

837 Health Care Claim: Institutional

HIPAA/V4010X096A1/837: 837 Health Care Claim: Institutional

Version: 2.0 Final

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Notes:	EDI Companion Guide

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837 Health Care Claim: Institutional

Functional Group=HC

Purpose: 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.

Not Defined:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Notes</u>	<u>Usage</u>	<u>Page</u>
	ISA	Interchange Control Header	M	1			Required	5
	GS	Functional Group Header	M	1			Required	7

Heading:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Notes</u>	<u>Usage</u>	<u>Page</u>
010	BHT	Beginning of Hierarchical Transaction	M	1			Required	8

LOOP ID - 1000A					<u>1</u>	<u>N1/020L</u>		9
020	NM1	Submitter Name	O	1		N1/020	Required	10
LOOP ID - 1000B					<u>1</u>	<u>N1/020L</u>		11
020	NM1	Receiver Name	O	1		N1/020	Required	12

Detail:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Notes</u>	<u>Usage</u>	<u>Page</u>
LOOP ID - 2000A					<u>>1</u>			13
LOOP ID - 2010AA					<u>1</u>	<u>N2/015L</u>		14
015	NM1	Billing Provider Name	O	1		N2/015	Required	15
035	REF	Billing Provider Secondary Identification	O	8			Situational	16
LOOP ID - 2010AB					<u>1</u>	<u>N2/015L</u>		17
015	NM1	Pay-To Provider Name	O	1		N2/015	Situational	18
035	REF	Pay-To Provider Secondary Identification	O	5			Situational	19
LOOP ID - 2000B					<u>>1</u>			20
001	HL	Subscriber Hierarchical	M	1			Required	21

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Notes</u>	<u>Usage</u>	<u>Page</u>
		Level						
005	SBR	Subscriber Information	O	1			Required	22
LOOP ID - 2300					100			24
155	PWK	Claim Supplemental Information	O	10			Situational	25
180	REF	Claim Identification Number For Clearinghouses and Other Transmission Intermediaries	O	1			Situational	27
231	HI	Principal, Admitting, E-Code and Patient Reason For Visit Diagnosis Information	O	1			Situational	28
231	HI	Principal Procedure Information	O	1			Situational	30
231	HI	Other Procedure Information	O	2			Situational	31
240	QTY	Claim Quantity	O	4			Situational	37
LOOP ID - 2310A					1	N2/250L		39
250	NM1	Attending Physician Name	O	1		N2/250	Situational	40
271	REF	Attending Physician Secondary Identification	O	5			Situational	41
LOOP ID - 2310B					1	N2/250L		42
250	NM1	Operating Physician Name	O	1		N2/250	Situational	43
271	REF	Operating Physician Secondary Identification	O	5			Situational	44
LOOP ID - 2310C					1	N2/250L		45
250	NM1	Other Provider Name	O	1		N2/250	Situational	46
271	REF	Other Provider Secondary Identification	O	5			Situational	48
LOOP ID - 2310E					1	N2/250L		49
250	NM1	Service Facility Name	O	1		N2/250	Situational	50
271	REF	Service Facility Secondary Identification	O	5			Situational	51
LOOP ID - 2320					10	N2/290L		52
LOOP ID - 2330B					1	N2/325L		53
325	NM1	Other Payer Name	O	1		N2/325	Required	54
LOOP ID - 2400					999	N2/365L		55
375	SV2	Institutional Service Line	O	1			Required	56
LOOP ID - 2430					25	N2/540L		58
540	SVD	Service Line Adjudication Information	O	1		N2/540	Situational	59

Not Defined:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Notes</u>	<u>Usage</u>	<u>Page</u>
	GE	Functional Group Trailer	M	1			Required	61

Notes:

- 1/020L Loop 1000 contains submitter and receiver information. If any intermediary receivers change or add data in any way, then they add an occurrence to the loop as a form of identification. The added loop occurrence must be the last occurrence of the loop.
- 1/020 Loop 1000 contains submitter and receiver information. If any intermediary receivers change or add data in any way, then they add an occurrence to the loop as a form of identification. The added loop occurrence must be the last occurrence of the loop.
- 1/020L Loop 1000 contains submitter and receiver information. If any intermediary receivers change or add data in any way, then they add an occurrence to the loop as a form of identification. The added loop occurrence must be the last occurrence of the loop.
- 1/020 Loop 1000 contains submitter and receiver information. If any intermediary receivers change or add data in any way, then they add an occurrence to the loop as a form of identification. The added loop occurrence must be the last occurrence of the loop.
- 2/015L Loop 2010 contains information about entities that apply to all claims in loop 2300. For example, these entities may include billing provider, pay-to provider, insurer, primary administrator, contract holder, or claimant.
- 2/015 Loop 2010 contains information about entities that apply to all claims in loop 2300. For example, these entities may include billing provider, pay-to provider, insurer, primary administrator, contract holder, or claimant.
- 2/015L Loop 2010 contains information about entities that apply to all claims in loop 2300. For example, these entities may include billing provider, pay-to provider, insurer, primary administrator, contract holder, or claimant.
- 2/015 Loop 2010 contains information about entities that apply to all claims in loop 2300. For example, these entities may include billing provider, pay-to provider, insurer, primary administrator, contract holder, or claimant.
- 2/250L Loop 2310 contains information about the rendering, referring, or attending provider.
- 2/250 Loop 2310 contains information about the rendering, referring, or attending provider.
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- 2/250L Loop 2310 contains information about the rendering, referring, or attending provider.
- 2/250 Loop 2310 contains information about the rendering, referring, or attending provider.
- 2/290L Loop 2320 contains insurance information about: paying and other Insurance Carriers for that Subscriber, Subscriber of the Other Insurance Carriers, School or Employer Information for that Subscriber.
- 2/325L Segments NM1-N4 contain name and address information of the insurance carriers referenced in loop 2320.
- 2/325 Segments NM1-N4 contain name and address information of the insurance carriers referenced in loop 2320.
- 2/365L Loop 2400 contains Service Line information.
- 2/540L SVD01 identifies the payer which adjudicated the corresponding service line and must match DE 67 in the NM109 position 325 for the payer.
- 2/540 SVD01 identifies the payer which adjudicated the corresponding service line and must match DE 67 in the NM109 position 325 for the payer.

Molina Note 1:

Molina cannot accept a quote(") within the file either surrounding a word or phrase or single quote in the file.

Molina Note 2:

A maximum of 15MB per file can only be accepted by Molina.

ISA Interchange Control Header

Pos:	Max: 1
Not Defined - Mandatory	
Loop: N/A	Elements: 4

User Option (Usage): Required

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

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
ISA05	I05	Interchange ID Qualifier	M	ID	2/2	Required

Description: Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified

Molina Note 1:
Value "30" is required.

