

**eMedNY**

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

**837 Health Care Claim:  
Professional Companion Guide  
for Non-Emergency  
Transportation**

**NPI EDITION**

X12N V4010X098A1 837: Health Care Claim: Professional

**Version: 4.0**

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# 837

## Health Care Claim: Professional

### 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 billing provider, subscriber, patient, claim level, and claim service line level. Billing providers who sort claims using this hierarchy will use the 837 more efficiently because information that applies to all lower levels in the hierarchy will not have to be repeated within the transaction.
2. This standard 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 ASC X12N 837 Professional Transaction, Addendum version (004010X098A1) to assist Providers, Clearinghouses and all trading partners of NYS Medicaid in preparing transactions for Non-emergency Transportation billing only. The specification described in this document is not applicable to claims for emergency transportation services.

This document was prepared using the Addenda version of the transaction. NYSDOH has focused primarily on the rules and policies regulating the submission of NYS Medicaid data as described within this Companion Guide. NYSDOH has provided this document and related information at <http://www.nyhipaadesk.com> as a tool to assist Providers in preparing X12N compliant electronic transactions in accordance with the program requirements of NYS Medicaid.

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

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

#### CG MODIFICATION TRACKING:

>V4.0

- 12/29/2008 Removed reference to 837P Supplemental CG from NYS Medicaid Note in CLM05-3, loop 2300.
- 10/20/2008 Added note in Transmission Type Identification REF segment that NYSDOH will reject all transactions that do not contain "004010X098A1" in this location.
- 09/09/2008 Reduced CG Modification section. Only 2006-current included.
- 08/21/2008 Revised National Provider Identifier section of front matter and NYS Medicaid Notes for all provider loops to reflect eMedNY system processing requirements after NPI implementation.

>V3.0

- 09/18/2007 Removed phone system options information from NYS Medicaid Note in front matter, leaving the call center 800 number. Added note to refer to Technical Supplementary Guide.
- 05/09/2007 Added text in NYS Medicaid Note in loop 2300, CLM05-3 to clarify that only previously paid claims should be adjusted or voided.
- 03/14/2007 Added information to refer to the Technical Supplementary Companion Guide in NYS Medicaid Notes in the front matter.
- 02/07/2007 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, removed "NPI Edition" from title.
- 01/17/2007 Modified text in NPI section of front matter to state 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.
- 11/08/2006 Modified National Provider Identifier section of front matter.
- 10/31/2006 Modified National Provider Identifier section of front matter and 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.
- 10/20/2006 Added NYS Medicaid Note to SBR segment in loop 2320 regarding prior payer coverage changes and note in element SBR09 regarding Medicare Managed Care which cannot be reported in the same claim as Medicare Part A or Part B.
- 07/18/2006 Minor rewording in Disclaimer, modified NYS Medicaid Note in front matter to state that for batch submission NYSDOH requires the 837P.
- 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.
- 03/14/2006 Added qualifiers and NYS Medicaid Notes to support sending the National Provider Identifier (NPI). Changes were in the NM1 and REF segments of Billing and Referring provider loops.

## **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.

Non-emergency transportation providers do not meet the definition of a healthcare provider as defined by the Social Security Act unless they also provide emergency (ambulance) transportation.

Non-emergency transportation providers who do not also provide emergency transportation services will not be affected by NPI requirements except when reporting the provider who ordered transportation services. This provider should be identified by an NPI in the Referring Provider Name loop.

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 New York State Department of Health (NYSDOH) requires batch submission of claims for Medicaid-covered Non-emergency medical transportation services to be conducted in standard electronic format as per the specifications described in this 837 Professional Companion Guide for Non-emergency Transportation.

Additional data items (vehicle and operator's license) are specified in this document that NYSDOH requires for Non-emergency Ambulette Transportation services only (Category of Service 602). These data items may be sent at the sender's discretion for other Non-emergency Transportation claims.

The Health Insurance Portability and Accountability Act (HIPAA) does not regulate non-emergency transportation services.

The New York State Department of Health (NYSDOH) has established the ASC X12N 837, Health Care Claim Professional (004010X098A1) transaction as the standard for Non-emergency Transportation electronic billing for NYS Medicaid.

This Companion Guide provided by the NYSDOH outlines the required format for a New York State Medicaid Professional Health Care Claim for Non-emergency transportation. It is important that Providers study the Companion Guide and become familiar with the data that will be received by NYSDOH in transmission of an 837 Health Care Claim: Professional Transaction when billing for Non-emergency transportation services.

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

guidance to ensure proper adjudication and subsequent claim payment.

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

Professional (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 transaction and receiving a 277.

#### SUPPORT:

Please refer to the Technical Supplementary Companion Guide for information about transaction header structures, transaction size limits, electronic communications methods, and enrollment as a trading partner. This document is available for download at [nyhipaadesk.com](http://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](mailto: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](http://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
<b>LOOP ID - 1000A</b>						<b>1</b>	<b>N1/020L</b>
020	NM1	Submitter Name	O	1		N1/020	Required
045	PER	Submitter EDI Contact Information	O	2			Required
<b>LOOP ID - 1000B</b>						<b>1</b>	<b>N1/020L</b>
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>
<b>LOOP ID - 2000A</b>						<b>&gt;1</b>	
001	HL	Billing/Pay-to Provider Hierarchical Level	M	1			Required
003	PRV	Billing/Pay-to Provider Specialty Information	O	1			Situational
<b>LOOP ID - 2010AA</b>						<b>1</b>	<b>N2/015L</b>
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		N2/030	Required
035	REF	Billing Provider Secondary Identification	O	4			Situational
<b>LOOP ID - 2000B</b>						<b>&gt;1</b>	
001	HL	Subscriber Hierarchical Level	M	1			Required
005	SBR	Subscriber Information	O	1			Required
007	PAT	Patient Information	O	1			Situational
<b>LOOP ID - 2010BA</b>						<b>1</b>	<b>N2/015L</b>
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
<b>LOOP ID - 2010BB</b>						<b>1</b>	<b>N2/015L</b>
015	NM1	Payer Name	O	1		N2/015	Required
<b>LOOP ID - 2300</b>						<b>100</b>	
130	CLM	Claim Information	O	1			Required
175	AMT	Patient Amount Paid	O	1			Situational
180	REF	Prior Authorization or Referral Number	O	2			Situational
180	REF	Original Reference Number (ICN/DCN)	O	1			Situational
231	HI	Health Care Diagnosis Code	O	1			Situational
<b>LOOP ID - 2310A</b>						<b>2</b>	<b>N2/250L</b>
250	NM1	Referring Provider Name	O	1		N2/250	Situational
271	REF	Referring Provider Secondary Identification	O	4			Situational
<b>LOOP ID - 2310A</b>						<b>2</b>	<b>N2/250L</b>
250	NM1	Referring Provider Name	O	1		N2/250	Situational
271	REF	Referring Provider Secondary	O	4			Situational

Identification

<b>LOOP ID - 2310B</b>		-	-	<b>1</b>	<b>N2/250L</b>	-
250	NM1	Rendering Provider Name	O	1	N2/250	Situational
271	REF	Rendering Provider Secondary Identification	O	1		Situational
<b>LOOP ID - 2320</b>		-	-	<b>10</b>	<b>N2/290L</b>	-
290	SBR	Other Subscriber Information	O	1	N2/290	Situational
295	CAS	Claim Level Adjustments	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
305	DMG	Subscriber Demographic Information	O	1		Situational
310	OI	Other Insurance Coverage Information	O	1		Required
320	MOA	Medicare Outpatient Adjudication Information	O	1		Situational
<b>LOOP ID - 2330A</b>		-	-	<b>1</b>	<b>N2/325L</b>	-
325	NM1	Other Subscriber Name	O	1	N2/325	Required
<b>LOOP ID - 2330B</b>		-	-	<b>1</b>	<b>N2/325L</b>	-
325	NM1	Other Payer Name	O	1	N2/325	Required
350	DTP	Claim Adjudication Date	O	1		Situational
<b>LOOP ID - 2400</b>		-	-	<b>50</b>	<b>N2/365L</b>	-
365	LX	Service Line	O	1	N2/365	Required
370	SV1	Professional Service	O	1		Required
455	DTP	Date - Service Date	O	1		Required
470	REF	Prior Authorization or Referral Number	O	2		Situational
470	REF	Line Item Control Number	O	1		Situational
<b>LOOP ID - 2420A</b>		-	-	<b>1</b>	<b>N2/500L</b>	-
500	NM1	Rendering Provider Name	O	1	N2/500	Situational
525	REF	Rendering Provider Secondary Identification	O	1	N2/525	Situational
<b>LOOP ID - 2420F</b>		-	-	<b>2</b>	<b>N2/500L</b>	-
500	NM1	Referring Provider Name	O	1	N2/500	Situational
525	REF	Referring Provider Secondary Identification	O	4		Situational
<b>LOOP ID - 2420F</b>		-	-	<b>2</b>	<b>N2/500L</b>	-
500	NM1	Referring Provider Name	O	1	N2/500	Situational
525	REF	Referring Provider Secondary Identification	O	4		Situational
<b>LOOP ID - 2430</b>		-	-	<b>25</b>	<b>N2/540L</b>	-
540	SVD	Line Adjudication Information	O	1	N2/540	Situational
545	CAS	Line Adjustment	O	99		Situational
550	DTP	Line Adjudication Date	O	1		Required
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	<b>Transaction Set Identifier Code</b>	M	ID	3/3	Required				
<p><b>Description:</b> Code uniquely identifying a Transaction Set</p> <p><b>HIPAA IG Note:</b> The only valid value within this transaction set for ST01 is 837.</p> <table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>837</td> <td>Health Care Claim REQUIRED</td> </tr> </tbody> </table>							<u>Code</u>	<u>Name</u>	837	Health Care Claim REQUIRED
<u>Code</u>	<u>Name</u>									
837	Health Care Claim REQUIRED									
ST02	329	<b>Transaction Set Control Number</b>	M	AN	4/9	Required				
<p><b>Description:</b> Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set</p> <p><b>Alias:</b> Transaction Set Control Number</p> <p><b>HIPAA IG Note:</b> 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.</p>										

# 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

**Notes:**

1. The second example denotes the case where the entire transaction set contains ENCOUNTERS.

**Example:**

BHT\*0019\*00\*0123\*19970618\*0932\*CH~  
 BHT\*0019\*00\*4444\*19970213\*0345\*RP~

**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	<b>Hierarchical Structure Code</b>	M	ID	4/4	Required						
<p><b>Description:</b> Code indicating the hierarchical application structure of a transaction set that utilizes the HL segment to define the structure of the transaction set</p> <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	<b>Transaction Set Purpose Code</b>	M	ID	2/2	Required						
<p><b>Description:</b> Code identifying purpose of transaction set</p> <p><b>Alias:</b> Transaction Set Purpose Code</p> <p><b>HIPAA IG Note:</b> BHT02 is intended to convey the electronic transmission status of the 837 batch contained in this ST-SE envelope. The terms "original" and "reissue" refer to the electronic transmission status of the 837 batch, not the billing status.</p> <p><b>ORIGINAL:</b> Original transmissions are claims/encounters which have never been sent to the receiver. Generally nearly all transmissions to a payer entity (as the ultimate destination of the transaction) are original.</p> <p><b>REISSUE:</b> In the case where a transmission was disrupted the receiver can request that the batch be sent again. Use "Reissue" when resending transmission batches that have been previously sent.</p> <table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>00</td> <td>Original</td> </tr> <tr> <td>18</td> <td>Reissue</td> </tr> </tbody> </table>							<u>Code</u>	<u>Name</u>	00	Original	18	Reissue
<u>Code</u>	<u>Name</u>											
00	Original											
18	Reissue											
BHT03	127	<b>Reference Identification</b>	O	AN	1/30	Required						
<p><b>Description:</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier</p> <p><b>Industry:</b> Originator Application Transaction Identifier</p> <p><b>HIPAA IG Note:</b> The inventory file number of the tape or 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 ST02.</p>												

**BHT04**      373      **Date**      O      DT      8/8      Required

**Description:** Date expressed as CCYYMMDD  
**Industry:** Transaction Set Creation Date  
**NYS MEDICAID NOTE:** NYSDOH expects to receive Billing Date in this field.  
**HIPAA IG Note:** Identifies the date that the submitter created the file.

**BHT05**      337      **Time**      O      TM      4/8      Required

**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)  
**Industry:** Transaction Set Creation Time  
**HIPAA IG Note:** Use this time to identify the time of day that the submitter created the file.

**BHT06**      640      **Transaction Type Code**      O      ID      2/2      Required

**Description:** Code specifying the type of transaction  
**Industry:** Claim or Encounter Identifier  
**Alias:** Claim or Encounter Indicator  
**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, if an ST-SE envelope contains both claims and encounters use CH. Some trading partner agreements may specify using only one code.

<u>Code</u>	<u>Name</u>
CH	Chargeable Use this code when the transaction contains only fee-for-service claims or claims with at least one chargeable line item. If it is not clear whether a transaction contains claims or encounters, or if the transaction contains a mix of claims and encounters, the developers of this implementation guide recommend using code CH.
RP	Reporting Use RP when the entire ST-SE envelope contains encounters. Use RP when the transaction is being sent to an entity (usually not a payer or a normal provider-payer transmission intermediary) for purposes other than adjudication of a claim. Such an entity could be a state health data agency which is using the 837 for health data reporting purposes.

# REF Transmission Type Identification

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

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

**Example:**

REF\*87\*004010X098A1~

**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	<b>Reference Identification Qualifier</b>	M	ID	2/3	Required
		<b>Description:</b> Code qualifying the Reference Identification				
		<b>Code</b>		<b>Name</b>		
		87		Functional Category		
		<b>Description:</b> An organization or groups of organizations with a common operational orientation such as Quality Control Engineering, etc				
REF02	127	<b>Reference Identification</b>	C	AN	1/30	Required
		<b>Description:</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier				
		<b>Industry:</b> Transmission Type Code				
		<b>NYS MEDICAID NOTE:</b> NYSDOH will reject all transactions that do not contain "004010X098A1" in this location.				
		<b>HIPAA IG Note:</b> When piloting the transaction set, this value is 004010X098DA1. When sending the transaction set in a production mode, this value is 004010X098A1.				

# NM1

# Submitter Name

<b>Pos: 020</b>	<b>Max: 1</b>
<b>Heading - Optional</b>	
<b>Loop: 1000A</b>	<b>Elements: 7</b>

**User Option (Usage):** Required

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

**Notes:**

1. The example in this NM1 and the subsequent N2 demonstrate how a name that is more than 35 characters long could be handled between the NM1 and N2 segments.
2. See Section 2.4, Loop ID-1000, Data Overview, for a detailed description about using Loop ID-1000. Ignore the Set Notes below.
3. Because this is a required segment, this is a required loop. See Appendix A for further details on ASC X12 syntax rules.

**Example:**

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

**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	<b>Entity Identifier Code</b> <b>Description:</b> 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>41</td> <td>Submitter</td> </tr> </table> <b>Description:</b> Entity transmitting transaction set	<u>Code</u>	<u>Name</u>	41	Submitter	M	ID	2/3	Required		
<u>Code</u>	<u>Name</u>											
41	Submitter											
NM102	1065	<b>Entity Type Qualifier</b> <b>Description:</b> 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	<b>Name Last or Organization Name</b> <b>Description:</b> Individual last name or organizational name <b>Industry:</b> Submitter Last or Organization Name <b>Alias:</b> Submitter Name	O	AN	1/35	Required						
NM104	1036	<b>Name First</b> <b>Description:</b> Individual first name <b>Industry:</b> Submitter First Name <b>Alias:</b> Submitter Name <b>HIPAA IG Note:</b> Required if NM102=1 (person).	O	AN	1/25	Situational						
NM105	1037	<b>Name Middle</b> <b>Description:</b> Individual middle name or initial <b>Industry:</b> Submitter Middle Name <b>Alias:</b> Submitter Name <b>HIPAA IG Note:</b> Required if NM102=1 and the middle name/initial of the person is known.	O	AN	1/25	Situational						
NM108	66	<b>Identification Code Qualifier</b> <b>Description:</b> Code designating the system/method of code structure used for Identification Code (67)  <table border="0"> <tr> <td><u>Code</u></td> <td><u>Name</u></td> </tr> <tr> <td>46</td> <td>Electronic Transmitter Identification Number (ETIN)</td> </tr> </table> <b>Description:</b> A unique number assigned to each transmitter and software developer Established by trading partner agreement.	<u>Code</u>	<u>Name</u>	46	Electronic Transmitter Identification Number (ETIN)	C	ID	1/2	Required		
<u>Code</u>	<u>Name</u>											
46	Electronic Transmitter Identification Number (ETIN)											

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).

Trading Partners with three-character ETIN numbers will continue to use their existing ETIN. Newly enrolled submitters will be assigned ETIN numbers of characters.

# PER Submitter EDI 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. 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.
2. The contact information in this segment should point to the person in the submitter organization who deals with data transmission issues. If data transmission problems arise, this is the person to contact in the submitter organization.
3. There are 2 repetitions of the PER segment to allow for six possible combination of communication numbers including extensions.

**Example:**

PER\*IC\*JANE DOE\*TE\*9005555555~

**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	<b>Contact Function Code</b> <b>Description:</b> Code identifying the major duty or responsibility of the person or group named  <table border="0"> <tr> <td><u>Code</u></td> <td><u>Name</u></td> </tr> <tr> <td>IC</td> <td>Information Contact</td> </tr> </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	<b>Name</b> <b>Description:</b> Free-form name <b>Industry:</b> Submitter Contact Name <b>HIPAA IG Note:</b> 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	<b>Communication Number Qualifier</b> <b>Description:</b> Code identifying the type of communication number  <table border="0"> <tr> <td><u>Code</u></td> <td><u>Name</u></td> </tr> <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> </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	<b>Communication Number</b> <b>Description:</b> Complete communications number including country or area code when applicable	C	AN	1/80	Required										
PER05	365	<b>Communication Number Qualifier</b> <b>Description:</b> Code identifying the type of communication number <b>HIPAA IG Note:</b> Used at the discretion of the submitter.  <table border="0"> <tr> <td><u>Code</u></td> <td><u>Name</u></td> </tr> <tr> <td>ED</td> <td>Electronic Data Interchange Access Number</td> </tr> <tr> <td>EM</td> <td>Electronic Mail</td> </tr> <tr> <td>EX</td> <td>Telephone Extension</td> </tr> <tr> <td>FX</td> <td>Facsimile</td> </tr> </table>	<u>Code</u>	<u>Name</u>	ED	Electronic Data Interchange Access Number	EM	Electronic Mail	EX	Telephone Extension	FX	Facsimile	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	<b>Communication Number</b>		C	AN	1/80	Situational
		<b>Description:</b> Complete communications number including country or area code when applicable <b>HIPAA IG Note:</b> Used at the discretion of the submitter.					
PER07	365	<b>Communication Number Qualifier</b>		C	ID	2/2	Situational
		<b>Description:</b> Code identifying the type of communication number <b>HIPAA IG Note:</b> Used at the discretion of the submitter.					
		<b><u>Code</u></b>	<b><u>Name</u></b>				
		ED	Electronic Data Interchange Access Number				
		EM	Electronic Mail				
		EX	Telephone Extension				
		FX	Facsimile				
		TE	Telephone				
PER08	364	<b>Communication Number</b>		C	AN	1/80	Situational
		<b>Description:</b> Complete communications number including country or area code when applicable <b>HIPAA IG Note:</b> Used at the discretion of the submitter.					

