

eMedNY

**New York State Department of
Health Office of Health
Insurance Programs**

**837 Institutional: Managed
Care Capitation Premium
Billing Companion Guide**

X12N V4010X096A1 837: Health Care Claim: Institutional

Version: 3.0

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837

Health Care Claim: Institutional

Functional Group=HC

Purpose: This Draft Standard for Trial Use contains the format and establishes the data contents of the Health Care Claim Transaction Set (837) for use within the context of an Electronic Data Interchange (EDI) environment. This transaction set can be used to submit health care claim billing information, encounter information, or both, from providers of health care services to payers, either directly or via intermediary billers and claims clearinghouses. It can also be used to transmit health care claims and billing payment information between payers with different payment responsibilities where coordination of benefits is required or between payers and regulatory agencies to monitor the rendering, billing, and/or payment of health care services within a specific health care/insurance industry segment. For purposes of this standard, providers of health care products or services may include entities such as physicians, hospitals and other medical facilities or suppliers, dentists, and pharmacies, and entities providing medical information to meet regulatory requirements. The payer refers to a third party entity that pays claims or administers the insurance product or benefit or both. For example, a payer may be an insurance company, health maintenance organization (HMO), preferred provider organization (PPO), government agency (Medicare, Medicaid, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), etc.) or an entity such as a third party administrator (TPA) or third party organization (TPO) that may be contracted by one of those groups. A regulatory agency is an entity responsible, by law or rule, for administering and monitoring a statutory benefits program or a specific health care/insurance industry segment.

COMPANION GUIDE DISCLAIMER:

The New York State Department of Health (NYSDOH) has provided this Medicaid Companion Guide for the 837 Institutional Transaction, Addendum version (ASC X12N 004010X096A1) to assist contracted Managed Care Organizations in preparing transactions for Capitation Premium billing. NYSDOH has focused primarily on the rules and policies regulating the submission of NYS Medicaid data as specified within this Companion Guide. NYSDOH has provided this document with related information at <https://www.nyhipaadesk.com> as a resource to assist Providers in preparing X12N compliant electronic transactions in accordance with the program requirements of NYS Medicaid.

NYSDOH does not offer individual training to assist Providers in the use of the ASC X12N transactions as documented in Companion Guides and other resources provided at <http://www.nyhipaadesk.com>.

The information presented herein is believed to be true and correct. Although Managed Care Capitation Premium billing is not regulated by HIPAA as of this publication date, the information provided herein is based on the Addenda Version of the HIPAA guidelines. These regulations are continuing to evolve, therefore NYSDOH makes no guarantee, expressed or implied, as to the accuracy of the information provided herein. Furthermore, this is a living document and the information provided herein is subject to change as NYSDOH policy changes or as HIPAA legislation is updated or revised.

CG MODIFICATION TRACKING:

>V3.0

- 12/29/2008 Removed reference to 837D Supplemental CG from NYS Medicaid Note in CLM05-3, loop 2300
- 11/05/2008 Removed Description text from "Statement Dates" Qualifier
- 10/17/2008 Added note in Transmission Type Identification segment that NYSDOH will reject transactions that do not contain "004010X096A1" in REF02.
- 09/18/2007 Removed phone system options information from NYS Medicaid Note in front matter, leaving the call center 800 number. Added note to refer to Technical Supplementary Guide.
- 05/09/2007 Added text in NYS Medicaid Note in loop 2300, CLM05-3 to clarify that only previously paid claims should be adjusted or voided.
- 03/14/2007 Added information to refer to the Technical Supplementary Companion Guide in NYS Medicaid Notes in the front matter.
- 02/07/2007 Changed title to reflect new name for NYSDOH Office of Health Insurance Programs.
- 01/25/2007 Slight rewording of NPI section in front matter - removed date.
- 11/06/2006 Removed NYS Medicaid Notes for loop 2010AA NM1 and N4 segments. NPI is not applicable for Managed Care Capitation.
- 10/06/2006 Corrected date in NPI section of front matter.
- 07/18/2006 Minor rewording in Disclaimer and front matter NYS Medicaid Notes. Removed "Phase II" from document footer.
- 03/20/2006 Added note that an MCO is not eligible to receive an NPI. Removed qualifier 'XX' from the Billing Provider Name segment.
- 02/01/2006 Removed references to specific sections in the 837 I Supplemental CG.
- 01/19/2006 Added NYS Medicaid Notes to the 2010BA NM1 segment to clarify that the eMedNY system uses the CIN number and not the subscriber name to identify the recipient.
- 09/23/2005 Updated support phone numbers in front matter, added NYS Medicaid Note in Statement Dates DTP segment that capitation billing should report the first of the month.
- 05/06/2005 Took 2000A PRV back out.
- 04/22/2005 Added loop 1000A PER segment, 2000A PRV segment, and 2400 Service Line Date segment.

-04/20/2005 Added note about 16-digit TCN number to CG Modification Tracking. Added note about using TCN in voids and adjustments; and added note about retrieving TCN using 276/277 to NYS Medicaid Note in front matter.
 -03/30/2005 Added NYS Medicaid Note to CLM01 to clarify that the 820 rather than the 835 is used for Remittance Advice. Removed CLM07 (not applicable). Corrected Institutional Unit phone number in front matter NYS Medicaid Note.

NATIONAL PROVIDER IDENTIFIER (NPI):

A Managed Care Organization (MCO) is not a Health Care Provider under HIPAA and is not eligible to receive a National Provider Identifier. Therefore the requirement to send the NPI on claims to the eMedNY system when NYSDOH is ready for NPI implementation does not apply to an MCO.

NYS MEDICAID NOTE:

The New York State Department of Health (NYSDOH) encourages its contracted Managed Care Organizations to submit claims for Capitation Premiums in standard electronic format as per the specifications described in this 837 Institutional: Managed Care Capitation Companion Guide. This is the only NYSDOH supported electronic standard for performing this business function.

For this purpose, we have provided a set of appropriate data items for these providers. The Health Insurance Portability and Accountability Act (HIPAA) does not regulate Managed Care Capitation Premium billing.

Refer also to the NYS Medicaid Companion Guide and Supplementary Companion Guide for the NYSDOH implementation of the ASC X12 820 transaction for information about electronic remittance notification.

The ASC X12N 837 Health Care Claim, Institutional Transaction, Addendum Version (004010X096A1) has been established by NYSDOH as the standard for Managed Care Capitation Premium billing, and this Companion Guide provided by NYSDOH outlines the required format for performing this function by means of Electronic Data Interchange (EDI).

It is important that Managed Care Organizations study the Companion Guide and become familiar with the data that will be received by NYSDOH in transmission of an 837 Health Care Claim: Institutional transaction.

This Companion Guide does not modify the X12N 837I standards; rather, it puts forth the subset of information from the Implementation Guide (IG) that will be required for processing transactions. It is important that Managed Care Organizations use this Companion Guide as a supplement to the IG. Within the IG, there are data elements, which have many different qualifiers available for use. Each qualifier identifies a different piece of information. This document omits code qualifiers that are not necessary for NYS Medicaid processing. Although not all available codes are listed in this document, NYSDOH will accept any codes named or listed in the HIPAA IG. When necessary, a "NYS MEDICAID NOTE" is included to describe NYSDOH specific requirements. These notes provide guidance to ensure proper adjudication and subsequent claim payment.

