

837 Health Care Claim: Institutional

HIPAA/V4010X096A1/837: 837 Health Care Claim: Institutional

Version: 1.0 Final

Author:	LIPA
Publication:	
Created:	06/04/2003
Modified:	06/04/2003
Notes:	

837 Health Care Claim: Institutional

Functional Group=HC

Note: This guide does not contain all the required and situation data that may be necessary to make up a HIPAA compliant claim. Only segment and elements that have LIPA specific notes or industry notes that LIPA is emphasizing are included. There is a more detailed guide available containing approximately 200 pages.

This Standard contains the format and establishes the data contents of the Health Care Claim Transaction Set (837) for use within the context of an Electronic Data Interchange (EDI) environment. This transaction set can be used to submit health care claim billing information, encounter information, or both, from providers of health care services to payers, either directly or via intermediary billers and claims clearinghouses. It can also be used to transmit health care claims and billing payment information between payers with different payment responsibilities where coordination of benefits is required or between payers and regulatory agencies to monitor the rendering, billing, and/or payment of health care services within a specific health care/insurance industry segment. For purposes of this standard, providers of health care products or services may include entities such as physicians, hospitals and other medical facilities or suppliers, dentists, and pharmacies, and entities providing medical information to meet regulatory requirements. The payer refers to a third party entity that pays claims or administers the insurance product or benefit or both. For example, a payer may be an insurance company, health maintenance organization (HMO), preferred provider organization (PPO), government agency (Medicare, Medicaid, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), etc.) or an entity such as a third party administrator (TPA) or third party organization (TPO) that may be contracted by one of those groups. A regulatory agency is an entity responsible, by law or rule, for administering and monitoring a statutory benefits program or a specific health care/insurance industry segment.

Not Defined:

Pos	Id	Segment Name	Req	Max Use	Repeat	Notes	Usage
	ISA	Interchange Control Header	M	1			Required
	GS	Functional Group Header	M	1			Required

Heading:

Pos	Id	Segment Name	Req	Max Use	Repeat	Notes	Usage
005	ST	Transaction Set Header	M	1			Required
010	BHT	Beginning of Hierarchical Transaction	M	1			Required

LOOP ID - 1000A					Repeat	Notes	Usage
020	NM1	Submitter Name	O	1	1	N1/020	Required

LOOP ID - 1000B					Repeat	Notes	Usage
020	NM1	Receiver Name	O	1	1	N1/020	Required

Detail:

Pos	Id	Segment Name	Req	Max Use	Repeat	Notes	Usage
LOOP ID - 2000A					>1		
LOOP ID - 2010AA					1	N2/015L	
035	REF	Billing Provider Secondary Identification	O	8			Situational

LOOP ID - 2000B					Repeat	Notes	Usage
001	HL	Subscriber Hierarchical Level	M	1	>1		Required

LOOP ID - 2010BA					1	N2/015L	
015	NM1	Subscriber Name	O	1		N2/015	Required

LOOP ID - 2010BC					1	N2/015L	
------------------	--	--	--	--	---	---------	--

LOOP ID - 2300					100		
130	CLM	Claim information	O	1			Required
180	REF	Original Reference Number (ICN/DCN)	O	1			Situational
180	REF	Prior Authorization or Referral Number	O	2			Situational

LOOP ID - 2310A					1	N2/250L	
271	REF	Attending Physician Secondary Identification	O	5			Situational

LOOP ID - 2310B					1	N2/250L	
271	REF	Operating Physician Secondary Identification	O	5			Situational

LOOP ID - 2310C					1	N2/250L	
271	REF	Other Provider Secondary Identification	O	5			Situational

LOOP ID - 2310E					1	N2/250L	
-----------------	--	--	--	--	---	---------	--

LOOP ID - 2400					999	N2/365L	
----------------	--	--	--	--	-----	---------	--

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Notes</u>	<u>Usage</u>
375	SV2	Institutional Service Line	O	1			Required
LOOP ID - 2420A						1	N2/500L
525	REF	Attending Physician Secondary Identification	O	1			Situational
LOOP ID - 2420B						1	N2/500L
LOOP ID - 2420C						1	N2/500L
555	SE	Transaction Set Trailer	M	1			Required

