837 PROFESSIONAL CLAIMS AND ENCOUNTERS TRANSACTION COMPANION GUIDE

JULY 23, 2015

A S C X 1 2 N 8 3 7 (0 0 5 0 10 X 222A1)

VERSION 1

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1.0 Background

1.1 Overview

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) legislation mandates that many of the major health care electronic data exchanges, such as electronic claims and remittance advices, be standardized into the same national format for all payers, providers, and clearinghouses. All providers who submit governed data electronically to CSC must submit in the mandated HIPAA formats. HIPAA specifically names several electronic standards that must be followed when certain health care information is exchanged. These standards are published as National Electronic Data Interchange Transaction Set Implementation Guides. They are commonly called Implementation Guides (IGs) and are referred to as IGs throughout this document. (The implementation guide for a 5010 transaction is also known as a Technical Report Type 3 or TR3). The following table lists the adopted standards and the related CSC business category.

This document is applicable to HIPAA 5010 standards and, as such, is effective January 1, 2012.

Business Category	Transaction Name/Implementation Guide	Description
Claims Processing	ASC X12N 837 (005010X222A1)	Health Care Claim: Professional
Explanation of Payment/Remittance Advice	ASC X12N 835 (005010X221A1)	Health Care Claim: Payment/Advice
Claim Status	ASC X12N 276/277 (005010X212)	Health Care Claims Status Request and Response
Prior Authorization	ASC X12N 278 (005010X217)	Health Care Services Review – Request for Review and Response

The IGs are available for download through the Washington Publishing Company Web site at http://www.wpc-edi.com and other locations. Developers should have copies of the respective IGs prior to beginning the development process.

CSC has developed technical companion guides to assist application developers during the implementation process. In most instances, an existing data exchange format has completely changed, for instance claims. In other cases, a new method for electronic data exchange has been developed, such as prior authorization. The information contained in the CSC Companion Guide is only intended to supplement the adopted IGs and provide guidance and clarification as it applies to CSC. The CSC Companion Guide is never intended to modify, contradict, or reinterpret the rules established by the IGs.

The companion guide is categorized into four sections:

1. Introduction
2. Interchange Control
3. Transaction Specifications
4. File Transfer and Verification

1.2 Introduction

This section, Introduction, provides general implementation information as well as specific instructions that apply to all transactions. Section 2 describes data exchange options for files being sent inbound to CSC. Section 3 contains transaction specific documentation, including segment usage, to assist developers with coding each transaction. Finally, Section 4 lists information regarding our web site for file transfer and verification.

The ASC X12N 837 (005010X222A1) transaction is the HIPAA mandated instrument by which professional claim or encounter data must be submitted. Any claim that would be submitted on a paper such as a service authorization billing form must be submitted using this transaction if the data is submitted electronically. This document is intended only as a companion guide and is not intended to contradict or replace any information in the IG or the Early Intervention Provider Billing Manual. It is highly recommended that implementers have the following resources available during the development process:

- This document, Companion Guide – 837 Professional Claims and Encounters Transactions
- ASC X12N 837 TR3 or Implementation Guide (IG) (005010X222A1)
- Early Intervention Provider Billing Manual

Additionally, there are several processing assumptions, limitations, and guidelines a developer must be aware of when implementing the 837P transaction. The following list identifies these processing stipulations:

- CSC will accept only one transaction (ST/SE) per interchange (ISA/IEA).
- CSC will accept up to 5000 CLM segments per ST – SE. The IG recommends creating this limitation to avert circumstances where file size management may become an issue.
- Patient loops, 2000C and 2010CA, are ignored because the CSC members/subscribers are always the same as the patient.
- All monetary amounts have explicit decimals. The decimal point always appears in the character stream if the decimal point is at any place other than the right end. If the value is an integer, decimal point at the right end, the decimal point should be omitted. See the IG for additional clarification.
- Negative quantities or amounts are rejected.
- Quantities and amounts have pre-adjudication edits. Refer to the appropriate segments for CSC formats.
- Other data elements with lengths greater than CSC definitions are truncated.
- Qualifier codes are case sensitive and should be presented as they are in the IGs.
- CSC is referred to as CRO-CSC in applicable Receiver segments.
- CSC treats all 837P transactions as original claims. Claim adjustments must be submitted through the paper process or via the website. See the Provider Billing Manual for details. Replacement or void claims are treated as original claims.
- For Version 5010, the Implementation Guide (IG) is also called the Technical Report 3 (TR3). In this document the terms are treated as synonymous.

2.0 Data Exchange Technical Specifications and Interchange Control

This section, Introduction, provides general implementation information as well as specific instructions that apply to all transactions. Section 2 describes data exchange options for files received by CSC. Section 3 contains transaction specific documentation, including segment usage, to assist developers with coding each transaction. Finally, Section 4 lists information regarding our web site for file transfer and verification.

2.1 Overview

Appendix A, Section A.1.1 of each X12N HIPAA IG provides detail about the rules for ensuring integrity and maintaining the efficiency of data exchange. Data files are transmitted in an electronic envelope. The communication envelope consists of an interchange envelope and functional groups. The interchange control structure is used for inbound and outbound files. An inbound interchange control structure is the envelope that wraps all transaction data (ST-SE) sent to CSC for processing. Examples include 837 and 276 transactions. An outbound interchange control structure wraps transactions that are created by CSC and returned to the requesting provider. Examples of outbound transactions include 835, 277, and 278 transactions. The following tables define the use of this control structure as it relates to outbound communication with CSC.

