscious or in shock
- 06 Patient was transported in an emergency situation
- 07 Patient had to be physically restrained
- 08 Patient had visible hemorrhaging
- 09 Ambulance service was medically necessary
- 60 Transportation Was To the Nearest Facility

CRC06 1321 Condition Indicator O ID 2/2 S

Code indicating a condition

X12N HIPAA Notes:

Required if additional condition codes are needed.

Use the codes listed in CRC03.

ALIAS: Condition Indicator

INDUSTRY: Condition Code

- 01 Patient was admitted to a hospital
- 02 Patient was bed confined before the ambulance service
- 03 Patient was bed confined after the ambulance service
- 04 Patient was moved by stretcher
- 05 Patient was unconscious or in shock
- 06 Patient was transported in an emergency situation
- 07 Patient had to be physically restrained
- 08 Patient had visible hemorrhaging
- 09 Ambulance service was medically necessary
- 60 Transportation Was To the Nearest Facility

CRC07 1321 Condition Indicator O ID 2/2 S

Code indicating a condition

X12N HIPAA Notes:

Required if additional condition codes are needed.

Use the codes listed in CRC03.

ALIAS: Condition Indicator

INDUSTRY: Condition Code

- 01 Patient was admitted to a hospital
- 02 Patient was bed confined before the ambulance service
- 03 Patient was bed confined after the ambulance service
- 04 Patient was moved by stretcher
- 05 Patient was unconscious or in shock
- 06 Patient was transported in an emergency situation
- 07 Patient had to be physically restrained
- 08 Patient had visible hemorrhaging
- 09 Ambulance service was medically necessary
- 60 Transportation Was To the Nearest Facility

Segment: **CRC Hospice Employee Indicator**
Position: 450
Loop: 2400 Optional (Must Use)
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To supply information on conditions
Syntax Notes:
Semantic Notes:

- 1 CRC01 qualifies CRC03 through CRC07.
- 2 CRC02 is a Certification Condition Code applies indicator. A "Y" value indicates the condition codes in CRC03 through CRC07 apply; an "N" value indicates the condition codes in CRC03 through CRC07 do not apply.

Comments:
Notes:

X12N HIPAA Notes

The example shows the method used to indicate whether the rendering provider is an employee of the hospice.

The maximum number of CRC segments which can occur per 2400 loop is 3. Submitters are free to mix and match the three types of service line level CRC segments shown in this implementation guide to meet their billing/reporting needs but no more than a total of 3 CRC segments per 2400 loop are allowed.

Required on all Medicare claims involving physician services to hospice patients.

ODJFS Application Notes

Required by HIPAA for Hospice claims. This must be completed when the hospice is submitting claims for physician services. Under Medicaid the provider assigned to the Medicaid provider number submitted in the REF02 of the 2310B must be employed by the hospice for reimbursement to be made to the hospice.

X12N HIPAA Example

Example: CRC*70*Y*65~

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
CRC01	1136	Code Category Specifies the situation or category to which the code applies X12N HIPAA Notes: INDUSTRY: Code Category 70 Hospice	M ID 2/2	R
CRC02	1073	Yes/No Condition or Response Code Code indicating a Yes or No condition or response X12N HIPAA Notes: A "Y" value indicates the provider is employed by the hospice. A "N" value indicates the provider is not employed by the hospice. ALIAS: Hospice Employee Indicator NSF Reference: FA0-40.0 INDUSTRY: Hospice Employed Provider Indicator N No Y Yes	M ID 1/1	R
CRC03	1321	Condition Indicator Code indicating a condition X12N HIPAA Notes: INDUSTRY: Condition Indicator	M ID 2/2	R

Open

X12N HIPAA Notes:

Use this code as a place holder (element is mandatory) when reporting whether the provider is a hospice employee.

Segment: **CRC** DMERC Condition Indicator
Position: 450
Loop: 2400 Optional (Must Use)
Level: Detail
Usage: Optional
Max Use: 2
Purpose: To supply information on conditions
Syntax Notes:
Semantic Notes:

- 1 CRC01 qualifies CRC03 through CRC07.
- 2 CRC02 is a Certification Condition Code applies indicator. A "Y" value indicates the condition codes in CRC03 through CRC07 apply; an "N" value indicates the condition codes in CRC03 through CRC07 do not apply.

Comments:
Notes:

X12N HIPAA Notes

Required on all oxygen therapy and DME claims that require a certificate of medical necessity (CMN).

The maximum number of CRC segments which can occur per 2400 loop is 3. Submitters are free to mix and match the three types of service line level CRC segments shown in this implementation guide to meet their billing/reporting needs but no more than a total of 3 CRC segments per 2400 loop are allowed.

The first example shows a case where an item billed was not a replacement item.

ODJFS Application Notes

Required by HIPAA for DME claims.

X12N HIPAA Example

Example: CRC*09*N*ZV~

CRC*11*Y*37*38*P1~

Data Element Summary

<u>Ref.</u>	<u>Data</u>	<u>Name</u>	<u>Base</u>	<u>User</u>
<u>Des.</u>	<u>Element</u>		<u>Attributes</u>	<u>Attributes</u>
CRC01	1136	Code Category Specifies the situation or category to which the code applies X12N HIPAA Notes: INDUSTRY: Code Category 09 Durable Medical Equipment Certification Prescription describing the need for durable medical equipment; usually included are the diagnosis and estimated duration of need 11 Oxygen Therapy Certification	M ID 2/2	R
CRC02	1073	Yes/No Condition or Response Code Code indicating a Yes or No condition or response X12N HIPAA Notes: ALIAS: Certification Condition Code Applies Indicator INDUSTRY: Certification Condition Indicator N No Y Yes	M ID 1/1	R
CRC03	1321	Condition Indicator Code indicating a condition X12N HIPAA Notes: Use "P1" (GX0-20.0) to answer the Medicare Oxygen CMN question: "The test was performed either with the patient in a chronic stable state as an outpatient or within two days prior to discharge from an inpatient facility to home." Code ZV was approved by ASC X12 in the version 004011 Data Dictionary but is included	M ID 2/2	R

in this guide to provide standard way to report DMERC claims within the HIPAA implementation time frame. It is recommended that entities who have a need to submit or receive DMERC claims customize their 004010 translator map to allow this exception code.

ALIAS: Condition Indicator

INDUSTRY: Condition Indicator

- 37 Oxygen delivery equipment is stationary
X12N HIPAA Notes:
GX0-05.0
- 38 Certification signed by the physician is on file at the supplier's office
X12N HIPAA Notes:
GX0-35.0
GU0-24.0
- AL Ambulation Limitations
X12N HIPAA Notes:
GX0-05.0
- P1 Patient was Discharged from the First Facility
X12N HIPAA Notes:
GX0-20.0
- ZV
X12N HIPAA Notes:
GU0-06.0

CRC04 1321 Condition Indicator O ID 2/2 S

Code indicating a condition

X12N HIPAA Notes:

Required if additional condition codes are needed.

Use the codes listed in CRC03.

ALIAS: Condition Indicator

INDUSTRY: Condition Indicator

- 37 Oxygen delivery equipment is stationary
- 38 Certification signed by the physician is on file at the supplier's office
- AL Ambulation Limitations
- P1 Patient was Discharged from the First Facility
- ZV

CRC05 1321 Condition Indicator O ID 2/2 S

Code indicating a condition

X12N HIPAA Notes:

Required if additional condition codes are needed.

Use the codes listed in CRC03.

ALIAS: Condition Indicator

INDUSTRY: Condition Indicator

- 37 Oxygen delivery equipment is stationary
- 38 Certification signed by the physician is on file at the supplier's office
- AL Ambulation Limitations
- P1 Patient was Discharged from the First Facility
- ZV

CRC06 1321 Condition Indicator O ID 2/2 S

Code indicating a condition

X12N HIPAA Notes:

Required if additional condition codes are needed.

