ADDENDA

National Electronic Data Interchange Transaction Set Implementation Guide

Health Care Claim: Institutional

837

ASC X12N 837 (004010X096A1)

October 2002

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1 Introduction to Modified Pages

This document is addenda to the X12N Health Care Claim: Institutional Implementation Guide, originally published May 2000 as 004010X096. 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 004010X096 Implementation Guide. Since the X12N 004010X096 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: Institutional Implementation Guide, originally published May 2000 as 004010X096 and incorporating the changes identified in the Addenda, the value used in GS08 must be "004010X096A1".

Each of the changes made to the 004010X096 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 004010X096 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.

IMPLEMENTATION

837 Health Care Claim: Institutional

Table 1 - Header

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
56	005	ST	Transaction Set Header	R	1	
57	010	BHT	Beginning of Hierarchical Transaction	R	1	
60	015	REF	Transmission Type Identification	R	1	
			LOOP ID - 1000A SUBMITTER NAME			1
61	020	NM1	Submitter Name	R	1	
64	045	PER	Submitter EDI Contact Information	R	2	
			LOOP ID - 1000B RECEIVER NAME			1
67	020	NM1	Receiver Name	R	1	

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
69	001	HL	Billing/Pay-To Provider Hierarchical Level	R	1	
71	003	PRV	Billing/Pay-To Provider Specialty Information	S	1	
73	010	CUR	Foreign Currency Information	S	1	
			LOOP ID - 2010AA BILLING PROVIDER NAME			1
76	015	NM1	Billing Provider Name	R	1	
79	025	N3	Billing Provider Address	R	1	
80	030	N4	Billing Provider City/State/ZIP Code	R	1	
82	035	REF	Billing Provider Secondary Identification	S	8	
85	035	REF	Credit/Debit Card Billing Information	S	8	
87	040	PER	Billing Provider Contact Information	S	2	
			LOOP ID - 2010AB PAY-TO PROVIDER NAME			1
91	015	NM1	Pay-To Provider Name	S	1	
94	025	N3	Pay-To Provider Address	R	1	
95	030	N4	Pay-To Provider City/State/ZIP Code	R	1	
97	035	REF	Pay-To Provider Secondary Identification	S	5	

Table 2 - Subscriber Detail

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
			LOOP ID - 2000B SUBSCRIBER HIERARCHICAL LEVEL			>1
99	001	HL	Subscriber Hierarchical Level	R	1	
101	005	SBR	~~Subscriber Information~~ PAT Segment Deleted	R	1	
			LOOP ID - 2010BA SUBSCRIBER NAME			1
106	015	NM1	Subscriber Name	R	1	
109	025	N3	Subscriber Address	S	1	

182	180	REF	Claim Identification Number For Clearinghouses and Other Transmission Intermediaries	S	1	Repeat Changed
184	180	REF	Document Identification Code	S	2	
185	180	REF	Original Reference Number (ICN/DCN)	S	1	
188	180	REF	Investigational Device Exemption Number	S	1	
190	180	REF	Service Authorization Exception Code	S	1	
192	180	REF	Peer Review Organization (PRO) Approval Number	S	1	
193	180	REF	Prior Authorization or Referral Number	S	2	
195	180	REF	Medical Record Number	S	1	
197	180	REF	Demonstration Project Identifier	S	1	
199	185	K3	File Information	S	10	
200	190	NTE	Claim Note	S	10	
203	190	NTE	Billing Note	S	1	
205	216	CR6	Home Health Care Information	S	1	
213	220	CRC	Home Health Functional Limitations	S	3	
220	220	CRC	Home Health Activities Permitted	S	3	
228	220	CRC	Home Health Mental Status	S	2	
234	231	HI	Principal, Admitting, E-Code and Patient Reason For Visit Diagnosis Information	S	1	Usage Changed
237	231	HI	Diagnosis Related Group (DRG) Information	S	1	
239	231	HI	Other Diagnosis Information	S	2	
248	231	HI	Principal Procedure Information	S	1	
250	231	HI	Other Procedure Information	S	2	
263	231	HI	Occurrence Span Information	S	2	
274	231	HI	Occurrence Information	S	2	
286	231	HI	Value Information	S	2	
295	231	HI	Condition Information	S	2	
304	231	HI	Treatment Code Information	S	2	
311	240	QTY	Claim Quantity	S	4	
313	241	HCP	Claim Pricing/Repricing Information	S	1	
			LOOP ID - 2305 HOME HEALTH CARE PLAN INFORMATION			**6**
319	242	CR7	Home Health Care Plan Information	S	1	
321	243	HSD	Health Care Services Delivery	S	12	
			LOOP ID - 2310A ATTENDING PHYSICIAN NAME			**1**
326	250	NM1	Attending Physician Name	S	1	
329	255	PRV	Attending Physician Specialty Information	S	1	Usage Changed
331	271	REF	Attending Physician Secondary Identification	S	5	
			LOOP ID - 2310B OPERATING PHYSICIAN NAME			**1**
333	250	NM1	Operating Physician Name	S	1	
338	271	REF	Operating Physician Secondary Identification	S	5	
			LOOP ID - 2310C OTHER PROVIDER NAME			**1**
340	250	NM1	Other Provider Name	S	1	
345	271	REF	Other Provider Secondary Identification	S	5	
			LOOP ID - 2310E SERVICE FACILITY NAME			**1**
347	250	NM1	Service Facility Name	S	1	
352	265	N3	Service Facility Address	R	1	
353	270	N4	Service Facility City/State/Zip Code	R	1	
355	271	REF	Service Facility Secondary Identification	S	5	
			LOOP ID - 2320 OTHER SUBSCRIBER INFORMATION			**10**
357	290	SBR	Other Subscriber Information	S	1	
363	295	CAS	Claim Level Adjustment	S	5	
369	300	AMT	Payer Prior Payment	S	1	
370	300	AMT	Coordination of Benefits (COB) Total Allowed Amount	S	1	
371	300	AMT	Coordination of Benefits (COB) Total Submitted Charges	S	1	

PRV Segments deleted

Loop 2310D Deleted

372	300	AMT	Diagnostic Related Group (DRG) Outlier Amount	S	1	
374	300	AMT	Coordination of Benefits (COB) Total Medicare Paid Amount	S	1	
376	300	AMT	Medicare Paid Amount - 100%	S	1	
378	300	AMT	Medicare Paid Amount - 80%	S	1	
380	300	AMT	Coordination of Benefits (COB) Medicare A Trust Fund Paid Amount	S	1	
382	300	AMT	Coordination of Benefits (COB) Medicare B Trust Fund Paid Amount	S	1	
384	300	AMT	Coordination of Benefits (COB) Total Non-covered Amount	S	1	
385	300	AMT	Coordination of Benefits (COB) Total Denied Amount	S	1	
386	305	DMG	Other Subscriber Demographic Information	S	1	
388	310	OI	Other Insurance Coverage Information	R	1	
390	315	MIA	Medicare Inpatient Adjudication Information	S	1	
395	320	MOA	Medicare Outpatient Adjudication Information	S	1	
			LOOP ID - 2330A OTHER SUBSCRIBER NAME			**1**
398	325	NM1	Other Subscriber Name	R	1	
402	332	N3	Other Subscriber Address	S	1	
404	340	N4	Other Subscriber City/State/ZIP Code	S	1	
406	355	REF	Other Subscriber Secondary Information	S	3	
			LOOP ID - 2330B OTHER PAYER NAME			**1**
408	325	NM1	Other Payer Name	R	1	
410	332	N3	Other Payer Address	S	1	
411	340	N4	Other Payer City/State/ZIP Code	S	1	
413	350	DTP	Claim Adjudication Date	S	1	
414	355	REF	Other Payer Secondary Identification and Reference Number	S	2	
416	355	REF	Other Payer Prior Authorization or Referral Number	S	1	
			LOOP ID - 2330C OTHER PAYER PATIENT INFORMATION			**1**
418	325	NM1	Other Payer Patient Information	S	1	
420	355	REF	Other Payer Patient Identification Number	S	3	
			LOOP ID - 2330D OTHER PAYER ATTENDING PROVIDER			**1**
422	325	NM1	Other Payer Attending Provider	S	1	
424	355	REF	Other Payer Attending Provider Identification	R	3	
			LOOP ID - 2330E OTHER PAYER OPERATING PROVIDER			**1**
426	325	NM1	Other Payer Operating Provider	S	1	
428	355	REF	Other Payer Operating Provider Identification	R	3	
			LOOP ID - 2330F OTHER PAYER OTHER PROVIDER			**1**
430	325	NM1	Other Payer Other Provider	S	1	
432	355	REF	Other Payer Other Provider Identification	R	3	
			LOOP ID - 2330H OTHER PAYER SERVICE FACILITY PROVIDER Loop 2330G Deleted			**1**
434	325	NM1	Other Payer Service Facility Provider	S	1	
436	355	REF	Other Payer Service Facility Provider Identification	R	3	
			LOOP ID - 2400 SERVICE LINE NUMBER			**999**
438	365	LX	Service Line Number	R	1	
439	375	SV2	Institutional Service Line SV4 Segment Deleted	R	1	
444	420	PWK	Line Supplemental Information	S	5	
448	455	DTP	Service Line Date	S	1	
450	455	DTP	Assessment Date	S	1	
452	475	AMT	Service Tax Amount	S	1	
453	475	AMT	Facility Tax Amount	S	1	

