HIPAA Transaction

Standard Companion Guide

ASC X12N Version 005010X222A1
Health Care Claim: Professional

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1 Introduction

1.1 Scope

This Companion Guide is intended to support the implementation of a batch processing application. MagnaCare will accept inbound submissions that are formatted correctly in X12 terms. The files must comply with the specifications outlined in this companion document as well as the corresponding HIPAA implementation guide. MagnaCare Electronic Data Interchange (EDI) applications will edit for these conditions and reject files that are out of compliance. This companion document will specify everything that is necessary to conduct EDI for this standard transaction.
This includes:

- Communications link specifications
- Submission methods specifications
- Transaction specifications

1.2 Overview

This document is intended to compliment the ASC X12N implementation guide currently adopted from HIPAA. It is compliant with the corresponding HIPAA implementation guides in terms of data element and code standards and requirements. It will be the vehicle that MagnaCare uses with its Clients to further qualify the HIPAA-adopted implementation guides.

Data elements that require mutual agreement and understanding will be specified in this companion guide. Types of information that will be clarified within this companion are;

- Qualifiers that will be used from the HIPAA implementation guides to describe certain data elements
- Situational segments and data elements that will be utilized to satisfy business conditions
- Client profile information for purpose of establishing who we are trading with for the transmissions exchanged

1.3 References

ASC X12N Implementation Guides

1. Health Care Claim: Professional
    - 837 (005010X222A1)

1.4 Additional Information

Electronic Data Interchange (EDI) is the computer-to-computer exchange of formatted business data between Clients, without human intervention. MagnaCare maintains a dedicated staff for the purpose of enabling and processing X12 EDI transmissions with its Clients. It is the goal of MagnaCare to establish Client relationships and to conduct EDI as opposed to paper information flows whenever and wherever possible.
The HIPAA implementation guides can be obtained from the Washington Publishing Company by calling 1-800-972-4334 or are available for download on their web site at www.wpc-edi.com/hipaa/.
Other important websites:

Workgroup for Electronic Data Interchange (WEDI) – http://www.wedi.org
United States Department of Health and Human Services (DHHS) – http://aspe.hhs.gov/admnsimp/

Centers for Medicare and Medicaid Services (CMS) – http://www.cms.gov/hipaa/hipaa2/
Designated Standard Maintenance Organizations (DSMO) – http://www.hipaa-dsmo.org/
National Council of Prescription Drug Programs (NCPDP) – http://www.ncpdp.org/
National Uniform Billing Committee (NUBC) – http://www.nubc.org/
Accredited Standards Committee (ASC X12) – http://www.x12.org/

2 Before you begin

2.1 Important information

Clients will be working with two units within MagnaCare to implement EDI transactions:

- MagnaCare EDI Business support unit will serve as the Client's central point of contact. This group will also facilitate the implementation of Clients through all steps of external testing. This group will coordinate closely with MagnaCare EDI team who will be accepting and translating data on behalf of MagnaCare.

- MagnaCare corporate EDI IT group is a centralized technical team that implements the communication link and facilitates the acceptance or rejection of a Client's EDI. This group maintains the EDI translator maps. They will also handle all issues relating to files that were accepted from our translator and moved forward to MagnaCare for processing.

2.2 Registration

To register as a Client with MagnaCare, you will need to do the following:

1. Initial conversations are held between the Client and MagnaCare.
2. Verbal and written agreements are reached as to the transactions that will be conducted.
3. A companion guide is provided and reviewed.
4. Submitter Id and Receiver Id is established for the purpose of identification.
5. Required Client profile is built into our EDI translator.
6. Test files are exchanged and test runs conducted.
7. Once the testing phase is completed, the Client is registered.

2.3 Testing Overview

MagnaCare require their Clients to do validations and test at their end or using third party certification such as Claredi so that the process to test and implement a Client for the purpose of conducting EDI with standard transactions is smooth and efficient.

The complexity of X12 files when not tested and certified by a third party will cause delays in the ability to enable the X12 submissions in a production environment.

MagnaCare wants to spend the majority of the testing period time working with prospective Clients on the agreed components of this companion document rather than X12 or HIPAA implementation guide syntax.

3 Testing Procedures

MagnaCare will establish a set of scenarios intended for testing with the Client. It should be a representation at a high level or cross section of the majority of conditions that will be encountered with production data from these transactions.

3.1 Phases of Testing

MagnaCare requires testing to be completed with all Clients. The testing phase will consist of several smaller phases of testing, as appropriate.

3.1.1 Syntactic Testing

MagnaCare uses an industry standard data translator, REDIX to validate transactions and to translate them into an acceptable format for internal processing. The 997 acknowledgement will be tested during this phase. Any issues identified during this phase of testing will have to be addressed in order for subsequent phases to continue.

3.1.2 Compliance Testing

Client specific setup, as defined in the companion guide will be verified. Generally, this will be done in conjunction with Syntactic testing.

3.1.3 Scenario Testing

This will normally involve all possible business scenarios to be tested.

3.1.4 Volume Testing

This will involve testing large claim and eligibility files. We will like to receive claim files with 200 claims each and eligibility files with 50 records each.

3.2 Testing Process

The following summarizes the testing process:

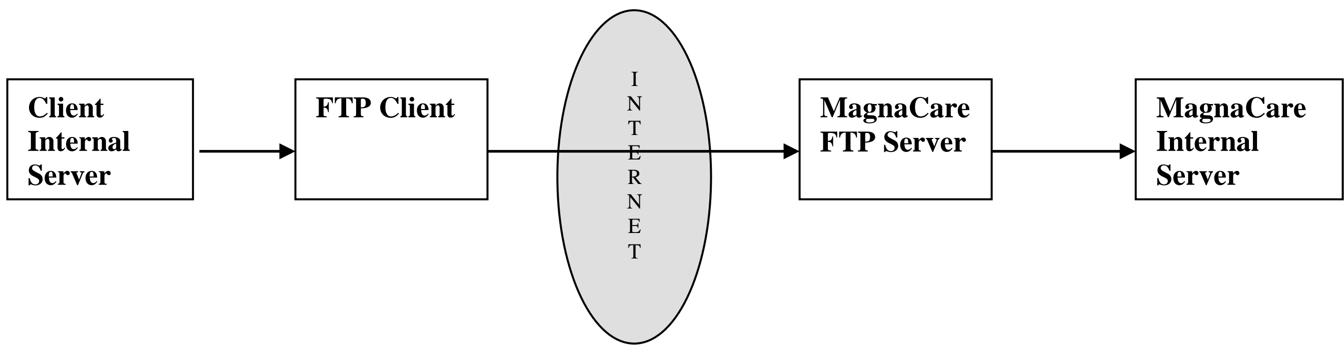
1. After initial contacts and agreements are made, Client will provide MagnaCare with its EDI certification.
2. Next, the Client will provide the MagnaCare HIPAA project manager with one or more files of the X12N formatted sample data, and samples of all relevant business scenarios.
3. MagnaCare HIPAA project manager will translate the files and then upload to the MagnaCare core system. Error messages or diagnostics will be relayed to the Client. This process will proceed by iteration until all parties are satisfied.
4. Once format issues are settled, the communication protocols are similarly implemented and tested.
5. Once the technical requirements have been settled and documented in the companion guide and it's Appendix, the Client and MagnaCare will sign off on the companion guide and move the transaction into production.

