



837 Health Care Claim Companion Guides 5010

Version 1.0
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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.

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 transactions that the health plans will accept.

- 837 Professional Health Care Claim - **ASC X12N 837 (005010X222A1)**
- 837 Institutional Health Care Claim - **ASC X12N 837 (005010X223A2)**

Response Transactions Supported

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

- ValueOptions system issued email response Acknowledgement
- 999 Functional Acknowledgement
- 835 Health Care Claim Payment Advice - **ASC X12N 835 (005010X221A1)**
- 227CA Claims Acknowledgment (**005010X214A1**) *(Can only be used if unique patient control numbers are utilized per claim.)*

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 |
| Repetition Separator | ^ Carat |

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 system allows a maximum of 1 ISA/IEA envelope per 837 file.**

- **The Service Line loop (2400) is limited to 50 service lines per professional claim or 50 service lines per institutional claim.**
- **The ST/SE envelope can be a maximum of 5000 claims per transaction as long as the file does not exceed the maximum file size of 8MB.**
- **If submitting both encounter and claim transactions, the files must be sent in separate Interchange Control structures (ISA/IEA envelopes).**

Validation Specifications

Initial validation is conducted at a batch level. If the batch file is not syntactically valid, the submitter will need to resubmit the corrected batch in its entirety.

Secondary validation is conducted at a claim level. If claims are rejected on the claim level validation, the submitter will need to rebuild the corrected claims in a new batch and submit the new batch for validation.

Do not resubmit the same batch after making the claim level corrections as this will cause any claims that have passed validation from the previous submission to duplicate in the system.

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 transactions. 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 Helpdesk:

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>.

Trading Partner Acceptance Testing Specifications

Trading partners are required to submit a test file prior to submitting claims electronically to ValueOptions.

To submit claims electronically, trading partners must obtain an ID & Password from the ValueOptions EDI Helpdesk. Based on the types of services provided, a trading partner may receive multiple submitter IDs. Test files will need to be submitted under all assigned submitter IDs.

Trading partners who upgrade or change software are also required to submit a test submission. Once the upgrade or change has been made, please contact the EDI Helpdesk to have the account put into “Test” mode.

Submitters will be notified via e-mail as to the results of the file validation. If the file failed validation, the e-mail message will provide explanations for the failure. Any error message that is not understood can be explained thoroughly by a ValueOptions EDI Coordinator.

After receiving notification that your test batch has passed validation, contact the EDI Help Desk to switch the account into “Production” mode. Provide the 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.

Test Submission Requirements:

- **Current Provider and Member data (claim data that has successfully processed within the last 3 months)**
- **Minimum 5 test claims/Maximum 15 test claims per batch**
- **Submit with dates of service within the past month**

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.

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 providers that are not bound to the NPI mandate, please contact the EDI Helpdesk to have your account configured accordingly.

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/NationalProvdentStand/>

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 (2310C on Professional claims. 2310E on Institutional Claims)** – is a required loop used in correlation with 2010AA to identify the provider record. This must be the physical 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 loop will only be included if the rendering provider is different from the pay-to-provider.
- Service Location loop (2310C 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 (2310C) – 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 (2310C) – 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: '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' value to indicate that a password will be present in ISA04. Use '00' value to indicate that no 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. |

| Seg | Data Element | Name | Usage | Comments | Expected Value |
|-----|--------------|--|-------|--|---|
| | ISA08 | Interchange Receiver ID | R | | Use 'FHC &Affiliates'. |
| | 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 | Delimiter used to separate repeated occurrences of a simple data element or a composite data structure. This value must be different than the data element separator, component element, and the segment terminator. Valid value: '^' Repetition Separator | Use the value specified in the implementation guide. '^' |
| | ISA12 | Interchange Control Version Number | R | Use the current standard approved for the ISA/IEA envelope. | '00501' |
| | 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, |

| 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. '.' (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 | <p>Multiple functional groups may be sent in one ISA/IEA envelope. This is the count of the GS/GE functional groups included in the interchange structure.</p> <p>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.</p> |
| | 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. |

| Seg | Data Element | Name | Usage | Comments | Expected Value |
|-----|--------------|----------------------------------|-------|--|--|
| | GS08 | Version/Release Industry ID Code | R | Professional Addenda Approved for Publication by ASC X12: 005010X222A1 Institutional Addenda Approved for Publication by ASCX12: 005010X223A2 | Use 005010X222A1 or 0051010X223A2 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

