

eMedNY

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

**276 Health Care Claim Status
Request Companion Guide**

NPI EDITION

HIPAA V4010X093A1 276: Health Care Claim Status Request

Version: 4.0

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Trading Partner:	eMedNY

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276

Health Care Claim Status Request

Functional Group=HR

Purpose: This Draft Standard for Trial Use contains the format and establishes the data contents of the Health Care Claim Status Request Transaction Set (276) for use within the context of an Electronic Data Interchange (EDI) environment. This transaction set can be used by a provider, recipient of health care products or services, or their authorized agent to request the status of a health care claim or encounter from a health care payer. This transaction set is not intended to replace the Health Care Claim Transaction Set (837), but rather to occur after the receipt of a claim or encounter information. The request may occur at the summary or service line detail level.

HIPAA IG NOTE:

1. The 276 transaction is designed to transmit one or more claim inquiry for each service provider. The hierarchy of the looping structure is information source (payer), information receiver (sender), service provider, subscriber (insured), and dependent. Information receivers who sort claims inquiries using this hierarchy will use the 276 more efficiently because information that applies to all lower levels in the hierarchy will not have to be repeated within the transaction.
2. This standard will allow for the submission of claim inquiries from providers of health care products and services to a Managed Care Organization or other payer.

COMPANION GUIDE DISCLAIMER:

The New York State Department Of Health (NYSDOH) has provided this Medicaid Companion Document for the 276 – Health Care Claim Status Request - ASC X12N Transaction and associated addendum (004010X093A1) to assist Providers, Clearinghouses and all Covered Entities in preparing HIPAA compliant transactions. This document was prepared using the Addendum version of the transaction. NYSDOH has focused primarily on the rules and policies regulating the submission of NYS Medicaid data that is provided within this Companion Guide document. NYSDOH has provided the information on www.nyhipaadesk.com as a tool to make the Provider's job easier in preparing electronic transactions in a HIPAA compliant manner.

NYSDOH does not offer individual training to assist Providers in the use of the ASC X12N transactions provided on www.nyhipaadesk.com.

The information provided herein is believed to be true and correct 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:

>V4.0

06/20/2008

- Added NATIONAL PROVIDER IDENTIFIER note into the "Eligibility, Coverage or Benefit Inquiry" section.
- Added NPI information to following Loop(s) and segment(s):

LOOP	SEGMENT	ELEMENT/LOCATION
2100C	NM1	NM108; NM109

v 3.0

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.

03/28/2007

- Changed title: Replaced "Office of Medicaid Management" with the new name "Office of Health Insurance Programs".

NATIONAL PROVIDER IDENTIFIER (NPI):

ALL NYS MEDICAID PROVIDERS WHO ARE HEALTH CARE PROVIDERS ARE REQUIRED TO VISIT EMEDNY.ORG TO REGISTER THEIR NPI(S) AS SOON AS POSSIBLE.

As per the Administrative Simplification provision (Standard for Unique Health Identifier for Health Care Providers), of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the National Provider Identifier (NPI) was adopted as the standard (unique health identifier) for health care providers for use in the health care system.

The New York State Department of Health (NYSDOH) will not be ready to implement the NPI system changes by May 23, 2008. As a result, NYS Medicaid provider IDs and license numbers will continue to be required for processing until the NPI system release is installed. This release is currently scheduled for September 1st, 2008. To find out how to obtain an NPI, please visit www.cms.hhs.gov/NationalProvIdentStand.

IMPORTANT NOTE: All updates provided in this guide are only intended to allow our trading partners to prepare for NPI. Since the 276 transaction can not handle both identifiers (NPI and legacy), **TRADING PARTNERS WILL NEED TO CONTINUE SENDING THEIR LEGACY IDENTIFIERS UNTIL SEPTEMBER 2008**, at which time eMedNY will be ready to accept the NPI for processing.

NYSDOH has developed the National Provider Identifier (NPI) Web Enabled Entry process as a means for providers/submitters to communicate their NPI to eMedNY. The NPI Web Enabled Entry system can be accessed by going to www.emedny.org and clicking on "Enter NPI" located in the green box on the right of the screen. It is required to register all NPI(s) associated with a NYS Medicaid provider by using the web-enabled application on the emedny.org website. A batch process for reporting the NPI to eMedNY is also available. Refer to the "NPI Information" area at www.emedny.org for the file specification for the batch process.

All submitters should be aware that the NPI will be the only permitted provider identifier (except for non-healthcare providers) other than Tax-ID. The NYS Medicaid Provider ID, the Locator Code, and the License Number will all be disallowed.

NYS MEDICAID NOTE:

The 276, Health Care Claim Status Request ASC X12N (004010X093A1) Implementation Guide (IG), Transaction has been established by Health and Human Services as the standard for Claim Status Request compliance.

The Companion Guide, which is provided by the New York Department of Health (NYSDOH), outlines the required format for the New York State Medicaid Health Care Claim Status Request. It is important that Providers study the Companion Guide and become familiar with the data that will be received by NYSDOH in transmission of a 276 Health Care Claim Status Request Transaction.

This Companion Guide does not modify the standards; rather, it puts forth the subset of information from the IG that will be required for processing transactions. It is important that providers 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 item of information. This document omits code qualifiers that are not necessary for NYS Medicaid processing. NYSDOH will provide the list of codes used by NYSDOH in this Companion Guide. When necessary, a "NYS MEDICAID NOTE" is included to describe NYSDOH specific requirements. These notes provide guidance to ensure proper processing of the transactions.

It is important to understand that NYSDOH has excluded situational loops and/or segments that are not relevant to the business requirements of NYS Medicaid. The Provider is advised to refer to the IG, which 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. 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.