4 Transfer of Information

4.1 Data Transfer

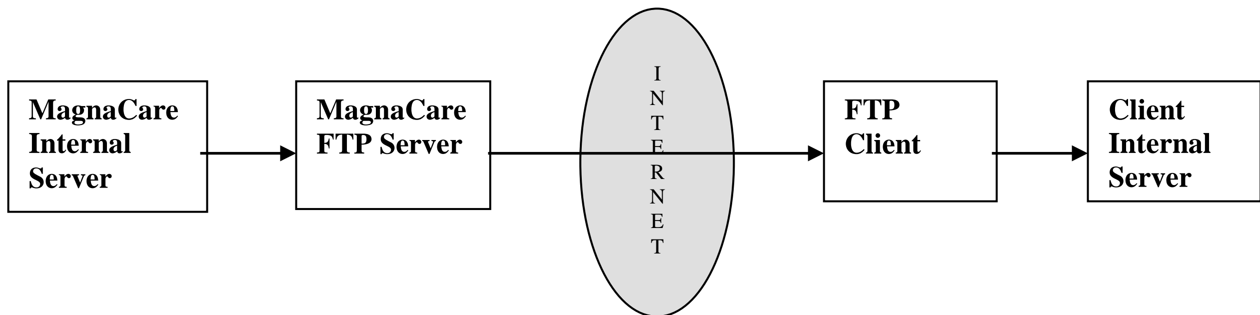
Data can be exchanged with MagnaCare via FTP over the Internet where the file is encrypted, sent over the Internet and then decrypted. For data inbound to MagnaCare (see Figure 1A), the Client would encrypt the data on an internal server, transfer it using FTP Client to MagnaCare's FTP server. MagnaCare will then move the encrypted file from MagnaCare's FTP server to an internal server where the file is decrypted and forwarded for processing.

Figure 1A
Encrypted Data sent over the Internet from Client to MagnaCare FTP Server



MagnaCare data sent to Client (see Figure 1B). MagnaCare will generate the X12 data file and encrypt it. Once encrypted, the file will be sent to MagnaCare's FTP server. At that time, the Client can retrieve the file, transfer it to their internal system using FTP client, decrypt it and process it.

Figure 1B
Encrypted Data sent over the Internet from MagnaCare FTP Server to Client



4.2 Administrative Transmission Procedures

As part of the process establishing the relationship, MagnaCare and the Client must exchange certain technical information.

The requested information will include:

1. Contacts: business, data and communications
2. Dates: testing, production
3. File information; size, naming
4. Transfer; schedule, protocol
5. Server information; host name, user ID, password, file location, file name
6. Notification; failure, success

4.2.1 Re-transmission procedures

When a file needs to be re-transmitted, the Client will contact their primary Account Management contact at MagnaCare.

4.3 Specification of Communication Protocol

The following items are required from the Client in order to exchange data with MagnaCare utilizing FTP server over the Internet.

1. Internet Connectivity; Client should consider a broadband connection for large files.
2. Computer with FTP client and connectivity to the Internet.
3. PGP software for encryption/decryption. RSA (or Legacy) keys must be generated and exchanged with MagnaCare via e-mail (public keys only).
4. E-mail capability to exchange configuration and testing information.

MagnaCare currently supports the receipt of the Health Care Claim in batch mode only. Initial setup will include confirming FTP connectivity, exchanging PGP public keys and performing end-to-end communications testing. Before sending data to MagnaCare, the data must be encrypted with PGP and then sent to the MagnaCare FTP using the FTP client over the Internet connection. When receiving data from MagnaCare, the FTP client will be used to get the data from the MagnaCare FTP server after which PGP will be used to decrypt the data.

MagnaCare provides following three connectivity options to establish interface with its servers.

1. MagnaCare offers FTP over SSL with explicit encryption. SSL (Secure Socket Layer) FTP provides reliable encryption for both the user login, and transferred files.

2. SFTP (Secure File Transfer Protocol) is based on SSH2 (Secure Shell 2). SFTP provides comprehensive protection for a user's data, ID, and password by establishing a secure channel for file transfers. MagnaCare recommends SFTP for small-to-medium size file transfers whenever possible.

3. VPN (Virtual Private Network) is the third connectivity option available to larger clients with extensive data interchange needs. VPN allows a user to connect directly to MagnaCare LAN via a controlled access point. The VPN protocol is used to establish a secure data tunnel between

MagnaCare and a client or vendor, where large numbers of files are to be transferred periodically. If appropriate, VPN access must be pre-arranged, and configured with MagnaCare's IT Dept.

4.4 Passwords

MagnaCare requires the use of User IDs and Passwords to access its systems and servers and will assign each Client a unique User ID and password when using MagnaCare server. In the event a Client forgets their password, MagnaCare will change the password after verifying the authenticity of the request.

4.5 Encryption

MagnaCare requires the encryption of data that is exchanged via the Internet or any other public network. MagnaCare utilizes Gnu PGP encryption with 1024 or 2048 bit keys for file encryption.

4.6 FTP Server

MagnaCare FTP server can be reached using the DNS name ftp://itbbs.magnacare.com . MagnaCare highly recommend using the DNS name rather than the IP address of the server, as we have more than one FTP server available to meet our Disaster Recovery needs.

5 Business Rules and Specifications

- Numeric fields should not be zero padded.
- Fields should not be space padded except ISA segment.
- All monetary amounts are to include decimal points with two positions allowed to the right of the decimal point to represent cents.
- Specific field descriptions may be found in the detailed file layout section of this Companion Guide. Although some elements are situational, MagnaCare may require them and may also require a specific value.
- **Use of NPI:** MagnaCare requires all providers and facilities to use their National Provider Identifier (NPI) number on all electronic transactions covered by HIPAA.

  This means that when billing, providers and facilities must use NPI numbers not only for the billing, pay to, and rendering fields, but also for all secondary provider fields such as referring and supervising provider when used. ***Tax ID number may only be used in connection with the billing provider loop.***

  MagnaCare requires providers with multiple specialties to submit their service location with ZIP + 4 and their taxonomy number.

  Providers and facilities must ***not*** include their existing MagnaCare provider ID or any secondary provider identifier in any of the provider loops except for TIN as required for billing/pay to loops.
  If a provider or facility uses a MagnaCare provider ID or any secondary provider identifier for electronic transactions, MagnaCare will reject them for NPI non-compliance.
- **Anesthesia Billing:** MagnaCare will require all anesthesia services to be billed using minutes (MJ) rather than units (UN).

6 Additional Requests

If requested, 997 Acknowledgement will be sent in batch mode to Clients.

7 Use of the 837 Health Care Claim: Professional

The 837 Professional Health Care Claim is designed to submit claim information electronically to the payer (MagnaCare).

Key Segments and Loops

1. NPI Identifier Qualifier NM108 -XX
   a. Billing Provider Identifier (Loop 2010AA – NM109)
   b. Pay-To Provider Identifier (Loop 2010AB – NM109)
   c. Rendering Provider Identifier (Loop 2310A – NM109)
2. Assignment Indicator (Loop 2000B – SBR01)
3. Subscriber Last Name (Loop 2010BA – NM103)
4. Subscriber First Name (Loop 2010BA – NM104)
5. Subscriber Identifier (Loop 2010BA – NM109)
6. Subscriber Date of Birth (Loop 2010BA – DMG02)
7. Unique Patient Account Number (Loop 2300 – CLM01)
8. Place of Service (Loop 2300 – CLM05-1)
9. Diagnosis Code (Loop 2300 – HI01-2)
10. Service Dates (Loop 2400 – DTP03)
11. Procedure Code (Loop 2400 – SV101-2)
12. Requested Amount (Loop 2400 – SV102)
13. Service Unit Count/Quantity (Loop 2400 – SV104)

