

New York State Department of Health Office of Medicaid Management 837 Health Care Claim: Institutional

HIPAA V4010X096A1 837: Health Care Claim: Institutional

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Table of Contents

Health Care Claim: Institutional	5
Transaction Set Header	12
Beginning of Hierarchical Transaction	13
Transmission Type Identification	15
Submitter Name	16
Submitter EDI Contact Information	18
Receiver Name	20
Billing/Pay-To Provider Hierarchical Level	21
Billing/Pay-To Provider Specialty Information	22
Foreign Currency Information	23
Billing Provider Name	24
Billing Provider Address	25
Billing Provider City/State/ZIP Code	26
Billing Provider Secondary Identification	27
Billing Provider Secondary Identification	28
Billing Provider Contact Information	29
Pay-To Provider Name	31
Pay-To Provider Address	33
Pay-To Provider City/State/ZIP Code	34
Pay-To Provider Secondary Identification	35
Subscriber Hierarchical Level	36
Subscriber Information	38
Subscriber Name	40
Subscriber Address	42
Subscriber City/State/ZIP Code	43
Subscriber Demographic Information	44
Subscriber Secondary Identification	45
Payer Name	46
Payer Address	47
Payer City/State/ZIP Code	48
Payer Secondary Identification	49
Claim information	50
Discharge Hour	54
Statement Dates	55
Admission Date/Hour	56
Institutional Claim Code	57
Claim Supplemental Information	58
Contract Information	60
Payer Estimated Amount Due	62
Patient Estimated Amount Due	63
Patient Paid Amount	64
Document Identification Code	65
Original Reference Number (ICN/DCN)	66
Investigational Device Exemption Number	67
Service Authorization Exception Code	68
Peer Review Organization (PRO) Approval Number	69
Prior Authorization or Referral Number	70

Medical Record Number	71
Demonstration Project Identifier	72
File Information	73
Claim Note	74
Billing Note	75
Home Health Care Information	76
Home Health Functional Limitations	80
Home Health Activities Permitted	83
Home Health Mental Status	86
Principal, Admitting, E-Code and Patient Reason For Visit Diagnosis Information	88
Diagnosis Related Group (DRG) Information	90
Other Diagnosis Information	91
Principal Procedure Information	96
Other Procedure Information	97
Occurrence Span Information	106
Occurrence Information	114
Value Information	121
Condition Information	127
Treatment Code Information	132
Claim Quantity	137
Home Health Care Plan Information	138
Health Care Services Delivery	139
Attending Physician Name	142
Attending Physician Specialty Information	144
Attending Physician Secondary Identification	145
Operating Physician Name	146
Operating Physician Secondary Identification	148
Other Provider Name	149
Other Provider Secondary Identification	151
Service Facility Name	152
Service Facility Address	154
Service Facility City/State/Zip Code	155
Service Facility Secondary Identification	156
Other Subscriber Information	157
Claim Level Adjustment	160
Payer Prior Payment	163
Coordination of Benefits (COB) Total Allowed Amount	164
Coordination of Benefits (COB) Total Submitted Charges	165
Diagnostic Related Group (DRG) Outlier Amount	166
Coordination of Benefits (COB) Total Medicare Paid Amount	167
Medicare Paid Amount - 100%	168
Medicare Paid Amount - 80%	169
Coordination of Benefits (COB) Medicare A Trust Fund Paid Amount	170
Coordination of Benefits (COB) Medicare B Trust Fund Paid Amount	171
Coordination of Benefits (COB) Total Non-covered Amount	172
Coordination of Benefits (COB) Total Denied Amount	173
Other Subscriber Demographic Information	174
Other Insurance Coverage Information	175

Medicare Inpatient Adjudication Information	176
Medicare Outpatient Adjudication Information	180
Other Subscriber Name	182
Other Subscriber Address	184
Other Subscriber City/State/ZIP Code	185
Other Subscriber Secondary Information	186
Other Payer Name	187
Other Payer Address	188
Other Payer City/State/ZIP Code	189
Claim Adjudication Date	190
Other Payer Secondary Identification and Reference Number	191
Other Payer Prior Authorization or Referral Number	192
Other Payer Patient Information	193
Other Payer Patient Identification Number	194
Other Payer Attending Provider	195
Other Payer Attending Provider Identification	196
Other Payer Operating Provider	197
Other Payer Operating Provider Identification	198
Other Payer Other Provider	199
Other Payer Other Provider Identification	200
Other Payer Service Facility Provider	201
Other Payer Service Facility Provider Identification	202
Service Line Number	203
Institutional Service Line	204
Line Supplemental Information	207
Service Line Date	209
Assessment Date	210
Service Tax Amount	211
Facility Tax Amount	212
Drug Identification	213
Drug Pricing	214
Prescription Number	215
Service Line Adjudication Information	216
Service Line Adjustment	219
Service Adjudication Date	222
Patient Hierarchical Level	223
Transaction Set Trailer	224

837

Health Care Claim: Institutional

Functional Group=HC

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

COMPANION GUIDE DISCLAIMER:

The New York State Department of Health (NYSDOH) has provided this DRAFT Medicaid Companion Guide for the 837 Institutional ASC X12N Transaction and associated addendum (004010X096A1) to assist Providers, Clearinghouses and all Covered Entities in preparing HIPAA compliant transactions. This document was prepared using the Addendum version of the transaction. NYSDOH has focused primarily on the rules and policies regulating the submission of NYS Medicaid data that is provided within this Companion Guide. NYSDOH has provided the information on this website as a tool to make the Provider's job easier in preparing electronic transactions in a HIPAA compliant manner.

NYSDOH does not offer individual training to assist Providers in the use of the ASC X12N transactions provided on this website. However, training will be offered to meet the individual needs of Providers in preparing their transactions to follow NYSDOH policy. Additional information regarding training dates and locations will be posted on this website as it becomes available.

The information provided herein is believed to be true and correct based on the Addenda Version of the HIPAA guidelines. These regulations are continuing to evolve, therefore NYSDOH makes no guarantee, expressed or implied, as to the accuracy of the information provided herein. Furthermore, this is a living document and the information provided herein is subject to change as NYSDOH policy changes or as HIPAA legislation is updated or revised.

NYS MEDICAID NOTE:

The 837, Health Care Claim ASC X12N Institutional (004010X096A1) Implementation Guide (IG), Transaction has been established by Health and Human Services as the standard for Institutional Claim compliance.

This Companion Guide, which is provided by the New York State Department of Health (NYSDOH), outlines the required format for the New York State Medicaid Institutional Health Care Claim. It is important that Providers study the Companion Guide and become familiar with the data that will be received by NYS Medicaid in transmission of an 837 Health Care Claim Institutional Transaction.

This Companion Guide does not modify the standards; rather, it puts forth the subset of information from the IG that will be required for processing transactions. It is important that providers use this Companion Guide as a supplement to the IG. Within the IG, there are data elements, which have many different qualifiers available for use. Each qualifier identifies a different 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 transaction 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.

NYSDOH will process rate-based claims at the claim level (Loop 2300). The rate code is to be provided as a value code in the HI (Value Information) segment of this loop. Submitters are still required to complete the line level information (Loop 2400) in a manner consistent with the services performed. When more than one procedure or revenue code is provided in the service line loop, rate-based claims will still be processed as a single claim.

Fee-for-service claims received with multiple service lines will be split into multiple claims and processed independently of each other as they are today.

For further assistance, NYSDOH and its fiscal agent, Computer Sciences Corporation (CSC), are urging providers to visit a web community, <http://www.hipaadesk.com/>, which will provide WEDI-SNIP level 1 thru 6 testing capabilities, as well as Companion Guide updates and other pertinent information.

The ASC X12N Implementation Guides and their associated addenda are available in electronic format at: www.wpc-edi.com/hipaa. Pharmacy Providers can acquire the NCPDP Implementation Guide from www.ncdp.org.

Heading:

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

Detail:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Notes</u>	<u>Usage</u>
LOOP ID - 2000A					≥1		
001	HL	Billing/Pay-To Provider Hierarchical Level	M	1			Required
003	PRV	Billing/Pay-To Provider Specialty Information	O	1			Situational
010	CUR	Foreign Currency Information	O	1			Situational
LOOP ID - 2010AA					1	N2/015L	
015	NM1	Billing Provider Name	O	1		N2/015	Required
025	N3	Billing Provider Address	O	1			Required
030	N4	Billing Provider City/State/ZIP Code	O	1			Required
035	REF	Billing Provider Secondary Identification	O	1			Situational
035	REF	Billing Provider Secondary Identification	O	1			Situational
040	PER	Billing Provider Contact Information	O	2			Situational
LOOP ID - 2010AB					1	N2/015L	
015	NM1	Pay-To Provider Name	O	1		N2/015	Situational
025	N3	Pay-To Provider Address	O	1			Required
030	N4	Pay-To Provider City/State/ZIP Code	O	1			Required
035	REF	Pay-To Provider Secondary Identification	O	5			Situational
LOOP ID - 2000B					≥1		
001	HL	Subscriber Hierarchical Level	M	1		N2/001	Required
005	SBR	Subscriber Information	O	1			Required
LOOP ID - 2010BA					1	N2/015L	
015	NM1	Subscriber Name	O	1		N2/015	Required
025	N3	Subscriber Address	O	1			Situational
030	N4	Subscriber City/State/ZIP Code	O	1			Situational
032	DMG	Subscriber Demographic Information	O	1			Situational
035	REF	Subscriber Secondary Identification	O	4			Situational
LOOP ID - 2010BC					1	N2/015L	
015	NM1	Payer Name	O	1		N2/015	Required
025	N3	Payer Address	O	1			Situational

030	N4	Payer City/State/ZIP Code	O	1		Situational
035	REF	Payer Secondary Identification	O	3		Situational
LOOP ID - 2300				100		
130	CLM	Claim information	O	1		Required
135	DTP	Discharge Hour	O	1		Situational
135	DTP	Statement Dates	O	1		Required
135	DTP	Admission Date/Hour	O	1		Situational
140	CL1	Institutional Claim Code	O	1		Situational
155	PWK	Claim Supplemental Information	O	10		Situational
160	CN1	Contract Information	O	1		Situational
175	AMT	Payer Estimated Amount Due	O	1		Situational
175	AMT	Patient Estimated Amount Due	O	1		Situational
175	AMT	Patient Paid Amount	O	1		Situational
180	REF	Document Identification Code	O	2		Situational
180	REF	Original Reference Number (ICN/DCN)	O	1		Situational
180	REF	Investigational Device Exemption Number	O	1		Situational
180	REF	Service Authorization Exception Code	O	1		Situational
180	REF	Peer Review Organization (PRO) Approval Number	O	1		Situational
180	REF	Prior Authorization or Referral Number	O	2		Situational
180	REF	Medical Record Number	O	1		Situational
180	REF	Demonstration Project Identifier	O	1		Situational
185	K3	File Information	O	10		Situational
190	NTE	Claim Note	O	10		Situational
190	NTE	Billing Note	O	1		Situational
216	CR6	Home Health Care Information	O	1		Situational
220	CRC	Home Health Functional Limitations	O	3		Situational
220	CRC	Home Health Activities Permitted	O	3		Situational
220	CRC	Home Health Mental Status	O	2		Situational
231	HI	Principal, Admitting, E-Code and Patient Reason For Visit Diagnosis Information	O	1		Situational
231	HI	Diagnosis Related Group (DRG) Information	O	1		Situational
231	HI	Other Diagnosis Information	O	2		Situational
231	HI	Principal Procedure Information	O	1		Situational
231	HI	Other Procedure Information	O	2		Situational
231	HI	Occurrence Span Information	O	2		Situational
231	HI	Occurrence Information	O	2		Situational
231	HI	Value Information	O	2		Situational
231	HI	Condition Information	O	2		Situational
231	HI	Treatment Code Information	O	2		Situational
240	QTY	Claim Quantity	O	4		Situational
LOOP ID - 2305				6		
242	CR7	Home Health Care Plan Information	O	1		Situational
243	HSD	Health Care Services Delivery	O	12		Situational
LOOP ID - 2310A				1	N2/250L	
250	NM1	Attending Physician Name	O	1	N2/250	Situational

255	PRV	Attending Physician Specialty Information	O	1		Situational
271	REF	Attending Physician Secondary Identification	O	5		Situational
LOOP ID - 2310B				1	<u>N2/250L</u>	
250	NM1	Operating Physician Name	O	1	N2/250	Situational
271	REF	Operating Physician Secondary Identification	O	5		Situational
LOOP ID - 2310C				1	<u>N2/250L</u>	
250	NM1	Other Provider Name	O	1	N2/250	Situational
271	REF	Other Provider Secondary Identification	O	5		Situational
LOOP ID - 2310E				1	<u>N2/250L</u>	
250	NM1	Service Facility Name	O	1	N2/250	Situational
265	N3	Service Facility Address	O	1		Required
270	N4	Service Facility City/State/Zip Code	O	1		Required
271	REF	Service Facility Secondary Identification	O	5		Situational
LOOP ID - 2320				10	<u>N2/290L</u>	
290	SBR	Other Subscriber Information	O	1	N2/290	Situational
295	CAS	Claim Level Adjustment	O	5		Situational
300	AMT	Payer Prior Payment	O	1		Situational
300	AMT	Coordination of Benefits (COB) Total Allowed Amount	O	1		Situational
300	AMT	Coordination of Benefits (COB) Total Submitted Charges	O	1		Situational
300	AMT	Diagnostic Related Group (DRG) Outlier Amount	O	1		Situational
300	AMT	Coordination of Benefits (COB) Total Medicare Paid Amount	O	1		Situational
300	AMT	Medicare Paid Amount - 100%	O	1		Situational
300	AMT	Medicare Paid Amount - 80%	O	1		Situational
300	AMT	Coordination of Benefits (COB) Medicare A Trust Fund Paid Amount	O	1		Situational
300	AMT	Coordination of Benefits (COB) Medicare B Trust Fund Paid Amount	O	1		Situational
300	AMT	Coordination of Benefits (COB) Total Non-covered Amount	O	1		Situational
300	AMT	Coordination of Benefits (COB) Total Denied Amount	O	1		Situational
305	DMG	Other Subscriber Demographic Information	O	1		Situational
310	OI	Other Insurance Coverage Information	O	1		Required
315	MIA	Medicare Inpatient Adjudication Information	O	1		Situational
320	MOA	Medicare Outpatient Adjudication Information	O	1		Situational
LOOP ID - 2330A				1	<u>N2/325L</u>	
325	NM1	Other Subscriber Name	O	1	N2/325	Required
332	N3	Other Subscriber Address	O	1		Situational
340	N4	Other Subscriber City/State/ZIP	O	1		Situational

355	REF	Code Other Subscriber Secondary Information	O	3		Situational
LOOP ID - 2330B				1	N2/325L	
325	NM1	Other Payer Name	O	1	N2/325	Required
332	N3	Other Payer Address	O	1		Situational
340	N4	Other Payer City/State/ZIP Code	O	1		Situational
350	DTP	Claim Adjudication Date	O	1		Situational
355	REF	Other Payer Secondary Identification and Reference Number	O	2		Situational
355	REF	Other Payer Prior Authorization or Referral Number	O	1		Situational
LOOP ID - 2330C				1	N2/325L	
325	NM1	Other Payer Patient Information	O	1	N2/325	Situational
355	REF	Other Payer Patient Identification Number	O	3		Situational
LOOP ID - 2330D				1	N2/325L	
325	NM1	Other Payer Attending Provider	O	1	N2/325	Situational
355	REF	Other Payer Attending Provider Identification	O	3		Required
LOOP ID - 2330E				1	N2/325L	
325	NM1	Other Payer Operating Provider	O	1	N2/325	Situational
355	REF	Other Payer Operating Provider Identification	O	3		Required
LOOP ID - 2330F				1	N2/325L	
325	NM1	Other Payer Other Provider	O	1	N2/325	Situational
355	REF	Other Payer Other Provider Identification	O	3		Required
LOOP ID - 2330H				1	N2/325L	
325	NM1	Other Payer Service Facility Provider	O	1	N2/325	Situational
355	REF	Other Payer Service Facility Provider Identification	O	3		Required
LOOP ID - 2400				999	N2/365L	
365	LX	Service Line Number	O	1	N2/365	Required
375	SV2	Institutional Service Line	O	1		Required
420	PWK	Line Supplemental Information	O	5		Situational
455	DTP	Service Line Date	O	1		Situational
455	DTP	Assessment Date	O	1		Situational
475	AMT	Service Tax Amount	O	1		Situational
475	AMT	Facility Tax Amount	O	1		Situational
LOOP ID - 2410				25	N2/493L	
493	LIN	Drug Identification	O	1	N2/493	Situational
494	CTP	Drug Pricing	O	1		Situational
495	REF	Prescription Number	O	1		Situational
LOOP ID - 2430				25	N2/540L	
540	SVD	Service Line Adjudication Information	O	1	N2/540	Situational
545	CAS	Service Line Adjustment	O	99		Situational
550	DTP	Service Adjudication Date	O	1		Situational

LOOP ID - 2000C					≥1	
001	HL	Patient Hierarchical Level	O	1		Situational
555	SE	Transaction Set Trailer	M	1		Required

ST Transaction Set Header

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

User Option (Usage): Required

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

Example:

ST*837*987654~

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
ST01	143	Transaction Set Identifier Code Description: Code uniquely identifying a Transaction Set	M	ID	3/3	Required
		Code Name 837 Health Care Claim REQUIRED				
ST02	329	Transaction Set Control Number Description: Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set HIPAA IG Note: The Transaction Set Control Number in ST02 and SE02 must be identical. This unique number also aids in error resolution research. Submitters could be sending transactions using the number 0001 in this element and increment from there. The number must be unique within a specific functional group (GS-GE) and interchange (ISA-IEA), but can repeat in other groups and interchanges.	M	AN	4/9	Required

BHT Beginning of Hierarchical Transaction

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

User Option (Usage): Required

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

Example:

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

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage						
BHT01	1005	Hierarchical Structure Code Description: Code indicating the hierarchical application structure of a transaction set that utilizes the HL segment to define the structure of the transaction set	M	ID	4/4	Required						
		<table border="1"> <thead> <tr> <th>Code</th> <th>Name</th> </tr> </thead> <tbody> <tr> <td>0019</td> <td>Information Source, Subscriber, Dependent</td> </tr> </tbody> </table>	Code	Name	0019	Information Source, Subscriber, Dependent						
Code	Name											
0019	Information Source, Subscriber, Dependent											
BHT02	353	Transaction Set Purpose Code Description: Code identifying purpose of transaction set NYS MEDICAID NOTE: NYSDOH expects code '00' however will process code '18' as an original transmission when received. HIPAA IG Note: BHT02 is intended to convey the electronic transmission status of the 837 batch contained in this ST-SE envelope. The terms "original" and "reissue" refer to the electronic transmission status of the 837 batch, not the billing status. ORIGINAL: original transmissions are claims/encounters which have never been sent to the receiver. Generally nearly all transmissions to a payer entity (as the ultimate destination of the transaction) are original. REISSUE: In the case where a transmission was disrupted the receiver can request that the batch be sent again. Use "Reissue" when resending transmission batches that have been previously sent.	M	ID	2/2	Required						
		<table border="1"> <thead> <tr> <th>Code</th> <th>Name</th> </tr> </thead> <tbody> <tr> <td>00</td> <td>Original</td> </tr> <tr> <td>18</td> <td>Reissue</td> </tr> </tbody> </table>	Code	Name	00	Original	18	Reissue				
Code	Name											
00	Original											
18	Reissue											
BHT03	127	Reference Identification Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier Industry: Originator Application Transaction Identifier NYS MEDICAID NOTE: For provider inquiries, NYSDOH will use the first six characters as part of the key used to track the transaction. HIPAA IG Note: Use this reference identifier to	O	AN	1/30	Required						

BHT04	373	<p>identify the inventory file number of the tape or transmission assigned by the submitter's system.</p> <p>Date 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: Use this date to identify the date on which the submitter created the file.</p>	O	DT	8/8	Required
BHT05	337	<p>Time 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.</p>	O	TM	4/8	Required
BHT06	640	<p>Transaction Type Code Description: Code specifying the type of transaction Industry: Claim or Encounter Identifier Alias: Claim or Encounter Indicator NYS MEDICAID NOTE: NYSDOH will only process transactions with a qualifier of 'CH'. Reporting transactions are not supported. HIPAA IG Note: Use RP when the entire ST-SE envelope contains encounter transmissions. Use RP when the transmission is being sent to an entity (usually not a payer or a normal provider-payer transmission intermediary) for purposes other than adjudication of a claim. Such an entity could be a state health agency which is using the 837 for health data reporting purposes.</p>	O	ID	2/2	Required
		<p>Code CH</p>	<p>Name Chargeable</p> <p>Use this code when the transmission contains only fee-for-service claims or claims with at least one chargeable line item. If it is not clear whether a transaction is a claim or encounter, the developers of this implementation guide recommend submitting the transaction as a claim.</p>			

REF Transmission Type Identification

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

User Option (Usage): Required

To specify identifying information

Example:

REF*87*004010X096A1~

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>						
REF01	128	Reference Identification Qualifier Description: Code qualifying the Reference Identification <table border="0"> <tr> <td>Code</td> <td>Name</td> </tr> <tr> <td>87</td> <td>Functional Category</td> </tr> <tr> <td colspan="2">Description: An organization or groups of organizations with a common operational orientation such as Quality Control Engineering, etc</td> </tr> </table>	Code	Name	87	Functional Category	Description: An organization or groups of organizations with a common operational orientation such as Quality Control Engineering, etc		M	ID	2/3	Required
Code	Name											
87	Functional Category											
Description: An organization or groups of organizations with a common operational orientation such as Quality Control Engineering, etc												
REF02	127	Reference Identification Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier Industry: Transmission Type Code HIPAA IG Note: When piloting the transaction set, this value is 004010X096DA1. When sending the transaction set in a production mode, this value is 004010X096A1.	C	AN	1/30	Required						

NM1**Submitter Name**

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

User Option (Usage): Required

To supply the full name of an individual or organizational entity

Notes:

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

Example:

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

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
NM101	98	Entity Identifier Code Description: Code identifying an organizational entity, a physical location, property or an individual Code Name 41 Submitter Description: Entity transmitting transaction set	M	ID	2/3	Required
NM102	1065	Entity Type Qualifier Description: Code qualifying the type of entity Code Name 1 Person 2 Non-Person Entity	M	ID	1/1	Required
NM103	1035	Name Last or Organization Name Description: Individual last name or organizational name Industry: Submitter Last or Organization Name Alias: Submitter Name	O	AN	1/35	Required
NM104	1036	Name First Description: Individual first name Industry: Submitter First Name Alias: Submitter Name HIPAA IG Note: Required if NM102=1 (person).	O	AN	1/25	Situational
NM105	1037	Name Middle Description: Individual middle name or initial Industry: Submitter Middle Name Alias: Submitter Name HIPAA IG Note: Required if NM102=1 and the middle name/initial of the person is known.	O	AN	1/25	Situational
NM108	66	Identification Code Qualifier Description: Code designating the system/method of code structure used for Identification Code (67) Code Name 46 Electronic Transmitter Identification Number (ETIN) Description: A unique number assigned to each transmitter and software developer Established by a trading partner agreement	C	ID	1/2	Required
NM109	67	Identification Code Description: Code identifying a party or other code Industry: Submitter Identifier Alias: Submitter Primary Identification Number	C	AN	2/80	Required

NYS MEDICAID NOTE: NYSDOH will return the 835 to the ETIN (Electronic Transmitter Identification Number) provided here. NYS Medicaid assigns this number to the submitter. In past implementations, this code was known as the Tape Supplier Number (TSN).

PER Submitter EDI Contact Information

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

User Option (Usage): Required

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

Notes:

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

Example:

PER*IC*JANE DOE*TE*9005555555~

NYS MEDICAID NOTE:

NYSDOH will ignore data when provided.

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
PER01	366	Contact Function Code Description: Code identifying the major duty or responsibility of the person or group named Code Name IC Information Contact	M	ID	2/2	Required
PER02	93	Name Description: Free-form name Industry: Submitter Contact Name	O	AN	1/60	Required
PER03	365	Communication Number Qualifier Description: Code identifying the type of communication number Code Name ED Electronic Data Interchange Access Number EM Electronic Mail FX Facsimile TE Telephone	C	ID	2/2	Required
PER04	364	Communication Number Description: Complete communications number including country or area code when applicable	C	AN	1/80	Required
PER05	365	Communication Number Qualifier Description: Code identifying the type of communication number HIPAA IG Note: Used when additional contact numbers are to be communicated. Code Name ED Electronic Data Interchange Access Number EM Electronic Mail EX Telephone Extension FX Facsimile The use of this code indicates it is the extension of the number in PER04.	C	ID	2/2	Situational

		TE Telephone				
PER06	364	Communication Number Description: Complete communications number including country or area code when applicable HIPAA IG Note: This data element is required when the submitter needs to convey additional submitter contact information. Used when additional contact numbers are to be communicated.	C	AN	1/80	Situational
PER07	365	Communication Number Qualifier Description: Code identifying the type of communication number HIPAA IG Note: Used when additional contact numbers are to be communicated. Code Name ED Electronic Data Interchange Access Number EM Electronic Mail EX Telephone Extension The use of this code indicates it is the extension of the number in PER06. FX Facsimile TE Telephone	C	ID	2/2	Situational
PER08	364	Communication Number Description: Complete communications number including country or area code when applicable HIPAA IG Note: This data element is required when the submitter needs to convey additional submitter contact information. Used when additional contact numbers are to be communicated.	C	AN	1/80	Situational

NM1 Receiver Name

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

User Option (Usage): Required

To supply the full name of an individual or organizational entity

Notes:

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

Example:

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

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
NM101	98	Entity Identifier Code Description: Code identifying an organizational entity, a physical location, property or an individual Code Name 40 Receiver Description: Entity to accept transmission	M	ID	2/3	Required
NM102	1065	Entity Type Qualifier Description: Code qualifying the type of entity Code Name 2 Non-Person Entity	M	ID	1/1	Required
NM103	1035	Name Last or Organization Name Description: Individual last name or organizational name Industry: Receiver Name NYS MEDICAID NOTE: NYSDOH expects to receive 'NYSDOH'.	O	AN	1/35	Required
NM108	66	Identification Code Qualifier Description: Code designating the system/method of code structure used for Identification Code (67) Industry: Information Receiver Identification Number Code Name 46 Electronic Transmitter Identification Number (ETIN) Description: A unique number assigned to each transmitter and software developer	C	ID	1/2	Required
NM109	67	Identification Code Description: Code identifying a party or other code Industry: Receiver Primary Identifier Alias: Receiver Primary Identification Number NYS MEDICAID NOTE: NYSDOH expects to receive '141797357'.	C	AN	2/80	Required

HL Billing/Pay-To Provider Hierarchical Level

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

User Option (Usage): Required

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

Notes:

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

Example:

HL*1**20*1~

Element Summary:

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

PRV Billing/Pay-To Provider Specialty Information

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

User Option (Usage): Situational

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 Service Facility 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-2310E is not used.
2. PRV02 qualifies PRV03.

Example:

PRV*BI*ZZ*203BA0200N~

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	Provider Code Description: Code identifying the type of provider	M	ID	1/3	Required						
		<table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>BI</td> <td>Billing</td> </tr> <tr> <td>PT</td> <td>Pay-To</td> </tr> </tbody> </table>	<u>Code</u>	<u>Name</u>	BI	Billing	PT	Pay-To				
<u>Code</u>	<u>Name</u>											
BI	Billing											
PT	Pay-To											
PRV02	128	Reference Identification Qualifier Description: Code qualifying the Reference Identification	M	ID	2/3	Required						
		HIPAA IG Note: 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: http://www.wpc-edi.com . This taxonomy is maintained by the Blue Cross Blue Shield Association and ASC X12N TG2 WG15.										
		<table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>ZZ</td> <td>Mutually Defined</td> </tr> </tbody> </table>	<u>Code</u>	<u>Name</u>	ZZ	Mutually Defined						
<u>Code</u>	<u>Name</u>											
ZZ	Mutually Defined											
PRV03	127	Reference Identification Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	M	AN	1/30	Required						
		Industry: Provider Taxonomy Code										
		Alias: Provider Specialty Code										
		ExternalCodeList										
		Name: HCPT										
		Description: Health Care Provider Taxonomy										

CUR Foreign Currency Information

Pos: 010	Max: 1
Detail - Optional	
Loop: 2000A	Elements: 2

User Option (Usage): Situational

To specify the currency (dollars, pounds, francs, etc.) used in a transaction

Notes:

1. The developers of this implementation guide added the CUR segment to allow billing providers and billing services to submit claims for services provided in foreign countries. The absence of the CUR segment indicates that the claim is submitted in the currency that is normally used by the receiver for processing claims. For example, claims submitted by United States (U.S.) providers to U.S. receivers are assumed to be in U.S. dollars. Claims submitted by Canadian providers to Canadian receivers are assumed to be in Canadian dollars.

Example:

CUR*85*CAN~

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>
CUR01	98	Entity Identifier Code Description: Code identifying an organizational entity, a physical location, property or an individual	M	ID	2/3	Required
		<u>Code</u> <u>Name</u> 85 Billing Provider				
CUR02	100	Currency Code Description: Code (Standard ISO) for country in whose currency the charges are specified	M	ID	3/3	Required
		<u>ExternalCodeList</u> Name: 5 Description: Countries, Currencies and Funds				

NM1 Billing Provider Name

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

User Option (Usage): Required

To supply the full name of an individual or organizational entity

Notes:

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

Example:

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

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
NM101	98	Entity Identifier Code Description: Code identifying an organizational entity, a physical location, property or an individual <u>Code</u> <u>Name</u> 85 Billing Provider Use this code to indicate billing provider, billing submitter, and encounter reporting entity.	M	ID	2/3	Required
NM102	1065	Entity Type Qualifier Description: Code qualifying the type of entity <u>Code</u> <u>Name</u> 2 Non-Person Entity	M	ID	1/1	Required
NM103	1035	Name Last or Organization Name Description: Individual last name or organizational name Industry: Billing Provider Last or Organizational Name Alias: Billing Provider Name	O	AN	1/35	Required
NM108	66	Identification Code Qualifier Description: Code designating the system/method of code structure used for Identification Code (67) HIPAA IG Note: If "XX - NPI" is used, then either the Employer's Identification Number or the Social Security Number of the provider must be carried in the REF in this loop. <u>Code</u> <u>Name</u> 24 Employer's Identification Number 34 Social Security Number XX Health Care Financing Administration National Provider Identifier Description: Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.	C	ID	1/2	Required
NM109	67	Identification Code Description: Code identifying a party or other code Industry: Billing Provider Identifier Alias: Billing Provider Primary ID <u>ExternalCodeList</u> Name: 537 Description: Health Care Financing Administration National Provider Identifier	C	AN	2/80	Required

N3 Billing Provider Address

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

User Option (Usage): Required

To specify the location of the named party

Example:

N3*225 MAIN STREET BARKLEY BUILDING~

NYS MEDICAID NOTE:

NYSDOH will ignore data when provided.

Element Summary:

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

N4**Billing Provider City/State/ZIP Code**

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

User Option (Usage): Required

To specify the geographic place of the named party

Example:

N4*CENTERVILLE*PA*17111~

NYS MEDICAID NOTE:

NYSDOH will ignore data when provided.

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
N401	19	City Name Description: Free-form text for city name Industry: Billing Provider City Name	O	AN	2/30	Required
N402	156	State or Province Code Description: Code (Standard State/Province) as defined by appropriate government agency Industry: Billing Provider State or Province Code ExternalCodeList Name: 22 Description: States and Outlying Areas of the U.S.	O	ID	2/2	Required
N403	116	Postal Code Description: Code defining international postal zone code excluding punctuation and blanks (zip code for United States) Industry: Billing Provider Postal Zone or ZIP Code ExternalCodeList Name: 51 Description: ZIP Code	O	ID	3/15	Required
N404	26	Country Code Description: Code identifying the country HIPAA IG Note: This data element is required when the address is outside of the U.S. ExternalCodeList Name: 5 Description: Countries, Currencies and Funds	O	ID	2/3	Situational

REF Billing Provider Secondary Identification

Pos: 035	Max: 1
Detail - Optional	
Loop: 2010AA	Elements: 2

User Option (Usage): Situational

To specify identifying information

Notes:

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

Example:

REF*SY*987654~

NYS MEDICAID NOTE:

This REF segment is repeated in this companion document to satisfy NYSDOH business requirements. It is necessary to receive both the Medicaid Provider ID and the Location Code in order to process a claim. This iteration will report the NYS Medicaid Provider ID.

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>				
REF01	128	Reference Identification Qualifier Description: Code qualifying the Reference Identification HIPAA IG Note: Codes 8U, LU, ST, TT, 06, IJ, RB, and EM were added to this implementation guide to support credit/debit card information billing. See Appendix G, Credit/Debit Card Use, for details.	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	Reference Identification Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier Industry: Billing Provider Additional Identifier	C	AN	1/30	Required				

REF Billing Provider Secondary Identification

Pos: 035	Max: 1
Detail - Optional	
Loop: 2010AA	Elements: 2

User Option (Usage): Situational

To specify identifying information

Notes:

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

Example:

REF*SY*987654~

NYS MEDICAID NOTE:

This REF segment is repeated in this companion document to satisfy NYSDOH business requirements. It is necessary to receive both the Medicaid Provider ID and the Location Code in order to process a claim. This iteration will report the Location 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>				
REF01	128	Reference Identification Qualifier Description: Code qualifying the Reference Identification HIPAA IG Note: Codes 8U, LU, ST, TT, 06, IJ, RB, and EM were added to this implementation guide to support credit/debit card information billing. See Appendix G, Credit/Debit Card Use, for details.	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>LU</td> <td>Location Number</td> </tr> </tbody> </table>	<u>Code</u>	<u>Name</u>	LU	Location Number				
<u>Code</u>	<u>Name</u>									
LU	Location Number									
REF02	127	Reference Identification Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier Industry: Billing Provider Additional Identifier	C	AN	1/30	Required				

PER Billing Provider Contact Information

Pos: 040	Max: 2
Detail - Optional	
Loop: 2010AA	Elements: 8

User Option (Usage): Situational

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

Notes:

1. Each communication number should always include the area code. The extension, when applicable, should be included in the appropriate PER element immediately after the telephone number (e.g., if the telephone number is included in PER03 then the extension should be in PER05).
2. Required if this information is different than that contained in the Loop 1000A - Submitter PER segment.
3. When the communication number represents a telephone number in the United States and other countries using the North American Dialing Plan (for voice, data, fax, etc.), the communication number should always include the area code and phone number using the format AAABBBCCCC. Where AAA is the area code, BBB is the telephone number prefix, and CCCC is the telephone number (e.g. (534)224-2525 would be represented as 5342242525). The extension, when applicable, should be included in the communication number immediately after the telephone number.
4. By definition of the standard, if PER05 is used, PER04 is required, and if PER07 is used, PER08 is required.

Example:

PER*IC*JOHN SMITH*TE*8007775555~

NYS MEDICAID NOTE:

NYSDOH will ignore data when provided.

