

**FMMIS Batch Professional Health
Care Claim and Encounter Claim
837P Companion Guide
004010 X098A1**

Version 1.3

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1 INTRODUCTION

The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicaid and all other health insurance payers in the United States comply with the EDI standards for health care as established by the Secretary of Health Services. The ANSI X12N implementation guides have been established as the standards of compliance for claim transactions.

The following information is intended to serve only as a companion guide to the HIPAA ANSI X12N implementation guides. The use of this guide is solely for the purpose of clarification. The information describes specific requirements to be used for processing data. This companion guide supplements, but does not contradict any requirements in the X12N implementation guide. Additional companion guides/trading partner agreements will be developed for use with other HIPAA standards, as they become available.

Additional information on the *Final Rule for Standards for Electronic Transactions* can be found at <http://aspe.hhs.gov/admnsimp/final/txfin00.htm>. The HIPAA Implementation Guides can be accessed at http://www.wpc-edi.com/hipaa/HIPAA_40.asp.

1.1 Purpose

The 837 Professional transaction is 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 the Agency for Health Care Administration (AHCA). 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 transaction is the electronic correspondent to the paper CMS-1500 claim forms; therefore, any claim types or encounter data submitted on the CMS-1500 forms correlate to the 837 Professional transaction, 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 transaction such as the Unsolicited Claim Status (277 Transaction Set) and the Remittance Advice (835 Transaction Set).

1.2 Special Considerations for 837 Professional Transaction

1. Subscriber, Insured = Recipient in the Florida Medicaid Eligibility Verification System:

The Florida Medicaid Eligibility Verification System does not allow for dependents to be enrolled under a primary subscriber, rather all enrollees/recipients are primary subscribers within each program or MCO (Managed Care Organization).

2. Provider Identification = Florida Medicaid ID or NPI:

The implementation date for National Provider Identifier (NPI) was May 23, 2007. The Agency for Health Care Administration has implemented the contingency plan for NPI and will continue to use the Florida Medicaid Provider Number until May 23, 2008.

Prior to May 23, 2008, if the Medicaid Provider Number is received in the 2010AA Billing Provider loop within the REF segment where REF01 equals 1D and the 2010AA NM1 segment where NM108 equals XX is not received, the claim will process correctly. If applicable the REF02, where REF01=1D can also be used within the 2010AB Pay-to-Provider, 2310A Referring Provider, 2310B Rendering Provider, 2310C Service Facility Provider and/or 2420A Rendering Provider loops.

Beginning May 23, 2008 for all health care providers, the Provider NPI, Taxonomy Code and Zip Code + 4 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 and the Zip Code + 4 postal code will be sent in the N403 and N404.

For all non-healthcare providers where an NPI is not assigned, the claim must contain the Florida Medicaid Provider Number within the appropriate loops within the REF segment where REF01 equals 1D.

Note: This information overrides the information documented in Section 3 for NM1 and REF segment provider number identification information.

3. 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.

4. Submitter:

Submissions by non-approved trading partners will be rejected.

5. Claims and Encounters:

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

6. Response/997 Functional Acknowledgement:

A response transaction will be returned to the trading partner that is present within the ISA06 data element.

The Agency for Health Care Administration will provide a 997 Functional Acknowledgment for all transactions that are received.

You will receive this acknowledgment 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 and unsolicited are only provided weekly.

7. 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 XX-XXXXXXX.

Note: This format includes the hyphen (-).

8. 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.

The Agency for Health Care Administration does not have a maximum for the number of claims per transaction (ST/SE envelope).

9. Document Level:

The Agency for Health Care Administration 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 within the Florida Medicaid Management Information System (FMMIS). Those claims that fail compliance will be reported on the 997.

10. Dependent Loop:

For the Agency for Health Care Administration, the subscriber is always the same as the patient (dependent). Claims containing data in the Patient Hierarchical Level (2000C loop) may not process correctly.

11. Compliance Checking:

Inbound 837 transactions are validated through Strategic National Implementation Process (SNIP) Level 4. In addition to Level 4, Level 7 patient (dependent) level will occur if 2000C patient loop is received. All other levels will be validated within the FMMIS.

12. Identification of TPL:

For each claim at the header level, if loop 2320 (Other Subscriber Information) is present and SBR09 (Claim Filing Indicator) is not equal to MB (Medicare), 16 (HMO Medicare Risk), HM (HMO) or MC (Medicaid), the COB Payer Paid Amounts (AMT01=D) received in the 2320 loop(s) will be summed together for the Payer Paid Amount.

Note: The 2320 loop can repeat multiple times per claim.

