ADDENDA

National Electronic Data Interchange Transaction Set Implementation Guide

Health Care Claim: Dental

837

ASC X12N 837 (004010X097A1)

October 2002

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1 Introduction to Modified Pages

This document is addenda to the X12N Health Care Claim: Dental Implementation Guide, originally published May 2000 as 004010X097. As a result of the post publication review process, items were identified that could be considered impediments to implementation. These items were passed to the X12N Health Care Work Group that created the original Implementation Guide for their review.

Modifications based on those comments were reflected in a draft version of the Addenda to the X12N 004010X097 Implementation Guide. Since the X12N 004010X097 Implementation Guide is named for use under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), an NPRM Draft Addenda went through a Notice of Proposed Rule Making (NPRM) comment process that began on May 31, 2002. The Addenda reflects changes based on comments received during the NPRM process and X12N's own review processes. Only the modifications noted in the NPRM Draft Addenda were considered in the NPRM and X12N review processes. The Addenda was approved for publication by X12N on October 10, 2002. When using the X12N Health Care Claim: Dental Implementation Guide, originally published May 2000 as 004010X097 and incorporating the changes identified in the Addenda, the value used in GS08 must be "004010X097A1".

Each of the changes made to the 004010X097 Implementation Guide has been annotated with a note in red and a line pointing to the location of the change. In the event that a segment or loop has been deleted, the deletion will be identified in the Implementation table beginning on Page 7. For convenience, the affected 004010X097 Implementation Guide page number is noted at the bottom of the page. Please note that as a result of insertion or deletion of material Addenda pages may not begin or end at the same place as the original referenced page. Because of this, Addenda pages are not page for page replacements and the original pages should be retained.

Changes in the Addenda may have caused changes to the Data Element Dictionary and the Data Element Name Index (Appendix E in the original Implementation Guide), but these changes are not identified in the Addenda. Changes in the Addenda may also have caused changes to the Examples and the EDI Transmission Examples (Section 4 in the original Implementation Guide), again these are not identified in the Addenda.

1.1.2 HIPAA Role in Implementation Guides

The Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191 - known as HIPAA) includes provisions for Administrative Simplification, which require the Secretary of Department of Health and Human Services to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. HIPAA directs the Secretary to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard.

Detailed Implementation Guides for each standard must be available at the time of the adoption of HIPAA standards so that health plans, providers, clearinghouses, and software vendors can ready their information systems and application software for compliance with the standards. Consistent usage of the standards, including loops, segments, data elements, etc., across all guides is mandatory to support the Secretary's commitment to standardization.

This Implementation Guide has been developed for use as a HIPAA Implementation Guide for Health Care Claim: Dental. Should the Secretary adopt the X12 837 Health Care Claim: Dental transaction as an industry standard, this Implementation Guide describes the consistent industry usage called for by HIPAA. If adopted under HIPAA, the X12N 837 Health Care Claim: Dental transaction cannot be implemented except as described in this Implementation Guide.

1.2 Version and Release

This implementation guide is based on the October 1997 ASC X12 standards, referred to as Version 4, Release 1, Sub-release 0 (004010).

1.3 Business Use and Definition

The ASC X12 standards are formulated to minimize the need for users to reprogram their data processing systems for multiple formats by allowing data interchange through the use of a common interchange structure. These standards do not define the method in which interchange partners should establish the required electronic media communication link, nor the hardware and translation software requirements to exchange EDI data. Each trading partner must provide these specific requirements separately.

First sentence replaced.

This implementation guide is intended to provide assistance in developing and executing the electronic transfer of health encounter data, health claim data and health care predetermination of dental benefits data. With a few exceptions, this implementation guide does not contain payer-specific instructions. Trading partners agreements are not allowed to set data specifications that conflict with the HIPAA implementations. Payers are required by law to have the capability to send/receive all HIPAA transactions. For example, a payer who does not pay claims with certain home health information must still be able to electronically accept on their front end an 837 with all the home health data. The payer cannot upfront reject such a claim. However, that does not mean that the payer is required to bring that data into their adjudication system. The payer, acting in accordance with policy and contractual agreements, can ignore data within the 837 data set. In light of this, it is permissible for trading partners to specify a subset of an

IMPLEMENTATION

837 Health Care Claim: Dental

1. The 837 transaction is designed to transmit one or more claims for each billing provider. The hierarchy of the looping structure is as follows: billing provider, subscriber, patient, claim level, and claim service line level. Billing providers who sort claims using this hierarchy use the 837 more efficiently because information that applies to all lower levels in the hierarchy does not have to be repeated within the transaction.

2. The developers of this implementation guide also recommend this standard for submitting similar data within a prepaid managed care context. Referred to as "capitated encounters," this data usually does not result in a payment, though it is possible to submit a mixed claim that includes both prepaid and request for payment services. This standard allows for the submission of data from providers of health care products and services to a Managed Care Organization or other payer. This standard may be used by payers to share data with plan sponsors, employers, regulatory entities, and Community Health Information Networks.

3. This standard also can be used as a transaction set in support of the Coordination of Benefits (COB) claims process. Additional looped segments can be used within both the claim and service line levels to transfer each payer's adjudication information to subsequent payers.

Table 1 - Header

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
53	005	ST	Transaction Set Header	R	1	
54	010	BHT	Beginning of Hierarchical Transaction	R	1	
57	015	REF	Transmission Type Identification	R	1	
			LOOP ID - 1000A SUBMITTER NAME			1
59	020	NM1	Submitter Name	R	1	
62	045	PER	Submitter Contact Information	R	2	
			LOOP ID - 1000B RECEIVER NAME			1
65	020	NM1	Receiver Name	R	1	

N2 Segment Deleted

Table 2 - Billing/Pay-to Provider Detail

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
			LOOP ID - 2000A BILLING/PAY-TO PROVIDER HIERARCHICAL LEVEL			>1
67	001	HL	Billing/Pay-to Provider Hierarchical Level	R	1	
69	003	PRV	Billing/Pay-to Provider Specialty Information	S	1	
71	010	CUR	Foreign Currency Information	S	1	
			LOOP ID - 2010AA BILLING PROVIDER NAME			1
74	015	NM1	Billing Provider Name	R	1	
77	025	N3	Billing Provider Address	R	1	
78	030	N4	Billing Provider City/State/ZIP Code	R	1	
80	035	REF	Billing Provider Secondary Identification Number	S	5	
82	035	REF	Claim Submitter Credit/Debit Card Information	S	8	
			LOOP ID - 2010AB PAY-TO PROVIDER'S NAME			1
84	015	NM1	Pay-to Provider's Name	S	1	
87	025	N3	Pay-to Provider's Address	R	1	
88	030	N4	Pay-to Provider City/State/Zip	R	1	
90	035	REF	Pay-to Provider Secondary Identification Number	S	5	

Table 2 - Subscriber Detail

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
			LOOP ID - 2000B SUBSCRIBER HIERARCHICAL LEVEL			**>1**
92	001	HL	Subscriber Hierarchical Level	R	1	
95	005	SBR	Subscriber Information	R	1	
			LOOP ID - 2010BA SUBSCRIBER NAME			**1**
99	015	NM1	Subscriber Name	R	1	
103	025	N3	Subscriber Address	S	1	
104	030	N4	Subscriber City/State/ZIP Code	S	1	
106	032	DMG	Subscriber Demographic Information	S	1	
108	035	REF	Subscriber Secondary Identification	S	4	
110	035	REF	Property and Casualty Claim Number	S	1	
			LOOP ID - 2010BB PAYER NAME			**1**
112	015	NM1	Payer Name	R	1	
115	025	N3	Payer Address	S	1	
116	030	N4	Payer City/State/ZIP Code	S	1	
118	035	REF	Payer Secondary Identification Number	S	3	
			LOOP ID - 2010BC CREDIT/DEBIT CARD HOLDER NAME			**1**
120	015	NM1	Credit/Debit Card Holder Name	S	1	
123	035	REF	Credit/Debit Card Information	S	3	

N2 Segment Deleted

Table 2 - Patient Detail

For purposes of this documentation, the claim detail information is presented only in the dependent level. Specific claim detail information can be given in either the subscriber or the dependent hierarchical level. Because of this the claim information is said to “float.” Claim information is positioned in the same hierarchical level that describes its owner-participant, either the subscriber or the dependent. In other words, the claim information, loop 2300, is placed following loop 2010BC in the subscriber hierarchical level when the patient is the subscriber, or it is placed at the patient/dependent hierarchical level when the patient is the dependent of the subscriber as shown here. When the patient is the subscriber, loops 2000C and 2010CA are not sent. See 2.3.2.1, HL Segment, for details.

