837 Health Care Claim Companion Guide Professional and Institutional

Version 1.14
November 24, 2010

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Version 1.0 Original **Published April 1, 2003**
Version 1.1 Published **April 24, 2003** Changes were made to the Provider Secondary Reference Identification Qualifiers on the following: Loop 2010AA, REF01 and REF02 Loop 2010AB, REF01 and REF02 Loop 2310B, REF01 Loop 2010AB, REF01 and REF02 Loop 2310A, REF01 and REF02 Change was made to the 837 Professional Identification Code Qualifier, Loop 2310A, NM108 Change was made to the 837 Institutional Claim Frequency Type Code, Loop 2300, CLM05-3
Version 1.2 Published **May 12, 2003** Changes were made to the Functional Group Header Version/Release Industry ID Code on GS08 Referring Provider Secondary Identification segment was added on Loop 2310A, REF01 and REF02 Changes were made to the Rendering Provider Secondary Reference Identification Qualifiers on Loop 2310B, REF01 and REF02
Version 1.3 Published **May 13, 2003** Changes were made to the Interchange ID Qualifier and the Interchange Receiver ID on ISA07 and ISA08 Changes were made to the Receiver Primary Identifier on NM109 Changes were made to the Payer Identifier on NM109
Version 1.4 Published **June 18, 2003** Changes were made to the Telecommunication Specifications.
Version 1.5 Published **October 7, 2003** Added rows to indicate comments regarding procedure modifiers.
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.
Version 1.7 Published **November 24, 2003** Instructions to provide whole number unit values were added to the document.
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.”
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
Version 1.10 Published **April 23, 2007** Instructions added for the National Provider Identifier (NPI) requirements
Version 1.11 Published **September 22, 2008** Updated Provider requirements to remove references for legacy numbers.
Version 1.12 Published **November 20, 2008** Added required Dx segment.
Version 1.13 Published **September 17, 2009** Added requirement for Service Location on all Professional and Institutional claims Added 2310D, 2310E, and 2310A to billing requirements and scenarios Added COB fields
Version 1.14 Published **November 24, 2010** Added maximum value for ISA/IEA envelope

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.ncpdp.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:

- Maximum of **1 ISA/IEA envelope per 837 file**
- 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**.

The **maximum file size is 8MB**. 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/providers/Adminforms.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/providers/ProCompliance.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 (8am – 6pm Eastern, Monday – Friday)
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 to review your submission and update your account to production status.

- 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 production files.

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

National Provider Identifier Specifications

Beginning May 23, 2007, ValueOptions in accordance with the HIPAA mandate will require covered entities to submit electronic claims with the NPI and taxonomy codes in the appropriate locations. The NPI is a standard provider identifier that will replace the provider numbers used in standard electronic transactions today and was adopted as a provision of HIPAA. The NPI Final Rule was published on January 23, 2004 and applies to all health care providers.

ValueOptions requires that all covered entities report their NPI to ValueOptions prior to submitting electronic transactions containing a NPI. For additional information on how to report your NPI to ValueOptions or Frequently Asked Questions, please visit http://www.valueoptions.com/providers/npi/npi.htm or contact our National Provider Line at (800) 397-1630, Monday through Friday.

All electronic transactions for covered entities should contain the provider NPI, taxonomy code, employee identification number and zip code + the 4 digit postal code in the appropriate loops beginning May 23, 2007. The NPI should be sent in the NM109, where NM108 equals XX. The taxonomy code should be sent in the PRV03, employee identification number will be sent in the REF02 and the zip code + the 4 digit postal code should be sent in the N403 and N404.

For all non-healthcare providers where a NPI is not assigned, the claim must contain the ValueOptions provider number in the appropriate provider loops within the appropriate REF segment.

Prior to May 23, 2007, the ValueOptions provider number must be received in the 2010AA Billing Provider loop within the Billing Provider Secondary Information (REF) segment. If the REF segment is not received, the claim may not process correctly. If applicable, the REF segment must also be received in the 2010AB Pay-to-Provider, 2310A Referring Provider, or 2310B Rendering Provider. The claim may not process correctly if this type of REF segment is not received within these loops when applicable.

Additional information on NPI including how to apply for a NPI can be found on the Centers for Medicare and Medicaid Services (CMS) website at:
http://www.cms.hhs.gov/NationalProvIdentStand/

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), attending (institutional claims) 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.