13. Private Transportation:

Private Transportation providers are currently required to submit start and stop time information on the claim. This information provides a means to distinguish between services submitted for the same recipient on the same day. The X12N 837 Professional transaction does not provide the capability for providers to submit start and stop times. Private Transportation claims will use two modifiers instead of start and stop times.

The values are:

- D** Diagnostic or therapeutic site other than ‘P’ or ‘H’
- E** Residential, domiciliary, custodial facility (nursing home, not a skilled nursing facility)
- G** Hospital-based dialysis facility (hospital or hospital-related)
- H** Hospital
- I** Site of transfer (for example, airport or helicopter pad) between types of ambulance
- J** Non-hospital-based dialysis facility
- N** Skilled nursing facility (SNF)
- P** Physician’s office (includes HMO non-hospital facility, clinic, etc.)
- R** Residence
- S** Scene of accident or acute event
- X** Intermediate stop at physician’s office in route to the hospital (includes HMO non-hospital facility, clinic, etc.)

Note: Modifier X can only be used as a designation code in the second modifier position.

The Origin and Destination codes will be billed together as a two-character modifier to provide combinations to uniquely identify services billed on the same day. If the provider needs to utilize the same procedure code and origin/destination modifier for the same recipient on the same day, a second modifier will be billed with the value of ‘76’ (Repeat Procedure by Same Physician).

Note about Round Trip: A round trip means that the patient was picked up, taken somewhere, and returned to the same place they were picked up. There are only two legs to a round trip, going out and coming back. If you made a trip with three legs (going out, going somewhere else, coming back) that is not a round trip.

- a. To bill a round trip if you bill for a base rate and mileage:

- (1) Round trips will be billed with Ambulance Transport Code ‘X’ in Loop2300 CR103.
 - (2) Bill only one line for mileage (unless you have a known exception). The modifier for origin and destination should reflect the pick up point and the stop point (e.g., Home to Doctor is a modifier of RP). Enter the total miles for the entire trip.
 - (3) If you bill a base rate, you will send that line item once. For wheelchair van and stretcher van, submit total charges of two times your base rate on this line item.
- b. To bill a round trip if you bill for a base rate only:
- (1) Round Trips will be billed with Ambulance Transport Code ‘X’ in Loop2300 CR103.
 - (2) Bill only one line item for base rate. The modifier for origin and destination should reflect the pick up point and the stop point (e.g., Home to Doctor is a modifier of RP). For wheelchair van and stretcher van, submit total charges of two times your base rate on this line item.

Note about Multi-Leg trips: A trip that had multiple segments and is not a round trip as described above, each segment must be billed as a separate line item.

- a. To bill a multiple leg trip if you bill for a base rate and mileage:
- (1) Multiple leg trips will be billed with Ambulance Transport Code ‘I’ in Loop 2300 CR103.
 - (2) Bill one line item for each segment of mileage. The modifier for origin and destination should reflect the start point and the stop point for that leg of the trip.
 - (3) All one line item for each segment of base rate. The modifier for origin and destination should reflect the start point and the stop point for that leg of the trip.
- b. To bill a multiple leg trip if you bill for a base rate only:
- (1) Multiple leg trips will be billed with Ambulance Transport Code ‘I’ in Loop 2300 CR103.
 - (2) Bill one line item for each segment of base rate. The modifier for origin and destination should reflect the start point and the stop point for that leg of the trip.

14. National Drug Code (NDC):

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. In order for the Agency for Health Care Administration to fully realize the drug rebate savings for claims billed, an NDC Code for the billed drug is required effective 01-01-2007.

2 TRANSMISSION AND DATA RETRIEVAL METHODS

EDS supports several types of data transport depending upon the trading partner’s need. Providers and their representatives can submit and receive data via: Web portal, Remote Access Server (RAS), and Value Added Network (VAN)/Switch Vendors for interactive transactions.

1. Web portal: Transaction files are uploaded/downloaded in the Trade Files menu on the secure Web portal.
2. Remote Access Server (RAS): This option is available to trading partners who do not have an existing Internet connection. The RAS server typically supports those who need a dial-up option. Once the RAS connection is established, transaction files are uploaded/downloaded in the Trade Files menu on the secure Web portal.
3. Value Added Networks (VANs) or Switch Vendors: VANs or Switch Vendors typically support interactive transactions through a dedicated connection to the fiscal agent. VANs sign a contract with the State and have unique, VAN specific communication arrangements with the fiscal agent. A list of approved vendors is listed on the fiscal agent Web site.

