Electronic Health Care Claim: Professional

Companion Guide

ANSI X12 837 (004010X098A1)

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This Companion Guide is a work in progress. Educators Mutual Insurance Association reserves the right to make changes to this Companion Guide at any time without notice. When changes are made, the document change management table on the last page of this section will identify those changes and give the date of the change.

INTRODUCTION

In an effort to reduce the administrative costs of health care across the nation, the Health Insurance Portability and Accountability Act (HIPAA) was passed in 1996. This legislation requires that health insurance payers in the United States comply with the electronic data interchange (EDI) standards for health care, established by the Secretary of Health and Human Services (HHS). For the health care industry to achieve the potential administrative cost savings with EDI, standard transactions and code sets have been developed and need to be implemented consistently by all organizations involved in the electronic exchange of data. The ANSI X12N 837 Health Care Claim: Professional transaction implementation guide provides the standardized data requirements to be implemented for electronic health care claims.

The 837 transaction is used to file a health care claim from the provider of the service to a member. All providers are required to use the ANSI X12N 837 transaction.

PURPOSE

The 837 Professional Transactions are used to submit health care claims and encounter data to a payer for payment. This transaction is the only acceptable format for electronic Professional claim submissions to Educators Mutual. The intent is to expedite the goal of achieving a totally electronic data interchange environment for health care encounter/claims processing, payment, corrections, and reversals. This transaction will support the submission of Professional claims and Professional encounters. The 837 Professional is the electronic correspondent to the paper HCFA 1500 claim forms; therefore, any claim types or encounter data submitted on the ADA forms correlate to the 837 Professional, if data is submitted electronically.

All required segments within the 837 Professional Transaction must always be sent by the submitter and received by the payer. Optional information will be sent when it is necessary for processing. Segments that are conditional are only sent when special criteria are met. Although required segments in the incoming transaction may not be used during claims processing, some of these data elements will be returned in other transactions such as the Unsolicited Claim Status (277 Transaction Set) and the Remittance Advice (835 Transaction Set).

Important websites:
Workgroup for Electronic Data Interchange (WEDI) – http://www.wedi.org
United States Department of Health and Human Services (DHHS) – http://aspe.hhs.gov/
Centers for Medicare and Medicaid Services (CMS) – http://www.cms.gov/hipaa/hipaa2/
Designated Standard Maintenance Organizations (DSMO) – http://www.hipaa-dsmo.org/
National Council of Prescription Drug Programs (NCPDP) – http://www.ncpdp.org/
National Uniform Billing Committee (NUBC) – http://www.nubc.org/
Accredited Standards Committee (ASC X12) – http://www.x12.org/

DEFINITION OF TERMS USED

Payer/Insurer: The payer is the party that pays claims and/or administers the insurance coverage, benefit, or product. A payer can be an insurance company, Health Maintenance Organization,

Preferred Provider Organization, government agency, or another organization contracted by one of these groups. The Payer may be referred to as the Insurer in certain sections of this document.

HIPAA IMPACT ON CURRENT BUSINESS PROCESSES

The 837 Health Care Claim - Professional transaction requires the provider to submit additional data not present in the pre-HIPAA claims bill transactions. The structure of the 837 may also enable the provider to relay information in a more efficient manner and may impact current business processes necessary to process a claims bill submission for payment.

SPECIAL CONSIDERATIONS

Provider Identification = Educators Mutual Member ID

Educators Mutual will use the EMIA legacy provider number until the National Provider Identifier (NPI) is implemented. The implementation date for NPI is scheduled for May 23, 2007. Prior to May 23, 2007, the EMIA legacy Provider Number must be received in the 2010AA Billing Provider loop within the REF segment where REF01 equals 1D. If REF02, where the REF01 equals 1D is not received, the claim will not process correctly. If, applicable the REF02, where REF01=1D must also be received in the 2010AB Pay-to-Provider, 2310A Referring Provider, 2310B Rendering Provider, 2310C Service Facility Provider and/or 2420A Rendering Provider loops. If this type of REF segment is not received within these loops, the claim may not process correctly.

Beginning May 23, 2007, for all health care providers, the Provider NPI, Taxonomy Code, Employee identification number, and Zip Code + the 4-digit postal code must be received in the appropriate loops. The NPI will be sent in the NM109, where NM108 equals XX. The Taxonomy Code will be sent in the PRV03, Employee identification number will be sent in the REF02 and the Zip Code + the 4-digit postal code will be sent in the N403 and N404. Beginning May 23, 2007, for all non-healthcare providers where an NPI is not assigned, the claim must contain the EMIA legacy Provider Number within the appropriate loops within the REF segment where REF01 equals 1D.

