

837 Health Care Claim: Professional

HIPAA/V4010X098A1/837: 837 Health Care Claim: Professional

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Notes:	EDI Companion Guide

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837 Health Care Claim: Professional

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	6
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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	9

LOOP ID - 1000A					1	N1/020L		10
020	NM1	Submitter Name	O	1		N1/020	Required	11
LOOP ID - 1000B					1	N1/020L		12
020	NM1	Receiver Name	O	1		N1/020	Required	13

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					>1			14
003	PRV	Billing/Pay-to Provider Specialty Information	O	1			Situational	15
LOOP ID - 2010AA					1	N2/015L		16
015	NM1	Billing Provider Name	O	1		N2/015	Required	17
035	REF	Billing Provider Secondary Identification	O	8			Situational	18
LOOP ID - 2010AB					1	N2/015L		19
015	NM1	Pay-to Provider Name	O	1		N2/015	Situational	20
035	REF	Pay-to-Provider Secondary Identification	O	5			Situational	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>
LOOP ID - 2000B						>1		22
001	HL	Subscriber Hierarchical Level	M	1			Required	23
005	SBR	Subscriber Information	O	1			Required	24
LOOP ID - 2010BA						1	N2/015L	26
015	NM1	Subscriber Name	O	1		N2/015	Required	27
LOOP ID - 2300						100		28
130	CLM	Claim Information	O	1			Required	29
155	PWK	Claim Supplemental Information	O	10			Situational	30
180	REF	Claim Identification Number for Clearing Houses and Other Transmission Intermediaries	O	1			Situational	32
195	CR1	Ambulance Transport Information	O	1		N2/195	Situational	33
220	CRC	EPSDT Referral	O	1			Required	34
231	HI	Health Care Diagnosis Code	O	1			Situational	35
LOOP ID - 2310A						2	N2/250L	36
250	NM1	Referring Provider Name	O	1		N2/250	Situational	37
271	REF	Referring Provider Secondary Identification	O	5			Situational	39
LOOP ID - 2310B						1	N2/250L	40
250	NM1	Rendering Provider Name	O	1		N2/250	Situational	41
271	REF	Rendering Provider Secondary Identification	O	5			Situational	42
LOOP ID - 2310C						1	N2/250L	43
250	NM1	Purchased Service Provider Name	O	1		N2/250	Situational	44
271	REF	Purchased Service Provider Secondary Identification	O	5			Situational	45
LOOP ID - 2310D						1	N2/250L	46
250	NM1	Service Facility Location	O	1		N2/250	Situational	47
265	N3	Service Facility Location Address	O	1			Required	49
271	REF	Service Facility Location Secondary Identification	O	5			Situational	50
LOOP ID - 2310E						1	N2/250L	51
250	NM1	Supervising Provider Name	O	1		N2/250	Situational	52
271	REF	Supervising Provider Secondary Identification	O	5			Situational	53
LOOP ID - 2320						10	N2/290L	54
290	SBR	Other Subscriber	O	1		N2/290	Situational	55

<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>
Information								
LOOP ID - 2400					50	<u>N2/365L</u>		56
370	SV1	Professional Service	O	1			Required	57
450	CRC	Hospice Employee Indicator	O	1			Situational	60
455	DTP	Date - Service Date	O	1			Required	61
LOOP ID - 2410					25	<u>N2/494L</u>		62
494	LIN	Drug Identification	O	1		N2/494	Situational	63
495	CTP	Drug Pricing	O	1			Situational	64
LOOP ID - 2430					25	<u>N2/540L</u>		65
540	SVD	Line Adjudication Information	O	1		N2/540	Situational	66

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	67

Notes:

- 1/020L Loop 1000 contains submitter and receiver information. If any intermediary receivers change or add data in any way, then they add an occurrence to the loop as a form of identification. The added loop occurrence must be the last occurrence of the loop.
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- 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.
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- 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.
- 2/195 The CR1 through CR5 and CRC certification segments appear on both the claim level and the service line level because certifications can be submitted for all services on a claim or for individual services. Certification information at the claim level applies to all service lines of the claim, unless overridden by certification information at the service line level.