2.2 Inbound Transaction

<table>
<tr><td>Segment Name S</td><td>Interchange Control Header</td></tr>
<tr><td>Segment ID</td><td>ISA</td></tr>
<tr><td>Loop ID</td><td>N/A</td></tr>
<tr><td>Usage</td><td>Required</td></tr>
<tr><td>Segment Notes</td><td>All positions within each data element in the ISA segment must be filled.
Delimiters are specified in the interchange header segment.
The character immediately following the segment ID, ISA, defines the data elements separator. The last character in the segment defines the component element separator, and the segment terminator is the byte that immediately follows the component element separator. Examples of the separators are as follows:
<table>
<tr><td>Character</td><td>Name</td><td>Delimiter</td></tr>
<tr><td>*</td><td>Asterisk</td><td>Data Element Separator</td></tr>
<tr><td>></td><td>Greater Than</td><td>Sub Element Separator</td></tr>
<tr><td>~</td><td>Tilde</td><td>Segment Terminator</td></tr>
<tr><td>^</td><td>Caret</td><td>Repetition Separator</td></tr>
</table></td></tr>
<tr><td>Examples</td><td>ISA*00*……..*00*…….*ZZ*IN999999…….*Z*CFO-CSC…*930602*1253*^*00501*000000905*0*P*>~</td></tr>
</table>

Element ID	Usage	Guide Description/Valid Values	Comments
ISA01	Required	Authorization Information Qualifier **00** – No Security Information Present	
ISA02	Required	Authorization Information Enter 10 spaces	
ISA03	Required	Security Information Qualifier **00** – No Security Information Present	
ISA04	Required	Security Information Enter 10 spaces	
ISA05	Required	Interchange ID Qualifier **ZZ** – Mutually Defined	

Element ID	Usage	Guide Description/Valid Values	Comments
ISA06	Required	Interchange Sender ID CSC issued Payer ID	Nine character federal tax ID. This field has a required length of 15 bytes; therefore, the field must be blank filled to the right.
ISA07	Required	Interchange ID Qualifier **ZZ** – Mutually Defined	
ISA08	Required	Interchange Receiver ID **CFO-CSC**	This field has a required length of 15 bytes; therefore, the field must be blank filled to the right
ISA09	Required	Interchange Date	YYMMDD format
ISA10	Required	Interchange Time	HHMM Format
ISA11	Required	Repetition Separator	
ISA12	Required	Interchange Control Version Number - **00501**	
ISA13	Required	Interchange Control Number	
ISA14	Required	Acknowledgement Request **0** – No Acknowledgement Requested	
ISA15	Required	Usage Indicator	
ISA16	Required	Component Element Separator	

Segment Name	Functional Group Header
Segment ID	GS
Loop ID	N/A
Usage	Required
Segment Notes	
Examples	GS*HC*912936336*CFO-CSC*20030808*145901*5*X*005010X222A1~

Element ID	Usage	Guide Description/Valid Values	Comments
GS01	Required	Functional Code Identifier: **HC** – Health Care Claim (837)	Use the appropriate Code for the type of transaction following the GS
GS02	Required	Application Sender's Code Payer EIN Number	Provider nine character federal tax ID
GS03	Required	Application Receiver's Code: **CFO-CSC**	
GS04	Required	Date	CCYYMMDD
GS05	Required	Time	HHMMSS
GS06	Required	Group Control Number	
GS07	Required	Responsible Agency Code: **X** – Accredited Standards Committee X 12	
GS08	Required	Version Release/Industry Identifier Code: **005010X222A1**	

Segment Name	Functional Group Trailer
Segment ID	GE
Loop ID	N/A
Usage	Required
Segment Notes	
Examples	GE*1*5 ~

Element ID	Usage	Guide Description/Valid Values	Comments
GE01	Required	Number of Transaction Sets Included	This is the number of transactions within this functional group
GE02	Required	Group Control Number	This number must match the number in GS06

Segment Name	Interchange Control Trailer
Segment ID	IEA
Loop ID	N/A
Usage	Required
Segment Notes	
Examples	IEA*2*000000905~

Element ID	Usage	Guide Description/Valid Values	Comments
IEA01	Required	Number of Functional Groups Included	This is the number of functional groups within this interchange
IEA02	Required	Group Control Number	This number must match the number in ISA13

Sample Inbound Interchange Control

This example illustrates a file that includes 276 and 837P transactions.
ISA* 00* .....* 00*.....*ZZ* 4472691280001..*ZZ*CFO-CSC……*930602* 1253*^* 00501*
000000905*
0* P* >~
GS*HS*4472691280001*CFO-CSC*20020606*105531*5*X*005010X222A1~
ST – 276 TRANSACTION SET HEADER
DETAIL SEGMENTS
SE – 276 TRANSACTION SET TRAILER
GE*1*5~
GS*HC*4472691280001*CSC*20020606*105531*5*X*005010X222A1~
ST – 837 TRANSACTION SET HEADER
DETAIL SEGMENTS
SE – 837 TRANSACTION SET TRAILER
GE*1*5~
IEA*2*000000905~

3.0 Segment Usage – 837 Professional

The following matrix lists all segments available for submission with the 5010 version of the 837P IG. Additionally, it includes a CSC Usage column that identifies segments that are required, situational, or not used by CSC. A required segment element must appear on all transactions. Failure to include a required segment results in a compliance error. A situational segment is not required for every type transaction; however, a situational segment may be required under certain circumstances. Please refer to the West Virginia Provider Manual for specific billing requirements. Any data in a segment that is identified in the Usage column with an X is ignored by the CSC. Any segment identified in the Usage column as required or situational is explained in detail in the Segment and Data Element Description section of the document.

Segment ID	Loop ID	Segment Name	CSC Usage R – Required S – Situational X – Not Used
ST	N/A	Transaction Set Header	R
BHT	N/A	Beginning of Hierarchical Transaction	R
REF	N/A	Transmission Type Identification	X - Deleted
NM1	N/A	Submitter Name	R
NM1	1000A	Submitter Name	R
PER	1000A	Submitter EDI Contact Information	R
NM1	1000B	Receiver Name	R
HL	2000A	Billing/Pay-To Hierarchical Level	R
PRV	2000A	Billing/Pay-To Specialty Information	X
CUR	2000A	Foreign Currency Information	X
NM1	2010AA	Billing Provider Name	R
N3	2010AA	Billing Provider Address	R
N4	2010AA	Billing Provider City/State/Zip	R
REF	2010AA	Billing Provider Tax Identification	X
REF	2010AA	Billing Provider UPIN/License Information	X
PER	2010AA	Billing Provider Contact Information	X
NM1	2010AB	Pay-To Provider Name	X
N3	2001AB	Pay-To Provider Address	X
N4	2010AB	Pay-To Provider City/State/Zip	X
REF	2010AB	Pay-To Provider Secondary Identification	X
NM1	2010AC	Pay-To Plan Name	X
N3	2010AC	Pay-To Plan Address	X
N4	2010AC	Pay-To Plan City/State/Zip	X
REF	2010AC	Pay-To Plan Secondary Identification	X
REF	2010AC	Pay-To Plan Tax Identification	X
HL	2000B	Subscriber Hierarchical Level	R
SBR	2000B	Subscriber Information	R
PAT	2000B	Patient Information	X
NM1	2010BA	Subscriber Name	R
N3	2010BA	Subscriber Address	R
N4	2010BA	Subscriber City/State/Zip	R
DMG	2010BA	Subscriber Demographic Information	R