Detailed information to assist with EDI related processes are available on the Provider Public Web site at: <http://www.mymedicaid-florida.com>

Information available includes:

1. Remote Access Server connectivity instructions for submitters without an existing Internet connection;
2. Trading Partner Testing Procedures (Ramp Manager) for all new trading partners, or trading partners adding a new transaction; and
3. Web Upload/Download instructions for submitters uploading/downloading via the secure Web portal.

File/System Specifications

EDI will only accept Windows\PC\DOS formatted files.

EDI will allow upload and download of zipped or compressed files.

Note: Only one X12 transaction file is permitted in each “zipped” file.

EDI does not require any specific file extensions. This includes acceptance of files without an extension.

The Web portal is designed to support the following Internet browsers:

1. Internet Explorer, version 6 or later;
2. Firefox, version 1.5 or later; and
3. Opera, version 8.5 or later.

3 TRANSMISSION RESPONSES

For every transaction received, there is an expected response. The available responses are an Interchange Acknowledgement (TA1), a Functional Acknowledgement (997), and an Unsolicited Claim Status (277U).

Once a transaction is received, it will go through a ‘front end’ compliance check called a TA1. The TA1 Acknowledgement is a means of replying to an interchange or transmission that has

been sent. The TA1 verifies the envelopes only. The TA1 is a single segment and is unique in the sense that this single segment is transmitted without the GS/GE envelope structure. The TA1 segment provides the capability for the receiving trading partner to notify the sending trading partner of problems that were encountered in the interchange control structure.

Once the transaction has passed the ‘front end’ compliance check it then goes through a syntax compliance edit. This edit is to verify the compliance within the ANSI X12 syntax according to the HIPAA Implementation Guides. The transaction will receive a Functional Acknowledgement (997) to provide feedback on the transaction. The 997 functional acknowledgement contains accepted or rejected information. If the transaction contains any syntactical errors, the segments and elements in which the error occurred will be reported in a rejected acknowledgement. If the transaction contains no syntactical errors, a positive 997 response will be generated and the transaction is passed on for processing.

4 EDI SUPPORT

The EDS EDI Unit is available to support trading partners and providers that exchange transactions electronically. Support functions include:

1. Enrollment processing for trading partners requesting to submit transactions electronically;
2. Installation assistance and submission support for Provider Electronic Solutions (PES) software;
3. Provide assistance to billing agents, clearinghouses and software vendors;
4. Identifying and troubleshooting technical issues; and
5. Data Exchange help.

EDI staff is available Monday through Friday 8:00 a.m. to 5:00 p.m., EST by choosing option 3 when dialing:

1. Inside Florida: 1-800-289-7799;
2. Outside Florida: 1-800-955-7799; and
3. Local calls from Tallahassee area: 850-xxx-xxxx.

5 CONTROL SEGMENT DEFINITIONS FOR FLORIDA MEDICAID 837 PROFESSIONAL TRANSACTION

X12N EDI Control Segments
ISA – Interchange Control Header Segment
IEA – Interchange Control Trailer Segment
GS – Functional Group Header Segment
GE – Functional Group Trailer Segment
ST – Transaction Set Header

X12N EDI Control Segments
SE – Transaction Set Trailer
TA1 – Interchange Acknowledgement

5.1 ISA - Interchange Control Header Segment

Communications transport protocol interchange control header segment. This segment within the X12N implementation guide identifies the start of an interchange of zero or more functional groups and interchange-related control segments. This segment may be thought of traditionally as the file header record.

837 Professional Health Care Claim and Encounter Claims				
Page	Loop	Segment	Data Element	Comments
B.3	N/A	ISA	ISA01 - Authorization Information Qualifier	'00' – No Authorization Information Present
B.3	N/A	ISA	ISA02 - Authorization Information	[space fill]
B.4	N/A	ISA	ISA03 - Security Information Qualifier	'00' – No Security Information Present
B.4	N/A	ISA	ISA04 - Security Information	[space fill]
B.4	N/A	ISA	ISA05 - Interchange ID Qualifier	'ZZ' – Mutually Defined
B.4	N/A	ISA	ISA06 - Interchange Sender ID	Trading Partner Supplied by Florida Medicaid, left justified space filled.
B.4 – B.5	N/A	ISA	ISA07 - Interchange ID Qualifier	'ZZ' – Mutually Defined
B.5	N/A	ISA	ISA08 - Interchange Receiver ID	'77027' left justified and space filled. Florida Medicaid Sender ID
B.5	N/A	ISA	ISA09 - Interchange Date	The date format is YYMMDD
B.5	N/A	ISA	ISA10 - Interchange Time	The time format is HHMM
B.5	N/A	ISA	ISA11 - Interchange Control Standards Identifier	'U' – Interchange Control Standards Identifier
B.5	N/A	ISA	ISA12 - Interchange Control	'00401' – Control Version

