

**Standard CMC Companion Guide (CG) Transaction Information  
Effective June 30, 2016**

**IEHP Instructions related to Implementation Guides (IG) based**

**837 Health Care Claim: Institutional Transaction based on ASC X12 Technical Report  
Type 3 (TR3), Version 005010X223A1**

**Companion Guide Version Number: 1.0**

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**Revisions**

<b>Action</b>	<b>Date</b>	<b>Responsible Party</b>
Creation date for 837 Health Care Claim: Institutional Transaction based on ASC X12 Technical Report Type 3 (TR3), Version 005010X223A1	06/30/2016	Encounter Data Team

## **Introduction**

### **A. The Purpose of the Companion Guide**

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) required the Federal Department of Health and Human Services to establish national standards for electronic Healthcare transaction and national identifier for providers, health plans, and employers. The mandates also address the security and privacy of health data.

### **B. The Version 005010X223A1 of the ASCX12 Implementation Guide includes HIPAA addenda updates or format, content, and field values. The HIS Companion Document are intended to supplement rather than replace or violate the standard Implementation Guide for each transaction set. The information in these documents is NOT intended to:**

1. Modify the definition, data condition, or use of any data element or segment in the standard Implementation Guides.
2. Add any additional data elements or segment to the defined data set.
3. Utilize any code or data values that are not valid in the standard implementation Guides
4. Change the meaning or intent or any implementation specifications' in the standard Implementations Guides.

### **C. Companion Documents are available to external entities (health plans, program contractors, providers, third party processors, and billing services) to clarify the information on HIPAA-compliant electronic interfaces. The Companion Documents are intended for members of the technical staff of external entities.**

### **D. This document does not describe the technical interface environment; including connectivity requirements and protocols, and electronic interchange IDs this document also provides specific information on the fields and values required for transactions exchanged with IEHP.**

## **Disclaimer**

### **A. This Companion Document is intended to be a technical document describing the specific technical and procedural requirements for interfaces between IEHP and its trading partners. It does not supersede either health plan contracts or the specific procedure manuals for various operational processes. If there are conflicts between this document and either the provider contracts or operational procedure manuals, the contract or procedure manual will prevail.**

### **B. Substantial effort has been taken to minimize conflicts or errors. IEHP, IEHP, and their employees will not be liable or responsible for any errors or expenses resulting from the use of information in this document. If you believe there is an error in the document, please notify IEHP immediately.**

## **837 Health Care Claim: Professional Transaction**

- A. The IEHP 837 Health Care Claim: Professional Transaction may be transmitted any day of the week to IEHP from a customer’s business partner. The transaction provides data on Medicare Advantage / Part D data.

**Technical Infrastructure and Procedures**

- A. Business partners transmitting 837 Health Care Claim: Professional Transaction to IEHP by connecting to the IEHP Network. They go from the Internet through a Virtual Private Network (VPN) tunnel to the IEHP File Transfer Protocol (SFTP) Server. In standard software-to-hardware VPN connections, VPN client software is installed and configured on each machine at the client site that requires SFTP access. Business partners can contact IEHP for more information on establishing connections through the SFTP Server.

**Transaction Standards**

- A. HIPAA standards are specified in the ASC X12 Implementation Guide for each mandated transaction and are not repeated here.
- B. An overview of requirements specific to each transaction can be found in the ASC X12 837 Health Care Claim: Institutional Transaction Implementation Guide. Each Guide contains information related to ASC X12 Implementation.
  - 1. Format and content of interchanges and functional groups;
  - 2. Format and content of the header, detailer and trailer segments specific to the transaction;
  - 3. Code sets and values authorized for use in the transaction;
  - 4. Allowed exceptions to specific transaction requirements;
  - 5. Transmission sizes are limited based on two factors; and
  - 6. Number of Segments/Records allowed by HIPAA and ASC X12 standards.
- C. Standards for the maximum file size of each transaction set are specified in the appropriate Implementation Guide or its authorized Addenda. 837 Transactions follow HIPAA updated ASC X12 standards. These standards involve Interchange (ISA/IEA) and Functional Group (GS/GE) Segments or “outer envelopes.” All Transactions are enclosed in transmission level ISA/IEA envelopes. Within the ISA/IEA envelope are at least one functional group level GS/GE envelope(s). Within the GS/GE groups are at least one transaction set ST/SE. ST/SEs contain the detail segments and data.
- D. This document uses the following names to refer to the data elements within the IEHP PDP data file.

<b>Loop ID</b>	The Implementation Guide’s identifier for a data loop within a transaction; the data loop consists of specific segments as identified in the HIPAA ANSI standard.
<b>Segment ID</b>	The Implementation Guide’s identifier for a data segment.
<b>Element ID</b>	The Implementation Guide’s identifier for a

	data element within a segment.
<b>Element Name</b>	A data element name as shown in the Implementation Guide. When the industry name differs from the Data Element Dictionary name, the more descriptive industry name is used.
<b>Element Definition / Length</b>	How the data element is defined in the Implementation Guide. For ISA and IEA Segments only, fields are of fixed lengths and are present whether or not they are populated. For this reason, field lengths are provided in this column after element definitions.
<b>Valid Values</b>	The valid values from the Implementation Guide that are used by IEHP.
<b>Definition/Format</b>	Definitions of valid values used by IEHP and additional information about IEHP data element requirements.