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 batch be sent again. | Use '00' Original |
| | BHT06 | Transaction Type Code | R | Separate claim and encounter data into two separate ISA/IEA envelopes (files). | 'CH' is used for Claims 'RP' is used for Encounters |
| 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 | | |
| | 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 | | | | | |

| Seg | Data Element | Name | Usage | Comments | Expected Value |
|--------------------------------------|--------------|--|-------|--|---|
| NM1 | | Billing Provider Name | R | | |
| | NM108 | Billing Provider Identification Code Qualifier | R | Required for ALL NPI submitters. See Implementation Guide for additional information. | Valid Value- 'XX' |
| | NM109 | Billing Provider Identifier | R | | Covered entities send the National Provider ID (NPI), |
| 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 |
| | 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 | R | An identifier must be present in the subscriber loop. | Valid value: 'MI' Member Identification Number. Refer to Implementation Guide for further details. |

| Seg | Data Element | Name | Usage | Comments | Expected Value |
|--------------------------------------|--------------|--|----------|---|--|
| | NM109 | Subscriber Primary Identifier | S | Use the ValueOptions Subscriber ID. | . *Note: Medical Assistance Number can be used if applicable. |
| 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 7 = Replacement 8 = Void | Record Action |
| PWK | | Claim Supplemental Information | S | | |
| | PWK02 | Attachment Transmission Code | R | Valid values: 'AA' Available on Request at Provider Site | 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 | R | | If this is a correction to a previously submitted claim use the ValueOptions claim number prefixed by an 'RC'. The |

| Seg | Data Element | Name | Usage | Comments | Expected Value |
|---|--------------|--|----------|--|--|
| | | (ICN/DCN) | | | whole claim number without spaces or dashes. |
| LOOP 2310A – REFERRING PROVIDER NAME | | | | | |
| NM1 | | Referring Provider Name | S | | |
| | NM108 | Identification Code Qualifier | S | National Provider Identifier | Valid Value- 'XX' |
| | NM109 | Identification Code | S | This element contains the NPI for the referring provider. | Use the NPI of the referring provider. |
| LOOP 2310B – RENDERING PROVIDER NAME | | | | | |
| REF | | Rendering Provider Name | S | | |
| | NM108 | Rendering Provider Identification Code Qualifier | S | The rendering provider loop is only required if ValueOptions contracts with the Rending provider directly. | Valid Value- 'XX' |
| | NM109 | Rendering Provider Identifier | S | This element contains the NPI for the rendering provider. | Use the NPI of the rendering provider. |
| LOOP 2310C – 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 |
| | NM108 | Identification Code Qualifier | S | | Valid Value- 'XX' |

| Seg | Data Element | Name | Usage | Comments | Expected Value |
|---|--------------|-------------------------------------|----------|---|--|
| | NM109 | Identification Code | S | Entities send the National Provider ID | Use the NPI of the Service Facility Location. |
| NM1 | | Loop 2310E-Ambulance Pick Up | S | | |
| 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; If there is another payer whose liability precedes VO's coverage, do not submit claim until you have received payment or denial from the other payer. | P (Primary) S (Secondary) T (Tertiary) See Implementation Guide for additional Values |
| | 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 | S | | See Implementation Guide for valid values |
| | SBR09 | Claim Filing | S | | See Implementation Guide for valid |

| Seg | Data Element | Name | Usage | Comments | Expected Value |
|--|--------------|---|----------|---|---|
| | | Indicator | | | values |
| AMT | | COB Payer Paid Amount | R | | |
| | AMT01 | Amount Qualifier | R | | D |
| | AMT02 | Monetary Amount | R | | Amount Paid by the Other Payer |
| AMT | | COB NON Covered Amount | | | |
| | AMT01 | Amount Qualifier Code | R | | A8 |
| | AMT02 | Monetary Amount | R | Non-covered charge amount | |
| OI | | Other Insurance Coverage Information | R | | |
| | OI03 | Benefits Assignment | R | | 'N'- NO 'W'- not applicable 'Y'-YES |
| | 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 | | |

| Seg | Data Element | Name | Usage | Comments | Expected Value |
|---------------------------------------|--------------|--|----------|---|-----------------------------------|
| | NM108 | Identification Code | R | | MI = Member Identification Number |
| | NM109 | Identification Number | R | Member Identification Number | |
| N3 | | Address | S | | |
| N4 | | City*State*ZIP | R | | |
| LOOP 2330B – PAYER INFORMATION | | | | | |
| NM1 | | Other Payer Name | R | | |
| | 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 | Identification Code | R | Payer ID | |
| N3 | | Address | S | | |
| N4 | | City*State*ZIP | R | | |
| 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 | Use 'HC' Health Care Financing Administration | Valid values: 'HC HCPCS codes' |