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
PER01	366	Contact Function Code Description: Code identifying the major duty or responsibility of the person or group named Code Name IC Information Contact	M	ID	2/2	Required
PER02	93	Name Description: Free-form name Industry: Billing Provider Contact Name	O	AN	1/60	Required
PER03	365	Communication Number Qualifier Description: Code identifying the type of communication number Code Name EM Electronic Mail FX Facsimile	C	ID	2/2	Required
		UB-92 Ref. [UB-Name]: 1, Line 4, Positions 12-21 [Provider Name, Address and Telephone Number]				
PER04	364	TE Telephone Communication Number Description: Complete communications number including country or area code when applicable	C	AN	1/80	Required
PER05	365	Communication Number Qualifier Description: Code identifying the type of communication number Code Name EM Electronic Mail EX Telephone Extension FX Facsimile	C	ID	2/2	Situational

UB-92 Ref. [UB-Name]:
 1, Line 4, Positions 12-21 [Provider Name, Address and Telephone Number]

TE Telephone

PER06	364	Communication Number	C	AN	1/80	Situational
Description: Complete communications number including country or area code when applicable						

PER07	365	Communication Number Qualifier	C	ID	2/2	Situational
Description: Code identifying the type of communication number						

<u>Code</u>	<u>Name</u>
EM	Electronic Mail
EX	Telephone Extension
FX	Facsimile

UB-92 Ref. [UB-Name]:
 1, Line 4, Positions 12-21 [Provider Name, Address and Telephone Number]

TE Telephone

UB-92 Ref. [UB-Name]:
 1, Line 4, Positions 1-10 [Provider Name, Address and Telephone Number]

PER08	364	Communication Number	C	AN	1/80	Situational
Description: Complete communications number including country or area code when applicable						

NM1 Pay-To Provider Name

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

User Option (Usage): Situational

To supply the full name of an individual or organizational entity

Notes:

1. Required if the Pay-to Provider is a different entity than the Billing Provider.
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 nomenclature.

Example:

NM1*87*2*ELLIS HOSPITAL*****24*123456789~

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>
NM101	98	Entity Identifier Code Description: Code identifying an organizational entity, a physical location, property or an individual Code Name 87 Pay-to Provider	M	ID	2/3	Required
NM102	1065	Entity Type Qualifier Description: Code qualifying the type of entity Code Name 2 Non-Person Entity If this entity is the Service Facility Provider, it is not necessary to use the Service Facility Provider NM1 loop, loop 2310D.	M	ID	1/1	Required
NM103	1035	Name Last or Organization Name Description: Individual last name or organizational name Industry: Pay-to Provider Last or Organizational Name Alias: Pay-to Provider Last Name or Organizational Name	O	AN	1/35	Required
NM108	66	Identification Code Qualifier Description: Code designating the system/method of code structure used for Identification Code (67) HIPAA IG Note: 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 5 times. 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	C	ID	1/2	Required

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

NM109	67	Identification Code	C	AN	2/80	Required
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Description: Code identifying a party or other code

Industry: Pay-to Provider Identifier

Alias: Pay-to Provider Primary Identification Number

ExternalCodeList

Name: 537

Description: Health Care Financing Administration National Provider Identifier

N3 Pay-To Provider Address

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

User Option (Usage): Required

To specify the location of the named party

Example:

N3*2216 N. MAIN STREET*COLDER BUILDING~

NYS MEDICAID NOTE:

NYSDOH will ignore data when provided.

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
N301	166	Address Information Description: Address information Industry: Pay-to Provider Address Line Alias: Pay-to Provider Address 1	M	AN	1/55	Required
N302	166	Address Information Description: Address information Industry: Pay-to Provider Address Line Alias: Pay-to Provider Address 2 HIPAA IG Note: Required if a second address line exists.	O	AN	1/55	Situational

N4

Pay-To Provider City/State/ZIP Code

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

User Option (Usage): Required

To specify the geographic place of the named party

Example:

N4*MADISON* NY*18298~

NYS MEDICAID NOTE:

NYSDOH will ignore data when provided.

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
N401	19	City Name Description: Free-form text for city name Industry: Pay-to Provider City Name	O	AN	2/30	Required
N402	156	State or Province Code Description: Code (Standard State/Province) as defined by appropriate government agency Industry: Pay-to Provider State Code ExternalCodeList Name: 22 Description: States and Outlying Areas of the U.S.	O	ID	2/2	Required
N403	116	Postal Code Description: Code defining international postal zone code excluding punctuation and blanks (zip code for United States) Industry: Pay-to Provider Postal Zone or ZIP Code Alias: Pay-to Provider Zip Code ExternalCodeList Name: 51 Description: ZIP Code	O	ID	3/15	Required
N404	26	Country Code Description: Code identifying the country Alias: Pay-to Provider Country Code HIPAA IG Note: Required if the address is outside the U.S. ExternalCodeList Name: 5 Description: Countries, Currencies and Funds	O	ID	2/3	Situational

REF Pay-To Provider Secondary Identification

Pos: 035	Max: 5
Detail - Optional	
Loop: 2010AB	Elements: 2

User Option (Usage): Situational

To specify identifying information

Notes:

1. Required when a secondary identification number is necessary to identify the entity. The primary identification number should be carried in NM109.
2. If "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 5 times.

Example:

REF*1G*98765~

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>				
REF01	128	Reference Identification Qualifier Description: Code qualifying the Reference Identification <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	M	ID	2/3	Required
<u>Code</u>	<u>Name</u>									
1D	Medicaid Provider Number									
REF02	127	Reference Identification Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier Industry: Pay-to Provider Additional Identifier	C	AN	1/30	Required				

HL Subscriber Hierarchical Level

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

User Option (Usage): Required

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

Notes:

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

Example:

HL*124*123*22*1~

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>				
HL01	628	Hierarchical ID Number Description: A unique number assigned by the sender to identify a particular data segment in a hierarchical structure	M	AN	1/12	Required				
HL02	734	Hierarchical Parent ID Number Description: Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to	O	AN	1/12	Required				
HL03	735	Hierarchical Level Code Description: Code defining the characteristic of a level in a hierarchical structure	M	ID	1/2	Required				
		<table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>22</td> <td>Subscriber</td> </tr> </tbody> </table> <p>Description: Identifies the employee or group member who is covered for insurance and to whom, or on behalf of whom, the insurer agrees to pay benefits</p>	<u>Code</u>	<u>Name</u>	22	Subscriber				
<u>Code</u>	<u>Name</u>									
22	Subscriber									
HL04	736	Hierarchical Child Code Description: Code indicating if there are hierarchical child data segments subordinate to the level being described NYS MEDICAID NOTE: NYSDOH expects to receive a value of '0' here. HIPAA IG Note: The claim loop (Loop ID-2300) can be used both when HL04 has no subordinate levels (HL04 = 0) or when HL04 has subordinate levels indicated (HL04 = 1). In the first case (HL04 = 0), the subscriber is the patient and there are no dependent claims. The second case (HL04 = 1) happens when claims/encounters for both the subscriber and a dependent of theirs are being sent under the same billing provider HL (e.g., a father and son are both	O	ID	1/1	Required				

involved in the same automobile accident and are treated by the same provider). In that case, the subscriber HL04 = 1 because there is a dependent to this subscriber, but the 2300 loop for the subscriber/patient (father) would begin after the subscriber HL. The dependent HL (son) would then be run and the 2300 loop for the dependent/patient would be run after that HL. HL04=1 would also be used when a claim/encounter for a only a dependent is being sent.

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

SBR Subscriber Information

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

User Option (Usage): Required

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

Example:

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

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage								
SBR01	1138	Payer Responsibility Sequence Number Code Description: Code identifying the insurance carrier's level of responsibility for a payment of a claim <table border="1"> <tr> <th>Code</th> <th>Name</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>	Code	Name	P	Primary	S	Secondary	T	Tertiary	M	ID	1/1	Required
Code	Name													
P	Primary													
S	Secondary													
T	Tertiary													
SBR02	1069	Individual Relationship Code Description: Code indicating the relationship between two individuals or entities Alias: Patients Relationship to Insured HIPAA IG Note: Use this code only when the subscriber is the same person as the patient. If the subscriber is not the same person as the patient, do not use this element. <table border="1"> <tr> <th>Code</th> <th>Name</th> </tr> <tr> <td>18</td> <td>Self</td> </tr> </table>	Code	Name	18	Self	O	ID	2/2	Situational				
Code	Name													
18	Self													
SBR03	127	Reference Identification Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier Industry: Insured Group or Policy Number Alias: Group Number HIPAA IG Note: Use this element to carry the subscriber's group number but not the number that uniquely identifies the subscriber. The subscriber's number should be carried in NM109. Using code IL in NM101 identifies the number in NM109 as the insured's Identification Number.	O	AN	1/30	Situational								
SBR04	93	Name Description: Free-form name Industry: Insured Group Name Alias: Plan Name (Group Name) NYS MEDICAID NOTE: NYSDOH expects to receive 'MEDICAID'. HIPAA IG Note: Used only when no group number is reported in SBR03.	O	AN	1/60	Situational								
SBR09	1032	Claim Filing Indicator Code Description: Code identifying type of claim NYS MEDICAID NOTE: NYSDOH expects to receive 'MC'. HIPAA IG Note: Required prior to mandated used of	O	ID	1/2	Situational								

PlanID. Not used after PlanID is mandated.

<u>Code</u>	<u>Name</u>
MC	Medicaid

NM1 Subscriber Name

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

User Option (Usage): Required

To supply the full name of an individual or organizational entity

Notes:

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

Example:

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

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
NM101	98	Entity Identifier Code Description: Code identifying an organizational entity, a physical location, property or an individual Code Name IL Insured or Subscriber	M	ID	2/3	Required
NM102	1065	Entity Type Qualifier Description: Code qualifying the type of entity NYS MEDICAID NOTE: NYSDOH expects to receive value '1'. Code Name 1 Person	M	ID	1/1	Required
NM103	1035	Name Last or Organization Name Description: Individual last name or organizational name Industry: Subscriber Last Name	O	AN	1/35	Required
NM104	1036	Name First Description: Individual first name Industry: Subscriber First Name HIPAA IG Note: This data element is required when NM102 equals one (1).	O	AN	1/25	Situational
NM105	1037	Name Middle Description: Individual middle name or initial Industry: Subscriber Middle Name Alias: Subscriber's Middle Initial HIPAA IG Note: This data element is required when NM102 = 1 and the Middle Name or Initial of the person is known.	O	AN	1/25	Situational
NM107	1039	Name Suffix Description: Suffix to individual name Industry: Subscriber Name Suffix HIPAA IG Note: This data element is required when the NM102 equals one (1) and the name suffix is known. Examples: I, II, III, IV, Jr, Sr.	O	AN	1/10	Situational
NM108	66	Identification Code Qualifier Description: Code designating the system/method of code structure used for Identification Code (67) HIPAA IG Note: This data element is required when NM102 equals one (1).	C	ID	1/2	Situational

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.

Code **Name**

MI Member Identification Number

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

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

Description: Code identifying a party or other code

Industry: Subscriber Primary Identifier

NYS MEDICAID NOTE: NYSDOH expects to receive client/recipient ID number here.

HIPAA IG Note: This data element is required when NM102 equals one (1).

N3 Subscriber Address

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

User Option (Usage): Situational

To specify the location of the named party

Notes:

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

Example:

N3*125 CITY AVENUE~

NYS MEDICAID NOTE:

NYSDOH will ignore data when provided.

Element Summary:

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

N4 Subscriber City/State/ZIP Code

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

User Option (Usage): Situational

To specify the geographic place of the named party

Notes:

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

Example:

N4*CENTERVILLE*PA*17111~

NYS MEDICAID NOTE:

NYSDOH will ignore data when provided.

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
N401	19	City Name Description: Free-form text for city name Industry: Subscriber City Name	O	AN	2/30	Required
N402	156	State or Province Code Description: Code (Standard State/Province) as defined by appropriate government agency Industry: Subscriber State Code	O	ID	2/2	Required
N403	116	Postal Code Description: States and Outlying Areas of the U.S. Description: Code defining international postal zone code excluding punctuation and blanks (zip code for United States) Industry: Subscriber Postal Zone or ZIP Code	O	ID	3/15	Required
N404	26	Country Code Description: ZIP Code Description: Code identifying the country HIPAA IG Note: This data element is required when the address is outside of the U.S.	O	ID	2/3	Situational

DMG Subscriber Demographic Information

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

User Option (Usage): Situational

To supply demographic information

Notes:

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

Example:

DMG*D8*19290730*M~

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
DMG01	1250	Date Time Period Format Qualifier Description: Code indicating the date format, time format, or date and time format Code Name D8 Date Expressed in Format CCYYMMDD	C	ID	2/3	Required
DMG02	1251	Date Time Period Description: Expression of a date, a time, or range of dates, times or dates and times Industry: Subscriber Birth Date Alias: Date of Birth - Patient	C	AN	1/35	Required
DMG03	1068	Gender Code Description: Code indicating the sex of the individual Industry: Subscriber Gender Code Alias: Gender - Patient NYS MEDICAID NOTE: NYSDOH cannot process code 'U' (Unknown). Any claim received populated with code 'U' will be denied. Code Name F Female M Male	O	ID	1/1	Required

REF Subscriber Secondary Identification

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

User Option (Usage): Situational

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.

Example:

REF*SY*030385074~

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>
REF01	128	Reference Identification Qualifier Description: Code qualifying the Reference Identification	M	ID	2/3	Required
		Code		Name		
		1W		Member Identification Number		If NM108 = MI, this qualifier cannot be used.
		23		Client Number		This code is intended to be used only in claims submitted to the Indian Health Service/Contract Health Services (IHS/CHS) Fiscal Intermediary for the purpose of reporting the Health Record Number.
		IG		Insurance Policy Number		
		SY		Social Security Number		The social security number may not be used for Medicare.
REF02	127	Reference Identification Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier Industry: Subscriber Supplemental Identifier	C	AN	1/30	Required

NM1 Payer Name

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

User Option (Usage): Required

To supply the full name of an individual or organizational entity

Notes:

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

Example:

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

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
NM101	98	Entity Identifier Code Description: Code identifying an organizational entity, a physical location, property or an individual <u>Code</u> <u>Name</u> PR Payer	M	ID	2/3	Required
NM102	1065	Entity Type Qualifier Description: Code qualifying the type of entity <u>Code</u> <u>Name</u> 2 Non-Person Entity	M	ID	1/1	Required
NM103	1035	Name Last or Organization Name Description: Individual last name or organizational name Industry: Payer Name NYS MEDICAID NOTE: NYSDOH expects to receive 'NYSDOH'.	O	AN	1/35	Required
NM108	66	Identification Code Qualifier Description: Code designating the system/method of code structure used for Identification Code (67) <u>Code</u> <u>Name</u> PI Payor Identification	C	ID	1/2	Required
NM109	67	Identification Code Description: Code identifying a party or other code Industry: Payer Identifier Alias: Primary Payer ID NYS MEDICAID NOTE: NYSDOH expects to receive '141797357'. <u>ExternalCodeList</u> Name: 540 Description: Health Care Financing Administration National PlanID	C	AN	2/80	Required

N3 Payer Address

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

User Option (Usage): Situational

To specify the location of the named party

Notes:

1. Payer Address is required when the submitter intends for the claim to be printed on paper at the next EDI location (e.g., a clearinghouse).

Example:

N3*225 MAIN STREET*BARKLEY BUILDING~

NYS MEDICAID NOTE:

NYSDOH will ignore data when provided.

Element Summary:

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

N4**Payer City/State/ZIP Code**

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

User Option (Usage): Situational

To specify the geographic place of the named party

Notes:

1. Payer Address is required when the submitter intends for the claim to be printed on paper at the next EDI location (e.g., a clearinghouse).

Example:

N4*CENTERVILLE*PA*17111~

NYS MEDICAID NOTE:

NYSDOH will ignore data when provided.

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
N401	19	City Name Description: Free-form text for city name Industry: Payer City Name	O	AN	2/30	Required
N402	156	State or Province Code Description: Code (Standard State/Province) as defined by appropriate government agency Industry: Payer State Code	O	ID	2/2	Required
		ExternalCodeList Name: 22 Description: States and Outlying Areas of the U.S.				
N403	116	Postal Code Description: Code defining international postal zone code excluding punctuation and blanks (zip code for United States) Industry: Payer Postal Zone or ZIP Code	O	ID	3/15	Required
		ExternalCodeList Name: 51 Description: ZIP Code				
N404	26	Country Code Description: Code identifying the country Alias: Payer Country Code HIPAA IG Note: This data element is required when the address is outside of the U.S.	O	ID	2/3	Situational
		ExternalCodeList Name: 5 Description: Countries, Currencies and Funds				

REF Payer Secondary Identification

Pos: 035	Max: 3
Detail - Optional	
Loop: 2010BC	Elements: 2

User Option (Usage): Situational

To specify identifying information

Notes:

1. Required if additional identification numbers other than the primary identification number in NM108/09 in this loop are necessary to adjudicate the claim/encounter.

Example:

REF*FY*435261708~

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>
REF01	128	Reference Identification Qualifier Description: Code qualifying the Reference Identification	M	ID	2/3	Required
		Code		Name		
		2U		Payer Identification Number		
				This code can be used to identify any payer's identification number (the payer can be Medicaid, a commercial payer, TPA, etc). Whatever number is used has been defined between trading partners.		
		FY		Claim Office Number		
				Description: The identification of the specific payer's location designated as responsible for the submitted claim		
		NF		National Association of Insurance Commissioners (NAIC) Code		
				Description: A unique number assigned to each insurance company		
				Code Source:		
				245: National Association of Insurance Commissioners (NAIC) Code		
		TJ		Federal Taxpayer's Identification Number		
REF02	127	Reference Identification Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	C	AN	1/30	Required
		Industry: Payer Additional Identifier				
		ExternalCodeList				
		Name: 245				
		Description: National Association of Insurance Commissioners (NAIC) Code				

CLM Claim information

Pos: 130	Max: 1
Detail - Optional	
Loop: 2300	Elements: 9

User Option (Usage): Required

To specify basic data about the claim

Notes:

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

Example:

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

NYS MEDICAID NOTE:

Please refer to NYS Medicaid Note in the front matter.

Element Summary:

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

the place of service or the type of bill related to the location at which a health care service was rendered

Alias: Type of Bill

1331		Facility Code Value	M	AN	1/2	Required
------	--	----------------------------	---	----	-----	----------

Description: Code identifying the type of facility where services were performed; the first and second positions of the Uniform Bill Type code or the Place of Service code from the Electronic Media Claims National Standard Format

Industry: Facility Type Code

NYS MEDICAID NOTE: NYSDOH will process as place of service.

ExternalCodeList

Name: 236

Description: Uniform Billing Claim Form Bill Type

1332		Facility Code Qualifier	O	ID	1/2	Required
------	--	--------------------------------	---	----	-----	----------

Description: Code identifying the type of facility referenced

Code

Name

A		Uniform Billing Claim Form Bill Type				
---	--	--------------------------------------	--	--	--	--

CODE SOURCE:

236: Uniform Billing Claim Form Bill Type

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

NYS MEDICAID NOTE: NYSDOH will process all values as original claims with the exception of codes '7' (Replacement) and '8' (Void).

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 to receive 'Y' or 'N'. Value 'Y' indicates the signature is on file.

Code

Name

N		No				
Y		Yes				

CLM07	1359	Provider Accept Assignment Code	O	ID	1/1	Situational
-------	------	--	---	----	-----	-------------

Description: Code indicating whether the provider accepts assignment

Industry: Medicare Assignment Code

HIPAA IG Note: CLM07 indicates whether the provider accepts Medicare assignment.

Code

Name

A		Assigned				
C		Not Assigned				

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

HIPAA IG Note: Use this value as an assignment of benefits indicator. Use a "Y" value to indicate that the

insured or authorized person authorizes benefits to be assigned to the provider. Use an "N" value to indicate that benefits have not been assigned to the provider.

<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

<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 UB-92 Ref. [UB-Name]: 52 Code R [Restricted or Modified Release]
N	No, Provider is Not Allowed to Release Data UB-92 Ref. [UB-Name]: 52 Code N [No Release]
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

CLM18 1073 **Yes/No Condition or Response Code** O ID 1/1 Required

Description: Code indicating a Yes or No condition or response

Industry: Explanation of Benefits Indicator
Alias: Explanation of Benefits (EOB) Indicator
NYS MEDICAID NOTE: NYSDOH does not support this business process.

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

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

Description: Code indicating the reason why a request was delayed

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

HIPAA IG Note: Delay Reason Code
This element may be used if a particular claim is being transmitted in response to a request for information (e.g., a 277), and the response has been delayed.

Required when claim is submitted late (past contracted date of filing limitations) and any of the codes below apply.

<u>Code</u>	<u>Name</u>
1	Proof of Eligibility Unknown or Unavailable
2	Litigation
3	Authorization Delays
4	Delay in Certifying Provider
5	Delay in Supplying Billing Forms
6	Delay in Delivery of Custom-made Appliances
7	Third Party Processing Delay

8	Delay in Eligibility Determination
9	Original Claim Rejected or Denied Due to a Reason Unrelated to the Billing Limitation Rules
10	Administration Delay in the Prior Approval Process
11	Other

DTP Discharge Hour

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

User Option (Usage): Situational

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

Notes:

1. The dates in Loop ID-2300 apply to all service lines within Loop ID-2400 unless a DTP segment occurs in Loop ID-2400 with the same value in DTP01. In that case, the DTP in Loop ID-2400 overrides the DTP in Loop ID-2300 for that service line only.
2. This segment is required on all final inpatient claims/encounters.

Example:

DTP*096*TM*1130~

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
DTP01	374	Date/Time Qualifier Description: Code specifying type of date or time, or both date and time Industry: Date Time Qualifier	M	ID	3/3	Required
		Code Name 096 Discharge				
DTP02	1250	Date Time Period Format Qualifier Description: Code indicating the date format, time format, or date and time format Code Name TM Time Expressed in Format HHMM Description: Time expressed in the format HHMM where HH is the numerical expression of hours in the day based on a twenty-four hour clock and MM is the numerical expression of minutes within an hour	M	ID	2/3	Required
DTP03	1251	Date Time Period Description: Expression of a date, a time, or range of dates, times or dates and times Industry: Discharge Hour	M	AN	1/35	Required

DTP Statement Dates

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

User Option (Usage): Required

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

Example:

DTP*434*RD8*19981209-19981214~

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
DTP01	374	Date/Time Qualifier Description: Code specifying type of date or time, or both date and time Industry: Date Time Qualifier	M	ID	3/3	Required
		Code Name 434 Statement Description: Date on which billing document was created				
DTP02	1250	Date Time Period Format Qualifier Description: Code indicating the date format, time format, or date and time format	M	ID	2/3	Required
		Code Name D8 Date Expressed in Format CCYYMMDD RD8 Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD Description: A range of dates expressed in the format CCYYMMDD-CCYYMMDD where CCYY is the numerical expression of the century CC and year YY, MM is the numerical expression of the month within the year, and DD is the numerical expression of the day within the year; the first occurrence of CCYYMMDD is the beginning date and the second occurrence is the ending date Use RD8 in DTP02 if it is necessary to indicate begin/end for from/to statement dates.				
DTP03	1251	Date Time Period Description: Expression of a date, a time, or range of dates, times or dates and times Industry: Statement From or To Date	M	AN	1/35	Required

DTP Admission Date/Hour

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

User Option (Usage): Situational

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

Notes:

1. The dates in Loop ID-2300 apply to all service lines within Loop ID-2400 unless a DTP segment occurs in Loop ID-2400 with the same value in DTP01. In that case, the DTP in Loop ID-2400 overrides the DTP in Loop ID-2300 for that service line only.
2. This segment is required on all Inpatient claims.

Example:

DTP*435*DT*199610131242~

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
DTP01	374	Date/Time Qualifier Description: Code specifying type of date or time, or both date and time Industry: Date Time Qualifier	M	ID	3/3	Required
		Code Name 435 Admission				
		Description: Date of entrance to a health care establishment				
DTP02	1250	Date Time Period Format Qualifier Description: Code indicating the date format, time format, or date and time format Industry: Date Time Qualifier	M	ID	2/3	Required
		Code Name DT Date and Time Expressed in Format CCYYMMDDHHMM				
DTP03	1251	Date Time Period Description: Expression of a date, a time, or range of dates, times or dates and times Industry: Admission Date and Hour	M	AN	1/35	Required

CL1 Institutional Claim Code

Pos: 140	Max: 1
Detail - Optional	
Loop: 2300	Elements: 3

User Option (Usage): Situational

To supply information specific to hospital claims

Notes:

1. This segment is required when reporting hospital based admission and Medicare outpatient registrations on claims/encounters. It may be used when provider wishes to communicate this information on non-Medicare outpatient claims/encounters.

Example:

CL1*1*7*30~

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>
CL101	1315	Admission Type Code Description: Code indicating the priority of this admission NYS MEDICAID NOTE: NYSDOH will recognize codes 1-4 as valid admission types. HIPAA IG Note: Required when patient is being admitted to the hospital for inpatient services. <u>ExternalCodeList</u> Name: 231 Description: Admission Type Code	O	ID	1/1	Situational
CL102	1314	Admission Source Code Description: Code indicating the source of this admission HIPAA IG Note: Required for all inpatient admissions. Required on Medicare outpatient registrations for diagnostic testing services. <u>ExternalCodeList</u> Name: 230 Description: Admission Source Code	O	ID	1/1	Situational
CL103	1352	Patient Status Code Description: Code indicating patient status as of the "statement covers through date" HIPAA IG Note: This element is required for inpatient claims/encounters. <u>ExternalCodeList</u> Name: 239 Description: Patient Status Code	O	ID	1/2	Situational

PWK Claim Supplemental Information

Pos: 155	Max: 10
Detail - Optional	
Loop: 2300	Elements: 5

User Option (Usage): Situational

To identify the type or transmission or both of paperwork or supporting information

Notes:

1. The PWK segment is required if there is paper documentation supporting this claim. The PWK segment should not be used if the information related to the claim is being sent within the 837 ST-SE envelope.
2. The PWK segment is required to identify attachments that are sent electronically (PWK02 = EL) but are transmitted in another functional group e.g., 275) rather than by paper. PWK06 is used to identify the attached electronic documentation. The number in PWK06 would be carried in the TRN of the electronic attachment.
3. The PWK segment can be used to identify paperwork that is being held at the provider's office and is available upon request by the payer (or appropriate entity), but that is not being sent with the claim. Use code AA in PWK02 to convey this specific use of the PWK segment. See element note under PWK02, code AA.

Example:

PWK*AS*BM***AC*DMN0012~

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>
PWK01	755	Report Type Code Description: Code indicating the title or contents of a document, report or supporting item Industry: Attachment Report Type Code	M	ID	2/2	Required
		Code Name				
		AS Admission Summary Description: A brief patient summary; it lists the patient's chief complaints and the reasons for admitting the patient to the hospital				
		B2 Prescription				
		B3 Physician Order				
		B4 Referral Form				
		CT Certification				
		DA Dental Models Description: Cast of the teeth; they are usually taken before partial dentures or braces are placed				
		DG Diagnostic Report Description: Report describing the results of lab tests x-rays or radiology films				
		DS Discharge Summary Description: Report listing the condition of the patient upon release from the hospital; it usually lists where the patient is being released to, what medication the patient is taking and when to follow-up with the doctor				
		EB Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payor) Description: Summary of benefits paid on the claim				
		MT Models				
		NN Nursing Notes Description: Notes kept by the nurse regarding a patient's physical and mental condition, what medication the patient is on and when it should be given				
		OB Operative Note Description: Step-by-step notes of exactly what takes place during an operation				

		OZ	Support Data for Claim Description: Medical records that would support procedures performed; tests given and necessary for a claim				
		PN	Physical Therapy Notes				
		PO	Prosthetics or Orthotic Certification				
		PZ	Physical Therapy Certification				
		RB	Radiology Films Description: X-rays, videos, and other radiology diagnostic tests				
		RR	Radiology Reports Description: Reports prepared by a radiologists after the films or x-rays have been reviewed				
		RT	Report of Tests and Analysis Report				
PWK02	756		Report Transmission Code Description: Code defining timing, transmission method or format by which reports are to be sent Industry: Attachment Transmission Code	O	ID	1/2	Required
		Code	Name				
		AA	Available on Request at Provider Site Paperwork is available at the provider's site. This means that the paperwork is not being sent with the claim at this time. Instead, it is available to the payer (or appropriate entity) at his or her request.				
		BM	By Mail				
		EL	Electronically Only				
		EM	E-Mail				
		FX	By Fax				
PWK05	66		Identification Code Qualifier Description: Code designating the system/method of code structure used for Identification Code (67) HIPAA IG Note: This data element is required when PWK02 DOES NOT equal 'AA'. Can be used when PWK02 equals 'AA' if the Provider wants to send a document control number for an attachment remaining at the Providers office.	C	ID	1/2	Situational
		Code	Name				
		AC	Attachment Control Number Description: Means of associating electronic claim with documentation forwarded by other means				
PWK06	67		Identification Code Description: Code identifying a party or other code Industry: Attachment Control Number HIPAA IG Note: Required if PWK02 equals BM, EL, EM or FX.	C	AN	2/80	Situational
PWK07	352		Description Description: A free-form description to clarify the related data elements and their content Industry: Attachment Description HIPAA IG Note: This data element is used to add any additional information about the attachment described in this segment.	O	AN	1/80	Not recommended

CN1 Contract Information

Pos: 160	Max: 1
Detail - Optional	
Loop: 2300	Elements: 6

User Option (Usage): Situational

To specify basic data about the contract or contract line item

Notes:

1. The developers of this implementation guide recommend that for non-capitated situations, contract information be maintained in the receiver's files and not be transmitted with each claim whenever possible. It is recommended that submitters always include CN1 for encounters that include only capitated services.
2. Required if the provider is contractually obligated to provide contract information on this claim.

Example:

CN1*02*550~

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>
CN101	1166	Contract Type Code Description: Code identifying a contract type	M	ID	2/2	Required
		Code Name				
		01 Diagnosis Related Group (DRG) Description: A patient classification scheme, which provides means of relating the type of patients a hospital treats to the costs incurred by the hospital, to determine quality of care and utilization of services in a hospital setting				
		02 Per Diem Description: A contract which allows certain charges to be on a rate per day basis				
		03 Variable Per Diem Description: A contract which allows certain charges to be on a rate per day basis, where the rate may not remain constant				
		04 Flat Description: A contract between the provider of service and the destination payor whereby the flat rate charges may differ from the total itemized charges				
		05 Capitated Description: A contract between the provider of service and the destination payor which allows payment to the provider of service on a per member per month basis				
		06 Percent				
		09 Other				
CN102	782	Monetary Amount Description: Monetary amount Industry: Contract Amount HIPAA IG Note: Required if provider is contractually obligated to provide this information on the claim.	O	R	1/18	Situational
CN103	332	Percent Description: Percent expressed as a percent Industry: Contract Percentage Alias: Allowance or Charge Percent HIPAA IG Note: Required if provider is contractually obligated to provide this information on the claim.	O	R	1/6	Situational
CN104	127	Reference Identification Description: Reference information as defined for a	O	AN	1/30	Situational

		particular Transaction Set or as specified by the Reference Identification Qualifier				
		Industry: Contract Code				
		HIPAA IG Note: Required if provider is contractually obligated to provide this information on the claim.				
CN105	338	Terms Discount Percent	O	R	1/6	Situational
		Description: Terms discount percentage, expressed as a percent, available to the purchaser if an invoice is paid on or before the Terms Discount Due Date				
		Industry: Terms Discount Percentage				
		HIPAA IG Note: Required if provider is contractually obligated to provide this information on the claim.				
CN106	799	Version Identifier	O	AN	1/30	Situational
		Description: Revision level of a particular format, program, technique or algorithm				
		Industry: Contract Version Identifier				
		HIPAA IG Note: Required if provider is contractually obligated to provide this information on the claim.				

AMT Payer Estimated Amount Due

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

User Option (Usage): Situational

To indicate the total monetary amount

Notes:

1. The amounts in this segment at the claim level Loop ID-2300 apply to all service lines unless overridden in the AMT segment in Loop ID-2400. An amount is considered to be overridden if the value in AMT01 is the same in both the claim level AMT segment and the service line level AMT segment.
2. This segment is required when the Payer Estimated Amount Due is applicable to this claim.

Example:

AMT*C5*14523.1~

NYS MEDICAID NOTE:

NYSDOH will ignore data when provided.

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
AMT01	522	Amount Qualifier Code Description: Code to qualify amount	M	ID	1/3	Required
		Code Name C5 Claim Amount Due - Estimated Description: Approximate value rightfully belonging to the individual				
AMT02	782	Monetary Amount Description: Monetary amount Industry: Estimated Claim Due Amount	M	R	1/18	Required

AMT Patient Estimated Amount Due

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

User Option (Usage): Situational

To indicate the total monetary amount

Notes:

1. The amounts in this segment at the claim level Loop ID-2300 apply to all service lines unless overridden in the AMT segment in Loop ID-2400. An amount is considered to be overridden if the value in AMT01 is the same in both the claim level AMT segment and the service line level AMT segment.
2. This segment is required when the Patient Responsibility Amount is applicable to this claim.

Example:

AMT*F3*123~

NYS MEDICAID NOTE:

NYSDOH will ignore data when provided.

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
AMT01	522	Amount Qualifier Code Description: Code to qualify amount	M	ID	1/3	Required
		Code Name F3 Patient Responsibility - Estimated Description: Approximate value one receiving medical care is obliged to pay				
AMT02	782	Monetary Amount Description: Monetary amount Industry: Patient Responsibility Amount	M	R	1/18	Required

AMT Patient Paid Amount

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

User Option (Usage): Situational

To indicate the total monetary amount

Notes:

1. The amounts in this segment at the claim level Loop ID-2300 apply to all service lines unless overridden in the AMT segment in Loop ID-2400. An amount is considered to be overridden if the value in AMT01 is the same in both the claim level AMT segment and the service line level AMT segment.
2. This segment is required when the Patient Paid Amount is applicable to this claim.

Example:

AMT*F5*8.5~

NYS MEDICAID NOTE:

NYSDOH will process as Patient Participation 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>
AMT01	522	Amount Qualifier Code Description: Code to qualify amount	M	ID	1/3	Required
		Code Name F5 Patient Amount Paid Description: Monetary amount value already paid by one receiving medical care				
AMT02	782	Monetary Amount Description: Monetary amount Industry: Patient Amount Paid	M	R	1/18	Required

REF Document Identification Code

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

User Option (Usage): Situational

To specify identifying information

Notes:

1. Reference numbers at this position apply to the entire claim.
2. This segment is used to convey submittal of HCFA-485 and HCFA-486 data OR HCFA-486 data only.

