



837 Health Care Claim Companion Guide Professional and Institutional

Version 1.9
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<p>Version 1.1 Published April 24, 2003 Changes were made to the Provider Secondary Reference Identification Qualifiers on the following pages: Page 19 Loop 2010AA, REF01 and REF02 Page 20 Loop 2010AB, REF01 and REF02 Page 24 Loop 2310B, REF01 Page 29 Loop 2010AB, REF01 and REF02 Page 33 Loop 2310A, REF01 and REF02 Change was made to the 837 Professional Identification Code Qualifier on page 23, Loop 2310A, NM108</p> <p>Change was made to the 837 Institutional Claim Frequency Type Code on page 31, Loop 2300, CLM05-3</p>
<p>Version 1.2 Published May 12, 2003 Changes were made to the Functional Group Header Version/Release Industry ID Code on page 15, GS08</p> <p>Referring Provider Secondary Identification segment was added on page 23, Loop 2310A, REF01 and REF02</p> <p>Changes were made to the Rendering Provider Secondary Reference Identification Qualifiers on page 24, Loop 2310B, REF01 and REF02</p>
<p>Version 1.3 Published May 13, 2003 Changes were made to the Interchange ID Qualifier and the Interchange Receiver ID on page 10, ISA07 and ISA08</p> <p>Changes were made to the Receiver Primary Identifier on page 19 and 28, NM109</p> <p>Changes were made to the Payer Identifier on page 22 and 30, NM109</p>
<p>Version 1.4 Published June 18, 2003 Changes were made to the Telecommunication Specifications on page 6.</p>
<p>Version 1.5 Published October 7, 2003 Added rows to indicate comments regarding procedure modifiers on page 26 and 35.</p>
<p>Version 1.6 Published November 12, 2003 Since the 837 Professional Implementation Guide Addendum indicates no valid codes to be used for the field "Claim Frequency Type Code", the requirements for CLM05-3 have been removed. The indication for original claim number for resubmitted claims has also been modified so that there is no reference to CLM05-3.</p>
<p>Version 1.7 Published November 24, 2003 Instructions to provide whole number unit values were added to the document.</p>
<p>Version 1.8 Published May 18, 2005 Removed requirements to provide a date span (RD8) at the claim line level (2400 loop) for institutional claims has been removed. Date span or a single date may be provided on the claim line. Removed: "Use 'RD8' to specify a range of dates. The from and thru service dates should be sent for each service line."</p>
<p>Version 1.9 Published August 8, 2006 New logo added. Text reformatted. URLs verified and updated Updated EDI Test file requirements for all users using both EDI Claims Link and 3rd party software</p>

INTRODUCTION

In an effort to reduce the administrative costs of health care across the nation, the Health Insurance Portability and Accountability Act (HIPAA) was passed in 1996. This legislation requires that health insurance payers in the United States comply with the electronic data interchange (EDI) standards for health care, established by the Secretary of Health and Human Services (HHS). For the health care industry to achieve the potential administrative cost savings with EDI, standard transactions and code sets have been developed and need to be implemented consistently by all organizations involved in the electronic exchange of data. The ANSI X12N 837 Health Care Claims transaction implementation guides provide the standardized data requirements to be implemented for all health care claim electronic submissions.

HIPAA does not require that a provider submit health care claims electronically. Providers may continue to submit paper claims and receive a paper remittance advice. However, if the provider elects to conduct business electronically, HIPAA does mandate the use of the standard transactions and code sets.

PURPOSE

The purpose of this document is to provide the information necessary to submit claims/encounters electronically to ValueOptions, Inc. This companion guide is to be used in conjunction with the ANSI X12N implementation guides. The information describes specific requirements for processing data within the payer's system. The companion guide supplements, but does not contradict or replace any requirements in the implementation guide. The implementation guides can be obtained from the Washington Publishing Company by calling 1-800-972-4334 or are available for download on their web site at <http://www.wpcedi.com/hipaa/>. Other important websites:

Workgroup for Electronic Data Interchange (WEDI) – <http://www.wedi.org>
United States Department of Health and Human Services (DHHS) – <http://aspe.hhs.gov/>
Centers for Medicare and Medicaid Services (CMS) – <http://www.cms.gov/hipaa/hipaa2/>
Designated Standard Maintenance Organizations (DSMO) – <http://www.hipaa-dsmo.org/>
National Council of Prescription Drug Programs (NCPDP) – <http://www.ncdp.org/>
National Uniform Billing Committee (NUBC) – <http://www.nubc.org/>
Accredited Standards Committee (ASC X12) – <http://www.x12.org/>

SPECIAL CONSIDERATIONS

Inbound Transactions Supported

This section is intended to identify the type and version of the ASC X12 837 Health Care Claim transaction that the health plan will accept.

- 837 Professional Health Care Claim - **ASC X12N 837 (004010X098A1)**
- 837 Institutional Health Care Claim - **ASC X12N 837 (004010X096A1)**
- 837 Dental Health Care Claim - **ASC X12N 837 (004010X097A1)**

Response Transactions Supported

This section is intended to identify the response transactions supported by the health plan.