- E. This implementation guide is based on the February 2011 005010X223A1 standards, referred to as Version 5, Release 1, Sub-release 0 (005010).
- F. The unique Version/Release/Industry Identifier Code for transaction sets that are defined by this implementation guide is 005010X223A1.
- G. The two-character Functional Identifier Code for the transaction set included in this implementation guide.
- H. 837 Health Care Claim: Professional Transaction
- I. The version/Release/Industry Identifier Code and the applicable Functional Identifier Code must be transmitted to allow users to request changes to the electronic transactions formats. To request changes for consideration to the ASC X12 standards, please contact the HIPAA Designated Standards Maintenance Organizations web site at.

**IEHP Functional Acknowledgement/Reports**

**A. TA1 – Interchange Acknowledgement**

The TA1 report enables the receiver to notify the sender when there are problems with the interchange control structure. As the interchange envelope enters the EDFES, the EDI translator performs TA1 validation of the control segments/envelope. The sender will only receive a TA1 if there are syntax errors in the submitted file. Errors found in this stage will cause the entire X12 interchange to reject with no further processing.

IPA will receive a TA1 interchange report acknowledging the syntactical inaccuracy of an X12 interchange header ISA and trailer IEA and the envelope’s structure. Encompassed in the TA1 is the interchange control number, interchange date and time, interchange acknowledgement code and interchange note code

### **999- Functional Acknowledgment**

- A. The 999 Acknowledgement may produce three (3) results:
  - 1. Accepted (A)
  - 2. Rejected (R)
  - 3. Accepted with errors (E)
- B. As a result, the 999 may acknowledge receipt of a transaction, such as a healthcare claim, but it does not necessarily mean that transaction will be processed. The 999 can also report on exactly what syntax issues caused the errors in the original transaction.

### **EVR- Encounter Validation Response (EVR) Extensible Markup Language (XML) files**

- A. The response files will provide details on whether a file was accepted or rejected and whether an encounter data record was accepted or denied. If errors were found in the encounter data files submitted, it will result in a rejected file and/or denied encounter data record.

### **CMS Acknowledgements and/or Reports**

- A. A submitted encounter file will be either accepted or rejected by CMS. The following response reports are provided by CMS:
  - 1. TA1 – Interchange Acknowledgement
    - a. The TA1 report enables the receiver to notify the sender when there are problems with the interchange control structure. The sender will only receive a TA1 if there are syntax errors in the submitted file.
  - 2. 999 – Functional Group acknowledgement
    - a. The 999 acknowledgement report provides information on the validation of the GS\GE functional groups(s) and the consistency of the data.
  - 3. 277CA – Claim Acknowledgement
    - a. The 277CA is used to acknowledge the acceptance or rejection of encounters submitted using a hierarchical level (HL) structure. The first level of hierarchical editing is at the Information Source level. The next level is at the Information Receiver level. The third hierarchal level is at the Billing Provider of Service level; and the fourth and final level is done at the Patient level. Edits received at any hierarchical level will stop and no further editing will take place.
  - 4. MAO-001 – Encounter Data Duplicate Report
    - a. MAO-001 report will not be provided if there are no duplicate errors received on submitted encounters.
  - 5. MAO-002- Encounter Data Processing Status Report

- a. The MAO-002 reflects two (2) statuses at the encounter and service line level: “accepted” and “rejected”. Lines that reflect a status of “accepted” yet contain an error message in the Edit Description column are considered “informational” edits.
6. MAO-004- Encounter Data Diagnosis Eligible for Risk Adjustment Report
  - a. The CMS acknowledgement and/or reports in Section 6 of the 837I Encounter Data System Companion Guide will apply with the following exceptions:
    - 1) Encounters designated as Medicaid will receive a 277CA report.
    - 2) Encounters designated as Medicaid will not receive the MAO-001 or MAO-002 reports.

### **Control Segment**

- A. This section contains some information needed to create the ISA/IEA, GS/GE and ST/SE control segments for transactions to be submitted to IEHP.
  1. Interchange Control (ISA/IEA) and Function Group (GS/GE) envelopes must be used as described in the TR3 documents.
  2. New X12 submitters may use their IEHP assigned Client id in ISA06 and GS02, and IEHP Tax id “in ISA08 and GS03, along with a value of “ZZ” in ISA05 and ISA07.
  3. IEHP only supports one interchange (ISA/IEA envelope) per incoming transmission (file).
  4. Multiple Functional Groups (GS/GE) may be used within an ISA/IEA as long as the GS08 Version/Release/Industry Identifier Code remains constant throughout Functional Groups.

### **Implementation Usage**

- A. This document establishes the data contents of the 837 Health Care Claim: Institutional Transaction Set (837) for use within the context of an Electronic Data Interchange (EDI) environment. The following tables describe the EDI tables, segments and loops supported by this Companion Guide. The Usage column indicates if the segment is required (R) or situational (S).

### **Implementation**

- A. This section describes all of the EDI headers, tables, segments, loops and trailers supported by this Companion Guide. If a segment or a data element is not listed it is not supported. The Usage column indicates if the segment is required (R) or situational (S).

