INDIANA HEALTH COVERAGE PROGRAMS

Companion Guide: 837 Professional Claims and Encounters Transaction

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Revision History

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Version 1.2	303	October 2004	Pages 3-15 through 3-19	Updated 2000B Segment Notes, Comments and Examples relating to the IHCP and HCI claims and payments. (20050131)	Systems/ Publications
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Version 1.9	1027	July 2007	Tables pages 3-51 and 3-52	July 2007	Publications/ Systems
Version 2.0	789	August 2007	Multiple	Revisions for NPI Final	Systems/ Publications
Version 2.1		February 2008	Table 3.20	NPI Implementation	Publications/ Systems

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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 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 professional

2. Interchange control

3. Transaction specifications

This section, *Introduction*, provides a general description of the 837 Professional 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 Professional

The *ASC X12N 837 (04010X098)* transaction is the Health Information Portability and Accountability Act (HIPAA)-mandated instrument by which professional claim or encounter data must be submitted. Any claim that would be submitted on a *HCFA/CMS-1500* claim form must be submitted using this transaction if the data is submitted electronically. This includes the following claim types:

• Medical related services

• Medicare Crossover Part B

This companion guide is for the 837 Professional 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 Professional Claims and Encounters Transactions*

• *National Electronic Data Interchange Transaction Set Implementation Guide: Health Care Claim: Professional: 837: ASC X12N 837 (004010X098)* and *(004010X098A1) Addenda*

• *IHCP Provider Manual*

• *First Steps Provider Billing Manual*, if applicable.

In addition to compliance checking and the resulting *997 Acknowledgement* file, the IHCP creates a *Biller Summary Report* (BSR) in response to all 837 submissions. This report provides summary

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information about the results of pre-adjudication claim and encounter processing. Information on this report indicates rejected claims not processed by the system. With the full National Provider Identifier (NPI) implementation, the report will also show rejection errors on claims from health care providers where the Billing NPI was not submitted, a submitted NPI has not been reported to the IHCP, or the reported NPI cross-walks to multiple IHCP Legacy Provider Identifiers (LPI).

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

- With the full implementation of NPI, 837P transactions must be submitted with the NPI for health care providers. Atypical providers may submit with either an NPI or the LPI.

- 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 are not 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 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, 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.

- All quantities have pre-adjudication edits. Refer to the appropriate segments for 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 a maximum of 50 service lines, or details on the 837P transaction. Claims with details in excess of 50 are rejected by compliance error.

- Coordination of benefits (COB) assumptions:
  Non-Medicare third party liability (TPL) is only reported at claim level.
  Medicare paid amounts, deductible, coinsurance, and psych adjustment must be reported at service line level.
  Shadow claims:

- 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 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 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 was denied in Indiana*AIM*.

- A replacement request cannot be performed against a claim that was 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 was denied in Indiana*AIM*.

- A replacement request cannot be performed against a denied claim 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 837P control structure as it relates to communication with the Indiana Health Coverage Programs (IHCP).

Inbound Transactions

Table 2.1 – Interchange Control Header

Segment Name	Interchange Control Header		
Segment ID	ISA		
Loop ID	N/A		
Usage	Required		
Segment Notes	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.		
	Character	**Name**	**Delimiter**
	*	Asterisk	Data Element Separator
	:	Colon	Sub-element Separator
	~	Tilde	Segment Terminator
While it is not required that submitters use these specific delimiters, they are the ones that the IHCP uses for all outbound transactions.			
Example	ISA* 00* ….......* 00*……….* ZZ* P123 ..* ZZ*IHCP……* 930602* 1253* U* 00401* 000000905* 1* P* :~		

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Table 2.2 – Element ID ISA01-ISA16

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	

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Table 2.2 – Element ID ISA01-ISA16

Element ID	Usage	Guide Description and Valid Values	Comments
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. |
| 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 from 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*HS*P123*IHCP*20020606*105531*5*X*004010X098A1~

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
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 **004010X098A1** – 837P	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~

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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 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 837P 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*004010X098A1~
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 837P Transactions

Section 3: Professional Claims and Encounters

Segment Usage – 837 Professional

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: Professional: 837: ASC X12N 837 (004010X098)* and *(004010X098A1) 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 <u>IHCP Provider Manual</u> for specific billing requirements.

Table 3.1 – 837 Professional, 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
N2	1000A	Additional Submitter Name Information	X – deleted per *Addenda*
PER	1000A	Submitter Electronic Data Interchange (EDI) Contact Information	R
NM1	1000B	Receiver Name	R
N2	1000B	Receiver Additional Name Information	X – deleted per *Addenda*
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
N2	2010AA	Additional Billing Provider Name Information	X – deleted per *Addenda*
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

Table 3.1 – 837 Professional, Segment Usage

Segment ID	Loop ID	Segment Name	IHCP Usage R – Required S – Situational X – Not Used
N2	2010AB	Additional Pay-to-Provider Name Information	X – deleted per *Addenda*
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
HL	2000B	Subscriber Hierarchical Level	R
SBR	2000B	Subscriber Information	R
PAT	2000B	Patient Information	S
NM1	2010BA	Subscriber Name	R
N2	2010BA	Additional Subscriber Name Information	X – deleted per *Addenda*
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	Payer Name	R
N2	2010BB	Additional Payer Name Information	X – deleted per *Addenda*
N3	2010BB	Payer Address	X
N4	2010BB	Payer City/State/ZIP Code	X
REF	2010BB	Payer Secondary Information	X
NM1	2010BC	Responsible Party Name	X
N2	2010BC	Additional Responsible Party Name Information	X – deleted per *Addenda*
N3	2010BC	Responsible Party Address	X
N4	2010BC	Responsible Party City/State/ZIP Code	X
NM1	2010BD	Credit/Debit Card Holder Name	X
N2	2010BD	Additional Credit/Debit Card Holder Name Information	X – deleted per *Addenda*
REF	2010BD	Credit/Debit Card Information	X
HL	2000C	Patient Hierarchical Level	S
PAT	2000C	Patient Information	S
NM1	2010CA	Patient Name	S
N2	2010CA	Additional Patient Name Information	X – deleted per *Addenda*
N3	2010CA	Patient Address	S
N4	2010CA	Patient City/State/ZIP Code	S
DMG	2010CA	Patient Demographic Information	S

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Table 3.1 – 837 Professional, Segment Usage

Segment ID	Loop ID	Segment Name	IHCP Usage R – Required S – Situational X – Not Used
REF	2010CA	Patient Secondary Information Number	S
REF	2010CA	Property and Casualty Claim Number	S
CLM	2300	Claim Information	R
DTP	2300	Date – Order Date	X – deleted per *Addenda*
DTP	2300	Date – Initial Treatment	X
DTP	2300	Date – Referral Date	X – deleted per *Addenda*
DTP	2300	Date – Date Last Seen	X
DTP	2300	Date – Onset of Current Illness/Symptom	X
DTP	2300	Date – Acute Manifestation	X
DTP	2300	Date – Similar Illness/Symptom Onset	X
DTP	2300	Date – Accident	X
DTP	2300	Date – Last Menstrual Period (LMP)	S
DTP	2300	Date – Last X-Ray	X
DTP	2300	Date – Estimated Date of Birth	X – deleted per *Addenda*
DTP	2300	Date – Hearing and Vision Prescription Date	X
DTP	2300	Date – Disability Begin	X
DTP	2300	Date – Disability End	X
DTP	2300	Date – Date Last Worked	X
DTP	2300	Date – Authorized Return to Work	X
DTP	2300	Date – Admission	S
DTP	2300	Date – Date Discharge	S
DTP	2300	Date – Assumed and Relinquished Care Dates	X
PWK	2300	Claim Supplemental Information	S
CN1	2300	Contract Information	S
AMT	2300	Credit/Debit Card Maximum Amount	X
AMT	2300	Patient Paid Amount	X
AMT	2300	Total Purchased Service Amount	X
REF	2300	Service Authorization Exception Code	X
REF	2300	Mandatory Medicare (Section 4081) Crossover Indicator	X
REF	2300	Mammography Certification Number	X
REF	2300	Referral Number – Certification Code	S
REF	2300	Original Reference Number (Internal Control Number/Document Control Number - ICN/DCN)	S

