

eMedNY

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

**837 Health Care Claim: Dental
Companion Guide**

NPI EDITION

HIPAA V4010X097A1 837: Health Care Claim: Dental

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837

Health Care Claim: Dental

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.

HIPAA IG NOTE:

1. The 837 transaction is designed to transmit one or more claims for each billing provider. The hierarchy of the looping structure is as follows: billing provider, subscriber, patient, claim level, and claim service line level. Billing providers who sort claims using this hierarchy use the 837 more efficiently because information that applies to all lower levels in the hierarchy does not have to be repeated within the transaction.
2. This standard is also recommended for the submission of similar data within a pre-paid managed care context. Referred to as capitated encounters, this data usually does not result in a payment, though it is possible to submit a "mixed" claim that includes both pre-paid and request for payment services. This standard will allow for the submission of data from providers of health care products and services to a Managed Care Organization or other payer. This standard may also be used by payers to share data with plan sponsors, employers, regulatory entities and Community Health Information Networks.
3. This standard can, also be used as a transaction set in support of the coordination of benefits claims process. Additional looped segments can be used within both the claim and service line levels to transfer each payer's adjudication information to subsequent payers.

COMPANION GUIDE DISCLAIMER:

The New York State Department of Health (NYSDOH) has provided this Medicaid Companion Guide for the 837 Dental Transaction, Addendum version (ASC X12N 004010X097A1) 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 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 HIPAA 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 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:

- >V3.0
- 01/06/2009 Minor typo correction
- 12/29/2008 Removed reference to 837D Supplemental CG from NYS Medicaid Note in CLM05-3, loop 2300..
- 10/17/2008 Corrected note in Transmission Type Identification REF segment, moved note from REF01 to REF02.
- 09/19/2008 Added note in Transmission Type Identification REF segment that "004010X097DA1" will not be supported.
- 07/01/2008 Added text in NYS Medicaid Note for the REF segments in loop 2010AA, 2310A, 2310B, 2310D, and 2420A regarding requirements prior to eMedNY NPI implementation.
- 06/20/2008 Added text in NYS Medicaid Note for the Billing Provider loop (2010AA) and Pay-to Provider loop (2010AB) that if an organization health care provider has enumerated its subparts an NPI sent in this location must belong to a subpart. Removed references to NPI data analysis in other provider loops.
- 05/22/2008 Corrected typos in NYS Medicaid Notes for loops 2010AA and 2310B.
- 03/02/2008 Added P3 "Primary Care Provider" Qualifier to loop 2310A, NM101.

- 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.
- 02/27/2007 Added notes in loop, 2310A, NM1 segment that the Referring Provider's NPI will only be required if known.
- 02/07/2007 Added notes in 2330B NM109 that the identifier must be unique for each payer, added notes in 2430 SVD01 to clarify that the value sent in these locations must match 2330B NM109.
- 02/05/2007 Changed title to reflect new name for NYSDOH Office of Health Insurance Programs.
- 01/22/2007 Modified text in NPI section of front matter to state that providers must register their NPI; and that NYSDOH will not be ready for implementation by the mandated date of May 23, 2007. Removed references to the compliance date in NYS Medicaid Notes in all "Provider" loops, also added reference to batch process for reporting NPI to the eMedNY system.
- 11/09/2006 Modified National Provider Identifier section of front matter.
- 10/31/2006 Removed the changes to SBR segment in loop 2320. This will be put back in to coincide with system processing changes. Modified NYS Medicaid Notes for the 2010 and 2310/2420 level provider loops. The notes now refer to data capture and analysis rather than to populating system tables.
- 09/29/2006 Minor rewording of NYS Medicaid Note in front matter.
- 08/31/2006 Added "except for non-healthcare providers" in last paragraph of NPI section in front matter.
- 07/18/2006 Minor rewording of Disclaimer. Removed references in loops 2310A, 2310B, 2310D and 2420A to sending a Secondary Identification REF segment when an NPI is present in NM1.
- 03/28/2006 Added note about reporting a Medicare MCO in loop 2320, SBR09.
- 03/23/2006 Modified NYS Medicaid Notes in CAS segment to clarify Coordination of Benefits balancing.
- 03/17/2006 Added National Provider Identifier (NPI) section to front matter with a discussion of the critical importance to providers of sending this and related information prior to the NPI Compliance Date of May 23, 2007.
- Added qualifiers and NYS Medicaid Notes to support sending the National Provider Identifier (NPI) and the full nine-digit zip code where applicable. Changes were in the NM1 and REF segments of all provider loops.
- Revised text in NYS Medicaid Notes for loop 2420A to state that when a NYS Medicaid Provider ID is sent in the first iteration of this loop it can override the Billing Provider.

>V2.2

- 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.
- 11/16/2005 Removed "Differences between Phase I and Phase II section, repaired links in the transaction set table at the front of the specification
- 10/28/2005 Added more detail about identifying a provider with a medical license number in NYS Medicaid Notes for the REF segments in loops 2310A, 2310B, 2310D, 2420A
- 09/23/2005 Updated support phone numbers in front matter
- 04/20/2005 Added note about 16-digit TCN in CG Modification Tracking; added note about TCN in voids and adjustments to NYS Medicaid Note in front matter. Corrected out-of-state Institutional Unit phone number.

>V2.1

- 02/16/2005 - Modified NYS Medicaid Note in 2320 COB Prior Payer Paid Amount AMT segment.
- Added 2330B Claim Paid Date segment
- 01/25/2005 - The requirements for the Rendering Provider loops 2310B and 2420A as described in New York State Medicaid Notes changed.

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.

For information about the requirements for reporting NPI refer to the NM1 segments for each loop at levels 2310 and 2420.

NYS MEDICAID NOTE:

The ASC X12N 837 Transaction, Health Care Claim - Dental, Addendum Version 4010A1, as published by the X12 Committee in Implementation Guide (IG) 004010X097A1, has been mandated by the Department of Health and Human Services as the national standard for electronic dental claims.

This Companion Guide is provided by the New York State Department of Health (NYSDOH) to clarify the requirements for using the 837 Dental transaction to transmit dental claims to New York State Medicaid. It is important that NYS Medicaid providers study this Companion Guide and become familiar with the data requirements that it specifies.

This Companion Guide does not modify the standards; rather, it puts forth the subset of information from the Implementation Guide that is required for successful submission of NYS Medicaid dental claims to NYSDOH. It is important that providers use this

Companion Guide as a supplement to the Implementation Guide.

The Implementation Guide includes various data elements, the contents of which are identified by qualifier codes. This Companion Guide omits code qualifiers and associated data content that are not necessary for NYS Medicaid processing. Although not all available qualifier codes are listed in this document, NYSDOH will accept for processing any codes named or listed in the Implementation Guide. When necessary, a "NYS MEDICAID NOTE" is included with a segment or data element's specification to describe NYS Medicaid's requirements. These notes provide guidance to ensure proper adjudication and subsequent claim payment within the program guidelines of NYS Medicaid.

It is important to understand that NYSDOH has provided "NYS MEDICAID NOTE(s)" stating "NYSDOH will ignore data when provided" in some segments that are "required" or "situational". The intent here is to advise the submitting entity to submit data (for "required" segments or when the Situational Rule applies), but that the data will not be used for NYS Medicaid transaction processing. The Implementation Guide lists all loops, segments, and elements included in the standard. The Companion Guide may omit some of these items, unless they are defined as required in the IG, or if a Situational Rule requires their use for NYS Medicaid processing. Although not all Implementation Guide items are listed in the Companion Guide, NYS Medicaid will accept for processing all transactions that comply with the specification defined in the Implementation Guide.

Providers are encouraged to use the Implementation Guide to understand the positioning of the data examples provided for every segment, since our Companion Guide may not list all the elements.

Dental (fee-for-service) claims received with multiple service lines will have each service line processed independently. When an 835 is generated it will group the individual SVC segment(s) under a single CLP segment.

Voids and adjustments to previous claims require the Transaction Control Number (TCN) from the remittance advice. The TCN can also be retrieved by submitting a 276 Claim Status Inquiry transaction and receiving a 277 Claim Status Response.

NYSDOH has produced an 837 Dental Supplemental Companion Guide which contains additional information on the following topics:

- Submitter Name
- National Provider Identifier (NPI)
- Provider(s) Identified in the 837D Dental Transaction
- Billing Provider Name
- Billing Provider Secondary Identification
- Pay-to Provider Name
- Rendering Provider
- Replacement/Void codes
- Over Ninety Day Indicator
- SBR Segment
- CAS Segment: Claim Level and Line Level Balancing
- Co-insurance and Deductibles
- Medicare Approved Amount Calculation
- Spend-down - Patient Participation
- Cost Avoidance Override/Zero Fill

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 Contact Information	O	2			Required
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 Number	O	4			Situational
LOOP ID - 2010AB					1	N2/015L	
015	NM1	Pay-to Provider's Name	O	1		N2/015	Situational
025	N3	Pay-to Provider's Address	O	1			Required
030	N4	Pay-to Provider City/State/Zip	O	1			Required
035	REF	Pay-to Provider Secondary Identification Number	O	3			Situational
LOOP ID - 2000B					>1		
001	HL	Subscriber Hierarchical Level	M	1			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 - 2010BB					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	Date - Service	O	1			Situational
175	AMT	Patient Amount Paid	O	1			Situational
180	REF	Original Reference Number (ICN/DCN)	O	1			Situational
180	REF	Prior Authorization or Referral Number	O	2			Situational
LOOP ID - 2310A					2	N2/250L	
250	NM1	Referring Provider Name	O	1		N2/250	Situational
271	REF	Referring Provider Secondary Identification	O	4			Situational

LOOP ID - 2310B				1	N2/250L	
250	NM1	Rendering Provider Name	O	1	N2/250	Situational
271	REF	Rendering Provider Secondary Identification	O	5		Situational
LOOP ID - 2310D				1	N2/250L	
250	NM1	Assistant Surgeon Name	O	1	N2/250	Situational
271	REF	Assistant Surgeon Secondary Identification	O	4		Situational
LOOP ID - 2320				10	N2/290L	
290	SBR	Other Subscriber Information	O	1	N2/290	Situational
295	CAS	Claim Adjustment	O	5		Situational
300	AMT	Coordination of Benefits (COB) Payer Paid Amount	O	1		Situational
300	AMT	Coordination of Benefits (COB) Patient Responsibility Amount	O	1		Situational
300	AMT	Coordination of Benefits (COB) Patient Paid Amount	O	1		Situational
310	OI	Other Insurance Coverage Information	O	1		Situational
LOOP ID - 2330A				1	N2/325L	
325	NM1	Other Subscriber Name	O	1	N2/325	Situational
LOOP ID - 2330B				1	N2/325L	
325	NM1	Other Payer Name	O	1	N2/325	Situational
350	DTP	Claim Paid Date	O	1		Situational
LOOP ID - 2400				50	N2/365L	
365	LX	Line Counter	O	1	N2/365	Required
380	SV3	Dental Service	O	1		Required
382	TOO	Tooth Information	O	32		Situational
455	DTP	Date - Service	O	1		Situational
470	REF	Prior Authorization or Referral Number	O	2		Situational
470	REF	Line Item Control Number	O	1		Situational
485	NTE	Line Note	O	10		Situational
LOOP ID - 2420A				1	N2/500L	
500	NM1	Rendering Provider Name	O	1	N2/500	Situational
525	REF	Rendering Provider Secondary Identification	O	5		Situational
LOOP ID - 2430				25	N2/540L	
540	SVD	Line Adjudication Information	O	1	N2/540	Situational
545	CAS	Service Adjustment	O	99		Situational
550	DTP	Line Adjudication Date	O	1		Required
LOOP ID - 2000C				>1		
001	HL	Patient Hierarchical Level	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

Description: Code uniquely identifying a Transaction Set

<u>Code</u>	<u>Name</u>
837	Health Care Claim
REQUIRED	

ST02	329	Transaction Set Control Number	M	AN	4/9	Required
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Description: Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set

Alias: Transaction Set Control Number
HIPAA IG Note: The Transaction Set Control Numbers in ST02 and SE02 must be identical. This unique number also aids in error resolution research. Submitters could begin 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*19980108*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 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						
		<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 Description: Code identifying purpose of transaction set NYS MEDICAID NOTE: NYSDOH expects '00', however, will process code '18' as an original transmission if it is submitted. 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.	M	ID	2/2	Required						
		<table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>00</td> <td>Original Original transmission 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.</td> </tr> <tr> <td>18</td> <td>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.</td> </tr> </tbody> </table>	<u>Code</u>	<u>Name</u>	00	Original Original transmission 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.	18	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.				
<u>Code</u>	<u>Name</u>											
00	Original Original transmission 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.											
18	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.											
BHT03	127	Reference Identification Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier Industry: Originator Application Transaction Identifier HIPAA IG Note: The inventory file number of the transmission assigned by the submitter's system. This number operates as a batch control number. It may or may not be identical to the number carried in the ST02.	O	AN	1/30	Required						
BHT04	373	Date Description: Date expressed as CCYYMMDD Industry: Transaction Set Creation Date NYS MEDICAID NOTE: NYSDOH expects to receive Billing Date.	O	DT	8/8	Required						

BHT05	337	<p>HIPAA IG Note: Use this date to identify the date on which the submitter created the file.</p>	O	TM	4/8	Required
		<p>Time</p> <p>Description: Time expressed in 24-hour clock time as follows: HHMM, or HHMMSS, or HHMMSSD, or HHMMSSDD, where H = hours (00-23), M = minutes (00-59), S = integer seconds (00-59) and DD = decimal seconds; decimal seconds are expressed as follows: D = tenths (0-9) and DD = hundredths (00-99)</p> <p>Industry: Transaction Set Creation Time</p> <p>HIPAA IG Note: Use the time to identify the time of day that the submitter created the file.</p>				

BHT06	640	<p>Transaction Type Code</p>	O	ID	2/2	Required
		<p>Description: Code specifying the type of transaction</p> <p>Industry: Claim or Encounter Identifier</p> <p>Alias: Claim or Encounter Indicator</p> <p>HIPAA IG Note: Although this element is required, submitters are not necessarily required to accurately batch claims and encounters at this level. Generally, CH is used for claims and RP is used for encounters. However, use "CH" if an ST-SE envelope contains both claims and encounters. Some trading partner agreements may specify using only one code.</p>				

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

REF Transmission Type Identification

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

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

Notes:

1. The information carried in this REF is identical to that carried in the GS08. Because the commercial translator community is roughly evenly split on where they look for the implementation guide type, this number is carried in both places.

Example:

REF*87*004010X097A1~

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						
		<u>Code</u>	<u>Name</u>			
		87	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
Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier						
Industry: Transmission Type Code						
NYS MEDICAID NOTE: NYSDOH will reject transactions that do not contain "00401X097A1" in this location.						
HIPAA IG Note: When piloting the transaction set, this value is 004010X097DA1. When sending the transaction set in a production mode, this value is 004010X097A1.						

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 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 X12 syntax rules.
3. The example in this NM1 and the subsequent N2 demonstrates how a name that is more than 35 characters long could be handled between the NM1 and N2 segments.

Example:

NM1*41*2*CRAMMER, DOLE, PALMER, AND JOHANSON*****46*W7933THU~

NYS MEDICAID NOTE:

Refer to the 837 Dental Supplemental Companion Guide, Section 2. "Provider(s) Identified in the 837 Dental Transaction" for more detailed information on NYSDOH's requirements and uses of the Submitter Name segment.

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 Code Name 41 Submitter Description: Entity transmitting transaction set	M	ID	2/3	Required
NM102	1065	Entity Type Qualifier Description: Code qualifying the type of entity Code Name 1 Person 2 Non-Person Entity	M	ID	1/1	Required
NM103	1035	Name Last or Organization Name Description: Individual last name or organizational name Industry: Submitter Last or Organization Name Alias: Submitter Name	O	AN	1/35	Required
NM104	1036	Name First Description: Individual first name Industry: Submitter First Name Alias: Submitter Name HIPAA IG Note: Required if NM102 = 1 (person).	O	AN	1/25	Situational
NM105	1037	Name Middle Description: Individual middle name or initial Industry: Submitter Middle Name Alias: Submitter Name HIPAA IG Note: Required if NM102 = 1 and the middle name/initial of the person is known.	O	AN	1/25	Situational
NM108	66	Identification Code Qualifier Description: Code designating the system/method of code structure used for Identification Code (67)	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 trading partner agreement.

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

Description: Code identifying a party or other code

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).