837 Professional Health Care Claim and Encounter Claims				
Page	Loop	Segment	Data Element	Comments
			Version Number	Number
B.5	N/A	ISA	ISA13 - Interchange Control Number	Interchange Unique Control Number – Must be identical to the interchange trailer IEA02
B.6	N/A	ISA	ISA14 - Acknowledgment Requested	'0' – No Acknowledgement Requested '1' – Acknowledgement Requested
B.6	N/A	ISA	ISA15 - Usage Indicator	'T' - Test Data 'P' - Production Data
B.6	N/A	ISA	ISA16 - Component Element Separator	'.' – Component Element Separator

5.2 IEA - Interchange Control Trailer

Communications transport protocol interchange control trailer segment. This segment within the X12N implementation guide defines the end of an interchange of zero or more functional groups and interchange-related control segments. This segment may be thought of traditionally as the file trailer record.

837 Professional Health Care Claim and Encounter Claims				
Page	Loop	Segment	Data Element	Comments
B.7	N/A	IEA	IEA01 - Number of included Functional Groups	Number of included Functional Groups
B.7	N/A	IEA	IEA02 - Interchange Control Number	Must be identical to the value in ISA13.

5.3 GS – Functional Group Header

Communications transport protocol functional group header segment. This segment within the X12N implementation guide indicates the beginning of a functional group and provides control

information concerning the batch of transactions. This segment may be thought of traditionally as the batch header record.

837 Professional Health Care Claim and Encounter Claims				
Page	Loop	Segment	Data Element	Comments
B.8	N/A	GS	GS01 - Functional ID Code	'HC' – Health Care Claim (837)
B.8	N/A	GS	GS02 - Application Sender's Code	Trading Partner Supplied by Florida Medicaid, left justified, do not space fill.
B.8	N/A	GS	GS03 - Application Receiver's Code	'77027' left justified do not space fill. Florida Medicaid Receiver ID
B.8	N/A	GS	GS04 - Date	The date format is CCYYMMDD.
B.8	N/A	GS	GS05 – Time	The time format is HHMM.
B.9	N/A	GS	GS06 - Group Control Number	Group Control Number
B.9	N/A	GS	GS07 - Responsible Agency Code	'X' – Responsible Agency Code
B.9	N/A	GS	GS08 - Version/ Release/ Industry ID Code	'004010X098A1' – Version / Release / Industry Identifier Code

5.4 GE – Functional Group Trailer

Communications transport protocol functional group trailer segment. This segment within the X12N implementation guide indicates the end of a functional group and provides control information concerning the batch of transactions. This segment may be thought of traditionally as the batch trailer record.

837 Professional Health Care Claim and Encounter Claims				
Page	Loop	Segment	Data Element	Comments
B.10	N/A	GE	GE01 – Number of Transaction Sets Included	Number of included Transaction Sets
B.10	N/A	GE	GE02 – Group Control Number	Must be identical to the value in GS06.

5.5 ST – Transaction Set Header

Communications transport protocol transaction set header segment. This segment within the X12N implementation guide indicates the start of the transaction set and assigns a control number to the transaction. This segment may be thought of traditionally as the claim header record.

837 Professional Health Care Claim and Encounter Claims				
Page	Loop	Segment	Data Element	Comments
62	N/A	ST	ST01 – Transaction Set Identifier Code	‘837’ – Health Care Claim
62	N/A	ST	ST02 – Transaction Set Control Number	Transaction Control Number

5.6 SE – Transaction Set Trailer

Communications transport protocol transaction set trailer. This segment within the X12N implementation guide indicates the end of the transaction set and provides the count of transmitted segments (including the beginning (ST) and ending (SE) segments). This segment may be thought of traditionally as the claim trailer record.

837 Professional Health Care Claim and Encounter Claims				
Page	Loop	Segment	Data Element	Comments
572	N/A	SE	SE01 – Number of Included Segments	Total Number of Segments included in Transaction Set Including ST and SE.
572	N/A	SE	SE02 – Transaction Set Control Number	Must be identical to the value in ST02.

5.7 TA1 – Interchange Acknowledgement

The TA1 Acknowledgement is a means of replying to an interchange or transmission that has been sent. The TA1 verifies the envelopes only. The TA1 is a single segment and is unique in the sense that this single segment is transmitted without the GS/GE envelope structure. The TA1 segment provides the capability for the receiving trading partner to notify the sending trading partner of problems that were encountered in the interchange control structure.

