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:

Pos	Id	Segment Name	Req	Max Use	Repeat	Notes	Usage	Page
	ISA	Interchange Control Header	M	1			Required	6
	GS	Functional Group Header	M	1			Required	8

Heading:

Pos	Id	Segment Name	Req	Max Use	Repeat	Notes	Usage	Page
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:

Pos	Id	Segment Name	Req	Max Use	Repeat	Notes	Usage	Page
LOOP ID - 2000A					**>1**			14
LOOP ID - 2010AA					**1**	**N2/015L**		15
015	NM1	Billing Provider Name	O	1		N2/015	Required	16
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
LOOP ID - 2000B					**>1**			22
001	HL	Subscriber Hierarchical	M	1			Required	23

Pos	Id	Segment Name	Req	Max Use	Repeat	Notes	Usage	Page
		Level						
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			Situational	29
155	PWK	Claim Supplemental Information	O	10			Situational	31
175	AMT	Patient Amount Paid	O	1			Situational	33
180	REF	Claim Identification Number for Clearing Houses and Other Transmission Intermediaries	O	1			Situational	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
295	CAS	Claim Level Adjustments	O	5			Situational	55
LOOP ID - 2330A					**1**	**N2/325L**		57
325	NM1	Other Subscriber Name	O	1		N2/325	Required	58
LOOP ID - 2400					**50**	**N2/365L**		59

Pos	Id	Segment Name	Req	Max Use	Repeat	Notes	Usage	Page
370	SV1	Professional Service	O	1			Required	60
LOOP ID - 2410					**25**	**N2/494L**		63
494	LIN	Drug Identification	O	1		N2/494	Situational	64
495	CTP	Drug Pricing	O	1			Situational	65
LOOP ID - 2430					**25**	**N2/540L**		66
540	SVD	Line Adjudication Information	O	1		N2/540	Situational	67

Not Defined:

Pos	Id	Segment Name	Req	Max Use	Repeat	Notes	Usage	Page
	GE	Functional Group Trailer	M	1			Required	68

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.

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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.
2/325L	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.
2/494L	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:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
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.

Ref	Id	Element Name	Req	Type	Min/Max	Usage
ISA08	I07	**Interchange Receiver ID**	M	AN	15/15	Required

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 Texas ID is: MTX201494502

Ref	Id	Element Name	Req	Type	Min/Max	Usage
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:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
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.

Ref	Id	Element Name	Req	Type	Min/Max	Usage
GS03	124	**Application Receiver's Code**	M	AN	2/15	Required

Description: Code identifying party receiving transmission; codes agreed to by trading partners

Molina Note 1:

Molina Healthcare of Texas ID is: MTX201494502

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:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
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:

Pos	Id	Segment Name	Req	Max Use	Repeat	Usage
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:

Pos	Id	Segment Name	Req	Max Use	Repeat	Usage
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 Texas

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: *Receiver Primary Identification Number*

Molina Note 1:

Molina Healthcare of Texas ID is: MTX201494502

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:

Pos	Id	Segment Name	Req	Max Use	Repeat	Usage
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~*

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:

Pos	Id	Segment Name	Req	Max Use	Repeat	Usage
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 JOHNANSE*****24*111223333~*

NM1 Billing Provider Name

Pos: 015 **Max: 1**
Detail - Optional
Loop: 2010AA **Elements: 3**

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
NM102	1065	**Entity Type Qualifier**	M	ID	1/1	Required

Description: Code qualifying the type of entity

Molina Note 1:

If person is used and if the Pay-to provider is the same as the rendering provider, then it is not necessary to use the rendering provider NM1 loop at the claim (2310B) loop.

Molina Note 2:

If non-person entity is used, then the rendering provider NM1 loop (Loop 2310B) should be used to supply the name of the rendering provider.

Code	Name
1	Person
2	Non-Person Entity

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

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

Industry: *Billing Provider Identifier*

Molina Note 1:

NPI = 10 digit number assigned by CMS through NPPES.