Segment ID	Loop ID	Segment Name	CSC Usage R – Required S – Situational X – Not Used
REF	2010BA	Subscriber Secondary Information	X
REF	2010BA	Property and Casualty Claim Number	X
PER	2010BA	Property and Casualty Subscriber Contact Information	X
NM1	2010BB	Payer Name	R
N3	2010BB	Payer Address	X
N4	2010BB	Payer City/State/Zip	X
REF	2010BB	Payer Secondary Information	X
REF	2010BB	Billing Provider Secondary Information	X
HL	2000C	Patient Hierarchical Level	X
PAT	2000C	Patient Information	X
NM1	2010CA	Patient Name	X
N3	2010CA	Patient Address	X
N4	2010CA	Patient City/State/Zip	X
DMG	2010CA	Patient Demographic Information	X
REF	2010CA	Patient Secondary Information Number	X
REF	2010CA	Property and Casualty Claim Number	X
PER	2010CA	Property and Casualty Patient Contact Information	X
CLM	2300	Claim Information	R
DTP	2300	Date - Onset of Current Illness or Symptom	X
DTP	2300	Date - Initial Treatment Date	X
DTP	2300	Date - Last Seen Date	X
DTP	2300	Date - Acute Manifestation	X
DTP	2300	Date - Accident	X
DTP	2300	Date - Last Menstrual Period	X
DTP	2300	Date - Last X-ray Date	X
DTP	2300	Date - Hearing and Vision Prescription Date	X
DTP	2300	Date - Disability Dates	X
DTP	2300	Date - Last Worked	X
DTP	2300	Date - Authorized Return to Work	X
DTP	2300	Date - Admission	X
DTP	2300	Date - Discharge	X
DTP	2300	Date - Assumed and Relinquished Care Dates	X
DTP	2300	Property and Casualty Date of First Contact	X
DTP	2300	Date - Repricer Received Date	X
PWK	2300	Claim Supplemental Information	X
CN1	2300	Contract Information	X
AMT	2300	Credit/Debit Card Maximum Amount	X
AMT	2300	Patient Amount Paid	S
AMT	2300	Total Purchased Service Amount	X
REF	2300	Service Authorization Exception Code	X
REF	2300	Mandatory Medicare (Secti0n 4081) Crossover	X
REF	2300	Mammography Certification Number	X
REF	2300	Prior Authorization or Referral Number	R
REF	2300	Original Reference Number (ICN/DCN)	X
REF	2300	Referral Number	X
REF	2300	Prior Authorization	X

Segment ID	Loop ID	Segment Name	CSC Usage R – Required S – Situational X – Not Used
REF	2300	Payer Claim Control Number	X
REF	2300	Clinical Laboratory Improvement Amendment (CLIA)	X
REF	2300	Repriced Claim Number	X
REF	2300	Adjusted Repriced Claim Number	X
REF	2300	Investigational Device Exemption Number	X
REF	2300	Ambulatory Patient Group (APG)	X
REF	2300	Medical Record Number	R
REF	2300	Demonstration Project Identifier	X
K3	2300	File Information	X
NTE	2300	Claim Note	X
CR2	2300	Spine Manipulation Service Information	X
CRC	2300	Ambulance Certification	X
CRC	2300	Patient Condition Information: Vision	X
CRC	2300	Homebound Indicator	X
CRC	2300	EPSDT Referral – New Segment per addenda	X
HI	2300	Health Care Diagnosis Code	R
HCP	2300	Claim Pricing/Repricing Information	X
CR7	2305	Home Health Care Plan Delivery	X
HSD	2305	Health Care Services Delivery	X
NM1	2310A	Referring Provider Name	X
PRV	2310A	Referring Provider Specialty Information	X
REF	2310A	Referring Provider Secondary Identification	X
NM1	2310B	Rendering Provider Name	R
PRV	2310B	Rendering Provider Specialty Information	R
REF	2310B	Rendering Provider Secondary Information	X
NM1	2310C	Purchased Service Provider Name	X
REF	2310C	Purchased Service Provider Secondary Identification	X
NM1	2310C	Service Facility Location	X
N3	2310C	Service Facility Location Address	X
N4	2310C	Service Facility Location City/State/Zip	X
REF	2310C	Service Facility Location Secondary Identification	X
REF	2310C	Service Facility Contact Information	X
NM1	2310D	Supervising Provider Name	X
REF	2310D	Supervising Provider Secondary Identification	X
NM1	2310E	Ambulance Pick Up Location	X
N3	2310E	Ambulance Pick Up Location Address	X
N4	2310E	Ambulance Pick Up Location City/State/Zip	X
NM1	2310F	Ambulance Drop Off Location	X
N3	2310F	Ambulance Drop Off Location Address	X
N4	2310F	Ambulance Drop Off Location City/State/Zip	X
SBR	2320	Other Subscriber Information	X
CAS	2320	Claim Level Adjustment	X
AMT	2320	Coordination of Benefits (COB) Approved Amount	X
AMT	2320	Coordination of Benefits (COB) Payer Paid Amount	X
AMT	2320	Coordination of Benefits (COB) Total Non-Covered Amount	X
AMT	2320	Remaining Patient Liability	X