837 Professional Health Care Claim and Encounter Claims				
Page	Loop	Segment	Data Element	Comments
B.11	N/A	TA1	TA101 - Interchange Control Number	Interchange control number of the original interchange received (ISA/IEA)
B.11	N/A	TA1	TA102 - Interchange Date	The date format is YYMMDD. Date within the original interchange received (ISA/IEA)
B.11	N/A	TA1	TA103 - Interchange Time	The time format is HHMM. Time within the original interchange received (ISA/IEA)
B.12	N/A	TA1	TA104 - Interchange Acknowledgement Code	‘A’ – Transmitted interchange control structure header/trailer received without errors. ‘E’ – Transmitted interchange control structure header/trailer received and accepted, errors are noted. ‘R’ – Transmitted interchange control structure header/trailer rejected due to errors.
B.12 – B.13	N/A	TA1	TA105 - Interchange Note Code	See 837P Implementation Guide for valid values.

5.8 Valid Delimiters

The following delimiters must be used for the 837P for Florida Medicaid otherwise the transaction may not process correctly.

Definition	ASCII	Decimal	Hexadecimal
Segment Separator	~	126	7E
Element Separator	*	42	2A
Compound Element Separator	:	58	3A

6 COMPANION GUIDE FOR THE 837P TRANSACTION

This section specifies X12 837P fields for which Florida Medicaid has specific requirements.

837 Professional Health Care Claim and Encounter Claims				
Page	Loop	Segment	Data Element	Comments
Header				
64	N/A	BHT	BHT02 - Transaction Set Purpose Code	'00' – Original
65	N/A	BHT	BHT06 - Transaction Type Code	'CH' – Chargeable (Use with Professional Health Care Claim) 'RP' – Reporting (Use with Professional Health Care Encounter)
Submitter Name				
69	1000A	NM1	NM109 - Identification Code	Florida EDI Trading Partner ID
Receiver Name				
75	1000B	NM1	NM103 – Name Last or Organization Name	'STATE OF FLORIDA MEDICAID'
75	1000B	NM1	NM109 - Identification Code	'77027' - Florida Medicaid Payer ID
Billing Provider Name				
79	2000A	PRV	PRV01 - Provider Code	'BI' – Billing Provider 'PT' – Pay-to-Provider
80	2000A	PRV	PRV02 - Reference Identification Qualifier	'ZZ' – Health Care Provider Taxonomy
80	2000A	PRV	PRV03 - Provider Specialty Code	Provider Taxonomy Code
86	2010AA	NM1	NM108 - Identification Code Qualifier	'XX' – Health Care Financing Administration National Provider Identifier (NPI) for Healthcare Providers '24' – Employer's Identification Number

				OR '34' – Social Security Number for non-healthcare provider
86	2010AA	NM1	NM109 - Identification Code	If NM108='XX' (NPI) If NM108='24' (EIN) If NM108='34' (SSN)
90	2010AA	N4	N403 - Zip Code	Billing Provider Zip Code + 4 postal code (excluding punctuation and blanks)
92	2010AA	REF	REF01 - Reference Identification Qualifier	'EI' - EIN or 'SY' - SSN Healthcare providers must send NPI in the associated NM109 and the REF01=1D should not be used. 'EI' or 'SY' must be used when NM108='XX'. Non-healthcare providers must send this REF segment where REF01='1D'. NM108 must equal '24' or '34' when REF01='1D'
92	2010AA	REF	REF02 - Reference Identification	If REF01='EI' (EIN) If REF01='SY' (SSN) If REF01='1D' (Florida Medicaid Provider ID) See comments on associated REF01.
Pay-to-Provider Name				
Note: Used if Different than the Billing Provider				
101	2010AB	NM1	NM108 - Identification Code Qualifier	'XX' – Health Care Financing Administration National Provider Identifier (NPI) for Healthcare Providers '24' – Employer's Identification Number OR '34' – Social Security Number for non-healthcare provider

