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Companion Guide: 837 Institutional Claims and Encounters Transaction

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Version 1.9	789	April 2007		NPI Stage 2	Publications/ Systems
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Table of Contents

Section 1: Introduction

Overview

The Indiana Health Coverage Programs (IHCP) has developed technical companion guides to assist application developers during the implementation process. The information contained in the *IHCP Companion Guide* is only intended to supplement the adopted *National Electronic Data Interchange Transaction Set Implementation Guide* (IG) and provide guidance and clarification as it applies to the IHCP. The IHCP *Companion Guide* is never intended to modify, contradict, or reinterpret the rules established by the IGs.

The *Companion Guide* is categorized into three sections:

1. Introduction to the 837 Institutional
2. Interchange control
3. Transaction specifications

This section, *Introduction*, provides a general description of the 837 Institutional Transaction. *Section 2* describes data exchange options and the relevant inbound and outbound interchange control structures. *Section 3* contains transaction specific documentation, including segment usage, to assist developers with coding each transaction.

> *Note: All references to the IHCP provider number included in this Companion Guide refer to the Indiana Health Coverage Program legacy provider number.*

837 Institutional

The *ASC X12N 837 (04010X096)* transaction is the Health Information Portability and Accountability Act (HIPAA)-mandated transaction for submitting institutional claims or encounter data. Any claim submitted on a *UB-92* or *UB04* claim form is submitted electronically using this transaction. This includes the following claim types:

- Inpatient
- Outpatient
- Long term care (LTC)
- Home health
- Inpatient/outpatient crossover

This companion guide is for the 837 Institutional transaction and is not intended to contradict or replace any information in the IG or the *IHCP Provider Manual*. It is highly recommended that the following resources are available during the development process:

- This document, *Companion Guide: 837 Institutional Claims and Encounters Transactions*
- *National Electronic Data Interchange Transaction Set Implementation Guide: Health Care Claim: Institutional: 837: ASC X12N 837 (004010X096)* and *(004010X096A1) Addenda*
- *IHCP Provider Manual*

In addition to the compliance checking and resulting *997 Acknowledgement* file, the IHCP creates a *Biller Summary Report* (BSR) in response to all 837 submissions. This report provides summary information about the results of pre-adjudication claim and encounter processing. Information on this report lists rejected claims not processed by the system. Until the full National Provider Identifier (NPI) implementation, the report will also show warning errors on claims where a submitted NPI has not been reported to the IHCP, or if reported, cannot be cross-walked to a unique IHCP Legacy Provider Identifier (LPI), cross-walks to multiple LPIs, or cross-walks to a unique LPI that does not match the submitted LPI.

There are several processing assumptions, limitations, and guidelines that a developer must be aware of when implementing the 837I transaction. The following list identifies these processing stipulations:

- The IHCP accepts up to 5000 CLM segments per ST – SE. The IG recommends creating this limitation to avert circumstances where file size management may become an issue.
- It is recommended that Patient Loops, 2000C and 2010CA, not be coded because the IHCP members/subscribers are always the same as the patient. If these loops are present, they do not pass the pre-adjudication edits if the subscriber's Medicaid Identification (ID) does not match the patient's Medicaid ID.
- All monetary amounts have explicit decimals. The decimal point always appears in the character stream if the decimal point is at any place other than the right end. If the value is an integer, with the decimal point at the right end, the decimal point should be omitted. See the IG for additional clarification.
- Negative quantities or amounts necessary for the adjudication of the claim are rejected.
- Almost all amounts have been extended to the HIPAA maximum of 99999999.99. An exception is the *Value Code* amounts, which are required to be in the IHCP format of 9999999.99. If the value amounts are not in this format, the claim rejects in the pre-adjudication edits. All other amounts not in the HIPAA format are rejected on 997s due to compliance errors.
- All quantities have pre-adjudication edits. Refer to the appropriate segments for the IHCP formats.
- Other data elements with lengths greater than IHCP definitions are truncated.
- The IHCP is referred to as IHCP in applicable *Receiver* segments.
- The IHCP processes the maximum of 450 service lines or details on the 837I transaction.
- Coordination of benefits (COB) assumptions:
  - Non-Medicare third-party liability (TPL) is only reported at claim level, Medicare is reported at claim or service line level.
  - Shadow claims:
    - Non-managed care organization (MCO) TPL is only reported at claim level.
    - Shadow claims are reports of individual patient encounters with an MCO's health care network that contain fee-for-service (FFS) equivalent detail as to procedures, diagnoses, places of service (POS), billed amounts, and rendering or billing providers. IHCP requires that shadow claims submitted from the MCOs follow the 837 COB format and expect the shadow claim information in the COB Loops of the transaction. Shadow claims are only accepted from MCOs and are rejected from all others.
    - MCOs only send claims that have been paid or denied at the claim and detail level in their system. MCOs exclude claims that have not been finalized in their system.
    - MCOs format the 837 with their payment information in the first iteration of the COB Loops prior to submitting to IHCP.

Electronic Voids and Replacements

If any of the following guidelines are not followed, refer to the BSR for more details.

A Web or electronic data interchange (EDI) replacement request may take up to one business day to process if submitted before 3 p.m. during a normal business day. The primary reason this may occur is that the original claim has already been through a financial.

Shadow Claims

- The MCO ID, provider ID and the state region must be identical on the replacement as it appears on the claim that is being replaced.
- The MCO ID, provider ID, state region and recipient information must be identical on a void as it appears on the claim that is being voided.
- The type of claim on the void or replacement must be the same type on the claim being voided or replaced.
- The void or replacement cannot be older than two years from the dates of service on the claim being voided or replaced.
- The void or replacement request must be done against the most recent occurrence of the bill.
- The void or replacement request must be for an IHCP claim that is found in the database.
- A void cannot be processed against a claim that denied in the Indiana*AIM*.
- A replacement request cannot be performed against a claim that denied due to a previous void request.

Fee-for-Service Claims

- The provider ID, service location and recipient information must be identical on the void as it appears on the claim that is being voided.
- If a void is submitted with an NPI, that NPI must cross-walk to the same IHCP LPI and service location that appears on the claim being voided.
- The provider ID and service location information must be identical on the replacement as it appears on the claim that is being replaced.
- If a replacement is submitted with an NPI, that NPI must cross-walk to the same IHCP LPI and service location that appears on the claim being replaced.
- The type of claim on the void or replacement must be the same type on the claim being voided or replaced.
- The replacement cannot be older than one year from the last activity that took place on the claim being replaced.
- The void or replacement request must be done against the most recent occurrence of the bill.
- The void or replacement request must be for an IHCP claim that is found in the database.
- A void cannot be processed against a claim that denied in the Indiana*AIM* system.
- A replacement request cannot be performed against a claim that denied due to a previous void request.

Section 2: Data Exchange Technical Specifications and Interchange Control Structure

Overview

Appendix A, Section A.1.1 of each *National Electronic Data Interchange Transaction Set Implementation Guide (ASC X12N~)* (IG), the Health Insurance Portability and Accountability Act (HIPAA), provides details about the rules for ensuring integrity and maintaining the efficiency of data exchange. Data files are transmitted in an *electronic envelope*. The communication envelope consists of an interchange envelope and functional groups.

The following table defines the use of the inbound 837I control structure as it relates to communication with the Indiana Health Coverage Programs (IHCP).

Inbound Transactions

Table 2.1 – Interchange Control Header

<table>
<tr><th>Segment Name</th><th colspan="3">Interchange Control Header</th></tr>
<tr><td>Segment ID</td><td colspan="3">ISA</td></tr>
<tr><td>Loop ID</td><td colspan="3">N/A</td></tr>
<tr><td>Usage</td><td colspan="3">Required</td></tr>
<tr><td rowspan="5">Segment Notes</td><td colspan="3">All positions within each data element in the ISA segment must be filled. Delimiters are specified in the interchange header segment.
The character immediately following the segment ID, ISA, defines the data elements separator. The last character in the segment defines the component element separator, and the segment terminator is the byte that immediately follows the component element separator. The following are examples of the separators.</td></tr>
<tr><td>Character</td><td>Name</td><td>Delimiter</td></tr>
<tr><td>*</td><td>Asterisk</td><td>Data Element Separator</td></tr>
<tr><td>:</td><td>Colon</td><td>Sub-element Separator</td></tr>
<tr><td>~</td><td>Tilde</td><td>Segment Terminator</td></tr>
<tr><td colspan="4">While it is not required that submitters use these specific delimiters, they are the ones that the IHCP uses for all outbound transactions.</td></tr>
<tr><td>Example</td><td colspan="3">ISA* 00* ….……..* 00*…….* ZZ* P123 ..* ZZ*IHCP……* 930602* 1253* U* 00401* 000000905* 1* P* :~</td></tr>
</table>

Table 2.2 – Element ID ISA01-ISA016

Element ID	Usage	Guide Description and Valid Values	Comments
ISA01	R	Authorization Information Qualifier **00** – No Authorization Information Present	
ISA02	R	Authorization Information Insert 10 blanks	Always blank. Insert 10 blank spaces.
ISA03	R	Security Information Qualifier **00** – No Security Information Present	
ISA04	R	Security Information Insert 10 blanks	Always blank. Insert 10 blank spaces.
ISA05	R	Interchange ID Qualifier **ZZ** – Mutually Defined	
ISA06	R	Interchange Sender ID	For batch transactions, this is the four-byte sender ID (four to eight characters) assigned by the IHCP. For interactive transactions, this is the eight-byte assigned terminal ID (**IN** followed by six digits). This field has a required length of 15 bytes; therefore, the field must be blank filled to the right.
ISA07	R	Interchange ID Qualifier **ZZ** – Mutually Defined	
ISA08	R	Interchange Receiver ID **IHCP**	This field has a required length of 15 bytes; therefore, the field must be blank filled to the right.
ISA09	R	Interchange Date	Format: YYMMDD.
ISA10	R	Interchange Time	Format: HHMM.
ISA11	R	Interchange Control Standards Identifier **U** – U.S. EDI Community of ASC X12, TDCC, and UCS	
ISA12	R	Interchange Control Version Number **00401** – Draft Standards for Trial Use Approved for Publication by ASC X12 Procedures Review Board through October 1997	
ISA13	R	Interchange Control Number	The interchange control number (ICN) is created by the submitter and must be identical to the associated Interchange Trailer (IEA02). This is a numeric field and must be zero-filled. This number should be unique and the IHCP recommends that it be incremented by one with each ISA segment.

(Continued)

Table 2.2 – Element ID ISA01-ISA016

Element ID	Usage	Guide Description and Valid Values	Comments
ISA14	R	Acknowledgment Requested **0** – No acknowledgment requested **1** – Interchange Acknowledgment Requested	The IHCP always creates an acknowledgment file for each file received.
ISA15	R	Usage Indicator **P** – Production Data **T** – Test Data	During testing the usage indicator entered must be **T**. After testing approval, **P** must be entered for production transactions.
ISA16	R	Component Element Separator	The component element separator is a delimiter and not a data element. This field provides the delimiter used to separate component data elements within a composite data structure; this value must be different than the data element separator and the segment terminator.

Table 2.3 – Functional Group Header

Segment Name	Functional Group Header
Segment ID	GS
Loop ID	N/A
Usage	Required
Segment Notes	
Example	`GS*HC*P123*IHCP*20020606*105531*5*X*004010X096A1~`

Table 2.4 – Element ID GS01-GS08

Element ID	Usage	Guide Description and Valid Values	Comments
GS01	R	Functional Identifier Code **HC** – Health Care Claim (837)	Use the appropriate identifier to designate the type of transaction data to follow the GS segment.
GS02	R	Application Sender's Code	For batch transactions, this is the four-byte sender ID assigned by the IHCP. For interactive transactions, this is the eight-byte assigned terminal ID (**IN** followed by six digits).
GS03	R	Application Receiver's Code **IHCP**	
GS04	R	Date	Format: CCYYMMDD.
GS05	R	Time	Format: HHMMSS

(Continued)

Table 2.4 – Element ID GS01-GS08

Element ID	Usage	Guide Description and Valid Values	Comments
GS06	R	Group Control Number	Assigned number originated and maintained by the sender. This must match the number in the corresponding GE02 data element on the GE group trailer segment.
GS07	R	Responsible Agency Code **X** – Accredited Standards Committee X12	
GS08	R	Version/Release/Industry Identifier Code **004010X096A1** – 837I	Use the appropriate identifier to designate the identifier code for the type of transaction data to follow the GS segment. Refer to specific transaction IG for proper value.

Table 2.5 – Functional Group Trailer

Segment Name	Functional Group Trailer
Segment ID	GE
Loop ID	N/A
Usage	Required
Segment Notes	
Example	`GE*1*5~`

Table 2.6 – Element ID GE01-GE02

Element ID	Usage	Guide Description and Valid Values	Comments
GE01	R	Number of Transaction Sets Included	Use the number of transaction sets included in this functional group.
GE02	R	Group Control Number	Group control number GE02 in this trailer must be identical to the same data element in the associated functional group header, GS06.

Table 2.7 – Interchange Control Trailer

Segment Name	Interchange Control Trailer
Segment ID	IEA
Loop ID	N/A
Usage	Required
Segment Notes	
Example	`IEA*1*000000905~`

Table 2.8 – Element ID IEA01-IEA02

Element ID	Usage	Guide Description and Valid Values	Comments
IEA01	R	Number of Included Functional Groups	Use the number of functional groups included in this interchange envelope.
IEA02	R	Interchange Control Number	Interchange control number (ICN) IEA02 in this trailer must be identical to the same data element in the associated interchange control header, ISA13, including padded zeros.

Sample Inbound Interchange Control

Figure 2.1 illustrates a file that includes 270 and 837I transactions.

```
ISA* 00* ..........* 00*…….* ZZ* P123     ..* ZZ*IHCP……* 930602*
1253* U* 00401* 000000905* 1* P* :~
GS*HS*P123*IHCP*20020606*105531*5*X*004010X092A1~
ST – 270 TRANSACTION SET HEADER
DETAIL SEGMENTS
SE – 270 TRANSACTION SET TRAILER
GE*1*5~
GS*HC*P123*IHCP*20020606*105531*5*X*004010X096A1~
ST – 837 TRANSACTION SET HEADER
DETAIL SEGMENTS
SE – 837 TRANSACTION SET TRAILER
GE*1*5~
IEA*2*000000905~
```

Figure 2.1 – Inbound Interchange Control, 270 and 837I Transactions

Section 3: Institutional Claims and Encounters

Segment Usage – 837 Institutional

The following matrix lists all segments available for submission using the 4010 version of the *National Electronic Data Interchange Transaction Set Implementation Guide: Health Care Claim: Institutional: 837: ASC X12N 837 (004010X096)* and *(004010X096A1) Addenda*. It includes a *Usage* column identifying segments that are required (**R**), situational (**S**), or not used (**N/A**) by the Indiana Health Coverage Programs (IHCP). A required segment element must appear on all transactions. Failure to include a required segment results in a compliance error. A situational segment is not required on every type of transaction; however, a situational segment may be required under certain circumstances. Any data in a segment identified in the *Usage* column with an **X** is ignored by the IHCP. Any segment identified in the *Usage* column as required, or situational, is explained in detail in this section. Any element identified as, *Not Used by the IHCP,* is not required for processing by the IHCP.