PER Submitter Contact Information

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

User Option (Usage): Required

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

Notes:

1. This segment is used to identify the EDI contact person.
2. Each communication number should always include the area code. The extension, when applicable, should be included in the appropriate PER element immediately after the telephone number (e.g., if the telephone number is included in the PER04, then the extension should be in the PER06).
3. 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.
4. By definition of the standard, if PER03 is used, PER04 is required.

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 Description: Code identifying the major duty or responsibility of the person or group named <table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>IC</td> <td>Information Contact</td> </tr> </tbody> </table>	<u>Code</u>	<u>Name</u>	IC	Information Contact	M	ID	2/2	Required						
<u>Code</u>	<u>Name</u>															
IC	Information Contact															
PER02	93	Name Description: Free-form name Industry: Submitter Contact Name HIPAA IG Note: Use this data element when the name of the individual to contact is not already defined or is different than the name within the prior name segment (e.g. N1 or NM1).	O	AN	1/60	Required										
PER03	365	Communication Number Qualifier Description: Code identifying the type of communication number <table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>ED</td> <td>Electronic Data Interchange Access Number</td> </tr> <tr> <td>EM</td> <td>Electronic Mail</td> </tr> <tr> <td>FX</td> <td>Facsimile</td> </tr> <tr> <td>TE</td> <td>Telephone</td> </tr> </tbody> </table>	<u>Code</u>	<u>Name</u>	ED	Electronic Data Interchange Access Number	EM	Electronic Mail	FX	Facsimile	TE	Telephone	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 Description: Complete communications number including country or area code when applicable	C	AN	1/80	Required										
PER05	365	Communication Number Qualifier Description: Code identifying the type of communication number HIPAA IG Note: Used at the discretion of the submitter. <table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>ED</td> <td>Electronic Data Interchange Access Number</td> </tr> </tbody> </table>	<u>Code</u>	<u>Name</u>	ED	Electronic Data Interchange Access Number	C	ID	2/2	Situational						
<u>Code</u>	<u>Name</u>															
ED	Electronic Data Interchange Access Number															

EM Electronic Mail
 EX Telephone Extension
 FX Facsimile
 TE Telephone

PER06 364 **Communication Number** C AN 1/80 Situational
Description: Complete communications number including country or area code when applicable
HIPAA IG Note: Used at the discretion of the submitter.

PER07 365 **Communication Number Qualifier** C ID 2/2 Situational
Description: Code identifying the type of communication number
HIPAA IG Note: Used at the discretion of the submitter.

<u>Code</u>	<u>Name</u>
ED	Electronic Data Interchange Access Number
EM	Electronic Mail
EX	Telephone Extension
FX	Facsimile
TE	Telephone

PER08 364 **Communication Number** C AN 1/80 Situational
Description: Complete communications number including country or area code when applicable
HIPAA IG Note: Used at the discretion of the submitter.

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. Because this is a required segment, this is a required loop. See Appendix A for further details on ASC X12 nomenclature X12 syntax rules.

Example:

NM1*40*2*UNION MUTUAL OF OREGON*****46*111222333~

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 <u>Code</u> <u>Name</u> 40 Receiver Description: Entity to accept transmission	M	ID	2/3	Required
NM102	1065	Entity Type Qualifier Description: Code qualifying the type of entity <u>Code</u> <u>Name</u> 2 Non-Person Entity	M	ID	1/1	Required
NM103	1035	Name Last or Organization Name Description: Individual last name or organizational name Industry: Receiver Name NYS MEDICAID NOTE: NYSDOH expects to receive 'NYSDOH'.	O	AN	1/35	Required
NM108	66	Identification Code Qualifier Description: Code designating the system/method of code structure used for Identification Code (67) <u>Code</u> <u>Name</u> 46 Electronic Transmitter Identification Number (ETIN) Description: A unique number assigned to each transmitter and software developer	C	ID	1/2	Required
NM109	67	Identification Code Description: Code identifying a party or other code Industry: Receiver Primary Identifier Alias: Receiver Primary Identification Number NYS MEDICAID NOTE: NYSDOH expects to receive '141797357'.	C	AN	2/80	Required

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-2010BB. The Billing Provider entity may be a health care provider, a billing service or some other representative of the provider.
2. The NSF fields shown in Loop ID-2010AA and Loop ID-2010AB are intended to carry the billing provider information, not billing service information. Refer to your NSF manual for proper use of these fields. If Loop 2010AA contains information on a billing service (rather than a billing provider), do not map the information in that loop to the NSF billing provider fields for Medicare claims.
3. The Billing/Pay-to Provider HL may contain information about the Pay-to Provider entity. If the Pay-to Provider entity is the same as the Billing Provider entity, then only use Loop ID-2010AA.
4. Because this is a required segment, this is a required loop. See Appendix A for further details on ASC X12 nomenclature X12 syntax rules.
5. Receiving trading partners may have system limitations regarding the size of the transmission they can receive. The developers of this implementation guide recommend that trading partners limit the size of the transaction (ST-SE envelope) to a maximum of 5000 CLM segments. While the implementation guide sets no specific limit to the number of Billing/Pay-to Provider Hierarchical Level loops; there is an implied maximum of 5000.
6. If the Billing or Pay-to Provider is also the Rendering Provider and Loop ID-2310A is not used, the Loop ID-2000 PRV must be used to indicate which entity (Billing or Pay-to) is the Rendering Provider.

Example:

HL*1**20*1~

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 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.	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
		Code Name 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
		Code Name 1 Additional Subordinate HL Data Segment in This Hierarchical Structure.				

NM1 Billing Provider Name

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

User Option (Usage): Required

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

Notes:

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

Example:

NM1*85*2*DENTAL ASSOCIATES*****34*123456789~

NYS MEDICAID NOTE:

In order to correctly identify the Billing Provider using a National Provider Identifier (NPI), the following rules should be considered.

When a health care provider organization has determined that it needs to enumerate its subparts, it will report the NPI of a subpart as the Billing Provider. The subpart reported as the Billing Provider MUST always represent the most detailed level of enumeration as determined by the organization health care provider and MUST be the same identifier sent to any trading partner. NYSDOH will accept and capture the Billing Provider's NPI in NM109 of this segment. This is the identifier that will be used for processing.

The full nine digits of the zipcode in the N4 segment of this loop will be of critical importance as it will be used to derive information previously supported by locator codes. The NYS Medicaid Provider ID and Locator Code in iterations of the REF segment will still be required for claims processing prior to the eMedNY NPI implementation. The current schedule for the NYSDOH implementation of NPI is September 1, 2008. Please monitor the eMedNY.org website for any implementation updates.

After NPI implementation the NPI will be the only permissible provider identifier in this location other than for non-healthcare providers. The NYS Medicaid Provider ID, Locator Code, and License Number will all be disallowed.

There are some providers who do not meet the federal definition of a "Health Care Provider". These providers are known as "atypical providers" and do not qualify to receive an NPI. Therefore, NYSDOH will continue to require NYS Medicaid Provider ID and three-digit Location Code for atypical providers. Atypical providers are defined within NYSDOH by category of service. To find out if you are affected, visit the eMedNY website for the list of atypical categories of service.

Atypical providers will continue to report their Medicaid ID and Locator code in the Billing Provider Secondary Identification REF segment (REF01=1D) will be processed as the default Billing Provider and (REF01=LU) will be processed as the locator code.

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 HIPAA IG Note: Use this code to indicate billing provider, billing submitter and encounter reporting entity.	M	ID	2/3	Required
		Code Name 85 Billing Provider				
NM102	1065	Entity Type Qualifier Description: Code qualifying the type of entity	M	ID	1/1	Required
		Code Name 1 Person 2 Non-Person Entity				
NM103	1035	Name Last or Organization Name Description: Individual last name or	O	AN	1/35	Required

		organizational name Industry: Billing Provider Last or Organizational Name Alias: Billing Provider Name												
NM104	1036	Name First Description: Individual first name Industry: Billing Provider First Name Alias: Billing Provider Name HIPAA IG Note: Required if NM102 = 1 (person).	O	AN	1/25	Situational								
NM105	1037	Name Middle Description: Individual middle name or initial Industry: Billing Provider Middle Name Alias: Billing Provider Name HIPAA IG Note: Required if NM102 = 1 and the middle name/initial of the person is known.	O	AN	1/25	Situational								
NM107	1039	Name Suffix Description: Suffix to individual name Industry: Billing Provider Name Suffix Alias: Billing Provider Name HIPAA IG Note: Required if known.	O	AN	1/10	Situational								
NM108	66	Identification Code Qualifier Description: Code designating the system/method of code structure used for Identification Code (67) HIPAA IG Note: If "XX - NPI" is used, then either the Employer's Identification Number, Social Security Number or Federal Tax Identification Number of the Provider must be carried in the REF in this loop.	C	ID	1/2	Required								
		<table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>24</td> <td>Employer's Identification Number</td> </tr> <tr> <td>34</td> <td>Social Security Number</td> </tr> <tr> <td>XX</td> <td>Health Care Financing Administration National Provider Identifier</td> </tr> </tbody> </table> <p>Description: Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.</p>	<u>Code</u>	<u>Name</u>	24	Employer's Identification Number	34	Social Security Number	XX	Health Care Financing Administration National Provider Identifier				
<u>Code</u>	<u>Name</u>													
24	Employer's Identification Number													
34	Social Security Number													
XX	Health Care Financing Administration National Provider Identifier													
NM109	67	Identification Code Description: Code identifying a party or other code Industry: Billing Provider Identifier Alias: Billing Provider's Primary Identification Number NYS MEDICAID NOTE: NYSDOH expects to receive the NPI here, when NM108 contains a qualifier of 'XX'. ExternalCodeList Name: 537 Description: Health Care Financing Administration National Provider Identifier	C	AN	2/80	Required								

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 Description: Address information Industry: Billing Provider Address Line Alias: Billing Provider Address 1	M	AN	1/55	Required
N302	166	Address Information Description: Address information Industry: Billing Provider Address Line Alias: Billing Provider Address 1 HIPAA IG Note: Required if a second address line exists.	O	AN	1/55	Situational

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~

NYS MEDICAID NOTE:

If an NPI was sent in NM1, NYSDOH will expect all nine digits of the zipcode in this segment.

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 Description: Free-form text for city name Industry: Billing Provider City Name Alias: Billing Provider's City	O	AN	2/30	Required
N402	156	State or Province Code Description: Code (Standard State/Province) as defined by appropriate government agency Industry: Billing Provider State or Province Code Alias: Billing Provider's State <u>ExternalCodeList</u> Name: 22 Description: States and Outlying Areas of the U.S.	O	ID	2/2	Required
N403	116	Postal Code Description: Code defining international postal zone code excluding punctuation and blanks (zip code for United States) Industry: Billing Provider Postal Zone or ZIP Code Alias: Billing Provider's ZIP Code <u>ExternalCodeList</u> Name: 51 Description: ZIP Code	O	ID	3/15	Required
N404	26	Country Code Description: Code identifying the country Alias: Billing Provider Country Code HIPAA IG Note: Required if the address is out of the U.S. <u>ExternalCodeList</u> Name: 5 Description: Countries, Currencies and Funds	O	ID	2/3	Situational

REF Billing Provider Secondary Identification Number

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 the NM109.
2. If the reason the number is being used in this REF can be met by the NPI, carried in the NM108/NM109 of this loop, then this REF is not used.
3. If code "XX - NPI" is used in the NM108/NM109 of this loop, then either the Employer's Identification Number, Social Security Number or Federal Tax Identification Number of the Provider must be carried in this REF.

Example:

REF*SY*111222333~

NYS MEDICAID NOTE:

Prior to the eMedNY NPI implementation date, 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.

An iteration containing a qualifier of 'EI' for EIN Number or 'SY' for Social Security Number is required by the Implementation Guide when the NPI was sent in NM1, however NYSDOH will not use this data in claims processing.

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			
		1D	Medicaid Provider Number			
		EI	Employer's Identification Number			
		LU	Location Number			
		SY	Social Security Number			
The Social Security Number may not be used for Medicare.						
REF02	127	Reference Identification	C	AN	1/30	Required
Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier						
Industry: Billing Provider Additional Identifier						
Alias: Billing Provider's Secondary Identification Number						

NM1 Pay-to Provider's Name

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

User Option (Usage): Situational

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

Notes:

1. If the billing provider and the pay-to provider are the same entity, then it is not necessary to put in the pay-to-provider loop.
2. Because the usage of this segment is "situational" this is not a syntactically required loop. If the loop is used, then it is a "required" segment. See Appendix A for further details on ASC X12 nomenclature X12 syntax rules.

Example:

NM1*87*1*JONES*WILLIAM****XX*0987654321~

NYS MEDICAID NOTE:

NYSDOH expects to receive the Group Provider information in this loop only when payment is to be made to the Group.

In order to correctly identify the Pay-to Provider using a National Provider Identifier (NPI), the following rules should be considered.

When a health care provider organization has determined that it needs to enumerate its subparts, it will report the NPI of a subpart as the Pay-to Provider. The subpart reported as the Pay-to Provider MUST always represent the most detailed level of enumeration as determined by the organization health care provider and MUST be the same identifier sent to any trading partner. NYSDOH will accept and capture the Pay-to Provider's NPI in NM109 of this segment. This is the identifier that will be used for processing.

The NYS Medicaid Provider ID and Locator Code in iterations of the REF segment will still be required for claims processing prior to the eMedNY NPI implementation date. The current schedule for the NYSDOH implementation of NPI is September 1, 2008. Please monitor the eMedNY.org website for any implementation updates.

After NPI implementation the NPI will be the only permissible provider identifier in this location other than for non-healthcare providers. The NYS Medicaid Provider ID, Locator Code, and License Number will all be disallowed.

There are some providers who do not meet the federal definition of a "Health Care Provider". These providers are known as "atypical providers" and do not qualify to receive an NPI. Therefore, NYSDOH will continue to require NYS Medicaid Provider ID and three-digit Location Code for atypical providers. Atypical providers are defined within NYSDOH by category of service. To find out if you are affected, visit the eMedNY website for the list of atypical categories of service.

Atypical providers will continue to report their Medicaid ID in the Pay-to Provider Secondary Identification REF segment; (REF01=1D) will be processed as the Pay-to Provider.

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
Description: Code identifying an organizational entity, a physical location, property or an individual						
		<u>Code</u>		<u>Name</u>		
		87		Pay-to Provider		
NM102	1065	Entity Type Qualifier	M	ID	1/1	Required
Description: Code qualifying the type of entity						
		<u>Code</u>		<u>Name</u>		
		1		Person		
		If person is used and if the pay-to provider is the same as the rendering provider, then it is not necessary to use the rendering provider NM1 loop at the claim (2300) loop.				
		2		Non-Person Entity		
		If non-person entity is used, then the rendering provider NM1 loop (Loop 2310B) should be used to supply the name of the rendering (warm body) provider.				

NM103	1035	<p>Name Last or Organization Name</p> <p>Description: Individual last name or organizational name Industry: Pay-to Provider Last or Organizational Name HIPAA IG Note: Pay-to Provider Last Name or Organization Name</p>	O	AN	1/35	Required								
NM104	1036	<p>Name First</p> <p>Description: Individual first name Industry: Pay-to Provider First Name HIPAA IG Note: Pay-to Provider First Name Required if NM102 = 1 (person).</p>	O	AN	1/25	Situational								
NM105	1037	<p>Name Middle</p> <p>Description: Individual middle name or initial Industry: Pay-to Provider Middle Name HIPAA IG Note: Pay-to Provider Middle Initial Required if NM102 = 1 and the middle name/initial of the person is known.</p>	O	AN	1/25	Situational								
NM107	1039	<p>Name Suffix</p> <p>Description: Suffix to individual name Industry: Pay-to Provider Name Suffix HIPAA IG Note: Pay-to Provider Name Suffix Required if known.</p>	O	AN	1/10	Situational								
NM108	66	<p>Identification Code Qualifier</p> <p>Description: Code designating the system/method of code structure used for Identification Code (67) HIPAA IG Note: If "XX - NPI" is used, then either the Employer's Identification Number, Social Security Number or Federal Tax Identification Number of the Provider must be carried in the REF in this loop.</p> <table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>24</td> <td>Employer's Identification Number</td> </tr> <tr> <td>34</td> <td>Social Security Number</td> </tr> <tr> <td>XX</td> <td>Health Care Financing Administration National Provider Identifier</td> </tr> </tbody> </table> <p>Description: Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.</p>	<u>Code</u>	<u>Name</u>	24	Employer's Identification Number	34	Social Security Number	XX	Health Care Financing Administration National Provider Identifier	C	ID	1/2	Required
<u>Code</u>	<u>Name</u>													
24	Employer's Identification Number													
34	Social Security Number													
XX	Health Care Financing Administration National Provider Identifier													
NM109	67	<p>Identification Code</p> <p>Description: Code identifying a party or other code Industry: Pay-to Provider Identifier NYS MEDICAID NOTE: NYSDOH expects to receive the NPI here, when NM108 contains a qualifier of 'XX'. HIPAA IG Note: Pay-to Provider's Primary Identification Number</p> <p>ExternalCodeList Name: 537 Description: Health Care Financing Administration National Provider Identifier</p>	C	AN	2/80	Required								

N3

Pay-to Provider's Address

Pos: 025	Max: 1
Detail - Optional	
Loop: 2010AB	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 Description: Address information Industry: Pay-to Provider Address Line Alias: Pay-to Provider's Address 1	M	AN	1/55	Required
N302	166	Address Information Description: Address information Industry: Pay-to Provider Address Line Alias: Pay-to Provider's Address 2 HIPAA IG Note: Required if second address line exists.	O	AN	1/55	Situational

N4 Pay-to Provider City/State/Zip

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

User Option (Usage): Required

Purpose: To specify the geographic place of the named party

Example:

N4*CENTERVILLE*PA*17111~

NYS MEDICAID NOTE:

If an NPI was sent in NM1, NYSDOH will capture all nine digits if the full nine-digit zipcode was sent in this segment.