SEARCH CRITERIA FOR CLAIM STATUS INQUIRY AND RESPONSE

To identify claims in the eMedNY adjudication system for Claim Status Response a match must be found on the Billing Provider, the Medicaid recipient, the NDC/Rate/Procedure code, the claim charge, and the date of service. Refer to the NYSDOH 837 Companion Guides and Supplemental Companion Guides for information about how the system processes provider information from an inbound claim X12N 837 claim. Refer to the NYS Medicaid Notes for the Claim Service Date and Service Line Date segments in this document for information about identifying the service date. The Claim Status Response transaction will not return multiple claims when the search criteria matches more than one claim in the system. NYSDOH does not support Claim Status Inquiry and Response via the X12N 276/277 for claims submitted in NCPDP format.

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, and Claim Status Category Codes and Claim Status Codes are available in electronic format at: www.wpc-edi.com/hipaa. Providers can locate information regarding External Code Sources in Appendix C of the IG. Additionally, NYSDOH has provided crosswalks of NYSDOH proprietary claim status codes to/from the National Code Sets at www.nyhipaadesk.com.

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>
010	ST	Transaction Set Header	M	1			Required
020	BHT	Beginning of Hierarchical Transaction	M	1			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							
010	HL	Information Source Level	M	1	≥1	-	Required
LOOP ID - 2100A							
050	NM1	Payer Name	O	1	≥1	-	Required
LOOP ID - 2000B							
010	HL	Information Receiver Level	M	1	≥1	-	Required
LOOP ID - 2100B							
050	NM1	Information Receiver Name	O	1	≥1	-	Required
LOOP ID - 2000C							
010	HL	Service Provider Level	M	1	≥1	-	Required
LOOP ID - 2100C							
050	NM1	Provider Name	O	1	≥1	-	Required
LOOP ID - 2000D							
010	HL	Subscriber Level	M	1	≥1	-	Required
040	DMG	Subscriber Demographic Information	O	1		N2/040	Situational
LOOP ID - 2100D							
050	NM1	Subscriber Name	O	1	1	-	Required
LOOP ID - 2200D							
090	TRN	Claim Submitter Trace Number	O	1	≥1	-	Situational
100	REF	Payer Claim Identification Number	O	1		-	Situational
100	REF	Institutional Bill Type Identification	O	1		-	Situational
100	REF	Medical Record Identification	O	1		-	Situational
100	REF	Group Number	O	1		-	Situational
110	AMT	Claim Submitted Charges	O	1		-	Situational
120	DTP	Claim Service Date	O	1		-	Situational
LOOP ID - 2210D							
130	SVC	Service Line Information	O	1	≥1	-	Situational
140	REF	Service Line Item Identification	O	1		-	Situational
150	DTP	Service Line Date	O	1		-	Required
LOOP ID - 2000E							
010	HL	Dependent Level	O	1	≥1	-	Situational
160	SE	Transaction Set Trailer	M	1		-	Required

ST Transaction Set Header

Pos: 010	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*276*0001~

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
		Description: Code uniquely identifying a Transaction Set				
		<u>Code</u>		<u>Name</u>		
		276		Health Care Claim Status Request		
ST02	329	Transaction Set Control Number	M	AN	4/9	Required
		Description: Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set				
		HIPAA IG Note: The value in ST02 must be identical to SE02.				

BHT

Beginning of Hierarchical Transaction

Pos: 020	Max: 1
Heading - Mandatory	
Loop: N/A	Elements: 3

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*0010*13**19961220~

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 Description: Code indicating the hierarchical application structure of a transaction set that utilizes the HL segment to define the structure of the transaction set	M	ID	4/4	Required
		Code Name 0010 Information Source, Information Receiver, Provider of Service, Subscriber, Dependent				
BHT02	353	Transaction Set Purpose Code Description: Code identifying purpose of transaction set	M	ID	2/2	Required
		Code Name 13 Request				
BHT04	373	Date Description: Date expressed as CCYYMMDD Industry: Transaction Set Creation Date	O	DT	8/8	Required

HL Information Source Level

Pos: 010	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

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 Description: A unique number assigned by the sender to identify a particular data segment in a hierarchical structure	M	AN	1/12	Required						
HL03	735	Hierarchical Level Code Description: Code defining the characteristic of a level in a hierarchical structure	M	ID	1/2	Required						
		<table border="0"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>20</td> <td>Information Source</td> </tr> <tr> <td></td> <td>Description: Identifies the payor, maintainer, or source of the information</td> </tr> </tbody> </table>	<u>Code</u>	<u>Name</u>	20	Information Source		Description: Identifies the payor, maintainer, or source of the information				
<u>Code</u>	<u>Name</u>											
20	Information Source											
	Description: Identifies the payor, maintainer, or source of the information											
HL04	736	Hierarchical Child Code Description: Code indicating if there are hierarchical child data segments subordinate to the level being described	O	ID	1/1	Required						
		<table border="0"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>1</td> <td>Additional Subordinate HL Data Segment in This Hierarchical Structure.</td> </tr> </tbody> </table>	<u>Code</u>	<u>Name</u>	1	Additional Subordinate HL Data Segment in This Hierarchical Structure.						
<u>Code</u>	<u>Name</u>											
1	Additional Subordinate HL Data Segment in This Hierarchical Structure.											

NM1 Payer Name

Pos: 050	Max: 1
Detail - Optional	
Loop: 2100A	Elements: 5

User Option (Usage): Required

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

Notes:

1. Payers with multiple locations or multiple lines of business may require that the payer name be completed.

Example:

NM1*PR*2*ABC INSURANCE****PI*12345~

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 Description: Code identifying an organizational entity, a physical location, property or an individual <table border="0"> <tr> <td><u>Code</u></td> <td><u>Name</u></td> </tr> <tr> <td>PR</td> <td>Payer</td> </tr> </table>	<u>Code</u>	<u>Name</u>	PR	Payer	M	ID	2/3	Required
<u>Code</u>	<u>Name</u>									
PR	Payer									
NM102	1065	Entity Type Qualifier Description: Code qualifying the type of entity <table border="0"> <tr> <td><u>Code</u></td> <td><u>Name</u></td> </tr> <tr> <td>2</td> <td>Non-Person Entity</td> </tr> </table>	<u>Code</u>	<u>Name</u>	2	Non-Person Entity	M	ID	1/1	Required
<u>Code</u>	<u>Name</u>									
2	Non-Person Entity									
NM103	1035	Name Last or Organization Name Description: Individual last name or organizational name Industry: Payer Name NYS MEDICAID NOTE: NYSDOH expects to receive 'NYSDOH'. HIPAA IG Note: This data element will be required until the National Payer Identifier is active.	O	AN	1/35	Required				
NM108	66	Identification Code Qualifier Description: Code designating the system/method of code structure used for Identification Code (67) HIPAA IG Note: Payer identifiers should be used with the following preferences: (FI) Tax ID <table border="0"> <tr> <td><u>Code</u></td> <td><u>Name</u></td> </tr> <tr> <td>FI</td> <td>Federal Taxpayer's Identification Number</td> </tr> </table>	<u>Code</u>	<u>Name</u>	FI	Federal Taxpayer's Identification Number	C	ID	1/2	Required
<u>Code</u>	<u>Name</u>									
FI	Federal Taxpayer's Identification Number									
NM109	67	Identification Code Description: Code identifying a party or other code Industry: Payer Identifier NYS MEDICAID NOTE: NYSDOH expects to receive '141797357'. HIPAA IG Note: For Medicare use, this is the carrier/fiscal intermediary-assigned code. <u>ExternalCodeList</u> Name: 121 Description: Health Industry Identification Number	C	AN	2/80	Required				

ExternalCodeList

Name: 245

Description: National Association of Insurance Commissioners (NAIC) Code

ExternalCodeList

Name: 540

Description: Health Care Financing Administration National PlanID

HL**Information Receiver Level**

Pos: 010	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. This entity expects response from the information source.

Example:

HL*2*1*21*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 Description: A unique number assigned by the sender to identify a particular data segment in a hierarchical structure	M	AN	1/12	Required
HL02	734	Hierarchical Parent ID Number Description: Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to	O	AN	1/12	Required
HL03	735	Hierarchical Level Code Description: Code defining the characteristic of a level in a hierarchical structure	M	ID	1/2	Required
		Code Name 21 Information Receiver Description: Identifies the provider or party(ies) who are the recipient(s) of the information				
HL04	736	Hierarchical Child Code Description: Code indicating if there are hierarchical child data segments subordinate to the level being described	O	ID	1/1	Required
		Code Name 1 Additional Subordinate HL Data Segment in This Hierarchical Structure.				

NM1 Information Receiver Name

Pos: 050	Max: 1
Detail - Optional	
Loop: 2100B	Elements: 8

User Option (Usage): Required

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

Notes:

1. This is the individual or organization requesting to receive the status information.

Example:

NM1*41*2*XYZ SERVICE****46*A22222221~

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 Description: Code identifying an organizational entity, a physical location, property or an individual <table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>41</td> <td>Submitter</td> </tr> </tbody> </table> Description: Entity transmitting transaction set	<u>Code</u>	<u>Name</u>	41	Submitter	M	ID	2/3	Required		
<u>Code</u>	<u>Name</u>											
41	Submitter											
NM102	1065	Entity Type Qualifier Description: Code qualifying the type of entity <table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>1</td> <td>Person</td> </tr> <tr> <td>2</td> <td>Non-Person Entity</td> </tr> </tbody> </table>	<u>Code</u>	<u>Name</u>	1	Person	2	Non-Person Entity	M	ID	1/1	Required
<u>Code</u>	<u>Name</u>											
1	Person											
2	Non-Person Entity											
NM103	1035	Name Last or Organization Name Description: Individual last name or organizational name Industry: Information Receiver Last or Organization Name	O	AN	1/35	Required						
NM104	1036	Name First Description: Individual first name Industry: Information Receiver First Name HIPAA IG Note: The first name is required when the value in NM102 is '1' and the person has a first name.	O	AN	1/25	Situational						
NM105	1037	Name Middle Description: Individual middle name or initial Industry: Information Receiver Middle Name HIPAA IG Note: Required if additional name information is needed to identify the information receiver. Recommended if the value in the entity type qualifier is a person.	O	AN	1/25	Situational						
NM107	1039	Name Suffix Description: Suffix to individual name Industry: Information Receiver Name Suffix HIPAA IG Note: Required if additional name information is needed to identify the information receiver. Recommended if the value in the entity type qualifier is a person.	O	AN	1/10	Situational						
NM108	66	Identification Code Qualifier Description: Code designating the system/method of code structure used for	C	ID	1/2	Required						

Identification Code (67)

NYS MEDICAID NOTE: NYSDOH expects qualifier '46'.

HIPAA IG Note: Established by trading partner agreement.

Code

Name

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

Description: Code identifying a party or other code

Industry: Information Receiver Identification Number

NYS MEDICAID NOTE: NYSDOH expects Provider's ETIN. In past implementations, this code was known as the Transmission Supplier Number (TSN).

ExternalCodeList

Name: 537

Description: Health Care Financing Administration National Provider Identifier

HL

Service Provider Level

Pos: 010	Max: 1
Detail - Mandatory	
Loop: 2000C	Elements: 4

User Option (Usage): Required

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

Example:

HL*3*2*19*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 Description: A unique number assigned by the sender to identify a particular data segment in a hierarchical structure	M	AN	1/12	Required
HL02	734	Hierarchical Parent ID Number Description: Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to	O	AN	1/12	Required
HL03	735	Hierarchical Level Code Description: Code defining the characteristic of a level in a hierarchical structure	M	ID	1/2	Required
		<u>Code</u> <u>Name</u> 19 Provider of Service				
HL04	736	Hierarchical Child Code Description: Code indicating if there are hierarchical child data segments subordinate to the level being described	O	ID	1/1	Required
		<u>Code</u> <u>Name</u> 1 Additional Subordinate HL Data Segment in This Hierarchical Structure.				