- TA1 Interchange Acknowledgement
- 997 Functional Acknowledgement
- 835 Health Care Claim Payment Advice - **ASC X12N 835 (004010X091A1)**

Delimiters Supported

A delimiter is a character used to separate two data elements or sub-elements, or to terminate a segment. Delimiters are specified in the interchange header segment, ISA. The ISA segment is a 105 byte fixed length record. The data element separator is byte number 4; the component element separator is byte number 105; and the segment terminator is the byte that immediately follows the component element separator. Once specified in the interchange header, delimiters are not to be used in a data element value elsewhere in the transaction.

Description	Default Delimiter
Data element separator	* Asterisk
Sub-element separator	: Colon
Segment Terminator	~ Tilde

ValueOptions will support these default delimiters or any delimiter specified by the trading partner in the ISA/IEA envelope structure.

Maximum Limitations

The 837 transaction is designed to transmit one or more claims for each billing provider. The hierarchy of the looping structure is billing provider, subscriber, patient, claim level, and claim service line level. Each transaction set contains groups of logically related data in units called segments. The number of times a loop or segment may repeat in the transaction set structure is defined in the implementation guide. Some of these limitations are explicit, such as:

- The Claim Information loop (2300) is limited to 100 claims per patient.
- The Service Line loop (2400) is limited to 50 service lines per professional and/or dental claim, and 999 per institutional claim.

However, some limitations are not explicitly defined. The developers of the implementation guide recommend that trading partners limit the size of the transaction (ST/SE envelope) to a maximum of 5000 claims per transaction set.

ValueOptions has no file size limitations. The Interchange Control structure (ISA/IEA envelope) will be treated as one file. Each Interchange Control structure may consist of multiple Functional Groups (GS/GE envelopes). ValueOptions requires that the Interchange Control structure is limited to one type of Functional Group, such as 837 Health Care Claim and that Institutional and Professional functional groups be submitted in separate Interchange Control structures (ISA/IEA envelopes).

Note: If submitting both encounter and claim transactions these too must be sent in separate Interchange Control structures (ISA/IEA envelopes).

ValueOptions will validate and accept or reject the entire Interchange Control structure (ISA/IEA envelope).

Telecommunication Specifications

Trading partners wishing to submit electronic Health Care Claims (837 transactions) to ValueOptions must have a valid ValueOptions Submitter ID/Password. If you do not have a Submitter ID you may obtain one by completing the Account Request form available on the ValueOptions website at <http://www.valueoptions.com/provider/handbooks/forms.htm>

ValueOptions can accommodate multiple submission methods for the 837 Health Care Claim transaction. Please refer to the ETS (Electronic Transport System) Electronic Data Exchange Overview document on the ValueOptions website at <http://www.valueoptions.com/provider/compliance.htm> for further details.

If you have any questions please contact the ValueOptions EDI help desk.

E-mail: e-supportservices@valueoptions.com
Telephone: 888-247-9311
FAX: 866-698-6032

Compliance Testing Specifications

The Workgroup for Electronic Data Interchange (WEDI) and the Strategic National Implementation Process (SNIP) have recommended seven types HIPAA compliance testing, these are:

1. Integrity Testing – This is testing the basic syntax and integrity of the EDI transmission to include: valid segments, segment order, element attributes, numeric values in numeric data elements, X12 syntax and compliance with X12 rules.
2. Requirement Testing – This is testing for HIPAA Implementation Guide specific syntax such as repeat counts, qualifiers, codes, elements and segments. Also testing for required or intra-segment situational data elements and non-medical code sets whose values are noted in the guide via a code list or table.
3. Balance Testing – This is testing the transaction for balanced totals, financial balancing of claims or remittance advice and balancing of summary fields.
4. Situational Testing – This is testing of inter-segment situations and validation of situational fields based on rules in the Implementation Guide.
5. External Code Set Testing – This is testing of external code sets and tables specified within the Implementation Guide. This testing not only validates the code value but also verifies that the usage is appropriate for the particular transaction.
6. Product Type or Line of Service Testing – This is testing that the segments and elements required for certain health care services are present and formatted correctly. This type of testing only applies to a trading partner candidate that conducts the specific line of business or product type.

7. Implementation Guide-Specific Trading Partners Testing – This is testing of HIPAA requirements that pertain to specific trading partners such as Medicare, Medicaid and Indian Health. Compliance testing with these payer specific requirements is not required from all trading partners. If the trading partner intends to exchange transactions with one of these special payers, this type of testing is required.

The WEDI/SNP white paper on Transaction Compliance and Certification and other white papers are found at <http://www.wedi.org/snip/public/articles/index.shtml>.

