13. IEHP 5010 837P PROFESSIONAL CLAIM COMPANION GUIDE

A. Included ASC X12 Implementation Guides

1. 005010X222A1 Health Care Claim: Professional

Standard Companion Guide (CG) Transaction Information
Effective January 1, 2018

IEHP Instructions related to Implementation Guides (IG) based

On X12 Version 005010X222A1
Health Care Claim: Professional (837)

Companion Guide Version Number: 1.7
2018

13. IEHP 5010 837P PROFESSIONAL CLAIM COMPANION GUIDE

A. Included ASC X12 Implementation Guides

1. 005010X222A1 Health Care Claim: Professional

Preface

A. This transaction instruction is expected to be used in parallel with the Technical Report Type 3 (TR3) implementation guides (IG) available for purchase from Washington Publishing Company http://www.wpc-edi.com. It is provided because Inland Empire Health Plan wants to clarify the IG instructions for submission of specific electronic transactions. This companion guide is not meant to exceed the requirements or usages of data nor replace the guidelines expressed in the TR3s.

Contact Information

A. For further questions regarding claims submissions, please contact

1. EDI Claims (Professional)- edispecialist@iehp.org or 909-890-2025

13. IEHP 5010 837P PROFESSIONAL CLAIM COMPANION GUIDE

A. Included ASC X12 Implementation Guides

1. 005010X222A1 Health Care Claim: Professional

Background

A. The Health Insurance Portability and Accountability Act (HIPAA) of 1996 carries provisions for administrative simplification. This requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between Health Care Providers and plans. HIPAA directs the Secretary to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard HIPAA serves to:

1. Create better access to health insurance
2. Limit fraud and abuse
3. Reduce administrative costs

B. Compliance according to HIPAA

The HIPAA regulations at 45 CFR 162.915 require that covered entities not enter into a trading partner agreement that would do any of the following:

1. Change the definition, data condition, or use of a data element or segment in a standard.
2. Add any data elements or segments to the maximum defined data set.
3. Use any code or data elements that are marked “not used” in the standard’s implementation specifications or are not in the standard’s implementation specification(s).
4. Change the meaning or intent of the standard’s implementation specification(s).

C. Compliance according to ASC X12

ASC X12 requirements include specific restrictions that prohibit trading partners from:

1. Modifying any defining, explanatory, or clarifying content contained in the implementation guide.
2. Modifying any requirement contained in the implementation guide.

D. Intended Use

The Transaction Instruction component of this companion guide must be used in conjunction with an associated ASC X12 Implementation Guide. The instructions in this companion guide are not intended to be stand-alone requirement documents. This companion guide conforms to all the requirements of any associated ASC X12 Implementation Guides and is in conformance with ASC X12’s Fair Use and Copyright statements.

13. IEHP 5010 837P PROFESSIONAL CLAIM COMPANION GUIDE

A. Included ASC X12 Implementation Guides

1. 005010X222A1 Health Care Claim: Professional

Below lists the X12N Implementation Guides for which specific transaction instructions apply and which are included in Heading 1 and 2 of section B in this document.

Unique ID	Section	Name
005010X222A1	B.1	Health Care Claim: Professional (837)

Section B.1 include tables that contain one or more rows for each segment for which a supplemental instruction is needed. The table does not represent all of the fields necessary for a successful transaction. The TR3 should be reviewed for that information.