Logical File Structure

There can be only one interchange (ISE/IEA) per logical file. The interchange can contain multiple functional groups (GS/GE); however, the functional groups must be the same type.

Submitter

Submissions by non-approved trading partners will be rejected. Signing up with the Utah Health Information Network (UHIN) is a requirement to obtain a trading partner number.

Claims and Encounters

Claims and encounters must be submitted in separate ISA/IEA envelopes.

Response/997 Acknowledgement

A response transaction will be returned to the trading partner that is present within the ISA06 data element. Educators Mutual will provide a 997 Acknowledgment for all transactions that are received. Acknowledgments will be received within 48 hours unless there are unforeseen technical difficulties. If the transaction submitted was translated without errors for a request type transaction, i.e. 270 or 276, you will receive the appropriate response transaction generated from the request. If the

transaction submitted was a claim transaction, i.e. 837, you will receive either the 835 or the unsolicited 277.

NOTE: The 835 is only provided twice a week.

When NM108 = 24 or REF01=EI
If the NM108 equals 24 (Employer Identification Number (EIN)) or the REF01 equals EI (EIN) within any loop, the value in the corresponding NM109 or REF02 must be in the format of XXXXXXXXX.

Claims Allowed per Transaction (ST/SE envelope)
The HIPAA implementation guide states on the CLM (Claim Information) segment that the developers recommend that trading partners limit the size of the transaction (ST/SE) envelope to a maximum of 5,000 CLM segments. Educators Mutual does not have a maximum for the number of claims per transaction (ST/SE envelope).

Document Level
Educators Mutual processes files at the claim level. It is possible, based on where the error(s) occur within the hierarchical structure, that some claims may pass compliance and others will fail compliance. Those claims that pass compliance will be processed. Those claims that fail compliance will be reported on the 997.

Field Definitions

R (Required): This field must always be included in the transmission.

S (Situational): This field is necessary in certain situations. Please review the ASC X12N Implementation Guide for instructions on when this is required.

N/U (Not Used): The shaded areas of the Companion Guide are NOT USED according to the standard and should not be included in transmissions.

Comments: This provides Educators Mutual's requirements/recommendations for some fields.

Delimiters Supported

A delimiter is a character used to separate two data elements or sub-elements or to terminate a segment. Delimiters are specified in the interchange header segment, ISA. The ISA segment is a 105 byte fixed length record. The data element separator is byte number 4; the component element separator is byte number 105; and the segment terminator is the byte that immediately follows the component element separator. Once specified in the interchange header, delimiters are not to be used in a data element value elsewhere in the transaction.

Description	Default Delimiter
Data element separator	* Asterisk
Sub-element separator	: Colon
Segment terminator	~ Tilde

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Educators Mutual will support these default delimiters or any delimiter specified by the trading partner in the ISA/IEA envelope structure.

Data Transmission instructions

Educators Mutual will be able to receive file submissions from those groups able to submit. In order for Educators Mutual to set up an entity for EDI submission, they must contact the Educators Mutual operations department. Educators Mutual will need the following information since the **setup could take two to four weeks to accomplish**:

1. Will the file be sent using PGP?
2. Will the file be sent via the UHIN portal (see www.UHIN.com)?
    - UHIN accepts HIPAA transactions
3. Does the entity have the EMIA Public PGP key?
4. Has the entity been set up as a user on Educators Mutual's FTP network?
5. Does Educators Mutual have the entity's IP address to be used for submitting the files?
6. Has the entity agreed to the Educators Mutual timeline for acceptance testing?

Maximum Limitations

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. Each transaction set contains groups of logically related data in units called segments. The number of times a loop or segment may repeat in the transaction set structure is defined in the implementation guide. Some of these limitations are explicit, such as the following:

- The Claim Information loop (2300) is limited to 100 claims per patient.
- The Service Line loop (2400) is limited to 50 service lines.

However, some limitations are not explicitly defined. The developers of the implementation guide recommend that trading partners limit the size of the transaction (ST/SE envelope) to a maximum of 5000 claims per transaction set. Educators Mutual has no file size limitations. The Interchange Control structure (ISA/IEA envelope) will be treated as one file. Each Interchange Control structure may consist of multiple Functional Groups (GS/GE envelopes). Educators Mutual requires that the Interchange Control structure is limited to one type of Functional Group, such as 837 Health Care Claim functional groups are submitted in separate Interchange Control structures (ISA/IEA envelopes).