8 Transaction Specifications

8.1 Control Segments

8.1.1 ISA - INTERCHANGE CONTROL HEADER

Element	Element Definition	Values	Description
ISA01	Authorization Information Qualifier	00	No Authorization Information Present
ISA02	Authorization Information		[space fill]
ISA03	Security Information Qualifier	00	No Security Information Present
ISA04	Security Information		[space fill]
ISA05	Interchange ID Qualifier	ZZ 30	Mutually Defined U.S. Federal Tax Identification Number
ISA06	Interchange Sender ID	**Inbound**: Client TIN/MagnaCare assigned Client Code **Outbound:** 11-3038233	
ISA07	Interchange ID Qualifier	ZZ 30	Mutually Defined U.S. Federal Tax Identification Number
ISA08	Interchange Receiver ID	**Inbound**: 11-3038233 **Outbound:** Client TIN/MagnaCare assigned Client Code	Inbound: "11-3038233" Outbound: Client TIN/ MagnaCare assigned client Code.
ISA09	Interchange Date	YYMMDD	Date of interchange
ISA10	Interchange Time	HHMM	Time of interchange
ISA11	Interchange Control Standards Identifier	^	Repetition separator
ISA12	Interchange Control Version Number	00501	Draft Standards approved by ASCX12
ISA13	Interchange Control Number	Assigned by sender	Must be identical to the interchange trailer IEA02
ISA14	Acknowledgment Request	0	No Acknowledgment Requested
ISA15	Usage Indicator	P or T	P = Production, T = Test
ISA16	Component Element Separator		":"

8.1.2 IEA - INTERCHANGE

Element	Element Definition	Values	Description
IEA01	Number of included Functional Groups		Number of included Functional Groups
IEA02	Interchange Control Number	Assigned by Sender	Must be identical to the value in ISA13

8.1.3 GS – FUNCTIONAL GROUP HEADER

Element	Element Definition	Values	Description
GS01	Functional Identifier Code	**HC**	Health Care Claim (837)
GS02	Application Sender's Code	**Inbound**: MagnaCare assigned client code **Outbound**: MagnaCare TIN	Sender's code / Tax Identification Number
GS03	Application Receiver's Code	**Inbound**: MagnaCare TIN **Outbound**: MagnaCare assigned client code	Receiver's code / Tax Identification Number
GS04	Date	CCYYMMDD	Group creation date
GS05	Time	HHMM	Creation time
GS06	Group Control Number		Assigned and maintained by the sender
GS07	Responsible Agency Code	X	Accredited Standards Committee X12
GS08	Version/Release/Industry Identifier Code	005010X222A1	Version/Release/Industry Identifier Code

8.1.4 GE – FUNCTIONAL GROUP TRAILER

Element	Element Definition	Values	Description
GE01	Number of Transaction Sets Included		Number of Transaction Sets Included
GE02	Group Control Number	Assigned by Sender	Must be identical to the value in GS06

8.1.5 ST – TRANSACTION SET HEADER

Element	Element Definition	Values	Description
ST01	Transaction Set Identifier Code	837	Health Care Claim
ST02	Transaction Set Control Number		The transaction set control numbers in ST02 and SE02 must be Identical. This number must be unique within a specific group and interchange
ST03	Implementation convention reference	005010X222A1	Implementation Guide Version Name

NOTE: MagnaCare can accept multiple ST-SE segments.

8.1.6 SE – TRANSACTION SET TRAILER

Element	Element Definition	Values	Description
SE01	Transaction Set Identifier Code		Total number of segments included in a transaction set including ST and SE segments**.**
SE02	Transaction Set Control Number	Assigned by Sender	The transaction set control numbers in ST02 and SE02 must be Identical. This number must be unique within a specific group and interchange.

8.1.7 VALID DELIMITERS FOR MAGNACARE EDI

Definition	ASCII	Decimal	Hexadecimal
Segment Separator	\n (New Line)	13	
Element Separator	*	42	2A
Compound element Separator	:	58	3A

8.2 837 Professional File Layout

This table specifies the columns and suggested use of the rows for the detailed description of the transaction set companion guides.

Attribute	Element	ELEMENT DEFINITION	Values	Description
R	**BHT**	**BEGINNING OF HIERARCHICAL TRANSACTION**		
R	01	HIERARCHICAL STRUCTURE CODE	0019	Information Source, Subscriber, Dependent
R	02	TRANSACTION SET PURPOSE CODE	00	00-Original
R	03	REFERENCE IDENTIFICATION		Batch control number and may not be identical to ST02.
R	04	DATE		Transaction set create date in CCYYMMDD format
R	05	TIME		Transaction set create time in HHMM format
R	06	TRANSACTION SET TYPE CODE	CH	Chargeable-fee for service
Loop 1000A				
R	**NM1**	**SUBMITTER NAME-1000A**		
R	01	ENTITY IDENTIFIER CODE	41	Submitter
R	02	ENTITY TYPE QUALIFIER	1, 2	1-Person, 2-Non-person entity
R	03	ORGANIZATION NAME/LAST NAME	“MAGNACARE” Or “MAGNACARE MAGPAY”	Submitter Name ***NOTE: If MAGPAY claim then Organization name will be “MAGNACARE MAGPAY” else “MAGNACARE”***
S	04	FIRST NAME		Subscriber First Name
S	05	MIDDLE NAME		Subscriber Middle Name
NOT USED	06	NAME PREFIX		NOT USED
NOT USED	07	NAME SUFFIX		NOT USED
R	08	IDENTIFICATION CODE QUALIFIER	46	Electronic Transmitter ID number
R	09	IDENTIFICATION CODE		Submitter tax ID
R	**PER**	**SUBMITTER EDI CONTACT INFORMATION-1000A**		
R	01	CONTACT FUNCTION CODE	IC	Information Contact
R	02	NAME		Submitter Contact Name
R	03	COMMUNICATION QUALIFIER	TE	Telephone
R	04	COMMUNICATION NUMBER		Area code number + phone number
S	05	COMMUNICATION QUALIFIER	FX	Fax
S	06	COMMUNICATION NUMBER		Area code number + phone number
S	07	COMMUNICATION QUALIFIER	EM	Email
S	08	COMMUNICATION NUMBER		Email address
Loop 1000B				
R	**NM1**	**RECEIVER NAME-1000B**		
R	01	ENTITY IDENTIFIER CODE	40	Receiver
R	02	ENTITY TYPE QUALIFIER	2	2-Non-person Entity
R	03	ORGANIZATION NAME		Receiver name
NOT USED	04	NAME FIRST		NOT USED
NOT USED	05	NAME MIDDLE		NOT USED
NOT USED	06	NAME PREFIX		NOT USED

Attribute	Element	ELEMENT DEFINITION	Values	Description
NOT USED	07	NAME SUFFIX		NOT USED
R	08	IDENTIFICATION CODE QUALIFIER	46	Electronic Transmitter ID number
R	09	IDENTIFICATION CODE		Receiver Identifier
Loop 2000A				
R	**HL**	**BILLING PROVIDER HIERARCHICAL LEVEL**		
R	01	HIERARCHICAL ID NUMBER		Unique number assigned by the sender, must begin at "1"
NOT USED	02	HIERARCHICAL PARENT ID NUMBER		NOT USED
R	03	HIERARCHICAL LEVEL CODE	20	Information Source
R	04	HIERARCHICAL CHILD CODE	1	Additional subordinate HL data segment
S	**PRV**	**BILLING PROVIDER SPECIALTY INFO 2000A**		****IDENTIFIES BILLING PROVIDER SPECIALTY**
R	01	PROVIDER CODE	BI	Provider Code
R	02	REFERENCE IDENTIFICATION QUALIFER	PXC	Health Care Provider Taxonomy Code Qualifier
R	03	REFERENCE IDENTIFICATION		Provider Taxonomy Code -Required if the provider has more than one specialty.
Loop 2010AA				
R	**NM1**	**BILLING PROVIDER NAME 2010AA**		
R	01	ENTITY IDENTIFIER CODE	85	Billing provider
R	2	ENTITY TYPE QUALIFIER	1 or 2	1-Person, 2-Non-person entity
R	03	NAME LAST		Billing Provider Last or Organizational Name
S	04	NAME FIRST		Billing Provider First Name
S	05	NAME MIDDLE		Billing Provider Middle Name
NOT USED	06	NAME PREFIX		NOT USED
S	07	NAME SUFFIX		Billing Provider Suffix, if known
R	08	IDENTIFICATION CODE QUALIFIER	XX	National Provider ID
R	09	IDENTIFICATION CODE		NPI Number
R	**N3**	**BILLING PROVIDER ADDRESS 2010AA**		
R	01	STREET		Billing Provider Street (Physical address)
S	02	STREET 2		Billing Provider Street 2
R	**N4**	**BILLING PROVIDER CIT/STATE/ZIP CODE 2010AA**		
R	01	CITY		Billing Provider City
R	02	STATE		Billing Provider State
R	03	POSTAL CODE		Billing Provider Zip code
R	**REF**	**BILLING PROVIDER TAX IDENTIFICATION 2010AA**		
R	01	REFERENCE IDENTIFICATION QUALIFIER	EI, SY	Billing Provider Federal Tax ID, Billing Provider SSN
R	02	REFERENCE IDENTIFICATION		Billing provider ID
S	**PER**	**BILLING PROVIDER CONTACT INFORMATION**		
R	01	CONTACT FUNCTION CODE	IC	Information contact
S	02	NAME		Billing provider contact name
R	03	COMMUNICATION QUALIFIER	TE	Telephone
R	04	COMMUNICATION NUMBER		Physician phone number