### **IEHP - Testing Requirements**

- A. CMC’s will be required to submit test files to ensure the submitter’s systems are properly configured for data submission. Before exchanging production transactions, each plan must complete testing to become certified. This process allows CMC’s to confirm that the CMS operational guidance has been properly programmed in their systems. A test file will need to be submitted containing twenty-five (25) encounters and must pass 100% of the front



end edits. In the event more than twenty-five (25) encounters are submitted, the file must receive an accepted or partially accepted 999, and 277CA with a minimum of an 80% acceptance rate.

### Void or Replacements

- A. Submitted encounters will be either accepted or rejected by CMS. When CMS rejects a submitted encounter the reasons for the rejection will be reported on IEHP EVR, (CMS) 277CA and (CMS) MAO-002 file.
- B. When a submitter needs to correct or void an encounter, the following data must be provided:
  1. The submitter of the voided or correcting encounter must be the same as the submitter of the encounter being corrected.
  2. CLM01 must equal the value of CLM01 on the encounter being replaced or voided.
  3. The Encounter-ID (from either EVR, 277 or MAO-002) for the encounter to be corrected must be placed in the Payer Claim Control Number REF segment in the 2300 loop (REF\*F8).
  4. A value of either “7” (replacement) or “8” (void) must be placed in the Claim Frequency Code in CLM05-03.

### Interchange Control Header

#### 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	(Filled with spaces)	10/10
R	ISA03	Security Information Qualifier	00 = No Security Information	2/2
R	ISA04	Security Information	(Filled with spaces)	10/10
R	ISA05	Interchange ID Qualifier	ZZ = Mutually Defined	2/2
R	ISA06	Interchange Sender ID	Value based on ISA05	15/15
R	ISA07	Code Identifying 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	5010 = Version 5 Release 1	5/5
R	ISA13	Interchange Control Number	Sequential Number (must be identical to the value in the associated Interchange Control trailer, IEA02)	9/9
R	ISA14	Acknowledgment Requested	1 = Interchange acknowledgment information.	1/1
R	ISA15	Usage Indicator	T = Test, P = Production	1/1
R	ISA16	Component Element Separator	Colon= Component Element Terminator	1/1
		Segment Terminator	Tilde= ~ Segment Terminator	
		Data Element Separator	Asterisk= * Data Element Separator	

**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	GS04	Date	CCYYMMDD (date of transmission)	8/8
R	GS05	Time	HHMM (time of transmission, 24 hour format)	4/8
R	GS06	Group Control Number	Sequential Number (assigned by IEHP; must be identical to value in the associated functional group trailer, GE02)	1/9

R	GS07	Responsible Agency Code	X = Accredited Standards Committee X12	1 / 2
R	GS08	Version/Release/Industry Identifier Code	005010X223A1	1/12

**Table 1-Header**

**ST 837- Header Segment**

Usage	Ref Des.	Name	Code/Definition	Length
R	ST01	Transaction Code of document	837 = Health Care Claim: Professional	3/3
R	ST02	Transaction Control Number	Sequential Number (must be identical to the value in the associated Transaction Set trailer, SE02)  Used to identify file level duplicates collectively with ISA13, GS06, and BHT03	4/9
R	ST03	Implementation Convention Reference	005010X223A1  Reference assigned to identify implementation convention. This field contains the same value as GS08.	1/35

**BHT – Beginning of Hierarchical Transaction**

Usage	Ref Des.	Name	Code/Definition	Length
R	BHT01	Beginning of Hierarchical Transaction	0019= Information Source, Subscriber, Dependent	4/4
R	BHT02	Transaction Set Purpose Code	00= Original	2/2
R	BHT03	Reference Identification	Originator Application Transaction Identifier	1/50
R	BHT04	Date	Transaction Set Creation Date	8/8
R	BHT05	Time	Transaction Set Creation Time	4/8
R	BHT06	Claim or Encounter Identifier	RP- Reporting	2/2

**Loop 1000A-NM1- Submitter Name Information**

Usage	Ref Des.	Name	Code/Definition	Length
R	NM101	Entity Identifier Code	41=Submitter	2/3
R	NM102	Entity Type Qualifier	1= Person 2= Non-Person Entity	1/1
R	NM103	Name Last or Organization Name	Submitter Last or Organization Name	1/60
S	NM104	Name First	Submitter First Name	1/35
S	NM105	Name Middle	Submitter Middle Name or Initial	1/25
R	NM108	Identification Code Qualifier	46= Electronic Transmitter Identification Number (ETIN)	1/2
FR	NM109	Identification Code	Sender Primary Identifier Check ID List	2/80

**Loop 1000A -PER- Submitter EDI Contact Information**

Usage	Ref Des.	Name	Code/Definition	Length
R	PER01	Contact Function Code	IC= Information Contact	2/2
S	PER02	Name	Submitter Contact Name	1/60
R	PER03	Communication Number Qualifier	TE= Telephone	2/2
R	PER04	Communication Number		1/256
S	PER05	Communication Number Qualifier		2/2
S	PER06	Communication Number		1/256
S	PER07	Communication Number Qualifier		2/2
S	PER08	Communication Number		1/256