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
			LOOP ID - 2000C PATIENT HIERARCHICAL LEVEL			**>1**
125	001	HL	Patient Hierarchical Level	S	1	
127	007	PAT	Patient Information	R	1	
			LOOP ID - 2010CA PATIENT NAME			**1**
129	015	NM1	Patient Name	R	1	
132	025	N3	Patient Address	R	1	
133	030	N4	Patient City/State/ZIP Code	R	1	
135	032	DMG	Patient Demographic Information	R	1	
137	035	REF	Patient Secondary Identification	S	5	
139	035	REF	Property and Casualty Claim Number	S	1	
			LOOP ID - 2300 CLAIM INFORMATION			**100**
141	130	CLM	Claim Information	R	1	
148	135	DTP	Date - Admission	S	1	
149	135	DTP	Date - Discharge	S	1	
151	135	DTP	Date - Referral	S	1	
152	135	DTP	Date - Accident	S	1	
153	135	DTP	Date - Appliance Placement	S	5	
155	135	DTP	Date - Service	S	1	

N2 Segment Deleted

157	145	DN1	Orthodontic Total Months of Treatment	S	1	
159	150	DN2	Tooth Status	S	35	
161	155	PWK	Claim Supplemental Information	S	10	
164	175	AMT	Patient Amount Paid	S	1	
165	175	AMT	Credit/Debit Card - Maximum Amount	S	1	
166	180	REF	Predetermination Identification	S	5	
168	180	REF	Service Authorization Exception Code	S	1	
170	180	REF	Original Reference Number (ICN/DCN)	S	1	
172	180	REF	Prior Authorization or Referral Number	S	2	
174	180	REF	Claim Identification Number for Clearinghouses and Other Transmission Intermediaries	S	1	
176	190	NTE	Claim Note	S	20	
			LOOP ID - 2310A REFERRING PROVIDER NAME			2
178	250	NM1	Referring Provider Name	S	1	
181	255	PRV	Referring Provider Specialty Information	S	1	
183	271	REF	Referring Provider Secondary Identification	S	5	
			LOOP ID - 2310B RENDERING PROVIDER NAME			1
185	250	NM1	Rendering Provider Name	S	1	
188	255	PRV	Rendering Provider Specialty Information	S	1	
190	271	REF	Rendering Provider Secondary Identification	S	5	
			LOOP ID - 2310C SERVICE FACILITY LOCATION			1
192	250	NM1	Service Facility Location	S	1	
195	271	REF	Service Facility Location Secondary Identification	S	5	
			LOOP ID - 2310D ASSISTANT SURGEON NAME			1
197	250	NM1	Assistant Surgeon Name	S	1	
200	255	PRV	Assistant Surgeon Specialty Information	S	1	
202	271	REF	Assistant Surgeon Secondary Identification	S	1	
			LOOP ID - 2320 OTHER SUBSCRIBER INFORMATION			10
204	290	SBR	Other Subscriber Information	S	1	
208	295	CAS	Claim Adjustment	S	5	
215	300	AMT	Coordination of Benefits (COB) Payer Paid Amount	S	1	
216	300	AMT	Coordination of Benefits (COB) Approved Amount	S	1	
217	300	AMT	Coordination of Benefits (COB) Allowed Amount	S	1	
218	300	AMT	Coordination of Benefits (COB) Patient Responsibility Amount	S	1	
219	300	AMT	Coordination of Benefits (COB) Covered Amount	S	1	
220	300	AMT	Coordination of Benefits (COB) Discount Amount	S	1	
221	300	AMT	Coordination of Benefits (COB) Patient Paid Amount	S	1	
222	305	DMG	Other Insured Demographic Information	S	1	
224	310	OI	Other Insurance Coverage Information	R	1	
			LOOP ID - 2330A OTHER SUBSCRIBER NAME			1
226	325	NM1	Other Subscriber Name	R	1	
229	332	N3	Other Subscriber Address	S	1	
230	340	N4	Other Subscriber City/State/Zip Code	S	1	
232	355	REF	Other Subscriber Secondary Identification	S	3	
			LOOP ID - 2330B OTHER PAYER NAME			1
234	325	NM1	Other Payer Name	R	1	
236	345	PER	Other Payer Contact Information	S	2	
239	350	DTP	Claim Paid Date	S	1	
240	355	REF	Other Payer Secondary Identifier	S	3	
242	355	REF	Other Payer Prior Authorization or Referral Number	S	2	
244	355	REF	Other Payer Claim Adjustment Indicator	S	1	

Segment Name Changed

Repeat Changed

N2 Deleted

N2 Deleted

Usage Changed

N2 Deleted

New Loop Added

N2 Deleted

Segment Name Changed

Repeat Changed

			LOOP ID - 2330C OTHER PAYER PATIENT INFORMATION				**1**
246	**325**	**NM1**	Other Payer Patient Information	**S**	**1**		
248	**355**	**REF**	Other Payer Patient Identification	**S**	**3**		
			LOOP ID - 2330D OTHER PAYER REFERRING PROVIDER				**1**
250	**325**	**NM1**	Other Payer Referring Provider	**S**	**1**		
252	**355**	**REF**	Other Payer Referring Provider Identification	**S**	**3**		
			LOOP ID - 2330E OTHER PAYER RENDERING PROVIDER				**1**
254	**325**	**NM1**	Other Payer Rendering Provider	**S**	**1**		
256	**355**	**REF**	Other Payer Rendering Provider Identification	**S**	**3**		
			LOOP ID - 2400 LINE COUNTER				**50**
258	**365**	**LX**	Line Counter	**R**	**1**		
259	**380**	**SV3**	Dental Service	**R**	**1**		
265	**382**	**TOO**	Tooth Information	**S**	**32**		
268	**455**	**DTP**	Date - Service	**S**	**1**		
270	**455**	**DTP**	Date - Prior Placement	**S**	**1**		
272	**455**	**DTP**	Date - Appliance Placement	**S**	**1**		
274	**455**	**DTP**	Date - Replacement	**S**	**1**		
276	**460**	**QTY**	Anesthesia Quantity	**S**	**5**		
278	**470**	**REF**	Service Predetermination Identification	**S**	**1**		
279	**470**	**REF**	Prior Authorization or Referral Number	**S**	**2**		
281	**470**	**REF**	Line Item Control Number	**S**	**1**		
283	**475**	**AMT**	Approved Amount	**S**	**1**		
284	**475**	**AMT**	Sales Tax Amount	**S**	**1**		
285	**485**	**NTE**	Line Note	**S**	**10**		
			LOOP ID - 2420A RENDERING PROVIDER NAME				**1**
286	**500**	**NM1**	Rendering Provider Name	**S**	**1**		
289	**505**	**PRV**	Rendering Provider Specialty Information	**S**	**1**		
291	**525**	**REF**	Rendering Provider Secondary Identification	**S**	**5**		
			LOOP ID - 2420B OTHER PAYER PRIOR AUTHORIZATION OR REFERRAL NUMBER				**1**
293	**500**	**NM1**	Other Payer Prior Authorization or Referral Number	**S**	**1**		
296	**525**	**REF**	Other Payer Prior Authorization or Referral Number	**S**	**2**		
			LOOP ID - 2420C ASSISTANT SURGEON NAME				**1**
298	**500**	**NM1**	Assistant Surgeon Name	**S**	**1**		
301	**505**	**PRV**	Assistant Surgeon Specialty Information	**S**	**1**		
303	**525**	**REF**	Assistant Surgeon Secondary Identification	**S**	**1**		
			LOOP ID - 2430 LINE ADJUDICATION INFORMATION				**25**
305	**540**	**SVD**	Line Adjudication Information	**S**	**1**		
309	**545**	**CAS**	Service Adjustment	**S**	**99**		
316	**550**	**DTP**	Line Adjudication Date	**R**	**1**		
317	**555**	**SE**	Transaction Set Trailer	**R**	**1**		

Segment Name Changed

Repeat Changed

New Segment Added

Usage Changed

N2 Deleted

Name Changed

Repeat Changed

New Loop Added

IMPLEMENTATION

TRANSMISSION TYPE IDENTIFICATION

Usage: **REQUIRED**

Repeat: **1**

Notes: **1. The information carried in this REF is identical to that carried in the GS08. Because the commercial translator community is roughly evenly split on where they look for the implementation guide type, this number is carried in both places.**