Table 3.1 – 837 Professional, Segment Usage

Segment ID	Loop ID	Segment Name	IHCP Usage R – Required S – Situational X – Not Used
REF	2300	Prior Authorization	S
REF	2300	Clinical Laboratory Improvement Amendment (CLIA)	X
REF	2300	Repriced Claim Number	X
REF	2300	Adjusted Repriced Claim Number	X
REF	2300	Investigational Device Exemption Number	X
REF	2300	Claim Identification Number for Clearinghouses and Other Transmission Intermediaries	X
REF	2300	Ambulatory Patient Group (APG)	X
REF	2300	Medical Record Number	S
REF	2300	Demonstration Project Identifier	X
K3	2300	File Information	X
NTE	2300	Claim Note	S
CR1	2300	Ambulance Transport Information	X
CR2	2300	Spine Manipulation Service Information	X
CRC	2300	Ambulance Certification	X
CRC	2300	Patient Condition Information: Vision	X
CRC	2300	Homebound Indicator	X
CRC	2300	Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Referral	X – new per *Addenda*
HI	2300	Health Care Diagnosis Code	R
HCP	2300	Claim Pricing/Repricing Information	X
CR7	2305	Home Health Care Plan Delivery	X
HSD	2305	Health Care Services Delivery	X
NM1	2310A	Referring Provider Name	S
PRV	2310A	Referring Provider Specialty Information	X
N2	2310A	Additional Referring Provider Name Information	X – deleted per *Addenda*
REF	2310A	Referring Provider Secondary Information	S
NM1	2310B	Rendering Provider Name	S
PRV	2310B	Rendering Provider Specialty Information	S
N2	2310B	Additional Rendering Provider Name Information	X – deleted per *Addenda*
REF	2310B	Rendering Provider Secondary Information	S
NM1	2310C	Purchased Service Provider Name	X
REF	2310C	Purchased Service Provider Secondary Information	X

Table 3.1 – 837 Professional, Segment Usage

Segment ID	Loop ID	Segment Name	IHCP Usage R – Required S – Situational X – Not Used
NM1	2310D	Service Facility Location	X
N2	2310D	Additional Service Facility Location Name Information	X – deleted per *Addenda*
N3	2310D	Service Facility Location Address	X
N4	2310D	Service Facility Location City/State/ZIP Code	X
REF	2310D	Service Facility Location Secondary Information	X
NM1	2310E	Supervising Provider Name	X
N2	2310E	Additional Supervising Provider Name Information	X – deleted per *Addenda*
REF	2310E	Supervising Provider Secondary Information	X
SBR	2320	Other Subscriber Information	S
CAS	2320	Claim Level Adjustment	S
AMT	2320	Coordination of Benefits (COB) Payer Paid Amount	S
AMT	2320	Coordination of Benefits (COB) Approved Amount	S
AMT	2320	Coordination of Benefits (COB) Allowed Amount	S
AMT	2320	Coordination of Benefits (COB) Patient Responsibility Amount	X
AMT	2320	Coordination of Benefits (COB) Covered Amount	S
AMT	2320	Coordination of Benefits (COB) Discount Amount	X
AMT	2320	Coordination of Benefits (COB) Per Day Limit Amount	X
AMT	2320	Coordination of Benefits (COB) Patient Paid Amount	X
AMT	2320	Coordination of Benefits (COB) Tax Amount	X
AMT	2320	Coordination of Benefits (COB) Total Claim Before Taxes Amount	X
DMG	2320	Subscriber Demographic Information	S
OI	2320	Other Insurance Coverage Information	X
MOA	2320	Medicare Outpatient Adjudication Information	X
NM1	2330A	Other Subscriber Name	S
N2	2330A	Additional Other Subscriber Name Information	X – deleted per *Addenda*
N3	2330A	Other Subscriber Address	S
N4	2330A	Other Subscriber City/State/ZIP Code	S
REF	2330A	Other Subscriber Secondary Information	S

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Table 3.1 – 837 Professional, Segment Usage

Segment ID	Loop ID	Segment Name	IHCP Usage R – Required S – Situational X – Not Used
NM1	2330B	Other Payer Name	S
N2	2330B	Additional Other Payer Name Information	X – deleted per *Addenda*
PER	2330B	Other Payer Contact Information	X
DTP	2330B	Claim Adjudication Date	S
REF	2330B	Other Payer Secondary Identifier	S
REF	2330B	Other Payer Prior Authorization or Referral Number	S
REF	2330B	Other Payer Claim Adjustment Indicator	X
NM1	2330C	Other Payer Patient Information	S
REF	2330C	Other Payer Patient Identification	S
NM1	2330D	Other Payer Referring Provider	S
REF	2330D	Other Payer Referring Provider Identification	S
NM1	2330E	Other Payer Rendering Provider	S
REF	2330E	Other Payer Rendering Provider Secondary Identification	S
NM1	2330F	Other Payer Purchased Service Provider	X
REF	2330F	Other Payer Purchased Service Provider Identification	X
NM1	2330G	Other Payer Service Facility Location	X
REF	2330G	Other Payer Service Facility Location Identification	X
NM1	2330H	Other Payer Supervising Provider	X
REF	2330H	Other Payer Supervising Provider Identification	X
LX	2400	Service Line Number	R
SV1	2400	Professional Service	R
SV4	2400	Prescription Number	X – deleted per *Addenda*
SV5	2400	Durable Medical Equipment (DME) Service	X
PWK	2400	Durable Medical Equipment Carrier (DMERC) Certificate of Medical Necessity (CMN) Indicator	X
CR1	2400	Ambulance Transport Information	X
CR2	2400	Spinal Manipulation Service Information	X
CR3	2400	Durable Medical Equipment (DMERC) Certification	X
CR5	2400	Home Oxygen Therapy Information	X
CRC	2400	Ambulance Certification	X

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Table 3.1 – 837 Professional, Segment Usage

Segment ID	Loop ID	Segment Name	IHCP Usage R – Required S – Situational X – Not Used
CRC	2400	Hospice Employee Indicator	X
CRC	2400	Durable Medical Equipment Carrier (DMERC) Condition Indicator	X
DTP	2400	Date – Service Date	R
DTP	2400	Date – Certification Revision Date	X
DTP	2400	Date – Referral Date	X – deleted per *Addenda*
DTP	2400	Date – Begin Therapy Date	X
DTP	2400	Date – Last Certification Date	X
DTP	2400	Date – Order Date	X – deleted per *Addenda*
DTP	2400	Date – Date Last Seen	X
DTP	2400	Date – Test	X
DTP	2400	Date – Oxygen Saturation/Arterial Blood Gas Test	X
DTP	2400	Date – Shipped	X
DTP	2400	Date – Onset of Current Symptom/Illness	X
DTP	2400	Date – Last X-ray	X
DTP	2400	Date – Acute Manifestation	X
DTP	2400	Date – Initial Treatment	X
DTP	2400	Date – Similar Illness/Symptom Onset	X
QTY	2400	Anesthesia Modifying Units	X – deleted per *Addenda*
MEA	2400	Test Result	X
CN1	2400	Contract Information	X
REF	2400	Repriced Line Item Reference Number	X
REF	2400	Adjusted Repriced Line Item Reference Number	X
REF	2400	Prior Authorization (PA) or Referral Number	X
REF	2400	Line Item Control Number (ICN)	S
REF	2400	Mammography Certification Number	X
REF	2400	Clinical Laboratory Improvement Amendment (CLIA) Information	X
REF	2400	Referring Clinical Laboratory Improvement Amendment (CLIA) Facility Identification	X
REF	2400	Immunization Batch Number	X
REF	2400	Ambulatory Patient Group (APG)	X
REF	2400	Oxygen Flow Rate	X
REF	2400	Universal Product Number (UPN)	X
AMT	2400	Sales Tax Amount	X

Table 3.1 – 837 Professional, Segment Usage

Segment ID	Loop ID	Segment Name	IHCP Usage R – Required S – Situational X – Not Used
AMT	2400	Approved Amount	X
REF	2400	Prior Authorization (PA) Number	S
AMT	2400	Postage Claimed Amount	X
K3	2400	File Information	X
NTE	2400	Line Note	S
PS1	2400	Purchased Service Information	X
HSD	2400	Health Care Services Delivery	X
HCP	2400	Line Pricing/Repricing Information	X
LIN	2410	Drug Identification	S – new per *Addenda*
CTP	2410	Drug Pricing	X – new per *Addenda*
REF	2410	Prescription Number	X – new per *Addenda*
NM1	2420A	Rendering Provider Name	S
PRV	2420A	Rendering Provider Specialty Information	S
N2	2420A	Additional Rendering Provider Name Information	X – deleted per *Addenda*
REF	2420A	Rendering Provider Secondary Information	S
NM1	2420B	Purchased Service Provider Name	X
REF	2420B	Purchased Service Provider Secondary Information	X
NM1	2420C	Service Facility Location	X
N2	2420C	Additional Service Facility Location Name Information	X – deleted per *Addenda*
N3	2420C	Service Facility Location Address	X
N4	2420C	Service Facility Location City/State/ZIP Code	X
REF	2420C	Service Facility Location Secondary Information	X
NM1	2420D	Supervising Provider Name	X
N2	2420D	Additional Supervising Provider Name Information	X – deleted per *Addenda*
REF	2420D	Supervising Provider Secondary Information	X
NM1	2420E	Ordering Provider Name	X
N2	2420E	Additional Ordering Provider Name Information	X – deleted per *Addenda*
N3	2420E	Ordering Provider Address	X
N4	2420E	Ordering Provider City/State/ZIP Code	X
REF	2420E	Ordering Provider Secondary Identification	X
PER	2420E	Ordering Provider Contact Information	X
NM1	2420F	Referring Provider Name	X

Table 3.1 – 837 Professional, Segment Usage

Segment ID	Loop ID	Segment Name	IHCP Usage R – Required S – Situational X – Not Used
PRV	2420F	Referring Provider Specialty Information	X
N2	2420F	Additional Referring Provider Name Information	X – deleted per *Addenda*
REF	2420F	Referring Provider Secondary Information	X
NM1	2420G	Other Payer Prior Authorization or Referral Number	S
REF	2420G	Other Payer Prior Authorization or Referral Number	S
SVD	2430	Line Adjudication Information	S
CAS	2430	Line Adjustment	S
DTP	2430	Line Adjudication Date	S
LQ	2440	Form Identification Code	X
FRM	2440	Supporting Documentation	X
SE	N/A	Transaction Set Trailer	R

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 837P. 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 a segment.
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 that determines 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 the transaction. All transactions are processed as originals.
BHT03	R	Originator Application Transaction Identifier	This value is assigned by the sender. Not used by the IHCP.