Code	Name
01	Duns (Dun & Bradstreet)
14	Duns Plus Suffix
20	Health Industry Number (HIN)

CODE SOURCE:
121: Health Industry Identification Number

27	Carrier Identification Number as assigned by Health Care Financing Administration (HCFA)
28	Fiscal Intermediary Identification Number as assigned by Health Care Financing Administration (HCFA)
29	Medicare Provider and Supplier Identification Number as assigned by Health Care Financing Administration (HCFA)
30	U.S. Federal Tax Identification Number
33	National Association of Insurance Commissioners Company Code (NAIC)
ZZ	Mutually Defined

ISA06	I06	Interchange Sender ID	M	AN	15/15	Required
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Description: The Sender ID is assigned by Molina for direct submitters. Please contact Molina if you have not obtained your Submitter Trading Partner ID.

All others - contact your Clearing House for this information.

Molina Note 1:
The Sender ID is assigned by Molina for direct submitters. Please contact Molina if you have not obtained your Submitter Trading Partner ID.
All others - contact your Clearing House for this information.

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

Molina Note 1:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
		<i>Molina Healthcare of New Mexico ID is: MHNM850408506</i>				
ISA14	I13	Acknowledgment Requested	M	ID	1/1	Required

Description: Zero "0" is preferred. Molina does not support the transmission of TA1, regardless of the value submitted.

Molina Note 1:

Zero "0" is preferred. Molina does not support the transmission of TA1, regardless of the value submitted.

Code Name

- 0 No Acknowledgment Requested
- 1 Interchange Acknowledgment Requested

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.

Example:

```
ISA*00*.....*01*SECRET....*ZZ*SUBMITTERS.ID..*ZZ*RECEIVERS.ID...*930602*
1253*U*00401*000000905*1*T*:~
```

GS Functional Group Header

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

User Option (Usage): Required

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

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
GS02	142	Application Sender's Code	M	AN	2/15	Required

Description: The Sender ID is assigned by Molina for direct submitters. Please contact Molina if you have not obtained your Submitter Trading Partner ID.

All others - contact your Clearing House for this information.

Molina Note 1:

The Sender ID is assigned by Molina for direct submitters. Please contact Molina if you have not obtained your Submitter Trading Partner ID.

All others - contact your Clearing House for this information.

GS03	124	Application Receiver's Code	M	AN	2/15	Required
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Description: Code identifying party receiving transmission; codes agreed to by trading partners

Molina Note 1:

Molina Healthcare of New Mexico ID is: MHNM850408506

Example:

*GS*HC*SENDER CODE*RECEIVER CODE*19940331*0802*1*X*004010X097~*

Molina Note 1:

Only "1" GS Functional Group can be accepted per file.

BHT Beginning of Hierarchical Transaction

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

User Option (Usage): Required

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

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
BHT06	640	Transaction Type Code	O	ID	2/2	Required

Description: Code specifying the type of transaction

Industry: *Claim or Encounter Identifier*

Molina Note 1:

Use CH for FEE for Service Claims submissions.

Molina Note 2:

Use RP for Encounter Submissions.

Code Name

CH Chargeable

RP Reporting

Example:

*BHT*0019*00*0123*19960618*0932*CH~*

Loop 1000A

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

User Option (Usage): Required

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

Loop Summary:

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

Notes:

1. See Section 2.4, Loop ID-1000, Data Overview, for a detailed description about using Loop ID-1000. Ignore the Set Notes below.
2. Because this is a required segment, this is a required loop. See Appendix A for further details on ASC X12 nomenclature.

Example:

NM1*41*2*ABC Submitter*****46*999999999~

NM1 Submitter Name

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

Loop Path: 1000A

User Option (Usage): Required

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

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
NM109	67	Identification Code	C	AN	2/80	Required

Description: Code identifying a party or other code

Alias: *Submitter Primary Identification Number*

Molina Note 1:

Trading Partner ID assigned by Molina.

Notes:

1. See Section 2.4, Loop ID-1000, Data Overview, for a detailed description about using Loop ID-1000. Ignore the Set Notes below.
2. Because this is a required segment, this is a required loop. See Appendix A for further details on ASC X12 nomenclature.

Example:

NM1*41*2*ABC Submitter*****46*999999999~

Loop 1000B

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

User Option (Usage): Required

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

Loop Summary:

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

Notes:

1. See Section 2.4, Loop ID-1000, Data Overview, for a detailed description about using Loop ID-1000. Ignore the Set Notes below.
2. Because this is a required segment, this is a required loop. See Appendix A for further details on ASC X12 nomenclature.

Example:

NM1*40*2*CSC HEALTHCARE*****46*112223333~

NM1 Receiver Name

Pos: 020	Max: 1
Heading - Optional	
Loop: 1000B	Elements: 2

Loop Path: 1000B

User Option (Usage): Required

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

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
NM103	1035	Name Last or Organization Name	O	AN	1/35	Required

Description: Individual last name or organizational name

Molina Note 1:

Molina Healthcare of New Mexico

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

Alias: Receiver Primary Identification Number

Molina Note 1:

Molina Healthcare of New Mexico ID is: MHNM850408506

Notes:

1. See Section 2.4, Loop ID-1000, Data Overview, for a detailed description about using Loop ID-1000. Ignore the Set Notes below.
2. Because this is a required segment, this is a required loop. See Appendix A for further details on ASC X12 nomenclature.

Example:

NM1*40*2*CSC HEALTHCARE*****46*112223333~

Loop 2000A

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

User Option (Usage): Required

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

Loop Summary:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Usage</u>
015		Loop 2010AA	O		1	Required
015		Loop 2010AB	O		1	Situational

Notes:

1. Use the Billing Provider HL to identify the original entity who submitted the electronic claim/encounter to the destination payer identified in Loop ID-2010BC. The billing provider entity may be a health care provider, a billing service, or some other representative of the provider
2. 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.
3. If the Service Facility Provider is the same entity as the Billing or the Pay-to Provider then do not use Loop 2310E.
4. If the Billing or Pay-to Provider is also the Service Facility Provider and Loop ID 2310E is not used, the Loop ID-2000 PRV must be used to indicate which entity (Billing or Pay-to) is the Service Facility Provider.
5. Because this is a required segment, this is a required loop. See Appendix A for further details on ASC X12 nomenclature.
6. 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.

Example:

HL*1**20*1~

Loop 2010AA

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

Loop Path: 2000A

User Option (Usage): Required

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

Loop Summary:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Usage</u>
015	NM1	Billing Provider Name	O	1		Required
035	REF	Billing Provider Secondary Identification	O	8		Situational

Notes:

1. Because this is a required segment, this is a required loop. See Appendix A for further details on ASC X12 nomenclature.
2. 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.