**Loop 1000B -NM1- Receiver Name Information**

Usage	Ref Des.	Name	Code/Definition	Length
R	NM101	Entity Identifier Code	40= Receiver	2/3
R	NM102	Entity Type Qualifier	2= Non-Person Entity	1/1
R	NM103	Name Last or Organization Name	IEHP= Inland Empire Health Plan	1/60
R	NM108	Identification Code Qualifier	46= Electronic Transmitter Identification Number (ETIN)	1/2
R	NM109	Identification Code	00303= Receiver Primary Identifier Note: Should match ISA06 and GS03	2/80

**Table 2-Billing Provider Detail**

**Loop 2000A -HL- Billing Provider Hierarchical Level Information**

Usage	Ref Des.	Name	Code/Definition	Length
R	HL01	Hierarchical ID Number		1/12
R	HL03	Hierarchical Level Code	20= Information Source	1/2
R	HL04	Hierarchical Child Code	1= Additional Subordinate HL Data Segment in This Hierarchical Structure	1/1

**Loop 2000A -PRV- Billing Provider Specialty Information**

Usage	Ref Des.	Name	Code/Definition	Length
R	PRV01	Provider Code	BI = Billing	1/3
R	PRV02	Reference ID Qualifier	PXC= Health Care Provider Taxonomy Code	2/3
R	PRV03	Provider Taxonomy Code		1/50

**Loop 2010AA -NM1- Billing Provider Name Information**

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		1/60
S	NM104	Name First	Billing Provider First Name	1/35
S	NM105	Name Middle	Billing Provider Middle Name or Initial	1/25
S	NM107	Name Suffix	Billing Provider Name Suffix	1/10
S	NM108	Identification Code Qualifier	XX= Centers for Medicare and Medicaid Services National Provider Identifier	1/2
S	NM109	Billing Provider Identifier		2/80

**Loop 2010AA -N3- Billing Provider Address Information**

Usage	Ref Des.	Name	Code/Definition	Length
R	N301	Address Information	Billing Provider Address Line Note: Must be a physical address	1/55
S	N302	Address Information	Billing Provider Address Line Note: Must be a physical address	1/55

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

Usage	Ref Des.	Name	Code/Definition	Length
R	N401	City Name	Billing Provider City Name	2/30
S	N402	State or Province		2/2
S	N403	Postal Code	Billing Provider Postal Zone or Zip	3/15

Usage	Ref Des.	Name	Code/Definition	Length
			Code Note: Full (9) digit Zip Code required. If last (4) digits are not available populate with “9998”.	

**Loop 2010AA -REF- Billing Provider Tax Identification Information**

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

**Loop 2010AB-NM1- Billing Provider Pay-to-Address Name**

Usage	Ref Des.	Name	Code/Definition	Length
S	NM101	Entity Identifier Code	87 = Pay-to-Provider	2/3
R	NM102	Entity Type Qualifier	2 = Non-Person Entity	2/2

**Loop 2010AB- Billing Provider Pay-to-Address-Address**

Usage	Ref Des.	Name	Code/Definition	Length
R	N301	Address information	Pay-to address	1/55
R	N401	City Name	Pay-to address City	2/30
R	N402	State or Province	Pay-to address State Code	2/2
R	N403	Postal Code	Pay-to address Postal Code	3/15

**Table 2-Subscriber Detail**

**Loop 2000B -SBR- Subscriber Information**

Usage	Ref Des.	Name	Code/Definition	Length
R	SBR01	Payer Responsibility Sequence Number Code	S= Secondary	1/1
R	SBR02	Individual Relationship Code	18= Self	2/2
S	SBR09	Claim Filling Indicator Code	MA- Medicare Part A MC= Medicaid	1/2

**Loop 2010BA -NM1- Subscriber Name Information**

Usage	Ref Des.	Name	Code/Definition	Length
R	NM101	Entity Identifier Code	IL = Insured or Subscriber	2/3
R	NM102	Entity Type Qualifier	1 = Person Individual Last Name or Organizational Name	1/1
R	NM103	Name Last or Organization Name	Individual Last Name or Organization Name	1/60
S	NM104	Name First	Individual First Name Note: Required when NM102 is equal to “1” (person) and the person have a first name. If not required by this implementation guide, do not send.	1/35
S	NM105	Name Middle	Individual middle name or initial Note: Required if supplied by member. If not required by this implementation guide, do not send	1/25
S	NM106	Name Prefix	Prefix to individual name Note: Required if supplied by member. If not required by this implementation guide, do not send	1/10
S	NM107	Name Suffix	Name suffix (Sr., Jr., etc.)	1/10



Usage	Ref Des.	Name	Code/Definition	Length
S	NM108	Identification Code Qualifier	MI = Member Identification Number	1 / 2
S	NM109	Identification Code	Must equal the **14-digit IEHP ID number or SSN#.	2/80

**Loop 2010BA -N3- Subscriber Residence Street Address**

Usage	Ref Des.	Name	Code/Definition	Length
R	N301	Address Information	Street address of subscriber	1/55
S	N302	Address Information	Additional street address information of subscriber	1/55