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Table 3.6 – Element ID BHT01-BHT06

Element ID	Usage	Guide Description and Valid Values	Comments
BHT04	R	Transaction Set Creation Date	Format: CCYYMMDD This is the bill date for all claims that follow. For MCOs and crossovers, this is the creation date of the claim files.
BHT05	R	Transaction Set Creation Time	
BHT06	R	Claim or Encounter Identifier **CH** – Chargeable **RP** – Reporting	Use **CH** for fee-for-service (FFS) claims. Use **RP** for shadow claims/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*004010X098A1~

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 **004010X098A1** – Production **004010X098DA1** – Test	This value assumes the 4010 implementation version. Contents of this field must be updated with subsequent version upgrades as they are named.

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	
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	If the rendering provider is the same as the billing provider, this segment provides the taxonomy code of the rendering provider for claims requiring taxonomy data. Segment usage changed from *Required* to *Situational* per the *Addenda*.
Example	PRV*BI*ZZ*2084P0805X~

Table 3.16 – Element ID PRV01-PRV06

Element ID	Usage	Guide Description and Valid Values	Comments
PRV01	R	Provider Code **BI** – Billing	
PRV02	R	Reference Identification Qualifier **ZZ** – Mutually Defined	

Table 3.16 – Element ID PRV01-PRV06

Element ID	Usage	Guide Description and Valid Values	Comments
PRV03	R	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 or First Steps LPI and will ignore the Tax ID or SSN submitted.
	The NPI will be returned on the *Biller Summary Report* (BSR) and returned for the payee identification on 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 **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	Not used

Table 3.18 – Element ID NM101 – NM111

Element ID	Usage	Guide Description and Valid Values	Comments
NM108	R	Identification Code Qualifier **XX** – NPI **24** – Employer's Identification Number **34** – Social Security Number	**XX**- NPI required for health care providers. Either the Employer's Identification Number or the SSN of the provider must be carried in the REF segment in this loop. Atypical, non-health care providers may continue to send either their EIN or SSN
NM109	R	Identification Code	If *XX* is sent in NM108, enter the 10-digit NPI. If 24 or 34 is sent, enter the nine digit number
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. See the IG for details.

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	City	Billing Provider's Service Location City

Table 3.21 – Element ID N401-N403

Element ID	Usage	Guide Description and Valid Values	Comments
N402	R	State	Billing Provider's Service Location Two character State
N403	R	ZIP Code	Billing Provider's **Service Location** Nine-digit ZIP Code

Table 3.22 – 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 Employer's Identification Number or the SSN when *XX*-NPI is used in the Billing Provider Name segment (NM108-109) of this loop. The IHCP billing provider LPI or First Steps LPI and service location, can be submitted in a repeat of this segment when submitting claims to the IHCP for an atypical provider.
	Managed care organizations (MCOs) submitting shadow/encounter claims must include their MCO ID and location code in a repeat of this segment.
	When submitting **atypical provider** claims to Medicare that are expected to crossover to the IHCP, the IHCP LPI and service location with the 1D qualifier can be included in a repeat of this segment along with submitting the Medicare provider number with the *1C* qualifier. Medicare will automatically crossover the claim with both the Medicare and the IHCP provider numbers 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 atypical provider to the IHCP or First Steps:** `REF*1D*100999250A~`
	Claims containing NPI submitted by provider to the IHCP or First Steps: `REF*EI*675438789~`
	Encounter claims submitted by MCO: `REF*B3*2008889902~`

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

Table 3.23 – Element ID REF01-REF04

Element ID	Usage	Guide Description and Valid Values	Comments
REF01	R	Reference Identification Qualifier **1D** – Medicaid or First Steps 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 tax ID sent must be the number used on the 1099. An additional 2010AA REF segment should be sent with the **1D** qualifier and IHCP LPI/service location for **atypical** providers
REF02	R	Billing Provider Additional Identifier	When sending the *1D* qualifier, use the 10-digit IHCP or First Steps provider number (nine numeric plus one alpha location code). When sending the *B3* qualifier, use the MCO ID (nine numeric plus region code). Invalid 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 3.24 – 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 3.25 – 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 3.26 – 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 **EDS** and **HCI**.
Example	`SBR*T*18*******MC~`

Table 3.27 – 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	R	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

Table 3.27 – Element ID SBR01-SBR09

Element ID	Usage	Guide Description and Valid Values	Comments
SBR09	R	Claim Filing Indicator Code **MC** – Medicaid	Not used by IHCP; however, required for compliance.

Table 3.28 – Patient Information

Segment Name	Patient Information
Segment ID	PAT
Loop ID	2000B
Usage	Situational
Segment Notes	This segment identifies a pregnant IHCP member. When submitting claims to Medicare that are expected to crossover to the IHCP, identify the pregnant IHCP member.
Example	PAT********Y~

Table 3.29 – Element ID PAT01-PAT09

Element ID	Usage	Guide Description and Valid Values	Comments
PAT01	N/A	Individual Relationship Code	Not used
PAT02	N/A	Patient Location Code	Not used
PAT03	N/A	Employment Status Code	Not used
PAT04	N/A	Student Status Code	Not used
PAT05	S	Date/Time Period Format Qualifier	Not used by the IHCP
PAT06	S	Date/Time Period	Not used by the IHCP
PAT07	S	Unit or Basis of Measurement Code	Not used by the IHCP
PAT08	S	Patient Weight	Not used by the IHCP
PAT09	S	Pregnancy Indicator **Y** – Yes	Use **Y** if the IHCP member is pregnant.

Table 3.30 – Subscriber Name

Segment Name	Subscriber Name
Segment ID	NM1
Loop ID	2010BA – Subscriber Name
Usage	Required
Segment Notes	This segment contains the IHCP or First Steps 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~

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Table 3.31 – 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 or First Steps member
NM104	R	Subscriber's First Name	Use the first name of the IHCP or First Steps 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 and First Steps claims are coded with **MI.** HCI claims are coded with **ZZ**. Medical review team (MRT)/pre-admission screening resident review (PASRR) claims are coded with **ZZ**.
NM109	R	Subscriber Primary Identifier	Use the 12-digit IHCP or First Steps member ID for Medicaid claims. For First Steps claims use the 12-digit First Steps member ID. For HCI claims, use the nine-digit recipient's SSN. Do not format the SSN with dashes. For MRT/PASRR claims use the 12-digit MRT/PASRR member ID.
NM110	N/A	Entity Relationship Code	Not used
NM111	N/A	Entity Identifier Code	Not used

Table 3.32 – 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 3.33 – 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 3.34 – 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; however, data submitted is not captured by the IHCP. See the IG for details.

Table 3.35 – Payer Name

Segment Name	Payer Name
Segment ID	NM1
Loop ID	2010BB
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 3.36 – 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

Table 3.36 – 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 **PI**	
NM109	R	Payer Identifier **EDS** **HCI**	Use **EDS** for IHCP or First Steps claims. Use **HCI** for HCI claims.
NM110	N/A	Entity Relationship Code	Not used
NM111	N/A	Entity Identifier Code	Not used

Table 3.37 – 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 3.38 – 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 3.39 – 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 3.40 – 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 or First Steps claims are coded with **MI.** HCI claims are coded with **ZZ**.
NM109	R	Subscriber Primary Identifier	If this segment is coded, the 12-digit IHCP member ID or First Steps 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 3.41 – 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 3.42 – 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 3.43 – 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 3.44 – Claim Information

Segment Name	Claim Information
Segment ID	CLM
Loop ID	2300
Usage	Required
Segment Notes	This segment begins the submission of the individual claim information. The IHCP processes a maximum of 5000 CLM segments per ST-SE.
Example	CLM*22334E45*325.1***11::1*Y*A*Y*Y**C*AA~

Table 3.45 – 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 byes. 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.