- 2/250L 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.
- 2/290 Loop 2320 contains insurance information about: paying and other Insurance Carriers for that Subscriber, Subscriber of the Other Insurance Carriers, School or Employer Information for that Subscriber.
- 2/365L Loop 2400 contains Service Line information.
- 2/494L Loop 2410 contains compound drug components, quantities and prices.
- 2/494 Loop 2410 contains compound drug components, quantities and prices.
- 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: 3

User Option (Usage): Required

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

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
ISA06	I06	Interchange Sender ID	M	AN	15/15	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.

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:

Molina Healthcare of Ohio ID is: MHO200750134

ISA14	I13	Acknowledgment Requested	M	ID	1/1	Required
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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 Ohio ID is: MHO200750134

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*

Alias: *Claim or Encounter Indicator*

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

Notes:

1. The second example denotes the case where the entire transaction set contains ENCOUNTERS.

Example:

*BHT*0019*00*0123*19970618*0932*CH~*
*BHT*0019*00*44445*19970213*0345*RP~*

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. The example in this NM1 and the subsequent N2 demonstrate how a name that is more than 35 characters long could be handled between the NM1 and N2 segments.
2. See Section 2.4, Loop ID-1000, Data Overview, for a detailed description about using Loop ID-1000. Ignore the Set Notes below.
3. Because this is a required segment, this is a required loop. See Appendix A for further details on ASC X12 syntax rules.

Example:

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

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:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
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. The example in this NM1 and the subsequent N2 demonstrate how a name that is more than 35 characters long could be handled between the NM1 and N2 segments.
2. See Section 2.4, Loop ID-1000, Data Overview, for a detailed description about using Loop ID-1000. Ignore the Set Notes below.
3. Because this is a required segment, this is a required loop. See Appendix A for further details on ASC X12 syntax rules.

Example:

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

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

Example:

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

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:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
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 Ohio

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 Ohio ID is: MHO200750134

Notes:

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

Example:

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

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>
003	PRV	Billing/Pay-to Provider Specialty Information	O	1		Situational
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-2010BB. The billing provider entity may be a health care provider, a billing service, or some other representative of the provider.
2. The NSF fields shown in Loop ID-2010AA and Loop ID-2010AB are intended to carry billing provider information, not billing service information. Refer to your NSF manual for proper use of these fields. If Loop 2010AA contains information on a billing service (rather than a billing provider), do not map the information in that loop to the NSF billing provider fields for Medicare claims.
3. 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.
4. Because this is a required segment, this is a required loop. See Appendix A for further details on ASC X12 syntax rules.
5. 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.
6. If the Billing or Pay-to Provider is also the Rendering Provider and Loop ID-2310A is not used, the Loop ID-2000 PRV must be used to indicate which entity (Billing or Pay-to) is the Rendering Provider.

Example:

HL*1**20*1~

PRV Billing/Pay-to Provider Specialty Information

Pos: 003	Max: 1
Detail - Optional	
Loop: 2000A	Elements: 1

Loop Path: 2000A

User Option (Usage): Situational

Purpose: To specify the identifying characteristics of a provider

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
PRV01	1221	Provider Code	M	ID	1/3	Required

Description: Code identifying the type of provider

Molina Note 1:

Enter "BI" if loop 2010AB or 2310B are not completed. Enter "PT" or "BI", (whichever is applicable) if both the 2010AA and 2010AB loops are submitted and the 2310B is not completed.

Code	Name
BI	Billing
PT	Pay-To

Notes:

1. Required when adjudication is known to be impacted by the provider taxonomy code, and the Rendering Provider is the same entity as the Billing and/or Pay-to Provider. In these cases, the Rendering Provider is being identified at this level for all subsequent claims/encounters in this HL and Loop ID-2310B is not used.
2. This PRV is not used when the Billing or Pay-to Provider is a group and the individual Rendering Provider is in loop 2310B. The PRV segment is then coded with the Rendering Provider in loop 2310B.
3. PRV02 qualifies PRV03.

Example:

PRV*BI*ZZ*203BA050N~

Molina Note 1:

When the billing or "Pay To" provider is a professional group practice the 2310B loop must be completed. For ODJFS, adjudication is not impacted by the taxonomy number.