Use the codes listed in CRC03.

ALIAS: Condition Indicator

INDUSTRY: Condition Indicator

- 37 Oxygen delivery equipment is stationary
- 38 Certification signed by the physician is on file at the supplier's office
- AL Ambulation Limitations
- P1 Patient was Discharged from the First Facility
- ZV

CRC07 1321 Condition Indicator O ID 2/2 S

Code indicating a condition

X12N HIPAA Notes:

Required if additional condition codes are needed.

Use the codes listed in CRC03.

ALIAS: Condition Indicator

INDUSTRY: Condition Indicator

- 37 Oxygen delivery equipment is stationary
- 38 Certification signed by the physician is on file at the supplier's office
- AL Ambulation Limitations
- P1 Patient was Discharged from the First Facility
- ZV

Segment: **DTP** Date - Service Date
Position: 455
Loop: 2400 Optional (Must Use)
Level: Detail
Usage: Optional (Must Use)
Max Use: 1
Purpose: To specify any or all of a date, a time, or a time period
Syntax Notes:
Semantic Notes: 1 DTP02 is the date or time or period format that will appear in DTP03.
Comments:
Notes:

X12N HIPAA Notes

The total number of DTP segments in the 2400 loop cannot exceed 15.

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.

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).

X12N HIPAA Example

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

ODJFS User Note

Medicaid does not allow date ranges even for drug services. The date of administration of the drug must be used. Drugs dispensed for administration at home may not be submitted on the 837 Professional.

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
DTP01	374	Date/Time Qualifier	M ID 3/3	R
		Code specifying type of date or time, or both date and time		
		X12N HIPAA Notes:		
		INDUSTRY: Date Time Qualifier		
		472 Service		
		Begin and end dates of the service being rendered		
		X12N HIPAA Notes:		
		Use RD8 in DTP02 to indicate begin/end or from/to dates.		
DTP02	1250	Date Time Period Format Qualifier	M ID 2/3	R
		Code indicating the date format, time format, or date and time format		
		X12N HIPAA Notes:		
		INDUSTRY: Date Time Period Format Qualifier		
		ODJFS User Note:		
		For Ohio Medicaid only D8 is valid. Medicaid does not allow date ranges. Billed procedures must be itemized separately for each date of service. This policy is applicable for home health and hospice claims even though other payers permit date span billing.		
		D8 Date Expressed in Format CCYYMMDD		
DTP03	1251	Date Time Period	M AN 1/35	R
		Expression of a date, a time, or range of dates, times or dates and times		
		X12N HIPAA Notes:		
		NSF Reference: FA0-05.0, FA0-06.0		
		INDUSTRY: Service Date		

Segment: **DTP** Date - Shipped
Position: 455
Loop: 2400 Optional (Must Use)
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To specify any or all of a date, a time, or a time period
Syntax Notes:
Semantic Notes: 1 DTP02 is the date or time or period format that will appear in DTP03.
Comments:
Notes:

X12N HIPAA Notes

Required when billing/reporting shipped products.

The total number of DTP segments in the 2400 loop cannot exceed 15.

ODJFS Application Notes

Used for Claim Processing

X12N HIPAA Example

Example: DTP*011*D8*19970526~

ODJFS User Note

Date that eyeglasses were shipped. Required on all vision eyewear claims to denote the date the eyeglasses were dispensed.

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
DTP01	374	Date/Time Qualifier Code specifying type of date or time, or both date and time X12N HIPAA Notes: INDUSTRY: Date Time Qualifier 011 Shipped	M ID 3/3	R
DTP02	1250	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format X12N HIPAA Notes: INDUSTRY: Date Time Period Format Qualifier D8 Date Expressed in Format CCYYMMDD	M ID 2/3	R
DTP03	1251	Date Time Period Expression of a date, a time, or range of dates, times or dates and times X12N HIPAA Notes: INDUSTRY: Shipped Date	M AN 1/35	R

Segment: **DTP** Date - Onset of Current Symptom/Illness
Position: 455
Loop: 2400 Optional (Must Use)
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To specify any or all of a date, a time, or a time period
Syntax Notes:
Semantic Notes: 1 DTP02 is the date or time or period format that will appear in DTP03.
Comments:
Notes:

X12N HIPAA Notes

Required if different from that entered at claim level (Loop ID-2300).

Required on claims involving services to a patient experiencing symptoms similar or identical to previously reported symptoms.

The total number of DTP segments in the 2400 loop cannot exceed 15.

X12N HIPAA Example

Example: DTP*431*D8*19971112~

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
DTP01	374	Date/Time Qualifier Code specifying type of date or time, or both date and time X12N HIPAA Notes: INDUSTRY: Date Time Qualifier	M ID 3/3	R
		431 Onset of Current Symptoms or Illness Date first symptoms appeared		
DTP02	1250	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format X12N HIPAA Notes: INDUSTRY: Date Time Period Format Qualifier	M ID 2/3	R
		D8 Date Expressed in Format CCYYMMDD		
DTP03	1251	Date Time Period Expression of a date, a time, or range of dates, times or dates and times X12N HIPAA Notes: NSF Reference: EA0-07.0, EA0-16.0 INDUSTRY: Onset Date	M AN 1/35	R

Segment: **DTP** Date - Last X-ray
Position: 455
Loop: 2400 Optional (Must Use)
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To specify any or all of a date, a time, or a time period
Syntax Notes:
Semantic Notes: 1 DTP02 is the date or time or period format that will appear in DTP03.
Comments:
Notes:

X12N HIPAA Notes

Required for spinal manipulation certifications if different than information at claim level (Loop ID-2300).

The total number of DTP segments in the 2400 loop cannot exceed 15.

X12N HIPAA Example

Example: DTP*455*D8*19970220~

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
DTP01	374	Date/Time Qualifier Code specifying type of date or time, or both date and time X12N HIPAA Notes: INDUSTRY: Date Time Qualifier 455 Last X-Ray Date of the most recent x-ray	M ID 3/3	R
DTP02	1250	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format X12N HIPAA Notes: INDUSTRY: Date Time Period Format Qualifier D8 Date Expressed in Format CCYYMMDD	M ID 2/3	R
DTP03	1251	Date Time Period Expression of a date, a time, or range of dates, times or dates and times X12N HIPAA Notes: NSF Reference: GC0-06.0 INDUSTRY: Last X-Ray Date	M AN 1/35	R

Segment: **DTP** Date - Acute Manifestation
Position: 455
Loop: 2400 Optional (Must Use)
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To specify any or all of a date, a time, or a time period
Syntax Notes:
Semantic Notes: 1 DTP02 is the date or time or period format that will appear in DTP03.
Comments:
Notes:

X12N HIPAA Notes

Required for spinal manipulation certifications if different than information at claim level (Loop ID-2300).

The total number of DTP segments in the 2400 loop cannot exceed 15.

X12N HIPAA Example

Example: DTP*453*D8*19961230~

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
DTP01	374	Date/Time Qualifier Code specifying type of date or time, or both date and time X12N HIPAA Notes: INDUSTRY: Date Time Qualifier 453 Acute Manifestation of a Chronic Condition Date serious symptoms were exhibited for a long term illness	M ID 3/3	R
DTP02	1250	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format X12N HIPAA Notes: INDUSTRY: Date Time Period Format Qualifier D8 Date Expressed in Format CCYYMMDD	M ID 2/3	R
DTP03	1251	Date Time Period Expression of a date, a time, or range of dates, times or dates and times X12N HIPAA Notes: NSF Reference: GC0-12.0 INDUSTRY: Acute Manifestation Date	M AN 1/35	R

Segment: **DTP** Date - Initial Treatment
Position: 455
Loop: 2400 Optional (Must Use)
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To specify any or all of a date, a time, or a time period
Syntax Notes:
Semantic Notes: 1 DTP02 is the date or time or period format that will appear in DTP03.
Comments:
Notes:

X12N HIPAA Notes

Required for spinal manipulation certifications if different than information at claim level (Loop ID-2300).