It is important to understand that NYSDOH has provided "NYS MEDICAID NOTE(s)" stating "NYSDOH will ignore data when provided" in some "required" or "situational" segments. The intent here is to advise the submitting entity to submit data (for "required" segments) required by the IG specification, but that the data will not be used for NYS Medicaid adjudication processing. The IG lists all loops, segments, and elements. The Companion Guide may omit some of the previously mentioned IG items, unless they are defined as required in the IG, or the situation requires their use for NYS Medicaid processing. Although not all IG items are listed in the Companion Guide, NYS Medicaid will accept for processing all transactions that comply with the HIPAA IG. Providers are encouraged to use the IG to understand the positioning of the data examples provided for every segment, since our Companion Guide may not list all the elements.

Voids and adjustments to previous claims require the Transaction Control Number (TCN) from the remittance advice. TCN will be returned in loop 2300B, RMR02 in an X12 820 transaction. The TCN can also be retrieved by submitting a 276 transaction and receiving a 277.

SUPPORT:

Please refer to the Technical Supplementary Companion Guide for information about transaction header structures, transaction size limits, electronic communications methods, and enrollment as a trading partner. This document is available for download at nyhipaadesk.com.

For further assistance, NYSDOH and its fiscal agent, Computer Sciences Corporation (CSC), are urging providers to visit a web community, <https://www.nyhipaadesk.com>, which will provide Companion Guide updates and other pertinent information. In addition, questions may be sent to NYSDOH's Test Support Team at nyhipaadesk@csc.com.

Providers with questions may call the eMedNY Call Center at: 1-800-343-9000.

Please be advised that Unit representatives will only answer questions related to New York Medicaid HIPAA requirements.

The ASC X12N Implementation Guides and their associated addenda are available in electronic format at: www.wpc-edi.com/hipaa.

Heading:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Notes</u>	<u>Usage</u>
005	ST	Transaction Set Header	M	1			Required
010	BHT	Beginning of Hierarchical Transaction	M	1			Required
015	REF	Transmission Type Identification	O	1			Required
LOOP ID - 1000A					1	N1/020L	
020	NM1	Submitter Name	O	1		N1/020	Required
045	PER	Submitter EDI Contact Information	O	2			Situational

LOOP ID - 1000B					1	N1/020L	
020	NM1	Receiver Name	O	1		N1/020	Required

Detail:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Notes</u>	<u>Usage</u>
LOOP ID - 2000A					≥1		
001	HL	Billing/Pay-To Provider Hierarchical Level	M	1			Required

LOOP ID - 2010AA					1	N2/015L	
015	NM1	Billing Provider Name	O	1		N2/015	Required
025	N3	Billing Provider Address	O	1			Required
030	N4	Billing Provider City/State/ZIP Code	O	1			Required
035	REF	Billing Provider Secondary Identification	O	4			Situational

LOOP ID - 2000B					≥1		
001	HL	Subscriber Hierarchical Level	M	1		N2/001	Required
005	SBR	Subscriber Information	O	1			Required

LOOP ID - 2010BA					1	N2/015L	
015	NM1	Subscriber Name	O	1		N2/015	Required
025	N3	Subscriber Address	O	1			Situational
030	N4	Subscriber City/State/ZIP Code	O	1			Situational
032	DMG	Subscriber Demographic Information	O	1			Situational

LOOP ID - 2010BC					1	N2/015L	
015	NM1	Payer Name	O	1		N2/015	Required

LOOP ID - 2300					100		
130	CLM	Claim information	O	1			Required
135	DTP	Statement Dates	O	1			Required
180	REF	Original Reference Number (ICN/DCN)	O	1			Situational
231	HI	Principal, Admitting, E-Code and Patient Reason For Visit	O	1			Situational
231	HI	Diagnosis Information Value Information	O	2			Situational

LOOP ID - 2400					999	N2/365L	
365	LX	Service Line Number	O	1		N2/365	Required
375	SV2	Institutional Service Line	O	1			Required
455	DTP	Service Line Date	O	1			Situational
555	SE	Transaction Set Trailer	M	1			Required

ST Transaction Set Header

Pos: 005	Max: 1
Heading - Mandatory	
Loop: N/A	Elements: 2

User Option (Usage): Required

Purpose: To indicate the start of a transaction set and to assign a control number

Example:

ST*837*987654~

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
ST01	143	Transaction Set Identifier Code	M	ID	3/3	Required
		<u>Code</u>		<u>Name</u>		
		837		Health Care Claim		
		REQUIRED				
ST02	329	Transaction Set Control Number	M	AN	4/9	Required

HIPAA IG Note: The Transaction Set Control Number in ST02 and SE02 must be identical. This unique number also aids in error resolution research. Submitters could be sending transactions using the number 0001 in this element and increment from there. The number must be unique within a specific functional group (GS-GE) and interchange (ISA-IEA), but can repeat in other groups and interchanges.

BHT

Beginning of Hierarchical Transaction

Pos: 010	Max: 1
Heading - Mandatory	
Loop: N/A	Elements: 6

User Option (Usage): Required

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

Example:

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

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>						
BHT01	1005	Hierarchical Structure Code	M	ID	4/4	Required						
		<table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>0019</td> <td>Information Source, Subscriber, Dependent</td> </tr> </tbody> </table>	<u>Code</u>	<u>Name</u>	0019	Information Source, Subscriber, Dependent						
<u>Code</u>	<u>Name</u>											
0019	Information Source, Subscriber, Dependent											
BHT02	353	Transaction Set Purpose Code	M	ID	2/2	Required						
		<p>NYS MEDICAID NOTE: NYSDOH expects code '00', however, will process code '18' as an original transmission, when received.</p> <p>HIPAA IG Note: BHT02 is intended to convey the electronic transmission status of the 837 batch contained in this ST-SE envelope. The terms "original" and "reissue" refer to the electronic transmission status of the 837 batch, not the billing status.</p> <p>ORIGINAL: original transmissions are claims/encounters which have never been sent to the receiver. Generally nearly all transmissions to a payer entity (as the ultimate destination of the transaction) are original.</p> <p>REISSUE: In the case where a transmission was disrupted the receiver can request that the batch be sent again. Use "Reissue" when resending transmission batches that have been previously sent.</p> <table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>00</td> <td>Original</td> </tr> <tr> <td>18</td> <td>Reissue</td> </tr> </tbody> </table>	<u>Code</u>	<u>Name</u>	00	Original	18	Reissue				
<u>Code</u>	<u>Name</u>											
00	Original											
18	Reissue											
BHT03	127	Reference Identification	O	AN	1/30	Required						
		<p>Industry: Originator Application Transaction Identifier</p> <p>HIPAA IG Note: Use this reference identifier to identify the inventory file number of the tape or transmission assigned by the submitter's system.</p>										
BHT04	373	Date	O	DT	8/8	Required						
		<p>Industry: Transaction Set Creation Date</p> <p>NYS MEDICAID NOTE: NYSDOH expects to receive Billing Date in this field.</p> <p>HIPAA IG Note: Use this date to identify the date on which the submitter created the file.</p>										
BHT05	337	Time	O	TM	4/8	Required						
		<p>Industry: Transaction Set Creation Time</p> <p>HIPAA IG Note: Use this time to identify the time of day that the submitter created the file.</p>										
BHT06	640	Transaction Type Code	O	ID	2/2	Required						
NYSDOH												

Industry: Claim or Encounter Identifier
Alias: Claim or Encounter Indicator
HIPAA IG Note: Use RP when the entire ST-SE envelope contains encounter transmissions. Use RP when the transmission is being sent to an entity (usually not a payer or a normal provider-payer transmission intermediary) for purposes other than adjudication of a claim. Such an entity could be a state health agency which is using the 837 for health data reporting purposes.