HCP Segment Added

New 2410 Loop Added

PRV Segments deleted

Loop 2420D Deleted

454	492	HCP	Line Pricing/Repricing Information	S	1	
			LOOP ID - 2410 DRUG IDENTIFICATION			25
459	494	LIN	Drug Identification	S	1	
462	495	CTP	Drug Pricing	S	1	
465	496	REF	Prescription Number	S	1	
			LOOP ID - 2420A ATTENDING PHYSICIAN NAME			1
467	500	NM1	Attending Physician Name	S	1	
472	525	REF	Attending Physician Secondary Identification	S	1	
			LOOP ID - 2420B OPERATING PHYSICIAN NAME			1
474	500	NM1	Operating Physician Name	S	1	
479	525	REF	Operating Physician Secondary Identification	S	1	
			LOOP ID - 2420C OTHER PROVIDER NAME			1
481	500	NM1	Other Provider Name	S	1	
486	525	REF	Other Provider Secondary Identification	S	1	
			LOOP ID - 2430 SERVICE LINE ADJUDICATION INFORMATION			25
488	540	SVD	Service Line Adjudication Information	S	1	
492	545	CAS	Service Line Adjustment	S	99	
500	550	DTP	Service Adjudication Date	S	1	
501	555	SE	Transaction Set Trailer	R	1	

IMPLEMENTATION

TRANSMISSION TYPE IDENTIFICATION

Usage: **REQUIRED**

Repeat: **1**

Example: **REF*87*004010X096A1~** Example Changed

STANDARD

REF Reference Identification

Level: Header

Position: 015

Loop: ____

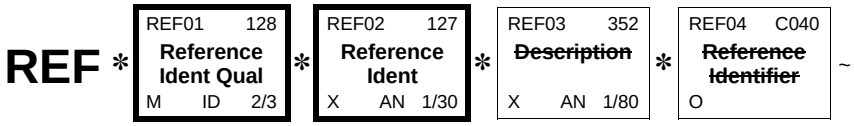
Requirement: Optional

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 / DEFINITION **87 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 004010X096DA1. When sending the transaction set in a production mode, this value is 004010X096A1.** Note Changed	**X AN 1/30**
NOT USED	**REF03**	**352**	**Description**	**X AN 1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**

IMPLEMENTATION

BILLING/PAY-TO PROVIDER SPECIALTY INFORMATION

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

Usage: SITUATIONAL

Repeat: 1

Notes:

1. **Required when adjudication is known to be impacted by the provider taxonomy code, and the Service Facility 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-2310E is not used.**

Note 1. Changed

2. **PRV02 qualifies PRV03.**

Example: PRV*BI*ZZ*203BA0200N~

STANDARD

PRV Provider Information

Level: Detail

Position: 003

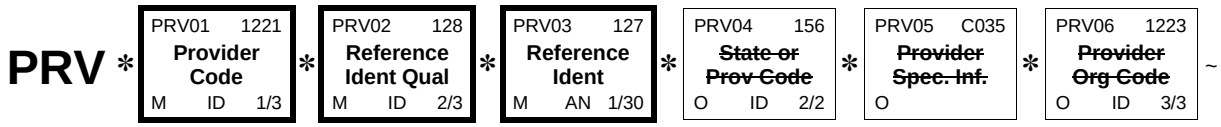
Loop: 2000

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
PT	Pay-To

IMPLEMENTATION

PROPERTY AND CASUALTY CLAIM NUMBER

Loop: **2010BA — SUBSCRIBER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **This is a property and casualty payer-assigned claim number. It is required on property and casualty claims. Providers receive this number from the property and casualty payer during eligibility determinations or some other communication with that payer. See Section 4.2, Property and Casualty, for additional information about property and casualty claims.**

2. **In the case where the patient is the same person as the subscriber, the property and casualty claim number is placed in Loop ID-2010BA. In the case where the patient is a different person than the subscriber, this number is placed in Loop ID-2010CA. This number should be transmitted in only one place.**

New Note 3. Added

3. **Not required for HIPAA (The statutory definition of a health plan does not specifically include workers' compensation programs, property and casualty programs, or disability insurance programs, and, consequently, we are not requiring them to comply with the standards.) but may be required for other uses.**

Example: **REF*Y4*4445555~**

STANDARD

REF Reference Identification

Level: Detail

Position: 035

Loop: 2010

Requirement: Optional

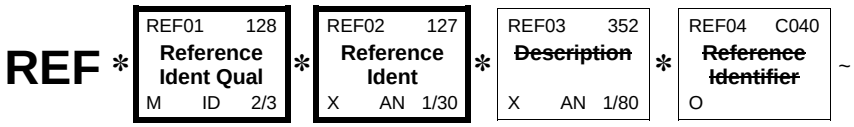
Max Use: 20

Purpose: To specify identifying information

Syntax:

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

DIAGRAM



NOT USED	PAT05	1250	Date Time Period Format Qualifier	X	ID	2/3
NOT USED	PAT06	1251	Date Time Period	X	AN	1/35
NOT USED	PAT07	355	Unit or Basis for Measurement Code	X	ID	2/2
NOT USED	PAT08	81	Weight	X	R	1/10
NOT USED	PAT09	1073	Yes/No Condition or Response Code	O	ID	1/1

Usage Changed

IMPLEMENTATION

PROPERTY AND CASUALTY CLAIM NUMBER

Loop: 2010CA — PATIENT NAME

Usage: SITUATIONAL

Repeat: 1

Notes:

1. **This is a property and casualty payer-assigned claim number. It is required on property and casualty claims. Providers receive this number from the property and casualty payer during eligibility determinations or some other communication with that payer. See Section 4.2, Property and Casualty, for additional information about property and casualty claims.**

2. **In the case where the patient is the same person as the subscriber, the property and casualty claim number is placed in Loop ID-2010BA. In the case where the patient is a different person than the subscriber, this number is placed in Loop ID-2010CA. This number should be transmitted in only one place.**

New Note 3. Added

3. **Not required for HIPAA (The statutory definition of a health plan does not specifically include workers' compensation programs, property and casualty programs, or disability insurance programs, and, consequently, we are not requiring them to comply with the standards.) but may be required for other uses.**

Example: REF*Y4*4445555~

STANDARD

REF Reference Identification

Level: Detail

Position: 035

Loop: 2010

Requirement: Optional

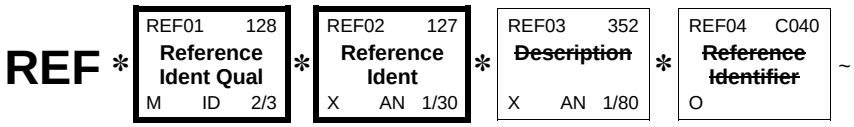
Max Use: 20

Purpose: To specify identifying information

Syntax:

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

DIAGRAM



REQUIRED	CLM09	1363	**Release of Information Code** Code indicating whether the provider has on file a signed statement by the patient authorizing the release of medical data to other organizations	O	ID	1/1

UB-92 Reference [UB-92 Name]:

52 (A-C) [Release of Information Certification Indicator]

EMC v.6.0 Reference:

Record Type 30 Field No. 16 (Sequence 01-03)