Table 3.45 – Element ID CLM01-CLM20

Element ID	Usage	Guide Description and Valid Values	Comments
CLM05-1	R	Facility Type Code	Use the two-character place of service (POS) code. See the *IHCP Provider Manual* or the *First Steps Provider Billing Manual* for a list of valid values.
CLM05-2	N/A	Facility Code Qualifier	Not used
CLM05-3	R	Claim Frequency Code **1** – Original **7** – Replacement **8** – Void	The IHCP processes all valid values as requested.
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	R	Medicare Assignment Code	This data element 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.
CLM08	R	Benefits Assignment Certification Indicator	This data element 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.
CLM09	R	Release of Information Code	This data element 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.
CLM10	S	Patient Signature Source Code	Not used by the IHCP
CLM11	S	Property and Casualty Related Cause Codes	This is a composite data element.
CLM11-1	R	Related Causes Code	1
CLM11-2	S	Related Causes Code	
CLM11-3	S	Related Causes Code	
CLM11-4	S	Related Causes Code	
CLM11-5	S	Country Code	Not used by the IHCP
CLM12	S	Special Program Indicator	
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	S	Participation Agreement	Not used by the IHCP
CLM17	N/A	Claim Status Code	Not used
CLM18	N/A	Yes/No Condition or Response Code	Not used
CLM19	N/A	Claim Submission Code	Not used

Table 3.45 – Element ID CLM01-CLM20

Element ID	Usage	Guide Description and Valid Values	Comments
CLM20	S	Delay Reason Code	Not used by the IHCP

Table 3.46 – Date – Last Menstrual Period

Segment Name	Date – Last Menstrual Period
Segment ID	DTP
Loop ID	2300
Usage	Situational
Segment Notes	This segment provides the date of a pregnant woman's last menstrual period (LMP).
Example	`DTP*484*D8*20021019~`

Table 3.47 – Element ID DTP01-DTP03

Element ID	Usage	Guide Description and Valid Values	Comments
DTP01	R	Date/Time Qualifier **484** – Last Menstrual Period	
DTP02	R	Date/Time Period Format Qualifier **D8** – Date Expressed in Format CCYYMMDD	
DTP03	R	Last Menstrual Period Date	Use the date of the IHCP member's LMP.

Table 3.48 – Date - Admission

Segment Name	Date – Admission
Segment ID	DTP
Loop ID	2300
Usage	Situational
Segment Notes	This segment provides the admission date or the hospitalization *From* date of service.
Example	`DTP*435*D8*20020727~`

Table 3.49 – Element ID DTP01-DTP03

Element ID	Usage	Guide Description and Valid Values	Comments
DTP01	R	Date/Time Qualifier **435** – Admission	

Table 3.49 – Element ID DTP01-DTP03

Element ID	Usage	Guide Description and Valid Values	Comments
DTP02	R	Date/Time Period Format Qualifier **D8** – Date Expressed in Format CCYYMMDD	
DTP03	R	Related Hospitalization Admission Date	Use the date the IHCP member is admitted to the hospital. For example, 20020727 represents an admit date of 7/27/2002.

Table 3.50 – Date - Discharge

Segment Name	Date – Discharge
Segment ID	DTP
Loop ID	2300
Usage	Situational
Segment Notes	This segment provides the discharge date or the hospitalization *To* date of service.
Example	`DTP*096*D8*20020801~`

Table 3.51 – Element ID DTP01-DTP03

Element ID	Usage	Guide Description and Valid Values	Comments
DTP01	R	Date/Time Qualifier **096**– Discharge	
DTP02	R	Date/Time Period Format Qualifier **D8** – Date Expressed in Format CCYYMMDD	
DTP03	R	Related Hospitalization Discharge Date	Use the date the IHCP member is discharged from the hospital. For example, 20020801 represents a discharge date of August 1, 2002.

Table 3.52 – Claim Supplemental Information

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

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Table 3.53 – 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 for a required attachment can only be 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	N/A	Attachment Description	Not used
PWK08	N/A	Actions Indicated	Not used
PWK09	N/A	Request Category Code	Not used

Table 3.54 – Contract Information

Segment Name	Contract Information
Segment ID	CN1
Loop ID	2300
Usage	Situational
Segment Notes	This segment identifies, for MCOs, an encounter from a network provider who has a capitated payment arrangement with the MCO. The IHCP expects to receive capitation indicator information at the claim level, not the service line level; thus, the Contract Information in the 2400 Loop is not discussed in this companion guide. Do not send this segment unless the provider has a capitated payment arrangement with an MCO.
Example	CN1*05~

Table 3.55 – 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

Table 3.55 – Element ID CN101-CN106

Element ID	Usage	Guide Description and Valid Values	Comments
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 3.56 – Referral Number

Segment Name	Referral Number
Segment ID	REF
Loop ID	2300
Usage	Situational
Segment Notes	This segment identifies the certification code for a primary medical provider (PMP). The IHCP expects to receive the certification code at the claim level, not the service line level; thus, the Certification Code information in the 2400 Loop is not discussed in this companion guide. This segment is not used by MCOs.
Example	REF*9F*3E~

Table 3.57 – Element ID REF01-REF04

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

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Table 3.58 – Prior Authorization – First Steps Only

Segment Name	Prior Authorization Number
Segment ID	REF
Loop ID	2300
Usage	Situational
Segment Notes	This segment identifies the prior authorization number for First Steps claims only. Prior Authorization must be entered at either the claim level or the service line level. If entered at the claim level, the prior authorization number will cascade to all details at the service line level that do not have a prior authorization number. If not entered at the claim level, a prior authorization number must be entered for each detail at the service line level.
Example	REF*G1*F452365142~

Table 3.59 – Element ID REF01-REF04

Element ID	Usage	Guide Description and Valid Values	Comments
REF01	R	Reference Identification Qualifier **G1 – Prior Authorization Number**	
REF02	R	Prior Authorization Number	
REF03	N/A	Description	Not used
REF04	N/A	Reference Identifier	Not used

Table 3.60 – 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 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 3.61 – 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 3.62 – 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.
Example	`REF*EA*D234345~`

Table 363 – 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 for 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	The segment provides additional narrative information about the claim.
Example	`NTE*ADD*REQUIRES FEEDING TUBE~`

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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 a list of valid values.
NTE02	R	Claim Note Text	Use up to 80 characters of narrative description.

Table 3.66 – Health Care Diagnosis Code

Segment Name	Health Care Diagnosis Code
Segment ID	HI
Loop ID	2300
Usage	Situational
Segment Notes	This segment identifies all diagnosis codes related to the claim. This segment is required for all claims submitted to the IHCP. IHCP recognizes all eight possible diagnosis codes. Decimal points in diagnosis codes are implied.
Example	HI*BK:V723******BF:4660~

Table 3.67 – Element ID HI01-HI02-7

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 for the principal diagnosis.
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. The seven data elements in this composite occur seven times in this segment. See the IG for complete details.
HI02-1	R	Code List Qualifier Code **BF** – Diagnosis	
HI02-2	R	Diagnosis Code	Use the appropriate *ICD-9* diagnosis code for all other diagnosis codes.
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

Table 3.67 – Element ID HI01-HI02-7

Element ID	Usage	Guide Description and Valid Values	Comments
HI02-6	N/A	Quantity	Not used
HI02-7	N/A	Version Identifier	Not used

Table 3.68 – Referring Provider Name

Segment Name	Referring Provider Name
Segment ID	NM1
Loop ID	2310A
Usage	Situational
Segment Notes	This segment provides PMP information on claims when PMP data is required. The IHCP expects to receive referring provider information at this level, not at the service line level; thus, the referring provider information in the 2420F Loop is not discussed in this companion guide. If the 2310A Loop is being used to provide PMP 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*DN*1*JONES*JANE****XX*1234567890~.

Table 3.69 – Element ID NM101-NM111

Element ID	Usage	Guide Description and Valid Values	Comments
NM101	R	Entity Identifier Code **DN – Referring Provider**	
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 **XX** – NPI **24** – Employer Identification Number **34** – Social Security Number	XX – NPI required for covered health care providers.
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 3.70 – Referring Provider Secondary Information

Segment Name	Referring Provider Secondary Information
Segment ID	REF
Loop ID	2310A
Usage	Situational
Segment Notes	This segment contains the IHCP LPI of the PMP, if a non-covered or atypical provider. The segment can repeat two times; however, only the segment containing the qualifier of **1D** is captured.
Example	REF*1D*100222999~

Table 3.71 – Element ID REF01-REF04

Element ID	Usage	Guide Description and Valid Values	Comments
REF01	R	Reference Identification Qualifier **1D** – Medicaid Provider Number	
REF02	R	Referring Provider Secondary Identifier	Use the nine-digit IHCP LPI for atypical providers.
REF03	N/A	Description	Not used
REF04	N/A	Reference Identifier	Not used

Table 3.72 – Rendering Provider Name

Segment Name	Rendering Provider Name
Segment ID	NM1
Loop ID	2310B
Usage	Situational
Segment Notes	This segment provides rendering provider information on claims when the rendering provider data is required. If using this loop to provide rendering provider information, this segment is required by the IG and must be submitted to be compliant. See the IG for details. Submission of this loop implies the stated rendering provider information applies to all service lines on the claim unless it is overridden with the rendering provider information in the 2420A Loop. If the NPI is being sent, the NPI will be returned for the rendering provider on the 835 transaction.
Example	**When submitted with the NPI:** NM1*82*1*JONES*JANE****XX*1234567890~. .