<u>Code</u>	<u>Name</u>
CH	Chargeable Use this code when the transmission contains only fee-for-service claims or claims with at least one chargeable line item. If it is not clear whether a transaction is a claim or encounter, the developers of this implementation guide recommend submitting the transaction as a claim.

REF Transmission Type Identification

Pos: 015	Max: 1
Heading - Optional	
Loop: N/A	Elements: 2

User Option (Usage): Required
Purpose: To specify identifying information

Example:
 REF*87*004010X096A1~

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
REF01	128	Reference Identification Qualifier	M	ID	2/3	Required
		<u>Code</u> 87		<u>Name</u> Functional Category		
				Description: An organization or groups of organizations with a common operational orientation such as Quality Control Engineering, etc		
REF02	127	Reference Identification	C	AN	1/30	Required
		Industry: Transmission Type Code NYS MEDICAID NOTE: NYSDOH will reject transactions that do not contain "004010X096A1" in this location. HIPAA IG Note: When piloting the transaction set, this value is 004010X096DA1. When sending the transaction set in a production mode, this value is 004010X096A1.				

NM1

Submitter Name

Pos: 020	Max: 1
Heading - Optional	
Loop: 1000A	Elements: 7

User Option (Usage): Required

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

Notes:

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

Example:

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

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
NM101	98	Entity Identifier Code	M	ID	2/3	Required
		<u>Code</u> <u>Name</u>				
		41 Submitter				
		Description: Entity transmitting transaction set				
NM102	1065	Entity Type Qualifier	M	ID	1/1	Required
		<u>Code</u> <u>Name</u>				
		2 Non-Person Entity				
NM103	1035	Name Last or Organization Name	O	AN	1/35	Required
		Industry: Submitter Last or Organization Name				
		Alias: Submitter Name				
NM104	1036	Name First	O	AN	1/25	Situational
		Industry: Submitter First Name				
		Alias: Submitter Name				
		HIPAA IG Note: Required if NM102=1 (person).				
NM105	1037	Name Middle	O	AN	1/25	Situational
		Industry: Submitter Middle Name				
		Alias: Submitter Name				
		HIPAA IG Note: Required if NM102=1 and the middle name/initial of the person is known.				
NM108	66	Identification Code Qualifier	C	ID	1/2	Required
		<u>Code</u> <u>Name</u>				
		46 Electronic Transmitter Identification Number (ETIN)				
		Description: A unique number assigned to each transmitter and software developer Established by a trading partner agreement				
NM109	67	Identification Code	C	AN	2/80	Required
		Industry: Submitter Identifier				
		Alias: Submitter Primary Identification Number				
		NYS MEDICAID NOTE: NYSDOH will return the Remittance Advice to the ETIN (Electronic Transmitter Identification Number) provided. NYS Medicaid assigns this number to the submitter. In past implementations, this code was known as the Transmission Supplier Number (TSN).				
		Trading Partners with three-character ETIN numbers should continue to use their current ETIN. Newly assigned ETIN numbers will be four characters.				

PER Submitter EDI Contact Information

Pos: 045	Max: 2
Heading - Optional	
Loop: 1000A	Elements: 8

User Option (Usage): Situational

Purpose: To identify a person or office to whom administrative communications should be directed

Notes:

1. The contact information in this segment should point to the person in the submitter organization who deals with data transmission issues. If data transmission problems arise, this is the person to contact in the submitter organization.
2. When the communication number represents a telephone number in the United States and other countries using the North American Dialing Plan (for voice, data, fax, etc.), the communication number should always include the area code and phone number using the format AAABBBCCCC. Where AAA is the area code, BBB is the telephone number prefix, and CCCC is the telephone number (e.g. (534)224-2525 would be represented as 5342242525). The extension, when applicable, should be included in the communication number immediately after the telephone number.

Example:

PER*IC*JANE DOE*TE*9005555555~

NYS MEDICAID NOTE:

NYSDOH will ignore data when provided.

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
PER01	366	Contact Function Code	M	ID	2/2	Required
		<u>Code</u> <u>Name</u>				
		IC Information Contact				
PER02	93	Name	O	AN	1/60	Required
		Industry: Submitter Contact Name				
PER03	365	Communication Number Qualifier	C	ID	2/2	Required
		<u>Code</u> <u>Name</u>				
		ED Electronic Data Interchange Access Number				
		EM Electronic Mail				
		FX Facsimile				
		TE Telephone				
PER04	364	Communication Number	C	AN	1/80	Required
PER05	365	Communication Number Qualifier	C	ID	2/2	Situational
		HIPAA IG Note: Used when additional contact numbers are to be communicated.				
		<u>Code</u> <u>Name</u>				
		ED Electronic Data Interchange Access Number				
		EM Electronic Mail				
		EX Telephone Extension				
		The use of this code indicates it is the extension of the number in PER04.				
		FX Facsimile				
		TE Telephone				
PER06	364	Communication Number	C	AN	1/80	Situational
		HIPAA IG Note: This data element is required when the submitter needs to convey additional submitter contact information. Used when additional contact numbers are to be communicated.				
PER07	365	Communication Number Qualifier	C	ID	2/2	Situational
		HIPAA IG Note: Used when additional contact				

numbers are to be communicated.

<u>Code</u>	<u>Name</u>
ED	Electronic Data Interchange Access Number
EM	Electronic Mail
EX	Telephone Extension
	The use of this code indicates it is the extension of the number in PER06.
FX	Facsimile
TE	Telephone

PER08	364	Communication Number	C	AN	1/80	Situational
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HIPAA IG Note: This data element is required when the submitter needs to convey additional submitter contact information. Used when additional contact numbers are to be communicated.

NM1 Receiver Name

Pos: 020	Max: 1
Heading - Optional	
Loop: 1000B	Elements: 5

User Option (Usage): Required

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

Notes:

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

Example:

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

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
NM101	98	Entity Identifier Code	M	ID	2/3	Required
		<u>Code</u> <u>Name</u>				
		40 Receiver				
		Description: Entity to accept transmission				
NM102	1065	Entity Type Qualifier	M	ID	1/1	Required
		<u>Code</u> <u>Name</u>				
		2 Non-Person Entity				
NM103	1035	Name Last or Organization Name	O	AN	1/35	Required
		Industry: Receiver Name NYS MEDICAID NOTE: NYSDOH expects to receive 'NYSDOH'.				
NM108	66	Identification Code Qualifier	C	ID	1/2	Required
		Industry: Information Receiver Identification Number				
		<u>Code</u> <u>Name</u>				
		46 Electronic Transmitter Identification Number (ETIN)				
		Description: A unique number assigned to each transmitter and software developer				
NM109	67	Identification Code	C	AN	2/80	Required
		Industry: Receiver Primary Identifier Alias: Receiver Primary Identification Number NYS MEDICAID NOTE: NYSDOH expects to receive '141797357'.				