- **Attending Provider Name loop (2310A)** – INSTITUTIONAL ONLY is a situational loop, required if the attending provider information is different than that carried in either the billing provider or pay-to provider (2010AA/AB) loops.

- **Service Facility Location (2310D on Professional claims. 2310E on Institutional Claims)** – is a required loop used to correlate along with 2010AA to identify the provider record. This must be the actual street address of where the services took place.

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.
- Attending Provider Name loop (2310A) – INSTITUTIONAL CLAIMS. This loops will only be included if the rendering provider is different from the pay-to-provider.
- Service Location loop (2310D on Professional claims. 2310E on Institutional Claims) – Required on all claims.

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 an entity other than the group in 2010AA.
- 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.
- Service Location loop (2310D) – Required on all claims.

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 billing 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 Location loop (2310D) – Required on all claims.

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 be included if payment is being made to an entity other than the group in 2010AA.
- Service Location loop (2310E) – Required on all claims

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**		
	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		Use 'ZZ' or Refer to the implementation guide for a list of valid qualifiers.
	ISA06	Interchange Sender ID	R		Usually Submitter ID out to 15 characters. 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. 'U'
	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. '00401'
	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. Out to 9 Characters.
	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. Either can used, Test mode is managed by the EDI Helpdesk.
	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	ValueOptions will accept any delimiter specified by the sender. The uniqueness of each delimiter will be verified.

Seg	Data Element	Name	Usage	Comments	Expected Value
				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.	':' (colon) usually

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 besent 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.
	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:	Use '004010X098A1'

Seg	Data Element	Name	Usage	Comments	Expected Value
				Professional Addenda Approved for Publication by ASC X12. '004010X098A1' Institutional Addenda Approved for Publication by ASCX12. '004010X096A1'	Other standards will not be accepted.

FUNCTIONAL GROUP TRAILER SPECIFICATIONS

Seg	Data Element	Name	Usage	Comments	Expected Value
TRAILER					
GE		**Functional Group Trailer**	**R**		
	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

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 be 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	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**		

Seg	Data Element	Name	Usage	Comments	Expected Value
	NM103	Receiver Name	R		Use 'ValueOptions, Inc'
	NM109	Receiver Primary Identifier	R	This element contains the Electronic Transaction Identifier Number (ETIN).	Use 'FHC &Affiliates'
LOOP 2010AA – BILLING PROVIDER NAME					
NM1		**Billing Provider Name**	**R**		
	NM108	Billing Provider Identification Code Qualifier	**R**		As of 5/23/07, covered entities must send 'XX' – NPI Qualifier, non-covered entities send '24' – Employer's Identification Number
	NM109	Billing Provider Identifier	**R**		As of 5/23/07, covered entities send the National Provider ID (NPI), a 10 digit number; non covered entities send Tax ID Number.
REF		**Billing Provider Secondary Identification**	**S**	When NPI is submitted in the NM108/09 of this loop, the either the EIN or SSN of the provider must be carried in this REF segment. The number sent is the one which be used on the 1099.	
	REF01	Reference Identification Qualifier	R		Place **EI** in REF01 if the Provider ID is EIN and place **SY** in REF01 if Provider ID is SSN and the associated submitted value in REF02.
	REF02	Billing Provider Additional Identifier	R		**EIN** or **SSN** of the billing provider.
LOOP 2010BA – SUBSCRIBER NAME					
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.	Use 'MI' Member Identification Number

Seg	Data Element	Name	Usage	Comments	Expected Value
				Valid values: 'MI' Member Identification Number 'ZZ' Mutually Defined HIPAA Individual Identifier (once adopted)	
	NM109	Subscriber Primary Identifier	S		Use the ValueOptions Subscriber ID. *Note: Maryland Medical Assistance Number or the ValueOptions Subscriber ID.
LOOP 2010BB – PAYER NAME					
NM1		**Payer Name**	**R**		
	NM103	Payer Name	R	Destination payer name	Use 'ValueOptions, Inc'
	NM108	Identification Code Qualifier	R	Valid values: 'PI' Payer Identification 'XV' HCFA Plan ID (when mandated)	Use 'PI' Payer Identifier' until the National Plan ID is mandated.
	NM109	Payer Identifier	R	Destination payer identifier	Use 'FHC &Affiliates'
LOOP 2300 – CLAIM INFORMATION					
CLM		**Claim Information**	**R**		
	CLM05-3	Claim Frequency Type Code	R	1 = Original 6 = Corrected 7 = Replacement 8 = Void	Record Action
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	Use 'AA' Available on Request at Provider Site