Table 3.73 – Element ID NM101-NM111

Element ID	Usage	Guide Description and Valid Values	Comments
NM101	R	Entity Identifier Code **82** – Rendering Provider	
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 **XX** – NPI **24** – Employer Identification Number **34** – Social Security Number	XX – NPI required for health care providers.
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 3.74 – Rendering Provider Specialty Information

Segment Name	Rendering Provider Specialty Information
Segment ID	PRV
Loop ID	2310B
Usage	Situational
Segment Notes	This segment provides the taxonomy code of the rendering provider on claims requiring taxonomy data. Segment usage changed from *Required* to *Situational* per the *Addenda*.
Example	PRV*PE*ZZ*404FX0500D~

Table 3.75 – Element ID PRV01-PRV06

Element ID	Usage	Guide Description and Valid Values	Comments
PRV01	R	Provider Code **PE** – Performing	Always use the provider code of the performing or rendering provider.
PRV02	R	Reference Identification Qualifier **ZZ** – Mutually Defined	

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Table 3.75 – Element ID PRV01-PRV06

Element ID	Usage	Guide Description and Valid Values	Comments
PRV03	R	Provider Taxonomy Code	Use the taxonomy code of the rendering provider.
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 3.76 – Rendering Provider Secondary Information

Segment Name	Rendering Provider Secondary Information
Segment ID	REF
Loop ID	2310B
Usage	Situational
Segment Notes	This segment contains the IHCP or First Steps LPI for a non-covered or atypical rendering provider. The segment can repeat five times; however, only the segment containing the **1D** qualifier is captured.
Example	REF*1D*100444999C~

Table 3.77 – Element ID REF01-REF04

Element ID	Usage	Guide Description and Valid Values	Comments
REF01	R	Reference Identification Qualifier **1D** – Medicaid Provider Number	
REF02	R	Rendering Provider Secondary Identifier	Use the nine-character IHCP or First Steps LPI of the rendering provider. The service location code is ignored if included.
REF03	N/A	Description	Not used
REF04	N/A	Reference Identifier	Not used

Table 3.78 – 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. It 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 3.79 – 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 **MB** -Medicare Part B.

Table 3.80 – Claim Level Adjustment

Segment Name	Claim Level Adjustment
Segment ID	CAS
Loop ID	2320
Usage	Situational
Segment Notes	Information submitted on the claim level CAS segment is used by the IHCP for utilization purposes only. All Medicare deductible, coinsurance, and psych adjustment amounts must be submitted on the service line CAS segment for payment by the IHCP. 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~`

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Table 3.81 – Element ID CAS01-CAS04

Element ID	Usage	Guide Description and Valid Values	Comments
CAS01	R	Claim Adjustment Group Code	
CAS02	R	Adjustment Reason Code	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. IHCP format is 99999999.99
CAS04	S	Adjustment Quantity	Use the quantity associated with the reason code identified in CAS02. IHCP format is 9999999.999

Table 3.82 – Coordination of Benefits Payer Paid Amount

Segment Name	Coordination of Benefits Payer Paid Amount
Segment ID	AMT
Loop ID	2320
Usage	Situational
Segment Notes	This segment reports the amount paid by non-Medicare insurers. Medicare paid amounts should be submitted at the service line in the SVD segment 2430 Loop. This amount correlates to the payer identified in the NM109 data element of the 2330B Loop.
Example	`AMT*D*75~`

Table 3.83 – Element ID AMT01-AMT03

Element ID	Usage	Guide Description and Valid Values	Comments
AMT01	R	Amount Qualifier Code **D** – Payer Amount Paid	
AMT02	R	Payer Paid Amount	Use the TPL amount paid by the insurer identified in this loop. When the other payer is an MCO, use the MCO paid amount. IHCP format is 99999999.99
AMT03	N/A	Credit/Debit Flag Code	Not used

Table 3.84 – Coordination of Benefits Approved Amount

Segment Name	Coordination of Benefits Approved Amount
Segment ID	AMT
Loop ID	2320
Usage	Situational
Segment Notes	This segment reports the amount approved by the other payer. This amount correlates to the payer identified in the NM109 data element of the 2330B Loop.
Example	AMT*AAE*75~

Table 3.85 – Element ID AMT01-AMT03

Element ID	Usage	Guide Description and Valid Values	Comments
AMT01	R	Amount Qualifier Code **AAE** - Approved Amount	
AMT02	R	Approved Amount	IHCP format is 99999999.99
AMT03	N/A	Credit/Debit Flag Code	Not used

Table 3.86 – Coordination of Benefits Total Allowed Amount

Segment Name	Coordination of Benefits Total Allowed Amount
Segment ID	AMT
Loop ID	2320
Usage	Situational
Segment Notes	This segment is used to convey the COB Total Allowed Amount. This amount correlates to the payer identified in the NM109 data element of the 2330B Loop.
Example	AMT*B6*85~

Table 3.87 – 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	IHCP format is 99999999.99
AMT03	N/A	Credit/Debit Flag Code	Not used

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Table 3.88 – Coordination of Benefits Covered Amount

Segment Name	Coordination of Benefits Covered Amount
Segment ID	AMT
Loop ID	2320
Usage	Situational
Segment Notes	This segment is used to convey the COB Covered Amount. This amount correlates to the payer identified in the NM109 data element of the 2330B Loop.
Example	`AMT*AU*50~`

Table 3.89 – Element ID AMT01-AMT03

Element ID	Usage	Guide Description and Valid Values	Comments
AMT01	R	Amount Qualifier Code **AU** - Coverage Amount	
AMT02	R	Allowed Amount	IHCP format is 99999999.99
AMT03	N/A	Credit/Debit Flag Code	Not used

Table 3.90 – 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*19520201*F~`

Table 3.91 – Element ID DMG01-DMG09

Element ID	Usage	Guide Description and Valid Values	Comments
DMG01	R	Date/Time Period Format Qualifier	
DMG02	R	Other Payer's Insured Birth Date	
DMG03	R	Other Payer's 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 3.92 – 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. It must be submitted to be compliant; however, data submitted is not captured by the IHCP. See the IG for details.

Table 3.93 – 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. See the IG for details.
Example	NM1*IL*1*DOE*JOE*T***MI*57464~

Table 3.94 – 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	

Table 3.94 – Element ID NM101-NM109

Element ID	Usage	Guide Description and Valid Values	Comments
NM105	R	Other Payer's Subscriber Middle Name	
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 3.95 – Other Subscriber Address

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

Table 3.96 – 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 3.97 – 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 subscribers address. See the IG for details.
Example	`N4*PALISADES*OR*23119~`

Table 3.98 – Element ID N401-N404

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	
N404	R	Other Payer's Subscriber Country Code	

Table 3.99 – 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 3.100 – 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	Use for the insurance policy number or SSN of the other subscriber.
REF03	N/A	Description	Not used
REF04	N/A	Reference Identifier	Not used

Table 3.101 – 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~
	Claims submitted by provider to Medicare, expecting to crossover to the IHCP: NM1*PR*2*Office Of Medicaid Policy & Planning*****PI*70035~

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Table 3.102 – 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 **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 3.103 – 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 3.104 – 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 3.105 – 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.
Example	`REF*F8*465980789~`

Table 3.106 – 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 payer's ICN or DCN identified in NM109.
REF03	N/A	Description	Not used
REF04	N/A	Reference Identifier	Not used

Table 3.607 – Other Payer Prior Authorization or Referral Number

Segment Name	Other Payer Prior Authorization or Referral Number
Segment ID	REF
Loop ID	2330B
Usage	Situational
Segment Notes	This segment specifies information about other payer's referral or PA number. See the IG for details.