Example:

NM1*85*2*JONES HOSPITAL *****XX*45609312~

NM1 Billing Provider Name

Pos: 015	Max: 1
Detail - Optional	
Loop: 2010AA	Elements: 2

Loop Path: 2000A-2010AA

User Option (Usage): Required

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

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
NM108	66	Identification Code Qualifier	C	ID	1/2	Required

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

Molina Note 1:

If no Pay-To Loop (2010AB) submitted (Pay-to Provider is the same entity as the Billing Provider), the loop 2010AA NM108 must contain the Health Care Financing Administration National Provider Identifier value XX.

Molina Note 2:

Beginning 5/23/2008

The NPI is required in NM108 must contain XX and NM109 NPI.

Code Name

XX Health Care Financing Administration National Provider Identifier

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

Industry: Billing Provider Identifier

Molina Note 1:

NPI = 10 digit number assigned by CMS through NPPES

ExternalCodeList

Name: 537

Description: Health Care Financing Administration National Provider Identifier

Notes:

1. Because this is a required segment, this is a required loop. See Appendix A for further details on ASC X12 nomenclature.
2. 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.

Example:

NM1*85*2*JONES HOSPITAL*****XX*45609312~

REF Billing Provider Secondary Identification

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

Loop Path: 2000A-2010AA
User Option (Usage): Situational
Purpose: To specify identifying information

Element Summary:

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

Description: Code qualifying the Reference Identification

Mode: Automatic

Control: Text

Molina Note 1:

The NPI is passed in the NM108/09 of this loop, then either the Employer's Identification Number (EI) or the Social Security Number (SY) of the provider must be passed in this REF segment.

Code Name

EI Employer's Identification Number
 SY Social Security Number

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

Industry: *Billing Provider Additional Identifier*

Molina Note 1:

EIN (EI) = Tax Identification Number

SSN (SY) = Social Security Number

Notes:

1. Required when a secondary identification number is necessary to identify the entity. The primary identification number should be carried in NM109.
2. 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.
3. 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.

Example:

REF*SY*987654~

Loop 2010AB

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

Loop Path: 2000A

User Option (Usage): Situational

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

Loop Summary:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Usage</u>
015	NM1	Pay-To Provider Name	O	1		Situational
035	REF	Pay-To Provider Secondary Identification	O	5		Situational

Notes:

1. Required if the Pay-to Provider is a different entity than the Billing Provider.
2. Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 nomenclature.

Example:

NM1*87*2*ELLIS HOSPITAL*****24*123456789~

NM1 Pay-To Provider Name

Pos: 015	Max: 1
Detail - Optional	
Loop: 2010AB	Elements: 2

Loop Path: 2000A-2010AB

User Option (Usage): Situational

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

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
NM108	66	Identification Code Qualifier	C	ID	1/2	Required

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

Molina Note 1:

If Pay-To Loop (2010AB) exists (Pay-to Provider is a different entity than the Billing Provider), then loop 2010AB must have the Health Care Financing Administration National Provider Identifier.

This means NM108 must have value "XX" and NM109 - NPI.

Code Name

XX Health Care Financing Administration National Provider Identifier

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

Industry: Pay-to Provider Identifier

Molina Note 1:

NPI = 10 digit number assigned by CMS through NPPES

ExternalCodeList

Name: 537

Description: Health Care Financing Administration National Provider Identifier

Notes:

1. Required if the Pay-to Provider is a different entity than the Billing Provider.
2. Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 nomenclature.

Example:

NM1*87*2*ELLIS HOSPITAL *****24*123456789~

REF Pay-To Provider Secondary Identification

Pos: 035	Max: 5
Detail - Optional	
Loop: 2010AB	Elements: 2

Loop Path: 2000A-2010AB

User Option (Usage): Situational

Purpose: To specify identifying information

Element Summary:

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

Description: Code qualifying the Reference Identification

Molina Note 1:

The NPI is passed in the NM108/09 of this loop, then either the Employer's Identification Number (EI) or the Social Security Number (SY) of the provider must be passed in this REF segment.

Code Name

EI Employer's Identification Number
 SY Social Security Number

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

Industry: *Pay-to Provider Additional Identifier*

Molina Note 1:

EIN (EI) = Tax Identification Number
SSN (SY) = Social Security Number

Notes:

- 1. Required when a secondary identification number is necessary to identify the entity. The primary identification number should be carried in NM109.*
- 2. 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.*

Example:

*REF*1G*98765~*

Loop 2000B

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

User Option (Usage): Required

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

Loop Summary:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Usage</u>
001	HL	Subscriber Hierarchical Level	M	1		Required
005	SBR	Subscriber Information	O	1		Required
130		Loop 2300	O		100	Situational

Notes:

1. If the insured and the patient are the same person, use this HL to identify the insured/patient, skip the subsequent (PATIENT) HL, and proceed directly to Loop ID-2300.
2. The Subscriber HL contains information about the person who is listed as the subscriber/insured for the destination payer entity (Loop ID-2010BA). The Subscriber HL contains information identifying the subscriber (Loop ID-2010BA), his or her insurance (Loop ID-2010BC), and responsible party (Loop ID-2010BD). In addition, information about the credit/debit card holder is placed in this HL (Loop ID-2010BB). 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.
3. Because this is a required segment, this is a required loop. See Appendix A for further details on ASC X12 nomenclature.
4. 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.

Example:

HL *124*123*22*1~

HL Subscriber Hierarchical Level

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

Loop Path: 2000B

User Option (Usage): Required

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

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
HL04	736	Hierarchical Child Code	O	ID	1/1	Required

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

Molina Note 1:

Recommended "0" (zero). Medicaid subscriber is always the patient.

Code Name

0	No Subordinate HL Segment in This Hierarchical Structure.
1	Additional Subordinate HL Data Segment in This Hierarchical Structure.

Notes:

1. If the insured and the patient are the same person, use this HL to identify the insured/patient, skip the subsequent (PATIENT) HL, and proceed directly to Loop ID-2300.
2. The Subscriber HL contains information about the person who is listed as the subscriber/insured for the destination payer entity (Loop ID-2010BA). The Subscriber HL contains information identifying the subscriber (Loop ID-2010BA), his or her insurance (Loop ID-2010BC), and responsible party (Loop ID-2010BD). In addition, information about the credit/debit card holder is placed in this HL (Loop ID-2010BB). 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.
3. Because this is a required segment, this is a required loop. See Appendix A for further details on ASC X12 nomenclature.
4. 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.