Note: If submitting both encounter and claim transactions, these too must be sent in separate Interchange Control structures (ISA/IEA envelopes). Educators Mutual will validate and accept or reject the entire Interchange Control structure (ISA/IEA envelope).

Compliance Testing Specifications

The Workgroup for Electronic Data Interchange (WEDI) and the Strategic National Implementation Process (SNIP) has recommended seven types of HIPAA compliance testing, as follows:

1. Integrity Testing – This is testing the basic syntax and integrity of the EDI transmission to include valid segments, segment order, element attributes, numeric values in numeric data elements, X12 syntax, and compliance with X12 rules.

2. Requirement Testing – This is testing for HIPAA Implementation Guide specific syntax such as repeat counts, qualifiers, codes, elements, and segments. This also includes testing for required or intra-segment situational data elements and non-medical code sets whose values are noted in the guide via a code list or table.
3. Balance Testing – This is testing the transaction for balanced totals, financial balancing of claims or remittance advice, and balancing of summary fields.
4. Situational Testing – This is testing of inter-segment situations and validation of situational fields based on rules in the Implementation Guide.
5. External Code Set Testing – This is testing of external code sets and tables specified within the Implementation Guide. This testing not only validates the code value but also verifies that the usage is appropriate for the particular transaction.
6. Product Type or Line of Service Testing – This is testing that the segments and elements required for certain health care services are present and formatted correctly. This type of testing only applies to a trading partner candidate that conducts the specific line of business or product type.
7. Implementation Guide-Specific Trading Partners Testing – This is testing of HIPAA requirements that pertain to specific trading partners such as Medicare, Medicaid, and Educators Mutual. Compliance testing with these payer-specific requirements is not required from all trading partners. If the trading partner intends to exchange transactions with one of these special payers, this type of testing is required.

The WEDI/SNP white paper on Transaction Compliance and Certification and other white papers are found at http://www.wedi.org/snip/public/articles/index%7E12.htm.

Educators will provide the necessary information for clients to submit a file for testing purposes.

Trading Partner Acceptance Testing Specifications

Trading partners wishing to submit enrollment electronically to Educators Mutual must first submit an error-free test file and receive verification from Educators Mutual that the file loaded correctly, prior to submitting a production file for processing.

To submit a test file, contact Educators Mutual's information technology department at (801) 270-2943.

The entire file ISA/IEA envelope will either pass (accept) or fail (reject) validation.

There must be a carriage return after each tilde character (~).

Helpful Hint: Create small batches of test enrollment transactions to ensure that you will not have to re-create too many claims billing transactions in the event of an error in the file. Once your files are received and verified to be error-free, you may send files of a larger size.

After receiving clearance to submit production enrollment files, contact Educators Mutual's Information Technology Operations department when you submit your first "live" claims 837 file. Provide your submitter ID and the Educators file tracking number (if available). The information technology department will work with the claims department to ensure that the file uploads properly and gets all the way through the claims adjudication processing system.

Provider Billing Requirements

The 837 Health Care Claim transactions provides a large amount of provider data at both the claim level and the service line level. Educators Mutual's claim adjudication system only utilizes the provider data present at the claim level. Much of the provider data is situational and must be provided if the condition is met. For example, the referring provider ***is required*** when a referral has been made, or the attending provider (institutional claim) ***is required*** when the claim is for an inpatient stay. The Billing/Pay-To loop (2000A) is a required loop. At a minimum the transaction must have a billing provider. The pay-to, rendering loops are dependent upon what is entered in the billing loop.

- Billing Provider Name loop (2010AA) - is a required loop used to identify the original entity that submitted the electronic claim/encounter. The billing provider entity may be a health care provider, a billing service, or some other representative of the provider.
- Pay-To Provider Name loop (2010AB) - is a situational loop, required if the pay-to provider is a different entity from the billing provider.
- Rendering Provider Name loop (2310B) – is a situational loop, required if the rendering provider information is different than that carried in either the billing provider or pay-to provider (2010AA/AB) loops.

Depending on the scenario one or more of the previously mentioned loops might be present in the 837 Health Care Claim transactions. Refer to the scenarios below to determine the loops to be included in your transaction.