ValueOptions' Recommendations:

- If you currently use ValueOptions' EDI Claims Link for Windows® (ECLW)

ValueOptions' has obtained certification from Claredi™, the certifying agency selected by Centers for Medicare and Medicaid Services (CMS). There is no need to recertify the software prior to testing with ValueOptions; however, you will still need to submit a test file and contact the ValueOptions EDI Helpdesk before submitting production files.

- If you currently use a Practice Management System (PMS) that is not HIPAA-Certified

According to the Centers for Medicare and Medicaid Services (CMS), you are responsible for ensuring that your EDI transactions are conducted in compliance with HIPAA regulations. In an effort to help you address your HIPAA EDI obligations as efficiently as possible, we recommend Claredi™, the nation's leading provider of HIPAA transaction and code set testing and certification. Claredi is an independent certifying agency, and the only testing and certification entity selected by CMS for their own compliance. As an additional benefit, using the same certification organization as ValueOptions greatly reduces the potential for any future discrepancies with transactions.

Trading Partner Acceptance Testing Specifications

Trading partners using ValueOptions' EDI Claims Link to generate their 837-transaction file are also required to submit a test file. They may begin submitting production files as soon as they have submitted a test file and contacted the ValueOptions EDI Helpdesk.

Other trading partners wishing to submit claims electronically to ValueOptions, must first submit an error free test file and receive verification from ValueOptions that the file loaded correctly, prior to submitting a production file for processing.

To submit a test file you must obtain an ID & Password from the ValueOptions EDI help desk. Please contact them via e-mail at e-supportservices@valueoptions.com or by calling 888-247-9311.

ValueOptions' Electronic Transport System (ETS) will validate the test file. The entire file will either pass (accept) or fail (reject) validation. ETS does not allow partial file submissions. Submitters will be notified via e-mail as to the results of the ETS validation. If your file failed validation, the message will provide explanations for the failure. Any error message you do not understand can be explained thoroughly by a ValueOptions EDI specialist.

Helpful Hint: Create small batches of test claims to ensure that you will not have to re-create too many claims in the event of an error in the file. Once your files are received and verified to be error-free, you may send files of any size.

After receiving notification that your test batch has passed validation, contact the EDI Help Desk to switch your account into live mode. Provide your submitter ID and the ValueOptions file

tracking number (if available). EDI services will work with the claim's department to ensure that the file uploads properly and gets all the way through the system.

Provider Billing Requirements

The 837 Health Care Claim transaction provides a large amount of provider data at both the claim level and the service line level. ValueOptions' claim adjudication system only utilizes the provider data present at the claim level. Much of the provider data is situational and must be provided if the condition is met. Such as, the referring provider is required when a referral has been made, or the attending provider (institutional claim) is required when the claim is for an inpatient stay.

The Billing/Pay-To loop (2000A) is a required loop. At a minimum the transaction must have a billing provider. The pay-to, rendering (professional claim) or service facility loops are dependent upon what is entered in the billing loop.

- **Billing Provider Name loop (2010AA)** - is a required loop used to identify the original entity that submitted the electronic claim/encounter. The billing provider entity may be a health care provider, a billing service or some other representative of the provider.
- **Pay-To Provider Name loop (2010AB)** - is a situational loop, required if the pay-to provider is a different entity from the billing provider.
- **Rendering Provider Name loop (2310B)** – PROFESSIONAL ONLY is a situational loop, required if the rendering provider information is different than that carried in either the billing provider or pay-to provider (2010AA/AB) loops

Depending on the scenario one or more of the previously mentioned loops might be present in the 837 Health Care Claim transaction. Refer to the scenarios below to determine the loops to be included in your transaction.

Billing Agent Scenario: (Professional or Institutional Claims)

In this scenario the provider, provider group or facility (institutional claims) contracts with a billing agent to perform their billing and reconciliation functions. In this case the following information should be provided:

- Billing Provider Name loop (2010AA) – this loop will contain the billing agent information.
- Pay-To Provider Name (2010AB) – this loop will contain the provider, provider group or facility (institutional claims) information. The entity receiving payment for the claim.
- Rendering Provider Name loop (2310B) – PROFESSIONAL CLAIMS. This loop will only be included if the rendering provider is different from the pay-to provider.

Provider Group Scenario: (Professional Claims)

In this scenario the provider, who performed the services, is a member of a group. In this case the following information should be provided:

- Billing Provider Name loop (2010AA) – this loop will contain the provider group information.
- Pay-To Provider Name loop (2010AB) – this loop will be included if payment is being made to the rendering provider and not the group. It will contain the rendering provider information.

- Rendering Provider Name loop (2310B) – this loop will only be included if the provider group is being paid for the claim (the pay-to provider loop (2010AB) is not included in the transaction). The rendering provider information will be provided in this loop.

Individual Provider Scenario: (Professional Claims)

In this scenario the provider is submitting the claim for payment. In this case the following information should be provided:

- Billing Provider Name loop (2010AA) – this loop will contain the rendering provider information.
- Pay-To Provider Name loop (2010AB) – this loop will not be included.
- Rendering Provider Name loop (2310B) – this loop will not be included.

