Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

Blue Shield of California Promise Health Plan

837 Institutional Companion Guide

For Health Care Claim/Encounter (837I)

Transactions based on ASC X12 Implementation Guides, Version 005010X223A2

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1.3	10/2/2019	
1.4	4/8/2020	Added: Loop 2400 HCP01, HCP02 Added: Loop 2430 SVD01, SVD02 Added: Appendix D Updates could require systems changes

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1. Introduction

1.1 Scope

This companion guide provides information on the submission of Medi-Cal, Medicare, and Cal MediConnect institutional claims and/or encounters. This guide is issued to Trading Partners with Blue Shield of California Promise Health Plan (Care1st Health Plan until 12/31/2018), hereafter referred to as "BSC Promise". Effective 1/1/2019, this companion guide will supersede any other previously-issued Care1st Health Plan Institutional claim or encounter data companion guide versions.

This companion guide is to be used in conjunction with the 5010 Implementation Guide ASC X12N / 005010X223A2 -- Health Care Claim Institutional (837I). The instructions in this companion guide are not intended to replace or be standalone requirements from the Implementation Guide (837I). Requirements that are identical to the Implementation Guide (837I) are not included in this companion guide.

1.2 Contact Information

Trading Partners needing assistance with electronic submissions and processing of an 837 file, contact EDI Platform Services at:

Email: EDI_PHP@blueshieldca.com

Phone 800-480-1221

1.3 References

Trading Partners may obtain access to the Implementation Guides at: http://www.x12.org/.

2. Submitting Encounters to BSC Promise

2.1 Initial Setup

Prior to the implementation of a new Trading Partner to submit claim or encounter data, BSC Promise will provide the following information to the Trading Partner:

2.1.1 File transmission location details
2.1.2 Secure login information
2.1.3 Submitter ID information
2.1.4 Test plan, with information on testing criteria
2.1.5 Any other pertinent information needed to submit Production data

2.2 Claim or Encounter Data Submission File Naming Convention

BSC Promise has a standardized file naming convention for file submission. All Trading Partners must adhere to the file naming convention.

All files must be named using capitalized letters only (case sensitive).

The maximum number of characters allowed in the file is **60 characters** (including the optional "_R" and ".DAT").

2.2.1 BSC Promise File Naming Convention

SENDER-ID_FILE-FORMAT_TRANSACTION-TYPE-CODE_ YYYYMMDD_NNNN_R.DAT

Element	Description	Requirement
SENDER-ID	Code assigned to each Trading Partner by BSC Promise	Must match the ISA06 segment
FILE-FORMAT	Code assigned to each submission based on transaction format	"837I" for 837 Institutional
TRANSACTION-TYPE-CODE	Code specifying the type of transaction	Must match the value submitted in
YYYYMMDD	Date of submission	
NNNN	Unique, sequential, numeric transaction identifier used to differentiate between files submitted on the same day by the same submitter	Must be 4 digits, and padded with leading zeros so it is 4 digits long.
R	**R** is optional and only used for the submitter to differentiate regular submissions from special submissions	"**R**" may include one or more characters. "**R**" only allows alpha and numeric characters; no symbol, no control character, no space, no tab

2.3 Testing with BSC Promise

Trading Partners should work with EDI Platform Services team to test file submissions. Trading Partners must notify EDI Platform Services prior to submitting a file for testing. Email notifications should be sent to: EDI_PHP@blueshieldca.com.

For test files, ISA15 must be populated with "T".

2.4 File Size Limitations

Claim or Encounter data files submitted to BSC Promise should not exceed the limits listed below:

File Size Limitations	
Maximum number of transactions (ST-SE) per file	5,000
Maximum number of claims or encounters per transaction (ST-SE)	5,000
Maximum number of claims or encounters per file	5,000

2.5 BSC Promise Processing Schedule

Files from Trading Partners are accepted 24 hours a day, 7 days a week. Trading Partners are notified prior to any scheduled system maintenance. Files are to be submitted after system maintenance is completed.

3. Acknowledgement and Response Files

3.1 Transmission of Response Files to Trading Partners Acknowledgement and

response files will be sent to the Trading Partners at the designated location communicated during the initial set up of claim and/or encounter submissions.

3.2 Validation Logic

Validation is performed at all levels including, but not limited to, the Header level, Claim Detail level, Member Level, Payer detail and Service Line level. However, record status is determined at the claim level. If one line in a claim or encounter is rejected, the entire claim or encounter is rejected.

3.3 TA1 – Interchange Acknowledgement

A TA1 acknowledgement report will be generated for each 837I file submitted to BSC Promise. The TA1 report provides information to the Trading Partner on whether the file was successfully received. The 837I file does not progress to the next step if a rejection occurs at this level.

The TA1 acknowledgement report will mirror the submitted file name with an added designation, as follows:

SENDER-ID_FILE-FORMAT_TRANSACTION-TYPE-CODE_YYYYMMDD_NNNN_R.RCPCCYYMMDDHHMMSS.DAT.TA1

Where:

RCP is a fixed value which represents receipt
CCYYMMDDHHMMSS is the file receipt date

3.4 999 – Functional Group Acknowledgement

A 999 acknowledgement report will be generated for each 837I file that was accepted at the TA1 level. The 999 report provides information to Trading Partners on whether functional groups were accepted or rejected, including validation on syntactical errors and any functional group errors. The claims or encounters within this transaction do not progress to the 277CA level if a rejection occurs at this level. The transaction will progress to the 277CA validation if it is accepted or accepted with error.