CODE	DEFINITION
A	**Appropriate Release of Information on File at Health Care Service Provider or at Utilization Review Organization**
I	**Informed Consent to Release Medical Information for Conditions or Diagnoses Regulated by Federal Statutes**
M	**The Provider has Limited or Restricted Ability to Release Data Related to a Claim** UB-92 Reference [UB-92 Name]: **52 Code R [Restricted or Modified Release]** EMC v.6.0 Reference: **Record Type 30 Field No. 16 Code R**
N	**No, Provider is Not Allowed to Release Data** UB-92 Reference [UB-92 Name]: **52 Code N [No Release]**
O	**On file at Payor or at Plan Sponsor**
Y	**Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim** UB-92 Reference [UB-92 Name]: **52 Code Y [Yes]**

Usage Changed

NOT USED	CLM10	1351	**Patient Signature Source Code**	O	ID	1/1
NOT USED	CLM11	C024	**RELATED CAUSES INFORMATION**	O		
NOT USED	CLM12	1366	**Special Program Code**	O	ID	2/3
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

IMPLEMENTATION

DOCUMENT IDENTIFICATION CODE

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **2** Repeat Count Changed

Notes:

1. **Reference numbers at this position apply to the entire claim.**
2. **This segment is used to convey submittal of HCFA-485 and HCFA-486 data OR HCFA-486 data only.**

Example: **REF*DD*485~** Example Changed

STANDARD

REF Reference Identification

Level: Detail

Position: 180

Loop: 2300

Requirement: Optional

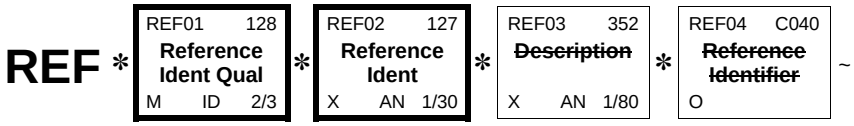
Max Use: 30

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: **DD** — DEFINITION: **Document Identification Code**	
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Document Control Identifier*** SYNTAX: R0203	**X AN 1/30**
			Use the form name as shown in the example. If both the 485 and 486 forms are being sent, repeat the segment.	

New Note Added

IMPLEMENTATION

HOME HEALTH CARE INFORMATION

Loop: 2300 — CLAIM INFORMATION

Usage: SITUATIONAL

Repeat: 1

Notes: 1. This segment is required for Home Health claims when applicable.

Note 1. Changed

Example: CR6*4*941101*RD8*19941101-19941231*941015*N*Y*I*****941101****A~

STANDARD

CR6 Home Health Care Certification

Level: Detail

Position: 216

Loop: 2300

Requirement: Optional

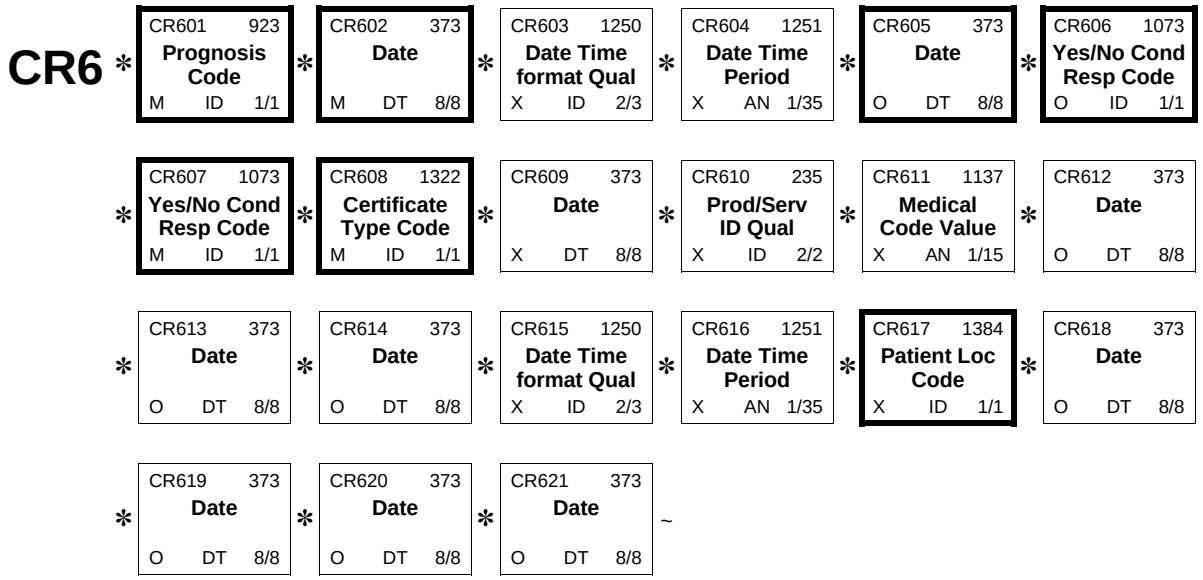
Max Use: 1

Purpose: To supply information related to the certification of a home health care patient

Syntax:

1. **P0304**
   If either CR603 or CR604 is present, then the other is required.
2. **P091011**
   If either CR609, CR610 or CR611 are present, then the others are required.
3. **P151617**
   If either CR615, CR616 or CR617 are present, then the others are required.

DIAGRAM



IMPLEMENTATION

PRINCIPAL, ADMITTING, E-CODE AND PATIENT REASON FOR VISIT DIAGNOSIS INFORMATION

Loop: 2300 — CLAIM INFORMATION

Usage: SITUATIONAL — Usage Changed

Repeat: 1

Notes:

Note 1. Changed

1. **Required on all claims and encounters except claims for Religious Non-medical claims (Bill Types 4XX and 5XX) and hospital other (Bill Types 14X).**
2. **The Admitting Diagnosis is required on all inpatient admission claims and encounters.**
3. **An E-Code diagnosis is required whenever a diagnosis is needed to describe an injury, poisoning or adverse effect.**
4. **The Patient Reason for Visit Diagnosis is required for all unscheduled outpatient visits.**

Example: HI*BK:9976~

STANDARD

HI Health Care Information Codes

Level: Detail

Position: 231

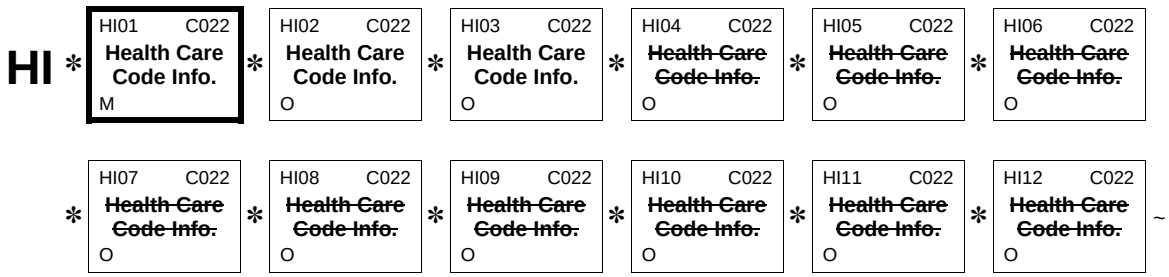
Loop: 2300

Requirement: Optional

Max Use: 25

Purpose: To supply information related to the delivery of health care

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	HI01	C022	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts and quantities	M

IMPLEMENTATION

ATTENDING PHYSICIAN NAME

Loop: **2310A — ATTENDING PHYSICIAN NAME** **Repeat:** **1**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

Note 1. Changed

1. **Information in Loop ID-2310 applies to the entire claim unless it is overridden on a service line by the presence of Loop ID-2420 with the same value in NM101.**
2. **Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 nomenclature.**
3. **Required on all inpatient claims or encounters.**
4. **Required to indicate the Primary Physician responsible on a Home Health Agency Plan of Treatment.**

Example: **NM1*71*1*JONES*JOHN****XX*12345678~**

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

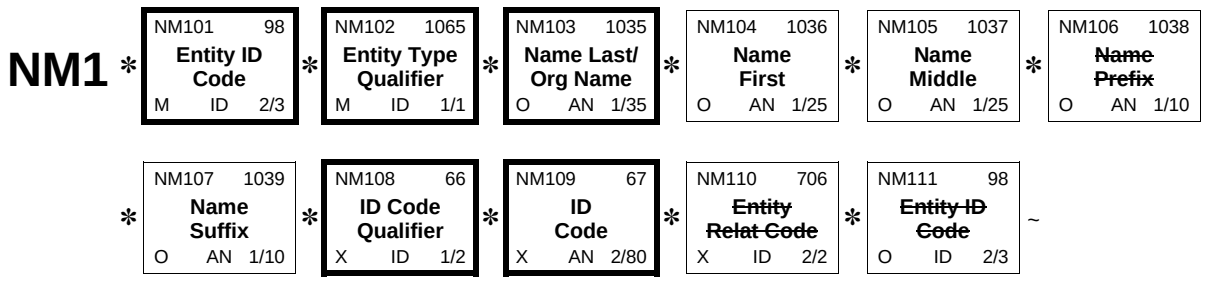
Set Notes:

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



IMPLEMENTATION

ATTENDING PHYSICIAN SPECIALTY INFORMATION

Loop: 2310A — ATTENDING PHYSICIAN 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 a PRV segment with the same value in PRV01.**
2. **Use code value AT to report the specialty of the attending physician. Use code value SU when the physician is responsible for the patient's Home Health Plan of Treatment.**
3. **PRV02 qualifies PRV03.**

New Note 4. Added — 4. **Required when the billing provider is a billing service and taxonomy is know to impact the adjudication of the claim.**

Example: PRV*AT*ZZ*363LP0200N~

STANDARD

PRV Provider Information

Level: Detail

Position: 255

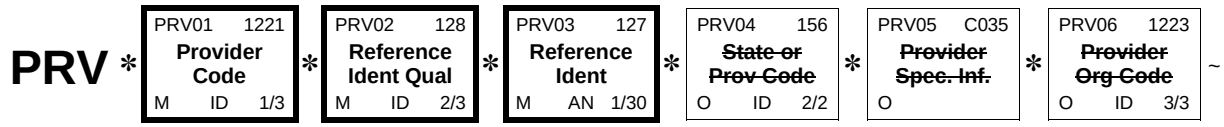
Loop: 2310

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
AT	Attending
SU	Supervising

IMPLEMENTATION

OPERATING PHYSICIAN NAME

Loop: **2310B — OPERATING PHYSICIAN NAME** **Repeat:** **1**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

Note 1. Changed

1. **Information in Loop ID-2310 applies to the entire claim unless it is overridden on a service line by the presence of Loop ID-2420 with the same value in NM101.**
2. **This segment is required when any surgical procedure code is listed on this claim.**
3. **Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 nomenclature.**

Example: **NM1*72*1*MEYERS*JANE****XX*12345678~**

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

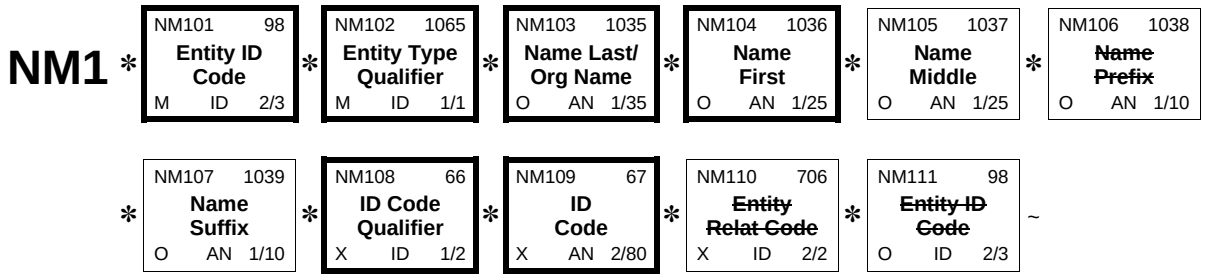
Set Notes:

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



IMPLEMENTATION

OTHER PROVIDER NAME

Loop: **2310C — OTHER PROVIDER NAME** **Repeat:** **1**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

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

Note 1. Changed

2. **Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 nomenclature.**

Note 3. Replaced

3. **Required when the claim/encounter involves an other provider such as, but not limited to: Referring Provider, Ordering Provider, Assisting Provider, etc.**

Note 4. Deleted

Example: **NM1*73*1*DOE*JOHN*A***34*201749586~**

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

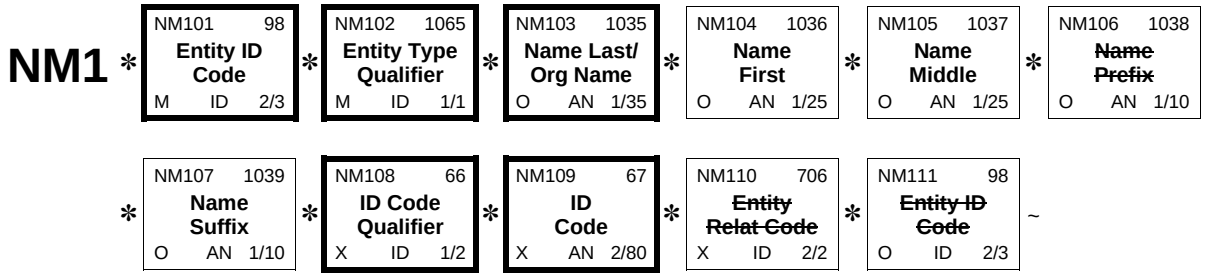
Set Notes:

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	**SV201**	**234**	**Product/Service ID** Identifying number for a product or service *INDUSTRY:* ***Service Line Revenue Code*** **SYNTAX:** R0102 **SEMANTIC:** SV201 is the revenue code. **UB-92 Reference [UB-92 Name]:** **42 [Revenue Code]** **EMC v.6.0 Reference:** **Record Type 50 Field No. 4, 11, 12, 13** **Record Type 60 Field No. 4, 13, 14** **Record Type 61 Field No. 4, 14, 15** **See Code Source 132: National Uniform Billing Committee (NUBC) Codes.**	**X AN 1/48**
SITUATIONAL	**SV202**	**C003**	**COMPOSITE MEDICAL PROCEDURE IDENTIFIER** To identify a medical procedure by its standardized codes and applicable modifiers *ALIAS:* ***Service Line Procedure Code*** **UB-92 Reference [UB-92 Name]:** **44 (HCPCS) [HCPCS/Rates/HIPPS Rate Codes]** New Note Added **This data element required for outpatient claims when an appropriate HCPCS exists for the service line item.**	**X**
REQUIRED	**SV202 - 1**	**235**	Note Deleted **Product/Service ID Qualifier** Code identifying the type/source of the descriptive number used in Product/Service ID (234) *INDUSTRY:* ***Product or Service ID Qualifier*** New Note Added **The NDC number is used for reporting prescribed drugs and biologics when required by government regulation, or as deemed by the provider to enhance claim reporting/adjudication processes. The NDC number is reported in the LIN segment of Loop ID-2410.**	**M ID 2/2**

CODE	DEFINITION
HC	**Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes** **Because the AMA's CPT codes are also level 1 HCPCS codes, they are reported under HC.** **CODE SOURCE 130:** Health Care Financing Administration Common Procedural Coding System

Codes N1, N2, N3 and N4 Deleted

New Note Added

			IV	**Home Infusion EDI Coalition (HIEC) Product/Service Code** **This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: 1) If a new rule names HIEC as an allowable code set under HIPAA. 2) For Property & Casualty claims/encounters that are not covered under HIPAA.** CODE SOURCE **513:** Home Infusion EDI Coalition (HIEC) Product/Service Code List			
			ZZ	**Mutually Defined** **Use code ZZ to convey the Health Insurance Prospective Payment System (HIPPS) Skilled Nursing Facility Rate Code. This code list is available from:** **Division of Institutional Care** **Health Care Financing Administration** **S1-03-06** **7500 Security Boulevard** **Baltimore, MD 21244-1850**			
REQUIRED	**SV202 - 2**	**234**	**Product/Service ID** Identifying number for a product or service *INDUSTRY:* ***Procedure Code*** *ALIAS:* ***HCPCS Procedure Code*** **UB-92 Reference [UB-92 Name]:** **44 (HCPCS) [HCPCS/Rates/HIPPS Rate Codes]** **EMC v.6.0 Reference:** **Record Type 60 Field No. 5, 13, 14** **Record Type 61 Field No. 5, 14, 15**	**M**	**AN**	**1/48**	
SITUATIONAL	**SV202 - 3**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners *ALIAS:* ***HCPCS Modifier 1*** **UB-92 Reference [UB-92 Name]:** **44 (HCPCS) [HCPCS/Rates/HIPPS Rate Codes]** **EMC v.6.0 Reference:** **Record Type 60 Field No. 9, 13, 14** **Use this modifier for the first procedure code modifier.** **This data element is required when the Provider needs to convey additional clarification for the associated procedure code.**	**O**	**AN**	**2/2**	