Billing Agent Scenario (Professional or Institutional Claims)
In this scenario, the provider, provider group, or facility (institutional claims) contracts with a billing agent to perform its billing and reconciliation functions. In this case, the following information should be provided:

- Billing Provider Name loop (2010AA) – This loop will contain the billing agent information.
- Pay-To Provider Name (2010AB) – This loop will contain the provider, provider group, or facility (institutional claims) information. This is the entity receiving payment for the claim.
- Rendering Provider Name loop (2310B) –This loop will only be included if the rendering provider is different from the pay-to provider. This is the provider of service to the member.

Provider Group Scenario (Professional Claims)
In this scenario, the provider who performed the services is a member of a group. In this case, the following information should be provided:

- Billing Provider Name loop (2010AA) – This loop will contain the provider group information.
- Pay-To Provider Name loop (2010AB) – This loop will be included if payment is being made to the rendering provider and not the group. It will contain the rendering provider information.
- Rendering Provider Name loop (2310B) – This loop will only be included if the provider group is being paid for the claim (the pay-to provider loop (2010AB) is not included in the transaction). The rendering provider information will be provided in this loop. This is the provider of service to the member.

Individual Provider Scenario: (Professional Claims)
In this scenario, the provider is submitting the claim for payment. In this case, the following information should be provided:

- Billing Provider Name loop (2010AA) – This loop will contain the rendering provider information.
- Pay-To Provider Name loop (2010AB) –This loop will not be included.
- Rendering Provider Name loop (2310B) – This loop will not be included.

Note: If a clearinghouse is employed to format and transmit the 837 transaction, the clearinghouse information should be sent in the Submitter Name loop (1000A).

ELECTRONIC DATA INTERCHANGE (HIPAA 837 format)

ASC X12N Version 004010X098A1

Loop ID	Page #(s)	Seg ID	Element ID	Elements Values	Element Description	Req (R/S)
	B.3	ISA	Interchange Control Header			R
			01 – Authorization Info Qualifier	00 = No authorization info present	Relates to no meaningful information in ISA02	R
	B.3	ISA	02 – not used Insert asterisk			R
	B.4	ISA	03 – Security Information Qualifier	00 = No security Relates to no meaningful information present information in ISA04		R
	B.4	ISA	04 – Security Info Insert 00			R
	B.4	ISA	05 – Interchange ID Qualifier	ZZ = Mutually Defined		R
	B.4-B-6	ISA	06 – Interchange Sender ID	ID code determined by sender	This is a unique ID number (i.e. Federal Tax ID.) Field length = 15	R
	B.5	ISA	07 – Interchange ID Qualifier	ZZ = Mutually Defined	This ID qualifies the receiver in ISA08	R
	B.5	ISA	08 – Interchange Receiver ID	ID=GroupNumber		R
	B.5	ISA	09 – Interchange Date	YYMMDD		R
	B.5	ISA	10 – Interchange	Time HHMM		R
	B.5	ISA	11 – Interchange Control Standards Identifier	U		R
	B.5	ISA	12 – Interchange Control Version Number	0040		R
	B.5	ISA	13 – Interchange Control Number		This number must be identical to the associated Interchange Trailer IEA02	R
	B.6	ISA	14 – Acknowledgement requested	1 = Interchange acknowledgement requested	All senders will receive a 997 upon successful receipt of requested file transfer	R
	B.6	ISA	15 – Usage Indicator	P = Production Data T = Test Data		R
	B.6	ISA	16 – Component Element Terminator	EMIA recommends using “>” as the segment terminator and using the “~”, tilde, as the segment separator.	Note: This value must be different than the data element separator and the segment terminator	
ISA SEGMENT EXAMPLE: ISA*00*……….*01*Password..*ZZ*Submitter.ID..*ZZ*Receiver.ID.........*030101*1200*U*00401*123456789*1*T*>~ Note: The ISA segment is a fixed format. Spaces in the example are presented by “.” for clarity.						
	B.8	GS	01 - Functional Group Header	HC – Health Care Claim		R
	B.8	GS	02 – Senders ID Code	Insert senders ID Same ID number as ISA06 R		
	B.8	GS	03 – Receivers ID Code	Insert receiver ID Same ID number as ISA08 R		
	B.8	GS	04 – Date of functional group creation date	CCYYMMDD		R
	B.8	GS	05 – Time of creation	HHMM		R
	B.9	GS	06 – Group Control Number		This number must match the data element in the associated functional group trailer in GE02	R
	B.9	GS	07 – Responsible Agency Code Identifier	X = Accredited Standards Committee X12		R