Not Defined:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Notes</u>	<u>Usage</u>
	GE	Functional Group Trailer	M	1			Required
	IEA	Interchange Control Trailer	M	1			Required

Notes:

- 1/020L Loop 1000 contains submitter and receiver information. If any intermediary receivers change or add data in any way, then they add an occurrence to the loop as a form of identification. The added loop occurrence must be the last occurrence of the loop.
- 1/020 Loop 1000 contains submitter and receiver information. If any intermediary receivers change or add data in any way, then they add an occurrence to the loop as a form of identification. The added loop occurrence must be the last occurrence of the loop.
- 1/020L Loop 1000 contains submitter and receiver information. If any intermediary receivers change or add data in any way, then they add an occurrence to the loop as a form of identification. The added loop occurrence must be the last occurrence of the loop.
- 1/020 Loop 1000 contains submitter and receiver information. If any intermediary receivers change or add data in any way, then they add an occurrence to the loop as a form of identification. The added loop occurrence must be the last occurrence of the loop.
- 2/015L Loop 2010 contains information about entities that apply to all claims in loop 2300. For example, these entities may include billing provider, pay-to provider, insurer, primary administrator, contract holder, or claimant.
- 2/015L Loop 2010 contains information about entities that apply to all claims in loop 2300. For example, these entities may include billing provider, pay-to provider, insurer, primary administrator, contract holder, or claimant.
- 2/015 Loop 2010 contains information about entities that apply to all claims in loop 2300. For example, these entities may include billing provider, pay-to provider, insurer, primary administrator, contract holder, or claimant.
- 2/015L Loop 2010 contains information about entities that apply to all claims in loop 2300. For example, these entities may include billing provider, pay-to provider, insurer, primary administrator, contract holder, or claimant.
- 2/250L Loop 2310 contains information about the rendering, referring, or attending provider.
- 2/250L Loop 2310 contains information about the rendering, referring, or attending provider.
- 2/250L Loop 2310 contains information about the rendering, referring, or attending provider.
- 2/250L Loop 2310 contains information about the rendering, referring, or attending provider.
- 2/365L Loop 2400 contains Service Line information.
- 2/500L 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.
- 2/500L 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.
- 2/500L 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.

ISA Interchange Control Header

Pos:	Max: 1
Not Defined - Mandatory	
Loop: N/A	Elements: 7

User Option (Usage): Required

To start and identify an interchange of zero or more functional groups and interchange-related control segments

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
ISA01	I01	Authorization Information Qualifier Description: Code to identify the type of information in the Authorization Information <i>Use '00' no authorization information</i>	M	ID	2/2	Required
ISA03	I03	Security Information Qualifier Description: Code to identify the type of information in the Security Information <i>Use '00' no password or encryption</i>	M	ID	2/2	Required
ISA05	I05	Interchange ID Qualifier Description: Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified <i>This ID qualifies the Sender in ISA06. Use 'ZZ' Mutually Defined.</i>	M	ID	2/2	Required
ISA06	I06	Interchange Sender ID Description: Identification code published by the sender for other parties to use as the receiver ID to route data to them; the sender always codes this value in the sender ID element <i>The sender's identification number as assigned by LIPA when the EDI Registration form is processed.</i> <i>Note: The sender may not be the organization submitting the transactions. If a billing service or clearinghouse is used, the number assigned that organization would appear here.</i>	M	AN	15/15	Required
ISA07	I05	Interchange ID Qualifier Description: Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified <i>This ID qualifies the Receiver in ISA08. Use 'ZZ' Mutually Defined.</i>	M	ID	2/2	Required
ISA08	I07	Interchange Receiver ID Description: Identification code published by the receiver of the data; When sending, it is used by the sender as their sending ID, thus other parties sending to them will use this as a receiving ID to route data to them <i>Use 'LIPA'</i>	M	AN	15/15	Required
ISA16	I15	Component Element Separator Description: Type is not applicable; the component element separator is a delimiter and not a data element; this field provides the delimiter used to separate component data elements within a composite data structure; this value must be different than the data element separator and the segment terminator <i>LIPA prefers the use of a colon ':' You may choose to use other values but they must be different from the Element Separator (usually '*') and the Segment separator (usually '~').</i>	M		1/1	Required