# NM1 Receiver Name

<b>Pos: 020</b>	<b>Max: 1</b>
<b>Heading - Optional</b>	
<b>Loop: 1000B</b>	<b>Elements: 5</b>

**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 syntax rules.

**Example:**

NM1\*40\*2\*CSC\*\*\*\*\*46\*95-2043126~

**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	<b>Entity Identifier Code</b>  <b>Description:</b> 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>40</td> <td>Receiver</td> </tr> </table> <b>Description:</b> Entity to accept transmission	<u>Code</u>	<u>Name</u>	40	Receiver	M	ID	2/3	Required
<u>Code</u>	<u>Name</u>									
40	Receiver									
NM102	1065	<b>Entity Type Qualifier</b>  <b>Description:</b> 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	<b>Name Last or Organization Name</b>  <b>Description:</b> Individual last name or organizational name <b>Industry:</b> Receiver Name <b>NYS MEDICAID NOTE:</b> NYSDOH expects to receive 'NYSDOH'.	O	AN	1/35	Required				
NM108	66	<b>Identification Code Qualifier</b>  <b>Description:</b> Code designating the system/method of code structure used for Identification Code (67)  <table border="0"> <tr> <td><u>Code</u></td> <td><u>Name</u></td> </tr> <tr> <td>46</td> <td>Electronic Transmitter Identification Number (ETIN)</td> </tr> </table> <b>Description:</b> A unique number assigned to each transmitter and software developer	<u>Code</u>	<u>Name</u>	46	Electronic Transmitter Identification Number (ETIN)	C	ID	1/2	Required
<u>Code</u>	<u>Name</u>									
46	Electronic Transmitter Identification Number (ETIN)									
NM109	67	<b>Identification Code</b>  <b>Description:</b> Code identifying a party or other code <b>Industry:</b> Receiver Primary Identifier <b>Alias:</b> Receiver Primary Identification Number <b>NYS MEDICAID NOTE:</b> 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 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 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	<b>Hierarchical ID Number</b>  <b>Description:</b> A unique number assigned by the sender to identify a particular data segment in a hierarchical structure <b>HIPAA IG Note:</b> 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	<b>Hierarchical Level Code</b>  <b>Description:</b> Code defining the characteristic of a level in a hierarchical structure	M	ID	1/2	Required
		<b>Code</b> <b>Name</b> 20                              Information Source <b>Description:</b> Identifies the payor, maintainer, or source of the information				
HL04	736	<b>Hierarchical Child Code</b>  <b>Description:</b> Code indicating if there are hierarchical child data segments subordinate to the level being described	O	ID	1/1	Required
		<b>Code</b> <b>Name</b> 1                                Additional Subordinate HL Data Segment in This Hierarchical Structure.				

# PRV Billing/Pay-to Provider Specialty Information

Pos: 003	Max: 1
Detail - Optional	
Loop: 2000A	Elements: 3

**User Option (Usage):** Situational

**Purpose:** To specify the identifying characteristics of a provider

**Notes:**

1. Required when adjudication is known to be impacted by the provider taxonomy code, and the Rendering Provider is the same entity as the Billing and/or Pay-to Provider. In these cases, the Rendering Provider is being identified at this level for all subsequent claims/encounters in this HL and Loop ID-2310B is not used.
2. This PRV is not used when the Billing or Pay-to Provider is a group and the individual Rendering Provider is in loop 2310B. The PRV segment is then coded with the Rendering Provider in loop 2310B.
3. PRV02 qualifies PRV03.

**Example:**

PRV\*BI\*ZZ\*203BA050N~

**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>
PRV01	1221	<b>Provider Code</b>	M	ID	1/3	Required
<b>Description:</b> Code identifying the type of provider						
		<u>Code</u>	<u>Name</u>			
		BI	Billing			
		PT	Pay-To			
PRV02	128	<b>Reference Identification Qualifier</b>	M	ID	2/3	Required
<b>Description:</b> Code qualifying the Reference Identification						
<b>HIPAA IG Note:</b> ZZ is used to indicate the "Health Care Provider Taxonomy" code list (provider specialty code) which is available on the Washington Publishing Company web site: <a href="http://www.wpc-edi.com">http://www.wpc-edi.com</a> . This taxonomy is maintained by the Blue Cross Blue Shield Association and ASC X12N TG2 WG15.						
		<u>Code</u>	<u>Name</u>			
		ZZ	Mutually Defined			
		Health Care Provider Taxonomy Code list				
PRV03	127	<b>Reference Identification</b>	M	AN	1/30	Required
<b>Description:</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier						
<b>Industry:</b> Provider Taxonomy Code						
<b>Alias:</b> Provider Specialty Code						
<u>ExternalCodeList</u>						
<b>Name:</b> HCPT						
<b>Description:</b> Health Care Provider Taxonomy						

# NM1

## Billing Provider Name

<b>Pos:</b> 015	<b>Max:</b> 1
Detail - Optional	
<b>Loop:</b> 2010AA	<b>Elements:</b> 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 this 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 syntax rules.

**Example:**

NM1\*85\*2\*CRAMMER, DOLE, PALMER, AND JOHNSON\*\*\*\*\*24\*11223333~

**NYS MEDICAID NOTE:**

TRANSPORTATION PROVIDERS WHO PROVIDE ONLY NON-EMERGENCY TRANSPORTATION SERVICES DO NOT MEET THE FEDERAL DEFINITION OF A HEALTH CARE PROVIDER AS DEFINED IN THE SOCIAL SECURITY ACT AND ARE NOT ELIGIBLE TO RECEIVE AN NPI. THE FOLLOWING INSTRUCTIONS APPLY TO THOSE PROVIDERS WHO ALSO PROVIDE EMERGENCY (AMBULANCE) SERVICES IN ADDITION TO THEIR NON-EMERGENCY (TAXI, WHEELCHAIR VAN, AMBULETTE, ETC...) SERVICES.

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	<b>Entity Identifier Code</b>	M	ID	2/3	Required
		<b>Description:</b> Code identifying an organizational entity, a physical location, property or an individual				
		<b>Code</b>	<b>Name</b>			
		85	Billing Provider			
		Use this code to indicate billing provider, billing submitter, and encounter reporting entity.				
NM102	1065	<b>Entity Type Qualifier</b>	M	ID	1/1	Required
		<b>Description:</b> Code qualifying the type of entity				

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

# N3

## Billing Provider Address

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

**User Option (Usage):** Required

**Purpose:** To specify the location of the named party

**Example:**

N3\*225 MAIN STREET\*BARKLEY BUILDING~

**Element Summary:**

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
N301	166	<b>Address Information</b> <b>Description:</b> Address information <b>Industry:</b> Billing Provider Address Line <b>Alias:</b> Billing Provider Address 1	M	AN	1/55	Required
N302	166	<b>Address Information</b> <b>Description:</b> Address information <b>Industry:</b> Billing Provider Address Line <b>Alias:</b> Billing Provider Address 2 <b>HIPAA IG Note:</b> 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	<b>City Name</b>  <b>Description:</b> Free-form text for city name <b>Industry:</b> Billing Provider City Name <b>Alias:</b> Billing Provider's City	O	AN	2/30	Required
N402	156	<b>State or Province Code</b>  <b>Description:</b> Code (Standard State/Province) as defined by appropriate government agency <b>Industry:</b> Billing Provider State or Province Code <b>Alias:</b> Billing Provider's State  <u>ExternalCodeList</u> <b>Name:</b> 22 <b>Description:</b> States and Outlying Areas of the U.S.	O	ID	2/2	Required
N403	116	<b>Postal Code</b>  <b>Description:</b> Code defining international postal zone code excluding punctuation and blanks (zip code for United States) <b>Industry:</b> Billing Provider Postal Zone or ZIP Code <b>Alias:</b> Billing Provider's Zip Code  <u>ExternalCodeList</u> <b>Name:</b> 51 <b>Description:</b> ZIP Code	O	ID	3/15	Required
N404	26	<b>Country Code</b>  <b>Description:</b> Code identifying the country <b>Alias:</b> Billing Provider Country Code <b>HIPAA IG Note:</b> Required if the address is out of the U.S.  <u>ExternalCodeList</u> <b>Name:</b> 5 <b>Description:</b> Countries, Currencies and Funds	O	ID	2/3	Situational

# REF Billing Provider Secondary Identification

<b>Pos:</b> 035	<b>Max:</b> 4
Detail - Optional	
<b>Loop:</b> 2010AA	<b>Elements:</b> 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 NM108/9 in this loop.
2. If the reason the number is being used in this REF can be met by the NPI, carried in the NM108/09 of this loop, then this REF is not used.
3. If "code XX - NPI" is used in the NM108/09 of this loop, then either the Employer's Identification Number or the Social Security Number of the provider must be carried in this REF. The number sent is the one which is used on the 1099. If additional numbers are needed the REF can be run up to 8 times.

**Example:**

REF\*1G\*98765~

**NYS MEDICAID NOTE:**

When the Billing Provider is not identified by an NPI in the Billing Provider Name NM1 segment, 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	<b>Reference Identification Qualifier</b>	M	ID	2/3	Required
<b>Description:</b> Code qualifying the Reference Identification						
		<b>Code</b>	<b>Name</b>			
		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	<b>Reference Identification</b>	C	AN	1/30	Required
<b>Description:</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier						
<b>Industry:</b> Billing Provider Additional Identifier						
<b>Alias:</b> Billing Provider Secondary Identification Number						

# HL

## Subscriber Hierarchical Level

<b>Pos:</b> 001	<b>Max:</b> 1
<b>Detail - Mandatory</b>	
<b>Loop:</b> 2000B	<b>Elements:</b> 4

**User Option (Usage):** Required

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

### Notes:

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

### Example:

HL\*2\*1\*22\*1~

### NYS MEDICAID NOTE:

NYSDOH will accept a maximum of one claim for real-time processing of the Interactive 837P. For batch transmissions, please refer to the Implementation Guide requirements and limitations.

### 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	<b>Hierarchical ID Number</b> <b>Description:</b> A unique number assigned by the sender to identify a particular data segment in a hierarchical structure	M	AN	1/2	Required
HL02	734	<b>Hierarchical Parent ID Number</b> <b>Description:</b> Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to	O	AN	1/2	Required
HL03	735	<b>Hierarchical Level Code</b> <b>Description:</b> Code defining the characteristic of a level in a hierarchical structure	M	ID	1/2	Required
		<b>Code</b> <b>Name</b> 22                              Subscriber <b>Description:</b> Identifies the employee or group member who is covered for insurance and to whom, or on behalf of whom, the insurer agrees to pay benefits				
HL04	736	<b>Hierarchical Child Code</b> <b>Description:</b> Code indicating if there are hierarchical child data segments subordinate to the level being described <b>NYS MEDICAID NOTE:</b> 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. <b>HIPAA IG Note:</b> The claim loop (Loop ID-2300)	O	ID	1/1	Required

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

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

# SBR Subscriber Information

<b>Pos: 005</b>	<b>Max: 1</b>
<b>Detail - Optional</b>	
<b>Loop: 2000B</b>	<b>Elements: 6</b>

**User Option (Usage):** Required

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

**Example:**

SBR\*\*P\*\*GRP01020102\*\*\*\*\*MB~  
 SBR\*\*P\*\*GRP01020102\*\*\*\*\*MC~

**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	<b>Payer Responsibility Sequence Number Code</b>  <b>Description:</b> Code identifying the insurance carrier's level of responsibility for a payment of a claim <b>Alias:</b> Payer Responsibility Sequence Number Code <b>NYS MEDICAID NOTE:</b> If one prior payer will be reported in loop 2320, 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'.  <table border="1"> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> <tr> <td>P</td> <td>Primary</td> </tr> <tr> <td>S</td> <td>Secondary</td> </tr> <tr> <td>T</td> <td>Tertiary</td> </tr> </table> Use to indicate 'payer of last resort'.	<u>Code</u>	<u>Name</u>	P	Primary	S	Secondary	T	Tertiary	M	ID	1/1	Required
<u>Code</u>	<u>Name</u>													
P	Primary													
S	Secondary													
T	Tertiary													
SBR02	1069	<b>Individual Relationship Code</b>  <b>Description:</b> Code indicating the relationship between two individuals or entities <b>Alias:</b> Relationship Code <b>HIPAA IG Note:</b> 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.  <table border="1"> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> <tr> <td>18</td> <td>Self</td> </tr> </table>	<u>Code</u>	<u>Name</u>	18	Self	O	ID	2/2	Situational				
<u>Code</u>	<u>Name</u>													
18	Self													
SBR03	127	<b>Reference Identification</b>  <b>Description:</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier <b>Industry:</b> Insured Group or Policy Number <b>Alias:</b> Group or Policy Number <b>HIPAA IG Note:</b> 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).	O	AN	1/30	Situational								
SBR04	93	<b>Name</b>	O	AN	1/60	Situational								

**Description:** Free-form name  
**Industry:** Insured Group Name  
**Alias:** Group or 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 Professional 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 a Group or Plan Name.

SBR05      1336      **Insurance Type Code**      O      ID      1/3      Situational

**Description:** Code identifying the type of insurance policy within a specific insurance program  
**Alias:** Insurance type code  
**HIPAA IG Note:** Required when the destination payer (Loop 2010BB) is Medicare and Medicare is not the primary payer (SBR01 equals "S" or "T").

<u>Code</u>	<u>Name</u>
12	Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan
13	Medicare Secondary End-Stage Renal Disease Beneficiary in the 12 month coordination period with an employer's group health plan
14	Medicare Secondary, No-fault Insurance including Auto is Primary
15	Medicare Secondary Worker's Compensation
16	Medicare Secondary Public Health Service (PHS) or Other Federal Agency
41	Medicare Secondary Black Lung
42	Medicare Secondary Veteran's Administration
43	Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health Plan (LGHP)
47	Medicare Secondary, Other Liability Insurance is Primary
AP	Auto Insurance Policy
C1	Commercial
MP	Medicare Primary

**Description:** Medicare has the primary responsibility to pay for health care services and/or supplies received by a covered beneficiary (a person entitled to medicare benefits)

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

**Description:** Code identifying type of claim  
**Alias:** Claim Filing Indicator Code  
**NYS MEDICAID NOTE:** NYSDOH expects to

receive 'MC'.  
**HIPAA IG Note:** Required prior to mandated  
used of PlanID. Not used after PlanID is  
mandated.

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

# PAT Patient Information

<b>Pos: 007</b>	<b>Max: 1</b>
<b>Detail - Optional</b>	
<b>Loop: 2000B</b>	<b>Elements: 5</b>

**User Option (Usage):** Situational  
**Purpose:** To supply patient information

**Notes:**

1. Required if the subscriber is the same person as the patient (Loop ID-2000B SBR02=18), and information in this PAT segment (date of death, and/or patient weight) is necessary to file the claim/encounter (see PAT05, 06, 07, and 08).

**Example:**

PAT\*\*\*\*\*D8\*19970314\*01\*146~

**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>
PAT05	1250	<b>Date Time Period Format Qualifier</b>  <b>Description:</b> Code indicating the date format, time format, or date and time format <b>HIPAA IG Note:</b> Required if patient is known to be deceased and the date of death is available to the provider billing system.  <b>Code</b> <b>Name</b> D8                Date Expressed in Format CCYYMMDD	C	ID	2/3	Situational
PAT06	1251	<b>Date Time Period</b>  <b>Description:</b> Expression of a date, a time, or range of dates, times or dates and times <b>Industry:</b> Insured Individual Death Date <b>Alias:</b> Date of Death <b>HIPAA IG Note:</b> Required if patient is known to be deceased and the date of death is available to the provider billing system.	C	AN	1/35	Situational
PAT07	355	<b>Unit or Basis for Measurement Code</b>  <b>Description:</b> Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken <b>HIPAA IG Note:</b> Required when PAT08 is used.  <b>Code</b> <b>Name</b> 01                Actual Pounds	C	ID	2/2	Situational
PAT08	81	<b>Weight</b>  <b>Description:</b> Numeric value of weight <b>Industry:</b> Patient Weight <b>HIPAA IG Note:</b> Required on: 1) claims/encounters involving EPO (epoetin) for patients on dialysis. 2) Medicare Durable Medical Equipment Regional Carriers certificate of medical necessity (DMERC CMN) 02.03 and 10.02.	C	R	1/10	Situational
PAT09	1073	<b>Yes/No Condition or Response Code</b>  <b>Description:</b> Code indicating a Yes or No condition or response <b>Industry:</b> Pregnancy Indicator <b>HIPAA IG Note:</b> Required when mandated by law. The determination of pregnancy should be completed in compliance with applicable law. The "Y" code indicates that the patient is pregnant. If PAT09 is not used it means the patient is not	O	ID	1/1	Situational

pregnant.

<u>Code</u>	<u>Name</u>
Y	Yes

# NM1

## Subscriber Name

<b>Pos:</b> 015	<b>Max:</b> 1
Detail - Optional	
<b>Loop:</b> 2010BA	<b>Elements:</b> 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 syntax rules.

**Example:**

NM1\*IL\*1\*DOE\*JOHN\*T\*\*JR\*MI\*123456~

**NYS MEDICAID NOTE:**

NYSDOH will accept a maximum of one claim for real-time processing of the Interactive 837P. For batch transmissions, please refer to the Implementation Guide requirements and limitations.

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	<b>Entity Identifier Code</b>  <b>Description:</b> Code identifying an organizational entity, a physical location, property or an individual  <u>Code</u> <u>Name</u> IL                    Insured or Subscriber	M	ID	2/3	Required
NM102	1065	<b>Entity Type Qualifier</b>  <b>Description:</b> Code qualifying the type of entity <b>NYS MEDICAID NOTE:</b> NYSDOH expects to receive value '1'.  <u>Code</u> <u>Name</u> 1                    Person	M	ID	1/1	Required
NM103	1035	<b>Name Last or Organization Name</b>  <b>Description:</b> Individual last name or organizational name <b>Industry:</b> Subscriber Last Name <b>NYS MEDICAID NOTE:</b> Although this is a required data element, NYSDOH will not use this information to identify the recipient.	O	AN	1/35	Required
NM104	1036	<b>Name First</b>  <b>Description:</b> Individual first name <b>Industry:</b> Subscriber First Name <b>NYS MEDICAID NOTE:</b> Although this is a required data element, NYSDOH will not use this information to identify the recipient. <b>HIPAA IG Note:</b> Required if NM102=1 (person).	O	AN	1/25	Situational
NM105	1037	<b>Name Middle</b>  <b>Description:</b> Individual middle name or initial <b>Industry:</b> Subscriber Middle Name <b>HIPAA IG Note:</b> Required if NM102=1 and the middle name/initial of the person is known.	O	AN	1/25	Situational
NM107	1039	<b>Name Suffix</b>	O	AN	1/10	Situational

**Description:** Suffix to individual name  
**Industry:** Subscriber Name Suffix  
**Alias:** Subscriber Generation  
**HIPAA IG Note:** Required if known.  
 Examples: I, II, III, IV, Jr, Sr

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 Professional 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 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 to receive client/recipient ID number.  
**HIPAA IG Note:** Required if the Subscriber is the patient. If the subscriber is not the patient, use if known. An identifier must be present in either the subscriber or the patient loop.