**Loop 2010BA -N4- Subscriber City, State, Zip Code**

Usage	Ref Des.	Name	Code/Definition	Length
R	N401	City Name	City of subscriber	2/30
S	N402	State or Province Code	Two letter postal abbreviation of subscriber's state	2/2
S	N403	Postal Code	Subscriber's Zip Code	3/15

**Loop 2010BA -DMG- Demographic Information**

Usage	Ref Des.	Name	Code/Definition	Length
R	DMG01	Date Time Period Format Qualifier	D8 = Date expressed in format CCYYMMDD	2/3
R	DMG02	Date Time Period	Member Birth Date	1/35
R	DMG03	Gender Code	F = Female M = Male	1/1
S	DMG04	Marital Status Code	B = Registered Domestic Partner D = Divorced	1 / 1

Usage	Ref Des.	Name	Code/Definition	Length
			I = Single M = Married R = Unreported S = Separated U = Unmarried W = Widowed X = Legally Separated	

**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 /0
R	NM108	Identification Code Qualifier	PI = Payer Identification	1/2
R	NM109	Payer Identifier	IEHP assigned Submitter ID	2/8

**Loop 2010BA -REF- Billing Provider Secondary Identification**

Usage	Ref Des.	Name	Code/Definition	Length
R	REF01	Original Reference Number	G2= Medicaid State Assigned Identification Number	2/3
R	REF02	Medicaid Subscriber ID Number	Medicaid State Assigned Identification Number	1/35

**Table 2-Patient Detail**

**Loop 2300 -CLM- Claim Information**

Usage	Ref Des.	Name	Code/Definition	Length
R	CLM01	Patient Control Number	PR = Payer	2/3
R	CLM02	Total Charge Amount		1/1
R	CLM05_01	Facility Type Code		1/2
R	CLM05_03	Claim Frequency Type Code	1 = Original Claim Submission 2= Interim - First Claim 3= Interim – Continuing Claim 4= Interim – Last Claim 7 = Replacement 8 = Void 9 = Final Claim for a Home Health PPS Episode	1/1

**Loop 2300 -DTP- Statement Dates**

Usage	Ref Des.	Name	Code/Definition	Length
R	DTP01	Date/Time Qualifier	434 = Statement	3/3
R	DTP02	Date Time Period Format Qualifier	RD8 = CCYYMMDD	2/3
R	DTP03	Date Time Period	Statement From and to Date	1/35
R	DTP01	Date/Time Qualifier	435 = Statement	3/3
R	DTP02	Date Time Period Format Qualifier	D8 = CCYYMMDD DT = CCYYMMDDHHMM Note: Required on all Inpatient claims	2/3
R	DTP03	Admission Date/Hour	Hours (HH) are expressed as “00” for midnight, “01” for 1A.M., and so on through “23” for 11P.M. Minutes (MM) are expressed as “00” through “59”. If the actual minutes are not known, use a default of “00”. This is only required for original or final bills	

Usage	Ref Des.	Name	Code/Definition	Length
R	DTP03	Date Time Period	Statement From and to Date	1/35

**2300 -PWK- Claim Supplemental Info**

Usage	Ref Des.	Name	Code/Definition	Length
S	PWK01	Report Type Code	09 = Populated for chart review submissions only 0Z = Populated for encounters generated as a result of paper claims PY = Populated for encounters generated as a result of 4010 submission only	2/2
S	PWK02	Attachment Transmission Code	AA = populated for chart review	1/2

**2300 -CL1- Contract Information**

Usage	Ref Des.	Name	Code/Definition	Length
R	CL101	Admission Type Code	1 = Emergency 2 = Urgent 3 = Elective 4 = Newborn 6 = Reserved 7 = Reserved 8 = Reserved 9 = unknown	1/1
R	CL102	Admission Source Code	Code Source 231: Point of origin for admission visit	1/18
R	CL103	Contract Amount	Note: Must match AMT02 in loop 2320	1/18

Usage	Ref Des.	Name	Code/Definition	Length
			and all SVD02 segments in loops 2430	

**2300 -CN1- Contract Information**

Usage	Ref Des.	Name	Code/Definition	Length
R	CN101	Contract Type Code	01 = Diagnosis Related Group (DRG) 02 = Paid 05 = Capitated 09 = Denied	2/2
R	CN102	Contract Amount	Note: Must match AMT02 in loop 2320 and all SVD02 segments in loops 2430	1/18

**2300 -REF- Payer Claim Control Number**

Usage	Ref Des.	Name	Code/Definition	Length
S	REF01	Reference Identification Qualifier	F8 = Original Reference Number Note: Required when CLM05_03 (Claim Frequency Code) indicates that the claim is a replacement or void.	2/3
S	REF02	Payer Claim Control Number	Note: Identifies ICN from original encounter when submitting adjustments	1/50

**2300 -REF- Claim Identifier for Transmission Intermediaries**

Usage	Ref Des.	Name	Code/Definition	Length
R	REF01	Claim Identifier for Transmission Intermediaries	D9 = Claim Number	2/3
R	REF02	Payer Claim Control Number	Note: Must match the PCN value present in 2300_CLM01	1/50