The 999 acknowledgement report will mirror the submitted file name with an added designation, as follows:

SENDER-ID_FILE-FORMAT_TRANSACTION-TYPE-CODE_YYYYMMDD_NNNN_R.RCPCCYYMMDDHHMMSS.DAT.999

Where:

RCP is a fixed value which represents receipt
CCYYMMDDHHMMSS is the file receipt date

3.5 277CA – Claim Acknowledgement

The Health Care Claim Acknowledgment 277CA transaction report will be created for claims or encounters within a transaction that are "accepted" or "accepted with errors" at the 999 level. The 277CA report provides accepted or rejected status at the claim or encounter level, including validation on BSC Promise custom Validation Checks as outlined in Sections 4, 5 and 6 of this document.

The 277 CA report will mirror the submitted file name with an added designation, as follows:

SENDER-ID_FILE-FORMAT_TRANSACTION-TYPE-CODE_YYYYMMDD_NNNN_R.RCPCCYYMMDDHHMMSS.DAT_ HHmmsssSSSS.277

Where:

RCP is a fixed value which represents receipt
CCYYMMDDHHMMSS is the file receipt date
HHmmsssSSSS is the system time that the acknowledgement/response file was generated

4. Claim or Encounter Submission Instructions

4.1 National Coding Standards

Trading Partners must adhere to all national coding standards including procedure, modifier, and diagnostic codes.

Any claims or encounters submitted with a date of service on or after October 1, 2015 must use ICD-10 diagnosis codes. Diagnostic codes must be coded to the highest specificity. External cause codes should not be used as a primary diagnosis code. Local codes will not be accepted.

4.2 Multipurpose Senior Services Program (MSSP) Encounter Submission

MSSP Encounters for the Medi-Cal and Cal MediConnect Medi-Cal lines of business must be submitted using the 837 Institutional file format only. MSSP encounters must use national standard procedure and revenue codes and include the NPI of the MSSP site. In order to properly submit MSSP encounter data, contact the BSC Promise Encounter team for the most updated local code crosswalks and NPI crosswalks.

4.3 Child Health and Disability Program (CHDP) and Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT) Submission

Effective June 30, 2018, BSC Promise does not process PM160 paper forms. All Medi-Cal Trading Partners should submit CHDP electronically using National Standard HIPPA 837 Formats. Please refer to the DHCS website for further information on converting local codes to CPT 4 National Codes.

For EPSDT that are part of CHDP, submissions in the 837I are required to adhere to the following:

4.3.1 Use the CRC segment ("Conditions Indicator") in the 2300 loop to indicate if an EPSDT referral was given for diagnostic or corrective treatment. The CRC segment should indicate the referral only, not the actual diagnostic or corrective treatment. The CRC referenced diagnostic or corrective treatment should be included on a separate submission.

4.3.2 Encounters for EPSDT Diagnostic or corrective treatments will be submitted differently: Identify the EPSDT Supplemental Services by reporting the "EP" procedure modifier with the appropriate CPT code(s) for services rendered.

Loop/Segment	Reference Designator	837I Expected Value
2300/CRC – EPSDT Referral	**CRC01** Code Qualifier	**"ZZ"** Mutually Defined EPSDT Screening referral information.
	CRC02 Certification Condition Code Applies Indicator	**"Y"** If EPSDT referral given. If no EPSDT referral was given, do not populate
	CRC03 **CRC04*** **CRC05*** Condition Indicator **Use CRC04 and CRC05 when a second and third condition code is necessary*	"**AV**": Available-Not Used Patient refused referral "**NU**": Not Used if CRC02 = "N",then "NU"must be used in CRC03 "**S2**": Under Treatment "**ST**" : New Services Requested
2400/SV2	**SV202-03,04,05,06** Procedure Modifier	"**EP**" Modifier to identify EPSDT Supplemental Services

4.4 Physician Administered Drug (PAD) Encounter Submissions – 340B

For the Medi-Cal line of business, services that include the use of 340B physician administered drugs should be reported accurately with the proper procedure code, National Drug Code, drug unit, and drug quantity to BSC Promise. The "UD" modifier must be included in one of the four available modifier positions (2400 SV202-03, 04, 05 or 06).

4.5 Date Validation Checks

BSC Promise requires Trading Partners to submit complete and accurate data. As part of this initiative, BSC Promise has implemented several customized Date Verification checks, including the following:

Edit Level	ID	Date Field	Loop / Segment	Field / Data Element	Business Rule
File	1	Submission Date (the date the file was uploaded to BSC Promise)		System generated	
	2	Transaction Set Creation Date		BHT04	Transaction Set Creation Date must be less than or equal to the file submission date
Detail	3	Admission Date	2300	DTP*435 DTP03 (may be DT or D8)	Admission Date must be less than or equal to To Statement Date.
					Admission Date must be populated for inpatient encounters
	4	Procedure Date	2300	Principal BBR/BR HI01-4 Other BBQ/BQ HI01-4, HI02-4, thru HI12-4	Procedure Date must be greater than or equal to From Statement Date
					Procedure Date must be less than or equal to To Statement Date
	5	Service Date	2400	DTP*472 DTP03 (may be D8 or RD8)	From Service Date must be less than or equal to To Service Date
					To Service Date must be less than or equal to Adjudication Date
	6	Statement Date	2300	DTP*434*RD8 DTP03	From Statement Date must be less than or equal to To Statement Date
					To Statement Date must be less than or equal to the file submission date

4.6 Present on Admission (POA)

For Inpatient claims or encounters, the Present on Admission indicator must be properly reported for all diagnosis codes. The POA is located in loop 2300 segment HI01-09; the 01 incrementally increases for each additional diagnosis reported. As indicated below, report "Y" for Present at the time of inpatient admission, "N" for Not present at the time of inpatient admission, "U" if the documentation is insufficient to determine if the condition was present on admission, "W" if the provider was unable to clinically determine if the condition was present on admission and do not populate if the POA does not apply.