Table 3.618 – 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 3.629 – Other Payer Referring Provider

Segment Name	Other Payer Referring Provider
Segment ID	NM1
Loop ID	2330D
Usage	Required, if 2330D Loop is used.
Segment Notes	This segment specifies information about payer specific provider identification. When submitting claims to Medicare that are expected to crossover to the IHCP, this segment provides PMP information on claims when PMP data is required. The IHCP expects to receive referring provider information at the claim level, not at the service line level. If using this loop to provide the IHCP PMP information, 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.
Example	NM1*DN*1*SUNSET HEALTH CENTER~

Table 3.110 – Element ID NM101-NM111

Element ID	Usage	Guide Description and Valid Values	Comments
NM101	R	Entity Identifier Code	
NM102	R	Entity Type Qualifier	
NM103	R	Referring Provider Last or Organization Name	
NM104	N/A		
NM105	N/A		
NM106	N/A		
NM107	N/A		
NM108	N/A		
NM109	N/A		
NM110	N/A		
NM111	N/A		

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Table 3.111 – Other Payer Referring Provider ID

Segment Name	Other Payer Referring Provider Identification
Segment ID	REF
Loop ID	2330D
Usage	Situational
Segment Notes	This segment specifies information about non-destination COB payers' referring provider identification numbers. See the IG for details

Table 3.112 – Element ID REF01-REF04

Element ID	Usage	Guide Description and Valid Values	Comments
REF01	R	Reference Identification Qualifier	
REF02	R	Reference Identification	Other Payer Referring Provider Identifier
REF03	N/A	Description	Not used
REF04	N/A	Reference Identifier	Not used

Table 3.113 – Other Payer Rendering Provider

Segment Name	Other Payer Rendering Provider
Segment ID	NM1
Loop ID	2330E
Usage	Required, if 2330E Loop is used.
Segment Notes	When submitting atypical provider claims to Medicare that are expected to crossover to the IHCP, this segment provides the IHCP rendering provider information on claims when the rendering provider data is required. Submission of this loop implies the stated rendering provider information applies to all service lines on the claim unless it is overridden with the rendering provider information in the 2420A Loop. If using this loop to provide rendering provider information, this segment is required by the IG and must be submitted to be compliant. See the IG for details.

Table 3.114 – Other Payer Rendering Provider ID

Segment Name	Other Payer Rendering Secondary Identification
Segment ID	REF
Loop ID	2330E
Usage	Situational

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Table 3.114 – Other Payer Rendering Provider ID

Segment Name	Other Payer Rendering Secondary Identification
Segment Notes	When submitting atypical provider claims to Medicare that are expected to crossover to the IHCP, this segment provides the IHCP rendering provider information on claims when the rendering provider data is required. The IHCP rendering provider LPI can be submitted with the 1D qualifier in a repeat of this segment in addition to submitting the Medicare provider number with the *1C* qualifier. Medicare automatically crossovers the claim with both Medicare and the IHCP provider number to the IHCP. Failure to submit the IHCP rendering provider number could result in the IHCP denying the claim when the rendering provider data is required.
Example	**Claims submitted for atypical providers to Medicare expecting to crossover to the IHCP:** REF*1C*236450~ REF*1D*100222999~

Table 3.115 – Element ID REF01-REF04

Element ID	Usage	Guide Description/Valid Values	Comments
REF01	R	Reference Identification Qualifier **1D** – Medicaid Provider Number	
REF02	R	Other Payer Rendering Provider Secondary Identifier	Use the nine-character IHCP LPI of the rendering provider. The service location code is ignored if included.
REF03	N/A	Description	Not used
REF04	N/A	Reference Identifier	Not used

Table 3.116 – Service Line

Segment Name	Service Line
Segment ID	LX
Loop ID	2400
Usage	Required
Segment Notes	This segment contains the line item number that increments by one for each service line or detail. The IHCP processes a maximum of 50 LX segments, 2400 Loops, for each CLM segment.
Example	LX*1~

Table 3.117 – 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 3.118 – Professional Service

Segment Name	Professional Service
Segment ID	SV1
Loop ID	2400
Usage	Required
Segment Notes	This segment reports procedure codes, modifiers, charge amounts, and units. The IHCP recognizes all service lines on a claim. The Total Claim Charge Amount from CLM02 must reflect the totals of all details. Failure to comply, results in compliance rejection.
Example	`SV1*HC:99396*110*UN*1*23**1:2**Y~`

Table 3.119 – Element ID SV101-SV121

Element ID	Usage	Guide Description and Valid Values	Comments
SV101	S	Composite Medical Procedure Identifier	This is a composite data element.
SV101-1	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.
SV101-2	R	Procedure Code	Use the five-digit HCPCS procedure code of the service rendered.
SV101-3	S	HCPCS Modifier 1	IHCP recognizes all four modifiers.
SV101-4	S	HCPCS Modifier 2	
SV101-5	S	HCPCS Modifier 3	
SV101-6	S	HCPCS Modifier 4	
SV101-7	N/A	Description	Not used
SV102	R	Line Item Charge Amount	IHCP format is 99999999.99
SV103	R	Unit or Basis of Measurement Code **F2** – International Unit **UN** – Units	
SV104	R	Service Unit Count	IHCP format is 9999.99
SV105	S	Place of Service Code	Required on First Steps claims.
SV106	N/A	Service Type Code	Not used
SV107	S	Composite Diagnosis Code Pointer	This composite element identifies the diagnosis submitted in the HI segment in the 2300 Loop that is associated with this service line. IHCP recognizes all diagnosis codes. Valid values for this element are **1**, **2**, **3**, **4, 5, 6, 7,** and **8.**
SV107-1	R	Diagnosis Code Pointer	

Table 3.119 – Element ID SV101-SV121

Element ID	Usage	Guide Description and Valid Values	Comments
SV107-2	R	Diagnosis Code Pointer	
SV107-3	R	Diagnosis Code Pointer	
SV107-4	R	Diagnosis Code Pointer	
SV108	N/A	Monetary Amount	Not used
SV109	R	Emergency Indicator **Y** – Yes	Send **Y** to denote emergency services. **N** was removed per addenda.
SV110	N/A	Multiple Procedure Code	Not used
SV111	S	EPSDT Indicator	Not used by the IHCP
SV112	S	Family Planning Indicator	Not used by the IHCP
SV113	N/A	Review Code	Not used
SV114	N/A	National or Local Assigned Review Value	Not used
SV115	S	Co-Pay Status Code	Not used by the IHCP
SV116	N/A	Health Care Professional Shortage Area Code	Not used
SV117	N/A	Reference Identification	Not used
SV118	N/A	Postal Code	Not used
SV119	N/A	Monetary Amount	Not used
SV120	N/A	Level of Care Code	Not used
SV121	N/A	Provider Agreement Code	Not used

Table 3.120 – Date – Service Date

Segment Name	Date – Service Date
Segment ID	DTP
Loop ID	2400
Usage	Required
Segment Notes	This segment is used to report the detail *To* and *From* dates of service.
Example	`DTP*472*RD8*20021001-20021001~`

Table 3.121 – Element ID DTP01-DTP03

Element ID	Usage	Guide Description and Valid Values	Comments
DTP01	R	Date/Time Qualifier **472** – Service	

Table 3.121 – Element ID DTP01-DTP03

Element ID	Usage	Guide Description and Valid Values	Comments
DTP02	R	Date/Time Period Format Qualifier **D8** – Date Expressed in Format CCYYDDMM **RD8** – Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD	If qualifier **D8** is used, the IHCP assumes that the *From* and *Through* dates for this service line are the same. The *From* and *Through* dates of service should always be the same on First Steps claims.
DTP03	R	Service Date	

Table 3.122 – Line Item Control Number

Segment Name	Line Item Control Number
Segment ID	REF
Loop ID	2400
Usage	Situational
Segment Notes	This segment enables providers to submit unique service line numbers to facilitate the electronic payment posting. This line item control number is returned on the 835 transaction. See the IG for more specific details.
Example	REF*6R*23033838383~

Table 3.123 – Element ID REF01-REF04

Element ID	Usage	Guide Description and Valid Values	Comments
REF01	R	Reference Identification Qualifier **6R** – Provider Control Number	
REF02	R	Line Item Control Number	The IHCP accepts up to 30 characters.
REF03	N/A	Description	Not used
REF04	N/A	Reference Identifier	Not used

Table 3.124 – Prior Authorization – First Steps Only

Segment Name	Line Item Control Number
Segment ID	REF
Loop ID	2400
Usage	Situational
Segment Notes	This segment identifies the prior authorization number for First Steps claims only. Prior Authorization must be entered at either the claim level or the service line level. If entered at the service line level only, it must be entered for each detail. If entered at the claim level, the prior authorization number will cascade to all details at the service line level that do not have a prior authorization level.