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

Example:

NM1*85*2*CRAMMER, DOLE, PALMER, AND JOHNSON****24*111223333~

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

Example:

NM1*85*2*CRAMMER, DOLE, PALMER, AND JOHNSON*****24*111223333~

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

Industry: Billing Provider Additional Identifier

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 NM108/9 in this loop.
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*1G*98765~

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 syntax rules.

Example:

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

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:

Provider Tax ID or Provider Social Security Number.

Molina Note 2:

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 syntax rules.

Example:

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

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 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 in this loop.
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
015		Loop 2010BA	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-2010BB), and responsible party (Loop ID-2010BC). In addition, information about the credit/debit card holder is placed in this HL (Loop ID-2010BD). The credit/debit card holder may or may not be the subscriber. See Appendix G, Credit/Debit Card Use, for a description of using Loop ID-2010BD.
3. Because this is a required segment, this is a required loop. See Appendix A for further details on ASC X12 syntax rules.
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 *2*1*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-2010BB), and responsible party (Loop ID-2010BC). In addition, information about the credit/debit card holder is placed in this HL (Loop ID-2010BD). The credit/debit card holder may or may not be the subscriber. See Appendix G, Credit/Debit Card Use, for a description of using Loop ID-2010BD.
3. Because this is a required segment, this is a required loop. See Appendix A for further details on ASC X12 syntax rules.
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*2*1*22*1~

SBR Subscriber Information

Pos: 005	Max: 1
Detail - Optional	
Loop: 2000B	Elements: 3

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:

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

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

Molina Note 1:

P = Primary when member has no other coverage, other than Molina.

S = Secondary when member has primary coverage other than Molina.

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

Molina Note 1:

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

Code Name

- 18 Self

SBR09	1032	Claim Filing Indicator Code	O	ID	1/2	Situational
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Description: Code identifying type of claim

Alias: *Claim Filing Indicator Code*

Molina Note 1:

Since Medicaid is the destination payer "MC" is required.

Code Name

- 09 Self-pay
- 10 Central Certification
- 11 Other Non-Federal Programs
- 12 Preferred Provider Organization (PPO)
- 13 Point of Service (POS)
- 14 Exclusive Provider Organization (EPO)
- 15 Indemnity Insurance
- 16 Health Maintenance Organization (HMO) Medicare Risk
- AM Automobile Medical

Code	Name
BL	Blue Cross/Blue Shield
CH	Champus
CI	Commercial Insurance Co.
DS	Disability
HM	Health Maintenance Organization
LI	Liability
LM	Liability Medical
MB	Medicare Part B
MC	Medicaid
OF	Other Federal Program
TV	Title V
VA	Veteran Administration Plan
WC	Workers' Compensation Health Claim
ZZ	Mutually Defined

Example:

*SBR*P**GRP01020102*****MB~*

Loop 2010BA

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

Loop Path: 2000B

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	Subscriber Name	O	1		Required

Notes:

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

Example:

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

NM1 Subscriber Name

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

Loop Path: 2000B-2010BA

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	Situational

Description: Code identifying a party or other code

Industry: *Subscriber Primary Identifier*

Molina Note 1:

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

Notes:

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

Example:

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

Molina Note 1:

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

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>
130	CLM	Claim Information	O	1		Required
155	PWK	Claim Supplemental Information	O	10		Situational
180	REF	Claim Identification Number for Clearing Houses and Other Transmission Intermediaries	O	1		Situational
195	CR1	Ambulance Transport Information	O	1		Situational
220	CRC	EPSDT Referral	O	1		Required
231	HI	Health Care Diagnosis Code	O	1		Situational
250		Loop 2310A	O		2	Situational
250		Loop 2310B	O		1	Situational
250		Loop 2310C	O		1	Situational
250		Loop 2310D	O		1	Situational
250		Loop 2310E	O		1	Situational
290		Loop 2320	O		10	Situational
365		Loop 2400	O		50	Required

Notes:

1. Because this is a required segment, this is a required loop. See Appendix A for further details on ASC X12 syntax rules.
2. 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.
3. 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*A37YH556*500***11::1*Y*A*Y*Y*C~