IMPLEMENTATION

SERVICE LINE DATE

Loop: 2400 — SERVICE LINE NUMBER

Usage: SITUATIONAL

Repeat: 1

Notes:

1. **Required on outpatient claims when revenue, procedure, HIEC or drug codes are reported in the SV2 segment.**
2. **In cases where a drug is being billed on a service line, the Date of Service DTP may be used to indicate the range of dates through which the drug will be used by the patient. Use RD8 for this purpose.**
3. **In cases where a drug is being billed on a service line, the Date of Service DTP is used to indicate the date the prescription was written (or otherwise communicated by the prescriber if not written).**

New Note 4. Added —

4. **Assessment Date DTP is not used when this segment is present.**

Example: DTP*472*D8*19960819~

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 455

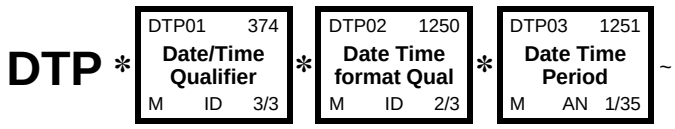
Loop: 2400

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** **Use RD8 in DTP02 to indicate begin/end or from/to dates.**

REQUIRED	DTP02	1250	**Date Time Period Format Qualifier**	M	ID	2/3

Code indicating the date format, time format, or date and time format

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

CODE	DEFINITION
D8	Date Expressed in Format CCYYMMDD
RD8	Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD

Note Deleted

REQUIRED	DTP03	1251	**Date Time Period**	M	AN	1/35

Expression of a date, a time, or range of dates, times or dates and times

INDUSTRY: ***Service Date***

UB-92 Reference [UB-92 Name]:

45 [Service Date]

EMC v.6.0 Reference:

Record Type 60 Field No. 12, 13, 14

Record Type 61 Field No. 9, 14, 15

IMPLEMENTATION

ASSESSMENT DATE

Loop: 2400 — SERVICE LINE NUMBER

Usage: SITUATIONAL

Repeat: 1

Notes:

1. Required when an assessment date is necessary (i.e. Medicare PPS processing).
2. Refer to Code Source 132 National Uniform Billing Committee (NUBC) Codes for instructions on the use of this date.

New Note 3. Added —

3. Service date DTP is not used when this segment is present.

Example: DTP*866*19981210~

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 455

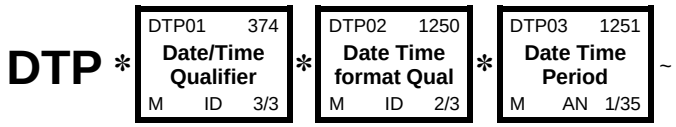
Loop: 2400

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 *INDUSTRY:* ***Date Time Qualifier***	M ID 3/3
			CODE: **866** — DEFINITION: **Examination**	
REQUIRED	DTP02	1250	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format SEMANTIC: DTP02 is the date or time or period format that will appear in DTP03.	M ID 2/3
			CODE: **D8** — DEFINITION: **Date Expressed in Format CCYYMMDD**	

IMPLEMENTATION

LINE PRICING/REPRICING INFORMATION

Loop: **2400 — SERVICE LINE NUMBER**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **Used only by repricers as needed. This information is specific to the destination payer reported in the 2010BB loop.**

Example: **HCP*03*100*10*RPO12345~**

STANDARD

HCP Health Care Pricing

Level: Detail

Position: 492

Loop: 2400

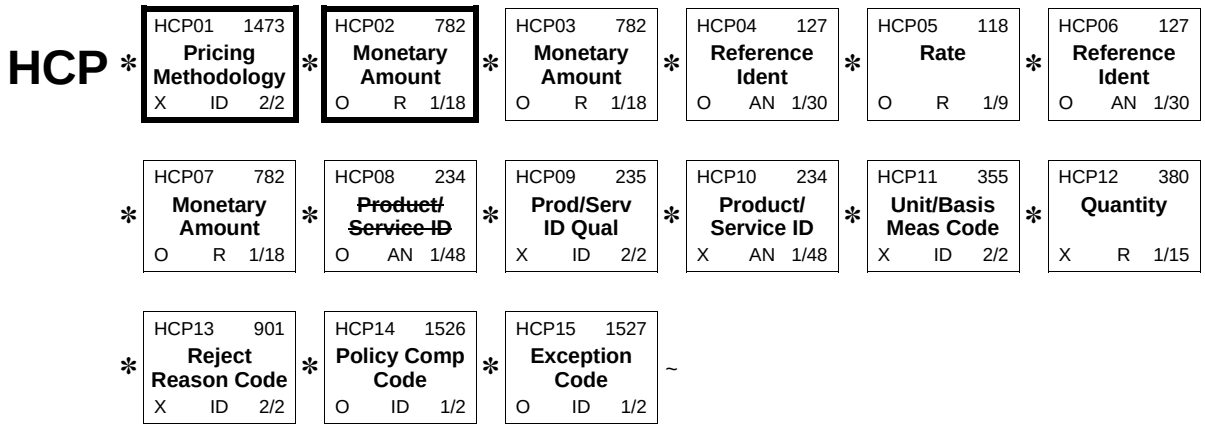
Requirement: Optional

Max Use: 1

Purpose: To specify pricing or repricing information about a health care claim or line item

Syntax:
1. **R0113**
   At least one of HCP01 or HCP13 is required.
2. **P0910**
   If either HCP09 or HCP10 is present, then the other is required.
3. **P1112**
   If either HCP11 or HCP12 is present, then the other is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	HCP01	1473	**Pricing Methodology** Code specifying pricing methodology at which the claim or line item has been priced or repriced *ALIAS:* ***Pricing/Repricing Methodology*** **SYNTAX:** R0113 **Trading partners need to agree on which codes to use in this data element. There do not appear to be standard definitions for the code elements.**	X ID 2/2
REQUIRED	HCP02	782	**Monetary Amount** Monetary amount *INDUSTRY:* ***Repriced Allowed Amount*** *ALIAS:* ***Pricing/Repricing Allowed Amount*** **SEMANTIC:** HCP02 is the allowed amount.	O R 1/18

CODE	DEFINITION
00	Zero Pricing (Not Covered Under Contract)
01	Priced as Billed at 100%
02	Priced at the Standard Fee Schedule
03	Priced at a Contractual Percentage
04	Bundled Pricing
05	Peer Review Pricing
06	Per Diem Pricing
07	Flat Rate Pricing
08	Combination Pricing
09	Maternity Pricing
10	Other Pricing
11	Lower of Cost
12	Ratio of Cost
13	Cost Reimbursed
14	Adjustment Pricing

SITUATIONAL	**HCP03**	**782**	**Monetary Amount** Monetary amount	**O**	**R**	**1/18**

INDUSTRY: ***Repriced Saving Amount***

ALIAS: ***Pricing/Repricing Saving Amount***

SEMANTIC: HCP03 is the savings amount.

This data element is required when it is necessary to report Savings Amount on claims which has been priced or repriced.

SITUATIONAL	**HCP04**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	**O**	**AN**	**1/30**

INDUSTRY: ***Repriced Organizational Identifier***

ALIAS: ***Pricing/Repricing Organizational Identifier***

SEMANTIC: HCP04 is the repricing organization identification number.

This data element is required when it is necessary to report Repricing Organization ID on claims which has been priced or repriced.

SITUATIONAL	**HCP05**	**118**	**Rate** Rate expressed in the standard monetary denomination for the currency specified	**O**	**R**	**1/9**

INDUSTRY: ***Repricing Per Diem or Flat Rate Amount***

ALIAS: ***Pricing/Repricing Rate***

SEMANTIC: HCP05 is the pricing rate associated with per diem or flat rate repricing.

This data element is required when it is necessary to report Pricing Rate on claims which has been priced or repriced.

SITUATIONAL	**HCP06**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	**O**	**AN**	**1/30**

INDUSTRY: ***Repriced Approved Ambulatory Patient Group Code***

ALIAS: ***Approved APG Code, Pricing***

SEMANTIC: HCP06 is the approved DRG code.

COMMENT: HCP06, HCP07, HCP08, HCP10, and HCP12 are fields that will contain different values from the original submitted values.

This data element is required when it is necessary to report Approved DRG Code on claims which has been priced or repriced.

SITUATIONAL	**HCP07**	**782**	**Monetary Amount** Monetary amount	**O**	**R**	**1/18**

INDUSTRY: ***Repriced Approved Ambulatory Patient Group Amount***

ALIAS: ***Approved APG Amount, Pricing***

SEMANTIC: HCP07 is the approved DRG amount.