Service Facility Scenario: (Institutional Claims)

In this scenario the facility is submitting the claim for payment. In this case the following information should be provided:

- Billing Provider Name loop (2010AA) – this loop will contain the facility information.
- Pay-To Provider Name loop (2010AB) – this loop will not be included.

Note: If a clearinghouse is employed to format and transmit the 837 transaction, the clearinghouse information should be sent in the Submitter Name loop (1000A).

INTERCHANGE CONTROL HEADER SPECIFICATIONS

Seg	Data Element	Name	Usage	Comments	Expected Value
ISA		Interchange Control Header	R	HEADER	
	ISA01	Authorization Information Qualifier	R	Valid values: '00' No Authorization Information Present '03' Additional Data Identification	Use '03' Additional Data Identification to indicate that a login ID will be present in ISA02.
	ISA02	Authorization Information	R	Information used for authorization.	Use the ValueOptions submitter ID as the login ID. Maximum 10 characters.
	ISA03	Security Information Qualifier	R	Valid values: '00' No Security Information Present '01' Password	Use '01' Password to indicate that a password will be present in ISA04.
	ISA04	Security Information	R	Additional security information identifying the sender.	Use the ValueOptions submitter ID password. Maximum 10 characters.
	ISA05	Interchange ID Qualifier	R		Refer to the implementation guide for a list of valid qualifiers.
	ISA06	Interchange Sender ID	R		Refer to the implementation guide specifications.
	ISA07	Interchange ID Qualifier	R		Use 'ZZ' Mutually Defined.
	ISA08	Interchange Receiver ID	R		Use 'FHC &Affiliates'.

Seg	Data Element	Name	Usage	Comments	Expected Value
	ISA09	Interchange Date	R	Date format YYMMDD.	The date (ISA09) is expected to be no more than seven days before the file is received. Any date that does not meet this criterion may cause the file to be rejected.
	ISA10	Interchange Time	R	Time format HHMM.	Refer to the implementation guide specifications.
	ISA11	Interchange Control Standards Identifier	R	Code to identify the agency responsible for the control standard used by the message. Valid value: 'U' U.S. EDI Community of ASC X12	Use the value specified in the implementation guide.
	ISA12	Interchange Control Version Number	R	Valid value: '00401' Draft Standards for Trial Use Approved for Publication by ASC X12 Procedures Review Board through October 1997	Use the current standard approved for the ISA/IEA envelope. Other standards will not be accepted.
	ISA13	Interchange Control Number	R	The interchange control number in ISA13 must be identical to the associated interchange trailer IEA02.	This value is defined by the sender's system. If the sender does not wish to define a unique identifier zero fill this element.
	ISA14	Acknowledgement Requested	R	This pertains to the TA1 acknowledgement. Valid values: '0' No Acknowledgement Requested '1' Interchange Acknowledgement Requested	Use '0' No Acknowledgement Requested. ValueOptions will not be generating the TA1 Interchange Acknowledgement or the 997 Functional Acknowledgement.
	ISA15	Usage Indicator	R	Valid values: 'P' Production 'T' Test	The Usage Indicator should be set appropriately. The value in this element will be verified against the accounts "test" status in ETS and rejected if they do not match.

Seg	Data Element	Name	Usage	Comments	Expected Value
	ISA16	Component Element Separator	R	The delimiter must be a unique character not found in any of the data included in the transaction set. This element contains the delimiter that will be used to separate component data elements within a composite data structure. This value must be different from the data element separator and the segment terminator.	ValueOptions will accept any delimiter specified by the sender. The uniqueness of each delimiter will be verified.

INTERCHANGE CONTROL TRAILER SPECIFICATIONS

Seg	Data Element	Name	Usage	Comments	Expected Value
TRAILER					
IEA		Interchange Control Trailer	R		
	IEA01	Number of Included Functional Groups		Count the number of functional groups in the interchange	Multiple functional groups may be present in one ISA/IEA envelope. This is the count of the GS/GE functional groups included in the interchange structure. Limit the ISA/IEA envelope to one type of functional group i.e. functional identifier code 'HC' Health Care Claim (837). Segregate professional and institutional functional groups into separate ISA/IEA envelopes.
	IEA02	Interchange Control Number		The interchange control number in IEA02 must be identical to the associated interchange header value sent in ISA13.	The interchange control number in IEA02 will be compared to the number sent in ISA13. If the numbers do not match the file will be rejected.

FUNCTIONAL GROUP HEADER SPECIFICATIONS

Seg	Data Element	Name	Usage	Comments	Expected Value
HEADER					
GS		Functional Group Header	R		
	GS01	Functional Identifier Code	R	Code identifying a group of application related transaction sets. Valid value: 'HC' Health Care Claim (837)	Use the value specified in the implementation guide.
	GS02	Application Sender's Code	R		The sender defines this value. ValueOptions will not be validating this value.
	GS03	Application Receiver's Code	R		This field will identify how the file is received by ValueOptions. Use 'EDI' for electronic transfer 'MAGMEDIA' for magnetic media such as tape or diskette.
	GS04	Date	R	Date format CCYYMMDD	Refer to the implementation guide for specifics.
	GS05	Time	R	Time format HHMM	Refer to the implementation guide for specifics.
	GS06	Group Control Number	R	The group control number in GS06, must be identical to the associated group trailer GE02.	This value is defined by the sender's system. If ValueOptions eventually implements the 997, this number will be used to identify the functional group being acknowledged.