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 Description: Free-form text for city name Industry: Pay-to Provider City Name Alias: Pay-to Provider's City	O	AN	2/30	Required
N402	156	State or Province Code Description: Code (Standard State/Province) as defined by appropriate government agency Industry: Pay-to Provider State Code Alias: Pay-to Provider's State <u>ExternalCodeList</u> Name: 22 Description: States and Outlying Areas of the U.S.	O	ID	2/2	Required
N403	116	Postal Code Description: Code defining international postal zone code excluding punctuation and blanks (zip code for United States) Industry: Pay-to Provider Postal Zone or ZIP Code Alias: Pay-to Provider's Zip Code <u>ExternalCodeList</u> Name: 51 Description: ZIP Code	O	ID	3/15	Required
N404	26	Country Code Description: Code identifying the country Alias: Pay-to Provider country code HIPAA IG Note: Required if the address is out of the U.S. <u>ExternalCodeList</u> Name: 5 Description: Countries, Currencies and Funds	O	ID	2/3	Situational

REF Pay-to Provider Secondary Identification Number

Pos: 035	Max: 3
Detail - Optional	
Loop: 2010AB	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 the NM108/109 of this loop.
2. If the reason the number is being used in this REF can be met by the NPI, carried in the NM108/NM109 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, Social Security Number or Federal Tax Identification Number of the Provider must be carried in this REF. The number sent is the one which is used in the 1099. If additional numbers are needed in the REF it can be run up to 5 times.

Example:

REF*SY*111222333~

NYS MEDICAID NOTE:

Prior to the eMedNY NPI implementation date, NYSDOH expects to receive the Medicaid Group Provider ID in an iteration of this segment with a qualifier of '1D'.

An iteration containing a qualifier of 'EI' for EIN Number or 'SY' for Social Security Number is required by the Implementation Guide when the NPI was sent in NM1, however NYSDOH will not use this data in claims processing.

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			
		1D	Medicaid Provider Number			
		EI	Employer's Identification Number			
		SY	Social Security Number			
The Social Security Number may not be used for Medicare.						
REF02	127	Reference Identification	C	AN	1/30	Required
Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier						
Industry: Pay-to Provider Identifier						

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 subscriber and the patient are the same person, use this HL to identify the subscriber/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) and his or her insurance (loop ID-2010BB). In addition, information about the credit/debit card holder is placed in this HL (loop ID-2010BC). The credit/debit card holder may or may not be the subscriber. See Appendix G, Credit/Debit card Use, for a description of using the loop ID-2010BC.
3. 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.
4. Because this is a required segment, this is a required loop. See Appendix A for further details on ASC X12 nomenclature X12 syntax rules.

Example:

HL*2*1*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> </table> <p>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</p>	<u>Code</u>	<u>Name</u>	22	Subscriber				
<u>Code</u>	<u>Name</u>									
22	Subscriber									
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 to receive '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 is not sent) or when HL04 has subordinate levels indicated (HL04=1). In the first	O	ID	1/1	Required				

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 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: 6

User Option (Usage): Required

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

Example:

SBR*P**GRP01020102***6***CI~

NYS MEDICAID NOTE:

NYSDOH expects Medicaid recipient/client information to be reported in this loop.

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	M	ID	1/1	Required

Description: Code identifying the insurance carrier's level of responsibility for a payment of a claim

NYS MEDICAID NOTE: If one prior payer is being reported, SBR01 should contain a 'S', indicating that NYS Medicaid is the secondary payer.

If two or more prior payers are being reported, SBR01 should contain a 'T'.

<u>Code</u>	<u>Name</u>
P	Primary UB-92 Ref. [UB-Name]: DA0-02.0-Pri
S	Secondary UB-92 Ref. [UB-Name]: DA1-02.0-Sec
T	Tertiary Use to indicate payer of last resort.

SBR02	1069	Individual Relationship Code	O	ID	2/2	Situational
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Description: Code indicating the relationship between two individuals or entities

HIPAA IG Note: Required 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

SBR03	127	Reference Identification	O	AN	1/30	Situational
-------	-----	---------------------------------	---	----	------	-------------

Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

Industry: Insured Group or Policy Number
HIPAA IG Note: Required if the subscriber's payer identification includes Group or Plan Number. This data element is intended to carry the subscriber's Group Number, not the number that uniquely identifies the subscriber (Subscriber ID, Loop 2010BA-NM109).

SBR04	93	Name	O	AN	1/60	Situational
-------	----	-------------	---	----	------	-------------

Description: Free-form name

Industry: Insured Group Name
Alias: Plan Name
NYS MEDICAID NOTE: NYSDOH will support the current "zero fill" process when the Provider indicates the plan name to process under is "0FILL". The "zero fill" process allows the Provider to by-pass claim submission to the primary payer as known by Medicaid when the following criteria are met: the Provider has documentation showing that an Eligibility Response or Remittance Advice from a prior submitted claim for the same service has been obtained explaining why this claim is not covered by other payer(s).

When the claim is not eligible for processing under the "0FILL" plan, NYSDOH recommends submitters enter "MEDICAID" in order to fulfill the HIPAA requirement.

Refer to the 837 Dental Supplemental Companion Guide section on "Cost Avoidance Override/Zero Fill" for more detailed information on NYSDOH's requirements and uses of the SBR04 Free-form Name information as reported in this segment.
HIPAA IG Note: Required if the Subscriber's payer identification includes Plan Name.

SBR06 1143 **Coordination of Benefits Code** O ID 1/1 Required

Description: Code identifying whether there is a coordination of benefits

<u>Code</u>	<u>Name</u>
1	Coordination of Benefits Description: A method of integrating benefits payable under more than one group health insurance plan so that the insured's benefits from all sources do not exceed 100 percent of the allowable medical expenses
6	No Coordination of Benefits

SBR09 1032 **Claim Filing Indicator Code** O ID 1/2 Situational

Description: Code identifying type of claim
NYS MEDICAID NOTE: NYSDOH expects to receive 'MC'.
HIPAA IG Note: Required prior to mandated use of PlanID. Not used after PlanID is mandated.

<u>Code</u>	<u>Name</u>
MC	Medicaid UB-92 Ref. [UB-Name]: CA0-23.0 (D), DA0-05.0 (D)

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 X12 syntax rules.

Example:

NM1*IL*1*DOE*JOHN*T**JR*MI*123456789~

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 Description: Code identifying an organizational entity, a physical location, property or an individual Code Name IL Insured or Subscriber	M	ID	2/3	Required
NM102	1065	Entity Type Qualifier Description: Code qualifying the type of entity NYS MEDICAID NOTE: NYSDOH expects to receive value '1'. Code Name 1 Person	M	ID	1/1	Required
NM103	1035	Name Last or Organization Name Description: Individual last name or organizational name Industry: Subscriber Last Name Alias: Subscriber's Last Name NYS MEDICAID NOTE: Although this is a required data element, NYSDOH will not use this information to identify the recipient.	O	AN	1/35	Required
NM104	1036	Name First Description: Individual first name Industry: Subscriber First Name Alias: Subscriber's 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: Required if NM102 = 1 (person).	O	AN	1/25	Situational
NM105	1037	Name Middle Description: Individual middle name or initial Industry: Subscriber Middle Name Alias: Subscriber's Middle Initial HIPAA IG Note: Required if NM102 = 1 and the middle name/initial of the person is known.	O	AN	1/25	Situational

NM107 1039 **Name Suffix** O AN 1/10 Situational
Description: Suffix to individual name
Industry: Subscriber Name Suffix
Alias: Subscriber's Generation
HIPAA IG Note: Examples: I, II, III, IV, Jr, Sr Required if known.

NM108 66 **Identification Code Qualifier** C ID 1/2 Situational
Description: Code designating the system/method of code structure used for Identification Code (67)
HIPAA IG Note: Required if NM102 = 1 (person).

<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 Dental Workgroup recommends using MI - Member Identification Number to convey the following terms: Insured's ID, Subscriber's ID, Health Insurance Claim Number (HIC), etc. 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 the REF02.

NM109 67 **Identification Code** C AN 2/80 Situational
Description: Code identifying a party or other code
Industry: Subscriber Primary Identifier
NYS MEDICAID NOTE: NYSDOH expects the Recipient ID.
HIPAA IG Note: Required if NM102 = 1 (person).

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. Required when the patient is the same person as the subscriber. (Required when Loop ID-2000B, SBR02 = 18 (self)).

Example:

N3*125 CITY AVENUE~

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>
N301	166	Address Information Description: Address information Industry: Subscriber Address Line Alias: Subscriber's Address 1	M	AN	1/55	Required
N302	166	Address Information Description: Address information Industry: Subscriber Address Line Alias: Subscriber's Address 2 HIPAA IG Note: Required if second address line exists.	O	AN	1/55	Situational

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. Required when the patient is the same person as the subscriber. (Required when Loop ID-2000B, SBR02 = 18 (self)).

Example:

N4*CENTERVILLE*PA*17111~

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>
N401	19	City Name Description: Free-form text for city name Industry: Subscriber City Name Alias: Subscriber's City	O	AN	2/30	Required
N402	156	State or Province Code Description: Code (Standard State/Province) as defined by appropriate government agency Industry: Subscriber State Code Alias: Subscriber's State <u>ExternalCodeList</u> Name: 22 Description: States and Outlying Areas of the U.S.	O	ID	2/2	Required
N403	116	Postal Code Description: Code defining international postal zone code excluding punctuation and blanks (zip code for United States) Industry: Subscriber Postal Zone or ZIP Code Alias: Subscriber's ZIP Code <u>ExternalCodeList</u> Name: 51 Description: ZIP Code	O	ID	3/15	Required
N404	26	Country Code Description: Code identifying the country HIPAA IG Note: Required if address is out 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. Required when the patient is the same person as the subscriber. (Required when Loop ID-2000B, SBR02 = 18 (self)).

Example:

DMG*D8*19491117*M~

NYS MEDICAID NOTE:

NYSDOH expects Medicaid recipient/client information to be reported in this segment.

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 Description: Code indicating the date format, time format, or date and time format	C	ID	2/3	Required						
		<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 Description: Expression of a date, a time, or range of dates, times or dates and times Industry: Subscriber Birth Date Alias: Date of Birth - Patient NYS MEDICAID NOTE: NYSDOH expects the subscriber's Date Of Birth.	C	AN	1/35	Required						
DMG03	1068	Gender Code Description: Code indicating the sex of the individual Industry: Subscriber Gender Code Alias: Gender - Patient NYS MEDICAID NOTE: NYSDOH cannot process code 'U' (Unknown). Claims received with an unknown gender will be denied.	O	ID	1/1	Required						
		<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

Payer Name

Pos: 015	Max: 1
Detail - Optional	
Loop: 2010BB	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 X12 syntax rules.
2. This is the destination payer.

Example:

NM1*PR*2*Union Mutual of Oregon****PI*123123123~

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 Code Name PR Payer	M	ID	2/3	Required
NM102	1065	Entity Type Qualifier Description: Code qualifying the type of entity Code Name 2 Non-Person Entity	M	ID	1/1	Required
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'.	O	AN	1/35	Required
NM108	66	Identification Code Qualifier Description: Code designating the system/method of code structure used for Identification Code (67) Code Name PI Payor Identification XV Health Care Financing Administration National Payer Identification Number (PAYERID) Description: Required if the National PlanID is mandated for use. Otherwise, one of the other listed codes may be used.	C	ID	1/2	Required
NM109	67	Identification Code Description: Code identifying a party or other code Industry: Payer Identifier Alias: Payer Primary Identification Number NYS MEDICAID NOTE: NYSDOH expects to receive '141797357'. ExternalCodeList Name: 540 Description: Health Care Financing Administration National PlanID	C	AN	2/80	Required

CLM Claim Information

Pos: 130	Max: 1
Detail - Optional	
Loop: 2300	Elements: 11

User Option (Usage): Required

Purpose: To specify basic data about the claim

Notes:

1. Because this is a required segment, this is a required loop. See Appendix A for further details on ASC X12 nomenclature X12 syntax rules.
2. The developers of this implementation guide recommend that trading partners limit the size of the transaction (SE-ST envelope) to a maximum of 5000 CLM segments. There is no recommended limit to the number of ST-SE transactions within a GS-GE or ISA-IEA. Willing trading partners can agree to set limits higher.
3. For purposes of this documentation, the claim detail information is presented only in the dependent level. Specific claim detail information can be given in either the subscriber or the dependent hierarchical level. Because of this the claim information is said to "float." Claim information is positioned in the same hierarchical level that describes its owner-participant, either the subscriber or the dependent. In other words, the claim information, loop 2300, is placed following loop 2010BC 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*013193000001*500***11::1*Y*A*Y*Y~

NYS MEDICAID NOTE:

Refer to the 837 Dental Supplemental Companion Guide for more detailed information on NYSDOH's requirements and uses of the CLM05 and CLM20 data elements as reported in this segment.