This data element is required when it is necessary to report Approved DRG Amount on claims which has been priced or repriced.

SITUATIONAL	**HCP08**	**234**	**Product/Service ID** Identifying number for a product or service	**O**	**AN**	**1/48**

INDUSTRY: ***Repriced Approved Revenue Code***

ALIAS: ***Approved Revenue Code***

SEMANTIC: HCP08 is the approved revenue code.

This data element is required when it is necessary to report Approved Revenue Code on claims which has been priced or repriced.

SITUATIONAL	**HCP09**	**235**	**Product/Service ID Qualifier** Code identifying the type/source of the descriptive number used in Product/Service ID (234)	**X**	**ID**	**2/2**

SYNTAX: P0910

Required when HCP10 exists.

CODE	DEFINITION
HC	**Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes** **This code includes Current Procedural Terminology (CPT) and HCPCS coding.**

CODE SOURCE 130: Health Care Financing Administration Common Procedural Coding System

SITUATIONAL	**HCP10**	**234**	**Product/Service ID** Identifying number for a product or service	**X**	**AN**	**1/48**

INDUSTRY: ***Procedure Code***

ALIAS: ***Pricing/Repricing Approved Procedure Code***

SYNTAX: P0910

SEMANTIC: HCP10 is the approved procedure code.

This data element is required when it is necessary to report Approved HCPCS Code on claims which has been priced or repriced.

SITUATIONAL	**HCP11**	**355**	**Unit or Basis for Measurement Code** Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken	**X**	**ID**	**2/2**

SYNTAX: P1112

CODE	DEFINITION
DA	**Days**
UN	**Unit**

SITUATIONAL	**HCP12**	**380**	**Quantity** Numeric value of quantity	**X**	**R**	**1/15**

INDUSTRY: ***Repricing Approved Service Unit Count***

ALIAS: ***Pricing/Repricing Approved Units or Inpatient Days***

SYNTAX: P1112

SEMANTIC: HCP12 is the approved service units or inpatient days.

This data element is required when it is necessary to report Approved Service Unit Count on claims which has been priced or repriced.

SITUATIONAL **HCP13** **901** **Reject Reason Code** **X** **ID** **2/2**
Code assigned by issuer to identify reason for rejection

ALIAS: ***Reject Reason Code***

SYNTAX: R0113

SEMANTIC: HCP13 is the rejection message returned from the third party organization.

This data element is required when it is necessary to report Rejection Message on claims which has been priced or repriced.

CODE	DEFINITION
T1	Cannot Identify Provider as TPO (Third Party Organization) Participant
T2	Cannot Identify Payer as TPO (Third Party Organization) Participant
T3	Cannot Identify Insured as TPO (Third Party Organization) Participant
T4	Payer Name or Identifier Missing
T5	Certification Information Missing
T6	Claim does not contain enough information for re-pricing

SITUATIONAL **HCP14** **1526** **Policy Compliance Code** **O** **ID** **1/2**
Code specifying policy compliance

This data element is required when it is necessary to report Policy Compliance Code on claims which has been priced or repriced.

CODE	DEFINITION
1	Procedure Followed (Compliance)
2	Not Followed - Call Not Made (Non-Compliance Call Not Made)
3	Not Medically Necessary (Non-Compliance Non-Medically Necessary)
4	Not Followed Other (Non-Compliance Other)
5	Emergency Admit to Non-Network Hospital

SITUATIONAL **HCP15** **1527** **Exception Code** **O** **ID** **1/2**
Code specifying the exception reason for consideration of out-of-network health care services

This data element is required when it is necessary to report Exception Reason Code on claims which have been priced or repriced.

SEMANTIC: HCP15 is the exception reason generated by a third party organization.

CODE	DEFINITION
1	Non-Network Professional Provider in Network Hospital
2	Emergency Care

3	Services or Specialist not in Network
4	Out-of-Service Area
5	State Mandates
6	Other

IMPLEMENTATION

DRUG IDENTIFICATION

Loop: **2410 — DRUG IDENTIFICATION** **Repeat:** **25**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **The NDC number is used for reporting prescribed drugs and biologics when required by government regulation, or as deemed by the provider to enhance claim reporting/adjudication processes. The NDC number is reported in the LIN segment of Loop ID-2410.**

2. **Use Loop ID 2410 to specify billing/reporting for drugs provided that may be part of the service(s) described in SV2.**

Example: **LIN*N4*12345123412~**

STANDARD

LIN Item Identification

Level: Detail

Position: 494

Loop: 2410 **Repeat:** >1

Requirement: Optional

Max Use: 1

Purpose: To specify basic item identification data

Set Notes:

1. Loop 2410 contains compound drug components, quantities and prices.

Syntax:

1. **P0405**
   If either LIN04 or LIN05 is present, then the other is required.
2. **P0607**
   If either LIN06 or LIN07 is present, then the other is required.
3. **P0809**
   If either LIN08 or LIN09 is present, then the other is required.
4. **P1011**
   If either LIN10 or LIN11 is present, then the other is required.
5. **P1213**
   If either LIN12 or LIN13 is present, then the other is required.
6. **P1415**
   If either LIN14 or LIN15 is present, then the other is required.
7. **P1617**
   If either LIN16 or LIN17 is present, then the other is required.
8. **P1819**
   If either LIN18 or LIN19 is present, then the other is required.
9. **P2021**
   If either LIN20 or LIN21 is present, then the other is required.

10. P2223
If either LIN22 or LIN23 is present, then the other is required.

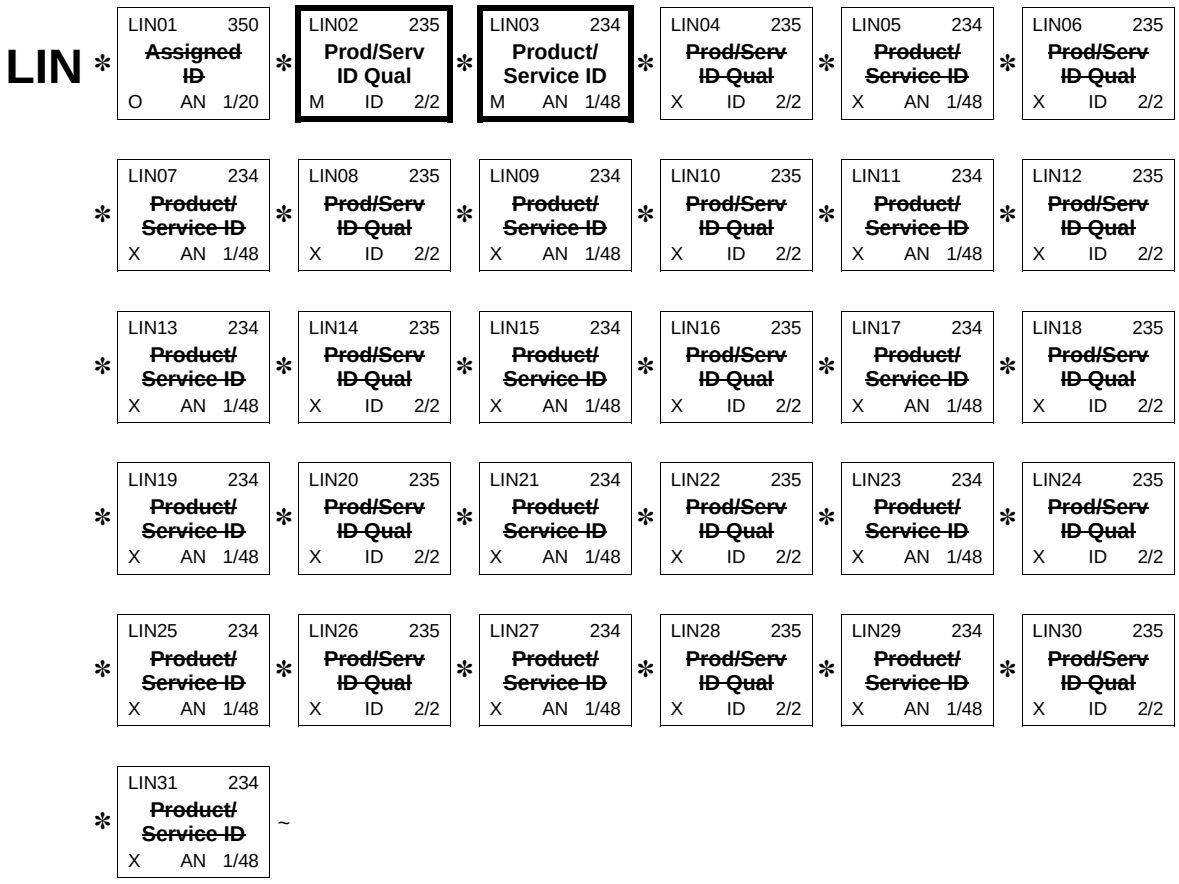
11. P2425
If either LIN24 or LIN25 is present, then the other is required.