Data submission criteria for electronic health care claim: Professional

Loop ID	Page #(s)	Seg ID	Element ID	Elements Values	Element Description	Req (R/S)
	B.9	GS	08 – Version Release/Industry Identifier Code	004010X098A1	Must use full code	R
GS SEGMENT EXAMPLE: GS*HC*SENDER CODE*EMIA7777777*20030101*1200*1*X*004010X098A1~						
	62	ST	01 – Transaction Set Identifier Code	837		R
	62	ST	02 -Transaction Set Control Number		Group Specific Control Number to identify transaction set. Must match number in SE02	R
ST SEGMENT EXAMPLE: ST*837*0001~						
	63	BHT	01- Hierarchical Structure Code	0019 – Information Source, Subscriber, Dependent		R
	64	BHT	02- Transaction Set Purpose Code	00 – Original 18 - Reissue		R
	64	BHT	03- Reference Identification			O
	64	BHT	04-Date		CCYYMMDD	O
	65	BHT	05-Time		HHMMSS	O
	65	BHT	06 – Transaction Type Code	CH – Chargeable RP - Reporting		O
BHT SEGMENT EXAMPLE: BHT*0019*00*0123*19980108*0932*CH~						
	66	REF	01 – Qualifier	87 – Functional Category		R
	66	REF	02 – Transmission Type Code	004010X098A1		R
REF SEGMENT EXAMPLE: REF*87*004010X098A1~						
1000A	68	NM1	01 – Entity Identifier Code	41 – Submitter		R
	68	NM1	02 – Entity Type Qualifier	2 – Non-Person Entity		R
	68	NM1	03 - Entity Name		Assigned by UHIN	O
	68	NM1	08 - Code Qualifier	46 – ETIN		R
	69	NM1	09 – Identification Code			R
NM1 SEGMENT EXAMPLE: NM1*41*2*HOSPITAL NAME***46*HT0000214-002~**						
1000A	72	PER	01 – Function Code	IC – Information Contact		R
	72	PER	02 – Contact Name			O
	72	PER	03 – Communication Qualifier	ED – EDI Access Number EM – E-mail FX – FAX TE – Telephone Number		R
	72	PER	04 – Communication Number			R
PER SEGMENT EXAMPLE: PER*IC*JANE DOE*TE*9005555555~						
1000B	75	NM1	01 – Entity Identifier	40 – Receiver		R
	75	NM1	02 – Entity Type Qualifier	2 – Non-Person Entity		R
	75	NM1	03 – Entity Name			O
	75	NM1	08 – Code Qualifier	46 – ETIN		R
	75	NM1	09 – Identification Code			R
NM1 SEGMENT EXAMPLE: NM1*40*2*EMIA***46*HT0000214-001~**						
Billing/Pay-To Provider Hierarchical Level						
2000A	78	HL	01 - Hierarchical ID Number			R
	78	HL	03 – Hierarchical Level Code	20 – Information Source		R
	78	HL	04 – Hierarchical Child Code	1 – Additional Data in Structure		R
HL SEGMENT EXAMPLE: HL*120*1~**						
2000A	79	PRV	01 – Provider Code	BI – Billing PT – Pay-To		R
	80	PRV	02 – Reference Qualifier	ZZ – Mutually Defined		R
	80	PRV	03 – Taxonomy Code			R
PRV SEGMENT EXAMPLE: PRV*PT*ZZ*1223G0001X~						
2010AA	85	NM1	01 – Entity Identifier	85 – Billing Provider		R
	85	NM1	02 – Entity Type Qualifier	2 – Non-Person Entity		R