HL

Billing/Pay-To Provider Hierarchical Level

Pos: 001	Max: 1
Detail - Mandatory	
Loop: 2000A	Elements: 3

User Option (Usage): Required

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

Notes:

1. Use the Billing Provider HL to identify the original entity who submitted the electronic claim/encounter to the destination payer identified in Loop ID-2010BC. The billing provider entity may be a health care provider, a billing service, or some other representative of the provider
2. The Billing/Pay-to Provider HL may contain information about the Pay-to Provider entity. If the Pay-to Provider entity is the same as the Billing Provider entity, then only use Loop ID-2010AA.
3. If the Service Facility Provider is the same entity as the Billing or the Pay-to Provider then do not use Loop 2310E.
4. If the Billing or Pay-to Provider is also the Service Facility Provider and Loop ID 2310E is not used, the Loop ID-2000 PRV must be used to indicate which entity (Billing or Pay-to) is the Service Facility Provider.
5. Because this is a required segment, this is a required loop. See Appendix A for further details on ASC X12 nomenclature.
6. Receiving trading partners may have system limitations regarding the size of the transmission they can receive. The developers of this implementation guide recommend that trading partners limit the size of the transaction (ST-SE envelope) to a maximum of 5000 CLM segments. While the implementation guide sets no specific limit to the number of Billing/Pay-to Provider Hierarchical Level loops, there is an implied maximum of 5000.

Example:

HL*1**20*1~

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
HL01	628	Hierarchical ID Number	M	AN	1/12	Required
HIPAA IG Note: HL01 must begin with "1" and be incremented by one each time an HL is used in the transaction. Only numeric values are allowed in HL01.						
HL03	735	Hierarchical Level Code	M	ID	1/2	Required
		<u>Code</u>		<u>Name</u>		
		20		Information Source		
Description: Identifies the payor, maintainer, or source of the information						
HL04	736	Hierarchical Child Code	O	ID	1/1	Required
HIPAA IG Note: The claim loop (Loop ID-2300) can be used only when HL04 has no subordinate levels (HL04 = 0).						
		<u>Code</u>		<u>Name</u>		
		1		Additional Subordinate HL Data Segment in This Hierarchical Structure.		

NM1 Billing Provider Name

Pos: 015	Max: 1
Detail - Optional	
Loop: 2010AA	Elements: 5

User Option (Usage): Required

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

Notes:

1. Because this is a required segment, this is a required loop. See Appendix A for further details on ASC X12 nomenclature.
2. Although the name of this loop/segment is "Billing Provider" the loop/segment really identifies the billing entity. The billing entity does not have to be a health care provider to use this loop. However, some payers do not accept claims from non-provider billing entities.

Example:

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

NYS MEDICAID NOTE:

For Managed Care Capitation Premium billing the Billing Provider will be the Managed Care Organization.

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
NM101	98	Entity Identifier Code	M	ID	2/3	Required
		<u>Code</u> 85		<u>Name</u> Billing Provider		
				Use this code to indicate billing provider, billing submitter, and encounter reporting entity.		
NM102	1065	Entity Type Qualifier	M	ID	1/1	Required
		<u>Code</u> 2		<u>Name</u> Non-Person Entity		
NM103	1035	Name Last or Organization Name	O	AN	1/35	Required
		Industry: Billing Provider Last or Organizational Name				
		Alias: Billing Provider Name				
NM108	66	Identification Code Qualifier	C	ID	1/2	Required
		HIPAA IG Note: If "XX - NPI" is used, then either the Employer's Identification Number or the Social Security Number of the provider must be carried in the REF in this loop.				
		<u>Code</u> 24		<u>Name</u> Employer's Identification Number		
NM109	67	Identification Code	C	AN	2/80	Required
		Industry: Billing Provider Identifier				
		Alias: Billing Provider Primary ID				
		<u>ExternalCodeList</u>				
		Name: 537				
		Description: Health Care Financing Administration National Provider Identifier				

N3

Billing Provider Address

Pos: 025	Max: 1
Detail - Optional	
Loop: 2010AA	Elements: 2

User Option (Usage): Required

Purpose: To specify the location of the named party

Example:

N3*225 MAIN STREET BARKLEY BUILDING~

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
N301	166	Address Information	M	AN	1/55	Required
		Industry: Billing Provider Address Line				
N302	166	Address Information	O	AN	1/55	Situational
		Industry: Billing Provider Address Line				
		HIPAA IG Note: Required if a second address line exists.				

N4

Billing Provider City/State/ZIP Code

Pos: 030	Max: 1
Detail - Optional	
Loop: 2010AA	Elements: 4

User Option (Usage): Required

Purpose: To specify the geographic place of the named party

Example:

N4*CENTERVILLE*PA*17111~

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
N401	19	City Name Industry: Billing Provider City Name	O	AN	2/30	Required
N402	156	State or Province Code Industry: Billing Provider State or Province Code <u>ExternalCodeList</u> Name: 22 Description: States and Outlying Areas of the U.S.	O	ID	2/2	Required
N403	116	Postal Code Industry: Billing Provider Postal Zone or ZIP Code <u>ExternalCodeList</u> Name: 51 Description: ZIP Code	O	ID	3/15	Required
N404	26	Country Code HIPAA IG Note: This data element is required when the address is outside of the U.S. <u>ExternalCodeList</u> Name: 5 Description: Countries, Currencies and Funds	O	ID	2/3	Situational

REF Billing Provider Secondary Identification

Pos: 035	Max: 4
Detail - Optional	
Loop: 2010AA	Elements: 2

User Option (Usage): Situational
Purpose: To specify identifying information

Notes:

1. Required when a secondary identification number is necessary to identify the entity. The primary identification number should be carried in NM109.
2. If the reason the number is being used in this REF can be met by the NPI, carried in the NM108/09 of this loop, then this REF is not used.
3. If "code XX - NPI" is used in the NM108/09 of this loop, then either the Employer's Identification Number or the Social Security Number of the provider must be carried in this REF. The number sent is the one which is used on the 1099. If additional numbers are needed the REF can be run up to 8 times.