Example:

HL*124*123*22*1~

SBR Subscriber Information

Pos: 005	Max: 1
Detail - Optional	
Loop: 2000B	Elements: 2

Loop Path: 2000B

User Option (Usage): Required

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

Element Summary:

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

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

UB-92 Ref. [UB-Name]: 50 (A-C) [Payer Identification]

51 (A-C) [Provider Number]

52 (A-C) [Release of Information Certification Indicator]

53 (A-C) [Assignment of Benefits Certification Indicator]

54 (A-C) [Prior Payments - Payers and Patient]

55 (A-C) [Estimated Amount Due]

58 (A-C) [Insured's Name]

59 (A-C) [Patient's Relationship to Insured]

60 (A-C) [Certificate/Social Security Number/Health Insurance Claim/Identification Number]

61 (A-C) [Insured Group Name]

62 (A-C) [Insurance Group Number]

63 (A-C) [Treatment Authorization Code]

64 (A-C) [Employment Status Code of the Insured]

65 (A-C) [Employer Name of the Insured]

66 (A-C) [Employer Location of the Insured]

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
		Molina Note 1:				
		<i>P = Primary when member has no other coverage, other than Molina.</i>				
		<i>S = Secondary when member has primary coverage other than Molina.</i>				
		Code Name				
		P Primary				
		S Secondary				
		T Tertiary				

SBR02	1069	Individual Relationship Code	O	ID	2/2	Situational
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Description: Code indicating the relationship between two individuals or entities

Alias: *Patients Relationship to Insured*

UB-92 Ref. [UB-Name]: 59 (A-C) [*Patient's Relationship to Insured*]

Molina Note 1:

This field must always be used and = '18'. For New Mexico Medicaid, the subscriber is always the same person as the patient. Submitters must not submit a Patient Loop. Files with Patient Loop 2000C will be rejected as not valid format.

Molina Note 2:

18 = Self. Subscriber <> patient do not use.

<u>Code</u>	<u>Name</u>
18	Self

Example:

*SBR*P**GRP01020102*****CI~*

Loop 2300

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

Loop Path: 2000B

User Option (Usage): Situational

Purpose: To specify basic data about the claim

Loop Summary:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Usage</u>
155	PWK	Claim Supplemental Information	O	10		Situational
180	REF	Claim Identification Number For Clearinghouses and Other Transmission Intermediaries	O	1		Situational
231	HI	Principal, Admitting, E-Code and Patient Reason For Visit Diagnosis Information	O	1		Situational
231	HI	Principal Procedure Information	O	1		Situational
231	HI	Other Procedure Information	O	2		Situational
240	QTY	Claim Quantity	O	4		Situational
250		Loop 2310A	O		1	Situational
250		Loop 2310B	O		1	Situational
250		Loop 2310C	O		1	Situational
250		Loop 2310E	O		1	Situational
290		Loop 2320	O		10	Situational
365		Loop 2400	O		999	Required

Notes:

- 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.*

Example:

*CLM*01319300001*500***11:A:1*Y*A*Y*Y***02*****N~*

PWK Claim Supplemental Information

Pos: 155	Max: 10
Detail - Optional	
Loop: 2300	Elements: 2

Loop Path: 2000B-2300

User Option (Usage): Situational

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

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
PWK01	755	Report Type Code	M	ID	2/2	Required

Description: Code indicating the title or contents of a document, report or supporting item

Industry: Attachment Report Type Code

Molina Note 1:

Electronic attachments are not currently supported by Molina.

Code Name

AS Admission Summary

Description: A brief patient summary; it lists the patient's chief complaints and the reasons for admitting the patient to the hospital

B2 Prescription

B3 Physician Order

B4 Referral Form

CT Certification

DA Dental Models

Description: Cast of the teeth; they are usually taken before partial dentures or braces are placed

DG Diagnostic Report

Description: Report describing the results of lab tests x-rays or radiology films

DS Discharge Summary

Description: Report listing the condition of the patient upon release from the hospital; it usually lists where the patient is being released to, what medication the patient is taking and when to follow-up with the doctor

EB Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payor)

Description: Summary of benefits paid on the claim

MT Models

NN Nursing Notes

Description: Notes kept by the nurse regarding a patient's physical and mental condition, what medication the patient is on and when it should be given

OB Operative Note

Code Name

Description: *Step-by-step notes of exactly what takes place during an operation*

OZ Support Data for Claim

Description: *Medical records that would support procedures performed; tests given and necessary for a claim*

PN Physical Therapy Notes

PO Prosthetics or Orthotic Certification

PZ Physical Therapy Certification

RB Radiology Films

Description: *X-rays, videos, and other radiology diagnostic tests*

RR Radiology Reports

Description: *Reports prepared by a radiologists after the films or x-rays have been reviewed*

RT Report of Tests and Analysis Report

PWK02 756 **Report Transmission Code** O ID 1/2 Required

Description: Code defining timing, transmission method or format by which reports are to be sent

Industry: *Attachment Transmission Code*

Molina Note 1:

Electronic attachments are not currently supported by Molina.

Code Name

AA Available on Request at Provider Site

BM By Mail

EL Electronically Only

EM E-Mail

FX By Fax

REF Claim Identification Number For Clearinghouses and Other Transmission Intermediaries

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

Loop Path: 2000B-2300

User Option (Usage): Situational

Purpose: To specify identifying information

Element Summary:

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

Description: Code qualifying the Reference Identification

Mode: Automatic

Control: Text

Molina Note 1:

Use "D9" for Clearinghouses

Code Name

D9 Claim Number

Description: *Sequence number to track the number of claims opened within a particular line of business*

Notes:

1. Used only by transmission intermediaries (Value-Added Networks, Automated Clearing Houses, and others) who need to attach their own unique claim number.
2. This number can be used to facilitate front-end acknowledgements such as the 277 Health Care Payer Unsolicited Claim Status.

Example:

REF*D9*4373649430ABES~

HI Principal, Admitting, E-Code and Patient Reason For Visit Diagnosis Information

Pos: 231	Max: 1
Detail - Optional	
Loop: 2300	Elements: 2

Loop Path: 2000B-2300

User Option (Usage): Situational

Purpose: To supply information related to the delivery of health care

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
HI01	C022	Health Care Code Information	M	Comp		Required

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

1270	Code List Qualifier Code	M	ID	1/3	Required
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Description: Code identifying a specific industry code list

Mode: Automatic

Control: Text

Molina Note 1:

Use "BK" (Principal Diagnosis)

Code Name

BK Principal Diagnosis

CODE SOURCE:

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

HI02	C022	Health Care Code Information	O	Comp		Situational
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Description: To send health care codes and their associated dates, amounts and quantities

1270	Code List Qualifier Code	M	ID	1/3	Required
------	--------------------------	---	----	-----	----------

Description: Code identifying a specific industry code list

Molina Note 1:

Use qualifier "BJ" for Inpatient Admitting Diagnosis and "ZZ" for Outpatient Admitting Diagnosis.

Code Name

BJ Admitting Diagnosis

CODE SOURCE:

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

ZZ Mutually Defined

Notes:

1. Required on all claims and encounters except claims for Religious Non-medical claims (Bill Types 4XX and 5XX) and hospital other (Bill Types 14X).

2. *The Admitting Diagnosis is required on all inpatient admission claims and encounters.*
3. *An E-Code diagnosis is required whenever a diagnosis is needed to describe an injury, poisoning or adverse effect.*
4. *The Patient Reason for Visit Diagnosis is required for all unscheduled outpatient visits.*

Example:

*HI*BK:9976~*

Molina Note 1:

At least one Diagnosis Code (Primary) must exist to accept a claim/encounter.