NM1 Provider Name

Pos: 050	Max: 1
Detail - Optional	
Loop: 2100C	Elements: 9

User Option (Usage): Required

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

Notes:

- 1. This is the billing provider from the original submitted claim.

Example:

NM1*1P*2*HOME MEDICAL*****SV*98766666~

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 Description: Code identifying an organizational entity, a physical location, property or an individual <table border="0"> <tr> <td><u>Code</u></td> <td><u>Name</u></td> </tr> <tr> <td>1P</td> <td>Provider</td> </tr> </table>	<u>Code</u>	<u>Name</u>	1P	Provider	M	ID	2/3	Required		
<u>Code</u>	<u>Name</u>											
1P	Provider											
NM102	1065	Entity Type Qualifier Description: Code qualifying the type of entity <table border="0"> <tr> <td><u>Code</u></td> <td><u>Name</u></td> </tr> <tr> <td>1</td> <td>Person</td> </tr> <tr> <td>2</td> <td>Non-Person Entity</td> </tr> </table>	<u>Code</u>	<u>Name</u>	1	Person	2	Non-Person Entity	M	ID	1/1	Required
<u>Code</u>	<u>Name</u>											
1	Person											
2	Non-Person Entity											
NM103	1035	Name Last or Organization Name Description: Individual last name or organizational name Industry: Provider Last or Organization Name	O	AN	1/35	Required						
NM104	1036	Name First Description: Individual first name Industry: Provider First Name HIPAA IG Note: The first name is required when the value in NM102 is '1' and the person has a first name.	O	AN	1/25	Situational						
NM105	1037	Name Middle Description: Individual middle name or initial Industry: Provider Middle Name HIPAA IG Note: The middle name or initial is required when the value in NM102 is '1' and the person has a middle name or initial.	O	AN	1/25	Situational						
NM106	1038	Name Prefix Description: Prefix to individual name Industry: Provider Name Prefix HIPAA IG Note: Required if additional name information is needed to identify the provider of service. Recommended if the value in the entity type qualifier is a person.	O	AN	1/10	Situational						
NM107	1039	Name Suffix Description: Suffix to individual name Industry: Provider Name Suffix HIPAA IG Note: Required if additional name information is needed to identify the provider of service. Recommended if the value in the entity	O	AN	1/10	Situational						

type qualifier is a person.

NM108 66 **Identification Code Qualifier** C ID 1/2 Required

Description: Code designating the system/method of code structure used for Identification Code (67)

NYS MEDICAID NOTE: NYSDOH expects qualifier 'XX' in this data element, for all covered entities. All non-covered entities must submit qualifier 'SV' in this data element. Prior to NYSDOH's implementation of NPI, 'SV' will be the only qualifier accepted in this data element.

Code

Name

SV

Service Provider Number

When the provider does not have a National Provider ID and Payer has assigned a specific ID number to this provider this code is required.

XX

Health Care Financing Administration National Provider Identifier

Description: Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.

NM109 67 **Identification Code** C AN 2/80 Required

Description: Code identifying a party or other code

Industry: Provider Identifier

NYS MEDICAID NOTE: NYSDOH expects to receive the billing provider's NPI in this data element, when the qualifier in NM108 is 'XX'. When NM108 is 'SV', the billing provider's NYS Medicaid ID must be sent in this data element.

ExternalCodeList

Name: 537

Description: Health Care Financing Administration National Provider Identifier

HL Subscriber Level

Pos: 010	Max: 1
Detail - Mandatory	
Loop: 2000D	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 subscriber and the patient are the same person, do not use the next HL (HL23) for the claim information.

Example:

HL*4*3*22*0~ or HL*4*3*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 Description: A unique number assigned by the sender to identify a particular data segment in a hierarchical structure	M	AN	1/12	Required						
HL02	734	Hierarchical Parent ID Number Description: Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to	O	AN	1/12	Required						
HL03	735	Hierarchical Level Code Description: Code defining the characteristic of a level in a hierarchical structure	M	ID	1/2	Required						
		<table border="0"> <tr> <td><u>Code</u></td> <td><u>Name</u></td> </tr> <tr> <td>22</td> <td>Subscriber</td> </tr> <tr> <td></td> <td>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</td> </tr> </table>	<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				
<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 Description: Code indicating if there are hierarchical child data segments subordinate to the level being described NYS MEDICAID NOTE: NYSDOH expects '0', since all members are enrolled as subscribers. A dependent loop is not expected.	O	ID	1/1	Situational						
		<table border="0"> <tr> <td><u>Code</u></td> <td><u>Name</u></td> </tr> <tr> <td>0</td> <td>No Subordinate HL Segment in This Hierarchical Structure.</td> </tr> <tr> <td></td> <td>Required when there are no dependent claim status requests for this subscriber.</td> </tr> </table>	<u>Code</u>	<u>Name</u>	0	No Subordinate HL Segment in This Hierarchical Structure.		Required when there are no dependent claim status requests for this subscriber.				
<u>Code</u>	<u>Name</u>											
0	No Subordinate HL Segment in This Hierarchical Structure.											
	Required when there are no dependent claim status requests for this subscriber.											

DMG Subscriber Demographic Information

Pos: 040	Max: 1
Detail - Optional	
Loop: 2000D	Elements: 3

User Option (Usage): Situational

Purpose: To supply demographic information

Notes:

1. Required when the subscriber is the patient. Not used when the subscriber is not the patient.

Example:

DMG*D8*19330706*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						
		Description: Code indicating the date format, time format, or date and time format										
		<table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>D8</td> <td>Date Expressed in Format CCYYMMDD</td> </tr> </tbody> </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						
		Description: Expression of a date, a time, or range of dates, times or dates and times										
		Industry: Subscriber Birth Date										
		Alias: Date of Birth - Subscriber										
DMG03	1068	Gender Code	O	ID	1/1	Required						
		Description: Code indicating the sex of the individual										
		Industry: Subscriber Gender Code										
		Alias: Gender - Subscriber										
		NYS MEDICAID NOTE: NYSDOH cannot process code 'U' (Unknown).										
		<table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>F</td> <td>Female</td> </tr> <tr> <td>M</td> <td>Male</td> </tr> </tbody> </table>	<u>Code</u>	<u>Name</u>	F	Female	M	Male				
<u>Code</u>	<u>Name</u>											
F	Female											
M	Male											