# N3

## Subscriber Address

<b>Pos:</b> 025	<b>Max:</b> 1
Detail - Optional	
<b>Loop:</b> 2010BA	<b>Elements:</b> 2

**User Option (Usage):** Situational

**Purpose:** To specify the location of the named party

**Notes:**

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

# N4

## Subscriber City/State/ZIP Code

<b>Pos:</b> 030	<b>Max:</b> 1
Detail - Optional	
<b>Loop:</b> 2010BA	<b>Elements:</b> 4

**User Option (Usage):** Situational

**Purpose:** To specify the geographic place of the named party

**Notes:**

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

# DMG Subscriber Demographic Information

<b>Pos:</b> 032	<b>Max:</b> 1
Detail - Optional	
<b>Loop:</b> 2010BA	<b>Elements:</b> 3

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

**Notes:**

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

**Example:**

DMG\*D8\*19330706\*M~

**NYS MEDICAID NOTE:**

NYSDOH expects to receive client/recipient date of birth and gender.

**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	<b>Date Time Period Format Qualifier</b>  <b>Description:</b> Code indicating the date format, time format, or date and time format	C	ID	2/3	Required						
		<table border="0"> <tr> <td><u>Code</u></td> <td><u>Name</u></td> </tr> <tr> <td>D8</td> <td>Date Expressed in Format CCYYMMDD</td> </tr> </table>	<u>Code</u>	<u>Name</u>	D8	Date Expressed in Format CCYYMMDD						
<u>Code</u>	<u>Name</u>											
D8	Date Expressed in Format CCYYMMDD											
DMG02	1251	<b>Date Time Period</b>  <b>Description:</b> Expression of a date, a time, or range of dates, times or dates and times <b>Industry:</b> Subscriber Birth Date <b>Alias:</b> Date of Birth - Patient	C	AN	1/35	Required						
DMG03	1068	<b>Gender Code</b>  <b>Description:</b> Code indicating the sex of the individual <b>Industry:</b> Subscriber Gender Code <b>Alias:</b> Gender - Patient <b>NYS MEDICAID NOTE:</b> NYSDOH cannot process code 'U' (Unknown). Claims received with an unknown gender will be denied.	O	ID	1/1	Required						
		<table border="0"> <tr> <td><u>Code</u></td> <td><u>Name</u></td> </tr> <tr> <td>F</td> <td>Female</td> </tr> <tr> <td>M</td> <td>Male</td> </tr> </table>	<u>Code</u>	<u>Name</u>	F	Female	M	Male				
<u>Code</u>	<u>Name</u>											
F	Female											
M	Male											

# NM1

# Payer Name

<b>Pos:</b> 015	<b>Max:</b> 1
Detail - Optional	
<b>Loop:</b> 2010BB	<b>Elements:</b> 5

**User Option (Usage):** Required

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

**Notes:**

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

**Example:**

NM1\*PR\*2\*UNION MUTUAL OF OREGON\*\*\*\*\*PI\*11122333~

**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	<b>Entity Identifier Code</b>  <b>Description:</b> 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	<b>Entity Type Qualifier</b>  <b>Description:</b> 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	<b>Name Last or Organization Name</b>  <b>Description:</b> Individual last name or organizational name <b>Industry:</b> Payer Name <b>NYS MEDICAID NOTE:</b> NYSDOH expects to receive 'NYSDOH'.	O	AN	1/35	Required						
NM108	66	<b>Identification Code Qualifier</b>  <b>Description:</b> Code designating the system/method of code structure used for Identification Code (67)  <table border="0"> <tr> <td><u>Code</u></td> <td><u>Name</u></td> </tr> <tr> <td>PI</td> <td>Payor Identification</td> </tr> <tr> <td>XV</td> <td>Health Care Financing Administration National Payer Identification Number (PAYERID)</td> </tr> </table> <b>Description:</b> Required if the National PlanID is mandated for use. Otherwise, one of the other listed codes may be used.	<u>Code</u>	<u>Name</u>	PI	Payor Identification	XV	Health Care Financing Administration National Payer Identification Number (PAYERID)	C	ID	1/2	Required
<u>Code</u>	<u>Name</u>											
PI	Payor Identification											
XV	Health Care Financing Administration National Payer Identification Number (PAYERID)											
NM109	67	<b>Identification Code</b>  <b>Description:</b> Code identifying a party or other code <b>Industry:</b> Payer Identifier <b>Alias:</b> Payer Primary Identifier <b>NYS MEDICAID NOTE:</b> NYSDOH expects to receive '141797357'.  <u>ExternalCodeList</u> <b>Name:</b> 540 <b>Description:</b> Health Care Financing Administration National PlanID	C	AN	2/80	Required						

# CLM Claim Information

<b>Pos: 130</b>	<b>Max: 1</b>
<b>Detail - Optional</b>	
<b>Loop: 2300</b>	<b>Elements: 12</b>

**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 syntax rules.
2. The developers of this implementation guide recommend that trading partners limit the size of the transaction (ST-SE envelope) to a maximum of 5000 CLM segments. There is no recommended limit to the number of ST-SE transactions within a GS-GE or ISA-IEA. Willing trading partners can agree to set limits higher.
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 2010BD in the subscriber hierarchical level when the patient is the subscriber, or it is placed at the patient/dependent hierarchical level when the patient is the dependent of the subscriber as shown here. When the patient is the subscriber, loops 2000C and 2010CA are not sent. See 2.3.2.1, HL Segment, for details.

**Example:**

CLM\*A37YH556\*500\*\*\*11::1\*Y\*A\*Y\*Y\*C~

**NYS MEDICAID NOTE:**

NYSDOH will accept a maximum of one claim for real-time processing of the Interactive 837P. For batch transmissions, please refer to the Implementation Guide requirements and limitations.

Refer to the 837 Professional Supplemental Companion Guide for more detailed information on NYSDOH's requirements and uses of the CLM05, CLM12, 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	<b>Claim Submitter's Identifier</b>  <b>Description:</b> Identifier used to track a claim from creation by the health care provider through payment <b>Industry:</b> Patient Account Number <b>NYS MEDICAID NOTE:</b> NYSDOH will process as Patient/Office Account Number. <b>HIPAA IG Note:</b> The number that the submitter transmits in this position is echoed back to the submitter in the 835 and other transactions. This permits the submitter to use the value in this field as a key in the submitter's system to match the claim to the payment information returned in the 835 transaction. The two recommended identifiers are either the Patient Account Number or the Claim Number in the billing 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	<b>Monetary Amount</b>  <b>Description:</b> Monetary amount	O	R	1/18	Required

**Industry:** Total Claim Charge Amount  
**Alias:** Total Submitted 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.

CLM05	C023	<p><b>Health Care Service Location Information</b></p> <p><b>Description:</b> 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><b>Alias:</b> Place of Service Code  <b>HIPAA IG Note:</b> CLM05 applies to all service lines unless it is over written at the line level.</p>	O	Comp	Required
-------	------	---	---	------	----------

CLM05-01	1331	<p><b>Facility Code Value</b></p> <p><b>Description:</b> 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><b>Industry:</b> Facility Type Code  <b>NYS MEDICAID NOTE:</b> For non-emergency transportation services (i.e. non-HIPAA regulated services) NYSDOH expects to receive '99'.  <b>HIPAA IG Note:</b> 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 guideline. 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  23 Emergency Room - Hospital  24 Ambulatory Surgical Center  25 Birthing Center  26 Military Treatment Facility  31 Skilled Nursing Facility  32 Nursing Facility  33 Custodial Care Facility  34 Hospice  41 Ambulance - Land  42 Ambulance - Air or Water  51 Inpatient Psychiatric Facility  52 Psychiatric Facility Partial Hospitalization  53 Community Mental Health Center  54 Intermediate Care Facility/Mentally Retarded  55 Residential Substance Abuse Treatment Facility  56 Psychiatric Residential Treatment Center  50 Federally Qualified Health Center  60 Mass Immunization Center  61 Comprehensive Inpatient Rehabilitation Facility  62 Comprehensive Outpatient Rehabilitation Facility</p>	M	AN	1/2	Required
----------	------	---	---	----	-----	----------

65 End Stage Renal Disease Treatment Facility  
 71 State or Local Public Health Clinic  
 72 Rural Health Clinic  
 81 Independent Laboratory  
 99 Other Unlisted Facility

**ExternalCodeList**

**Name:** 237

**Description:** Place of Service from Health Care Financing Administration Claim Form

CLM05-03 1325 **Claim Frequency Type Code** O ID 1/1 Required

**Description:** Code specifying the frequency of the claim; this is the third position of the Uniform Billing Claim Form Bill Type

**Industry:** Claim Frequency Code

**Alias:** Claim Submission Reason Code

**NYS MEDICAID NOTE:** NYSDOH will process all values as original claims with the exception of codes '7' (Replacement) and '8' (Void). In these cases, NYSDOH expects to receive the Transaction Control Number (formerly known as CRN Number) that was returned in a remittance advice (paper or 835 transaction). These values should only be sent for previously paid claims that are being adjusted or voided.

Refer to the 837 Professional Supplemental Companion Guide, Section "Replacement/Void codes" for more detailed information on NYSDOH's requirements and uses of the CLM05-3 data element as reported in this segment.

**ExternalCodeList**

**Name:** 235

**Description:** Claim Frequency Type Code

CLM06 1073 **Yes/No Condition or Response Code** O ID 1/1 Required

**Description:** Code indicating a Yes or No condition or response

**Industry:** Provider or Supplier Signature Indicator

**Alias:** Provider Signature on File

**NYS MEDICAID NOTE:** NYSDOH expects 'Y'.

<u>Code</u>	<u>Name</u>
Y	Yes

CLM07 1359 **Provider Accept Assignment Code** O ID 1/1 Required

**Description:** Code indicating whether the provider accepts assignment

**Industry:** Medicare Assignment Code

**HIPAA IG Note:** CLM07 indicates whether the provider accepts Medicare assignment. The NSF mapping to FA0-59.0 occurs only in payer-to-payer COB situations.

<u>Code</u>	<u>Name</u>
A	Assigned
B	Assignment Accepted on Clinical Lab Services Only
C	Not Assigned
P	Patient Refuses to Assign Benefits

CLM08 1073 **Yes/No Condition or Response Code** O ID 1/1 Required

**Description:** Code indicating a Yes or No condition or response

**Industry:** Benefits Assignment Certification

Indicator  
**Alias:** Assignment of Benefits Indicator

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

CLM09 1363 **Release of Information Code** O ID 1/1 Required

**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 Code

<u>Code</u>	<u>Name</u>
A	Appropriate Release of Information on File at Health Care Service Provider or at Utilization Review Organization
I	Informed Consent to Release Medical Information for Conditions or Diagnoses Regulated by Federal Statutes
M	The Provider has Limited or Restricted Ability to Release Data Related to a Claim
N	No, Provider is Not Allowed to Release Data
O	On file at Payor or at Plan Sponsor
Y	Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim

CLM10 1351 **Patient Signature Source Code** O ID 1/1 Situational

**Description:** Code indicating how the patient or subscriber authorization signatures were obtained and how they are being retained by the provider

**Alias:** Patient Signature Source Code  
**HIPAA IG Note:** CLM10 is required except in cases where code "N" is used in CLM09.

<u>Code</u>	<u>Name</u>
B	Signed signature authorization form or forms for both HCFA-1500 Claim Form block 12 and block 13 are on file
C	Signed HCFA-1500 Claim Form on file
M	Signed signature authorization form for HCFA-1500 Claim Form block 13 on file
P	Signature generated by provider because the patient was not physically present for services
S	Signed signature authorization form for HCFA-1500 Claim Form block 12 on file

CLM11 C024 **Related Causes Information** O Comp Situational

**Description:** To identify one or more related causes and associated state or country information

**Alias:** Accident/Employment/Related Causes  
**HIPAA IG Note:** CLM11-1, CLM11-2, or CLM11-3 are required when the condition being reported is accident or employment related. If CLM11-1, CLM11-2, or CLM11-3 equals AP, then map Yes to EA0-09.0. 2440 If DTP - Date of Accident (DTP01=439) is used, then CLM11 is required.

CLM11-01 1362 **Related-Causes Code** M ID 2/3 Required

**Description:** Code identifying an accompanying cause of an illness, injury or an accident  
**Industry:** Related Causes Code

<u>Code</u>	<u>Name</u>
AA	Auto Accident
AP	Another Party Responsible
EM	Employment
OA	Other Accident

CLM11-02	1362	<p><b>Related-Causes Code</b></p> <p><b>Description:</b> Code identifying an accompanying cause of an illness, injury or an accident  <b>Industry:</b> Related Causes Code  <b>HIPAA IG Note:</b> Used if more than one code applies.</p> <table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>AA</td> <td>Auto Accident</td> </tr> <tr> <td>AP</td> <td>Another Party Responsible</td> </tr> <tr> <td>EM</td> <td>Employment</td> </tr> <tr> <td>OA</td> <td>Other Accident</td> </tr> </tbody> </table>	<u>Code</u>	<u>Name</u>	AA	Auto Accident	AP	Another Party Responsible	EM	Employment	OA	Other Accident	O	ID	2/3	Situational
<u>Code</u>	<u>Name</u>															
AA	Auto Accident															
AP	Another Party Responsible															
EM	Employment															
OA	Other Accident															
CLM11-03	1362	<p><b>Related-Causes Code</b></p> <p><b>Description:</b> Code identifying an accompanying cause of an illness, injury or an accident  <b>Industry:</b> Related Causes Code  <b>HIPAA IG Note:</b> Used if more than one code applies.</p> <table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>AA</td> <td>Auto Accident</td> </tr> <tr> <td>AP</td> <td>Another Party Responsible</td> </tr> <tr> <td>EM</td> <td>Employment</td> </tr> <tr> <td>OA</td> <td>Other Accident</td> </tr> </tbody> </table>	<u>Code</u>	<u>Name</u>	AA	Auto Accident	AP	Another Party Responsible	EM	Employment	OA	Other Accident	O	ID	2/3	Situational
<u>Code</u>	<u>Name</u>															
AA	Auto Accident															
AP	Another Party Responsible															
EM	Employment															
OA	Other Accident															
CLM11-04	156	<p><b>State or Province Code</b></p> <p><b>Description:</b> Code (Standard State/Province) as defined by appropriate government agency  <b>Industry:</b> Auto Accident State or Province Code  <b>HIPAA IG Note:</b> Required if CLM11-1, -2, or -3 = AA to identify the state in which the automobile accident occurred. Use state postal code (CA = California, UT = Utah, etc).</p> <p><b>ExternalCodeList</b>  <b>Name:</b> 22  <b>Description:</b> States and Outlying Areas of the U.S.</p>	O	ID	2/2	Situational										
CLM11-05	26	<p><b>Country Code</b></p> <p><b>Description:</b> Code identifying the country  <b>HIPAA IG Note:</b> Required if the automobile accident occurred out of the United States to identify the country in which the accident occurred.</p> <p><b>ExternalCodeList</b>  <b>Name:</b> 5  <b>Description:</b> Countries, Currencies and Funds</p>	O	ID	2/3	Situational										
CLM12	1366	<p><b>Special Program Code</b></p> <p><b>Description:</b> Code indicating the Special Program under which the services rendered to the patient were performed  <b>Industry:</b> Special Program Indicator  <b>Alias:</b> Special Program Code  <b>NYS MEDICAID NOTE:</b> Refer also to the NYS Medicaid 837 Professional Supplemental Companion Guide for more information about the Special Program Indicator for EPSDT referrals.  <b>HIPAA IG Note:</b> Required if the services were rendered under one of the following circumstances/programs/projects.</p> <table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> </table>	<u>Code</u>	<u>Name</u>	O	ID	2/3	Situational								
<u>Code</u>	<u>Name</u>															

01	<p>Early &amp; Periodic Screening, Diagnosis, and Treatment (EPSDT) or Child Health Assessment Program (CHAP)</p> <p><b>CODE SOURCE:</b>                  NYSDOH will ignore this value. Please refer to segment CRC EPSDT Referral if this value is submitted.</p>
02	<p>Physically Handicapped Children's Program</p> <p><b>CODE SOURCE:</b>                  This value will be processed.</p>
03	<p>Special Federal Funding</p> <p>This code is used for Medicaid claims only.</p> <p><b>CODE SOURCE:</b>                  NYSDOH will ignore this value.</p>
05	<p>Disability</p> <p>This code is used for Medicaid claims only.</p> <p><b>CODE SOURCE:</b>                  This value will be processed.</p>
07	<p>Induced Abortion - Danger to Life</p> <p>This code is used for Medicaid claims only.</p> <p><b>CODE SOURCE:</b>                  These values are acceptable, but if this field (CLM12) is needed for another value (i.e., "02"), then use Loop 2300 NTE segment to report abortion.</p>
08	<p>Induced Abortion - Rape or Incest</p> <p>This code is used for Medicaid claims only.</p> <p><b>CODE SOURCE:</b>                  These values are acceptable, but if this field (CLM12) is needed for another value (i.e., "02"), then use Loop 2300 NTE segment to report abortion.</p>
09	<p>Second Opinion or Surgery</p> <p>This code is used for Medicaid claims only.</p> <p><b>CODE SOURCE:</b>                  NYSDOH will ignore this value.</p>

CLM16	1360	<p><b>Provider Agreement Code</b></p> <p><b>Description:</b> Code indicating the type of agreement under which the provider is submitting this claim</p> <p><b>Industry:</b> Participation Agreement</p> <p><b>HIPAA IG Note:</b> Required if a non-participating (non-par) provider is submitting a participating (par) claim/encounter. Sending the "P" code indicates that a non-par provider is sending a par claim as allowed under certain plans.</p> <table border="0"> <tr> <td><u>Code</u></td> <td><u>Name</u></td> </tr> <tr> <td>P</td> <td>Participation Agreement</td> </tr> </table> <p><b>Description:</b> Any agreement between the provider of service and the plan administrator</p>	<u>Code</u>	<u>Name</u>	P	Participation Agreement	O	ID	1/1	Situational
<u>Code</u>	<u>Name</u>									
P	Participation Agreement									
CLM20	1514	<p><b>Delay Reason Code</b></p> <p><b>Description:</b> Code indicating the reason why a request was delayed</p> <p><b>Alias:</b> Delay Reason Code</p> <p><b>NYS MEDICAID NOTE:</b> NYSDOH will process as Over 90 Day Indicator and deny a code value of "6" for business purposes.</p> <p>Refer to the 837 Professional Supplemental Companion Guide, Section 4. "Over 90 Day</p>	O	ID	1/2	Situational				

Indicator” for more information on NYSDOH’s requirements and uses of this data element.

**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

# 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 when patient has made payment specifically toward this claim.
2. Patient Amount Paid refers to the sum of all amounts paid on the claim by the patient or his/her representative(s).

**Example:**

AMT\*F5\*152.45~

**NYS MEDICAID NOTE:**

NYSDOH expects to receive patient participation amount.

**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	<b>Amount Qualifier Code</b>	M	ID	1/3	Required
		<b>Description:</b> Code to qualify amount				
		<u>Code</u>		<u>Name</u>		
		F5		Patient Amount Paid		
		<b>Description:</b> Monetary amount value already paid by one receiving medical care				
AMT02	782	<b>Monetary Amount</b>	M	R	1/18	Required
		<b>Description:</b> Monetary amount				
		<b>Industry:</b> Patient Amount Paid				

# 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 UMO (Utilization Management Organization) is generally the entity empowered to make a decision regarding the outcome of a health services review or the owner of information. 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.