Example: **REF*87*004010X097A1~** Example Changed

STANDARD

REF Reference Identification

Level: Header

Position: 015

Loop: ____

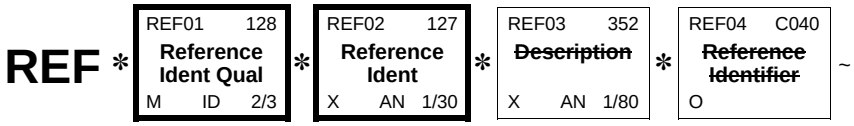
Requirement: Optional

Max Use: 3

Purpose: To specify identifying information

Syntax: **1. R0203**
At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**
			CODE: **87** DEFINITION: **Functional Category**	
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Transmission Type Code*** SYNTAX: R0203 **When piloting the transaction set, this value is 004010X097DA1.** **When sending the transaction set in a production mode, this value is 004010X097A1.**	**X AN 1/30**

Note Changed

IMPLEMENTATION

BILLING/PAY-TO PROVIDER SPECIALTY INFORMATION

Loop: 2000A — BILLING/PAY-TO PROVIDER HIERARCHICAL LEVEL

Usage: SITUATIONAL

Repeat: 1

Notes:

Note 1. Changed

1. **Required when adjudication is known to be impacted by the provider taxonomy code, and the Rendering Provider is the same entity as the Billing and/or Pay-to Provider. In these cases, the Rendering Provider is being identified at this level for all subsequent claims/encounters in this HL and Loop ID-2310B is not used.**
2. **If the Billing or Pay-to Provider is also the Rendering Provider, and Loop 2310B is not used, this PRV segment is required.**
3. **This PRV is not used when the Billing or Pay-to Provider is a group and the individual Rendering Provider is in Loop ID-2310B. The PRV segment is then coded with the Rendering Provider in Loop ID-2310B.**
4. **PRV02 qualifies PRV03.**

Example: PRV*PT*ZZ*1223S0112Y~

STANDARD

PRV Provider Information

Level: Detail

Position: 003

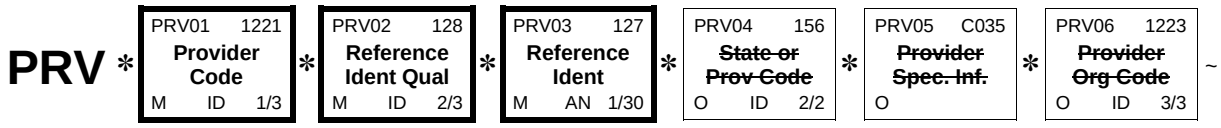
Loop: 2000

Requirement: Optional

Max Use: 1

Purpose: To specify the identifying characteristics of a provider

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	PRV01	1221	**Provider Code** Code indentifying the type of provider	M ID 1/3

CODE	DEFINITION
BI	Billing

IMPLEMENTATION

PAYER CITY/STATE/ZIP CODE

Loop: **2010BB — PAYER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Payer Address is required when the Submitter intends for the claim to be printed to paper at the next EDI location (e.g., clearinghouse).**

Example: **N4*CENTERVILLE*PA*17111~**

STANDARD

N4 Geographic Location

Level: Detail

Position: 030

Loop: 2010

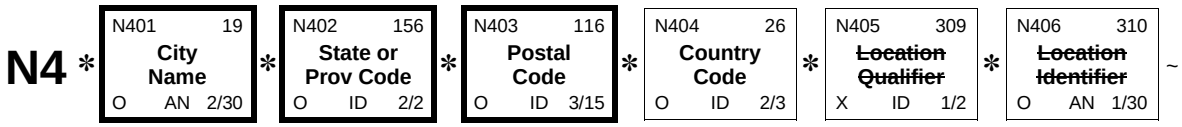
Requirement: Optional

Max Use: 1

Purpose: To specify the geographic place of the named party

Syntax: **1. C0605**
If N406 is present, then N405 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**N401**	**19**	**City Name** Free-form text for city name *INDUSTRY:* ***Payer City Name*** *ALIAS:* ***Payer's City*** **COMMENT:** A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location. **NSF Reference:** **DA1-06.0**	**O AN 2/30**

Note Deleted

REQUIRED **CLM05** **C023** **HEALTH CARE SERVICE LOCATION INFORMATION** **O**

To provide information that identifies the place of service or the type of bill related to the location at which a health care service was rendered

ALIAS: ***Place of Service Code***

NSF Reference:

FA0-07.0

CLM05 applies to all service lines unless it is over written at the line level.

REQUIRED **CLM05 - 1** **1331** **Facility Code Value** **M** **AN** **1/2**

Code identifying the type of facility where services were performed; the first and second positions of the Uniform Bill Type code or the Place of Service code from the Electronic Media Claims National Standard Format

INDUSTRY: ***Facility Type Code***

Use this element for codes identifying a place of service from code source 237. As a courtesy, the codes are listed below; however, the code list is thought to be complete at the time of publication of this implementation guide. Since this list is subject to change, only codes contained in the document available from code source 237 are to be supported in this transaction and take precedence over any and all codes listed here.

11 Office
12 Home
21 Inpatient Hospital
22 Outpatient Hospital
31 Skilled Nursing Facility
35 Adult Living Care Facility

NOT USED **CLM05 - 2** **1332** **Facility Code Qualifier** **O** **ID** **1/2**

REQUIRED **CLM05 - 3** **1325** **Claim Frequency Type Code** **O** **ID** **1/1**

Code specifying the frequency of the claim; this is the third position of the Uniform Billing Claim Form Bill Type

Codes and Notes Deleted

INDUSTRY: ***Claim Submission Reason Code***

CODE SOURCE **235:** Claim Frequency Type Code

REQUIRED **CLM06** **1073** **Yes/No Condition or Response Code** **O** **ID** **1/1**

Code indicating a Yes or No condition or response

INDUSTRY: ***Provider or Supplier Signature Indicator***

ALIAS: ***Provider Signature on File Code***

SEMANTIC: CLM06 is provider signature on file indicator. A “Y” value indicates the provider signature is on file; an “N” value indicates the provider signatue is not on file.

NSF Reference:

EA0-35.0

CODE	DEFINITION
N	**No**
Y	**Yes**

SITUATIONAL	CLM12	1366	**Special Program Code** Code indicating the Special Program under which the services rendered to the patient were performed	O	ID	2/3

INDUSTRY: ***Special Program Indicator***

NSF Reference:

EA0-43.0

Required if the services were rendered under one of the following circumstances/programs/projects.

CODE	DEFINITION
01	Early & Periodic Screening, Diagnosis, and Treatment (EPSDT) or Child Health Assessment Program (CHAP)
02	Physically Handicapped Children's Program
03	Special Federal Funding
05	Disability

NOT USED	CLM13	1073	Yes/No Condition or Response Code	O	ID	1/1
NOT USED	CLM14	1338	Level of Service Code	O	ID	1/3
NOT USED	CLM15	1073	Yes/No Condition or Response Code	O	ID	1/1
NOT USED	CLM16	1360	Provider Agreement Code	O	ID	1/1
NOT USED	CLM17	1029	Claim Status Code	O	ID	1/2
NOT USED	CLM18	1073	Yes/No Condition or Response Code	O	ID	1/1
SITUATIONAL	CLM19	1383	**Claim Submission Reason Code** Code identifying reason for claim submission	O	ID	2/2

ALIAS: ***Predetermination of Benefits Code***

Replaced Note

CLM19 is required when the entire claim is being submitted for Predetermination of Benefits.

CODE	DEFINITION
PB	Predetermination of Dental Benefits

SITUATIONAL	CLM20	1514	**Delay Reason Code** Code indicating the reason why a request was delayed	O	ID	1/2

This element may be used if a particular claim is being transmitted in response to a request for information (e.g., a 277), and the response has been delayed.

Required when claim is submitted late (past contracted date of filing limitations) and any of the codes below apply.