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 Description: Identifier used to track a claim from creation by the health care provider through payment Industry: Patient Account Number HIPAA IG Note: The number that the submitter transmits in this position is echoed back to the submitter in the 835 transaction. The two recommended identifiers are either the Patient Account Number or the Claim Number in the billing submitter's patient management system. The developers of this implementation guide strongly recommend that submitters use completely unique numbers for this field for each individual claim. 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 837 receiving system.	M	AN	1/38	Required
CLM02	782	Monetary Amount Description: Monetary amount Industry: Total Claim Charge Amount Alias: Total Claim Charges NYS MEDICAID NOTE: NYSDOH expects the total amount of all submitted charges for this claim. HIPAA IG Note: For encounter transmissions, zero (0) may be a valid amount.	O	R	1/18	Required

CLM05	C023	<p>Health Care Service Location Information</p> <p>Description: To provide information that identifies the place of service or the type of bill related to the location at which a health care service was rendered</p> <p>Alias: Place of Service Code</p> <p>HIPAA IG Note: CLM05 applies to all service lines unless it is over written at the line level.</p>	O	Comp		Required
CLM05-01	1331	<p>Facility Code Value</p> <p>Description: Code identifying the type of facility where services were performed; the first and second positions of the Uniform Bill Type code or the Place of Service code from the Electronic Media Claims National Standard Format</p> <p>Industry: Facility Type Code</p> <p>NYS MEDICAID NOTE: NYSDOH will process as the Place of Service.</p> <p>A value of '03' identifies the Facility Type as a Dental School. Refer to the 837D supplemental Companion Guide, Section 2, for a discussion of the Rendering Provider loop for dental school claims.</p> <p>HIPAA IG Note: Use this element for codes identifying a place of service from code source 237. As a courtesy, the codes are listed below; however, the code list is thought to be complete at the time of publication of this implementation guide. Since this list is subject to change, only codes contained in the document available from code source 237 are to be supported in this transaction and take precedence over any and all codes listed here.</p> <p>11 Office 12 Home 21 Inpatient Hospital 22 Outpatient Hospital 31 Skilled Nursing Facility 35 Adult Living Care Facility</p> <p>ExternalCodeList Name: 237</p> <p>Description: Place of Service from Health Care Financing Administration Claim Form</p>	M	AN	1/2	Required
CLM05-03	1325	<p>Claim Frequency Type Code</p> <p>Description: Code specifying the frequency of the claim; this is the third position of the Uniform Billing Claim Form Bill Type</p> <p>Industry: Claim Submission Reason Code</p> <p>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 a remittance advice (paper or 835 transaction). These values should only be sent for previously paid claims that are being adjusted or voided.</p> <p>ExternalCodeList Name: 235</p> <p>Description: Claim Frequency Type Code</p>	O	ID	1/1	Required

CLM06	1073	Yes/No Condition or Response Code Description: Code indicating a Yes or No condition or response Industry: Provider or Supplier Signature Indicator Alias: Provider Signature on File Code NYS MEDICAID NOTE: NYSDOH expects to receive 'Y'.	O	ID	1/1	Required
		<u>Code</u> <u>Name</u> Y Yes				
CLM07	1359	Provider Accept Assignment Code Description: Code indicating whether the provider accepts assignment Industry: Medicare Assignment Code HIPAA IG Note: The NSF mapping to FA0-59.0 occurs only in payer-to-payer COB situations. Required for Medicare claims only.	O	ID	1/1	Situational
		<u>Code</u> <u>Name</u> A Assigned C Not Assigned P Patient Refuses to Assign Benefits				
CLM08	1073	Yes/No Condition or Response Code Description: Code indicating a Yes or No condition or response Industry: Benefits Assignment Certification Indicator Alias: Assignment of Benefits Code	O	ID	1/1	Required
		<u>Code</u> <u>Name</u> N No Y Yes				
CLM09	1363	Release of Information Code Description: Code indicating whether the provider has on file a signed statement by the patient authorizing the release of medical data to other organizations	O	ID	1/1	Required
		<u>Code</u> <u>Name</u> N No, Provider is Not Allowed to Release Data Y Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim				
CLM11	C024	Related Causes Information Description: To identify one or more related causes and associated state or country information NYS MEDICAID NOTE: NYSDOH expects to receive Accident Code, if applicable. HIPAA IG Note: CLM11-1, CLM11-2, or CLM11-3 are required when the condition being reported is accident or employment related. If DTP - Date of Accident (DTP01 = 439) is used, then CLM11 is required.	O	Comp		Situational
CLM11-01	1362	Related-Causes Code Description: Code identifying an accompanying cause of an illness, injury or an accident Industry: Related Causes Code	M	ID	2/3	Required
		<u>Code</u> <u>Name</u> AA Auto Accident				

		UB-92 Ref. [UB-Name]: EA0-05.0
EM		Employment
		UB-92 Ref. [UB-Name]: EA0-04.0
OA		Other Accident
		UB-92 Ref. [UB-Name]: EA0-05.0

CLM11-02 1362 **Related-Causes Code** O ID 2/3 Situational

Description: Code identifying an accompanying cause of an illness, injury or an accident

Industry: Related Causes Code
HIPAA IG Note: Used if more than one code applies.

<u>Code</u>	<u>Name</u>
AA	Auto Accident
EM	Employment
OA	Other Accident

CLM11-03 1362 **Related-Causes Code** O ID 2/3 Situational

Description: Code identifying an accompanying cause of an illness, injury or an accident

Industry: Related Causes Code
HIPAA IG Note: Used if more than one code applies.

<u>Code</u>	<u>Name</u>
AA	Auto Accident
EM	Employment
OA	Other Accident

CLM11-04 156 **State or Province Code** O ID 2/2 Situational

Description: Code (Standard State/Province) as defined by appropriate government agency

Industry: Auto Accident State or Province Code
Alias: Accident State
HIPAA IG Note: Required if CLM11-1, CLM11-2 or CLM11-3 has a value of "AA".

ExternalCodeList
Name: 22
Description: States and Outlying Areas of the U.S.

CLM11-05 26 **Country Code** O ID 2/3 Situational

Description: Code identifying the country
HIPAA IG Note: Required if the automobile accident occurred out of the U.S. to identify the country in which the accident occurred.

ExternalCodeList
Name: 5
Description: Countries, Currencies and Funds

CLM12 1366 **Special Program Code** O ID 2/3 Situational

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

Industry: Special Program Indicator
NYS MEDICAID NOTE: NYSDOH expects to receive code '02' when services within this claim include orthodontic procedures.
HIPAA IG Note: Required if the services were

rendered under one of the following circumstances/programs/projects.

<u>Code</u>	<u>Name</u>
01	Early & Periodic Screening, Diagnosis, and Treatment (EPSDT) or Child Health Assessment Program (CHAP)
02	Physically Handicapped Children's Program
03	Special Federal Funding
05	Disability

CLM19 1383 **Claim Submission Reason Code** O ID 2/2 Situational

Description: Code identifying reason for claim submission

Alias: Predetermination of Benefits Code
NYS MEDICAID NOTE: NYSDOH does not support the business process of predetermination of benefits.
HIPAA IG Note: CLM19 is required when the entire claim is being submitted for Predetermination of Benefits.

<u>Code</u>	<u>Name</u>
PB	Predetermination of Dental Benefits

Description: Information is intended for dental predetermination purposes only

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

Description: Code indicating the reason why a request was delayed

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 Dental Supplemental Companion Guide, Section 4 "Over Ninety Day Indicator" for more detailed information on NYSDOH's requirements and uses of the CLM05-20 data element as reported in this segment.

HIPAA IG Note: 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 Date - Service

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

User Option (Usage): Situational

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

Notes:

1. The dates in Loop ID-2300 apply to all service lines within Loop ID-2400 unless a DTP segment occurs in Loop ID-2400 with the same value in DTP01. In that case, the DTP in Loop ID-2400 overrides the DTP in Loop ID-2300 for that service line only.
2. Required if all of the services on the claim/encounter were performed. This DTP should not be used if the claim is being submitted for Predetermination of Benefits.

Example:

DTP*472*D8*19980108~

NYS MEDICAID NOTE:

NYSDOH expects to receive Date of Service.

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
Description: Code specifying type of date or time, or both date and time						
Industry: Date Time Qualifier						
		<u>Code</u>	<u>Name</u>			
		472	Service			
DTP02	1250	Date Time Period Format Qualifier	M	ID	2/3	Required
Description: Code indicating the date format, time format, or date and time format						
		<u>Code</u>	<u>Name</u>			
		D8	Date Expressed in Format CCYYMMDD			
		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
Description: Expression of a date, a time, or range of dates, times or dates and times						
Industry: Service Date						

AMT Patient Amount Paid

Pos: 175	Max: 1
Detail - Optional	
Loop: 2300	Elements: 2

User Option (Usage): Situational

Purpose: To indicate the total monetary amount

Notes:

1. Required if the patient has paid any amount toward the claim.
2. Patient Amount Paid refers to the sum of all amounts paid on the claim by the patient or his/her representative.
3. The Patient amount Paid indicated in this segment applies to the entire claim. It is recommended that the Patient Amount Paid AMT segment be used at either the line or claim level but not at both.

Example:

AMT*F5*8.5~

NYS MEDICAID NOTE:

NYSDOH will process Patient Amount Paid.

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				
		<u>Code</u>		<u>Name</u>		
		F5		Patient Amount Paid		
		Description: Monetary amount value already paid by one receiving medical care				
AMT02	782	Monetary Amount	M	R	1/18	Required
		Description: Monetary amount				
		Industry: Patient Amount Paid				

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. Required when CLM05-3 (Claim Submission Reason code) = "6", "7" or "8" and the payer has assigned a payer number to the claim. The resubmission number is assigned to a previously submitted claim/encounter by the destination payer or receiver.
2. This segment can be used for the payer assigned Original Document Control Number/Internal Control Number (DCN/ICN) assigned to this claim by the payer identified in the 2010BB loop of this claim. This number would be received from a payer in a case where the payer had received the original claim and for whatever reason, had (1) asked the provider to resubmit the claim and (2) had given the provider the payer's claim identification number so that the payer can match it in their adjudication system. By matching this number in the adjudication system, the payer knows this is not a duplicate claim. This information is specific to the destination payer reported in the 2010BB loop. If other payers have a similar number, report that information in the 2330 loop which holds that payer's information.

Example:

REF*F8*R555588~

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			
		F8	Original Reference Number			
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: Claim Original Reference Number						
NYS MEDICAID NOTE: NYSDOH expects to receive the previous CRN number to replace or void a previously paid claim.						

REF Prior Authorization or Referral Number

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

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

Notes:

1. Numbers at this position apply to the entire claim unless they are overridden in the REF segment in Loop ID-2400. A reference identification is considered to be overridden if the value in REF01 is the same in both the Loop ID-2300 REF segment and the Loop ID-2400 REF segment. In that case, the Loop ID-2400 REF applies only to that specific line.
2. Required where services on this claim were preauthorized or where a referral is involved. Generally, preauthorization/referral numbers are those numbers assigned by the payer/UMO to authorize a service prior to its being performed. The referral or prior authorization number carried in this REF is specific to the destination payer reported in the 2010BB loop. If other payers have similar numbers for this claim, report that information in the 2330 loop REF which holds that payer's information.
3. This segment should not be used for Predetermination of Benefits.

Example:

REF*9F*12345~

NYS MEDICAID NOTE:

NYSDOH expects to receive the Prior Approval Number whenever it is assigned.

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 to receive 'G1', if a Prior Approval Number has been assigned to this service.	M	ID	2/3	Required
		Code Name G1 Prior Authorization Number Description: An authorization number acquired prior to the submission of a claim				
REF02	127	Reference Identification Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier Industry: Referral Number NYS MEDICAID NOTE: NYSDOH expects to receive the eleven-digit Prior Approval Number assigned to this service. HIPAA IG Note: If applicable, enter Prior Authorization Number.	C	AN	1/30	Required

NM1 Referring Provider Name

Pos: 250	Max: 1
Detail - Optional	
Loop: 2310A	Elements: 8

User Option (Usage): Situational

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

Notes:

1. When there is only one referral on the claim, use "DN - Referring Provider". When more than one referral exists and there is a requirement to report the additional referral, use code "DN" in the first iteration of this loop to indicate the referral received by the rendering provider on this claim. Use code "P3 - Primary Care Provider" in the second iteration of the loop to indicate the initial referral from the primary care provider or whatever provider wrote the initial referral for this patient's episode of care being billed/reported in this transaction.
2. Because the usage of this segment is "situational" this is not a syntatically required loop. If the loop is used, then it is a "required" segment. See Appendix A for further details on ASC X12 nomenclature X12 syntax rules.
3. Required if claim involved a referral.

Example:

NM1*DN*1*SWANSON*HARRY****24*123123123~

NYS MEDICAID NOTE:

NYSDOH will accept and capture the National Provider Identifier (NPI) in this location.

After the eMedNY NPI implementation date NYSDOH will only require the NPI of the Referring Provider when known. The Referring Provider's NYS Medicaid ID or License Number will be accepted if the NPI is not known or if the Referring Provider does not have an NPI.

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												
<p>Description: Code identifying an organizational entity, a physical location, property or an individual</p> <p>NYS MEDICAID NOTE: NYSDOH expects to receive 'DN' or 'P3' to indicate the Referring Provider ID or Primary Care Physician ID, respectively, is entered in REF02.</p> <p>HIPAA IG Note: The entity identifier in NM101 applies to all segments in Loop ID-2310.</p> <table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>DN</td> <td>Referring Provider</td> </tr> <tr> <td colspan="2">Use on first iteration of this loop. Use if loop is used only once.</td> </tr> <tr> <td>P3</td> <td>Primary Care Provider</td> </tr> <tr> <td colspan="2">Description: Physician that is selected by the insured to provide medical care</td> </tr> <tr> <td colspan="2">Use only if loop is used twice. Use only on second iteration of this loop.</td> </tr> </tbody> </table>							<u>Code</u>	<u>Name</u>	DN	Referring Provider	Use on first iteration of this loop. Use if loop is used only once.		P3	Primary Care Provider	Description: Physician that is selected by the insured to provide medical care		Use only if loop is used twice. Use only on second iteration of this loop.	
<u>Code</u>	<u>Name</u>																	
DN	Referring Provider																	
Use on first iteration of this loop. Use if loop is used only once.																		
P3	Primary Care Provider																	
Description: Physician that is selected by the insured to provide medical care																		
Use only if loop is used twice. Use only on second iteration of this loop.																		
NM102	1065	Entity Type Qualifier	M	ID	1/1	Required												
<p>Description: Code qualifying the type of entity</p> <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						
<u>Code</u>	<u>Name</u>																	
1	Person																	
2	Non-Person Entity																	
NM103	1035	Name Last or Organization Name	O	AN	1/35	Required												
<p>Description: Individual last name or organizational name</p> <p>Industry: Referring Provider Last Name</p>																		
NM104	1036	Name First	O	AN	1/25	Situational												
<p>Description: Individual first name</p> <p>Industry: Referring Provider First Name</p> <p>HIPAA IG Note: Required if NM102 = 1 (person).</p>																		

NM105	1037	Name Middle Description: Individual middle name or initial Industry: Referring Provider Middle Name HIPAA IG Note: Required if NM102 = 1 and the middle name/initial of the person is known.	O	AN	1/25	Situational								
NM107	1039	Name Suffix Description: Suffix to individual name Industry: Referring Provider Name Suffix HIPAA IG Note: Required if known.	O	AN	1/10	Situational								
NM108	66	Identification Code Qualifier Description: Code designating the system/method of code structure used for Identification Code (67) HIPAA IG Note: Required if the Employer's Identification Number, Social Security Number or National Provider Identifier is known. <table border="1"> <thead> <tr> <th>Code</th> <th>Name</th> </tr> </thead> <tbody> <tr> <td>24</td> <td>Employer's Identification Number</td> </tr> <tr> <td>34</td> <td>Social Security Number</td> </tr> <tr> <td>XX</td> <td>Health Care Financing Administration National Provider Identifier</td> </tr> </tbody> </table> Description: Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.	Code	Name	24	Employer's Identification Number	34	Social Security Number	XX	Health Care Financing Administration National Provider Identifier	C	ID	1/2	Situational
Code	Name													
24	Employer's Identification Number													
34	Social Security Number													
XX	Health Care Financing Administration National Provider Identifier													
NM109	67	Identification Code Description: Code identifying a party or other code Industry: Referring Provider Identifier NYS MEDICAID NOTE: NYSDOH expects to receive the NPI here, when NM108 contains a qualifier of 'XX'. HIPAA IG Note: Required if the Employer's Identification Number, Social Security Number or National Provider Identifier is known. Referring Provider Primary Identification Number ExternalCodeList Name: 537 Description: Health Care Financing Administration National Provider Identifier	C	AN	2/80	Situational								

REF Referring Provider Secondary Identification

Pos: 271	Max: 4
Detail - Optional	
Loop: 2310A	Elements: 2

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

Notes:

1. Required if NM108/NM109 in this loop is not used or if a secondary number is necessary to identify the provider. Until the NPI is mandated for use, this REF may be required if necessary to adjudicate the claim.

Example:

REF*0B*123123311~

NYS MEDICAID NOTE:

Prior to the eMedNY NPI implementation, NYSDOH expects the Referring Provider Secondary Identification REF segment populated with:

- a qualifier of '1D' (Medicaid Provider Number) in REF01 and the NYS Medicaid Provider ID consisting of eight numeric characters in REF02;
- or a qualifier of '0B' (State License Number) in REF01 and eleven characters in REF02. A State License Number must be preceded by the three-character Profession Code and in most cases, two zeros (exceptions exist for nurses, midwives, and eye-care providers with prescribing privilege). Refer to the 'License Type to Profession Code Mapping' document on nyhipaadesk.com for more information about using a license to identify a medical provider.

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 to receive '0B' to indicate the Referring Provider ID entered in REF02 is a State License Number, preceded by a three-character Profession Code, or '1D' to indicate the NYS Medicaid Provider ID is entered in REF02.</p> <table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>0B</td> <td>State License Number</td> </tr> <tr> <td>1D</td> <td>Medicaid Provider Number</td> </tr> <tr> <td>EI</td> <td>Employer's Identification Number</td> </tr> <tr> <td>SY</td> <td>Social Security Number</td> </tr> </tbody> </table> <p>The Social Security Number may not be used for Medicare.</p>							<u>Code</u>	<u>Name</u>	0B	State License Number	1D	Medicaid Provider Number	EI	Employer's Identification Number	SY	Social Security Number
<u>Code</u>	<u>Name</u>															
0B	State License Number															
1D	Medicaid Provider Number															
EI	Employer's Identification Number															
SY	Social Security Number															
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: Referring Provider Secondary Identifier</p> <p>NYS MEDICAID NOTE: NYSDOH expects to receive the State License Number or the NYS Medicaid Provider ID. If the State License Number is submitted, the three-character Profession Code must precede it.</p>																

NM1 Rendering Provider Name

Pos: 250	Max: 1
Detail - Optional	
Loop: 2310B	Elements: 8

User Option (Usage): Situational

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

Notes:

- Information in the Loop ID-2310 applies to the entire claim unless overridden on a service line by the presence of loop ID-2420 with the same value in the NM101.
- Because the usage of this segment is "situational" this is not a syntactically required loop. If the loop is used, then it is a "required" segment. See Appendix A for further details on ASC X12 nomenclature X12 syntax rules.
- Required when the Rendering Provider NM1 information is different than that carried in either the Billing Provider NM1 or the Pay-to Provider NM1 in the 2010AA/AB loops.