13. IEHP 5010 837P Professional Claim Companion Guide

A. Included ASC X12 Implementation Guides

2. 005010X222A2 Health Care Claims: Professional

ISA Segment - Interchange Control Header

Usage	Ref Des.	Name	Code/Definition	Length
R	ISA01	Authorization Information Qualifier	00 = No Authorization Sent	2/2
R	ISA02	Authorization Information	Blank (Space Fill)	10/10
R	ISA03	Security Information Qualifier	00 = No Security Information	2/2
R	ISA04	Security Information	Blank (Space Fill)	10/10
R	ISA05	Interchange ID Qualifier (Sender)	ZZ = Mutually Defined	2/2
R	ISA06	Interchange Sender ID	3 digit ID assigned by IEHP	15/15
R	ISA07	Interchange ID Qualifier (Receiver)	ZZ = Mutually Defined	2/2
R	ISA08	Interchange Receiver ID	00303	15/15
R	ISA09	Interchange Date	YYMMDD format	6/6
R	ISA10	Interchange Time	HHMM format	4/4
R	ISA11	Repetition Separator	Carat ^ Repetition Separator	1/1
R	ISA12	Interchange Control Version Number	00501 Version	5/5
R	ISA13	Interchange Control Number	Must be identical to IEA02	9/9
R	ISA14	Acknowledgment Requested	1 = Interchange acknowledgment information.	1/1
R	ISA15	Interchange Usage Indicator	T = Test, P = Production	1/1
R	ISA16	Component Element Separator	Colon : Component Element Terminator	1/1
		Note: Segment Terminator	Tilde ~ Segment Terminator	
		Note: Data Element Separator	Asterisk * Data Element	

GS Segment - Functional Group Header

Usage	Ref Des.	Name	Code/Definition	Length
R	GS01	Functional Identifier Code	HC= Health Care Claim	2/2
R	GS02	Application Sender's Code	Assigned by IEHP. Same as ISA06	2/15
R	GS03	Application Receiver's Code	00303 (IEHP ID)	2/15
R	GS08	Version/Release/Industry Identifier Code	005010X222A1	1/12

ST – 837- Transaction Set Header

Usage	Ref Des.	Name	Code/Definition	Length

R	ST02	Transaction Control Number	Sequential Number (must be identical to the value in the associated Transaction Set trailer, SE02)	4/9
R	ST03	Implementation Convention Reference	005010X222A1 This field contains the same value as GS08.	1/35

BHT – Beginning of Hierarchical Transaction

Usage	Ref Des.	Name	Code/Definition	Length
R	BHT06	Transaction Type Code	CH – Chargeable	2/2

Loop 1000A-NM1-Submitter Name

Usage	Ref Des.	Name	Code/Definition	Length
R	NM109	Identification Code	Sender Primary Identifier Check ID List	2/80

1000A -PER- Submitter EDI Contact Information

Usage	Ref Des.	Name	Code/Definition	Length
R	PER01	Contact Function Code	IC= Information Contact	2/2
R	PER03	Communication Number Qualifier	TE= Telephone	2/2
R	PER04	Communication Number	Compliant, (10) digit, phone number when PER03 = “TE”.	1/256
S	PER05	Communication Number Qualifier	“EM” It is recommended that Submitters populate the submitter’s email address.	2/2

Loop 1000B -NM1- Receiver Name

Usage	Ref Des.	Name	Code/Definition	Length
R	NM109	Identification Code	00303= Receiver Primary Identifier	2/80

Loop 2000A -PRV- Billing Provider Specialty Information

Usage	Ref Des.	Name	Code/Definition	Length

S	PRV01	Provider Code	BI=Billing	1/3
R	PRV02	Reference Identification Qualifier	PXC= Health Care Provider Taxonomy Code	2/3
R	PRV03	Provider Taxonomy Code	Provider Taxonomy Code Note: This is requested in order to possibly qualify for the P4P Program.	1/50

Loop 2010AA -NM1- Billing Provider Name

Usage	Ref Des.	Name	Code/Definition	Length
R	NM101	Entity Identifier Code	85= Billing Provider	2/3
R	NM102	Entity Type Qualifier	1= Person 2= Non-Person Entity	1/1
R	NM103	Name Last or Organization Name	Billing Provider Last or Organizational Name	1/60
S	NM108	Identification Code Qualifier	XX= NPI Identifier	1/2
S	NM109	Identification Code	Billing Provider Identifier	2/80

Loop 2010AA N3- Billing Provider Address

Usage	Ref Des.	Name	Code/Definition	Length
R	N301	Address Information	Billing Provider Address Line. Must Be A Street Address (No PoBox Allowed).	1/55
S	N302	Second Address Line	Must Be A Street Address (No PoBox Allowed).	1/55