CODE	DEFINITION
1	Proof of Eligibility Unknown or Unavailable
2	Litigation

IMPLEMENTATION

PRIOR AUTHORIZATION OR REFERRAL NUMBER

Segment Name Changed

Loop: 2300 — CLAIM INFORMATION

Usage: SITUATIONAL

Repeat: 2 — Repeat Changed

Notes:

1. **Numbers at this position apply to the entire claim unless they are overridden in the REF segment in Loop ID-2400. A reference identification is considered to be overridden if the value in REF01 is the same in both the Loop ID-2300 REF segment and the Loop ID-2400 REF segment. In that case, the Loop ID-2400 REF applies only to that specific line.**

Note 2. Changed

2. **Required where services on this claim were preauthorized or where a referral is involved. Generally, preauthorization/referral numbers are those numbers assigned by the payer/UMO to authorize a service prior to its being performed. The referral or prior authorization number carried in this REF is specific to the destination payer reported in the 2010BB loop. If other payers have similar numbers for this claim, report that information in the 2330 loop REF which holds that payer's information.**

New Note 3. Added

3. **This segment should not be used for Predetermination of Benefits.**

Example: REF*9F*12345~

STANDARD

REF Reference Identification

Level: Detail

Position: 180

Loop: 2300

Requirement: Optional

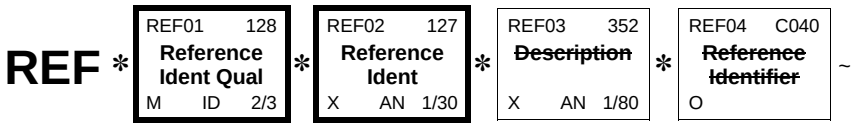
Max Use: 30

Purpose: To specify identifying information

Syntax:

1. **R0203**
   At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M**	**ID**	**2/3**
			CODE / DEFINITION			
			9F — **Referral Number**			
New Code Added			**G1** — **Prior Authorization Number**			
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Referral Number*** **SYNTAX:** R0203	**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**	**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**		

IMPLEMENTATION

REFERRING PROVIDER SPECIALTY INFORMATION

Loop: 2310A — REFERRING PROVIDER NAME

Usage: SITUATIONAL

Repeat: 1

Notes:
1. **Required when adjudication is known to be impacted by provider taxonomy code.**

Note 1. Changed

2. **PRV02 qualifies PRV03.**

Example: PRV*RF*ZZ*1223E0200Y~

STANDARD

PRV Provider Information

Level: Detail

Position: 255

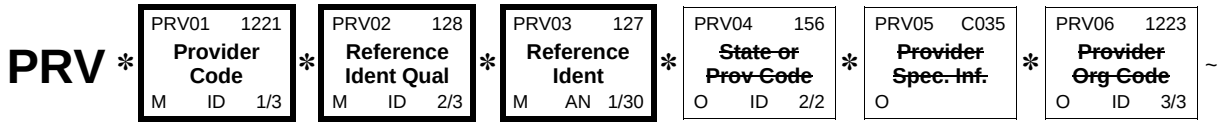
Loop: 2310

Requirement: Optional

Max Use: 1

Purpose: To specify the identifying characteristics of a provider

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	PRV01	1221	**Provider Code** Code indentifying the type of provider	M ID 1/3

CODE	DEFINITION
RF	Referring

IMPLEMENTATION

RENDERING PROVIDER SPECIALTY INFORMATION

Loop: 2310B — RENDERING PROVIDER NAME

Usage: SITUATIONAL — Usage Changed

Repeat: 1

Notes:

1. **The PRV segment in Loop ID-2310 applies to the entire claim unless overridden on the service line level by the presence of the PRV segment with the same value in PRV01.**
2. **PRV02 qualifies PRV03.**

New Note 3. Added —

3. **Required when adjudication is known to be impacted by provider taxonomy code.**

Example: PRV*PE*ZZ*1223E0200Y~

STANDARD

PRV Provider Information

Level: Detail

Position: 255

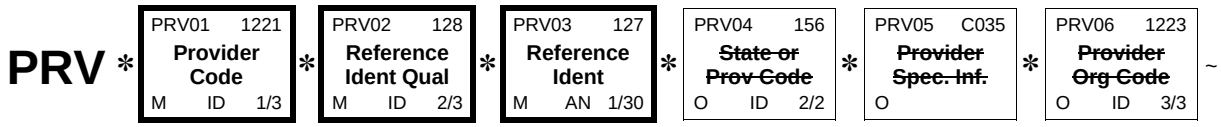
Loop: 2310

Requirement: Optional

Max Use: 1

Purpose: To specify the identifying characteristics of a provider

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**PRV01**	**1221**	**Provider Code** Code indentifying the type of provider	**M ID 1/3**
			CODE / **DEFINITION**	
			PE — **Performing**	

IMPLEMENTATION

ASSISTANT SURGEON NAME

Loop: **2310D — ASSISTANT SURGEON NAME** **Repeat:** **1**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Information in the Loop ID-2310 applies to the entire claim unless overridden on a service line by the presence of loop ID-2420 with the same value in the NM101.**
2. **Because the usage of this segment is "situational" this is not a syntactically required loop. If the loop is used, then it is a "required" segment. See Appendix A for further details on ASC X12 nomenclature and X12 syntax rules.**
3. **Required when the Assistant Surgeon information is needed to facilitate reimbursement of the claim.**
4. **The Assistant Surgeon information must not be used when the Rendering Provider loop (Loop ID-2310B) is also present for the claim.**

Example: **NM1*DD*1*SMITH*JOHN*S***34*123456789~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 250

Loop: 2310 **Repeat:** 9

Requirement: Optional

Max Use: 1

Purpose: To supply the full name of an individual or organizational entity

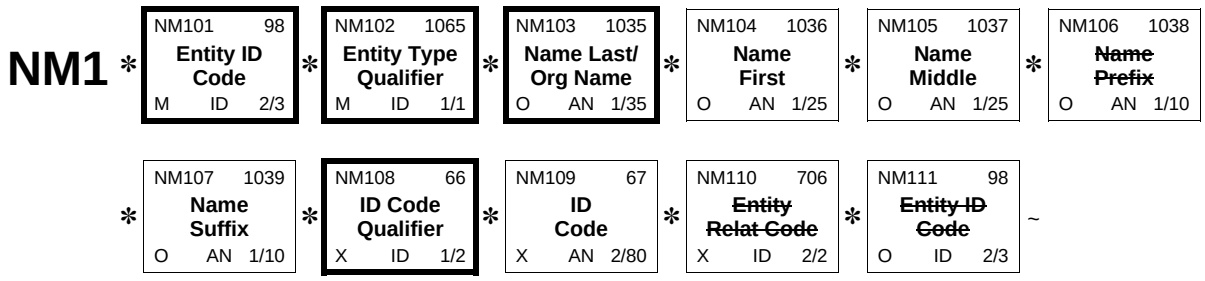
Set Notes:

1. Loop 2310 contains information about the rendering, referring, or attending provider.

Syntax:

1. **P0809**
   If either NM108 or NM109 is present, then the other is required.
2. **C1110**
   If NM111 is present, then NM110 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	NM101	98	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual **The entity identifier in NM101 applies to all segments in Loop ID-2310.** CODE / DEFINITION **DD** Assistant Surgeon	M ID 2/3
REQUIRED	NM102	1065	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. CODE / DEFINITION **1** Person **2** Non-Person Entity	M ID 1/1
REQUIRED	NM103	1035	**Name Last or Organization Name** Individual last name or organizational name *INDUSTRY: **Assistant Last or Organization Name*** *ALIAS: **Assistant Surgeon Last Name***	O AN 1/35
SITUATIONAL	NM104	1036	**Name First** Individual first name *INDUSTRY: **Assistant Surgeon First Name*** **Required if NM102 = 1 (person).**	O AN 1/25
SITUATIONAL	NM105	1037	**Name Middle** Individual middle name or initial *INDUSTRY: **Assistant Surgeon Middle Name*** **Required when middle name/initial of person is known.**	O AN 1/25
NOT USED	NM106	1038	**Name Prefix**	O AN 1/10
SITUATIONAL	NM107	1039	**Name Suffix** Suffix to individual name *INDUSTRY: **Assistant Surgeon Name Suffix*** **Required if known.**	O AN 1/10
REQUIRED	NM108	66	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) SYNTAX: P0809 CODE / DEFINITION **24** Employer's Identification Number **34** Social Security Number	X ID 1/2

			XX	**Health Care Financing Administration National Provider Identifier** ***Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.***		
REQUIRED	**NM109**	**67**	**Identification Code** Code identifying a party or other code *INDUSTRY:* ***Assistant Surgeon Identifier*** *ALIAS:* ***Assistant Surgeon's Primary Identification Number*** SYNTAX: P0809	**X**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**

IMPLEMENTATION

ASSISTANT SURGEON SPECIALTY INFORMATION

Loop: **2310D — ASSISTANT SURGEON NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Information in the Loop ID-2310 applies to the entire claim unless overridden on a service line by the presence of loop ID-2420 with the same value in the NM101.**

2. **Required when the Assistant Surgeon specialty information is needed to facilitate reimbursement of the claim.**