Example:

REF*SY*987654~

NYS MEDICAID NOTE:

NYSDOH expects to receive a minimum of two iterations of the Billing Provider Secondary Identification REF segment:

- an iteration with REF01 = '1D' to indicate that the Medicaid Provider Number is being sent in REF02
- and an iteration with REF01 = 'LU' to indicate that the three-digit Location Number is being sent in REF02;

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>						
REF01	128	Reference Identification Qualifier	M	ID	2/3	Required						
<p>HIPAA IG Note: Codes 8U, LU, ST, TT, 06, IJ, RB, and EM were added to this implementation guide to support credit/debit card information billing. See Appendix G, Credit/Debit Card Use, for details.</p> <table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>1D</td> <td>Medicaid Provider Number</td> </tr> <tr> <td>LU</td> <td>Location Number</td> </tr> </tbody> </table>							<u>Code</u>	<u>Name</u>	1D	Medicaid Provider Number	LU	Location Number
<u>Code</u>	<u>Name</u>											
1D	Medicaid Provider Number											
LU	Location Number											
REF02	127	Reference Identification	C	AN	1/30	Required						
<p>Industry: Billing Provider Additional Identifier</p>												

HL

Subscriber Hierarchical Level

Pos: 001	Max: 1
Detail - Mandatory	
Loop: 2000B	Elements: 4

User Option (Usage): Required

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

Notes:

1. If the insured and the patient are the same person, use this HL to identify the insured/patient, skip the subsequent (PATIENT) HL, and proceed directly to Loop ID-2300.
2. The Subscriber HL contains information about the person who is listed as the subscriber/insured for the destination payer entity (Loop ID-2010BA). The Subscriber HL contains information identifying the subscriber (Loop ID-2010BA), his or her insurance (Loop ID-2010BC), and responsible party (Loop ID-2010BD). In addition, information about the credit/debit card holder is placed in this HL (Loop ID-2010BB). The credit/debit card holder may or may not be the subscriber. See Appendix G, Credit/Debit Card Use, for a description of using Loop ID-2010BD.
3. Because this is a required segment, this is a required loop. See Appendix A for further details on ASC X12 nomenclature.
4. Receiving trading partners may have system limitations regarding the size of the transmission they can receive. The developers of this implementation guide recommend that trading partners limit the size of the transaction (ST-SE envelope) to a maximum of 5000 CLM segments. While the implementation guide sets no specific limit to the number of Subscriber Hierarchical Level loops, there is an implied maximum of 5000.

Example:

HL*124*123*22*1~

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
HL01	628	Hierarchical ID Number	M	AN	1/12	Required
HL02	734	Hierarchical Parent ID Number	O	AN	1/12	Required
HL03	735	Hierarchical Level Code	M	ID	1/2	Required
		<u>Code</u>		<u>Name</u>		
		22		Subscriber		
		Description: Identifies the employee or group member who is covered for insurance and to whom, or on behalf of whom, the insurer agrees to pay benefits				
HL04	736	Hierarchical Child Code	O	ID	1/1	Required

NYS MEDICAID NOTE: NYSDOH expects to receive value '0'. NYSDOH will reject any claim that reports the Patient HL segment, loop 2000C. The patient is always the subscriber for NYS Medicaid claims. The HIPAA IG prohibits submission of the Patient HL when the patient and subscriber are the same person.

HIPAA IG Note: The claim loop (Loop ID-2300) can be used both when HL04 has no subordinate levels (HL04 = 0) or when HL04 has subordinate levels indicated (HL04 = 1). In the first case (HL04 = 0), the subscriber is the patient and there are no dependent claims. The second case (HL04 = 1) happens when claims/encounters for both the subscriber and a dependent of theirs are being sent under the same billing provider HL (e.g., a father and son are both involved in the same automobile accident and are treated by the same provider). In that case, the subscriber HL04 = 1 because there is a dependent to this subscriber, but the 2300 loop for the subscriber/patient (father) would begin after the subscriber HL. The dependent HL (son) would then be run and the 2300 loop for the dependent/patient would be run after that HL.

HL04=1 would also be used when a claim/encounter for a only a dependent is being sent.

<u>Code</u>	<u>Name</u>
0	No Subordinate HL Segment in This Hierarchical Structure.

SBR Subscriber Information

Pos: 005	Max: 1
Detail - Optional	
Loop: 2000B	Elements: 5

User Option (Usage): Required

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

Example:

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

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
SBR01	1138	Payer Responsibility Sequence Number Code NYS MEDICAID NOTE: Because Capitation Premium billing is not a Health Care Claim, Coordination of Benefits information is not included. The value of "P" can be sent in all Capitation Premium claims. <u>Code</u> <u>Name</u> P Primary	M	ID	1/1	Required
SBR02	1069	Individual Relationship Code Alias: Patients Relationship to Insured HIPAA IG Note: Use this code only when the subscriber is the same person as the patient. If the subscriber is not the same person as the patient, do not use this element. <u>Code</u> <u>Name</u> 18 Self	O	ID	2/2	Situational
SBR03	127	Reference Identification Industry: Insured Group or Policy Number Alias: Group Number HIPAA IG Note: Use this element to carry the subscriber's group number but not the number that uniquely identifies the subscriber. The subscriber's number should be carried in NM109. Using code IL in NM101 identifies the number in NM109 as the insured's Identification Number.	O	AN	1/30	Situational
SBR04	93	Name Industry: Insured Group Name Alias: Plan Name (Group Name) NYS MEDICAID NOTE: NYSDOH expects to receive "MEDICAID" in this data element. HIPAA IG Note: Used only when no group number is reported in SBR03.	O	AN	1/60	Situational
SBR09	1032	Claim Filing Indicator Code HIPAA IG Note: Required prior to mandated use of PlanID. Not used after PlanID is mandated. <u>Code</u> <u>Name</u> MC Medicaid	O	ID	1/2	Situational

NM1 Subscriber Name

Pos: 015	Max: 1
Detail - Optional	
Loop: 2010BA	Elements: 8

User Option (Usage): Required

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

Notes:

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

Example:

NM1*IL*1*DOE*JOHN*T***MI*739004273~

NYS MEDICAID NOTE:

NYSDOH expects Medicaid recipient/client information to be reported in this loop. The eMedNY system will use the Medicaid Client ID Number (CIN) in NM109 to identify the recipient, not the name in NM103 and NM104.

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
NM101	98	Entity Identifier Code	M	ID	2/3	Required
		<u>Code</u> <u>Name</u>				
		IL Insured or Subscriber				
NM102	1065	Entity Type Qualifier	M	ID	1/1	Required
		<u>Code</u> <u>Name</u>				
		1 Person				
NM103	1035	Name Last or Organization Name	O	AN	1/35	Required
		Industry: Subscriber Last Name NYS MEDICAID NOTE: Although this is a required data element, NYSDOH will not use this information to identify the recipient.				
NM104	1036	Name First	O	AN	1/25	Situational
		Industry: Subscriber First Name NYS MEDICAID NOTE: Although this is a required data element, NYSDOH will not use this information to identify the recipient. HIPAA IG Note: This data element is required when NM102 equals one (1).				
NM105	1037	Name Middle	O	AN	1/25	Situational
		Industry: Subscriber Middle Name Alias: Subscriber's Middle Initial HIPAA IG Note: This data element is required when NM102 = 1 and the Middle Name or Initial of the person is known.				
NM107	1039	Name Suffix	O	AN	1/10	Situational
		Industry: Subscriber Name Suffix HIPAA IG Note: This data element is required when the NM102 equals one (1) and the name suffix is known. Examples: I, II, III, IV, Jr, Sr.				
NM108	66	Identification Code Qualifier	C	ID	1/2	Situational
		HIPAA IG Note: This data element is required when NM102 equals one (1). MI is also intended to be used in claims submitted to the Indian Health Service/Contract Health Services (IHS/CHS) Fiscal Intermediary for				

the purpose of reporting the Tribe Residency Code (Tribe County State). In the event that a Social Security Number is also available on an IHS/CHS claim, put the SSN in REF02.