**Example:**

REF\*G1\*13579~

**NYS MEDICAID NOTE:**

NYSDOH expects to receive the Prior Authorization number. This is required for all Non-emergency transportation services.

**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	<b>Reference Identification Qualifier</b>  <b>Description:</b> Code qualifying the Reference Identification <b>NYS MEDICAID NOTE:</b> NYSDOH will only process a code value of 'G1'.	M	ID	2/3	Required
		<b>Code</b> <b>Name</b> G1                              Prior Authorization Number <b>Description:</b> An authorization number acquired prior to the submission of a claim				
REF02	127	<b>Reference Identification</b>  <b>Description:</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier <b>Industry:</b> Prior Authorization or Referral Number	C	AN	1/30	Required

# 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. In this case the payer is expecting the provider to give them back their (the payer's) claim 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~

**NYS MEDICAID NOTE:**

NYSDOH expects this field when the submitter desires to replace or void a previously paid claim.

**Element Summary:**

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
REF01	128	<b>Reference Identification Qualifier</b>	M	ID	2/3	Required
<b>Description:</b> Code qualifying the Reference Identification						
		<u>Code</u>	<u>Name</u>			
		F8	Original Reference Number			
REF02	127	<b>Reference Identification</b>	C	AN	1/30	Required
<b>Description:</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier						
<b>Industry:</b> Claim Original Reference Number						
<b>Alias:</b> Claim Original Reference Number (ICN/DCN)						

# HI Health Care Diagnosis Code

<b>Pos:</b> 231	<b>Max:</b> 1
<b>Detail - Optional</b>	
<b>Loop:</b> 2300	<b>Elements:</b> 8

**User Option (Usage):** Situational

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

**Notes:**

1. Required on all claims/encounters except claims for which there are no diagnoses (e.g., taxi claims).
2. Do not transmit the decimal points in the diagnosis codes. The decimal point is assumed.

**Example:**

HI\*BK:8901\*BF:87200\*BF:5559~

**NYS MEDICAID NOTE:**

Information about the recipient's medical condition may not be available. It is permissible to use ICD-9 code 799.9 - Other Unknown and Unspecified Cause (because the decimal point is not sent in the 837, populate the HI01-2 sub-element with a value of '7999').

**Element Summary:**

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
HI01	C022	<b>Health Care Code Information</b>  <b>Description:</b> To send health care codes and their associated dates, amounts and quantities <b>Alias:</b> Principal Diagnosis <b>HIPAA IG Note:</b> With a few exceptions, it is not recommended to put E codes in HI01. E codes may be put in any other HI element using BF as the qualifier. The diagnosis listed in this element is assumed to be the principal diagnosis.	M	Comp		Required
HI01-01	1270	<b>Code List Qualifier Code</b>  <b>Description:</b> Code identifying a specific industry code list <b>Industry:</b> Diagnosis Type Code	M	ID	1/3	Required
		<b>Code</b> <b>Name</b> BK                              Principal Diagnosis ICD-9 Codes				
HI01-02	1271	<b>Industry Code</b>  <b>Description:</b> Code indicating a code from a specific industry code list <b>Industry:</b> Diagnosis Code	M	AN	1/30	Required
		<b>ExternalCodeList</b> <b>Name:</b> 131 <b>Description:</b> International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure				
HI02	C022	<b>Health Care Code Information</b>  <b>Description:</b> To send health care codes and their associated dates, amounts and quantities <b>Alias:</b> Diagnosis <b>HIPAA IG Note:</b> Refer to HI01-1(C022-01) and HI01-3(C022-03) for C022-01 and C022-03. Required if needed to report an additional diagnoses and if the preceding HI data elements have been used to report other diagnoses.	O	Comp		Situational
HI02-01	1270	<b>Code List Qualifier Code</b>  <b>Description:</b> Code identifying a specific industry	M	ID	1/3	Required

code list  
**Industry:** Diagnosis Type Code

<u>Code</u>	<u>Name</u>
BF	Diagnosis
ICD-9 Codes	

HI02-02 1271 **Industry Code** M AN 1/30 Required

**Description:** Code indicating a code from a specific industry code list  
**Industry:** Diagnosis Code

**ExternalCodeList**  
**Name:** 131

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

HI03 C022 **Health Care Code Information** O Comp Situational

**Description:** To send health care codes and their associated dates, amounts and quantities  
**Alias:** Diagnosis  
**HIPAA IG Note:** Refer to HI01-1(C022-01) and HI01-3(C022-03) for C022-01 and C022-03. Required if needed to report an additional diagnoses and if the preceding HI data elements have been used to report other diagnoses.

HI03-01 1270 **Code List Qualifier Code** M ID 1/3 Required

**Description:** Code identifying a specific industry code list  
**Industry:** Diagnosis Type Code

<u>Code</u>	<u>Name</u>
BF	Diagnosis
ICD-9 Codes	

HI03-02 1271 **Industry Code** M AN 1/30 Required

**Description:** Code indicating a code from a specific industry code list  
**Industry:** Diagnosis Code

**ExternalCodeList**  
**Name:** 131

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

HI04 C022 **Health Care Code Information** O Comp Situational

**Description:** To send health care codes and their associated dates, amounts and quantities  
**Alias:** Diagnosis  
**HIPAA IG Note:** Refer to HI01-1(C022-01) and HI01-3(C022-03) for C022-01 and C022-03. Required if needed to report an additional diagnoses and if the preceding HI data elements have been used to report other diagnoses.

HI04-01 1270 **Code List Qualifier Code** M ID 1/3 Required

**Description:** Code identifying a specific industry code list  
**Industry:** Diagnosis Type Code

<u>Code</u>	<u>Name</u>
BF	Diagnosis
ICD-9 Codes	

HI04-02 1271 **Industry Code** M AN 1/30 Required

**Description:** Code indicating a code from a specific industry code list

**Industry:** Diagnosis Code

**ExternalCodeList**

**Name:** 131

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

HI05 C022 **Health Care Code Information** O Comp Situational

**Description:** To send health care codes and their associated dates, amounts and quantities

**Alias:** Diagnosis

**HIPAA IG Note:** Refer to HI01-1(C022-01) and HI01-3(C022-03) for C022-01 and C022-03. Required if needed to report an additional diagnoses and if the preceding HI data elements have been used to report other diagnoses.

HI05-01 1270 **Code List Qualifier Code** M ID 1/3 Required

**Description:** Code identifying a specific industry code list

**Industry:** Diagnosis Type Code

<u>Code</u>	<u>Name</u>
BF	Diagnosis
	ICD-9 Codes

HI05-02 1271 **Industry Code** M AN 1/30 Required

**Description:** Code indicating a code from a specific industry code list

**Industry:** Diagnosis Code

**ExternalCodeList**

**Name:** 131

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

HI06 C022 **Health Care Code Information** O Comp Situational

**Description:** To send health care codes and their associated dates, amounts and quantities

**Alias:** Diagnosis

**HIPAA IG Note:** Refer to HI01-1(C022-01) and HI01-3(C022-03) for C022-01 and C022-03. Required if needed to report an additional diagnoses and if the preceding HI data elements have been used to report other diagnoses.

HI06-01 1270 **Code List Qualifier Code** M ID 1/3 Required

**Description:** Code identifying a specific industry code list

**Industry:** Diagnosis Type Code

<u>Code</u>	<u>Name</u>
BF	Diagnosis
	ICD-9 Codes

HI06-02 1271 **Industry Code** M AN 1/30 Required

**Description:** Code indicating a code from a specific industry code list

**Industry:** Diagnosis Code

**ExternalCodeList**

**Name:** 131

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

HI07 C022 **Health Care Code Information** O Comp Situational

**Description:** To send health care codes and their associated dates, amounts and quantities

**Alias:** Diagnosis

**HIPAA IG Note:** Refer to HI01-1(C022-01) and HI01-3(C022-03) for C022-01 and C022-03. Required if needed to report an additional diagnoses and if the preceding HI data elements have been used to report other diagnoses.

HI07-01 1270 **Code List Qualifier Code** M ID 1/3 Required  
**Description:** Code identifying a specific industry code list  
**Industry:** Diagnosis Type Code

<u>Code</u>	<u>Name</u>
BF	Diagnosis ICD-9 Codes

HI07-02 1271 **Industry Code** M AN 1/30 Required  
**Description:** Code indicating a code from a specific industry code list  
**Industry:** Diagnosis Code

**ExternalCodeList**  
**Name:** 131  
**Description:** International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure

HI08 C022 **Health Care Code Information** O Comp Situational  
**Description:** To send health care codes and their associated dates, amounts and quantities  
**Alias:** Diagnosis  
**HIPAA IG Note:** Refer to HI01-1(C022-01) and HI01-3(C022-03) for C022-01 and C022-03. Required if needed to report an additional diagnoses and if the preceding HI data elements have been used to report other diagnoses.

HI08-01 1270 **Code List Qualifier Code** M ID 1/3 Required  
**Description:** Code identifying a specific industry code list  
**Industry:** Diagnosis Type Code

<u>Code</u>	<u>Name</u>
BF	Diagnosis ICD-9 Codes

HI08-02 1271 **Industry Code** M AN 1/30 Required  
**Description:** Code indicating a code from a specific industry code list  
**Industry:** Diagnosis Code

**ExternalCodeList**  
**Name:** 131  
**Description:** International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure

# NM1 Referring Provider Name

<b>Pos: 250</b>	<b>Max: 1</b>
<b>Detail - Optional</b>	
<b>Loop: 2310A</b>	<b>Elements: 8</b>

**User Option (Usage):** Situational

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

**Notes:**

- Information in 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 NM101.
- When there is only one referral on the claim, use code "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.
- Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 syntax rules.
- Required if claim involved a referral.
- When reporting the provider who ordered services such as diagnostic and lab utilize the 2310A loop at the claim level. For ordered services such as DMERC utilize the 2420E Loop at the line level.

**Example:**

NM1\*DN\*1\*WELBY\*MARCUS\*W\*\*JR\*34\*444332222~

**NYS MEDICAID NOTE:**

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

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.

Non-emergency Transportation is not regulated by HIPAA.

The New York State Department of Health requires at least one iteration of the 2310A Referring Provider Name loop for all Non-emergency Transportation claims. An iteration of loop 2310A must be sent with the qualifier 'DN' (Referring Provider) in NM101 when billing for services that do not involve a Restricted Recipient. This loop iteration will be used to transmit information about the medical provider who ordered transportation services.

For services involving a Restricted Recipient the ordering medical provider information is sent with the qualifier "P3" (Primary Care Provider) in NM101. Please refer to the following loop 2310A NM1 segment.

- Non-emergency Ambulette Transportation Providers

When billing for Non-emergency Ambulette Transportation services (Category of Service 602) involving a Restricted Recipient this loop iteration, with "DN" in NM101, will be used to transmit the Operator License Number (driver's license) in the REF segment following this NM1 segment. In this case data elements NM102 through NM109 may contain the same values that were sent in the NM1 segment in loop 2010AA (Billing 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	<b>Entity Identifier Code</b>	M	ID	2/3	Required
<b>Description:</b> Code identifying an organizational entity, a physical location, property or an individual						
<b>HIPAA IG Note:</b> The entity identifier in NM101 applies to all segments in this Loop ID-2310.						
		<u>Code</u>	<u>Name</u>			
		DN	Referring Provider			
Use on first iteration of this loop. Use if loop is used only once.						
NM102	1065	<b>Entity Type Qualifier</b>	M	ID	1/1	Required
<b>Description:</b> Code qualifying the type of entity						
		<u>Code</u>	<u>Name</u>			

		1	Person				
		2	Non-Person Entity				
NM103	1035	<b>Name Last or Organization Name</b>		O	AN	1/35	Required
		<b>Description:</b> Individual last name or organizational name					
		<b>Industry:</b> Referring Provider Last Name					
NM104	1036	<b>Name First</b>		O	AN	1/25	Situational
		<b>Description:</b> Individual first name					
		<b>Industry:</b> Referring Provider First Name					
		<b>HIPAA IG Note:</b> Required if NM102=1 (person).					
NM105	1037	<b>Name Middle</b>		O	AN	1/25	Situational
		<b>Description:</b> Individual middle name or initial					
		<b>Industry:</b> Referring Provider Middle Name					
		<b>HIPAA IG Note:</b> Required if NM102=1 and the middle name/initial of the person is known.					
NM107	1039	<b>Name Suffix</b>		O	AN	1/10	Situational
		<b>Description:</b> Suffix to individual name					
		<b>Industry:</b> Referring Provider Name Suffix					
		<b>Alias:</b> Referring Provider Generation					
		<b>HIPAA IG Note:</b> Required if known.					
NM108	66	<b>Identification Code Qualifier</b>		C	ID	1/2	Situational
		<b>Description:</b> Code designating the system/method of code structure used for Identification Code (67)					
		<b>HIPAA IG Note:</b> Required if Employer's Identification/Social Security number (Tax ID) or National Provider Identifier is known.					
		<b>Code</b>	<b>Name</b>				
		24	Employer's Identification Number				
		34	Social Security Number				
		XX	Health Care Financing Administration National Provider Identifier				
							<b>Description:</b> Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.
NM109	67	<b>Identification Code</b>		C	AN	2/80	Situational
		<b>Description:</b> Code identifying a party or other code					
		<b>Industry:</b> Referring Provider Identifier					
		<b>Alias:</b> Referring Provider Primary Identifier					
		<b>NYS MEDICAID NOTE:</b> NYSDOH expects to receive the NPI here, when NM108 contains a qualifier of 'XX'.					
		<b>HIPAA IG Note:</b> Required if Employer's Identification/Social Security number (Tax ID) or National Provider Identifier is known.					
		<b>ExternalCodeList</b>					
		<b>Name:</b> 537					
		<b>Description:</b> Health Care Financing Administration National Provider Identifier					

# 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 NM108/09 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\*1D\*A12345~

**NYS MEDICAID NOTE:**

The New York State Department of Health expects to receive the following values in this REF segment:

When using this segment to transmit the Operator License Number (driver's license) a value of '0B' must be sent in REF01 and REF02 must contain nine numeric characters (refer to REF02 for instructions for out-of-state driver's licenses).

When using this REF segment to identify the provider who ordered transportation services, if their NPI of is not available, either of the following may be sent, as in previous non-NPI implementations;

- a qualifier of '1D' (Medicaid Provider Number) in REF01 and 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 nyhipaadestk.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	<b>Reference Identification Qualifier</b>	M	ID	2/3	Required
<b>Description:</b> Code qualifying the Reference Identification						
		<b>Code</b>	<b>Name</b>			
		0B	State License Number			
		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	<b>Reference Identification</b>	C	AN	1/30	Required
<b>Description:</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier						
<b>Industry:</b> Referring Provider Secondary Identifier						
<b>NYS MEDICAID NOTE:</b> - Non-emergency Ambulette Transportation Providers						
When sending an out-of-state Operator License Number (driver's license) of more than nine digits the first nine positions must be sent.						
When sending an out-of-state Operator License of less than nine digits, leading zeros must be added to the left to create a nine-digit value.						

# NM1 Referring Provider Name

<b>Pos:</b> 250	<b>Max:</b> 1
<b>Detail - Optional</b>	
<b>Loop:</b> 2310A	<b>Elements:</b> 7

**User Option (Usage):** Situational

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

**Notes:**

- Information in 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 NM101.
- When there is only one referral on the claim, use code "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.
- Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 syntax rules.
- Required if claim involved a referral.
- When reporting the provider who ordered services such as diagnostic and lab utilize the 2310A loop at the claim level. For ordered services such as DMERC utilize the 2420E Loop at the line level.

**Example:**

NM1\*DN\*1\*\*WELBY\*MARCUS\*W\*\*JR\*34\*444332222~

**NYS MEDICAID NOTE:**

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

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.

Non-emergency Transportation is not regulated by HIPAA.

The New York State Department of Health conditionally requires this iteration of the 2310A Referring Provider Name loop for Non-emergency Transportation claims. This iteration uses the qualifier 'P3' (Primary Care Provider) in NM101.

For services involving a Restricted Recipient this loop iteration must be sent to transmit information about the recipient's Primary Care Provider.

**- Non-emergency Ambulette Transportation Providers**

When billing for Non-emergency Ambulette Transportation services (Category of Service 602) NOT involving a Restricted Recipient this loop iteration, with "P3" in NM101, will be used to transmit the Operator License Number (driver's license) in the REF segment following this NM1 segment. In this case data elements NM102 through NM109 may contain the same values that were sent in the NM1 segment in loop 2010AA (Billing Provider). Note that for Non-emergency Ambulette Transportation services that DO involve a Restricted Recipient the Operator License Number (driver's license) is sent in the previous loop iteration, with "DN" in NM101.

**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	<b>Entity Identifier Code</b>  <b>Description:</b> Code identifying an organizational entity, a physical location, property or an individual <b>NYS MEDICAID NOTE:</b> NYSDOH expects to receive value 'P3'. <b>HIPAA IG Note:</b> The entity identifier in NM101 applies to all segments in this Loop ID-2310.  <b>Code</b> <b>Name</b> P3                              Primary Care Provider <b>Description:</b> 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.	M	ID	2/3	Required
NM102	1065	<b>Entity Type Qualifier</b>  <b>Description:</b> 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	<b>Name Last or Organization Name</b>		O	AN	1/35	Required
		<b>Description:</b> Individual last name or organizational name					
		<b>Industry:</b> Referring Provider Last Name					
NM104	1036	<b>Name First</b>		O	AN	1/25	Situational
		<b>Description:</b> Individual first name					
		<b>Industry:</b> Referring Provider First Name					
		<b>HIPAA IG Note:</b> Required if NM102=1 (person).					
NM105	1037	<b>Name Middle</b>		O	AN	1/25	Situational
		<b>Description:</b> Individual middle name or initial					
		<b>Industry:</b> Referring Provider Middle Name					
		<b>HIPAA IG Note:</b> Required if NM102=1 and the middle name/initial of the person is known.					
NM108	66	<b>Identification Code Qualifier</b>		C	ID	1/2	Situational
		<b>Description:</b> Code designating the system/method of code structure used for Identification Code (67)					
		<b>HIPAA IG Note:</b> Required if Employer's Identification/Social Security number (Tax ID) or National Provider Identifier is known.					
		<u>Code</u>	<u>Name</u>				
		24	Employer's Identification Number				
		34	Social Security Number				
		XX	Health Care Financing Administration National Provider Identifier				
				<b>Description:</b> Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.			
NM109	67	<b>Identification Code</b>		C	AN	2/80	Situational
		<b>Description:</b> Code identifying a party or other code					
		<b>Industry:</b> Referring Provider Identifier					
		<b>Alias:</b> Referring Provider Primary Identifier					
		<b>NYS MEDICAID NOTE:</b> NYSDOH expects to receive the NPI here, when NM108 contains a qualifier of 'XX'.					
		<b>HIPAA IG Note:</b> Required if Employer's Identification/Social Security number (Tax ID) or National Provider Identifier is known.					
		<b>ExternalCodeList</b>					
		<b>Name:</b> 537					
		<b>Description:</b> Health Care Financing Administration National Provider Identifier					

# 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 NM108/09 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\*1D\*A12345~

**NYS MEDICAID NOTE:**

The New York State Department of Health expects to receive the following values in this REF segment:

When using this REF segment to transmit the Operator License Number (driver's license) a value of '0B' must be sent in REF01. REF02 must contain nine numeric characters (refer to REF02 for instructions for out-of-state licenses).