Loop / Segment	Value	Description
2300/ HI01 - 09	Y	Present at time of Inpatient Admission
	N	Not present at time of inpatient admission
	U	Insufficient documentation to determine of condition present
	W	Provider unable to clinically determine of condition present on admission
	<Do not populate>	POA does not apply

4.7 Duplicate Claims or Encounters

All submissions will be evaluated by duplicate validation checks at three levels.

4.7.1 Duplicate File Validation Check

Duplicate File validation check is to verify the uniqueness of the file submitted. The combination of Submitter ID (ISA06) and Interchange Control Number (ISA13) will be used. If the combination is not unique, the file will be rejected.

4.7.2 Duplicate Claim Number Validation Check

Duplicate Claim Number validation check is to verify the uniqueness of Claim Submitter ID (CLM01). The Claim Submitter ID (CLM01) used in the file needs to be unique. Previously accepted Claim Submitter ID (CLM01) cannot be reused.

4.7.3 Duplicate Record Validation Check

Claim or Encounter records will be evaluated for duplicates at the service line level. If a service line is found to be a duplicate of a previously accepted service line, the entire claim or encounter will be rejected.

Additionally, the uniqueness of a record will be validated against:

a) Line of business (Medi-Cal, Medicare, Cal MediConnect)
b) File type (837P, 837I, 837D, NCPDP 4.2)
c) Claim Type (Refer to Appendix A).

As such, two claims or encounters with different lines of business, file types, or claim types will not be considered duplicates of each other.

Please refer to Appendix C for the detail data elements for duplicate claim or encounter record validation check.

4.8 Void and Replacement of a Claim or Encounter

Claims or Encounters that have been submitted and accepted can be subsequently corrected by either a void or a replacement action. When a Trading Partner needs to submit a Replacement or Void claim or encounter to a previously accepted claim or encounter, the following data must be provided:

1) The submitter (ISA06) of the correcting claim or encounter must be the same as the submitter of the claim or encounter being corrected.
2) The Claim Control Number (CLM01) must be unique.
3) A value of either "7" (replacement) or "8" (void) must be placed in the Claim Frequency Code in CLM05-03.
4) In the correcting claim or encounter, the Claim Control Number of the original accepted claim or encounter must be populated in the Payer Claim Control Number REF segment in the 2300 loop (REF*F8).

5. Control Segment/Envelopes

5.1 ISA/IEA

Interchange Control (ISA/IEA) must be utilized as portrayed in the National Electronic Data Interchange Transaction Set Implementation Guides. BSC Promise will work with Trading Partners to determine the submitter ID prior to testing for all electronic transactions. BSC Promise will accept only one ISA/IEA header per file.

Loop ID	Reference	Name	Codes	Notes/Comments
ISA	ISA	Interchange Control Header		
	ISA01	Authorization Information Qualifier	00	No Authorization information present
	ISA02	Authorization Information		Authorization User Code " " Fill with 10 spaces
	ISA03	Security Information Qualifier	00	No Security Information Present (no meaningful information in I04)
	ISA04	Security Information		Fill with 10 spaces
	ISA05	Interchange ID Qualifier	ZZ	Mutually defined
	ISA06	Interchange Sender ID		Value will be specific to Trading Partner. This value will be provided individually to each Trading Partner during initial setup
	ISA07	Interchange ID Qualifier	30	

Loop ID	Reference	Name	Codes	Notes/Comments
ISA	ISA08	Interchange Receiver ID	954468482	
	ISA11	Repetition Separator	^	
	ISA12	Interchange Control Version Number	00501	
	ISA13	Interchange Control Number		Must be a positive unsigned number identical to the associated Interchange Trailer IEA02
	ISA14	Acknowledgement Requested	1	
	ISA15	Usage Indicator	P, T	P: Production Data T: Test Data
	ISA16	Component Element Separator	:	
IEA	IEA	Interchange Control Trailer		
	IEA02	Interchange Control Number		Must match the value in ISA13

5.2 GS/GE

The Functional Group Header (GS) is intended to group similar transaction sets within the same interchange. BSC Promise will accept only one GS/GE header per file.

Loop ID	Reference	Name	Codes	Notes/Comments
GS	**GS**	Functional Group Header		
	GS01	Functional Identifier Code	HC	
	GS02	Application Sender's Code		Value must match value in ISA06
	GS03	Application Receiver's Code	954468482	
	GS06	Group Control Number		GS06 must be unique within a single ISA to IEA enveloping structure

	GS08	Version / Release / Industry Identifier Code	005010X223A2	
GE	**GE**	Functional Group Header		
	GE02	Group Control Number		Value must match value in GS06

5.3 ST/SE

Loop ID	Reference	Name	Codes	Notes/Comments
ST	**ST**	Transaction Set Header		
	ST01	Transaction Set Identifier Code	837	
	ST02	Transaction Set Control Number		The Number must be unique within a specific Interchange (ISA-IEA), but can repeat in other Interchange Files.
	ST03	Implementation Convention Reference	005010X223A2	
SE	**SE**	Transaction Set Trailer		
	SE01	Number of Included Segments		Total number of segments included in a transaction set including ST and SE segments
	SE02	Transaction Set Control Number		The Transaction Set Control Number in ST02 and SE02 must be identical

5.4 BHT

Loop ID	Reference	Name	Codes	Notes/Comments
BHT	**BHT**	Beginning of Hierarchical Transaction		
	BHT01	Hierarchical Structure	0019	
	BHT02	Transaction Set Purpose Code	00	
	BHT06	Claim or Encounter ID	CH, RP	Use 'CH' when the transaction contains only fee for service claims with at least one chargeable line item. Use 'RP' when the entire ST-SE envelope contains only capitated encounters. If unsure, use 'CH'. It must match the Transaction Type Code in the file name

6. Transaction Specific Information

Under the Usage column in the following tables, "R" indicates Required and "S" indicates Situational.