Example:

REF*DD*485~

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>				
REF01	128	Reference Identification Qualifier Description: Code qualifying the Reference Identification <table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>DD</td> <td>Document Identification Code</td> </tr> </tbody> </table>	<u>Code</u>	<u>Name</u>	DD	Document Identification Code	M	ID	2/3	Required
<u>Code</u>	<u>Name</u>									
DD	Document Identification Code									
REF02	127	Reference Identification Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier Industry: Document Control Identifier HIPAA IG Note: Use the form name as shown in the example. If both the 485 and 486 forms are being sent, repeat the segment.	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

To specify identifying information

Notes:

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

Example:

REF*F8*1234636854~

NYS MEDICAID NOTE:

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

Element Summary:

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

REF Investigational Device Exemption Number

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

User Option (Usage): Situational

To specify identifying information

Notes:

1. Required only on claims involving an FDA assigned investigational device exemption (IDE) number. Only one IDE per claim is to be reported.

Example:

REF*LX*432907~

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>
REF01	128	Reference Identification Qualifier Description: Code qualifying the Reference Identification	M	ID	2/3	Required
		Code Name LX Qualified Products List				
REF02	127	Reference Identification Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier Industry: Investigational Device Exemption Identifier	C	AN	1/30	Required

REF

Service Authorization Exception Code

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

User Option (Usage): Situational

To specify identifying information

Notes:

1. Used only in claims where providers are required by state law (e.g., New York State Medicaid) to obtain authorization for specific services but, for the reasons listed in REF02, performed the service without obtaining the service authorization. Check with your state Medicaid to see if this applies in your state.

Example:

REF*4N*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>
REF01	128	Reference Identification Qualifier Description: Code qualifying the Reference Identification	M	ID	2/3	Required
		Code Name				
		4N Special Payment Reference Number				
REF02	127	Reference Identification Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier Industry: Service Authorization Exception Code	C	AN	1/30	Required
		Code Name				
		1 Immediate/Urgent Care				
		2 Services Rendered in a Retroactive Period				
		3 Emergency Care				
		4 Client as Temporary Medicaid				
		5 Request from Country for Second Option to Recipient can Work				
		6 Request for Override Pending				
		7 Special Handling				

REF

Peer Review Organization (PRO) Approval Number

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

User Option (Usage): Situational

To specify identifying information

Notes:

1. Required when an external Peer Review Organization assigns an Approval Number to services deemed medically necessary by that organization.

Example:

REF*G4*284746~

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>
REF01	128	Reference Identification Qualifier Description: Code qualifying the Reference Identification	M	ID	2/3	Required
		Code Name G4 Peer Review Organization (PRO) Approval Number Description: An authorization number for certain surgical procedures and for an assistant at cataract surgery				
REF02	127	Reference Identification Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier Industry: Peer Review Authorization Number	C	AN	1/30	Required

REF Prior Authorization or Referral Number

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

User Option (Usage): Situational

To specify identifying information

Notes:

1. 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 2010BC 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*200398~

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
REF01	128	Reference Identification Qualifier Description: Code qualifying the Reference Identification <u>Code</u> <u>Name</u> G1 Prior Authorization Number Description: An authorization number acquired prior to the submission of a claim	M	ID	2/3	Required
REF02	127	Reference Identification Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier Industry: Prior Authorization Number NYS MEDICAID NOTE: NYSDOH expects to receive the eight digit prior approval number assigned to this service.	C	AN	1/30	Required

REF Medical Record Number

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

User Option (Usage): Situational

To specify identifying information

Notes:

1. Required if provider needs to identify for future inquiries the actual medical record of the patient identified in either Loop ID - 2010BA or 2010CA for this episode of care.
2. Used if provider will utilize this information in a 276 - Claim Status Inquiry in order to receive and process a 277 -Claim Status Response.

Example:

REF*EA*1230484376R~

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
REF01	128	Reference Identification Qualifier Description: Code qualifying the Reference Identification	M	ID	2/3	Required
		Code Name EA Medical Record Identification Number Description: A unique number assigned to each patient by the provider of service (hospital) to assist in retrieval of medical records				
REF02	127	Reference Identification Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier Industry: Medical Record Number	C	AN	1/30	Required

REF

Demonstration Project Identifier

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

User Option (Usage): Situational

To specify identifying information

Notes:

1. Required on claims/encounters where a demonstration project is being billed/reported. This information is specific to the destination payer reported in the 2010BC loop. If other payers have a similar number, report that information in the 2330 loop which holds that payer's information.

Example:

REF*P4*THJ1222~

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>
REF01	128	Reference Identification Qualifier Description: Code qualifying the Reference Identification	M	ID	2/3	Required
		Code Name P4 Project Code				
REF02	127	Reference Identification Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier Industry: Demonstration Project Identifier	C	AN	1/30	Required

K3 File Information

Pos: 185	Max: 10
Detail - Optional	
Loop: 2300	Elements: 1

User Option (Usage): Situational

To transmit a fixed-format record or matrix contents

Notes:

1. At the time of publication K3 segments have no specific use. However, they have been included in this implementation guide to be used as an emergency kludge (fix-it) in the case of an unexpected data requirement by a state regulatory authority.
2. This segment may only be required if a state concludes it must use the K3 to meet an emergency legislative requirement AND the administering state agency or other state organization has contacted the X12N workgroup, requested a review of the K3 data requirement to ensure there is not an existing method within the implementation guide to meet this requirement, and X12N determines that there is no method to meet the requirement. Only then may the state require the temporary use of the K3 to meet the requirement. X12N will submit the necessary data maintenance and refer the request to the appropriate data content committee.

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>
K301	449	Fixed Format Information Description: Data in fixed format agreed upon by sender and receiver	M	AN	1/80	Required

NTE Claim Note

Pos: 190	Max: 10
Detail - Optional	
Loop: 2300	Elements: 2

User Option (Usage): Situational

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

Notes:

1. Information in the NTE segment in Loop ID-2300 applies to the entire claim unless overridden by information in the NTE segment in Loop ID-2400. Information is considered to be overridden when the value in NTE01 in Loop ID-2400 is the same as the value in NTE01 in Loop ID-2300. The developers of this implementation guide discourage using narrative information within the 837. Trading partners who require narrative information with claims are encouraged to codify that information within the X12 environment.
2. Home Health Corresponding Data This segment is used to convey Home Health narrative information from the forms "Home Health Certification and Plan of Treatment" and "Medical Update and Patient Information."
3. Required only when provider deems it necessary to transmit information not otherwise supported in this implementation.

Example:

NTE*NTR*PATIENT REQUIRES TUBE FEEDING~

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>
NTE01	363	Note Reference Code Description: Code identifying the functional area or purpose for which the note applies	O	ID	3/3	Required
		Code Name				
		ALG Allergies				
		DCP Goals, Rehabilitation Potential, or Discharge Plans				
		DGN Diagnosis Description				
		Description: Verbal description of the condition involved				
		DME Durable Medical Equipment (DME) and Supplies				
		MED Medications				
		NTR Nutritional Requirements				
		ODT Orders for Disciplines and Treatments				
		RHB Functional Limitations, Reason Homebound, or Both				
		RLH Reasons Patient Leaves Home				
		RNH Times and Reasons Patient Not at Home				
		SET Unusual Home, Social Environment, or Both				
		SFM Safety Measures				
		SPT Supplementary Plan of Treatment				
		UPI Updated Information				
NTE02	352	Description Description: A free-form description to clarify the related data elements and their content Industry: Claim Note Text	M	AN	1/80	Required

NTE Billing Note

Pos: 190	Max: 1
Detail - Optional	
Loop: 2300	Elements: 2

User Option (Usage): Situational

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

Notes:

1. This segment is used to convey additional information necessary to adjudicate the claim.
2. Required when: (1) State regulations mandate information not identified elsewhere within the claim set; or (2) in the opinion of the provider, the information is needed to substantiate the medical treatment and is not supported elsewhere within the claim data set.

Example:

NTE*ADD*NO LIABILITY, PATIENT FELL AT HOME~

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

CR6 Home Health Care Information

Pos: 216	Max: 1
Detail - Optional	
Loop: 2300	Elements: 21

User Option (Usage): Situational

To supply information related to the certification of a home health care patient

Notes:

This segment is required for Home Health claims when applicable.

Example:

CR6*4*941101*RD8*19941101- 19941231*941015*N*Y*I*****941101****A~

NYS MEDICAID NOTE:

NYSDOH will ignore data when provided.

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage																		
CR601	923	Prognosis Code Description: Code indicating physician's prognosis for the patient Alias: Prognosis Indicator <table border="1"> <thead> <tr> <th>Code</th> <th>Name</th> </tr> </thead> <tbody> <tr><td>1</td><td>Poor</td></tr> <tr><td>2</td><td>Guarded</td></tr> <tr><td>3</td><td>Fair</td></tr> <tr><td>4</td><td>Good</td></tr> <tr><td>5</td><td>Very Good</td></tr> <tr><td>6</td><td>Excellent</td></tr> <tr><td>7</td><td>Less than 6 Months to Live</td></tr> <tr><td>8</td><td>Terminal</td></tr> </tbody> </table>	Code	Name	1	Poor	2	Guarded	3	Fair	4	Good	5	Very Good	6	Excellent	7	Less than 6 Months to Live	8	Terminal	M	ID	1/1	Required
Code	Name																							
1	Poor																							
2	Guarded																							
3	Fair																							
4	Good																							
5	Very Good																							
6	Excellent																							
7	Less than 6 Months to Live																							
8	Terminal																							
CR602	373	Date Description: Date expressed as CCYYMMDD Industry: Service From Date Alias: SOC Date	M	DT	8/8	Required																		
CR603	1250	Date Time Period Format Qualifier Description: Code indicating the date format, time format, or date and time format HIPAA IG Note: Required on claims/encounters when a certification for Home Health Services was previously or is being submitted to the destination payer. <table border="1"> <thead> <tr> <th>Code</th> <th>Name</th> </tr> </thead> <tbody> <tr> <td>RD8</td> <td>Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD Description: A range of dates expressed in the format CCYYMMDD-CCYYMMDD where CCYY is the numerical expression of the century CC and year YY, MM is the numerical expression of the month within the year, and DD is the numerical expression of the day within the year; the first occurrence of CCYYMMDD is the beginning date and the second occurrence is the ending date</td> </tr> </tbody> </table>	Code	Name	RD8	Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD Description: A range of dates expressed in the format CCYYMMDD-CCYYMMDD where CCYY is the numerical expression of the century CC and year YY, MM is the numerical expression of the month within the year, and DD is the numerical expression of the day within the year; the first occurrence of CCYYMMDD is the beginning date and the second occurrence is the ending date	C	ID	2/3	Situational														
Code	Name																							
RD8	Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD Description: A range of dates expressed in the format CCYYMMDD-CCYYMMDD where CCYY is the numerical expression of the century CC and year YY, MM is the numerical expression of the month within the year, and DD is the numerical expression of the day within the year; the first occurrence of CCYYMMDD is the beginning date and the second occurrence is the ending date																							
CR604	1251	Date Time Period Description: Expression of a date, a time, or range of dates, times or dates and times Industry: Home Health Certification Period Alias: Certification Period	C	AN	1/35	Situational																		

		HIPAA IG Note: Required on claims/encounters when a certification for Home Health Services was previously or is being submitted to the destination payer.				
CR605	373	Date Description: Date expressed as CCYYMMDD Industry: Diagnosis Date Alias: Date of Onset or Exacerbation of Principal Diagnosis	O	DT	8/8	Required
CR606	1073	Yes/No Condition or Response Code Description: Code indicating a Yes or No condition or response Industry: Skilled Nursing Facility Indicator Alias: Patient Receiving Care in 1861 (j) (1) Facility Indicator	O	ID	1/1	Required
		Code Name N No U Unknown Y Yes				
CR607	1073	Yes/No Condition or Response Code Description: Code indicating a Yes or No condition or response Industry: Medicare Coverage Indicator Alias: Medicare Covered Indicator	M	ID	1/1	Required
		Code Name N No Y Yes				
CR608	1322	Certification Type Code Description: Code indicating the type of certification Alias: Certification Type Indicator HIPAA IG Note: Required on claims/encounters when a certification for Home Health Services was previously or is being submitted to the destination payer.	M	ID	1/1	Required
		Code Name I Initial R Renewal S Revised				
CR609	373	Date Description: Date expressed as CCYYMMDD Industry: Surgery Date Alias: Date Surgical Procedure Performed HIPAA IG Note: This data element is required when a surgical procedure was performed on the patient.	C	DT	8/8	Situational
CR610	235	Product/Service ID Qualifier Description: Code identifying the type/source of the descriptive number used in Product/Service ID (234) Industry: Product or Service ID Qualifier HIPAA IG Note: This data element is required when a surgical procedure was performed on the patient.	C	ID	2/2	Situational
		Code Name HC Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes Description: HCFA coding scheme to group procedure(s) performed on an outpatient basis for payment to hospital under Medicare; primarily used for ambulatory surgical and other diagnostic departments This code includes Current Procedural Terminology (CPT) and HCPCS coding. CODE SOURCE: 130: Health Care Financing Administration Common Procedural Coding System				
		ID International Classification of Diseases Clinical Modification (ICD-9-CM) - Procedure				

Description: The International Classification of Diseases, Clinical Modification, is designated for the classification of morbidity and mortality information for statistical purposes and for the indexing of hospital records by disease and operations, for data storage and retrieval; this is a procedure code

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

CR611	1137	<p>Medical Code Value</p> <p>Description: Code value for describing a medical condition or procedure</p> <p>Industry: Surgical Procedure Code</p> <p>HIPAA IG Note: This data element is required when a surgical procedure was performed on the patient.</p> <p>ExternalCodeList</p> <p>Name: 130</p> <p>Description: Health Care Financing Administration Common Procedural Coding System</p> <p>ExternalCodeList</p> <p>Name: 131</p> <p>Description: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure</p>	C	AN	1/15	Situational
CR612	373	<p>Date</p> <p>Description: Date expressed as CCYYMMDD</p> <p>Industry: Physician Order Date</p> <p>Alias: Verbal SOC Date</p> <p>HIPAA IG Note: This data element is required when the Provider has the Physician Order Date information on file.</p>	O	DT	8/8	Situational
CR613	373	<p>Date</p> <p>Description: Date expressed as CCYYMMDD</p> <p>Industry: Last Visit Date</p> <p>Alias: Date Physician Last Saw Patient</p> <p>HIPAA IG Note: This data element is required when the Provider has the Last Visit Date information on file.</p>	O	DT	8/8	Situational
CR614	373	<p>Date</p> <p>Description: Date expressed as CCYYMMDD</p> <p>Industry: Physician Contact Date</p> <p>Alias: Date Last Contacted Physician</p> <p>HIPAA IG Note: This data element is required when the Provider has the Physician Contact Date information on file.</p>	O	DT	8/8	Situational
CR615	1250	<p>Date Time Period Format Qualifier</p> <p>Description: Code indicating the date format, time format, or date and time format</p> <p>HIPAA IG Note: This data element is required when a hospital admission occurred to the patient.</p> <p>Code Name</p> <p>RD8 Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD</p> <p>Description: A range of dates expressed in the format CCYYMMDD-CCYYMMDD where CCYY is the numerical expression of the century CC and year YY, MM is the numerical expression of the month within the year, and DD is the numerical expression of the day within the year; the first occurrence of CCYYMMDD is the beginning date and the second occurrence is the ending date</p>	C	ID	2/3	Situational
CR616	1251	<p>Date Time Period</p> <p>Description: Expression of a date, a time, or range of dates, times or dates and times</p> <p>Industry: Last Admission Period</p> <p>Alias: Admission Date and Discharge Date</p> <p>HIPAA IG Note: This data element is required when a hospital admission occurred to the patient.</p>	C	AN	1/35	Situational
CR617	1384	<p>Patient Location Code</p> <p>Description: Code identifying the location where</p>	C	ID	1/1	Required

patient is receiving medical treatment

Industry: Patient Discharge Facility Type Code
Alias: Type of Facility

<u>Code</u>	<u>Name</u>
A	Acute Care Facility
B	Boarding Home
C	Hospice
D	Intermediate Care Facility
E	Long-term or Extended Care Facility
F	Not Specified
G	Nursing Home
H	Sub-acute Care Facility
L	Other Location
M	Rehabilitation Facility
O	Outpatient Facility
R	Residential Treatment Facility
S	Skilled Nursing Home
T	Rest Home

CR618	373	<p>Date Description: Date expressed as CCYYMMDD Industry: Diagnosis Date Alias: Date Secondary Diagnosis - 1 HIPAA IG Note: This data element is required when a secondary diagnosis code is present on this claim.</p>	O	DT	8/8	Situational
CR619	373	<p>Date Description: Date expressed as CCYYMMDD Industry: Diagnosis Date Alias: Date Secondary Diagnosis - 2 HIPAA IG Note: This data element is required when a second secondary diagnosis code is present on this claim.</p>	O	DT	8/8	Situational
CR620	373	<p>Date Description: Date expressed as CCYYMMDD Industry: Diagnosis Date Alias: Date Secondary Diagnosis - 3 HIPAA IG Note: This data element is required when a third secondary diagnosis code is present on this claim.</p>	O	DT	8/8	Situational
CR621	373	<p>Date Description: Date expressed as CCYYMMDD Industry: Diagnosis Date Alias: Date Secondary Diagnosis - 4 HIPAA IG Note: This data element is required when a fourth secondary diagnosis code is present on this claim.</p>	O	DT	8/8	Situational

CRC Home Health Functional Limitations

Pos: 220	Max: 3
Detail - Optional	
Loop: 2300	Elements: 7

User Option (Usage): Situational

To supply information on conditions

Notes:

1. The CRC segment in Loop ID-2300 applies to the entire claim unless it is overridden by a CRC segment at the service line level in Loop ID-2400 with the same value in CRC01.
2. This segment is required to convey Home Health Plan of Treatment information when applicable.

Example:

CRC*75*Y*AL~

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>
CRC01	1136	Code Category Description: Specifies the situation or category to which the code applies	M	ID	2/2	Required
		Code Name 75 Functional Limitations				
CRC02	1073	Yes/No Condition or Response Code Description: Code indicating a Yes or No condition or response Industry: Certification Condition Indicator	M	ID	1/1	Required
		Code Name N No Y Yes				
CRC03	1321	Condition Indicator Description: Code indicating a condition Industry: Functional Limitation Code HIPAA IG Note: The codes for CRC03 also can be used for CRC04 through CRC07.	M	ID	2/2	Required
		Code Name AA Amputation AL Ambulation Limitations BL Bowel Limitations, Bladder Limitations, or both (Incontinence) CO Contracture DY Dyspnea with Minimal Exertion EL Endurance Limitations HL Hearing Limitations LB Legally Blind OL Other Limitation PA Paralysis SL Speech Limitations				
CRC04	1321	Condition Indicator Description: Code indicating a condition Industry: Functional Limitation Code HIPAA IG Note: See CRC03	O	ID	2/2	Situational

This data element is required when more than one Functional Limitation Code is applicable to the patient.

<u>Code</u>	<u>Name</u>
AA	Amputation
AL	Ambulation Limitations
BL	Bowel Limitations, Bladder Limitations, or both (Incontinence)
CO	Contracture
DY	Dyspnea with Minimal Exertion
EL	Endurance Limitations
HL	Hearing Limitations
LB	Legally Blind
OL	Other Limitation
PA	Paralysis
SL	Speech Limitations

CRC05 1321 **Condition Indicator** O ID 2/2 Situational

Description: Code indicating a condition
Industry: Functional Limitation Code
HIPAA IG Note: See CRC03
 This data element is required when more than one Functional Limitation Code is applicable to the patient.

<u>Code</u>	<u>Name</u>
AA	Amputation
AL	Ambulation Limitations
BL	Bowel Limitations, Bladder Limitations, or both (Incontinence)
CO	Contracture
DY	Dyspnea with Minimal Exertion
EL	Endurance Limitations
HL	Hearing Limitations
LB	Legally Blind
OL	Other Limitation
PA	Paralysis
SL	Speech Limitations

CRC06 1321 **Condition Indicator** O ID 2/2 Situational

Description: Code indicating a condition
Industry: Functional Limitation Code
HIPAA IG Note: See CRC03
 This data element is required when more than one Functional Limitation Code is applicable to the patient.

<u>Code</u>	<u>Name</u>
AA	Amputation
AL	Ambulation Limitations
BL	Bowel Limitations, Bladder Limitations, or both (Incontinence)
CO	Contracture
DY	Dyspnea with Minimal Exertion
EL	Endurance Limitations
HL	Hearing Limitations
LB	Legally Blind
OL	Other Limitation
PA	Paralysis
SL	Speech Limitations

CRC07 1321 **Condition Indicator** O ID 2/2 Situational

Description: Code indicating a condition
Industry: Functional Limitation Code
HIPAA IG Note: See CRC03

This data element is required when more than one Functional Limitation Code is applicable to the patient.

<u>Code</u>	<u>Name</u>
AA	Amputation
AL	Ambulation Limitations
BL	Bowel Limitations, Bladder Limitations, or both (Incontinence)
CO	Contracture
DY	Dyspnea with Minimal Exertion
EL	Endurance Limitations
HL	Hearing Limitations
LB	Legally Blind
OL	Other Limitation
PA	Paralysis
SL	Speech Limitations

CRC Home Health Activities Permitted

Pos: 220	Max: 3
Detail - Optional	
Loop: 2300	Elements: 7

User Option (Usage): Situational

To supply information on conditions

Notes:

1. This segment is required to convey Home Health Plan of Treatment information when applicable.

Example:

CRC*76*Y*CB~

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>																										
CRC01	1136	Code Category Description: Specifies the situation or category to which the code applies Industry: Certification Condition Indicator	M	ID	2/2	Required																										
		<table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>76</td> <td>Activities Permitted</td> </tr> </tbody> </table>	<u>Code</u>	<u>Name</u>	76	Activities Permitted																										
<u>Code</u>	<u>Name</u>																															
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CRC02	1073	Yes/No Condition or Response Code Description: Code indicating a Yes or No condition or response Industry: Functional Limitation Code	M	ID	1/1	Required																										
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<u>Code</u>	<u>Name</u>																															
N	No																															
Y	Yes																															
CRC03	1321	Condition Indicator Description: Code indicating a condition Industry: Activities Permitted Code HIPAA IG Note: The codes for CRC03 also can be used for CRC04 through CRC07.	M	ID	2/2	Required																										
		<table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>BR</td> <td>Bedrest BRP (Bathroom Privileges)</td> </tr> <tr> <td>CA</td> <td>Cane Required</td> </tr> <tr> <td>CB</td> <td>Complete Bedrest</td> </tr> <tr> <td>CR</td> <td>Crutches Required</td> </tr> <tr> <td>EP</td> <td>Exercises Prescribed</td> </tr> <tr> <td>IH</td> <td>Independent at Home</td> </tr> <tr> <td>NR</td> <td>No Restrictions</td> </tr> <tr> <td>PW</td> <td>Partial Weight Bearing</td> </tr> <tr> <td>TR</td> <td>Transfer to Bed, or Chair, or Both</td> </tr> <tr> <td>UT</td> <td>Up as Tolerated</td> </tr> <tr> <td>WA</td> <td>Walker Required</td> </tr> <tr> <td>WR</td> <td>Wheelchair Required</td> </tr> </tbody> </table>	<u>Code</u>	<u>Name</u>	BR	Bedrest BRP (Bathroom Privileges)	CA	Cane Required	CB	Complete Bedrest	CR	Crutches Required	EP	Exercises Prescribed	IH	Independent at Home	NR	No Restrictions	PW	Partial Weight Bearing	TR	Transfer to Bed, or Chair, or Both	UT	Up as Tolerated	WA	Walker Required	WR	Wheelchair Required				
<u>Code</u>	<u>Name</u>																															
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WA	Walker Required																															
WR	Wheelchair Required																															
CRC04	1321	Condition Indicator Description: Code indicating a condition Industry: Activities Permitted Code HIPAA IG Note: This data element is required when more than one Activities Permitted Code is	O	ID	2/2	Situational																										

applicable to the patient.

<u>Code</u>	<u>Name</u>
BR	Bedrest BRP (Bathroom Privileges)
CA	Cane Required
CB	Complete Bedrest
CR	Crutches Required
EP	Exercises Prescribed
IH	Independent at Home
NR	No Restrictions
PW	Partial Weight Bearing
TR	Transfer to Bed, or Chair, or Both
UT	Up as Tolerated
WA	Walker Required
WR	Wheelchair Required

CRC05 1321 **Condition Indicator** O ID 2/2 Situational

Description: Code indicating a condition
Industry: Activities Permitted Code
HIPAA IG Note: This data element is required when more than one Activities Permitted Code is applicable to the patient.

<u>Code</u>	<u>Name</u>
BR	Bedrest BRP (Bathroom Privileges)
CA	Cane Required
CB	Complete Bedrest
CR	Crutches Required
EP	Exercises Prescribed
IH	Independent at Home
NR	No Restrictions
PW	Partial Weight Bearing
TR	Transfer to Bed, or Chair, or Both
UT	Up as Tolerated
WA	Walker Required
WR	Wheelchair Required

CRC06 1321 **Condition Indicator** O ID 2/2 Situational

Description: Code indicating a condition
Industry: Activities Permitted Code
HIPAA IG Note: This data element is required when more than one Activities Permitted Code is applicable to the patient.

<u>Code</u>	<u>Name</u>
BR	Bedrest BRP (Bathroom Privileges)
CA	Cane Required
CB	Complete Bedrest
CR	Crutches Required
EP	Exercises Prescribed
IH	Independent at Home
NR	No Restrictions
PW	Partial Weight Bearing
TR	Transfer to Bed, or Chair, or Both
UT	Up as Tolerated
WA	Walker Required
WR	Wheelchair Required

CRC07 1321 **Condition Indicator** O ID 2/2 Situational

Description: Code indicating a condition
Industry: Activities Permitted Code
HIPAA IG Note: This data element is required when

more than one Activities Permitted Code is applicable to the patient.

<u>Code</u>	<u>Name</u>
BR	Bedrest BRP (Bathroom Privileges)
CA	Cane Required
CB	Complete Bedrest
CR	Crutches Required
EP	Exercises Prescribed
IH	Independent at Home
NR	No Restrictions
PW	Partial Weight Bearing
TR	Transfer to Bed, or Chair, or Both
UT	Up as Tolerated
WA	Walker Required
WR	Wheelchair Required

CRC Home Health Mental Status

Pos: 220	Max: 2
Detail - Optional	
Loop: 2300	Elements: 7

User Option (Usage): Situational

To supply information on conditions

Notes:

1. This segment is required to convey Home Health Plan of Treatment information when applicable.

Example:

CRC*77*Y*DI~

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>																		
CRC01	1136	Code Category Description: Specifies the situation or category to which the code applies Industry: Certification Condition Indicator <table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>77</td> <td>Mental Status</td> </tr> </tbody> </table>	<u>Code</u>	<u>Name</u>	77	Mental Status	M	ID	2/2	Required														
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CRC02	1073	Yes/No Condition or Response Code Description: Code indicating a Yes or No condition or response Industry: Functional Limitation Code <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	M	ID	1/1	Required												
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N	No																							
Y	Yes																							
CRC03	1321	Condition Indicator Description: Code indicating a condition Industry: Mental Status Code HIPAA IG Note: The codes for CRC03 also can be used for CRC04 through CRC07. <table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>AG</td> <td>Agitated</td> </tr> <tr> <td>CM</td> <td>Comatose</td> </tr> <tr> <td>DI</td> <td>Disoriented</td> </tr> <tr> <td>DP</td> <td>Depressed</td> </tr> <tr> <td>FO</td> <td>Forgetful</td> </tr> <tr> <td>LE</td> <td>Lethargic</td> </tr> <tr> <td>MC</td> <td>Other Mental Condition</td> </tr> <tr> <td>OT</td> <td>Oriented</td> </tr> </tbody> </table>	<u>Code</u>	<u>Name</u>	AG	Agitated	CM	Comatose	DI	Disoriented	DP	Depressed	FO	Forgetful	LE	Lethargic	MC	Other Mental Condition	OT	Oriented	M	ID	2/2	Required
<u>Code</u>	<u>Name</u>																							
AG	Agitated																							
CM	Comatose																							
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DP	Depressed																							
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MC	Other Mental Condition																							
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CRC04	1321	Condition Indicator Description: Code indicating a condition <table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>AG</td> <td>Agitated</td> </tr> <tr> <td>CM</td> <td>Comatose</td> </tr> <tr> <td>DI</td> <td>Disoriented</td> </tr> <tr> <td>DP</td> <td>Depressed</td> </tr> <tr> <td>FO</td> <td>Forgetful</td> </tr> <tr> <td>LE</td> <td>Lethargic</td> </tr> </tbody> </table>	<u>Code</u>	<u>Name</u>	AG	Agitated	CM	Comatose	DI	Disoriented	DP	Depressed	FO	Forgetful	LE	Lethargic	O	ID	2/2	Situational				
<u>Code</u>	<u>Name</u>																							
AG	Agitated																							
CM	Comatose																							
DI	Disoriented																							
DP	Depressed																							
FO	Forgetful																							
LE	Lethargic																							

		MC	Other Mental Condition				
		OT	Oriented				
CRC05	1321	Condition Indicator		O	ID	2/2	Situational
		Description: Code indicating a condition					
		<u>Code</u>	<u>Name</u>				
		AG	Agitated				
		CM	Comatose				
		DI	Disoriented				
		DP	Depressed				
		FO	Forgetful				
		LE	Lethargic				
		MC	Other Mental Condition				
		OT	Oriented				
CRC06	1321	Condition Indicator		O	ID	2/2	Situational
		Description: Code indicating a condition					
		<u>Code</u>	<u>Name</u>				
		AG	Agitated				
		CM	Comatose				
		DI	Disoriented				
		DP	Depressed				
		FO	Forgetful				
		LE	Lethargic				
		MC	Other Mental Condition				
		OT	Oriented				
CRC07	1321	Condition Indicator		O	ID	2/2	Situational
		Description: Code indicating a condition					
		<u>Code</u>	<u>Name</u>				
		AG	Agitated				
		CM	Comatose				
		DI	Disoriented				
		DP	Depressed				
		FO	Forgetful				
		LE	Lethargic				
		MC	Other Mental Condition				
		OT	Oriented				

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

Pos: 231	Max: 1
Detail - Optional	
Loop: 2300	Elements: 3

User Option (Usage): Situational

To supply information related to the delivery of health care

Notes:

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

Example:

HI*BK:9976~

NYS MEDICAID NOTE:

NYSDOH will process the Principal and Admitting Diagnosis Codes here, when required.

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
HI01	C022	Health Care Code Information Description: To send health care codes and their associated dates, amounts and quantities	M	Comp		Required
	1270	Code List Qualifier Code Description: Code identifying a specific industry code list	M	ID	1/3	Required
		Code Name BK Principal Diagnosis				
		CODE SOURCE: 131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure				
	1271	Industry Code Description: Code indicating a code from a specific industry code list	M	AN	1/30	Required
		ExternalCodeList Name: 131 Description: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure				
HI02	C022	Health Care Code Information Description: To send health care codes and their associated dates, amounts and quantities	O	Comp		Situational
		HIPAA IG Note: Required for all unscheduled outpatient visits or upon the patient's admission to the hospital.				
	1270	Code List Qualifier Code Description: Code identifying a specific industry code list	M	ID	1/3	Required
		HIPAA IG Note: ZZ used to indicate the "Patient Reason For Visit."				
		Code Name BJ Admitting Diagnosis				

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

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

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

NYS MEDICAID NOTE: NYSDOH will ignore this information when provided.

HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.

1270 **Code List Qualifier Code** M ID 1/3 Required
Description: Code identifying a specific industry code list

Code

Name

BN United States Department of Health and Human Services, Office of Vital Statistics E-code

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

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

ExternalCodeList

Name: 131

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

HI

Diagnosis Related Group (DRG) Information

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

User Option (Usage): Situational

To supply information related to the delivery of health care

Notes:

1. DRG Information is required when an inpatient hospital is under DRG contract with a payer and the contract requires the provider to identify the DRG to the payer.

Example:

HI*DR:123~

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>
HI01	C022	Health Care Code Information Description: To send health care codes and their associated dates, amounts and quantities	M	Comp		Required
	1270	Code List Qualifier Code Description: Code identifying a specific industry code list	M	ID	1/3	Required
		Code Name DR Diagnosis Related Group (DRG)				
		CODE SOURCE: 229: Diagnosis Related Group Number (DRG)				
	1271	Industry Code Description: Code indicating a code from a specific industry code list Industry: Diagnosis Related Group (DRG) Code	M	AN	1/30	Required
		ExternalCodeList Name: 229 Description: Diagnosis Related Group Number (DRG)				

HI

Other Diagnosis Information

Pos: 231	Max: 2
Detail - Optional	
Loop: 2300	Elements: 12

User Option (Usage): Situational

To supply information related to the delivery of health care

Notes:

1. Required when other condition(s) co-exists with the principal diagnosis, co-exists at the time of admission or develops subsequently during the patient's treatment.

Example:

HI*BF:V9782~

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
HI01	C022	Health Care Code Information Description: To send health care codes and their associated dates, amounts and quantities	M	Comp		Required
	1270	Code List Qualifier Code Description: Code identifying a specific industry code list	M	ID	1/3	Required
		Code Name BF Diagnosis				
		CODE SOURCE: 131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure				
	1271	Industry Code Description: Code indicating a code from a specific industry code list Industry: Other Diagnosis	M	AN	1/30	Required
		ExternalCodeList Name: 131 Description: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure				
HI02	C022	Health Care Code Information Description: To send health care codes and their associated dates, amounts and quantities HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.	O	Comp		Situational
	1270	Code List Qualifier Code Description: Code identifying a specific industry code list	M	ID	1/3	Required
		Code Name BF Diagnosis				
		CODE SOURCE: 131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure				
	1271	Industry Code Description: Code indicating a code from a specific industry code list Industry: Other Diagnosis	M	AN	1/30	Required
		ExternalCodeList Name: 131 Description: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure				
HI03	C022	Health Care Code Information Description: To send health care codes and their	O	Comp		Situational

associated dates, amounts and quantities
HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.

1270 **Code List Qualifier Code** M ID 1/3 Required
Description: Code identifying a specific industry code list

Code **Name**
 BF Diagnosis

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

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

Industry: Other Diagnosis

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

HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.

1270 **Code List Qualifier Code** M ID 1/3 Required
Description: Code identifying a specific industry code list

Code **Name**
 BF Diagnosis

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

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

Industry: Other Diagnosis

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

HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.