When using this REF segment to identify the Primary Care Provider of a Restricted Recipient, if their NPI is not available a qualifier of '1D' (Medicaid Provider Number) must be sent in REF01 and the eight-digit NYS Medicaid Provider ID must be sent in REF02.

**Element Summary:**

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
REF01	128	<b>Reference Identification Qualifier</b>	M	ID	2/3	Required
<b>Description:</b> Code qualifying the Reference Identification						
		<u>Code</u>	<u>Name</u>			
		0B	State License Number			
		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	<b>Reference Identification</b>	C	AN	1/30	Required
<b>Description:</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier						
<b>Industry:</b> Referring Provider Secondary Identifier						
<b>NYS MEDICAID NOTE:</b> When sending an out-of-state Operator License Number (driver's license) of more than nine digits the first nine positions must be sent.						
When sending an out-of-state Operator License of less than nine digits leading zeros must be added to the left to create a nine-digit value.						
When identifying a Restricted Recipient's Primary Care Provider the NYS Medicaid Provider ID must be sent.						

# NM1 Rendering Provider Name

<b>Pos:</b> 250	<b>Max:</b> 1
<b>Detail - Optional</b>	
<b>Loop:</b> 2310B	<b>Elements:</b> 8

**User Option (Usage):** Situational

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

**Notes:**

1. Information in 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 NM101.
2. Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 syntax rules.
3. 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 respectively.
4. Used for all types of rendering providers including laboratories. The Rendering Provider is the person or company (laboratory or other facility) who rendered the care. In the case where a substitute provider (locum tenans) was used, that person should be entered here.

**Example:**

NM1\*82\*1\*BEATTY\*GARY\*C\*\*SR\*XX\*12345678~

**NYS MEDICAID NOTE:**

Non-emergency Transportation is not regulated by HIPAA.

The New York State Department of Health requires the 2310B Rendering Provider loop for Non-emergency Ambulette Transportation claims (Category of Service 602). This loop must contain the vehicle license plate number in the REF segment that follows this NM1 segment. For all other Non-emergency transportation claims this loop may be sent at the sender's discretion.

This NM1 segment may contain in NM102 through NM109 the same values that were sent in the NM1 segment in either loop 2010AA (Billing Provider) or loop 2310A (Referring 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	<b>Entity Identifier Code</b>  <b>Description:</b> Code identifying an organizational entity, a physical location, property or an individual <b>HIPAA IG Note:</b> The entity identifier in NM101 applies to all segments in this Loop ID-2310.	M	ID	2/3	Required
		<b>Code</b> <b>Name</b> 82                    Rendering Provider				
NM102	1065	<b>Entity Type Qualifier</b>  <b>Description:</b> Code qualifying the type of entity	M	ID	1/1	Required
		<b>Code</b> <b>Name</b> 1                     Person 2                     Non-Person Entity				
NM103	1035	<b>Name Last or Organization Name</b>  <b>Description:</b> Individual last name or organizational name <b>Industry:</b> Rendering Provider Last or Organization Name <b>Alias:</b> Rendering Provider Last Name	O	AN	1/35	Required
NM104	1036	<b>Name First</b>  <b>Description:</b> Individual first name <b>Industry:</b> Rendering Provider First Name <b>HIPAA IG Note:</b> Required if NM102=1 (person).	O	AN	1/25	Situational
NM105	1037	<b>Name Middle</b>  <b>Description:</b> Individual middle name or initial	O	AN	1/25	Situational

		<p><b>Industry:</b> Rendering Provider Middle Name  <b>HIPAA IG Note:</b> Required if NM102=1 and the middle name/initial of the person is known.</p>												
NM107	1039	<p><b>Name Suffix</b></p> <p><b>Description:</b> Suffix to individual name  <b>Industry:</b> Rendering Provider Name Suffix  <b>Alias:</b> Rendering Provider Generation  <b>HIPAA IG Note:</b> Required if known.</p>	O	AN	1/10	Situational								
NM108	66	<p><b>Identification Code Qualifier</b></p> <p><b>Description:</b> Code designating the system/method of code structure used for Identification Code (67)  <b>HIPAA IG Note:</b> FA0-57.0 crosswalk is only used in Medicare COB payer-to-payer claims.</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><b>Description:</b> 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><b>Identification Code</b></p> <p><b>Description:</b> Code identifying a party or other code  <b>Industry:</b> Rendering Provider Identifier  <b>Alias:</b> Rendering Provider Primary Identifier  <b>NYS MEDICAID NOTE:</b> NYSDOH expects to receive the NPI here, when NM108 contains a qualifier of 'XX'.  <b>HIPAA IG Note:</b> FA0-58.0 crosswalk is only used in Medicare COB payer-to-payer claims.</p> <p><b>ExternalCodeList</b>  <b>Name:</b> 537  <b>Description:</b> Health Care Financing Administration National Provider Identifier</p>	C	AN	2/80	Required								

# REF Rendering Provider Secondary Identification

Pos: 271	Max: 1
Detail - Optional	
Loop: 2310B	Elements: 2

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

**Notes:**  
 1. Required when a secondary identification number is necessary to identify the entity. The primary identification number should be carried in NM109 in this loop.

**Example:**  
 REF\*1D\*A12345~

**NYS MEDICAID NOTE:**  
 Non-emergency Transportation is not regulated by HIPAA.

The New York State Department of Health requires the 2310B Rendering Provider loop for Non-emergency Ambulette Transportation claims (Category of Service 602). This segment must contain the vehicle license plate number.

**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	<b>Reference Identification Qualifier</b>  <b>Description:</b> Code qualifying the Reference Identification <b>NYS MEDICAID NOTE:</b> The New York State Department of Health requires a value of '1D' in this data element.	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>1D</td> <td>Medicaid Provider Number</td> </tr> </tbody> </table>	<u>Code</u>	<u>Name</u>	1D	Medicaid Provider Number				
<u>Code</u>	<u>Name</u>									
1D	Medicaid Provider Number									
REF02	127	<b>Reference Identification</b>  <b>Description:</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier <b>Industry:</b> Rendering Provider Secondary Identifier <b>NYS MEDICAID NOTE:</b> The New York State Department of Health requires the vehicle license plate number in this data element. A valid license plate number will contain at least one alphabetic character.	C	AN	1/30	Required				

# SBR Other Subscriber Information

<b>Pos:</b> 290	<b>Max:</b> 1
<b>Detail - Optional</b>	
<b>Loop:</b> 2320	<b>Elements:</b> 6

**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 syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC 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 it's respective 2330 Loops.  
See Section 1.4.4 for more information on handling COB.
4. See Section 1.4.5 Crosswalking COB Data Elements for more information on handling COB in the 837.

**Example:**

SBR\*S\*01\*GR00786\*\*MC\*\*\*\*OF~

**NYS MEDICAID NOTE:**

NYSDOH will process this information when provided.

If the patient's coverage (non-Medicaid) changed from one plan to another during the period being billed the claim must be split so that a separate claim is created for each period that was covered under each plan.

When reporting a Medicare Managed Care Organization in this location a value of '16' must be sent in SBR09.

**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	<b>Payer Responsibility Sequence Number Code</b> <b>Description:</b> Code identifying the insurance carrier's level of responsibility for a payment of a claim <b>Alias:</b> Payer responsibility sequence number code <b>NYS MEDICAID NOTE:</b> 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 another as Secondary. If other payers exist, they should be listed as Tertiary.	M	ID	1/1	Required																
		<table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></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>	<u>Code</u>	<u>Name</u>	P	Primary	S	Secondary	T	Tertiary												
<u>Code</u>	<u>Name</u>																					
P	Primary																					
S	Secondary																					
T	Tertiary																					
SBR02	1069	<b>Individual Relationship Code</b> <b>Description:</b> Code indicating the relationship between two individuals or entities <b>Alias:</b> Individual relationship code	O	ID	2/2	Required																
		<table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>01</td> <td>Spouse</td> </tr> <tr> <td>04</td> <td>Grandfather or Grandmother</td> </tr> <tr> <td>05</td> <td>Grandson or Granddaughter</td> </tr> <tr> <td>07</td> <td>Nephew or Niece</td> </tr> <tr> <td>10</td> <td>Foster Child</td> </tr> <tr> <td>15</td> <td>Ward</td> </tr> <tr> <td>17</td> <td>Stepson or Stepdaughter</td> </tr> </tbody> </table>	<u>Code</u>	<u>Name</u>	01	Spouse	04	Grandfather or Grandmother	05	Grandson or Granddaughter	07	Nephew or Niece	10	Foster Child	15	Ward	17	Stepson or Stepdaughter				
<u>Code</u>	<u>Name</u>																					
01	Spouse																					
04	Grandfather or Grandmother																					
05	Grandson or Granddaughter																					
07	Nephew or Niece																					
10	Foster Child																					
15	Ward																					
17	Stepson or Stepdaughter																					

- 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
- 23 Sponsored Dependent  
**Description:** Dependents between the ages of 19 and 25 not attending school; age qualifications may vary depending on policy
- 24 Dependent of a Minor Dependent  
**Description:** A child not legally of age who has been granted adult status
- 29 Significant Other
- 32 Mother
- 33 Father
- 36 Emancipated Minor  
**Description:** A person who has been judged by a court of competent jurisdiction to be allowed to act in his or her own interest; no adult is legally responsible for this minor; this may be declared as a result of marriage
- 39 Organ Donor  
**Description:** Individual receiving medical service in order to donate organs for a transplant
- 40 Cadaver Donor  
**Description:** Deceased individual donating body to be used for research or transplants
- 41 Injured Plaintiff
- 43 Child Where Insured Has No Financial Responsibility  
**Description:** Child is covered by the insured but the insured is not the legal guardian
- 53 Life Partner
- G8 Other Relationship

SBR03	127	<b>Reference Identification</b> <b>Description:</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier <b>Industry:</b> Insured Group or Policy Number <b>Alias:</b> Group or Policy Number <b>HIPAA IG Note:</b> 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).	O	AN	1/30	Situational										
SBR04	93	<b>Name</b> <b>Description:</b> Free-form name <b>Industry:</b> Other Insured Group Name <b>Alias:</b> Group or Plan Name <b>HIPAA IG Note:</b> Required if the subscriber's payer identification includes a Group or Plan Name.	O	AN	1/60	Situational										
SBR05	1336	<b>Insurance Type Code</b> <b>Description:</b> Code identifying the type of insurance policy within a specific insurance program <b>Alias:</b> Insurance type code <table border="0" style="margin-top: 10px;"> <tr> <td style="padding-right: 20px;"><b>Code</b></td> <td><b>Name</b></td> </tr> <tr> <td>AP</td> <td>Auto Insurance Policy</td> </tr> <tr> <td>C1</td> <td>Commercial</td> </tr> <tr> <td>CP</td> <td>Medicare Conditionally Primary</td> </tr> <tr> <td>GP</td> <td>Group Policy</td> </tr> </table>	<b>Code</b>	<b>Name</b>	AP	Auto Insurance Policy	C1	Commercial	CP	Medicare Conditionally Primary	GP	Group Policy	O	ID	1/3	Required
<b>Code</b>	<b>Name</b>															
AP	Auto Insurance Policy															
C1	Commercial															
CP	Medicare Conditionally Primary															
GP	Group Policy															

	<b>Description:</b> Two or more people who are part of complete unit who enter into an insurance contract with an insurance company
HM	Health Maintenance Organization (HMO)
IP	Individual Policy
LD	Long Term Policy
LT	Litigation
MB	Medicare Part B
MC	Medicaid <b>Description:</b> Program of health care services made available to medically indigent and other needy persons, regardless of age, under terms of a 1965 amendment to the U.S. Social Security Act
MI	Medigap Part B <b>Description:</b> Health insurance policy intended to cover the non-covered portion of expenses eligible for Medicare Part B reimbursement which must be paid by a Medicare beneficiary for health care services and/or supplies received
MP	Medicare Primary <b>Description:</b> Medicare has the primary responsibility to pay for health care services and/or supplies received by a covered beneficiary (a person entitled to medicare benefits)
OT	Other
PP	Personal Payment (Cash - No Insurance)
SP	Supplemental Policy <b>Description:</b> An insurance policy intended to cover non-covered charges of another insurance policy

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

**Description:** Code identifying type of claim  
**Alias:** Claim filing indicator code  
**NYS MEDICAID NOTE:** If the payer reported in an iteration of loop 2320 is a Medicare HMO the value in SBR09 must be '16'.  
  
 Claims will be denied if there is a Claim Filing Indicator Code indicating Medicare Part A (code value 'MA') or Medicare Part B (code value 'MB') in SBR09 of an iteration of loop 2320 together with a Claim Filing Indicator Code indicating Health Maintenance Organization (HMO) Medicare Risk (code value '16') in another iteration of loop 2320.  
**HIPAA IG Note:** Required prior to mandated used of PlanID. Not used after PlanID is mandated.

<u>Code</u>	<u>Name</u>
09	Self-pay
10	Central Certification <b>UB-92 Ref. [UB-Name]:</b> CA0-23.0 (K), DA0-05.0 (K)
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
AM	Automobile Medical
BL	Blue Cross/Blue Shield
CH	Champus
CI	Commercial Insurance Co.
DS	Disability
HM	Health Maintenance Organization
LI	Liability

LM	Liability Medical
MB	Medicare Part B
MC	Medicaid
OF	Other Federal Program
TV	Title V
VA	Veteran Administration Plan
	Refers to Veterans Affairs Plan.
WC	Workers' Compensation Health Claim
ZZ	Mutually Defined
	Unknown

# CAS Claim Level Adjustments

<b>Pos:</b> 295	<b>Max:</b> 5
<b>Detail - Optional</b>	
<b>Loop:</b> 2320	<b>Elements:</b> 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 this CAS segment to report prior payers' claim level adjustments that cause the amount paid to differ from the amount originally charged.
2. Only one Group Code is allowed per CAS. If it is necessary to send more than one Group Code at the claim level, repeat the CAS segment again.
3. Codes and associated amounts should come from 835s (Remittance Advice) received on the claim. If no previous payments have been made, omit this segment.
4. Required if claim has been adjudicated by payer identified in this loop and has claim level adjustment information.
5. To locate the claim adjustment group codes (CAS01) and claim adjustment reason codes (CAS02, 05, 08, 11, 14, and 17) see the Washington Publishing Company web site: <http://www.wpc-edi.com>. Follow the buttons to Code Lists - Claim Adjustment Reason Codes.
6. There 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 adjustment 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 amount (FA0-53.0) This amount would equal the sum of all the adjustment amounts in 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 COB claim by subtracting all claim adjustments carried in the claim and line level CAS from the original billed amount.

**Example:**

CAS\*PR\*1\*7.93~  
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 Professional Supplemental Companion Guide, Section 7. "CAS Segment: Claim Level and Line Level Balancing" and Section 8. "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	<b>Claim Adjustment Group Code</b>	M	ID	1/2	Required
<b>Description:</b> Code identifying the general category of payment adjustment						
<b>Alias:</b> Claim Adjustment Group Code						
		<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	<b>Claim Adjustment Reason Code</b> <b>Description:</b> Code identifying the detailed reason the adjustment was made <b>Industry:</b> Adjustment Reason Code <b>Alias:</b> Adjustment Reason Code - Claim Level <b>ExternalCodeList</b> <b>Name:</b> 139 <b>Description:</b> Claim Adjustment Reason Code	M	ID	1/5	Required
CAS03	782	<b>Monetary Amount</b> <b>Description:</b> Monetary amount <b>Industry:</b> Adjustment Amount <b>Alias:</b> Adjusted Amount - Claim Level	M	R	1/18	Required
CAS04	380	<b>Quantity</b> <b>Description:</b> Numeric value of quantity <b>Industry:</b> Adjustment Quantity <b>Alias:</b> Adjusted Units - Claim Level <b>HIPAA IG Note:</b> Use as needed to show payer adjustment.	O	R	1/15	Situational
CAS05	1034	<b>Claim Adjustment Reason Code</b> <b>Description:</b> Code identifying the detailed reason the adjustment was made <b>Industry:</b> Adjustment Reason Code <b>Alias:</b> Adjustment Reason Code - Claim Level <b>HIPAA IG Note:</b> Use as needed to show payer adjustment. <b>ExternalCodeList</b> <b>Name:</b> 139 <b>Description:</b> Claim Adjustment Reason Code	C	ID	1/5	Situational
CAS06	782	<b>Monetary Amount</b> <b>Description:</b> Monetary amount <b>Industry:</b> Adjustment Amount <b>Alias:</b> Adjusted Amount - Claim Level <b>HIPAA IG Note:</b> Use as needed to show payer adjustment.	C	R	1/18	Situational
CAS07	380	<b>Quantity</b> <b>Description:</b> Numeric value of quantity <b>Industry:</b> Adjustment Quantity <b>Alias:</b> Adjusted Units - Claim Level <b>HIPAA IG Note:</b> Use as needed to show payer adjustment.	C	R	1/15	Situational
CAS08	1034	<b>Claim Adjustment Reason Code</b> <b>Description:</b> Code identifying the detailed reason the adjustment was made <b>Industry:</b> Adjustment Reason Code <b>Alias:</b> Adjustment Reason Code - Claim Level <b>HIPAA IG Note:</b> Use as needed to show payer adjustment. <b>ExternalCodeList</b> <b>Name:</b> 139 <b>Description:</b> Claim Adjustment Reason Code	C	ID	1/5	Situational
CAS09	782	<b>Monetary Amount</b> <b>Description:</b> Monetary amount <b>Industry:</b> Adjustment Amount	C	R	1/18	Situational

		<p><b>Alias:</b> Adjusted Amount - Claim Level  <b>HIPAA IG Note:</b> Use as needed to show payer adjustment.</p>				
CAS10	380	<p><b>Quantity</b></p> <p><b>Description:</b> Numeric value of quantity  <b>Industry:</b> Adjustment Quantity  <b>Alias:</b> Adjusted Units - Claim Level  <b>HIPAA IG Note:</b> Use as needed to show payer adjustment.</p>	C	R	1/15	Situational
CAS11	1034	<p><b>Claim Adjustment Reason Code</b></p> <p><b>Description:</b> Code identifying the detailed reason the adjustment was made  <b>Industry:</b> Adjustment Reason Code  <b>Alias:</b> Adjustment Reason Code - Claim Level  <b>HIPAA IG Note:</b> Use as needed to show payer adjustment.</p> <p><b>ExternalCodeList</b>  <b>Name:</b> 139  <b>Description:</b> Claim Adjustment Reason Code</p>	C	ID	1/5	Situational
CAS12	782	<p><b>Monetary Amount</b></p> <p><b>Description:</b> Monetary amount  <b>Industry:</b> Adjustment Amount  <b>Alias:</b> Adjusted Amount - Claim Level  <b>HIPAA IG Note:</b> Use as needed to show payer adjustment.</p>	C	R	1/18	Situational
CAS13	380	<p><b>Quantity</b></p> <p><b>Description:</b> Numeric value of quantity  <b>Industry:</b> Adjustment Quantity  <b>Alias:</b> Adjusted Units - Claim Level  <b>HIPAA IG Note:</b> Use as needed to show payer adjustment.</p>	C	R	1/15	Situational
CAS14	1034	<p><b>Claim Adjustment Reason Code</b></p> <p><b>Description:</b> Code identifying the detailed reason the adjustment was made  <b>Industry:</b> Adjustment Reason Code  <b>Alias:</b> Adjustment Reason Code - Claim Level  <b>HIPAA IG Note:</b> Use as needed to show payer adjustment.</p> <p><b>ExternalCodeList</b>  <b>Name:</b> 139  <b>Description:</b> Claim Adjustment Reason Code</p>	C	ID	1/5	Situational
CAS15	782	<p><b>Monetary Amount</b></p> <p><b>Description:</b> Monetary amount  <b>Industry:</b> Adjustment Amount  <b>Alias:</b> Adjusted Amount - Claim Level  <b>HIPAA IG Note:</b> Use as needed to show payer adjustment.</p>	C	R	1/18	Situational
CAS16	380	<p><b>Quantity</b></p> <p><b>Description:</b> Numeric value of quantity  <b>Industry:</b> Adjustment Quantity  <b>Alias:</b> Adjusted Units - Claim Level  <b>HIPAA IG Note:</b> Use as needed to show payer adjustment.</p>	C	R	1/15	Situational
CAS17	1034	<p><b>Claim Adjustment Reason Code</b></p> <p><b>Description:</b> Code identifying the detailed reason</p>	C	ID	1/5	Situational

the adjustment was made  
**Industry:** Adjustment Reason Code  
**Alias:** Adjustment Reason Code - Claim Level  
**HIPAA IG Note:** Use as needed to show payer adjustment.