Attribute	Element	ELEMENT DEFINITION	Values	Description
Loop 2010AB	NAME CHANGE ON LOOP			
S	NM1	PAY TO ADDRESS NAME 2010AB		
R	01	ENTITY IDENTIFIER CODE	87	Pay to provider
R	2	ENTITY TYPE QUALIFIER	1 or 2	Person/non-person entity
NOT USED	03	NAME LAST		Pay to provider last name *(Please refer to MAGPAY change in Loop 1000A – Submitter Name)*
NOT USED	04	NAME FIRST		Pay to provider first name
NOT USED	05	NAME MIDDLE		Pay to provider middle initial
NOT USED	06	NAME PREFIX		NOT USED
NOT USED	07	NAME SUFFIX		Pay to provider suffix
NOT USED	08	IDENTIFICATION CODE QUALIFIER		National Provider ID
NOT USED	09	IDENTIFICATION CODE		NPI Number
R	N3	PAY-TO ADDRESS 2010AB		
R	01	ADDRESS INFORMATION		Pay to provider address
S	02	ADDRESS INFORMATION		Pay to provider address 2
R	N4	PAY TO ADDRESS CITY/STATE/ZIP CODE 2010AB		
R	01	CITY NAME		Pay to provider city
R	02	STATE		Pay to provider state
R	03	ZIP CODE		Pay to provider zip code
Loop 2000B				
R	HL	SUBSCRIBER HIERARCHICAL LEVEL 2000B		
R	01	HIERARCHICAL ID NUMBER		Unique number assigned by the sender
R	02	HIERARCHICAL PARENT ID NUMBER		ID number of the next higher hierarchical segment
R	03	HIERARCHICAL LEVEL CODE	22	Subscriber
R	04	HIERARCHICAL CHILD CODE	0 or 1	No subordinates or has subordinates
R	SBR	SUBSCRIBER INFORMATION 2000B		
R	01	PAYER RESPONSIBILITY SEQUENCE CODE NUMBER	A -H P, S, T, U	Primary Payer, Secondary Payer. If claim is for primary payer then “P” else if claim is for secondary payer then “S”.
S	02	INDIVIDUAL RELATIONSHIP CODE	18	18-Self (required when subscriber is patient)
S	03	REFERENCE IDENTIFICATION		Group number
S	04	NAME		Group name
S	05	INSURANCE TYPE CODE		Type of policy
NOT USED	06	COORDINATION OF BENEFITS CODE		NOT USED
NOT USED	07	YES/NO CONDITION OR REPONSE CODE		NOT USED
NOT USED	08	EMPLOYMENT STATUS CODE		NOT USED
S	09	CLAIM FILING INDICATOR	HM, ZZ	Health Maintenance Organization
Loop 2010BA				
R	NM1	SUBSCRIBER NAME 2010BA		
R	01	ENTITY IDENTIFIER CODE	IL	Insured or subscriber
R	02	ENTITY TYPE QUALIFIER	1	Person
R	03	NAME LAST		Subscriber last name
S	04	NAME FIRST		Subscriber first name

Attribute	Element	ELEMENT DEFINITION	Values	Description
S	05	NAME MIDDLE		Subscriber middle name
NOT USED	06	NAME PREFIX		NOT USED
S	07	NAME SUFFIX		Subscriber suffix
R	08	IDENTIFICATION CODE QUALIFIER	MI	Member Identification number
R	09	IDENTIFICATION CODE		MagnaCare Subscriber member number (Alternate ID/SSN)
S	**N3**	**SUBSCRIBER ADDRESS 2010BA**		
R	01	ADDRESS INFORMATION		Subscriber address
S	02	ADDRESS INFORMATION		Subscriber address 2
S	**N4**	**SUBSCRIBER CITY/STATE/ZIP CODE 2010BA**		
R	01	CITY NAME		Subscriber City
R	02	STATE		Subscriber State
R	03	POSTAL CODE		Subscriber Zip code
S	**DMG**	**SUBSCRIBER DEMOGRAPHIC INFORMATION 2010BA**		
R	01	DATE FORMAT QUALIFIER	D8	CCYYMMDD
R	02	DATE TIME PERIOD		Subscriber date of birth
R	03	GENDER CODE	F, M, U	Female, male, unknown
Loop 2010BB				
R	**NM1**	**PAYER NAME**		
R	01	ENTITY IDENTIFIER CODE	PR	Payer
R	02	ENTITY TYPE DESCRIPTION	2	Non-Person Entity
R	03	NAME LAST OR ORGANIZATION		Payer Name
NOTUSED	04	NAME FIRST		NOTUSED
NOTUSED	05	NAME MIDDLE		NOTUSED
NOTUSED	06	NAME PREFIX		NOTUSED
NOTUSED	07	NAME SUFFIX		NOTUSED
R	08	IDENTIFICATION CODE QUALIFER	XV, PI	Payer Identification PI Prior to mandated Plan ID
R	09	IDENTIFICATION CODE NUMBER		Health Care's Tax Identification Number
S	**N3**	**PAYER ADDRESS 2010BB**		
R	01	ADDRESS INFORMATION		PAYER ADDRESS LINE
S	02	ADDRESS INFORMATION		PAYER ADDRESS LINE
R	**N4**	**PAYER CITY/STATE/ZIP CODE 2010BB**		
R	01	CITY NAME		PAYER CITY NAME
S	02	STATE OR PROVINCE CODE		PAYER STATE OR PROVINCE CODE
S	03	POSTAL CODE		PAYER POSTAL ZONE OR ZIP CODE
S	04	COUNTRY CODE		
Loop 2000C				
R	**HL**	**PATIENT HIERARCHICAL LEVEL 2000C**		
R	01	HIERARCHICAL ID NUMBER		Unique number assigned by the sender
R	02	HIERARCHICAL PARENT ID NUMBER		ID number of the next higher hierarchical segment