Notes:

The ISA is a fixed record length segment and all positions within each of the data elements must be filled. The first element separator defines the element separator to be used through the entire interchange. The segment terminator used after the ISA defines the segment terminator to be used throughout the entire interchange. Spaces in the example are represented by '.' for clarity.

Example:

ISA*00*.....*01*SECRET....*ZZ*SUBMITTERS.ID..*ZZ*RECEIVERS.ID...*930602*1253*U*00401*000000905*1*T*::~~

GS Functional Group Header

Pos:	Max: 1
Not Defined - Mandatory	
Loop: N/A	Elements: 2

User Option (Usage): Required

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

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
GS02	142	Application Sender's Code Description: Code identifying party sending transmission; codes agreed to by trading partners <i>This identifies the organization sending the claims in the file. This may be the same as the value found in ISA 06 Interchange Sender ID. Do not put the ID of a billing service or clearinghouse here. This value must match the ID placed in loop 1000A Field NM 109, Submitter Identifier.</i>	M	AN	2/15	Required
GS03	124	Application Receiver's Code Description: Code identifying party receiving transmission; codes agreed to by trading partners <i>Use 'LIPA'</i>	M	AN	2/15	Required

Semantics:

- GS04 is the group date.
- GS05 is the group time.
- The data interchange control number GS06 in this header must be identical to the same data element in the associated functional group trailer, GE02.

Comments:

- A functional group of related transaction sets, within the scope of X12 standards, consists of a collection of similar transaction sets enclosed by a functional group header and a functional group trailer.

Example:

```
GS*HC*SENDER CODE*RECEIVER CODE*19940331*0802*1*X*004010X097~
```

ST Transaction Set Header

Pos: 005	Max: 1
Heading - Mandatory	
Loop: N/A	Elements: 2

User Option (Usage): Required

To indicate the start of a transaction set and to assign a control number

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
ST01	143	Transaction Set Identifier Code Description: Code uniquely identifying a Transaction Set <i>Use '837'</i>	M	ID	3/3	Required
ST02	329	Transaction Set Control Number Description: Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set <i>The Transaction Set Control Number in ST02 and SE02 must be identical. This unique number also aids in error resolution research. Submitters could be sending transactions using the number 0001 in this element and increment from there. The number must be unique within a specific functional group (GS-GE) and interchange (ISA-IEA), but can repeat in other groups and interchanges.</i>	M	AN	4/9	Required

Semantics:

1. The transaction set identifier (ST01) used by the translation routines of the interchange partners to select the appropriate transaction set definition (e.g., 810 selects the Invoice Transaction Set).

Example:

ST*837*987654~

BHT Beginning of Hierarchical Transaction

Pos: 010	Max: 1
Heading - Mandatory	
Loop: N/A	Elements: 1

User Option (Usage): Required

To define the business hierarchical structure of the transaction set and identify the business application purpose and reference data, i.e., number, date, and time

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
BHT06	640	Transaction Type Code	O	ID	2/2	Required
Description: Code specifying the type of transaction						
Industry: <i>Claim or Encounter Identifier</i>						
Alias: <i>Claim or Encounter Indicator</i>						
<i>Use 'CH' for all transactions.</i>						

Semantics:

1. BHT03 is the number assigned by the originator to identify the transaction within the originator's business application system.
2. BHT04 is the date the transaction was created within the business application system.
3. BHT05 is the time the transaction was created within the business application system.