Loop ID	Page #(s)	Seg ID	Element ID	Elements Values	Element Description	Req (R/S)
	85	NM1	03 – Entity Last Name/Name			R
	86	NM1	08 – Code Qualifier	XX - NPI		R
	86	NM1	09 – Identification Code			R
NM1 SEGMENT EXAMPLE: NM1*85*2*MY INSITUTION**XX*1234567890~**						
2010AA	88	N3	01 – Address line 1			O
	88	N3	02 – Address line 2			O
N3 SEGMENT EXAMPLE: N3*123 MAIN ST~						
2010AA	89	N4	01 – City Name			O
	90	N4	02 – State			O
	90	N4	03 – Zip Code			O
	90	N4	04 - Country Code			O
N4 SEGMENT EXAMPLE: N4*ANYTOWN*KY*12345~						
2010AA	92	REF	01 – Qualifier	SY – SSN 1E – License Number G2 – Commercial Number TJ – TIN EI - EIN		O
	92	REF	02 – Billing Provider Secondary ID Number			O
REF SEGMENT EXAMPLE: REF*SY*123456789~ **REF SEGMENT EXAMPLE: REF*G2*123456789ABC~** **REF SEGMENT EXAMPLE: REF*E1*123456~**						
Subscriber Hierarchical Level						
2000B	109	HL	01 - Hierarchical ID Number			R
	109	HL	02 – Hierarchical Parent			R
	109	HL	03 – Hierarchical Level Code	22 – Information Source		R
	109	HL	04 – Hierarchical Child Code	1 – Additional Data in Structure		R
HL SEGMENT EXAMPLE: HL*2*1*22*1~						
2000B	110	SBR	01 – Payer Responsibility Code	P – Primary S – Secondary T - Tertiary		R
	111	SBR	02 – Relationship Code	18 – Self BLANK – All Others		R
	111	SBR	03 – Group Number			O
	111	SBR	04 – Group Name			O
	112	SBR	09 – Claim Filing Code	CI – Commercial Insurance		O
SBR SEGMENT EXAMPLE: SBR*PEMIARXD***6***CI~**						
2000B	115	PAT	01 – Relationship to Insured	01 – Spouse 18 – Dependent		R
	115	PAT	07 – Unit of Measure Code	GR - Gram		O
	115	PAT	08 – Weight			O
	116	PAT	09 – Pregnancy Indicator	Y - Yes		O
PAT SEGMENT EXAMPLE: PAT*19~						
2010BA	118	NM1	01 – Entity Identifier	IL – Insured or Subscriber		R
	118	NM1	02 – Entity Type Qualifier	1 – Person 2 – Non-Person Entity		R
	118	NM1	03 – Entity Last Name/Name			R
	118	NM1	04 – Entity First Name			O
	118	NM1	05 – Entity Middle Name			O
	119	NM1	08 – Code Qualifier	MI – Member Number ZZ – Mutual Defined		R
	119	NM1	09 – Identification Code			R
NM1 SEGMENT EXAMPLE: NM1*IL*1*SMITH*JOHN**MI*12345678901~**						
2010BA	121	N3	01 – Address line 1			O
	121	N3	02 – Address line 2			O

Data submission criteria for electronic health care claim: Professional

Loop ID	Page #(s)	Seg ID	Element ID	Elements Values	Element Description	Req (R/S)
N3 SEGMENT EXAMPLE: N3*123 Main Street~						
2010BA	122	N4	01 – City Name			O
	123	N4	02 – State			O
	123	N4	03 – Zip Code			O
	123	N4	04 - Country Code			O
N4 SEGMENT EXAMPLE: N4*Anytown*KY* 1234567890~						
2010BA	124	DMG	01 – Format Qualifier	D8 – Date Format	CCYYMMDD	O
	125	DMG	02 – Subscriber DOB			O
	125	DMG	03 - Subscriber Gender	F – Female M - Male U - Unknown		O
DMG SEGMENT EXAMPLE: DMG*D8*19470531*M~						
2010BB	131	NM1	01 – Entity Identifier	PR – Payer		R
	131	NM1	02 – Entity Type Qualifier	2 – Non-Person Entity		R
	131	NM1	03 – Entity Last Name/Name		Organization Name	R
	131	NM1	08 – Code Qualifier	PI – Member Number		R
	131	NM1	09 – Identification Code			R
NM1 SEGMENT EXAMPLE: NM1*PR*2*Educators Insurance***PI*HT000214-001~**						
2010BB	134	N3	01 – Address line 1			O
	134	N3	02 – Address line 2			O
N3 SEGMENT EXAMPLE: N3*123 Main Street~						
2010BB	135	N4	01 – City Name			O
	136	N4	02 – State			O
	136	N4	03 – Zip Code			O
	136	N4	04 - Country Code			O
N4 SEGMENT EXAMPLE: N4*Anytown*KY* 1234567890~						
Patient Hierarchical Level						
2000C	153	HL	01 - Hierarchical ID Number			R
	153	HL	02 – Hierarchical Parent			R
	153	HL	03 – Hierarchical Level Code	23 – Information Source		R
	153	HL	04 – Hierarchical Child Code	0 – Additional Data in Structure		R
HL SEGMENT EXAMPLE: HL*3*2*23*0~						
2000C	154	PAT	01 – Relationship to Insured	01 – Spouse 18 – Dependent		R
	155	PAT	07 – Unit of Measure Code	GR - Gram		O
	155	PAT	08 – Weight			O
	155	PAT	09 – Pregnancy Indicator	Y - Yes		O
PAT SEGMENT EXAMPLE: PAT*19~						
2010CA	157	NM1	01 – Entity Identifier	QC – Patient		R
	158	NM1	02 – Entity Type Qualifier	1 – Person		R
	158	NM1	03 – Entity Last Name/Name			R
	158	NM1	04 – Entity First Name			O
	158	NM1	05 – Entity Middle Name			O
	159	NM1	08 – Code Qualifier	MI – Member Number ZZ – Mutual Defined		R
	159	NM1	09 – Identification Code			R
NM1 SEGMENT EXAMPLE: NM1*QC*1*SMITH*JENN**MI*12345678902~**						
2010CA	161	N3	01 – Address line 1			O
	161	N3	02 – Address line 2			O
N3 SEGMENT EXAMPLE: N3*123 Main Street~						
2010CA	162	N4	01 – City Name			O
	162	N4	02 – State			O
	163	N4	03 – Zip Code			O
	163	N4	04 - Country Code			O
N4 SEGMENT EXAMPLE: N4*Anytown*KY* 1234567890~						
2010CA	164	DMG	01 – Format Qualifier	D8 – Date Format	CCYYMMDD	O