**ExternalCodeList**

**Name:** 139

**Description:** Claim Adjustment Reason Code

CAS18	782	<b>Monetary Amount</b>	C	R	1/18	Situational
-------	-----	------------------------	---	---	------	-------------

**Description:** Monetary amount  
**Industry:** Adjustment Amount  
**Alias:** Adjusted Amount - Claim Level  
**HIPAA IG Note:** Use as needed to show payer adjustment.

CAS19	380	<b>Quantity</b>	C	R	1/15	Situational
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**Description:** Numeric value of quantity  
**Industry:** Adjustment Quantity  
**Alias:** Adjusted Units - Claim Level  
**HIPAA IG Note:** Use as needed to show payer adjustment.

# 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 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>
AMT01	522	<b>Amount Qualifier Code</b> <b>Description:</b> Code to qualify amount	M	ID	1/3	Required
		<b>Code</b> <b>Name</b> D                    Payor Amount Paid				
AMT02	782	<b>Monetary Amount</b> <b>Description:</b> Monetary amount <b>Industry:</b> Payer Paid Amount <b>HIPAA IG Note:</b> This is a crosswalk from CLP04 in 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	<b>Amount Qualifier Code</b>	M	ID	1/3	Required
<b>Description:</b> Code to qualify amount						
		<u>Code</u>		<u>Name</u>		
		F2		Patient Responsibility - Actual		
<b>Description:</b> Calculated value one receiving medical care is obliged to pay						
AMT02	782	<b>Monetary Amount</b>	M	R	1/18	Required
<b>Description:</b> Monetary amount						
<b>Industry:</b> Other Payer Patient Responsibility Amount						
<b>HIPAA IG Note:</b> This is a crosswalk from CLP05 in 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\*152.45~

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

# DMG Subscriber Demographic Information

Pos: 305	Max: 1
Detail - Optional	
Loop: 2320	Elements: 3

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

**Notes:**

1. Required when 2330A NM102 = 1 (person).
2. See Section 1.4.5 Crosswalking COB Data Elements for more information on handling COB in the 837.

**Example:**

DMG\*D8\*19671105\*F~

**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>
DMG01	1250	<b>Date Time Period Format Qualifier</b>  <b>Description:</b> Code indicating the date format, time format, or date and time format	C	ID	2/3	Required
		<b>Code</b> <b>Name</b> D8                    Date Expressed in Format CCYYMMDD				
DMG02	1251	<b>Date Time Period</b>  <b>Description:</b> Expression of a date, a time, or range of dates, times or dates and times <b>Industry:</b> Other Insured Birth Date <b>Alias:</b> Date of Birth - Subscriber	C	AN	1/35	Required
DMG03	1068	<b>Gender Code</b>  <b>Description:</b> Code indicating the sex of the individual <b>Industry:</b> Other Insured Gender Code <b>Alias:</b> Gender - Subscriber <b>NYS MEDICAID NOTE:</b> NYSDOH cannot process code 'U' (Unknown) and if present the claim will be denied.	O	ID	1/1	Required
		<b>Code</b> <b>Name</b> F                    Female M                    Male				

# OI Other Insurance Coverage Information

Pos: 310	Max: 1
Detail - Optional	
Loop: 2320	Elements: 3

**User Option (Usage):** Required

**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.
2. See Section 1.4.5 Crosswalking COB Data Elements for more information on handling COB in the 837.

**Example:**

OI\*\*\*Y\*B\*\*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	<b>Yes/No Condition or Response Code</b>  <b>Description:</b> Code indicating a Yes or No condition or response <b>Industry:</b> Benefits Assignment Certification Indicator <b>Alias:</b> Assignment of Benefits Indicator <b>HIPAA IG Note:</b> This is a crosswalk from CLM08 when doing COB.  <table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>N</td> <td>No</td> </tr> <tr> <td>Y</td> <td>Yes</td> </tr> </tbody> </table>	<u>Code</u>	<u>Name</u>	N	No	Y	Yes	O	ID	1/1	Required						
<u>Code</u>	<u>Name</u>																	
N	No																	
Y	Yes																	
OI04	1351	<b>Patient Signature Source Code</b>  <b>Description:</b> Code indicating how the patient or subscriber authorization signatures were obtained and how they are being retained by the provider <b>Alias:</b> Patient Signature Source Code <b>HIPAA IG Note:</b> Required except in cases where "N" is used in OI06. This is a crosswalk from CLM10 when doing COB.  <table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>B</td> <td>Signed signature authorization form or forms for both HCFA-1500 Claim Form block 12 and block 13 are on file</td> </tr> <tr> <td>C</td> <td>Signed HCFA-1500 Claim Form on file</td> </tr> <tr> <td>M</td> <td>Signed signature authorization form for HCFA-1500 Claim Form block 13 on file</td> </tr> <tr> <td>P</td> <td>Signature generated by provider because the patient was not physically present for services</td> </tr> <tr> <td>S</td> <td>Signed signature authorization form for HCFA-1500 Claim Form block 12 on file</td> </tr> </tbody> </table>	<u>Code</u>	<u>Name</u>	B	Signed signature authorization form or forms for both HCFA-1500 Claim Form block 12 and block 13 are on file	C	Signed HCFA-1500 Claim Form on file	M	Signed signature authorization form for HCFA-1500 Claim Form block 13 on file	P	Signature generated by provider because the patient was not physically present for services	S	Signed signature authorization form for HCFA-1500 Claim Form block 12 on file	O	ID	1/1	Situational
<u>Code</u>	<u>Name</u>																	
B	Signed signature authorization form or forms for both HCFA-1500 Claim Form block 12 and block 13 are on file																	
C	Signed HCFA-1500 Claim Form on file																	
M	Signed signature authorization form for HCFA-1500 Claim Form block 13 on file																	
P	Signature generated by provider because the patient was not physically present for services																	
S	Signed signature authorization form for HCFA-1500 Claim Form block 12 on file																	
OI06	1363	<b>Release of Information Code</b>  <b>Description:</b> Code indicating whether the provider has on file a signed statement by the patient authorizing the release of medical data to other organizations <b>Alias:</b> Release of Information Code <b>HIPAA IG Note:</b> This is a crosswalk from CLM09 when doing COB.  <table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> </table>	<u>Code</u>	<u>Name</u>	O	ID	1/1	Required										
<u>Code</u>	<u>Name</u>																	

- A Appropriate Release of Information on File at Health Care Service Provider or at Utilization Review Organization
- I Informed Consent to Release Medical Information for Conditions or Diagnoses Regulated by Federal Statutes
- M The Provider has Limited or Restricted Ability to Release Data Related to a Claim
- N No, Provider is Not Allowed to Release Data
- O On file at Payor or at Plan Sponsor
- Y Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim

# MOA Medicare Outpatient Adjudication Information

Pos: 320	Max: 1
Detail - Optional	
Loop: 2320	Elements: 9

**User Option (Usage):** Situational

**Purpose:** To convey claim-level data related to the adjudication of Medicare claims not related to an inpatient setting

**Notes:**

- 1. Required if returned in the electronic remittance advice (835).

**Example:**

MOA\*\*\*A4~

**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>
MOA01	954	<b>Percent</b> <b>Description:</b> Percentage expressed as a decimal <b>Industry:</b> Reimbursement Rate <b>Alias:</b> Outpatient Reimbursement Rate <b>HIPAA IG Note:</b> Required if returned in the electronic remittance advice (835).	O	R	1/10	Situational
MOA02	782	<b>Monetary Amount</b> <b>Description:</b> Monetary amount <b>Industry:</b> HCPCS Payable Amount <b>HIPAA IG Note:</b> Required if returned in the electronic remittance advice (835).	O	R	1/18	Situational
MOA03	127	<b>Reference Identification</b> <b>Description:</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier <b>Industry:</b> Remark Code <b>Alias:</b> Remarks Code <b>HIPAA IG Note:</b> Required if returned in the electronic remittance advice (835). <b>ExternalCodeList</b> <b>Name:</b> 411 <b>Description:</b> Remittance Remark Codes	O	AN	1/30	Situational
MOA04	127	<b>Reference Identification</b> <b>Description:</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier <b>Industry:</b> Remark Code <b>Alias:</b> Remarks Code <b>HIPAA IG Note:</b> Required if returned in the electronic remittance advice (835). <b>ExternalCodeList</b> <b>Name:</b> 411 <b>Description:</b> Remittance Remark Codes	O	AN	1/30	Situational
MOA05	127	<b>Reference Identification</b> <b>Description:</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier <b>Industry:</b> Remark Code	O	AN	1/30	Situational

		<p><b>Alias:</b> Remarks Code  <b>HIPAA IG Note:</b> Required if returned in the electronic remittance advice (835).</p> <p><b>ExternalCodeList</b>  <b>Name:</b> 411  <b>Description:</b> Remittance Remark Codes</p>				
MOA06	127	<p><b>Reference Identification</b></p> <p><b>Description:</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier  <b>Industry:</b> Remark Code  <b>Alias:</b> Remarks Code  <b>HIPAA IG Note:</b> Required if returned in the electronic remittance advice (835).</p> <p><b>ExternalCodeList</b>  <b>Name:</b> 411  <b>Description:</b> Remittance Remark Codes</p>	O	AN	1/30	Situational
MOA07	127	<p><b>Reference Identification</b></p> <p><b>Description:</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier  <b>Industry:</b> Remark Code  <b>Alias:</b> Remarks Code  <b>HIPAA IG Note:</b> Required if returned in the electronic remittance advice (835).</p> <p><b>ExternalCodeList</b>  <b>Name:</b> 411  <b>Description:</b> Remittance Remark Codes</p>	O	AN	1/30	Situational
MOA08	782	<p><b>Monetary Amount</b></p> <p><b>Description:</b> Monetary amount  <b>Industry:</b> End Stage Renal Disease Payment Amount  <b>Alias:</b> ESRD Paid Amount  <b>HIPAA IG Note:</b> Required if returned in the electronic remittance advice (835).</p>	O	R	1/18	Situational
MOA09	782	<p><b>Monetary Amount</b></p> <p><b>Description:</b> Monetary amount  <b>Industry:</b> Non-Payable Professional Component Billed Amount  <b>Alias:</b> Professional Component  <b>HIPAA IG Note:</b> Required if returned in the electronic remittance advice (835).</p>	O	R	1/18	Situational

# NM1 Other Subscriber Name

<b>Pos:</b> 325	<b>Max:</b> 1
<b>Detail - Optional</b>	
<b>Loop:</b> 2330A	<b>Elements:</b> 8

**User Option (Usage):** Required

**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. This 2330 loop is required when Loop ID-2320 - Other Subscriber Information is used. Otherwise, this loop is not used.
3. See Section 1.4.5 Crosswalking COB Data Elements for more information on handling COB in the 837.

**Example:**

NM1\*IL\*1\*DOE\*JOHN\*T\*\*JR\*MI\*123456~

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

Identification Code (67)

<u>Code</u>	<u>Name</u>
MI	<p>Member Identification Number</p> <p>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 Professional Workgroup recommends using MI - Member Identification Number to convey the following terms: Insured's ID, Subscriber's ID, Health Insurance Claim Number (HIC), etc.</p>
ZZ	<p>Mutually Defined</p> <p>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.</p>

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

**Description:** Code identifying a party or other code

**Industry:** Other Insured Identifier

**Alias:** Other Subscriber Primary Identifier

# NM1 Other Payer Name

<b>Pos: 325</b>	<b>Max: 1</b>
<b>Detail - Optional</b>	
<b>Loop: 2330B</b>	<b>Elements: 5</b>

**User Option (Usage):** Required

**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.
2. This 2330 loop is required when Loop ID-2320 - Other Subscriber Information is used. Otherwise, this loop is not used.
3. See Section 1.4.5 Crosswalking COB Data Elements for more information on handling COB in the 837.

**Example:**

NM1\*PR\*2\*UNION MUTUAL OF OREGON\*\*\*\*\*PI\*11122333~

**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	<b>Entity Identifier Code</b> <b>Description:</b> 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	<b>Entity Type Qualifier</b> <b>Description:</b> 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	<b>Name Last or Organization Name</b> <b>Description:</b> Individual last name or organizational name <b>Industry:</b> Other Payer Last or Organization Name <b>Alias:</b> Payer Name <b>NYS MEDICAID NOTE:</b> NYSDOH expects the Payer Name.	O	AN	1/35	Required				
NM108	66	<b>Identification Code Qualifier</b> <b>Description:</b> Code designating the system/method of code structure used for Identification Code (67) <b>NYS MEDICAID NOTE:</b> 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	<b>Identification Code</b> <b>Description:</b> Code identifying a party or other code <b>Industry:</b> Other Payer Primary Identifier <b>Alias:</b> Other Payer Primary Identification Number <b>NYS MEDICAID NOTE:</b> If there are multiple prior payers being identified in the claim, the Identifiers in NM109 must be unique for each one. <b>HIPAA IG Note:</b> This number must be identical to SVD01 (Loop ID-2430) for COB.	C	AN	2/80	Required				

**ExternalCodeList**

**Name:** 540

**Description:** Health Care Financing Administration National PlanID

# DTP Claim Adjudication Date

<b>Pos: 350</b>	<b>Max: 1</b>
<b>Detail - Optional</b>	
<b>Loop: 2330B</b>	<b>Elements: 3</b>

**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 the payer identified in this iteration of the 2330 loop has previously adjudicated the claim and Loop-ID 2430 (Line Adjudication Information) is not used.

**Example:**

DTP\*573\*D8\*19980314~

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

# LX

## Service Line

<b>Pos: 365</b>	<b>Max: 1</b>
<b>Detail - Optional</b>	
<b>Loop: 2400</b>	<b>Elements: 1</b>

**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 datum in the LX is not usually returned in the 835 (Remittance Advice) transaction. LX01 may be used as a line item control number by the payer in the 835 if a line item control number has not been submitted on the service line. See that REF for more information. LX01 is used to indicate bundling/unbundling in SVC06. See Section 1.4.3 for more information on bundling and unbundling.
3. Because this is a required segment, this is a required loop. See Appendix A for further details on ASC X12 syntax rules.

**Example:**

LX\*1~

**NYS MEDICAID NOTE:**

NYSDOH expects a maximum of 4 lines (loop 2400) for real-time processing. For batch, please refer to the IG requirements/limitations.

**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	<b>Assigned Number</b>	M	NO	1/6	Required
<p><b>Description:</b> Number assigned for differentiation within a transaction set</p> <p><b>Alias:</b> Line Counter</p> <p><b>HIPAA IG Note:</b> The service line number incremented by 1 for each service line.</p>						

# SV1 Professional Service

<b>Pos: 370</b>	<b>Max: 1</b>
<b>Detail - Optional</b>	
<b>Loop: 2400</b>	<b>Elements: 10</b>

**User Option (Usage):** Required

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

**Example:**

SV1\*HC:99211:25\*12.25\*UN\*1\*11\*\*1:2:3\*\*N~

**NYS MEDICAID NOTE:**

NYSDOH expects to receive Procedure Codes and Modifiers here. NYSDOH has established specific codes for use by transportation providers when billing NYS Medicaid.

In the Interactive 837P, NYSDOH will accept a maximum of four SV1 segments in a claim.