Seg	Data Element	Name	Usage	Comments	Expected Value
	GS07	Responsible Agency Code	R	Code identifying the issuer of the standard. Valid value: 'X' Accredited Standards Committee X12	Use the value specified in the implementation guide.
	GS08	Version/Release Industry ID Code	R	Valid value: Professional Addenda Approved for Publication by ASC X12. '004010X098A1' Institutional Addenda Approved for Publication by ASCX12. '004010X096A1'	Use the current standard approved for publication by ASC X12. Other standards will not be accepted.

FUNCTIONAL GROUP TRAILER SPECIFICATIONS

Seg	Data Element	Name	Usage	Comments	Expected Value
GE		Functional Group Trailer	R	TRAILER	
	GE01	Number of Transaction Sets Included	R	Count of the number of transaction sets in the functional group.	Multiple transaction sets may be sent in one GS/GE functional group. Only similar transaction sets may be included in the functional group.
	GE02	Group Control Number	R	The group control number in GE02 must be identical to the associated functional group header value sent in GS06.	The group control number in GE02 will be compared to the number sent in GS06. If the numbers do not match the entire file will be rejected.

837 PROFESSIONAL CLAIM TRANSACTION SPECIFICATIONS

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Seg	Data Element	Name	Usage	Comments	Expected Value
HEADER					
BHT		Beginning of Hierarchical Transaction	R		
	BHT02	Transaction Set Purpose Code	R	Valid values: '00' Original '18' Reissue Case where the transmission was interrupted and the receiver requests that the batch be sent again.	Use '00' Original
	BHT06	Transaction Type Code	R	Although this element is required, submitters are not necessarily required to accurately batch claims and encouters at this level. Generally CH is used for claims and RP is used for encouters. However, if an ST-SE envelope contains both claims and encouters use CH. Some trading partner agreements may specify using only one code.	Separate claim and encouter data into two separate ISA/IEA envelopes (files). Use 'CH' for claims and 'RP' for encouters.
REF		Transmission Type Identification	R		
	REF02	Transmission Type Code	R	The element contains the version number.	Use '004010X098A1' for Production transaction sets. Use "004010X098DA1" for Test transaction sets.
LOOP 1000A – SUBMITTER NAME					
NM1		Submitter Name	R		
	NM109	Submitter Primary Identifier	R	This element contains the Electronic Transaction Identifier Number (ETIN).	Use the ValueOptions assigned submitter ID Maximum 10 characters.
Loop 1000B					
NM1		Receiver Name	R		
	NM102	Receiver Name	R		Use 'ValueOptions, Inc'
	NM109	Receiver Primary Identifier	R	This element contains the Electronic Transaction Identifier Number (ETIN).	Use 'FHC &Affiliates'

Seg	Data Element	Name	Usage	Comments	Expected Value
REF		Billing Provider Secondary Identification	R	<p>LOOP 2010AA – BILLING PROVIDER NAME</p> <p>Required when a secondary identification number is necessary to identify the entity. The primary identification number should be carried in NM108/09 in this loop.</p> <p>See implementation guide for list of valid qualifiers.</p>	<p>The Billing Provider Secondary ID is required by ValueOptions only when the Billing Provider is the Pay-To Provider (Loop 2010AB) is not sent.</p> <p>Use: 'LU' Location (ValueOptions practice location vendor # 'G2' Provider commercial number (ValueOptions Provider #) '1D' Medicaid Provider # (State assigned #)</p>
	REF01	Reference Identification Qualifier	R		
	REF02	Billing Provider Additional Identifier	R	Multiple iterations of this segment may be sent	<p>For most clients this element should contain the ValueOptions Vendor # (LU). If this loop contains the rendering provider information, <u>both</u> the vendor number (LU) and the provider number (G2) are required.</p> <p>For use of the '1D' qualifier and other client specific requirements, please refer to the ValueOptions website at http://www.valueoptions.com/provider/compliance/know_your_HIPAA_claims.htm</p>