1270 **Code List Qualifier Code** M ID 1/3 Required
Description: Code identifying a specific industry code list

Code **Name**
 BF Diagnosis

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

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

Industry: Other Diagnosis

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

		HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.				
1270		Code List Qualifier Code Description: Code identifying a specific industry code list	M	ID	1/3	Required
		Code Name BF Diagnosis				
		CODE SOURCE: 131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure				
1271		Industry Code Description: Code indicating a code from a specific industry code list	M	AN	1/30	Required
		Industry: Other Diagnosis				
		ExternalCodeList Name: 131				
		Description: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure				
HI07	C022	Health Care Code Information Description: To send health care codes and their associated dates, amounts and quantities	O	Comp		Situational
		HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.				
1270		Code List Qualifier Code Description: Code identifying a specific industry code list	M	ID	1/3	Required
		Code Name BF Diagnosis				
		CODE SOURCE: 131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure				
1271		Industry Code Description: Code indicating a code from a specific industry code list	M	AN	1/30	Required
		Industry: Other Diagnosis				
		HIPAA IG Note: Record Type 70 Field No. 5, 6, 7, 8, 9, 10, 11, 12				
		ExternalCodeList Name: 131				
		Description: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure				
HI08	C022	Health Care Code Information Description: To send health care codes and their associated dates, amounts and quantities	O	Comp		Situational
		HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.				
1270		Code List Qualifier Code Description: Code identifying a specific industry code list	M	ID	1/3	Required
		Code Name BF Diagnosis				
		CODE SOURCE: 131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure				
1271		Industry Code Description: Code indicating a code from a specific industry code list	M	AN	1/30	Required
		Industry: Other Diagnosis				
		HIPAA IG Note: Record Type 70 Field No. 5, 6, 7, 8, 9, 10, 11, 12				
		ExternalCodeList Name: 131				
		Description: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure				

HI09	C022	<p>Health Care Code Information Description: To send health care codes and their associated dates, amounts and quantities HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.</p>	O	Comp		Situational
	1270	<p>Code List Qualifier Code Description: Code identifying a specific industry code list</p> <p>Code Name BF Diagnosis</p> <p>CODE SOURCE: 131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure</p>	M	ID	1/3	Required
	1271	<p>Industry Code Description: Code indicating a code from a specific industry code list Industry: Other Diagnosis HIPAA IG Note: Record Type 70 Field No. 5, 6, 7, 8, 9, 10, 11, 12</p> <p>ExternalCodeList Name: 131 Description: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure</p>	M	AN	1/30	Required
HI10	C022	<p>Health Care Code Information Description: To send health care codes and their associated dates, amounts and quantities HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.</p>	O	Comp		Situational
	1270	<p>Code List Qualifier Code Description: Code identifying a specific industry code list</p> <p>Code Name BF Diagnosis</p> <p>CODE SOURCE: 131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure</p>	M	ID	1/3	Required
	1271	<p>Industry Code Description: Code indicating a code from a specific industry code list Industry: Other Diagnosis HIPAA IG Note: Record Type 70 Field No. 5, 6, 7, 8, 9, 10, 11, 12</p> <p>ExternalCodeList Name: 131 Description: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure</p>	M	AN	1/30	Required
HI11	C022	<p>Health Care Code Information Description: To send health care codes and their associated dates, amounts and quantities HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.</p>	O	Comp		Situational
	1270	<p>Code List Qualifier Code Description: Code identifying a specific industry code list</p> <p>Code Name BF Diagnosis</p> <p>CODE SOURCE: 131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure</p>	M	ID	1/3	Required
	1271	<p>Industry Code Description: Code indicating a code from a specific industry code list Industry: Other Diagnosis HIPAA IG Note: Record Type 70 Field No. 5, 6, 7, 8.</p>	M	AN	1/30	Required

9, 10, 11, 12

ExternalCodeList

Name: 131

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

HI12

C022

Health Care Code Information

O

Comp

Situational

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

HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.

1270

Code List Qualifier Code

M

ID

1/3

Required

Description: Code identifying a specific industry code list

Code

Name

BF

Diagnosis

CODE SOURCE:

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

1271

Industry Code

M

AN

1/30

Required

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

Industry: Other Diagnosis

HIPAA IG Note: Record Type 70 Field No. 5, 6, 7, 8, 9, 10, 11, 12

ExternalCodeList

Name: 131

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

HI

Principal Procedure Information

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

User Option (Usage): Situational

To supply information related to the delivery of health care

Notes:

1. Required on Home IV therapy claims or encounters when surgery was performed during the inpatient stay from which the course of therapy was initiated.
2. Required on inpatient claims or encounters when a procedure was performed.

Example:

HI*BR:92795:D8:19980321~

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
HI01	C022	Health Care Code Information Description: To send health care codes and their associated dates, amounts and quantities	M	Comp		Required
	1270	Code List Qualifier Code Description: Code identifying a specific industry code list	M	ID	1/3	Required
		Code Name				
		BO Health Care Financing Administration Common Procedural Coding System				
		BP Health Care Financing Administration Common Procedural Coding System Principal Procedure				
		CODE SOURCE:				
		130: Health Care Financing Administration Common Procedural Coding System				
		BQ International Classification of Diseases Clinical Modification (ICD-9-CM) Procedure				
		BR International Classification of Diseases Clinical Modification (ICD-9-CM) Principal Procedure				
		CODE SOURCE:				
		131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure				
	1271	Industry Code Description: Code indicating a code from a specific industry code list Industry: Principal Procedure Code	M	AN	1/30	Required
		ExternalCodeList Name: 130 Description: Health Care Financing Administration Common Procedural Coding System				
		ExternalCodeList Name: 131 Description: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure				
	1250	Date Time Period Format Qualifier Description: Code indicating the date format, time format, or date and time format	C	ID	2/3	Situational
		Code Name				
		D8 Date Expressed in Format CCYYMMDD				
		Use code D8 when the value in composite data element HI01-1 equals "BR".				
	1251	Date Time Period Description: Expression of a date, a time, or range of dates, times or dates and times HIPAA IG Note: Required when HI01-3 is used.	C	AN	1/35	Situational

HI

Other Procedure Information

Pos: 231	Max: 2
Detail - Optional	
Loop: 2300	Elements: 12

User Option (Usage): Situational

To supply information related to the delivery of health care

Notes:

1. Required on Home IV therapy claims or encounters when surgery was performed during the inpatient stay from which the course of therapy was initiated.
2. Required on inpatient claims or encounters when additional procedures must be reported.

Example:

HI*BQ:92795:D8:19980321~

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
HI01	C022	Health Care Code Information Description: To send health care codes and their associated dates, amounts and quantities	M	Comp		Required
	1270	Code List Qualifier Code Description: Code identifying a specific industry code list	M	ID	1/3	Required
		Code Name BO Health Care Financing Administration Common Procedural Coding System CODE SOURCE: 130: Health Care Financing Administration Common Procedural Coding System				
		BQ International Classification of Diseases Clinical Modification (ICD-9-CM) Procedure CODE SOURCE: 131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure				
	1271	Industry Code Description: Code indicating a code from a specific industry code list Industry: Procedure Code ExternalCodeList Name: 130 Description: Health Care Financing Administration Common Procedural Coding System ExternalCodeList Name: 131 Description: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure	M	AN	1/30	Required
	1250	Date Time Period Format Qualifier Description: Code indicating the date format, time format, or date and time format HIPAA IG Note: Required if the procedure code reported is ICD-9-CM in the preceding data element. Used if needed to report a procedure date when the code reported is HCPCS. If used, the immediately following element is required.	C	ID	2/3	Situational
		Code Name D8 Date Expressed in Format CCYYMMDD				
	1251	Date Time Period Description: Expression of a date, a time, or range of dates, times or dates and times Industry: Procedure Date	C	AN	1/35	Situational

HI02	C022	Health Care Code Information Description: To send health care codes and their associated dates, amounts and quantities HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.	O	Comp		Situational
	1270	Code List Qualifier Code Description: Code identifying a specific industry code list Code Name BO Health Care Financing Administration Common Procedural Coding System CODE SOURCE: 130: Health Care Financing Administration Common Procedural Coding System BQ International Classification of Diseases Clinical Modification (ICD-9-CM) Procedure CODE SOURCE: 131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure	M	ID	1/3	Required
	1271	Industry Code Description: Code indicating a code from a specific industry code list Industry: Procedure Code ExternalCodeList Name: 130 Description: Health Care Financing Administration Common Procedural Coding System ExternalCodeList Name: 131 Description: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure	M	AN	1/30	Required
	1250	Date Time Period Format Qualifier Description: Code indicating the date format, time format, or date and time format HIPAA IG Note: Required if the procedure code reported is ICD-9-CM in the preceding data element. Used if needed to report a procedure date when the code reported is HCPCS. If used, the immediately following element is required. Code Name D8 Date Expressed in Format CCYYMMDD	C	ID	2/3	Situational
	1251	Date Time Period Description: Expression of a date, a time, or range of dates, times or dates and times Industry: Procedure Date	C	AN	1/35	Situational
HI03	C022	Health Care Code Information Description: To send health care codes and their associated dates, amounts and quantities HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.	O	Comp		Situational
	1270	Code List Qualifier Code Description: Code identifying a specific industry code list Code Name BO Health Care Financing Administration Common Procedural Coding System CODE SOURCE: 130: Health Care Financing Administration Common Procedural Coding System BQ International Classification of Diseases Clinical Modification (ICD-9-CM) Procedure CODE SOURCE: 131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure	M	ID	1/3	Required
	1271	Industry Code Description: Code indicating a code from a specific industry code list Industry: Procedure Code	M	AN	1/30	Required

ExternalCodeList

Name: 130

Description: Health Care Financing Administration Common Procedural Coding System

ExternalCodeList

Name: 131

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

1250	Date Time Period Format Qualifier	C	ID	2/3	Situational
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Description: Code indicating the date format, time format, or date and time format

HIPAA IG Note: Required if the procedure code reported is ICD-9-CM in the preceding data element. Used if needed to report a procedure date when the code reported is HCPCS. If used, the immediately following element is required.

<u>Code</u>	<u>Name</u>
--------------------	--------------------

D8	Date Expressed in Format CCYYMMDD
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1251	Date Time Period	C	AN	1/35	Situational
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Description: Expression of a date, a time, or range of dates, times or dates and times

Industry: Procedure Date

HI04

C022	Health Care Code Information	O	Comp		Situational
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Description: To send health care codes and their associated dates, amounts and quantities

HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.

1270	Code List Qualifier Code	M	ID	1/3	Required
------	---------------------------------	---	----	-----	----------

Description: Code identifying a specific industry code list

<u>Code</u>	<u>Name</u>
--------------------	--------------------

BO	Health Care Financing Administration Common Procedural Coding System
----	--

CODE SOURCE:

130: Health Care Financing Administration Common Procedural Coding System

BQ	International Classification of Diseases Clinical Modification (ICD-9-CM) Procedure
----	---

CODE SOURCE:

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

1271	Industry Code	M	AN	1/30	Required
------	----------------------	---	----	------	----------

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

Industry: Procedure Code

ExternalCodeList

Name: 130

Description: Health Care Financing Administration Common Procedural Coding System

ExternalCodeList

Name: 131

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

1250	Date Time Period Format Qualifier	C	ID	2/3	Situational
------	--	---	----	-----	-------------

Description: Code indicating the date format, time format, or date and time format

HIPAA IG Note: Required if the procedure code reported is ICD-9-CM in the preceding data element. Used if needed to report a procedure date when the code reported is HCPCS. If used, the immediately following element is required.

<u>Code</u>	<u>Name</u>
--------------------	--------------------

D8	Date Expressed in Format CCYYMMDD
----	-----------------------------------

1251	Date Time Period	C	AN	1/35	Situational
------	-------------------------	---	----	------	-------------

Description: Expression of a date, a time, or range of dates, times or dates and times

HI05	C022	Industry: Procedure Date Health Care Code Information Description: To send health care codes and their associated dates, amounts and quantities HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.	O	Comp		Situational
	1270	Code List Qualifier Code Description: Code identifying a specific industry code list	M	ID	1/3	Required
		Code Name BO Health Care Financing Administration Common Procedural Coding System CODE SOURCE: 130: Health Care Financing Administration Common Procedural Coding System BQ International Classification of Diseases Clinical Modification (ICD-9-CM) Procedure CODE SOURCE: 131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure				
	1271	Industry Code Description: Code indicating a code from a specific industry code list Industry: Procedure Code ExternalCodeList Name: 130 Description: Health Care Financing Administration Common Procedural Coding System ExternalCodeList Name: 131 Description: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure	M	AN	1/30	Required
	1250	Date Time Period Format Qualifier Description: Code indicating the date format, time format, or date and time format HIPAA IG Note: Required if the procedure code reported is ICD-9-CM in the preceding data element. Used if needed to report a procedure date when the code reported is HCPCS. If used, the immediately following element is required.	C	ID	2/3	Situational
		Code Name D8 Date Expressed in Format CCYYMMDD				
	1251	Date Time Period Description: Expression of a date, a time, or range of dates, times or dates and times	C	AN	1/35	Situational
HI06	C022	Industry: Procedure Date Health Care Code Information Description: To send health care codes and their associated dates, amounts and quantities HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.	O	Comp		Situational
	1270	Code List Qualifier Code Description: Code identifying a specific industry code list	M	ID	1/3	Required
		Code Name BO Health Care Financing Administration Common Procedural Coding System CODE SOURCE: 130: Health Care Financing Administration Common Procedural Coding System BQ International Classification of Diseases Clinical Modification (ICD-9-CM) Procedure CODE SOURCE: 131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure				
	1271	Industry Code Description: Code indicating a code from a specific industry code list	M	AN	1/30	Required

Industry: Procedure Code

ExternalCodeList

Name: 130

Description: Health Care Financing Administration Common Procedural Coding System

ExternalCodeList

Name: 131

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

1250	Date Time Period Format Qualifier	C	ID	2/3	Situational
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Description: Code indicating the date format, time format, or date and time format

HIPAA IG Note: Required if the procedure code reported is ICD-9-CM in the preceding data element. Used if needed to report a procedure date when the code reported is HCPCS. If used, the immediately following element is required.

<u>Code</u>	<u>Name</u>
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D8	Date Expressed in Format CCYYMMDD
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1251	Date Time Period	C	AN	1/35	Situational
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Description: Expression of a date, a time, or range of dates, times or dates and times

Industry: Procedure Date

HI07	C022	Health Care Code Information	O	Comp	Situational
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Description: To send health care codes and their associated dates, amounts and quantities

HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.

1270	Code List Qualifier Code	M	ID	1/3	Required
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Description: Code identifying a specific industry code list

<u>Code</u>	<u>Name</u>
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BO	Health Care Financing Administration Common Procedural Coding System
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CODE SOURCE:

130: Health Care Financing Administration Common Procedural Coding System

BQ	International Classification of Diseases Clinical Modification (ICD-9-CM) Procedure
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CODE SOURCE:

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

1271	Industry Code	M	AN	1/30	Required
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Description: Code indicating a code from a specific industry code list

Industry: Procedure Code

ExternalCodeList

Name: 130

Description: Health Care Financing Administration Common Procedural Coding System

ExternalCodeList

Name: 131

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

1250	Date Time Period Format Qualifier	C	ID	2/3	Situational
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Description: Code indicating the date format, time format, or date and time format

HIPAA IG Note: Required if the procedure code reported is ICD-9-CM in the preceding data element. Used if needed to report a procedure date when the code reported is HCPCS. If used, the immediately following element is required.

<u>Code</u>	<u>Name</u>
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D8	Date Expressed in Format CCYYMMDD
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1251	Date Time Period	C	AN	1/35	Situational
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Description: Expression of a date, a time, or range

		of dates, times or dates and times				
		Industry: Procedure Date				
HI08	C022	Health Care Code Information Description: To send health care codes and their associated dates, amounts and quantities HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.	O	Comp		Situational
	1270	Code List Qualifier Code Description: Code identifying a specific industry code list	M	ID	1/3	Required
		Code Name				
		BO Health Care Financing Administration Common Procedural Coding System				
		CODE SOURCE: 130: Health Care Financing Administration Common Procedural Coding System				
		BQ International Classification of Diseases Clinical Modification (ICD-9-CM) Procedure				
		CODE SOURCE: 131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure				
	1271	Industry Code Description: Code indicating a code from a specific industry code list Industry: Procedure Code	M	AN	1/30	Required
		ExternalCodeList Name: 130 Description: Health Care Financing Administration Common Procedural Coding System				
		ExternalCodeList Name: 131 Description: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure				
	1250	Date Time Period Format Qualifier Description: Code indicating the date format, time format, or date and time format HIPAA IG Note: Required if the procedure code reported is ICD-9-CM in the preceding data element. Used if needed to report a procedure date when the code reported is HCPCS. If used, the immediately following element is required.	C	ID	2/3	Situational
		Code Name				
		D8 Date Expressed in Format CCYYMMDD				
	1251	Date Time Period Description: Expression of a date, a time, or range of dates, times or dates and times	C	AN	1/35	Situational
		Industry: Procedure Date				
HI09	C022	Health Care Code Information Description: To send health care codes and their associated dates, amounts and quantities HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.	O	Comp		Situational
	1270	Code List Qualifier Code Description: Code identifying a specific industry code list	M	ID	1/3	Required
		Code Name				
		BO Health Care Financing Administration Common Procedural Coding System				
		CODE SOURCE: 130: Health Care Financing Administration Common Procedural Coding System				
		BQ International Classification of Diseases Clinical Modification (ICD-9-CM) Procedure				
		CODE SOURCE: 131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure				
	1271	Industry Code Description: Code indicating a code from a specific	M	AN	1/30	Required

industry code list

Industry: Procedure Code

ExternalCodeList

Name: 130

Description: Health Care Financing Administration Common Procedural Coding System

ExternalCodeList

Name: 131

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

1250	Date Time Period Format Qualifier	C	ID	2/3	Situational
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Description: Code indicating the date format, time format, or date and time format

HIPAA IG Note: Required if the procedure code reported is ICD-9-CM in the preceding data element. Used if needed to report a procedure date when the code reported is HCPCS. If used, the immediately following element is required.

<u>Code</u>	<u>Name</u>
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D8	Date Expressed in Format CCYYMMDD
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1251	Date Time Period	C	AN	1/35	Situational
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Description: Expression of a date, a time, or range of dates, times or dates and times

Industry: Procedure Date

HI10	C022	Health Care Code Information	O	Comp	Situational
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Description: To send health care codes and their associated dates, amounts and quantities

HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.

1270	Code List Qualifier Code	M	ID	1/3	Required
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Description: Code identifying a specific industry code list

<u>Code</u>	<u>Name</u>
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BO	Health Care Financing Administration Common Procedural Coding System
----	--

CODE SOURCE:

130: Health Care Financing Administration Common Procedural Coding System

BQ	International Classification of Diseases Clinical Modification (ICD-9-CM) Procedure
----	---

CODE SOURCE:

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

1271	Industry Code	M	AN	1/30	Required
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Description: Code indicating a code from a specific industry code list

Industry: Procedure Code

ExternalCodeList

Name: 130

Description: Health Care Financing Administration Common Procedural Coding System

ExternalCodeList

Name: 131

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

1250	Date Time Period Format Qualifier	C	ID	2/3	Situational
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Description: Code indicating the date format, time format, or date and time format

HIPAA IG Note: Required if the procedure code reported is ICD-9-CM in the preceding data element. Used if needed to report a procedure date when the code reported is HCPCS. If used, the immediately following element is required.

<u>Code</u>	<u>Name</u>
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D8	Date Expressed in Format CCYYMMDD
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1251	Date Time Period	C	AN	1/35	Situational
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		Description: Expression of a date, a time, or range of dates, times or dates and times				
		Industry: Procedure Date				
HI11	C022	Health Care Code Information Description: To send health care codes and their associated dates, amounts and quantities HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.	O	Comp		Situational
	1270	Code List Qualifier Code Description: Code identifying a specific industry code list	M	ID	1/3	Required
		Code Name				
		BO Health Care Financing Administration Common Procedural Coding System				
		CODE SOURCE:				
		130: Health Care Financing Administration Common Procedural Coding System				
		BQ International Classification of Diseases Clinical Modification (ICD-9-CM) Procedure				
		CODE SOURCE:				
		131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure				
	1271	Industry Code Description: Code indicating a code from a specific industry code list Industry: Procedure Code	M	AN	1/30	Required
		ExternalCodeList Name: 130 Description: Health Care Financing Administration Common Procedural Coding System				
		ExternalCodeList Name: 131 Description: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure				
	1250	Date Time Period Format Qualifier Description: Code indicating the date format, time format, or date and time format HIPAA IG Note: Required if the procedure code reported is ICD-9-CM in the preceding data element. Used if needed to report a procedure date when the code reported is HCPCS. If used, the immediately following element is required.	C	ID	2/3	Situational
		Code Name				
		D8 Date Expressed in Format CCYYMMDD				
	1251	Date Time Period Description: Expression of a date, a time, or range of dates, times or dates and times	C	AN	1/35	Situational
		Industry: Procedure Date				
HI12	C022	Health Care Code Information Description: To send health care codes and their associated dates, amounts and quantities HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.	O	Comp		Situational
	1270	Code List Qualifier Code Description: Code identifying a specific industry code list	M	ID	1/3	Required
		Code Name				
		BO Health Care Financing Administration Common Procedural Coding System				
		CODE SOURCE:				
		130: Health Care Financing Administration Common Procedural Coding System				
		BQ International Classification of Diseases Clinical Modification (ICD-9-CM) Procedure				
		CODE SOURCE:				
		131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure				
	1271	Industry Code	M	AN	1/30	Required

	Description: Code indicating a code from a specific industry code list				
	Industry: Procedure Code				
	ExternalCodeList				
	Name: 130				
	Description: Health Care Financing Administration Common Procedural Coding System				
	ExternalCodeList				
	Name: 131				
	Description: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure				
1250	Date Time Period Format Qualifier	C	ID	2/3	Situational
	Description: Code indicating the date format, time format, or date and time format				
	HIPAA IG Note: Required if the procedure code reported is ICD-9-CM in the preceding data element. Used if needed to report a procedure date when the code reported is HCPCS. If used, the immediately following element is required.				
	Code		Name		
	D8		Date Expressed in Format CCYYMMDD		
1251	Date Time Period	C	AN	1/35	Situational
	Description: Expression of a date, a time, or range of dates, times or dates and times				
	Industry: Procedure Date				

HI

Occurrence Span Information

Pos: 231	Max: 2
Detail - Optional	
Loop: 2300	Elements: 12

User Option (Usage): Situational

To supply information related to the delivery of health care

Notes:

- 1. Required when occurrence span information applies to the claim or encounter.

Example:

HI*BI:70:RD8:19981202-19981212~

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
HI01	C022	Health Care Code Information Description: To send health care codes and their associated dates, amounts and quantities	M	Comp		Required
	1270	Code List Qualifier Code Description: Code identifying a specific industry code list	M	ID	1/3	Required
		Code Name BI Occurrence Span				
		CODE SOURCE: 132: National Uniform Billing Committee (NUBC) Codes				
	1271	Industry Code Description: Code indicating a code from a specific industry code list Industry: Occurrence Span Code	M	AN	1/30	Required
		ExternalCodeList Name: 132 Description: National Uniform Billing Committee (NUBC) Codes				
	1250	Date Time Period Format Qualifier Description: Code indicating the date format, time format, or date and time format	C	ID	2/3	Required
		Code Name RD8 Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD				
		Description: A range of dates expressed in the format CCYYMMDD-CCYYMMDD where CCYY is the numerical expression of the century CC and year YY, MM is the numerical expression of the month within the year, and DD is the numerical expression of the day within the year; the first occurrence of CCYYMMDD is the beginning date and the second occurrence is the ending date				
	1251	Date Time Period Description: Expression of a date, a time, or range of dates, times or dates and times	C	AN	1/35	Required
		Industry: Occurrence or Occurrence Span Code Associated Date				
HI02	C022	Health Care Code Information Description: To send health care codes and their associated dates, amounts and quantities	O	Comp		Situational
		HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.				
	1270	Code List Qualifier Code Description: Code identifying a specific industry code list	M	ID	1/3	Required

	<u>Code</u>	<u>Name</u>				
	BI	Occurrence Span				
		CODE SOURCE:				
		132: National Uniform Billing Committee (NUBC) Codes				
1271	Industry Code		M	AN	1/30	Required
	Description:	Code indicating a code from a specific industry code list				
	Industry:	Occurrence Span Code				
	ExternalCodeList					
	Name:	132				
	Description:	National Uniform Billing Committee (NUBC) Codes				
1250	Date Time Period Format Qualifier		C	ID	2/3	Required
	Description:	Code indicating the date format, time format, or date and time format				
	Code	Name				
	RD8	Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD				
	Description:	A range of dates expressed in the format CCYYMMDD-CCYYMMDD where CCYY is the numerical expression of the century CC and year YY, MM is the numerical expression of the month within the year, and DD is the numerical expression of the day within the year; the first occurrence of CCYYMMDD is the beginning date and the second occurrence is the ending date				
1251	Date Time Period		C	AN	1/35	Required
	Description:	Expression of a date, a time, or range of dates, times or dates and times				
	Industry:	Occurrence or Occurrence Span Code Associated Date				
HI03	C022	Health Care Code Information	O	Comp		Situational
	Description:	To send health care codes and their associated dates, amounts and quantities				
	HIPAA IG Note:	Used when necessary to report multiple additional co-existing conditions.				
1270	Code List Qualifier Code		M	ID	1/3	Required
	Description:	Code identifying a specific industry code list				
	Code	Name				
	BI	Occurrence Span				
		CODE SOURCE:				
		132: National Uniform Billing Committee (NUBC) Codes				
1271	Industry Code		M	AN	1/30	Required
	Description:	Code indicating a code from a specific industry code list				
	Industry:	Occurrence Span Code				
	ExternalCodeList					
	Name:	132				
	Description:	National Uniform Billing Committee (NUBC) Codes				
1250	Date Time Period Format Qualifier		C	ID	2/3	Required
	Description:	Code indicating the date format, time format, or date and time format				
	Code	Name				
	RD8	Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD				
	Description:	A range of dates expressed in the format CCYYMMDD-CCYYMMDD where CCYY is the numerical expression of the century CC and year YY, MM is the numerical expression of the month within the year, and DD is the numerical expression of the day within the year; the first occurrence of CCYYMMDD is the beginning date and the second occurrence is the ending date				
1251	Date Time Period		C	AN	1/35	Required
	Description:	Expression of a date, a time, or range of dates, times or dates and times				
	Industry:	Occurrence or Occurrence Span Code				

		Associated Date				
HI04	C022	Health Care Code Information Description: To send health care codes and their associated dates, amounts and quantities HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.	O	Comp		Situational
	1270	Code List Qualifier Code Description: Code identifying a specific industry code list	M	ID	1/3	Required
		Code Name BI Occurrence Span				
		CODE SOURCE: 132: National Uniform Billing Committee (NUBC) Codes				
	1271	Industry Code Description: Code indicating a code from a specific industry code list Industry: Occurrence Span Code	M	AN	1/30	Required
		ExternalCodeList Name: 132 Description: National Uniform Billing Committee (NUBC) Codes				
	1250	Date Time Period Format Qualifier Description: Code indicating the date format, time format, or date and time format	C	ID	2/3	Required
		Code Name RD8 Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD				
		Description: A range of dates expressed in the format CCYYMMDD-CCYYMMDD where CCYY is the numerical expression of the century CC and year YY, MM is the numerical expression of the month within the year, and DD is the numerical expression of the day within the year; the first occurrence of CCYYMMDD is the beginning date and the second occurrence is the ending date				
	1251	Date Time Period Description: Expression of a date, a time, or range of dates, times or dates and times Industry: Occurrence or Occurrence Span Code	C	AN	1/35	Required
		Associated Date				
HI05	C022	Health Care Code Information Description: To send health care codes and their associated dates, amounts and quantities HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.	O	Comp		Situational
	1270	Code List Qualifier Code Description: Code identifying a specific industry code list	M	ID	1/3	Required
		Code Name BI Occurrence Span				
		CODE SOURCE: 132: National Uniform Billing Committee (NUBC) Codes				
	1271	Industry Code Description: Code indicating a code from a specific industry code list Industry: Occurrence Span Code	M	AN	1/30	Required
		ExternalCodeList Name: 132 Description: National Uniform Billing Committee (NUBC) Codes				
	1250	Date Time Period Format Qualifier Description: Code indicating the date format, time format, or date and time format	C	ID	2/3	Required
		Code Name RD8 Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD				

Description: A range of dates expressed in the format CCYYMMDD-CCYYMMDD where CCYY is the numerical expression of the century CC and year YY, MM is the numerical expression of the month within the year, and DD is the numerical expression of the day within the year; the first occurrence of CCYYMMDD is the beginning date and the second occurrence is the ending date

	1251	Date Time Period Description: Expression of a date, a time, or range of dates, times or dates and times Industry: Occurrence or Occurrence Span Code Associated Date	C	AN	1/35	Required
HI06	C022	Health Care Code Information Description: To send health care codes and their associated dates, amounts and quantities HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.	O	Comp		Situational
	1270	Code List Qualifier Code Description: Code identifying a specific industry code list Code Name BI Occurrence Span CODE SOURCE: 132: National Uniform Billing Committee (NUBC) Codes	M	ID	1/3	Required
	1271	Industry Code Description: Code indicating a code from a specific industry code list Industry: Occurrence Span Code ExternalCodeList Name: 132 Description: National Uniform Billing Committee (NUBC) Codes	M	AN	1/30	Required
	1250	Date Time Period Format Qualifier Description: Code indicating the date format, time format, or date and time format Code Name RD8 Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD Description: A range of dates expressed in the format CCYYMMDD-CCYYMMDD where CCYY is the numerical expression of the century CC and year YY, MM is the numerical expression of the month within the year, and DD is the numerical expression of the day within the year; the first occurrence of CCYYMMDD is the beginning date and the second occurrence is the ending date	C	ID	2/3	Required
	1251	Date Time Period Description: Expression of a date, a time, or range of dates, times or dates and times Industry: Occurrence or Occurrence Span Code Associated Date	C	AN	1/35	Required
HI07	C022	Health Care Code Information Description: To send health care codes and their associated dates, amounts and quantities HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.	O	Comp		Situational
	1270	Code List Qualifier Code Description: Code identifying a specific industry code list Code Name BI Occurrence Span CODE SOURCE: 132: National Uniform Billing Committee (NUBC) Codes	M	ID	1/3	Required
	1271	Industry Code Description: Code indicating a code from a specific industry code list	M	AN	1/30	Required

Industry: Occurrence Span Code

ExternalCodeList

Name: 132

Description: National Uniform Billing Committee (NUBC) Codes

1250	Date Time Period Format Qualifier	C	ID	2/3	Required
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Description: Code indicating the date format, time format, or date and time format

Code	Name
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RD8	Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD
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Description: A range of dates expressed in the format CCYYMMDD-CCYYMMDD where CCYY is the numerical expression of the century CC and year YY, MM is the numerical expression of the month within the year, and DD is the numerical expression of the day within the year; the first occurrence of CCYYMMDD is the beginning date and the second occurrence is the ending date

1251	Date Time Period	C	AN	1/35	Required
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Description: Expression of a date, a time, or range of dates, times or dates and times

Industry: Occurrence or Occurrence Span Code
Associated Date

HI08	C022	Health Care Code Information	O	Comp	Situational
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Description: To send health care codes and their associated dates, amounts and quantities

HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.

1270	Code List Qualifier Code	M	ID	1/3	Required
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Description: Code identifying a specific industry code list

Code	Name
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BI	Occurrence Span
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CODE SOURCE:

132: National Uniform Billing Committee (NUBC) Codes

1271	Industry Code	M	AN	1/30	Required
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Description: Code indicating a code from a specific industry code list

Industry: Occurrence Span Code
ExternalCodeList

Name: 132

Description: National Uniform Billing Committee (NUBC) Codes

1250	Date Time Period Format Qualifier	C	ID	2/3	Required
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Description: Code indicating the date format, time format, or date and time format

Code	Name
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RD8	Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD
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Description: A range of dates expressed in the format CCYYMMDD-CCYYMMDD where CCYY is the numerical expression of the century CC and year YY, MM is the numerical expression of the month within the year, and DD is the numerical expression of the day within the year; the first occurrence of CCYYMMDD is the beginning date and the second occurrence is the ending date

1251	Date Time Period	C	AN	1/35	Required
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Description: Expression of a date, a time, or range of dates, times or dates and times

Industry: Occurrence or Occurrence Span Code
Associated Date

HI09	C022	Health Care Code Information	O	Comp	Situational
------	------	-------------------------------------	---	------	-------------

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

HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.

1270	Code List Qualifier Code	M	ID	1/3	Required
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Description: Code identifying a specific industry code list

<u>Code</u>	<u>Name</u>
BI	Occurrence Span

CODE SOURCE:
132: National Uniform Billing Committee (NUBC) Codes

1271	Industry Code Description: Code indicating a code from a specific industry code list	M	AN	1/30	Required
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Industry: Occurrence Span Code

ExternalCodeList

Name: 132

Description: National Uniform Billing Committee (NUBC) Codes

1250	Date Time Period Format Qualifier Description: Code indicating the date format, time format, or date and time format	C	ID	2/3	Required
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<u>Code</u>	<u>Name</u>
RD8	Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD

Description: A range of dates expressed in the format CCYYMMDD-CCYYMMDD where CCYY is the numerical expression of the century CC and year YY, MM is the numerical expression of the month within the year, and DD is the numerical expression of the day within the year; the first occurrence of CCYYMMDD is the beginning date and the second occurrence is the ending date

1251	Date Time Period Description: Expression of a date, a time, or range of dates, times or dates and times	C	AN	1/35	Required
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Industry: Occurrence or Occurrence Span Code Associated Date

HI10	C022 Health Care Code Information Description: To send health care codes and their associated dates, amounts and quantities	O	Comp		Situational
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HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.

1270	Code List Qualifier Code Description: Code identifying a specific industry code list	M	ID	1/3	Required
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<u>Code</u>	<u>Name</u>
BI	Occurrence Span

CODE SOURCE:
132: National Uniform Billing Committee (NUBC) Codes

1271	Industry Code Description: Code indicating a code from a specific industry code list	M	AN	1/30	Required
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Industry: Occurrence Span Code

ExternalCodeList

Name: 132

Description: National Uniform Billing Committee (NUBC) Codes

1250	Date Time Period Format Qualifier Description: Code indicating the date format, time format, or date and time format	C	ID	2/3	Required
------	---	---	----	-----	----------

<u>Code</u>	<u>Name</u>
RD8	Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD

Description: A range of dates expressed in the format CCYYMMDD-CCYYMMDD where CCYY is the numerical expression of the century CC and year YY, MM is the numerical expression of the month within the year, and DD is the numerical expression of the day within the year; the first occurrence of CCYYMMDD is the beginning date and the second occurrence is the ending date

1251	Date Time Period Description: Expression of a date, a time, or range	C	AN	1/35	Required
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of dates, times or dates and times

Industry: Occurrence or Occurrence Span Code
Associated Date

HI11 C022 **Health Care Code Information** O Comp Situational

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

HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.