Seg	Data Element	Name	Usage	Comments	Expected Value
				'FX' By FAX	
REF		**Original Reference Number (ICN/DCN)**	**S**	**Required if Claim Frequency Type Code is 6, 7, or 8**	
	REF01	Reference Identification Qualifier	R		'F8' Original Reference Number
	REF02	Original Reference Number (ICN/DCN)	R		If this is a correction to a previously submitted claim use the ValueOptions claim number prefixed by an 'RC'. The **whole claim number without spaces or dashes.**
LOOP 2310A – REFERRING PROVIDER NAME					
NM1		**Referring Provider Name**	**S**		
	NM108	Identification Code Qualifier	S	Valid values: '24' Employer's Identification Number '34' Social Security Number 'XX' National Provider Identifier (required when mandated).	As of 5/23/07 use 'XX' – National Provider Identifier
	NM109	Identification Code	S		Use the NPI of the referring provider.
LOOP 2310B – RENDERING PROVIDER NAME					
REF		**Rendering Provider Name**	**S**		**This segment is required by ValueOptions to identify the provider when the rendering provider differs from the Billing Provider.**
	NM108	Rendering Provider Identification Code Qualifier	R		As of 5/23/07, covered entities must send 'XX' – NPI Qualifier, non-covered entities send '24' – Employer's Identification Number
		Rendering Provider Identifier	R	This element contains the NPI for the rendering provider.	As of 5/23/07, covered entities send the National Provider ID (NPI), a 10 digit number; non covered entities send Tax ID Number.
LOOP 2310D – SERVICE FACILITY LOCATION					
NM1		**Professional Service**	**R**		
	NM101	Entity Identifier Code	R		77= Service Location or FA= Facility
	NM102	Entity Type Qualifier	R		2= non-person entity
	NM103	Last Name or Organization Name	R		Last Name or Organization Name

Seg	Data Element	Name	Usage	Comments	Expected Value
	NM108	Identification Code Qualifier	R		Covered entities must send 'XX' as the NPI Qualifier, non-covered entities use qualifier '24'
	NM109	Identification Code	R		Covered entities send the National Provider ID (NPI), a 10 digit number; non covered entities send Tax ID Number.
N3		**Address Information**	**R**		
	N301	Address Line 1	R		Address Line 1
	N302	Address Line 2	R		Address Line 2
N4		**Consumer City/State/Zip Code**	R		
	N401	City Name	R		City Name
	N402	State	R		State
	N403	Postal Code	R		Zip Code
LOOP 2320 – COORDINATION OF BENEFITS (COB) OTHER PAYER INFORMATION					
SBR		**Subscriber Information**	**S**		
	SBR01	Payer responsibility	R	This loop is for OTHER PAYER ONLY, Do not use this loop if you have not submitted this claim previously to another payer.	P (Primary) S (Secondary) T (Tertiary)
	SBR02	Individual Relationship Code	R	See Implementation Guide for other values	18 = Self
	SBR03	Reference Identification	S		Group or Policy Number
	SBR04	Name	S	Free-form name	Other Insured Group Name
	SBR05	Insurance Type Code	R	See Implementation Guide for valid values	
	SBR06	Not Used			
	SBR07	Not Used			
	SBR08	Not Used			
	SBR09	Claim Filing Indicator		See Implementation Guide for valid values	
AMT		**COB Payer Paid Amount**	**R**		
	AMT01	Amount Qualifier	R		D
	AMT02	Monetary Amount	R		Amount Paid by the Other Payer