6.1 Header Detail

Loop ID	Reference	Name	USAGE	Codes	Notes/Comments
1000A	**NM1**	Submitter Name	R		
	NM101	Entity Identifier Code	R	41	Submitter
	NM102	Entity Type Qualifier	R	1, 2	1: Person 2: Non-Person Entity
	NM109	Submitter Identifier	R	Value assigned by BSC Promise	Original Submitter ID
1000B	**NM1**	Receiver Name	R		
	NM101	Entity Identifier Code	R	40	

Loop ID	Reference	Name	USAGE	Codes	Notes/Comments
	NM102	Entity Type Qualifier	R	2	Non-person Entity
	NM103		R	BSC Promise Health Plan	
	NM108		R	46	
	NM109	Receiver Primary Identifier	R	954468482	

6.2 Billing Provider Detail

Loop ID	Reference	Name	USAGE	Codes	Notes/Comments
2000A	**PRV**	Billing Specialty Provider Info	R		Taxonomy code is required.
	PRV01	Provider Code	R	BI	Billing
2010AA	**NM1**	Billing Provider Name	R		
	NM101	Entity Identifier Code	R	85	Billing Provider
	NM108	Identification Code Qualifier	S	XX	For Atypical Providers NM108 should not be populated
	NM109	Identification Code	S		For Atypical Providers NM109 should not be populated and the secondary identifier should be used; otherwise populate with NPI. The NPI is validated against the NPPES registry
	REF	Billing Provider Tax ID	R		Tax ID is required.
	REF01	Reference Identification Qualifier	R	EI	Employer's Identification Number
	REF02	Reference Identification	R		Billing Provider Federal Tax ID

6.3 Subscriber Detail

Each beneficiary is viewed as an individual subscriber. As such, each member must be identified in the Subscriber loop (2010BA). The Patient loop (2010CA) should not be used.

Loop ID	Reference	Name	USAGE	Codes	Notes/Comments
2010BA	**NM1**	Subscriber Name	R		
	NM108	Identification Code Qualifier	R	MI	
	NM109	Subscriber Primary Identifier	R	Subscriber ID	FACETS ID, MBI, CIN, HICN, BSC Promise Member ID are acceptable. FACETS ID is recommended. Note: If BSC Promise Member ID is used with an asterisk (i.e., 1234567*01), then an asterisk (*) cannot be used as a delimiter

6.4 Payer Detail

Loop ID	Reference	Name	USAGE	Codes	Notes/Comments
2010BB	**NM1**	Payer Name	R		
	NM101	Entity Identifier Code	R	PR	
	NM103	Name Last Or Organization Name	R	BSC Promise Health Plan	
	NM108	Identification Code Qualifier	R	PI	
	NM109	Identification Code	R	954468482	

6.5 Claim Level Detail

Loop ID	Referenc	Name	USAGE	Codes	Notes/Comments
2300	**CLM**	Claim Information	R		Must be unique value per submitter
	CLM01	Claim Control Number	R		
	CLM05-3	Claim Frequency Code	R	1, 2, 3, 4, 7, 8	1: Original encounter submission 2: Interim – First Claim 3: Interim – Continuing Claim 4: Interim – Last Claim 7: Replacement submission 8: Void submission
	CN1	Contract Information	S		Required for Medicare
	REF	Payer Claim Control Number	S		Required for void and replacements
	REF01	Reference Identification Qualifier	R	F8	
	REF02	Claim Original Reference Number	R		Populate with the originally submitted CLM01 that the Trading Partner intends to take action on
	AMT	Patient Amount Paid	S		Required for Medicare
	AMT01	Amount Qualifier Code	R	F3	Patient Responsibility Amount
	K3	File Information	S		Required if an MSO was used for submission
	K301	Fixed Format Information	R	MSO Group Name	

Loop ID	Reference	Name	USAGE	Codes	Notes/Comments
2310A	**NM1**	Attending Provider Name	S		Required when the claim or encounter contains any services other than non-scheduled transportation
	NM101	Entity identifier Code	R	71	Attending Physician
	NM109	Attending Provider Primary Identifier	R		The NPI is validated against the NPPES registry
	PRV	Attending Provider Specialty Information	S		Required when the claim or encounter contains any services other than non-scheduled transportation
	PRV01	Provider Code	R	AT	Attending Physician
	REF	Attending Provider Secondary Information	S		
	REF01	Reference Identification Qualifier	R	OB, 1G, G2 and LU	0B: State License Number 1G: Provider UPIN G2: Medi-Cal Provider Number LU: Location Number
2310B	**NM1**	Operating Physician Name	S		Required when a surgical procedure code is listed on the encounter
	NM101	Entity identifier Code	R	72	Operating Physician
	NM109	Operating Physician Primary Identifier	R		The NPI is validated against the NPPES registry
	REF	Operating Physician Secondary Identification	S		
	REF01	Reference Identification Qualifier	R	OB, 1G, G2 and LU	0B: State License Number 1G: Provider UPIN G2: Medi-Cal Provider Number LU: Location Number
2310C	**NM1**	Other Operating Physician Name	S		
	NM101	Entity identifier Code	R	ZZ	Other Operating Physician
	NM109	Other Operating Physician Identifier	R		The NPI is validated against the NPPES registry