Segment ID	Loop ID	Segment Name	CSC Usage R – Required S – Situational X – Not Used
AMT	2320	COB Patient Responsibility Amount	X
AMT	2320	Coordination of Benefits (COB) Covered Amount	X
AMT	2320	Coordination of Benefits (COB) Discount Amount	X
AMT	2320	Coordination of Benefits (COB) Per Day Limit Amount	X
AMT	2320	Coordination of Benefits (COB) Patient Paid Amount	X
AMT	2320	Coordination of Benefits (COB) Tax Amount	X
AMT	2320	Coordination of Benefits (COB) Total Claim Before Taxes Amount	X
DMG	2320	Subscriber Demographic Information	X
OI	2320	Other Insurance Coverage Information	X
MOA	2320	Medicare Outpatient Adjudication Information	X
NM1	2330A	Other Subscriber Name	X
N3	2330A	Other Subscriber Address	X
N4	2330A	Other Subscriber City/State/Zip	X
REF	2330A	Other Subscriber Secondary Identification	X
NM1	2330B	Other Payer Name	X
N3	2330B	Other Payer Address	X
N4	2330B	Other Payer City/State/Zip	X
PER	2330B	Other Payer Contact Information	X
DTP	2330B	Claim Adjudication Date	X
REF	2330B	Other Payer Secondary Identifier	X
REF	2330B	Other Payer Prior Authorization or Referral Number	X
REF	2330B	Other Payer Claim Adjustment Indicator	X
REF	2330B	Other Payer Claim Control Number	X
NM1	2330C	Other Payer Referring Provider	X
REF	2330C	Other Payer Referring Provider Secondary Identification	X
NM1	2330D	Other Payer Rendering Provider	X
REF	2330D	Other Payer Rendering Provider Secondary Identification	X
NM1	2330E	Other Payer Service Facility Location	X
REF	2330E	Other Payer Service Facility Location Identification	X
NM1	2330F	Other Payer Supervising Provider	X
REF	2330F	Other Payer Supervising Provider Identification	X
NM1	2330G	Other Payer Billing Provider	X
REF	2330G	Other Payer Billing Provider Secondary Identification	
LX	2400	Service Line Number	R
SV1	2400	Professional Service	R
SV5	2400	Durable Medical Equipment Service	X
PWK	2400	DMERC Necessity Indicator	X
CR1	2400	Ambulance Transportation Information	X
CR2	2400	Spinal Manipulation Service Information	X
CR3	2400	Durable Medical Equipment Certification	X
CR5	2400	Home Oxygen Therapy Information	X
CRC	2400	Ambulance Certification	X
CRC	2400	Hospice Employee Indicator	X
CRC	2400	DMERC Condition Indicator	X
DTP	2400	Date – Service Date	R

Segment ID	Loop ID	Segment Name	CSC Usage R – Required S – Situational X – Not Used
DTP	2400	Date – Prescription Date	X
DTP	2400	Date – Certification Revision/Recertification Date	X
DTP	2400	Date – Begin Therapy Date	X
DTP	2400	Date – Last Certification Date	X
DTP	2400	Date – Date Last Seen	X
DTP	2400	Date – Test Date	X
DTP	2400	Date – Shipped Date	X
DTP	2400	Date – Last X-Ray Date	X
DTP	2400	Date – Initial Treatment Date	X
QTY	2400	Ambulance Patient Count	X
QTY	2400	Obstetric Anesthesia Additional Units	X
MEA	2400	Test Result	X
CN1	2400	Contract Information	X
REF	2400	Repriced Line Item Reference Number	X
REF	2400	Adjusted Repriced Line Item Reference Number	X
REF	2400	Prior Authorization	S
REF	2400	Line Item Control Number	S
REF	2400	Mammography Certification Number	X
REF	2400	Clinical Laboratory Improvement Amendment (CLIA) Number	X
REF	2400	Referring Clinical Laboratory Improvement Amendment (CLIA) Facility Identification	X
REF	2400	Immunization Batch Number	X
REF	2400	Ambulatory Patient Group (APG)	X
REF	2400	Oxygen Flow Rate	X
REF	2400	Referral Number	X
AMT	2400	Sales Tax Amount	S
AMT	2400	Approved Amount	X
AMT	2400	Postage Claimed Amount	X
K3	2400	File Information	X
NTE	2400	Line Note	R
NTE	2400	Third Party Organization Note	X
PSI	2400	Purchased Service Information	X
HSD	2400	Health Care Services Delivery	X
HCP	2410	Line Pricing/Repricing Information	X
LIN	2410	Drug Identification – New segment per Addenda	X
CTP	2410	Drug Pricing – New Segment per Addenda	X
REF	2410	Prescription or Compound Drug Association Number	X
NM1	2420A	Rendering Provider Name	X
PRV	2420A	Rendering Provider Specialty Information	X
REF	2420A	Rendering Provider Secondary Identification	X
NM1	2420B	Purchased Service Provider Name	X
REF	2420B	Purchased Service Provider Secondary Identification	X
NM1	2420C	Service Facility Location Name	X
N3	2420C	Service Facility Location Address	X
N4	2420C	Service Facility Location City/State/Zip	X

Segment ID	Loop ID	Segment Name	CSC Usage R – Required S – Situational X – Not Used
REF	2420C	Service Facility Location Secondary Identification	X
REF	2420D	Supervising Provider Secondary Identification	X
NM1	2420E	Ordering Provider Name	X
N3	2420E	Ordering Provider Address	X
N4	2420E	Ordering Provider City/State/Zip	X
REF	2420E	Ordering Provider Secondary Identification	X
PER	2420E	Ordering Provider Contact Information	X
NM1	2420F	Referring Provider Name	X
PRV	2420F	Referring Provider Specialty Information	X
REF	2420G	Referring Provider Secondary Identification	X
NM1	2420G	Other Payer Prior Authorization or Referral Number	X
NM1	2420G	Ambulance Pick Up Location	X
N3	2420G	Ambulance Pick Up Location Address	X
N4	2420G	Ambulance Pick Up Location City/State/Zip	X
NM1	2420H	Ambulance Drop Off Location	X
N3	2420H	Ambulance Drop Off Location Address	X
N4	2420H	Ambulance Drop Off Location City/State/Zip	X
SVD	2430	Line Adjudication Information	X
CAS	2430	Line Adjustment	X
DTP	2430	Line Check or Remittance Date	X
AMT	2430	Remaining Patient Liability	X
LQ	2440	Form Identification Code	X
FRM	2440	Supporting Documentation	X
SE	N/A	Transaction Set Trailer	R
GE	N/A	Functional Group Trailer	R
IEA	N/A	Interchange Control Trailer	R

3.1 Segment and Data Element Description

This section contains a tabular representation of any segment required or situational for CSC HIPAA implementation of the 837P. Each segment table contains rows and columns describing different segment elements.

Segment Name – The industry assigned segment name as identified in the IG.
Segment ID – The industry assigned segment ID as identified in the IG.
Loop ID – The loop within which the segment should appear.
Usage – Identifies the segment as required or situational.
Segment Notes – A brief description of the purpose or use of the segment.
Example – An example of complete segment.