Example: **PRV*AS*ZZ*1223S0112Y~**

STANDARD

PRV Provider Information

Level: Detail

Position: 255

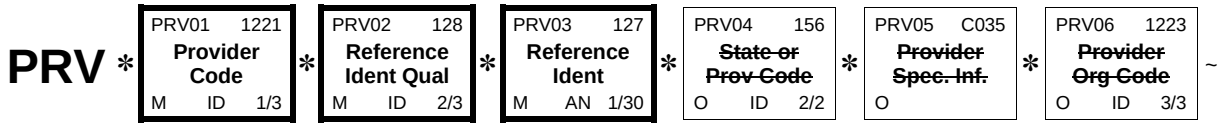
Loop: 2310

Requirement: Optional

Max Use: 1

Purpose: To specify the identifying characteristics of a provider

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**PRV01**	**1221**	**Provider Code** Code indentifying the type of provider	**M ID 1/3**

CODE	DEFINITION
AS	**Assistant Surgeon**

REQUIRED	**PRV02**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M**	**ID**	**2/3**

CODE	DEFINITION
ZZ	**Mutually Defined** **ZZ is used to indicate the "Health Care Provider Taxonomy" code list (provider specialty code) which is available on the Washington Publishing Company web site: http://www.wpc-edi.com. This taxonomy is maintained by the Blue Cross Blue Shield Association and ANSI ASC X12N TG2 WG15.**

REQUIRED	**PRV03**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Provider Taxonomy Code*** *ALIAS:* ***Provider Specialty Code***	**M**	**AN**	**1/30**
NOT USED	**PRV04**	**156**	**State or Province Code**	**O**	**ID**	**2/2**
NOT USED	**PRV05**	**C035**	**PROVIDER SPECIALTY INFORMATION**	**O**		
NOT USED	**PRV06**	**1223**	**Provider Organization Code**	**O**	**ID**	**3/3**

IMPLEMENTATION

ASSISTANT SURGEON SECONDARY IDENTIFICATION

Loop: **2310D — ASSISTANT SURGEON NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Use this REF segment only if a second number is necessary to identify the provider. The primary identification number should be contained in the NM109.**

Example: **REF*0B*12345~**

STANDARD

REF Reference Identification

Level: Detail

Position: 271

Loop: 2310

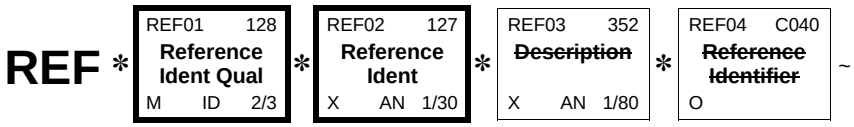
Requirement: Optional

Max Use: 20

Purpose: To specify identifying information

Syntax: **1. R0203**
At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**

CODE	DEFINITION
0B	**State License Number**
1A	**Blue Cross Provider Number**
1B	**Blue Shield Provider Number**
1C	**Medicare Provider Number**
1D	**Medicaid Provider Number**
1E	**Dentist License Number**

			1H	**CHAMPUS Identification Number**			
			G2	**Provider Commercial Number**			
			LU	**Location Number**			
			TJ	**Federal Taxpayer's Identification Number**			
			X4	**Clinical Laboratory Improvement Amendment Number**			
			X5	**State Industrial Accident Provider Number**			
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Assistant Surgeon Secondary Identifier*** *ALIAS:* ***Assistant Surgeon Secondary Identification Number*** **SYNTAX:** R0203	**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**	**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**		

IMPLEMENTATION

CLAIM ADJUSTMENT

Loop: 2320 — OTHER SUBSCRIBER INFORMATION

Usage: SITUATIONAL

Repeat: 5

Notes:

1. **Submitters should use the CAS segment to report claim level adjustments from prior payers that cause the amount paid to differ from the amount originally charged.**

Note 2. Changed

2. **If it is necessary to send more than one Group Code at the claim level, repeat the CAS segment.**

3. **Codes and associated amounts should come from the 835s (Remittance Advice) received on the claim. If no previous payments have been made, omit this segment. See the 835 for definitions of the group codes (CAS01).**

4. **Required if the claim has been adjudicated by payer identified in this loop and has claim level adjustment information.**

5. **To locate the claim adjustment reason codes that are used in CAS02, 05, 08, 11, 14 and 17 see the Washington Publishing Company website: http://www.wpc-edi.com. Follow the buttons to Code Lists - Claim Adjustment Reason Codes.**

IMPLEMENTATION

OTHER PAYER PRIOR AUTHORIZATION OR REFERRAL NUMBER

Segment Name Changed

Loop: 2330B — OTHER PAYER NAME

Usage: SITUATIONAL

Repeat: 2 — Repeat Changed

Notes:

Note 1. Changed

1. **Used when the payer identified in this loop has given a prior authorization or referral number to this claim. This element is primarily used in payer-to-payer COB situations.**

2. **There can only be a maximum of three REF segments in any one iteration of the 2330 loop.**

New Note 3. Added

3. **This segment should not be used for Predetermination of Benefits.**

Example: REF*9F*AB333-Y5~

STANDARD

REF Reference Identification

Level: Detail

Position: 355

Loop: 2330

Requirement: Optional

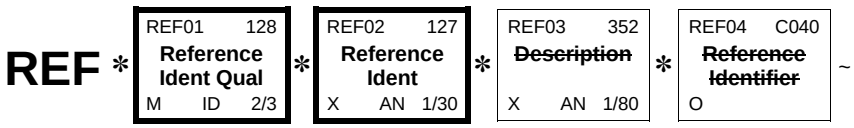
Max Use: 3

Purpose: To specify identifying information

Syntax:

1. **R0203**
   At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**

CODE	DEFINITION
9F	**Referral Number**
G1	**Prior Authorization Number**

New Code Added

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	NM101	98	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual CODE: QC — DEFINITION: Patient	M ID 2/3
REQUIRED	NM102	1065	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. CODE: 1 — DEFINITION: Person	M ID 1/1
NOT USED	NM103	1035	**Name Last or Organization Name**	O AN 1/35
NOT USED	NM104	1036	**Name First**	O AN 1/25
NOT USED	NM105	1037	**Name Middle**	O AN 1/25
NOT USED	NM106	1038	**Name Prefix**	O AN 1/10
NOT USED	NM107	1039	**Name Suffix**	O AN 1/10
REQUIRED	NM108	66	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) SYNTAX: P0809 CODE: MI — DEFINITION: Member Identification Number	X ID 1/2
REQUIRED	NM109	67	**Identification Code** Code identifying a party or other code *INDUSTRY:* ***Other Payer Patient Primary Identifier*** *ALIAS:* ***Patient's Other Payer Primary Identification Number*** SYNTAX: P0809	X AN 2/80
NOT USED	NM110	706	**Entity Relationship Code**	X ID 2/2
NOT USED	NM111	98	**Entity Identifier Code**	O ID 2/3

Usage Changed

REQUIRED	**SV301 - 2**	**234**	**Product/Service ID** Identifying number for a product or service *INDUSTRY:* ***Procedure Code***	**M**	**AN 1/48**
			NSF Reference: **FA0-09.0**		
SITUATIONAL	**SV301 - 3**	**1339**	**Procedure Modifier** This identifes special circumstances related to the performance of the service, as defined by trading partners *ALIAS:* ***Procedure Code Modifier***	**O**	**AN 2/2**
			NSF Reference: **FA0-10.0**		
			Use this modifier for the first procedure code modifier.		
Note Changed			**A modifier must be from code source 135 (American Dental Association) found in the 'Code on Dental Procedures and Nomenclature', if such modifier is available.**		
SITUATIONAL	**SV301 - 4**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners *ALIAS:* ***Procedure Code Modifier***	**O**	**AN 2/2**
			NSF Reference: **FA0-11.0**		
			Use this modifier for the second procedure code modifier.		
Note Changed			**A modifier must be from code source 135 (American Dental Association) found in the 'Code on Dental Procedures and Nomenclature', if such modifier is available.**		
SITUATIONAL	**SV301 - 5**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners *ALIAS:* ***Procedure Code Modifier***	**O**	**AN 2/2**
			NSF Reference: **FA0-12.0**		
			Use this modifier for the third procedure code modifier.		
Note Changed			**A modifier must be from code source 135 (American Dental Association) found in the 'Code on Dental Procedures and Nomenclature', if such modifier is available.**		

SITUATIONAL **SV301 - 6** **1339** **Procedure Modifier** **O AN 2/2**
This identifies special circumstances related to the performance of the service, as defined by trading partners

ALIAS: ***Procedure Code Modifier***

NSF Reference:

FA0-36.0

Use this modifier for the fourth procedure code modifier.