Seg	Data Element	Name	Usage	Comments	Expected Value
AMT		**COB Allowed Amount**	**R**		
	AMT01	Amount Qualifier	R		B6
	AMT02	Monetary Amount	R		Amount Paid by the Other Payer
AMT		**COB Patient Paid Amount**	**R**		
	AMT01	Amount Qualifier	R		F5
	AMT02	Monetary Amount	R		Amount Paid by the Other Payer
DMG		**Subscriber Demographic**	**R**		
	DMG01	Format Qualifier	R		D8
	DMG02	Date of Birth	R	Format YYYYMMDD	
	DMG03	Gender	R		M, F, U
OI		**Other Insurance Coverage Information**	**R**		
	OI03	Benefits Assignment	R		Y
	OI04	Patient Signature Source	S	See Implementation Guide for valid values	
	OI06	Release of Information Code	R	See Implementation Guide for valid values	
LOOP 2330A – SUBSCRIBER INFORMATION					
NM1			**S**	Required if Loop 2320 is present	
	NM101	Entity ID	R	Insured or Subscriber	IL
	NM102	Entity Type	R		1 = Person
	NM103	Last Name	R		
	NM104	First Name	S		
	NM105	Middle Name	S		
	NM107	Suffix	S		
	NM108	Identification Code	R		MI = Member Identification Number
	NM109	Identification Number			
N3		**Address**			
N4		**City*State*ZIP**			
LOOP 2330B – PAYER INFORMATION					
NM1		**Other Payer Name**	**R**		
	NM101	Entity Identifier	R		PR = Payer
	NM102	Entity Type	R		2 = Non-Person Entity

Seg	Data Element	Name	Usage	Comments	Expected Value
	NM103	Organization Name	R	Name of Payer (Other Insurance Company)	
	NM108	ID Code Qualifier	R		PI = Payer Identification
	NM109	Idnentification Code	R	Payer ID	
DTP		**Claim Adjudication Date**	**R**		
	DTP01	Date/Time Qualifier	R	Date Claim Paid	573
	DTP02	Format Qualifier	R		D8
	DTP03	Adjudication Date	R	YYYYMMDD	
LOOP 2400 – SERVICE LINE					
SV1		**Professional Service**	**R**		
	SV101	Composite Medical Procedure Identifier	R		
	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.
HI		**Health Care Diagnosis Code**	**R**		
	HI101-1	Code List Qualifier Code	R		BK - Principal Diagnosis
	HI101-2	Industry Code	R	Use ICD-9 standard Dx Code	
	HI102-1	Code List Qualifier Code	S		BF - Diagnosis
	HI102-2	Industry Code	S	Use ICD-9 standard Dx Code	

Seg	Data Element	Name	Usage	Comments	Expected Value
	HI103-1	Code List Qualifier Code	S		BF - Diagnosis
	HI103-2	Industry Code	S	Use ICD-9 standard Dx Code	
	HI104-1	Code List Qualifier Code	S		BF - Diagnosis
	HI104-2	Industry Code	S	Use ICD-9 standard Dx Code	
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.
LOOP 2430 – LINE ADJUDICATION INFORMATION					
SVD		**Professional Service**	**R**		
	SVD01	Payer ID	R	Payer Identification Code/Number	
	SVD02	Monetary Amount	R	Paid Amount	
	SVD03-1	Procedure Code/ID Qualifier	R		HC = HCPCS
	SVD03-2	Procedure Code/ID	R		
	SVD03-3 through 6	Modifiers	S		
	SVD06	Assigned Number	R	Number of Units Paid for by Other Payer	(Whole Units Only)

837 INSTITUTIONAL CLAIM TRANSACTION SPECIFICATIONS

Seg	Data Element	Name	Usage	Comments	Expected Value	Notes
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	Tranmission Type Code	**R**	This element contains the version number.	Use '004010X096A1' for Production transaction sets. Use '004010X096DA1' for Test transaction sets.	
LOOP 1000A						
NM1		**Submitter Name**	**R**			
	NM109	Submitter Primary Identifier	**R**	This element contains the Electronic Transaction Identifier Number (ETIN).	Use the ValueOptions assigned submitter ID. Maxiumum 10 characters.	

Seg	Data Element	Name	Usage	Comments	Expected Value	Notes
LOOP 1000B – RECEIVER NAME						
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'	
LOOP 2010AA – BILLING PROVIDER NAME						
NM1		**Billing Provider Name**	**R**			
	NM108	Billing Provider Identification Code Qualifier	**R**		As of 5/23/07, covered entities must send 'XX' – NPI Qualifier, non-covered entities send '24' – Employer's Identification Number	
	NM109	Billing Provider Identifier	**R**	This element contains the NPI for the Billing Provider.	As of 5/23/07, covered entities send the National Provider ID (NPI), a 10 digit number; non covered entities send Tax ID Number.	
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		Place EI in REF01 if the Provider ID is EIN and place SY in REF01 if Provider ID is SSN and the associated submitted value in REF02.	
	REF02	Billing Provider Additional Identifier	R		EIN or SSN of the billing provider.	
LOOP 2010AB – PAY-TO PROVIDER NAME						