Ref	Id	Element Name	Req	Type	Min/Max	Usage

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 JOHNANSE*****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

Ref	Id	Element Name	Req	Type	Min/Max	Usage
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: *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:

Pos	Id	Segment Name	Req	Max Use	Repeat	Usage
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:

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 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

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

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 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

Ref	Id	Element Name	Req	Type	Min/Max	Usage
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: *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:

Pos	Id	Segment Name	Req	Max Use	Repeat	Usage
001	HL	Subscriber Hierarchical Level	M	1		Required
005	SBR	Subscriber Information	O	1		Required
015		Loop 2010BA	O		1	Situational
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)

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

Alias: *Payer Responsibility Sequence Number Code*

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

Ref	Id	Element Name	Req	Type	Min/Max	Usage
SBR02	1069	**Individual Relationship Code**	O	ID	2/2	Situational

Description: Code indicating the relationship between two individuals or entities

Alias: *Relationship Code*

Molina Note 1:

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

Code	Name
18	Self

Ref	Id	Element Name	Req	Type	Min/Max	Usage
SBR09	1032	**Claim Filing Indicator Code**	O	ID	1/2	Situational

Description: Code identifying type of claim

Alias: *Claim Filing Indicator Code*

Molina Note 1:

STAR-specific: Use "MC" - Medicaid

Molina Note 2:

Chip-specific: Use "11" - Other Non-Federal Programs

Molina Note 3:

STAR-Plus-specific: Use "MC" - Medicaid

Molina Note 4:

NorthSTAR-specific: Use "MC" for Medicaid population and "11" for

Ref	Id	Element Name	Req	Type	Min/Max	Usage
		non-Medicaid population				

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

Loop Summary:

Pos	Id	Segment Name	Req	Max Use	Repeat	Usage
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:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
NM109	67	**Identification Code**	C	AN	2/80	Situational

Description: Code identifying a party or other code

Industry: *Subscriber Primary Identifier*

Molina Note 1:

STAR-specific: Texas Medicaid ID.

Chip-specific: CHIP ID.

STAR+Plus-specific: Texas Medicaid ID.

NorthSTAR-specific: NorthSTAR ID.

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~*

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:

Pos	Id	Segment Name	Req	Max Use	Repeat	Usage
130	CLM	Claim Information	O	1		Situational
155	PWK	Claim Supplemental Information	O	10		Situational
175	AMT	Patient Amount Paid	O	1		Situational
180	REF	Claim Identification Number for Clearing Houses and Other Transmission Intermediaries	O	1		Situational
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: 3

Loop Path: 2000B-2300
User Option (Usage): Situational
Purpose: To specify basic data about the claim

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
CLM05	C023	**Health Care Service Location Information**	O	Comp		Required

Description: To provide information that identifies the place of service or the type of bill related to the location at which a health care service was rendered

Alias: *Place of Service Code*

Molina Note 1:

This is one of the most important composite fields in the transaction. From this composite field, information such as: "Place of Service", "Bill Type" and "Original/Adjustment/Void"

Ref	Id	Element Name	Req	Type	Min/Max	Usage
CLM07	1359	**Provider Accept Assignment Code**	O	ID	1/1	Required

Description: Code indicating whether the provider accepts assignment

Industry: *Medicare Assignment Code*

Molina Note 1:

Chip-specific: "A" - Assigned, "B" - Assignment Accepted on Clinical Lab Services Only, "C" - Not Assigned, and "P" - Patient Refuses to Assign Benefits

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

Ref	Id	Element Name	Req	Type	Min/Max	Usage
CLM12	1366	**Special Program Code**	O	ID	2/3	Situational

Description: Code indicating the Special Program under which the services rendered to the patient were performed

Industry: *Special Program Indicator*

Molina Note 1:

STAR-specific: This field is used to indicate that the appropriate services shown is an EPSDT benefit.

Molina Note 2:

STAR+Plus-specific: This field is used to indicate that the appropriate services shown is an EPSDT benefit.

Code	Name
01	Early & Periodic Screening, Diagnosis, and Treatment (EPSDT) or Child Health Assessment Program (CHAP)

Code	Name
02	Physically Handicapped Children's Program
03	Special Federal Funding
05	Disability
07	Induced Abortion - Danger to Life
08	Induced Abortion - Rape or Incest
09	Second Opinion or Surgery

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:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
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

AMT Patient Amount Paid

Pos: 175	Max: 1
Detail - Optional	
Loop: 2300	Elements: 0

Loop Path: 2000B-2300
User Option (Usage): Situational
Purpose: To indicate the total monetary amount

Notes:

1. Required when patient has made payment specifically toward this claim.
2. Patient Amount Paid refers to the sum of all amounts paid on the claim by the patient or his/her representative(s).