Attribute	Element	ELEMENT DEFINITION	Values	Description
R	03	HIERARCHICAL LEVEL CODE	23	Subscriber
R	04	HIERARCHICAL CHILD CODE	0 or 1	No subordinates or has subordinates
R	**PAT**	**PATIENT INFORMATION**		
R	01	INDIVIDUAL RELATIONSHIP CODE	01, 19, 20, 21, 39, 40, 53, G8	Specifies patient relationship to the person insured
Loop 2010CA				
R	**NM1**	**PATIENT NAME 2010CA**		
R	01	ENTITY IDENTIFIER CODE	QC	Patient
R	02	ENTITY TYPE QUALIFIER	1	Person
R	03	NAME LAST		Patient last name
S	04	NAME FIRST		Patient first name
S	05	NAME MIDDLE		Patient middle name
NOT USED	06	NAME PREFIX		NOT USED
S	07	NAME SUFFIX		Patient suffix
NOT USED	08	IDENTIFICATION CODE QUALIFIER		Patient Identification number
NOT USED	09	IDENTIFICATION CODE		Patient member number (Alternate ID/SSN)
S	**N3**	**PATIENT ADDRESS 2010CA**		
R	01	ADDRESS INFORMATION		Subscriber address
S	02	ADDRESS INFORMATION		Subscriber address 2
S	**N4**	**PATIENT CITY/STATE/ZIPCODE 2010CA**		
R	01	CITY NAME		Subscriber City
R	02	STATE		Subscriber State
R	03	POSTAL CODE		Subscriber Zip code
S	**DMG**	**PATIENT DEMOGRAPHIC INFORMATION 2010CA**		
R	01	DATE FORMAT QUALIFIER	D8	CCYYMMDD
R	02	DATE TIME PERIOD		Subscriber date of birth
R	03	GENDER CODE	F, M, U	Female, male, unknown
Loop 2300				
R	**CLM**	**CLAIM INFORMATION 2300**		
R	01	CLAIM SUBMITTER'S IDENTIFIER		Patient account number
R	02	MONETARY AMOUNT		Total charges (must equal sum of the SV102's)
NOT USED	03	CLAIM FILING INDICATOR CODE		NOT USED
NOT USED	04	NON-INSTITUTIONAL CLAIM TYPE CODE		N0T USED
R	05	HEALTH CARE SERVICE LOCATION		Place of service
R	05-1	FACILITY CODE VALUE/PLACE OF SERVICE		Facility code
R	05-2	FACILITY CODE QUALIFIER	B	Place of service Codes for Professional or Dental Services
R	05-3	CLAIM FREQUENCY TYPE CODE		Original-claim frequency
R	06	RESPONSE CODE	Y or N	Provider signature on file
R	07	PROVIDER ACCEPT ASSIGN	A, B, C	Assignment or Plan Participation Code
R	08	RESPONSE CODE	Y, N, W	Assign of by Insurer benefits indicator. W- NOT

Attribute	Element	ELEMENT DEFINITION	Values	Description
				APPLICABLE
R	09	RELEASE OF INFORMATION	I, Y,W	Release of information
S	10	PATIENT SIGNATURE SOURCE CODE	P	Patient signature on file
S	11	RELATED CAUSES INFORMATION		Related causes
R	11 -1	RELATED CAUSES CODE	AA, EM, OA	Auto Accident, Employment, Other Accident
S	11 -2	RELATED CAUSES CODE	AA, EM, OA	Used if more than 1 applies
NOT USED	11 -3	RELATED CAUSES CODE	AA, EM, OA	NOT USED
S	11 -4	STATE		State where accident occurred
S	11 -5	COUNTRY		Country where accident occurred
S	12	SPECIAL PROGRAM CODE		Special circumstances
NOT USED	13	YES/NO CONDITION OR RESPONSE CODE		NOTUSED
NOT USED	14	LEVEL OF SERVICE CODE		NOT USED
NOT USED	15	YES/NO CONDITION OR RESPONSE CODE		NOT USED
NOT USED	16	PROVIDER AGREEMENT CODE		P-Participation agreement
NOT USED	17	CLAIM STATUS CODE		NOTUSED
NOT USED	18	YES/NO CONDITION OR RESPONSE CODE		NOT USED
NOT USED	19	CLAIM SUBMISSION REASON CODE		NOT USED
S	20	DELAY REASON CODE		Delay reason code
S	**DTP**	**DATE ONSET OF CURRENT ILLNESS OR SYMPTOM 2300 - POSITION CHANGE IN 5010**		
R	01	DATE/TIME QUALIFIER	431	
R	02	DATE/TIME PERIOD FORMAT QUALIFIER	D8	
R	03	DATE/TIME PERIOD		
S	**DTP**	**DATE -INITIAL TREATMENT DATE 2300**		
R	01	DATE/TIME QUALIFIER	454	
R	02	DATE/TIME PERIOD FORMAT QUALIFIER	D8	
R	03	DATE TIME PERIOD		INITIAL TREATMENT DATE
R	**DTP**	**DATE -LAST SEEN DATE 2300**		
R	01	DATE/TIME QUALIFIER	304	
R	02	DATE TIME PERIOD FORMAT QUALIFIER	D8	
R	03	DATE TIME PERIOD		
S	**DTP**	**DATE OF ACCIDENT 2300**		
R	01	DATE QUALIFIER	439	Accident date
R	02	DATE FORMAT	D8	Date format: CCYYMMDD , Value DT- deleted
R	03	DATE OF CURRENT		Accident Date
S	**DTP**	**DATE – DISABILITY DATES 2300 (NEW SEGMENT)**		
R	01	DATE QUALIFIER	314,360,361	Certification Expiration Date
R	02	DATE FORMAT	D8	Date format: CCYYMMDD
R	03	DATE OF CURRENT		Level of service code
S	**DTP**	**DATE LAST WORKED 2300**		

Attribute	Element	ELEMENT DEFINITION	Values	Description
R	01	DATE QUALIFIER	297	Date last worked
R	02	DATE FORMAT	D8	Date format: CCYYMMDD
R	03	DATE OF CURRENT		Date Last Worked
S	**DTP**	**DATE AUTHORIZED RETURN TO WORK 2300**		
R	01	DATE QUALIFIER	296	Authorized return to work date
R	02	DATE FORMAT	D8	Date format: CCYYMMDD
R	03	DATE TO RETURN TO WORK		Date Authorized return to work
S	**DTP**	**DATE OF ADMISSION 2300**		
R	01	DATE QUALIFIER	435	Admission date
R	02	DATE FORMAT	D8	Date format: CCYYMMDD
R	03	DATE ADMISSION		Date of Admission
S	**DTP**	**DATE OF DISCHARGE 2300**		
R	01	DATE QUALIFIER	096	Discharge date
R	02	DATE FORMAT	D8	Date format: CCYYMMDD
R	03	DATE DISCHARGE		Date of Discharge
S	**PWK**	**CLAIM SUPPLEMENTAL INFORMATION 2300**		
	01	REPORT TYPE CODE		More codes added
R	02	REPORT TRANSMISSION CODE		Code defining timing, transmission method or format
NOT USED	03	REPORT COPIES NEEDED		NOT USED
NOT USED	04	ENTITY IDENTIFIER CODE		NOT USED
S	05	IDENITIFICATION CODE QUALIFIER	AC	Required when PWK02=BM, EL, EM, FX, OR FT
S	06	IDENTIFICATION CODE		
S	**AMT**	**PATIENT AMOUNT PAID 2300**		
R	01	AMOUNT QUALIFIER	F5	Patient amount paid
R	02	MONETARY AMOUNT		Amount Paid
S	**REF**	**REFERRAL NUMBER 2300**		****Required when Referring Provider is sent (REF*DN)**
R	01	REFERENCE IDENTIFICATION QUALIFIER	9F	Referral number qualifier
R	02	REFERENCE IDENTIFICATION		Referral number
S	**REF**	**PAYER CLAIM CONTROL NUMBER 2300**		(Required when CLM05-03 indicates replacement or void
R	01	REFERENCE IDENTIFICATION QUALIFIER	F8	to a previously adjudicated claim)
R	02	REFERENCE IDENTIFICATION		Original claim number
S	**REF**	**CLAIM IDENTIFIER FOR TRANSMISSION INTERMDIARIES**		**Client or clearing house claim number**
R	01	REFERENCE IDENTIFICATION QUALIFIER	D9	
R	02	REFERENCE IDENTIFICATION		Clinical Laboratory Improvement Amendment Number
S	**REF**	**MEDICAL RECORD NUMBER 2300**		ACTUAL MEDICAL RECORD OF THE PATIENT
R	01	REFERENCE IDENTIFICATION QUALIFIER	EA	Medical record qualifier