HI Principal Procedure Information

Pos: 231	Max: 1
Detail - Optional	
Loop: 2300	Elements: 0

Loop Path: 2000B-2300

User Option (Usage): Situational

Purpose: To supply information related to the delivery of health care

Notes:

1. Required on Home IV therapy claims or encounters when surgery was performed during the inpatient stay from which the course of therapy was initiated.
2. Required on inpatient claims or encounters when a procedure was performed.

Example:

HI*BR:92795:D8:19980321~

Molina Note 1:

Section 45 CFR 162.1002(e) of the Federal Regulations re: HIPAA restricts the use of ICD-9-CM procedure codes to the reporting of inpatient procedures by hospitals. Therefore, the value for HI01-1 cannot be "BR" unless the claim has an inpatient bill type.

HI Other Procedure Information

Pos: 231	Max: 2
Detail - Optional	
Loop: 2300	Elements: 12

Loop Path: 2000B-2300

User Option (Usage): Situational

Purpose: To supply information related to the delivery of health care

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
HI01	C022	Health Care Code Information	M	Comp		Required
		Description: To send health care codes and their associated dates, amounts and quantities				
	1270	Code List Qualifier Code	M	ID	1/3	Required
		Description: Code identifying a specific industry code list				
		Mode: Automatic				
		Control: Text				
		Molina Note 1:				
		<i>If used value BQ is required.</i>				
		Code Name				
		BO Health Care Financing Administration Common Procedural Coding System				
		CODE SOURCE:				
		<i>130: Health Care Financing Administration Common Procedural Coding System</i>				
		BQ International Classification of Diseases Clinical Modification (ICD-9-CM) Procedure				
		CODE SOURCE:				
		<i>131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure</i>				
	1271	Industry Code	M	AN	1/30	Required
		Description: Code indicating a code from a specific industry code list				
		Industry: Procedure Code				
		UB-92 Ref. [UB-Name]: 81 (A-E) [Other Procedure Codes and Dates]				
		Molina Note 1:				
		<i>If HI01-1 is BQ then this fiels is used.</i>				
		ExternalCodeList				
		Name: 130				
		Description: Health Care Financing Administration Common Procedural Coding System				
		ExternalCodeList				
		Name: 131P				
		Description: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure				
HI02	C022	Health Care Code Information	O	Comp		Situational
		Description: To send health care codes and their associated dates, amounts and quantities				

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
	1270	Code List Qualifier Code	M	ID	1/3	Required

Description: Code identifying a specific industry code list

Molina Note 1:

If used value BQ required.

Code Name

BO Health Care Financing Administration Common Procedural Coding System

CODE SOURCE:

130: Health Care Financing Administration Common Procedural Coding System

BQ International Classification of Diseases Clinical Modification (ICD-9-CM) Procedure

CODE SOURCE:

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

HI03	C022	Health Care Code Information	O	Comp		Situational
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Description: To send health care codes and their associated dates, amounts and quantities

	1270	Code List Qualifier Code	M	ID	1/3	Required
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Description: Code identifying a specific industry code list

Molina Note 1:

If used value BQ required.

Code Name

BO Health Care Financing Administration Common Procedural Coding System

CODE SOURCE:

130: Health Care Financing Administration Common Procedural Coding System

BQ International Classification of Diseases Clinical Modification (ICD-9-CM) Procedure

CODE SOURCE:

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

HI04	C022	Health Care Code Information	O	Comp		Situational
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Description: To send health care codes and their associated dates, amounts and quantities

	1270	Code List Qualifier Code	M	ID	1/3	Required
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Description: Code identifying a specific industry code list

Molina Note 1:

If used value BQ required.

Code Name

BO Health Care Financing Administration Common Procedural Coding System

CODE SOURCE:

130: Health Care Financing Administration Common Procedural

Code Name

Coding System

BQ International Classification of Diseases Clinical Modification (ICD-9-CM) Procedure

CODE SOURCE:

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

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

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

1270 **Code List Qualifier Code** M ID 1/3 Required

Description: Code identifying a specific industry code list

Molina Note 1:

If used value BQ required.

Code Name

BO Health Care Financing Administration Common Procedural Coding System

CODE SOURCE:

130: Health Care Financing Administration Common Procedural Coding System

BQ International Classification of Diseases Clinical Modification (ICD-9-CM) Procedure

CODE SOURCE:

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

HI06 C022 **Health Care Code Information** O Comp Situational

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

1270 **Code List Qualifier Code** M ID 1/3 Required

Description: Code identifying a specific industry code list

Molina Note 1:

If used value BQ required.

Code Name

BO Health Care Financing Administration Common Procedural Coding System

CODE SOURCE:

130: Health Care Financing Administration Common Procedural Coding System

BQ International Classification of Diseases Clinical Modification (ICD-9-CM) Procedure

CODE SOURCE:

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

HI07 C022 **Health Care Code Information** O Comp Situational

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

1270 **Code List Qualifier Code** M ID 1/3 Required

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
		Description: Code identifying a specific industry code list				
		Molina Note 1: <i>If used value BQ required.</i>				
		Code Name				
	BO	Health Care Financing Administration Common Procedural Coding System				
		CODE SOURCE: <i>130: Health Care Financing Administration Common Procedural Coding System</i>				
	BQ	International Classification of Diseases Clinical Modification (ICD-9-CM) Procedure				
		CODE SOURCE: <i>131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure</i>				
HI08	C022	Health Care Code Information	O	Comp		Situational
		Description: To send health care codes and their associated dates, amounts and quantities				
	1270	Code List Qualifier Code	M	ID	1/3	Required
		Description: Code identifying a specific industry code list				
		Molina Note 1: <i>If used value BQ required.</i>				
		Code Name				
	BO	Health Care Financing Administration Common Procedural Coding System				
		CODE SOURCE: <i>130: Health Care Financing Administration Common Procedural Coding System</i>				
	BQ	International Classification of Diseases Clinical Modification (ICD-9-CM) Procedure				
		CODE SOURCE: <i>131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure</i>				
HI09	C022	Health Care Code Information	O	Comp		Situational
		Description: To send health care codes and their associated dates, amounts and quantities				
	1270	Code List Qualifier Code	M	ID	1/3	Required
		Description: Code identifying a specific industry code list				
		Molina Note 1: <i>If used value BQ required.</i>				
		Code Name				
	BO	Health Care Financing Administration Common Procedural Coding System				
		CODE SOURCE: <i>130: Health Care Financing Administration Common Procedural Coding System</i>				

Code Name

BQ International Classification of Diseases Clinical Modification (ICD-9-CM) Procedure

CODE SOURCE:

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

HI10 C022 **Health Care Code Information** O Comp Situational

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

1270 **Code List Qualifier Code** M ID 1/3 Required

Description: Code identifying a specific industry code list

Molina Note 1:

If used value BQ required.