**Element Summary:**

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>	
SV101	C003	<b>Composite Medical Procedure Identifier</b> <b>Description:</b> To identify a medical procedure by its standardized codes and applicable modifiers <b>Alias:</b> Procedure identifier	M	Comp		Required	
SV101-01	235	<b>Product/Service ID Qualifier</b> <b>Description:</b> Code identifying the type/source of the descriptive number used in Product/Service ID (234) <b>Industry:</b> Product or Service ID Qualifier <b>NYS MEDICAID NOTE:</b> NYSDOH expects to receive qualifier 'HC'. <b>HIPAA IG Note:</b> The NDC number is used for reporting prescribed drugs and biologics when required by government regulation, or as deemed by the provider to enhance claim reporting/adjudication processes. The NDC number is reported in the LIN segment of Loop ID-2410 only.	M	ID	2/2	Required	
		<b>Code</b> HC		<b>Name</b> Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes <b>Description:</b> HCFA coding scheme to group procedure(s) performed on an outpatient basis for payment to hospital under Medicare; primarily used for ambulatory surgical and other diagnostic departments Because the AMA's CPT codes are also level 1 HCPCS codes, they are reported under HC.			
SV101-02	234	<b>Product/Service ID</b> <b>Description:</b> Identifying number for a product or service <b>Industry:</b> Procedure Code	M	AN	1/48	Required	
		<b>ExternalCodeList</b> <b>Name:</b> 130 <b>Description:</b> Health Care Financing Administration Common Procedural Coding System					
		<b>ExternalCodeList</b> <b>Name:</b> 513 <b>Description:</b> Home Infusion EDI Coalition (HIEC) Product/Service Code List					
SV101-03	1339	<b>Procedure Modifier</b> <b>Description:</b> This identifies special circumstances related to the performance of the	O	AN	2/2	Situational	

		<p>service, as defined by trading partners</p> <p><b>Alias:</b> Procedure Modifier 1</p> <p><b>HIPAA IG Note:</b> Use this modifier for the first procedure code modifier.</p> <p>Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.</p>																
SV101-04	1339	<p><b>Procedure Modifier</b></p> <p><b>Description:</b> This identifies special circumstances related to the performance of the service, as defined by trading partners</p> <p><b>Alias:</b> Procedure Modifier 2</p> <p><b>HIPAA IG Note:</b> Use this modifier for the second procedure code modifier.</p> <p>Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.</p>	O	AN	2/2	Situational												
SV101-05	1339	<p><b>Procedure Modifier</b></p> <p><b>Description:</b> This identifies special circumstances related to the performance of the service, as defined by trading partners</p> <p><b>Alias:</b> Procedure Modifier 3</p> <p><b>HIPAA IG Note:</b> Use this modifier for the third procedure code modifier.</p> <p>Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.</p>	O	AN	2/2	Situational												
SV101-06	1339	<p><b>Procedure Modifier</b></p> <p><b>Description:</b> This identifies special circumstances related to the performance of the service, as defined by trading partners</p> <p><b>Alias:</b> Procedure Modifier 4</p> <p><b>HIPAA IG Note:</b> Use this modifier for the fourth procedure code modifier.</p> <p>Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.</p>	O	AN	2/2	Situational												
SV102	782	<p><b>Monetary Amount</b></p> <p><b>Description:</b> Monetary amount</p> <p><b>Industry:</b> Line Item Charge Amount</p> <p><b>Alias:</b> Submitted charge amount</p> <p><b>HIPAA IG Note:</b> For encounter transmissions, zero (0) may be a valid amount.</p>	O	R	1/18	Required												
SV103	355	<p><b>Unit or Basis for Measurement Code</b></p> <p><b>Description:</b> Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken</p> <p><b>HIPAA IG Note:</b> FA0-50.0 is only used in Medicare COB payer-to-payer situations.</p> <table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>F2</td> <td>International Unit</td> </tr> <tr> <td></td> <td><b>Description:</b> A unit accepted by an international agency; potency of a drug/vitamin based on a specific weight of that drug/vitamin</td> </tr> <tr> <td></td> <td>International Unit is used to indicate dosage amount. Dosage amount is only used for drug claims when the dosage of the drug is variable within a single NDC number (e.g., blood factors).</td> </tr> <tr> <td>MJ</td> <td>Minutes</td> </tr> <tr> <td>UN</td> <td>Unit</td> </tr> </tbody> </table>	<u>Code</u>	<u>Name</u>	F2	International Unit		<b>Description:</b> A unit accepted by an international agency; potency of a drug/vitamin based on a specific weight of that drug/vitamin		International Unit is used to indicate dosage amount. Dosage amount is only used for drug claims when the dosage of the drug is variable within a single NDC number (e.g., blood factors).	MJ	Minutes	UN	Unit	C	ID	2/2	Required
<u>Code</u>	<u>Name</u>																	
F2	International Unit																	
	<b>Description:</b> A unit accepted by an international agency; potency of a drug/vitamin based on a specific weight of that drug/vitamin																	
	International Unit is used to indicate dosage amount. Dosage amount is only used for drug claims when the dosage of the drug is variable within a single NDC number (e.g., blood factors).																	
MJ	Minutes																	
UN	Unit																	

SV104	380	<p><b>Quantity</b></p> <p><b>Description:</b> Numeric value of quantity  <b>Industry:</b> Service Unit Count  <b>Alias:</b> Units or Minutes  <b>NYS MEDICAID NOTE:</b> NYSDOH expects to receive units of service.  <b>HIPAA IG Note:</b> Note: If a decimal is needed to report units, include it in this element, e.g., "15.6".</p>	C	R	1/15	Required
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SV105	1331	<p><b>Facility Code Value</b></p> <p><b>Description:</b> 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  <b>Industry:</b> Place of Service Code  <b>Alias:</b> Place of Service Code  <b>HIPAA IG Note:</b> Required if value is different than value carried in CLM05-1 in Loop ID-2300. 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 guideline. 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> <ul style="list-style-type: none"> <li>11 Office</li> <li>12 Home</li> <li>21 Inpatient Hospital</li> <li>22 Outpatient Hospital</li> <li>23 Emergency Room - Hospital</li> <li>24 Ambulatory Surgical Center</li> <li>25 Birthing Center</li> <li>26 Military Treatment Facility</li> <li>31 Skilled Nursing Facility</li> <li>32 Nursing Facility</li> <li>33 Custodial Care Facility</li> <li>34 Hospice</li> <li>41 Ambulance - Land</li> <li>42 Ambulance - Air or Water</li> <li>51 Inpatient Psychiatric Facility</li> <li>52 Psychiatric Facility Partial Hospitalization</li> <li>53 Community Mental Health Center</li> <li>54 Intermediate Care Facility/Mentally Retarded</li> <li>55 Residential Substance Abuse Treatment Facility</li> <li>56 Psychiatric Residential Treatment Center</li> <li>50 Federally Qualified Health Center</li> <li>60 Mass Immunization Center</li> <li>61 Comprehensive Inpatient Rehabilitation Facility</li> <li>62 Comprehensive Outpatient Rehabilitation Facility</li> <li>65 End Stage Renal Disease Treatment Facility</li> <li>71 State or Local Public Health Clinic</li> <li>72 Rural Health Clinic</li> <li>81 Independent Laboratory</li> <li>99 Other Unlisted Facility</li> </ul>	O	AN	1/2	Situational
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**ExternalCodeList**

**Name:** 237

**Description:** Place of Service from Health Care Financing Administration Claim Form

SV107	C004	<b>Composite Diagnosis Code Pointer</b> <b>Description:</b> To identify one or more diagnosis code pointers <b>Alias:</b> Diagnosis Code Pointer <b>NYS MEDICAID NOTE:</b> NYSDOH expects to receive Primary and Secondary Diagnosis code pointers in SV107-1 and in SV107-2, respectively. NYSDOH will be unable to determine the appropriate diagnosis codes without these pointers. <b>HIPAA IG Note:</b> Required if HI segment in Loop ID-2300 is used.	O	Comp		Situational
SV107-01	1328	<b>Diagnosis Code Pointer</b> <b>Description:</b> A pointer to the claim diagnosis code in the order of importance to this service <b>HIPAA IG Note:</b> Use this pointer for the first diagnosis code pointer (primary diagnosis for this service line). Use remaining diagnosis pointers in declining level of importance to service line. Acceptable values are 1 through 8, inclusive.	M	NO	1/2	Required
SV107-02	1328	<b>Diagnosis Code Pointer</b> <b>Description:</b> A pointer to the claim diagnosis code in the order of importance to this service <b>HIPAA IG Note:</b> Use this pointer for the second diagnosis code pointer. Required if the service relates to that specific diagnosis and is needed to substantiate the medical treatment. Acceptable values are 1 through 8, inclusive.	O	NO	1/2	Situational
SV109	1073	<b>Yes/No Condition or Response Code</b> <b>Description:</b> Code indicating a Yes or No condition or response <b>Industry:</b> Emergency Indicator <b>NYS MEDICAID NOTE:</b> NYSDOH expects to receive Emergency Indicator here. <b>HIPAA IG Note:</b> Required when the service is known to be an emergency by the provider. Emergency definition: The patient requires immediate medical intervention as a result of severe, life threatening, or potentially disabling conditions.	O	ID	1/1	Situational
		<b>Code</b> <b>Name</b> Y                              Yes				
SV111	1073	<b>Yes/No Condition or Response Code</b> <b>Description:</b> Code indicating a Yes or No condition or response <b>Industry:</b> EPSDT Indicator <b>HIPAA IG Note:</b> Required if Medicaid services are the result of a screening referral.	O	ID	1/1	Situational
		<b>Code</b> <b>Name</b> Y                              Yes				
SV112	1073	<b>Yes/No Condition or Response Code</b> <b>Description:</b> Code indicating a Yes or No condition or response <b>Industry:</b> Family Planning Indicator <b>NYS MEDICAID NOTE:</b> NYSDOH expects to receive Family Planning Indicator here. <b>HIPAA IG Note:</b> Required if applicable for	O	ID	1/1	Situational

Medicaid claims.

<u>Code</u>	<u>Name</u>
Y	Yes

SV115	1327	<b>Copay Status Code</b>	O	ID	1/1	Situational
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**Description:** Code indicating whether or not co-payment requirements were met on a line by line basis

**Industry:** Co-Pay Status Code  
**Alias:** Co-Pay Waiver  
**NYS MEDICAID NOTE:** NYSDOH expects to receive Co-Pay Bypass Indicator here.  
**HIPAA IG Note:** Required if patient was exempt from co-pay.

<u>Code</u>	<u>Name</u>
0	Copay exempt

**Description:** No copayment is required of patient for this service

# DTP Date - Service Date

<b>Pos: 455</b>	<b>Max: 1</b>
<b>Detail - Optional</b>	
<b>Loop: 2400</b>	<b>Elements: 3</b>

**User Option (Usage):** Required

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

**Notes:**

1. The total number of DTP segments in the 2400 loop cannot exceed 15.
2. In cases where a drug is being billed on a service line, the Date of Service DTP may be used to indicate the range of dates through which the drug will be used by the patient. Use RD8 for this purpose.
3. In cases where a drug is being billed on a service line, the Date of Service DTP is used to indicate the date the prescription was written (or otherwise communicated by the prescriber if not written).

**Example:**

DTP\*472\*RD8\*19970607-19970608~

**NYS MEDICAID NOTE:**

NYSDOH expects to receive Date of Service 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>
DTP01	374	<b>Date/Time Qualifier</b> <b>Description:</b> Code specifying type of date or time, or both date and time <b>Industry:</b> Date Time Qualifier	M	ID	3/3	Required
		<b>Code</b> <b>Name</b> 472            Service Use RD8 in DTP02 to indicate begin/end or from/to dates.				
DTP02	1250	<b>Date Time Period Format Qualifier</b> <b>Description:</b> Code indicating the date format, time format, or date and time format <b>NYS MEDICAID NOTE:</b> NYSDOH expects to receive qualifier 'D8'.	M	ID	2/3	Required
		<b>Code</b> <b>Name</b> D8            Date Expressed in Format CCYYMMDD				
DTP03	1251	<b>Date Time Period</b> <b>Description:</b> Expression of a date, a time, or range of dates, times or dates and times <b>Industry:</b> 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:**  
 Required if service line involved a prior authorization number or referral number that is different than the number reported at the claim level (Loop-ID 2300).

**Example:**  
 REF\*9F\*12345678~

**NYS MEDICAID NOTE:**  
 Please refer to the loop 2300 Prior Authorization or Referral Number REF segment.

If present at this location NYSDOH will process this number as an override to the number sent in loop 2300. Loop 2300 is the recommended location for this 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>
REF01	128	<b>Reference Identification Qualifier</b>	M	ID	2/3	Required
		<b>Description:</b> Code qualifying the Reference Identification				
		<b>Code</b>		<b>Name</b>		
		G1		Prior Authorization Number		
		<b>Description:</b> An authorization number acquired prior to the submission of a claim				
REF02	127	<b>Reference Identification</b>	C	AN	1/30	Required
		<b>Description:</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier				
		<b>Industry:</b> Prior Authorization or Referral Number				

# REF Line Item Control Number

<b>Pos: 470</b>	<b>Max: 1</b>
<b>Detail - Optional</b>	
<b>Loop: 2400</b>	<b>Elements: 2</b>

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

**Notes:**

1. Required if it is necessary to send a line control or inventory number. Providers are STRONGLY encouraged to routinely send a unique line item control number on all service lines, particularly if the provider automatically posts their remittance advice. Submitting a unique line item control number gives providers the capability to automatically post by service line. The line item control number should be unique within a patient control number (CLM01). Payers are required to return this number in the remittance advice transaction (835) if the providers sends it to them in the 837.

**Example:**

REF\*6R\*54321~

**NYS MEDICAID NOTE:**

NYSDOH expects a unique Line Item Control Number on all service lines.

**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	<b>Reference Identification Qualifier</b>	M	ID	2/3	Required
		<b>Description:</b> Code qualifying the Reference Identification				
		<b>Code</b>		<b>Name</b>		
		6R		Provider Control Number		
		<b>Description:</b> Number assigned by information provider company for tracking and billing purposes				
REF02	127	<b>Reference Identification</b>	C	AN	1/30	Required
		<b>Description:</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier				
		<b>Industry:</b> Line Item Control Number				

# 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 this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC 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. The identifying payer-specific numbers are those that belong to the destination payer identified in loop 2010BB.
3. Used for all types of rendering providers including laboratories. The Rendering Provider is the person or company (laboratory or other facility) who rendered the care. In the case where a substitute provider (locum tenans) was used, that person should be entered here.

**Example:**

NM1\*82\*1\*SMITH\*JUNE\*L\*\*\*XX\*87654321~

**NYS MEDICAID NOTE:**

Non-emergency Transportation is not regulated by HIPAA.

Refer to the NYS Medicaid Notes in loop 2310B for details. If loop 2420A is sent in the first (LX\*1) iteration of the Service Line loop (loop 2400) it will overwrite the loop 2310B data.

**Element Summary:**

Ref	Id	Element Name	Req	Type	Min/Max	Usage						
NM101	98	<b>Entity Identifier Code</b> <b>Description:</b> Code identifying an organizational entity, a physical location, property or an individual <b>HIPAA IG Note:</b> The entity identifier in NM101 applies to all segments in this iteration of Loop ID-2420. <table border="1"> <tr> <th>Code</th> <th>Name</th> </tr> <tr> <td>82</td> <td>Rendering Provider</td> </tr> </table>	Code	Name	82	Rendering Provider	M	ID	2/3	Required		
Code	Name											
82	Rendering Provider											
NM102	1065	<b>Entity Type Qualifier</b> <b>Description:</b> Code qualifying the type of entity <table border="1"> <tr> <th>Code</th> <th>Name</th> </tr> <tr> <td>1</td> <td>Person</td> </tr> <tr> <td>2</td> <td>Non-Person Entity</td> </tr> </table>	Code	Name	1	Person	2	Non-Person Entity	M	ID	1/1	Required
Code	Name											
1	Person											
2	Non-Person Entity											
NM103	1035	<b>Name Last or Organization Name</b> <b>Description:</b> Individual last name or organizational name <b>Industry:</b> Rendering Provider Last or Organization Name <b>Alias:</b> Rendering Provider Last Name	O	AN	1/35	Required						
NM104	1036	<b>Name First</b> <b>Description:</b> Individual first name <b>Industry:</b> Rendering Provider First Name <b>HIPAA IG Note:</b> Required if NM102=1 (person).	O	AN	1/25	Situational						
NM105	1037	<b>Name Middle</b> <b>Description:</b> Individual middle name or initial <b>Industry:</b> Rendering Provider Middle Name	O	AN	1/25	Situational						

		<b>HIPAA IG Note:</b> Required if NM102=1 and the middle name/initial of the person is known.																
NM107	1039	<b>Name Suffix</b> <b>Description:</b> Suffix to individual name <b>Industry:</b> Rendering Provider Name Suffix <b>Alias:</b> Rendering Provider Generation <b>HIPAA IG Note:</b> Required if known.	O	AN	1/10	Situational												
NM108	66	<b>Identification Code Qualifier</b> <b>Description:</b> Code designating the system/method of code structure used for Identification Code (67) <b>NYS MEDICAID NOTE:</b> Because Non-emergency Transportation is not regulated by HIPAA, it is permissible to sent any of the listed qualifiers if this data element is populated.	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></td> <td>Social Security Number cannot be used for Medicare claims.</td> </tr> <tr> <td>XX</td> <td>Health Care Financing Administration National Provider Identifier</td> </tr> <tr> <td></td> <td><b>Description:</b> Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.</td> </tr> </tbody> </table>	<u>Code</u>	<u>Name</u>	24	Employer's Identification Number	34	Social Security Number		Social Security Number cannot be used for Medicare claims.	XX	Health Care Financing Administration National Provider Identifier		<b>Description:</b> Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.				
<u>Code</u>	<u>Name</u>																	
24	Employer's Identification Number																	
34	Social Security Number																	
	Social Security Number cannot be used for Medicare claims.																	
XX	Health Care Financing Administration National Provider Identifier																	
	<b>Description:</b> Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.																	
NM109	67	<b>Identification Code</b> <b>Description:</b> Code identifying a party or other code <b>Industry:</b> Rendering Provider Identifier <b>Alias:</b> Rendering Provider Primary Identifier <b>NYS MEDICAID NOTE:</b> NYSDOH expects to receive the NPI here, when NM108 contains a qualifier of 'XX'.	C	AN	2/80	Required												
		<b>ExternalCodeList</b> <b>Name:</b> 537 <b>Description:</b> Health Care Financing Administration National Provider Identifier																

# REF Rendering Provider Secondary Identification

Pos: 525	Max: 1
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 NM109 in this loop.

**Example:**

REF\*1D\*A12345~

**NYS MEDICAID NOTE:**

Refer to the NYS Medicaid Notes in loop 2310B for details.

**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	<b>Reference Identification Qualifier</b>	M	ID	2/3	Required
		<b>Description:</b> Code qualifying the Reference Identification				
		<u>Code</u> <u>Name</u>				
		1D                              Medicaid Provider Number				
REF02	127	<b>Reference Identification</b>	C	AN	1/30	Required
		<b>Description:</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier				
		<b>Industry:</b> Rendering Provider Secondary Identifier				

# NM1 Referring Provider Name

<b>Pos: 500</b>	<b>Max: 1</b>
<b>Detail - Optional</b>	
<b>Loop: 2420F</b>	<b>Elements: 8</b>

**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 this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 syntax rules.
2. Required if this service line involves a referral and the referring provider is different than the rendering provider and if the referring provider differs from that reported at the claim level (loop 2310A). All payer-specific identifying numbers belong to the destination payer identified in the 2010BB loop.
3. When there is only one referral on the service line use code "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 service line. 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.

**Example:**

NM1\*DN\*1\*WELBY\*MARCUS\*W\*\*JR\*34\*444332222~

**NYS MEDICAID NOTE:**

Please refer to corresponding loop 2310A. If loop 2420F is sent in the first (LX\*1) iteration of the Service Line loop (loop 2400) it will overwrite the loop 2310A data.

**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	<b>Entity Identifier Code</b>  <b>Description:</b> Code identifying an organizational entity, a physical location, property or an individual  <b>Code</b> <b>Name</b> DN                Referring Provider Use on the first iteration of this loop. Use if loop is used only once.	M	ID	2/3	Required
NM102	1065	<b>Entity Type Qualifier</b>  <b>Description:</b> Code qualifying the type of entity  <b>Code</b> <b>Name</b> 1                 Person	M	ID	1/1	Required
NM103	1035	<b>Name Last or Organization Name</b>  <b>Description:</b> Individual last name or organizational name <b>Industry:</b> Referring Provider Last Name	O	AN	1/35	Required
NM104	1036	<b>Name First</b>  <b>Description:</b> Individual first name <b>Industry:</b> Referring Provider First Name	O	AN	1/25	Required
NM105	1037	<b>Name Middle</b>  <b>Description:</b> Individual middle name or initial <b>Industry:</b> Referring Provider Middle Name <b>HIPAA IG Note:</b> Required if NM102=1 and the middle name/initial of the person is known.	O	AN	1/25	Situational
NM107	1039	<b>Name Suffix</b>  <b>Description:</b> Suffix to individual name <b>Industry:</b> Referring Provider Name Suffix <b>Alias:</b> Referring Provider Generation <b>HIPAA IG Note:</b> Required if known.	O	AN	1/10	Situational

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 either Employer's Identification/Social Security Number (Referring Provider tax ID) or National Provider Identifier is known.

**Code** **Name**

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 Situational

**Description:** Code identifying a party or other code

**Industry:** Referring Provider Identifier

**Alias:** Referring Provider's Identification Number

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

**HIPAA IG Note:** Required if either Employer's Identification/Social Security Number (Referring Provider tax ID) or National Provider Identifier is known.