NM1 Subscriber Name

Pos: 050	Max: 1
Detail - Optional	
Loop: 2100D	Elements: 9

User Option (Usage): Required

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

Example:

NM1*QC*1*SMITH*FRED****MI*123456789A~ or
 NM1*IL*1*SMITH*ROBERT****MI*9876543210~

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 Description: Code identifying an organizational entity, a physical location, property or an individual NYS MEDICAID NOTE: NYSDOH expects value 'QC'. <table border="0"> <tr> <td>Code</td> <td>Name</td> </tr> <tr> <td>QC</td> <td>Patient</td> </tr> </table> Description: Individual receiving medical care Use this code only when the subscriber is the patient.	Code	Name	QC	Patient	M	ID	2/3	Required
Code	Name									
QC	Patient									
NM102	1065	Entity Type Qualifier Description: Code qualifying the type of entity NYS MEDICAID NOTE: NYSDOH expects qualifier '1'. <table border="0"> <tr> <td>Code</td> <td>Name</td> </tr> <tr> <td>1</td> <td>Person</td> </tr> </table>	Code	Name	1	Person	M	ID	1/1	Required
Code	Name									
1	Person									
NM103	1035	Name Last or Organization Name Description: Individual last name or organizational name Industry: Subscriber Last Name	O	AN	1/35	Required				
NM104	1036	Name First Description: Individual first name Industry: Subscriber First Name HIPAA IG Note: The first name is required when the value in NM102 is '1' and the person has a first name.	O	AN	1/25	Situational				
NM105	1037	Name Middle Description: Individual middle name or initial Industry: Subscriber Middle Name HIPAA IG Note: The middle name or initial is required when the value in NM102 is '1' and the person has a middle name or initial.	O	AN	1/25	Situational				
NM106	1038	Name Prefix Description: Prefix to individual name Industry: Subscriber Name Prefix HIPAA IG Note: Required if additional name information is needed to identify the subscriber. Recommended if the value in the entity type qualifier is a person.	O	AN	1/10	Situational				
NM107	1039	Name Suffix Description: Suffix to individual name	O	AN	1/10	Situational				

NM108	66	<p>Industry: Subscriber Name Suffix HIPAA IG Note: Required if additional name information is needed to identify the subscriber. Recommended if the value in the entity type qualifier is a person.</p>	C	ID	1/2	Required				
		<p>Description: Code designating the system/method of code structure used for Identification Code (67)</p>								
		<p>NYS MEDICAID NOTE: NYSDOH expects qualifier 'MI'.</p>								
		<table border="1"> <thead> <tr> <th data-bbox="388 499 456 527"><u>Code</u></th> <th data-bbox="558 499 630 527"><u>Name</u></th> </tr> </thead> <tbody> <tr> <td data-bbox="388 531 420 558">MI</td> <td data-bbox="558 531 883 558">Member Identification Number</td> </tr> </tbody> </table>	<u>Code</u>	<u>Name</u>	MI	Member Identification Number				
<u>Code</u>	<u>Name</u>									
MI	Member Identification Number									
NM109	67	<p>Identification Code</p> <p>Description: Code identifying a party or other code</p> <p>Industry: Subscriber Identifier NYS MEDICAID NOTE: NYSDOH expects Client ID in order to aid in Claim Status determination.</p>	C	AN	2/80	Required				

TRN Claim Submitter Trace Number

Pos: 090	Max: 1
Detail - Optional	
Loop: 2200D	Elements: 2

User Option (Usage): Situational

Purpose: To uniquely identify a transaction to an application

Notes:

1. This segment is required if the subscriber is the patient. If the subscriber is not the patient do not use this segment, use TRN segment in Loop 2200E.
2. Use this segment to convey a unique trace or reference number from the originator of the transaction to be returned by the receiver of the transaction.
3. The TRN segment is required by the ASC X12 syntax when Loop ID-2200D is used.

Example:

TRN*1*1722634842~

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>				
TRN01	481	Trace Type Code Description: Code identifying which transaction is being referenced	M	ID	1/2	Required				
		<table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>1</td> <td>Current Transaction Trace Numbers</td> </tr> </tbody> </table>	<u>Code</u>	<u>Name</u>	1	Current Transaction Trace Numbers				
<u>Code</u>	<u>Name</u>									
1	Current Transaction Trace Numbers									
TRN02	127	Reference Identification Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier Industry: Trace Number Alias: Patient Account Number NYS MEDICAID NOTE: NYSDOH will return this information in the 277. HIPAA IG Note: This data element corresponds to the CLM01 data element of the ASC X12N Dental, Institutional, and Professional Implementation Guide(s). Paper based claims may not require a Patient Account Number for adjudication. When inquiring on paper based claims the trace number is required to be returned in the TRN of the 277 Health Care Claim Status Response transaction in TRN02.	M	AN	1/30	Required				

REF Payer Claim Identification Number

Pos: 100	Max: 1
Detail - Optional	
Loop: 2200D	Elements: 2

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

Notes:

1. Use this only if the subscriber is the patient.
2. This is the payer's assigned control number, also known as, Internal Control Number (ICN), Document Control Number (DCN), or Claim Control Number (CCN). This should be sent on claim inquiries when the number is known.
3. The authors recommend sending this segment on claim inquires when the information is known. It will provide a direct look up key into the payer's adjudication system and will reduce the possibility of returning more claim status information than was intended. For example, when a claim status inquiry is performed and many claims meet the conditions of the inquiry all will be returned. By providing the information within this particular segment the search criteria is narrowed to the specific claim in question.
4. The total number of REF segments in the 2200 Loop cannot exceed 3.