Table 3.124 – Prior Authorization – First Steps Only

Example	REF*G1*F452365142~

Table 3.125 – Element ID REF01-REF04

Element ID	Usage	Guide Description and Valid Values	Comments
REF01	R	Reference Identification Qualifier **G1 – Prior Authorization Number**	
REF02	R	Prior Authorization Number	
REF03	N/A	Description	Not used
REF04	N/A	Reference Identifier	Not used

Table 3.126 – Line Note

Segment Name	Line Note
Segment ID	NTE
Loop ID	2400
Usage	Situational
Segment Notes	The segment provides additional narrative information about this claim.
Example	NTE*ADD*REQUIRES FEEDING TUBE~

Table 3.127 – Element ID NTE01-NTE02

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

Table 3.128 – Drug Identification

Segment Name	Drug Identification
Segment ID	LIN
Loop ID	2410
Usage	Situational

Table 3.128 – Drug Identification

Segment Name	Drug Identification
Segment Notes	If applicable, this segment contains the NDC. LIN04 through LIN31 are listed in this segment but marked as not used; therefore, they do not appear in this illustration. This newly created segment appears in the Addenda. The NDC field is situational and is required when submitting claims for certain physician administered drugs. When required, the NDC, NDC quantity and NDC units of measure must be billed along with the procedure code. Only the NDC, NDC quantity, and NDC units of measure from the first LIN and CTP segments of each detail are stored. However, providers are allowed to submit up to 25 per detail.
Example	`LIN**N4*00045012423~`

Table 3.129 – 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 3.130 – Drug Pricing

Segment Name	Drug Pricing
Segment ID	CTP
Loop ID	2410
Usage	Situational
Segment Notes	This segment contains information about the quantity for the NDC listed in the previous LIN segment. CTP05-2 through CTP05-15 and CTP06 through CTP11 listed in this segment are 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 3.131 – Element ID CTP01-CTP05-15

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 3.131 – Element ID CTP01-CTP05-15

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 associated with the NDC listed in LIN03.
CTP05-2	N/A		Not used
CTP05-3	N/A		Not used
CTP05-4	N/A		Not used
CTP05-5	N/A		Not used
CTP05-6	N/A		Not used
CTP05-7	N/A		Not used
CTP05-8	N/A		Not used
CTP05-9	N/A		Not used
CTP05-10	N/A		Not used
CTP05-11	N/A		Not used
CTP05-11	N/A		Not used
CTP05-12	N/A		Not used
CTP05-13	N/A		Not used
CTP05-14	N/A		Not used
CPT05-15	N/A		Not used

Table 3.132 – Rendering Provider Name

Segment Name	Rendering Provider Name
Segment ID	NM1
Loop ID	2420A
Usage	Situational
Segment Notes	This segment provides rendering provider information for service lines when rendering provider data is required. If using this loop to provide rendering provider information, the IG requires this segment. It must be submitted to be compliant. Submitting the data in this loop overrides any rendering provider information previously submitted in the 2310B Loop. If the NPI is being sent the NPI will be returned for the service level rendering provider on the 835 transaction.

Table 3.133 – Element ID NM101-NM111

Element ID	Usage	Guide Description and Valid Values	Comments

Table 3.133 – Element ID NM101-NM111

Element ID	Usage	Guide Description and Valid Values	Comments
NM101	R	Entity Identifier Code **82** – Rendering Provider	
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 **XX** – NPI **24** – Employer's Identification Number **34** – Social Security Number	XX – NPI required for health care providers
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 3.134 – Rendering Provider Specialty Information

Segment Name	Rendering Provider Specialty Information
Segment ID	PRV
Loop ID	2420A
Usage	Situational
Segment Notes	This segment is used to provide the taxonomy code of the rendering provider on claims where taxonomy data is required. Segment usage changed from *Required* to *Situational* per the *Addenda*.
Example	PRV*PE*ZZ*303BR0900X~

Table 3.135 – Element ID PRV01-PRV06

Element ID	Usage	Guide Description and Valid Values	Comments
PRV01	R	Provider Code **PE** – Performing	Always use the provider code of the performing provider.
PRV02	R	Reference Identification Qualifier **ZZ** – Mutually Defined	

Table 3.135 – Element ID PRV01-PRV06

Element ID	Usage	Guide Description and Valid Values	Comments
PRV03	R	Provider Taxonomy Code	Use the rendering provider taxonomy code. Taxonomy is required on First Steps claims.
PRV04	N/A		Not used
PRV05	N/A		Not used
PRV06	N/A		Not used

Table 3.136 – Rendering Provider Secondary Information

Segment Name	Rendering Provider Secondary Information
Segment ID	REF
Loop ID	2420A
Usage	Situational
Segment Notes	This segment contains the IHCP rendering LPI for atypical providers. The segment can repeat five times, however, only the segment containing the **1D** qualifier is captured. Submitting data in this loop overrides the service line rendering provider information previously submitted in the 2310B and 2330E Loop. When submitting atypical provider claims to Medicare that are expected to crossover to the IHCP, the IHCP rendering LPI with qualifier 1D can be submitted in a repeat of this segment in addition to submitting the Medicare provider number with the *1C* qualifier. Medicare will automatically crossover the claim with both numbers to the IHCP.
Example	`REF*1D*212345430~`

Table 3.137 – Element ID REF01-REF04

Element ID	Usage	Guide Description and Valid Values	Comments
REF01	R	Reference Identification Qualifier **1D** – Medicaid Provider Number	
REF02	R	Rendering Provider Secondary Identifier	Use the nine-character IHCP or First Steps LPI for the rendering provider. The service location code is ignored if included.
REF03	N/A	Description	Not used
REF04	N/A	Reference Identifier	Not used

Table 3.138 – Other Payer Prior Authorization or Referral Number

Segment Name	Other Payer Prior Authorization or Referral Number
Segment ID	NM1
Loop ID	2420G

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Table 3.138 – Other Payer Prior Authorization or Referral Number

Segment Name	Other Payer Prior Authorization or Referral Number
Usage	Required, if 2320 Loop is used.
Segment Notes	This segment is used to specify payer specific line level referral or PA numbers.
Example	NM1*PR*2*Family Insurance*****PI*01234~

Table 3.139 – 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	
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	Must match an Other Payer ID in NM109 of 2330B Loop.
NM110	N/A	Entity Relationship Code	Not used
NM111	N/A	Entity Identifier Code	Not used

Table 3.140 – Other Payer Prior Authorization or Referral Number

Segment Name	Other Payer Prior Authorization or Referral Number
Segment ID	REF
Loop ID	2420G
Usage	Situational
Segment Notes	Use when the payer identified in this loop has given a PA or referral number to this claim. This element is primarily used in payer-to-payer COB situations.
Example	REF*G1*AB333-Y5~

Table 3.141 – Element ID REF01-REF04

Element ID	Usage	Guide Description and Valid Values	Comments
REF01	R	Reference Identification Qualifier	
REF02	R	Reference Identification	Other Payer Referral or PA number
REF03	N/A	Description	Not used
REF04	N/A	Reference Identifier	Not used

Table 3.142 – Service Line Adjudication Information

Segment Name	Service Line Adjudication Information
Segment ID	SVD
Loop ID	2430
Usage	Situational
Segment Notes	This segment contains the Medicare paid amount detail. This amount is submitted only at the service line level, not the claim level.
Example	SVD*00230*345.1*HC:99396~

Table 3.143 – Element ID SVD01-SVD06

Element ID	Usage	Guide Description and Valid Values	Comments
SVD-01	R	Other Payer Primary Identifier	This must match a 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 Medicare, MCO, and any other payer paid amount detail. IHCP format is 99999999.99
SVD03	R	Composite Medical Procedure Identifier	This is a composite data element and is not used by the IHCP.

Table 3.143 – Element ID SVD01-SVD06

Element ID	Usage	Guide Description and Valid Values	Comments
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	N/A	Product Service ID	Not used
SVD05	R	Paid Service Unit Count	Not used by the IHCP
SVD06	S	Bundled Line Number	Not used by the IHCP

Table 3.144 – 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 psych amounts for Medicare 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*1*66.7**2*25.54~`

Table 3.145 – Element ID CAS01-CAS04

Element ID	Usage	Guide Description and Valid Values	Comments
CAS01	R	Claim Adjustment Group Code **PR** – Patient Responsibility	Medicare deductible, coinsurance, and psych adjustment amounts are always reported with a **PR** claim adjustment group code for crossover claims.
CAS02	R	Adjustment Reason Code Adjustments used in IHCP processing of Medicare claims: **1** – Deductible **2** – Coinsurance **122** – Psych	Only deductible, coinsurance, and psych adjustments are used in IHCP processing of crossover 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.

Table 3.145 – Element ID CAS01-CAS04

Element ID	Usage	Guide Description and Valid Values	Comments
CAS03	R	Adjustment Amount	Use the dollar amount associated with the reason code identified in CAS02. IHCP format is 99999999.99
CAS04	S	Adjustment Quantity	IHCP format is 9999999.999

Table 3.146 – Service Adjudication Date

Segment Name	Service Adjudication Date
Segment ID	DTP
Loop ID	2430
Usage	Situational
Segment Notes	This segment is required when the Claim Adjudication Date is not used and the claim has been adjudicated.
Example	DTP*573*D8*19981*1226~

Table 3.147 – 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	Payment or Adjudication Date MCOs submit payment date.