Loop 2010AA N4- Billing Provider City, State, Zip Code

Usage	Ref Des.	Name	Code/Definition	Length
R	N401	City Name	Billing Provider City name	2/30
S	N402	State or Province	**NOTE: Please Make Sure To Include The Two Charater State ID IE. "CA"**	2/2

13. IEHP 5010 837P Professional Claim Companion Guide

A. Included ASC X12 Implementation Guides

2. 005010X222A2 Health Care Claims: Professional

Usage	Ref Des.	Name	Code/Definition	Length
R	N403	Postal Code	Billing Provider Postal Zone or Zip Code Note: Full (9) digit Zip Code required. If last (4) digits are not available populate with "9998". **(Do Not Send with "0000" or "9999").**	3/15

Loop 2010AA -REF- Billing Provider Tax Identification

Usage	Ref Des.	Name	Code/Definition	Length
R	REF01	Reference Identification Qualifier	EI= Employer's Identification Number SY= Social Security Number	2/3
R	REF02	Reference Identification	Billing Provider Tax Identification Number	1/50

Loop 2000B –SBR- Subscriber Information

Usage	Ref Des.	Name	Code/Definition	Length
S	SBR09	Claim Filling Indicator Code	MediCal Members = MC MediCare Members = MB	1/2

Loop 2010BA –NM1- Subscriber Name Information

Usage	Ref Des.	Name	Code/Definition	Length
R	NM108	Subscriber ID Qualifier	MI = Member Identification Number	1/2
R	NM109	Identification Code	Must equal the **14-digit IEHP ID number, CIN(Medi-Cal ID) or SS#	2/80

Loop 2010BB -NM1- Payer Name

Usage	Ref Des.	Name	Code/Definition	Length
R	NM101	Entity Identifier Code	PR - Payer	2/3
R	NM102	Entity Type Qualifier	2 – Non-Person Entity	1/1
R	NM103	Payer Name	IEHP or Inland Empire Health Plan	1/60
R	NM108	Identification Code Qualifier	PI – Payor Identification XV – Centers for Medicare and Medicaid	1/2
R	NM109	Payer Identifier	IEHP ID – Note: Provide this Value 00303	2/80

13. IEHP 5010 837P Professional Claim Companion Guide

A. Included ASC X12 Implementation Guides

2. 005010X222A2 Health Care Claims: Professional

Loop 2300 -CLM- Claim Information

Usage	Ref Des.	Name	Code/Definition	Length
R	CLM01	Claim Control Number	Patient Control Number Must be a unique number when Claim Frequency Type Code (CLM05-3) = "1".	1/38
R	CLM02	Monetary Amount	Total Claim ChargeAmount Must balance to the sum of all SV1-02 (Service line in Loop 2400) **NOTE: No Leading Zero Allowed**	1/18
R	CLM05-3	Claim Frequency Type Code	1 = Original claim submission 7= Replacement 8= Void	1/2 1/1

Loop 2300 -REF- Payer Claim Control Number

Usage	Ref Des.	Name	Code/Definition	Length
R	REF01	Reference ID Qualifier	F8 = Original Reference Number	2/3
R	REF02	Payer Claim Control Number	Identifies ICN from original claim when submitting adjustment (replacement or (void).	1/50

Loop 2300 -REF- Claim Identifier for Transmission Intermediaries

Usage	Ref Des.	Name	Code/Definition	Length
R	REF01	Reference Identification Qualifier	D9= Claim Number	2/3
R	REF02	Payer Claim Control Number	Unique claim number required for all submissions.	1/50

Loop 2300 -HI- Health Care Diagnosis Code

Usage	Ref Des.	Name	Code/Definition	Length
R	HI01	Health Care Code Information	The diagnosis listed in this element is assumed to be the principal diagnosis	
R	HI01-1	Code List Qualifier Code	ABK= (ICD-10) Principal Diagnosis BK = (ICD-9) Principal Diagnosis	1/3
R	HI01-2	Industry Code	Diagnosis Code	1/30