Example:

NM1*82*1*SMITH*BRAD****34*123456789~

NYS MEDICAID NOTE:

NYSDOH will accept and capture the National Provider Identifier (NPI) in NM109 of this segment.

After the NYSDOH implementation date the NPI will be the only permissible provider identifier in this location except for non-health care providers. The NYS Medicaid Provider ID and License Number will be disallowed.

If the Rendering Provider loop is submitted with a NYS Medicaid Provider ID in REF02, the three-digit Location Code must also be submitted if it is different from the Location Code in loop 2010AA.

By default, if the Rendering Provider loop is submitted it will be processed as the Servicing Provider.

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 HIPAA IG Note: The entity identifier in NM101 applies to all segments in Loop ID-2310.	M	ID	2/3	Required
		Code Name 82 Rendering Provider				
NM102	1065	Entity Type Qualifier Description: Code qualifying the type of entity	M	ID	1/1	Required
		Code Name 1 Person 2 Non-Person Entity				
NM103	1035	Name Last or Organization Name Description: Individual last name or organizational name Industry: Rendering Provider Last or Organization Name Alias: Rendering Provider Last Name	O	AN	1/35	Required
NM104	1036	Name First Description: Individual first name Industry: Rendering Provider First Name HIPAA IG Note: Required if NM102 = 1 (person).	O	AN	1/25	Situational
NM105	1037	Name Middle Description: Individual middle name or initial Industry: Rendering Provider Middle Name HIPAA IG Note: Required when middle	O	AN	1/25	Situational

		name/initial of person is known.												
NM107	1039	<p>Name Suffix</p> <p>Description: Suffix to individual name Industry: Rendering Provider Name Suffix HIPAA IG Note: Required if known.</p>	O	AN	1/10	Situational								
NM108	66	<p>Identification Code Qualifier</p> <p>Description: Code designating the system/method of code structure used for Identification Code (67)</p> <table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>24</td> <td>Employer's Identification Number</td> </tr> <tr> <td>34</td> <td>Social Security Number</td> </tr> <tr> <td>XX</td> <td>Health Care Financing Administration National Provider Identifier</td> </tr> </tbody> </table> <p>Description: Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.</p>	<u>Code</u>	<u>Name</u>	24	Employer's Identification Number	34	Social Security Number	XX	Health Care Financing Administration National Provider Identifier	C	ID	1/2	Required
<u>Code</u>	<u>Name</u>													
24	Employer's Identification Number													
34	Social Security Number													
XX	Health Care Financing Administration National Provider Identifier													
NM109	67	<p>Identification Code</p> <p>Description: Code identifying a party or other code Industry: Rendering Provider Identifier NYS MEDICAID NOTE: NYSDOH expects to receive the NPI here, when NM108 contains a qualifier of 'XX'. HIPAA IG Note: NSF Reference: FA0-58.0, FA0-57.0 crosswalk is only used in Medicare COB payer-to-payer claims.</p> <p>ExternalCodeList Name: 537 Description: Health Care Financing Administration National Provider Identifier</p>	C	AN	2/80	Required								

REF Rendering Provider Secondary Identification

Pos: 271	Max: 5
Detail - Optional	
Loop: 2310B	Elements: 2

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

Notes:

1. Use this REF segment only if a second number is necessary to identify the provider. The primary identification number should be contained in the NM109.

Example:

REF*0B*12312321~

NYS MEDICAID NOTE:

Prior to the eMedNY NPI implementation, when the Rendering Provider is not the Billing Provider the Rendering Provider Secondary Identification REF segment should be sent with:

- a qualifier of '1D' (Medicaid Provider Number) in REF01 and the NYS Medicaid Provider ID consisting of eight numeric characters in REF02;
- or a qualifier of '0B' (State License Number) in REF01 and eleven characters in REF02. A State License Number must be preceded by the three-character Profession Code and in most cases, two zeros (exceptions exist for nurses, midwives, and eye-care providers with prescribing privilege). Refer to the 'License Type to Profession Code Mapping' document on nyhipadesk.com for more information about using a license to identify a medical provider;
- an iteration of the Rendering Provider Secondary Identification REF segment should also be sent with REF01='LU' and the three-digit Location Number (Locator Code) in REF02, only if different from the Location Number sent in the Billing Provider Name loop (loop 2010AA).

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 to receive '0B' to indicate the Rendering Physician's ID entered in REF02 is a State License Number, preceded by a three-character Profession Code, or '1D' to indicate the NYS Medicaid Provider ID is entered in REF02.	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>0B</td> <td>State License Number</td> </tr> <tr> <td>1D</td> <td>Medicaid Provider Number</td> </tr> <tr> <td>EI</td> <td>Employer's Identification Number</td> </tr> <tr> <td>LU</td> <td>Location Number</td> </tr> <tr> <td>SY</td> <td>Social Security Number</td> </tr> </tbody> </table> <p>The Social Security Number may not be used for Medicare.</p>	<u>Code</u>	<u>Name</u>	0B	State License Number	1D	Medicaid Provider Number	EI	Employer's Identification Number	LU	Location Number	SY	Social Security Number				
<u>Code</u>	<u>Name</u>																	
0B	State License Number																	
1D	Medicaid Provider Number																	
EI	Employer's Identification Number																	
LU	Location Number																	
SY	Social Security Number																	
REF02	127	Reference Identification Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier Industry: Rendering Provider Secondary Identifier NYS MEDICAID NOTE: NYSDOH expects to receive the NYS Medicaid Provider ID or State License Number, preceded by a three-character Profession Code.	C	AN	1/30	Required												

NM1 Assistant Surgeon Name

Pos: 250	Max: 1
Detail - Optional	
Loop: 2310D	Elements: 8

User Option (Usage): Situational

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

Notes:

- Information in the Loop ID-2310 applies to the entire claim unless overridden on a service line by the presence of loop ID-2420 with the same value in the NM101.
- Because the usage of this segment is "situational" this is not a syntactically required loop. If the loop is used, then it is a "required" segment. See Appendix A for further details on ASC X12 nomenclature and X12 syntax rules.
- Required when the Assistant Surgeon information is needed to facilitate reimbursement of the claim.
- The Assistant Surgeon information must not be used when the Rendering Provider loop (Loop ID-2310B) is also present for the claim.

Example:

NM1*DD*1*SMITH*JOHN*S***34*123456789~

NYS MEDICAID NOTE:

NYSDOH will accept and capture the National Provider Identifier (NPI) in this location.

After the eMEdNY NPI implementation date the NPI will be the only permissible provider identifier in this location other than for non-healthcare providers. The NYS Medicaid Provider ID and License Number will be disallowed.

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 HIPAA IG Note: The entity identifier in NM101 applies to all segments in Loop ID-2310. <table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>DD</td> <td>Assistant Surgeon</td> </tr> </tbody> </table>	<u>Code</u>	<u>Name</u>	DD	Assistant Surgeon	M	ID	2/3	Required		
<u>Code</u>	<u>Name</u>											
DD	Assistant Surgeon											
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: Assistant Last or Organization Name Alias: Assistant Surgeon Last Name	O	AN	1/35	Required						
NM104	1036	Name First Description: Individual first name Industry: Assistant Surgeon First Name HIPAA IG Note: Required if NM102 = 1 (person).	O	AN	1/25	Situational						
NM105	1037	Name Middle Description: Individual middle name or initial Industry: Assistant Surgeon Middle Name HIPAA IG Note: Required when middle name/initial of person is known.	O	AN	1/25	Situational						
NM107	1039	Name Suffix Description: Suffix to individual name Industry: Assistant Surgeon Name Suffix	O	AN	1/10	Situational						

HIPAA IG Note: Required if known.

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

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

<u>Code</u>	<u>Name</u>
24	Employer's Identification Number
34	Social Security Number
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: Assistant Surgeon Identifier
Alias: Assistant Surgeon's Primary Identification Number

NYS MEDICAID NOTE: NYSDOH expects to receive the NPI here, when NM108 contains a qualifier of 'XX'.

ExternalCodeList

Name: 537

Description: Health Care Financing Administration National Provider Identifier

REF Assistant Surgeon Secondary Identification

Pos: 271	Max: 4
Detail - Optional	
Loop: 2310D	Elements: 2

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

Notes:

1. Use this REF segment only if a second number is necessary to identify the provider. The primary identification number should be contained in the NM109.

Example:

REF*0B*12345~

NYS MEDICAID NOTE:

Prior to the eMedNY NPI implementation date, when Loop 2310D is sent, NYSDOH expects to receive the Assistant Surgeon Secondary Identification REF segment populated with:

- a qualifier of '1D' (Medicaid Provider Number) in REF01 and the NYS Medicaid Provider ID consisting of eight numeric characters in REF02;

- or a qualifier of '0B' (State License Number) in REF01 and eleven characters in REF02. A State License Number must be preceded by the three-character Profession Code and two zeros. Refer to the 'License Type to Profession Code Mapping' document on nyhipaadesk.com for more information about using a license to identify a provider;

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 to receive '0B' to indicate the Assistant Surgeon's ID entered in REF02 is a State License Number, preceded by a three-character Profession Code, or '1D' to indicate the NYS Medicaid Provider ID is entered in REF02.</p> <table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>0B</td> <td>State License Number</td> </tr> <tr> <td>1D</td> <td>Medicaid Provider Number</td> </tr> <tr> <td>EI</td> <td>Employer's Identification Number</td> </tr> <tr> <td>SY</td> <td>Social Security Number</td> </tr> </tbody> </table>							<u>Code</u>	<u>Name</u>	0B	State License Number	1D	Medicaid Provider Number	EI	Employer's Identification Number	SY	Social Security Number
<u>Code</u>	<u>Name</u>															
0B	State License Number															
1D	Medicaid Provider Number															
EI	Employer's Identification Number															
SY	Social Security Number															
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: Assistant Surgeon Secondary Identifier</p> <p>Alias: Assistant Surgeon Secondary Identification Number</p>																

SBR Other Subscriber Information

Pos: 290	Max: 1
Detail - Optional	
Loop: 2320	Elements: 5

User Option (Usage): Situational

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

Notes:

1. Required if other payers are known to potentially be involved in paying on this claim.
2. Because the usage of this segment is "situational" this is not a syntatically required loop. If the loop is used, then it is a "required" segment. See Appendix A for further details on ASC X12 nomenclature X12 syntax rules.
3. All information contained in the 2320 loop applies only to the payer who is identified in the 2330B Loop of this iteration of the 2320 loop. It is specific only to that payer. If information on additional payers is needed to be carried, run the 2320 loop again with its respective 2330 loops.

Example:

SBR*P*01*003450*GOLDEN PLUS*****CI~

NYS MEDICAID NOTE:

NYSDOH will process this information when provided.

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage																				
SBR01	1138	Payer Responsibility Sequence Number Code Description: Code identifying the insurance carrier's level of responsibility for a payment of a claim NYS MEDICAID NOTE: If multiple payers exist, NYSDOH expects to receive P for the Primary, S for the Secondary, and T for all others. Only one can be listed as Primary and one as Secondary. In the case where a claim was paid by two prior payers the provider must designate one as Primary and the other as Secondary. If other payers exist, they should be listed as Tertiary.	M	ID	1/1	Required																				
		<table border="1"> <thead> <tr> <th>Code</th> <th>Name</th> </tr> </thead> <tbody> <tr> <td>P</td> <td>Primary</td> </tr> <tr> <td>S</td> <td>Secondary</td> </tr> <tr> <td>T</td> <td>Tertiary</td> </tr> </tbody> </table>	Code	Name	P	Primary	S	Secondary	T	Tertiary																
Code	Name																									
P	Primary																									
S	Secondary																									
T	Tertiary																									
SBR02	1069	Individual Relationship Code Description: Code indicating the relationship between two individuals or entities HIPAA IG Note: Use this code to specify the relationship to the person insured.	O	ID	2/2	Required																				
		<table border="1"> <thead> <tr> <th>Code</th> <th>Name</th> </tr> </thead> <tbody> <tr> <td>01</td> <td>Spouse</td> </tr> <tr> <td>18</td> <td>Self</td> </tr> <tr> <td>19</td> <td>Child</td> </tr> <tr> <td></td> <td>Description: Dependent between the ages of 0 and 19; age qualifications may vary depending on policy</td> </tr> <tr> <td>20</td> <td>Employee</td> </tr> <tr> <td>21</td> <td>Unknown</td> </tr> <tr> <td>22</td> <td>Handicapped Dependent</td> </tr> <tr> <td>29</td> <td>Significant Other</td> </tr> <tr> <td>76</td> <td>Dependent</td> </tr> </tbody> </table>	Code	Name	01	Spouse	18	Self	19	Child		Description: Dependent between the ages of 0 and 19; age qualifications may vary depending on policy	20	Employee	21	Unknown	22	Handicapped Dependent	29	Significant Other	76	Dependent				
Code	Name																									
01	Spouse																									
18	Self																									
19	Child																									
	Description: Dependent between the ages of 0 and 19; age qualifications may vary depending on policy																									
20	Employee																									
21	Unknown																									
22	Handicapped Dependent																									
29	Significant Other																									
76	Dependent																									
SBR03	127	Reference Identification Description: Reference information as defined for a particular Transaction Set or as specified by	O	AN	1/30	Situational																				

the Reference Identification Qualifier
Industry: Insured Group or Policy Number
HIPAA IG Note: Required if the subscriber's payer identification includes Group or Plan Number. This data element is intended to carry the subscriber's Group Number, not the number that uniquely identifies the subscriber (Subscriber ID, Loop 2010BA-NM109).

SBR04	93	Name	O	AN	1/60	Situational
Description: Free-form name Industry: Policy Name Alias: Plan Name HIPAA IG Note: Required if the Subscriber's payer identification includes Plan Name.						

SBR09	1032	Claim Filing Indicator Code	O	ID	1/2	Situational
Description: Code identifying type of claim NYS MEDICAID NOTE: If the payer reported in an iteration of loop 2320 is a Medicare HMO the value in SBR09 must be '16'. HIPAA IG Note: Required prior to mandated use of PlanID. Not used after PlanID is mandated.						

<u>Code</u>	<u>Name</u>
09	Self-pay
11	Other Non-Federal Programs
12	Preferred Provider Organization (PPO)
13	Point of Service (POS)
14	Exclusive Provider Organization (EPO)
15	Indemnity Insurance
16	Health Maintenance Organization (HMO) Medicare Risk
17	Dental Maintenance Organization
BL	Blue Cross/Blue Shield
CH	Champus
CI	Commercial Insurance Co.
DS	Disability
FI	Federal Employees Program
HM	Health Maintenance Organization
LM	Liability Medical
MB	Medicare Part B
MC	Medicaid
MH	Managed Care Non-HMO
OF	Other Federal Program
SA	Self-administered Group
VA	Veteran Administration Plan
	Refers to Veteran's Affairs Plan.
WC	Workers' Compensation Health Claim
ZZ	Mutually Defined
	Unknown

CAS Claim Adjustment

Pos: 295	Max: 5
Detail - Optional	
Loop: 2320	Elements: 19

User Option (Usage): Situational

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

Notes:

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

Example:

CAS*PR*1*793~
CAS*OA*93*15.06~

NYS MEDICAID NOTE:

NYSDOH will process Medicare or other insurance information as received by the submitter in a remittance advice.

Any adjustment amount from one adjustment should be reported only once. Do not repeat a claim-level adjustment at the line level. Also do not report the total of the line-level adjustments in a claim-level CAS segment.

When amounts from distinct claim level and line level adjustments are reported balancing should be done at both the line level (line charge minus total of line level CAS amounts equals paid) and claim level (claim total charge minus total CAS amounts from both claim and line level equals claim level paid).

Refer to the 837 Dental Supplemental Companion Guide, Section 6. "CAS Segment: Claim Level and Line Level Balancing" and Section 7. "Coinsurance and Deductibles" for more information on NYSDOH's requirements and uses of this segment.