Example:

*AMT*F5*152.45~*

Molina Note 1:

CHIP-specific: This is where co-pay is shown.

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:

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
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 (Automated Clearing Houses, and others) who need to attach their own unique claim number.
2. 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~*

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:

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

Alias: *Principal Diagnosis*

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

Description: Code identifying a specific industry code list

Industry: *Diagnosis Type Code*

Molina Note 1:

Use "BK" (Principal Diagnosis)

Code	Name
BK	Principal Diagnosis

Notes:

1. Required on all claims/encounters except claims for which there are no diagnoses (e.g., taxi claims).
2. Do not transmit the decimal points in the diagnosis codes. The decimal point is assumed.

Example:

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

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:

Pos	Id	Segment Name	Req	Max Use	Repeat	Usage
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:

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

Ref	Id	Element Name	Req	Type	Min/Max	Usage
NM109	67	**Identification Code**	C	AN	2/80	Situational

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:

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~*

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:

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 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

Ref	Id	Element Name	Req	Type	Min/Max	Usage
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: *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:

Pos	Id	Segment Name	Req	Max Use	Repeat	Usage
250	NM1	Rendering Provider Name	O	1		Situational
271	REF	Rendering 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 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.
4. 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 subsitute provider (locum tenans) was used, that person should be entered here.

Example:

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

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

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: *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:

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 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.
4. 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 subsitute 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

Ref	Id	Element Name	Req	Type	Min/Max	Usage
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: *Rendering 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 NM109 in this loop.

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:

Pos	Id	Segment Name	Req	Max Use	Repeat	Usage
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

Ref	Id	Element Name	Req	Type	Min/Max	Usage
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:

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~*

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:

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 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

Ref	Id	Element Name	Req	Type	Min/Max	Usage
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:

Pos	Id	Segment Name	Req	Max Use	Repeat	Usage
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:

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

Ref	Id	Element Name	Req	Type	Min/Max	Usage
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:

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

Ref	Id	Element Name	Req	Type	Min/Max	Usage
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: *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:

Pos	Id	Segment Name	Req	Max Use	Repeat	Usage
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:

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

Ref	Id	Element Name	Req	Type	Min/Max	Usage
NM109	67	**Identification Code**	C	AN	2/80	Situational

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:

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 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

Ref	Id	Element Name	Req	Type	Min/Max	Usage
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:

Pos	Id	Segment Name	Req	Max Use	Repeat	Usage
295	CAS	Claim Level Adjustments	O	5		Situational
325		Loop 2330A	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~*

CAS Claim Level Adjustments

Pos: 295	Max: 5
Detail - Optional	
Loop: 2320	Elements: 0

Loop Path: 2000B-2300-2320

User Option (Usage): Situational

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

Notes:

1. Submitters should use this CAS segment to report prior payers' claim level adjustments that cause the amount paid to differ from the amount originally charged.
2. Only one Group Code is allowed per CAS. If it is necessary to send more than one Group Code at the claim level, repeat the CAS segment again.
3. Codes and associated amounts should come from 835s (Remittance Advice) received on the claim. If no previous payments have been made, omit this segment.
4. Required if claim has been adjudicated by payer identified in this loop and has claim level adjustment information.
5. To locate the claim adjustment group codes (CAS01) and claim adjustment reason codes (CAS02, 05, 08, 11, 14, and 17) see the Washington Publishing Company web site: http://www.wpc-edi.com. Follow the buttons to Code Lists - Claim Adjustment Reason Codes.
6. There several NSF fields which are not directly crosswalked from the 837 to NSF, particularly with respect to payer-to-payer COB situations. Below is a list of some of these NSF fields and some suggestions regarding how to handle them in the 837.
Provider Adjustment Amt (DA3-25.0). This would equal the sum of all the adjustment amounts in CAS03, 06, 09, 12, 15, and 18 at both the claim and the line level. See the 835 for how to balance the CAS adjustments against the total billed amount.
Beneficiary liability amount (FA0-53.0) This amount would equal the sum of all the adjustment amounts in CAS03, 06, 09, 12, 15, and 18 at both the claim and the line level when CAS01 = PR (patient responsibility).
Amount paid to Provider (DA1-33.0). This would be calculated through the use of the CAS codes. Please see the detail on the codes and the discussion of how to use them in the 835 implementation guide. Balance bill limit charge (FA0-54.0). This would equal any CAS adjustment where CAS01=CO and one of the adjustment reason code elements equaled "45".
Beneficiary Adjustment Amt (DA3-26.0) Amount paid to beneficiary (DA1-30.0)). The amount paid to the beneficiary is indicated by the use of CAS code "100 - Payment made to patient/insured/responsible party."
Original Paid Amount (DA3-28.0): The original paid amount can be calculated from the original COB claim by subtracting all claim adjustments carried in the claim and line level CAS from the original billed amount.