Seg	Data Element	Name	Usage	Comments	Expected Value
REF		Pay-To Provider Secondary Identification	S	LOOP 2010AB – PAY-TO PROVIDER NAME	The Pay-To-Provider Secondary ID is always required by ValueOptions, if the Pay-To Loop 2010AB is sent.
	REF01	Reference Identification Qualifier	R	Required when a secondary identification is necessary to identify the entity. The primary identification number should be carried in NM108/09 in this loop. See implementation guide for list of valid qualifiers.	Use: 'LU' Location (ValueOptions practice location vendor # 'G2' Provider commercial number (ValueOptions Provider #) '1D' Medicaid Provider # (State assigned #)
	REF02	Pay-To-Provider Additional Identifier	R	Multiple iterations of this segment may be sent	For most clients this element should contain the ValueOptions Vendor # (LU). If this loop contains the rendering provider information, both the vendor number (LU) and the provider number (G2) are required. For use of the '1D' qualifier and other client specific requirements, please refer to the ValueOptions website at http://www.valueoptions.com/provider/compliance/know_your_HIPAA_claims.htm

Seg	Data Element	Name	Usage	Comments	Expected Value
NM1		Subscriber Name	R		
	NM108	Identification Code Qualifier	S	Required if the subscriber is a person (NM102 = 1). Required if the subscriber is the patient. If the subscriber is not the patient, use if known. An identifier must be present in either the subscriber or the patient loop. Valid values: 'M' Member Identification Number 'ZZ' Mutually Defined HIPAA Individual Identifier (once adopted)	Use 'M' Member Identification Number
	NM109	Subscriber Primary Identifier	S		Use the ValueOptions Subscriber ID. *Note: If this is a Medicaid Encounter transaction, use the member's Medicaid ID instead of the ValueOptions Subscriber ID.
LOOP 2010BB – PAYER NAME					
NM1		Payer Name	R		
	NM103	Payer Name	R	Destination payer name	Use 'FHC &Affiliates'
	NM108	Identification Code Qualifier	R	Valid values: 'P' Payer Identification 'XV' HCFA Plan ID (when mandated)	Use 'P' Payer Identifier' until the National Plan ID is mandated. Use 'FHC &Affiliates'
	NM109	Payer Identifier	R	Destination payer identifier	
LOOP 2010CA – PATIENT NAME					
NM1		Patient Name	R		
	NM108	Identification Code Qualifier	S	Required if the patient identifier is different than the subscriber identifier. Valid values: 'M' Member Identification Number 'ZZ' Mutually Defined HIPAA Individual Identifier (once adopted)	Use 'M' Member Identification number

Seg	Data Element	Name	Usage	Comments	Expected Value
	NM109	Patient Primary Identifier	S		Use the ValueOptions Member ID
LOOP 2300 – CLAIM INFORMATION					
PWK		Claim Supplemental Information	S		
	PWK02	Attachement Transmission Code	R	Valid values: 'AA' Available on Request at Provider Site 'BM' By Mail 'EL' Electronic Only 'EM' E-mail 'FX' By FAX	Use 'AA' Available on Request at Provider Site
REF		Original Reference Number (ICN/DCN)	S		
	REF02	Original Reference Number (ICN/DCN)			If this is a correction to a previously submitted claim use the ValueOptions claim number prefixed by an 'RC'.
LOOP 2310A – REFERRING PROVIDER NAME					
NM1		Referring Provider Name	S		
	NM108	Referring Provider Code Qualifier	S	Valid values: '24' Employer's Identification Number '34' Social Security Number 'XX' National Provider Identifier (required when mandated).	Use '24' Employer's Identification Number or use '34' SSN
	NM109	Referring Provider Identification Code	S		Use the Tax ID of the referring provider.
REF		Referring Provider Secondary Identification	S		This segment is required by ValueOptions to identify the provider.
	REF01	Referring Provider Secondary Identification Qualifier	R	Required if NM108/09 in this loop is not used or if a secondary number is necessary to identify the provider. Until the NPI is mandated for use, this REF may be required if necessary to adjudicate the claim. See implementation guide for list of valid qualifiers.	Use: '1D' Medicaid Provider Number (State assigned #)
	REF02	Referring Provider Secondary Identifier			For use of the '1D' qualifier and other client specific requirements, please refer to the ValueOptions website at

Seg	Data Element	Name	Usage	Comments	Expected Value
LOOP 2310B – RENDERING PROVIDER NAME					
REF		Rendering Provider Secondary Identification	S		This segment is required by ValueOptions to identify the provider.
	REF01	Reference Identification Qualifier	R	Required when a secondary identification number is necessary to identify the entity. The primary identification number should be carried in NM108/09 in this loop. See implementation guide for list of valid qualifiers.	Use: 'G2' Provider Commercial Number. (ValueOptions Provider #) '1D' Medicaid Provider Number (State assigned #)
	REF02	Rendering Provider Secondary Identifier	R		For most clients this element should contain the ValueOptions Provider Number (G2). For use of the '1D' qualifier and other client specific requirements, please refer to the ValueOptions website at http://www.valueoptions.com/provider/compliance/know_your_HIPAA_claims.htm
LOOP 2400 – SERVICE LINE					
SV1		Professional Service	R		
	SV101	Composite Medical Procedure Identifier	R		

Seg	Data Element	Name	Usage	Comments	Expected Value
	SV101-1	Product/Service ID Qualifier	R	Valid values: 'HC' HCPCS codes 'IV' Home Infusion EDI Coalition Product/Service Code (not allowed for use under HIPAA) 'ZZ' Mutually Defined Jurisdictionally defined procedure and supply codes. (used for worker's comp claims)	Use 'HC' Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes.
	SV101-3 SV101-4 SV101-5 SV101-6	Procedure Modifier	S	Modifiers must be billed in the order they appear on the benefit grid.	
	SV104	Quantity	S		Use whole number unit values.
DTP		Date – Service Date	R		
	DTP02	Date Time Period Format Qualifier	R	Valid values: 'D8' Expressed in format CCYYMMDD 'RD8' Range of dates	Use 'RD8' to specify a range of dates. The from and through service dates should be sent for each service line.