Code Name

BO Health Care Financing Administration Common Procedural Coding System

CODE SOURCE:

130: Health Care Financing Administration Common Procedural Coding System

BQ International Classification of Diseases Clinical Modification (ICD-9-CM) Procedure

CODE SOURCE:

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

HI11 C022 **Health Care Code Information** O Comp Situational

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

1270 **Code List Qualifier Code** M ID 1/3 Required

Description: Code identifying a specific industry code list

Molina Note 1:

If used value BQ required.

Code Name

BO Health Care Financing Administration Common Procedural Coding System

CODE SOURCE:

130: Health Care Financing Administration Common Procedural Coding System

BQ International Classification of Diseases Clinical Modification (ICD-9-CM) Procedure

CODE SOURCE:

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

HI12 C022 **Health Care Code Information** O Comp Situational

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

1270 **Code List Qualifier Code** M ID 1/3 Required

Description: Code identifying a specific industry code list

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
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Molina Note 1:

If used value BQ required.

Code Name

BO Health Care Financing Administration Common Procedural Coding System

CODE SOURCE:

130: Health Care Financing Administration Common Procedural Coding System

BQ International Classification of Diseases Clinical Modification (ICD-9-CM) Procedure

CODE SOURCE:

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

Notes:

- 1. Required on Home IV therapy claims or encounters when surgery was performed during the inpatient stay from which the course of therapy was initiated.*
- 2. Required on inpatient claims or encounters when additional procedures must be reported.*

Example:

*HI*BQ:92795:D8:19980321~*

QTY Claim Quantity

Pos: 240	Max: 4
Detail - Optional	
Loop: 2300	Elements: 2

Loop Path: 2000B-2300

User Option (Usage): Situational

Purpose: To specify quantity information

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
QTY01	673	Quantity Qualifier	M	ID	2/2	Required

Description: Code specifying the type of quantity

Molina Note 1:

Valid values are CA of NA.

Code Name

CA Covered - Actual

Description: *Days covered on this service*

UB-92 Ref. [UB-Name]:

7 [Covered Days]

CD Co-insured - Actual

UB-92 Ref. [UB-Name]:

9 [Coinsurance Days]

LA Life-time Reserve - Actual

Description: *Medicare hospital insurance includes extra hospital days to be used if the patient has a long illness and is required to stay in the hospital over a specified number of days; this is the actual number of days in reserve*

UB-92 Ref. [UB-Name]:

10 [Lifetime Reserve Days]

NA Number of Non-covered Days

UB-92 Ref. [UB-Name]:

8 [Non-Covered Days]

QTY02	380	Quantity	C	R	1/15	Required
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Description: Numeric value of quantity

Industry: *Claim Days Count*

Molina Note 1:

If QTY01 values are CA of NA then this field is used.

Notes:

1. Use the Quantity segment at the claim level Loop ID-2300 to transmit quantities that apply to the entire claim.
2. Required on Inpatient claims or encounters when covered, co-insured, life-time reserved or non-covered days are being reported.

Example:

QTY*LA*20*DA~

Loop 2310A

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

Loop Path: 2000B-2300

User Option (Usage): Situational

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

Loop Summary:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Usage</u>
250	NM1	Attending Physician Name	O	1		Situational
271	REF	Attending Physician Secondary Identification	O	5		Situational

Notes:

1. Information in Loop ID-2310 applies to the entire claim unless it is overridden on a service line by the presence of Loop ID-2420 with the same value in NM101.
2. Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 nomenclature.
3. Required on all inpatient claims or encounters.
4. Required to indicate the Primary Physician responsible on a Home Health Agency Plan of Treatment.

Example:

NM1*71*1*JONES*JOHN****XX*12345678~

NM1 Attending Physician Name

Pos: 250	Max: 1
Detail - Optional	
Loop: 2310A	Elements: 2

Loop Path: 2000B-2300-2310A

User Option (Usage): Situational

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

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
NM108	66	Identification Code Qualifier	C	ID	1/2	Required

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

Molina Note 1:

Beginning 5/23/2008

The NPI is required in NM108 must contain XX and NM109 NPI.

Code Name

XX Health Care Financing Administration National Provider Identifier

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

Industry: *Attending Physician Primary Identifier*

UB-92 Ref. [UB-Name]: 82, Line a [Attending Physician ID]

Molina Note 1:

NPI = 10 digit number assigned by CMS through NPPES

ExternalCodeList

Name: 537

Description: Health Care Financing Administration National Provider Identifier

Notes:

1. Information in Loop ID-2310 applies to the entire claim unless it is overridden on a service line by the presence of Loop ID-2410 with the same value in NM101.
2. Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 nomenclature.
3. Required on all inpatient claims or encounters.
4. Required to indicate the Primary Physician responsible on a Home Health Agency Plan of Treatment.

Example:

NM1*71*1*JONES*JOHN****XX*12345678~

REF Attending Physician Secondary Identification

Pos: 271	Max: 5
Detail - Optional	
Loop: 2310A	Elements: 2

Loop Path: 2000B-2300-2310A

User Option (Usage): Situational

Purpose: To specify identifying information

Element Summary:

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

Description: Code qualifying the Reference Identification

Molina Note 1:

The NPI is passed in the NM108/09 of this loop, then either the Employer's Identification Number (EI) or the Social Security Number (SY) of the provider must be passed in this REF segment.

Code Name

EI Employer's Identification Number
SY Social Security Number

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

Industry: *Attending Physician Secondary Identifier*

Molina Note 1:

EIN (EI) = Tax Identification Number
SSN (SY) = Social Security Number

Notes:

1. Use this REF only when a second number is necessary to identify the provider. The primary identification must be contained in NM109.

Example:

REF*1G*A12345~

Loop 2310B

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

Loop Path: 2000B-2300

User Option (Usage): Situational

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

Loop Summary:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Usage</u>
250	NM1	Operating Physician Name	O	1		Situational
271	REF	Operating Physician Secondary Identification	O	5		Situational

Notes:

1. Information in Loop ID-2310 applies to the entire claim unless it is overridden on a service line by the presence of Loop ID-2420 with the same value in NM101.
2. This segment is required when any surgical procedure code is listed on this claim.
3. 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 nomenclature.

Example:

NM1*72*1*MEYERS*JANE****XX*12345678~

NM1 Operating Physician Name

Pos: 250	Max: 1
Detail - Optional	
Loop: 2310B	Elements: 2

Loop Path: 2000B-2300-2310B

User Option (Usage): Situational

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

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
NM108	66	Identification Code Qualifier	C	ID	1/2	Required

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

Molina Note 1:

Beginning 5/23/2008

The NPI is required in NM108 must contain XX and NM109 NPI.