Example:

*CAS*PR*1*7.93~*

*CAS*OA*93*15.06~*

Molina Note 1:

The segment is required for STAR and CHIP participating plans. The first iteration is the total amount of money that the plan has paid on this transaction.

Loop 2330A

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

Loop Path: 2000B-2300-2320

User Option (Usage): Situational

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

Loop Summary:

Pos	Id	Segment Name	Req	Max Use	Repeat	Usage
325	NM1	Other Subscriber Name	O	1		Required

Notes:

1. Submitters are required to send information on all known other subscribers in Loop ID-2330.
2. This 2330 loop is required when Loop ID-2320 - Other Subscriber Information is used. Otherwise, this loop is not used.
3. See Section 1.4.5 Crosswalking COB Data Elements for more information on handling COB in the 837.

Example:

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

NM1 Other Subscriber Name

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

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

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: *Other Subscriber Primary Identifier*

Molina Note 1:

When "Other Subscriber" is the MCO, this value is the "Plan Code". This is the location used to determine the participating plan. If additional loops are used, this value won't be a Plan Code as defined by HHSC.

Notes:

1. Submitters are required to send information on all known other subscribers in Loop ID-2330.
2. This 2330 loop is required when Loop ID-2320 - Other Subscriber Information is used. Otherwise, this loop is not used.
3. See Section 1.4.5 Crosswalking COB Data Elements for more information on handling COB in the 837.

Example:

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

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:

Pos	Id	Segment Name	Req	Max Use	Repeat	Usage
370	SV1	Professional Service	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: 3**

Loop Path: 2000B-2300-2400
User Option (Usage): Required
Purpose: To specify the claim service detail for a Health Care professional

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
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*

Ref	Id	Element Name	Req	Type	Min/Max	Usage
	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*
IV	Home Infusion EDI Coalition (HIEC) Product/Service Code
ZZ	Mutually Defined

Ref	Id	Element Name	Req	Type	Min/Max	Usage
	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

Ref	Id	Element Name	Req	Type	Min/Max	Usage
	1339	**Procedure Modifier**	O	AN	2/2	Situational

Ref	Id	Element Name	Req	Type	Min/Max	Usage

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

Description: Monetary amount

Industry: *Line Item Charge Amount*

Molina Note 1:

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

Ref	Id	Element Name	Req	Type	Min/Max	Usage
		with trailing zeros (example: 2315 = $2315.00).				
		Molina Note 2:				
		When submitting charges, charge has dollars with cents, submit with decimal to separate (example: 23.15 = $23.15).				
		Molina Note 3:				
		Monetary Amount, enter 0 if dollars billed are included in other procedure(s).				
SV107	C004	**Composite Diagnosis Code Pointer**	O	Comp		Situational
		Description: To identify one or more diagnosis code pointers				
		Alias: *Diagnosis Code Pointer*				
		Molina Note 1:				
		Submit up to four diagnosis pointers per service line.				

Example:

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

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:

Pos	Id	Segment Name	Req	Max Use	Repeat	Usage
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 eporting/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:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
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 eporting/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:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
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*

Ref	Id	Element Name	Req	Type	Min/Max	Usage
	355	**Unit or Basis for Measurement Code**	M	ID	2/2	Required

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 = Mililiter

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:

Pos	Id	Segment Name	Req	Max Use	Repeat	Usage
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:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
SVD02	782	**Monetary Amount**	M	R	1/18	Required

Description: Monetary amount

Industry: *Service Line Paid Amount*

Alias: *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:

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~*

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.