Data submission criteria for electronic health care claim: Professional

Loop ID	Page #(s)	Seg ID	Element ID	Elements Values	Element Description	Req (R/S)
	165	DMG	02 – Subscriber DOB			O
	165	DMG	03 - Subscriber Gender	F – Female M - Male U - Unknown		O
DMG SEGMENT EXAMPLE: DMG*D8*19740531*F~						
2300	171	CLM	01 – Patient Account Number			R
	172	CLM	02 – Claim Charge Amount			O
	173	CLM	051 – Facility Code	11 – Office 12 – Home 21 – Inpatient Hospital 22 – Outpatient Hospital 31 – Skilled Nursing Fac 32 – Adult Care Fac		O
	173	CLM	053 – Frequency Type Code	1 – Original 6 – Corrected 7 – Replacement 8 - Void		O
	174	CLM	06 – Provider Signature on File	N – No Y - Yes		O
	174	CLM	07 – Provider Accept Assignment	A – Assigned C – Not Assigned P – Patient Refuses to Assign		O
	175	CLM	08 – Assignment of Benefits	N – No Y – Yes		O
	175	CLM	09 – Release of Information	N – No Y - Yes		O
	176	CLM	111 - Related Causes Code	AA – Auto Accident EM – Employment OA – Other Accident		O
	177	CLM	112 - Related Causes Code	AA – Auto Accident EM – Employment OA – Other Accident		O
	177	CLM	113 - Related Causes Code	AA – Auto Accident EM – Employment OA – Other Accident		O
	177	CLM	114 - Accident State			O
	178	CLM	115 - Country Code			O
	178	CLM	12 – Special Program Indicator	01 – Early & Periodic Screening 02 – Physically Handicapped 03 – Special Federal Fund 05 – Disability 07 – Induced Abortion – Danger to Life 08 – Induced Abortion – Rape or Incest 09 – Second Opinion or Surgery		O
	179	CLM	20 – Delay Reason Code	1 – Proof of Eligibility Unknown 2 – Litigation 3 – Authorization Delays 4 – Delay in Certifying Provider 5 – Delay in Supplying Forms 6 – Delay in Delivery of Appliances		O