The total number of DTP segments in the 2400 loop cannot exceed 15.

ODJFS Application Notes

Used for Claim Processing

X12N HIPAA Example

Example: DTP*454*D8*19970112~

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
DTP01	374	Date/Time Qualifier Code specifying type of date or time, or both date and time X12N HIPAA Notes: INDUSTRY: Date Time Qualifier 454 Initial Treatment Date medical treatment first began	M ID 3/3	R
DTP02	1250	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format X12N HIPAA Notes: INDUSTRY: Date Time Period Format Qualifier D8 Date Expressed in Format CCYYMMDD	M ID 2/3	R
DTP03	1251	Date Time Period Expression of a date, a time, or range of dates, times or dates and times X12N HIPAA Notes: NSF Reference: GC0-05.0 INDUSTRY: Initial Treatment Date	M AN 1/35	R

Segment: **REF** Prior Authorization or Referral Number
Position: 470
Loop: 2400 Optional (Must Use)
Level: Detail
Usage: Optional
Max Use: 2
Purpose: To specify identifying information
Syntax Notes:
Semantic Notes: 1 REF04 contains data relating to the value cited in REF02.
Comments:
Notes:

X12N HIPAA Notes

Required if service line involved a prior authorization number or referral number that is different than the number reported at the claim level (Loop-ID 2300).

ODJFS Application Notes

Used for Claim Processing

X12N HIPAA Example

Example: REF*9F*12345678~

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification	M ID 2/3	R
		X12N HIPAA Notes: INDUSTRY: Reference Identification Qualifier		
		ODJFS User Note: ODJFS only uses G1 in Claims Processing.		
		G1 Prior Authorization Number An authorization number acquired prior to the submission of a claim		
REF02	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	O AN 1/30	R
		X12N HIPAA Notes: INDUSTRY: Prior Authorization or Referral Number		

Segment: **REF** Line Item Control Number
Position: 470
Loop: 2400 Optional (Must Use)
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To specify identifying information
Syntax Notes:
Semantic Notes: 1 REF04 contains data relating to the value cited in REF02.
Comments:
Notes:

X12N HIPAA Notes

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.

X12N HIPAA Example

Example: REF*6R*54321~

ODJFS User Note

Returned on 835

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification X12N HIPAA Notes: INDUSTRY: Reference Identification Qualifier 6R Provider Control Number Number assigned by information provider company for tracking and billing purposes	M ID 2/3	R
REF02	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier X12N HIPAA Notes: NSF Reference: FA0-04.0, FB0-04.0, FB1-04.0, FB2-04.0, FD0-04.0, FE0-04.0, HA0-04.0 INDUSTRY: Line Item Control Number	O AN 1/30	R

Segment: **REF** Clinical Laboratory Improvement Amendment (CLIA) Identification
Position: 470
Loop: 2400 Optional (Must Use)
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To specify identifying information
Syntax Notes:
Semantic Notes: 1 REF04 contains data relating to the value cited in REF02.
Comments:
Notes:

X12N HIPAA Notes

Required for all CLIA certified facilities performing CLIA covered laboratory services and if number is different than CLIA number reported at claim level (Loop ID-2300).

X12N HIPAA Example

Example: REF*X4*12D4567890~

ODJFS User Note

Required for all non-CLIA exempt clinical laboratory procedures and for a few radiology procedures covered under CLIA.

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification X12N HIPAA Notes: INDUSTRY: Reference Identification Qualifier X4 Clinical Laboratory Improvement Amendment Number	M ID 2/3	R
REF02	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier X12N HIPAA Notes: NSF Reference: FA0-34.0 INDUSTRY: Clinical Laboratory Improvement Amendment Number	O AN 1/30	R

Segment: **REF** Referring Clinical Laboratory Improvement Amendment (CLIA) Facility Identification

Position: 470

Loop: 2400 Optional (Must Use)

Level: Detail

Usage: Optional

Max Use: 1

Purpose: To specify identifying information

Syntax Notes:

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

Comments:

Notes:

X12N HIPAA Notes

Required for Medicare claims for any laboratory that referred tests to another laboratory covered by the CLIA Act that is billed on this line.

X12N HIPAA Example

Example: REF*F4*34D1234567~

ODJFS User Note

Required for Medicaid claims when laboratory services are referred to another laboratory covered by the CLIA Act. With the exception of hospitals, Medicaid providers should not be billing for referred laboratory services.

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification	M ID 2/3	R
		X12N HIPAA Notes: INDUSTRY: Reference Identification Qualifier F4 Facility Certification Number A unique number assigned to qualifying facilities to perform services		
REF02	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	O AN 1/30	R
		X12N HIPAA Notes: INDUSTRY: Referring CLIA Number		

Segment: **AMT** Approved Amount
Position: 475
Loop: 2400 Optional (Must Use)
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To indicate the total monetary amount
Syntax Notes:
Semantic Notes:
Comments:
Notes:

X12N HIPAA 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 service line that was approved by the payer sending this 837 to another payer.

X12N HIPAA Example

Example: AMT*AAE*125~

Data Element Summary

<u>Ref.</u>	<u>Data</u>	<u>Name</u>	<u>Base</u>	<u>User</u>
<u>Des.</u>	<u>Element</u>		<u>Attributes</u>	<u>Attributes</u>
AMT01	522	Amount Qualifier Code Code to qualify amount	M ID 1/3	R
		X12N HIPAA Notes: INDUSTRY: Amount Qualifier Code		
		AAE Approved Amount		
AMT02	782	Monetary Amount Monetary amount	M R 1/10	R
		X12N HIPAA Notes: NSF Reference: FA0-51.0		
		INDUSTRY: Approved Amount		
		ODJFS User Note: Must be completed for all Medicare A & B crossover, Medicare (Part C) HMO crossover and Third Party Liability coordination of benefit claims.		

Segment: **LIN Drug Identification**
Position: 494
Loop: 2410 Optional
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To specify basic item identification data
Syntax Notes:

- 1 If either LIN04 or LIN05 is present, then the other is required.
- 2 If either LIN06 or LIN07 is present, then the other is required.
- 3 If either LIN08 or LIN09 is present, then the other is required.
- 4 If either LIN10 or LIN11 is present, then the other is required.
- 5 If either LIN12 or LIN13 is present, then the other is required.
- 6 If either LIN14 or LIN15 is present, then the other is required.
- 7 If either LIN16 or LIN17 is present, then the other is required.
- 8 If either LIN18 or LIN19 is present, then the other is required.
- 9 If either LIN20 or LIN21 is present, then the other is required.
- 10 If either LIN22 or LIN23 is present, then the other is required.
- 11 If either LIN24 or LIN25 is present, then the other is required.
- 12 If either LIN26 or LIN27 is present, then the other is required.
- 13 If either LIN28 or LIN29 is present, then the other is required.
- 14 If either LIN30 or LIN31 is present, then the other is required.

Semantic Notes:

- 1 LIN01 is the line item identification

Comments:

- 1 See the Data Dictionary for a complete list of IDs.
- 2 LIN02 through LIN31 provide for fifteen different product/service IDs for each item. For example: Case, Color, Drawing No., U.P.C. No., ISBN No., Model No., or SKU.

Notes: **X12N HIPAA Notes**

The NDC number is used for reporting prescribed drugs and biologics when required by government regulation, or as deemed by the provider to enhance claim reporting/adjudication processes. The NDC number is reported in the LIN segment of Loop ID-2410.

Use Loop 2410 to specify billing/reporting for drugs provided that may be part of the service(s) described in SV1.