**ExternalCodeList**

**Name:** 537

**Description:** Health Care Financing Administration National Provider Identifier

# REF Referring Provider Secondary Identification

Pos: 525	Max: 4
Detail - Optional	
Loop: 2420F	Elements: 2

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

**Notes:**  
 1. Required when a secondary identification number is necessary to identify the entity. The primary identification number should be carried in NM109 in this loop.  
**Example:**  
 REF\*1D\*A12345~

**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	<b>Reference Identification Qualifier</b>	M	ID	2/3	Required
<b>Description:</b> Code qualifying the Reference Identification						
		<b>Code</b>	<b>Name</b>			
		0B	State License Number			
		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	<b>Reference Identification</b>	C	AN	1/30	Required
<b>Description:</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier						
<b>Industry:</b> Referring Provider Secondary Identifier						

# NM1 Referring Provider Name

<b>Pos:</b> 500	<b>Max:</b> 1
<b>Detail - Optional</b>	
<b>Loop:</b> 2420F	<b>Elements:</b> 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 this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 syntax rules.
2. Required if this service line involves a referral and the referring provider is different than the rendering provider and if the referring provider differs from that reported at the claim level (loop 2310A). All payer-specific identifying numbers belong to the destination payer identified in the 2010BB loop.
3. When there is only one referral on the service line use code "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 service line. 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.

**Example:**

NM1\*DN\*1\*WELBY\*MARCUS\*W\*\*JR\*34\*444332222~

**NYS MEDICAID NOTE:**

Please refer to corresponding loop 2310A. If loop 2420F is sent in the first (LX\*1) iteration of the Service Line loop (loop 2400) it will overwrite the loop 2310A data.

**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	<b>Entity Identifier Code</b>	M	ID	2/3	Required
		<b>Description:</b> Code identifying an organizational entity, a physical location, property or an individual				
		<u>Code</u>		<u>Name</u>		
		P3		Primary Care Provider		
		<b>Description:</b> 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	<b>Entity Type Qualifier</b>	M	ID	1/1	Required
		<b>Description:</b> Code qualifying the type of entity				
		<u>Code</u>		<u>Name</u>		
		1		Person		
NM103	1035	<b>Name Last or Organization Name</b>	O	AN	1/35	Required
		<b>Description:</b> Individual last name or organizational name				
		<b>Industry:</b> Referring Provider Last Name				
NM104	1036	<b>Name First</b>	O	AN	1/25	Required
		<b>Description:</b> Individual first name				
		<b>Industry:</b> Referring Provider First Name				
NM105	1037	<b>Name Middle</b>	O	AN	1/25	Situational
		<b>Description:</b> Individual middle name or initial				
		<b>Industry:</b> Referring Provider Middle Name				
		<b>HIPAA IG Note:</b> Required if NM102=1 and the middle name/initial of the person is known.				
NM107	1039	<b>Name Suffix</b>	O	AN	1/10	Situational
		<b>Description:</b> Suffix to individual name				
		<b>Industry:</b> Referring Provider Name Suffix				
		<b>Alias:</b> Referring Provider Generation				

		<b>HIPAA IG Note:</b> Required if known.				
NM108	66	<b>Identification Code Qualifier</b>	C	ID	1/2	Situational
		<b>Description:</b> Code designating the system/method of code structure used for Identification Code (67)				
		<b>HIPAA IG Note:</b> Required if either Employer's Identification/Social Security Number (Referring Provider tax ID) or National Provider Identifier is known.				
		<b>Code</b>	<b>Name</b>			
		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			
			<b>Description:</b> Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.			
NM109	67	<b>Identification Code</b>	C	AN	2/80	Situational
		<b>Description:</b> Code identifying a party or other code				
		<b>Industry:</b> Referring Provider Identifier				
		<b>Alias:</b> Referring Provider's Identification Number				
		<b>NYS MEDICAID NOTE:</b> NYSDOH expects to receive the NPI here, when NM108 contains a qualifier of 'XX'.				
		<b>HIPAA IG Note:</b> Required if either Employer's Identification/Social Security Number (Referring Provider tax ID) or National Provider Identifier is known.				
		<b>ExternalCodeList</b>				
		<b>Name:</b> 537				
		<b>Description:</b> Health Care Financing Administration National Provider Identifier				

# REF Referring Provider Secondary Identification

Pos: 525	Max: 4
Detail - Optional	
Loop: 2420F	Elements: 2

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

**Notes:**  
 1. Required if NM108/09 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\*1D\*A12345~

**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	<b>Reference Identification Qualifier</b>	M	ID	2/3	Required										
<p><b>Description:</b> Code qualifying the Reference 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>SY</td> <td>Social Security Number</td> </tr> </tbody> </table> <p style="background-color: #f0f0f0; padding: 2px;">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	<b>Reference Identification</b>	C	AN	1/30	Required										
<p><b>Description:</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier</p> <p><b>Industry:</b> Referring Provider Secondary Identifier</p> <p style="background-color: #f0f0f0; padding: 2px;"><b>NYS MEDICAID NOTE:</b> NYSDOH expects to receive the Operator's License Number.</p>																

# SVD Line Adjudication Information

<b>Pos: 540</b>	<b>Max: 1</b>
<b>Detail - Optional</b>	
<b>Loop: 2430</b>	<b>Elements: 5</b>

**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 this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC 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\*HC:84550\*\*3~

**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>
SVD01	67	<b>Identification Code</b> <b>Description:</b> Code identifying a party or other code <b>Industry:</b> Other Payer Primary Identifier <b>Alias:</b> Other Payer identification code <b>NYS MEDICAID NOTE:</b> 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. <b>HIPAA IG Note:</b> This number should match NM109 in Loop ID-2330B identifying Other Payer.	M	AN	2/80	Required
SVD02	782	<b>Monetary Amount</b> <b>Description:</b> Monetary amount <b>Industry:</b> Service Line Paid Amount <b>Alias:</b> Paid Amount <b>HIPAA IG Note:</b> Zero "0" is an acceptable value for this element. The FA0-52.0 NSF crosswalk is only used in payer-to-payer COB situations.	M	R	1/18	Required
SVD03	C003	<b>Composite Medical Procedure Identifier</b> <b>Description:</b> To identify a medical procedure by its standardized codes and applicable modifiers <b>Alias:</b> Procedure identifier <b>HIPAA IG Note:</b> This element contains the procedure code that was used to pay this service line. It crosswalks from SVC01 in the 835 transmission.	O	Comp		Required
SVD03-01	235	<b>Product/Service ID Qualifier</b> <b>Description:</b> Code identifying the type/source of the descriptive number used in Product/Service ID (234) <b>Industry:</b> Product or Service ID Qualifier <b>HIPAA IG Note:</b> The NDC number is used for reporting prescribed drugs and biologics when required by government regulation, or as deemed	M	ID	2/2	Required

by the provider to enhance claim reporting/adjudication processes. The NDC number is reported in the LIN segment of Loop ID-2410 only.

<b>Code</b>	<b>Name</b>
HC	Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes <b>Description:</b> HCFA coding scheme to group procedure(s) performed on an outpatient basis for payment to hospital under Medicare; primarily used for ambulatory surgical and other diagnostic departments Because the AMA's CPT codes are also level 1 HCPCS codes, they are reported under HC.
IV	Home Infusion EDI Coalition (HIEC) Product/Service Code This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: 1) If a new rule names HIEC as an allowable code set under HIPAA. 2) For Property & Casualty claims/encounters that are not covered under HIPAA.
ZZ	Mutually Defined Jurisdictionally Defined Procedure and Supply Codes. (Used for Worker's Compensation claims). Contact your local (State) Jurisdiction for a list of these codes.

SVD03-02	234	<b>Product/Service ID</b>	M	AN	1/48	Required
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**Description:** Identifying number for a product or service  
**Industry:** Procedure Code

**ExternalCodeList**

**Name:** 130  
**Description:** Health Care Financing Administration Common Procedural Coding System

**ExternalCodeList**

**Name:** 513  
**Description:** Home Infusion EDI Coalition (HIEC) Product/Service Code List

SVD03-03	1339	<b>Procedure Modifier</b>	O	AN	2/2	Situational
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**Description:** This identifies special circumstances related to the performance of the service, as defined by trading partners  
**Alias:** Procedure Modifier 1  
**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.

SVD03-04	1339	<b>Procedure Modifier</b>	O	AN	2/2	Situational
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**Description:** This identifies special circumstances related to the performance of the service, as defined by trading partners  
**Alias:** Procedure Modifier 2  
**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.

SVD03-05	1339	<b>Procedure Modifier</b>	O	AN	2/2	Situational
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**Description:** This identifies special circumstances related to the performance of the service, as defined by trading partners  
**Alias:** Procedure Modifier 3  
**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.				
SVD03-06	1339	<p><b>Procedure Modifier</b></p> <p><b>Description:</b> This identifies special circumstances related to the performance of the service, as defined by trading partners</p> <p><b>Alias:</b> Procedure Modifier 4</p> <p><b>HIPAA IG Note:</b> Use this modifier for the fourth procedure code modifier. Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.</p>	O	AN	2/2	Situational
SVD03-07	352	<p><b>Description</b></p> <p><b>Description:</b> A free-form description to clarify the related data elements and their content</p> <p><b>Industry:</b> Procedure Code Description</p> <p><b>HIPAA IG Note:</b> Required if SVC01-7 was returned in the 835 transaction.</p>	O	AN	1/80	Situational
SVD05	380	<p><b>Quantity</b></p> <p><b>Description:</b> Numeric value of quantity</p> <p><b>Industry:</b> Paid Service Unit Count</p> <p><b>Alias:</b> Paid units of service</p> <p><b>HIPAA IG Note:</b> Crosswalk from SVC05 in 835 or, if not present in 835, use original billed units.</p>	O	R	1/15	Required
SVD06	554	<p><b>Assigned Number</b></p> <p><b>Description:</b> Number assigned for differentiation within a transaction set</p> <p><b>Industry:</b> Bundled Line Number</p> <p><b>Alias:</b> Bundled Line Number</p> <p><b>HIPAA IG Note:</b> Use the LX from this transaction which points to the bundled line. Required if payer bundled this service line.</p>	O	NO	1/6	Situational

# CAS Line Adjustment

<b>Pos: 545</b>	<b>Max: 99</b>
<b>Detail - Optional</b>	
<b>Loop: 2430</b>	<b>Elements: 19</b>

**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 specific 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 to 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\*7.93~  
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.

The amounts paid at the line level less any claim level adjustments should equal the claim paid. When adjustments are sent in both the claim level and the line level, balancing should be done at both the line level (charge minus CAS equals paid) and claim level (charge minus CAS, both claim and line level equals claim level paid). If either balance check fails, the claim will be rejected.

Refer to the 837 Professional Supplemental Companion Guide, Section 7. "CAS Segment: Claim Level and Line Level Balancing" and Section 8. "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	<b>Claim Adjustment Group Code</b> <b>Description:</b> Code identifying the general category of payment adjustment <b>Alias:</b> Adjustment Group Code	M	ID	1/2	Required												
		<table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>CO</td> <td>Contractual Obligations</td> </tr> <tr> <td>CR</td> <td>Correction and Reversals</td> </tr> <tr> <td>OA</td> <td>Other adjustments</td> </tr> <tr> <td>PI</td> <td>Payor Initiated Reductions</td> </tr> <tr> <td>PR</td> <td>Patient Responsibility</td> </tr> </tbody> </table>	<u>Code</u>	<u>Name</u>	CO	Contractual Obligations	CR	Correction and Reversals	OA	Other adjustments	PI	Payor Initiated Reductions	PR	Patient Responsibility				
<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	<b>Claim Adjustment Reason Code</b> <b>Description:</b> Code identifying the detailed reason the adjustment was made <b>Industry:</b> Adjustment Reason Code <b>Alias:</b> Adjustment Reason Code - Line Level <b>HIPAA IG Note:</b> Use the Claim Adjustment Reason Code list (See Appendix C).	M	ID	1/5	Required												
		<p><b>ExternalCodeList</b> <b>Name:</b> 139 <b>Description:</b> Claim Adjustment Reason Code</p>																
CAS03	782	<b>Monetary Amount</b> <b>Description:</b> Monetary amount <b>Industry:</b> Adjustment Amount <b>Alias:</b> Adjusted Amount - Line Level	M	R	1/18	Required												

		<b>HIPAA IG Note:</b> Use this amount for the adjustment amount.				
CAS04	380	<b>Quantity</b> <b>Description:</b> Numeric value of quantity <b>Industry:</b> Adjustment Quantity <b>Alias:</b> Adjusted Units - Line Level <b>HIPAA IG Note:</b> Use this quantity for the units of service being adjusted. Use as needed to show payer adjustment.	O	R	1/15	Situational
CAS05	1034	<b>Claim Adjustment Reason Code</b> <b>Description:</b> Code identifying the detailed reason the adjustment was made <b>Industry:</b> Adjustment Reason Code <b>Alias:</b> Adjustment Reason Code - Line Level <b>HIPAA IG Note:</b> Use as needed to show payer adjustment. Use the Claim Adjustment Reason Code list (See Appendix C).  <b>ExternalCodeList</b> <b>Name:</b> 139 <b>Description:</b> Claim Adjustment Reason Code	C	ID	1/5	Situational
CAS06	782	<b>Monetary Amount</b> <b>Description:</b> Monetary amount <b>Industry:</b> Adjustment Amount <b>Alias:</b> Adjusted Amount - Line Level <b>HIPAA IG Note:</b> Use this amount for the adjustment amount. Use as needed to show payer adjustment.	C	R	1/18	Situational
CAS07	380	<b>Quantity</b> <b>Description:</b> Numeric value of quantity <b>Industry:</b> Adjustment Quantity <b>Alias:</b> Adjusted Units - Line Level <b>HIPAA IG Note:</b> Use this quantity for the units of service being adjusted. Use as needed to show payer adjustment.	C	R	1/15	Situational
CAS08	1034	<b>Claim Adjustment Reason Code</b> <b>Description:</b> Code identifying the detailed reason the adjustment was made <b>Industry:</b> Adjustment Reason Code <b>Alias:</b> Adjustment Reason Code - Line Level <b>HIPAA IG Note:</b> Use as needed to show payer adjustment. Use the Claim Adjustment Reason Code list (See Appendix C).  <b>ExternalCodeList</b> <b>Name:</b> 139 <b>Description:</b> Claim Adjustment Reason Code	C	ID	1/5	Situational
CAS09	782	<b>Monetary Amount</b> <b>Description:</b> Monetary amount <b>Industry:</b> Adjustment Amount <b>Alias:</b> Adjusted Amount - Line Level <b>HIPAA IG Note:</b> Use this amount for the adjustment amount. Use as needed to show payer adjustment.	C	R	1/18	Situational
CAS10	380	<b>Quantity</b> <b>Description:</b> Numeric value of quantity	C	R	1/15	Situational

		<p><b>Industry:</b> Adjustment Quantity  <b>Alias:</b> Adjusted Units - Line Level  <b>HIPAA IG Note:</b> Use this quantity for the units of service being adjusted.                  Use as needed to show payer adjustment.</p>				
CAS11	1034	<p><b>Claim Adjustment Reason Code</b></p> <p><b>Description:</b> Code identifying the detailed reason the adjustment was made</p> <p><b>Industry:</b> Adjustment Reason Code  <b>Alias:</b> Adjustment Reason Code - Line Level  <b>HIPAA IG Note:</b> Use as needed to show payer adjustment.                  Use the Claim Adjustment Reason Code list (See Appendix C).</p> <p><b>ExternalCodeList</b>  <b>Name:</b> 139  <b>Description:</b> Claim Adjustment Reason Code</p>	C	ID	1/5	Situational
CAS12	782	<p><b>Monetary Amount</b></p> <p><b>Description:</b> Monetary amount</p> <p><b>Industry:</b> Adjustment Amount  <b>Alias:</b> Adjusted Amount - Line Level  <b>HIPAA IG Note:</b> Use this amount for the adjustment amount.                  Use as needed to show payer adjustment.</p>	C	R	1/18	Situational
CAS13	380	<p><b>Quantity</b></p> <p><b>Description:</b> Numeric value of quantity</p> <p><b>Industry:</b> Adjustment Quantity  <b>Alias:</b> Adjusted Units - Line Level  <b>HIPAA IG Note:</b> Use this quantity for the units of service being adjusted.                  Use as needed to show payer adjustment.</p>	C	R	1/15	Situational
CAS14	1034	<p><b>Claim Adjustment Reason Code</b></p> <p><b>Description:</b> Code identifying the detailed reason the adjustment was made</p> <p><b>Industry:</b> Adjustment Reason Code  <b>Alias:</b> Adjustment Reason Code - Line Level  <b>HIPAA IG Note:</b> Use as needed to show payer adjustment.                  Use the Claim Adjustment Reason Code list (See Appendix C).</p> <p><b>ExternalCodeList</b>  <b>Name:</b> 139  <b>Description:</b> Claim Adjustment Reason Code</p>	C	ID	1/5	Situational
CAS15	782	<p><b>Monetary Amount</b></p> <p><b>Description:</b> Monetary amount</p> <p><b>Industry:</b> Adjustment Amount  <b>Alias:</b> Adjusted Amount - Line Level  <b>HIPAA IG Note:</b> Use this amount for the adjustment amount.                  Use as needed to show payer adjustment.</p>	C	R	1/18	Situational
CAS16	380	<p><b>Quantity</b></p> <p><b>Description:</b> Numeric value of quantity</p> <p><b>Industry:</b> Adjustment Quantity  <b>Alias:</b> Adjusted Units - Line Level  <b>HIPAA IG Note:</b> Use this quantity for the units of service being adjusted.                  Use as needed to show payer adjustment.</p>	C	R	1/15	Situational

CAS17	1034	<p><b>Claim Adjustment Reason Code</b></p> <p><b>Description:</b> Code identifying the detailed reason the adjustment was made</p> <p><b>Industry:</b> Adjustment Reason Code</p> <p><b>Alias:</b> Adjustment Reason Code - Line Level</p> <p><b>HIPAA IG Note:</b> Use as needed to show payer adjustment.</p> <p>Use the Claim Adjustment Reason Code list (See Appendix C).</p> <p><b>ExternalCodeList</b></p> <p><b>Name:</b> 139</p> <p><b>Description:</b> Claim Adjustment Reason Code</p>	C	ID	1/5	Situational
CAS18	782	<p><b>Monetary Amount</b></p> <p><b>Description:</b> Monetary amount</p> <p><b>Industry:</b> Adjustment Amount</p> <p><b>Alias:</b> Adjusted Amount - Line Level</p> <p><b>HIPAA IG Note:</b> Use this amount for the adjustment amount.</p> <p>Use as needed to show payer adjustment.</p>	C	R	1/18	Situational
CAS19	380	<p><b>Quantity</b></p> <p><b>Description:</b> Numeric value of quantity</p> <p><b>Industry:</b> Adjustment Quantity</p> <p><b>Alias:</b> Adjusted Units - Line Level</p> <p><b>HIPAA IG Note:</b> Use this quantity for the units of service being adjusted.</p> <p>Use as needed to show payer adjustment.</p>	C	R	1/15	Situational

# 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\*19970131~

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

# SE Transaction Set Trailer

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

**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	<b>Number of Included Segments</b> <b>Description:</b> Total number of segments included in a transaction set including ST and SE segments <b>Industry:</b> Transaction Segment Count <b>Alias:</b> Segment Count	M	NO	1/10	Required
SE02	329	<b>Transaction Set Control Number</b> <b>Description:</b> Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set <b>Alias:</b> Transaction Set Control Number <b>HIPAA IG Note:</b> 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