**837 INSTITUTIONAL CLAIM
TRANSACTION
SPECIFICATIONS**

837 INSTITUTIONAL CLAIM TRANSACTION SPECIFICATIONS

Seg	Data Element	Name	Usage	Comments	Expected Value
HEADER					
BHT		Beginning of Hierarchal Transaction	R		
	BHT02	Transaction Set Purpose Code	R	Valid Values '00' Original '18' Reissue Case where the transmission was interrupted and the receiver requests that the batch be sent again.	Use '00' Original
	BHT06	Transaction Type Code	R	Although this element is required, submitters are not necessarily required to accurately batch claims and encounters at this level. Generally CH is used for claims and RP is used for encounters. However, if an ST-SE envelope contains both claims and encounters use CH. Some trading partner agreements may specify using only one code.	Separate claim and encounter data into two separate ISA/IEA envelopes (files). Use 'CH' for claims and 'RP' for encounters.
REF		Transmission Type Identification	R		
	REF02	Transmission Type Code	R	This element contains the version number.	Use '004010X096A1' for Production transaction sets. Use '004010X096DA1' for Test transaction sets.
LOOP 1000B – RECEIVER NAME					
NM1		Submitter Name	R		
	NM109	Submitter Primary Identifier	R	This element contains the Electronic Transaction Identifier Number (ETIN).	Use the ValueOptions assigned submitter ID. Maximum 10 characters.
NM1		Receiver Name	R		
	NM103	Receiver Name	R		Use 'ValueOptions, Inc.'
	NM109	Receiver Primary Identifier	R	This element contains the Electronic Transaction Identifier Number (ETIN).	Use 'FHC &Affiliates'

Seg	Data Element	Name	Usage	Comments	Expected Value
LOOP 2010AA – BILLING PROVIDER NAME					
REF		Billing Provider Secondary Identification	S		The Billing Provider Secondary ID is required by ValueOptions only when the Billing Provider is the Pay-To Provider (Loop 2010AB is not sent).
	REF01	Reference Identification Qualifier	R	Required when a secondary identification number is necessary to identify the entity. The primary identification number should be carried in NM108/09 in this loop. See implementation guide for list of valid values.	Use: 'LU' Location (ValueOptions Practice Location Vendor #) 'G2' Provider Commercial Number (ValueOptions Provider #) '1D' Medicaid Provider Number (State assigned #)
	REF02	Billing Provider Additional Identifier	R	Multiple iterations of this segment may be sent.	For most clients both the ValueOptions Vendor Number (LU) and the Provider Number (G2) are required. For use of the '1D' qualifier and other client specific requirements, please refer to the ValueOptions website at http://www.valueoptions.com/provider/compliance/know_your_HIPAA_claims.htm
LOOP 2010AB – PAY-TO PROVIDER NAME					
REF		Pay-To-Provider Secondary Identification	S		The Pay-To Provider Secondary ID is always required by ValueOptions, if the Pay-To Loop 2010AB is sent.
	REF01	Reference Identification Qualifier	R	Required when a secondary identification number is necessary to identify the entity. The primary identification number should be carried in NM108/09 in this loop. See implementation guide for list of valid values.	Use: 'LU' Location (ValueOptions Practice Location Vendor #) 'G2' Provider Commercial Number (ValueOptions Provider #) '1D' Medicaid Provider Number (State assigned #)
	REF02	Pay-To-Provider Additional Identifier	R	Multiple iterations of this segment may be sent.	For most clients both the ValueOptions Vendor Number (LU) and the Provider Number (G2) are required. For use of the '1D' qualifier and other