Example:

REF*1K*9918046987~

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 Description: Code qualifying the Reference Identification HIPAA IG Note: Examples of this element include ICN, DCN, CCN. Submit this element if the payer supplied it previously.	M	ID	2/3	Required				
		<table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>1K</td> <td>Payor's Claim Number</td> </tr> </tbody> </table>	<u>Code</u>	<u>Name</u>	1K	Payor's Claim Number				
<u>Code</u>	<u>Name</u>									
1K	Payor's Claim Number									
REF02	127	Reference Identification Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier Industry: Payer Claim Control Number NYS MEDICAID NOTE: NYSDOH expects the original reference number assigned to the claim during adjudication.	C	AN	1/30	Required				

REF Institutional Bill Type Identification

Pos: 100	Max: 1
Detail - Optional	
Loop: 2200D	Elements: 2

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

Notes:

1. This segment is the institutional bill type submitted on the original claim. The institutional bill type consists of the two position, Facility Type Code, and the one position, Claim Frequency Code. The payer may use it as a primary lookup key.
2. Only use this segment if the subscriber is the patient and bill type is being sent in the inquiry request in connection with an institutional bill.
3. The total number of REF segments in the 2200 Loop cannot exceed 3.

Example:

REF*BLT*111~

NYS MEDICAID NOTE:

This iteration of the REF segment is for Institutional Claim Status Requests only.

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 Description: Code qualifying the Reference Identification NYS MEDICAID NOTE: NYSDOH expects qualifier 'BLT'.	M	ID	2/3	Required
		Code Name BLT Billing Type				
REF02	127	Reference Identification Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier Industry: Bill Type Identifier HIPAA IG Note: Found on UB92 - record 40 - 4 As submitted on the Institutional 837 claim in composite element CLM05. Found on UB92 paper form locator 4 Required for institutional claims inquiries.	C	AN	1/30	Required

REF Medical Record Identification

Pos: 100	Max: 1
Detail - Optional	
Loop: 2200D	Elements: 2

User Option (Usage): Situational

Purpose: To specify identifying information

Notes:

1. This is the Medical Record number submitted on the original claim and should be sent when available from the submitted claim.
2. Use this only if the subscriber is the patient.
3. The total number of REF segments in the 2200 Loop cannot exceed 3.

Example:

REF*EA*J354789~

NYS MEDICAID NOTE:

This iteration of the REF segment is for Fee-Based Claim Status Requests only.

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>Description: Code qualifying the Reference Identification</p> <p>NYS MEDICAID NOTE: NYSDOH expects qualifier 'EA'.</p> <table border="0"> <tr> <td>Code</td> <td>Name</td> </tr> <tr> <td>EA</td> <td>Medical Record Identification Number</td> </tr> <tr> <td colspan="2">Description: A unique number assigned to each patient by the provider of service (hospital) to assist in retrieval of medical records</td> </tr> </table>							Code	Name	EA	Medical Record Identification Number	Description: A unique number assigned to each patient by the provider of service (hospital) to assist in retrieval of medical records	
Code	Name											
EA	Medical Record Identification Number											
Description: A unique number assigned to each patient by the provider of service (hospital) to assist in retrieval of medical records												
REF02	127	Reference Identification	C	AN	1/30	Required						
<p>Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier</p> <p>Industry: Medical Record Number</p> <p>HIPAA IG Note: Found on UB92 record 20 field 25</p> <p>As submitted on the Dental, Institutional, and Professional 837 Claim in Medical Record Number segment in REF02 (EA)</p> <p>Found on UB92 paper form locator 23</p>												

REF Group Number

Pos: 100	Max: 1
Detail - Optional	
Loop: 2200D	Elements: 2

User Option (Usage): Situational

Purpose: To specify identifying information

Notes:

1. This REF segment is used to identify the location or Application System Number believed to contain the claim being inquired upon. For example, if a payer has multiple adjudication systems processing the same type of claim (e.g. professional or Institutional) and this Location Number points to the proper system that contains information about the claim being inquired upon. In Institutional claim situations where REF01 contains LU the inquirer must determine which REF segment (Bill Type or Medical Record Number) not to be included in the inquiry transaction.
2. The total number of REF segments in the 2200 loop cannot exceed 3.

Example:

REF*LU*SYS5963~

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 Description: Code qualifying the Reference Identification NYS MEDICAID NOTE: NYSDOH expects qualifier 'LU'.	M	ID	2/3	Required
		Code Name LU Location Number				
REF02	127	Reference Identification Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier Industry: Group Number	C	AN	1/30	Required

AMT Claim Submitted Charges

Pos: 110	Max: 1
Detail - Optional	
Loop: 2200D	Elements: 2

User Option (Usage): Situational

Purpose: To indicate the total monetary amount

Notes:

1. Required when the subscriber is the patient.
2. Not all payer's systems retain the original submitted charges. This may be a result of bundling/unbundling situations. This amount can be used as a secondary match criteria within the payer's system if the claim has not been changed.

Example:

AMT*T3*75~

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>
AMT01	522	Amount Qualifier Code	M	ID	1/3	Required

Description: Code to qualify amount
NYS MEDICAID NOTE: NYSDOH will return this information in the 277.

<u>Code</u>	<u>Name</u>
T3	Total Submitted Charges Found on UB92 - Revenue Code 0001 and also in record 90 Found on UB92 Paper form - Revenue Code 0001 Found on 837 CLM02 (Professional); Revenue Code 0001 (Institutional) Found on NSF - XA0 Record field 12 Found on HCFA 1500 - Block 28

AMT02	782	Monetary Amount	M	R	1/18	Required
-------	-----	------------------------	---	---	------	----------

Description: Monetary amount
Industry: Total Claim Charge Amount
NYS MEDICAID NOTE: NYSDOH will return this information in the 277.

DTP Claim Service Date

Pos: 120	Max: 1
Detail - Optional	
Loop: 2200D	Elements: 3

User Option (Usage): Situational

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

Notes:

1. Required for institutional claims. The date is the statement from and through date.
2. For professional claims this will be the claim from and through date. If claim level date range is not used then the Line Service Date at Loop 2210D is required.