Seg	Data Element	Name	Usage	Comments	Expected Value	Notes
REF		**Pay-To-Provider Name**	**S**		**The Pay-To Provider loop is required if the pay-to provider is a *different entity* from the billing provider.**	
	NM108	Pay-To Provider Identification Code Qualifier	**R**		As of 5/23/07, covered entities must send 'XX' – NPI Qualifier, non-covered entities send '24' – Employer's Identification Number	
	NM109	Pay To Provider Identifier	**R**	This element contains the NPI for the Pay-To Provider.	As of 5/23/07, covered entities send the National Provider ID (NPI), a 10 digit number; non covered entities send Tax ID Number.	
LOOP 2010BA – SUBSCRIBER NAME						
NM1		**Subscriber Name**	**R**			
	NM108	Identification Code Qualifier	**S**	Required if the subscriber is a person (NM102 =1). Valid values: 'MI' Member Identification Number 'ZZ' Mutually Defined HIPAA Individual Identifier (once adopted)	'MI'	
	NM109	Subscriber Primary Identifier	**S**		Use the ValueOptions Subscriber ID. *Note: Maryland Medical Assistance Number or the ValueOptions Subscriber ID.	
LOOP 2010BC – PAYER NAME						

Seg	Data Element	Name	Usage	Comments	Expected Value	Notes
NM1		**Payer Name**	**R**			
	NM103	Payer Name	**R**	Destination payer name.	Use 'ValueOptions, Inc.'	
	NM108	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	Identification Code Qualifier	**S**	Required if the patienr identifier is different than the subscriber identifier. Valid values: 'MI' Member Identification Number 'ZZ' Mutually Defined HIPAA Individual Identifier (once adopted)	Use 'MI' Member Identification Number	
	NM109	Patient Primary Identifier	**S**		Use the ValueOptions Member ID.	
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 '7' Replacement of Prior Claim '8' Void/Cancel Prior Claim	Use '1', '2', '3', '4', '5', '7', or '8'	
	CLM18	Yes/No Condition or Response Code	**R**	This explanation of benefits indicator identifies whether a paper EOB is requested.	Use 'Y' Yes ValueOptions will always print a paper	

Seg	Data Element	Name	Usage	Comments	Expected Value	Notes
				Valid values: 'N' No 'Y' Yes	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**	**Required if Claim Frequency Type Code is 7 or 8**		
	REF01	Reference Identification Qualifier	R		'F8' Original Reference Number	
	REF02	Original Reference Number (ICN/DCN)	R		If this is a correction to a previously submitted claim use the ValueOptions claim number prefixed by an 'RC'. The **whole claim number without spaces or dashes.**	
HI		**Principal Procedure Information**	**S**			
	HI01	Health Care Code Information	R			
	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	Use 'BP' Health Care Financing Administration Common Procedural Coding System Principal Procedure.	

Seg	Data Element	Name	Usage	Comments	Expected Value	Notes
				Administration Common Procedural Coding System Principal Procedure 'BR' International Classification of Diseases Clinical Modification (ICD-9-CM) Principal Procedure		
HI		**Other Procedure Information**	**R**			
	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 Principal Procedure '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 Name**	**S**		**The Attending Provider Secondary Identification is only required by ValueOptions for specific clients.**	
	NM108	Attending Provider Identification Code Qualifier	**R**		As of 5/23/07, covered entities must send 'XX' – NPI Qualifier, non-covered entities send '24' – Employer's Identification Number	
	NM109	Attending Identifier	**R**	This element contains the NPI for the Attending Provider.	As of 5/23/07, covered entities send the National Provider ID (NPI), a 10 digit number; non covered entities send Tax ID Number.	