Element ID – The industry assigned data element ID as identified in the IG.
Usage – Identifies the data element as R-required, S-situational, or N/A-not used based on CSC guidelines.
Guide Description/Valid Values – Industry name associated with the data element. If no industry name exists, this is the IG data element name. This column also lists in **BOLD** the values and/or code sets to be used.
Comments – Description of the contents of the data elements including field lengths.

Segment Name	Transaction Set Header
Segment ID	ST
Loop ID	N/A
Usage	Required
Segment Notes	This segment begins the transaction.
Example	ST*837*1234567*005010X222A1~

Element ID	Usage	Guide Description/Valid Values	Comments
ST01	Required	Transaction Set Identifier Code: **837** -Health Care Claim	
ST02	Required	Transaction Set Control Number	The number is created uniquely by the sender and should match the number in SE02.
ST03	Required	Implementation Convention Reference: **005010X222A1**	Same as in GS08

Segment Name	Beginning of Hierarchical Transaction
Segment ID	BHT
Loop ID	N/A
Usage	Required
Segment Notes	This segment provides the bill date and indicator that determines whether the claim submitted is a fee-for-service or encounter claim.
Example	BHT*0019*00*X2FF1*20020901*1230*CH~

Element ID	Usage	Guide Description/Valid Values	Comments
BHT01	Required	Hierarchical Structure Code: **0019** – Information Source	
BHT02	Required	Transaction Set Purpose Code: **00** – Original	This data element has no affect on the processing of this transaction.
BHT03	Required	Reference Identification	This value is assigned by the sender
BHT04	Required	Date	This is the bill date for all the claims that follow: CCYYMMDD
BHT05	Required	Time	HHMM format
BHT06	Required	Transaction Type Code: **CH** – Chargeable	Use CH for fee-for service claims.

Segment Name	Submitter Name
Segment ID	NM1
Loop ID	1000A
Usage	Required
Segment Notes	This segment identifies the submitter and must include the CSC-assigned sender ID (ETIN).
Example	NM1*41*2*Clearinghouse Inc.*****46*956741230001~

Element ID	Usage	Guide Description/Valid Values	Comments
NM101	Required	Entity Identifier Code: **41** – Submitter	
NM102	Required	Entity Type Qualifier: **1** – Person **2** – Non Person Entity	
NM103	Required	Submitter Last Name or Organization Name	
NM104	Situational	Submitter Name First	
NM105	Situational	Submitter Name Middle	
NM106	Not Used	Submitter Name Prefix	
NM107	Not Used	Submitter Name Suffix	
NM108	Required	Submitter Identification Code Qualifier: **46** – Electronic Transmitter Identification Number (ETIN)	
NM109	Required	Submitter Identification Code	
NM110	Not Used	Entity Relationship Code	
NM112	Not Used	Entity Identifier Code	

Segment Name	Submitter EDI Contact Information
Segment ID	PER
Loop ID	1000A
Usage	Required
Segment Notes	This segment is required by the IG and must be submitted to be compliant; however, data submitted is not captured by the CSC. See the IG for details.

Segment Name	Receiver Name
Segment ID	NM1
Loop ID	1000B
Usage	Required
Segment Notes	This segment is required by the IG and must be submitted to be compliant; however, data submitted is not captured by the CSC. See the IG for details.

Segment Name	Billing/Pay-To Provider Hierarchical Level
Segment ID	HL
Loop ID	2000A
Usage	Required
Segment Notes	This segment must be repeated for every billing provider submitting claims.
Example	HL*1**20*1~

Element ID	Usage	Guide Description/Valid Values	Comments
HL01	Required	Hierarchical ID Number	Must begin with "**1**"
HL02	N/A	Hierarchical Parent ID Number	Not Used
HL03	Required	Hierarchical Level Code: **20** – Information Source	
HL04	Required	Hierarchical Child Code: **1** – Additional Subordinate	

Segment Name	Billing Provider Name
Segment ID	NM1
Loop ID	2010AA
Usage	Required
Segment Notes	This segment is required by the IG and must be submitted to be compliant; however, data submitted is not captured by the CSC. See the IG for details.

Segment Name	Billing Provider Address
Segment ID	N3
Loop ID	2010AA
Usage	Required
Segment Notes	This segment is required by the IG and must be submitted to be compliant; however, data submitted is not captured by the CSC. See the IG for details.

Segment Name	Billing Provider City/State/Zip
Segment ID	N4
Loop ID	2010AA
Usage	Required
Segment Notes	This segment is required by the IG and must be submitted to be compliant; however, data submitted is not captured by the CSC. See the IG for details.

Segment Name	Subscriber Hierarchical Level
Segment ID	HL
Loop ID	2000B
Usage	Required
Segment Notes	This segment and following subscriber loops must repeat for every CSC member claim submitted. See the IG for additional information about creating HL segments.
Example	HL*2*1*22*0~

Element ID	Usage	Guide Description/Valid Values	Comments
HL01	Required	Hierarchical ID Number	
HL02	Required	Hierarchical Parent ID Number	This HL segment is always subordinate to the Billing Pay-To Provider HL. The value in this field must match the Billing/Pay-To Provider Hierarchical ID number.
HL03	Required	Hierarchical Level Code: **22** – Subscriber	
HL04	Required	Hierarchical Child Code: **0** – No Subordinate HL Segments in this Hierarchical Structure	Because our subscriber is always the patient there are no subordinate HL's to this HL segment.