CLM Claim Information

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

Loop Path: 2000B-2300

User Option (Usage): Required

Purpose: To specify basic data about the claim

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
CLM02	782	Monetary Amount	O	R	1/18	Required

Description: Monetary amount

Industry: Total Claim Charge Amount

Molina Note 1:

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

Notes:

1. Because this is a required segment, this is a required loop. See Appendix A for further details on ASC X12 syntax rules.
2. 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.
3. 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*A37YH556*500***11::1*Y*A*Y*Y*C~

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

77 Support Data for Verification

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

Code Name

- OB Operative Note
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 Clearing Houses 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:

- Used only by transmission intermediaries (Automated Clearing Houses, and others) who need to attach their own unique claim number.*
- Although this REF is supplied for transmission intermediaries to attach their own unique claim number to a claim/encounter, 837- recipients are not required under HIPAA to return this number in any HIPAA transaction. Trading partners may voluntarily agree to this interaction if they wish.*

Example:

*REF*D9*TJ98UU321~*

CR1 Ambulance Transport Information

Pos: 195	Max: 1
Detail - Optional	
Loop: 2300	Elements: 0

Loop Path: 2000B-2300

User Option (Usage): Situational

Purpose: To supply information related to the ambulance service rendered to a patient

Notes:

- 1. The CR1 segment in Loop ID-2300 applies to the entire claim unless an exception is reported in the CR1 segment in Loop ID-2400.*
- 2. Required on all claims involving ambulance services.*

Example:

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

Molina Note 1:

Required by HIPAA for Ambulance Transportation claims. Not used in adjudication, but is collected and stored in the Claim Extension File.

CRC EPSDT Referral

Pos: 220	Max: 1
Detail - Optional	
Loop: 2300	Elements: 1

Loop Path: 2000B-2300

User Option (Usage): Required

Purpose: To supply information on conditions

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>
CRC02	1073	Yes/No Condition or Response Code	M	ID	1/1	Required

Description: Code indicating a Yes or No condition or response

Industry: Certification Condition Indicator

Code Name

N No

Molina Note 1:

If no, then choose "NU" in CRC03 indicating no referral given.

Y Yes

Notes:

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

Example:

CRC*ZZ*Y*ST~

Molina Note 1:

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

HI Health Care Diagnosis Code

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

Loop Path: 2000B-2300

User Option (Usage): Situational

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

Element Summary:

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

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

Alias: *Principal Diagnosis*

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

Industry: *Diagnosis Type Code*

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

Notes:

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

Example:

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

Molina Note 1:

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

Loop 2310A

Pos: 250	Repeat: 2
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	Referring Provider Name	O	1		Situational
271	REF	Referring Provider 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. When there is only one referral on the claim, use code "DN - Referring Provider". When more than one referral exists and there is a requirement to report the additional referral, use code DN in the first iteration of this loop to indicate the referral received by the rendering provider on this claim. Use code "P3 - Primary Care Provider" in the second iteration of the loop to indicate the initial referral from the primary care provider or whatever provider wrote the initial referral for this patient's episode of care being billed/reported in this transaction.
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 syntax rules.
4. Required if claim involved a referral.
5. When reporting the provider who ordered services such as diagnostic and lab utilize the 2310A loop at the claim level. For ordered services such as DMERC utilize the 2420E Loop at the line level.

Example:

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

NM1 Referring Provider 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:

<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

Alias: Referring Provider 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.
- When there is only one referral on the claim, use code "DN - Referring Provider". When more than one referral exists and there is a requirement to report the additional referral, use code DN in the first iteration of this loop to indicate the referral received by the rendering provider on this claim. Use code "P3 - Primary Care Provider" in the second iteration of the loop to indicate the initial referral from the primary care provider or whatever provider wrote the initial referral for this patient's episode of care being billed/reported in this transaction.
- Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 syntax rules.
- Required if claim involved a referral.
- When reporting the provider who ordered services such as diagnostic and lab utilize the 2310A loop at the claim level. For ordered services such as DMERC utilize the 2420E Loop at the line level.

Example:

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

Molina Note 1:

Required on all inpatient claims or encounters.