X12N HIPAA Example

Example: LIN**N4*01234567891~

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
LIN01	350	Assigned Identification	O AN 1/20	N/U
LIN02	235	Product/Service ID Qualifier	M ID 2/2	R

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

X12N HIPAA Notes:

Industry: Product or Service ID Qualifier

N4 National Drug Code in 5-4-2 Format
5-digit manufacturer ID, 4-digit product ID, 2-digit trade package size

LIN03	234	Product/Service ID	M AN 1/48	R
-------	-----	--------------------	-----------	---

Identifying number for a product or service

X12N HIPAA Notes:

Industry: National Drug Code

Alias: National Drug Code

Segment: **NM1** Rendering Provider Name
Position: 500
Loop: 2420A Optional
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To supply the full name of an individual or organizational entity
Syntax Notes: 1 If either NM108 or NM109 is present, then the other is required.
Semantic Notes: 1 NM102 qualifies NM103.
Comments:
Notes:

X12N HIPAA Notes

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.

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/AB) and this particular service line has a different Rendering Provider that what is given in the 2010AA/AB loop. The identifying payer-specific numbers are those that belong to the destination payer identified in loop 2010BB.

Used for all types of rendering providers including laboratories. The Rendering Provider is the person or company (laboratory or other facility) who rendered the care. In the case where a substitute provider (locum tenens) was used, that person should be entered here.

X12N HIPAA Example

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

ODJFS User Note

If a rendering provider number is required by ODJFS and the NM109 of the 2310B and the 2420A loops are also not present, the service line will be denied.

If a rendering provider number is required by ODJFS and the REF02 of the 2310B loop contains the NPI assigned to the individual practitioner, all the service lines billed in the 2400 loop will be attributed to this rendering provider, even if a different rendering provider number is given in the NM109 of the 2420A loop.

If a rendering provider is required by ODJFS and the NM109 of the 2310B loop is blank but the NM109 of the 2420A loop contains the NPI of the individual practitioner(s) (i.e., the rendering provider within a group practice), all the service lines billed will be attributed to the rendering provider NPI listed for the first service line in the 2400 loop, even if a different rendering provider number is given in the NM109 of the 2420A loop for any subsequent service line (i.e., service lines 2, 3, 4.....,etc.) contained in the 2400 loop.

The National Provider Identifier is mandated to be used on electronic claims on and after May 23, 2008. ODJFS will deny electronic claims that are missing an NPI in the rendering provider field, if it is required on a claim. Although the Medicaid legacy ID is not required, ODJFS will continue to accept claims that contain both NPI and the Medicaid legacy ID in the rendering provider field. If it is included, a legacy ID will be validated. An invalid legacy ID will be rejected.

For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop with the EI or SY qualifier code.

A claim that contains an NPI that does not pass check digit validation WILL DENY.

Atypical providers should send their EIN or SSN in the NM1 segment.

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
NM101	98	Entity Identifier Code Code identifying an organizational entity, a physical location, property or an individual X12N HIPAA Notes: The entity identifier in NM101 applies to all segments in this iteration of Loop ID-2420. INDUSTRY: Entity Identifier Code 82 Rendering Provider	M ID 2/3	R
NM102	1065	Entity Type Qualifier Code qualifying the type of entity X12N HIPAA Notes: INDUSTRY: Entity Type Qualifier 1 Person 2 Non-Person Entity	M ID 1/1	R
NM103	1035	Name Last or Organization Name Individual last name or organizational name X12N HIPAA Notes: ALIAS: Rendering Provider Last Name NSF Reference: FB1-14.0 INDUSTRY: Rendering Provider Last or Organization Name	O AN 1/35	R
NM104	1036	Name First Individual first name X12N HIPAA Notes: Required if NM102=1 (person). ALIAS: Rendering Provider First Name NSF Reference: FB1-15.0 INDUSTRY: Rendering Provider First Name	O AN 1/25	S
NM105	1037	Name Middle Individual middle name or initial X12N HIPAA Notes: Required if NM102=1 and the middle name/initial of the person is known. ALIAS: Rendering Provider Middle Name NSF Reference: FB1-16.0 INDUSTRY: Rendering Provider Middle Name	O AN 1/25	S
NM106	1038	Name Prefix	O AN 1/10	N/U
NM107	1039	Name Suffix Suffix to individual name X12N HIPAA Notes: Required if known. ALIAS: Rendering Provider Generation INDUSTRY: Rendering Provider Name Suffix	O AN 1/10	S
NM108	66	Identification Code Qualifier Code designating the system/method of code structure used for Identification Code (67) X12N HIPAA Notes:	X ID 1/2	R

NSF Reference: FA0-57.0

INDUSTRY: Identification Code Qualifier

24 Employer's Identification Number

34 Social Security Number

X12N HIPAA Notes:

Social Security Number cannot be used for Medicare claims.

XX Health Care Financing Administration National Provider Identifier

NM109

67

Identification Code

X AN 2/80 R

Code identifying a party or other code

X12N HIPAA Notes:

ALIAS: Rendering Provider Primary Identifier

NSF Reference: FA0-23.0, FA0-58.0

INDUSTRY: Rendering Provider Identifier

ODJFS User Note:

For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop with the EI or SY qualifier code.

A claim that contains an NPI that does not pass check digit validation WILL DENY.

Atypical providers should send their EIN or SSN in the NM1 segment.

Segment: **PRV** **Rendering Provider Specialty Information**
Position: 505
Loop: 2420A Optional
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To specify the identifying characteristics of a provider
Syntax Notes:
Semantic Notes:
Comments:
Notes:

X12N HIPAA Notes

PRV02 qualifies PRV03.

Required when adjudication is known to be impacted by provider taxonomy code.

X12N HIPAA Example

Example: PRV*PE*ZZ*203BA050N~

ODJFS User Note

For ODJFS, adjudication is not impacted by the taxonomy code. ODJFS does require the use of certain modifiers to denote the type of healthcare provider who rendered the services incident to the rendering provider. (E.G. APN Services, physician assistants, psychologists, social workers, clinical counselors, etc..)

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
PRV01	1221	Provider Code Code identifying the type of provider X12N HIPAA Notes: INDUSTRY: Provider Code PE Performing	M ID 1/3	R
PRV02	128	Reference Identification Qualifier Code qualifying the Reference Identification X12N HIPAA Notes: ZZ is used to indicate the "Health Care Provider Taxonomy" code list (provider specialty code) which is available on the Washington Publishing Company web site: http://www.wpc-edi.com . This taxonomy is maintained by the Blue Cross Blue Shield Association and ASC X12N TG2 WG15. INDUSTRY: Reference Identification Qualifier ZZ Mutually Defined X12N HIPAA Notes: Health Care Provider Taxonomy Code list	M ID 2/3	R
PRV03	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier X12N HIPAA Notes: ALIAS: Provider Specialty Code Provider Specialty Code NSF Reference: FA0-37.0 INDUSTRY: Provider Taxonomy Code	M AN 1/30	R

Segment: **REF** Rendering Provider Secondary Identification
Position: 525
Loop: 2420A Optional
Level: Detail
Usage: Optional
Max Use: 5
Purpose: To specify identifying information
Syntax Notes:
Semantic Notes: 1 REF04 contains data relating to the value cited in REF02.
Comments:
Notes:

X12N HIPAA Notes

Required when a secondary identification number is necessary to identify the entity. The primary identification number should be carried in NM109 in this loop.

X12N HIPAA Example

Example: REF*1D*A12345~

ODJFS User Note

If a rendering provider number is required by ODJFS and the NM109 of the 2310B and the 2420A loop is also blank, the service line will be denied.

If a rendering provider number is required by ODJFS and the REF02 of the 2310B loop contains the NPI assigned to the individual practitioner, all the service lines billed in the 2400 loop will be attributed to this rendering provider, even if a different rendering provider number is given in the NM109 of the 2420A loop.