13. IEHP 5010 837P Professional Claim Companion Guide

A. Included ASC X12 Implementation Guides

2. 005010X222A2 Health Care Claims: Professional

Loop 2310B -NM1- Rendering Provider Name

Usage	Ref Des.	Name	Code/Definition	Length
R	NM101	Entity Identifier Code	82= Rendering Provider	2/3
R	NM102	Entity Type Qualifier	1= Person 2= Non-Person Entity	1/60
R	NM103	Name Last or Organization Name	Rendering Provider Last Name	1/60
R	NM109	Rendering Provider Identifier	Must be a valid 10 digit NPI.	2/80

Loop 2310B -PRV- Rendering Provider Specialty Information

Usage	Ref Des.	Name	Code/Definition	Length
S	PRV01	Provider Code	PE= Performing	1/3
R	PRV02	Reference Identification	PXC= HealthCare Provider Taxonomy Code	2/3
R	PRV03	Reference Identification	Provider Taxonomy Code Note: This is requested in order to possibly qualify for the P4P Program.	1/50

Loop 2310C -NM1- Service Facility Location Name

Usage	Ref Des.	Name	Code/Definition	Length
R	NM101	Entity Identifier Code	77= Service Location Required when the location is different than the billing provider	2/3
R	NM102	Entity Type Qualifier	2= Non-Person Entity	1/1
R	NM103	Name Last or Organization Name	Laboratory or Facility Name	1/60
R	NM109	Identification Code	Laboratory or Facility PrimaryIdentifier Must be a valid 10 digit NPI.	2/80

13. IEHP 5010 837P Professional Claim Companion Guide

A. Included ASC X12 Implementation Guides

2. 005010X222A2 Health Care Claims: Professional

Loop 2310E -NM1- Ambulance Pick-up Location

NOTE: This loop is Only Required When The POS is Either 41 or 42.

Usage	Ref Des.	Name	Code/Definition	Length
S	NM101	Entity Identifier Code	PW = Pick Up Address	2/3
S	NM102	Entity Type Qualifier	2 = Non Person Entity	1/1

Loop 2310E –N3- Ambulance Pick-up Location Address

Usage	Ref Des.	Name	Code/Definition	Length
S	N301	Address Information	Pick Up Address	1/55
S	N302	Address Information	Second Address Line	1/55

Loop 2310E –N4 – Ambulance Pick-up Locatiuon City, State, Zip Code

Usage	Ref Des.	Name	Code/Definition	Length
S	N401	City Name	Ambulance Pick Up City Name	2/30
S	N402	State	Ambulance Pick Up State	2/2
S	N403	Postal Code	Ambulance Pick Up Postal Code	3/15

Loop 2310F -NM1- Ambulance Drop-Off Location

NOTE: This loop is Only Required When The POS is Either 41 or 42.

Usage	Ref Des.	Name	Code/Definition	Length
S	NM101	Entity Identifier Code	45 = Drop Off Location	2/3
S	NM102	Entity Type Qualifier	2 = Non-Person Entity	1/1
S	NM103	Name Last or Organization Name	Required when drop-off location name is known.	1/60

Loop 2310F –N3- Ambulance Drop-Off Location Address

Usage	Ref Des.	Name	Code/Definition	Length
S	N301	Address Information	Ambulance Drop-Off Address Line	1/55
S	N302	Address Information	Second Address Line	1/55

13. IEHP 5010 837P Professional Claim Companion Guide

A. Included ASC X12 Implementation Guides

2. 005010X222A2 Health Care Claims: Professional

Loop 2310F –N4 – Ambulance Drop-Off Locatiuon City, State, Zip Code

Usage	Ref Des.	Name	Code/Definition	Length
S	N401	City Name	Ambulance Drop-Off City Name	2/30
S	N402	State	Ambulance Drop-Off State	2/2
S	N403	Postal Code	Ambulance Zip Code	3/15