Example:

*BHT*0019*00*0123*19960618*0932*CH~*

NM1 Submitter Name

Pos: 020	Max: 1
Heading - Optional	
Loop: 1000A	Elements: 4

User Option (Usage): Required

To supply the full name of an individual or organizational entity

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
NM103	1035	Name Last or Organization Name Description: Individual last name or organizational name Industry: <i>Submitter Last or Organization Name</i> Alias: <i>Submitter Name</i>	O	AN	1/35	Required
NM104	1036	Name First Description: Individual first name Industry: <i>Submitter First Name</i> Alias: <i>Submitter Name</i> <i>Required if NM102=1 (person).</i>	O	AN	1/25	Situational
NM108	66	Identification Code Qualifier Description: Code designating the system/method of code structure used for Identification Code (67)	C	ID	1/2	Required
NM109	67	Identification Code Description: Code identifying a party or other code Industry: <i>Submitter Identifier</i> Alias: <i>Submitter Primary Identification Number</i> <i>The same value should appear here as in the GS02, Application Sender's Code.</i>	C	AN	2/80	Required

Syntax:

1. P0809 - If either NM108,NM109 is present, then all are required
2. C1110 - If NM111 is present, then all of NM110 are required

Semantics:

1. NM102 qualifies NM103.

Comments:

1. NM110 and NM111 further define the type of entity in NM101.

Notes:

1. See Section 2.4, Loop ID-1000, Data Overview, for a detailed description about using Loop ID-1000. Ignore the Set Notes below.
2. Because this is a required segment, this is a required loop. See Appendix A for further details on ASC X12 nomenclature.

Example:

NM1*41*2*ABC Submitter*****46*999999999~

NM1 Receiver Name

Pos: 020	Max: 1
Heading - Optional	
Loop: 1000B	Elements: 3

User Option (Usage): Required

To supply the full name of an individual or organizational entity

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
NM103	1035	Name Last or Organization Name Description: Individual last name or organizational name Industry: <i>Receiver Name</i> <i>Use 'LIPA'</i>	O	AN	1/35	Required
NM108	66	Identification Code Qualifier Description: Code designating the system/method of code structure used for Identification Code (67) Industry: <i>Information Receiver Identification Number</i>	C	ID	1/2	Required
NM109	67	Identification Code Description: Code identifying a party or other code Industry: <i>Receiver Primary Identifier</i> Alias: <i>Receiver Primary Identification Number</i> <i>Use 'LIPA'</i>	C	AN	2/80	Required

Syntax:

- P0809 - If either NM108, NM109 is present, then all are required
- C1110 - If NM111 is present, then all of NM110 are required

Semantics:

- NM102 qualifies NM103.

Comments:

- NM110 and NM111 further define the type of entity in NM101.

Notes:

- See Section 2.4, Loop ID-1000, Data Overview, for a detailed description about using Loop ID-1000. Ignore the Set Notes below.
- Because this is a required segment, this is a required loop. See Appendix A for further details on ASC X12 nomenclature.

Example:

NM1*40*2*CSC HEALTHCARE*****46*112223333~

REF Billing Provider Secondary Identification

Pos: 035	Max: 8
Detail - Optional	
Loop: 2010AA	Elements: 2

User Option (Usage): Situational

To specify identifying information

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
REF01	128	Reference Identification Qualifier Description: Code qualifying the Reference Identification <i>Codes 8U, LU, ST, TT, 06, IJ, RB, and EM were added to this implementation guide to support credit/debit card information billing. See Appendix G, Credit/Debit Card Use, for details.</i>	M	ID	2/3	Required
REF02	127	Reference Identification Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier Industry: <i>Billing Provider Additional Identifier</i> <i>LIPA Provider ID or UPIN</i>	C	AN	1/30	Required

Syntax:

1. R0203 - At least one of REF02,REF03 is required

Semantics:

1. REF04 contains data relating to the value cited in REF02.

Notes:

1. Required when a secondary identification number is necessary to identify the entity. The primary identification number should be carried in NM109.
2. If the reason the number is being used in this REF can be met by the NPI, carried in the NM108/09 of this loop, then this REF is not used.
3. If "code XX - NPI" is used in the NM108/09 of this loop, then either the Employer's Identification Number or the Social Security Number of the provider must be carried in this REF. The number sent is the one which is used on the 1099. If additional numbers are needed the REF can be run up to 8 times.