Loop ID	Reference	Name	USAGE	Codes	Notes/Comments
2310D	**NM1**	Rendering Provider Name	S		Required if the rendering provider is different from the attending provider
	NM101	Entity Identifier Code	R	82	Rendering Provider
	NM109	Rendering Provider Identifier	S		The NPI is validated against the NPPES registry
	REF	Rendering Provider Secondary Identification	S		
	REF01	Reference Identification Qualifier	R	OB, 1G, G2 and LU	0B: State License Number 1G: Provider UPIN G2: Medi-Cal Provider Number LU: Location Number
2310E	**NM1**	Service Facility Location	S		Required when the location is different than the billing provider
	NM101	Entity Identifier	R	77	Service Location
	NM109	Service Facility Primary Identifier	R		NPI-This will be validated against NPPES file
	REF	Service Facility Secondary Identification	S		
	REF01	Reference Identification Qualifier	R	0B, G2, LU	0B: State License Number G2: Medi-Cal Provider number
2310F	**NM1**	Referring Provider Name	S		Required on an outpatient claim or encounter when different from the attending provider
	NM101	Entity Identifier	R	DN	Referring Provider
	NM109	Referring Provider Identifier	R		NPI-This will be validated against NPPES file
	REF	Referring Provider Secondary Identification	S		
	REF01	Reference Identification Qualifier	R	0B, 1G, G2	

6.6 Service Line Detail

Loop ID	Reference	Name	USAGE	Codes	Notes/Comments
2400	**SV2**	Institutional Service Line	R		
	SV201	Service Line Revenue Code	R		Populate with 4 digit revenue code. If Revenue Code is 2 digits, add leading zeros. E.G. '23' = '0023'
	SV202	Composite Procedure Medical Identifier	S		
	SV202-01	Product or Service ID Qualifier	R		For LA County Medi-Cal submissions, populate with HP if revenue code is '0022', '0023', '0024'. If revenue code is not '0022', '0023' or '0024', and the service is outpatient, populate with 'HC'
	SV202-02	Procedure Code	R		For LA County Medi-Cal Submissions, populate with valid HIPPS code if SV202-01 is 'HP'. Populate with valid HCPC code if SV202-01 is 'HC'
	SV202-07	Description	S		Required for Medicare if a Not Otherwise Classified procedure code is submitted in SV202-02
	SV204	Unit or Basis for Measurement Code	R	DA, UN	If the revenue code submitted is a Room and Board Revenue code, then populate with 'DA' and the corresponding line days in SV205. Otherwise, use 'UN' and populate the corresponding quantity in SV205

Loop ID	Reference	Name	USAGE	Codes	Notes/Comments
2400	**HCP***	Line Pricing/Re- pricing Information	S		Required for Medicare and Cal MediConnect For Medi-Cal: If cost share information is available, submit appropriately. If cost share information is not available, do not submit this segment. Required when the claim has been previously adjudicated by payer identified in Loop ID-2330B and this service line has payments and/or adjustments applied to it.
	HCP01	Pricing Methodology	S		Note: See Implementation Guide for codes
	HCP02	Monetary Amount	S		Allowed Amount
	HCP03	Reject Reason Code	S	T1	Populate with 'T1' if out of network. If in network, do not populate
2410	**LIN**	Drug Identification	S		
	LIN02	Product Service ID/ Qualifier	R	N4	
	LIN03	National Drug Code	R	National Drug Cod in 5-4-2 Format	11 bytes
	REF	Prescription or Compound Drug Association	S		Required when a prescription number is available
2420A	**NM1**	Operating Physician Name	S		Required when a surgical procedure code is listed on the claim or encounter and the operating physician is different than at the claim level
		Entity Identifier Code	R	72	Operating Physician
	NM109	Operating Physician Primary Identifier	R		NPI – This will be validated against NPPES file
	REF	Operating Physician Secondary Identification	S		
	REF01	Reference Identification Qualifier	R	OB, 1G, G2, and LU	OB: State License Number 1G: Provider UPIN G2: Medi-Cal Provider Number LU: Location Number

*See **Appendix D** for examples

Loop ID	Reference	Name	USAGE	Codes	Notes/Comments
2420B	**NM1**	Other Operating Physician Name	S		Required when another operating physician is involved, and the other operating physician is different than at the claim level
		Entity Identifier Code	R	ZZ	Mutually Defined
	NM109	Other Operating Physician Identifier	R		NPI – This will be validated against NPPES file
	REF	Other Operating Physician Secondary Identification	S		
	REF01	Reference Identification Qualifier	R	OB, 1G, G2, and LU	OB: State License Number 1G: Provider UPIN G2: Medi-Cal Provider Number LU: Location Number
2420C	**NM1**	Rendering Provider Name	S		Required if the rendering provider is different than the attending provider at the claim level, and when the rendering provider is different than at the claim level
	NM101	Entity Identifier Code	R	82	Rendering Provider
	NM109	Rendering Provider Identifier	S		The NPI is validated against the NPPES registry
	REF	Rendering Provider Secondary Identification	S		
	REF01	Reference Identification Qualifier	R	OB, 1G, G2 and LU	0B: State License Number 1G: Provider UPIN G2: Medi-Cal Provider Number LU: Location Number
2420D	**NM1**	Referring Provider Name	S		Required on an outpatient claim or encounter when different from the attending provider, and the referring provider is different than that at the claim level
	NM101	Entity Identifier Code	R	DN	DN: Referring Provider
	NM109	Identification Code	R		NPI- This will be validated against the NPPES file
	REF	Referring Provider Secondary Identification	R		
	REF01	Referring Provider Secondary Identification	R	0B, 1G, G2	0B: State License Number 1G: Provider UPIN G2: Medi-Cal Provider Number