Code Name

XX Health Care Financing Administration National Provider Identifier

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

Industry: *Operating Physician Primary Identifier*

UB-92 Ref. [UB-Name]: 83A, Line a [Other Physician ID]

Molina Note 1:

NPI = 10 digit number assigned by CMS through NPPES

ExternalCodeList

Name: 537

Description: Health Care Financing Administration National Provider Identifier

Notes:

1. Information in Loop ID-2310 applies to the entire claim unless it is overridden on a service line by the presence of Loop ID-2410 with the same value in NM101.
2. This segment is required when any surgical procedure code is listed on this claim.
3. 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 nomenclature.

Example:

NM1*72*1*MEYERS*JANE****XX*12345678~

REF Operating Physician Secondary Identification

Pos: 271	Max: 5
Detail - Optional	
Loop: 2310B	Elements: 2

Loop Path: 2000B-2300-2310B

User Option (Usage): Situational

Purpose: To specify identifying information

Element Summary:

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

Description: Code qualifying the Reference Identification

Molina Note 1:

The NPI is passed in the NM108/09 of this loop, then either the Employer's Identification Number (EI) or the Social Security Number (SY) of the provider must be passed in this REF segment.

Code Name

EI Employer's Identification Number
SY Social Security Number

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

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

Industry: *Operating Physician Secondary Identifier*

Molina Note 1:

EIN (EI) = Tax Identification Number
SSN (SY) = Social Security Number

Notes:

1. Use this REF only when a second number is necessary to identify the provider. The primary identification must be contained in NM109.

Example:

REF*1G*A12345~

Loop 2310C

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

Loop Path: 2000B-2300

User Option (Usage): Situational

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

Loop Summary:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Usage</u>
250	NM1	Other Provider Name	O	1		Situational
271	REF	Other Provider Secondary Identification	O	5		Situational

Notes:

1. Information in Loop ID-2310 applies to the entire claim unless it is overridden on a service line by the presence of Loop ID-2420 with the same value in NM101.
2. Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 nomenclature.
3. Required when the claim/encounter involves an other provider such as, but not limited to: Referring Provider, Ordering Provider, Assisting Provider, etc.

Example:

NM1*73*1*DOE*JOHN*A***34*201749586~

NM1 Other Provider Name

Pos: 250	Max: 1
Detail - Optional	
Loop: 2310C	Elements: 2

Loop Path: 2000B-2300-2310C

User Option (Usage): Situational

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

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
NM108	66	Identification Code Qualifier	C	ID	1/2	Required

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

Molina Note 1:

Beginning 5/23/2008

The NPI is required in NM108 must contain XX and NM109 NPI.

Code Name

XX Health Care Financing Administration National Provider Identifier

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

Industry: *Other Physician Identifier*

UB-92 Ref. [UB-Name]: 83B, Line a [Other Physician ID]

Molina Note 1:

NPI = 10 digit number assigned by CMS through NPPES

ExternalCodeList

Name: 537

Description: Health Care Financing Administration National Provider Identifier

Notes:

1. Information in Loop ID-2310 applies to the entire claim unless it is overridden on a service line by the presence of Loop ID-2410 with the same value in NM101.
2. Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 nomenclature.
3. Required on all outpatient and home health claims/encounters to indicate the person or organization (Home Health Agency) who rendered the care. In the case where a substitute provider (locum tenans) was used, that person should be entered here. Required when the Other Provider NM1 information is different than that carried in either the Billing Provider NM1 or the Pay-to Provider in the 2010AA/AB loops.
4. Required on non-outpatient (e.g inpatient, SNF, ICF etc.) claims or encounters to indicate the physician who rendered service for the principal procedure if other than the operating physician reported in Loop 2310B. Not required on non-outpatient claims or encounters if no principal procedure was performed.

Example:

*NM1*73*1*DOE*JOHN*A***34*201749586~*

REF Other Provider Secondary Identification

Pos: 271	Max: 5
Detail - Optional	
Loop: 2310C	Elements: 2

Loop Path: 2000B-2300-2310C

User Option (Usage): Situational

Purpose: To specify identifying information

Element Summary:

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

Description: Code qualifying the Reference Identification

Molina Note 1:

The NPI is passed in the NM108/09 of this loop, then either the Employer's Identification Number (EI) or the Social Security Number (SY) of the provider must be passed in this REF segment.

Code Name

EI Employer's Identification Number
 SY Social Security Number

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

Industry: *Other Provider Secondary Identifier*

Molina Note 1:

EIN (EI) = Tax Identification Number
SSN (SY) = Social Security Number

Notes:

1. Use this REF only when a second number is necessary to identify the provider. The primary identification must be contained in NM109.

Example:

REF*1G*A12345~

Loop 2310E

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

Loop Path: 2000B-2300

User Option (Usage): Situational

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

Loop Summary:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Usage</u>
250	NM1	Service Facility Name	O	1		Situational
271	REF	Service Facility Secondary Identification	O	5		Situational

Notes:

1. Information in Loop ID-2310 applies to the entire claim unless overridden on a service line by the presence of Loop ID-2420 with the same value in NM101.
2. Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 nomenclature.
3. This loop is required when the location of health care service is different than that carried in the 2010AA (Billing Provider) or 2010AB (Pay-to Provider) loops.

Example:

NM1*FA*2*Rehab Facility*****XX*12345678~

NM1 Service Facility Name

Pos: 250	Max: 1
Detail - Optional	
Loop: 2310E	Elements: 2

Loop Path: 2000B-2300-2310E

User Option (Usage): Situational

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

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
NM108	66	Identification Code Qualifier	C	ID	1/2	Situational

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

Molina Note 1:

Beginning 5/23/2008

The NPI is required in NM108 must contain XX and NM109 NPI.

Code Name

XX Health Care Financing Administration National Provider Identifier

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

Industry: *Laboratory or Facility Primary Identifier*

Molina Note 1:

NPI = 10 digit number assigned by CMS through NPPES

ExternalCodeList

Name: 537

Description: Health Care Financing Administration National Provider Identifier

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 nomenclature.
- This loop is required when the location of health care service is different than that carried in the 2010AA (Billing Provider) or 2010AB (Pay-to Provider) loops.

Example:

NM1*FA*2*Rehab Facility*****XX*12345678~

REF Service Facility Secondary Identification

Pos: 271	Max: 5
Detail - Optional	
Loop: 2310E	Elements: 2

Loop Path: 2000B-2300-2310E

User Option (Usage): Situational

Purpose: To specify identifying information

Element Summary:

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

Description: Code qualifying the Reference Identification

Molina Note 1:

The NPI is passed in the NM108/09 of this loop, then the Federal Taxpayer's Identification Number (TJ) of the provider must be passed in this REF segment.

Code Name

TJ Federal Taxpayer's Identification Number

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

Industry: *Laboratory or Facility Secondary Identifier*

Molina Note 1:

(TJ) = Federal Taxpayer's Identification Number

Notes:

1. Use this REF only when a second number is necessary to identify the provider. The primary identification must be contained in NM109.