If a rendering provider is required by ODJFS and the NM109 of the 2310B loop is blank but the NM109 of the 2420A loop contains the NPI of the individual practitioner(s) (i.e., the rendering provider within a group practice), all the service lines billed will be attributed to the rendering provider NPI listed for the first service line in the 2400 loop, even if a different rendering provider number is given in the NM109 of the 2420A loop for any subsequent service line (i.e., service lines 2, 3, 4.....,etc.) contained in the 2400 loop.

The National Provider Identifier is mandated to be used on electronic claims on and after May 23, 2008. ODJFS will deny electronic claims that are missing an NPI in the rendering provider field, if required on a claim. Although the Medicaid legacy ID is not required, ODJFS will continue to accept claims that contain both NPI and the Medicaid legacy ID in the rendering provider field. If it is included, a legacy ID will be validated. An invalid legacy ID will be rejected.

For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop with the EI or SY qualifier code.

A claim that contains an NPI that does not pass check digit validation WILL DENY.

Atypical providers should send their EIN or SSN in the NM1 segment.

Data Element Summary

<u>Ref.</u>	<u>Data</u>	<u>Name</u>	<u>Base</u>	<u>User</u>
<u>Des.</u>	<u>Element</u>		<u>Attributes</u>	<u>Attributes</u>
REF01	128	Reference Identification Qualifier	M ID 2/3	R

Code qualifying the Reference Identification

X12N HIPAA Notes:

INDUSTRY: Reference Identification Qualifier

1D	Medicaid Provider Number
EI	Employer's Identification Number
SY	Social Security Number

X12N HIPAA Notes:

The social security number may not be used for Medicare.

REF02

127

Reference Identification

O AN 1/30 R

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

X12N HIPAA Notes:

ALIAS: Rendering Provider Secondary Identifier

INDUSTRY: Rendering Provider Secondary Identifier

ODJFS User Note:

For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop with the EI or SY qualifier code.

A claim that contains an NPI that does not pass check digit validation WILL DENY.

Atypical providers should send their EIN or SSN in the NM1 segment.

Segment: **NM1** Referring Provider Name
Position: 500
Loop: 2420F Optional
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To supply the full name of an individual or organizational entity
Syntax Notes: 1 If either NM108 or NM109 is present, then the other is required.
Semantic Notes: 1 NM102 qualifies NM103.
Comments:
Notes:

X12N HIPAA Notes

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.

Required if this service line involves a referral and the referring provider is different than the rendering provider and if the referring provider differs from that reported at the claim level (loop 2310A). All payer-specific identifying numbers belong to the destination payer identified in the 2010BB loop.

When there is only one referral on the service line use code "DN - Referring Provider". When more than one referral exists and there is a requirement to report the additional referral, use code DN in the first iteration of this loop to indicate the referral received by the rendering provider on this service line. Use code "P3 - Primary Care Provider" in the second iteration of the loop to indicate the initial referral from the primary care provider or whatever provider wrote the initial referral for this patient's episode of care being billed/reported in this transaction.

X12N HIPAA Example

Example: NM1*DN*1*WELBY*MARCUS*W**JR*34*444332222~

ODJFS User Note

ODJFS will not use this field in the adjudication of the claim unless the Ohio Medicaid program requires a referring provider number for the provider and category of service type, and the NM109 of the 2310A loop is blank. Note, completion of this loop is only required by ODJFS for claims coming in from professional group practices and only when the referring provider number was not submitted in the NM109 of the 2310A loop. See special note in the NM109 element of the 2310A loop for the list of professional group practices.

If a referring provider number is required by ODJFS and the NM109 of the 2310A and the 2420F loop is also blank, the service line will be denied.

If a referring provider number is required by ODJFS and the REF02 of the 2310A loop contains an NPI assigned to the individual practitioner, all the service lines billed in the 2400 loop will be attributed to this referring provider, even if a different referring provider number is given in the NM109 of the 2420F loop.

If a referring provider is required by ODJFS and the NM109 of the 2310A loop is blank but the NM109 of the 2420F loop contains the NPI of the individual practitioner(s) (i.e., the referring provider within a group practice), all the service lines billed will be attributed to the referring provider number listed for the first service line in the 2400 loop, even if a different referring provider number is given in the NM109 of the 2420F loop for any subsequent service line (i.e., service lines 2, 3, 4.....etc.) contained in the 2400 loop.

The National Provider Identifier is mandated to be used on electronic claims on and after May 23, 2008. The referring provider loop is situational, depending on the claim type. If the loop is present in the 837, ODJFS will deny any claims that do not include the NPI in the loop. Although the legacy ID is not required, ODJFS will continue to accept claims that contain both the NPI and legacy ID in the referring provider loop of the electronic

claim until further notice. If it is included, a legacy ID will be validated. An invalid legacy ID will be rejected.

If the referring entity or provider is required to be identified and does not furnish an NPI, the billing provider must first attempt to obtain that NPI by directly contacting the referring entity or provider. If the attempt is not successful, the billing provider may use the NPI Registry (<https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do>) to obtain the referring entity or provider's NPI to enter it on the claim.

The 9111115 value is no longer an ODJFS acceptable value. Do not use 9111115 in this field.

For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop.

Atypical providers should send their EIN or SSN in the NM1 segment and their Medicaid 7-digit legacy ID in the REF segment with an REF01 qualifier of 1D.

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
NM101	98	Entity Identifier Code Code identifying an organizational entity, a physical location, property or an individual X12N HIPAA Notes: INDUSTRY: Entity Identifier Code DN Referring Provider X12N HIPAA Notes: Use on the first iteration of this loop. Use if loop is used only once. P3 Primary Care Provider Physician that is selected by the insured to provide medical care X12N HIPAA Notes: Use only if loop is used twice. Use only on second iteration of this loop.	M ID 2/3	R
NM102	1065	Entity Type Qualifier Code qualifying the type of entity X12N HIPAA Notes: INDUSTRY: Entity Type Qualifier 1 Person	M ID 1/1	R
NM103	1035	Name Last or Organization Name Individual last name or organizational name X12N HIPAA Notes: NSF Reference: FB1-10.0	O AN 1/35	R
NM104	1036	INDUSTRY: Referring Provider Last Name Name First Individual first name X12N HIPAA Notes: NSF Reference: FB1-11.0	O AN 1/25	R
NM105	1037	INDUSTRY: Referring Provider First Name Name Middle Individual middle name or initial X12N HIPAA Notes: Required if NM102=1 and the middle name/initial of the person is known.	O AN 1/25	S

NSF Reference: FB1-12.0

NM106	1038	INDUSTRY: Referring Provider Middle Name			
		Name Prefix	O	AN 1/10	N/U
NM107	1039	Name Suffix	O	AN 1/10	S

Suffix to individual name

X12N HIPAA Notes:

Required if known.

ALIAS: Referring Provider Generation

NM108	66	INDUSTRY: Referring Provider Name Suffix			
		Identification Code Qualifier	X	ID 1/2	S

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

X12N HIPAA Notes:

Required if either Employer's Identification/Social Security Number (Referring Provider tax ID) or National Provider Identifier is known.

INDUSTRY: Identification Code Qualifier

24 Employer's Identification Number

34 Social Security Number

X12N HIPAA Notes:

The social security number may not be used for Medicare.

XX Health Care Financing Administration National Provider Identifier

NM109	67	Identification Code	X	AN 2/80	S
--------------	-----------	----------------------------	----------	----------------	----------

Code identifying a party or other code

X12N HIPAA Notes:

Required if either Employer's Identification/Social Security Number (Referring Provider tax ID) or National Provider Identifier is known.

ALIAS: Referring Provider's Identification Number

NSF Reference: FB1-13.0, FA0-24.0

INDUSTRY: Referring Provider Identifier

ODJFS User Note:

The 9111115 value is no longer an ODJFS acceptable value. Do not use 9111115 in this field.

For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop with the EI or SY qualifier code.

Atypical providers should send their EIN or SSN in the NM1 segment and their Medicaid 7-digit legacy ID in the REF segment with an REF01 qualifier of 1D.