Loop ID	Reference	Name	USAGE	Codes	Notes/Comments
2430	**SVD***	Line Adjudication Information	S		Required for Medicare and Cal MediConnect For Medi-Cal: If cost share information is available, submit appropriately. If cost share information is not available, do not submit this segment. Required when the claim has been previously adjudicated by payer identified in Loop ID-2330B and this service line has payments and/or adjustments applied to it.
	SVD01	Identification Code	S		Must match Loop 2330B NM109
	SVD02	Monetary Amount	S		Paid Amount Note: Loop 2400 SV103 Line Item Charge Amount Loop minus (-) Loop 2340 CAS Monetary Amount(s) = SVD02
	CAS*	Claim Level Adjustments	S		Required for Medicare and Cal MediConnect. For Medi-Cal: If cost share information is available, submit appropriately. If cost share information is not available, do not submit this segment. Required when the claim has been previously adjudicated by payer identified in Loop ID-2330B and this service line has payments and/or adjustments applied to it.
	CAS01	Claim Adjustment Group Code	R	PR	Patient Responsibility
	CAS02	Adjustment Reason Code	R	1, 2, 3	1: Deductible Amount 2: Co-Insurance Amount 3: Co-pay Amount

*See **Appendix D** for examples

Appendix A Claim Type

There are five Claim Types:

1) Pharmacy

The Claim Type of the encounter data submitted in the file type NCPDP 4.2 is "Pharmacy" with a value of "01".

2) Long Term Care

The Claim Type of claim or encounter data submitted in the file type 837I depending upon its Facility Type and/or the Room & Board Indicator of the Revenue Code is "Long Term Care" with a value of "02".

3) Hospital Inpatient

The Claim Type of claim or encounter data submitted in the file type 837I depending upon its Facility Type is "Hospital Inpatient" with a value of "03".

4) Outpatient

The Claim Type of claim or encounter data submitted in the file type 837I depending upon its Facility Type and/or the Room & Board Indicator of the Revenue Code is "Outpatient" with a value of "04".

5) Physician

The Claim Type of claim or encounter data submitted in the file type 837P is "Physician" with a value of "05".

Claim Types

Claim Type	Description	File Type
01	Pharmacy	NCPDP
02	Long Term Care	837I
03	Hospital Inpatient	837I
04	Outpatient	837I
05	Physician	837P

Appendix B Facility Type

Facility Type will be determined by the first two digits of Bill Types.

Claim Type will be determined by File type, Facility Type (first two digits of the Bill Types), Room & Board Indicator of the Revenue Codes.

Facility Type and Claim Type

File Type	Type of Bill – 1st 2 Digits	Facility Type	Room & Board Indicator of Revenue Code	Claim Type
837P				05
NCPDP				01
837I	11	Hospital Inpatient (Including Medicare Part A)		03
837I	12	Hospital Inpatient (Medicare Part B only)		04
837I	13	Hospital Outpatient		04
837I	14	Hospital Laboratory Services Provided to Non-patients		04
837I	18	Hospital Swing Beds		02
837I	21	Skilled Nursing Inpatient (Including Medicare Part A)		02
837I	22	Skilled Nursing Inpatient (Medicare Part B only)		04
837I	23	Skilled Nursing Outpatient		04
837I	28	Skilled Nursing Swing Beds	One of the Revenue Codes is a bed code	02
837I	28	Skilled Nursing Swing Beds	No revenue codes are bed codes	04
837I	32	Home Health-Inpatient(Plan of treatment under Part B only)		04
837I	33	Home Health Outpatient		04
837I	34	Home Health-Other (for medical and surgical services not under a plan of treatment)		04

File Type	Type of Bill – 1st 2 Digits	Facility Type	Room & Board Indicator of Revenue Code	Claim Type
837I	41	Religious Non-Medical Health Care Institutions Hospital Inpatient (formerly referred to as Christian Science) - Inpatient (Including Medicare Part A)		03
837I	43	Religious Non-Medical Health Care Institutions Hospital Inpatient (formerly referred to as Christian Science) - Outpatient		04
837I	65	Intermediate Care - Level I	One of the Revenue Codes is a bed code	02
837I	65	Intermediate Care - Level I	No revenue codes are bed codes	04
837I	66	Intermediate Care Intermediate Care - Level II	One of the Revenue Codes is a bed code	02
837I	66	Intermediate Care Intermediate Care - Level II	No revenue codes are bed codes	04
837I	69	Intermediate Care Reserved for National Assignment		02
837I	71	Clinic - Rural Health		04
837I	72	Clinic - Hospital Based or Independent		04
837I	73	Clinic - Free Standing		04
837I	74	Clinic - Outpatient Rehabilitation Facility		04
837I	75	Clinic - Comprehensive Outpatient Rehabilitation		04
837I	76	Clinic - Community Mental Health Center		04
837I	77	Clinic - Federally Qualified Health Center (FQHC)		04
837I	78	Licensed Freestanding Emergency Medical Facility		04
837I	79	Clinic - Other		04

File Type	Type of Bill – 1st 2 Digits	Facility Type	Room & Board Indicator of Revenue Code	Claim Type
837I	81	Hospice (non-hospital based)		04
837I	82	Hospice (hospital based)		04
837I	83	Ambulatory Surgery Center		04
837I	84	Free Standing Birthing Center		04
837I	85	Critical Access Hospital		04
837I	86	Residential Facility	One of the Revenue Codes is a bed code	02
837I	86	Residential Facility	No revenue codes are bed codes	04
837I	89	Special Facility - Other	One of the Revenue Codes is a bed code	02
837I	89	Special Facility - Other	No revenue codes are bed codes	04

Appendix C Service Line Duplicate Logic

A submitted claim or encounter can only be duplicated against a claim or encounter that was submitted and accepted. If a service line is found to be a duplicate of a previously submitted and accepted service line, the entire claim or encounter will be rejected.