Example:

REF*1G*A12345~

Loop 2320

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

Loop Path: 2000B-2300

User Option (Usage): Situational

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

Loop Summary:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Usage</u>
325		Loop 2330B	O		1	Required

Notes:

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

Example:

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

Loop 2330B

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

Loop Path: 2000B-2300-2320

User Option (Usage): Required

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

Loop Summary:

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

Notes:

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

Example:

NM1*PR*2*UNION MUTUAL OF OREGON*****PI*43140~

NM1 Other Payer Name

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

Loop Path: 2000B-2300-2320-2330B

User Option (Usage): Required

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

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
NM109	67	Identification Code	C	AN	2/80	Required

Description: Code identifying a party or other code

Industry: *Other Payer Primary Identifier*

Molina Note 1:

Valid payor ID number required if available. If no payor ID number is available, please use the name of the payor. (e.g. "MEDICARE" or other payor name as appropriate.) Use of all zeroes or all spaces is invalid.

ExternalCodeList

Name: 540

Description: Health Care Financing Administration National PlanID

Notes:

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

Example:

NM1*PR*2*UNION MUTUAL OF OREGON*****PI*43140~

Loop 2400

Pos: 365 Repeat: 999
 Optional
 Loop: 2400 Elements: N/A

Loop Path: 2000B-2300

User Option (Usage): Required

Purpose: To reference a line number in a transaction set

Loop Summary:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Usage</u>
375	SV2	Institutional Service Line	O	1		Required
540		Loop 2430	O		25	Situational

Notes:

1. The Service Line LX segment begins with 1 and is incremented by one for each additional service line of a claim. The LX functions as a line counter.
2. The data in the LX is not returned in the 835 (Remittance Advice) transaction. It is used to indicate bundling/unbundling in SVC06.
3. Because this is a required segment, this is a required loop. See Appendix A for further details on ASC X12 nomenclature.

Example:

LX*1~

SV2 Institutional Service Line

Pos: 375	Max: 1
Detail - Optional	
Loop: 2400	Elements: 2

Loop Path: 2000B-2300-2400

User Option (Usage): Required

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

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
SV202	C003	Composite Medical Procedure Identifier	C	Comp		Situational

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

Alias: *Service Line Procedure Code*

UB-92 Ref. [UB-Name]: *44 (HCPCS) [HCPCS/Rates/HIPPS Rate Codes]*

235	Product/Service ID Qualifier	M	ID	2/2	Required
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Description: Code identifying the type/source of the descriptive number used in Product/Service ID (234)

Industry: *Product or Service ID Qualifier*

Molina Note 1:

If SV202 is used, then value HC is required.

Code Name

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

Description: *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*

CODE SOURCE:

130: Health Care Financing Administration Common Procedural Coding System

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

CODE SOURCE:

513: Home Infusion EDI Coalition (HIEC) Product/Service Code List

ZZ Mutually Defined

SV203	782	Monetary Amount	O	R	1/18	Situational
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Description: Monetary amount

Industry: *Line Item Charge Amount*

UB-92 Ref. [UB-Name]: *47 [Total Charges (by Revenue Code Category)]*

Molina Note 1:

When submitting charges, charge is a whole number do not submit

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
		<i>with trailing zeros (example: 2315 = \$2315.00)</i>				
		Molina Note 2:				
		<i>When submitting charges, charge has dollars with cents, submit with decimal to separate (example: 23.15 = \$23.15)</i>				
		Molina Note 3:				
		<i>Monetary Amount, enter 0 if dollars billed are included in other procedure(s).</i>				

Notes:

1. This segment is required for inpatient claims or outpatient or other claims that require procedure or drug information to be reported for claim adjudication.

Example:

SV2*300*HC:80019*73.42*UN*1~
 SV2*120**1500*DA*5*300~

Molina Note 1:

A maximum of 1-50 line segments are allowed per single claim.

Loop 2430

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

Loop Path: 2000B-2300-2400

User Option (Usage): Situational

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

Loop Summary:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Usage</u>
540	SVD	Service Line Adjudication Information	O	1		Situational

Notes:

1. Required if claim has been previously adjudicated by payer identified in Loop 2330B and service line has adjustments applied to it.
2. Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 nomenclature.
3. To show unbundled lines: if in the original claim, line 3 is unbundled into lines numbers 8 and 9, then in the secondary claim, LX08 would show 3 in SVD06 and LX09 would also show 3 in SVD06. This indicates that line 3 was unbundled into lines 8 and 9.
4. 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.

Example:

SVD*NR002*50.5**0305*1~

SVD Service Line Adjudication Information

Pos: 540	Max: 1
Detail - Optional	
Loop: 2430	Elements: 3

Loop Path: 2000B-2300-2400-2430

User Option (Usage): Situational

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

Element Summary:

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

Description: Code identifying a party or other code

Industry: *Payer Identifier*

Molina Note 1:

Valid payor ID number required if available. If no payor ID number is available, please use the name of the payor. (e.g. "Medicare" or the payor name as appropriate.) Use of all zeros or all spaces is invalid.

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

Industry: *Service Line Paid Amount*

Alias: *Service Line Amount Paid*

Molina Note 1:

When submitting prior paid information, paid amount is a whole number do not submit with trailing zeros (example: 2315 = \$2315.00)

Molina Note 2:

When submitting prior paid information, paid amount has dollars with cents, submit with decimal to separate (example: 23.15 = \$23.15)

Molina Note 3:

Monetary Amount, enter 0 if prior paid dollars are included in other procedure(s).

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

235	Product/Service ID Qualifier	M	ID	2/2	Required
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Description: Code identifying the type/source of the descriptive number used in Product/Service ID (234)

Industry: *Product or Service ID Qualifier*

Molina Note 1:

If SVD03 is used, then value HC is required.

Code Name

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

Description: *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*

CODE SOURCE:

130: Health Care Financing Administration Common Procedural Coding System

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

CODE SOURCE:

513: Home Infusion EDI Coalition (HIEC) Product/Service Code List

ZZ Mutually Defined

Notes:

1. Required if claim has been previously adjudicated by payer identified in Loop 2330B and service line has adjustments applied to it.
2. Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 nomenclature.
3. To show unbundled lines: if in the original claim, line 3 is unbundled into lines numbers 8 and 9, then in the secondary claim, LX08 would show 3 in SVD06 and LX09 would also show 3 in SVD06. This indicates that line 3 was unbundled into lines 8 and 9.
4. 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.

Example:

*SVD*NR002*50.5**0305*1~*

GE Functional Group Trailer

Pos:	Max: 1
Not Defined - Mandatory	
Loop: N/A	Elements: 0

User Option (Usage): Required

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

Example:

*GE*1*1~*

Molina Note 1:

Only "1" GE Functional Group can be accepted per file.