Table 3.148 – 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*32*7656543~

Table 3.149 – Element ID SE01-SE02

Element ID	Usage	Guide Description and Valid Values	Comments

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Table 3.149 – Element ID SE01-SE02

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

Transaction Examples

Medicaid Primary – No COB

Figure 3.1 illustrates an 837P transaction with Medicaid primary and no COB.

```
ST*837*987654~
BHT*0019*00*X2FF1*20020901*1230*CH~
REF*87*004010X098A1~
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*24*311400511~
HL*2*1*22*0~
SBR*P*18**IHCP*****MC~
NM1*IL*1*DOE*JILL****MI*100444555999~
N3*6000 WEST STREET~
N4*INDIANAPOLIS*IN*46410~
DMG*D8*19590529*M~
NM1*PR*2*EDS*****PI*EDS~
CLM*755555M*126***11::1*Y*A*Y*Y*C*AA:::IN~
DTP*484*D8*20021019~
DTP*435*D8*20021030~
DTP*439*D8*20021030~
DTP*096*D8*20021101~
PWK*AS*BM***AC*86576~
AMT*F5*35~
REF*9F*12~
REF*EA*D234345~
HI*BK:V723*BF:4660~
NM1*DN*1*WILSON*JOEL****34*212222122~
```

```
PRV*RF*ZZ*363LP0200X~
REF*1D*100555999D~
LX*1~
SV1*HC:99396*110*UN*1***1:2*1~
DTP*472*RD8*20021030-20021030~
REF*6R*24210~
NM1*82*2*ANDERSON*MARTIN****XX*1123321221~
PRV*PE*ZZ*207RI0001X~
LX*2~
SV1*HC:99000*16*UN*1**1:2*1~
DTP*472*RD8*20021030-20021030~
REF*6R*24211~
NM1*82*2*ANDERSON*MARTIN****XX*1123321221~
PRV*PE*ZZ*207RI0001X~
REF*34*212222122~
SE*46*987654~
```

Figure 3.1 – 837P Transaction with Medicaid Primary and No COB

Medicaid Secondary to Medicare

Figure 3.2 illustrates an 837P transaction with Medicaid secondary to Medicare.

```
ST*837*987655~
BHT*0019*00*X2FF1*20020901*1230*CH~
REF*87*004010X098A1~
NM1*41*2*ANDERSON MEDICAL GROUP*****46*P123~
PER*IC*ALICE WILSON*TE*3174880000~
NM1*40*2*IHCP*****46*00120~
HL*1**20*1~
NM1*85*2*ANDERSON MEDICAL GROUP*****XX*1391053631~
N3*4000 E MELROSE STREET~
N4*INDIANAPOLIS*IN*46204~
REF*24*363915363~
HL*2*1*22*0~
SBR*P*18**IHCP*****MC~
NM1*IL*1*DOE*JILL****MI*100444555999~
N3*6000 WEST STREET~
N4*INDIANAPOLIS*IN*46410~
DMG*D8*19590529*M~
NM1*PR*2*EDS*****PI*EDS~
CLM*755555M*126***11::1*Y*A*Y*N**EM~
DTP*484*D8*20021019~
DTP*435*D8*20021030~
DTP*096*D8*20021101~
PWK*AS*BM***AC*86576~
AMT*F5*35~
REF*9F*12~
REF*EA*D234345~
HI*BK:V723*BF:4660~
NM1*DN*1*WILSON*JOEL****34*212222122~
PRV*RF*ZZ*363LP0200X~
REF*1D*100555999D~
SBR*P*18***GP***MB~
DMG*D8*19251014*F~
OI***Y*C**Y~
NM1*IL*1*DOE*JILL****MI*7767654A~
NM1*PR*2*MEDICARE*****PI*00630~
LX*1~
SV1*HC:99396*110*UN*1**1:2*1~
DTP*472*RD8*20021030-20021030~
REF*6R*24210~
NM1*82*2*ANDERSON*MARTIN****XX*1212222122~
PRV*PE*ZZ*456BN0700L~
```

```
SVD*00330*65*HC:99396**1~
CAS*PR*2*10~
DTP*573*D8*20021030~
LX*2~
SV1*HC:99000*16*UN*1**1:2*1~
DTP*472*RD8*20021030-20021030~
REF*6R*24211~
NM1*82*2*ANDERSON*MARTIN****XX*1212222122~
PRV*PE*ZZ*456BN0700L~
SVD*00330*8*HC:99000**1~
CAS*PR*2*2~
DTP*573*D8*20021030~
SE*56*987655~
```

Figure 3.2 – 837P Transaction with Medicaid Secondary To Medicare

Medicaid Tertiary to Medicare and Other Insurer

Figure 3.3 illustrates an 837P transaction with Medicaid tertiary to Medicare and another insurer.

```
ST*837*987656~
BHT*0019*00*X2FF1*20020901*1230*CH~
REF*87*004010X098A1~
NM1*41*2*ANDERSON MEDICAL GROUP*****46*P123~
PER*IC*ALICE WILSON*TE*3174880000~
NM1*40*2*IHCP*****46*00120~
HL*1**20*1~
NM1*85*2*ANDERSON MEDICAL GROUP*****XX*1234567890~
N3*4000 E MELROSE STREET~
N4*INDIANAPOLIS*IN*46204~
REF*24*351915555~
HL*2*1*22*0~
SBR*P*18**IHCP*****MC~
NM1*IL*1*DOE*JILL****MI*100444555999~
N3*6000 WEST STREET~
N4*INDIANAPOLIS*IN*46410~
DMG*D8*19590529*M~
NM1*PR*2*EDS*****PI*EDS~
CLM*755555M*126***11::1*Y*A*Y*Y*C*EM~
DTP*484*D8*20021019~
DTP*435*D8*20021030~
DTP*096*D8*20021101~
PWK*AS*BM***AC*86576~
AMT*F5*35~
REF*9F*12~
```

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```
REF*EA*D234345~
HI*BK:V723*BF:4660~
NM1*DN*1*WILSON*JOEL****34*212222122~
PRV*RF*ZZ*363LP0200N~
REF*1D*100555999D~
SBR*P*18***GP***MB~
DMG*D8*19591014*F~
OI***Y*C**Y~
NM1*IL*1*DOE*JILL****MI*7767654A~
NM1*PR*2*MEDICARE****PI*00630~
SBR*P*18***GP***CI~
AMT*D*40~
DMG*D8*19591014*M~
OI***Y*C**Y~
NM1*IL*1*DOE*JILL****MI*7767654A~
NM1*PR*2*AETNA****PI*88368~
LX*1~
SV1*HC:99396*110*UN*1**1:2*1~
DTP*472*RD8*20021030-20021030~
REF*6R*24210~
NM1*82*2*ANDERSON*MARTIN****XX*1123122122~
PRV*PE*ZZ*456BN0700L~
SVD*00630*65*HC:99396**1~
CAS*PR*2*10~
DTP*573*D8*20021030~
LX*2~
SV1*HC:99000*16*UN*1**1:2*1~
DTP*472*RD8*20021030-20021030~
REF*6R*24211~
NM1*82*2*ANDERSON*MARTIN****XX*1212222122~
PRV*PE*ZZ*456BN0700L~
SVD*88368*8*HC:99000**1~
CAS*PR*2*2~
DTP*573*D8*20021030~
SE*62*987656~
```

Figure 3.3 – 837P Transaction with Medicaid Tertiary To Medicare and Other Insurer

Medicaid Secondary to Primary Insurer (TPL)

Figure 3.4 illustrates an 837P transaction with Medicaid secondary to a primary insurer.

```
ST*837*987657~
BHT*0019*00*X2FF1*20020901*1230*CH~
REF*87*004010X098A1~
```

```
NM1*41*2*ANDERSON MEDICAL GROUP*****46*P123~
PER*IC*ALICE WILSON*TE*3174880000~
NM1*40*2*IHCP*****46*00120~
HL*1**20*1~
NM1*85*2*ANDERSON MEDICAL GROUP*****XX*1234567890~
N3*4000 E MELROSE STREET~
N4*INDIANAPOLIS*IN*46204~
REF*24*333222111~
HL*2*1*22*0~
SBR*P*18**IHCP*****MC~
NM1*IL*1*DOE*JILL****MI*100444555999~
N3*6000 WEST STREET~
N4*INDIANAPOLIS*IN*46410~
DMG*D8*19590529*M~
NM1*PR*2*EDS*****PI*EDS~
CLM*755555M*126***11::1*Y*A*Y*Y*C*EM~
DTP*484*D8*20021019~
DTP*435*D8*20021030~
DTP*096*D8*20021101~
PWK*AS*BM***AC*86576~
AMT*F5*35~
REF*9F*12~
REF*EA*D234345~
HI*BK:V723*BF:4660~
NM1*DN*1*WILSON*JOEL****34*212222122~
PRV*RF*ZZ*363LP0200N~
REF*1D*100555999D~
SBR*P*18***GP***CI~
AMT*D*40~
DMG*D8*19591014*M~
OI***Y*C**Y~
NM1*IL*1*DOE*JILL****MI*7767654A~
NM1*PR*2*AETNA*****PI*88368~
LX*1~
SV1*HC:99396*110*UN*1**1:2*1~
DTP*472*RD8*20021030-20021030~
REF*6R*24210~
NM1*82*2*ANDERSON*MARTIN****XX*1234567890~
PRV*PE*ZZ*456BN0700L~
LX*2~
SV1*HC:99000*16*UN*1**1:2*1~
DTP*472*RD8*20021030-20021030~
REF*6R*24211~
NM1*82*2*ANDERSON*MARTIN****XX*1234567890~
```

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```
PRV*PE*ZZ*456BN0700L~
SE*51*987657~
```

Figure 3.4 – 837P Transaction with Medicaid Secondary To a Primary Insurer

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