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>
CAS01	1033	Claim Adjustment Group Code	M	ID	1/2	Required
Description: Code identifying the general category of payment adjustment						
	<u>Code</u>	<u>Name</u>				
	CO	Contractual Obligations				
	CR	Correction and Reversals				
	OA	Other adjustments				
	PI	Payor Initiated Reductions				
	PR	Patient Responsibility				

CAS02	1034	Claim Adjustment Reason Code Description: Code identifying the detailed reason the adjustment was made Industry: Adjustment Reason Code <u>ExternalCodeList</u> Name: 139 Description: Claim Adjustment Reason Code	M	ID	1/5	Required
CAS03	782	Monetary Amount Description: Monetary amount Industry: Adjustment Amount	M	R	1/18	Required
CAS04	380	Quantity Description: Numeric value of quantity Industry: Adjustment Quantity HIPAA IG Note: Used as needed to show payer adjustments.	O	R	1/15	Situational
CAS05	1034	Claim Adjustment Reason Code Description: Code identifying the detailed reason the adjustment was made Industry: Adjustment Reason Code HIPAA IG Note: Used as needed to show payer adjustments. <u>ExternalCodeList</u> Name: 139 Description: Claim Adjustment Reason Code	C	ID	1/5	Situational
CAS06	782	Monetary Amount Description: Monetary amount Industry: Adjustment Amount HIPAA IG Note: Used as needed to show payer adjustments.	C	R	1/18	Situational
CAS07	380	Quantity Description: Numeric value of quantity Industry: Adjustment Quantity HIPAA IG Note: Used as needed to show payer adjustments.	C	R	1/15	Situational
CAS08	1034	Claim Adjustment Reason Code Description: Code identifying the detailed reason the adjustment was made Industry: Adjustment Reason Code HIPAA IG Note: Used as needed to show payer adjustments. <u>ExternalCodeList</u> Name: 139 Description: Claim Adjustment Reason Code	C	ID	1/5	Situational
CAS09	782	Monetary Amount Description: Monetary amount Industry: Adjustment Amount HIPAA IG Note: Used as needed to show payer adjustments.	C	R	1/18	Situational
CAS10	380	Quantity Description: Numeric value of quantity Industry: Adjustment Quantity HIPAA IG Note: Used as needed to show payer adjustments.	C	R	1/15	Situational

CAS11	1034	<p>Claim Adjustment Reason Code</p> <p>Description: Code identifying the detailed reason the adjustment was made</p> <p>Industry: Adjustment Reason Code</p> <p>HIPAA IG Note: Used as needed to show payer adjustments.</p> <p><u>ExternalCodeList</u></p> <p>Name: 139</p> <p>Description: Claim Adjustment Reason Code</p>	C	ID	1/5	Situational
CAS12	782	<p>Monetary Amount</p> <p>Description: Monetary amount</p> <p>Industry: Adjustment Amount</p> <p>HIPAA IG Note: Used as needed to show payer adjustments.</p>	C	R	1/18	Situational
CAS13	380	<p>Quantity</p> <p>Description: Numeric value of quantity</p> <p>Industry: Adjustment Quantity</p> <p>HIPAA IG Note: Used as needed to show payer adjustments.</p>	C	R	1/15	Situational
CAS14	1034	<p>Claim Adjustment Reason Code</p> <p>Description: Code identifying the detailed reason the adjustment was made</p> <p>Industry: Adjustment Reason Code</p> <p>HIPAA IG Note: Used as needed to show payer adjustments.</p> <p><u>ExternalCodeList</u></p> <p>Name: 139</p> <p>Description: Claim Adjustment Reason Code</p>	C	ID	1/5	Situational
CAS15	782	<p>Monetary Amount</p> <p>Description: Monetary amount</p> <p>Industry: Adjustment Amount</p> <p>HIPAA IG Note: Used as needed to show payer adjustments.</p>	C	R	1/18	Situational
CAS16	380	<p>Quantity</p> <p>Description: Numeric value of quantity</p> <p>Industry: Adjustment Quantity</p> <p>HIPAA IG Note: Used as needed to show payer adjustments.</p>	C	R	1/15	Situational
CAS17	1034	<p>Claim Adjustment Reason Code</p> <p>Description: Code identifying the detailed reason the adjustment was made</p> <p>Industry: Adjustment Reason Code</p> <p>HIPAA IG Note: Used as needed to show payer adjustments.</p> <p><u>ExternalCodeList</u></p> <p>Name: 139</p> <p>Description: Claim Adjustment Reason Code</p>	C	ID	1/5	Situational
CAS18	782	<p>Monetary Amount</p> <p>Description: Monetary amount</p> <p>Industry: Adjustment Amount</p> <p>HIPAA IG Note: Used as needed to show payer adjustments.</p>	C	R	1/18	Situational
CAS19	380	<p>Quantity</p> <p>Description: Numeric value of quantity</p>	C	R	1/15	Situational

Industry: Adjustment Quantity
HIPAA IG Note: Used as needed to show payer adjustments.

AMT Coordination of Benefits (COB) Payer Paid Amount

Pos: 300	Max: 1
Detail - Optional	
Loop: 2320	Elements: 2

User Option (Usage): Situational

Purpose: To indicate the total monetary amount

Notes:

1. Required if claim has been adjudicated by payer identified in this loop. It is acceptable to show "0" amount paid.

Example:

AMT*D*411~

NYS MEDICAID NOTE:

NYSDOH will process prior payer insurance information as received by the submitter in a Remittance Advice.

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 Description: Code to qualify amount	M	ID	1/3	Required
		Code Name D Payor Amount Paid				
AMT02	782	Monetary Amount Description: Monetary amount Industry: Payer Paid Amount HIPAA IG Note: This amount is a crosswalk from CLP04 in the 835 when doing COB.	M	R	1/18	Required

AMT

Coordination of Benefits (COB) Patient Responsibility Amount

Pos: 300	Max: 1
Detail - Optional	
Loop: 2320	Elements: 2

User Option (Usage): Situational

Purpose: To indicate the total monetary amount

Notes:

1. Required if patient is responsible for payment according to another payer's adjudication. This is the amount of money which is the responsibility of the patient according to the payer identified in this loop (2330B NM1).

Example:

AMT*F2*15~

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>
AMT01	522	Amount Qualifier Code	M	ID	1/3	Required
Description: Code to qualify amount						
		<u>Code</u>		<u>Name</u>		
		F2		Patient Responsibility - Actual		
Description: Calculated value one receiving medical care is obliged to pay						
AMT02	782	Monetary Amount	M	R	1/18	Required
Description: Monetary amount						
Industry: Patient Responsibility Amount						
HIPAA IG Note: This amount is a crosswalk from CLP05 in the 835 when doing COB.						

AMT Coordination of Benefits (COB) Patient Paid Amount

Pos: 300	Max: 1
Detail - Optional	
Loop: 2320	Elements: 2

User Option (Usage): Situational
Purpose: To indicate the total monetary amount

Notes:

1. Required if claim has been adjudicated by the payer identified in this loop and if this information was included in the remittance advice reporting those adjudication results.
2. The amount carried in this segment is the total amount of money paid by the payer to the patient (rather than to the provider) on this claim.

Example:

AMT*F5*15~

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>
AMT01	522	Amount Qualifier Code	M	ID	1/3	Required
		Description: Code to qualify amount				
		<u>Code</u>		<u>Name</u>		
		F5		Patient Amount Paid		
		Description: Monetary amount value already paid by one receiving medical care				
AMT02	782	Monetary Amount	M	R	1/18	Required
		Description: Monetary amount				
		Industry: Other Payer Patient Paid Amount				
		HIPAA IG Note: This amount is a crosswalk from AMT in the 835 (Loop CLP, position 062) when AMT01 = F5.				

OI Other Insurance Coverage Information

Pos: 310	Max: 1
Detail - Optional	
Loop: 2320	Elements: 2

User Option (Usage): Situational

Purpose: To specify information associated with other health insurance coverage

Notes:

1. All information contained in the OI segment applies only to the payer who is identified in the 2330B loop of this iteration of the 2320 loop. It is specific only to that payer.

Example:

OI***Y***Y~

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>						
OI03	1073	Yes/No Condition or Response Code Description: Code indicating a Yes or No condition or response Industry: Benefits Assignment Certification Indicator HIPAA IG Note: This code is a crosswalk from CLM08 when doing COB.	O	ID	1/1	Required						
		<table border="0"> <tr> <td><u>Code</u></td> <td><u>Name</u></td> </tr> <tr> <td>N</td> <td>No</td> </tr> <tr> <td>Y</td> <td>Yes</td> </tr> </table>	<u>Code</u>	<u>Name</u>	N	No	Y	Yes				
<u>Code</u>	<u>Name</u>											
N	No											
Y	Yes											
OI06	1363	Release of Information Code Description: Code indicating whether the provider has on file a signed statement by the patient authorizing the release of medical data to other organizations Alias: Release of Information HIPAA IG Note: This code is a crosswalk from CLM09 when doing COB.	O	ID	1/1	Required						
		<table border="0"> <tr> <td><u>Code</u></td> <td><u>Name</u></td> </tr> <tr> <td>N</td> <td>No, Provider is Not Allowed to Release Data</td> </tr> <tr> <td>Y</td> <td>Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim</td> </tr> </table>	<u>Code</u>	<u>Name</u>	N	No, Provider is Not Allowed to Release Data	Y	Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim				
<u>Code</u>	<u>Name</u>											
N	No, Provider is Not Allowed to Release Data											
Y	Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim											

NM1 Other Subscriber Name

Pos: 325	Max: 1
Detail - Optional	
Loop: 2330A	Elements: 8

User Option (Usage): Situational

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

Notes:

1. Submitters are required to send information on all known other subscribers in Loop ID-2330.
2. The 2330A loop is required when Loop ID-2320 - Other Subscriber Information, is used. Otherwise, the loop is not used.

Example:

NM1*IL*1*DOE*JOHN*T**JR*MI*333224444~

NYS MEDICAID NOTE:

NYSDOH will process Medicare or other insurance information received by the submitter on a Remittance Advice.

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>IL</td> <td>Insured or Subscriber</td> </tr> </table>	<u>Code</u>	<u>Name</u>	IL	Insured or Subscriber	M	ID	2/3	Required		
<u>Code</u>	<u>Name</u>											
IL	Insured or Subscriber											
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: Other Insured Last Name Alias: Other Insured's Last Name	O	AN	1/35	Required						
NM104	1036	Name First Description: Individual first name Industry: Other Insured First Name Alias: Other Insured's First Name	O	AN	1/25	Required						
NM105	1037	Name Middle Description: Individual middle name or initial Industry: Other Insured Middle Name Alias: Other Insured's Middle Name HIPAA IG Note: Required if NM102 = 1 and the middle name/initial of the person is known.	O	AN	1/25	Situational						
NM107	1039	Name Suffix Description: Suffix to individual name Industry: Other Insured Name Suffix Alias: Other Insured's Generation HIPAA IG Note: Examples: I, II, III, IV, Jr, Sr Required if known.	O	AN	1/10	Situational						
NM108	66	Identification Code Qualifier Description: Code designating the system/method of code structure used for Identification Code (67)	C	ID	1/2	Required						

Code	Name
24	Employer's Identification Number
MI	Member Identification Number
ZZ	Mutually Defined

The value "ZZ", when used in this data element shall be defined as "HIPAA Individual Identifier" once this identifier has been adopted. Under the Health Insurance Portability and Accountability Act of 1996, the Secretary of the Department of Health and Human Services must adopt a standard individual identifier for use in this transaction.

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

Description: Code identifying a party or other code

Industry: Other Insured Identifier

Alias: Other Insured's Identification Number

NM1 Other Payer Name

Pos: 325	Max: 1
Detail - Optional	
Loop: 2330B	Elements: 5

User Option (Usage): Situational

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

Notes:

1. Submitters are required to send all known information on other payers in this loop ID-2330.

Example:

NM1*PR*2*UNION MUTUAL OF OREGON*****XV*43~

NYS MEDICAID NOTE:

NYSDOH will process Medicare or other insurance information received by the submitter on a Remittance Advice.

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: Other Payer Last or Organization Name Alias: Other Payer Name NYS MEDICAID NOTE: NYSDOH expects the Payer Name.	O	AN	1/35	Required				
NM108	66	Identification Code Qualifier Description: Code designating the system/method of code structure used for Identification Code (67) NYS MEDICAID NOTE: NYSDOH expects to receive 'PI'. <table border="0"> <tr> <td><u>Code</u></td> <td><u>Name</u></td> </tr> <tr> <td>PI</td> <td>Payor Identification</td> </tr> </table>	<u>Code</u>	<u>Name</u>	PI	Payor Identification	C	ID	1/2	Required
<u>Code</u>	<u>Name</u>									
PI	Payor Identification									
NM109	67	Identification Code Description: Code identifying a party or other code Industry: Other Payer Primary Identifier Alias: Other Payer Primary Identification Number NYS MEDICAID NOTE: If there are multiple prior payers being identified in the claim, the Identifiers in NM109 must be unique for each one. <u>ExternalCodeList</u> Name: 540 Description: Health Care Financing Administration National PlanID	C	AN	2/80	Required				

DTP

Claim Paid Date

Pos: 350	Max: 1
Detail - Optional	
Loop: 2330B	Elements: 3

User Option (Usage): Situational

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

Notes:

1. This segment is required when Loop ID-2430 (Service Adjudication Information) is not used.

Example:

DTP*573*D8*19991212~

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>
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 573 Date Claim Paid				
DTP02	1250	Date Time Period Format Qualifier Description: Code indicating the date format, time format, or date and time format	M	ID	2/3	Required
		Code Name D8 Date Expressed in Format CCYYMMDD				
DTP03	1251	Date Time Period Description: Expression of a date, a time, or range of dates, times or dates and times Industry: Date Claim Paid	M	AN	1/35	Required

LX Line Counter

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 X12 syntax rules.

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	N0	1/6	Required

Description: Number assigned for differentiation within a transaction set

Alias: Line Counter

HIPAA IG Note: The service line number is incremented by one for each service line.

SV3 Dental Service

Pos: 380	Max: 1
Detail - Optional	
Loop: 2400	Elements: 6

User Option (Usage): Required

Purpose: To specify the claim service detail for dental work

Example:

SV3*AD:D2150*80****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>
SV301	C003	Composite Medical Procedure Identifier Description: To identify a medical procedure by its standardized codes and applicable modifiers	M	Comp		Required
SV301-01	235	Product/Service ID Qualifier Description: Code identifying the type/source of the descriptive number used in Product/Service ID (234) Industry: Product or Service ID Qualifier	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 CDT = Current Dental Terminology				
SV301-02	234	Product/Service ID Description: Identifying number for a product or service Industry: Procedure Code	M	AN	1/48	Required
		ExternalCodeList Name: 135 Description: American Dental Association Codes				
SV301-03	1339	Procedure Modifier Description: This identifies special circumstances related to the performance of the service, as defined by trading partners Alias: Procedure Code Modifier HIPAA IG Note: Use this modifier for the first procedure code modifier. A modifier must be from code source 135 (American Dental Association) found in the 'Code on Dental Procedures and Nomenclature', if such modifier is available.	O	AN	2/2	Situational
SV301-04	1339	Procedure Modifier Description: This identifies special circumstances related to the performance of the service, as defined by trading partners Alias: Procedure Code Modifier HIPAA IG Note: Use this modifier for the second procedure code modifier. A modifier must be from code source 135 (American Dental Association) found in the 'Code on Dental Procedures and Nomenclature', if such modifier is available.	O	AN	2/2	Situational
SV301-05	1339	Procedure Modifier	O	AN	2/2	Situational

SV301-06	1339	<p>Description: This identifies special circumstances related to the performance of the service, as defined by trading partners</p> <p>Alias: Procedure Code Modifier</p> <p>HIPAA IG Note: Use this modifier for the third procedure code modifier. A modifier must be from code source 135 (American Dental Association) found in the 'Code on Dental Procedures and Nomenclature', if such modifier is available.</p>	O	AN	2/2	Situational
SV302	782	<p>Procedure Modifier</p> <p>Description: This identifies special circumstances related to the performance of the service, as defined by trading partners</p> <p>Alias: Procedure Code Modifier</p> <p>HIPAA IG Note: Use this modifier for the fourth procedure code modifier. A modifier must be from code source 135 (American Dental Association) found in the 'Code on Dental Procedures and Nomenclature', if such modifier is available.</p>	O	R	1/18	Required
SV303	1331	<p>Monetary Amount</p> <p>Description: Monetary amount</p> <p>Industry: Line Item Charge Amount</p> <p>Alias: Line Charge Amount</p> <p>HIPAA IG Note: Zero "0" is an acceptable value for this element.</p> <p>Facility Code Value</p> <p>Description: Code identifying the type of facility where services were performed; the first and second positions of the Uniform Bill Type code or the Place of Service code from the Electronic Media Claims National Standard Format</p> <p>Industry: Facility Type Code</p> <p>HIPAA IG Note: Required if the Place of Service is different than the Place of Service reported in the CLM segment in the 2300 loop. Use this element for codes identifying a place of service from code source 237. As a courtesy, the codes are listed below; however, the code list is thought to be complete at the time of publication of this implementation guide. Since this list is subject to change, only codes contained in the document available from code source 237 are to be supported in this transaction and take precedence over any and all codes listed here.</p> <p>11 Office 12 Home 21 Inpatient Hospital 22 Outpatient Hospital 31 Skilled Nursing Facility 35 Adult Living Care Facility</p> <p>ExternalCodeList Name: 237</p> <p>Description: Place of Service from Health Care Financing Administration Claim Form</p>	O	AN	1/2	Situational
SV304	C006	<p>Oral Cavity Designation</p> <p>Description: To identify one or more areas of the oral cavity</p> <p>HIPAA IG Note: Required to report areas of the</p>	O	Comp	Situational	

mouth that are being treated.