Note Changed

A modifier must be from code source 135 (American Dental Association) found in the 'Code on Dental Procedures and Nomenclature', if such modifier is available.

NOT USED **SV301 - 7** **352** **Description** **O AN 1/80**

REQUIRED **SV302** **782** **Monetary Amount** **O R 1/18**
Monetary amount

INDUSTRY: ***Line Item Charge Amount***

ALIAS: ***Line Charge Amount***

SEMANTIC: SV302 is a submitted charge amount.

NSF Reference:

FA0-13.0

Zero "0" is an acceptable value for this element.

SITUATIONAL **SV303** **1331** **Facility Code Value** **O AN 1/2**
Code identifying the type of facility where services were performed; the first and second positions of the Uniform Bill Type code or the Place of Service code from the Electronic Media Claims National Standard Format

INDUSTRY: ***Facility Type Code***

SEMANTIC: SV303 is the place of service code representing the location where the dental treatment was rendered.

Required if the Place of Service is different than the Place of Service reported in the CLM segment in the 2300 loop.

Use this element for codes identifying a place of service from code source 237. As a courtesy, the codes are listed below; however, the code list is thought to be complete at the time of publication of this implementation guide. Since this list is subject to change, only codes contained in the document available from code source 237 are to be supported in this transaction and take precedence over any and all codes listed here.

- **11 Office**
- **12 Home**
- **21 Inpatient Hospital**
- **22 Outpatient Hospital**
- **31 Skilled Nursing Facility**
- **35 Adult Living Care Facility**

SITUATIONAL **SV304** **C006** **ORAL CAVITY DESIGNATION** **O**
To identify one or more areas of the oral cavity

Required to report areas of the mouth that are being treated.

IMPLEMENTATION

DATE - SERVICE

Loop: 2400 — LINE COUNTER

Usage: SITUATIONAL

Repeat: 1

Notes: 1. Required if the service date is different than the service date reported at the DTP segment in the 2300 loop and the service was performed.

Replaced Note 1.

Example: DTP*472*D8*19980108~

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 455

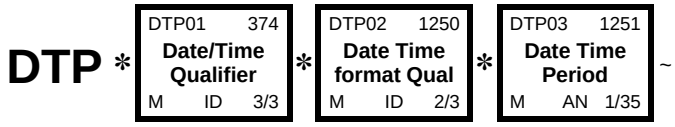
Loop: 2400

Requirement: Optional

Max Use: 15

Purpose: To specify any or all of a date, a time, or a time period

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	DTP01	374	**Date/Time Qualifier** Code specifying type of date or time, or both date and time	M ID 3/3

INDUSTRY: ***Date Time Qualifier***

CODE	DEFINITION
472	Service

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	DTP02	1250	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format	M ID 2/3

SEMANTIC: DTP02 is the date or time or period format that will appear in DTP03.

CODE	DEFINITION
D8	Date Expressed in Format CCYYMMDD

IMPLEMENTATION

PRIOR AUTHORIZATION OR REFERRAL NUMBER

Segment Name Changed

Loop: 2400 — LINE COUNTER

Usage: SITUATIONAL

Repeat: 2

Repeat Changed

Notes:

Note 1. Changed

1. **Required if service line involved a prior authorization number or referral number that is different than the number reported at the claim.**

New Note 2. Added

2. **This segment should not be used for Predetermination of Benefits.**

Example: REF*9F*123456567~

STANDARD

REF Reference Identification

Level: Detail

Position: 470

Loop: 2400

Requirement: Optional

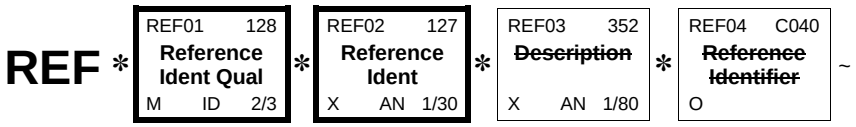
Max Use: 30

Purpose: To specify identifying information

Syntax:

1. **R0203**
   At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**
			CODE / DEFINITION	
			9F — **Referral Number**	
New Code Added			**G1** — **Prior Authorization Number**	
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Referral Number*** SYNTAX: R0203	**X AN 1/30**

IMPLEMENTATION

SALES TAX AMOUNT

Loop: **2400 — LINE COUNTER**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required if sales tax applies to service line and submitter is required to report that information to the receiver.**

Example: **AMT*T*45~**

STANDARD

AMT Monetary Amount

Level: Detail

Position: 475

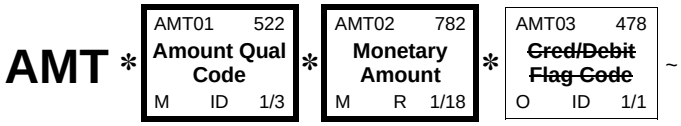
Loop: 2400

Requirement: Optional

Max Use: 15

Purpose: To indicate the total monetary amount

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**AMT01**	**522**	**Amount Qualifier Code** Code to qualify amount	**M**	**ID**	**1/3**
			CODE / DEFINITION			
			T **Tax**			
REQUIRED	**AMT02**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Sales Tax Amount***	**M**	**R**	**1/18**
NOT USED	**AMT03**	**478**	**Credit/Debit Flag Code**	**O**	**ID**	**1/1**

IMPLEMENTATION

RENDERING PROVIDER SPECIALTY INFORMATION

Loop: 2420A — RENDERING PROVIDER NAME

Usage: SITUATIONAL ——— Usage Changed

Repeat: 1

Notes: 1. PRV02 qualifies PRV03.

New Note 2. Added —— 2. Required when adjudication is known to be impacted by provider taxonomy code.

Example: PRV*PE*ZZ*1223P0300Y~

STANDARD

PRV Provider Information

Level: Detail

Position: 505

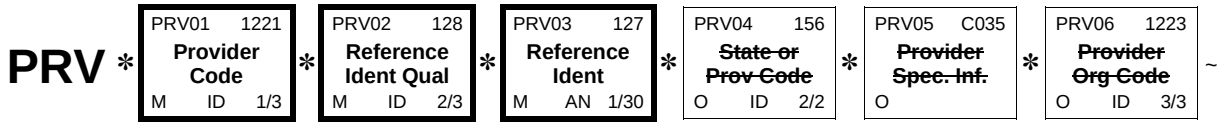
Loop: 2420

Requirement: Optional

Max Use: 1

Purpose: To specify the identifying characteristics of a provider

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	PRV01	1221	**Provider Code** Code indentifying the type of provider	M ID 1/3

CODE	DEFINITION
PE	Performing

IMPLEMENTATION

OTHER PAYER PRIOR AUTHORIZATION OR REFERRAL NUMBER

Segment Name Changed

Loop: 2420B — OTHER PAYER REFERRAL NUMBER

Usage: SITUATIONAL

Repeat: 2 — Repeat Changed

Notes:
1. **Used when COB Payer (listed in 2330B loop) has one or more line-level referral numbers for this service line.**

New Note 2. Added —
2. **This segment should not be used for Predetermination of Benefits.**

Example: REF*9F*AB333-Y6~

STANDARD

REF Reference Identification

Level: Detail

Position: 525

Loop: 2420

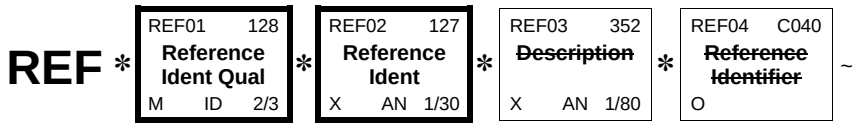
Requirement: Optional

Max Use: 20

Purpose: To specify identifying information

Syntax:
1. **R0203**
   At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**
			CODE / DEFINITION	
			9F **Referral Number**	
New Code Added —			**G1** **Prior Authorization Number**	
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Other Payer Prior Authorization or Referral Number*** SYNTAX: R0203	**X AN 1/30**

IMPLEMENTATION

ASSISTANT SURGEON NAME

Loop: **2420C — ASSISTANT SURGEON NAME** **Repeat:** **1**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Required if the Assistant Surgeon information in this Loop ID-2420C is different from the Assistant Surgeon information supplied in the Loop ID-2310D.**
2. **Because the usage of this segment is "situational" this is not a syntactically required loop. If the loop is used, then it is a "required" segment. See Appendix A for further details on ASC X12 nomenclature and X12 syntax rules.**
3. **Required when the Assistant Surgeon information is needed to facilitate reimbursement of the claim.**
4. **The Assistant Surgeon information must not be used when the Rendering Provider loop (Loop ID-2420A) is also present for the claim.**