Example:

DTP*232*RD8*19960401-19960402~

NYS MEDICAID NOTE:

When this segment is present the date reported here is used as part of the search criteria for returning a Claim Status Response (277).

- NYSDOH expects this segment to be populated for all claim inquiries on rate-based claims. When not present an error message will be sent in the 277 Claim Status Response. For all inquiries on rate-based claims that were submitted using the 837 Institutional the date sent here must match the claim's STATEMENT DATE (DTP*434) information reported in loop 2300. If the claim's Statement Dates data element was a single date rather than a range the same date should be used as the From and Through dates in the inquiry.

- For inquiries on Dental claims submitted using the 837 Dental the date sent here can be from the DATE - SERVICE segment (DTP*472) in loop 2300 if it was sent at that level in the claim.

- For inquiries on all other fee-based claims if this segment is present the date(s) sent here must fall within the range of the lowest and highest service line dates in the claim.

If this segment is not sent the Service Line Date segment is required.

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						
<p>Description: Code specifying type of date or time, or both date and time</p> <p>Industry: Date Time Qualifier</p> <p>HIPAA IG Note: Use this element for the dates of service submitted on the original claim.</p> <table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>232</td> <td>Claim Statement Period Start</td> </tr> <tr> <td colspan="2">This includes the claim statement period end.</td> </tr> </tbody> </table>							<u>Code</u>	<u>Name</u>	232	Claim Statement Period Start	This includes the claim statement period end.	
<u>Code</u>	<u>Name</u>											
232	Claim Statement Period Start											
This includes the claim statement period end.												
DTP02	1250	Date Time Period Format Qualifier	M	ID	2/3	Required						
<p>Description: Code indicating the date format, time format, or date and time format</p> <p>HIPAA IG Note: If the date is a single date of service, the begin date equals the end date.</p> <table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>RD8</td> <td>Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD</td> </tr> <tr> <td colspan="2">Description: A range of dates expressed in the format CCYYMMDD-CCYYMMDD where CCYY is the numerical expression of the century CC and year YY, MM is the numerical expression of the month within the year, and DD is the numerical expression of the day within the year; the first occurrence of CCYYMMDD is the beginning date and the second occurrence is the ending date</td> </tr> </tbody> </table>							<u>Code</u>	<u>Name</u>	RD8	Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD	Description: A range of dates expressed in the format CCYYMMDD-CCYYMMDD where CCYY is the numerical expression of the century CC and year YY, MM is the numerical expression of the month within the year, and DD is the numerical expression of the day within the year; the first occurrence of CCYYMMDD is the beginning date and the second occurrence is the ending date	
<u>Code</u>	<u>Name</u>											
RD8	Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD											
Description: A range of dates expressed in the format CCYYMMDD-CCYYMMDD where CCYY is the numerical expression of the century CC and year YY, MM is the numerical expression of the month within the year, and DD is the numerical expression of the day within the year; the first occurrence of CCYYMMDD is the beginning date and the second occurrence is the ending date												
DTP03	1251	Date Time Period	M	AN	1/35	Required						
<p>Description: Expression of a date, a time, or range of dates, times or dates and times</p>												

Industry: Claim Service Period

SVC Service Line Information

Pos: 130	Max: 1
Detail - Optional	
Loop: 2210D	Elements: 4

User Option (Usage): Situational

Purpose: To supply payment and control information to a provider for a particular service

Notes:

1. Use this segment to request status information about a service line.
2. This segment is required if loop is used by ASC X12 syntax because it is the first segment in Loop ID -2210 (Service Line Information).
3. For Medicare Institutional claims, SVC01 would be the Health Care Financing Administration (HCFA), Common Procedural Coding System (HCPCS) Code (See Code Source 130) and SVC04 would be the Revenue Code (see Code Source 132).

Example:

SVC*HC:99214*75*****1~
 or
 SVC*NU:71X*50*****1~

NYS MEDICAID NOTE:

NOTE FOR LOOP 2210D:

For inquiries on fee-based claims if the Claim Service Date in loop 2200D is not submitted the Service Line Information loop is required.

NOTE FOR SVC SEGMENT:

This segment is required when loop 2210D is sent. The DTP Service Line Date segment is also required.

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>
SVC01	C003	Composite Medical Procedure Identifier Description: To identify a medical procedure by its standardized codes and applicable modifiers Industry: Product or Service ID Qualifier HIPAA IG Note: SVC01 will contain the procedure code of the adjudicated claim. If the adjudicated code is not known then SVC01 will contain the original submitted procedure code.	M	Comp		Required
SVC01-01	235	Product/Service ID Qualifier Description: Code identifying the type/source of the descriptive number used in Product/Service ID (234) NYS MEDICAID NOTE: NYSDOH expects one of the following qualifiers:	M	ID	2/2	Required
		Code Name				
		AD American Dental Association Codes Description: This association's membership consists of U.S. dentists. It sets standards for the dental profession 135: American Dental Association Codes				
		HC Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes Description: HCFA coding scheme to group procedure(s) performed on an outpatient basis for payment to hospital under Medicare; primarily used for ambulatory surgical and other diagnostic departments 130: Health Care Financing Administration Common Procedural Coding System Because the CPT codes of the American Medical Association are also level 1 HCPCS codes, the CPT codes are reported under the code HC.				