SV304-01 1361 Oral Cavity Designation Code M ID 1/3 Required

Description: Code Identifying the area of the oral cavity in which service is rendered

<u>Code</u>	<u>Name</u>
L	Left Description: Refers to the oral and skeletal structures on the left side
R	Right Description: Refers to the oral and skeletal structures on the right side
00	Entire Oral Cavity
01	Maxillary Area
02	Mandibular Area
09	Other Area of Oral Cavity Description: An area specified in an annexed document or further explanation available
10	Upper Right Quadrant
20	Upper Left Quadrant
30	Lower Left Quadrant
40	Lower Right Quadrant

SV304-02 1361 Oral Cavity Designation Code O ID 1/3 Situational

Description: Code Identifying the area of the oral cavity in which service is rendered

HIPAA IG Note: Use this code for the additional oral cavity designation codes. The code values in SV304-1 apply to all occurrences of the oral cavity designation code.

<u>Code</u>	<u>Name</u>
L	Left Description: Refers to the oral and skeletal structures on the left side
R	Right Description: Refers to the oral and skeletal structures on the right side
00	Entire Oral Cavity
01	Maxillary Area
02	Mandibular Area
09	Other Area of Oral Cavity Description: An area specified in an annexed document or further explanation available
10	Upper Right Quadrant
20	Upper Left Quadrant
30	Lower Left Quadrant
40	Lower Right Quadrant

SV304-03 1361 Oral Cavity Designation Code O ID 1/3 Situational

Description: Code Identifying the area of the oral cavity in which service is rendered

HIPAA IG Note: Use this code for the additional oral cavity designation codes. The code values in SV304-1 apply to all occurrences of the oral cavity designation code.

<u>Code</u>	<u>Name</u>
L	Left Description: Refers to the oral and skeletal structures on the left side
R	Right Description: Refers to the oral and skeletal structures on the right side
00	Entire Oral Cavity
01	Maxillary Area
02	Mandibular Area
09	Other Area of Oral Cavity

Description: An area specified in an annexed document or further explanation available
 10 Upper Right Quadrant
 20 Upper Left Quadrant
 30 Lower Left Quadrant
 40 Lower Right Quadrant

SV304-04 1361 **Oral Cavity Designation Code** O ID 1/3 Situational

Description: Code Identifying the area of the oral cavity in which service is rendered
HIPAA IG Note: Use this code for the additional oral cavity designation codes. The code values in SV304-1 apply to all occurrences of the oral cavity designation code.

<u>Code</u>	<u>Name</u>
L	Left Description: Refers to the oral and skeletal structures on the left side
R	Right Description: Refers to the oral and skeletal structures on the right side
00	Entire Oral Cavity
01	Maxillary Area
02	Mandibular Area
09	Other Area of Oral Cavity Description: An area specified in an annexed document or further explanation available
10	Upper Right Quadrant
20	Upper Left Quadrant
30	Lower Left Quadrant
40	Lower Right Quadrant

SV304-05 1361 **Oral Cavity Designation Code** O ID 1/3 Situational

Description: Code Identifying the area of the oral cavity in which service is rendered
HIPAA IG Note: Use this code for the additional oral cavity designation codes. The code values in SV304-1 apply to all occurrences of the oral cavity designation code.

<u>Code</u>	<u>Name</u>
L	Left Description: Refers to the oral and skeletal structures on the left side
R	Right Description: Refers to the oral and skeletal structures on the right side
00	Entire Oral Cavity
01	Maxillary Area
02	Mandibular Area
09	Other Area of Oral Cavity Description: An area specified in an annexed document or further explanation available
10	Upper Right Quadrant
20	Upper Left Quadrant
30	Lower Left Quadrant
40	Lower Right Quadrant

SV305 1358 **Prosthesis, Crown or Inlay Code** O ID 1/1 Situational

Description: Code specifying the placement status for the dental work
Industry: Prosthesis, Crown, or Inlay Code
HIPAA IG Note: Required to indicate the placement status of the prosthetic on this line.

<u>Code</u>	<u>Name</u>
I	Initial Placement

R Replacement

If the SV305 = R, then the DTP segment in the 2400 loop for Prior Placement is Required.

SV306

380

Quantity

O

R

1/15

Required

Description: Numeric value of quantity

Industry: Procedure Count

NYS MEDICAID NOTE: NYSDOH expects quantity to be the number of times the procedure was performed.

HIPAA IG Note: Number of procedures

TOO Tooth Information

Pos: 382	Max: 32
Detail - Optional	
Loop: 2400	Elements: 3

User Option (Usage): Situational

Purpose: To identify a tooth by number and, if applicable, one or more tooth surfaces

Notes:

Required to report tooth number and/or tooth surface related to this procedure line.

Example:

TOO*JP*12*L:O~

NYS MEDICAID NOTE:

NYSDOH requires at least one tooth number to be reported in the TOO segment when a value of '09' is reported as an Oral Cavity Designation Code in SV304-1. The tooth number(s) reported will be used to derive whether the quadrant depicted is the Upper Anterior or Lower Anterior.

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>												
TOO01	1270	Code List Qualifier Code Description: Code identifying a specific industry code list	C	ID	1/3	Required												
		<table border="0"> <tr> <td><u>Code</u></td> <td><u>Name</u></td> </tr> <tr> <td>JP</td> <td>National Standard Tooth Numbering System</td> </tr> </table>	<u>Code</u>	<u>Name</u>	JP	National Standard Tooth Numbering System												
<u>Code</u>	<u>Name</u>																	
JP	National Standard Tooth Numbering System																	
TOO02	1271	Industry Code Description: Code indicating a code from a specific industry code list Industry: Tooth Code Alias: Tooth Number HIPAA IG Note: See Appendix C for code source 135: American Dental Association Codes.	C	AN	1/30	Situational												
		<p>ExternalCodeList Name: 135 Description: American Dental Association Codes</p>																
TOO03	C005	Tooth Surface Description: To identify one or more tooth surface codes NYS MEDICAID NOTE: The Tooth Surface Codes should include values D, L, M, B or F, and I or O. Please note: B and F are mutually exclusive; and also O and I are mutually exclusive (if one of the pair is sent, then the other can not be sent in the same service line). HIPAA IG Note: Required if the procedure code requires tooth surface codes.	O	Comp		Situational												
TOO03-01	1369	Tooth Surface Code Description: Code identifying the area of the tooth that was treated	M	ID	1/2	Required												
		<table border="0"> <tr> <td><u>Code</u></td> <td><u>Name</u></td> <td>Description:</td> </tr> <tr> <td>B</td> <td>Buccal</td> <td>The surface of the tooth which is closest to the cheek</td> </tr> <tr> <td>D</td> <td>Distal</td> <td>The surface of the tooth facing away from an invisible line drawn vertically through the center of the face</td> </tr> <tr> <td>F</td> <td>Facial</td> <td></td> </tr> </table>	<u>Code</u>	<u>Name</u>	Description:	B	Buccal	The surface of the tooth which is closest to the cheek	D	Distal	The surface of the tooth facing away from an invisible line drawn vertically through the center of the face	F	Facial					
<u>Code</u>	<u>Name</u>	Description:																
B	Buccal	The surface of the tooth which is closest to the cheek																
D	Distal	The surface of the tooth facing away from an invisible line drawn vertically through the center of the face																
F	Facial																	

- I **Description:** The surface of a tooth that is directed towards the face
Incisal
- L **Description:** The cutting edges of the anterior teeth
Lingual
- M **Description:** The surface of the tooth that is directed towards the tongue
Mesial
- O **Description:** The surface of a tooth which faces toward an invisible line drawn vertically through the center of the face
Occlusal
- Description:** The surfaces of the posterior (back) teeth which provides the chewing function

TOO03-02 1369 **Tooth Surface Code** O ID 1/2 Situational

Description: Code identifying the area of the tooth that was treated

HIPAA IG Note: Additional tooth surface codes can be carried in TOO03-2 through TOO03-5. The code values are the same as in TOO03-1. Required to report a second tooth surface.

- | <u>Code</u> | <u>Name</u> |
|-------------|---|
| B | Buccal
Description: The surface of the tooth which is closest to the cheek |
| D | Distal
Description: The surface of the tooth facing away from an invisible line drawn vertically through the center of the face |
| F | Facial
Description: The surface of a tooth that is directed towards the face |
| I | Incisal
Description: The cutting edges of the anterior teeth |
| L | Lingual
Description: The surface of the tooth that is directed towards the tongue |
| M | Mesial
Description: The surface of a tooth which faces toward an invisible line drawn vertically through the center of the face |
| O | Occlusal
Description: The surfaces of the posterior (back) teeth which provides the chewing function |

TOO03-03 1369 **Tooth Surface Code** O ID 1/2 Situational

Description: Code identifying the area of the tooth that was treated

HIPAA IG Note: Required to report a third tooth surface.

- | <u>Code</u> | <u>Name</u> |
|-------------|---|
| B | Buccal
Description: The surface of the tooth which is closest to the cheek |
| D | Distal
Description: The surface of the tooth facing away from an invisible line drawn vertically through the center of the face |
| F | Facial
Description: The surface of a tooth that is directed towards the face |
| I | Incisal
Description: The cutting edges of the anterior teeth |
| L | Lingual
Description: The surface of the tooth that is directed towards the tongue |
| M | Mesial
Description: The surface of a tooth which faces toward an invisible line drawn vertically through the center of the face |
| O | Occlusal |

Description: The surfaces of the posterior (back) teeth which provides the chewing function

TOO03-04 1369 **Tooth Surface Code** O ID 1/2 Situational

Description: Code identifying the area of the tooth that was treated

HIPAA IG Note: Required to report a third tooth surface.

<u>Code</u>	<u>Name</u>
B	Buccal Description: The surface of the tooth which is closest to the cheek
D	Distal Description: The surface of the tooth facing away from an invisible line drawn vertically through the center of the face
F	Facial Description: The surface of a tooth that is directed towards the face
I	Incisal Description: The cutting edges of the anterior teeth
L	Lingual Description: The surface of the tooth that is directed towards the tongue
M	Mesial Description: The surface of a tooth which faces toward an invisible line drawn vertically through the center of the face
O	Occlusal Description: The surfaces of the posterior (back) teeth which provides the chewing function

TOO03-05 1369 **Tooth Surface Code** O ID 1/2 Situational

Description: Code identifying the area of the tooth that was treated

HIPAA IG Note: Required to report a third tooth surface.

<u>Code</u>	<u>Name</u>
B	Buccal Description: The surface of the tooth which is closest to the cheek
D	Distal Description: The surface of the tooth facing away from an invisible line drawn vertically through the center of the face
F	Facial Description: The surface of a tooth that is directed towards the face
I	Incisal Description: The cutting edges of the anterior teeth
L	Lingual Description: The surface of the tooth that is directed towards the tongue
M	Mesial Description: The surface of a tooth which faces toward an invisible line drawn vertically through the center of the face
O	Occlusal Description: The surfaces of the posterior (back) teeth which provides the chewing function

DTP Date - Service

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 if the service date is different than the service date reported at the DTP segment in the 2300 loop and the service was performed.

Example:

DTP*472*D8*19980108~

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	M	ID	2/3	Required
		Code Name D8 Date Expressed in Format CCYYMMDD				
DTP03	1251	Date Time Period Description: Expression of a date, a time, or range of dates, times or dates and times Industry: Service Date	M	AN	1/35	Required

REF Prior Authorization or Referral Number

Pos: 470	Max: 2
Detail - Optional	
Loop: 2400	Elements: 2

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

Notes:

1. Required if service line involved a prior authorization number or referral number that is different than the number reported at the claim.
2. This segment should not be used for Predetermination of Benefits.

Example:

REF*9F*123456567~

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 to receive value 'G1'.</p> <table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>G1</td> <td>Prior Authorization Number</td> </tr> </tbody> </table> <p>Description: An authorization number acquired prior to the submission of a claim</p>							<u>Code</u>	<u>Name</u>	G1	Prior Authorization Number
<u>Code</u>	<u>Name</u>									
G1	Prior Authorization Number									
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: Referral Number</p> <p>NYS MEDICAID NOTE: This overrides the value reported in the REF segment in Loop 2300.</p>										

REF	Line Item Control Number	Pos: 470 Max: 1 Detail - Optional Loop: 2400 Elements: 2
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User Option (Usage): Situational
Purpose: To specify identifying information

Notes:

1. Required if it is necessary to send a line control or inventory number. It is strongly suggested that providers send this number, particularly if the provider automatically posts their remittance advice. Payers are required to return this number in the remittance advice transaction (835) if the provider sends it to them in the 837.

Example:

REF*6R*543211~

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				
		<u>Code</u>		<u>Name</u>		
		6R		Provider Control Number		
		Description: Number assigned by information provider company for tracking and billing 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				

NTE

Line Note

Pos: 485	Max: 10
Detail - Optional	
Loop: 2400	Elements: 2

User Option (Usage): Situational

Purpose: To transmit information in a free-form format, if necessary, for comment or special instruction

Notes:

1. Required if the submitter used a "Not Otherwise Classified" (NOC) or a "By Report" procedure code or to report the following information on this service line: Date of Initial Impression, Date of Initial Preparation Crown, Initial Preparation Crown Tooth Number or Initial Endodontic Treatment.

Example:

NTE*ADD*PATIENT IS HANDICAPPED AND REQUIRED BEHAVIORAL MANAGEMENT TO COMPLETE TREATMENT~

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>
NTE01	363	Note Reference Code	O	ID	3/3	Required
		Description: Code identifying the functional area or purpose for which the note applies				
		Code		Name		
		ADD		Additional Information		
NTE02	352	Description	M	AN	1/80	Required
		Description: A free-form description to clarify the related data elements and their content				
		Industry: Claim Note Text				

NM1 Rendering Provider Name

Pos: 500	Max: 1
Detail - Optional	
Loop: 2420A	Elements: 8

User Option (Usage): Situational

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

Notes:

1. Because the usage of this segment is "situational" this is not a syntactically required loop. If the loop is used, then it is a "required" segment. See Appendix A for further details on ASC X12 nomenclature X12 syntax rules.
2. Required if the Rendering Provider NM1 information is different than that carried in the 2310B (claim) loop, or if the Rendering Provider information is carried at the Billing/Pay-to Provider loop level (2010AA/AB) and this particular service line has a different Rendering Provider that what is given in the 2010AA/AB loop.

Example:

NM1*82*1*DICE*LINDA****34*123456789~

NYS MEDICAID NOTE:

NYSDOH will accept and capture the National Provider Identifier (NPI) in this location.

Refer to the NYS Medicaid Notes in loop 2310B for more detailed information.

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 HIPAA IG Note: The entity identifier in NM101 applies to all segments in Loop ID-2420.	M	ID	2/3	Required
		<u>Code</u> <u>Name</u> 82 Rendering Provider				
NM102	1065	Entity Type Qualifier Description: Code qualifying the type of 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: Rendering Provider Last or Organization Name	O	AN	1/35	Required
NM104	1036	Name First Description: Individual first name Industry: Rendering Provider First Name HIPAA IG Note: Required if NM102 = 1 (person).	O	AN	1/25	Situational
NM105	1037	Name Middle Description: Individual middle name or initial Industry: Rendering Provider Middle Name HIPAA IG Note: Required if NM102 = 1 and the middle name/initial of the person is known.	O	AN	1/25	Situational
NM107	1039	Name Suffix Description: Suffix to individual name Industry: Rendering Provider Name Suffix HIPAA IG Note: Required if known.	O	AN	1/10	Not recommended
NM108	66	Identification Code Qualifier	C	ID	1/2	Required

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

<u>Code</u>	<u>Name</u>
24	Employer's Identification Number
34	Social Security Number
	The Social Security Number may not be used for Medicare.
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
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Description: Code identifying a party or other code

Industry: Rendering Provider Identifier
Alias: Rendering Provider Primary Identification Number
NYS MEDICAID NOTE: NYSDOH expects to receive the NPI here, when NM108 contains a qualifier of 'XX'.