Segment: **PRV** Referring Provider Specialty Information
Position: 505
Loop: 2420F Optional
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To specify the identifying characteristics of a provider
Syntax Notes:
Semantic Notes:
Comments:
Notes:

X12N HIPAA Notes

Required if required under provider-payer contract.

PRV02 qualifies PRV03.

X12N HIPAA Example

Example: PRV*RF*ZZ*363LP0200N~

ODJFS User Note

For ODJFS, adjudication is not impacted by the taxonomy code.

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
PRV01	1221	Provider Code Code identifying the type of provider X12N HIPAA Notes: INDUSTRY: Provider Code	M ID 1/3	R
PRV02	128	RF Referring Reference Identification Qualifier Code qualifying the Reference Identification X12N HIPAA Notes: ZZ is used to indicate the "Health Care Provider Taxonomy" code list (provider specialty code) which is available on the Washington Publishing Company web site: http://www.wpc-edi.com . This taxonomy is maintained by the Blue Cross Blue Shield Association and ASC X12N TG2 WG15. INDUSTRY: Reference Identification Qualifier	M ID 2/3	R
PRV03	127	ZZ Mutually Defined Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier X12N HIPAA Notes: Health Care Provider Taxonomy Code list ALIAS: Provider Specialty Code Provider Specialty Code INDUSTRY: Provider Taxonomy Code	M AN 1/30	R

Segment: **REF** Referring Provider Secondary Identification
Position: 525
Loop: 2420F Optional
Level: Detail
Usage: Optional
Max Use: 5
Purpose: To specify identifying information
Syntax Notes:
Semantic Notes: 1 REF04 contains data relating to the value cited in REF02.
Comments:
Notes:

X12N HIPAA Notes

Required when a secondary identification number is necessary to identify the entity. The primary identification number should be carried in NM109 in this loop.

X12N HIPAA Example

Example: REF*1D*A12345~

ODJFS User Note

ODJFS will not use this field in the adjudication of the claim unless the Ohio Medicaid program requires a referring provider number for the provider and category of service type, and the NM109 of the 2310A loop is blank. Note, completion of this loop is only required by ODJFS for claims coming in from professional group practices and only when the referring provider number was not submitted in the NM109 of the 2310A loop. See special note in the NM109 element of the 2310A loop for the list of professional group practices.

If a referring provider number is required by ODJFS and the NM109 of the 2310A and the 2420F loop is also blank, the service line will be denied.

If a referring provider number is required by ODJFS and the REF02 of the 2310A loop contains an NPI assigned to the individual practitioner, all the service lines billed in the 2400 loop will be attributed to this referring provider, even if a different referring provider number is given in the NM109 of the 2420F loop.

If a referring provider is required by ODJFS and the NM109 of the 2310A loop is blank but the NM109 of the 2420F loop contains the NPI of the individual practitioner(s) (i.e., the referring provider within a group practice), all the service lines billed will be attributed to the referring provider number listed for the first service line in the 2400 loop, even if a different referring provider number is given in the NM109 of the 2420F loop for any subsequent service line (i.e., service lines 2, 3, 4.....,etc.) contained in the 2400 loop.

The National Provider Identifier is mandated to be used on electronic claims on and after May 23, 2008. The referring provider loop is situational, depending on the claim type. If the loop is present in the 837, ODJFS will deny any claims that do not include the NPI in the loop. Although the legacy ID is not required, ODJFS will continue to accept claims that contain both the NPI and legacy ID in the referring provider loop of the electronic claim until further notice. If it is included, a legacy ID will be validated. An invalid legacy ID will be rejected.

If the referring entity or provider is required to be identified and does not furnish an NPI, the billing provider must first attempt to obtain that NPI by directly contacting the referring entity or provider. If the attempt is not successful, the billing provider may use the NPI Registry (<https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do>) to obtain the referring entity or provider's NPI to enter it on the claim.

The 9111115 value is no longer an ODJFS acceptable value. Do not use 9111115 in this field.

For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the

REF segment of this loop.

Atypical providers should send their EIN or SSN in the NM1 segment and their Medicaid 7-digit legacy ID in the REF segment with an REF01 qualifier of 1D.

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
REF01	128	Reference Identification Qualifier	M ID 2/3	R

Code qualifying the Reference Identification

X12N HIPAA Notes:

INDUSTRY: Reference Identification Qualifier

1D	Medicaid Provider Number
EI	Employer's Identification Number
SY	Social Security Number

X12N HIPAA Notes:

The social security number may not be used for Medicare.

REF02	127	Reference Identification	O AN 1/30	R
-------	-----	--------------------------	-----------	---

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

X12N HIPAA Notes:

INDUSTRY: Referring Provider Secondary Identifier

ODJFS User Note:

The 9111115 value is no longer an ODJFS acceptable value. Do not use 9111115 in this field.

For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop with the EI or SY qualifier code.

Atypical providers should send their EIN or SSN in the NM1 segment and their Medicaid 7-digit legacy ID in the REF segment with an REF01 qualifier of 1D.

Segment: **SVD** Line Adjudication Information
Position: 540
Loop: 2430 Optional
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To convey service line adjudication information for coordination of benefits between the initial payers of a health care claim and all subsequent payers

Syntax Notes:

Semantic Notes:

- 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:

X12N HIPAA Notes

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.

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.

Required if claim has been previously adjudicated by payer identified in Loop 2330B and service line has adjustments applied to it.

ODJFS Application Notes

Used for Claim Processing

X12N HIPAA Example

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

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
SVD01	67	Identification Code Code identifying a party or other code X12N HIPAA Notes: This number should match NM109 in Loop ID-2330B identifying Other Payer. ALIAS: Other Payer identification code	M AN 2/80	R
SVD02	782	INDUSTRY: Other Payer Primary Identifier Monetary Amount Monetary amount X12N HIPAA Notes: Zero "0" is an acceptable value for this element. The FA0-52.0 NSF crosswalk is only used in payer-to-payer COB situations. ALIAS: Paid Amount NSF Reference: FA0-52.0	M R 1/10	R

INDUSTRY: Service Line Paid Amount

ODJFS Application Notes:

Used for Claim Processing; subtract this amount from the line level total charges.

ODJFS User Note:

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

SVD03 C003

Composite Medical Procedure Identifier O R

To identify a medical procedure by its standardized codes and applicable modifiers

X12N HIPAA Notes:

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

C00301 235

ALIAS: Procedure identifier

Product/Service ID Qualifier M ID 2/2 R

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

X12N HIPAA Notes:

INDUSTRY: Product or Service ID Qualifier

The NDC number is used for reporting prescribed drugs and biologics when required by government regulation, or as deemed by the provider to enhance claim reporting/adjudication processes. The NDC number is reported in the LIN segment of Loop ID-2410 only.

HC Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes
HCFA coding scheme to group procedure(s) performed on an outpatient basis for payment to hospital under Medicare; primarily used for ambulatory surgical and other diagnostic departments

X12N HIPAA Notes:

Because the AMA's CPT codes are also level 1 HCPCS codes, they are reported under HC.

IV Home Infusion EDI Coalition (HIEC) Product/Service Code

X12N HIPAA Notes:

This code set is not allowed for use under HIPAA at the time of this writing. the qualifier can only be used: 1) If a new rule names HIEC as an allowable code set under HIPAA. 2) For property & Casualty claims/encounters that are not covered under HIPAA.

ZZ Mutually Defined

X12N HIPAA Notes:

Jurisdictionally Defined Procedure and Supply Codes. (Used for Worker's Compensation claims). Contact your local (State) Jurisdiction for a list of these codes.

C00302 234

Product/Service ID M AN 1/48 R

Identifying number for a product or service

X12N HIPAA Notes:

INDUSTRY: Procedure Code

C00303 1339

Procedure Modifier O AN 2/2 S

This identifies special circumstances related to the performance of the service, as defined by trading partners

X12N HIPAA Notes:

Use this modifier for the first procedure code modifier.