Example:

REF*SY*987654~

HL Subscriber Hierarchical Level

Pos: 001	Max: 1
Detail - Mandatory	
Loop: 2000B	Elements: 1

User Option (Usage): Required

To identify dependencies among and the content of hierarchically related groups of data segments

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
HL04	736	Hierarchical Child Code Description: Code indicating if there are hierarchical child data segments subordinate to the level being described <i>Use '0'. Claim sbille dto LIPA use the subscriber as the patient. No patient loop will be present.</i>	O	ID	1/1	Required

Comments:

1. The HL segment is used to identify levels of detail information using a hierarchical structure, such as relating line-item data to shipment data, and packaging data to line-item data.
2. The HL segment defines a top-down/left-right ordered structure.
3. HL01 shall contain a unique alphanumeric number for each occurrence of the HL segment in the transaction set. For example, HL01 could be used to indicate the number of occurrences of the HL segment, in which case the value of HL01 would be "1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction.
4. HL02 identifies the hierarchical ID number of the HL segment to which the current HL segment is subordinate.
5. HL03 indicates the context of the series of segments following the current HL segment up to the next occurrence of an HL segment in the transaction. For example, HL03 is used to indicate that subsequent segments in the HL loop form a logical grouping of data referring to shipment, order, or item-level information.
6. HL04 indicates whether or not there are subordinate (or child) HL segments related to the current HL segment.

Notes:

1. If the insured and the patient are the same person, use this HL to identify the insured/patient, skip the subsequent (PATIENT) HL, and proceed directly to Loop ID-2300.
2. The Subscriber HL contains information about the person who is listed as the subscriber/insured for the destination payer entity (Loop ID-2010BA). The Subscriber HL contains information identifying the subscriber (Loop ID-2010BA), his or her insurance (Loop ID-2010BC), and responsible party (Loop ID-2010BD). In addition, information about the credit/debit card holder is placed in this HL (Loop ID-2010BB). The credit/debit card holder may or may not be the subscriber. See Appendix G, Credit/Debit Card Use, for a description of using Loop ID-2010BD.
3. Because this is a required segment, this is a required loop. See Appendix A for further details on ASC X12 nomenclature.
4. Receiving trading partners may have system limitations regarding the size of the transmission they can receive. The developers of this implementation guide recommend that trading partners limit the size of the transaction (ST-SE envelope) to a maximum of 5000 CLM segments. While the implementation guide sets no specific limit to the number of Subscriber Hierarchical Level loops, there is an implied maximum of 5000.

Example:

HL*124*123*22*1~

NM1 Subscriber Name

Pos: 015	Max: 1
Detail - Optional	
Loop: 2010BA	Elements: 5

User Option (Usage): Required

To supply the full name of an individual or organizational entity

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
NM103	1035	Name Last or Organization Name Description: Individual last name or organizational name Industry: <i>Subscriber Last Name</i> UB-92 Ref. [UB-Name]: 58 (A-C) [Insured's Name] EMC v.6.0 Reference: Record Type 30 Field No. 12 (Sequence 01-03)	O	AN	1/35	Required
NM104	1036	Name First Description: Individual first name Industry: <i>Subscriber First Name</i> UB-92 Ref. [UB-Name]: 58 (A-C) [Insured's Name] EMC v.6.0 Reference: Record Type 30 Field No. 13 (Sequence 01-03) <i>This data element is required when NM102 equals one (1).</i>	O	AN	1/25	Situational
NM105	1037	Name Middle Description: Individual middle name or initial Industry: <i>Subscriber Middle Name</i> Alias: <i>Subscriber's Middle Initial</i> UB-92 Ref. [UB-Name]: 58 (A-C) [Insured's Name] EMC v.6.0 Reference: Record Type 30 Field No. 14 (Sequence 01-03) <i>This data element is required when NM102 = 1 and the Middle Name or Initial of the person is known.</i>	O	AN	1/25	Situational
NM108	66	Identification Code Qualifier Description: Code designating the system/method of code structure used for Identification Code (67) <i>This data element is required when NM102 equals one (1). Use 'M' Member Identification Number</i>	C	ID	1/2	Situational
NM109	67	Identification Code Description: Code identifying a party or other code Industry: <i>Subscriber Primary Identifier</i> UB-92 Ref. [UB-Name]: 60 (A-C) [Certificate/Social Security Number/Health Insurance Claim/Identification Number] EMC v.6.0 Reference: Record Type 30 Field No. 7 (Sequence 01-03) <i>Use the patient's Member Id. If this is a Medicaid member the OMAP Prime number should be used, not the SSN. For commercial plans the MemberID from their card should be used.</i>	C	AN	2/80	Situational