101	2010AB	NM1	NM109 - Identification Code	If NM108='XX' (NPI) If NM108='24' (EIN) If NM108='34' (SSN)
105	2010AB	N4	N403 - Zip Code	Billing Provider Zip Code + 4 postal code (excluding punctuation and blanks)
106-107	2010AB	REF	REF01 - Reference Identification Qualifier	'EI' – EIN or 'SY' – SSN Healthcare providers must send NPI in the associated NM109 and the REF01='1D' should not be used. 'EI' or 'SY' must be used when NM108='XX'. Non-healthcare providers must send this REF segment where REF01='1D'. NM108 must equal '24' or '34' when REF01='1D.'
107	2010AB	REF	REF02 - Reference Identification	If REF01='EI' (EIN) If REF01='SY' (SSN) If REF01='1D' (Florida Medicaid Provider ID) See comments on associated REF01.
Subscriber Level				
Note: For Florida Medicaid, the insured and the patient are always the same person. Use this HL segment to identify the recipient and proceed to Loop 2300. Do not send the Patient Hierarchical Level (Loop 2000C). Claims received with the 2000C Loop may not process correctly.				
109	2000B	HL	HL04 - Hierarchical Child Code	'0' – No Subordinate HL Segment in this Hierarchical Structure
110	2000B	SBR	SBR01 - Payer Responsibility Sequence Number Code	Refer to 837P Implementation Guide for Valid Values.
112	2000B	SBR	SBR09 - Claim Filing Indicator Code	'MC' - Medicaid
116	2000B	PAT	PAT09 – Pregnancy Indicator	'Y' – Pregnancy Indicator when the recipient is pregnant

				to reflect exception from co-payment.
Subscriber Name				
118	2010BA	NM1	NM102 - Entity Type Qualifier	'1' – Person
119	2010BA	NM1	NM108 - Identification Code Qualifier	'MI' – Member Identification Number
119	2010BA	NM1	NM109 - Identification Code	Florida Recipient 10-digit Medicaid ID
Payer Name				
131	2010BB	NM1	NM103 - Name Last or Organization Name	'STATE OF FLORIDA MEDICAID'
131	2010BB	NM1	NM108 - Identification Code Qualifier	'PI' – Payer Identification
131	2010BB	NM1	NM109 - Identification Code	'77027' - Florida Medicaid Payer ID
Claim Information				
171	2300	CLM	CLM01 - Claim Submitter's Identifier	Patient Control Number Value received will be returned on the 835 Remittance Advice.
173	2300	CLM	CLM05-1 - Facility Type Code	Enter the 2-digit Place of Service code at the claim header. Note: See the Medicaid Provider Reimbursement Handbook for a list of all of the valid values. Enter Place of Service code '99' for public transportation claims.
173-174	2300	CLM	CLM05-3 - Claim Frequency Type Code	Value indicates whether the current claim is an original claim, a void, or an adjustment. Valid values are as follows: '1' = Original Claim '7' = Adjustment

				<p>(Replacement of Paid Claim) ‘8’ = Void (Credit only).</p> <p>The ICN to credit should be placed in the REF02, where REF01=’F8’.</p> <p>Providers must use the most recently paid ICN when voiding or adjusting. Consult your appropriate Reimbursement Handbook for additional guidelines for filing voids and adjustments.</p>
176-177	2300	CLM	CLM11-1, CLM11-2, CLM11-3: Related Causes Code	<p>If the services being rendered are the result of an injury or accident, enter one of the standard two-character injury codes listed below in each Data Element if they apply. Otherwise, this field may be left blank.</p> <p>‘AA’ = Auto Accident ‘EM’ = Employment ‘OA’ = Other Accident</p>
228	2300	REF	REF01 - Reference Identification Qualifier	<p>‘G1’ – Prior Authorization Number ‘9F’ – Referral Number</p>
228	2300	REF	REF02 - Reference Identification	<p>If REF01=‘G1’ (Prior Authorization) If REF01=‘9F’ (Referral Number)</p> <p>Prior Authorization Number only if the services rendered required and received approved Prior Authorization from AHCA or a Peer Review Organization such as KePRO or First Mental Health. This number must be entered with the qualifier ‘G1’ (Prior Authorization Number).</p>

				Enter DS Waiver Coordinator Number with the REF01='9F'. Enter MediPass Authorization Number for MediPass claims with the Qualifier of '9F'.
230	2300	REF	REF01 - Reference Identification Qualifier	'F8' – Original Reference Number
230	2300	REF	REF02 - Reference Identification	Enter the 13-digit ICN or 17-digit TCN assigned to the original claim submission. (ICN/TCN to be credit/voided).
245	2300	K3	K301 - Fixed Format Information	MCO Receipt Date – Format CCYYMMDD Required for MCO Encounters
Ambulance Transport Information				
249	2300	CR1	CR103 – Ambulance Transport Code	Enter the Ambulance Transport Code. Note: Refer to the 837P Implementation Guide for the valid code values.
249-250	2300	CR1	CR104 – Ambulance Transport Reason Code	Enter the Ambulance Transport Reason Code. Note: Refer to the 837P Implementation Guide for the valid code values.
250	2300	CR1	CR105 – Unit or Basis for Measurement Code	'DH' - Miles
250	2300	CR1	CR106 – Transport Distance	Florida Medicaid will process only the whole number when units are entered with decimals. Example: Units entered on the transaction 3.75 will be processed as 3 units.
Spinal Manipulation Service Information				
255	2300	CR2	CR208 – Nature of Condition Code	Enter the corresponding Condition Code. Note: Refer to the 837P