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

ALIAS: Procedure Modifier 1

C00304	1339	INDUSTRY: Procedure Modifier	Procedure Modifier	O	AN 2/2	S	
		This identifies special circumstances related to the performance of the service, as defined by trading partners					
		X12N HIPAA Notes:					
		Use this modifier for the second procedure code modifier.					
Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.							
ALIAS: Procedure Modifier 2							
C00305	1339	INDUSTRY: Procedure Modifier	Procedure Modifier	O	AN 2/2	S	
		This identifies special circumstances related to the performance of the service, as defined by trading partners					
		X12N HIPAA Notes:					
		Use this modifier for the third procedure code modifier.					
Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.							
ALIAS: Procedure Modifier 3							
C00306	1339	INDUSTRY: Procedure Modifier	Procedure Modifier	O	AN 2/2	S	
		This identifies special circumstances related to the performance of the service, as defined by trading partners					
		X12N HIPAA Notes:					
		Use this modifier for the fourth procedure code modifier.					
Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.							
ALIAS: Procedure Modifier 4							
C00307	352	INDUSTRY: Procedure Modifier	Description	O	AN 1/80	S	
		A free-form description to clarify the related data elements and their content					
		X12N HIPAA Notes:					
Required if SVC01-7 was returned in the 835 transaction.							
SVD04	234	INDUSTRY: Procedure Code Description	Product/Service ID	O	AN 1/48	N/U	
		SVD05	Quantity	O	R 1/15	R	
Numeric value of quantity							
X12N HIPAA Notes:							
Crosswalk from SVC05 in 835 or, if not present in 835, use original billed units.							
ALIAS: Paid units of service							
SVD06	554	INDUSTRY: Paid Service Unit Count	Assigned Number	O	N0 1/6	S	
		Number assigned for differentiation within a transaction set					
		X12N HIPAA Notes:					
Use the LX from this transaction which points to the bundled line.							
Required if payer bundled this service line.							

ALIAS: Bundled Line Number

INDUSTRY: Bundled Line Number

Segment: **CAS** Line Adjustment

Position: 545

Loop: 2430 Optional

Level: Detail

Usage: Optional

Max Use: 99

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

- Syntax Notes:**
- 1 If CAS05 is present, then at least one of CAS06 or CAS07 is required.
 - 2 If CAS06 is present, then CAS05 is required.
 - 3 If CAS07 is present, then CAS05 is required.
 - 4 If CAS08 is present, then at least one of CAS09 or CAS10 is required.
 - 5 If CAS09 is present, then CAS08 is required.
 - 6 If CAS10 is present, then CAS08 is required.
 - 7 If CAS11 is present, then at least one of CAS12 or CAS13 is required.
 - 8 If CAS12 is present, then CAS11 is required.
 - 9 If CAS13 is present, then CAS11 is required.
 - 10 If CAS14 is present, then at least one of CAS15 or CAS16 is required.
 - 11 If CAS15 is present, then CAS14 is required.
 - 12 If CAS16 is present, then CAS14 is required.
 - 13 If CAS17 is present, then at least one of CAS18 or CAS19 is required.
 - 14 If CAS18 is present, then CAS17 is required.
 - 15 If CAS19 is present, then CAS17 is required.

- Semantic Notes:**
- 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: **X12N HIPAA Notes**

Required if the payer identified in Loop 2330B made line level adjustments which caused the amount paid to differ from the amount originally charged.

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.

There are some NSF COB elements which are covered through the use of the CAS segment. Please see the claim level CAS segment for a note on handling those crosswalks at the claim level. Some of that information may apply at the line level. Further information is given below which is more specific to line level issues.

Balance bill limiting charge (FA0-54.0). The adjustment for this information would be conveyed in a CAS amount element if the provider billed for more than they were allowed to under contract.

The Claim Adjustment Reason codes are located on the Washington Publishing Company web site <http://www.wpc-edi.com>.

X12N HIPAA Example

Example: CAS*PR*1*7.93~

ODJFS User Note

All Medicare Part A, Medicare Part B, Medicare Part C, and all TPL claims submitted to ODJFS must contain, at a minimum, the CAS codes and associated monetary amounts issued by the payer who adjudicated the claim immediately prior to submitting the claim to ODJFS. The sum of the CAS code monetary amounts (2320 and 2430 loops) and the payer paid amount must balance to equal the total billed charges.

ODJFS requires the claim to be adjudicated by all other payers prior to submitting the claim.

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
CAS01	1033	Claim Adjustment Group Code Code identifying the general category of payment adjustment X12N HIPAA Notes: ALIAS: Adjustment Group Code INDUSTRY: Claim Adjustment Group Code CO Contractual Obligations CR Correction and Reversals OA Other adjustments PI Payor Initiated Reductions PR Patient Responsibility	M ID 1/2	R
CAS02	1034	Claim Adjustment Reason Code Code identifying the detailed reason the adjustment was made X12N HIPAA Notes: Use the Claim Adjustment Reason Code list (See Appendix C). ALIAS: Adjustment Reason Code - Line Level NSF Reference: FB3-05.0, FB3-07.0, FB3-09.0, FB3-11.0, FB3-13.0, FB3-15.0, FB3-17.0 INDUSTRY: Adjustment Reason Code	M ID 1/5	R
CAS03	782	Monetary Amount Monetary amount X12N HIPAA Notes: Use this amount for the adjustment amount. ALIAS: Adjusted Amount - Line Level NSF Reference: FA0-27.0, FA0-28.0, FA0-35.0, FA0-48.0, FB0-06.0, FB0-07.0, FB0-08.0, FB3-06.0, FB3-08.0, FB3-10.0, FB3-12.0, FB3-14.0, FB3-16.0, FB3-18.0, FA0-53.0, FA0-54.0 INDUSTRY: Adjustment Amount	M R 1/10	R
CAS04	380	Quantity Numeric value of quantity X12N HIPAA Notes: Use this quantity for the units of service being adjusted. Use as needed to show payer adjustment. ALIAS: Adjusted Units - Line Level INDUSTRY: Adjustment Quantity	O R 1/15	S

CAS05	1034	Claim Adjustment Reason Code Code identifying the detailed reason the adjustment was made X12N HIPAA Notes: Use as needed to show payer adjustment. Use the Claim Adjustment Reason Code list (See Appendix C). ALIAS: Adjustment Reason Code - Line Level NSF Reference: FB3-05.0, FB3-07.0, FB3-09.0, FB3-11.0, FB3-13.0, FB3-15.0, FB3-17.0 INDUSTRY: Adjustment Reason Code	X	ID 1/5	S
CAS06	782	Monetary Amount Monetary amount X12N HIPAA Notes: Use this amount for the adjustment amount. Use as needed to show payer adjustment. ALIAS: Adjusted Amount - Line Level NSF Reference: FB3-06.0, FB3-08.0, FB3-10.0, FB3-12.0, FB3-14.0, FB3-16.0, FB3-18.0, FA0-53.0, FA0-54.0 INDUSTRY: Adjustment Amount	X	R 1/10	S
CAS07	380	Quantity Numeric value of quantity X12N HIPAA Notes: Use this quantity for the units of service being adjusted. Use as needed to show payer adjustment. ALIAS: Adjusted Units - Line Level INDUSTRY: Adjustment Quantity	X	R 1/15	S
CAS08	1034	Claim Adjustment Reason Code Code identifying the detailed reason the adjustment was made X12N HIPAA Notes: Use as needed to show payer adjustment. Use the Claim Adjustment Reason Code list (See Appendix C). ALIAS: Adjustment Reason Code - Line Level NSF Reference: FB3-05.0, FB3-07.0, FB3-09.0, FB3-11.0, FB3-13.0, FB3-15.0, FB3-17.0 INDUSTRY: Adjustment Reason Code	X	ID 1/5	S
CAS09	782	Monetary Amount Monetary amount X12N HIPAA Notes: Use this amount for the adjustment amount. Use as needed to show payer adjustment. ALIAS: Adjusted Amount - Line Level NSF Reference: FB3-06.0, FB3-08.0, FB3-10.0, FB3-12.0, FB3-14.0, FB3-16.0, FB3-18.0, FA0-53.0, FA0-54.0	X	R 1/10	S