1270 **Code List Qualifier Code** M ID 1/3 Required

Description: Code identifying a specific industry code list

Code **Name**

BI Occurrence Span

CODE SOURCE:

132: National Uniform Billing Committee (NUBC) Codes

1271 **Industry Code** M AN 1/30 Required

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

Industry: Occurrence Span Code

ExternalCodeList

Name: 132

Description: National Uniform Billing Committee (NUBC) Codes

1250 **Date Time Period Format Qualifier** C ID 2/3 Required

Description: Code indicating the date format, time format, or date and time format

Code **Name**

RD8 Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD

Description: A range of dates expressed in the format CCYYMMDD-CCYYMMDD where CCYY is the numerical expression of the century CC and year YY, MM is the numerical expression of the month within the year, and DD is the numerical expression of the day within the year; the first occurrence of CCYYMMDD is the beginning date and the second occurrence is the ending date

1251 **Date Time Period** C AN 1/35 Required

Description: Expression of a date, a time, or range of dates, times or dates and times

Industry: Occurrence or Occurrence Span Code
Associated Date

HI12 C022 **Health Care Code Information** O Comp Situational

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

HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.

1270 **Code List Qualifier Code** M ID 1/3 Required

Description: Code identifying a specific industry code list

Code **Name**

BI Occurrence Span

CODE SOURCE:

132: National Uniform Billing Committee (NUBC) Codes

1271 **Industry Code** M AN 1/30 Required

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

Industry: Occurrence Span Code

ExternalCodeList

Name: 132

Description: National Uniform Billing Committee (NUBC) Codes

1250 **Date Time Period Format Qualifier** C ID 2/3 Required

Description: Code indicating the date format, time format, or date and time format

<u>Code</u>	<u>Name</u>				
RD8	Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD				
	Description: A range of dates expressed in the format CCYYMMDD-CCYYMMDD where CCYY is the numerical expression of the century CC and year YY, MM is the numerical expression of the month within the year, and DD is the numerical expression of the day within the year; the first occurrence of CCYYMMDD is the beginning date and the second occurrence is the ending date				
1251	Date Time Period Description: Expression of a date, a time, or range of dates, times or dates and times Industry: Occurrence or Occurrence Span Code Associated Date	C	AN	1/35	Required

HI Occurrence Information

Pos: 231	Max: 2
Detail - Optional	
Loop: 2300	Elements: 12

User Option (Usage): Situational

To supply information related to the delivery of health care

Notes:

- 1. Required when occurrence information applies to the claim or encounter.

Example:

HI*BH:42:D8:19981208~

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
HI01	C022	Health Care Code Information Description: To send health care codes and their associated dates, amounts and quantities	M	Comp		Required
	1270	Code List Qualifier Code Description: Code identifying a specific industry code list	M	ID	1/3	Required
		Code Name BH Occurrence				
		CODE SOURCE: 132: National Uniform Billing Committee (NUBC) Codes				
	1271	Industry Code Description: Code indicating a code from a specific industry code list Industry: Occurrence Code	M	AN	1/30	Required
		ExternalCodeList Name: 132 Description: National Uniform Billing Committee (NUBC) Codes				
	1250	Date Time Period Format Qualifier Description: Code indicating the date format, time format, or date and time format	C	ID	2/3	Required
		Code Name D8 Date Expressed in Format CCYYMMDD				
	1251	Date Time Period Description: Expression of a date, a time, or range of dates, times or dates and times Industry: Occurrence or Occurrence Span Code Associated Date	C	AN	1/35	Required
HI02	C022	Health Care Code Information Description: To send health care codes and their associated dates, amounts and quantities HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.	O	Comp		Situational
	1270	Code List Qualifier Code Description: Code identifying a specific industry code list	M	ID	1/3	Required
		Code Name BH Occurrence				
		CODE SOURCE:				

132: National Uniform Billing Committee (NUBC) Codes

1271	Industry Code Description: Code indicating a code from a specific industry code list Industry: Occurrence Code ExternalCodeList Name: 132 Description: National Uniform Billing Committee (NUBC) Codes	M	AN	1/30	Required
1250	Date Time Period Format Qualifier Description: Code indicating the date format, time format, or date and time format Code Name D8 Date Expressed in Format CCYYMMDD	C	ID	2/3	Required
1251	Date Time Period Description: Expression of a date, a time, or range of dates, times or dates and times Industry: Occurrence or Occurrence Span Code Associated Date	C	AN	1/35	Required
HI03	C022 Health Care Code Information Description: To send health care codes and their associated dates, amounts and quantities HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.	O	Comp		Situational
1270	Code List Qualifier Code Description: Code identifying a specific industry code list Code Name BH Occurrence CODE SOURCE: 132: National Uniform Billing Committee (NUBC) Codes	M	ID	1/3	Required
1271	Industry Code Description: Code indicating a code from a specific industry code list Industry: Occurrence Code ExternalCodeList Name: 132 Description: National Uniform Billing Committee (NUBC) Codes	M	AN	1/30	Required
1250	Date Time Period Format Qualifier Description: Code indicating the date format, time format, or date and time format Code Name D8 Date Expressed in Format CCYYMMDD	C	ID	2/3	Required
1251	Date Time Period Description: Expression of a date, a time, or range of dates, times or dates and times Industry: Occurrence or Occurrence Span Code Associated Date	C	AN	1/35	Required
HI04	C022 Health Care Code Information Description: To send health care codes and their associated dates, amounts and quantities HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.	O	Comp		Situational
1270	Code List Qualifier Code Description: Code identifying a specific industry code list Code Name BH Occurrence	M	ID	1/3	Required

CODE SOURCE:
132: National Uniform Billing Committee (NUBC) Codes

1271 **Industry Code** M AN 1/30 Required
Description: Code indicating a code from a specific industry code list
Industry: Occurrence Code
ExternalCodeList
Name: 132

1250 **Date Time Period Format Qualifier** C ID 2/3 Required
Description: Code indicating the date format, time format, or date and time format
Code **Name**
 D8 Date Expressed in Format CCYYMMDD

1251 **Date Time Period** C AN 1/35 Required
Description: Expression of a date, a time, or range of dates, times or dates and times
Industry: Occurrence or Occurrence Span Code Associated
 Date

HI05 C022 **Health Care Code Information** O Comp Situational
Description: To send health care codes and their associated dates, amounts and quantities
HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.

1270 **Code List Qualifier Code** M ID 1/3 Required
Description: Code identifying a specific industry code list
Code **Name**
 BH Occurrence

CODE SOURCE:
132: National Uniform Billing Committee (NUBC) Codes

1271 **Industry Code** M AN 1/30 Required
Description: Code indicating a code from a specific industry code list
Industry: Occurrence Code
ExternalCodeList
Name: 132

1250 **Date Time Period Format Qualifier** C ID 2/3 Required
Description: Code indicating the date format, time format, or date and time format
Code **Name**
 D8 Date Expressed in Format CCYYMMDD

1251 **Date Time Period** C AN 1/35 Required
Description: Expression of a date, a time, or range of dates, times or dates and times
Industry: Occurrence or Occurrence Span Code Associated
 Date

HI06 C022 **Health Care Code Information** O Comp Situational
Description: To send health care codes and their associated dates, amounts and quantities
HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.

1270 **Code List Qualifier Code** M ID 1/3 Required
Description: Code identifying a specific industry code list
Code **Name**

BH Occurrence

CODE SOURCE:

132: National Uniform Billing Committee (NUBC) Codes

1271 **Industry Code** M AN 1/30 Required

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

Industry: Occurrence Code

ExternalCodeList

Name: 132

Description: National Uniform Billing Committee (NUBC) Codes

1250 **Date Time Period Format Qualifier** C ID 2/3 Required

Description: Code indicating the date format, time format, or date and time format

Code Name

D8 Date Expressed in Format CCYYMMDD

1251 **Date Time Period** C AN 1/35 Required

Description: Expression of a date, a time, or range of dates, times or dates and times

Industry: Occurrence or Occurrence Span Code Associated Date

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

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

HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.

1270 **Code List Qualifier Code** M ID 1/3 Required

Description: Code identifying a specific industry code list

Code Name

BH Occurrence

CODE SOURCE:

132: National Uniform Billing Committee (NUBC) Codes

1271 **Industry Code** M AN 1/30 Required

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

Industry: Occurrence Code

ExternalCodeList

Name: 132

Description: National Uniform Billing Committee (NUBC) Codes

1250 **Date Time Period Format Qualifier** C ID 2/3 Required

Description: Code indicating the date format, time format, or date and time format

Code Name

D8 Date Expressed in Format CCYYMMDD

1251 **Date Time Period** C AN 1/35 Required

Description: Expression of a date, a time, or range of dates, times or dates and times

Industry: Occurrence or Occurrence Span Code Associated Date

HI08 C022 **Health Care Code Information** O Comp Situational

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

HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.

1270 **Code List Qualifier Code** M ID 1/3 Required

Description: Code identifying a specific industry code list

	<u>Code</u>	<u>Name</u>				
	BH	Occurrence				
		CODE SOURCE:				
		132: National Uniform Billing Committee (NUBC) Codes				
1271	Industry Code		M	AN	1/30	Required
	Description:	Code indicating a code from a specific industry code list				
	Industry:	Occurrence Code				
	ExternalCodeList					
	Name:	132				
	Description:	National Uniform Billing Committee (NUBC) Codes				
1250	Date Time Period Format Qualifier		C	ID	2/3	Required
	Description:	Code indicating the date format, time format, or date and time format				
	Code	Name				
	D8	Date Expressed in Format CCYYMMDD				
1251	Date Time Period		C	AN	1/35	Required
	Description:	Expression of a date, a time, or range of dates, times or dates and times				
	Industry:	Occurrence or Occurrence Span Code Associated Date				
HI09	C022	Health Care Code Information	O	Comp		Situational
	Description:	To send health care codes and their associated dates, amounts and quantities				
	HIPAA IG Note:	Used when necessary to report multiple additional co-existing conditions.				
1270	Code List Qualifier Code		M	ID	1/3	Required
	Description:	Code identifying a specific industry code list				
	Code	Name				
	BH	Occurrence				
		CODE SOURCE:				
		132: National Uniform Billing Committee (NUBC) Codes				
1271	Industry Code		M	AN	1/30	Required
	Description:	Code indicating a code from a specific industry code list				
	Industry:	Occurrence Code				
	ExternalCodeList					
	Name:	132				
	Description:	National Uniform Billing Committee (NUBC) Codes				
1250	Date Time Period Format Qualifier		C	ID	2/3	Required
	Description:	Code indicating the date format, time format, or date and time format				
	Code	Name				
	D8	Date Expressed in Format CCYYMMDD				
1251	Date Time Period		C	AN	1/35	Required
	Description:	Expression of a date, a time, or range of dates, times or dates and times				
	Industry:	Occurrence or Occurrence Span Code Associated Date				
HI10	C022	Health Care Code Information	O	Comp		Situational
	Description:	To send health care codes and their associated dates, amounts and quantities				
	HIPAA IG Note:	Used when necessary to report multiple additional co-existing conditions.				
1270	Code List Qualifier Code		M	ID	1/3	Required
	Description:	Code identifying a specific industry				

code list

Code **Name**
 BH Occurrence

CODE SOURCE:

132: National Uniform Billing Committee (NUBC) Codes

1271	Industry Code	M	AN	1/30	Required
	Description: Code indicating a code from a specific industry code list				
	Industry: Occurrence Code				
	ExternalCodeList				
	Name: 132				
	Description: National Uniform Billing Committee (NUBC) Codes				
1250	Date Time Period Format Qualifier	C	ID	2/3	Required
	Description: Code indicating the date format, time format, or date and time format				
	Code Name				
	D8 Date Expressed in Format CCYYMMDD				
1251	Date Time Period	C	AN	1/35	Required
	Description: Expression of a date, a time, or range of dates, times or dates and times				
	Industry: Occurrence or Occurrence Span Code Associated Date				
HI11	C022	O	Comp		Situational
	Health Care Code Information				
	Description: To send health care codes and their associated dates, amounts and quantities				
	HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.				
1270	Code List Qualifier Code	M	ID	1/3	Required
	Description: Code identifying a specific industry code list				
	Code Name				
	BH Occurrence				
	CODE SOURCE:				
	132: National Uniform Billing Committee (NUBC) Codes				
1271	Industry Code	M	AN	1/30	Required
	Description: Code indicating a code from a specific industry code list				
	Industry: Occurrence Code				
	ExternalCodeList				
	Name: 132				
	Description: National Uniform Billing Committee (NUBC) Codes				
1250	Date Time Period Format Qualifier	C	ID	2/3	Required
	Description: Code indicating the date format, time format, or date and time format				
	Code Name				
	D8 Date Expressed in Format CCYYMMDD				
1251	Date Time Period	C	AN	1/35	Required
	Description: Expression of a date, a time, or range of dates, times or dates and times				
	Industry: Occurrence or Occurrence Span Code Associated Date				
HI12	C022	O	Comp		Situational
	Health Care Code Information				
	Description: To send health care codes and their associated dates, amounts and quantities				
	HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.				
1270	Code List Qualifier Code	M	ID	1/3	Required

Description: Code identifying a specific industry code list

<u>Code</u>	<u>Name</u>
BH	Occurrence

CODE SOURCE:
132: National Uniform Billing Committee (NUBC) Codes

1271	Industry Code	M	AN	1/30	Required
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Description: Code indicating a code from a specific industry code list

Industry: Occurrence Code

ExternalCodeList

Name: 132

Description: National Uniform Billing Committee (NUBC) Codes

1250	Date Time Period Format Qualifier	C	ID	2/3	Required
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Description: Code indicating the date format, time format, or date and time format

<u>Code</u>	<u>Name</u>
D8	Date Expressed in Format CCYYMMDD

1251	Date Time Period	C	AN	1/35	Required
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Description: Expression of a date, a time, or range of dates, times or dates and times

Industry: Occurrence or Occurrence Span Code Associated Date

HI Value Information

Pos: 231	Max: 2
Detail - Optional	
Loop: 2300	Elements: 12

User Option (Usage): Situational

To supply information related to the delivery of health care

Notes:

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

Example:

HI*BE:08:::1740~

NYS MEDICAID NOTE:

NYSDOH will process rate code under code source "BE". Additionally, NYSDOH will process Birth Weight, Medicare Co-Insurance and LTR amounts, as well as surplus codes here.

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
HI01	C022	Health Care Code Information Description: To send health care codes and their associated dates, amounts and quantities	M	Comp		Required
	1270	Code List Qualifier Code Description: Code identifying a specific industry code list	M	ID	1/3	Required
		Code Name BE Value				
		CODE SOURCE: 132: National Uniform Billing Committee (NUBC) Codes				
	1271	Industry Code Description: Code indicating a code from a specific industry code list Industry: Value Code	M	AN	1/30	Required
		ExternalCodeList Name: 132 Description: National Uniform Billing Committee (NUBC) Codes				
	782	Monetary Amount Description: Monetary amount Industry: Value Code Associated Amount HIPAA IG Note: This data element must contain the Value Code Amount when HIxx-1 value equals BE (Value Code).	O	R	1/18	Required
HI02	C022	Health Care Code Information Description: To send health care codes and their associated dates, amounts and quantities HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.	O	Comp		Situational
	1270	Code List Qualifier Code Description: Code identifying a specific industry code list	M	ID	1/3	Required
		Code Name BE Value				
		CODE SOURCE: 132: National Uniform Billing Committee (NUBC) Codes				
	1271	Industry Code	M	AN	1/30	Required

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

Industry: Value Code

ExternalCodeList

Name: 132

Description: National Uniform Billing Committee (NUBC) Codes

	782	Monetary Amount	O	R	1/18	Required
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Description: Monetary amount

Industry: Value Code Associated Amount

HIPAA IG Note: This data element must contain the Value Code Amount when Hlxx-1 value equals BE (Value Code).

HI03	C022	Health Care Code Information	O	Comp		Situational
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Description: To send health care codes and their associated dates, amounts and quantities

HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.

	1270	Code List Qualifier Code	M	ID	1/3	Required
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Description: Code identifying a specific industry code list

Code	Name
BE	Value

CODE SOURCE:

132: National Uniform Billing Committee (NUBC) Codes

	1271	Industry Code	M	AN	1/30	Required
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Description: Code indicating a code from a specific industry code list

Industry: Value Code

ExternalCodeList

Name: 132

Description: National Uniform Billing Committee (NUBC) Codes

	782	Monetary Amount	O	R	1/18	Required
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Description: Monetary amount

Industry: Value Code Associated Amount

HIPAA IG Note: This data element must contain the Value Code Amount when Hlxx-1 value equals BE (Value Code).

HI04	C022	Health Care Code Information	O	Comp		Situational
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Description: To send health care codes and their associated dates, amounts and quantities

HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.

	1270	Code List Qualifier Code	M	ID	1/3	Required
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Description: Code identifying a specific industry code list

Code	Name
BE	Value

CODE SOURCE:

132: National Uniform Billing Committee (NUBC) Codes

	1271	Industry Code	M	AN	1/30	Required
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Description: Code indicating a code from a specific industry code list

Industry: Value Code

ExternalCodeList

Name: 132

Description: National Uniform Billing Committee (NUBC) Codes

	782	Monetary Amount	O	R	1/18	Required
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Description: Monetary amount

Industry: Value Code Associated Amount

		HIPAA IG Note: This data element must contain the Value Code Amount when Hlxx-1 value equals BE (Value Code).				
HI05	C022	Health Care Code Information Description: To send health care codes and their associated dates, amounts and quantities HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.	O	Comp		Situational
	1270	Code List Qualifier Code Description: Code identifying a specific industry code list	M	ID	1/3	Required
		Code Name BE Value				
		CODE SOURCE: 132: National Uniform Billing Committee (NUBC) Codes				
	1271	Industry Code Description: Code indicating a code from a specific industry code list Industry: Value Code	M	AN	1/30	Required
		ExternalCodeList Name: 132 Description: National Uniform Billing Committee (NUBC) Codes				
	782	Monetary Amount Description: Monetary amount Industry: Value Code Associated Amount HIPAA IG Note: This data element must contain the Value Code Amount when Hlxx-1 value equals BE (Value Code).	O	R	1/18	Required
HI06	C022	Health Care Code Information Description: To send health care codes and their associated dates, amounts and quantities HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.	O	Comp		Situational
	1270	Code List Qualifier Code Description: Code identifying a specific industry code list	M	ID	1/3	Required
		Code Name BE Value				
		CODE SOURCE: 132: National Uniform Billing Committee (NUBC) Codes				
	1271	Industry Code Description: Code indicating a code from a specific industry code list Industry: Value Code	M	AN	1/30	Required
		ExternalCodeList Name: 132 Description: National Uniform Billing Committee (NUBC) Codes				
	782	Monetary Amount Description: Monetary amount Industry: Value Code Associated Amount HIPAA IG Note: This data element must contain the Value Code Amount when Hlxx-1 value equals BE (Value Code).	O	R	1/18	Required
HI07	C022	Health Care Code Information Description: To send health care codes and their associated dates, amounts and quantities HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.	O	Comp		Situational
	1270	Code List Qualifier Code	M	ID	1/3	Required

Description: Code identifying a specific industry code list

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

CODE SOURCE:
132: National Uniform Billing Committee (NUBC) Codes

1271	Industry Code	M	AN	1/30	Required
	Description: Code indicating a code from a specific industry code list				

Industry: Value Code

ExternalCodeList

Name: 132

Description: National Uniform Billing Committee (NUBC) Codes

782	Monetary Amount	O	R	1/18	Required
	Description: Monetary amount				

Industry: Value Code Associated Amount

HIPAA IG Note: This data element must contain the Value Code Amount when Hlxx-1 value equals BE (Value Code).

HI08	C022	Health Care Code Information	O	Comp	Situational
		Description: To send health care codes and their associated dates, amounts and quantities			

HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.

1270	Code List Qualifier Code	M	ID	1/3	Required
	Description: Code identifying a specific industry code list				

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

CODE SOURCE:
132: National Uniform Billing Committee (NUBC) Codes

1271	Industry Code	M	AN	1/30	Required
	Description: Code indicating a code from a specific industry code list				

Industry: Value Code

ExternalCodeList

Name: 132

Description: National Uniform Billing Committee (NUBC) Codes

782	Monetary Amount	O	R	1/18	Required
	Description: Monetary amount				

Industry: Value Code Associated Amount

HIPAA IG Note: This data element must contain the Value Code Amount when Hlxx-1 value equals BE (Value Code).

HI09	C022	Health Care Code Information	O	Comp	Situational
		Description: To send health care codes and their associated dates, amounts and quantities			

HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.

1270	Code List Qualifier Code	M	ID	1/3	Required
	Description: Code identifying a specific industry code list				

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

CODE SOURCE:
132: National Uniform Billing Committee (NUBC) Codes

1271	Industry Code	M	AN	1/30	Required
	Description: Code indicating a code from a specific industry code list				

		Industry: Value Code				
		ExternalCodeList				
		Name: 132				
		Description: National Uniform Billing Committee (NUBC) Codes				
782		Monetary Amount	O	R	1/18	Required
		Description: Monetary amount				
		Industry: Value Code Associated Amount				
		HIPAA IG Note: This data element must contain the Value Code Amount when Hlxx-1 value equals BE (Value Code).				
HI10	C022	Health Care Code Information	O	Comp		Situational
		Description: To send health care codes and their associated dates, amounts and quantities				
		HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.				
1270		Code List Qualifier Code	M	ID	1/3	Required
		Description: Code identifying a specific industry code list				
		Code				
		BE				
		Name				
		Value				
		CODE SOURCE:				
		132: National Uniform Billing Committee (NUBC) Codes				
1271		Industry Code	M	AN	1/30	Required
		Description: Code indicating a code from a specific industry code list				
		Industry: Value Code				
		ExternalCodeList				
		Name: 132				
		Description: National Uniform Billing Committee (NUBC) Codes				
782		Monetary Amount	O	R	1/18	Required
		Description: Monetary amount				
		Industry: Value Code Associated Amount				
		HIPAA IG Note: This data element must contain the Value Code Amount when Hlxx-1 value equals BE (Value Code).				
HI11	C022	Health Care Code Information	O	Comp		Situational
		Description: To send health care codes and their associated dates, amounts and quantities				
		HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.				
1270		Code List Qualifier Code	M	ID	1/3	Required
		Description: Code identifying a specific industry code list				
		Code				
		BE				
		Name				
		Value				
		CODE SOURCE:				
		132: National Uniform Billing Committee (NUBC) Codes				
1271		Industry Code	M	AN	1/30	Required
		Description: Code indicating a code from a specific industry code list				
		Industry: Value Code				
		ExternalCodeList				
		Name: 132				
		Description: National Uniform Billing Committee (NUBC) Codes				
782		Monetary Amount	O	R	1/18	Required
		Description: Monetary amount				
		Industry: Value Code Associated Amount				
		HIPAA IG Note: This data element must contain the Value Code Amount when Hlxx-1 value equals BE				

HI12	C022	(Value Code). Health Care Code Information Description: To send health care codes and their associated dates, amounts and quantities HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.	O	Comp		Situational
	1270	Code List Qualifier Code Description: Code identifying a specific industry code list Code Name BE Value CODE SOURCE: 132: National Uniform Billing Committee (NUBC) Codes	M	ID	1/3	Required
	1271	Industry Code Description: Code indicating a code from a specific industry code list Industry: Value Code ExternalCodeList Name: 132 Description: National Uniform Billing Committee (NUBC) Codes	M	AN	1/30	Required
	782	Monetary Amount Description: Monetary amount Industry: Value Code Associated Amount HIPAA IG Note: This data element must contain the Value Code Amount when Hlxx-1 value equals BE (Value Code).	O	R	1/18	Required

HI**Condition Information**

Pos: 231	Max: 2
Detail - Optional	
Loop: 2300	Elements: 12

User Option (Usage): Situational

To supply information related to the delivery of health care

Notes:

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

Example:

HI*BG:67~

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
HI01	C022	Health Care Code Information Description: To send health care codes and their associated dates, amounts and quantities	M	Comp		Required
	1270	Code List Qualifier Code Description: Code identifying a specific industry code list	M	ID	1/3	Required
		Code Name BG Condition				
		CODE SOURCE: 132: National Uniform Billing Committee (NUBC) Codes				
	1271	Industry Code Description: Code indicating a code from a specific industry code list Industry: Condition Code	M	AN	1/30	Required
		ExternalCodeList Name: 132				
		Description: National Uniform Billing Committee (NUBC) Codes				
HI02	C022	Health Care Code Information Description: To send health care codes and their associated dates, amounts and quantities HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.	O	Comp		Situational
	1270	Code List Qualifier Code Description: Code identifying a specific industry code list	M	ID	1/3	Required
		Code Name BG Condition				
		CODE SOURCE: 132: National Uniform Billing Committee (NUBC) Codes				
	1271	Industry Code Description: Code indicating a code from a specific industry code list Industry: Condition Code	M	AN	1/30	Required
		ExternalCodeList Name: 132				
		Description: National Uniform Billing Committee (NUBC) Codes				
HI03	C022	Health Care Code Information Description: To send health care codes and their associated dates, amounts and quantities	O	Comp		Situational

		HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.				
1270		Code List Qualifier Code Description: Code identifying a specific industry code list	M	ID	1/3	Required
	Code	Name				
	BG	Condition				
		CODE SOURCE:				
		132: National Uniform Billing Committee (NUBC) Codes				
1271		Industry Code Description: Code indicating a code from a specific industry code list	M	AN	1/30	Required
		Industry: Condition Code				
		ExternalCodeList				
		Name: 132				
		Description: National Uniform Billing Committee (NUBC) Codes				
HI04	C022	Health Care Code Information Description: To send health care codes and their associated dates, amounts and quantities	O	Comp		Situational
		HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.				
1270		Code List Qualifier Code Description: Code identifying a specific industry code list	M	ID	1/3	Required
	Code	Name				
	BG	Condition				
		CODE SOURCE:				
		132: National Uniform Billing Committee (NUBC) Codes				
1271		Industry Code Description: Code indicating a code from a specific industry code list	M	AN	1/30	Required
		Industry: Condition Code				
		ExternalCodeList				
		Name: 132				
		Description: National Uniform Billing Committee (NUBC) Codes				
HI05	C022	Health Care Code Information Description: To send health care codes and their associated dates, amounts and quantities	O	Comp		Situational
		HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.				
1270		Code List Qualifier Code Description: Code identifying a specific industry code list	M	ID	1/3	Required
	Code	Name				
	BG	Condition				
		CODE SOURCE:				
		132: National Uniform Billing Committee (NUBC) Codes				
1271		Industry Code Description: Code indicating a code from a specific industry code list	M	AN	1/30	Required
		Industry: Condition Code				
		ExternalCodeList				
		Name: 132				
		Description: National Uniform Billing Committee (NUBC) Codes				
HI06	C022	Health Care Code Information Description: To send health care codes and their associated dates, amounts and quantities	O	Comp		Situational
		HIPAA IG Note: Used when necessary to report				

		multiple additional co-existing conditions.				
1270		Code List Qualifier Code Description: Code identifying a specific industry code list	M	ID	1/3	Required
		Code BG		Name Condition		
		CODE SOURCE: 132: National Uniform Billing Committee (NUBC) Codes				
1271		Industry Code Description: Code indicating a code from a specific industry code list	M	AN	1/30	Required
		Industry: Condition Code				
		ExternalCodeList Name: 132				
		Description: National Uniform Billing Committee (NUBC) Codes				
HI07	C022	Health Care Code Information Description: To send health care codes and their associated dates, amounts and quantities HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.	O	Comp		Situational
1270		Code List Qualifier Code Description: Code identifying a specific industry code list	M	ID	1/3	Required
		Code BG		Name Condition		
		CODE SOURCE: 132: National Uniform Billing Committee (NUBC) Codes				
1271		Industry Code Description: Code indicating a code from a specific industry code list	M	AN	1/30	Required
		Industry: Condition Code				
		ExternalCodeList Name: 132				
		Description: National Uniform Billing Committee (NUBC) Codes				
HI08	C022	Health Care Code Information Description: To send health care codes and their associated dates, amounts and quantities HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.	O	Comp		Situational
1270		Code List Qualifier Code Description: Code identifying a specific industry code list	M	ID	1/3	Required
		Code BG		Name Condition		
		CODE SOURCE: 132: National Uniform Billing Committee (NUBC) Codes				
1271		Industry Code Description: Code indicating a code from a specific industry code list	M	AN	1/30	Required
		Industry: Condition Code				
		ExternalCodeList Name: 132				
		Description: National Uniform Billing Committee (NUBC) Codes				
HI09	C022	Health Care Code Information Description: To send health care codes and their associated dates, amounts and quantities HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.	O	Comp		Situational

	1270	Code List Qualifier Code Description: Code identifying a specific industry code list	M	ID	1/3	Required
		<u>Code</u> <u>Name</u> BG Condition				
		CODE SOURCE: 132: National Uniform Billing Committee (NUBC) Codes				
	1271	Industry Code Description: Code indicating a code from a specific industry code list	M	AN	1/30	Required
		Industry: Condition Code				
		<u>ExternalCodeList</u> Name: 132				
		Description: National Uniform Billing Committee (NUBC) Codes				
HI10	C022	Health Care Code Information Description: To send health care codes and their associated dates, amounts and quantities	O	Comp		Situational
		HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.				
	1270	Code List Qualifier Code Description: Code identifying a specific industry code list	M	ID	1/3	Required
		<u>Code</u> <u>Name</u> BG Condition				
		CODE SOURCE: 132: National Uniform Billing Committee (NUBC) Codes				
	1271	Industry Code Description: Code indicating a code from a specific industry code list	M	AN	1/30	Required
		Industry: Condition Code				
		<u>ExternalCodeList</u> Name: 132				
		Description: National Uniform Billing Committee (NUBC) Codes				
HI11	C022	Health Care Code Information Description: To send health care codes and their associated dates, amounts and quantities	O	Comp		Situational
		HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.				
	1270	Code List Qualifier Code Description: Code identifying a specific industry code list	M	ID	1/3	Required
		<u>Code</u> <u>Name</u> BG Condition				
		CODE SOURCE: 132: National Uniform Billing Committee (NUBC) Codes				
	1271	Industry Code Description: Code indicating a code from a specific industry code list	M	AN	1/30	Required
		Industry: Condition Code				
		<u>ExternalCodeList</u> Name: 132				
		Description: National Uniform Billing Committee (NUBC) Codes				
HI12	C022	Health Care Code Information Description: To send health care codes and their associated dates, amounts and quantities	O	Comp		Situational
		HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.				
	1270	Code List Qualifier Code Description: Code identifying a specific industry code list	M	ID	1/3	Required

Description: Code identifying a specific industry code list

<u>Code</u>	<u>Name</u>
BG	Condition

CODE SOURCE:
 132: National Uniform Billing Committee (NUBC) Codes

1271	Industry Code	M	AN	1/30	Required
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Description: Code indicating a code from a specific industry code list

Industry: Condition Code

ExternalCodeList

Name: 132

Description: National Uniform Billing Committee (NUBC) Codes

HI Treatment Code Information

Pos: 231	Max: 2
Detail - Optional	
Loop: 2300	Elements: 12

User Option (Usage): Situational

To supply information related to the delivery of health care

Notes:

1. Required when Home Health Agencies need to report Plan of Treatment information under various payer contracts.

Example:

HI*TC:A01~

NYS MEDICAID NOTE:

NYSDOH will ignore data when provided.

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
HI01	C022	Health Care Code Information Description: To send health care codes and their associated dates, amounts and quantities	M	Comp		Required
	1270	Code List Qualifier Code Description: Code identifying a specific industry code list	M	ID	1/3	Required
		Code Name TC Treatment Codes				
		CODE SOURCE: 359: Treatment Codes				
HI02	1271	Industry Code Description: Code indicating a code from a specific industry code list	M	AN	1/30	Required
		Industry: Treatment Code				
		ExternalCodeList Name: 359				
		Description: Treatment Codes				
HI02	C022	Health Care Code Information Description: To send health care codes and their associated dates, amounts and quantities	O	Comp		Situational
	1270	Code List Qualifier Code Description: Code identifying a specific industry code list	M	ID	1/3	Required
		Code Name TC Treatment Codes				
		CODE SOURCE: 359: Treatment Codes				
HI02	1271	Industry Code Description: Code indicating a code from a specific industry code list	M	AN	1/30	Required
		Industry: Treatment Code				
		ExternalCodeList Name: 359				
		Description: Treatment Codes				

HI03	C022	Health Care Code Information Description: To send health care codes and their associated dates, amounts and quantities HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.	O	Comp		Situational
	1270	Code List Qualifier Code Description: Code identifying a specific industry code list <u>Code</u> <u>Name</u> TC Treatment Codes CODE SOURCE: 359: Treatment Codes	M	ID	1/3	Required
	1271	Industry Code Description: Code indicating a code from a specific industry code list Industry: Treatment Code <u>ExternalCodeList</u> Name: 359 Description: Treatment Codes	M	AN	1/30	Required
HI04	C022	Health Care Code Information Description: To send health care codes and their associated dates, amounts and quantities HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.	O	Comp		Situational
	1270	Code List Qualifier Code Description: Code identifying a specific industry code list <u>Code</u> <u>Name</u> TC Treatment Codes CODE SOURCE: 359: Treatment Codes	M	ID	1/3	Required
	1271	Industry Code Description: Code indicating a code from a specific industry code list Industry: Treatment Code <u>ExternalCodeList</u> Name: 359 Description: Treatment Codes	M	AN	1/30	Required
HI05	C022	Health Care Code Information Description: To send health care codes and their associated dates, amounts and quantities HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.	O	Comp		Situational
	1270	Code List Qualifier Code Description: Code identifying a specific industry code list <u>Code</u> <u>Name</u> TC Treatment Codes CODE SOURCE: 359: Treatment Codes	M	ID	1/3	Required
	1271	Industry Code Description: Code indicating a code from a specific industry code list Industry: Treatment Code <u>ExternalCodeList</u> Name: 359 Description: Treatment Codes	M	AN	1/30	Required
HI06	C022	Health Care Code Information	O	Comp		Situational

		Description: To send health care codes and their associated dates, amounts and quantities HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.				
1270		Code List Qualifier Code Description: Code identifying a specific industry code list	M	ID	1/3	Required
	Code	Name				
	TC	Treatment Codes				
		CODE SOURCE: 359: Treatment Codes				
1271		Industry Code Description: Code indicating a code from a specific industry code list Industry: Treatment Code	M	AN	1/30	Required
		ExternalCodeList Name: 359 Description: Treatment Codes				
HI07	C022	Health Care Code Information Description: To send health care codes and their associated dates, amounts and quantities HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.	O	Comp		Situational
1270		Code List Qualifier Code Description: Code identifying a specific industry code list	M	ID	1/3	Required
	Code	Name				
	TC	Treatment Codes				
		CODE SOURCE: 359: Treatment Codes				
1271		Industry Code Description: Code indicating a code from a specific industry code list Industry: Treatment Code	M	AN	1/30	Required
		ExternalCodeList Name: 359 Description: Treatment Codes				
HI08	C022	Health Care Code Information Description: To send health care codes and their associated dates, amounts and quantities HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.	O	Comp		Situational
1270		Code List Qualifier Code Description: Code identifying a specific industry code list	M	ID	1/3	Required
	Code	Name				
	TC	Treatment Codes				
		CODE SOURCE: 359: Treatment Codes				
1271		Industry Code Description: Code indicating a code from a specific industry code list Industry: Treatment Code	M	AN	1/30	Required
		ExternalCodeList Name: 359 Description: Treatment Codes				
HI09	C022	Health Care Code Information Description: To send health care codes and their	O	Comp		Situational

associated dates, amounts and quantities
HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.