Seg	Data Element	Name	Usage	Comments	Expected Value
					client specific requirements, please refer to the ValueOptions website at http://www.valueoptions.com/provider/compliance/know_your_HIPAA_claims.htm
LOOP 2010BA – SUBSCRIBER NAME					
NM1		Subscriber Name	R		
	NM108	Subscriber Name Identification Code Qualifier	S	Required if the subscriber is a person (NM102 =1). Valid values: 'MI' Member Identification Number Mutually Defined 'ZZ' HIPAA Individual Identifier (once adopted)	
	NM109	Subscriber Primary Identifier	S		Use the ValueOptions Subscriber ID. *Note: If this is a Medicaid Encounter transaction, use the member's Medicaid ID instead of the ValueOptions Subscriber ID.
LOOP 2010BC – PAYER NAME					
NM1		Payer Name	R		
	NM103	Payer Name	R	Destination payer name.	Use 'ValueOptions, Inc.'
	NM108	Subscriber Name Identification Code Qualifier	R	Valid values: 'PI' Payor Identification 'XV' HCFA Plan ID (when mandated)	Use 'PI' Payer Identifier until the National Plan ID is mandated.
	NM019	Payer Identifier	R	Desintation payer identifier	Use 'FHC &Affiliates'
LOOP 2010CA - PATIENT NAME					
NM1		Patient Name	R		
	NM108	Patient Name Identification Code Qualifier	S	Required if the patientr identifier is different than the subscriber identifier. Valid values: 'MI' Member Identification Number Mutually Defined 'ZZ' HIPAA Individual Identifier (once adopted)	Use 'MI' Member Identification Number
	NM109	Patient Primary Identifier	S		Use the ValueOptions Member ID.

Seg	Data Element	Name	Usage	Comments	Expected Value
LOOP 2300 – CLAIM INFORMATION					
CLM		Claim Information	R		
	CLM05	Health Care Service Location Information	R		
	CLM05-3	Claim Frequency Type Code	R	UB-92 Type of Bill. Valid values: '1' Admit through Discharge Claim '2' Interim – First Claim '3' Interim – Continuing Claims '4' Interim – Last Claim '5' Late Charge Only	Use '1', '2', '3', '4', or '5'
	CLM18	Yes/No Condition or Response Code	R	This explanation of benefits indicator identifies whether a paper EOB is requested. Valid values: 'N' No 'Y' Yes	Use 'Y' Yes ValueOptions will always print a paper EOB to be sent to providers.
PWK		Claim Supplemental Information	S		
	PWK02	Attachment Transmission Code	R	Valid values: 'AA' Available on Request at Provider Site 'BM' By Mail 'EL' Electronic Only 'EM' E-mail 'FX' By FAX	Use 'AA' Available on Request at Provider Site.
REF		Original Reference Number (ICN/DCN)	S		
	REF02	Original Reference Number (ICN/DCN)	R	The control number assigned to the original bill by the payer to identify a unique claim.	If this is a correction to a previously submitted claim use the ValueOptions claim number prefixed by an 'RC'.
HI		Principal Procedure Information	S		
	HI01	Health Care Code Information	R		

Seg	Data Element	Name	Usage	Comments	Expected Value
	HI01-1	Code List Qualifier	R	Both HCPCS and ICD-9-CM codes may be sent in the procedure code field. Valid value: 'BP' Health Care Financing Administration Common Procedural Coding System 'BR' International Classification of Diseases Clinical Modification (ICD-9-CM) Principal Procedure	Use 'BP' Health Care Financing Administration Common Procedural Coding System Principal Procedure.
HI		Other Procedure Information	S		
	HI01	Health Care Code Information	R		
	HI01-1 to HI12-1	Code List Qualifier		Both HCPCS and ICD-9-CM codes may be sent in the procedure code field. Valid value: 'BO' Health Care Financing Administration Common Procedural Coding System 'BQ' International Classification of Diseases Clinical Modification (ICD-9-CM) Principal Procedure	Use 'BP' Health Care Financing Administration Common Procedural Coding System.
LOOP 2310A – ATTENDING PHYSICIAN NAME					
REF		Attending Physician Secondary Identification	S		The Attending Provider Secondary Identification is only required by ValueOptions for specific clients.
	REF01	Reference Identification Qualifier	R	Use this REF only when a second number is necessary to identify the provider. The primary identification must be contained in NM109. See implementation guide for list of valid qualifiers.	Use: 'OB' State License Number '1D' Medicaid Provider Number (State Assigned #)
	REF02	Attending Physician Secondary Identifier	R		For use of the 'OB' or '1D' qualifier and other client specific requirements, please refer to the ValueOptions website at http://www.valueoptions.com/provider/compliance/know_your_HIPAA_claims.htm

Seg	Data Element	Name	Usage	Comments	Expected Value
SV2		Institutional Service Line	R	LOOP 2400 – SERVICE LINE NUMBER	
	SV202	Composite Medical Procedure Identifier	S		
	SC202-1	Product/Service ID Qualifier	R	Valid values: 'HC' HCPCS codes 'IV' Home Infusion EDI Coalition Product/Service Code (not allowed for use under HIPAA) 'ZZ' Mutually Defined Jurisdictionally defined procedure and supply Codes.	Use 'HC' Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes.
	SV202-3 SV202-4 SC202-5 SV202-6	Procedure Modifier	S	Modifiers must be billed in the order they appear on the benefit grid.	
	SV205	Quantity	S		Use whole number unit values.
DTP		Date – Service Date	R		
	DTP02	Date Time Period Format Qualifier	R	Valid values: 'D8' Date expressed in format CCYYMMDD 'RD8' Range of dates	