Loop 2330B -NM1- Other Payer Name

Usage	Ref Des.	Name	Code/Definition	Length
R	NM101	Entity Identifier Code	PR= Payer	2/3
R	NM102	Entity Type Qualifier	2= Non-Person Entity	1/1
R	NM103	Other Payer Organization Name	Other Payer Organization Name	1/60
R	NM108	Identification Code Qualifier	PI= Payer Identification	1/2
R	NM109	Identification Code	Other Payer Primary Identifier When sending Line Adjudication Information for this payer, the identifier sent in SVD01(Payer Identifier) of Loop ID 2430 (Line Adjudication Information) must match this value	2/80

Loop 2400 -SV1- Professional Service

Usage	Ref Des.	Name	Code/Definition	Length
R	SV101	Composite Medical Procedure Identifier	Medical procedure by standardized codes and applicable modifiers	1
R	SV101-1	Product or Service ID Qualifier	Product or Service ID Qualifier HC- Health Care Financing Admistration Common Procedureal Code System (HCPCS) Codes	2/2
R	SV101-2	Product/Service ID	Identity number for a product or service.	1/48
R	SV102	Monetary Amount	Line item charge amount. **NOTE: No Leading Zero Allowed**	1/18

13. IEHP 5010 837P Professional Claim Companion Guide

A. Included ASC X12 Implementation Guides

2. 005010X222A2 Health Care Claims: Professional

Usage	Ref Des.	Name	Code/Definition	Length
R	SV103	Unit or Basis for Measurement Code	MJ-Minutes (required for Anesthesia claims. UN- Unit	2/2
R	SV104	Quantity	Service Unit Count	1/15
R	SV107	Composite Diagnosis Code Pointer	To identify one or more deiagnosis code pointers	1
R	SV107-7	Diagnosis Code Poiner	Pointer to the diagnosis code in the order of importance to this service	1/2

Loop 2420A -NM1- Rendering Provider Name

Usage	Ref Des.	Name	Code/Definition	Length
R	NM101	Entity Identifier Code	82 = Rendering Provider Code identifying an organizational entity, a physical location, property or an individual	2/3
R	NM102	Entity Type Qualifier	1-Person 2-Non-Person Entiy	1/1
R	NM103	Name Last or Organization Name	Rendering Provider Last or Organization Name	1/60
R	NM104	Name First	Required when NMM102=1 (person) and the person has a first name	1/35
R	NM109	Rendering Provider Identifier	NPI= Renderin Provider Identifier	2/80

Loop 2420A -PRV-Rendering Provider Specialy Information

Usage	Ref Des.	Name	Code/Definition	Length
R	PRV01	Provider Code	PE-Performing	1/3
R	PRV02	Reference Identification Qualifer	PXC- Health Care Provider Taxonomy Code	2/3
R	PRV03	Reference Identificaton	Provider Taxonomy Code	1/50

Loop 2420C -NM1- Service Facility Location Name

Usage	Ref Des.	Name	Code/Definition	Length
R	NM101	Entity Identifier Code	77 – Service Location	2/3

13. IEHP 5010 837P Professional Claim Companion Guide

A. Included ASC X12 Implementation Guides

2. 005010X222A2 Health Care Claims: Professional

Usage	Ref Des.	Name	Code/Definition	Length
			Note: Required When The Location Is Different Than At The Claim Level.	
R	NM102	Entity Type Qualifier	1-Person 2 – Non-Person Entity	1/1
R	NM103	Name Last or Organization Name	Rendering Provider Last Organization Name	1/60
S	NM108	Identification Code Qualifier	XX- Center for Medicare and Medicaid Services National Provider Identifier	1 /2
R	NM109	Identification Code	NPI- Rendering Provider Identifier	2/80

Example 3- Clearinghouse/IEHP Direct Providers Submitting Claim Data

Clearinghouses are largely used as an intermediary for fee-for-service Providers, hospitals, and other Providers submitting claims to IEHP electronically. Capitated IEHP Direct Providers may also elect to submit data through the claim system directly or through a clearinghouse. The clearinghouses must follow the instructions outlined in this guide and will pass it on to their Providers as appropriate to ensure compliance. The same situations and requirements laid out in the Implementation Guides published by Washington Publishing Company will be expected to be followed by Clearinghouse and IEHP Direct submitters alike.