Refer to the *IHCP Provider Manual* for specific billing requirements.

Table 3.1 –Segment Usage

Segment ID	Loop ID	Segment Name	IHCP Usage R –Required S- Situational X – Not Used
ST	N/A	Transaction Set Header	R
BHT	N/A	Beginning of Hierarchical Transaction	R
REF	N/A	Transmission Type Identification	R
NM1	1000A	Submitter Name	R
PER	1000A	Submitter Electronic Data Interchange (EDI) Contact Information	R
NM1	1000B	Receiver Name	R
HL	2000A	Billing/Pay-To Hierarchical Level (HL)	R
PRV	2000A	Billing/Pay-To Specialty Information	S
CUR	2000A	Foreign Currency Information	X
NM1	2010AA	Billing Provider Name	R
N3	2010AA	Billing Provider Address	R
N4	2010AA	Billing Provider City/State/ZIP Code	R
REF	2010AA	Billing Provider Secondary Information	R
REF	2010AA	Credit/Debit Card Billing Information	X
PER	2010AA	Billing Provider Contact Information	X
NM1	2010AB	Pay-to Provider Name	X
N3	2010AB	Pay-to Provider Address	X
N4	2010AB	Pay-to Provider City/State/ZIP Code	X
REF	2010AB	Pay-to Provider Secondary Information	X

Table 3.1 –Segment Usage

Segment ID	Loop ID	Segment Name	IHCP Usage R –Required S- Situational X – Not Used
HL	2000B	Subscriber Hierarchical Level	R
SBR	2000B	Subscriber Information	R
PAT	2000B	Patient Information	X – deleted per *Addenda*
NM1	2010BA	Subscriber Name	R
N3	2010BA	Subscriber Address	R
N4	2010BA	Subscriber City/State/ZIP Code	R
DMG	2010BA	Subscriber Demographic Information	R
REF	2010BA	Subscriber Secondary Information	X
REF	2010BA	Property and Casualty Claim Number	X
NM1	2010BB	Credit/Debit Card Account Holder Name	X
REF	2010BB	Credit/Debit Card Information	X
NM1	2010BC	Payer Name	R
N3	2010BC	Payer Address	X
N4	2010BC	Payer City/State/ZIP Code	X
REF	2010BC	Payer Secondary Information	X
NM1	2010BD	Responsible Party Name	X
N3	2010BD	Responsible Party Address	X
N4	2010BD	Responsible Party City/State/ZIP Code	X
HL	2000C	Patient Hierarchical Level	S
PAT	2000C	Patient Information	S
NM1	2010CA	Patient Name	S
N3	2010CA	Patient Address	S
N4	2010CA	Patient City/State/ZIP Code	S
DMG	2010CA	Patient Demographic Information	S
REF	2010CA	Patient Secondary Information Number	S
REF	2010CA	Property and Casualty Claim Number	S
CLM	2300	Claim Information	R
DTP	2300	Discharge Hour	X
DTP	2300	Statement Dates	R
DTP	2300	Admission Date/Hour	S
CL1	2300	Institutional Claim Code	S
PWK	2300	Claim Supplemental Information	S
CN1	2300	Contract Information	S
AMT	2300	Payer Estimated Amount Due	R

Table 3.1 –Segment Usage

Segment ID	Loop ID	Segment Name	IHCP Usage R –Required S- Situational X – Not Used
AMT	2300	Patient Estimated Amount Due	X
AMT	2300	Patient Paid Amount	S
AMT	2300	Credit/Debit Card Maximum Amount	X
REF	2300	Adjusted Repriced Claim Number	X
REF	2300	Repriced Claim Number	X
REF	2300	Claim Identification Number for Clearinghouses and Other Transmission Intermediaries	X
REF	2300	Document Identification Code	X
REF	2300	Original Reference Number (ICN/DCN)	S
REF	2300	Investigational Device Exemption Number	X
REF	2300	Service Authorization Exception Code	X
REF	2300	Peer Review Organization (PRO) Approval Number	X
REF	2300	Prior Authorization or Referral Number	S
REF	2300	Medical Record Number	S
REF	2300	Demonstration Project Identifier	X
K3	2300	File Information	X
NTE	2300	Claim Note	S
NTE	2300	Billing Note	X
CR6	2300	Home Health Care Information	X
CRC	2300	Home Health Functional Liabilities	X
CRC	2300	Home Health Activities Permitted	X
CRC	2300	Home Health Mental Status	X
HI	2300	Principal, Admitting, E-code, and Patient Reason for Visit Diagnosis Information	R
HI	2300	Diagnosis Related Group (DRG) Information	X
HI	2300	Other Diagnosis Information	S
HI	2300	Principal Procedure Information	S
HI	2300	Other Procedure Information	S
HI	2300	Occurrence Span Information	S
HI	2300	Occurrence Information	S
HI	2300	Value Information	S
HI	2300	Condition Information	S
HI	2300	Treatment Code Information	X
QTY	2300	Claim Quantity	S

Table 3.1 –Segment Usage

Segment ID	Loop ID	Segment Name	IHCP Usage R –Required S- Situational X – Not Used
HCP	2300	Claim Pricing/Repricing Information	X
CR7	2305	Home Health Care Plan Information	X
HSD	2305	Home Care Services Delivery	X
NM1	2310A	Attending Physician Name	S
PRV	2310A	Attending Physician Specialty Information	S
REF	2310A	Attending Physician Secondary Information	S
NM1	2310B	Operating Physician Name	S
PRV	2310B	Operating Physician Specialty Information	X – deleted per *Addenda*
REF	2310B	Operating Physician Secondary Information	S
NM1	2310C	Other Provider Name	S
PRV	2310C	Other Provider Specialty Information	X – deleted per *Addenda*
REF	2310C	Other Provider Secondary Information	S
NM1	2310D	Referring Provider Name	X – deleted per *Addenda*
PRV	2310D	Referring Provider Specialty Information	X – deleted per *Addenda*
REF	2310D	Referring Provider Secondary Information	X – deleted per *Addenda*
NM1	2310E	Service Facility Name	X
PRV	2310E	Service Facility Specialty Information	X – deleted per *Addenda*
N3	2310E	Service Facility Address	X
N4	2310E	Service Facility City/State/ZIP Code	X
REF	2310E	Service Facility Secondary Information	X
SBR	2320	Other Subscriber Information	S
CAS	2320	Claim Level Adjustment	S
AMT	2320	Payer Prior Payment	S
AMT	2320	Coordination of Benefits (COB) Total Allowed Amount	S
AMT	2320	Coordination of Benefits (COB) Total Submitted Charges	X
AMT	2320	Diagnosis Related Group (DRG) Outlier Amount	X
AMT	2320	Coordination of Benefits (COB) Total Medicare Paid Amount	S
AMT	2320	Medicare Paid Amount – 100 percent	X
AMT	2320	Medicare Paid Amount – 80 percent	X
AMT	2320	Coordination of Benefits (COB) Medicare A Trust Fund Paid Amount	X
AMT	2320	Coordination of Benefits (COB) Medicare B Trust Fund Paid Amount	X

Table 3.1 –Segment Usage

Segment ID	Loop ID	Segment Name	IHCP Usage R –Required S- Situational X – Not Used
AMT	2320	Coordination of Benefits (COB) Total Non-covered Amount	X
AMT	2320	Coordination of Benefits (COB) Total Denied Amount	S
DMG	2320	Other Subscriber Demographic Information	S
OI	2320	Other Insurance Coverage Information	X
MIA	2320	Medicare Inpatient Adjudication Information	X
MOA	2320	Medicare Outpatient Adjudication Information	X
NM1	2330A	Other Subscriber Name	S
N3	2330A	Other Subscriber Address	S
N4	2330A	Other Subscriber City/State/ZIP Code	S
REF	2330A	Other Subscriber Secondary Information	S
NM1	2330B	Other Payer Name	S
N3	2330B	Other Payer Address	S
N4	2330B	Other Payer City/State/ZIP Code	S
DTP	2330B	Claim Adjudication Date	S
REF	2330B	Other Payer Secondary Identification and Reference Number	S
REF	2330B	Other Payer Prior Authorization or Referral Number	S
NM1	2330C	Other Payer Patient Information	S
REF	2330C	Other Payer Patient Identification Number	S
NM1	2330D	Other Payer Attending Provider	X
REF	2330D	Other Payer Attending Provider Identification	X
NM1	2330E	Other Payer Operating Provider	X
REF	2330E	Other Payer Operating Provider Identification	X
NM1	2330F	Other Payer Other Provider	X
REF	2330F	Other Payer Other Provider Identification	X
NM1	2330G	Other Payer Referring Provider	X
REF	2330G	Other Payer Referring Provider Identification	X
NM1	2330H	Other Payer Service Facility Provider	X
REF	2330H	Other Payer Service Facility Provider Identification	X
LX	2400	Service Line Number	R
SV2	2400	Institutional Service Line	R
SV4	2400	Prescription Number	X – deleted per *Addenda*
PWK	2400	Line Supplemental Information	S

Table 3.1 –Segment Usage

Segment ID	Loop ID	Segment Name	IHCP Usage R –Required S- Situational X – Not Used
DTP	2400	Service Line Date	S
STP	2400	Assessment Date	X
AMT	2400	Service Tax Amount	X
AMT	2400	Facility Tax Amount	X
LIN	2410	Drug Identification – New segment per *Addenda*	S
CTP	2410	Drug Pricing – New segment per *Addenda*	S
REF	2410	Prescription Number	X
NM1	2420A	Attending Physician Name	X
PRV	2420A	Attending Physician Specialty Information	X – deleted per *Addenda*
REF	2420A	Attending Physician Secondary Information	X
NM1	2420B	Operating Physician Name	X
PRV	2420B	Operating Physician Specialty Information	X – deleted per *Addenda*
REF	2420B	Operating Physician Secondary Information	X
NM1	2420C	Other Provider Name	X
PRV	2420C	Other Provider Specialty Information	X – deleted per *Addenda*
REF	2420C	Other Provider Secondary Information	X
NM1	2420D	Referring Provider Name	X – deleted per *Addenda*
PRV	2420D	Referring Provider Specialty Information	X – deleted per *Addenda*
REF	2420D	Referring Provider Secondary Information	X – deleted per *Addenda*
SVD	2430	Service Line Adjudication Information	S

Segment and Data Element Description

This section contains tables representing segments required or situational for the Indiana Health Information Portability and Accountability Act (HIPAA) implementation of the 837I. Each segment table contains rows and columns describing different segment elements.

Table 3.2 – Segment and Data Element Description

Segment/Data Element	Description
Segment Name	The industry-assigned segment name identified in the IG.
Segment ID	The industry-assigned segment ID identified in the IG.
Loop ID	The loop where the segment should appear.
Usage	This identifies the segment as required or situational.
Segment Notes	A brief description of the purpose or use of the segment.
Example	An example of complete segment.

Table 3.2 – Segment and Data Element Description

Segment/Data Element	Description
Element ID	The industry-assigned segment ID as identified in the IG.
Usage	Identifies the data element as **R**-required, **S**-situational, or **X**-not used based on the IHCP guidelines.
Guide Description and Valid Values	Industry name associated with the data element. If no industry name exists, this is the IG data element name. This column also lists in **BOLD** the values and code sets to use.
Comments	Description of the contents of the data elements, including field lengths.

Table 3.3 – Transaction Set Header

Segment Name	Transaction Set Header
Segment ID	ST
Loop ID	N/A
Usage	Required
Segment Notes	This segment begins the transaction.
Example	`ST*837*7656543~`

Table 3.4 – Element ID ST01-ST02

Element ID	Usage	Guide Description and Valid Values	Comments
ST01	R	Transaction Set Identifier Code **837**	
ST02	R	Transaction Set Control Number	This number is assigned locally by the sender and should match the value in the corresponding SE segment.

Table 3.5 – Beginning of Hierarchical Transaction

Segment Name	Beginning of Hierarchical Transaction
Segment ID	BHT
Loop ID	N/A
Usage	Required
Segment Notes	This segment provides the bill date and indicator to determine whether the claim submitted is a fee for service or encounter claim.
Example	`BHT*0019*00*X2FF1*20020901*1230*CH~`

Table 3.6 – Element ID BHT01-BHT06

Element ID	Usage	Guide Description and Valid Values	Comments
BHT01	R	Hierarchical Structure Code **0019** – Information Source	
BHT02	R	Transaction Set Purpose Code **00** – Original **19** – Reissue	See the IG for specific usage. This field has no affect on the processing of this transaction.
BHT03	R	Originator Application Transaction Identifier	This value is assigned by the sender. Not used by the IHCP.
BHT04	R	Transaction Set Creation Date	Format: CCYYMMDD. This is the bill date for all claims that follow.
BHT05	R	Transaction Set Creation Time	Not used by the IHCP
BHT06	R	Claim or Encounter Identifier **CH** – Chargeable **RP** – Reporting	Use **CH** for fee-for-service (FFS) claims. Use **RP** for shadow claims or encounters.

Table 3.7 – Transaction Type Identification

Segment Name	Transaction Type Identification
Segment ID	REF
Loop ID	N/A
Usage	Required
Segment Notes	This segment identifies the X12N version and the production versus test status of the transaction.
Example	`REF*87*004010X096A1~`

Table 3.8 – Element ID REF01 – REF02

Element ID	Usage	Guide Description and Valid Values	Comments
REF01	R	Reference Identification Qualifier **87** – Functional Category	
REF02	R	Transmission Type Code **004010X096A1** – Production **004010X096DA1** – Test	This value assumes the 4010 implementation version. Contents of this field must be updated with subsequent version upgrades as they are named. The ISA segment determines submission is for production or test. While this data element must be submitted to be complaint, the value here is ignored by the IHCP.

Table 3.9 – Submitter Name

Segment Name	Submitter Name
Segment ID	NM1
Loop ID	1000A
Usage	Required
Segment Notes	This segment identifies the submitter and must include the IHCP-assigned sender ID ETIN.
Example	`NM1*41*2*Clearinghouse Inc.*****46*A23I~`

Table 3.10 – Element ID NM101-NM111

Element ID	Usage	Guide Description and Valid Values	Comments
NM101	R	Entity Identifier Code **41** – Submitter	
NM102	R	Entity Type Qualifier **1** – Person **2** – Non-Person Entity	
NM103	R	Submitter Last Name or Organization Name	
NM104	S	Submitter First Name	
NM105	S	Submitter Middle Name	
NM106	N/A	Name Prefix	Not used
NM107	N/A	Name Suffix	Not used
NM108	R	Identification Code Qualifier **46** – ETIN	
NM109	R	Submitter Identifier	Use the sender ID assigned by EDS Electronic Solutions.
NM110	N/A	Entity Relationship Code	Not used
NM111	N/A	Entity Identifier Code	Not used

Table 3.11 – Submitter EDI Contact Information

Segment Name	Submitter EDI Contact Information
Segment ID	PER
Loop ID	1000A
Usage	Required
Segment Notes	This segment is required by the IG and must be submitted to be compliant; however, data submitted is not captured by the IHCP. See the IG for details.