				Implementation Guide for the valid code values.
EPSDT Referral				
October 2002 Addenda 37	2300	CRC	CRC01 – Code Category	‘ZZ’ – Mutually Defined Enter this for Child Health Check-Up Screening Referral Information.
October 2002 Addenda 38	2300	CRC	CRC02 – Certification Condition Indicator	‘Y’ – Yes ‘N’ – No For Child Health Check-Up screenings enter a ‘Y’ if the patient is referred to another provider as a result of the screening. Enter ‘N’ if no referral is made. If ‘N’ is entered here, enter ‘NU’ in 2300, CRC03
October 2002 Addenda 38	2300	CRC	CRC03 – Condition Code	Enter one of the following valid values. For Child Health Check-Up Exam Result: ‘AV’ – Patient Refused Referral ‘NU’ – Not Used (Patient Not Referred) ‘S2’ – Under Treatment ‘ST’ – New Services Requested
Referring Provider Name				
283	2310A	NM1	NM101 – Identify Identifier Code	Enter ‘DN’ (Referring Provider) For DS Waiver and MediPass claims refer to the instructions on Loop 2300 REF01 and REF02. Do not use this Loop to specify a referring provider when claim is DS Waiver or MediPass.
284	2310A	NM1	NM108 - Identification	‘XX’ – Health Care Financing

			Code Qualifier	Administration National Provider Identifier (NPI) for Healthcare Providers '24' – Employer's Identification Number OR '34' – Social Security Number for non-healthcare provider
284	2310A	NM1	NM109 - Identification Code	If NM108='XX' (NPI) If NM108='24' (EIN) If NM108='34' (SSN)
286	2310A	PRV	PRV03 - Provider Specialty Code	Referring Provider Taxonomy Code Used for claims submitted with NPI
288-289	2310A	REF	REF01 - Reference Identification Qualifier	'1D' – Medicaid Provider Number Beginning May 23, 2008, Healthcare providers were required to send NPI in the associated NM109 data element and the REF01=1D should not be used. Non-healthcare providers must send this REF segment where REF01='1D'.
289	2310A	REF	REF02 - Reference Identification	If REF01='1D' (Florida Medicaid Provider ID) See comments on associated REF01.
Rendering Provider Name				
292	2310B	NM1	NM108 - Identification Code Qualifier	'XX' – Health Care Financing Administration National Provider Identifier (NPI) for Healthcare Providers '24' – Employer's Identification Number OR '34' – Social Security Number

				for non-healthcare provider
292	2310B	NM1	NM109 - Identification Code	If NM108='XX' (NPI) If NM108='24' (EIN) If NM108='34' (SSN)
294	2310B	PRV	PRV03 - Reference Identification	Rendering Provider Taxonomy Code Used for claims submitted with NPI.
296-297	2310B	REF	REF01 - Reference Identification Qualifier	'1D' – Medicaid Provider Number Beginning May 23, 2008, Healthcare providers were required to send NPI in the associated NM109 data element and the REF01=1D should not be used. Non-healthcare providers must send this REF segment where REF01='1D'.
297	2310B	REF	REF02 - Reference Identification	If REF01='1D' (Florida Medicaid Provider ID) See comments on associated REF01.
Other Subscriber Information				
327-330	2320	CAS	CAS02, CAS05, CAS08, CAS11, CAS14, CAS17 – Adjustment Reason Code	All external code source values from code source 139 are allowed.
332	2320	AMT	AMT01 - Amount Qualifier Code	'D' – Payer Amount Paid
332	2320	AMT	AMT02 - Payer Paid Amount	Other Payer Amount Paid (TPL or MCO) Used for Fee-for-Service and Encounters
334	2320	AMT	AMT01 - Amount Qualifier Code	'B6' – Payer Allowed Amount
334	2320	AMT	AMT02 - Payer Paid	Other Payer Allowed Amount