12. P2627
If either LIN26 or LIN27 is present, then the other is required.

13. P2829
If either LIN28 or LIN29 is present, then the other is required.

14. P3031
If either LIN30 or LIN31 is present, then the other is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
NOT USED	LIN01	350	Assigned Identification	O	AN	1/20

REQUIRED	LIN02	235	**Product/Service ID Qualifier** Code identifying the type/source of the descriptive number used in Product/Service ID (234) COMMENT: LIN02 through LIN31 provide for fifteen different product/service IDs for each item. For example: Case, Color, Drawing No., U.P.C. No., ISBN No., Model No., or SKU.	M	ID	2/2

CODE	DEFINITION
N4	**National Drug Code in 5-4-2 Format**
	CODE SOURCE **240:** National Drug Code by Format

REQUIRED	LIN03	234	**Product/Service ID** Identifying number for a product or service *ALIAS:* ***National Drug Code***	M	AN	1/48
NOT USED	LIN04	235	**Product/Service ID Qualifier**	X	ID	2/2
NOT USED	LIN05	234	**Product/Service ID**	X	AN	1/48
NOT USED	LIN06	235	**Product/Service ID Qualifier**	X	ID	2/2
NOT USED	LIN07	234	**Product/Service ID**	X	AN	1/48
NOT USED	LIN08	235	**Product/Service ID Qualifier**	X	ID	2/2
NOT USED	LIN09	234	**Product/Service ID**	X	AN	1/48
NOT USED	LIN10	235	**Product/Service ID Qualifier**	X	ID	2/2
NOT USED	LIN11	234	**Product/Service ID**	X	AN	1/48
NOT USED	LIN12	235	**Product/Service ID Qualifier**	X	ID	2/2
NOT USED	LIN13	234	**Product/Service ID**	X	AN	1/48
NOT USED	LIN14	235	**Product/Service ID Qualifier**	X	ID	2/2
NOT USED	LIN15	234	**Product/Service ID**	X	AN	1/48
NOT USED	LIN16	235	**Product/Service ID Qualifier**	X	ID	2/2
NOT USED	LIN17	234	**Product/Service ID**	X	AN	1/48
NOT USED	LIN18	235	**Product/Service ID Qualifier**	X	ID	2/2
NOT USED	LIN19	234	**Product/Service ID**	X	AN	1/48
NOT USED	LIN20	235	**Product/Service ID Qualifier**	X	ID	2/2
NOT USED	LIN21	234	**Product/Service ID**	X	AN	1/48
NOT USED	LIN22	235	**Product/Service ID Qualifier**	X	ID	2/2
NOT USED	LIN23	234	**Product/Service ID**	X	AN	1/48
NOT USED	LIN24	235	**Product/Service ID Qualifier**	X	ID	2/2
NOT USED	LIN25	234	**Product/Service ID**	X	AN	1/48
NOT USED	LIN26	235	**Product/Service ID Qualifier**	X	ID	2/2
NOT USED	LIN27	234	**Product/Service ID**	X	AN	1/48
NOT USED	LIN28	235	**Product/Service ID Qualifier**	X	ID	2/2
NOT USED	LIN29	234	**Product/Service ID**	X	AN	1/48
NOT USED	LIN30	235	**Product/Service ID Qualifier**	X	ID	2/2
NOT USED	LIN31	234	**Product/Service ID**	X	AN	1/48

IMPLEMENTATION

DRUG PRICING

Loop: **2410 — DRUG IDENTIFICATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **Required when it is necessary to provide a price specific to the NDC provided in LIN03 that is different than the price reported in SV203.**

Example: **CTP***1.15*2*UN~

STANDARD

CTP Pricing Information

Level: Detail

Position: 495

Loop: 2410

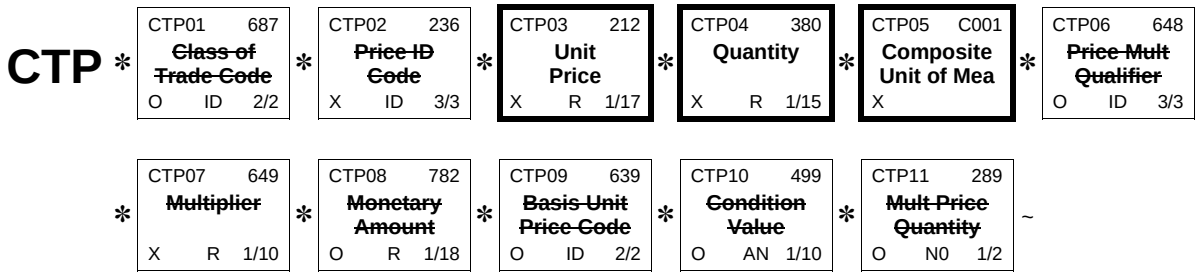
Requirement: Optional

Max Use: 1

Purpose: To specify pricing information

Syntax:
1. **P0405**
   If either CTP04 or CTP05 is present, then the other is required.
2. **C0607**
   If CTP06 is present, then CTP07 is required.
3. **C0902**
   If CTP09 is present, then CTP02 is required.
4. **C1002**
   If CTP10 is present, then CTP02 is required.
5. **C1103**
   If CTP11 is present, then CTP03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
NOT USED	CTP01	687	Class of Trade Code	O ID 2/2

NOT USED	CTP02	236	**Price Identifier Code**	X	ID	3/3
REQUIRED	CTP03	212	**Unit Price** Price per unit of product, service, commodity, etc. *ALIAS:* ***Drug Unit Price*** **SYNTAX:** C1103	X	R	1/17
REQUIRED	CTP04	380	**Quantity** Numeric value of quantity *ALIAS:* ***National Drug Unit Count*** **SYNTAX:** P0405	X	R	1/15
REQUIRED	CTP05	C001	**COMPOSITE UNIT OF MEASURE** To identify a composite unit of measure *ALIAS:* ***Unit/Basis of Measurement***	X		
REQUIRED	CTP05 - 1	355	**Unit or Basis for Measurement Code** Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken *ALIAS:* ***Code Qualifier***	M	ID	2/2

CODE	DEFINITION
F2	International Unit
GR	Gram
ML	Milliliter
UN	Unit

NOT USED	CTP05 - 2	1018	Exponent	O	R	1/15
NOT USED	CTP05 - 3	649	Multiplier	O	R	1/10
NOT USED	CTP05 - 4	355	Unit or Basis for Measurement Code	O	ID	2/2
NOT USED	CTP05 - 5	1018	Exponent	O	R	1/15
NOT USED	CTP05 - 6	649	Multiplier	O	R	1/10
NOT USED	CTP05 - 7	355	Unit or Basis for Measurement Code	O	ID	2/2
NOT USED	CTP05 - 8	1018	Exponent	O	R	1/15
NOT USED	CTP05 - 9	649	Multiplier	O	R	1/10
NOT USED	CTP05 - 10	355	Unit or Basis for Measurement Code	O	ID	2/2
NOT USED	CTP05 - 11	1018	Exponent	O	R	1/15
NOT USED	CTP05 - 12	649	Multiplier	O	R	1/10
NOT USED	CTP05 - 13	355	Unit or Basis for Measurement Code	O	ID	2/2
NOT USED	CTP05 - 14	1018	Exponent	O	R	1/15
NOT USED	CTP05 - 15	649	Multiplier	O	R	1/10
NOT USED	CTP06	648	Price Multiplier Qualifier	O	ID	3/3
NOT USED	CTP07	649	Multiplier	X	R	1/10
NOT USED	CTP08	782	Monetary Amount	O	R	1/18
NOT USED	CTP09	639	Basis of Unit Price Code	O	ID	2/2
NOT USED	CTP10	499	Condition Value	O	AN	1/10
NOT USED	CTP11	289	Multiple Price Quantity	O	N0	1/2