Table 3.12 – Receiver Name

Segment Name	Receiver Name
Segment ID	NM1
Loop ID	1000B
Usage	Required
Segment Notes	This segment is required by the IG and must be submitted to be compliant; however, data submitted is not captured by the IHCP. See the IG for details.

Table 3.13 – Billing/Pay-to-Provider Hierarchical Level

Segment Name	Billing/Pay-to Provider Hierarchical Level
Segment ID	HL
Loop ID	2000A
Usage	Required
Segment Notes	This segment and following billing/pay-to provider loops must repeat for every billing provider submitting claims.
Example	`HL*1**20*1~`

Table 3.14 – Element ID HL01-HL04

Element ID	Usage	Guide Description and Valid Values	Comments
HL01	R	Hierarchical ID Number **1**	
HL02	N/A	Hierarchical Parent ID Number	Not used
HL03	R	Hierarchical Level Code **20** – Information Source	
HL04	R	Hierarchical Child Code **1**	

Table 3.15 – Billing/Pay-to Provider Specialty Information

Segment Name	Billing/Pay-to Provider Specialty Information
Segment ID	PRV
Loop ID	2000A
Usage	Situational
Segment Notes	This segment provides the taxonomy code of the billing provider.
Example	`PRV*BI*ZZ*404FX0500D~`

Table 3.16 – Element ID PRV01-PRV06

Element ID	Usage	Guide Description and Valid Values	Comments
PRV01	S	Provider Code **BI** – Billing	
PRV02	S	Reference Identification Qualifier **ZZ** – Mutually Defined	
PRV03	S	Provider Taxonomy Code	Use the taxonomy code of the billing provider.
PRV04	N/A		Not used
PRV05	N/A		Not used
PRV06	N/A		Not used

Table 3.17 – Billing Provider Name

Segment Name	Billing Provider Name
Segment ID	NM1
Loop ID	2010AA
Usage	Required
Segment Notes	This segment is required by the IG and must be submitted to be compliant. See the IG for details. This segment contains the National Provider Identifier (NPI) information. If the NPI is used in the NM108/NM109 of this loop, then either the Employer's Identification Number or the Social Security Number (SSN) of the provider must be carried in the Billing Provider Secondary Identification segment (REF). However, the IHCP will continue to use the Tax ID or SSN on file for the IHCP billing LPI and will ignore the Tax ID or SSN submitted. If submitted, the NPI will be returned on the Biller Summary Report (BSR) and the 835 transaction.
Example	**Segment with NPI:** `NM1*85*2*JONES HOSPITAL****XX*1234567890~`

Table 3.18 – Element ID NM101-NM111

Element ID	Usage	Guide Description and Valid Values	Comments
NM101	R	Entity Identifier Code **85** – Billing Provider	
NM102	R	Entity Type Qualifier **2** – Non-Person Entity	
NM103	R	Name Last or Organization Name	
NM104	N/A	Name First	Not used
NM105	N/A	Name Middle	Not used
NM106	N/A	Name Prefix	Not used

Table 3.18 – Element ID NM101-NM111

Element ID	Usage	Guide Description and Valid Values	Comments
NM107	N/A	Name Suffix	Not used
NM108	R	Identification Code Qualifier **24** – Employer's Identification Number **34** – Social Security Number **XX** – NPI	If **XX** - NPI is used, then either the Employer's Identification Number or the SSN of the provider must be carried in the REF segment in this loop. This value will be required when the NPI is mandated for use.
NM109	R	Identification Code	If *XX* is sent in NM108, enter the 10-digit NPI.
NM110	N/A	Entity Relationship Code	Not used
NM111	N/A	Entity Identifier Code	Not used

Table 3.19 – Billing Provider Address

Segment Name	Billing Provider Address
Segment ID	N3
Loop ID	2010AA
Usage	Required
Segment Notes	This segment is required by the IG and must be submitted to be compliant; however, data submitted is not captured by the IHCP.

Table 3.20 – Billing Provider City/State/ZIP Code

Segment Name	Billing Provider City/State/ZIP Code
Segment ID	N4
Loop ID	2010AA
Usage	Required
Segment Notes	This segment is required by the IG and must be submitted to be compliant. See the IG for details. This is the Billing Provider's **Service Location** City, State, and ZIP Code. The ZIP code entered in N403 is used for the NPI to Legacy Provider Identifier (LPI) crosswalk. Effective May 23, 2008 the crosswalk must successfully identify a unique billing provider in order for the claim to be accepted.

Table 3.21 – Element Id N401-N403

Element ID	Usage	Guide Description and Valid Values	Comments
N401	R	Billing Provider City	Billing Provider's Service Location City
N402	R	Billing Provider State	Billing Provider's Service Location State
N403	R	Billing Provider ZIP Code	Billing Provider's Service Location nine-digit ZIP Code

Table 3.21 – Billing Provider Secondary Identification

Segment Name	Billing Provider Secondary Identification
Segment ID	REF
Loop ID	2010AA
Usage	Required
Segment Notes	This segment is used for multiple purposes. The primary usage is to submit the IHCP billing provider LPI and service location, when submitting claims to the IHCP. If code XX-NPI is used in the Billing Provider Name segment (NM108-109) of this loop, then enter the Employer's Identification Number or the SSN in this segment. The IHCP requests that the 1D qualifier and the IHCP LPI be submitted in a repeat of this segment in order to validate the NPI to LPI cross-walk, and to assist in claims adjudication. The IHCP LPI is also required if the submitted NPI has not been reported to the IHCP or cannot be cross-walked to a unique LPI. Managed care organizations (MCOs) submitting shadow/encounter claims must include their MCO ID and location code in a repeat of this segment. When submitting claims to Medicare that are expected to crossover to the IHCP, the IHCP LPI and service location with the **1D** qualifier should be included along with submitting the Medicare provider number with the *1C* qualifier. Medicare automatically crossovers the claim with both the Medicare and the IHCP LPI to the IHCP. Failure to submit the IHCP LPI and service location when submitting to Medicare could result in claim denial by the IHCP. The denied claim may not be reported to the provider if the Medicaid provider number is missing.
Examples	**Claims submitted by provider to the IHCP:** `REF*1D*100999250A~`

	Claims containing NPI submitted by provider to the IHCP:
	`REF*1D*100999250A~`
	`REF*EI*675438789~`
	`REF*SY*309761542~`

	Encounter claims submitted by MCO:
	`REF*1D*100999250A~`
	`REF*B3*200888990N~`

	Claims submitted by provider to Medicare, expecting to crossover to the IHCP:
	`REF*1C*236450~`
	`REF*1D*100999250A~`

Table 3.22 – Element ID REF01-REF04

Element ID	Usage	Guide Description and Valid Values	Comments
REF01	R	Reference Identification Qualifier **1D** – Medicaid Provider Number **B3** – Preferred Provider Organization Number **EI** – Employer's Identification Number **SY** – Social Security Number	**B3** is used only by MCOs. **EI** or **SY** must be used when the 10-digit NPI is sent in the Billing Provider Name segment of this loop. The number sent must be the number which is used on the 1099. When sending NPI information, an additional 2010AA REF segment can be sent with the **1D** qualifier.

Table 3.22 – Element ID REF01-REF04

Element ID	Usage	Guide Description and Valid Values	Comments
REF02	R	Billing Provider Additional Identifier	When sending the *1D* qualifier, use the 10-digit IHCP provider number (nine numeric plus one alpha location code). When sending the *B3* qualifier, use the MCO ID (nine numeric plus one alpha region code). Invalid IHCP provider numbers and MCO IDs are rejected and reported on the BSR. When sending the *EI* qualifier, use the Employer Identification Number used on the 1099. When sending the *SY* qualifier, use the SSN used on the 1099.
REF03	N/A	Description	Not used
REF04	N/A	Reference Identifier	Not used

Table 3.23 – Subscriber Hierarchical Level

Segment Name	Subscriber Hierarchical Level
Segment ID	HL
Loop ID	2000B
Usage	Required
Segment Notes	This segment and following subscriber loops must repeat for every subscriber claim submitted. This Includes claims for IHCP members and HCI. See the IG for additional information about creating HL segments.
Example	`HL*2*1*22*0~`

Table 3.24 – Element ID HL01-HL04

Element ID	Usage	Guide Description and Valid Values	Comments
HL01	R	Hierarchical ID Number	The number increments by one for each member regardless of program eligibility.
HL02	R	Hierarchical Parent ID Number	This HL segment is always subordinate to the Billing Pay-to Provider HL. The value in this field must match the Billing/Pay-to Provider Hierarchical ID number.
HL03	R	Hierarchical Level Code **22** – Subscriber	
HL04	R	Hierarchical Child Code **0** – No Subordinate HL Segments in This Hierarchical Structure	Because the member is always the patient, there should be no subordinate HLs to this HL segment.

Table 3.25 – Subscriber Information

Segment Name	Subscriber Information
Segment ID	SBR
Loop ID	2000B
Usage	Required
Segment Notes	This segment identifies the intended payer of this claim. Valid payers include Medicaid, the IHCP, and HCI.
Example	SBR*T*18*******MC~

Table 3.26 – Element ID SBR01-SBR09

Element ID	Usage	Guide Description and Valid Values	Comments
SBR01	R	Payer Responsibility Sequence Number Code **T** – Tertiary **P** – Primary	This data element is not captured by the IHCP for processing; however, it is recommended that submitters use **T** for Medicaid claims, as the IHCP is traditionally the payer of last resort. For HCI claims, **P** for Primary payer is recommended.
SBR02	S	Patients Relationship to Insured **18** – Self	Not used by the IHCP; however, required for compliance.
SBR03	S	Insured Group or Policy Number	Not used by the IHCP
SBR04	S	Insured Group Name	Not used by the IHCP
SBR05	N/A	Insurance Type Code	Not used
SBR06	N/A	Coordination of Benefits Code	Not used
SBR07	N/A	Yes/No Condition or Response Code	Not used
SBR08	N/A	Employment Status Code	Not used
SBR09	S	Claim Filing Indicator Code MC – Medicaid	Not used by the IHCP; however, required for compliance.

Table 3.27 – Subscriber Name

Segment Name	Subscriber Name
Segment Name	NM1
Loop ID	2010BA – Subscriber Name
Usage	Required
Segment Notes	This segment contains the IHCP member name and ID number. For HCI claims, it contains the recipient's name and SSN.
Example	NM1*IL*1*DOE*JOE*X***MI*123456989999~

Table 3.28 – Element ID NM101-NM111

Element ID	Usage	Guide Description and Valid Values	Comments
NM101	R	Entity Identifier Code **IL** – Insured or Subscriber	
NM102	R	Entity Type Qualifier **1** – Person	
NM103	R	Subscriber's Last Name	Use the last name of the IHCP member.
NM104	R	Subscriber's First Name	Use the first name of the IHCP member.
NM105	S	Subscriber's Middle Initial	Not used by the IHCP
NM106	N/A	Name Prefix	Not used
NM107	S	Subscriber Name Suffix	Not used by the IHCP
NM108	R	Identification Code Qualifier **MI** – Member Identification Number **ZZ** – Mutually Defined	IHCP claims are coded with **MI**. HCI claims are coded with **ZZ**.
NM109	R	Subscriber Primary Identifier	Use the 12-digit IHCP member ID for Medicaid claims. For HCI claims, use the nine-digit recipient's SSN. Do not format the SSN with dashes.
NM110	N/A	Entity Relationship Code	Not used
NM111	N/A	Entity Identifier Code	Not used

Table 3.29 – Subscriber Address

Segment Name	Subscriber Address
Segment ID	N3
Loop ID	2010BA – Subscriber Name
Usage	Required
Segment Notes	This segment is required by the IG and must be submitted to be compliant; however, data submitted is not captured by the IHCP. See the IG for details.

Table 3.30 – Subscriber City/State/ZIP Code

Segment Name	Subscriber City/State/ZIP Code
Segment ID	N4
Loop ID	2010BA – Subscriber Name
Usage	Required
Segment Notes	This segment is required by the IG and must be submitted to be compliant; however, data submitted is not captured by the IHCP. See the IG for details.

Table 3.31 – Subscriber Demographic Information

Segment Name	Subscriber Demographic Information
Segment ID	DMG
Loop ID	2010BA – Subscriber Name
Usage	Required
Segment Notes	This segment is required by the IG and must be submitted to be compliant. Data submitted is not captured by the IHCP for Medicaid claims. For HCI inpatient claims, the recipient's gender and birth date are required for inpatient claim pricing.
Example	`DMG*D8*19430706*M~`

Table 3.32 – Element ID DMG01-DMG03

Element ID	Usage	Guide Description and Valid Values	Comments
DMG01	R	Date/Time Period Format Qualifier **D8**—Date Expressed in format CCYYMMDD	
DMG02	R	Date/Time Period	
DMG03	R	Gender Code	

Table 3.33 – Payer Name

Segment Name	Payer Name
Segment ID	NM1
Loop ID	2010BC
Usage	Required
Segment Notes	This segment identifies EDS as the destination payer for Medicaid claims and HCI for HCI claims.
Example	`NM1*PR*2*EDS*****PI*EDS~`

Table 3.34 – Element ID NM101-NM111

Element ID	Usage	Guide Description and Valid Values	Comments
NM101	R	Entity Identifier Code **PR** – Payer	
NM102	R	Entity Type Qualifier **2** – Non-Person Entity	
NM103	R	Payer Name **EDS** **HCI**	
NM104	N/A	Name First	Not used
NM105	N/A	Name Middle	Not used
NM106	N/A	Name Last	Not used
NM107	N/A	Name Suffix	Not used
NM108	R	Identification Code Qualifier **PI**	
NM109	R	Payer Identifier **EDS** **HCI**	Use **EDS** for IHCP claims. Use **HCI** for HCI claims.
NM110	N/A	Entity Relationship Code	Not used
NM111	N/A	Entity Identifier Code	Not used

Table 3.35 – Patient Hierarchical Level

Segment Name	Patient Hierarchical Level
Segment ID	HL
Loop ID	2000C
Usage	Situational
Segment Notes	The IG requires this segment if the 2000C Loop is used and must be submitted to be compliant. Data submitted is not captured by the IHCP. See the IG for details.

Table 3.36 – Patient Information

Segment Name	Patient Information
Segment ID	PAT
Loop ID	2000C – Patient Information
Usage	Situational
Segment Notes	The IG requires this segment if the 2000C Loop is used and must be submitted to be compliant. Data submitted is not captured by the IHCP. See the IG for details.