Attribute	Element	ELEMENT DEFINITION	Values	Description
R	02	MEDICAL RECORD NUMBER		Medical record number
S	**NTE**	**CLAIM NOTE 2300**		
R	01	REFERENCE CODE	ADD, CER, DCP, DGN, TPO	Note reference code
R	02	MESSAGE		Free form data-Additional information
R	**HI**	**HEALTH CARE DIAGNOSIS CODE 2300**		
R	01	HEALTH CARE CODE INFORMATION		
R	01-1	CODE LIST QUALIFIER	ABK BK	Principal diagnosis ICD-10 codes Principal diagnosis ICD-9 codes
R	01-2	INDUSTRY CODE		Diagnosis code
S	02	HEALTH CARE CODE INFORMATION		
R	02-1	CODE LIST QUALIFIER	ABF BF	Diagnosis ICD-10 codes Diagnosis ICD-9 codes
R	02-2	INDUSTRY CODE		Diagnosis code
S	03	HEALTH CARE CODE INFORMATION		
R	03-1	CODE LIST QUALIFIER	ABF BF	Diagnosis ICD-10 codes Diagnosis ICD-9 codes
R	03-2	INDUSTRY CODE		Diagnosis code
S	04	HEALTH CARE CODE INFORMATION		
R	04-1	CODE LIST QUALIFIER	ABF BF	Diagnosis ICD-10 codes Diagnosis ICD-9 codes
R	04-2	INDUSTRY CODE		DIAGNOSIS CODE
S	05	HEALTH CARE CODE INFORMATION		
R	05-1	CODE LIST QUALIFIER	ABF BF	Diagnosis ICD-10 codes Diagnosis ICD-9 codes
R	05-2	INDUSTRY CODE		DIAGNOSIS CODE
S	06	HEALTH CARE CODE INFORMATION		
R	06-1	CODE LIST QUALIFIER	ABF BF	Diagnosis ICD-10 codes Diagnosis ICD-9 codes
R	06-2	INDUSTRY CODE		DIAGNOSIS CODE
S	07	HEALTH CARE CODE INFORMATION		
R	07-1	CODE LIST QUALIFIER	ABF BF	Diagnosis ICD-10 codes Diagnosis ICD-9 codes
R	07-2	INDUSTRY CODE		DIAGNOSIS CODE
S	08	HEALTH CARE CODE INFORMATION		
R	08-1	CODE LIST QUALIFIER	ABF BF	Diagnosis ICD-10 codes Diagnosis ICD-9 codes
R	08-2	INDUSTRY CODE		DIAGNOSIS CODE
S	H109	HEALTH CARE CODE INFORMATION		
R	09-1	CODE LIST QUALIFIER CODE	ABF BF	Diagnosis ICD-10 codes Diagnosis ICD-9 codes
R	09-2	INDUSTRY CODE		DIAGNOSIS CODE
S	H110	HEALTH CARE CODE INFORMATION		
R	10-1	CODE LIST QUALIFIER CODE	ABF BF	Diagnosis ICD-10 codes Diagnosis ICD-9 codes
R	10-2	INDUSTRY CODE		DIAGNOSIS CODE
S	H111	HEALTH CARE CODE INFORMATION		
R	11-1	CODE LIST QUALIFIER CODE	ABF BF	Diagnosis ICD-10 codes Diagnosis ICD-9 codes
R	11-2	INDUSTRY CODE		DIAGNOSIS CODE

Attribute	Element	ELEMENT DEFINITION	Values	Description
S	H112	HEALTH CARE CODE INFORMATION		
R	12-1	CODE LIST QUALIFIER CODE	ABF BF	Diagnosis ICD-10 codes Diagnosis ICD-9 codes
R	12-2	INDUSTRY CODE		DIAGNOSIS CODE
S	**HI**	**ANESTHESIA RELATED PROCEDURE 2300 (NEW SEGMENT)**		
R	01	HEALTH CARE CODE INFORMATION		
R	01-1	CODE LIST QUALIFIER	BP	Healthcare Common Procedural Coding System
R	01-2	INDUSTRY CODE		Anesthesia related Surgical Procedure
S	**HI**	**CONDITION INFORMATION 2300 (NEW SEGMENT)**		
R	01	HEALTH CARE CODE INFORMATION		
R	01-1	CODE LIST QUALIFIER	BG	Healthcare Common Procedural Coding System
R	01-2	INDUSTRY CODE		Condition Code
S	**HCP**	**CLAIM PRICING/REPRICING INFORMATION 2300**		
R	01	PRICING METHODOLOGY		Specific code use is determined by Trading Partner Agreement due to the variances in contracting policies in the industry.
R	02	MONETARY AMOUNT		Repriced Allowed Amount
R	03	MONETARY AMOUNT		Repriced Savings Amount
Loop 2310A				
S	**NM1**	**REFERRING PROVIDER NAME 2310A**		
R	01	ENTITY IDENTIFIER CODE	DN P3	Referring provider. Primary care provider.
R	02	ENTITY TYPE	1	MUST BE A PERSON
R	03	LAST NAME		Referring physician last name
S	04	FIRST NAME		Referring physician first name
S	05	NAME MIDDLE		Referring physician middle initial
S	07	NAME SUFFIX		Referring physician suffix
S	08	IDENTIFICATION CODE QUALIFIER	XX	National Provider ID
S	09	IDENTIFICATION CODE		NPI Number
Loop 2310B				
S	**NM1**	**RENDERING PROVIDER NAME 2310B**		
R	01	ENTITY IDENTIFIER CODE	82	Rendering provider
R	02	ENTITY TYPE QUALIFIER	1	Person
R	03	NAME LAST OR ORGANIZATION NAME		Rendering provider last name
S	04	NAME FIRST		Rendering provider first name
S	05	NAME MIDDLE		Rendering provider middle initial
NOT USED	06	NAME PREFIX		NOT USED
S	07	NAME SUFFIX		Rendering provider suffix
R	08	IDENTIFICATION CODE QUALIFIER	XX	National Provider ID
R	09	IDENTIFICATION CODE		NPI Number
S	**PRV**	**RENDERING PROVIDER SPECIALTY**		

Attribute	Element	ELEMENT DEFINITION	Values	Description
R	01	PROVIDER CODE	PE	Performing Provider
R	02	REFERENCE IDENTIFICATION QUALIFER	PXC	Mutually Defined
R	03	REFERENCE IDENTIFICATION		Provider Taxonomy Code -Required if the provider has more than one specialty.
Loop 2310C				
R	**NM1**	**SERVICE FACILITY LOCATION 2310C**		
R	01	ENTITY IDENTIFIER CODE	77	77-Service location. Note: FA-Facility, LI – Independent Lab, TL -Testing Lab codes deleted)
R	02	ENTITY TYPE QUALIFIER	2	Non-person entity
S	03	NAME LAST OR ORGANIZATION NAME		Laboratory/facility name
NOT USED	04	NAME FIRST		NOT USED
NOT USED	05	NAME MIDDLE		NOT USED
NOT USED	06	NAME PREFIX		NOT USED
NOT USED	07	NAME SUFFIX		NOT USED
S	08	IDENTIFICATION CODE QUALIFIER	XX	National Provider ID
S	09	IDENTIFICATION CODE		NPI Number
Loop 2320				
S	**SBR**	**OTHER SUBSCRIBER INFORMATION 2320**		
R	01	PAYER RESPONSIBILITY SEQUENCE NUMBER	P, S	If claim is for secondary payer then this should equal "P" for Primary Payer else "S" for Secondary Payer
R	02	INDIVIDUAL RELATIONSHIP CODE		Individual Relationship Code
S	03	REFERENCE IDENTIFICATION		Group number
S	04	NAME		Group or plan name
R	05	INSURANCE TYPE CODE		Required when Medicare is other payer but not primary
NOT USED	06	COORDINATION OF BENEFITS		NOT USED
NOT USED	07	YES/NO CONDITION OR RESPONSE CODE		NOT USED
NOT USED	08	EMPLOYMENT STATUS CODE		NOT USED
S	09	CLAIM FILING INDICATOR CODE	WC, MB, MA, HM	Workers' Compensation Health Claim, Medicare Part B, Medicare Part A, Health maintenance organization
S	**CAS**	**LINE ADJUDICATION INFORMATION 2320**		
R	01	CLAIM ADJUSTMENT GROUP CODE	PR, CO, CR, OA, PI	If multiple adjustment group codes available the "PR" adjustment group code is required to be the first CAS segment sent.
R	02	CLAIM ADJUSTMENT REASON CODE		Adjustment Reason Code. **CODE SOURCE 139:** Claim Adjustment Reason Code
R	03	MONETARY AMOUNT		Adjusted Amount -Claim Level
S	04	QUANTITY		Adjusted Units -Claim Level
S	05	CLAIM ADJUSTMENT REASON CODE		Adjustment Reason Code. **CODE SOURCE 139:** Claim Adjustment Reason Code
S	06	MONETARY AMOUNT		Adjusted Amount -Claim Level
S	07	QUANTITY		Adjusted Units -Claim Level
S	08	CLAIM ADJUSTMENT REASON CODE		Adjustment Reason Code. **CODE SOURCE 139:** Claim Adjustment Reason Code
S	09	MONETARY AMOUNT		Adjusted Amount -Claim Level
S	10	QUANTITY		Adjusted Units -Claim Level
S	11	CLAIM ADJUSTMENT REASON CODE		Adjustment Reason Code. **CODE SOURCE 139:** Claim Adjustment Reason Code
S	12	MONETARY AMOUNT		Adjusted Amount -Claim Level
S	13	QUANTITY		Adjusted Units -Claim Level
S	14	CLAIM ADJUSTMENT REASON CODE		Adjustment Reason Code. **CODE SOURCE 139:** Claim