Example: **NM1*DD*1*SMITH*JOHN*S***34*123456789~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 500

Loop: 2420 **Repeat:** 10

Requirement: Optional

Max Use: 1

Purpose: To supply the full name of an individual or organizational entity

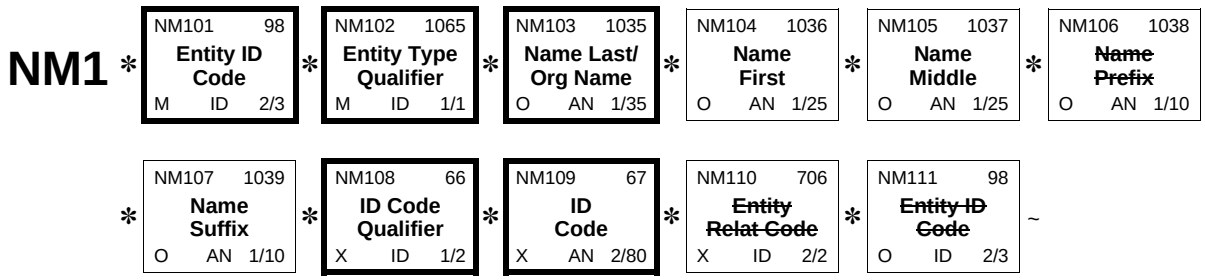
Set Notes:

1. Loop 2420 contains information about the rendering, referring, or attending provider on a service line level. These segments override the information in the claim - level segments if the entity identifier codes in each NM1 segment are the same.

Syntax:

1. **P0809**
   If either NM108 or NM109 is present, then the other is required.
2. **C1110**
   If NM111 is present, then NM110 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	**M ID 2/3**
			The entity identifier in NM101 applies to all segments in Loop ID-2310.	
			CODE / DEFINITION **DD** **Assistant Surgeon**	
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity	**M ID 1/1**
			SEMANTIC: NM102 qualifies NM103. CODE / DEFINITION **1** **Person** **2** **Non-Person Entity**	
REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name ***INDUSTRY:*** ***Assistant Surgeon Last or Organization Name*** ***ALIAS:*** ***Assistant Surgeon Last Name***	**O AN 1/35**
SITUATIONAL	**NM104**	**1036**	**Name First** Individual first name ***INDUSTRY:*** ***Assistant Surgeon First Name*** **Required if NM102 = 1 (person).**	**O AN 1/25**
SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial ***INDUSTRY:*** ***Assistant Surgeon Middle Name*** **Required when middle name/initial of person is known.**	**O AN 1/25**
NOT USED	**NM106**	**1038**	**Name Prefix**	**O AN 1/10**
SITUATIONAL	**NM107**	**1039**	**Name Suffix** Suffix to individual name ***INDUSTRY:*** ***Assistant Surgeon Name Suffix*** **Required if known.**	**O AN 1/10**

REQUIRED	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) **SYNTAX:** P0809	**X**	**ID**	**1/2**

CODE	DEFINITION
24	**Employer's Identification Number**
34	**Social Security Number**
XX	**Health Care Financing Administration National Provider Identifier** ***Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.***

REQUIRED	**NM109**	**67**	**Identification Code** Code identifying a party or other code ***INDUSTRY:*** ***Assistant Surgeon Identifier*** ***ALIAS:*** ***Assistant Surgeon's Primary Identification Number*** **SYNTAX:** P0809	**X**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**

IMPLEMENTATION

ASSISTANT SURGEON SPECIALTY INFORMATION

Loop: 2420C — ASSISTANT SURGEON NAME

Usage: SITUATIONAL

Repeat: 1

Notes:
1. PRV02 qualifies PRV03.
2. Required when the Assistant Surgeon specialty information is needed to facilitate reimbursement of the claim.

Example: PRV*AS*ZZ*1223S0112Y~

STANDARD

PRV Provider Information

Level: Detail

Position: 505

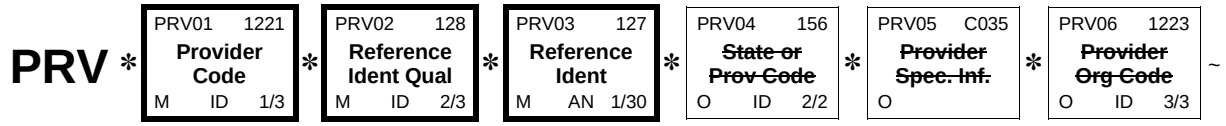
Loop: 2420

Requirement: Optional

Max Use: 1

Purpose: To specify the identifying characteristics of a provider

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	PRV01	1221	**Provider Code** Code indentifying the type of provider	M ID 1/3

CODE	DEFINITION
AS	Assistant Surgeon

REQUIRED	**PRV02**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M**	**ID**	**2/3**

CODE	DEFINITION
ZZ	**Mutually Defined** **ZZ is used to indicate the "Health Care Provider Taxonomy" code list (provider specialty code) which is available on the Washington Publishing Company web site: http://www.wpc-edi.com. This taxonomy is maintained by the Blue Cross Blue Shield Association and ANSI ASC X12N TG2 WG15.**

REQUIRED	**PRV03**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Provider Taxonomy Code*** *ALIAS:* ***Provider Specialty Code***	**M**	**AN**	**1/30**
NOT USED	**PRV04**	**156**	**State or Province Code**	**O**	**ID**	**2/2**
NOT USED	**PRV05**	**C035**	**PROVIDER SPECIALTY INFORMATION**	**O**		
NOT USED	**PRV06**	**1223**	**Provider Organization Code**	**O**	**ID**	**3/3**

IMPLEMENTATION

ASSISTANT SURGEON SECONDARY IDENTIFICATION

Loop: **2420C — ASSISTANT SURGEON NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Use this REF segment only if a second number is necessary to identify the provider. The primary identification number should be contained in the NM109.**

Example: **REF*0B*12345~**

STANDARD

REF Reference Identification

Level: Detail

Position: 525

Loop: 2420

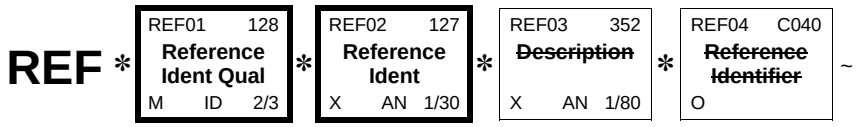
Requirement: Optional

Max Use: 20

Purpose: To specify identifying information

Syntax: **1. R0203**
At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**

CODE	DEFINITION
0B	**State License Number**
1A	**Blue Cross Provider Number**
1B	**Blue Shield Provider Number**
1C	**Medicare Provider Number**
1D	**Medicaid Provider Number**
1E	**Dentist License Number**

			1H	**CHAMPUS Identification Number**			
			G2	**Provider Commercial Number**			
			LU	**Location Number**			
			TJ	**Federal Taxpayer's Identification Number**			
			X4	**Clinical Laboratory Improvement Amendment Number**			
			X5	**State Industrial Accident Provider Number**			
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Assistant Surgeon Secondary Identifier*** *ALIAS:* ***Assistant Surgeon Secondary Identification Number*** **SYNTAX:** R0203	**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**	**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**		

SITUATIONAL	SVD03 - 3	1339	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners	O	AN	2/2
			Use this modifier for the first procedure code modifier.			
			Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.			
New Note Added			**A modifier must be from code source 135 (American Dental Association) found in the 'Code on Dental Procedures and Nomenclature', if such modifier is available.**			
SITUATIONAL	SVD03 - 4	1339	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners	O	AN	2/2
			Use this modifier for the second procedure code modifier.			
			Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.			
New Note Added			**A modifier must be from code source 135 (American Dental Association) found in the 'Code on Dental Procedures and Nomenclature', if such modifier is available.**			
SITUATIONAL	SVD03 - 5	1339	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners	O	AN	2/2
			Use this modifier for the third procedure code modifier.			
			Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.			
New Note Added			**A modifier must be from code source 135 (American Dental Association) found in the 'Code on Dental Procedures and Nomenclature', if such modifier is available.**			
SITUATIONAL	SVD03 - 6	1339	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners	O	AN	2/2
			Use this modifier for the fourth procedure code modifier.			
			Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.			
New Note Added			**A modifier must be from code source 135 (American Dental Association) found in the 'Code on Dental Procedures and Nomenclature', if such modifier is available.**			
SITUATIONAL	SVD03 - 7	352	**Description** A free-form description to clarify the related data elements and their content *INDUSTRY:* ***Procedure Code Description***	O	AN	1/80
			Required if SVC01-7 was returned in the 835 transaction.			
NOT USED	SVD04	234	**Product/Service ID**	O	AN	1/48

Data elements are assigned a unique reference number. Each data element has a name, description, type, minimum length, and maximum length. For ID type data elements, this guide provides the applicable ASC X12 code values and their descriptions or references where the valid code list can be obtained.