An 837I claim or encounter will be considered a duplicate if a service line had been previously submitted and accepted with the following identical values:

1) Member Number, CIN, or HICN – 2010BA NM1*IL NM109
2) Beginning Date of Service – 2400 DTP*472 DTP03
3) End Date of Service – 2400 DTP*472 DTP03 when Date of Service is a range (2400 DTP02 is RD8)
4) Admission Date/Hour - 2300 DTP*435 DTP03 (can be a date or a date/time)
5) Discharge Hour - 2300 DTP*096 DTP03
6) Place of Service – 2300 CLM05-01 (only applies to Medi-Cal Los Angeles County when the Claim Type is 'Outpatient')
7) Attending Provider NPI – 2310A NM109
8) Revenue Code – 2400 SV201
9) Procedure Code – 2400 SV202-02
10) Procedure Modifier(s) – 2400 SV202-03, 04, 05, 06 (the order of all modifiers is irrelevant)
11) Drug code – 2410 LIN03 – Drug code is used when it is present.

*Conditional usage of Drug Code - If all other key fields match between two claims or encounters, but the drug codes are different, the situation is not a duplicate. However, if all other key fields match, but one of the claims or encounters contains a drug code while the other does not contain a drug code, the situation is still identified as a duplicate.

In order to appropriately represent claims or encounters for the same service that can be performed multiple times in a day, usage of modifiers: 59, 76 and 77 will over-ride the duplicate logic; however, the use of these modifiers will be strictly monitored.

As described in 4.8, Duplicate logic for Claims or Encounters in 837I varies by line of business. All data elements and positions that Care1st Encounter system uses to identify duplicate claims or encounters at the line level are combined in the table below.

Column	Position	Comments	Medi-Cal LA County			Medi-Cal SD County, CMC, Medicare		
			Outpatient	Inpatient	LTC	Outpatient	Inpatient	LTC
Member Number/ CIN/ HICN	2010B A NM1*IL NM109	1)Member Number: Num issued by Care1st;2)CIN: Member Number issued by DHCS for members with Medi-Cal coverage; 3)HICN: Member Numbers issued by CMS for members with Medicare coverage	Used	Used	Used	Used	Used	Used
Beginning Date of Service	2400 DTP*472 DTP03		Used	Used	Used	Used	Used	Used
End Date of Service	2400 DTP*472 DTP03	Required if it is range: 2400 DTP02 is RD8	Situational	Situational	Situational	Situational	Situational	Situational
Provider NPI	2310A NM109 OR 2010A A NM109	Provider NPI refers to Attending Provider NPI. When Attending Provider is BLANK, Billing Provider will be used.	Used	Used	Used	Used	Used	Used
Revenue Code	2400 SV201	Required for all claims/encounters in 837I	Used	Used	Used	Used	Used	Used
Procedure Code	2400 SV202-02	Required for claims/encounter Outpatient	Used	Situational	Situational	Used	Situational	Situational
Procedure Code Modifier 1	2400 SV202-03	All modifiers will be checked irrespective of the order. Modifiers 59, 76 and 77 will over-ride the duplicate logic.	Situational	Situational	Situational	Situational	Situational	Situational
Procedure Code Modifier 2	2400 SV202-04	All modifiers will be checked irrespective of the order. Modifiers 59, 76 and 77 will over-ride the duplicate logic.	Situational	Situational	Situational	Situational	Situational	Situational
Procedure Code Modifier 4	2400 SV202-06	All modifiers will be checked irrespective of the order. Modifiers 59, 76 and 77 will over-ride the duplicate logic.	Situational	Situational	Situational	Situational	Situational	Situational

Column	Position	Comments	Medi-Cal LA County			Medi-Cal SD County, CMC, Medicare		
			Outpatient	Inpatient	LTC	Outpatient	Inpatient	LTC
Place of Service OR Bill Type	2300 CLM05-01	Required in L.A. County when Claim Type is "Outpatient"	Used	Not Used	Not Used	Not Used	Not Used	Not Used
Admission Date	2300 DTP*435 DTP03	Required for Claim Types: 1)Inpatient; 2)Long Term Care	Not Used	Used	Used	Not Required	Used	Used
Discharge Hour	2300 DTP*096 DTP03	Required for Claim Types: 1)Inpatient; 2)Long Term Care	Not Used	Used	Used	Not Used	Used	Used
Drug Code	2410 LIN03	Situational: Drug Code is used when it is present: 1) If Drug Codes are present to the previous submitted claim or encounter and the current claim or encounter, then, Drug Code will be used as a data element for the duplicate logic. If the drug codes are same, these two claims or encounters are duplicate; if the drug codes are NOT same, these two claims or encounters are NOT duplicate; 2) If Drug Code is ONLY present to one of the previous submitted claim or encounter and the current claim or encounter, then, Drug Code will NOT be used as a data element for the duplicate logic. If all other required data elements are same, these two claims or encounters are duplicate; if at least one of other required data elements is NOT same, these two claims or encounters are NOT duplicate.	Situational	Situational	Situational	Situational	Situational	Situational