Attribute	Element	ELEMENT DEFINITION	Values	Description
				Adjustment Reason Code
S	15	MONETARY AMOUNT		Adjusted Amount -Claim Level
S	16	QUANTITY		Adjusted Units -Claim Level
S	17	CLAIM ADJUSTMENT REASON CODE		Adjustment Reason Code. **CODE SOURCE 139:** Claim Adjustment Reason Code
S	18	MONETARY AMOUNT		Adjusted Amount -Claim Level
S	19	QUANTITY		Adjusted Units -Claim Level
S	**AMT**	**COORDINATION OF BENEFITS (COB) PAYER PAID AMOUNT 2320**		
R	01	AMOUNT QUALIFIER	D	Payer amount paid
R	02	MONETARY AMOUNT		Amount Paid
S	**AMT**	**COORDINATION OF BENEFITS (COB TOTAL NONCOVERED AMOUNT 2320**		
REMOVED	01	AMOUNT QUALIFIER CODE	A8	
R	02	MONETARY AMOUNT		NON COVERED AMOUNT
R	**OI**	**OTHER INSURANCE COVERAGE INFO**		
NOT USED	01	CLAIM FILING INDICATOR CODE		NOT USED
NOT USED	02	CLAIM SUBMISSION REASON CODE		NOT USED
R	03	YES/NO CONDITION REPONSE	Y, N, W	Assignment of Benefits Indicator
S	04	PATIENT SIGNATURE SOURCE CODE	P	Patient Signature Source Code
NOT USED	05	PROVIDER AGREEMENT CODE		NOT USED
R	06	RELEASE OF INFORMATION CODE	I, Y	Release of Information Code
S	**MOA**	**OUTPATIENT ADJUDICATION INFORMATION 2320**		********************
S	01	PERCENTAGE AS DECIMAL		REIMBURSEMENT RATE
S	02	MONETARY AMOUNT		REQUIRED WHEN RETURNED IN TNE REMITTANCE
S	03 -07	REFERENCE IDENTIFICATION		ADVICE
S	08 -09	MONETARY AMOUNT		********************
Loop 2330A				
S	**NM1**	**OTHER SUBSCRIBER NAME 2330A**		
R	01	ENTITY IDENTIFIER CODE	IL	Insured or subscriber
R	02	ENTITY TYPE QUALIFIER	1	Person
R	03	NAME LAST		SUBSCRIBER LAST NAME
S	04	NAME FIRST		SUBSCRIBER FIRST NAME
S	05	NAME MIDDLE		SUBSCRIBER MIDDLE NAME
NOT USED	06	NAME PREFIX		NOT USED
S	07	NAME SUFFIX		SUBSCRIBER SUFFIX
R	08	IDENTIFICATION CODE QUALIFIER	MI	MEMBER IDENTIFICATION
R	09	IDENTIFICATION CODE		SUBSCRIBER IDENTIFCATION NUMBER
Loop 2330B				
S	**NM1**	**OTHER PAYER NAME 2330B**		
R	01	ENTITY IDENTIFIER CODE	PR	PAYER
R	02	ENTITY TYPE QUALIFIER	2	NON-PERSON
R	03	ORGANIZATION NAME		OTHER PAYER ORGANIZATION NAME

Attribute	Element	ELEMENT DEFINITION	Values	Description
NOT USED	04	NAME FIRST		NOT USED
NOT USED	05	NAME MIDDLE		NOT USED
NOT USED	06	NAME PREFIX		NOT USED
NOT USED	07	NAME SUFFIX		NOT USED
R	08	IDENTIFICATION CODE QUALIFIER	PI	PAYER IDENTIFICATION
R	09	IDENTIFICATION CODE		PAYER IDENTIFICATION NUMBER
Loop 2330C				
S	**NM1**	**OTHER PAYER PATIENT INFORMATION 2330C**		
R	01	ENTITY IDENTIFIER CODE	QC	PATIENT
R	02	ENTITY TYPE QUALIFIER	1	PERSON
R	03	ORGANIZATION NAME/LAST NAME		OTHER PAYER NAME
NOT USED	04	NAME FIRST		NOT USED
NOT USED	05	NAME MIDDLE		NOT USED
NOT USED	06	NAME PREFIX		NOT USED
NOT USED	07	NAME SUFFIX		NOT USED
R	08	IDENTIFICATION CODE QUALIFIER	MI	MEMBER IDENTIFICATION
R	09	IDENTIFICATION CODE		OTHER INSURANCE MEMBER NUMBER
Loop 2400				
R	**LX**	**SERVICE LINE NUMBER 2400**		
R	01	ASSIGNED NUMBER		Line counter
R	**SV1**	**PROFESSIONAL SERVICE 2400**		
R	01-1	COMPOSITE MEDICAL PROCEDURE IDENTIFIER	ER, HC, IV, WK	HC-HCPCS codes,
R	01-2	PRODUCT/SERVICE ID		Procedure Code
S	01-3	PROCEDURE MODIFIER		Procedure Modifier 1
S	01-4	PROCEDURE MODIFIER		Procedure Modifier 2
S	01-5	PROCEDURE MODIFIER		Procedure Modifier 3
S	01-6	PROCEDURE MODIFIER		Procedure Modifier 4
S	01-7	DESCRIPTION		DEFINITIVE DESCRIPTION OF PROCEDURE CODE
NOT USED	01-08	PRODUCT/ SERVICE ID		NOT USED
R	SV102	MONETARY AMOUNT		Line item charge amount
R	SV103	MINUTES	UN, MJ(Anesthesia)	MINUTES are required if Anesthesia claim.
R	SV104	QUANTITY		
S	05	FACILITY CODE VALUE		Place of service
NOT USED	06	SERVICE TYPE CODE		NOT USED
R	07	DIAGNOSIS CODE POINTER		
R	07-1	DIAGNOSIS CODE POINTER		Diagnosis Code Pointer
S	07-2	DIAGNOSIS CODE POINTER		Diagnosis Code Pointer
S	07-3	DIAGNOSIS CODE POINTER		Diagnosis Code Pointer
S	07-4	DIAGNOSIS CODE POINTER		Diagnosis Code Pointer
NOT USED	08	MONETARY AMOUNT		NOT USED
S	09	YES/NO INDICATOR	Y	Emergency indicator
NOT USED	10	MULTIPLE PROCEDUE CODE		NOT USED
S	11	YES/NO CONDITION OR RESPONSE CODE	Y	Y=EPSDT-MEDICAID SCREENING FOR CHILDREN