Segment Name	Subscriber Information
Segment ID	SBR
Loop ID	2000B
Usage	Required
Segment Notes	This segment specifies the primary insured and the insurance carrier for that insured.
Example	SBR*P*18*******OF~

Element ID	Usage	Guide Description/Valid Values	Comments
SBR01	Required	Payer Responsibility Sequence Number Code: **P** – Primary	
SBR02	Required	Individual Relationship Code: **18** – Self	The patient is always the insured in the EI program.
SBR03	Situational	Reference Number	Insured Group or Policy Number
SBR04	Situational	Name	Insured Group Name
SBR05	Not Used	Insurance Type Code	
SBR06	Not Used	Coordination of Benefits Code	
SBR07	Not Used	Yes/No Condition or Response Code	
SBR08	Not Used	Employment Status Code	
SBR09	Situational	Claim Filing Indicator Code: **OF** – Other Federal	

Segment Name	Subscriber Name
Segment ID	NM1
Loop ID	2010BA
Usage	Required
Segment Notes	This segment contains the CSC member name and ID number.
Example	NM1*IL*1*DOE*JOHN*T***MI*123456789~

Element ID	Usage	Guide Description/Valid Values	Comments
NM101	Required	Subscriber Entity Identifier Code: **IL** – Subscriber	
NM102	Required	Subscriber Entity Type Qualifier: **1** – Person	
NM103	Required	Subscriber Name Last or Organization Name	
NM104	Situational	Subscriber Name First	
NM105	Situational	Subscriber Name Middle	
NM106	Not Used	Subscriber Name Prefix	
NM107	Required	Subscriber Name Suffix	
NM108	Required	Subscriber Identification Code Qualifier: **MI** – Member Identification Number	
NM109	Situational	Subscriber Identification Code	EI Child ID
NM110	Not Used	Entity Relationship Code	
NM111	Not Used	Entity Identifier Code	

Segment Name	Subscriber Address
Segment ID	N3
Loop ID	2010BA
Usage	Required
Segment Notes	Required because the patient is the same person as the subscriber, however, CSC will not capture this data.

Segment Name	Subscriber City/State/Zip
Segment ID	N4
Loop ID	2010BA
Usage	Required
Segment Notes	Required because the patient is the same person as the subscriber, however, CSC will not capture this data.

Segment Name	Subscriber Demographic Information
Segment ID	DMG
Loop ID	2010BA
Usage	Required
Segment Notes	Required because the patient is the same person as the subscriber.
Example	DMG*D8*20011123*M~

Data Element ID	Usage	Guide Description/Valid Values	Comments
DMG01	Required	Date Time Period Format Qualifier: **D8** – Date expressed in CCYYMMDD	
DMG02	Required	Subscriber Birth Date	CCYYMMDD format
DMG03	Required	Subscriber Gender Code: **M** – Male **F** – Female **U** -Unknown	
DMG04	Not Used	Marital Status Code	
DMG05	Not Used	Race or Ethnicity Code	
DMG6	Not Used	Citizen Status Code	
DMG07	Not Used	Country Code	
DMG08	Not Used	Basis of Verification Code	
DMG09	Not Used	Quantity	

Segment Name	Payer Name
Segment ID	NM1
Loop ID	2010BB
Usage	Required
Segment Notes	This segment contains the destination Payer.
Example	NM1*PR*2*DHHR*****PI*336814161~

Element ID	Usage	Guide Description/Valid Values	Comments
NM101	Required	Entity Identifier Code: **PR** – Payer	
NM102	Required	Entity Type Qualifier: **2** – Non Person Entity	
NM103	Required	Payer Last Name or Organization Name	**DHHR**
NM104	Situational	Payer Name First	
NM105	Situational	Payer Name Middle	
NM106	Not Used	Payer Name Prefix	
NM107	Not Used	Payer Name Suffix	
NM108	Required	Payer Identification Code Qualifier: **PI** – Payer Identification	
NM109	Required	Payer Identification Code	**336814161**
NM110	Not Used	Entity Relationship Code	
NM112	Not Used	Entity Identifier Code	

Segment Name	Payer City/State/Zip
Segment ID	N4
Loop ID	2010BB
Usage	Required
Segment Notes	

Segment Name	Claim Information
Segment ID	CLM
Loop ID	2300
Usage	Required
Segment Notes	This segment contains basic data about the claim.
Example	CLM*ABCUKIJ1234567*100***11>B>1*Y*A*Y*Y*P~

Element ID	Usage	Guide Description/Valid Values	Comments
CLM01	Required	Claim Submitter's Identifier or Patient Account Number	Up to 20 characters will be returned in the remittance advice
CLM02	Required	Monetary Amount or Total Claim Charge Amount	This is the sum of all service line/detail charges.
CLM03	Not Used	Claim Filing Indicator Code	
CLM04	Not Used	Non Institutional Claim Type Code	
CLM05	Required	Health Care Service Location Information or Place of Service Code	This is a composite
CLM05-1	Required	Facility Type Code	See IG for two character code for place of service. If there is no appropriate value list in the IG, use 99, Other Unlisted Facility and enter the POS in the NTE segment of the 2400 loop.
CLM05-2	Required	Facility Code Qualifier Code: **B** – Place of Service Codes for Professional or Dental Services.	
CLM05-3	Required	Claim Frequency Code: **1** – Original	Required by the standard, Not Used by CSC– All corrections, voids and replacement claims should be sent on paper.
CLM06	Required	Yes/No Condition or Response Code: **Y** – Provider signature on file **N** – Provider signature not on file	
CLM07	Required	Provider Accepts Assignment Code: **A** – Assigned **B** – Assignment Accepted on Clinical Lab Services Only **C** – Not Assigned	Code **P** no longer valid
CLM08	Required	Benefit Assignment Certification Indicator: **Y** – Yes **N** -No **W** – Not Applicable	Use Code W when patient refuses to assign benefits
CLM09	Required	Release of Information Code**:** **I** – Informed Consent to Release Medical Information **Y** – Yes, Provider has a Signed Statement Permitting Release of Medical Data Related to a Claim.	Codes **A**, **M**, **N**, and **O** are no longer valid. **I** required when the provider has not collected a signature and state and federal laws do not supersede the HIPAA Privacy Rule by requiring a signature to be collected. **Y** required when the provider has collected a signature

Element ID	Usage	Guide Description/Valid Values	Comments
			OR when state or federal laws require a signature to be collected.
CLM10	Situational	Patient Signature Source Code: **P** – Signature generated by provider because the patient was not physically present for services.	**B**, **C**, **M**, and **S** are no longer valid. Required when a signature was executed on the patient's behalf under state or federal law. If not required by this implementation guide, do not send.
CLM11	Not Used	Related Cause Information	This is a composite
CLM11-1	Not Used	Related Cause Code	Not Used
CLM11-2	Not Used	Related Cause Code	Not Used
CLM11-3	Not Used	Related Cause Code	Not Used
CLM11-4	Not Used	State or Providence Code	Not Used
CLM11-5	Not Used	Country Code	Not Used
CLM12	Not Used	Special Program Code	Not Used
CLM13	Not Used	Yes/No Condition or Response Code	Not Used
CLM14	Not Used	Level of Service Code	Not Used
CLM15	Not Used	Yes/No Condition or Response Code	Not Used
CLM16	Not Used	Provider Agreement Code	Not Used
CLM17	Not Used	Claim Status Code	Not Used
CLM18	Not Used	Yes/No Condition or Response Code	Not Used
CLM19	Not Used	Claim Submission Reason Code	Not Used
CLM20	Not Used	Delay Reason Code	Not Used