Table 3.37 – Patient Name

Segment Name	Patient Name
Segment Name	NM1
Loop ID	2010CA – Patient Name
Usage	Situational
Segment Notes	The IG requires this segment if the 2000C Loop is used and must be submitted to be compliant. It is not recommended that a patient loop be coded for the IHCP claims. However, if it is coded, the NM109 of the subscriber must equal the NM109 of the patient or the claim rejects in the pre-adjudication reports.
Example	`NM1*QC*1*DOE*JOE*X***MI*123456989999~`

Table 3.38 – Element ID NM101-NM111

Element ID	Usage	Guide Description and Valid Values	Comments
NM101	R	Entity Identifier Code **QC** – Patient	
NM102	R	Entity Type Qualifier **1** – Person	
NM103	R	Subscriber's Last Name	Not used by the IHCP
NM104	R	Subscriber's First Name	Not used by the IHCP
NM105	S	Subscriber's Middle Initial	Not used by the IHCP
NM106	N/A	Name Prefix	Not used
NM107	S	Subscriber Name Suffix	Not used by the IHCP
NM108	R	Identification Code Qualifier **MI** – Member Identification Number **ZZ** – Mutually Defined	IHCP claims are coded with **MI**. HCI claims are coded with **ZZ**.

Table 3.38 – Element ID NM101-NM111

Element ID	Usage	Guide Description and Valid Values	Comments
NM109	R	Subscriber Primary Identifier	If this segment is coded, the 12-digit IHCP member ID for of the patient must match the ID submitted in the 2010BA Loop. For HCI claims, use the nine-digit recipient's SSN. Do not format the SSN with dashes.
NM110	N/A	Entity Relationship Code	Not used
NM111	N/A	Entity Identifier Code	Not used

Table 3.39 – Patient Address

Segment Name	Patient Address
Segment ID	N3
Loop ID	2010CA – Patient Address
Usage	Patient
Segment Notes	The IG requires this segment if the 2010CA Loop is used and must be submitted to be compliant. Data submitted is not captured by the IHCP. See the IG for details.

Table 3.40 – Patient City/State/ZIP Code

Segment Name	Patient City/State/ZIP Code
Segment ID	N4
Loop ID	2010CA – Patient City/State/ZIP Code
Usage	Patient
Segment Notes	The IG requires this segment if the 2010CA Loop is used and must be submitted to be compliant. Data submitted is not captured by the IHCP. See the IG for details.

Table 3.41 – Patient Demographic Information

Segment Name	Patient Demographic Information
Segment ID	DMG
Loop ID	2010CA – Patient Demographic Information
Usage	Required
Segment Notes	The IG requires this segment if the 2010CA Loop is used and must be submitted to be compliant. Data submitted is not captured by the IHCP. See the IG for details.

Table 3.42 – Claim Information

Segment Name	Claim Information
Segment ID	CLM
Loop ID	2300
Usage	Required
Segment Notes	This segment begins submission of the individual claim information. The IHCP processes a maximum of 5000 CLM segments per ST-SE.
Example	`CLM*3343E66*2555.51***11:A:1*Y**Y*Y*********Y~`

Table 3.43 – Element ID CLM01-CLM20

Element ID	Usage	Guide Description and Valid Values	Comments
CLM01	R	Patient Account Number	Use patient account number of up to 20 characters.
CLM02	R	Total Claim Charge Amount	Use the sum of all service line or detail charges up to 10 bytes. The IHCP accepts the maximum HIPAA format of 99999999.99
CLM03	N/A	Claim Filing Indicator Code	Not used
CLM04	N/A	Non-Institutional Claim Type Code	Not used
CLM05	R	Health Care Service Location Information	This is a composite data element.
CLM05-1	R	Facility Type Code	Use the first two digits of the type of bill code.
CLM05-2	R	Facility Type Code Qualifier **A** – Uniform Billing Claim Form Bill Type	
CLM05-3	R	Claim Frequency Code	Use the third digit of the type of bill code. Note: The third digit of type of bill code represents the action requested. For a void this value is **8**; for a replacement it is **7**.
CLM06	R	Provider Signature Indicator **N** – No **Y** – Yes	This data element indicates whether the billing provider signature is on file in the billing office.
CLM07	S	Medicare Assignment Code	Not used by the IHCP
CLM08	R	Benefits Assignment Certification Indicator	Not used by the IHCP
CLM09	R	Release of Information Code	Not used by the IHCP
CLM10	N/A	Patient Signature Source Code	Not used
CLM11	N/A	Property and Casualty Related Cause Codes	Not used

Table 3.43 – Element ID CLM01-CLM20

Element ID	Usage	Guide Description and Valid Values	Comments
CLM12	S	Special Program Indicator	Not used by the IHCP
CLM13	N/A	Yes/No Condition or Response Code	Not used
CLM14	N/A	Level of Service Code	Not used
CLM15	N/A	Yes/No Condition or Response Code	Not used
CLM16	N/A	Provider Agreement Code	Not used
CLM17	N/A	Claim Status Code	Not used
CLM18	R	Explanation of Benefits Indicator **N** – No **Y** – Yes	Not used by the IHCP
CLM19	N/A	Claim Submission Code	Not used
CLM20	S	Delay Reason Code	Not used by the IHCP

Table 3.44 – Statement Dates

Segment Name	Statement Dates
Segment ID	DTP
Loop ID	2300
Usage	Required
Segment Notes	This segment provides the Statement Covers Period or the *From* and *Through* dates of service.
Example	`DTP*434*RD8*20011019-20011118~`

Table 3.45 – Element ID DTP01-DTP03

Element ID	Usage	Guide Description and Valid Values	Comments
DTP01	R	Date/Time Qualifier **434** – Statement	
DTP02	R	Date/Time Period Format Qualifier **RD8** – Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD **D8** – Date Expressed in Format CCYYMMDD	If **D8** is submitted as the qualifier, the date submitted is used as both *From* and *Through* dates.
DTP03	R	Date/Time Period	Use the *From* and *Through Dates of Service* from the Statement Covers Period.

Table 3.46 – Admission Date/Time

Segment Name	Admission Date/Time
Segment ID	DTP
Loop ID	2300
Usage	Situational
Segment Notes	This segment relays admission date and time information.
Example	`DTP*435*DT*200107271400~`

Table 3.47 – Element ID DTP01-DTP03

Element ID	Usage	Guide Description and Valid Values	Comments
DTP01	R	Date/Time Qualifier **435** – Admission	
DTP02	R	Date/Time Period Format Qualifier **DT** – Date and Time Expressed in format CCYYMMDDHHMM	
DTP03	R	Date/Time Period	Use the date and time the IHCP member was admitted. For example, 200107271400 represents an admit date of 7/27/2001 and an admit hour of 2 p.m. Value **99** is invalid for HHMM.

Table 3.48 – Institutional Claim Code

Segment Name	Institutional Claim Code
Segment ID	CL1
Loop ID	2300
Usage	Situational
Segment Notes	This segment conveys admission type and patient status.
Example	`CL1*3**02~`

Table 3.49 – Element ID CL101-CL103

Element ID	Usage	Guide Description and Valid Values	Comments
CL101	S	Admission Type Code **1** – Emergency **2** – Urgent **3** – Elective **4** – Newborn	For the IHCP processing, **9** is not a valid code.
CL102	S	Admission Source Code	Not used by the IHCP
CL103	S	Patient Status Code	See the *IHCP Provider Manual* for valid Patient Status Codes and definitions.

Table 3.50 – Claim Supplemental Information

Segment Name	Claim Supplemental Information
Segment ID	PWK
Loop ID	2300
Usage	Situational
Segment Notes	This segment is used when additional information is required to process the claim, and the information is mailed to the IHCP. This segment is ignored if BHT06 = *RP* or the claim is a Medicare submitted crossover claim.
Example	`PWK*AS*BM***AC*86576*ADMISSION COMMENTS~`

Table 3.51 – Element ID PWK01-PWK09

Element ID	Usage	Guide Description and Valid Values	Comments
PWK01	R	Attachment Report Type Code	See the IG for list of valid values.
PWK02	R	Attachment Transmission Code **BM** – By mail	Even though all Attachment Transmission Codes are accepted, claims that suspend because of an attachment requirement are only resolved by sending the attachment by mail.
PWK03	N/A	Report Copies Needed	Not used
PWK04	N/A	Entity Identifier Code	Not used
PWK05	R	Identification Code Qualifier **AC** – Attachment Control Number	
PWK06	R	Attachment Control Number	A unique attachment control number of up to 30 characters must be used and must match the number associated with the paper documentation sent by mail. This number is used to link the claim with the paper documentation and must be unique per billing location across all claims.

Table 3.51 – Element ID PWK01-PWK09

Element ID	Usage	Guide Description and Valid Values	Comments
PWK07	S	Attachment Description	
PWK08	N/A	Actions Indicated	Not used
PWK09	N/A	Request Category Code	Not used

Table 3.52 – Contract Information

Segment Name	Contract Information
Segment ID	CN1
Loop ID	2300
Usage	Situational
Segment Notes	This segment is used by MCOs to identify an encounter from a network provider who has a capitated payment arrangement with the MCO. Do not send this segment except for a capitated provider.
Example	`CN1*05~`

Table 3.53 – Element ID CN101-CN106

Element ID	Usage	Guide Description and Valid Values	Comments
CN101	R	Contract Type Code **05** – Capitated	A value of **05** indicates the provider has a capitated payment arrangement.
CN102	S	Contract Amount	Not used by the IHCP
CN103	S	Contract Percentage	Not used by the IHCP
CN104	S	Contract Code	Not used by the IHCP
CN105	S	Term Discount Percentage	Not used by the IHCP
CN106	S	Contract Version Identifier	Not used by the IHCP

Table 3.54 – Payer Estimated Amount Due

Segment Name	Payer Estimated Amount Due
Segment ID	AMT
Loop ID	2300
Usage	Situational
Segment Notes	This segment is required for IHCP claims. It is an estimate of the amount to be paid by Medicaid.
Example	`AMT*C5*1500~`

Table 3.55 – Element ID AMT01-AMT03

Element ID	Usage	Guide Description and Valid Values	Comments
AMT01	R	Amount Code Qualifier **C5** – Claim Amount Due – Estimated	
AMT02	R	Estimated Claim Due Amount	Use the estimated amount due for the claim. This is the equivalent of the C payer amount due on the *UB-92*. The IHCP accepts the maximum HIPAA format of 99999999.99
AMT03	N/A	Credit/Debit Flag Code	Not used

Table 3.56 – Patient Paid Amount

Segment Name	Patient Paid Amount
Segment ID	AMT
Loop ID	2300
Usage	Situational
Segment Notes	This segment reports any prior payment other than third party liability TPL and is deducted from the allowed amount.
Example	`AMT*F5*110.3~`

Table 3.57 – Element ID AMT01-AMT03

Element ID	Usage	Guide Description and Valid Values	Comments
AMT01	R	Amount Qualifier Code **F5** – Patient Paid Amount	
AMT02	R	Estimated Claim Due Amount	Use the estimated amount due for the claim. This is the equivalent of the C payer amount due on the *UB-92*. The IHCP accepts the maximum HIPAA format of 99999999.99
AMT03	N/A	Credit/Debit Flag Code	Not used

Table 3.58 – Original Reference Number ICN/DCN

Segment Name	Original Reference Number ICN/DCN
Segment ID	REF
Loop ID	2300
Usage	Situational
Segment Notes	This segment is required only if the CLM05-3 Claim Frequency Code Type of Bill in the 2300 Loop is a **7** - Replacement or an **8** - Void. This segment identifies the original IHCP ICN/DCN of the desired claim to be voided or replaced. This is reflected as the original claim on the 835.
Example	`REF*F8*2004394623999~`

Table 3.59 – Element ID REF01-REF04

Element ID	Usage	Guide Description and Valid Values	Comments
REF01	R	Reference Identification Qualifier **F8** – Referral Number	
REF02	R	Reference Identification – Claim Original Reference Number ICN/DCN	The IHCP ICN of the claim needing to be voided or replaced.
REF03	N/A	Description	Not used
REF04	N/A	Reference Identifier	Not used

Table 3.60 – Prior Authorization or Referral Number

Segment Name	Prior Authorization or Referral Number
Segment ID	REF
Loop ID	2300
Usage	Situational
Segment Notes	This segment identifies the PMP certification code.
Example	`REF*9F*3E~`

Table 3.61 – Element ID REF01-REF04

Element ID	Usage	Guide Description and Valid Values	Comments
REF01	R	Reference Identification Qualifier **9F** – Referral Number	
REF02	R	Prior Authorization Number	Use the two-character PMP certification code. This code is not used by MCOs.
REF03	N/A	Description	Not used
REF04	N/A	Reference Identifier	Not used

Table 3.62 – Medical Record Number

Segment Name	Medical Record Number
Segment ID	REF
Loop ID	2300
Usage	Situational
Segment Notes	The segment submits a medical record number.
Examples	`REF*EA*D234345~`

Table 3.63 – Element ID REF01-REF02

Element ID	Usage	Guide Description and Valid Values	Comments
REF01	R	Reference Identification Qualifier **EA** – Medical Record Number	
REF02	R	Medical Record Number	Use the medical record number of the IHCP member. The IHCP accepts the full HIPAA length of 30 characters. Previously, only the first 20 characters were accepted.

Table 3.64 – Claim Note

Segment Name	Claim Note
Segment ID	NTE
Loop ID	2300
Usage	Situational
Segment Notes	This segment provides additional narrative information about this claim. The IHCP accepts the HIPAA maximum of 10 claim notes
Example	`NTE*NTR*PATIENT REQUIRES TUBE FEEDING~`

Table 3.65 – Element ID NTE01-NTE02

Element ID	Usage	Guide Description and Valid Values	Comments
NTE01	R	Note Reference Code	See the IG for list of valid values.
NTE02	R	Claim Note Text	Use up to 80 characters of narrative description.