Syntax:

1. P0809 - If either NM108,NM109 is present, then all are required
2. C1110 - If NM111 is present, then all of NM110 are required

Semantics:

1. NM102 qualifies NM103.

Comments:

1. NM110 and NM111 further define the type of entity in NM101.

Notes:

1. In worker's compensation or other property and casualty claims, the "subscriber" may be a non-person entity (i.e., the employer). However, this varies by state.

2. Because this is a required segment, this is a required loop. See Appendix A for further details on ASC X12 nomenclature.

Example:

NM1*IL*1*DOE*JOHN*T***MI*739004273~

CLM Claim information

Pos: 130	Max: 1
Detail - Optional	
Loop: 2300	Elements: 1

User Option (Usage): Required

To specify basic data about the claim

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
CLM05	C023	Health Care Service Location Information Description: 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	O	Comp		Required
	1325	Alias: <i>Type of Bill</i> Claim Frequency Type Code Description: Code specifying the frequency of the claim; this is the third position of the Uniform Billing Claim Form Bill Type Industry: <i>Claim Frequency Code</i> UB-92 Ref. [UB-Name]: 4, Position 3 [<i>Type of Bill</i>] EMC v.6.0 Reference: <i>Record Type 40 Field No. 4, Position 3</i> <i>Record Type 10 Field No. 2, Position 3</i> <i>Record Type 95 Field No. 5, Position 3 (Batch Control)</i> <i>LIPA only recognizes the following codes:</i> <i>'1' = New Claim</i> <i>'2' = corrected claim</i> <i>'8' = deleted claim</i> <i>The reason for the correction or deletion should be stated in loop 2320 CAS 02</i>	O	ID	1/1	Required

Semantics:

- CLM02 is the total amount of all submitted charges of service segments for this claim.
- CLM06 is provider signature on file indicator. A "Y" value indicates the provider signature is on file; an "N" value indicates the provider signature is not on file.
- CLM08 is assignment of benefits indicator. A "Y" value indicates insured or authorized person authorizes benefits to be assigned to the provider; an "N" value indicates benefits have not been assigned to the provider.
- CLM13 is CHAMPUS nonavailability indicator. A "Y" value indicates a statement of non-availability is on file; an "N" value indicates statement of nonavailability is not on file or not necessary.
- CLM15 is charges itemized by service indicator. A "Y" value indicates charges are itemized by service; an "N" value indicates charges are summarized by service.
- CLM18 is explanation of benefit (EOB) indicator. A "Y" value indicates that a paper EOB is requested; an "N" value indicates that no paper EOB is requested.

Notes:

- The developers of this implementation guide recommend that trading partners limit the size of the transaction (ST-SE envelope) to a maximum of 5000 CLM segments. There is no recommended limit to the number of ST-SE transactions within a GS-GE or ISA-IEA. Willing trading partners can agree to set limits higher.
- 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 2010BD 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.