			Amount	Paid (TPL or MCO) Used for Fee-for-Service and Encounters.
Other Payer Name				
361	2330B	NM1	NM109 – Identification Code	This number must be identical to at least once occurrence of the 2430-SVD01 to identify the other payer. Florida Medicaid captures third party payment amount(s) from the service line(s) in 2430-SVD02. Note: The 2320/2330 Loop(s) can repeat up to 10 times for a single claim and the 2430 Loop can repeat up to 25 times for a single detail.
366	2330B	DTP	DTP01 - Date Claim Paid	'573' - Other Payer or MCO Claim Adjudication Date
366	2330B	DTP	DTP02 – Date Time Period Format Qualifier	'D8' – Date Format (CCYYMMDD)
367	2330B	DTP	DTP03 – Date Time Period	TPL or MCO Adjudication Date (CCYYMMDD)
Service Line				
399	2400	LX	LX01 – Line Counter	Florida Medicaid will accept up to the HIPAA allowed 50 detail lines per claim.
401	2400	SV1	SV101-1 - Product/Service ID Qualifier	'HC' – Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes
401	2400	SV1	SV101-2 – Procedure Code	Enter the procedure code for this service line. For Child Health Check Up (CHCUP) claims, enter the screening procedure code on the first service line. Enter procedure code '99998' for Public Transportation

				Claims
403	2400	SV1	SV104 – Service Unit Count	Enter the Service Unit Count. Submit whole numbers only.
406	2400	SV1	SV109 – Emergency Indicator	Enter ‘Y’ if the services are known to be an emergency.
406	2400	SV1	SV111 - EPSDT Indicator	Enter ‘Y’ when the recipient was referred for services as the result of a Child Health Check-up screening.
406	2400	SV1	SV112 – Family Planning Indicator	Enter ‘Y’ if the services relate to pregnancy or if the services were for Family Planning.

Ambulance Certification

428-429	2400	CRC	CRC03 thru 07 – Condition Code	Enter the Patient Condition Code. Use this Loop and Segment if Condition Code is different by line item, otherwise use CRC03 in the 2300 Loop if Condition Code applies to entire claim. Used only for Ambulance claims.
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Drug Identification

October 2002 Addenda 73	2410	LIN	LIN02 – Service ID Qualifier	Enter ‘N4’ for National Drug Code.
October 2002 Addenda 73	2410	LIN	LIN03 – Drug Identification	Enter National Drug Code (NDC)
October 2002 Addenda 75	2410	CTP	CTP03 – Unit Price	Drug Unit Price
October 2002 Addenda 75	2410	CTP	CTP04 – Quantity	National Drug Unit Count
October 2002	2410	CTP	CTP05-1 – Unit or Basis for	Please refer to 837P October 2002 Addenda for valid code

Addenda 75			Measurement Code	values
Detail Line Rendering Provider Name				
Note: Required if the Rendering Provider NM1 information is different than that carried in the 2310B (claim) loop, or if the Rendering provider information is different than the Billing/Pay-to Provider (2010AA\AB).				
503	2420A	NM1	NM108 - Identification Code Qualifier	‘XX’ – Health Care Financing Administration National Provider Identifier (NPI) for Healthcare Providers ‘24’ – Employer’s Identification Number OR ‘34’ – Social Security Number for non-healthcare provider
503	2420A	NM1	NM109 - Identification Code	If NM108=‘XX’ (NPI) If NM108=‘24’ (EIN) If NM108=‘34’ (SSN)
505	2420A	PRV	PRV03 - Reference Identification	Detail Level Rendering Provider Taxonomy Code Used for claims submitted with NPI
507-508	2420A	REF	REF01 - Reference Identification Qualifier	‘1D’ – Medicaid Provider Number Beginning May 23, 2008 Healthcare providers were required to send NPI in the associated NM109 data element and the REF01=‘1D’ should not be used. Non-healthcare providers must send this REF segment where REF01=‘1D’
508	2420A	REF	REF02 - Reference	If REF01=‘1D’ (Florida

			Identification	Medicaid Provider ID) See comments on associated REF01
Line Adjudication Information				
555	2430	SVD	SVD01 – Identification Code	This number should match one occurrence of the 2330B-NM109 identifying Other Payer
IG 555/ October 2002 Addenda 80	2430	SVD	SVD02 – Service Line Paid Amount	Enter the Third Party Payment Amount (TPL) at the line item level only. This will also be used for crossover detail paid amount.
Line Adjustment				
560-565	2430	CAS	CAS02, CAS05, CAS08, CAS11, CAS14, CAS17 – Adjustment Reason Code	'1' – Deductible '2' – Coinsurance Other external code source values from code source 139 are allowed.
560-565	2430	CAS	CAS03, CAS06, CAS09, CAS12, CAS15, CAS18 – Adjustment Amount	If Adjustment Group Code (CAS01)=PR and Adjustment Reason Code value is: '1' enter the Medicare Deductible Amount '2' enter the Medicare Coinsurance Amount

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