N4 National Drug Code in 5-4-2 Format
Description: 5-digit manufacturer ID, 4-digit product ID, 2-digit trade package size
 240: National Drug Code by Format

NU National Uniform Billing Committee (NUBC) UB92 Codes
 This code is the NUBC Revenue Code.
CODE SOURCE:
 132: National Uniform Billing Committee (NUBC) Codes

SVC01-02	234	Product/Service ID	M	AN	1/48	Required
		Description: Identifying number for a product or service				
		Industry: Service Identification Code				
		HIPAA IG Note: 130: Health Care Financing Administration Common Procedural Coding System				
		ExternalCodeList				
		Name: 130				
		Description: Health Care Financing Administration Common Procedural Coding System				
		ExternalCodeList				
		Name: 131				
		Description: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure				
		ExternalCodeList				
		Name: 132				
		Description: National Uniform Billing Committee (NUBC) Codes				
		ExternalCodeList				
		Name: 134				
		Description: National Drug Code				
		ExternalCodeList				
		Name: 135				
		Description: American Dental Association Codes				
		ExternalCodeList				
		Name: 240				
		Description: National Drug Code by Format				
		ExternalCodeList				
		Name: 513				
		Description: Home Infusion EDI Coalition (HIEC) Product/Service Code List				
SVC01-03	1339	Procedure Modifier	O	AN	2/2	Situational
		Description: This identifies special circumstances related to the performance of the service, as defined by trading partners				
		HIPAA IG Note: Required if submitted on the original claim service line.				
SVC01-04	1339	Procedure Modifier	O	AN	2/2	Situational
		Description: This identifies special circumstances related to the performance of the service, as defined by trading partners				
		HIPAA IG Note: Required if submitted on the original claim service line.				
SVC01-05	1339	Procedure Modifier	O	AN	2/2	Situational
		Description: This identifies special circumstances related to the performance of the service, as defined by trading partners				
		HIPAA IG Note: Required if submitted on the original claim service line.				
SVC01-06	1339	Procedure Modifier	O	AN	2/2	Situational
		Description: This identifies special circumstances related to the performance of the				

		service, as defined by trading partners HIPAA IG Note: Required if submitted on the original claim service line.				
SVC02	782	Monetary Amount Description: Monetary amount Industry: Line Item Charge Amount NYS MEDICAID NOTE: NYSDOH expects the original submitted charge.	M	R	1/18	Required
SVC04	234	Product/Service ID Description: Identifying number for a product or service Industry: Revenue Code ExternalCodeList Name: 132 Description: National Uniform Billing Committee (NUBC) Codes	O	AN	1/48	Situational
SVC07	380	Quantity Description: Numeric value of quantity Industry: Original Units of Service Count HIPAA IG Note: These are the submitted units of service. The default is 1 unit. This element is required when the submitted units are greater than 1.	O	R	1/15	Situational

REF Service Line Item Identification

Pos: 140	Max: 1
Detail - Optional	
Loop: 2210D	Elements: 2

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

Notes:

1. Use this segment if the subscriber is the patient.
2. Required when available from the original claim. When the Information Receiver is the Provider, this is required when the number was assigned by the provider on the original claim.
3. Will be used primarily for professional claim service line inquiry, and bill type is being sent in the inquiry request in connection with institutional bill.

Example:

REF*FJ*6042201~

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
REF01	128	Reference Identification Qualifier	M	ID	2/3	Required
		Description: Code qualifying the Reference Identification				
		Code		Name		
		FJ		Line Item Control Number		
		Description: A unique number assigned to each charge line used for tracking purposes				
REF02	127	Reference Identification	C	AN	1/30	Required
		Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier				
		Industry: Line Item Control Number				
		HIPAA IG Note: May or may not help the payer in the identification of the claim.				

DTP Service Line Date

Pos: 150	Max: 1
Detail - Optional	
Loop: 2210D	Elements: 3

User Option (Usage): Required

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

Notes:

1. When the 2210D loop is used this segment must be present.

Example:

DTP*472*RD8*19960401-19960402~

NYS MEDICAID NOTE:

NYSDOH expects this segment for fee-based claim inquiries only.

For inquiries on fee-based claims if the Claim Service Date in loop 2200D is not submitted this segment is required. The SVC segment is also required.

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 Description: Code specifying type of date or time, or both date and time Industry: Date Time Qualifier	M	ID	3/3	Required
		Code Name 472 Service				
DTP02	1250	Date Time Period Format Qualifier Description: Code indicating the date format, time format, or date and time format HIPAA IG Note: If the date is a single date of service, the begin date equals the end date.	M	ID	2/3	Required
		Code Name RD8 Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD Description: A range of dates expressed in the format CCYYMMDD-CCYYMMDD where CCYY is the numerical expression of the century CC and year YY, MM is the numerical expression of the month within the year, and DD is the numerical expression of the day within the year; the first occurrence of CCYYMMDD is the beginning date and the second occurrence is the ending date If the date is a single date of service, the begin date equals the end date.				
DTP03	1251	Date Time Period Description: Expression of a date, a time, or range of dates, times or dates and times Industry: Service Line Date	M	AN	1/35	Required

HL Dependent Level

Pos: 010	Max: 1
Detail - Optional	
Loop: 2000E	Elements: 3

User Option (Usage): Situational

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

Notes:

1. Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 nomenclature.
2. Required when the patient is not the same entity as subscriber.

Example:

HL*5*4*23~

NYS MEDICAID NOTE:

NYSDOH will reject any Claim Status Inquiry that reports this HL segment and any segments within the 2000E Loop, due to the Implementation Guide restriction of repeating patient information. Within the Medicaid program, the patient always equals the subscriber.

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 Description: A unique number assigned by the sender to identify a particular data segment in a hierarchical structure	M	AN	1/12	Required
HL02	734	Hierarchical Parent ID Number Description: Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to	O	AN	1/12	Required
HL03	735	Hierarchical Level Code Description: Code defining the characteristic of a level in a hierarchical structure	M	ID	1/2	Required
		Code 23		Name Dependent		Description: Identifies the individual who is affiliated with the subscriber, such as spouse, child, etc., and therefore may be entitled to benefits

SE Transaction Set Trailer

Pos: 160	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*34*0001~

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 Description: Total number of segments included in a transaction set including ST and SE segments Industry: Transaction Segment Count	M	NO	1/10	Required
SE02	329	Transaction Set Control Number Description: Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set HIPAA IG Note: Data value in SE02 must be identical to ST02.	M	AN	4/9	Required