Each data element is assigned a minimum and maximum length. The length of the data element value is the number of character positions used except as noted for numeric, decimal, and binary elements.

The data element types shown in matrix A4, Data Element Types, appear in this implementation guide.

SYMBOL	TYPE
Nn	Numeric
R	Decimal
ID	Identifier
AN	String
DT	Date
TM	Time
B	Binary

Matrix A4. Data Element Types

A.1.3.1.1 Numeric

A numeric data element is represented by one or more digits with an optional leading sign representing a value in the normal base of 10. The value of a numeric data element includes an implied decimal point. It is used when the position of the decimal point within the data is permanently fixed and is not to be transmitted with the data.

This set of guides denotes the number of implied decimal positions. The representation for this data element type is “Nn” where N indicates that it is numeric and n indicates the number of decimal positions to the right of the implied decimal point.

If n is 0, it need not appear in the specification; N is equivalent to N0. For negative values, the leading minus sign (-) is used. Absence of a sign indicates a positive value. The plus sign (+) should not be transmitted.

EXAMPLE
A transmitted value of 1234, when specified as numeric type N2, represents a value of 12.34.

Leading zeros should be suppressed unless necessary to satisfy a minimum length requirement. The length of a numeric type data element does not include the optional sign.

A.1.3.1.2 Decimal

A decimal data element may contain an explicit decimal point and is used for numeric values that have a varying number of decimal positions. This data element type is represented as “R.”

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. For negative values, the leading minus sign (-) is used. Absence of a sign indicates a positive value. The plus sign (+) should not be transmitted.

Leading zeros should be suppressed unless necessary to satisfy a minimum length requirement. Trailing zeros following the decimal point should be suppressed unless necessary to indicate precision. The use of triad separators (for example, the commas in 1,000,000) is expressly prohibited. The length of a decimal type data element does not include the optional leading sign or decimal point.

EXAMPLE
A transmitted value of 12.34 represents a decimal value of 12.34.

New note

For implementation of this guide under the rules promulgated under the Health Insurance Portability and Accountability Act (HIPAA), decimal data elements in Data Element 782 (Monetary Amount) will be limited to a maximum length of 10 characters including reported or implied places for cents (implied value of 00 after the decimal point). Note the statement in the preceding paragraph that the decimal point and leading sign, if sent, are not part of the character count.

A.1.3.1.3 Identifier

An identifier data element always contains a value from a predefined list of codes that is maintained by the ASC X12 Committee or some other body recognized by the Committee. Trailing spaces should be suppressed unless they are necessary to satisfy a minimum length. An identifier is always left justified. The representation for this data element type is “ID.”

A.1.3.1.4 String

A string data element is a sequence of any characters from the basic or extended character sets. The significant characters shall be left justified. Leading spaces, when they occur, are presumed to be significant characters. Trailing spaces should be suppressed unless they are necessary to satisfy a minimum length. The representation for this data element type is “AN.”

A.1.3.1.5 Date

A date data element is used to express the standard date in either YYMMDD or CCYYMMDD format in which CC is the first two digits of the calendar year, YY is the last two digits of the calendar year, MM is the month (01 to 12), and DD is the day in the month (01 to 31). The representation for this data element type is “DT.” Users of this guide should note that all dates within transactions are 8-character dates (millennium compliant) in the format CCYYMMDD. The only date data element that is in format YYMMDD is the Interchange Date data element in the ISA segment, and also used in the TA1 Interchange Acknowledgment, where the century can be readily interpolated because of the nature of an interchange header.

A.1.3.1.6 Time

A time data element is used to express the ISO standard time HHMMSSd..d format in which HH is the hour for a 24 hour clock (00 to 23), MM is the minute (00 to 59), SS is the second (00 to 59) and d..d is decimal seconds. The representation for this data element type is “TM.” The length of the data element determines the format of the transmitted time.

EXAMPLE
Transmitted data elements of four characters denote HHMM. Transmitted data elements of six characters denote HHMMSS.

IMPLEMENTATION

FUNCTIONAL GROUP HEADER

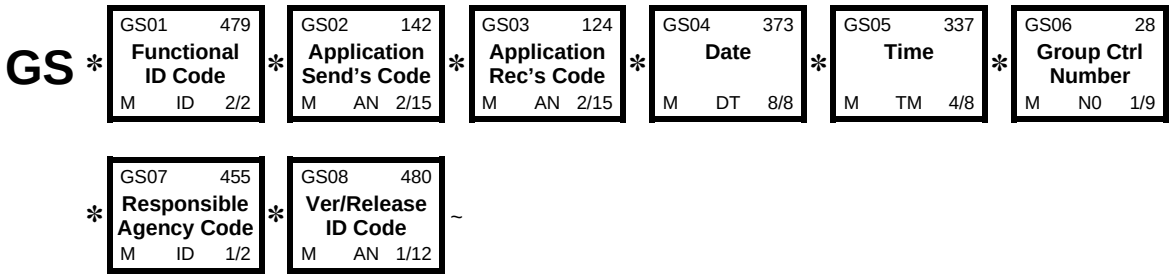
Example: **GS*HC*SENDER CODE*RECEIVER CODE*19940331*0802*1*X*004010X097A1~** ——— Example changed

STANDARD

GS Functional Group Header

Purpose: To indicate the beginning of a functional group and to provide control information

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	GS01	479	**Functional Identifier Code** Code identifying a group of application related transaction sets CODE: **HC** — DEFINITION: **Health Care Claim (837)**	**M ID 2/2**
REQUIRED	GS02	142	**Application Sender's Code** Code identifying party sending transmission; codes agreed to by trading partners **Use this code to identify the unit sending the information.**	**M AN 2/15**
REQUIRED	GS03	124	**Application Receiver's Code** Code identifying party receiving transmission. Codes agreed to by trading partners **Use this code to identify the unit receiving the information.**	**M AN 2/15**
REQUIRED	GS04	373	**Date** Date expressed as CCYYMMDD **SEMANTIC:** GS04 is the group date. **Use this date for the functional group creation date.**	**M DT 8/8**
REQUIRED	GS05	337	**Time** Time expressed in 24-hour clock time as follows: HHMM, or HHMMSS, or HHMMSSD, or HHMMSSDD, where H = hours (00-23), M = minutes (00-59), S = integer seconds (00-59) and DD = decimal seconds; decimal seconds are expressed as follows: D = tenths (0-9) and DD = hundredths (00-99) **SEMANTIC:** GS05 is the group time. **Use this time for the creation time. The recommended format is HHMM.**	**M TM 4/8**

REQUIRED	GS06	28	**Group Control Number** Assigned number originated and maintained by the sender SEMANTIC: The data interchange control number GS06 in this header must be identical to the same data element in the associated functional group trailer, GE02.	M	N0	1/9
REQUIRED	GS07	455	**Responsible Agency Code** Code used in conjunction with Data Element 480 to identify the issuer of the standard	M	ID	1/2

CODE	DEFINITION
X	**Accredited Standards Committee X12**

REQUIRED	GS08	480	**Version / Release / Industry Identifier Code** Code indicating the version, release, subrelease, and industry identifier of the EDI standard being used, including the GS and GE segments; if code in DE455 in GS segment is X, then in DE 480 positions 1-3 are the version number; positions 4-6 are the release and subrelease, level of the version; and positions 7-12 are the industry or trade association identifiers (optionally assigned by user); if code in DE455 in GS segment is T, then other formats are allowed	M	AN	1/12

CODE	DEFINITION
New code value → **004010X097A1**	**Draft Standards Approved for Publication by ASC X12 Procedures Review Board through October 1997, as published in this implementation guide.** **When using the X12N Health Care Claim: Dental Implementation Guide, originally published May 2000 as 004010X097 and incorporating the changes identified in the Addenda, the value used in GS08 must be "004010X097A1".**