| Seg | Data Element | Name | Usage | Comments | Expected Value |
|-----------|--|-----------------------------------|----------|---|-------------------------------|
| | | | | 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 | R | | 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 (code should include all positions 4 or 5 digits) | |
| | HI102-1 | Code List Qualifier Code | S | | BF- Diagnosis |
| | HI102-2 | Industry Code | S | Use ICD-9 standard DX Code (code should include all positions 4 or 5 digits) | |
| | HI103-1 | Code List Qualifier Code | S | | BF- Diagnosis |
| | HI103-2 | Industry Code | S | Use ICD-9 standard DX Code (code should include all positions 4 or 5 digits) | |
| | HI104-1 | Code List Qualifier Code | S | | BF- Diagnosis |
| | HI104-2 | Industry Code | S | Use ICD-9 standard DX Code (code should include all positions 4 or 5 digits) | |

| Seg | Data Element | Name | Usage | Comments | Expected Value |
|--|-------------------|-----------------------------------|-------|--|---|
| 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 | Bundled or Unbundled Line Number | R | Number of Units Paid for by Other Payer | (Whole Units Only) |

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 | Separate claim and encounter data into separate ISA/IEA envelopes (files). | Use 'CH' for claims and 'RP' for encounters. |
| 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 – 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 | | |

| Seg | Data Element | Name | Usage | Comments | Expected Value |
|--|--------------|--|----------|---|---|
| | NM108 | Billing Provider Identification Code Qualifier | R | A business requirement by ValueOptions. | |
| | NM109 | Billing Provider Identifier | R | This element contains the NPI for the Billing Provider. | |
| 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. |
| | REF02 | Billing Provider Additional Identifier | R | | EIN or SSN of the billing provider. |
| LOOP 2010AB – PAY-TO ADDRESS NAME | | | | | |
| NM1 | | Pay-To-Provider Name | S | | The Pay-To Provider loop is required if the pay-to provider is a <i>different entity</i> from the billing provider. |
| LOOP 2010BA – SUBSCRIBER NAME | | | | | |
| NM1 | | Subscriber Name | R | | |
| | NM109 | Subscriber Primary Identifier | R | | Use the contract holder's -ID number in effect for the date of service that is being submitted for this claim. |
| 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' |

| Seg | Data Element | Name | Usage | Comments | Expected Value |
|---|--------------|--|----------|--|--|
| LOOP 2300 – CLAIM INFORMATION | | | | | |
| CLM | | Claim Information | R | | |
| | CLM05-3 | Claim Frequency Type Code | R | 1 = Original 7 = Replacement 8 = Void | Record Action |
| PWK | | Claim Supplemental Information | S | | |
| | PWK02 | Attachment Transmission Code | R | 'AA' Available on Request at | Use 'AA' Available on Request at Provider Site. |
| REF | | Payer Claim Control Number | 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 | R | | |
| | HI01 | Health Care Code Information | R | | All diagnoses being submitted must include all characters out to the furthest position as defined by the diagnosis coding system. Do not include a decimal point. |
| LOOP 2320 – COORDINATION OF BENEFITS (COB) OTHER PAYER INFORMATION | | | | | |
| AMT | | COB Payer Paid Amount | R | | |
| | AMT02 | Monetary | R | | Amount Paid by the Other Payer. |

| Seg | Data Element | Name | Usage | Comments | Expected Value |
|--|--------------|--|----------|---|---|
| | | Amount | | | When submitting claims with multiple claim lines where not all claim lines have a COB relationship; send separate claims. |
| LOOP 2400 – SERVICE LINE NUMBER | | | | | |
| DTP | | Service Line Number | R | | |
| | DTP01 | Date/Time Qualifier | R | Valid Value: '472' Service | Use '472' Service |
| | DTP02 | Date Time Period Format Qualifier | R | Valid Values: 'D8' Date Expressed in Format CCYYMMDD 'RD8' Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD | Use 'RD8' to specify a range of dates. The from and through service dates should be sent for each service line. |
| | DTP03 | Date Time Period | R | Service Date | |
| SV2 | | Institutional Service Line | R | | |
| | SV205 | Quantity | S | | Use whole number unit values. |
| LOOP 2430 – LINE ADJUDICATION INFORMATION | | | | | |
| SVD | | Professional Service | R | | |
| | SVD06 | Assigned Number | R | Number of Units Paid for by Other Payer | (Whole Units Only) |