**2300 -HI- Diagnosis Code**

Usage	Ref Des.	Name	Code/Definition	Length
R	HI01	Principal Diagnosis	BK = ICD-9 Code List Qualifier ABK = ICD-10 Code List Qualifier	1/3
S	HI01	Admitting Diagnosis Code	BJ = ICD-9 Code List Qualifier ABJ = ICD-10 Code List Qualifier Note: Required when claim involves an Inpatient admission	1/3
S	HI01	Patient Reason for Visit	PR = ICD-9 Code List Qualifier APR = ICD-10 Code List Qualifier Note: Required when claim involves an Outpatient visit.	1/3
S	HI01	External Cause of Injury	BN = ICD-9 Code List Qualifier ABN = ICD-10 Code List Qualifier Note: Required when an external cause of injury is needed to describe an injury or poisoning.	1/3
S	HI01	Diagnosis Related Group (DRG)	DR = Diagnosis Related Group (DRG) Note: Required when an inpatient hospital is under DRG contract with payer and the contract requires the provider to provide the DRG	1/3
S	HI01	Other Diagnosis Code Information	BF = ICD-9 Code List Qualifier ABF=ICD-10 Code List Qualifier Note: Required when other conditions coexist or develop during the patients treatment	1/3
S	HI01	Principal Procedure Code	BR = ICD-9 Code List Qualifier BBR= ICD-10 Code List Qualifier Note: Required on Inpatient claims when a procedure was performed.	1/3

Usage	Ref Des.	Name	Code/Definition	Length
S	HI01	Other Procedure Information	BQ = ICD-9 Code List Qualifier BBQ = ICD-10 Code List Qualifier Note: Required on inpatient claims when additional procedures must be reported.	1/3
S	HI01	Occurrence Span Information	BI = Occurrence Span Note: Required when there is an occurrence span codes that applies to this claim.	1/3
S	HI01	Occurrence Information	BH = Occurrence Note: Required when there is an occurrence code that applies to this claim	1/3
S	HI01	Value Information	BE = Value Note: Required when there is a value code that applies to this claim.  HI01-2 must = A0 on all ambulance encounters.  Ambulance pick up location zip must be (9) digits. If (9) are not available use '9998' as final (4) digits	1/3
S	HI01	Condition Information	BG = Condition Note: Required when there is a condition code that applies to this claim.	1/3
S	HI01	Treatment Code Information	TC = Note: Required when Home Health Agencies need to report Plan of Treatment information	1/3

**2310A -NM1- Attending Provider Name**

Usage	Ref Des.	Name	Code/Definition	Length
S	NM101	Entity Identifier Code	71 = Attending Physician Note: Required when the claim contains any services than non scheduled transportation claims.	2/3
S	NM102	Entity Type Qualifier	1 = Person	1/1
S	NM103	Name Last of Organization Name	Provider Last or Organization Name	1/60
S	NM104	Name First	Provider First Name	1/35
S	NM105	Name Middle	Provider Middle Name	1/25
S	NM106	Name Prefix	Provider Name Prefix	1/10
S	NM107	Name Suffix	Provider Name Suffix	1/10
S	NM108	Identification Code Qualifier	XX = National Provider Identifier	1 / 2
S	NM109	Identification Code	National Provider Number (NPI)	2/80

**2310B -NM1- Operating Physicians Name**

Usage	Ref Des.	Name	Code/Definition	Length
S	NM101	Entity Identifier Code	72 = Operating Physician Note: Required when a surgical procedure code is listed on this claim.	2/3
S	NM102	Entity Type Qualifier	1 = Person	1/1
S	NM103	Operating Physicians Last Name		1/60
S	NM104	Operating Physicians First Name		1/35
S	NM108	Identification Code Qualifier	XX	1/2
S	NM109	Identification Code		2/80



**2310C -NM1- Other Operating Physicians Name**

Usage	Ref Des.	Name	Code/Definition	Length
S	NM101	Entity Identifier Code	ZZ = Operating Physician Note: Required when another Operating Physicians is involved.	2/3
S	NM102	Entity Type Qualifier	1 = Person	1/1
S	NM103	Other Operating Physicians Last Name		1/60
S	NM104	Other Operating Physicians First Name		1/35
S	NM108	Identification Code Qualifier	XX	1/2
S	NM109	Identification Code		2/80

**2310D -NM1- Rendering Provider Name**

Usage	Ref Des.	Name	Code/Definition	Length
S	NM101	Entity Identifier Code	82 = Rendering Provider Note: Required when Rendering Provider is different than the Attending Provider in 2010A	2/3
S	NM102	Entity Type Qualifier	1 = Person	1/1
S	NM103	Rendering Provider Last Name		1/60
S	NM104	Rendering Provider First Name		1/35
S	NM108	Identification Code Qualifier	XX	1/2
S	NM109	Identification Code		2/80

**2310E -NM1- Service Facility Location**

Usage	Ref Des.	Name	Code/Definition	Length
S	NM101	Entity Identifier Code	77 = Service Location  Note: Required when the location of health care service is different than that carried in Loop 2010AA (Billing Provider)	2/3
S	NM102	Entity Type Qualifier	2 = non – Person Entity	1/1
S	NM103	Name Last of Organization Name	Name Last or Organization Name	1/60
S	NM108	Identification Code Qualifier	XX	1/2
S	NM109	Identification Code		2/80