Table 3.66 – Principal, Admitting, E-code and Patient Reason for Visit Diagnosis Information

Segment Name	Principal, Admitting, E-code, and Patient Reason for Visit Diagnosis Information
Segment ID	HI
Loop ID	2300
Usage	Required
Segment Notes	This segment reports the principal and admitting diagnosis codes and the E-Code. If the decimal is submitted with the diagnosis code or E-Code and it does not comply with the diagnosis *ICD-9* code, the claim is initially be accepted; however, it will deny when processed in Indiana*AIM*. See the *Other Diagnosis Information* segment for reporting other diagnosis codes.
Example	`HI*BK:51881*BJ:51881~`

Table 3.67 – Element ID HI01-HI12

Element ID	Usage	Guide Description and Valid Values	Comments
HI01	R	Health Care Code Information	This is a composite data element.
HI01-1	R	Code List Qualifier Code **BK** – Principal Diagnosis	
HI01-2	R	Principal Diagnosis Code	Use the appropriate *ICD-9* diagnosis code.
HI01-3	N/A	Date/Time Period Format Qualifier	Not used
HI01-4	N/A	Date/Time Period	Not used
HI01-5	N/A	Monetary Amount	Not used
HI01-6	N/A	Quantity	Not used
HI01-7	N/A	Version Identifier	Not used
HI02	S	Health Care Code Information	This is a composite data element.
HI02-1	R	Code List Qualifier Code **BJ** – Admitting Diagnosis	
HI02-2	R	Admitting Diagnosis Code	Use the appropriate *ICD-9* diagnosis code.
HI02-3	N/A	Date/Time Period Format Qualifier	Not used
HI02-4	N/A	Date/Time Period	Not used
HI02-5	N/A	Monetary Amount	Not used
HI02-6	N/A	Quantity	Not used
HI02-7	N/A	Version Identifier	Not used
HI03	S	Health Care Code Information	This is a composite data element.
HI03-1	R	Code List Qualifier Code **BN** – US DHHS, Office of Vital Statistics E-Code	
HI03-2	R	E-Code	Use the appropriate *ICD-9* diagnosis code.
HI03-3	N/A	Date/Time Period Format Qualifier	Not used
HI03-4	N/A	Date/Time Period	Not used
HI03-5	N/A	Monetary Amount	Not used
HI03-6	N/A	Quantity	Not used
HI03-7	N/A	Version Identifier	Not used
HI04	N/A	Health Care Code Information	Not used
HI05	N/A	Health Care Code Information	Not used
HI06	N/A	Health Care Code Information	Not used
HI07	N/A	Health Care Code Information	Not used
HI08	N/A	Health Care Code Information	Not used
HI09	N/A	Health Care Code Information	Not used
HI10	N/A	Health Care Code Information	Not used
HI11	N/A	Health Care Code Information	Not used

Table 3.67 – Element ID HI01-HI12

Element ID	Usage	Guide Description and Valid Values	Comments
HI12	N/A	Health Care Code Information	Not used

Table 3.68 – Other Diagnosis Information

Segment Name	Other Diagnosis Information
Segment ID	HI
Loop ID	2300
Usage	Situational
Segment Notes	This segment conveys additional diagnosis codes not submitted on previous HI segments. All 24 other diagnosis codes are recognized. Previously, the first eight values submitted were recognized by the IHCP. If the decimal is submitted with the diagnosis codes, and it does not comply with the diagnosis *ICD-9* codes, the claim is initially accepted; however, it will deny when processed in Indiana*AIM*.
Example	`HI*BF*7070*BF:5789*BF:42731*BF:78039*BF:5119*BF:2761*BF:03811*BF:4280~`

Table 3.69 – Element ID HI01-HI01-7

Element ID	Usage	Guide Description and Valid Values	Comments
HI01	R	Health Care Code Information	This is a composite data element. The seven data elements in this composite occur 12 times in this segment. Only the first occurrence is used in this illustration. See the IG for complete details.
HI01-1	R	Code List Qualifier Code **BF** – Other Diagnosis	
HI01-2	R	Other Diagnosis Code	Use the appropriate *ICD-9* diagnosis code.
HI01-3	N/A	Date/Time Period Format Qualifier	Not used
HI01-4	N/A	Date/Time Period	Not used
HI01-5	N/A	Monetary Amount	Not used
HI01-6	N/A	Quantity	Not used
HI01-7	N/A	Version Identifier	Not used

Table 3.70 – Principal Procedure Information

Segment Name	Principal Procedure Information
Segment ID	HI
Loop ID	2300
Usage	Situational
Segment Notes	This segment conveys the principal surgical procedure code and date information. If the decimal is submitted with the principal procedure code and it does not comply with the *ICD-9* code, the claim is initially accepted; however, it will deny when processed in Indiana*AIM*. See the *Other Procedure Code Information* segment for reporting other procedure codes.
Example	`HI*BR:8894:D8:20021001~`

Table 3.71 – Element ID HI01-HI12

Element ID	Usage	Guide Description and Valid Values	Comments
HI01	R	Health Care Code Information	This is a composite data element.
HI01-1	R	Code List Qualifier **BR** – International Classification of Diseases Clinical Modification *ICD-9-CM* Principle Procedure	
HI01-2	R	Principal Procedure Code	Use the four-byte principal surgical procedure code.
HI01-3	R	Date/Time Period Format Qualifier **D8** – Date Expressed in Format CCYYMMDD	
HI01-4	R	Date/Time Period	Use principal surgical procedure code date.
HI01-5	N/A	Monetary Amount	Not used
HI01-6	N/A	Quantity	Not used
HI01-7	N/A	Version Identifier	Not used
HI02	N/A	Health Care Code Information	Not used
HI03	N/A	Health Care Code Information	Not used
HI04	N/A	Health Care Code Information	Not used
HI05	N/A	Health Care Code Information	Not used
HI06	N/A	Health Care Code Information	Not used
HI07	N/A	Health Care Code Information	Not used
HI08	N/A	Health Care Code Information	Not used
HI09	N/A	Health Care Code Information	Not used
HI10	N/A	Health Care Code Information	Not used
HI11	N/A	Health Care Code Information	Not used
HI12	N/A	Health Care Code Information	Not used

Table 3.72 – Other Procedure Information

Segment Name	Other Procedure Information
Segment ID	HI
Loop ID	2300
Usage	Situational
Segment Notes	This segment conveys additional surgical procedure codes and dates not submitted on the previous HI segment. The segment may be repeated two times; thus, the maximum number of procedures reported is 24. The IHCP recognizes all 24 other procedures submitted. Previously, only the first five values were recognized. If the decimal is submitted and it does not comply with the *ICD-9* code, the claim is initially accepted; however, it will deny when processed in Indiana*AIM*.
Example	`HI*BQ:8894:D8:20021001*BQ:7883:20021001~`

Table 3.73 – Element ID HI01-HI01-7

Element ID	Usage	Guide Description and Valid Values	Comments
HI01	S	Health Care Code Information	This is a composite data element. The seven data elements in this composite occur 12 times in this segment. Only the first occurrence is used in this illustration. See the IG for complete details.
HI01-1	R	Code List Qualifier Code **BQ** – International Classification of Diseases Clinical Modification *ICD-9 CM* Procedure	**BQ** is the only valid value recognized by the IHCP.
HI01-2	R	Procedure Code	Use the four-byte surgical procedure code.
HI01-3	R	Date/Time Period Format Qualifier **D8** – Date Expressed in Format CCYYMMDD	
HI01-4	R	Date/Time Period	Use the surgical procedure code date.
HI01-5	N/A	Monetary Amount	Not used
HI01-6	N/A	Quantity	Not used
HI01-7	N/A	Version Identifier	Not used

Table 3.74 – Occurrence Span Information

Segment Name	Occurrence Span Information
Segment ID	HI
Loop ID	2300
Usage	Situational

Table 3.74 – Occurrence Span Information

Segment Name	Occurrence Span Information
Segment Notes	This segment conveys occurrence codes and span dates. The segment may be repeated two times. The maximum number of occurrence span code/dates used for processing is 12. Occurrence span codes/dates are typically used only on home health claims. Only the first two occurrence code values are recognized by the IHCP.
Example	`HI*BI:51:RD8:20021001-20021005~`

Table 3.75 – Element ID HI01-HI01-7

Element ID	Usage	Guide Description and Valid Values	Comments
HI01	S	Health Care Code Information	This is a composite data element. The seven data elements in this composite occur 12 times in this segment. Only the first occurrence is used in this illustration. See the IG for complete details.
HI01-1	R	Code List Qualifier Code **BI** – Occurrence Span	
HI01-2	R	Occurrence Span Code	Use the two-byte occurrence span code. See the *IHCP Provider Manual* for a list of valid values and descriptions.
HI01-3	R	Date/Time Period Format Qualifier **RD8** – Date Expressed in Format CCYYMMDD- CCYYMMDD	
HI01-4	R	Date/Time Period	Use the occurrence span *From* and *Through* date.
HI01-5	N/A	Monetary Amount	Not used
HI01-6	N/A	Quantity	Not used
HI01-7	N/A	Version Identifier	Not used

Table 3.76 – Occurrence Information

Segment Name	Occurrence Information
Segment ID	HI
Loop ID	2300
Usage	Situational
Segment Notes	This segment conveys occurrence codes and dates. The segment may be repeated two times. The maximum number of occurrence codes used for processing is 12. Only the first eight occurrence codes are recognized by the IHCP. Occurrence span codes and dates are typically used only on home health and outpatient claims.
Example	`HI*BH:51:D8:20011118~`

Table 3.77 – Element ID HI01-HI01-7

Element ID	Usage	Guide Description and Valid Values	Comments
HI01	S	Health Care Code Information	This is a composite data element. The seven data elements in this composite occur 12 times in this segment. Only the first occurrence is used in this illustration. See the IG for complete details.
HI01-1	R	Code List Qualifier Code **BH** – Occurrence	
HI01-2	R	Occurrence Span Code	Use the two-character occurrence code. See the *IHCP Provider Manual* for a list of valid values and descriptions.
HI01-3	R	Date/Time Period Format Qualifier **D8** – Date Expressed in Format CCYYMMDD	
HI01-4	R	Date/Time Period	Use the occurrence code date.
HI01-5	N/A	Monetary Amount	Not used
HI01-6	N/A	Quantity	Not used
HI01-7	N/A	Version Identifier	Not used

Table 3.78 – Value Information

Segment Name	Value Information
Segment ID	HI
Loop ID	2300
Usage	Situational
Segment Notes	This segment conveys value codes and dollar amounts. The segment may be repeated two times. The maximum number of value code/amounts reported used for processing is 12.
Example	`HI*BE:80:::125~`

Table 3.79 – Element ID HI01-HI01-7

Element ID	Usage	Guide Description and Valid Values	Comments
HI01	S	Health Care Code Information	This is a composite data element. The seven data elements in this composite occur 12 times in this segment. Only the first occurrence is used in this illustration. See the IG for complete details.
HI01-1	R	Code List Qualifier Code **BE** – Value	

Table 3.79 – Element ID HI01-HI01-7

Element ID	Usage	Guide Description and Valid Values	Comments
HI01-2	R	Value Code	Use the two-byte value code. See the *IHCP Provider Manual* for a list of valid values and descriptions.
HI01-3	N/A	Date/Time Period Format Qualifier	Not used
HI01-4	N/A	Date/Time Period	Not used
HI01-5	R	Value Code Amount	Use the value code amount. IHCP format 9999999.99
HI01-6	N/A	Quantity	Not used
HI01-7	N/A	Version Identifier	Not used

Table 3.80 – Condition Information

Segment Name	Condition Information
Segment ID	HI
Loop ID	2300
Usage	Situational
Segment Notes	This segment conveys condition codes. The segment may be repeated two times. The maximum number of condition codes used for processing is seven.
Example	`HI*BG:C1~`

Table 3.81 – Element ID HI01-HI01-7

Element ID	Usage	Guide Description and Valid Values	Comments
HI01	S	Health Care Code Information	This is a composite data element. The seven data elements in this composite occur 12 times in this segment; however, only the first occurrence is used in this illustration. See the IG for complete details.
HI01-1	R	Code List Qualifier Code **BG** – Condition	
HI01-2	R	Condition Code	Use the two-byte condition code. See the *IHCP Provider Manual* for a list of valid values and descriptions.
HI01-3	N/A	Date/Time Period Format Qualifier	Not used
HI01-4	N/A	Date/Time Period	Not used
HI01-5	N/A	Monetary Amount	Not used
HI01-6	N/A	Quantity	Not used
HI01-7	N/A	Version Identifier	Not used

Table 3.82 – Claim Quantity

Segment Name	Claim Quantity
Segment ID	QTY
Loop ID	2300
Usage	Situational
Segment Notes	This segment reports covered days for inpatient and LTC claims.
Example	QTY*CA*30*DA~

Table 3.83 – Element ID QTY01-QTY04

Element ID	Usage	Guide Description and Valid Values	Comments
QTY01	R	Quantity Qualifier **CA** – Covered-Actual	
QTY02	R	Claim Days Count	Use the covered days for services billed on the claim.
QTY03	R	Composite Unit of Measure	This is a composite data element.
QTY03-1	R	Unit or Basis for Measurement Code **DA** – Days	
QTY03-2	N/A	Exponent	Not used
QTY03-3	N/A	Multiplier	Not used
QTY03-4	N/A	Unit of Basis for Measurement Code	Not used
QTY03-5	N/A	Exponent	Not used
QTY03-6	N/A	Multiplier	Not used
QTY03-7	N/A	Unit of Basis for Measurement Code	Not used
QTY03-8	N/A	Exponent	Not used
QTY03-9	N/A	Multiplier	Not used
QTY03-10	N/A	Unit of Basis for Measurement Code	Not used
QTY03-11	N/A	Exponent	Not used
QTY03-12	N/A	Multiplier	Not used
QTY03-13	N/A	Unit of Basis for Measurement Code	Not used
QTY03-14	N/A	Exponent	Not used
QTY03-15	N/A	Multiplier	Not used
QTY04	N/A	Free form message	Not used

Table 3.84 – Attending Physician Name

Segment Name	**Attending Physician Name**
Segment ID	NM1
Loop ID	2310A
Usage	Situational
Segment Notes	This segment conveys attending physician information for claims requiring the attending physician data. If using this loop to provide attending physician information, this segment is required by the IG and must be submitted to be compliant. See the IG for details.
Example	**When submitted with NPI:** `NM1*71*1*JONES*JANE****XX*1234567890~`

Table 3.85 – Element ID NM101-NM111

Element ID	Usage	Guide Description and Valid Values	Comments
NM101	R	Entity Identifier Code **71** – Attending Physician	
NM102	R	Entity Type Qualifier **1** - Person **2** – Non-Person Entity	
NM103	R	Name Last or Organization Name	
NM104	S	Name First	
NM105	S	Name Middle	
NM106	N/A	Name Prefix	Not used
NM107	S	Name Suffix	
NM108	R	Identification Code Qualifier **24** – Employer's Identification Number **34** – Social Security Number **XX** – NPI	If **XX**- NPI is used, then either the Employer's Identification Number or the Social Security Number of the provider must be carried in the REF segment in this loop. This value will be required when the **NPI** is mandated for use.
NM109	R	Identification Code	If *XX* is sent in NM108, enter the 10-digit NPI.
NM110	N/A	Entity Relationship Code	Not used
NM111	N/A	Entity Identifier Code	Not used

Table 3.86 – Attending Physician Specialty Information

Segment Name	Attending Physician Specialty Information
Segment ID	PRV
Loop ID	2310A
Usage	Situational
Segment Notes	This segment conveys taxonomy information for the attending physician when claims require the attending physician data.
Example	`PRV*AT*ZZ*424BF0411F~`

Table 3.87 – Element ID PRV01-PRV06

Element ID	Usage	Guide Description and Valid Values	Comments
PRV01	R	Provider Code **AT** – Attending	
PRV02	R	Reference Identification Qualifier **ZZ** – Mutually Defined	
PRV03	R	Provider Taxonomy Code	Use the provider taxonomy code for the attending physician, if applicable.
PRV04	N/A	State or Province Code	Not used
PRV05	N/A	Provider Specialty Information	Not used
PRV06	N/A	Provider Organization Code	Not used

Table 3.88 – Attending Physician Secondary Information

Segment Name	Attending Physician Secondary Information
Segment ID	REF
Loop ID	2310A
Usage	Situational
Segment Notes	This segment contains the state license number of the attending physician. The segment may repeat five times. Only the segment containing the **0B** qualifier is captured.
Example	`REF*0B*01234543~`

Table 3.89 – Element ID REF01-REF04

Element ID	Usage	Guide Description and Valid Values	Comments
REF01	R	Reference Identification Qualifier **0B** – State License Number	
REF02	R	Attending Physician Secondary Identifier	Use the state license number of the attending physician. The IHCP accepts the eight-digit license number.