Segment Name	Patient Amount Paid
Segment ID	AMT
Loop ID	2300
Usage	Situational
Segment Notes	This segment contains the sum of all amounts paid on the claim by the patient or his/her representative.
Example	REF*F5*20~

Element ID	Usage	Guide Description/Valid Values	Comments
AMT01	Required	Reference Identification Qualifier: **F5** – Patient Amount Paid	
AMT02	Required	Patient Amount Paid	
AMT03	Not Used	Credit/Debit Flag Code	

Segment Name	Prior Authorization
Segment ID	REF
Loop ID	2300
Usage	Required
Segment Notes	This segment contains prior authorization or referral number.
Example	REF*G1*A99000629513~

Element ID	Usage	Guide Description/Valid Values	Comments
REF01	Required	Reference Identification Qualifier: **G1** – Prior Authorization Number	
REF02	Required	Reference Identification	This is the authorization number generated by the SPOE software
REF03	Not Used	Description	
REF04	Not Used	Reference Identifier	

Segment Name	Medical Record Number
Segment ID	REF
Loop ID	2300
Usage	Required
Segment Notes	This segment contains the medical record number for the patient.
Example	REF*EA*990006295~

Element ID	Usage	Guide Description/Valid Values	Comments
REF01	Required	Reference Identification Qualifier: **EA** – Medical Record Number	
REF02	Required	Reference Identification	EI Child ID
REF03	Not Used	Description	
REF04	Not Used	Reference Identifier	

Segment Name	Health Care Diagnosis Code
Segment ID	HI
Loop ID	2300
Usage	Required
Segment Notes	This segment identifies all diagnosis codes related to the claim. This segment is required for all claims submitted to CSC. Only the Principal diagnosis code is recognized by CSC. As of 10/01/2015, ICD-10 Codes will be required for all dates of service. A new Code List Qualifier code (ABK) will also be required.
Example	HI*BK>4205~ (ICD-9) HI*ABK>B9561~ (ICD-10)

Element ID	Usage	Guide Description/Valid Values	Comments
HI01	Required	Principal Diagnosis	This is a composite
HI01-1	Required	Code List Qualifier Code: **BK** – Principal Diagnosis for ICD-9 **ABK** -- Principal Diagnosis for ICD-10	
HI01-2	Required	Principal Diagnosis Code	

HI01-3	Not Used	Date Time Period Format Qualifier	
HI01-4	Not Used	Date Time Period	
HI01-5	Not Used	Monetary Amount	
HI01-6	Not Used	Quantity	
HI01-7	Not used	Version Identifier	

Segment Name	Rendering Provider Name
Segment ID	NM1
Loop ID	2310B
Usage	Required
Segment Notes	This segment conveys the name of the Rendering Provider and primary number at the claim level. The Rendering Provider's NPI number is required if it is on file with CSC. If it is not, omit the elements as shown in the example below and enter the Federal Tax ID + four character sequence number of the Rendering Provider in the REF*G2 segment.
Example	NM1*82*1*LASTNAME*FIRSTNAME****XX*1234567893~ (With NPI Number) NM1*82*1*LASTNAME*FIRSTNAME~ (Without NPI Number)

Element ID	Usage	Guide Description/Valid Values	Comments
NM101	Required	Entity Identifier Code: **82** – Rendering Provider	
NM102	Required	Entity Type Qualifier: **1** –Person **2** – Non Person Entity	
NM103	Required	Rendering Provider Last Name or Organization Name	
NM104	Situational	Rendering Provider Name First	
NM105	Situational	Rendering Provider Name Middle	
NM106	Not Used	Rendering Provider Name Prefix	
NM107	Not Used	Rendering Provider Name Suffix	
NM108	Situational	Rendering Provider Identification Code Qualifier: **XX** – Health Care Financing Administration National Provider Identifier	Codes 24 and 34 are no longer valid.
NM109	Situational	Rendering Provider Identifier	NPI Number
NM110	Not Used	Entity Relationship Code	
NM112	Not Used	Entity Identifier Code	

Segment Name	Rendering Provider Specialty Information
Segment ID	PRV
Loop ID	2310B
Usage	Required
Segment Notes	
Example	PRV*PE*PXC*235Z00000X~

Element ID	Usage	Guide Description/Valid Values	Comments
PRV01	Required	Provider Code PE – Performing	

PRV02	Required	Reference Identification Qualifier **PXC** -- Health Care Provider Taxonomy Code.	Code ZZ replaced by PXC, Health Care Provider Taxonomy Code
PRV03	Required	Reference Identification	Taxonomy Code

Segment ID	REF
Loop ID	2310B
Usage	Situational
Segment Notes	This segment contains the Rendering Provider Identification Code.
Example	REF*G2*1122334450001~

Element ID	Usage	Guide Description/Valid Values	Comments
REF01	Required	Reference Identification Qualifier: **G2** -- Provider Commercial Number	
REF02	Required	Reference Identification	Rendering Provider's Federal Tax ID + four character sequence number for the Rendering Provider.
REF03	Not Used	Description	
REF04	Not Used	Reference Identifier	

Segment Name	Service Line
Segment ID	LX
Loop ID	2400
Usage	Required
Segment Notes	The Service Line LX segment begins with 1 and is incremented by one for each additional service line of a claim. The LX functions as a line counter.
Example	LX*1~

Element ID	Usage	Guide Description/Valid Values	Comments
LX01	Required	Assigned Number	

Segment Name	Professional Service
Segment ID	SV1
Loop ID	2400
Usage	Required
Segment Notes	To specify the claim service detail for a Health Care professional.
Example	SV1*HC>99211>GG*25*UN*1*11**1~

Element ID	Usage	Guide Description/Valid Values	Comments
SV101	Required	Composite Medical Procedure Identifier	
SV101-1	Required	Product/Service ID Qualifier: **HC** – HCPCS Codes	
SV101-2	Required	Procedure Code	
SV101-3	Situational	Procedure Modifier 1	Modifier **GG** should be used for Same patient/same day
SV101-4	Not Used	Procedure Modifier 2	
SV101-5	Not Used	Procedure Modifier 3	