REF Referring Provider 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	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	Situational
-------	-----	--------------------------	---	----	------	-------------

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

Industry: Referring Provider Secondary Identifier

Molina Note 1:

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

Notes:

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

Example:

REF*1D*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	Rendering Provider Name	O	1		Situational
271	REF	Rendering Provider Secondary Identification	O	5		Situational

Example:

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

Molina Note 1:

This loop is always required when the billing provider (2010AA) and/or the Pay-to provider is a professional group practice (e.g., a physician group, APN group, psychology group, etc.). For group practices a Medicaid provider number assigned to an individual provider must be in the REF02 of the 2310B loop.

NM1 Rendering Provider 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:

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
-------	----	---------------------	---	----	------	----------

Description: Code identifying a party or other code

Alias: *Rendering Provider 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 syntax rules.
- Required when the Rendering Provider NM1 information is different than that carried in either the Billing Provider NM1 or the Pay-to Provider NM1 in the 2010AA/AB loops respectively.
- Used for all types of rendering providers including laboratories. The Rendering Provider is the person or company (laboratory or other facility) who rendered the care. In the case where a substitute provider (locum tenans) was used, that person should be entered here.

Example:

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

REF Rendering Provider 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:

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
-------	-----	--------------------------	---	----	------	----------

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

Molina Note 1:

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

Notes:

Required when Rendering Provider is submitted.

Example:

*REF*1D*A12345~*

Molina Note 1:

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

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	Purchased Service Provider Name	O	1		Situational
271	REF	Purchased Service Provider 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 syntax rules.
3. Required if purchased services are being billed/reported on this claim. Purchased services are situations where (for example) a physician purchases a diagnostic exam from an outside entity. Purchased services do not include substitute (locum tenens) provider situations. All payer-specific identifying numbers belong to the destination payer identified in the 2010BB loop.

Example:

NM1*QB*2*****FI*111223333~

NM1 Purchased Service 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	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
-------	----	---------------------	---	----	------	-------------

Description: Code identifying a party or other code

Alias: Purchased Service Provider 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 syntax rules.
- Required if purchased services are being billed/reported on this claim. Purchased services are situations where (for example) a physician purchases a diagnostic exam from an outside entity. Purchased services do not include substitute (locum tenens) provider situations. All payer-specific identifying numbers belong to the destination payer identified in the 2010BB loop.

Example:

NM1*QB*2*****FI*111223333~

REF Purchased Service 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
-------	-----	--------------------------	---	----	------	----------

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

Industry: *Purchased Service Provider Secondary 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 NM108/9 in this loop.

Example:

REF*1D*A12345~

Loop 2310D

Pos: 250	Repeat: 1
Optional	
Loop: 2310D	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 Location	O	1		Situational
265	N3	Service Facility Location Address	O	1		Required
271	REF	Service Facility Location 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 syntax rules.
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.
4. Required if the service was rendered in a Health Professional Shortage Area (QB or QU modifier billed) and the place of service is different than the HPSA billing address.
5. The purpose of this loop is to identify specifically where the service was rendered. In cases where it was rendered at the patient's home, do not use this loop. In that case, the place of service code in CLM05- 1 should indicate that the service occurred in the patient's home.

Example:

NM1*TL*2*A-OK MOBILE CLINIC*****24*11122333~

NM1 Service Facility Location

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

Loop Path: 2000B-2300-2310D

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
-------	----	---------------------	---	----	------	-------------

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:

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 syntax rules.
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.
4. Required if the service was rendered in a Health Professional Shortage Area (QB or QU modifier billed) and the place of service is different than the HPSA billing address.
5. The purpose of this loop is to identify specifically where the service was rendered. In cases where it was rendered at the patient's home, do not use this loop. In that case, the place of service code in CLM05- 1 should indicate that the service occurred in the patient's home.

Example:

*NM1*TL*2*A-OK MOBILE CLINIC*****24*11122333~*

N3 Service Facility Location Address

Pos: 265	Max: 1
Detail - Optional	
Loop: 2310D	Elements: 0

Loop Path: 2000B-2300-2310D

User Option (Usage): Required

Purpose: To specify the location of the named party

Notes:

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

Example:

N3*123 MAIN STREET~

Molina Note 1:

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.