Table 3.89 – Element ID REF01-REF04

Element ID	Usage	Guide Description and Valid Values	Comments
REF03	N/A	Description	Not used
REF04	N/A	Reference Identifier	Not used

Table 3.90 – Operating Physician Name

Segment Name	Operating Physician Name
Segment ID	NM1
Loop ID	2310B
Usage	Situational
Segment Notes	This segment conveys operating physician information when operating physician data is required. If using this loop to provide operating physician information, this segment is required by the IG and must be submitted to be compliant. See the IG for details.
Example	**When submitted with the NPI:** `NM1*72*1*SMITH*ROBERT****XX*1234567890~`

Table 3.91 – Element ID NM101-NM111

Element ID	Usage	Guide Description and Valid Values	Comments
NM101	R	Entity Identifier Code **72** – Operating Physician	
NM102	R	Entity Type Qualifier **1** - Person	
NM103	R	Name Last or Organization Name	
NM104	R	Name First	
NM105	S	Name Middle	
NM106	N/A	Name Prefix	Not used
NM107	S	Name Suffix	
NM108	R	Identification Code Qualifier **24** – Employer's Identification Number **34** – Social Security Number **XX** – NPI	If **XX**- NPI is used, then either the Employer's Identification Number or the SSN of the provider must be carried in the REF segment in this loop. This value will be required when the NPI is mandated for use.
NM109	R	Identification Code	If *XX* is sent in NM108, enter the 10-digit NPI.
NM110	N/A	Entity Relationship Code	Not used
NM111	N/A	Entity Identifier Code	Not used

Table 3.92 – Operating Physician Secondary Information

Segment Name	Operating Physician Secondary Information
Segment ID	REF
Loop ID	2310B
Usage	Situational
Segment Notes	This segment contains the state license number of the operating physician. The segment may repeat five times. Only the segment containing the qualifier of 0B is captured.
Example	`REF*0B*01234543~`

Table 3.93 – Element ID REF01-REF04

Element ID	Usage	Guide Description and Valid Values	Comments
REF01	R	Reference Identification Qualifier **0B** – State License Number	
REF02	R	Operating Physician Secondary Identifier	Use the state license number of the operating physician. The IHCP accepts the eight-digit license number.
REF03	N/A	Description	Not used
REF04	N/A	Reference Identifier	Not used

Table 3.94 – Other Provider Name

Segment Name	Other Provider Name
Segment ID	NM1
Loop ID	2310C
Usage	Situational
Segment Notes	This segment conveys PMP information on claims when PMP data is required. If using this loop to provide PMP information, this segment is required by the IG and must be submitted to be compliant. See the IG for details.
Eample	**When submitted with NPI:** `NM1*73*1*DOE*JOHN****XX*1234567890~`

Table 3.95 – Element ID NM101-NM111

Element ID	Usage	Guide Description and Valid Values	Comments
NM101	R	Entity Identifier Code **73** – Other Physician	
NM102	R	Entity Type Qualifier **1** - Person **2** – Non-Person Entity	
NM103	R	Name Last or Organization Name	
NM104	S	Name First	
NM105	S	Name Middle	
NM106	N/A	Name Prefix	Not used
NM107	S	Name Suffix	
NM108	R	Identification Code Qualifier **24** – Employer's Identification Number **34** – Social Security Number **XX** – NPI	If **XX**- NPI is used, then either the Employer's Identification Number or the SSN of the provider must be carried in the REF segment in this loop. This value will be required when the NPI is mandated for use.
NM109	R	Identification Code	If *XX* is sent in NM108, enter the 10-digit NPI.
NM110	N/A	Entity Relationship Code	Not used
NM111	N/A	Entity Identifier Code	Not used

Table 3.96 – Other Provider Secondary Information

Segment Name	Other Provider Secondary Information
Segment ID	REF
Loop ID	2310C
Usage	Situational
Segment Notes	This segment contains the state license number of the PMP. The segment may repeat five times. Only the segment containing the qualifier of **0B** is captured. This is not used by MCOs.
Example	`REF*0B*01234543~`

Table 3.97 – Element ID REF01-REF04

Element ID	Usage	Guide Description and Valid Values	Comments
REF01	R	Reference Identification Qualifier **0B** – State License Number	
REF02	R	Other Provider Secondary Identifier	Use the state license number of the IHCP member's PMP. The IHCP accepts the eight-digit license number.

Table 3.97 – Element ID REF01-REF04

Element ID	Usage	Guide Description and Valid Values	Comments
REF03	N/A	Description	Not used
REF04	N/A	Reference Identifier	Not used

Table 3.98 – Other Subscriber Information

Segment Name	Other Subscriber Information
Segment ID	SBR
Loop ID	2320
Usage	Situational
Segment Notes	The IG requires this segment if the 2320 Loop is used and must be submitted to be compliant. IHCP verifies that the Claim Filing Indicator Code correctly represents whether the other insurance carrier for the subscriber is a Medicare payer.
Example	`SBR*S*01*GR00786******OF~`

Table 3.99 – Element ID SBR01-SBR09

Element ID	Usage	Guide Description and Valid Values	Comments
SBR01	R	Payer Responsibility Sequence Number Code	Not used by IHCP.
SBR02	R	Individual Relationship Code	
SBR03	S	Reference Identification	
SBR04	S	Name	
SBR05	N/A	Insurance Type Code	
SBR06	N/A	Coordination of Benefits Code	
SBR07	N/A	Yes/No Condition or Response Code	
SBR08	N/A	Employment Status Code	
SBR09	S	Claim Filing Indicator Code	The Claim Filing Indicator Code is used to identify Medicare crossover claims. If the claim is a crossover, the Claim Filing Indicator must be set to **MA** - Medicare Part A or **MB** - Medicare Part B.

Table 3.100 – Claim Level Adjustment

Segment Name	Claim Level Adjustment
Segment ID	CAS
Loop ID	2320
Usage	Situational

Table 3.100 – Claim Level Adjustment

Segment Name	Claim Level Adjustment
Segment Notes	This segment submits Medicare deductible, coinsurance, and blood deductible amounts for Medicare Part A claims. For non-Medicare or non-crossover claims, this segment submits all adjustment amounts. The combination of Adjustment Reason Code, Adjustment Amount, and Adjustment Quantity is reported six times on this segment. The following illustration shows only the first iteration. See the IG for complete details about CAS05-19.
Example	`CAS*PR*1*153.2~`

Table 3.101 – Element ID CAS01-CAS04

Element ID	Usage	Guide Description and Valid Values	Comments
CAS01	R	Claim Adjustment Group Code	
CAS02	R	Adjustment Reason Code Adjustments used in IHCP processing of Medicare claims: **1** – Deductible **2** – Coinsurance **66** – Blood Deductible	Only Medicare deductible, coinsurance, and blood deductible adjustments are used by IHCP for crossover claim processing. All adjustments and adjustment amounts are captured by IHCP for claims that were previously adjudicated by another payer for example, MCO, Medicare, or TPL claims.
CAS03	R	Adjustment Amount	Use the dollar amount associated with the reason code identified in CAS02. The IHCP accepts the maximum HIPAA format of 99999999.99
CAS04	S	Adjustment Quantity	Use the quantity associated with the reason code identified in CAS02. IHCP format 9999999.999.

Table 3.102 – Payer Prior Payment

Segment Name	Payer Prior Payment
Segment ID	AMT
Loop ID	2320
Usage	Situational
Segment Notes	This segment reports the amount paid by the other insurer. Medicare paid amounts are captured on the following segment COB Total Medicare Paid Amount.
Example	`AMT*C4*75~`

Table 3.103 – Element ID AMT01-AMT03

Element ID	Usage	Guide Description and Valid Values	Comments
AMT01	R	Amount Qualifier Code **C4** – Prior Payment – Actual	

Table 3.103 – Element ID AMT01-AMT03

Element ID	Usage	Guide Description and Valid Values	Comments
AMT02	R	Other Payer Patient Paid Amount	Use the TPL amount paid by the other insurer. When the other payer is an MCO, use the MCO paid amount here. The IHCP accepts the maximum HIPAA format of 99999999.99
AMT03	N/A	Credit/Debit Flag Code	Not used

Table 3.104 – Total Allowed Amount

Segment Name	Total Allowed Amount
Segment ID	AMT
Loop ID	2320
Usage	Situational
Segment Notes	This segment reports the amount allowed by the other insurer.
Example	`AMT*B6*85~`

Table 3.105 – Element ID AMT01-AMT03

Element ID	Usage	Guide Description and Valid Values	Comments
AMT01	R	Amount Qualifier Code **B6** – Allowed – Actual	
AMT02	R	Allowed Amount	Use the total claim allowed amount by the other insurer. The IHCP accepts the maximum HIPAA format of 99999999.99
AMT03	N/A	Credit/Debit Flag Code	Not used

Table 3.106 – Coordination of Benefits COB Total Medicare Paid Amount

Segment Name	Coordination of Benefits COB Total Medicare Paid Amount
Segment ID	AMT
Loop ID	2320
Usage	Situational
Segment Notes	This segment contains the Medicare paid amount. For Medicare payments, if an amount is supplied in the C4 segment, but the N1 segment is missing or the amount is zero, the claim rejects on the BSR.
Example	`AMT*N1*606.15~`

Table 3.107 – Element ID AMT01-AMT03

Element ID	Usage	Guide Description and Valid Values	Comments
AMT01	R	Amount Qualifier Code **N1** – Net Worth	
AMT02	R	Total Medicare Paid Amount	Use the Medicare paid amount. The IHCP accepts the maximum HIPAA format of 99999999.99
AMT03	N/A	Credit/Debit Flag	Not used

Table 3.108 – Total Denied Charge Amount

Segment Name	Total Denied Charge Amount
Segment ID	AMT
Loop ID	2320
Usage	Situational
Segment Notes	This segment contains the Total Denied Amount.
Example	`AMT*YT*32~`

Table 3.109 – Element ID AMT01-AMT03

Element ID	Usage	Guide Description and Valid Values	Comments
AMT01	R	Amount Qualifier Code **YT** – Denied	
AMT02	R	Claim Total Denied Charge Amount	Use the other payer total denied charge amount by the other insurer. The IHCP accepts the maximum HIPAA format of 99999999.99
AMT03	N/A	Credit/Debit Flag Code	Not used

Table 3.110 – Other Subscriber Demographic Information

Segment Name	Other Subscriber Demographic Information
Segment ID	DMG
Loop ID	2320
Usage	Situational
Segment Notes	Segment contains other payer's subscriber information.
Example	`DMG*D8*19550101*F~`

Table 3.111 – Element ID DMG01-DMG09

Element ID	Usage	Guide Description and Valid Values	Comments
DMG01	R	Date/Time Period Format Qualifier	
DMG02	R	Other Insured Birth Date	
DMG03	R	Other Insured Gender Code	
DMG04	N/A	Marital Status Code	Not Used
DMG05	N/A	Race or Ethnicity Code	Not Used
DMG06	N/A	Citizenship Status Code	Not Used
DMG07	N/A	Country Code	Not Used
DMG08	N/A	Basis of Verification Code	Not Used
DMG09	N/A	Quantity	Not Used

Table 3.112 – Other Insurance Coverage Information

Segment Name	Other Insurance Coverage Information
Segment ID	OI
Loop ID	2320
Usage	Required, if the 2320 Loop is used.
Segment Notes	The IG requires this segment if the 2320 Loop is used and must be submitted to be compliant. Data submitted is not captured by the IHCP. See the IG for details.

Table 3.113 – Other Subscriber Name

Segment Name	Other Subscriber Name
Segment ID	NM1
Loop ID	2330A
Usage	Required if 2320 Loop is used
Segment Notes	This segment specifies information about other subscribers. See the IG for details.
Example	`NM1*IL*1*DOE*JOHN*T***34*123456789~`

Table 3.114 – Element ID NM101-NM109

Element ID	Usage	Guide Description and Valid Values	Comments
NM101	R	Entity Identifier Code **IL** – Insured or Subscriber	
NM102	R	Entity Type Qualifier	Not used by IHCP.
NM103	R	Other Payer's Subscriber Name	
NM104	R	Other Payer's Subscriber First Name	
NM105	R	Other Payer's Subscriber Middle Name	

Table 3.114 – Element ID NM101-NM109

Element ID	Usage	Guide Description and Valid Values	Comments
NM106	N/A	Name Prefix	Not used
NM107	R	Other Payer's Subscriber Name Suffix	
NM108	R	Identification Code Qualifier	Not used by IHCP.
NM109	R	Other Insured Identifier	

Table 3.115 – Other Subscriber Address

Segment Name	Other Subscriber Address
Segment ID	N3
Loop ID	2330A
Usage	Situational
Segment Notes	This segment specifies information about other subscriber's address. See the IG for details.
Example	`N3*4320 WASHINGTON ST SUITE 100~`

Table 3.116 – Element ID N301-N302

Element ID	Usage	Guide Description and Valid Values	Comments
N301	R	Other Payer's Subscriber Address 1	
N302	R	Other Payer's Subscriber Address 2	

Table 3.117 – Other Subscriber City/State/ZIP Code

Segment Name	Other Subscriber City/State/ZIP Code
Segment ID	N4
Loop ID	2330A
Usage	Situational Required when N3 segment is present.
Segment Notes	This segment specifies information about other subscriber's address. See the IG for details.
Example	`N4*PALISADES*OR*23119~`

Table 3.118 – Element ID N401-N403

Element ID	Usage	Guide Description and Valid Values	Comments
N401	R	Other Payer's Subscriber City	
N402	R	Other Payer's Subscriber State	
N403	R	Other Payer's Subscriber ZIP Code	

Table 3.119 – Other Subscriber Secondary Information

Segment Name	Other Subscriber Secondary Information
Segment ID	REF
Loop ID	2330A
Usage	Situational
Segment Notes	This segment specifies information about other subscriber's additional identifiers. See the IG for details.
Example	`REF*SY*030385074~`

Table 3.120 – Element ID REF01-REF04

Element ID	Usage	Guide Description and Valid Values	Comments
REF01	R	Reference Identification Qualifier **IG** - Insurance Policy Number **SY** – Social Security number	
REF02	R	Reference Identification	IHCP only uses the insurance policy number and SSN of the other subscriber.
REF03	N/A	Description	Not used
REF04	N/A	Reference Identifier	Not used

Table 3.121 – Other Subscriber Name

Segment Name	Other Subscriber Name
Segment ID	NM1
Loop ID	2330A
Usage	Required if 2320 Loop is used
Segment Notes	The IG requires this segment if the 2320 Loop is used and must be submitted to be compliant. Data submitted is not captured by the IHCP. See the IG for details.