Data submission criteria for electronic health care claim: Professional

Loop ID	Page #(s)	Seg ID	Element ID	Elements Values	Element Description	Req (R/S)
				7 – Third Party Processing Delay 8 – Delay in Eligibility Determination 9 – Original Claim Rejected 10 – Administration Delay 11 - Other		
CLM SEGMENT EXAMPLE: CLM*123456789*163*11::1*Y*C*Y*Y~**						
2300	1	DTP	01 – Date Qualifier	096 – Discharge Date		R
	167	DTP	02 – Format	D8 – Date	CCYYMMDD	R
	168	DTP	03 – Discharge Date			R
DTP SEGMENT EXAMPLE: DTP*96*D8*20050630~						
2300	167	DTP	01 – Date Qualifier	435 – Admission		R
	167	DTP	02 – Format	D8 – Date	CCYYMMDD	R
	168	DTP	03 – Admission Date			R
DTP SEGMENT EXAMPLE: DTP*435*D8*20050113~						
	200	REF	01 – Qualifier	EA – Medical Record Identification		R
	201	REF	02 – Transmission Type Code			R
REF SEGMENT EXAMPLE: REF*EA*123456789~						
2300	265	HI	011 – Code Qualifier	BK – Principle Diagnosis		R
	266	HI	012 – Diagnosis Code			R
	266	HI	021 – Code Qualifier	BF – Other Diagnosis		R
	266	HI	022 – Diagnosis Code			R
	267	HI	031 – Code Qualifier	BF – Other Diagnosis		R
	267	HI	032 – Diagnosis Code			R
	267	HI	041 – Code Qualifier	BF – Other Diagnosis		R
	268	HI	042 – Diagnosis Code			R
	268	HI	051 – Code Qualifier	BF – Other Diagnosis		R
	268	HI	052 – Diagnosis Code			R
	269	HI	061 – Code Qualifier	BF – Other Diagnosis		R
	269	HI	062 – Diagnosis Code			R
	269	HI	071 – Code Qualifier	BF – Other Diagnosis		R
	269	HI	072 – Diagnosis Code			R
	270	HI	081 – Code Qualifier	BF – Other Diagnosis		R
	270	HI	082 – Diagnosis Code			R
HI SEGMENT EXAMPLE: HI*BK:V9782*BF:5559~						
2300	272	HCP	01 – Pricing Methodology	02 – Priced at Standard Fee Schedule		R
	272	HCP	02 – Monetary Amount			R
HCP SEGMENT EXAMPLE: HCP*02*100~						
2310A	290	NM1	01 – Entity Identifier	82 – Rendering Provider		R
	290	NM1	02 – Entity Type Qualifier	1 – Person		R
	290	NM1	03 – Entity Last Name			R
	290	NM1	04 – Entity First Name			R
	290	NM1	05 – Entity Middle Name			R
	290	NM1	08 – Code Qualifier	XX - NPI		R
	290	NM1	09 – Identification Code			R
NM1 SEGMENT EXAMPLE: NM1*82*1*SMITH*JOHN*XX*1234567890~**						
2310A	296	REF	01 – Qualifier	SY – SSN 1E – License Number G2 – Commercial Number TJ – TIN EI - EIN		O
	297	REF	02 – Rendering Provider Secondary ID Number			O
REF SEGMENT EXAMPLE: REF*SY*123456789~						

Data submission criteria for electronic health care claim: Professional

Loop ID	Page #(s)	Seg ID	Element ID	Elements Values	Element Description	Req (R/S)
Line Counter						
2400	398	LX	01 – Assigned Number			R
LX SEGMENT EXAMPLE: LX*1~						
	401	SV1	011 – Procedure			R
	401	SV1	012 – Procedure Modifier			R
	401	SV1	013 – Procedure Modifier			O
	402	SV1	014 – Procedure Modifier			O
	402	SV1	015 – Description			O
	402	SV1	016 – Line Item Charge			O
	402	SV1	02 – Monetary Amount			R
	403	SV1	03 – Unit/Basis Meas Code			O
	403	SV1	04 – Quantity			O
	404	SV1	05 – Facility Code			O
	404	SV1	06 – Monetary Amount			O
	405	SV1	071 – Diagnosis Code Pointer			R
	405	SV1	072 – Diagnosis Code Pointer			R
	405	SV1	073 – Diagnosis Code Pointer			O
	405	SV1	074 – Diagnosis Code Pointer			O
	406	SV1	09 – Response Code			R
	406	SV1	11 – Response Code			O
	406	SV1	12 – Response Code			R
	407	SV1	15 – Response Code			O
SV1 SEGMENT EXAMPLE: SV1*HC:20550:LT*83*UN*1*1:2~**						
2300	435	DTP	01 – Date Qualifier	472 – Service Date		R
	435	DTP	02 – Format	D8 Date RD8 Date Range	CCYYMMDD CCYYMMDD-CCYYMMDD	R
	435	DTP	03 – Service Date(s)			R
DTP SEGMENT EXAMPLE: DTP*472*D8*20070430~						
	572	SE	01 – Number Included Segments			R
	572	SE	02 -Transaction Set Control Number		Group Specific Control Number to identify transaction set. Must match number in ST02	R
SE SEGMENT EXAMPLE: SE*39*0001~						
	B.10	GE	01 – Number of transaction sets included			R
	B.10	GE	02 – Group control number		This data element must be identical to GS06	R
GE SEGMENT EXAMPLE: GE*1*123456~						
	B.7	IEA	01 – Number of included functional groups			R
	B.7	IEA	02 – Interchange control number		This data element must be identical to ISA13	R
IEA SEGMENT EXAMPLE: IEA*1*123456~						

Document Change Management

Date	Who	Description of Change
06/13/2007	Loren	Initial document creation