1270 **Code List Qualifier Code** M ID 1/3 Required
Description: Code identifying a specific industry code list

Code **Name**
 TC Treatment Codes

CODE SOURCE:
 359: Treatment Codes

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

Industry: Treatment Code

ExternalCodeList

Name: 359

Description: Treatment Codes

HI10 C022 **Health Care Code Information** O Comp Situational
Description: To send health care codes and their associated dates, amounts and quantities

HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.

1270 **Code List Qualifier Code** M ID 1/3 Required
Description: Code identifying a specific industry code list

Code **Name**
 TC Treatment Codes

CODE SOURCE:
 359: Treatment Codes

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

Industry: Treatment Code

ExternalCodeList

Name: 359

Description: Treatment Codes

HI11 C022 **Health Care Code Information** O Comp Situational
Description: To send health care codes and their associated dates, amounts and quantities

HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.

1270 **Code List Qualifier Code** M ID 1/3 Required
Description: Code identifying a specific industry code list

Code **Name**
 TC Treatment Codes

CODE SOURCE:
 359: Treatment Codes

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

Industry: Treatment Code

ExternalCodeList

Name: 359

Description: Treatment Codes

HI12 C022 **Health Care Code Information** O Comp Situational
Description: To send health care codes and their associated dates, amounts and quantities

HIPAA IG Note: Used when necessary to report multiple additional co-existing conditions.

1270	Code List Qualifier Code Description: Code identifying a specific industry code list	M	ID	1/3	Required
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<u>Code</u>	<u>Name</u>
TC	Treatment Codes

CODE SOURCE:
359: Treatment Codes

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

Industry: Treatment Code

ExternalCodeList
Name: 359
Description: Treatment Codes

QTY Claim Quantity

Pos: 240	Max: 4
Detail - Optional	
Loop: 2300	Elements: 3

User Option (Usage): Situational

To specify quantity information

Notes:

1. Use the Quantity segment at the claim level Loop ID-2300 to transmit quantities that apply to the entire claim.
2. Required on Inpatient claims or encounters when covered, co-insured, life-time reserved or non-covered days are being reported.

Example:

QTY*LA*20*DA~

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>														
QTY01	673	Quantity Qualifier Description: Code specifying the type of quantity NYS MEDICAID NOTE: NYSDOH expects to receive a value 'CA' - for Covered Actual, 'CD' - for Co-Insured Actual, 'LA' - for Life-Time Reserve Actual, or 'NA' - for Number of Non-Covered Days.	M	ID	2/2	Required														
		<table border="0"> <tr> <td><u>Code</u></td> <td><u>Name</u></td> </tr> <tr> <td>CA</td> <td>Covered - Actual</td> </tr> <tr> <td></td> <td>Description: Days covered on this service</td> </tr> <tr> <td>CD</td> <td>Co-insured - Actual</td> </tr> <tr> <td>LA</td> <td>Life-time Reserve - Actual</td> </tr> <tr> <td></td> <td>Description: Medicare hospital insurance includes extra hospital days to be used if the patient has a long illness and is required to stay in the hospital over a specified number of days; this is the actual number of days in reserve</td> </tr> <tr> <td>NA</td> <td>Number of Non-covered Days</td> </tr> </table>	<u>Code</u>	<u>Name</u>	CA	Covered - Actual		Description: Days covered on this service	CD	Co-insured - Actual	LA	Life-time Reserve - Actual		Description: Medicare hospital insurance includes extra hospital days to be used if the patient has a long illness and is required to stay in the hospital over a specified number of days; this is the actual number of days in reserve	NA	Number of Non-covered Days				
<u>Code</u>	<u>Name</u>																			
CA	Covered - Actual																			
	Description: Days covered on this service																			
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LA	Life-time Reserve - Actual																			
	Description: Medicare hospital insurance includes extra hospital days to be used if the patient has a long illness and is required to stay in the hospital over a specified number of days; this is the actual number of days in reserve																			
NA	Number of Non-covered Days																			
QTY02	380	Quantity Description: Numeric value of quantity Industry: Claim Days Count	C	R	1/15	Required														
QTY03	C001	Composite Unit of Measure Description: To identify a composite unit of measure(See Figures Appendix for examples of use) Alias: Unit/Basis of Measurement	O	Comp		Required														
	355	Unit or Basis for Measurement Code Description: Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken	M	ID	2/2	Required														
		<table border="0"> <tr> <td><u>Code</u></td> <td><u>Name</u></td> </tr> <tr> <td>DA</td> <td>Days</td> </tr> </table>	<u>Code</u>	<u>Name</u>	DA	Days														
<u>Code</u>	<u>Name</u>																			
DA	Days																			

CR7 Home Health Care Plan Information

Pos: 242	Max: 1
Detail - Optional	
Loop: 2305	Elements: 3

User Option (Usage): Situational

To supply information related to the home health care plan of treatment and services

Notes:

1. Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 nomenclature.
2. This segment is required to convey Home Health Plan of Treatment information for this claim when applicable.

Example:

CR7*PT*4*12~

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>														
CR701	921	Discipline Type Code Description: Code indicating disciplines ordered by a physician Alias: Discipline Type Code	M	ID	2/2	Required														
		<table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>AI</td> <td>Home Health Aide</td> </tr> <tr> <td>MS</td> <td>Medical Social Worker</td> </tr> <tr> <td>OT</td> <td>Occupational Therapy</td> </tr> <tr> <td>PT</td> <td>Physical Therapy</td> </tr> <tr> <td>SN</td> <td>Skilled Nursing</td> </tr> <tr> <td>ST</td> <td>Speech Therapy</td> </tr> </tbody> </table>	<u>Code</u>	<u>Name</u>	AI	Home Health Aide	MS	Medical Social Worker	OT	Occupational Therapy	PT	Physical Therapy	SN	Skilled Nursing	ST	Speech Therapy				
<u>Code</u>	<u>Name</u>																			
AI	Home Health Aide																			
MS	Medical Social Worker																			
OT	Occupational Therapy																			
PT	Physical Therapy																			
SN	Skilled Nursing																			
ST	Speech Therapy																			
CR702	1470	Number Description: A generic number Industry: Visits Prior to Recertification Date Count Alias: Total Visits Prior to Recertification Date	M	N0	1/9	Required														
CR703	1470	Number Description: A generic number Industry: Total Visits Projected This Certification Count Alias: Total Visits Projected During Certification Period	M	N0	1/9	Required														

HSD Health Care Services Delivery

Pos: 243	Max: 12
Detail - Optional	
Loop: 2305	Elements: 8

User Option (Usage): Situational

To specify the delivery pattern of health care services

Notes:

1. Required on claims/encounters billing/reporting home health visits where further detail is necessary to clearly substantiate medical treatment.
2. HSD01 qualifies HSD02: If the value in HSD02=1 and the value in HSD01=VS (Visits), this means "one visit". Between HSD02 and HSD03 verbally insert a "per every." HSD03 qualifies HSD04: If the value in HSD04=3 and the value in HSD03=DA (Day), this means "three days." Between HSD04 and HSD05 verbally insert a "for." HSD05 qualifies HSD06: If the value in HSD06=21 and the value in HSD05=7 (Days), this means "21 days." The total message reads: HSD*VS*1*DA*3*7*21~ = "One visit per every three days for 21 days."
3. Another similar data string of HSD*VS*2*DA*4*7*20~ = Two visits per every four days for 20 days.
4. An alternate way to use HSD is to employ HSD07 and/or HSD08. A data string of HSD*VS*1*****SX*D~ means "1 visit on Wednesday and Thursday morning."

Example:

HSD*VS*1*DA**7*10~ (This indicates "1 visit every (per) 1 day (daily) for 10 days.")

HSD*VS*1*DA~ (This indicates one visit per day.)

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>
HSD01	673	Quantity Qualifier Description: Code specifying the type of quantity Industry: Visits Alias: Quantity Qualifier HIPAA IG Note: Required if the physician's order or prescription for the service contains the data.	C	ID	2/2	Situational
		Code Name VS Visits				
HSD02	380	Quantity Description: Numeric value of quantity Industry: Number of Visits Alias: Frequency Number - 1 HIPAA IG Note: Required if the physician's order or prescription for the service contains the data.	C	R	1/15	Situational
HSD03	355	Unit or Basis for Measurement Code Description: Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken Industry: Frequency Period Alias: Frequency Period - 1 HIPAA IG Note: Required if the physician's order or prescription for the service contains the data.	O	ID	2/2	Situational
		Code Name DA Days MO Months Q1 Quarter (Time) WK Week				
HSD04	1167	Sample Selection Modulus	O	R	1/6	Situational

		<p>Description: To specify the sampling frequency in terms of a modulus of the Unit of Measure, e.g., every fifth bag, every 1.5 minutes</p> <p>Industry: Frequency Count</p> <p>HIPAA IG Note: Required if the physician's order or prescription for the service contains the data.</p>																																																												
HSD05	615	<p>Time Period Qualifier</p> <p>Description: Code defining periods</p> <p>Industry: Duration of Visits Units</p> <p>Alias: Frequency Time Period</p> <p>HIPAA IG Note: Absence of data indicates PRN orders. Required if the physician's order or prescription for the service contains the data.</p>	C	ID	1/2	Situational																																																								
		<table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>7</td> <td>Day</td> </tr> <tr> <td>35</td> <td>Week</td> </tr> </tbody> </table>	<u>Code</u>	<u>Name</u>	7	Day	35	Week																																																						
<u>Code</u>	<u>Name</u>																																																													
7	Day																																																													
35	Week																																																													
HSD06	616	<p>Number of Periods</p> <p>Description: Total number of periods</p> <p>Industry: Duration of Visits, Number of Units</p> <p>Alias: Duration - 1</p> <p>HIPAA IG Note: Required if the physician's order or prescription for the service contains the data.</p>	O	N0	1/3	Situational																																																								
HSD07	678	<p>Ship/Delivery or Calendar Pattern Code</p> <p>Description: Code which specifies the routine shipments, deliveries, or calendar pattern</p> <p>Industry: Ship, Delivery or Calendar Pattern Code</p> <p>HIPAA IG Note: Required if the physician's order or prescription for the service contains the data.</p>	O	ID	1/2	Situational																																																								
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<u>Code</u>	<u>Name</u>																																																													
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L	Monday through Thursday																																																													
N	As Directed																																																													
O	Daily Mon. through Fri.																																																													
S	Once Anytime Mon. through Fri.																																																													
W	Whenever Necessary																																																													
SA	Sunday, Monday, Thursday, Friday, Saturday																																																													
SB	Tuesday through Saturday																																																													
SC	Sunday, Wednesday, Thursday, Friday, Saturday																																																													

SD Monday, Wednesday, Thursday, Friday, Saturday
 SG Tuesday through Friday
 SL Monday, Tuesday and Thursday
 SP Monday, Tuesday and Friday
 SX Wednesday and Thursday
 SY Monday, Wednesday and Thursday
 SZ Tuesday, Thursday and Friday

HSD08 679 **Ship/Delivery Pattern Time Code** O ID 1/1 Situational

Description: Code which specifies the time for routine shipments or deliveries

Industry: Delivery Pattern Time Code

HIPAA IG Note: Required if the physician's order or prescription for the service contains the data.

<u>Code</u>	<u>Name</u>
D	A.M.
E	P.M.
F	As Directed

NM1 Attending Physician Name

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

User Option (Usage): Situational

To supply the full name of an individual or organizational entity

Notes:

1. Information in Loop ID-2310 applies to the entire claim unless it is overridden on a service line by the presence of Loop ID-2410 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 nomenclature.
3. Required on all inpatient claims or encounters.
4. Required to indicate the Primary Physician responsible on a Home Health Agency Plan of Treatment.

Example:

NM1*71*1*JONES*JOHN****XX*12345678~

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
NM101	98	Entity Identifier Code Description: Code identifying an organizational entity, a physical location, property or an individual HIPAA IG Note: The entity identifier in NM101 applies to all segments in Loop ID-2310.	M	ID	2/3	Required
		Code Name 71 Attending Physician Description: Physician present when medical services are performed				
NM102	1065	Entity Type Qualifier Description: Code qualifying the type of entity	M	ID	1/1	Required
		Code Name 1 Person 2 Non-Person Entity				
NM103	1035	Name Last or Organization Name Description: Individual last name or organizational name Industry: Attending Physician Last Name	O	AN	1/35	Required
NM104	1036	Name First Description: Individual first name Industry: Attending Physician First Name HIPAA IG Note: Required if NM102=1 (person).	O	AN	1/25	Situational
NM105	1037	Name Middle Description: Individual middle name or initial Industry: Attending Physician Middle Name HIPAA IG Note: Required if NM102=1 and the middle name/initial of the person is known.	O	AN	1/25	Situational
NM107	1039	Name Suffix Description: Suffix to individual name Industry: Attending Physician Name Suffix HIPAA IG Note: Required if known.	O	AN	1/10	Situational
NM108	66	Identification Code Qualifier Description: Code designating the system/method of code structure used for Identification Code (67)	C	ID	1/2	Required
		Code Name 24 Employer's Identification Number				

34 Social Security Number

XX Health Care Financing Administration National Provider Identifier

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

NM109 67

Identification Code

C

AN

2/80

Required

Description: Code identifying a party or other code

Industry: Attending Physician Primary Identifier

ExternalCodeList

Name: 537

Description: Health Care Financing Administration National Provider Identifier

PRV Attending Physician Specialty Information

Pos: 255	Max: 1
Detail - Optional	
Loop: 2310A	Elements: 3

User Option (Usage): Situational

To specify the identifying characteristics of a provider

Notes:

1. The PRV segment in Loop ID-2310 applies to the entire claim unless overridden on the service line level by the presence of a PRV segment with the same value in PRV01.
2. Use code value AT to report the specialty of the attending physician. Use code value SU when the physician is responsible for the patient's Home Health Plan of Treatment.
3. PRV02 qualifies PRV03.
4. Required when the billing provider is a billing service and taxonomy is know to impact the adjudication of the claim.

Example:

PRV*AT*ZZ*363LP0200N~

NYS MEDICAID NOTE:

NYSDOH will ignore data when provided.

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
PRV01	1221	Provider Code Description: Code identifying the type of provider	M	ID	1/3	Required
		Code Name AT Attending SU Supervising				
PRV02	128	Reference Identification Qualifier Description: Code qualifying the Reference Identification	M	ID	2/3	Required
		HIPAA IG Note: 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: http://www.wpc-edi.com . This taxonomy is maintained by the Blue Cross Blue Shield Association and ASC X12N TG2 WG15.				
		Code Name ZZ Mutually Defined Provider Taxonomy Code				
PRV03	127	Reference Identification Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	M	AN	1/30	Required
		Industry: Provider Taxonomy Code Alias: Provider Specialty Code				
		ExternalCodeList Name: HCPT Description: Health Care Provider Taxonomy				

REF Attending Physician Secondary Identification

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

User Option (Usage): Situational

To specify identifying information

Notes:

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

Example:

REF*1G*A12345~

NYS MEDICAID NOTE:

NYSDOH expects to receive either the state license number or the NYS Medicaid ID number. If the state license number is submitted, it must be preceded by the two-character license type. In most cases the ID number would be the Service Provider ID.

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
REF01	128	Reference Identification Qualifier Description: Code qualifying the Reference Identification	M	ID	2/3	Required
		Code Name				
		0B State License Number				
		1D Medicaid Provider Number				
REF02	127	Reference Identification Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier Industry: Attending Physician Secondary Identifier	C	AN	1/30	Required

NM1 Operating Physician Name

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

User Option (Usage): Situational

To supply the full name of an individual or organizational entity

Notes:

1. Information in Loop ID-2310 applies to the entire claim unless it is overridden on a service line by the presence of Loop ID-2410 with the same value in NM101.
2. This segment is required when any surgical procedure code is listed on this claim.
3. Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 nomenclature.

Example:

NM1*72*1*MEYERS*JANE****XX*12345678~

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
NM101	98	Entity Identifier Code Description: Code identifying an organizational entity, a physical location, property or an individual HIPAA IG Note: The entity identifier in NM101 applies to all segments in Loop ID-2310.	M	ID	2/3	Required
		Code Name 72 Operating Physician Description: Doctor who performs a surgical procedure				
NM102	1065	Entity Type Qualifier Description: Code qualifying the type of entity	M	ID	1/1	Required
		Code Name 1 Person				
NM103	1035	Name Last or Organization Name Description: Individual last name or organizational name Industry: Operating Physician Last Name	O	AN	1/35	Required
NM104	1036	Name First Description: Individual first name Industry: Operating Physician First Name	O	AN	1/25	Required
NM105	1037	Name Middle Description: Individual middle name or initial Industry: Operating Physican Middle Name HIPAA IG Note: This data element is required when NM102 equals one (1) and the Middle Name or Initial of the person is known by the provider.	O	AN	1/25	Situational
NM107	1039	Name Suffix Description: Suffix to individual name Industry: Operating Physician Name Suffix HIPAA IG Note: Required if known.	O	AN	1/10	Situational
NM108	66	Identification Code Qualifier Description: Code designating the system/method of code structure used for Identification Code (67)	C	ID	1/2	Required
		Code Name 24 Employer's Identification Number 34 Social Security Number XX Health Care Financing Administration National Provider Identifier				

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

NM109	67	Identification Code	C	AN	2/80	Required
		Description: Code identifying a party or other code				
		Industry: Operating Physician Primary Identifier				
		ExternalCodeList				
		Name: 537				
		Description: Health Care Financing Administration National Provider Identifier				

REF Operating Physician Secondary Identification

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

User Option (Usage): Situational

To specify identifying information

Notes:

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

Example:

REF*1G*A12345~

NYS MEDICAID NOTE:

NYSDOH expects to receive either the state license number. The state license number must be preceded by the two-character license type.

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
REF01	128	Reference Identification Qualifier Description: Code qualifying the Reference Identification	M	ID	2/3	Required
		<u>Code</u> <u>Name</u> 0B State License Number				
REF02	127	Reference Identification Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier Industry: Operating Physician Secondary Identifier	C	AN	1/30	Required

NM1 Other Provider Name

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

User Option (Usage): Situational

To supply the full name of an individual or organizational entity

Notes:

1. Information in Loop ID-2310 applies to the entire claim unless it is overridden on a service line by the presence of Loop ID-2410 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 nomenclature.
3. Required on all outpatient and home health claims/encounters to indicate the person or organization (Home Health Agency) who rendered the care. In the case where a substitute provider (locum tenans) was used, that person should be entered here. Required when the Other Provider NM1 information is different than that carried in either the Billing Provider NM1 or the Pay-to Provider in the 2010AA/AB loops.
4. Required on non-outpatient (e.g inpatient, SNF, ICF etc.) claims or encounters to indicate the physician who rendered service for the principal procedure if other than the operating physician reported in Loop 2310B. Not required on non-outpatient claims or encounters if no principal procedure was performed.

Example:

NM1*73*1*DOE*JOHN*A***34*201749586~

NYS MEDICAID NOTE:

NYSDOH expects to receive the referring provider here for all claims that are the result of a referral. In the case of a restricted recipient, the recipient's primary care provider must be reported.

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
NM101	98	Entity Identifier Code Description: Code identifying an organizational entity, a physical location, property or an individual HIPAA IG Note: The entity identifier in NM101 applies to all segments in Loop ID-2310.	M	ID	2/3	Required
		Code Name 73 Other Physician Description: Physician not one of the other specified choices				
NM102	1065	Entity Type Qualifier Description: Code qualifying the type of entity	M	ID	1/1	Required
		Code Name 1 Person 2 Non-Person Entity				
NM103	1035	Name Last or Organization Name Description: Individual last name or organizational name Industry: Other Physician Last Name	O	AN	1/35	Required
NM104	1036	Name First Description: Individual first name Industry: Other Physician First Name HIPAA IG Note: Required if NM102=1 (person).	O	AN	1/25	Situational
NM105	1037	Name Middle Description: Individual middle name or initial Industry: Other Provider Middle Name HIPAA IG Note: Required when NM102=1-Person and the Middle Name or Initial of the person is known by the provider.	O	AN	1/25	Situational

NM107	1039	Name Suffix Description: Suffix to individual name Industry: Other Provider Name Suffix HIPAA IG Note: Other Provider Generation Required if known.	O	AN	1/10	Situational								
NM108	66	Identification Code Qualifier Description: Code designating the system/method of code structure used for Identification Code (67) <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> Description: 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	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	Identification Code Description: Code identifying a party or other code Industry: Other Physician Identifier Alias: Other Physician Primary ID <u>ExternalCodeList</u> Name: 537 Description: Health Care Financing Administration National Provider Identifier	C	AN	2/80	Required								

REF Other Provider Secondary Identification

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

User Option (Usage): Situational

To specify identifying information

Notes:

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

Example:

REF*1G*A12345~

NYS MEDICAID NOTE:

NYSDOH expects to receive either the state license number or the NYS Medicaid ID number. If the state license number is submitted, it must be preceded by the two-character license type.

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
REF01	128	Reference Identification Qualifier Description: Code qualifying the Reference Identification	M	ID	2/3	Required
		<u>Code</u> <u>Name</u>				
		0B State License Number				
		1D Medicaid Provider Number				
REF02	127	Reference Identification Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier Industry: Other Provider Secondary Identifier	C	AN	1/30	Required

NM1 Service Facility Name

Pos: 250	Max: 1
Detail - Optional	
Loop: 2310E	Elements: 5

User Option (Usage): Situational

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 nomenclature.
3. This loop is required when the location of health care service is different than that carried in the 2010AA (Billing Provider) or 2010AB (Pay-to Provider) loops.

Example:

NM1*FA*2*Rehab Facility*****XX*12345678~

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>
NM101	98	Entity Identifier Code Description: Code identifying an organizational entity, a physical location, property or an individual Code Name FA Facility	M	ID	2/3	Required
NM102	1065	Entity Type Qualifier Description: Code qualifying the type of entity Code Name 2 Non-Person Entity	M	ID	1/1	Required
NM103	1035	Name Last or Organization Name Description: Individual last name or organizational name Industry: Laboratory or Facility Name Alias: Laboratory/Facility Name	O	AN	1/35	Required
NM108	66	Identification Code Qualifier Description: Code designating the system/method of code structure used for Identification Code (67) HIPAA IG Note: Required if either Employer's Identification/Social Security Number or National Provider Identifier is known. Code Name 24 Employer's Identification Number 34 Social Security Number XX Health Care Financing Administration National Provider Identifier Description: Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.	C	ID	1/2	Situational
NM109	67	Identification Code Description: Code identifying a party or other code Industry: Laboratory or Facility Primary Identifier Alias: Laboratory/Facility Primary Identifier HIPAA IG Note: Required if either Employer's Identification/Social Security Number or National Provider Identifier is known.	C	AN	2/80	Situational

ExternalCodeList

Name: 537

Description: Health Care Financing Administration National Provider Identifier

N3 Service Facility Address

Pos: 265	Max: 1
Detail - Optional	
Loop: 2310E	Elements: 2

User Option (Usage): Required

To specify the location of the named party

Example:

N3*123 MAIN STREET~

NYS MEDICAID NOTE:

NYSDOH will ignore data when provided.

Element Summary:

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

N4**Service Facility City/State/Zip Code**

Pos: 270	Max: 1
Detail - Optional	
Loop: 2310E	Elements: 4

User Option (Usage): Required

To specify the geographic place of the named party

Example:

N4*ANY TOWN*TX*75123~

NYS MEDICAID NOTE:

NYSDOH will ignore data when provided.

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
N401	19	City Name Description: Free-form text for city name Industry: Laboratory or Facility City Name Alias: Laboratory/Facility City	O	AN	2/30	Required
N402	156	State or Province Code Description: Code (Standard State/Province) as defined by appropriate government agency Industry: Laboratory or Facility State or Province Code Alias: Laboratory/Facility State ExternalCodeList Name: 22 Description: States and Outlying Areas of the U.S.	O	ID	2/2	Required
N403	116	Postal Code Description: Code defining international postal zone code excluding punctuation and blanks (zip code for United States) Industry: Laboratory or Facility Postal Zone or ZIP Code Alias: Laboratory/Facility Zip Code ExternalCodeList Name: 51 Description: ZIP Code	O	ID	3/15	Required
N404	26	Country Code Description: Code identifying the country Alias: Laboratory/Facility Country Code HIPAA IG Note: Required if the address is out of the U.S. ExternalCodeList Name: 5 Description: Countries, Currencies and Funds	O	ID	2/3	Situational

REF Service Facility Secondary Identification

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

User Option (Usage): Situational

To specify identifying information

Notes:

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

Example:

REF*1G*A12345~

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>
REF01	128	Reference Identification Qualifier Description: Code qualifying the Reference Identification	M	ID	2/3	Required
		Code Name				
		0B State License Number				
		1A Blue Cross Provider Number				
		1B Blue Shield Provider Number				
		1C Medicare Provider Number				
		1D Medicaid Provider Number				
		1G Provider UPIN Number				
		1H CHAMPUS Identification Number				
		1J Facility ID Number				
		EI Employer's Identification Number				
		FH Clinic Number Description: A unique number identifying the clinic location that rendered services				
		G2 Provider Commercial Number Description: A unique number assigned to a provider by a commercial insurer				
		G5 Provider Site Number				
		LU Location Number				
		N5 Provider Plan Network Identification Number Description: A number assigned to identify a specific provider in a health care plan network				
		X5 State Industrial Accident Provider Number				
REF02	127	Reference Identification Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier Industry: Laboratory or Facility Secondary Identifier	C	AN	1/30	Required

SBR Other Subscriber Information

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

User Option (Usage): Situational

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 nomenclature.
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.

Example:

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

NYS MEDICAID NOTE:

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

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
SBR01	1138	Payer Responsibility Sequence Number Code Description: Code identifying the insurance carrier's level of responsibility for a payment of a claim	M	ID	1/1	Required
		Code Name				
		P Primary				
		S Secondary				
		T Tertiary				
		Used to indicate "payer of last resort".				
SBR02	1069	Individual Relationship Code Description: Code indicating the relationship between two individuals or entities	O	ID	2/2	Required
		HIPAA IG Note: Use this code to specify the patient's relationship to the person insured.				
		Code Name				
		01 Spouse				
		UB-92 Ref. [UB-Name]:				
		59 Code 02 [Spouse]				
		04 Grandfather or Grandmother				
		UB-92 Ref. [UB-Name]:				
		59 Code 19 [Grandparent]				
		05 Grandson or Granddaughter				
		UB-92 Ref. [UB-Name]:				
		59 Code 13 [Grandchild]				
		07 Nephew or Niece				
		UB-92 Ref. [UB-Name]:				
		59 Code 14 [Niece/Nephew]				
		10 Foster Child				
		UB-92 Ref. [UB-Name]:				
		59 Code 06 [Foster Child]				
		15 Ward				
		UB-92 Ref. [UB-Name]:				

	59 Code 07 [Ward of the Court]
17	Stepson or Stepdaughter UB-92 Ref. [UB-Name]: 59 Code 05 [Step Child]
18	Self UB-92 Ref. [UB-Name]: 59 Code 01 [Patient Is Insured]
19	Child Description: Dependent between the ages of 0 and 19; age qualifications may vary depending on policy UB-92 Ref. [UB-Name]: 59 Code 03 [Natural Child/Insured Financial Responsibility]
20	Employee UB-92 Ref. [UB-Name]: 59 Code 08 [Employee]
21	Unknown UB-92 Ref. [UB-Name]: 59 Code 09 [Unknown]
22	Handicapped Dependent UB-92 Ref. [UB-Name]: 59 Code 10 [Handicapped Dependent]
23	Sponsored Dependent Description: Dependents between the ages of 19 and 25 not attending school; age qualifications may vary depending on policy UB-92 Ref. [UB-Name]: 59 Code 16 [Sponsored Dependent]
24	Dependent of a Minor Dependent Description: A child not legally of age who has been granted adult status UB-92 Ref. [UB-Name]: 59 Code 17 [Minor Dependent of a Minor Dependent]
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 UB-92 Ref. [UB-Name]: 59 Code 11 [Organ Donor]
40	Cadaver Donor Description: Deceased individual donating body to be used for research or transplants UB-92 Ref. [UB-Name]: 59 Code 12 [Cadaver Donor]
41	Injured Plaintiff UB-92 Ref. [UB-Name]: 59 Code 15 [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 UB-92 Ref. [UB-Name]: 59 Code 04 [Natural Child/Insured Does not Have Financial Responsibility]
53	Life Partner UB-92 Ref. [UB-Name]: 59 Code 20 [Life Partner]

59 Code 20 [Life Partner]

		G8	Other Relationship				
SBR03	127		Reference Identification	O	AN	1/30	Situational

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

Industry: Insured Group or Policy Number

HIPAA IG Note: Use this element to carry the subscriber's group number but not the number that uniquely identifies the subscriber. The subscriber's number should be carried in NM109. Using code IL in NM101 identifies the number in NM109 as the insured's Identification Number.

		93					
SBR04	93		Name	O	AN	1/60	Situational

Description: Free-form name

Industry: Other Insured Group Name

HIPAA IG Note: Plan Name (Group Name)

This data element is required when the Provider has the Plan Name (Group Name) within their files.

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

Description: Code identifying type of claim

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
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
MA	Medicare Part A
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 Adjustment

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

User Option (Usage): Situational

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. Submitter 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 amount should come from 835 (Remittance Advice) received on the claim. If no previous payments have been made, omit this segment. See the 835 for definitions of the Group Codes (CAS01).
4. Required if claim has been adjudicated by payer identified in this loop and has claim level adjustment information.
5. To locate the claim adjustment reason codes that are used in CAS02, 05, 08, 11, 14, and 17 see the Washington Publishing Company web site: <http://www.wpc-edi.com>. Follow the buttons to Code Lists - Claim Adjustment Reason Codes.

Example:

CAS*CO*96*555.52~

NYS MEDICAID NOTE:

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

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
CAS01	1033	Claim Adjustment Group Code Description: Code identifying the general category of payment adjustment	M	ID	1/2	Required
		Code Name				
		CO Contractual Obligations				
		CR Correction and Reversals				
		OA Other adjustments				
		PI Payor Initiated Reductions				
		PR Patient Responsibility				
CAS02	1034	Claim Adjustment Reason Code Description: Code identifying the detailed reason the adjustment was made Industry: Adjustment Reason Code	M	ID	1/5	Required
		ExternalCodeList Name: 139 Description: Claim Adjustment Reason Code				
CAS03	782	Monetary Amount Description: Monetary amount Industry: Adjustment Amount	M	R	1/18	Required
CAS04	380	Quantity Description: Numeric value of quantity Industry: Adjustment Quantity HIPAA IG Note: Use this number for the units of service being adjusted.	O	R	1/15	Situational
CAS05	1034	Claim Adjustment Reason Code Description: Code identifying the detailed reason the adjustment was made Industry: Adjustment Reason Code HIPAA IG Note: Used when additional adjustment information applies to claim.	C	ID	1/5	Situational

		<u>ExternalCodeList</u>				
		Name: 139				
		Description: Claim Adjustment Reason Code				
CAS06	782	Monetary Amount	C	R	1/18	Situational
		Description: Monetary amount				
		Industry: Adjustment Amount				
		HIPAA IG Note: Used when additional adjustment information applies to claim.				
CAS07	380	Quantity	C	R	1/15	Situational
		Description: Numeric value of quantity				
		Industry: Adjustment Quantity				
		HIPAA IG Note: Used when additional adjustment information applies to claim.				
CAS08	1034	Claim Adjustment Reason Code	C	ID	1/5	Situational
		Description: Code identifying the detailed reason the adjustment was made				
		Industry: Adjustment Reason Code				
		HIPAA IG Note: Used when additional adjustment information applies to claim.				
		<u>ExternalCodeList</u>				
		Name: 139				
		Description: Claim Adjustment Reason Code				
CAS09	782	Monetary Amount	C	R	1/18	Situational
		Description: Monetary amount				
		Industry: Adjustment Amount				
		HIPAA IG Note: Used when additional adjustment information applies to claim.				
CAS10	380	Quantity	C	R	1/15	Situational
		Description: Numeric value of quantity				
		Industry: Adjustment Quantity				
		HIPAA IG Note: Used when additional adjustment information applies to claim.				
CAS11	1034	Claim Adjustment Reason Code	C	ID	1/5	Situational
		Description: Code identifying the detailed reason the adjustment was made				
		Industry: Adjustment Reason Code				
		HIPAA IG Note: Used when additional adjustment information applies to claim.				
		<u>ExternalCodeList</u>				
		Name: 139				
		Description: Claim Adjustment Reason Code				
CAS12	782	Monetary Amount	C	R	1/18	Situational
		Description: Monetary amount				
		Industry: Adjustment Amount				
		HIPAA IG Note: Used when additional adjustment information applies to claim.				
CAS13	380	Quantity	C	R	1/15	Situational
		Description: Numeric value of quantity				
		Industry: Adjustment Quantity				
		HIPAA IG Note: Used when additional adjustment information applies to claim.				
CAS14	1034	Claim Adjustment Reason Code	C	ID	1/5	Situational
		Description: Code identifying the detailed reason the adjustment was made				
		Industry: Adjustment Reason Code				
		HIPAA IG Note: Used when additional adjustment information applies to claim.				
		<u>ExternalCodeList</u>				
		Name: 139				
		Description: Claim Adjustment Reason Code				

CAS15	782	Monetary Amount Description: Monetary amount Industry: Adjustment Amount HIPAA IG Note: Used when additional adjustment information applies to claim.	C	R	1/18	Situational
CAS16	380	Quantity Description: Numeric value of quantity Industry: Adjustment Quantity HIPAA IG Note: Used when additional adjustment information applies to claim.	C	R	1/15	Situational
CAS17	1034	Claim Adjustment Reason Code Description: Code identifying the detailed reason the adjustment was made Industry: Adjustment Reason Code HIPAA IG Note: Used when additional adjustment information applies to claim. <u>ExternalCodeList</u> Name: 139 Description: Claim Adjustment Reason Code	C	ID	1/5	Situational
CAS18	782	Monetary Amount Description: Monetary amount Industry: Adjustment Amount HIPAA IG Note: Used when additional adjustment information applies to claim.	C	R	1/18	Situational
CAS19	380	Quantity Description: Numeric value of quantity Industry: Adjustment Quantity HIPAA IG Note: Used when additional adjustment information applies to claim.	C	R	1/15	Situational

AMT Payer Prior Payment

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

User Option (Usage): Situational

To indicate the total monetary amount

Notes:

1. The amount this payer has paid to the provider towards this bill.
2. This segment is required when the present payer has paid an amount to the provider towards this bill.

Example:

AMT*C4*150~

NYS MEDICAID NOTE:

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

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
AMT01	522	Amount Qualifier Code Description: Code to qualify amount	M	ID	1/3	Required
		<u>Code</u> <u>Name</u> C4 Prior Payment - Actual Description: Amount paid in reality at an earlier time				
AMT02	782	Monetary Amount Description: Monetary amount Industry: Other Payer Patient Paid Amount	M	R	1/18	Required

AMT Coordination of Benefits (COB) Total Allowed Amount

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

User Option (Usage): Situational

To indicate the total monetary amount

Notes:

1. This segment is for COB use.
2. This segment is used to convey the COB Total Allowed Amount applicable to this claim when known.