Attribute	Element	ELEMENT DEFINITION	Values	Description
S	12	YES/NO CONDITION OR RESPONSE CODE	Y	
NOT USED	13	REVIEW CODE		NOT USED
NOT USED	14	NATIONAL OR LOCAL ASSIGNED REVIEW VALUE		NOT USED
S	15	COPAY STATUS CODE	0	COPAY EXEMPT
S	**SV5**	**DURABLE MEDICAL EQUIPMENT 2400**		
R	01	COMPOSITE MEDICAL PROCEDURE		TO IDENTIFY A MEDICAL PROCEDURE
R	01-1	PRODUCT/SERVICE ID QUALIFIER	HC	HCPCS CODES
R	01-2	PRODUCT/SERVICE ID		PROCEDURE CODE-VALUE MUST EQUAL SV101-2
R	02	UNITS OR BASIS FOR MEASUREMENT CODE	DA	DAYS
R	03	QUANITY		LENGTH OF MEDICAL NECESSITY
R	04	MONETARY AMOUNT		DME RENTAL PRICE
R	05	MONETARY AMOUNT		DME PURCHASE PRICE
R	06	FREQUENCY CODE	1, 4, 6	FREQ. AT WHICH RENTAL IS BILLED(W-M-D)
S	**PWK**	**PWK -LINE SUPPLEMENTAL INFORMATION 2400 (NEW SEGMENT)**		
R	01	REPORT CODE TYPE		TITLE OF SUPPORTING DOCUMENTATION REPORT
R	02	REPORT TRANSMISSION CODE	AA, BM, EL, EM, FT, FX	METHOD OR FORMAT OF TRANSMSSION
NOT USED	03 -04			NOT USED
S	05	IDENTIFICATION CODE QUALIFIER	AC	
S	06	IDENTIFICATION CODE		ATTACHMENT CONTROL NUMBER
R	**DTP**	**DATE-SERVICE DATE 2400**		
R	01	DATE/TIME QUALIFIER	472	SERVICE DATE QUALIFIER
R	02	DATE/TIME FORMAT	RD8	Date Time Period Format Qualifier
R	03	DATE/TIME PERIOD	CCYYMMDD-CCYYMMDD	SERVICE DATE
S	**HCP**	**LINE PRICING/REPRICING INFORMATION 2300**		
R	01	PRICING METHODOLOGY		Specific code use is determined by Trading Partner Agreement due to the variances in contracting policies in the industry.
R	02	MONETARY AMOUNT		Repriced Allowed Amount
R	03	MONETARY AMOUNT		Repriced Savings Amount
Loop 2410				
S	**LIN**	**DRUG IDENTIFICATION**		
NOT USED	01	ASSIGNED IDENTIFICATION		NOT USED
	02	PRODUCT/SERVICE ID QUALIFIER	N4	National Drug Code Qualifier
	03	PRODUCT/SERVICE ID		National Drug Code
Loop 2420A				
S	**NM1**	**RENDERING PROVIDER NAME**		
R	01	ENTITY IDENTIFIER CODE	82	RENDERING
R	02	ENTITY TYPE QUALIFIER	1	PERSON
R	03	NAME LAST		RENDERING PROVIDER LAST NAME
S	04	NAME FIRST		RENDERING PROVIDER FIRST NAME
S	05	NAME MIDDLE		RENDERING PROVIDER MIDDLE INITIAL

Attribute	Element	ELEMENT DEFINITION	Values	Description
NOT USED	06	NAME PREFIX		NOT USED
S	07	NAME SUFFIX		RENDERING PROVIDER SUFFIX
R	08	IDENTIFICATION CODE QUALIFIER	XX	NATIONAL PROVIDER ID
R	09	IDENTIFICATION CODE		NPI NUMBER
Loop 2430				
S	**SVD**	**LINE ADJUDICATION INFORMATION 2430**		
R	01	IDENTIFICATION CODE		Other Payer Primary Identifier. This number should match NM109 in Loop ID-2330B identifying Other Payer.
R	02	MONETARY AMOUNT		Service Line Paid Amount.
R	03	COMPOSITE MEDICAL PROCEDURE IDENTIFIER		
R	03-1	PRODUCT/SERVICE ID QUALIFIER	HC	Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes
R	03-2	PRODUCT/SERVICE ID		Procedure Code
S	03-3	PROCEDURE MODIFIER		Procedure Modifier 1
S	03-4	PROCEDURE MODIFIER		Procedure Modifier 2
S	03-5	PROCEDURE MODIFIER		Procedure Modifier 3
S	03-6	PROCEDURE MODIFIER		Procedure Modifier 4
S	03-7	DESCRIPTION		Procedure Code Description
NOT USED	04	PRODUCT/SERVICE ID		NOT USED
R	05	QUANTITY		Paid Service Unit Count
S	06	ASSIGNED NUMBER		Bundled or Unbundled Line Number
S	**CAS**	**LINE ADJUDICATION INFORMATION 2430**		
R	01	CLAIM ADJUSTMENT GROUP CODE	PR, CO, CR, OA, PI	If multiple adjustment group codes available the "PR" adjustment group code is required to be the first CAS segment sent.
R	02	CLAIM ADJUSTMENT REASON CODE		Adjustment Reason Code. **CODE SOURCE 139:** Claim Adjustment Reason Code
R	03	MONETARY AMOUNT		Adjusted Amount -Line Level
S	04	QUANTITY		Adjusted Units -Line Level
S	05	CLAIM ADJUSTMENT REASON CODE		Adjustment Reason Code. **CODE SOURCE 139:** Claim Adjustment Reason Code
S	06	MONETARY AMOUNT		Adjusted Amount -Line Level
S	07	QUANTITY		Adjusted Units -Line Level
S	08	CLAIM ADJUSTMENT REASON CODE		Adjustment Reason Code. **CODE SOURCE 139:** Claim Adjustment Reason Code
S	09	MONETARY AMOUNT		Adjusted Amount -Line Level
S	10	QUANTITY		Adjusted Units -Line Level
S	11	CLAIM ADJUSTMENT REASON CODE		Adjustment Reason Code. **CODE SOURCE 139:** Claim Adjustment Reason Code
S	12	MONETARY AMOUNT		Adjusted Amount -Line Level
S	13	QUANTITY		Adjusted Units -Line Level
S	14	CLAIM ADJUSTMENT REASON CODE		Adjustment Reason Code. **CODE SOURCE 139:** Claim Adjustment Reason Code
S	15	MONETARY AMOUNT		Adjusted Amount -Line Level
S	16	QUANTITY		Adjusted Units -Line Level
S	17	CLAIM ADJUSTMENT REASON CODE		Adjustment Reason Code. **CODE SOURCE 139:** Claim Adjustment Reason Code
S	18	MONETARY AMOUNT		Adjusted Amount -Line Level
S	19	QUANTITY		Adjusted Units -Line Level

Attribute	Element	ELEMENT DEFINITION	Values	Description
S	**DTP**	**LINE CHECK OR REMITTANCE DATE**		
R	01	DATE/TIME QUALIFIER	573	Date Claim Paid
R	02	DATE/TIME FORMAT	D8	Date Time Period Format Qualifier
R	03	DATE/TIME PERIOD	CCYYMMDD	Adjudication or Payment Date

9 Appendix

A. Implementation Checklist

The following task list should be completed to facilitate a smooth implementation of the EDI process.

TASK	Responsibility	Date
☐ Establish Standard ISA and GS information	Client & MagnaCare	
☐ Confirm business rules	Client & MagnaCare	
☐ Determine communication method	Client & MagnaCare	
☐ Set up the encryption process	Client & MagnaCare	
☐ Establish a schedule for testing	Client & MagnaCare	
☐ Complete testing	Client & MagnaCare	
☐ Sign off on Companion Guide	Client & MagnaCare	
☐ Production cut-over	Client & MagnaCare	