CAS10	380	INDUSTRY: Adjustment Amount			
		Quantity	X	R 1/15	S
		Numeric value of quantity			
		X12N HIPAA Notes: Use this quantity for the units of service being adjusted. Use as needed to show payer adjustment. ALIAS: Adjusted Units - Line Level			
CAS11	1034	INDUSTRY: Adjustment Quantity			
		Claim Adjustment Reason Code	X	ID 1/5	S
		Code identifying the detailed reason the adjustment was made			
		X12N HIPAA Notes: Use as needed to show payer adjustment. Use the Claim Adjustment Reason Code list (See Appendix C). ALIAS: Adjustment Reason Code - Line Level NSF Reference: FB3-05.0, FB3-07.0, FB3-09.0, FB3-11.0, FB3-13.0, FB3-15.0, FB3-17.0			
CAS12	782	INDUSTRY: Adjustment Reason Code			
		Monetary Amount	X	R 1/10	S
		Monetary amount			
		X12N HIPAA Notes: Use this amount for the adjustment amount. Use as needed to show payer adjustment. ALIAS: Adjusted Amount - Line Level NSF Reference: FB3-06.0, FB3-08.0, FB3-10.0, FB3-12.0, FB3-14.0, FB3-16.0, FB3-18.0, FA0-53.0, FA0-54.0			
CAS13	380	INDUSTRY: Adjustment Amount			
		Quantity	X	R 1/15	S
		Numeric value of quantity			
		X12N HIPAA Notes: Use this quantity for the units of service being adjusted. Use as needed to show payer adjustment. ALIAS: Adjusted Units - Line Level			
CAS14	1034	INDUSTRY: Adjustment Quantity			
		Claim Adjustment Reason Code	X	ID 1/5	S
		Code identifying the detailed reason the adjustment was made			
		X12N HIPAA Notes: Use as needed to show payer adjustment. Use the Claim Adjustment Reason Code list (See Appendix C). ALIAS: Adjustment Reason Code - Line Level NSF Reference: FB3-05.0, FB3-07.0, FB3-09.0, FB3-11.0, FB3-13.0, FB3-15.0, FB3-17.0			

CAS15	782	INDUSTRY: Adjustment Reason Code	X	R 1/10	S
		Monetary Amount			
		Monetary amount			
		X12N HIPAA Notes: Use this amount for the adjustment amount. Use as needed to show payer adjustment. ALIAS: Adjusted Amount - Line Level NSF Reference: FB3-06.0, FB3-08.0, FB3-10.0, FB3-12.0, FB3-14.0, FB3-16.0, FB3-18.0, FA0-53.0, FA0-54.0			
CAS16	380	INDUSTRY: Adjustment Amount	X	R 1/15	S
		Quantity			
		Numeric value of quantity			
		X12N HIPAA Notes: Use this quantity for the units of service being adjusted. Use as needed to show payer adjustment. ALIAS: Adjusted Units - Line Level			
CAS17	1034	INDUSTRY: Adjustment Quantity	X	ID 1/5	S
		Claim Adjustment Reason Code			
		Code identifying the detailed reason the adjustment was made			
		X12N HIPAA Notes: Use as needed to show payer adjustment. Use the Claim Adjustment Reason Code list (See Appendix C). ALIAS: Adjustment Reason Code - Line Level NSF Reference: FB3-05.0, FB3-07.0, FB3-09.0, FB3-11.0, FB3-13.0, FB3-15.0, FB3-17.0			
CAS18	782	INDUSTRY: Adjustment Reason Code	X	R 1/10	S
		Monetary Amount			
		Monetary amount			
		X12N HIPAA Notes: Use this amount for the adjustment amount. Use as needed to show payer adjustment. ALIAS: Adjusted Amount - Line Level NSF Reference: FB3-06.0, FB3-08.0, FB3-10.0, FB3-12.0, FB3-14.0, FB3-16.0, FB3-18.0, FA0-53.0, FA0-54.0			
CAS19	380	INDUSTRY: Adjustment Amount	X	R 1/15	S
		Quantity			
		Numeric value of quantity			
		X12N HIPAA Notes: Use this quantity for the units of service being adjusted. Use as needed to show payer adjustment. ALIAS: Adjusted Units - Line Level			

Segment: **DTP** Line Adjudication Date
Position: 550
Loop: 2430 Optional
Level: Detail
Usage: Optional (Must Use)
Max Use: 1
Purpose: To specify any or all of a date, a time, or a time period
Syntax Notes:
Semantic Notes: 1 DTP02 is the date or time or period format that will appear in DTP03.
Comments:
Notes: **X12N HIPAA Example**

Example: DTP*573*D8*19970131~

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
DTP01	374	Date/Time Qualifier	M ID 3/3	R
Code specifying type of date or time, or both date and time				
X12N HIPAA Notes:				
INDUSTRY: Date Time Qualifier				
		573 Date Claim Paid		
DTP02	1250	Date Time Period Format Qualifier	M ID 2/3	R
Code indicating the date format, time format, or date and time format				
X12N HIPAA Notes:				
INDUSTRY: Date Time Period Format Qualifier				
		D8 Date Expressed in Format CCYYMMDD		
DTP03	1251	Date Time Period	M AN 1/35	R
Expression of a date, a time, or range of dates, times or dates and times				
X12N HIPAA Notes:				
INDUSTRY: Adjudication or Payment Date				

Segment: **SE** Transaction Set Trailer
Position: 555
Loop:
Level: Summary
Usage: Mandatory
Max Use: 1
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)

Syntax Notes:

Semantic Notes:

Comments: 1 SE is the last segment of each transaction set.

Notes: **X12N HIPAA Example**

Example: SE*211*987654~

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
SE01	96	Number of Included Segments	M N0 1/10	R
		Total number of segments included in a transaction set including ST and SE segments		
		X12N HIPAA Notes:		
		ALIAS: Segment Count		
		INDUSTRY: Transaction Segment Count		
SE02	329	Transaction Set Control Number	M AN 4/9	R
		Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set		
		X12N HIPAA Notes:		
		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.		
		ALIAS: Transaction Set Control Number		
		INDUSTRY: Transaction Set Control Number		

Segment: **GE** Functional Group Trailer
Position: 565
Loop:
Level: Summary
Usage: Optional (Must Use)
Max Use: 1
Purpose: To indicate the end of a functional group and to provide control information
Syntax Notes:
Semantic Notes: 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.
Notes: **X12N HIPAA Example**

GE*1*1~

Data Element Summary

<u>Ref.</u>	<u>Data</u>		<u>Base</u>	<u>User</u>
<u>Des.</u>	<u>Element</u>	<u>Name</u>	<u>Attributes</u>	<u>Attributes</u>
GE01	97	Number of Transaction Sets Included	M N0 1/6	R
		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 N0 1/9	R
		Assigned number originated and maintained by the sender		

Segment: **IEA** Interchange Control Trailer
Position: 575
Loop:
Level: Summary
Usage: Optional (Must Use)
Max Use: 1
Purpose: To define the end of an interchange of zero or more functional groups and interchange-related control segments

Syntax Notes:

Semantic Notes:

Comments:

Notes: X12N HIPAA Example

IEA*1*000000905~

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
IEA01	I16	Number of Included Functional Groups A count of the number of functional groups included in an interchange	M N0 1/5	R
IEA02	I12	Interchange Control Number A control number assigned by the interchange sender	M N0 9/9	R