<u>Code</u>	<u>Name</u>
MI	Member Identification Number

The code MI is intended to be the subscriber's identification number as assigned by the payer. Payers use different terminology to convey the same number, therefore, the 837 Institutional Workgroup recommends using MI - Member Identification Number to convey the following terms: Insured's ID, Subscriber's ID, Medicaid Recipient ID, Health Insurance Claim Number (HIC), etc.

NM109	67	Identification Code	C	AN	2/80	Situational
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Industry: Subscriber Primary Identifier
NYS MEDICAID NOTE: NYSDOH expects to receive Client/Recipient ID here.
HIPAA IG Note: This data element is required when NM102 equals one (1).

N3

Subscriber Address

Pos: 025	Max: 1
Detail - Optional	
Loop: 2010BA	Elements: 2

User Option (Usage): Situational

Purpose: To specify the location of the named party

Notes:

1. This segment is required when the Patient is the same person as the Subscriber. (Required when Loop ID 2000B, SBR02- 18 (self)).

Example:

N3*125 CITY AVENUE~

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
N301	166	Address Information	M	AN	1/55	Required
		Industry: Subscriber Address Line				
N302	166	Address Information	O	AN	1/55	Situational
		Industry: Subscriber Address Line				
		HIPAA IG Note: Required if a second address line exists.				

N4

Subscriber City/State/ZIP Code

Pos: 030	Max: 1
Detail - Optional	
Loop: 2010BA	Elements: 4

User Option (Usage): Situational

Purpose: To specify the geographic place of the named party

Notes:

1. This segment is required when the Patient is the same person as the Subscriber. (Required when Loop ID 2000B, SBR02- 18 (self)).

Example:

N4*CENTERVILLE*PA*17111~

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
N401	19	City Name Industry: Subscriber City Name	O	AN	2/30	Required
N402	156	State or Province Code Industry: Subscriber State Code <u>ExternalCodeList</u> Name: 22 Description: States and Outlying Areas of the U.S.	O	ID	2/2	Required
N403	116	Postal Code Industry: Subscriber Postal Zone or ZIP Code <u>ExternalCodeList</u> Name: 51 Description: ZIP Code	O	ID	3/15	Required
N404	26	Country Code HIPAA IG Note: This data element is required when the address is outside of the U.S. <u>ExternalCodeList</u> Name: 5 Description: Countries, Currencies and Funds	O	ID	2/3	Situational

DMG Subscriber Demographic Information

Pos: 032	Max: 1
Detail - Optional	
Loop: 2010BA	Elements: 3

User Option (Usage): Situational
Purpose: To supply demographic information

Notes:
 1. This segment is required when the Patient is the same person as the Subscriber. (Required when Loop ID 2000B, SBR02- 18 (self)).
Example:
 DMG*D8*19290730*M~

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>												
DMG01	1250	Date Time Period Format Qualifier	C	ID	2/3	Required												
		<table border="0"> <tr> <td><u>Code</u></td> <td><u>Name</u></td> </tr> <tr> <td>D8</td> <td>Date Expressed in Format CCYYMMDD</td> </tr> </table>	<u>Code</u>	<u>Name</u>	D8	Date Expressed in Format CCYYMMDD												
<u>Code</u>	<u>Name</u>																	
D8	Date Expressed in Format CCYYMMDD																	
DMG02	1251	Date Time Period	C	AN	1/35	Required												
		<table border="0"> <tr> <td colspan="2">Industry: Subscriber Birth Date</td> </tr> <tr> <td colspan="2">Alias: Date of Birth - Patient</td> </tr> </table>	Industry: Subscriber Birth Date		Alias: Date of Birth - Patient													
Industry: Subscriber Birth Date																		
Alias: Date of Birth - Patient																		
DMG03	1068	Gender Code	O	ID	1/1	Required												
		<table border="0"> <tr> <td colspan="2">Industry: Subscriber Gender Code</td> </tr> <tr> <td colspan="2">Alias: Gender - Patient</td> </tr> <tr> <td colspan="2">NYS MEDICAID NOTE: NYSDOH cannot process code 'U' (Unknown). Any claim received populated with code 'U' will be denied.</td> </tr> </table> <table border="0"> <tr> <td><u>Code</u></td> <td><u>Name</u></td> </tr> <tr> <td>F</td> <td>Female</td> </tr> <tr> <td>M</td> <td>Male</td> </tr> </table>	Industry: Subscriber Gender Code		Alias: Gender - Patient		NYS MEDICAID NOTE: NYSDOH cannot process code 'U' (Unknown). Any claim received populated with code 'U' will be denied.		<u>Code</u>	<u>Name</u>	F	Female	M	Male				
Industry: Subscriber Gender Code																		
Alias: Gender - Patient																		
NYS MEDICAID NOTE: NYSDOH cannot process code 'U' (Unknown). Any claim received populated with code 'U' will be denied.																		
<u>Code</u>	<u>Name</u>																	
F	Female																	
M	Male																	

NM1

Payer Name

Pos: 015	Max: 1
Detail - Optional	
Loop: 2010BC	Elements: 5

User Option (Usage): Required

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

Notes:

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

Example:

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

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
NM101	98	Entity Identifier Code	M	ID	2/3	Required
		<u>Code</u> <u>Name</u>				
		PR Payer				
NM102	1065	Entity Type Qualifier	M	ID	1/1	Required
		<u>Code</u> <u>Name</u>				
		2 Non-Person Entity				
NM103	1035	Name Last or Organization Name	O	AN	1/35	Required
		Industry: Payer Name NYS MEDICAID NOTE: NYSDOH expects to receive 'NYSDOH'.				
NM108	66	Identification Code Qualifier	C	ID	1/2	Required
		<u>Code</u> <u>Name</u>				
		PI Payor Identification				
NM109	67	Identification Code	C	AN	2/80	Required
		Industry: Payer Identifier Alias: Primary Payer ID NYS MEDICAID NOTE: NYSDOH expects to receive '141797357'.				
		<u>ExternalCodeList</u>				
		Name: 540				
		Description: Health Care Financing Administration National PlanID				

CLM Claim information

Pos: 130	Max: 1
Detail - Optional	
Loop: 2300	Elements: 8

User Option (Usage): Required

Purpose: To specify basic data about the claim

Notes:

1. The developers of this implementation guide recommend that trading partners limit the size of the transaction (ST-SE envelope) to a maximum of 5000 CLM segments. There is no recommended limit to the number of ST-SE transactions within a GS-GE or ISA-IEA. Willing trading partners can agree to set limits higher.
2. For purposes of this documentation, the claim detail information is presented only in the dependent level. Specific claim detail information can be given in either the subscriber or the dependent hierarchical level. Because of this the claim information is said to "float." Claim information is positioned in the same hierarchical level that describes its owner-participant, either the subscriber or the dependent. In other words, the claim information, loop 2300, is placed following loop 2010BD in the subscriber hierarchical level when the patient is the subscriber, or it is placed at the patient/dependent hierarchical level when the patient is the dependent of the subscriber as shown here. When the patient is the subscriber, loops 2000C and 2010CA are not sent. See 2.3.2.1, HL Segment, for details.