**2310F -NM1- Referring Provider Name**

Usage	Ref Des.	Name	Code/Definition	Length
S	NM101	Entity Identifier Code	DN = Referring Provider  Note: Required on outpatient claim when the Referring Provider is different than the Attending Provider	2/3
S	NM102	Entity Type Qualifier	1 = Person	1/1
S	NM103	Name Last of Organization Name	Referring Provider Last Name	1/60
S	NM104	First Name	Referring Provider First Name	1/35
S	NM108	Identification Code Qualifier	XX	1/2
S	NM109	Identification Code		2/80

**Loop 2320 -SBR- Coordination of Benefits**

Usage	Ref Des.	Name	Code/Definition	Length
R	SBR01	Payer Responsibility Sequence Number Code	P = Primary	1/1
R	SBR02	Individual Relationship Code	18 = Self	1/1
R	SBR09	Claim Filing Indicator Code	16 = Health Maintenance Organization (HMO) Medicare Risk	1/2
R	AMT01	Amount Qualifier Code	D = Payer Amount Paid	1/3
R	AMT02	Payer Paid Amount	Note: This value should match the value found in the CN102 segment in loop 2300	1/18
R	OI03	Yes/No Condition or Response Code	N = No W = Not Applicable Y = Yes  Note: This is a cross walk from 2300_CLM08	1/1
R	OI06	Release of Information Code	I = Informed consent to release medical information for conditions or diagnoses regulated by federal statutes.  Y = Yes, provider has signed statement permitting release of medical billing data related to claim  Note: This a cross walk from 2300_CLM09	1/1

**Loop 2330A -NM1- Other Subscribers Name**

Usage	Ref Des.	Name	Code/Definition	Length
R	NM101	Entity Identifier Code	IL = Insurer	2/3
R	NM102	Entity Type Qualifier	1 = Person 2 = Non-Person Entity	1/1
R	NM103	Name Last or		1/60

Usage	Ref Des.	Name	Code/Definition	Length
		Organization		
R	NM104	Name First		1/35
R	NM105	Name Middle		1/25
R	NM108	Identification Code Qualifier	MI	1/2
R	NM109	Subscriber Primary ID	Must match the value in 2010BA_NM109	1/60

**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	Organization Name	The organization responsible for the adjudication information provided in the SVD02 segment of loop 2430. Not IEHP	1/60
R	NM108	Identification Code Qualifier	PI = Payer Identification	1/2
R	NM109	Subscriber Primary ID	This should be the Submitter ID assigned by IEHP and must match the value populated in the SVD01 segment of loop 2430.	1/60

The Palmetto GBA assigned ICN will be populated in the 2330B Loop REF02 segment with an FY qualifier. This ICN will be passed to the State Agency in an 837 delimited file. If the MMP populates data in the 2330B Loop REF02 segment when the REF01 = FY, Palmetto GBA will overlay the data populated in the REF02 segment with the Palmetto GBA assigned ICN. PLEASE NOTE, currently this only applies to the State of California and its MMPs. No other MMPs are affected.

**Loop 2330B -REF- Other Payer Secondary Identifier**

Usage	Ref Des.	Name	Code/Definition	Length
R	REF01	Reference Identifications Qualifier	FY  Note: If the MMP populates data in the 2330B Loop/REF02 segment, when the REF01 = FY, Palmetto GBA will overlay the data populated in the REF02 segment with the Palmetto GBA assigned ICN.	2/3

**Loop 2400 -SV2- Service Line Information**

Usage	Ref Des.	Name	Code/Definition	Length
R	SV201	Service Line Revenue Code		2/3
R	SV202-1	Product/Service ID Qualifier	HC = HCPCS	
R	SV202-2	Procedure Code		1/1
S	SV202-3	Procedure Modifier		1/60
S	SV202-7	Description	PI = Payer Identification	1/2
R	SV203	Line Item Charge Amount		1/18

**Loop 2400 -DTP- Service Date**

Usage	Ref Des.	Name	Code/Definition	Length
S	DTP01	Date/Time Qualifier	472 = Service  Note: Required on outpatient service lines where a drug is not being billed and statement date is greater than one day.	2/3

Usage	Ref Des.	Name	Code/Definition	Length
S	DTP02	Date Time Period Format Qualifier	D8 = Date Expressed in CCYYMMDD RD8 = Date Ranges expressed in CCYYMMDD-CCYYMMD	2/3
S	DTP03	Service Date		1/1

**Loop 2430 -SVD- Line Adjudication Information**

Usage	Ref Des.	Name	Code/Definition	Length
R	SVD01	Other Payer Primary Identifier	Must match the value in 2330B_NM109	2/3
R	SVD02	Service Line Paid Amount	“0” is acceptable	1/18
S	SVD03-1	Product/Service ID Qualifier	HC = HCPS	2/2
S	SVD03-2	Procedure Code		1/48
S	SVD03-3	Modifier Code		1/18
R	SVD04	Service Line Revenue Code		1/48
R	SVD05	Paid Service Unit Count		1/15