Example:

CLM*01319300001*500***11:A:1*Y*A*Y*Y***02*****N~

REF Original Reference Number (ICN/DCN)

Pos: 180	Max: 1
Detail - Optional	
Loop: 2300	Elements: 1

User Option (Usage): Situational

To specify identifying information

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
REF02	127	Reference Identification Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier Industry: <i>Claim Original Reference Number</i> UB-92 Ref. [UB-Name]: 37 (A-C) [<i>Internal Control Number (ICN)/ Document Control Number (DCN)</i>] EMC v.6.0 Reference: <i>Record Type 31 Field No. 14 (Sequence 01-03)</i> <i>Complete 15 Digit LIPA Claim Number required on rebills.</i>	C	AN	1/30	Required

Syntax:

1. R0203 - At least one of REF02,REF03 is required

Semantics:

1. REF04 contains data relating to the value cited in REF02.

Notes:

1. Reference numbers at this position apply to the entire claim.
2. This segment is used to convey the control number assigned to the original bill by the payer to identify a unique claim.

Example:

REF*F8*1234636854~

REF Prior Authorization or Referral Number

Pos: 180	Max: 2
Detail - Optional	
Loop: 2300	Elements: 1

User Option (Usage): Situational

To specify identifying information

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
REF02	127	Reference Identification	C	AN	1/30	Required

Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

Industry: *Prior Authorization Number*

UB-92 Ref. [UB-Name]: 63 (A-C) [Treatment Authorization Code]

EMC v.6.0 Reference: Record Type 40 Field No. 5, 6, 7 (Treatment Authorization Number)

Complete 15 digit LIPA Authorization number should be used if necessary.

Syntax:

1. R0203 - At least one of REF02,REF03 is required

Semantics:

1. REF04 contains data relating to the value cited in REF02.

Notes:

1. 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 UMO (Utilization Management Organization) is generally the entity empowered to make a decision regarding the outcome of a health services review or the owner of information. The referral or prior authorization number carried in this REF is specific to the destination payer reported in the 2010BC loop. If other payers have similar numbers for this claim, report that information in the 2330 loop REF which holds that payer's information.

Example:

REF*G1*200398~

REF Attending Physician Secondary Identification

Pos: 271	Max: 5
Detail - Optional	
Loop: 2310A	Elements: 1

User Option (Usage): Situational

To specify identifying information

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
REF02	127	Reference Identification Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier Industry: <i>Attending Physician Secondary Identifier</i> <i>The LIPA Provider ID or UPIN should appear.</i>	C	AN	1/30	Required

Syntax:

1. R0203 - At least one of REF02,REF03 is required

Semantics:

1. REF04 contains data relating to the value cited in REF02.

Notes:

1. Use this REF only when a second number is necessary to identify the provider. The primary identification must be contained in NM109.

Example:

REF*1G*A12345~

REF Operating Physician Secondary Identification

Pos: 271	Max: 5
Detail - Optional	
Loop: 2310B	Elements: 0

User Option (Usage): Situational

To specify identifying information

Syntax:

1. R0203 - At least one of REF02,REF03 is required

Semantics:

1. REF04 contains data relating to the value cited in REF02.

Notes:

1. Use this REF only when a second number is necessary to identify the provider. The primary identification must be contained in NM109.

Example:

REF*1G*A12345~

REF Other Provider Secondary Identification

Pos: 271	Max: 5
Detail - Optional	
Loop: 2310C	Elements: 0

User Option (Usage): Situational

To specify identifying information

Syntax:

1. R0203 - At least one of REF02,REF03 is required

Semantics:

1. REF04 contains data relating to the value cited in REF02.

Notes:

1. Use this REF only when a second number is necessary to identify the provider. The primary identification must be contained in NM109.