Table 3.122 – Other Payer Name

Segment Name	Other Payer Name
Segment ID	NM1
Loop ID	2330B
Usage	Required if 2320 Loop is used
Segment Notes	This segment specifies information about other payers. When submitting claims to Medicare that are expected to crossover to the IHCP, this segment must be included and contain the payer ID assigned to the IHCP by Medicare. The payer ID representing the IHCP is **70035**.
Examples	**Claims submitted to the IHCP:** `NM1*PR*2*Family Insurance*****PI*01234~`

Table 3.122 – Other Payer Name

Segment Name	Other Payer Name
	Claims submitted by provider to Medicare, expecting to crossover to the IHCP: `NM1*PR*2*Office Of Medicaid Policy & Planning*****PI*70035~`

Table 3.123 – Element ID NM101-NM111

Element ID	Usage	Guide Description and Valid Values	Comments
NM101	R	Entity Identifier Code **PR** – Payer	
NM102	R	Entity Type Qualifier **2** – Non-Person Entity	
NM103	R	Other Payer Organization Name	
NM104	N/A	Name First	Not used
NM105	N/A	Name Middle	Not used
NM106	N/A	Name Prefix	Not used
NM107	N/A	Name Suffix	Not used
NM108	R	Identification Code Qualifier **PI** – Payer Identification	
NM109	R	Other Payer Primary Identifier For crossover claims, the valid payer identifier list can be located at: http://www.indianamedicaid.com/ihcp/Misc_PDF/Medicare_Payer_IDs.pdf When submitting claims to Medicare that are expected to crossover to the IHCP, use the payer id for the IHCP – **70035**. For shadow claims, the payer identifier should be from this list: **300119960** – Managed Health Services (MHS) **500307680** – MDWise 400752220 - Anthem	For Medicare payments, if the payer is a Medicare payer and the 2320 SBR09 Claim Filing Indicator is **MA** or **MB**, the claim is identified as a crossover claim. If the payer is in the Medicare list, but the Claim Filing Indicator does not indicate that the claim is a Medicare crossover claim, the payment is identified as a commercial payment and is summed into TPL. MCO payers are identified by using the NM109 payer ID. Any other payers are identified as TPL.
NM110	N/A	Entity Relationship Code	Not used
NM111	N/A	Entity Identifier Code	Not used

Table 3.124 – Other Payer Address

Segment Name	Other Payer Address
Segment ID	N3
Loop ID	2330A
Usage	Situational

Table 3.124 – Other Payer Address

Segment Name	Other Payer Address
Segment Notes	This segment specifies information about other payer's address. See the IG for details.
Example	`N3*4320 WASHINGTON ST SUITE 100~`

Table 3.125 – Element ID N301-N302

Element ID	Usage	Guide Description and Valid Values	Comments
N301	R	Other Payer Address Line 1	
N302	R	Other Payer Address Line 2	

Table 3.126 – Other Payer City/State/ZIP Code

Segment Name	Other Payer City/State/ZIP Code
Segment ID	N4
Loop ID	2330A
Usage	Situational *Required* when N3 segment is present.
Segment Notes	This segment specifies information about other payer's address.
Example	`N4*PALISADES*OR*23119~`

Table 3.127 – Element ID N401-N404

Element ID	Usage	Guide Description and Valid Values	Comments
N401	R	Other Payer City Name	
N402	R	Other Payer State	
N403	R	Other Payer ZIP Code	
N404	R	Other Payer Country Code	

Table 3.128 – Claim Adjudication Date

Segment Name	Claim Adjudication Date
Segment ID	DTP
Loop ID	2330B
Usage	Situational
Segment Notes	This segment is required when the Line Adjudication Date is not used and the claim has been adjudicated.
Example	`DTP*573*D8*19981226~`

Table 3.129 – Element ID DTP01-DTP03

Element ID	Usage	Guide Description and Valid Values	Comments
DTP01	R	Date/Time Qualifier **573** - Date Claim Paid	
DTP02	R	Date/Time Period Format Qualifier **D8** – Date Expressed in Format CCYYMMDD	
DTP03	R	Date/Time Period	Adjudication or Payment Date MCOs submit payment date.

Table 3.130 – Other Payer Secondary Identification and Reference Number

Segment Name	Other Payer Secondary Identification and Reference Number
Segment ID	REF
Loop ID	2330B
Usage	Situational
Segment Notes	Utilize segment to send other payer's claim number. IHCP utilizes the information to do replacements and voids of claims.
Example	`REF*F8*465980789~`

Table 3.131 – Element ID REF01-REF04

Element ID	Usage	Guide Description and Valid Values	Comments
REF01	R	Reference Identification Qualifier **F8** – Original Reference Number	Use **F8** to send the other payer's claim number ICN or DCN. *Note: MCO must provide ICN in order to Void or Replace the claim in the future. This encounter claim is reflected on the 835 along with the equivalent IHCP ICN.*
REF02	R	Reference Identification	Use the other payer's ICN or DCN identified in NM109.
REF03	N/A	Description	Not used
REF04	N/A	Reference Identifier	Not used

Table 3.132 – Other Payer Prior Authorization or Referral Number

Segment Name	Other Payer Prior Authorization or Referral Number
Segment ID	REF
Loop ID	2330B
Usage	Situational

Table 3.132 – Other Payer Prior Authorization or Referral Number

Segment Name	Other Payer Prior Authorization or Referral Number
Segment Notes	This segment specifies information about other payer's referral or PA number. See the IG for details.

Table 3.133 – Element ID REF01-REF04

Element ID	Usage	Guide Description and Valid Values	Comments
REF01	R	Reference Identification Qualifier **G1** - Prior Authorization Number **9F** - Referral Number	
REF02	R	Reference Identification	Referral Number or PA Number.
REF03	N/A	Description	Not used
REF04	N/A	Reference Identifier	Not used

Table 3.134 – Other Payer Patient Identification Number

Segment Name	Other Payer Patient Identification Number
Segment ID	REF
Loop ID	2330C
Usage	Situational
Segment Notes	This segment specifies information about other payer's patient identification. See the IG for details
Example	`REF*SY*123521234~`

Table 3.135 – Element ID REF01-REF04

Element ID	Usage	Guide Description and Valid Values	Comments
REF01	R	Reference Identification Qualifier **IG** - Insurance Policy Number **SY** - Social Security number	
REF02	R	Reference Identification	Other Payer Patient Secondary Identifier
REF03	N/A	Description	Not used
REF04	N/A	Reference Identifier	Not used

Table 3.136 – Service Line Number

Segment Name	Service Line Number
Segment ID	LX
Loop ID	2400
Usage	Required

Table 3.136 – Service Line Number

Segment Name	Service Line Number
Segment Notes	This segment contains the line item number that is incremented by one for each service line or detail. The IHCP processes a maximum of 450 LX segments 2400 Loops for each CLM segment.
Example	LX*1~

Table 3.137 – Element ID LX01

Element ID	Usage	Guide Description and Valid Values	Comments
LX01	R	Assigned Number	The first service line should begin with the number **1**. Each subsequent service line/detail should be incremented by one.

Table 3.138 – Institutional Service Line

Segment Name	Institutional Service Line
Segment ID	SV2
Loop ID	2400
Usage	Required
Segment Notes	This segment reports revenue code, procedure code, modifiers, charge amounts, and units. The IHCP only recognizes the first 450 service lines on a claim. The Total Claim Charge Amount from CLM02 must reflect the total of the first 450 details. Failure to comply results in denial of the claim for an out of balance condition.
Example	SV2*300*HC:80019*301*UN*5~

Table 3.139 – Element ID SV201-SV210

Element ID	Usage	Guide Description and Valid Values	Comments
SV201	R	Service Line Revenue Code	Use the appropriate revenue code for the service rendered.
SV202	S	Composite Medical Procedure Identifier	This is a composite data element.
SV202-1	R	Product/Service ID Qualifier **HC** – Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes	**HC** is the only valid value accepted by the IHCP. Per the addenda, National Drug Code (NDC) information now resides on the LIN/CTP segments in the 2410 Loop.
SV202-2	R	Procedure Code	Use the five-digit HCPCS procedure code for the service rendered.
SV202-3	S	HCPCS Modifier 1	
SV202-4	S	HCPCS Modifier 2	
SV202-5	S	HCPCS Modifier 3	
SV202-6	S	HCPCS Modifier 4	
SV202-7	N/A	Description	Not used
SV203	R	Line Item Charge Amount	The IHCP accepts the maximum HIPAA format of 99999999.99
SV204	R	Unit or Basis of Measurement Code **DA** – Days **UN** – Units	
SV205	R	Service Unit Count	The IHCP only recognizes up to a seven-digit whole number. Fractional quantities are not recognized. IHCP format 9999999.999
SV206	S	Service Line Rate	Not used by the IHCP
SV207	S	Line Item Denied Charge or Non-Covered Charge Amount	Not used by the IHCP
SV208	N/A	Yes/No Condition or Response Code	Not used
SV209	N/A	Nursing Home Residential Status Code	Not used
SV210	N/A	Level of Care Code	Not used

Table 3.140 – Line Supplemental Information

Segment Name	Line Supplemental Information
Segment ID	PWK
Loop ID	2400
Usage	Situational
Segment Notes	This segment is used when additional information is required to process the claim, and the information must be mailed to the IHCP.
Example	`PWK*AS*BM***AC*1522353~`

Table 3.141 – Element ID PWK01-PWK09

Element ID	Usage	Guide Description and Valid Values	Comments
PWK01	R	Attachment Report Type Code	See the IG for a list of valid values.
PWK02	R	Attachment Transmission Code **BM** – By Mail	Even though all Attachment Transmission Codes are accepted, claims that suspend because of an attachment requirement are only resolved by sending the attachment by mail.
PWK03	N/A	Report Copies Needed	Not used
PWK04	N/A	Entity Identifier Code	Not used
PWK05	R	Identification Code Qualifier **AC** – Attachment Control Number	
PWK06	R	Attachment Control Number	A unique attachment control number of up to 30 characters must be used and must match the number associated with the paper documentation sent by mail. This number is used to link the claim with the paper documentation and must be unique per billing location across all claims.
PWK07	S	Attachment Description	Not used by the IHCP
PWK08	N/A	Actions Indicated	Not used
PWK09	N/A	Request Category Code	Not used

Table 3.142 – Service Line Date

Segment Name	Service Line Date
Segment ID	DTP
Loop ID	2400
Usage	Situational
Segment Notes	This segment reports the detail date of service. Required for home health and outpatient claims.
Example	`DTP*472*D8*20021130~`

Table 3.143 – Element ID DTP01-DTP03

Element ID	Usage	Guide Description and Valid Values	Comments
DTP01	R	Date/Time Qualifier **472** – Service	
DTP02	R	Date/Time Period Format Qualifier **D8** – Date Expressed in Format CCYYDDMM **RD8** – Date Expressed in Format CCYYMMDD-CCYYMMDD	If qualifier **RD8** is used, the IHCP uses the first occurrence of CCYYMMDD as the detail date of service.
DTP03	R	Service Date	

Table 3.144 – Drug Identification

Segment Name	Drug Identification
Segment ID	LIN
Loop ID	2410
Usage	Situational
Segment Notes	This segment contains the NDC if applicable. LIN04through LIN31 are listed in this segment, but marked as not used and do not appear in this illustration. This newly created segment appears in the *Addenda*. Only the first occurrence of the segment submitted is recognized by the IHCP.
Example	`LIN*N4*00045012424~`

Table 3.145 – Element ID LIN01-LIN03

Element ID	Usage	Guide Description and Valid Values	Comments
LIN01	N/A	Assigned Identification	Not used
LIN02	R	Product/Service ID Qualifier **N4** – National Drug Code in 5-4-2 format	
LIN03	R	National Drug Code	Use the 11-digit NDC.

Table 3.146 – Drug Pricing

Segment Name	Drug Pricing
Segment ID	CTP
Loop ID	2410
Usage	Situational
Segment Notes	This segment contains information necessary to price the NDC listed in the previous LIN segment. CTP05-2 through CTP05-15 and CTP06 through CTP11 are listed in this segment but marked as not used and do not appear in this illustration. This newly created segment appears in the *Addenda*.
Example	`CTP***1.2*300*ML~`

Table 3.147 – Element ID CTP01-CTP05-1

Element ID	Usage	Guide Description and Valid Values	Comments
CTP01	N/A	Class of Trade Code	Not used
CTP02	N/A	Price Identifier Code	Not used
CTP03	R	Drug Unit Price	Not used by the IHCP
CTP04	R	National Drug Unit Count	Use the quantity associated with the NDC listed in LIN03. The IHCP format is 9999999.999
CTP05	R	Composite Unit of Measure	This is a composite data element.

Table 3.147 – Element ID CTP01-CTP05-1

Element ID	Usage	Guide Description and Valid Values	Comments
CTP05-1	R	Unit or Basis of Measurement Code **GR** – Gram **ML** – Milliliter **UN** – Unit **F2** – International Units	Use the appropriate unit of measure.

Table 3.148 – Service Line Adjudication Information

Segment Name	Service Line Adjudication Information
Segment ID	SVD
Loop ID	2430
Usage	Situational
Segment Notes	This segment contains the detail other payer paid amount. See the *IHCP Provider Manual* for guidelines for using the detail paid amount.
Example	`SVD*00130*678.9~`

Table 3.149 – Element ID SVD01-SVD06

Element ID	Usage	Guide Description and Valid Values	Comments
SVD01	R	Payer Identification	This must match the value submitted in NM109 in the 2330B Loop. For crossover claims with Medicare payment submitted at the detail, refer to the companion guide values specified for NM109 in Loop 2330B.
SVD02	R	Service Line Paid Amount	Use the detail Medicare, MCO and any other payer paid amount. The IHCP accepts the maximum HIPAA format of 99999999.99
SVD03	S	Composite Medical Procedure Identifier	This is a composite data element and is not used by the IHCP.
SVD03-1	R	Product or Service ID Qualifier	Not used by the IHCP
SVD03-2	R	Procedure Code	Not used by the IHCP
SVD03-3	S	Procedure Modifier	Not used by the IHCP
SVD03-4	S	Procedure Modifier	Not used by the IHCP
SVD03-5	S	Procedure Modifier	Not used by the IHCP
SVD03-6	S	Procedure Modifier	Not used by the IHCP
SVD03-7	S	Procedure Code Description	Not used by the IHCP
SVD04	R	Service Line Revenue Code	Not used by the IHCP
SVD05	R	Adjustment Quantity	Not used by the IHCP

Table 3.149 – Element ID SVD01-SVD06

Element ID	Usage	Guide Description and Valid Values	Comments
SVD06	S	Bundled or Unbundled Line Number	Not used by the IHCP

Table 3.150 – Service Line Adjustment

Segment Name	Service Line Adjustment
Segment ID	CAS
Loop ID	2430
Usage	Situational
Segment Notes	This segment submits Medicare deductible, coinsurance, and blood deductible amounts for Medicare Part B claims. For non-crossover claims, this segment submits all adjustment amounts. The combination of Adjustment Reason Code, Adjustment Amount, and Adjustment Quantity is reported six times on this segment. The following illustration shows only the first iteration. See the IG for complete details about CAS05-19.
Example	`CAS*PR*2*25.1~`

Table 3.151 – Element ID CAS01-CAS04

Element ID	Usage	Guide Description and Valid Values	Comments
CAS01	R	Claim Adjustment Group Code	
CAS02	R	Adjustment Reason Code **1** – Deductible **2** – Coinsurance **66** – Blood Deductible	Only Medicare deductible, coinsurance, and blood deductible adjustments are used by IHCP for crossover claim processing. All adjustments and adjustment amounts are captured by IHCP for claims that were previously adjudicated by another payer for example, MCO, Medicare, or TPL claims.
CAS03	R	Adjustment Amount	Use the dollar amount associated with the reason code identified in CAS02. The IHCP accepts the maximum HIPAA format of 99999999.99
CAS04	S	Adjustment Quantity	IHCP format 9999999.999

Table 3.152 – Service Adjudication Date

Segment Name	Service Adjudication Date
Segment ID	DTP
Loop ID	2430
Usage	Situational
Segment Notes	This segment specifies the date when a service line was adjudicated. See the IG for details.