Example:

AMT*B6*3794.82~

NYS MEDICAID NOTE:

NYSDOH will ignore data when provided.

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
AMT01	522	Amount Qualifier Code Description: Code to qualify amount	M	ID	1/3	Required
		Code Name B6 Allowed - Actual Description: Amount considered for payment under the provisions of the contract				
AMT02	782	Monetary Amount Description: Monetary amount Industry: Allowed Amount	M	R	1/18	Required

AMT Coordination of Benefits (COB) Total Submitted Charges

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

User Option (Usage): Situational

To indicate the total monetary amount

Notes:

- 1. This segment is for COB use.
- 2. This segment is used to convey the COB Total Submitted Charges applicable to this claim when known.

Example:

AMT*T3*7490.7~

NYS MEDICAID NOTE:

NYSDOH will ignore data when provided.

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
AMT01	522	Amount Qualifier Code Description: Code to qualify amount	M	ID	1/3	Required
		Code Name T3 Total Submitted Charges				
AMT02	782	Monetary Amount Description: Monetary amount Industry: Coordination of Benefits Total Submitted Charge Amount	M	R	1/18	Required

AMT Diagnostic Related Group (DRG) Outlier Amount

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

User Option (Usage): Situational

To indicate the total monetary amount

Notes:

1. This segment is for COB use.
2. This segment is used to convey the DRG Outlier Amount applicable to this claim when known.

Example:

AMT*ZZ*9034.7~

NYS MEDICAID NOTE:

NYSDOH will ignore data when provided.

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>				
AMT01	522	Amount Qualifier Code Description: Code to qualify amount HIPAA IG Note: Use this qualifier until a more suitable one is developed. At this time, the qualifier represents what the amount is being used for (see monetary amount description).	M	ID	1/3	Required				
		<table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>ZZ</td> <td>Mutually Defined</td> </tr> </tbody> </table>	<u>Code</u>	<u>Name</u>	ZZ	Mutually Defined				
<u>Code</u>	<u>Name</u>									
ZZ	Mutually Defined									
AMT02	782	Monetary Amount Description: Monetary amount Industry: Claim DRG Outlier Amount HIPAA IG Note: Record Type 92 Field No. 15 (For COB use [temporary qualifier]. Use this amount for the DRG outlier amount.)	M	R	1/18	Required				

AMT Coordination of Benefits (COB) Total Medicare Paid Amount

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

User Option (Usage): Situational

To indicate the total monetary amount

Notes:

- 1. This segment is for COB use.
- 2. This segment is used to convey the COB Total Medicare Paid Amount applicable to this claim when known.

Example:

AMT*N1*873.4~

NYS MEDICAID NOTE:

NYSDOH will ignore data when provided.

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>				
AMT01	522	Amount Qualifier Code Description: Code to qualify amount HIPAA IG Note: Use this qualifier until a more suitable one is developed. At this time, the qualifier represents what the amount is being used for (see monetary amount description).	M	ID	1/3	Required				
		<table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>N1</td> <td>Net Worth</td> </tr> </tbody> </table>	<u>Code</u>	<u>Name</u>	N1	Net Worth				
<u>Code</u>	<u>Name</u>									
N1	Net Worth									
AMT02	782	Monetary Amount Description: Monetary amount Industry: Total Medicare Paid Amount HIPAA IG Note: Record Type 92 Field No. 9 (For COB use [temporary qualifier]. Use this amount for the total Medicare reimbursement.)	M	R	1/18	Required				

AMT Medicare Paid Amount - 100%

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

User Option (Usage): Situational

To indicate the total monetary amount

Notes:

1. This segment is for COB use.
2. This segment is used to convey the COB Medicare Paid Amount -100% applicable to this claim when known.

Example:

AMT*KF*73.01~

NYS MEDICAID NOTE:

NYSDOH will ignore data when provided.

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>				
AMT01	522	Amount Qualifier Code Description: Code to qualify amount HIPAA IG Note: Use this qualifier until a more suitable one is developed. At this time, the qualifier represents what the amount is being used for (see monetary amount description).	M	ID	1/3	Required				
		<table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>KF</td> <td>Net Paid Amount</td> </tr> </tbody> </table>	<u>Code</u>	<u>Name</u>	KF	Net Paid Amount				
<u>Code</u>	<u>Name</u>									
KF	Net Paid Amount									
AMT02	782	Monetary Amount Description: Monetary amount Industry: Medicare Paid at 100% Amount HIPAA IG Note: Record Type 93 Field No. 4 (For COB use [temporary qualifier]. Use this amount for the claim level allowed charges Medicare paid at 100%.)	M	R	1/18	Required				

AMT Medicare Paid Amount - 80%

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

User Option (Usage): Situational

To indicate the total monetary amount

Notes:

1. This segment is for COB use.
2. This segment is used to convey the COB Medicare Paid Amount - 80% applicable to this claim when known.

Example:

AMT*PG*639.4~

NYS MEDICAID NOTE:

NYSDOH will ignore data when provided.

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>				
AMT01	522	Amount Qualifier Code Description: Code to qualify amount HIPAA IG Note: Use this qualifier until a more suitable one is developed. At this time, the qualifier represents what the amount is being used for (see monetary amount description).	M	ID	1/3	Required				
		<table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>PG</td> <td>Payoff</td> </tr> </tbody> </table>	<u>Code</u>	<u>Name</u>	PG	Payoff				
<u>Code</u>	<u>Name</u>									
PG	Payoff									
AMT02	782	Monetary Amount Description: Monetary amount Industry: Medicare Paid at 80% Amount HIPAA IG Note: Record Type 93 Field No. 5 (For COB use [temporary qualifier]. Use this amount for the claim level allowed charges Medicare paid at 80%.)	M	R	1/18	Required				

AMT Coordination of Benefits (COB) Medicare A Trust Fund Paid Amount

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

User Option (Usage): Situational

To indicate the total monetary amount

Notes:

1. This segment is for COB use.
2. This segment is used to convey the COB Medicare A Trust Fund Paid Amount applicable to this claim when known.

Example:

AMT*AA*4394.7~

NYS MEDICAID NOTE:

NYSDOH will ignore data when provided.

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>				
AMT01	522	Amount Qualifier Code Description: Code to qualify amount HIPAA IG Note: Use this qualifier until a more suitable one is developed. At this time, the qualifier represents what the amount is being used for (see monetary amount description).	M	ID	1/3	Required				
		<table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>AA</td> <td>Allocated</td> </tr> </tbody> </table>	<u>Code</u>	<u>Name</u>	AA	Allocated				
<u>Code</u>	<u>Name</u>									
AA	Allocated									
AMT02	782	Monetary Amount Description: Monetary amount Industry: Paid From Part A Medicare Trust Fund Amount HIPAA IG Note: Record Type 93 Field No. 6 (For COB use [temporary qualifier]. Use this amount for the amount paid from the Medicare A trust fund.)	M	R	1/18	Required				

AMT Coordination of Benefits (COB) Medicare B Trust Fund Paid Amount

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

User Option (Usage): Situational

To indicate the total monetary amount

Notes:

1. This segment is for COB use.
2. This segment is used to convey the COB Medicare B Trust Fund Paid Amount applicable to this claim when known.

Example:

AMT*B1*150~

NYS MEDICAID NOTE:

NYSDOH will ignore data when provided.

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>						
AMT01	522	Amount Qualifier Code Description: Code to qualify amount HIPAA IG Note: Use this qualifier until a more suitable one is developed. At this time, the qualifier represents what the amount is being used for (see monetary amount description).	M	ID	1/3	Required						
		<table border="0"> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> <tr> <td>B1</td> <td>Benefit Amount</td> </tr> <tr> <td colspan="2">Use this qualifier until a more suitable one is developed. At this time, B1 represents the Paid From Medicare B Trust Fund Amount.</td> </tr> </table>	<u>Code</u>	<u>Name</u>	B1	Benefit Amount	Use this qualifier until a more suitable one is developed. At this time, B1 represents the Paid From Medicare B Trust Fund Amount.					
<u>Code</u>	<u>Name</u>											
B1	Benefit Amount											
Use this qualifier until a more suitable one is developed. At this time, B1 represents the Paid From Medicare B Trust Fund Amount.												
AMT02	782	Monetary Amount Description: Monetary amount Industry: Paid From Part B Medicare Trust Fund Amount	M	R	1/18	Required						

AMT Coordination of Benefits (COB) Total Non-covered Amount

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

User Option (Usage): Situational

To indicate the total monetary amount

Notes:

- 1. This segment is for COB use.
- 2. This segment is used to convey the COB Total Non-Covered Amount applicable to this claim when known.

Example:

AMT*A8*273~

NYS MEDICAID NOTE:

NYSDOH will ignore data when provided.

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
AMT01	522	Amount Qualifier Code Description: Code to qualify amount	M	ID	1/3	Required
		Code Name A8 Noncovered Charges - Actual Description: Calculated value not covered by the benefit plan				
AMT02	782	Monetary Amount Description: Monetary amount Industry: Non-Covered Charge Amount	M	R	1/18	Required

AMT Coordination of Benefits (COB) Total Denied Amount

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

User Option (Usage): Situational

To indicate the total monetary amount

Notes:

1. This segment is for COB use.
2. This segment is used to convey the COB Total Denied Amount applicable to this claim when known.

Example:

AMT*YT*32~

NYS MEDICAID NOTE:

NYSDOH will ignore data when provided.

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
AMT01	522	Amount Qualifier Code Description: Code to qualify amount	M	ID	1/3	Required
		<u>Code</u> <u>Name</u> YT Denied				
AMT02	782	Monetary Amount Description: Monetary amount Industry: Claim Total Denied Charge Amount	M	R	1/18	Required

DMG Other Subscriber Demographic Information

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

User Option (Usage): Situational

To supply demographic information

Notes:

1. Required when 2330A - Other Subscriber Name NM102 = 1 (Person).

Example:

DMG***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	Date Time Period Format Qualifier Description: Code indicating the date format, time format, or date and time format	C	ID	2/3	Required
		Code Name D8 Date Expressed in Format CCYYMMDD				
DMG02	1251	Date Time Period Description: Expression of a date, a time, or range of dates, times or dates and times	C	AN	1/35	Required
		Industry: Other Insured Birth Date				
DMG03	1068	Gender Code Description: Code indicating the sex of the individual	O	ID	1/1	Required
		Industry: Other Insured Gender Code				
		Code Name F Female M Male U Unknown				

OI Other Insurance Coverage Information

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

User Option (Usage): Required

To specify information associated with other health insurance coverage

Notes:

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

Example:

OI***Y***Y~

NYS MEDICAID NOTE:

NYSDOH will ignore data when provided.

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>														
OI03	1073	Yes/No Condition or Response Code Description: Code indicating a Yes or No condition or response Industry: Benefits Assignment Certification Indicator HIPAA IG Note: Assignment of Benefits Indicator <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																			
OI06	1363	Release of Information Code Description: Code indicating whether the provider has on file a signed statement by the patient authorizing the release of medical data to other organizations <table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>A</td> <td>Appropriate Release of Information on File at Health Care Service Provider or at Utilization Review Organization</td> </tr> <tr> <td>I</td> <td>Informed Consent to Release Medical Information for Conditions or Diagnoses Regulated by Federal Statutes</td> </tr> <tr> <td>M</td> <td>The Provider has Limited or Restricted Ability to Release Data Related to a Claim</td> </tr> <tr> <td>N</td> <td>No, Provider is Not Allowed to Release Data</td> </tr> <tr> <td>O</td> <td>On file at Payor or at Plan Sponsor</td> </tr> <tr> <td>Y</td> <td>Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim</td> </tr> </tbody> </table>	<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	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																			

MIA Medicare Inpatient Adjudication Information

Pos: 315	Max: 1
Detail - Optional	
Loop: 2320	Elements: 24

User Option (Usage): Situational

To provide claim-level data related to the adjudication of Medicare inpatient claims

Notes:

1. This segment is used to convey the Medicare Inpatient Adjudication Information if returned in the 835.

Example:

MIA*1***3568.98*MAO*****21***MA25~

NYS MEDICAID NOTE:

NYSDOH expects to receive Medicare covered days and lifetime reserve days here. It is important to note this is not a simple copy of the MIA segment as received in the 835 transaction. The covered and lifetime reserve days are reported in the QTY segment of the 835.

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>
MIA01	380	Quantity Description: Numeric value of quantity Industry: Covered Days or Visits Count	M	R	1/15	Required
MIA02	380	Quantity Description: Numeric value of quantity Industry: Lifetime Reserve Days Count HIPAA IG Note: Use this quantity to indicate the lifetime reserve days.	O	R	1/15	Situational
MIA03	380	Quantity Description: Numeric value of quantity Industry: Lifetime Psychiatric Days Count	O	R	1/15	Situational
MIA04	782	Monetary Amount Description: Monetary amount Industry: Claim DRG Amount HIPAA IG Note: Use this amount to indicate the Diagnosis Related Group (DRG) amount.	O	R	1/18	Situational
MIA05	127	Reference Identification Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier Industry: Remark Code HIPAA IG Note: Use this reference identification for the Health Care Financing Administration claim payment remark code. ExternalCodeList Name: 411 Description: Remittance Remark Codes	O	AN	1/30	Situational
MIA06	782	Monetary Amount Description: Monetary amount Industry: Claim Disproportionate Share Amount HIPAA IG Note: Use this amount to indicate the disproportionate share amount.	O	R	1/18	Situational
MIA07	782	Monetary Amount Description: Monetary amount Industry: Claim MSP Pass-through Amount HIPAA IG Note: Use this amount to indicate the	O	R	1/18	Situational

		Medicare Secondary Payer (MSP) pass-through amount.				
MIA08	782	Monetary Amount Description: Monetary amount Industry: Claim PPS Capital Amount HIPAA IG Note: Use this amount to indicate the Total Prospective Payment System (PPS) capital amount.	O	R	1/18	Situational
MIA09	782	Monetary Amount Description: Monetary amount Industry: PPS-Capital FSP DRG Amount HIPAA IG Note: Use this amount to indicate the Prospective Payment System (PPS) capital, federal-specific portion, Diagnosis Related Group (DRG) amount.	O	R	1/18	Situational
MIA10	782	Monetary Amount Description: Monetary amount Industry: PPS-Capital HSP DRG Amount HIPAA IG Note: Use this amount to indicate the Prospective Payment System (PPS) capital, hospital-specific portion, Diagnosis Related Group (DRG) amount.	O	R	1/18	Situational
MIA11	782	Monetary Amount Description: Monetary amount Industry: PPS-Capital DSH DRG Amount HIPAA IG Note: Use this amount to indicate the Prospective Payment System (PPS) capital, disproportionate share, hospital Diagnosis Related Group (DRG) amount.	O	R	1/18	Situational
MIA12	782	Monetary Amount Description: Monetary amount Industry: Old Capital Amount HIPAA IG Note: Use this amount to indicate the old capital amount.	O	R	1/18	Situational
MIA13	782	Monetary Amount Description: Monetary amount Industry: PPS-Capital IME amount HIPAA IG Note: Use this amount to indicate the Prospective Payment System (PPS) capital indirect medical education claim amount.	O	R	1/18	Situational
MIA14	782	Monetary Amount Description: Monetary amount Industry: PPS-Operating Hospital Specific DRG Amount HIPAA IG Note: Use this amount to indicate the hospital-specific, Diagnosis Related Group (DRG) amount.	O	R	1/18	Situational
MIA15	380	Quantity Description: Numeric value of quantity Industry: Cost Report Day Count	O	R	1/15	Situational
MIA16	782	Monetary Amount Description: Monetary amount Industry: PPS-Operating Federal Specific DRG Amount HIPAA IG Note: Use this amount to indicate the federal-specific, Diagnosis Related Group (DRG) amount.	O	R	1/18	Situational
MIA17	782	Monetary Amount Description: Monetary amount Industry: Claim PPS Capital Outlier Amount HIPAA IG Note: Use this amount to indicate the Prospective Payment System (PPS) Capital Outlier	O	R	1/18	Situational

		amount.				
MIA18	782	Monetary Amount Description: Monetary amount Industry: Claim Indirect Teaching Amount HIPAA IG Note: Use this amount to indicate the indirect teaching amount.	O	R	1/18	Situational
MIA19	782	Monetary Amount Description: Monetary amount Industry: Nonpayable Professional Component Amount HIPAA IG Note: Use this amount to indicate the professional component amount billed but not payable.	O	R	1/18	Situational
MIA20	127	Reference Identification Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier Industry: Remark Code HIPAA IG Note: Use this reference identification for the Health Care Financing Administration claim payment remark code. ExternalCodeList Name: 411 Description: Remittance Remark Codes	O	AN	1/30	Situational
MIA21	127	Reference Identification Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier Industry: Remark Code HIPAA IG Note: Use this reference identification for the Health Care Financing Administration claim payment remark code. ExternalCodeList Name: 411 Description: Remittance Remark Codes	O	AN	1/30	Situational
MIA22	127	Reference Identification Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier Industry: Remark Code HIPAA IG Note: Use this reference identification for the Health Care Financing Administration claim payment remark code. ExternalCodeList Name: 411 Description: Remittance Remark Codes	O	AN	1/30	Situational
MIA23	127	Reference Identification Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier Industry: Remark Code HIPAA IG Note: Use this reference identification for the Health Care Financing Administration claim payment remark code. ExternalCodeList Name: 411 Description: Remittance Remark Codes	O	AN	1/30	Situational
MIA24	782	Monetary Amount Description: Monetary amount	O	R	1/18	Situational

Industry: PPS-Capital Exception Amount
HIPAA IG Note: Use this amount to indicate the capital exception amount.

MOA Medicare Outpatient Adjudication Information

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

User Option (Usage): Situational

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

Notes:

1. Required to convey the Medicare Outpatient Adjudication Information if returned in the Electronic Remittance Advice (835).

Example:

MOA*12.5**MA01~

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	Percent Description: Percentage expressed as a decimal Industry: Reimbursement Rate HIPAA IG Note: Required if returned on the Electronic Remittance Advice (835).	O	R	1/10	Situational
MOA02	782	Monetary Amount Description: Monetary amount Industry: Claim HCPCS Payable Amount HIPAA IG Note: Use this amount to indicate the Claim Health Care Financing Administration Common Procedural Coding System (HCPCS) payable amount. Required if returned on the Electronic Remittance Advice (835).	O	R	1/18	Situational
MOA03	127	Reference Identification Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier HIPAA IG Note: Use this amount to indicate the Claim Health Care Financing Administration Common Procedural Coding System (HCPCS) payable amount. Required if returned on the Electronic Remittance Advice (835). ExternalCodeList Name: 411 Description: Remittance Remark Codes	O	AN	1/30	Situational
MOA04	127	Reference Identification Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier Industry: Remark Code HIPAA IG Note: Use this reference identification for the Health Care Financing Administration claim payment remark code. Required if returned on the Electronic Remittance Advice (835). ExternalCodeList	O	AN	1/30	Situational

MOA05	127	<p>Name: 411 Description: Remittance Remark Codes</p> <p>Reference Identification Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier Industry: Remark Code HIPAA IG Note: Use this reference identification for the Health Care Financing Administration claim payment remark code. Required if returned on the Electronic Remittance Advice (835).</p> <p>ExternalCodeList Name: 411 Description: Remittance Remark Codes</p>	O	AN	1/30	Situational
MOA06	127	<p>Name: 411 Description: Remittance Remark Codes</p> <p>Reference Identification Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier Industry: Remark Code HIPAA IG Note: Use this reference identification for the Health Care Financing Administration claim payment remark code. Required if returned on the Electronic Remittance Advice (835).</p> <p>ExternalCodeList Name: 411 Description: Remittance Remark Codes</p>	O	AN	1/30	Situational
MOA07	127	<p>Name: 411 Description: Remittance Remark Codes</p> <p>Reference Identification Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier Industry: Remark Code HIPAA IG Note: Use this reference identification for the Health Care Financing Administration claim payment remark code. Required if returned on the Electronic Remittance Advice (835).</p> <p>ExternalCodeList Name: 411 Description: Remittance Remark Codes</p>	O	AN	1/30	Situational
MOA08	782	<p>Monetary Amount Description: Monetary amount Industry: Remark Code HIPAA IG Note: Use this reference identification for the Health Care Financing Administration claim payment remark code. Required if returned on the Electronic Remittance Advice (835).</p>	O	R	1/18	Situational
MOA09	782	<p>Monetary Amount Description: Monetary amount Industry: Nonpayable Professional Component Amount HIPAA IG Note: Use this amount to indicate the professional component amount billed but not payable. Required if returned on the Electronic Remittance Advice (835).</p>	O	R	1/18	Situational

NM1 Other Subscriber Name

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

User Option (Usage): Required

To supply the full name of an individual or organizational entity

Notes:

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

Example:

NM1*IL*1*DOE*JOHN*T***34*123456789~

NYS MEDICAID NOTE:

NYSDOH will ignore data when provided.

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
NM101	98	Entity Identifier Code Description: Code identifying an organizational entity, a physical location, property or an individual Code Name IL Insured or Subscriber	M	ID	2/3	Required
NM102	1065	Entity Type Qualifier Description: Code qualifying the type of entity Code Name 1 Person 2 Non-Person Entity	M	ID	1/1	Required
NM103	1035	Name Last or Organization Name Description: Individual last name or organizational name Industry: Other Insured Last Name Alias: Subscriber's Last Name	O	AN	1/35	Required
NM104	1036	Name First Description: Individual first name Industry: Other Insured First Name Alias: Subscriber's First Name HIPAA IG Note: This data element is required when NM102 equals one (1).	O	AN	1/25	Situational
NM105	1037	Name Middle Description: Individual middle name or initial Industry: Other Insured Middle Name Alias: Subscriber's Middle Initial HIPAA IG Note: Required if NM102=1 and the middle name/initial of the person is known.	O	AN	1/25	Situational
NM107	1039	Name Suffix Description: Suffix to individual name Industry: Other Insured Name Suffix HIPAA IG Note: Examples: I, II, III, IV, Jr, Sr Required if known.	O	AN	1/10	Situational
NM108	66	Identification Code Qualifier Description: Code designating the system/method of code structure used for Identification Code (67) Code Name MI Member Identification Number	C	ID	1/2	Required

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

ZZ

Mutually Defined

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

NM109	67	Identification Code	C	AN	2/80	Required
		Description: Code identifying a party or other code				
		Industry: Other Insured Identifier				
		Alias: Subscriber Primary ID				

N3**Other Subscriber Address**

Pos: 332	Max: 1
Detail - Optional	
Loop: 2330A	Elements: 2

User Option (Usage): Situational

To specify the location of the named party

Notes:

1. This segment is required when the Provider has the Other Subscriber Address information on file.

Example:

N3*4320 WASHINGTON ST SUITE 100~

NYS MEDICAID NOTE:

NYSDOH will ignore data when provided.

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
N301	166	Address Information Description: Address information Industry: Other Insured Address Line Alias: Subscriber's Address 1	M	AN	1/55	Required
N302	166	Address Information Description: Address information Industry: Other Insured Address Line Alias: Subscriber Address 2 HIPAA IG Note: Required if a second address line exists.	O	AN	1/55	Situational

N4**Other Subscriber City/State/ZIP Code**

Pos: 340	Max: 1
Detail - Optional	
Loop: 2330A	Elements: 4

User Option (Usage): Situational

To specify the geographic place of the named party

Notes:

1. This segment is required when the associated N3 segment is present.

Example:

N4*PALISADES*OR*23119~

NYS MEDICAID NOTE:

NYSDOH will ignore data when provided.

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
N401	19	City Name Description: Free-form text for city name Industry: Other Insured City Name Alias: Subscriber's City	O	AN	2/30	Required
N402	156	State or Province Code Description: Code (Standard State/Province) as defined by appropriate government agency Industry: Other Insured State Code Alias: Subscriber's State ExternalCodeList Name: 22 Description: States and Outlying Areas of the U.S.	O	ID	2/2	Required
N403	116	Postal Code Description: Code defining international postal zone code excluding punctuation and blanks (zip code for United States) Industry: Other Insured Postal Zone or ZIP Code Alias: Subscriber's ZIP Code ExternalCodeList Name: 51 Description: ZIP Code	O	ID	3/15	Required
N404	26	Country Code Description: Code identifying the country Alias: Subscriber Country Code HIPAA IG Note: This data element is required when the address is outside of the U.S. ExternalCodeList Name: 5 Description: Countries, Currencies and Funds	O	ID	2/3	Situational

REF Other Subscriber Secondary Information

Pos: 355	Max: 3
Detail - Optional	
Loop: 2330A	Elements: 2

User Option (Usage): Situational

To specify identifying information

Notes:

1. This segment is required when additional identification numbers are required.

Example:

REF*SY*030385074~

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>
REF01	128	Reference Identification Qualifier Description: Code qualifying the Reference Identification	M	ID	2/3	Required
		Code Name				
		1W Member Identification Number				
		If NM108 = MI, this qualifier cannot be used.				
		23 Client Number				
		This code is intended to be used only in claims submitted to the Indian Health Services (IHS/CHS) Fiscal Intermediary for the purpose of reporting the Health Record Number.				
		IG Insurance Policy Number				
		SY Social Security Number				
		The social security number may not be used for Medicare.				
REF02	127	Reference Identification Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier Industry: Other Insured Additional Identifier	C	AN	1/30	Required

NM1 Other Payer Name

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

User Option (Usage): Required

To supply the full name of an individual or organizational entity

Notes:

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

Example:

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

NYS MEDICAID NOTE:

Providers are required to submit this information when there is another payer involved.

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
NM101	98	Entity Identifier Code Description: Code identifying an organizational entity, a physical location, property or an individual Code Name PR Payer	M	ID	2/3	Required
NM102	1065	Entity Type Qualifier Description: Code qualifying the type of entity Code Name 2 Non-Person Entity	M	ID	1/1	Required
NM103	1035	Name Last or Organization Name Description: Individual last name or organizational name Industry: Other Payer Last or Organization Name Alias: Payer Name	O	AN	1/35	Required
NM108	66	Identification Code Qualifier Description: Code designating the system/method of code structure used for Identification Code (67) Code Name PI Payor Identification XV Health Care Financing Administration National Payer Identification Number (PAYERID) Description: Required if the National PlanID is mandated for use. Otherwise, one of the other listed codes may be used. CODE SOURCE: 540: Health Care Financing Administration National PlanID	C	ID	1/2	Required
NM109	67	Identification Code Description: Code identifying a party or other code Industry: Other Payer Primary Identifier Alias: Payer Primary ID NYS MEDICAID NOTE: NYSDOH expects this identifier to be generated by the submitter. When multiple payers exist, this identifier must be unique within the claim. HIPAA IG Note: This number must be identical to SVD01 (L00p ID - 2430) for COB. ExternalCodeList Name: 540 Description: Health Care Financing Administration National PlanID	C	AN	2/80	Required

N3 Other Payer Address

Pos: 332	Max: 1
Detail - Optional	
Loop: 2330B	Elements: 2

User Option (Usage): Situational

To specify the location of the named party

Notes:

- 1. This segment is only to be used when the Provider needs to identify the address for paper claim printing purposes.

Example:

N3*4320 WASHINGTON ST SUITE 100~

NYS MEDICAID NOTE:

NYSDOH will ignore data when provided.

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
N301	166	Address Information Description: Address information Industry: Other Payer Address Line Alias: Payer's Address 1	M	AN	1/55	Required
N302	166	Address Information Description: Address information Industry: Other Payer Address Line Alias: Payer's Address 2 HIPAA IG Note: Required if a second address line exists.	O	AN	1/55	Situational

N4**Other Payer City/State/ZIP Code**

Pos: 340	Max: 1
Detail - Optional	
Loop: 2330B	Elements: 4

User Option (Usage): Situational

To specify the geographic place of the named party

Notes:

1. This segment is required when the associated N3 segment is present.

Example:

N4*PALISADES*OR*23119~

NYS MEDICAID NOTE:

NYSDOH will ignore data when provided.

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
N401	19	City Name Description: Free-form text for city name Industry: Other Payer City Name Alias: Payer City Name	O	AN	2/30	Required
N402	156	State or Province Code Description: Code (Standard State/Province) as defined by appropriate government agency Industry: Other Payer State Code Alias: Payer State Code ExternalCodeList Name: 22	O	ID	2/2	Required
N403	116	Postal Code Description: Code defining international postal zone code excluding punctuation and blanks (zip code for United States) Industry: Other Payer Postal Zone or ZIP Code Alias: Payer Postal Code ExternalCodeList Name: 51	O	ID	3/15	Required
N404	26	Country Code Description: ZIP Code Description: Code identifying the country Alias: Payer Country Code HIPAA IG Note: This data element is required when the address is outside of the U.S. ExternalCodeList Name: 5	O	ID	2/3	Situational
		Description: Countries, Currencies and Funds				

DTP Claim Adjudication Date

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

User Option (Usage): Situational

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

Notes:

1. This segment is required when Loop-ID 2430 (Line Adjudication Date) is not used and this payer has adjudicated the claim.

Example:

DTP*573*D8*19981226~

NYS MEDICAID NOTE:

NYSDOH will ignore data when provided.

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
DTP01	374	Date/Time Qualifier Description: Code specifying type of date or time, or both date and time Industry: Date Time Qualifier	M	ID	3/3	Required
		Code Name 573 Date Claim Paid				
DTP02	1250	Date Time Period Format Qualifier Description: Code indicating the date format, time format, or date and time format Industry: Date Time Qualifier	M	ID	2/3	Required
		Code Name D8 Date Expressed in Format CCYYMMDD				
DTP03	1251	Date Time Period Description: Expression of a date, a time, or range of dates, times or dates and times Industry: Adjudication or Payment Date	M	AN	1/35	Required

REF Other Payer Secondary Identification and Reference Number

Pos: 355	Max: 2
Detail - Optional	
Loop: 2330B	Elements: 2

User Option (Usage): Situational

To specify identifying information

Notes:

1. This segment is required when a secondary number is needed to identify the payer.
2. Used when it is necessary to identify the 'other' payer's claim number in a payer-to-payer COB situation (use code F8).

Example:

REF*FY*465980789~

NYS MEDICAID NOTE:

NYSDOH will ignore data when provided.

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage																						
REF01	128	Reference Identification Qualifier Description: Code qualifying the Reference Identification HIPAA IG Note: Use code F8 to indicate the payer's claim number assigned to this claim by the payer referenced in this interation of Loop ID - 2330B.	M	ID	2/3	Required																						
		<table border="0"> <tr> <th>Code</th> <th>Name</th> </tr> <tr> <td>2U</td> <td>Payer Identification Number</td> </tr> <tr> <td>F8</td> <td>Original Reference Number</td> </tr> <tr> <td></td> <td>UB-92 Ref. [UB-Name]:</td> </tr> <tr> <td></td> <td>37 (A-C) [Internal Control Number (ICN)/ Document Control Number (DCN)]</td> </tr> <tr> <td>FY</td> <td>Claim Office Number</td> </tr> <tr> <td></td> <td>Description: The identification of the specific payer's location designated as responsible for the submitted claim</td> </tr> <tr> <td>NF</td> <td>National Association of Insurance Commissioners (NAIC) Code</td> </tr> <tr> <td></td> <td>Description: A unique number assigned to each insurance company</td> </tr> <tr> <td></td> <td>CODE SOURCE:</td> </tr> <tr> <td></td> <td>245: National Association of Insurance Commissioners (NAIC) Code</td> </tr> </table>	Code	Name	2U	Payer Identification Number	F8	Original Reference Number		UB-92 Ref. [UB-Name]:		37 (A-C) [Internal Control Number (ICN)/ Document Control Number (DCN)]	FY	Claim Office Number		Description: The identification of the specific payer's location designated as responsible for the submitted claim	NF	National Association of Insurance Commissioners (NAIC) Code		Description: A unique number assigned to each insurance company		CODE SOURCE:		245: National Association of Insurance Commissioners (NAIC) Code				
Code	Name																											
2U	Payer Identification Number																											
F8	Original Reference Number																											
	UB-92 Ref. [UB-Name]:																											
	37 (A-C) [Internal Control Number (ICN)/ Document Control Number (DCN)]																											
FY	Claim Office Number																											
	Description: The identification of the specific payer's location designated as responsible for the submitted claim																											
NF	National Association of Insurance Commissioners (NAIC) Code																											
	Description: A unique number assigned to each insurance company																											
	CODE SOURCE:																											
	245: National Association of Insurance Commissioners (NAIC) Code																											
REF02	127	Reference Identification Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier Industry: Other Payer Secondary Identifier ExternalCodeList Name: 245 Description: National Association of Insurance Commissioners (NAIC) Code	C	AN	1/30	Required																						

REF Other Payer Prior Authorization or Referral Number

Pos: 355	Max: 1
Detail - Optional	
Loop: 2330B	Elements: 2

User Option (Usage): Situational

To specify identifying information

Notes:

1. Used when the payer identified in this loop has given a prior authorization or referral number to this claim. This element is primarily used in payer-to-payer COB situations.
2. There can only be a maximum of three REF segments in any one iteration of the 2330 loop.

Example:

REF*G1*AB333-Y5~

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>
REF01	128	Reference Identification Qualifier Description: Code qualifying the Reference Identification	M	ID	2/3	Required
		Code Name				
		9F Referral Number				
		G1 Prior Authorization Number				
		Description: An authorization number acquired prior to the submission of a claim				
REF02	127	Reference Identification Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier Industry: Other Payer Prior Authorization or Referral Number	C	AN	1/30	Required

NM1 Other Payer Patient Information

Pos: 325	Max: 1
Detail - Optional	
Loop: 2330C	Elements: 4

User Option (Usage): Situational

To supply the full name of an individual or organizational entity

Notes:

1. Required when it is necessary, in COB situations, to send one or more payer-specific patient identification numbers. The patient identification number(s) carried in this iteration of the 2330C loop are those patient ID's which belong to non-destination (COB) payers. The patients ID(s) for the destination payer are carried in the 2010CA loop NM1 and REF segments.
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.

Example:

NM1*QC*1*****EI*128848726~

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>
NM101	98	Entity Identifier Code Description: Code identifying an organizational entity, a physical location, property or an individual <u>Code</u> <u>Name</u> QC Patient Description: Individual receiving medical care	M	ID	2/3	Required
NM102	1065	Entity Type Qualifier Description: Code qualifying the type of entity <u>Code</u> <u>Name</u> 1 Person	M	ID	1/1	Required
NM108	66	Identification Code Qualifier Description: Code designating the system/method of code structure used for Identification Code (67) <u>Code</u> <u>Name</u> EI Employee Identification Number MI Member Identification Number The code MI is intended to be the subscriber's identification number as assigned by the payer. Payers use different terminology to convey the same number, therefore, the 837 Institutional Workgroup recommends using MI - Member Identification Number to convey the following terms: Insured's ID, Subscriber's ID, Medicaid Recipient ID, Health Insurance Claim Number (HIC), etc.	C	ID	1/2	Required
NM109	67	Identification Code Description: Code identifying a party or other code Industry: Other Payer Patient Primary Identifier Alias: Patient's Other Payer Primary Identification Number	C	AN	2/80	Required

REF Other Payer Patient Identification Number

Pos: 355	Max: 3
Detail - Optional	
Loop: 2330C	Elements: 2

User Option (Usage): Situational

To specify identifying information

Notes:

1. Used when a COB payer (listed in 2330B loop) has one or more proprietary patient identification numbers for this claim. The patient (name, DOB, etc) is identified in the 2010BA or 2010CA loop.