Example 4- Fee-for-Service Hospital Submitting Claim Data

Fee-for-Service Hospitals may elect to submit 837 Institutional files without using a clearinghouse. All the same guidelines and requirements apply. The same situations and requirements laid out in the Implementation Guides published by Washington Publishing Company will be expected to be followed by Hospital submitters.

13. IEHP 5010 837P Professional Claim Companion Guide

B. Frequently Asked Questions

Q. How do I decrypt the 999 or 277 or log file?

A. Providers must use software compatible with the Open PGP standard to encrypt and decrypt data files exchanged with IEHP. To decrypt the files, Providers choose "Decrypt", select the transmitted files, and then enter their Pass Phrase. Please refer to EDI Manual Section II- D, "Getting Started File transfer Procedures" for more detailed information.

Q. Where do I find information on file naming conventions, connectivity protocol, and file transfer procedures?

A. Please refer to the EDI manual published at http://ww2.iehp.org/IEHP/Providers/Information+Resources/HandbooksandManuals/EDIManual.htm for information regarding the above areas. The information published in this companion guide is meant to be used in conjunction with the implementation guides from Washington Publishing Company for detailed instructions on the line level and IEHP's EDI Manual for connectivity and processing procedures.

13. IEHP 5010 837P Professional Claim Companion Guide

B. Frequently Asked Questions

A. https://ww3.iehp.org/en/providers/provider-pnp-manual/

IEHP's website where the EDI manual and other resources are located.

B. http://www.wpc-edi.com

Washington Publishing Company Implementation guides (TR3) can be purchased from this site.

C. http://www.wedi.org

Workgroup for Electronic Data Interchange in Healthcare.

D. http://www.cms.gov/Versions5010andD0/

CMS website that contains additional information and resources related to 5010.

13. IEHP 5010 837P PROFESSIONAL CLAIM COMPANION GUIDE

D. Change Log

Version	Date of Release	Changes
1.0	6/1/2011	Initial Draft
1.1	10/7/2011	• ISA 11 preferred Repetition Separator changed from "*" to "^" • ISA 16 preferred Component Element Separator changed from "~" to ":" • Professional: BHT06: Clarified from if submitting encounter, use "RP" to if submitting encounter/post-adjudicated claim, use "RP" • Institutional: BHT06: Clarified from if submitting encounter, use "RP" to if submitting encounter/post-adjudicated claim, use "RP" • Professional: 2300, CN1- *entire segment is no longer required* for post-adjudicated claims and capitated encounters. *CN101 and CN102 is required* for post-adjudicated claims and capitated encounters. • Institutional: 2300, CN1- *entire segment is no longer required* for post-adjudicated claims and capitated encounters.*CN101 and CN102 is required* for post-adjudicated claims and capitated encounters. • Professional: Clarified 2300 HI01-1 as principal diagnosis. Updated secondary diagnosis from HI01-1 - HI12-1 to HI02-1-HI12-1. • Institutional: Expanded 2300 HI01-1 for patient reason for visit to HI01-1 to HI03-1. • Professional: Added loop 2330B, DTP as requirement for encounters/post-adjudicated claims date. • Institutional: Added loop 2330B, DTP as requirement for encounters/post-adjudicated claims date. • Professional: Added loop 2400, SV103 as further instruction for Anesthesia Claims. • Added Q&A regarding billing provider address and 9-digit zip code requirements in Section E. FAQ. • Added Q&A regarding Anesthesia Time Reporting Changes
1.2	11/09/2011	• Professional: Updated 2420A, PRV (Name =Provider Taxonomy Code) reference to PRV03 • Professional: 2000A, PRV03 / 2310B, PRV03 / 2420A, PRV03: Clarified that Taxonomy codes are required for all submitters. Notes changed from "If submitting encounter, Taxonomy code always required for submissions as IEHP's Regulators require it. If submitting claim, follow IG" to "Taxonomy code always required for submissions." • Institutional: 2000A, PRV03 / 2310A, PRV03: Clarified