**Loop 2430 -CAS- Line Adjustment**

Usage	Ref Des.	Name	Code/Definition	Length
R	CAS	Claims Adjustment Group Code	CO = Contractual Obligations CR = Correction Reversals OA = Other Adjustments PI = Payer Initiated Reductions PR = Patient Responsibility	1/2

Usage	Ref Des.	Name	Code/Definition	Length
R	CAS02	Claims Adjustment Reason Codes		1/5
R	CAS03	Adjustment Amounts		1/18

**Loop 2430 -DTP- Claim Check Remittance Date**

Usage	Ref Des.	Name	Code/Definition	Length
R	DTP01	Date Time Qualifier	573 = Date Claim Paid	3/3
R	DTP02	Date Time Period Format Qualifier	D8 = Date expressed in format CCYYMMDD	1/35
R	DTP03	Date Time Period	Adjudication or Payment Date	1/35

**Trailer Segments**

**SE – Transaction Set Trailer**

Usage	Ref Des.	Name	Code/Definition	Length
R	SE01	Number of Included Segments	<i>Transaction Segment Count</i>	1/10
R	SE02	Transaction Set Control Number	<i>Sequential Number</i> (must be identical to value in element ST02)	4/9

**GE Segment – Functional Group Trailer**

Usage	Ref Des.	Name	Code/Definition	Length
R	GE01	Number of Transaction Sets Included	Number of ST Segments	1/6
R	GE02	Group Control Number	Sequential Number (must be identical to the value in the associated functional group header, GS06)	1/9

**IEA Segment - Interchange Control Trailer**

Usage	Ref Des.	Name	Code/Definition	Length
R	IEA01	Number of Included Functional Groups	Number of GS Segments	1/5
R	IEA02	Interchange Control Number	Sequential Number (same as ISA13)	9/9

**Business Scenarios****A. Example 1- IPA Submitting Institutional Encounter Data**

Encounter data must be submitted by IPAs for all covered services provided to assigned Capitated members. Covered services include PCP visits as well as subcapitated services, regardless of place of service, type of service, or method of reimbursement to the provider of services. Failure to provide adequate and valid encounter data in the required format results in penalties being imposed as described in IEHP Capitated Agreement. IPAs will indicate adjudication status in loop 2300 and adjudication date in loop 2430. In accordance with CMS regulations, IEHP requires Providers to submit encounter data within ninety (90) days of each month end.

**B. Example 2- Capitated Hospital Submitting Encounter Data**

Capitated Hospitals are required to submit encounter data through the encounter data system within ninety (90) days of each month end. CMS requires IEHP to report Outpatient Medical Encounters, Inpatient Admission Encounters, Long Term Care Encounters and Pharmacy Encounters. CMS defines an Outpatient Encounter as each physician encounter, laboratory test, X-ray, therapy procedure, DME, prosthetic, orthotic, transportation, outpatient service, home health, skilled nursing, etc.

**Frequently Asked Questions****Q. What is the difference between a claim file and an encounter file?**

- A.** For the purposes of IEHP and as used in this guide, claim files are generally submitted by IEHP's directly contracted fee-for-service providers which can include hospitals, urgent cares, and IEHP Direct providers. Encounter files are submitted by IEHP's Capitated IPAs and Capitated Facilities. Claim files will be adjudicated by IEHP while encounter files have already been adjudicated by the IPA or facility and are primarily for data capture and regulatory reporting. Therefore, while the file format is identical, claims and encounters have different protocols for submission and likewise different internal contacts. Instructions for Claim Processing Procedures can be located in Section VI of the EDI manual while directions for Encounter Processing Procedures can be found in Section IV of the EDI manual.



**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 <https://ww3.iehp.org/en/providers/edi-manual/> 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.

**Q. What is IEHP’s policy on Billing Provider Address and 9-Digit Zip Codes?**

A. IEHP supports the instructions in the Technical Report Type 3 (TR3) implementation guides (IG) available for purchase from Washington Publishing Company <http://www.wpc-edi.com> regarding Billing Provider Address and 9-digit zip codes. Therefore, the Billing Provider Address (2010AA, N3) is required and must be a physical address. PO Box and lock box addresses cannot be reported as a Billing Provider Address, but can continue to be reported in the pay-to address (2010AB, N3). The 5010 requires that all used N403 segments must contain a full 9-digit zip code. The best way to determine the 4-digit extension to your standard zip code is by contacting the US postal Service. <https://tools.usps.com/go/ZipLookupAction!input.action>. These instructions apply to all encounters for all healthcare providers.

**Contact Information**

**Mark Alexander**  
Encounter Data Specialist  
[Alexander-M@iehp.org](mailto:Alexander-M@iehp.org)  
(951) 374-3119

**Veronica Aleman**  
EDI Encounter Data Specialist  
[Aleman-V@iehp.org](mailto:Aleman-V@iehp.org)  
(909) 890-2091

**Troy Smith**  
EDI and Encounters  
[Smith-T@iehp.org](mailto:Smith-T@iehp.org)  
(909) 386-6437

**Audrey Kelley**  
Encounter Data Manager  
[kelley-A@iehp.org](mailto:kelly-A@iehp.org)  
(951) 374-3376