Example:

REF*1G*A12345~

SV2 Institutional Service Line

Pos: 375	Max: 1
Detail - Optional	
Loop: 2400	Elements: 1

User Option (Usage): Required

To specify the claim service detail for a Health Care institution

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
SV202	C003	Composite Medical Procedure Identifier Description: To identify a medical procedure by its standardized codes and applicable modifiers Alias: <i>Service Line Procedure Code</i> UB-92 Ref. [UB-Name]: 44 (HCPCS) <i>[HCPCS/Rates/HIPPS Rate Codes]</i> <i>This data element required for outpatient claims when an appropriate HCPCS exists for the service line item.</i> <i>LIPA will only process the first 2 modifiers sent for adjudication purposes.</i>	C	Comp		Situational

Syntax:

1. R0102 - At least one of SV201,SV202 is required
2. P0405 - If either SV204,SV205 is present, then all are required

Semantics:

1. SV201 is the revenue code.
2. SV203 is a submitted charge amount.
3. SV207 is a noncovered charge amount.
4. SV208 is the detail service line indicator. A "Y" value indicates a detail service line; an "N" value indicates a summary service line.

Notes:

1. This segment is required for inpatient claims or outpatient or other claims that require procedure or drug information to be reported for claim adjudication.

Example:

```
SV2*300*HC:80019*73.42*UN*1~
SV2*120**1500*DA*5*300~
```

REF Attending Physician Secondary Identification

Pos: 525	Max: 1
Detail - Optional	
Loop: 2420A	Elements: 0

User Option (Usage): Situational

To specify identifying information

Syntax:

1. R0203 - At least one of REF02,REF03 is required

Semantics:

1. REF04 contains data relating to the value cited in REF02.

Notes:

1. Required when a secondary identification number is necessary to identify the entity. The primary identification number should be carried in NM109 in this loop.

Example:

REF*1D*AC12345H~

SE Transaction Set Trailer

Pos: 555	Max: 1
Detail - Mandatory	
Loop: N/A	Elements: 2

User Option (Usage): Required

To indicate the end of the transaction set and provide the count of the transmitted segments (including the beginning (ST) and ending (SE) segments)

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
SE01	96	Number of Included Segments Description: Total number of segments included in a transaction set including ST and SE segments Industry: <i>Transaction Segment Count</i>	M	N0	1/10	Required
SE02	329	Transaction Set Control Number Description: Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set <i>SE02 must match ST02.</i>	M	AN	4/9	Required

Comments:

- SE is the last segment of each transaction set.

Example:

SE*1230*987654~

GE Functional Group Trailer

Pos:	Max: 1
Not Defined - Mandatory	
Loop: N/A	Elements: 2

User Option (Usage): Required

To indicate the end of a functional group and to provide control information

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
GE01	97	Number of Transaction Sets Included Description: Total number of transaction sets included in the functional group or interchange (transmission) group terminated by the trailer containing this data element	M	N0	1/6	Required
GE02	28	Group Control Number Description: Assigned number originated and maintained by the sender	M	N0	1/9	Required

Semantics:

1. The data interchange control number GE02 in this trailer must be identical to the same data element in the associated functional group header, GS06.

Comments:

1. The use of identical data interchange control numbers in the associated functional group header and trailer is designed to maximize functional group integrity. The control number is the same as that used in the corresponding header.

IEA Interchange Control Trailer

Pos:	Max: 1
Not Defined - Mandatory	
Loop: N/A	Elements: 2

User Option (Usage): Required

To define the end of an interchange of zero or more functional groups and interchange-related control segments

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
IEA01	I16	Number of Included Functional Groups Description: A count of the number of functional groups included in an interchange	M	N0	1/5	Required
IEA02	I12	Interchange Control Number Description: A control number assigned by the interchange sender	M	N0	9/9	Required

Example:

*IEA*1*000000905~*

Table of Contents

Health Care Claim: Institutional 2

Interchange Control Header 4

Functional Group Header 6

Transaction Set Header 7

Beginning of Hierarchical Transaction 8

Submitter Name 9

Receiver Name 10

Billing Provider Secondary Identification 11

Subscriber Hierarchical Level 12

Subscriber Name 13

Claim information 15

Original Reference Number (ICN/DCN) 16

Prior Authorization or Referral Number 17

Attending Physician Secondary Identification 18

Operating Physician Secondary Identification 19

Other Provider Secondary Identification 20

Institutional Service Line 21

Attending Physician Secondary Identification 22

Transaction Set Trailer 23

Functional Group Trailer 24

Interchange Control Trailer 25