Element ID	Usage	Guide Description/Valid Values	Comments
SV101-6	Not Used	Procedure Modifier 4	
SV101-7	Not Used	Description	
SV102	Required	Line Item Charge Amount	
SV103	Required	Unit or Basis for Measurement: **UN** -Unit	Decimal values not accepted
SV104	Required	Service Unit Count	
SV105	Situational	Facility Code Value -See IG for Values	If the IG provides a valid Place of Service use this data element. Otherwise enter POS in the NTE segment.
SV106	Not Used	Service Type Code	
SV107	Required	Composite Diagnosis Code Pointer	
SV107-1	Required	Diagnosis Code Pointer	
SV107-2	Situational	Diagnosis Code Pointer	
SV107-3	Situational	Diagnosis Code Pointer	
SV107-4	Situational	Diagnosis Code Pointer	
SV108	Not Used	Monetary Amount	
SV109	Not Used	Emergency Indicator	
SV110	Not Used	Multiple Procedure Code	
SV111	Not Used	EPSDT Indicator	
SV112	Not Used	Family Planning Indicator	
SV113	Not Used	Review Code	
SV114	Not Used	National or Local Review Code	
SV115	Not Used	Co-Pay Status Code	
SV116	Not Used	Health Care Professional Shortage Area Code	
SV117	Not Used	Reference Identification	
SV118	Not Used	Postal Code	
SV119	Not Used	Monetary Amount	
SV120	Not Used	Level of Care Code	
SV121	Not Used	Provider Agreement Code	

Segment Name	Durable Medical Equipment Services
Segment ID	SV5
Loop ID	2400
Usage	Not Used
Segment Notes	To report rental or purchase price information.
Example	

Element ID	Usage	Guide Description/Valid Values	Comments
SV501	Required	Composite Medical Procedure Identifier	Composite Element
SV501-1	Required	Procedure Identifier Qualifier **HC** – HCPCS Code	
SV501-2	Required	Product/Service ID	Value must be the same as reported in SV101-2
SV501-3	Not Used	Procedure Modifier 1	
SV501-4	Not Used	Procedure Modifier 2	

Element ID	Usage	Guide Description/Valid Values	Comments
SV501-5	Not Used	Procedure Modifier 3	
SV501-6	Not Used	Procedure Modifier 4	
SV501-7	Not Used	Description	
SV502	Required	Unit or Basis for Measurement Code **DA** - Days	Required by IG. Ignored by CSC.
SV503	Required	Quantity	
SV503	Required	Quantity	
SV504	Not Used	DME Rental Price	
SV505	Required	DME Purchase Price	
SV506	Not Used	Rental Unit Price Indicator	
SV507	Not Used	Prognosis Code	

Segment Name	Date – Service Date
Segment ID	DTP
Loop ID	2400
Usage	Required
Segment Notes	To specify the claim service date.
Example	DTP*472*D8*20030615~

Element ID	Usage	Guide Description/Valid Values	Comments
DTP01	Required	Date Time Qualifier: **472** – Service	
DTP02	Required	Date Time Period Format Qualifier: **D8** – CCYYMMDD format **RD8** – Date Range	RD8 may be used for DME
DTP03	Required	Date	

Segment Name	Prior Authorization
Segment ID	REF
Loop ID	2400
Usage	Situational
Segment Notes	Use this segment if the authorization is different than the number reported at the claim level.
Example	REF*G1* A99000629513~

Element ID	Usage	Guide Description/Valid Values	Comments
REF01	Required	Reference Identification Qualifier: **G1** – Prior Authorization Number	
REF02	Required	Prior Authorization Number	
REF03	Not Used	Description	
REF04	Not Used	Reference Identifier	

Segment Name	Line Item Control Number
Segment ID	REF
Loop ID	2400
Usage	Situational
Segment Notes	This segment is strongly recommended and will be returned in the remittance advice if received.
Example	REF*6R*7865~

Element ID	Usage	Guide Description/Valid Values	Comments
REF01	Required	Reference Identification Qualifier: **6R** – Provider Control Number	
REF02	Required	Line Item Control Number	
REF03	Not Used	Description	
REF04	Not Used	Reference Identifier	

Segment Name	Sales Tax Amount
Segment ID	AMT
Loop ID	2400
Usage	Situational
Segment Notes	Required if sales tax applies to service line and submitter is required to report that information to the receiver.
Example	AMT*T*1.75~

Element ID	Usage	Guide Description/Valid Values	Comments
AMT01	Required	Amount Qualifier Code: **T** -Tax	
AMT02	Required	Monetary Amount	
AMT03	Not Used	Credit Debit Flag Code	

Segment Name	Line Note
Segment ID	NTE
Loop ID	2400
Usage	Required
Segment Notes	This segment is used to convey the EI procedure code received in the authorization and the place of service, if necessary.
Example	NTE*ADD*EI=X1011,POS=15~

Element ID	Usage	Guide Description/Valid Values	Comments
NTE01	Required	Amount Qualifier Code: **ADD**-Additional Information	
NTE02	Required	Description	Example of data to be entered: EI procedure=X1011, POS=15 The comma is very important after the EI procedure code. POS need not be entered if a valid value exists in SV105-1.

Segment Name	Transaction Set Trailer
Segment ID	SE
Loop ID	N/A
Usage	Required
Segment Notes	To indicate the end of the transaction set and provide the count of the transmitted segments (including the beginning (ST) and ending (SE) segments)
Example	SE*545*1234567~

Element ID	Usage	Guide Description/Valid Values	Comments
SE01	Required	Number of Segments included	Count includes ST and SE
SE02	Required	Transaction Set Control Number	This number must be the same as ST

4.0 File Transfer and Verification

CSC utilizes EDIFECS for testing of HIPAA X12 files. This site can be accessed by providers once a trading Partner Agreement has been signed. Once signed, the website will allow the providers to submit test files. These test files will be processed against the CSC companion guide. Once both parties are confident in the consistency of the test files submitted, the provider will be able to upload submission files, download files and check the status of files submitted. The normal processing of the files will occur nightly. The status of the files will be posted the next business day after successful upload of the files.