ExternalCodeList

Name: 537

Description: Health Care Financing Administration National Provider Identifier

REF Rendering Provider Secondary Identification

Pos: 525	Max: 5
Detail - Optional	
Loop: 2420A	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 the NM109.

Example:

REF*0B*A12345~

NYS MEDICAID NOTE:

Prior to the eMedNY NPI implementation date, when loop 2420A is sent NYSDOH expects to receive the Rendering Provider Secondary Identification REF segment populated with:

- a qualifier of '1D' (Medicaid Provider Number) in REF01 and the NYS Medicaid Provider ID consisting of eight numeric characters in REF02;

- or a qualifier of '0B' (State License Number) in REF01 and eleven characters in REF02. A State License Number must be preceded by the three-character Profession Code and in most cases, two zeros (exceptions exist for nurses, midwives, and eye-care providers with prescribing privilege). Refer to the 'License Type to Profession Code Mapping' document on nyhipaadesk.com for more information about using a license to identify a medical provider;

- an iteration of the Rendering Provider Secondary Identification REF segment should also be sent with REF01='LU' and the three-digit Location Number (Locator Code) in REF02, only if different from the Location Number sent in the Billing Provider Name loop (loop 2010AA).

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 at minimum to receive an iteration of '1D' for Medicaid Provider Number. An additional iteration of 'LU' for location number is necessary if the location is different than that reported in the 2010AA REF Billing Provider Secondary Identification.</p> <table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>0B</td> <td>State License Number</td> </tr> <tr> <td>1D</td> <td>Medicaid Provider Number</td> </tr> <tr> <td>EI</td> <td>Employer's Identification Number</td> </tr> <tr> <td>LU</td> <td>Location Number</td> </tr> <tr> <td>SY</td> <td>Social Security Number</td> </tr> </tbody> </table> <p>The Social Security Number may not be used for Medicare.</p>							<u>Code</u>	<u>Name</u>	0B	State License Number	1D	Medicaid Provider Number	EI	Employer's Identification Number	LU	Location Number	SY	Social Security Number
<u>Code</u>	<u>Name</u>																	
0B	State License Number																	
1D	Medicaid Provider Number																	
EI	Employer's Identification Number																	
LU	Location Number																	
SY	Social Security Number																	
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: Rendering Provider Secondary Identifier</p>																		

SVD Line Adjudication Information

Pos: 540	Max: 1
Detail - Optional	
Loop: 2430	Elements: 5

User Option (Usage): Situational

Purpose: To convey service line adjudication information for coordination of benefits between the initial payers of a health care claim and all subsequent payers

Notes:

1. To show unbundled lines: If, in the original claim, line 3 is unbundled into (for examples) 2 additional lines, then the SVD for line 3 is used 3 times: once for the original adjustment to line 3 and then two more times for the additional unbundled lines. If a line item control number (REF01 = 6R) exists for the line, that number may be used in SVD06 instead of the LX number when a line is unbundled.
2. Because the usage of this segment is "situational" this is not a syntactically required loop. If the loop is used, then it is a "required" segment. See Appendix A for further details on ASC X12 nomenclature X12 syntax rules.
3. Required if claim has been previously adjudicated by payer identified in Loop 2330B and service line has adjustments applied to it.

Example:

SVD*43*55*AD:D0330**1~

NYS MEDICAID NOTE:

NYSDOH will process prior payer insurance information as received by the submitter in a Remittance Advice.

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>
SVD01	67	Identification Code Description: Code identifying a party or other code Industry: Other Payer Primary Identifier Alias: Payer Identification Code NYS MEDICAID NOTE: The Identifier sent in SVD01 must match the Identifier sent in NM109 of the loop 2330B that was sent for the payer whose payment is reported in this segment. HIPAA IG Note: This number shown matches NM109 in the Loop ID-2330B Identifying other payer. Crosswalked from 004010 835 Loop 1000A N104 (if PlanID is used) or REF02.	M	AN	2/80	Required
SVD02	782	Monetary Amount Description: Monetary amount Industry: Service Line Paid Amount Alias: Amount Paid for This Service Line HIPAA IG Note: Zero "0" is an acceptable value for this element. The FA0-52.0 NSF crosswalk is only used in payer-to-payer COB situations. Crosswalked from 004010 835 SVC03.	M	R	1/18	Required
SVD03	C003	Composite Medical Procedure Identifier Description: To identify a medical procedure by its standardized codes and applicable modifiers HIPAA IG Note: This element contains the procedure code that was used to pay this service line. It crosswalks from SVC01 in the 835 transaction. Crosswalked from 004010 835 SVC01.	O	Comp		Required
SVD03-01	235	Product/Service ID Qualifier Description: Code identifying the type/source of the descriptive number used in Product/Service ID (234)	M	ID	2/2	Required

Industry: Product or Service ID Qualifier

<u>Code</u>	<u>Name</u>
AD	American Dental Association Codes Description: This association's membership consists of U.S. dentists. It sets standards for the dental profession
ZZ	Mutually Defined Jurisdictionally Defined Procedure and Supply Codes (used for Worker's Compensation claims).

SVD03-02	234	Product/Service ID	M	AN	1/48	Required
Description: Identifying number for a product or service						
Industry: Procedure Code						
ExternalCodeList						
Name: 135						
Description: American Dental Association Codes						
SVD03-03	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: Use this modifier for the first procedure code modifier. Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code. A modifier must be from code source 135 (American Dental Association) found in the 'Code on Dental Procedures and Nomenclature', if such modifier is available.						
SVD03-04	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: Use this modifier for the second procedure code modifier. Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code. A modifier must be from code source 135 (American Dental Association) found in the 'Code on Dental Procedures and Nomenclature', if such modifier is available.						
SVD03-05	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: Use this modifier for the third procedure code modifier. Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code. A modifier must be from code source 135 (American Dental Association) found in the 'Code on Dental Procedures and Nomenclature', if such modifier is available.						
SVD03-06	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: Use this modifier for the fourth procedure code modifier.
 Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.
 A modifier must be from code source 135 (American Dental Association) found in the 'Code on Dental Procedures and Nomenclature', if such modifier is available.

SVD03-07	352	<p>Description</p> <p>Description: A free-form description to clarify the related data elements and their content Industry: Procedure Code Description HIPAA IG Note: Required if SVC01-7 was returned in the 835 transaction.</p>	O	AN	1/80	Situational
SVD05	380	<p>Quantity</p> <p>Description: Numeric value of quantity Industry: Paid Service Unit Count HIPAA IG Note: Crosswalk from SVC05 in 835 or, if not present in 835, use original billed units. Crosswalked from 004010 835 SVC05.</p>	O	R	1/15	Required
SVD06	554	<p>Assigned Number</p> <p>Description: Number assigned for differentiation within a transaction set Industry: Bundled or Unbundled Line Number Alias: Bundled/Unbundled Line Number HIPAA IG Note: Use the line item control number (REF01 = 6R) or the LX from this transaction which points to the bundled line. Required if payer bundled the service line.</p>	O	N0	1/6	Situational

CAS Service Adjustment

Pos: 545	Max: 99
Detail - Optional	
Loop: 2430	Elements: 19

User Option (Usage): Situational

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

Notes:

1. Required if the payer identified in loop 2330B made line level adjustments which caused the amount paid to differ from the amount originally charged.
2. Mapping CAS information into a flat file format may involve reading specific Claim Adjustment Reason Codes and then mapping the subsequent Monetary Amount and/or Quantity elements to specified fields in the flat file.
3. There are some NSF COB elements which are covered through the use of the CAS segment. Please see the claim level CAS segment for a note on handling those crosswalks at the claim level. Some of that information may apply at the line level. Further information is given below which is more specific to line level issues. Balance bill limiting charge (FA0-54.0). The adjustment for this information would be conveyed in a CAS amount element if the provider billed for more than they were allowed under contract.
4. The Claim Adjustment Reason codes are located on the Washington Publishing Company web site: <http://www.wpc-edi.com>.

Example:

CAS*PR*1*793~
CAS*OA*93*0~

NYS MEDICAID NOTE:

NYSDOH will process Medicare or other insurance information as received by the submitter in a remittance advice.

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>
CAS01	1033	Claim Adjustment Group Code Description: Code identifying the general category of payment adjustment Alias: Adjustment Group Code	M	ID	1/2	Required
		Code Name CO Contractual Obligations CR Correction and Reversals OA Other adjustments PI Payor Initiated Reductions PR Patient Responsibility				
CAS02	1034	Claim Adjustment Reason Code Description: Code identifying the detailed reason the adjustment was made Industry: Adjustment Reason Code Alias: Adjustment Reason Code - Line Level HIPAA IG Note: Use the Claim Adjustment Reason code list (see Appendix C).	M	ID	1/5	Required
		ExternalCodeList Name: 139 Description: Claim Adjustment Reason Code				
CAS03	782	Monetary Amount Description: Monetary amount Industry: Adjustment Amount Alias: Adjusted Amount - Line Level HIPAA IG Note: Use this amount for the adjustment amount.	M	R	1/18	Required
CAS04	380	Quantity Description: Numeric value of quantity Industry: Adjustment Quantity Alias: Adjusted Units - Line Level	O	R	1/15	Situational

		HIPAA IG Note: Use this quantity for the units of service being adjusted. Use as needed to show payer adjustments.				
CAS05	1034	Claim Adjustment Reason Code Description: Code identifying the detailed reason the adjustment was made Industry: Adjustment Reason Code Alias: Adjustment Reason Code - Line Level HIPAA IG Note: Use the Claim Adjustment Reason Code list (see Appendix C). Use as needed to show payer adjustments. ExternalCodeList Name: 139 Description: Claim Adjustment Reason Code	C	ID	1/5	Situational
CAS06	782	Monetary Amount Description: Monetary amount Industry: Adjustment Amount Alias: Adjusted Amount - Line Level HIPAA IG Note: Use this amount for the adjustment amounts. Use as needed to show payer adjustments.	C	R	1/18	Situational
CAS07	380	Quantity Description: Numeric value of quantity Industry: Adjustment Quantity Alias: Adjusted Units - Line Level HIPAA IG Note: Use this quantity for the units of service being adjusted. Use as needed to show payer adjustments.	C	R	1/15	Situational
CAS08	1034	Claim Adjustment Reason Code Description: Code identifying the detailed reason the adjustment was made Industry: Adjustment Reason Code Alias: Adjustment Reason Code - Line Level HIPAA IG Note: Use the Claim Adjustment Reason Code list (see Appendix C). Use as needed to show payer adjustments. ExternalCodeList Name: 139 Description: Claim Adjustment Reason Code	C	ID	1/5	Situational
CAS09	782	Monetary Amount Description: Monetary amount Industry: Adjustment Amount Alias: Adjusted Amount - Line Level HIPAA IG Note: Use this amount for the adjustment amounts. Use as needed to show payer adjustments.	C	R	1/18	Situational
CAS10	380	Quantity Description: Numeric value of quantity Industry: Adjustment Quantity Alias: Adjusted Units - Line Level HIPAA IG Note: Use this quantity for the units of service being adjusted. Use as needed to show payer adjustments.	C	R	1/15	Situational
CAS11	1034	Claim Adjustment Reason Code Description: Code identifying the detailed reason the adjustment was made	C	ID	1/5	Situational

		<p>Industry: Adjustment Reason Code Alias: Adjustment Reason Code - Line Level HIPAA IG Note: Use the Claim Adjustment Reason Code list (see Appendix C). Use as needed to show payer adjustments.</p> <p>ExternalCodeList Name: 139 Description: Claim Adjustment Reason Code</p>				
CAS12	782	<p>Monetary Amount</p> <p>Description: Monetary amount Industry: Adjustment Amount Alias: Adjusted Amount - Line Level HIPAA IG Note: Use this amount for the adjustment amounts. Use as needed to show payer adjustments.</p>	C	R	1/18	Situational
CAS13	380	<p>Quantity</p> <p>Description: Numeric value of quantity Industry: Adjustment Quantity Alias: Adjusted Units - Line Level HIPAA IG Note: Use this quantity for the units of service being adjusted. Use as needed to show payer adjustments.</p>	C	R	1/15	Situational
CAS14	1034	<p>Claim Adjustment Reason Code</p> <p>Description: Code identifying the detailed reason the adjustment was made Industry: Adjustment Reason Code Alias: Adjustment Reason Code - Line Level HIPAA IG Note: Use the Claim Adjustment Reason Code list (see Appendix C). Use as needed to show payer adjustments.</p> <p>ExternalCodeList Name: 139 Description: Claim Adjustment Reason Code</p>	C	ID	1/5	Situational
CAS15	782	<p>Monetary Amount</p> <p>Description: Monetary amount Industry: Adjustment Amount Alias: Adjusted Amount - Line Level HIPAA IG Note: Use this amount for the adjustment amounts. Use as needed to show payer adjustments.</p>	C	R	1/18	Situational
CAS16	380	<p>Quantity</p> <p>Description: Numeric value of quantity Industry: Adjustment Quantity Alias: Adjusted Units - Line Level HIPAA IG Note: Use this quantity for the units of service being adjusted. Use as needed to show payer adjustments.</p>	C	R	1/15	Situational
CAS17	1034	<p>Claim Adjustment Reason Code</p> <p>Description: Code identifying the detailed reason the adjustment was made Industry: Adjustment Reason Code Alias: Adjustment Reason Code - Line Level HIPAA IG Note: Use the Claim Adjustment Reason Code list (see Appendix C). Use as needed to show payer adjustments.</p> <p>ExternalCodeList</p>	C	ID	1/5	Situational

Name: 139
Description: Claim Adjustment Reason Code

CAS18	782	Monetary Amount	C	R	1/18	Situational
Description: Monetary amount Industry: Adjustment Amount Alias: Adjusted Amount - Line Level HIPAA IG Note: Use this amount for the adjustment amounts. Use as needed to show payer adjustments.						

CAS19	380	Quantity	C	R	1/15	Situational
Description: Numeric value of quantity Industry: Adjustment Quantity Alias: Adjusted Units - Line Level HIPAA IG Note: Use this quantity for the units of service being adjusted. Use as needed to show payer adjustments.						

DTP Line Adjudication Date

Pos: 550	Max: 1
Detail - Optional	
Loop: 2430	Elements: 3

User Option (Usage): Required

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

Example:

DTP*573*D8*19961131~

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 573 Date Claim Paid				
DTP02	1250	Date Time Period Format Qualifier Description: Code indicating the date format, time format, or date and time format	M	ID	2/3	Required
		Code Name D8 Date Expressed in Format CCYYMMDD				
DTP03	1251	Date Time Period Description: Expression of a date, a time, or range of dates, times or dates and times Industry: Adjudication or Payment Date	M	AN	1/35	Required

HL

Patient Hierarchical Level

Pos: 001	Max: 1
Detail - Optional	
Loop: 2000C	Elements: 4

User Option (Usage): Situational

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

Notes:

1. This HL is required when the patient is a different person than the subscriber. There are no HLs subordinate to the Patient HL.
2. Because the usage of this segment is "situational" this is not a syntatically required loop. If the loop is used, then it is a "required" segment. See Appendix A for further details on ASC X12 nomenclature X12 syntax rules.
3. 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 numer of Patient Hierarchical Level loops, there is an implied maximum of 5000.

Example:

HL*3*2*23*0~

NYS MEDICAID NOTE:

NYSDOH will reject any claim that reports this HL segment, 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 HIPAA IG Note: The code DEPENDENT is meant to convey that the information in this HL applies to the patient when the subscriber and the patient are not the same person.	M	ID	1/2	Required
		Code Name 23 Dependent Description: Identifies the individual who is affiliated with the subscriber, such as spouse, child, etc., and therefore may be entitled to benefits				
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 0 No Subordinate HL Segment in This Hierarchical Structure.				

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*211*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 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 Alias: Transaction Set Control Number HIPAA IG Note: The Transaction Set Control Numbers in ST02 and SE02 must be identical. The Transaction Set Control Number is assigned by the originator and must be unique within a functional group (GS-GE) and interchange (ISA-IEA). This unique number also aids in error resolution research.	M	AN	4/9	Required