Seg	Data Element	Name	Usage	Comments	Expected Value	Notes
LOOP 2310E – SERVICE FACILITY LOCATION						
Institutional Services			**R**			
	NM101	Entity Identifier Code	**R**		FA - Facility Location	
	NM102	Entity Type Qualifier	**R**		2 – Non-Person Entity	
	NM103	Last Name or Organization Name	**R**		Last Name or Organization Name	
	NM108	Identification Code Qualifier	**R**		Covered Entities must send 'XX' as the NPI Qualifier.	
	NM109	Identification Code	**R**		Covered entities send the National Provider ID (NPI)	
Address Information			**R**			
	N301	Address Line 1	**R**		Address Line 1	
	N302	Address Line 2	**S**		Address Line 2	
City/State/Zip Code			**R**			
	N401	City Name	**R**		City Name	
	N402	State	**R**		State	
	N403	Postal Code	**R**		Zip Code	
LOOP 2320 – COORDINATION OF BENEFITS (COB) OTHER PAYER INFORMATION						
SBR		**Subscriber Information**	**S**			
	SBR01	Payer responsibility	R	This loop is for OTHER PAYER ONLY, Do not use this loop if you have not submitted this claim previously to another payer.	P (Primary) S (Secondary) T (Tertiary)	
	SBR02	Individual Relationship Code	R	See Implementation Guide for other values	18 = Self	
	SBR03	Reference Identification	S		Group or Policy Number	
	SBR04	Name	S	Free-form name	Other Insured Group Name	
	SBR05	Not Used				
	SBR06	Not Used				
	SBR07	Not Used				
	SBR08	Not Used				
	SBR09	Claim Filing Indicator		See Implementation Guide for valid values		
CAS		**Patient Paid Amount**	**R**			
	CAS01	Claim Adjustment Group Code	R		PR	
	CAS02	Claim Adjustment Reason	R		3	

Seg	Data Element	Name	Usage	Comments		Expected Value	Notes
		Code					
	CAS03	Monetary Amount		R	Amount Patient Paid		
AMT		**COB Payer Paid Amount**		**R**			
	AMT01	Amount Qualifier		R		C4	
	AMT02	Monetary Amount		R		Amount Paid by the Other Payer	
AMT		**COB Allowed Amount**		**R**			
	AMT01	Amount Qualifier		R		B6	
	AMT02	Monetary Amount		R		Amount Paid by the Other Payer	
DMG		**Subscriber Demographic**		**R**			
	DMG01	Format Qualifier		R		D8	
	DMG02	Date of Birth		R	Format YYYYMMDD		
	DMG03	Gender		R		M, F, U	
OI		**Other Insurance Coverage Information**		**R**			
	OI03	Benefits Assignment		R		Y	
	OI04	Patient Signature Source		S	See Implementation Guide for valid values		
	OI06	Release of Information Code		R	See Implementation Guide for valid values		
LOOP 2330A – SUBSCRIBER INFORMATION							
NM1				**S**	Required if Loop 2320 is present		
	NM101	Entity ID		R	Insured or Subscriber	IL	
	NM102	Entity Type		R		1 = Person	
	NM103	Last Name		R			
	NM104	First Name		S			
	NM105	Middle Name		S			
	NM107	Suffix		S			
	NM108	Identification Code		R		MI = Member Identification Number	
	NM109	Identification Number					
N3		**Address**					
N4		**City*State*ZIP**					
LOOP 2330B – PAYER INFORMATION							
NM1		**Other Payer Name**		**R**			

Seg	Data Element	Name	Usage	Comments	Expected Value	Notes
	NM101	Entity Identifier	R		PR = Payer	
	NM102	Entity Type	R		2 = Non-Person Entity	
	NM103	Organization Name	R	Name of Payer (Other Insurance Company)		
	NM108	ID Code Qualifier	R		PI = Payer Identification	
	NM109	Idnentification Code	R	Payer ID		
DTP		**Claim Adjudication Date**	**R**			
	DTP01	Date/Time Qualifier	R	Date Claim Paid	573	
	DTP02	Format Qualifier	R		D8	
	DTP03	Adjudication Date	R	YYYYMMDD		
LOOP 2400 – SERVICE LINE NUMBER						
SV2		**Institutional Service Line**	**R**			
	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		

Seg	Data Element	Name	Usage	Comments	Expected Value	Notes
LOOP 2430 – LINE ADJUDICATION INFORMATION						
SVD		**Professional Service**	**R**			
	SVD01	Payer ID	R	Payer Identification Code/Number		
	SVD02	Monetary Amount	R	Paid Amount		
	SVD03-1	Procedure Code/ID Qualifier	R		HC = HCPCS	
	SVD03-2	Procedure Code/ID	R			
	SVD03-3 through 6	Modifiers	S			
	SVD06	Assigned Number	R	Number of Units Paid for by Other Payer	(Whole Units Only)	