Appendix D Cost Share Information

Data Elements	Loop	Segment Position	Example
Allowed Amount	2400	HCP02	HCP*10*100~
Paid Amount	2430	SVD02	SVD*IPA*60~
Any other Adjudicated Amounts (Not part of balancing, only shown here as an example that CAS segments are used for non-Member Out of Pockets as well)	2430	CAS03 where CAS02, CAS05, etc. does not = 1, 2, 3, 66, 241, 247, 248	CAS*CO*45*50~
Member Out of Pockets			
Deductible	2430	CAS03 where CAS02, CAS05, etc. = 1, 66, 247	CAS*PR*1*10
Coinsurance	2430	CAS03 where CAS02, CAS05, etc. = 2, 248	CAS*PR*2*10
Copayment	2430	CAS03 where CAS02, CAS05, etc. = 3, 241	CAS*PR*3*10
Any other Patient Responsibility Amounts	2430	CAS03 where CAS01, CAS04, etc. = PR	CAS*PR*96*10

Scenario A: No member out of pocket dollars: Paid at 100% of Allowance

LX*1~
SV1*HC>88305>>>>>TISSUE EXAM BY PATHOLOGIST*3000*UN*12***1~ [BILLED AMOUNT: $3000]
DTP*472*D8*20200219~
REF*6R*403834930971~
HCP*10*883.73~ [ALLOWED AMOUNT: $888.73]
SVD*IPA*883.73*HC>88305**12~ [PAID AMOUNT: $888.73]
CAS*CO*45*2116.27~ [OTHER ADJUDICATED AMOUNTS: $2116.27]
DTP*573*D8*20200318~

Scenario B: Member out of pocket: Member Out of Pocket Amounts + Paid Amount = Allowance

Variation 1: ($5 + $76.73 = $81.73)
LX*1~
SV1*HC>99214>>>>>OFFICEOUTPATIENT VISIT, EST*178.14*UN*1***1~ [BILLED AMOUNT: $178.14]
DTP*472*D8*20200206~
REF*6R*4038378969Z1~
HCP*10*81.73~ [ALLOWED AMOUNT: $81.73]
SVD*IPA*76.73*HC>99214**1~ [PAID AMOUNT: $76.73]
CAS*CO*45*96.41~ [OTHER ADJUDICATED AMOUNTS: $96.41]
CAS*PR*3*5~ [ADJUDICATED AMOUNT APPLIED TO PATIENT RESPONSIBILITY "PR" FOR COPAY AMOUNT: $5]
DTP*573*D8*20200227~

Scenario B continued

Variation 2: ($222.32 + $871.47 = $ 1093.79)
LX*1~
SV1*HC>E0483>RR>KX>KJ>>HI FREQ CHST WALL AIR-PULSE GEN EA*1642.5*UN*1***1~ *[BILLED AMOUNT: $1642.5]*
DTP*472*D8*20200207~
REF*6R*4038357099Z1~
HCP*10*1093.79~ *[ALLOWED AMOUNT: $1093.79]*
SVD*IPA*871.47*HC>E0483**1~ *[PAID AMOUNT: $871.47]*
CAS*OA*45*548.71~ *[OTHER ADJUDICATION AMOUNT: $548.71]*
CAS*PR*2*222.32~ *[ADJUDICATED AMOUNT APPLIED TO PATIENT RESPONSIBILITY "PR" FOR COINSURANCE AMOUNT: $222.32]*
DTP*573*D8*20200228~

Variation 3: ($35 + $35 = $70)
LX*1
SV1*HC>99212*80*UN*1***1 *[BILLED AMOUNT: $80]*
DTP*472*D8*20200129
REF*6R*3988779796Z1
HCP*10*70~ *[ALLOWED AMOUNT: $70]*
SVD*95414204477*35*HC>99212**1 *[PAID AMOUNT: $35]*
CAS*CO*45*10 *[OTHER ADJUDICATION AMOUNT: $10]*
CAS*PR*3*35 *[ADJUDICATED AMOUNT APPLIED TO PATIENT RESPONSIBILITY "PR" FOR COPAYMENT AMOUNT: $35]*
DTP*573*D8*20200228

Scenario C: Service is denied, Billed Amount equals Patient Responsibility

LX*1~
SV1*HC>90691*313*UN*1***1>2~ *[BILLED AMOUNT: $313]*
DTP*472*D8*20191230~
REF*6R*P1281605630-2~
LIN**N4*49281079020~
CTP****.5*ML~
HCP*00*0*~ *[ALLOWED AMOUNT: $0]*
SVD*002*0*HC>90691**1~ *[PAID AMOUNT: $0]*
CAS*PR*96*313~ *[ADJUDICATED AMOUNT APPLIED TO PATIENT RESPONSIBILITY "PR": $313]*
DTP*573*D8*20200228~

Scenarios specific to Medi-Cal on the next page…

<u>Scenario D</u>: Services are for Medi-Cal member and cost share information is available however configured as zero dollars applied.

LX*1~
SV1*HC>90691*313*UN*1***1>2~ _[BILLED AMOUNT: $313]_
DTP*472*D8*20191230~
REF*6R*P1281605630-2~
LIN**N4*49281079020~
CTP****.5*ML~
HCP*00*0*~ _[ALLOWED AMOUNT: $0]_
SVD*002*0*HC>90691**1~ _[PAID AMOUNT: $0]_
CAS*CO*24*313~ _[OTHER ADJUDICATED AMOUNT APPLIED: $313]_
DTP*573*D8*20200228~

<u>Scenario E</u>: Services are for Medi-Cal member and cost share information is not available

LX*1~
SV1*HC>90691*313*UN*1***1>2~ _[BILLED AMOUNT: $313]_
DTP*472*D8*20191230~
REF*6R*P1281605630-2~
LIN**N4*49281079020~
CTP****.5*ML~
[No HCP, SVD, CAS and DTP*573 segments are submitted]