Table 3.152 – Service Adjudication Date

Segment Name	Service Adjudication Date
Example	DTP*573*D8*19981226~

Table 3.153 – Element ID DTP01-DTP03

Element ID	Usage	Guide Description and Valid Values	Comments
DTP01	R	Date/Time Qualifier **573** – Date Claim Paid	
DTP02	R	Date/Time Period Format Qualifier **D8** – Date Expressed in Format CCYYDDMM	
DTP03	R	Service Adjudication or Payment Date	Payment or Adjudication Date MCOs submit payment date.

Table 3.154 – Transaction Set Trailer

Segment Name	Transaction Set Trailer
Segment ID	SE
Loop ID	N/A
Usage	Required
Segment Notes	This segment ends the transaction set.
Example	SE*837*7656543~

Table 3.155 – Element ID SE01-SE02

Element ID	Usage	Guide Description and Valid Values	Comments
SE01	R	Transaction Set Identifier Code **837**	
SE02	R	Transaction Set Control Number	This number is assigned locally by the sender and should match the value in the preceding ST segment.

Transaction Examples

Medicaid Primary – No COB

Figure 3.1 illustrates a Medicaid primary with no COB 837 Institutional transaction.

```
ST*837*987654~
BHT*0019*00*X2FF1*20020901*1230*CH~
```

```
REF*87*004010X096A1~
NM1*41*2*ANDERSON MEDICAL GROUP*****46*P123~
PER*IC*ALICE WILSON*TE*3174880000~
NM1*40*2*IHCP*****46*IHCP~
HL*1**20*1~
NM1*85*2*ANDERSON MEDICAL GROUP*****XX*1234567890~
N3*4000 E MELROSE STREET~
N4*INDIANAPOLIS*IN*46204~
REF*EI*211311411~
REF*1D*100444000A~
HL*2*1*22*0~
SBR*P*18**IHCP*****MC~
NM1*IL*1*DOE*JACK****MI*100444555999~
N3*6000 WEST STREET~
N4*INDIANAPOLIS*IN*46410~
DMG*D8*19390529*M~
NM1*PR*2*EDS*****PI*EDS~
CLM*755555M*105951.4***11:A:1*Y**Y*Y*********N~
DTP*434*RD8*20021019-20021118~
DTP*435*DT*200210191400~
CL1*3**20~
PWK*AS*BM***AC*86576*Admission comments~
AMT*C5*105851.4~
AMT*F3*100~
REF*9F*12~
REF*EA*D234345~
HI*BK:51881*BJ:51881~
HI*BF:7070*BF:5789*BF:42731*BF:78039*BF:5119*BF:2761*BF:03811*BF:4280~
HI*BH:51:D8:20021118~
HI*BG:C1~
QTY*CA*30*DA~
NM1*71*2*ANDERSON*JOEL****XX*1234567890~
PRV*AT*ZZ*363LP0200N~
REF*0B*0123454321~
LX*1~
SV2*120**31500*UN*30*1050~
LX*2~
SV2*250**25276.85*UN*791~
LX*3~
SV2*258**4360.80*UN*150~
LX*4~
SV2*270**13148.10*UN*495~
LX*5~
SV2*300**301*UN*5~
LX*6~
SV2*301**3118.25*UN*133~
LX*7~
SV2*305**240.60*UN*5~
```

```
LX*8~
SV2*306**497.15*UN*8~
LX*9~
SV2*307**45.40*UN*4~
LX*10~
SV2*320**632.75*UN*4~
LX*11~
SV2*410**26830.5*UN*96~
SE*58*987654~
```

Figure 3.1 – 837I Transaction for Medicaid Primary and No COB

Medicaid Secondary to Medicare

Figure 3.2 illustrates a Medicaid secondary to Medicare 837 Institutional transaction.

```
ST*837*987654~
BHT*0019*00*X2FF1*20020901*1230*CH~
REF*87*004010X096A1~
NM1*41*2*ANDERSON MEDICAL GROUP*****46*P123~
PER*IC*ALICE WILSON*TE*3174880000~
NM1*40*2*IHCP*****46*IHCP~
HL*1**20*1~
NM1*85*2*ANDERSON MEDICAL GROUP*****24*363915363~
N3*4000 E MELROSE STREET~
N4*INDIANAPOLIS*IN*46204~
REF*1D*100444000A~
HL*2*1*22*0~
SBR*P*18**IHCP*****MC~
NM1*IL*1*DOE*JACK****MI*100444555999~
N3*6000 WEST STREET~
N4*INDIANAPOLIS*IN*46410~
DMG*D8*19390529*M~
NM1*PR*2*EDS*****PI*EDS~
CLM*755555M*105951.4***11:A:1*Y**Y*Y*********N~
DTP*434*RD8*20021019-20021118~
DTP*435*DT*200210191400~
CL1*3**20~
PWK*AS*BM***AC*86576*Admission comments~
AMT*C5*61295.95~
AMT*F3*100~
REF*9F*12~
REF*EA*D234345~
HI*BK:51881*BJ:51881~
HI*BF:7070*BF:5789*BF:42731*BF:78039*BF:5119*BF:2761*BF:03811*BF:4280~
HI*BH:51:D8:20021118~
HI*BG:C1~
QTY*CA*30*DA~
NM1*71*2*ANDERSON*JOEL****34*212222122~
PRV*AT*ZZ*363LP0200N~
REF*0B*0123454321~
SBR*P*18*******MA~
CAS*PR*1*1153.2~
AMT*N1*44455.45~
DMG*D8*19251014*F~
OI***Y***Y~
NM1*IL*1*DOE*JACK****MI*7767654A~
```

```
NM1*PR*2*MEDICARE*****PI*00130~
LX*1~
SV2*120**31500*UN*30*1050~
LX*2~
SV2*250**25276.85*UN*791~
LX*3~
SV2*258**4360.80*UN*150~
LX*4~
SV2*270**13148.10*UN*495~
LX*5~
SV2*300**301*UN*5~
LX*6~
SV2*301**3118.25*UN*133~
LX*7~
SV2*305**240.60*UN*5~
LX*8~
SV2*306**497.15*UN*8~
LX*9~
SV2*307**45.40*UN*4~
LX*10~
SV2*320**632.75*UN*4~
LX*11~
SV2*410**26830.5*UN*96~
SE*65*987654~
```

Figure 3.2 – 837I Transaction for Medicaid Secondary to Medicare

Medicaid Tertiary to Medicare and Other Insurer

Figure 3.3 illustrates a Medicaid tertiary to Medicare and another insurer 837 Institutional transaction.

```
ST*837*987654~
BHT*0019*00*X2FF1*20020901*1230*CH~
REF*87*004010X096A1~
NM1*41*2*ANDERSON MEDICAL GROUP*****46*P123~
PER*IC*ALICE WILSON*TE*3174880000~
NM1*40*2*IHCP*****46*IHCP~
HL*1**20*1~
NM1*85*2*ANDERSON MEDICAL GROUP*****24*363915363~
N3*4000 E MELROSE STREET~
N4*INDIANAPOLIS*IN*46204~
REF*1D*100444000A~
HL*2*1*22*0~
SBR*P*18**IHCP*****MC~
NM1*IL*1*DOE*JACK****MI*100444555999~
```

```
N3*6000 WEST STREET~
N4*INDIANAPOLIS*IN*46410~
DMG*D8*19390529*M~
NM1*PR*2*EDS*****PI*EDS~
CLM*755555M*105951.4***11:A:1*Y**Y*Y*********N~
DTP*434*RD8*20021019-20021118~
DTP*435*DT*200210191400~
CL1*3**20~
PWK*AS*BM***AC*86576*Admission comments~
AMT*C5*62055.45~
AMT*F3*100~
REF*9F*12~
REF*EA*D234345~
HI*BK:51881*BJ:51881~
HI*BF:7070*BF:5789*BF:42731*BF:78039*BF:5119*BF:2761*BF:03811*BF:4280~
HI*BH:51:D8:20021118~
HI*BG:C1~
QTY*CA*30*DA~
NM1*71*2*ANDERSON*JOEL****34*212222122~
PRV*AT*ZZ*363LP0200N~
REF*0B*0123454321~
SBR*P*18*******MA~
CAS*PR*1*1153.2~
AMT*N1*44455.45~
DMG*D8*19251014*M~
OI***Y***Y~
NM1*IL*1*DOE*JACK****MI*7767654A~
NM1*PR*2*MEDICARE*****PI*00130~
SBR*P*18*******CI~
AMT*C4*17500~
DMG*D8*19251014*M~
OI***Y***Y~
NM1*IL*1*DOE*JACK****MI*7767654A~
NM1*PR*2*AETNA*****PI*98366~
LX*1~
SV2*120**31500*UN*30*1050~
LX*2~
SV2*250**25276.85*UN*791~
LX*3~
SV2*258**4360.80*UN*150~
LX*4~
SV2*270**13148.10*UN*495~
LX*5~
SV2*300**301*UN*5~
```

```
LX*6~
SV2*301**3118.25*UN*133~
LX*7~
SV2*305**240.60*UN*5~
LX*8~
SV2*306**497.15*UN*8~
LX*9~
SV2*307**45.40*UN*4~
LX*10~
SV2*320**632.75*UN*4~
LX*11~
SV2*410**26830.5*UN*96~
SE*71*987654~
```

Figure 3.3 – 837I Transaction for Medicaid Tertiary to Medicare and Other Insurer

Medicaid Secondary to Primary Insurer (TPL)

Figure 3.4 illustrates a Medicaid secondary to a primary insurer (TPL) 837 Institutional transaction.

```
ST*837*987654~
BHT*0019*00*X2FF1*20020901*1230*CH~
REF*87*004010X096A1~
NM1*41*2*ANDERSON MEDICAL GROUP*****46*P123~
PER*IC*ALICE WILSON*TE*3174880000~
NM1*40*2*IHCP*****46*IHCP~
HL*1**20*1~
NM1*85*2*ANDERSON MEDICAL GROUP*****24*363915363~
N3*4000 E MELROSE STREET~
N4*INDIANAPOLIS*IN*46204~
REF*1D*100444000A~
HL*2*1*22*0~
SBR*P*18**IHCP*****MC~
NM1*IL*1*DOE*JACK****MI*100444555999~
N3*6000 WEST STREET~
N4*INDIANAPOLIS*IN*46410~
DMG*D8*19390529*M~
NM1*PR*2*EDS*****PI*EDS~
CLM*755555M*105951.4***11:A:1*Y**Y*Y*********N~
DTP*434*RD8*20021019-20021118~
DTP*435*DT*200210191400~
CL1*3**20~
PWK*AS*BM***AC*86576*Admission comments~
AMT*C5*88351.4~
AMT*F3*100~
```

```
REF*9F*12~
REF*EA*D234345~
HI*BK:51881*BJ:51881~
HI*BF:7070*BF:5789*BF:42731*BF:78039*BF:5119*BF:2761*BF:03811*BF:4280~
HI*BH:51:D8:20021118~
HI*BG:C1~
QTY*CA*30*DA~
NM1*71*2*ANDERSON*JOEL****34*212222122~
PRV*AT*ZZ*363LP0200N~
REF*0B*0123454321~
SBR*P*18*******CI~
AMT*C4*17500~
DMG*D8*19251014*M~
OI***Y***Y~
NM1*IL*1*DOE*JACK****MI*7767654A~
NM1*PR*2*AETNA*****PI*98366~
LX*1~
SV2*120**31500*UN*30*1050~
LX*2~
SV2*250**25276.85*UN*791~
LX*3~
SV2*258**4360.80*UN*150~
LX*4~
SV2*270**13148.10*UN*495~
LX*5~
SV2*300**301*UN*5~
LX*6~
SV2*301**3118.25*UN*133~
LX*7~
SV2*305**240.60*UN*5~
LX*8~
SV2*306**497.15*UN*8~
LX*9~
SV2*307**45.40*UN*4~
LX*10~
SV2*320**632.75*UN*4~
LX*11~
SV2*410**26830.5*UN*96~
SE*64*987654~
```

Figure 3.4 – 837I Transaction for Medicaid Secondary to Primary Insurer (TPL)

MCO Shadow Claim to Medicaid

Figure 3.5 illustrates an MCO shadow claim to Medicaid 837 Institutional transaction.

```
ST*837*987655~
BHT*0019*00*SHADOW WITH COB*20010901*1230*RP~
REF*87*004010X096A1~
NM1*41*2*MANAGED HEALTH SERVICES CENTRAL*****46*44444~
PER*IC*REQUIRED BUT WE DONT USE*TE*3174885059~
NM1*40*2*INDIANA HEALTH COVERAGE PROGRAM*****46*IHCP~
HL*1**20*1~
NM1*85*2*DR.  MARCUS WELBY*****24*123321123~
N3*4444 WEST STREET~
N4*INDIANAPOLIS*IN*12345~
REF*1A*123321123~
REF*1D*100000000A~
REF*B3*100467390N~
HL*2*1*22*0~
SBR*T*18**SBR03 OR 04 IS REQUIRED*****CI~
NM1*IL*1*PATIENT*JOE****MI*104455668899~
N3*1111 South Street~
N4*INDIANAPOLIS*IN*88888~
DMG*D8*19751010*M~
NM1*PR*2*EDS*****PI*EDS~
CLM*PAT12345*1000***13:A:1*Y**Y*M*********Y~
DTP*434*RD8*20021019-20021118~
AMT*C5*200~
HI*BK:25000*BJ:25000~
NM1*71*2* DR.  MARCUS WELBY * ****XX*1234567890~
PRV*SU*ZZ*363LP0200N~
SBR*S*18*******12~
CAS*PI*23*650~
CAS*CO*42*200~
AMT*C4*150~
DMG*D8*19751010*M~
OI***Y***Y~
NM1*IL*1*PATIENT*JOE****MI*104455668899~
NM1*PR*2*MANAGED HEALTH SERVICES CENTRAL*****PI*MHS~
REF*F8*1234567890123456~
SBR*P*18*******CI~
CAS*PR*1*250**2*100~
AMT*C4*650~
DMG*D8*19751010*M~
OI***Y***Y~
NM1*IL*1*PATIENT*JOE****MI*607840G~
```

```
NM1*PR*2*ANTHEM INSURANCE*****PI*ANTHEM~
LX*1~
SV2*450**1000*UN*1~
SVD*MHS*150**270*1~
SVD*ANTHEM*650**270*1~
SE*46*987655~
```

Figure 3.5 – 837I Transaction for MCO Shadow Claim to Medicaid

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