Example:

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

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
CLM01	1028	Claim Submitter's Identifier Industry: Patient Account Number Alias: Patient Control Number NYS MEDICAID NOTE: The Implementation Guide's reference to the 835 is not relevant to a NYS Medicaid remittance for Capitation Premium. Managed Care Organizations will receive an 820 for this purpose. The Patient Control Number in CLM01 will be returned in ENT04 of the 820. HIPAA IG Note: The number that the submitter transmits in this position is echoed back to the submitter in the 835 and other transactions. This permits the submitter to use the value in this field as a key in the submitter's system to match the claim to the payment information returned in the 835 transaction. The two recommended identifiers are either the patient account number or the claim number in the billing provider's system. The MAXIMUM NUMBER OF CHARACTERS to be supported for this field is '20'. A Provider may submit fewer characters depending upon their needs. However, the HIPAA maximum requirement to be supported by any responding system is '20'. Characters beyond 20 are not required to be stored nor returned by any receiving system.	M	AN	1/38	Required
CLM02	782	Monetary Amount Industry: Total Claim Charge Amount Alias: Total Claim Charges HIPAA IG Note: Use this element to indicate the total amount of all submitted charges of service segments for this claim. Zero may be a valid amount.	O	R	1/18	Required
CLM05	C023	Health Care Service Location Information	O	Comp		Required

		Alias: Type of Bill				
CLM05-01	1331	Facility Code Value	M	AN	1/2	Required
		Industry: Facility Type Code NYS MEDICAID NOTE: It is permissible to use a value of 89, "Special Facility, Other" in this data element.				
		ExternalCodeList Name: 236 Description: Uniform Billing Claim Form Bill Type				
CLM05-02	1332	Facility Code Qualifier	O	ID	1/2	Required
		Code Name A Uniform Billing Claim Form Bill Type				
		CODE SOURCE: 236: Uniform Billing Claim Form Bill Type				
CLM05-03	1325	Claim Frequency Type Code	O	ID	1/1	Required
		Industry: Claim Frequency Code NYS MEDICAID NOTE: NYSDOH will process all values as original claims with the exception of codes '7' (Replacement) and '8' (Void). In these cases, NYSDOH expects to receive the Transaction Control Number (formerly known as CRN Number) that was returned in an 820 transaction. These values should only be sent for previously paid claims that are being adjusted or voided.				
		ExternalCodeList Name: 235 Description: Claim Frequency Type Code				
CLM06	1073	Yes/No Condition or Response Code	O	ID	1/1	Required
		Industry: Provider or Supplier Signature Indicator Alias: Provider Signature on File NYS MEDICAID NOTE: NYSDOH expects to receive 'Y'. Value 'Y' indicates the signature is on file.				
		Code Name Y Yes				
CLM08	1073	Yes/No Condition or Response Code	O	ID	1/1	Required
		Industry: Benefits Assignment Certification Indicator Alias: Assignment of Benefits Indicator HIPAA IG Note: Use this value as an assignment of benefits indicator. Use a "Y" value to indicate that the insured or authorized person authorizes benefits to be assigned to the provider. Use an "N" value to indicate that benefits have not been assigned to the provider.				
		Code Name Y Yes				
CLM09	1363	Release of Information Code	O	ID	1/1	Required
		Code Name O On file at Payor or at Plan Sponsor				
CLM18	1073	Yes/No Condition or Response Code	O	ID	1/1	Required
		Industry: Explanation of Benefits Indicator Alias: Explanation of Benefits (EOB) Indicator				

NYS MEDICAID NOTE: NYSDOH does not support this business process.

<u>Code</u>	<u>Name</u>
N	No
Y	Yes

CLM20 1514 **Delay Reason Code** O ID 1/2 Situational

NYS MEDICAID NOTE: NYSDOH will process as Over 90 Day Indicator and deny a code value of '6' for business purposes.

Refer to the 837 Institutional Supplemental Companion Guide for more information on NYSDOH's requirements and uses of this data element.

HIPAA IG Note: Delay Reason Code
 This element may be used if a particular claim is being transmitted in response to a request for information (e.g., a 277), and the response has been delayed.
 Required when claim is submitted late (past contracted date of filing limitations) and any of the codes below apply.

<u>Code</u>	<u>Name</u>
1	Proof of Eligibility Unknown or Unavailable
2	Litigation
3	Authorization Delays
4	Delay in Certifying Provider
5	Delay in Supplying Billing Forms
6	Delay in Delivery of Custom-made Appliances
7	Third Party Processing Delay
8	Delay in Eligibility Determination
9	Original Claim Rejected or Denied Due to a Reason Unrelated to the Billing Limitation Rules
10	Administration Delay in the Prior Approval Process
11	Other

DTP Statement Dates

Pos: 135	Max: 1
Detail - Optional	
Loop: 2300	Elements: 3

User Option (Usage): Required

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

Example:

DTP*434*RD8*19981209-19981214~

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
DTP01	374	Date/Time Qualifier	M	ID	3/3	Required
		Industry: Date Time Qualifier				
		<u>Code</u>		<u>Name</u>		
		434		Statement		
DTP02	1250	Date Time Period Format Qualifier	M	ID	2/3	Required
		<u>Code</u>		<u>Name</u>		
		D8		Date Expressed in Format CCYYMMDD		
DTP03	1251	Date Time Period	M	AN	1/35	Required
		Industry: Statement From or To Date				
		NYS MEDICAID NOTE: For capitation billing the Statement Date is the first of the month.				

REF

Original Reference Number (ICN/DCN)

Pos: 180	Max: 1
Detail - Optional	
Loop: 2300	Elements: 2

User Option (Usage): Situational

Purpose: To specify identifying information

Notes:

1. Reference numbers at this position apply to the entire claim.
2. This segment is used to convey the control number assigned to the original bill by the payer to identify a unique claim.

Example:

REF*F8*1234636854~

NYS MEDICAID NOTE:

NYSDOH expects this segment when the submitter desires to adjust or void a previously paid claim.

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
REF01	128	Reference Identification Qualifier	M	ID	2/3	Required
		<u>Code</u> <u>Name</u>				
		F8 Original Reference Number				
REF02	127	Reference Identification	C	AN	1/30	Required
		Industry: Claim Original Reference Number NYS MEDICAID NOTE: NYSDOH expects to receive the original claim TCN (Transaction Control Number, also known as Claim Reference Number or CRN).				

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

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

User Option (Usage): Situational

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

Notes:

1. Required on all claims and encounters except claims for Religious Non-medical claims (Bill Types 4XX and 5XX) and hospital other (Bill Types 14X).
2. The Admitting Diagnosis is required on all inpatient admission claims and encounters.
3. An E-Code diagnosis is required whenever a diagnosis is needed to describe an injury, poisoning or adverse effect.
4. The Patient Reason for Visit Diagnosis is required for all unscheduled outpatient visits.