		that Taxonomy codes are required for all submitters. Notes changed from "If submitting encounter, Taxonomy code always required for submissions as IEHP's Regulators require it. If submitting claim, follow IG" to "Taxonomy code always required for submissions." • Professional: Clarified 2300, CN101 by adding to notes/comments "when loop ID- 2400, CN101, line level contract type, is not used." • Professional: Deleted 2300, CN102. • Professional: Added 2430, SVD segment as required field for post-adjudicated claims and capitated encounters. • Professional: Added 2400, CN101 as required field for post-adjudicated claims and capitated encounters if the line level information is different than the claim level. • Institutional: Deleted 2300, CN102. • Institutional: Deleted 2400, SV1 Professional Service Line • Institutional: Added 2430, SVD segment as required field for post-adjudicated claims and capitated encounters. • Professional: Added 2300, NTE segment to provide instructions for post-adjudicated claims and capitated encounters on providing denied reasons on the claim level. Required for Medicare Members Only. • Institutional: Added 2300, NTE segment to provide instructions for post-adjudicated claims and capitated encounters on providing denied reasons on the claim level. Required for Medicare Members Only. • Professional: Added 2400, NTE segment to provide instructions for post-adjudicated claims and capitated encounters on providing denied reasons on the service line level. Required for Medicare Members Only. • Institutional: Added 2400, NTE segment to provide instructions for post-adjudicated claims and capitated encounters on providing denied reasons on the service line level. Required for Medicare Members Only. • Professional: Clarified 2330B.DTP segment, Claim Check or Remittance Date, by adding "DTP01 = 573" to notes/comment section. • Professional: Clarified 2330B.DTP segment, Claim Check or Remittance Date, by adding "DTP01 = 573" to notes/comment section.
1.3	12/1/2011	• Professional: Removed 2300, NTE segment to provide instructions for post-adjudicated claims and capitated encounters on providing denied reasons on the claim level. Required for Medicare Members Only.

		• Institutional: Removed 2300, NTE segment to provide instructions for post-adjudicated claims and capitated encounters on providing denied reasons on the claim level. Required for Medicare Members Only. • Professional: Removed 2400, NTE segment to provide instructions for post-adjudicated claims and capitated encounters on providing denied reasons on the service line level. Required for Medicare Members Only. • Institutional: Removed 2400, NTE segment to provide instructions for post-adjudicated claims and capitated encounters on providing denied reasons on the service line level. Required for Medicare Members Only. • Professional: Added 2320, CAS Segment to provide instructions for post-adjudicated claims and capitated encounters on providing the denial reason code if a claim is denied. Required for Medicare Members Only. • Institutional: Added 2320, CAS Segment to provide instructions for post-adjudicated claims and capitated encounters on providing the denial reason code if a claim is denied. Required for Medicare Members Only. • Professional: Added 2430, CAS Segment to provide instructions for post-adjudicated claims and capitated encounters on providing the denial reason code if a claim is denied on the service line. Required for Medicare Members Only. • Institutional: Added 2430, CAS Segment to provide instructions for post-adjudicated claims and capitated encounters on providing the denial reason code if a claim is denied on the service line. Required for Medicare Members Only.
1.4	04/24/2012	• Professional: Added 1000A, PER segment to recommend submitter's to provide telephone and email address for better future communication. • Professional: Added 1000B, NM102 to clarify qualifier to be used as "2" for non-person entity. • Professional: Removed 2000B SBR segment reference following CMS updated companion guide. • Professional: Added 2010AA Billing Provider Name Segment to clarify that Billing Provider must be populated and be a ten digit number, beginning with 1. Also provided default NPI for atypical providers (i.e. non-emergency transportation). • Professional: Added 2010AA N4 Billing Provider City, State, Zip Code to provide instructions if nine (9) digit