If this loop is not provided, Service Location information will be pulled from the Billing Provider loop.

REF Service Facility Location Secondary Identification

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

Loop Path: 2000B-2300-2310D

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

Example:

REF*1D*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	Supervising Provider Name	O	1		Situational
271	REF	Supervising Provider 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. Required when the rendering provider is supervised by a physician.
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 syntax rules.

Example:

NM1*DQ*1*KILLIAN*BART*B**II*24*222334444~

NM1 Supervising Provider 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

Alias: *Supervising Provider 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:

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. Required when the rendering provider is supervised by a physician.
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 syntax rules.

Example:

NM1*DQ*1*KILLIAN*BART*B**II*24*222334444~

REF Supervising Provider 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:

<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: *Supervising Provider Secondary 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 NM108/9 in this loop.

Example:

REF*1D*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>
290	SBR	Other Subscriber Information	O	1		Situational

Notes:

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

Example:

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

SBR Other Subscriber Information

Pos: 290	Max: 1
Detail - Optional	
Loop: 2320	Elements: 0

Loop Path: 2000B-2300-2320

User Option (Usage): Situational

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

Notes:

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

Example:

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

Molina Note 1:

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

Loop 2400

Pos: 365 Repeat: 50
 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>
370	SV1	Professional Service	O	1		Required
450	CRC	Hospice Employee Indicator	O	1		Situational
455	DTP	Date - Service Date	O	1		Required
494		Loop 2410	O		25	Situational
540		Loop 2430	O		25	Situational

Notes:

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

Example:

LX*1~

SV1 Professional Service

Pos: 370	Max: 1
Detail - Optional	
Loop: 2400	Elements: 4

Loop Path: 2000B-2300-2400

User Option (Usage): Required

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

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
SV101	C003	Composite Medical Procedure Identifier	M	Comp		Required

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

Alias: *Procedure identifier*

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

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

Industry: *Product or Service ID Qualifier*

Molina Note 1:

Submit the corresponding HCPCS codes in SV1 segment with HC.

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

1339		Procedure Modifier	O	AN	2/2	Situational
------	--	---------------------------	---	----	-----	-------------

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

Alias: *Procedure Modifier 1*

Molina Note 1:

Submit up to four modifiers per service line.

ExternalCodeList

Name: 130

Description: Health Care Financing Administration Common Procedural Coding System

ExternalCodeList

Name: 513

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

1339 **Procedure Modifier** O AN 2/2 Situational

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

Alias: *Procedure Modifier 2*

Molina Note 1:

Submit up to four modifiers per service line.

ExternalCodeList

Name: 130

Description: Health Care Financing Administration Common Procedural Coding System

ExternalCodeList

Name: 513

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

1339 **Procedure Modifier** O AN 2/2 Situational

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

Alias: *Procedure Modifier 3*

Molina Note 1:

Submit up to four modifiers per service line.

ExternalCodeList

Name: 130

Description: Health Care Financing Administration Common Procedural Coding System

ExternalCodeList

Name: 513

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

1339 **Procedure Modifier** O AN 2/2 Situational

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

Alias: *Procedure Modifier 4*

Molina Note 1:

Submit up to four modifiers per service line.

ExternalCodeList

Name: 130

Description: Health Care Financing Administration Common Procedural Coding System

ExternalCodeList

Name: 513

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

SV102 782 **Monetary Amount** O R 1/18 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: Monetary amount				
		Industry: <i>Line Item Charge Amount</i>				
		Molina Note 1:				
		<i>When submitting charges, charge is a whole number do not submit 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>				

SV103	355	Unit or Basis for Measurement Code	C	ID	2/2	Situational
		Description: Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken				
		Molina Note 1:				
		<i>"MJ" may only be used for anesthesia claims.</i>				
		Molina Note 2:				
		<i>"UN" must be used for all claims except anesthesia claims.</i>				

Code Name

F2 International Unit

Description: *A unit accepted by an international agency; potency of a drug/vitamin based on a specific weight of that drug/vitamin*