Example:

REF*AZ*B333-Y5~

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>
REF01	128	Reference Identification Qualifier Description: Code qualifying the Reference Identification	M	ID	2/3	Required
		Code Name				
		1W Member Identification Number				
		If NM108 = MI, this qualifier cannot be used.				
		IG Insurance Policy Number				
		SY Social Security Number				
		Do not use this code for Medicare.				
REF02	127	Reference Identification Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier Industry: Other Payer Patient Secondary Identifier	C	AN	1/30	Required

NM1 Other Payer Attending Provider

Pos: 325	Max: 1
Detail - Optional	
Loop: 2330D	Elements: 2

User Option (Usage): Situational

To supply the full name of an individual or organizational entity

Notes:

1. Used when it is necessary to send an additional payer-specific provider identification number for non-destination (COB) payers.
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.

Example:

NM1*71*1~

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>
NM101	98	Entity Identifier Code Description: Code identifying an organizational entity, a physical location, property or an individual	M	ID	2/3	Required
		Code Name 71 Attending Physician Description: Physician present when medical services are performed				
NM102	1065	Entity Type Qualifier Description: Code qualifying the type of entity	M	ID	1/1	Required
		Code Name 1 Person 2 Non-Person Entity				

REF Other Payer Attending Provider Identification

Pos: 355	Max: 3
Detail - Optional	
Loop: 2330D	Elements: 2

User Option (Usage): Required

To specify identifying information

Notes:

1. Non-destination (COB) payers' provider identification number(s).

Example:

REF*N5*RF446~

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>
REF01	128	Reference Identification Qualifier Description: Code qualifying the Reference Identification	M	ID	2/3	Required
		Code		Name		
		1A		Blue Cross Provider Number		
		1B		Blue Shield Provider Number		
		1C		Medicare Provider Number		
		1D		Medicaid Provider Number		
		1G		Provider UPIN Number		
		1H		CHAMPUS Identification Number		
		EI		Employer's Identification Number		
		G2		Provider Commercial Number		
				Description: A unique number assigned to a provider by a commercial insurer		
		LU		Location Number		
		N5		Provider Plan Network Identification Number		
				Description: A number assigned to identify a specific provider in a health care plan network		
REF02	127	Reference Identification Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier Industry: Other Payer Attending Provider Identifier	C	AN	1/30	Required

NM1 Other Payer Operating Provider

Pos: 325	Max: 1
Detail - Optional	
Loop: 2330E	Elements: 2

User Option (Usage): Situational

To supply the full name of an individual or organizational entity

Notes:

1. Used when it is necessary to send an additional payer-specific provider identification number for non-destination (COB) payers.
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.

Example:

NM1*72*1~

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>
NM101	98	Entity Identifier Code Description: Code identifying an organizational entity, a physical location, property or an individual	M	ID	2/3	Required
		Code Name 72 Operating Physician Description: Doctor who performs a surgical procedure				
NM102	1065	Entity Type Qualifier Description: Code qualifying the type of entity	M	ID	1/1	Required
		Code Name 1 Person				

REF Other Payer Operating Provider Identification

Pos: 355	Max: 3
Detail - Optional	
Loop: 2330E	Elements: 2

User Option (Usage): Required

To specify identifying information

Example:

REF*N5*RF446~

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>
REF01	128	Reference Identification Qualifier Description: Code qualifying the Reference Identification	M	ID	2/3	Required
		Code Name				
		1A Blue Cross Provider Number				
		1B Blue Shield Provider Number				
		1C Medicare Provider Number				
		1D Medicaid Provider Number				
		1G Provider UPIN Number				
		1H CHAMPUS Identification Number				
		EI Employer's Identification Number				
		G2 Provider Commercial Number Description: A unique number assigned to a provider by a commercial insurer				
		LU Location Number				
		N5 Provider Plan Network Identification Number Description: A number assigned to identify a specific provider in a health care plan network				
REF02	127	Reference Identification Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier Industry: Other Payer Operating Provider Identifier	C	AN	1/30	Required

NM1 Other Payer Other Provider

Pos: 325	Max: 1
Detail - Optional	
Loop: 2330F	Elements: 2

User Option (Usage): Situational

To supply the full name of an individual or organizational entity

Notes:

1. Used when it is necessary to send an additional payer-specific provider identification number for non-destination (COB) payers.
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.

Example:

NM1*73*1~

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>
NM101	98	Entity Identifier Code Description: Code identifying an organizational entity, a physical location, property or an individual	M	ID	2/3	Required
		Code Name 73 Other Physician Description: Physician not one of the other specified choices				
NM102	1065	Entity Type Qualifier Description: Code qualifying the type of entity	M	ID	1/1	Required
		Code Name 1 Person 2 Non-Person Entity				

REF Other Payer Other Provider Identification

Pos: 355	Max: 3
Detail - Optional	
Loop: 2330F	Elements: 2

User Option (Usage): Required

To specify identifying information

Notes:

1. Non-destination (COB) payers' provider identification number(s).

Example:

REF*N5*RF446~

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>
REF01	128	Reference Identification Qualifier Description: Code qualifying the Reference Identification	M	ID	2/3	Required
		Code		Name		
		1A		Blue Cross Provider Number		
		1B		Blue Shield Provider Number		
		1C		Medicare Provider Number		
		1D		Medicaid Provider Number		
		1G		Provider UPIN Number		
		1H		CHAMPUS Identification Number		
		EI		Employer's Identification Number		
		G2		Provider Commercial Number		
				Description: A unique number assigned to a provider by a commercial insurer		
		LU		Location Number		
		N5		Provider Plan Network Identification Number		
				Description: A number assigned to identify a specific provider in a health care plan network		
		SY		Social Security Number		
				The social security number may not be used for Medicare.		
REF02	127	Reference Identification Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier Industry: Other Payer Other Provider Identifier	C	AN	1/30	Required

NM1 Other Payer Service Facility Provider

Pos: 325	Max: 1
Detail - Optional	
Loop: 2330H	Elements: 2

User Option (Usage): Situational

To supply the full name of an individual or organizational entity

Notes:

1. Used when it is necessary to send an additional payer-specific provider identification number for non-destination (COB) payers.
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.

Example:

NM1*FA*1~

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>
NM101	98	Entity Identifier Code Description: Code identifying an organizational entity, a physical location, property or an individual	M	ID	2/3	Required
		Code Name FA Facility				
NM102	1065	Entity Type Qualifier Description: Code qualifying the type of entity	M	ID	1/1	Required
		Code Name 2 Non-Person Entity				

REF Other Payer Service Facility Provider Identification

Pos: 355	Max: 3
Detail - Optional	
Loop: 2330H	Elements: 2

User Option (Usage): Required

To specify identifying information

Notes:

1. Non-destination (COB) payers' provider identification number(s).

Example:

REF*N5*RF446~

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>																				
REF01	128	Reference Identification Qualifier Description: Code qualifying the Reference Identification <table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>1B</td> <td>Blue Shield Provider Number</td> </tr> <tr> <td>1C</td> <td>Medicare Provider 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>G2</td> <td>Provider Commercial Number</td> </tr> <tr> <td></td> <td>Description: A unique number assigned to a provider by a commercial insurer</td> </tr> <tr> <td>LU</td> <td>Location Number</td> </tr> <tr> <td>N5</td> <td>Provider Plan Network Identification Number</td> </tr> <tr> <td></td> <td>Description: A number assigned to identify a specific provider in a health care plan network</td> </tr> </tbody> </table>	<u>Code</u>	<u>Name</u>	1B	Blue Shield Provider Number	1C	Medicare Provider Number	1D	Medicaid Provider Number	EI	Employer's Identification Number	G2	Provider Commercial Number		Description: A unique number assigned to a provider by a commercial insurer	LU	Location Number	N5	Provider Plan Network Identification Number		Description: A number assigned to identify a specific provider in a health care plan network	M	ID	2/3	Required
<u>Code</u>	<u>Name</u>																									
1B	Blue Shield Provider Number																									
1C	Medicare Provider Number																									
1D	Medicaid Provider Number																									
EI	Employer's Identification Number																									
G2	Provider Commercial Number																									
	Description: A unique number assigned to a provider by a commercial insurer																									
LU	Location Number																									
N5	Provider Plan Network Identification Number																									
	Description: A number assigned to identify a specific provider in a health care plan network																									
REF02	127	Reference Identification Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier Industry: Other Payer Service Facility Provider Identifier	C	AN	1/30	Required																				

LX Service Line Number

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

User Option (Usage): Required

To reference a line number in a transaction set

Notes:

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

Example:

LX*1~

NYS MEDICAID NOTE:

Please refer to NYS Medicaid Note in the front matter.

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
LX01	554	Assigned Number Description: Number assigned for differentiation within a transaction set HIPAA IG Note: This is the service line number. Begin with 1 and increment by 1 for each new LX segment within a claim.	M	N0	1/6	Required

SV2 Institutional Service Line

Pos: 375	Max: 1
Detail - Optional	
Loop: 2400	Elements: 7

User Option (Usage): Required

To specify the claim service detail for a Health Care institution

Notes:

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

Example:

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

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
SV201	234	Product/Service ID Description: Identifying number for a product or service Industry: Service Line Revenue Code NYS MEDICAID NOTE: NYSDOH will process revenue codes here if provided. HIPAA IG Note: See Code Source 132: National Uniform Billing Committee (NUBC) Codes. <u>ExternalCodeList</u> Name: 132 Description: National Uniform Billing Committee (NUBC) Codes	C	AN	1/48	Required
SV202	C003	Composite Medical Procedure Identifier Description: To identify a medical procedure by its standardized codes and applicable modifiers Alias: Service Line Procedure Code HIPAA IG Note: This data element required for outpatient claims when an appropriate HCPCS exists for the service line item.	C	Comp		Situational
	235	Product/Service ID Qualifier Description: Code identifying the type/source of the descriptive number used in Product/Service ID (234) Industry: Product or Service ID Qualifier HIPAA IG Note: 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.	M	ID	2/2	Required
		<u>Code</u> HC				<u>Name</u> Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes Description: HCFA coding scheme to group procedure(s) performed on an outpatient basis for payment to hospital under Medicare; primarily used for ambulatory surgical and other diagnostic departments Because the AMA's CPT codes are also level 1 HCPCS codes, they are reported under HC. CODE SOURCE:

130: Health Care Financing Administration Common Procedural Coding System

234	Product/Service ID Description: Identifying number for a product or service Industry: Procedure Code Alias: HCPCS Procedure Code ExternalCodeList Name: 130 Description: Health Care Financing Administration Common Procedural Coding System	M	AN	1/48	Required
1339	Procedure Modifier Description: This identifies special circumstances related to the performance of the service, as defined by trading partners Alias: HCPCS Modifier 1 HIPAA IG Note: Use this modifier for the first procedure code modifier. This data element is required when the Provider needs to convey additional clarification for the associated procedure code.	O	AN	2/2	Situational
1339	Procedure Modifier Description: This identifies special circumstances related to the performance of the service, as defined by trading partners Alias: HCPCS Modifier 2 HIPAA IG Note: Use this modifier for the second procedure code modifier. See SV202-3	O	AN	2/2	Situational
1339	Procedure Modifier Description: This identifies special circumstances related to the performance of the service, as defined by trading partners Alias: HCPCS Modifier 3 HIPAA IG Note: See SV202-3	O	AN	2/2	Situational
1339	Procedure Modifier Description: This identifies special circumstances related to the performance of the service, as defined by trading partners Alias: HCPCS Modifier 4 HIPAA IG Note: See SV202-3	O	AN	2/2	Situational
SV203	782 Monetary Amount Description: Monetary amount Industry: Line Item Charge Amount Alias: Service Line Charge Amount HIPAA IG Note: Use this amount to indicate the submitted charge amount.	O	R	1/18	Required
SV204	355 Unit or Basis for Measurement Code Description: Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken Code Name DA Days UN Unit	C	ID	2/2	Required
SV205	380 Quantity Description: Numeric value of quantity Industry: Service Unit Count Alias: Service Line Units	C	R	1/15	Required
SV206	1371 Unit Rate Description: The rate per unit of associate revenue for hospital accommodation Industry: Service Line Rate	O	R	1/10	Situational

SV207	782	<p>Alias: Service Line Rate Amount HIPAA IG Note: This data element is required when the associated revenue code is 100-219.</p> <p>Monetary Amount Description: Monetary amount</p> <p>Industry: Line Item Denied Charge or Non-Covered Charge Amount Alias: Service Line Non-Covered Charge Amount HIPAA IG Note: Use this amount if needed to report line specific non-covered charge amount.</p>	O	R	1/18	Situational
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PWK Line Supplemental Information

Pos: 420	Max: 5
Detail - Optional	
Loop: 2400	Elements: 4

User Option (Usage): Situational

To identify the type or transmission or both of paperwork or supporting information

Notes:

1. The PWK segment is required if there is paper documentation supporting this claim. The PWK segment should not be used if the information related to the claim is being sent within the 837 ST-SE envelope unless reporting Home Infusion (see codes AD & AF in PWK02).
2. The PWK segment is required to identify attachments that are sent electronically (PWK02 = EL) but are transmitted in another functional group (e.g., 275) rather than by paper. PWK06 is used to identify the attached electronic documentation. The number in PWK06 would be carried in the TRN of the electronic attachment.
3. The PWK segment can be used to identify paperwork that is being held at the provider's office and is available upon request by the payer (or appropriate entity), but that is not being sent with the claim. Use code AA in PWK02 to convey this specific use of the PWK segment. See element note under PWK02, code AA.

Example:

PWK*B2*AA***AC*29438476~

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>
PWK01	755	Report Type Code Description: Code indicating the title or contents of a document, report or supporting item Industry: Attachment Report Type Code	M	ID	2/2	Required
		Code		Name		
		AS		Admission Summary Description: A brief patient summary; it lists the patient's chief complaints and the reasons for admitting the patient to the hospital		
		B2		Prescription		
		B3		Physician Order		
		B4		Referral Form		
		CT		Certification		
		DA		Dental Models Description: Cast of the teeth; they are usually taken before partial dentures or braces are placed		
		DG		Diagnostic Report Description: Report describing the results of lab tests x-rays or radiology films		
		DS		Discharge Summary Description: Report listing the condition of the patient upon release from the hospital; it usually lists where the patient is being released to, what medication the patient is taking and when to follow-up with the doctor		
		EB		Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payor) Description: Summary of benefits paid on the claim		
		MT		Models		
		NN		Nursing Notes Description: Notes kept by the nurse regarding a patient's physical and mental condition, what medication the patient is on and when it should be given		
		OB		Operative Note		

- Description:** Step-by-step notes of exactly what takes place during an operation
- OZ Support Data for Claim
 - Description:** Medical records that would support procedures performed; tests given and necessary for a claim
- PN Physical Therapy Notes
- PO Prosthetics or Orthotic Certification
- PZ Physical Therapy Certification
- RB Radiology Films
 - Description:** X-rays, videos, and other radiology diagnostic tests
- RR Radiology Reports
 - Description:** Reports prepared by a radiologists after the films or x-rays have been reviewed
- RT Report of Tests and Analysis Report

PWK02 756 **Report Transmission Code** O ID 1/2 Required

Description: Code defining timing, transmission method or format by which reports are to be sent

Industry: Attachment Transmission Code

HIPAA IG Note: Codes AB, AD, AF and AG are not in the ASC X12 004-010 Data Dictionary but are included in this guide to provide a standard way to report Home Infusion services until these codes are added to a later version of the 837. A Data Maintenance request for these codes is in the ASC X12 process. It is recommended that entities who have a need to submit or receive Home Infusion Services customize their 004-010 translator map to allow these exception codes.

Code **Name**

- AA Available on Request at Provider Site
 - Paperwork is available at the provider's site. This means that the paperwork is not being sent with the claim at this time. Instead, it is available to the payer (or appropriate entity) at his or her request.
- AB Previously Submitted to Payer
- AD Certification Included in this Claim
- AF Narrative Segment Included in this Claim
- AG No Documentation is Required
- BM By Mail
- EL Electronically Only
- EM E-Mail
- FX By Fax

PWK05 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 PWK02 = "BM", "EL", "EM" or "FX"

Code **Name**

- AC Attachment Control Number
 - Description:** Means of associating electronic claim with documentation forwarded by other means

PWK06 67 **Identification Code** C AN 2/80 Situational

Description: Code identifying a party or other code

Industry: Attachment Control Number

HIPAA IG Note: Required if PWK02 = "BM", "EL", "EM" or "FX"

DTP Service Line Date

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

User Option (Usage): Situational

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

Notes:

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

Example:

DTP*472*D8*19960819~

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
DTP01	374	Date/Time Qualifier Description: Code specifying type of date or time, or both date and time Industry: Date Time Qualifier	M	ID	3/3	Required
		Code Name 472 Service Use RD8 in DTP02 to indicate begin/end or from/to dates.				
DTP02	1250	Date Time Period Format Qualifier Description: Code indicating the date format, time format, or date and time format	M	ID	2/3	Required
		Code Name D8 Date Expressed in Format CCYYMMDD RD8 Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD Description: A range of dates expressed in the format CCYYMMDD-CCYYMMDD where CCYY is the numerical expression of the century CC and year YY, MM is the numerical expression of the month within the year, and DD is the numerical expression of the day within the year; the first occurrence of CCYYMMDD is the beginning date and the second occurrence is the ending date				
DTP03	1251	Date Time Period Description: Expression of a date, a time, or range of dates, times or dates and times Industry: Service Date	M	AN	1/35	Required

DTP Assessment Date

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

User Option (Usage): Situational

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

Notes:

1. Required when an assessment date is necessary (i.e. Medicare PPS processing).
2. Refer to Code Source 132 National Uniform Billing Committee (NUBC) Codes for instructions on the use of this date.
3. Service date DTP is not used when this segment is present.

Example:

DTP*866*19981210~

NYS MEDICAID NOTE:

NYSDOH will use this date as the date of service when provided.

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
DTP01	374	Date/Time Qualifier Description: Code specifying type of date or time, or both date and time Industry: Date Time Qualifier	M	ID	3/3	Required
		Code Name 866 Examination				
DTP02	1250	Date Time Period Format Qualifier Description: Code indicating the date format, time format, or date and time format Code Name D8 Date Expressed in Format CCYYMMDD	M	ID	2/3	Required
DTP03	1251	Date Time Period Description: Expression of a date, a time, or range of dates, times or dates and times Industry: Assessment Date	M	AN	1/35	Required

AMT Service Tax Amount

Pos: 475	Max: 1
Detail - Optional	
Loop: 2400	Elements: 2

User Option (Usage): Situational

To indicate the total monetary amount

Notes:

1. Required when a service tax/surcharge applies to the service being reported in SV201.

Example:

AMT*GT*15~

NYS MEDICAID NOTE:

NYSDOH will ignore data when provided.

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
AMT01	522	Amount Qualifier Code Description: Code to qualify amount	M	ID	1/3	Required
		Code Name GT Goods and Services Tax Description: Canadian value-added tax				
AMT02	782	Monetary Amount Description: Monetary amount Industry: Service Tax Amount	M	R	1/18	Required

AMT Facility Tax Amount

Pos: 475	Max: 1
Detail - Optional	
Loop: 2400	Elements: 2

User Option (Usage): Situational

To indicate the total monetary amount

Notes:

1. Required when a service tax/surcharge applies to the service being reported in SV201.

Example:

AMT*N8*22~

NYS MEDICAID NOTE:

NYSDOH will ignore data when provided.

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
AMT01	522	Amount Qualifier Code Description: Code to qualify amount	M	ID	1/3	Required
		<u>Code</u> <u>Name</u> N8 Miscellaneous Taxes				
AMT02	782	Monetary Amount Description: Monetary amount Industry: Facility Tax Amount	M	R	1/18	Required

LIN Drug Identification

Pos: 493	Max: 1
Detail - Optional	
Loop: 2410	Elements: 2

User Option (Usage): Situational

To specify basic item identification data

Notes:

1. 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.
2. Use Loop ID 2410 to specify billing/reporting for drugs provided that may be part of the service(s) described in SV2.

Example:

LIN*N4*12345123412~

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>
LIN02	235	Product/Service ID Qualifier Description: Code identifying the type/source of the descriptive number used in Product/Service ID (234)	M	ID	2/2	Required
		Code Name N4 National Drug Code in 5-4-2 Format Description: 5-digit manufacturer ID, 4-digit product ID, 2-digit trade package size				
		CODE SOURCE: 240: National Drug Code by Format				
LIN03	234	Product/Service ID Description: Identifying number for a product or service Alias: National Drug Code	M	AN	1/48	Required
		ExternalCodeList Name: 240 Description: National Drug Code by Format				

CTP Drug Pricing

Pos: 494	Max: 1
Detail - Optional	
Loop: 2410	Elements: 3

User Option (Usage): Situational

To specify pricing information

Notes:

1. Required when it is necessary to provide a price specific to the NDC provided in LIN03 that is different than the price reported in SV203.

Example:

CTP***1.15*2*UN~

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>
CTP03	212	Unit Price Description: Price per unit of product, service, commodity, etc. Alias: Drug Unit Price	X	R	1/17	Required
CTP04	380	Quantity Description: Numeric value of quantity Alias: National Drug Unit Count	X	R	1/15	Required
CTP05	C001	Composite Unit of Measure Description: To identify a composite unit of measure(See Figures Appendix for examples of use) Alias: Unit/Basis of Measurement	O	Comp		Required
	355	Unit or Basis for Measurement Code Description: Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken	M	ID	2/2	Required
		Code		Name		
		F2		International Unit		Description: A unit accepted by an international agency; potency of a drug/vitamin based on a specific weight of that drug/vitamin
		GR		Gram		
		ML		Milliliter		
		UN		Unit		

REF Prescription Number

Pos: 495	Max: 1
Detail - Optional	
Loop: 2410	Elements: 2

User Option (Usage): Situational

To specify identifying information

Notes:

1. Required if dispense of the drug has been done with an assigned Rx number.
2. In cases where a compound drug is being billed, the components of the compound will all have the same prescription number. Payers receiving the claim can relate all the components by matching the prescription number.

Example:

REF*XZ*123456~

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>				
REF01	128	Reference Identification Qualifier Description: Code qualifying the Reference Identification Alias: Code Qualifier	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>XZ</td> <td>Pharmacy Prescription Number</td> </tr> </tbody> </table>	<u>Code</u>	<u>Name</u>	XZ	Pharmacy Prescription Number				
<u>Code</u>	<u>Name</u>									
XZ	Pharmacy Prescription Number									
REF02	127	Reference Identification Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier Alias: Prescription Number	X	AN	1/30	Required				

SVD Service Line Adjudication Information

Pos: 540	Max: 1
Detail - Optional	
Loop: 2430	Elements: 6

User Option (Usage): Situational

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. Required if claim has been previously adjudicated by payer identified in Loop 2330B and service line has adjustments applied to it.
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 nomenclature.
3. To show unbundled lines: if in the original claim, line 3 is unbundled into lines numbers 8 and 9, then in the secondary claim, LX08 would show 3 in SVD06 and LX09 would also show 3 in SVD06. This indicates that line 3 was unbundled into lines 8 and 9.
4. 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.

Example:

SVD*NR002*50.5**0305*1~

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
SVD01	67	Identification Code Description: Code identifying a party or other code Industry: Payer Identifier	M	AN	2/80	Required
SVD02	782	Monetary Amount Description: Monetary amount Industry: Service Line Paid Amount Alias: Service Line Amount Paid	M	R	1/18	Required
SVD03	C003	Composite Medical Procedure Identifier Description: To identify a medical procedure by its standardized codes and applicable modifiers HIPAA IG Note: Required when returned on an 835 payment for this claim or when needed to identify the service line adjudicated.	O	Comp		Situational
	235	Product/Service ID Qualifier Description: Code identifying the type/source of the descriptive number used in Product/Service ID (234) Industry: Product or Service ID Qualifier HIPAA IG Note: 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.	M	ID	2/2	Required
		Code		Name		
		HC		Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes Description: HCFA coding scheme to group procedure(s) performed on an outpatient basis for payment to hospital under Medicare; primarily used for ambulatory surgical and other diagnostic departments Because the AMA's CPT codes are also level 1 HCPCS codes, they are reported under HC.		

		CODE SOURCE:			
		130: Health Care Financing Administration Common Procedural Coding System			
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.				
		CODE SOURCE:			
		513: Home Infusion EDI Coalition (HIEC) Product/Service Code List			
ZZ	Mutually Defined				
	Use code ZZ to convey the Health Insurance Prospective Payment System (HIPPS) Skilled Nursing Facility Rate Code.				
234	Product/Service ID	M	AN	1/48	Required
	Description: Identifying number for a product or service				
	Industry: Procedure Code				
	HIPAA IG Note: This code list is available from: Division of Institutional Care Health Care Financing Administration S1-03-06 7500 Security Boulevard Baltimore, MD 21244-1850				
	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				
	ExternalCodeList				
	Name: SNFR				
	Description: Skilled Nursing Facility Rate Code				
1339	Procedure Modifier	O	AN	2/2	Situational
	Description: This identifies special circumstances related to the performance of the service, as defined by trading partners				
	HIPAA IG Note: Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.				
1339	Procedure Modifier	O	AN	2/2	Situational
	Description: This identifies special circumstances related to the performance of the service, as defined by trading partners				
	HIPAA IG Note: Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.				
1339	Procedure Modifier	O	AN	2/2	Situational
	Description: This identifies special circumstances related to the performance of the service, as defined by trading partners				
	HIPAA IG Note: Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.				
1339	Procedure Modifier	O	AN	2/2	Situational
	Description: This identifies special circumstances related to the performance of the service, as defined by trading partners				
	HIPAA IG Note: Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.				
352	Description	O	AN	1/80	Situational
	Description: A free-form description to clarify the				

related data elements and their content

Industry: Procedure Code Description

HIPAA IG Note: Required if SVC01-7 was returned in the 835 transaction.

SVD04	234	<p>Product/Service ID</p> <p>Description: Identifying number for a product or service</p> <p>Industry: Service Line Revenue Code</p>	O	AN	1/48	Required
SVD05	380	<p>Quantity</p> <p>Description: Numeric value of quantity</p> <p>Industry: Adjustment Quantity</p> <p>Alias: Paid Units of Service</p> <p>HIPAA IG Note: Crosswalk from SVC05 in 835 or, if not present in 835, use original billed units.</p>	O	R	1/15	Required
SVD06	554	<p>Assigned Number</p> <p>Description: Number assigned for differentiation within a transaction set</p> <p>Industry: Bundled or Unbundled Line Number</p> <p>HIPAA IG Note: Use the LX from this transaction which points to the bundled/unbundled line. Required if payer bundled/unbundled this service line.</p>	O	N0	1/6	Situational

CAS Service Line Adjustment

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

User Option (Usage): Situational

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. Inpatient or Outpatient - Service Line Adjustments
2. Submitters should use this CAS segment to report line level adjustments from prior payments which cause the amount paid to differ from the amount originally charged.
3. The Claim Adjustment Reason codes are located on the Washington Publishing Company web site <http://www.wpc-edi.com>.
4. Required when the prior payment had service line adjustments reported on a remittance.

Example:

CAS*CO*A1*25~

NYS MEDICAID NOTE:

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

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
CAS01	1033	Claim Adjustment Group Code Description: Code identifying the general category of payment adjustment Code Name CO Contractual Obligations CR Correction and Reversals OA Other adjustments PI Payor Initiated Reductions PR Patient Responsibility	M	ID	1/2	Required
CAS02	1034	Claim Adjustment Reason Code Description: Code identifying the detailed reason the adjustment was made Industry: Adjustment Reason Code ExternalCodeList Name: 139 Description: Claim Adjustment Reason Code	M	ID	1/5	Required
CAS03	782	Monetary Amount Description: Monetary amount Industry: Adjustment Amount HIPAA IG Note: Use this amount for the amount of adjustment. Use this amount for the charges applied to the preceding reason code.	M	R	1/18	Required
CAS04	380	Quantity Description: Numeric value of quantity Industry: Adjustment Quantity HIPAA IG Note: Use this value for the quantity applied to the preceding reason code.	O	R	1/15	Situational
CAS05	1034	Claim Adjustment Reason Code Description: Code identifying the detailed reason the adjustment was made Industry: Adjustment Reason Code HIPAA IG Note: See CAS02	C	ID	1/5	Situational

		<u>ExternalCodeList</u>				
		Name: 139				
		Description: Claim Adjustment Reason Code				
CAS06	782	Monetary Amount	C	R	1/18	Situational
		Description: Monetary amount				
		Industry: Adjustment Amount				
		HIPAA IG Note: Use this amount for the charges applied to the preceding reason code. See CAS03				
CAS07	380	Quantity	C	R	1/15	Situational
		Description: Numeric value of quantity				
		Industry: Adjustment Quantity				
		HIPAA IG Note: Use this value for the quantity applied to the preceding reason code. See CAS04				
CAS08	1034	Claim Adjustment Reason Code	C	ID	1/5	Situational
		Description: Code identifying the detailed reason the adjustment was made				
		Industry: Adjustment Reason Code				
		HIPAA IG Note: See CAS02				
		<u>ExternalCodeList</u>				
		Name: 139				
		Description: Claim Adjustment Reason Code				
CAS09	782	Monetary Amount	C	R	1/18	Situational
		Description: Monetary amount				
		Industry: Adjustment Amount				
		HIPAA IG Note: Use this amount for the charges applied to the preceding reason code. See CAS03				
CAS10	380	Quantity	C	R	1/15	Situational
		Description: Numeric value of quantity				
		Industry: Adjustment Quantity				
		HIPAA IG Note: Use this value for the quantity applied to the preceding reason code. See CAS04				
CAS11	1034	Claim Adjustment Reason Code	C	ID	1/5	Situational
		Description: Code identifying the detailed reason the adjustment was made				
		Industry: Adjustment Reason Code				
		HIPAA IG Note: See CAS02				
		<u>ExternalCodeList</u>				
		Name: 139				
		Description: Claim Adjustment Reason Code				
CAS12	782	Monetary Amount	C	R	1/18	Situational
		Description: Monetary amount				
		Industry: Adjustment Amount				
		HIPAA IG Note: Use this amount for the charges applied to the preceding reason code. See CAS03				
CAS13	380	Quantity	C	R	1/15	Situational
		Description: Numeric value of quantity				
		Industry: Adjustment Quantity				
		HIPAA IG Note: Use this value for the quantity applied to the preceding reason code. See CAS04				
CAS14	1034	Claim Adjustment Reason Code	C	ID	1/5	Situational
		Description: Code identifying the detailed reason the adjustment was made				
		Industry: Adjustment Reason Code				
		HIPAA IG Note: See CAS02				
		<u>ExternalCodeList</u>				

		Name: 139 Description: Claim Adjustment Reason Code				
CAS15	782	Monetary Amount Description: Monetary amount Industry: Adjustment Amount HIPAA IG Note: Use this amount for the charges applied to the preceding reason code. See CAS03	C	R	1/18	Situational
CAS16	380	Quantity Description: Numeric value of quantity Industry: Adjustment Quantity HIPAA IG Note: Use this value for the quantity applied to the preceding reason code. See CAS04	C	R	1/15	Situational
CAS17	1034	Claim Adjustment Reason Code Description: Code identifying the detailed reason the adjustment was made Industry: Adjustment Reason Code HIPAA IG Note: See CAS02 ExternalCodeList Name: 139 Description: Claim Adjustment Reason Code	C	ID	1/5	Situational
CAS18	782	Monetary Amount Description: Monetary amount Industry: Adjustment Amount HIPAA IG Note: Use this amount for the charges applied to the preceding reason code. See CAS03	C	R	1/18	Situational
CAS19	380	Quantity Description: Numeric value of quantity Industry: Adjustment Quantity HIPAA IG Note: Use this value for the quantity applied to the preceding reason code. See CAS04	C	R	1/15	Situational

DTP Service Adjudication Date

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

User Option (Usage): Situational

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

Notes:

1. This segment is required when Service line adjudication has been performed.

Example:

DTP*573*D8*19981226~

NYS MEDICAID NOTE:

NYSDOH will ignore data when provided.

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
DTP01	374	Date/Time Qualifier Description: Code specifying type of date or time, or both date and time Industry: Date Time Qualifier	M	ID	3/3	Required
		Code Name 573 Date Claim Paid				
DTP02	1250	Date Time Period Format Qualifier Description: Code indicating the date format, time format, or date and time format Industry: Date Time Qualifier	M	ID	2/3	Required
		Code Name D8 Date Expressed in Format CCYYMMDD				
DTP03	1251	Date Time Period Description: Expression of a date, a time, or range of dates, times or dates and times Industry: Service Adjudication or Payment Date	M	AN	1/35	Required

HL Patient Hierarchical Level

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

User Option (Usage): Situational

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

Notes:

1. This HL is required when the patient is a different person than the subscriber. There are no HL's subordinate to the Patient HL.
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 nomenclature.
3. Receiving trading partners may have system limitations regarding the size of the transmission they can receive. The developers of this implementation guide recommend that trading partners limit the size of the transaction (ST-SE envelope) to a maximum of 5000 CLM segments. While the implementation guide sets no specific limit to the number of Patient Hierarchical Level loops, there is an implied maximum of 5000.

Example:

HL*125*124*23*0~

NYS MEDICAID NOTE:

NYSDOH will reject any claim that reports the Patient HL segment. 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.

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
HL01	628	Hierarchical ID Number Description: A unique number assigned by the sender to identify a particular data segment in a hierarchical structure	M	AN	1/12	Required
HL02	734	Hierarchical Parent ID Number Description: Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to	O	AN	1/12	Required
HL03	735	Hierarchical Level Code Description: Code defining the characteristic of a level in a hierarchical structure	M	ID	1/2	Required
		Code Name 23 Dependent Description: Identifies the individual who is affiliated with the subscriber, such as spouse, child, etc., and therefore may be entitled to benefits				
HL04	736	Hierarchical Child Code Description: Code indicating if there are hierarchical child data segments subordinate to the level being described HIPAA IG Note: The claim loop (Loop ID-2300) can be used only when HL04 has no subordinate levels (HL04 = 0).	O	ID	1/1	Required
		Code Name 0 No Subordinate HL Segment in This Hierarchical Structure.				

SE Transaction Set Trailer

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

User Option (Usage): Required

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

Example:

SE*1230*987654~

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
SE01	96	Number of Included Segments Description: Total number of segments included in a transaction set including ST and SE segments Industry: Transaction Segment Count	M	N0	1/10	Required
SE02	329	Transaction Set Control Number Description: Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set HIPAA IG Note: SE02 must match ST02.	M	AN	4/9	Required