		zip code is unavailable. • Professional: Added 2010AA REF segment for specific instructions regarding Atypical providers (i.e. non-emergency transportation) that are coming through as an encounter. • Professional: Added 2010BA NM108 to clarify qualifier for Member ID (MI). • Professional: Added 2300, CLM Segment to clarify instructions for this segment (i.e. options for claim frequency code provided.) • Professional: Added 2300 REF*F8 as a place to hold ICN from original claim when submitting adjustment. • Professional: Added 2300 REF*D9 as requirement for unique claim number. • Professional: Removed date (10/1/2013) reference for ICD10 in all Diagnosis Segments (HI) • Professional: Updated 2320, CAS segment from being required for Medicare Members only to being required for all LOBS for post-adjudicated claims and capitated encounters if a claim is denied. • Professional: Updated 2430, CAS segment from being required for Medicare Members only to being required for all LOBS for post-adjudicated claims and capitated encounters if a claim is denied on the service line. • Institutional: Added 1000A, PER segment to recommend submitter's to provide telephone and email address for better future communication. • Institutional: Added 1000B, NM102 to clarify qualifier to be used as "2" for non-person entity • Institutional: Removed 2000B SBR segment reference following CMS updated companion guide. • Institutional: Added 2010AA Billing Provider Name Segment to clarify that Billing Provider must be populated and be a ten digit number, beginning with 1. Also provided default NPI for atypical providers (i.e. non-emergency transportation). • Institutional: Added 2010AA N4 Billing Provider City, State, Zip Code to provide instructions if nine (9) digit zip code is unavailable. • Institutional: Added 2010AA REF segment for specific instructions regarding Atypical providers (i.e. non-emergency transportation) that are coming through as an

		encounter. • Institutional: Added 2010BA NM108 to clarify qualifier for Member ID (MI). • Institutional: Added 2300, CLM Segment to clarify instructions for this segment. (i.e. options for claim frequency code provided.) • Institutional: Added 2300, DTP Date- Admission Date/Hour as clarifying instructions. • Institutional: Removed date (10/1/2013) reference for ICD10 in all Diagnosis Segments (HI) • Institutional: Added 2300 REF*F8 as a place to hold ICN from original claim when submitting adjustment. • Institutional: Added 2300 REF*D9 as requirement for unique claim number. • Institutional: Updated 2320, CAS segment from being required for Medicare Members only to being required for all LOBS for post-adjudicated claims and capitated encounters if a claim is denied. • Institutional: Updated 2430, CAS segment from being required for Medicare Members only to being required for all LOBS for post-adjudicated claims and capitated encounters if a claim is denied on the service line. • Updated Testing Procedures in Section H for Claims Submitters from claims\editest\5010\inbound' to 'claims\5010\editest' and for Encounter Submitters from 'editest\5010' to '5010\editest'
1.5	06/18/2012	• Corrected the Loop designation for Professional & Institutional Payer Name Identifier NM109 to 2010BB from 2010BC. • DTP segment corrected to loop 2430 from 2330B.
1.6	1/22/2013	• Updated IEHP's EDI Manual web links throughout to reference http://www.iehp.org/edi • FAQ modifications to include removal of reference to encryption no longer relevant and clarifying details added to claims/encounter differences. • Updated Testing Procedures in Section H to reference EDI Manual testing guidance.
1.7	09/14/2015	• Professional: Added 2000A PRV03 Billing Provider Taxonomy Code as requested.

		• Professional: 2310B NM11 Rendering Provider Name. • Professional: 2310B NM101 Entity Identifier Code 82. • Professional: 2310B NM109 NPI. • Professional: 2310B PRV03 Provider Taxonomy Code requested. • Professional: 2310C NM1 Service Facility Name (Required when the location is different than the billing provider). • Professional: 2310C NM101 Identifier Code 77. • Professional: NM109 NPI. • Institutional: 2000A PRV03 Taxonomy Code requested. • Institutional: 2310B Operating Physician Name. (Required when a surgical procedure code is listed) • Institutional: 2310B NM101 Entity Identifier Code 72. • Institutional: 2310B NM109 NPI. • Institutional: 2310D NM1 Rendering Provider Name. (Required if rendering provider is different than the attending provider). • Institutional: 2310D NM101 Entity Identifier Code 82. • Institutional: 2310D NM109 NPI. • Institutional: 2310E NM1 Service Facility Name. (Required when the location is different than the billing provider). • Institutional: 2310E NM110 Identifier Code 77. • Institutional: 2310E NPI.