MJ Minutes

UN Unit

SV107	C004	Composite Diagnosis Code Pointer	O	Comp		Situational
		Description: To identify one or more diagnosis code pointers				
		Alias: <i>Diagnosis Code Pointer</i>				
		Molina Note 1:				
		<i>Submit up to four diagnosis pointers per service line.</i>				

Example:

*SV1*HC:99211:25*12.25*UN*1*11**1:2:3**N~*

CRC Hospice Employee Indicator

Pos: 450	Max: 1
Detail - Optional	
Loop: 2400	Elements: 0

Loop Path: 2000B-2300-2400

User Option (Usage): Situational

Purpose: To supply information on conditions

Notes:

1. The example shows the method used to indicate whether the rendering provider is an employee of the hospice.
2. The maximum number of CRC segments which can occur per 2400 loop is 3. Submitters are free to mix and match the three types of service line level CRC segments shown in this implementation guide to meet their billing/reporting needs but no more than a total of 3 CRC segments per 2400 loop are allowed.
3. Required on all Medicare claims involving physician services to hospice patients.

Example:

CRC*70*Y*65~

Molina Note 1:

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

DTP Date - Service Date

Pos: 455	Max: 1
Detail - Optional	
Loop: 2400	Elements: 0

Loop Path: 2000B-2300-2400

User Option (Usage): Required

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

Notes:

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

Example:

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

Molina Note 1:

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

Loop 2410

Pos: 494 Repeat: 25
 Optional
 Loop: 2410 Elements: N/A

Loop Path: 2000B-2300-2400

User Option (Usage): Situational

Purpose: To specify basic item identification data

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>
494	LIN	Drug Identification	O	1		Situational
495	CTP	Drug Pricing	O	1		Situational

Notes:

- 1. The NDC number is used for reporting prescribed drugs and biologics when required by government regulation, or as deemed by the provider to enhance claim reporting/adjudication processes. The NDC number is reported in the LIN segment of Loop ID-2410.*
- 2. Use Loop ID 2410 to specify billing/reporting for drugs provided that may be part of the service(s) described in SV1.*

Example:

*LIN**N4*01234567891~*

LIN Drug Identification

Pos: 494	Max: 1
Detail - Optional	
Loop: 2410	Elements: 1

Loop Path: 2000B-2300-2400-2410

User Option (Usage): Situational

Purpose: To specify basic item identification data

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>
LIN03	234	Product/Service ID	M	AN	1/48	Required

Description: Identifying number for a product or service

Industry: *National Drug Code*

Molina Note 1:

Use the 11 digit NDC

ExternalCodeList

Name: 240

Description: National Drug Code by Format

Notes:

1. The NDC number is used for reporting prescribed drugs and biologics when required by government regulation, or as deemed by the provider to enhance claim reporting/adjudication processes. The NDC number is reported in the LIN segment of Loop ID-2410.
2. Use Loop ID 2410 to specify billing/reporting for drugs provided that may be part of the service(s) described in SV1.

Example:

LIN**N4*01234567891~

Molina Note 1:

Molina cannot accept dashes (-) within any NDC in the file.

CTP Drug Pricing

Pos: 495	Max: 1
Detail - Optional	
Loop: 2410	Elements: 1

Loop Path: 2000B-2300-2400-2410

User Option (Usage): Situational

Purpose: To specify pricing 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>
CTP05	C001	Composite Unit of Measure	X	Comp		Required

Description: To identify a composite unit of measure(See Figures Appendix for examples of use)

Industry: *Unit or Basis of Measurement*

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

Alias: *Code qualifier*

Molina Note 1:

UN = Unit, GR = Gram, ML = Milliliter

Code Name

F2 International Unit

Description: *A unit accepted by an international agency; potency of a drug/vitamin based on a specific weight of that drug/vitamin*

GR Gram

ML Milliliter

UN Unit

Notes:

1. Required when it is necessary to provide a price specific to the NDC provided in LIN03 that is different than the price reported in SV102.

Example:

*CTP***1.15*2*UN~*

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	Line Adjudication Information	O	1		Situational

Notes:

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

Example:

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

SVD Line Adjudication Information

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

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>
SVD02	782	Monetary Amount	M	R	1/18	Required

Description: Monetary amount

Industry: *Service Line Paid Amount*

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).

Notes:

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

Example:

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

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.