IMPLEMENTATION

PRESCRIPTION NUMBER

Loop: 2410 — DRUG IDENTIFICATION

Usage: SITUATIONAL

Repeat: 1

Notes:
1. **Required if dispense of the drug has been done with an assigned Rx number.**
2. **In cases where a compound drug is being billed, the components of the compound will all have the same prescription number. Payers receiving the claim can relate all the components by matching the prescription number.**

Example: REF*XZ*123456~

STANDARD

REF Reference Identification

Level: Detail

Position: 496

Loop: 2410

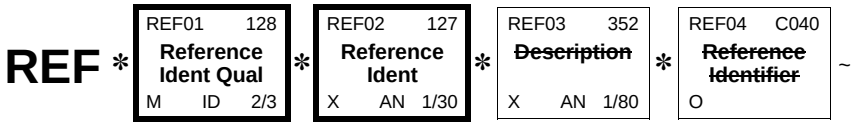
Requirement: Optional

Max Use: 1

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 *ALIAS:* ***Code Qualifier***	**M ID 2/3**

CODE	DEFINITION
XZ	**Pharmacy Prescription Number**

REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *ALIAS:* ***Prescription Number*** **SYNTAX:** R0203	**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**	**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**		

IMPLEMENTATION

ATTENDING PHYSICIAN NAME

Loop: **2420A — ATTENDING PHYSICIAN NAME** **Repeat:** **1**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 nomenclature.**

Note 2. Changed
2. **Required when line level provider information is known to impact adjudication.**

Example: **NM1*71*1*JONES*JOHN***SR.*24*123456789~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 500

Loop: 2420 **Repeat:** 10

Requirement: Optional

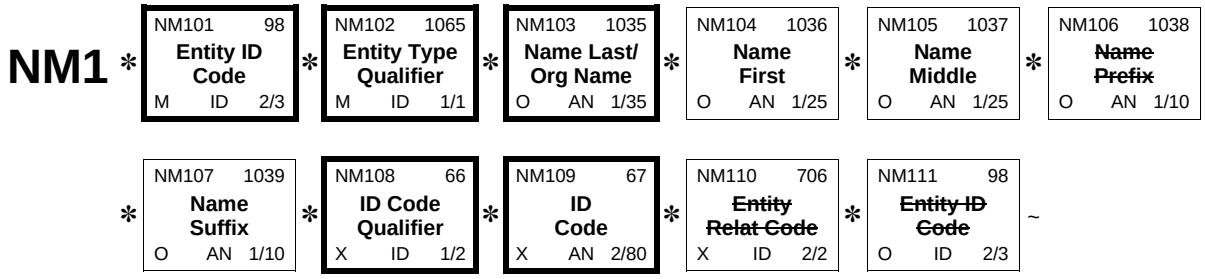
Max Use: 1

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



IMPLEMENTATION

OPERATING PHYSICIAN NAME

Loop: **2420B — OPERATING PHYSICIAN NAME** **Repeat:** **1**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 nomenclature.**

Note 2. Changed
2. **Required when line level provider information is known to impact adjudication.**

Example: **NM1*72*1*MEYERS*JANE*I***34*129847263~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 500

Loop: 2420 **Repeat:** 10

Requirement: Optional

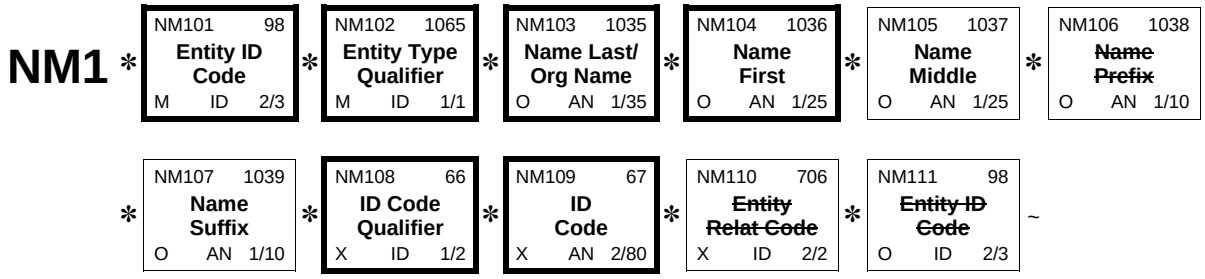
Max Use: 1

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



IMPLEMENTATION

OTHER PROVIDER NAME

Loop: **2420C — OTHER PROVIDER NAME** **Repeat:** **1**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 nomenclature.**

Note 2. Changed

2. **Required when line level provider information is known to impact adjudication.**

Note 3. Replaced

3. **Required when the claim/encounter involves an other provider such as, but not limited to: Referring Provider, Ordering Provider, Assisting Provider, etc.**

Note 4. Deleted

Example: **NM1*73*1*JONES*JOHN***SR.*24*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.

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**SVD01**	**67**	**Identification Code** Code identifying a party or other code *INDUSTRY:* ***Payer Identifier*** **SEMANTIC:** SVD01 is the payer identification code. **EMC v.6.0 Reference:** **Record Type 30 Field No. 5, 6 (This must match one of the corresponding loops: 2010BC - Payer Name, or 2330B - Other Payer Name.)**	**M AN 2/80**
REQUIRED	**SVD02**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Service Line Paid Amount*** *ALIAS:* ***Service Line Amount Paid*** **SEMANTIC:** SVD02 is the amount paid for this service line.	**M R 1/18**
SITUATIONAL	**SVD03**	**C003**	**COMPOSITE MEDICAL PROCEDURE IDENTIFIER** To identify a medical procedure by its standardized codes and applicable modifiers **Required when returned on an 835 payment for this claim or when needed to identify the service line adjudicated.**	**O**
REQUIRED	**SVD03 - 1**	**235**	**Product/Service ID Qualifier** Code identifying the type/source of the descriptive number used in Product/Service ID (234) *INDUSTRY:* ***Product or Service ID Qualifier*** **The NDC number is used for reporting prescribed drugs and biologics when required by government regulation, or as deemed by the provider to enhance claim reporting/adjudication processes. The NDC number is reported in the LIN segment of Loop ID-2410.**	**M ID 2/2**

New Note Added

CODE	DEFINITION
HC	**Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes** **Because the AMA's CPT codes are also level 1 HCPCS codes, they are reported under HC.**
	CODE SOURCE 130: Health Care Financing Administration Common Procedural Coding System
IV	**Home Infusion EDI Coalition (HIEC) Product/Service Code** **This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: 1) If a new rule names HIEC as an allowable code set under HIPAA. 2) For Property & Casualty claims/encounters that are not covered under HIPAA.**
	CODE SOURCE 513: Home Infusion EDI Coalition (HIEC) Product/Service Code List

New Note Added

Codes N1, N2, N3, and N4 Deleted

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

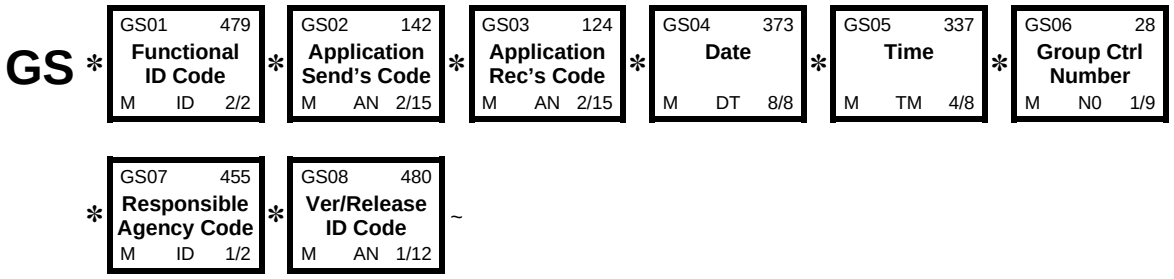
Example: **GS*HC*SENDER CODE*RECEIVER CODE*19940331*0802*1*X*004010X096A1~** ——— Example changed

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**	M	N0	1/9

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.

REQUIRED	GS07	455	**Responsible Agency Code**	M	ID	1/2

Code used in conjunction with Data Element 480 to identify the issuer of the standard

CODE	DEFINITION
X	**Accredited Standards Committee X12**

REQUIRED	GS08	480	**Version / Release / Industry Identifier Code**	M	AN	1/12

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

CODE	DEFINITION
004010X096A1	**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: Institutional Implementation Guide, originally published May 2000 as 004010X096 and incorporating the changes identified in the Addenda, the value used in GS08 must be "004010X096A1".**

New code value