Example:

HI*BK:9976~

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
HI01	C022	Health Care Code Information	M	Comp		Required
HI01-01	1270	Code List Qualifier Code	M	ID	1/3	Required

<u>Code</u>	<u>Name</u>
BK	Principal Diagnosis

CODE SOURCE:

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

HI01-02	1271	Industry Code	M	AN	1/30	Required
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NYS MEDICAID NOTE: Information about the recipient's medical condition may not be available. It is permissible to use ICD-9 code 799.9 - Other Unknown and Unspecified Cause (because the decimal point is not sent in the 837, populate the HI01-2 sub-element with a value of '7999').

ExternalCodeList

Name: 131

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

HI Value Information

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

User Option (Usage): Situational

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

Notes:

1. Required when value information applies to the claim or encounter.

Example:

HI*BE:08:::1740~

NYS MEDICAID NOTE:

NYSDOH will process Rate Code under Code Source 'BE'.

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
HI01	C022	Health Care Code Information	M	Comp		Required
HI01-01	1270	Code List Qualifier Code	M	ID	1/3	Required

<u>Code</u>	<u>Name</u>
BE	Value

CODE SOURCE:

132: National Uniform Billing Committee (NUBC) Codes

HI01-02	1271	Industry Code	M	AN	1/30	Required
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Industry: Value Code
NYS MEDICAID NOTE: NYSDOH expects a value of 24, "Rate Code".

ExternalCodeList

Name: 132
Description: National Uniform Billing Committee (NUBC) Codes

HI01-03	1250	Date Time Period Format Qualifier	C	ID	2/3	Situational
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NYS MEDICAID NOTE: HI01-3 is NOT USED for HIPAA claims. Do not send this sub-element. However you must send the component element separator.

HI01-04	1251	Date Time Period	C	AN	1/35	Situational
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NYS MEDICAID NOTE: HI01-4 is NOT USED for HIPAA claims. Do not send this sub-element. However you must send the component element separator.

HI01-05	782	Monetary Amount	O	R	1/18	Required
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Industry: Value Code Associated Amount
NYS MEDICAID NOTE: NYSDOH expects to receive the Rate Code.
HIPAA IG Note: This data element must contain the Value Code Amount when HIxx-1 value equals BE (Value Code).

LX Service Line Number

Pos: 365	Max: 1
Detail - Optional	
Loop: 2400	Elements: 1

User Option (Usage): Required

Purpose: To reference a line number in a transaction set

Notes:

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

Example:

LX*1~

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
LX01	554	Assigned Number	M	NO	1/6	Required

HIPAA IG Note: This is the service line number. Begin with 1 and increment by 1 for each new LX segment within a claim.

SV2 Institutional Service Line

Pos: 375	Max: 1
Detail - Optional	
Loop: 2400	Elements: 5

User Option (Usage): Required

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

Notes:

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

Example:

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

NYS MEDICAID NOTE:

NYSDOH requires a Revenue Code in this segment in order to process a claim. There are no Revenue Codes assigned for Managed Care Capitation Premiums. NYSDOH expects to receive a Revenue Code of '010x'. Because capitation is for a full month, the units reported in SV205 should be '1'. The SV206 Service Line Rate (Unit Charge Amount) and SV203 Line Charge Amount should be equal.

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>												
SV201	234	Product/Service ID	C	AN	1/48	Required												
		Industry: Service Line Revenue Code HIPAA IG Note: See Code Source 132: National Uniform Billing Committee (NUBC) Codes. <u>ExternalCodeList</u> Name: 132 Description: National Uniform Billing Committee (NUBC) Codes																
SV203	782	Monetary Amount	O	R	1/18	Required												
		Industry: Line Item Charge Amount Alias: Service Line Charge Amount HIPAA IG Note: Use this amount to indicate the submitted charge amount.																
SV204	355	Unit or Basis for Measurement Code	C	ID	2/2	Required												
		<table border="0"> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> <tr> <td>DA</td> <td>Days</td> </tr> <tr> <td>F2</td> <td>International Unit</td> </tr> <tr> <td></td> <td>Description: A unit accepted by an international agency; potency of a drug/vitamin based on a specific weight of that drug/vitamin</td> </tr> <tr> <td></td> <td>Dosage amount is only used for drug claims when the dosage of the drug is variable within a single NDC number (e.g. blood factors).</td> </tr> <tr> <td>UN</td> <td>Unit</td> </tr> </table>	<u>Code</u>	<u>Name</u>	DA	Days	F2	International Unit		Description: A unit accepted by an international agency; potency of a drug/vitamin based on a specific weight of that drug/vitamin		Dosage amount is only used for drug claims when the dosage of the drug is variable within a single NDC number (e.g. blood factors).	UN	Unit				
<u>Code</u>	<u>Name</u>																	
DA	Days																	
F2	International Unit																	
	Description: A unit accepted by an international agency; potency of a drug/vitamin based on a specific weight of that drug/vitamin																	
	Dosage amount is only used for drug claims when the dosage of the drug is variable within a single NDC number (e.g. blood factors).																	
UN	Unit																	
SV205	380	Quantity	C	R	1/15	Required												
		Industry: Service Unit Count Alias: Service Line Units																
SV206	1371	Unit Rate	O	R	1/10	Situational												
		Industry: Service Line Rate Alias: Service Line Rate Amount HIPAA IG Note: This data element is required when the associated revenue code is 100-219.																

DTP

Service Line Date

Pos: 455	Max: 1
Detail - Optional	
Loop: 2400	Elements: 3

User Option (Usage): Situational

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

Notes:

1. Required on outpatient claims when revenue, procedure, HIEC or drug codes are reported in the SV2 segment.
2. In cases where a drug is being billed on a service line, the Date of Service DTP may be used to indicate the range of dates through which the drug will be used by the patient. Use RD8 for this purpose.
3. In cases where a drug is being billed on a service line, the Date of Service DTP is used to indicate the date the prescription was written (or otherwise communicated by the prescriber if not written).
4. Assessment Date DTP is not used when this segment is present.

Example:

DTP*472*D8*19960819~

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
DTP01	374	Date/Time Qualifier	M	ID	3/3	Required
		Industry: Date Time Qualifier				
		Code	Name			
		472	Service			
		Use RD8 in DTP02 to indicate begin/end or from/to dates.				
DTP02	1250	Date Time Period Format Qualifier	M	ID	2/3	Required
		Code	Name			
		D8	Date Expressed in Format CCYYMMDD			
DTP03	1251	Date Time Period	M	AN	1/35	Required
		Industry: Service Date				

SE Transaction Set Trailer

Pos: 555	Max: 1
Detail - Mandatory	
Loop: N/A	Elements: 2

User Option (Usage): Required

Purpose: To indicate the end of the transaction set and provide the count of the transmitted segments (including the beginning (ST) and ending (SE) segments)

Example:

SE*1230*987654~

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
SE01	96	Number of Included Segments	M	NO	1/10	Required
		Industry: Transaction Segment Count				
SE02	329	Transaction Set Control Number	M	AN	4/9	Required
		HIPAA IG Note: SE02 must match ST02.				