



Companion Guide: Healthy Indiana Plan 837 Institutional Claims and Encounters Transaction

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Section 1: Introduction

Overview

The Indiana Health Coverage Programs (IHCP) has developed technical companion guides to assist application developers during the implementation process. The information contained in the *IHCP Companion Guide* is only intended to supplement the adopted *National Electronic Data Interchange Transaction Set Implementation Guide* (IG) and provide guidance and clarification as it applies to the IHCP. The *IHCP Companion Guide* is never intended to modify, contradict, or reinterpret the rules established by the IGs.

The *Companion Guide* is categorized into three sections:

1. Introduction to the 837 Institutional
2. Interchange control
3. Transaction specifications

This section, *Introduction*, provides a general description of the 837 Institutional Transaction. *Section 2* describes data exchange options and the relevant inbound and outbound interchange control structures. *Section 3* contains transaction specific documentation, including segment usage, to assist developers with coding each transaction.

Note: All references to the IHCP provider number included in this Companion Guide refer to the Indiana Health Coverage Program legacy provider number.

837 Institutional

The ASC X12N 837 (04010X096) transaction is the Health Information Portability and Accountability Act (HIPAA)-mandated transaction for submitting institutional claims or encounter data. Any claim submitted on a UB04 claim form is submitted electronically using this transaction. This includes the following claim types:

- Inpatient
- Outpatient
- Long term care (LTC)
- Home health
- Inpatient/outpatient crossover

This companion guide is for the 837 Institutional transaction and is not intended to contradict or replace any information in the IG or the *IHCP Provider Manual*. It is highly recommended that the following resources are available during the development process:

- This document, *Companion Guide: 837 Institutional Claims and Encounters Transactions*
- *National Electronic Data Interchange Transaction Set Implementation Guide: Health Care Claim. Institutional: 837: ASC X12N 837 (004010X096) and (004010X096A1) Addenda*
- *IHCP Provider Manual*

In addition to the compliance checking and resulting 997 Acknowledgement file, the IHCP creates a *Biller Summary Report* (BSR) in response to all 837 submissions. This report provides summary

information about the results of pre-adjudication claim and encounter processing. Information on this report lists rejected claims not processed by the system.

The report will also show rejection errors on claims from healthcare providers where the Billing NPI was not submitted, a submitted NPI has not been reported to the IHCP, or the reported NPI cross-walks to multiple IHCP Legacy Provider Identifiers (LPI).

There are several processing assumptions, limitations, and guidelines that a developer must be aware of when implementing the 837I transaction. The following list identifies these processing stipulations:

- The IHCP accepts up to 5000 CLM segments per ST – SE. The IG recommends creating this limitation to avert circumstances where file size management may become an issue.
- It is recommended that Patient Loops, 2000C and 2010CA, not be coded because the IHCP members/subscribers are always the same as the patient. If these loops are present, they do not pass the pre-adjudication edits if the subscriber’s Medicaid Identification (ID) does not match the patient’s Medicaid ID.
- All monetary amounts have explicit decimals. The decimal point always appears in the character stream if the decimal point is at any place other than the right end. If the value is an integer, with the decimal point at the right end, the decimal point should be omitted. See the IG for additional clarification.
- Negative quantities or amounts necessary for the adjudication of the claim are rejected.
- Almost all amounts have been extended to the HIPAA maximum of 99999999.99. An exception is the *Value Code* amounts, which are required to be in the IHCP format of 9999999.99. If the value amounts are not in this format, the claim rejects in the pre-adjudication edits. All other amounts not in the HIPAA format are rejected on 997s due to compliance errors.
- All quantities have pre-adjudication edits. Refer to the appropriate segments for the IHCP formats.
- Other data elements with lengths greater than IHCP definitions are truncated.
- The IHCP is referred to as IHCP in applicable *Receiver* segments.
- The IHCP processes the maximum of 450 service lines or details on the 837I transaction.
- Coordination of benefits (COB) assumptions:
 - Non-Medicare third-party liability (TPL) is only reported at claim level, Medicare is reported at claim or service line level.
 - Encounter claims:
 - Non-managed care organization (MCO) TPL is only reported at claim level.
 - Encounter claims are reports of individual patient encounters with an MCO's health care network that contain fee-for-service (FFS) equivalent detail as to procedures, diagnoses, places of service (POS), billed amounts, and rendering or billing providers. IHCP requires that encounter claims submitted from the MCOs follow the 837 COB format and expect the encounter claim information in the COB Loops of the transaction. Encounter claims are only accepted from MCOs and are rejected from all others.
 - MCOs only send claims that have been paid or denied at the claim and detail level in their system. MCOs exclude claims that have not been finalized in their system.
 - MCOs format the 837 with their payment information in the first iteration of the COB Loops prior to submitting to IHCP.

Electronic Voids and Replacements

Note: If any of the following guidelines are not followed, refer to the BSR for more details.

A Web or electronic data interchange (EDI) replacement request may take up to one business day to process if submitted before 3 p.m. during a normal business day. The primary reason this may occur is that the original claim has already been through a financial.

Encounter Claims

- The MCO ID, provider ID and the state region must be identical on the replacement as it appears on the claim that is being replaced.
- The MCO ID, provider ID, state region and recipient information must be identical on a void as it appears on the claim that is being voided.
- The type of claim on the void or replacement must be the same type on the claim being voided or replaced.
- The void or replacement cannot be older than two years from the dates of service on the claim being voided or replaced.
- The void or replacement request must be done against the most recent occurrence of the bill.
- The void or replacement request must be for an IHCP claim that is found in the database.
- A void cannot be processed against a claim that denied in the IndianaAIM.
- A replacement request cannot be performed against a claim that denied due to a previous void request.

Fee-for-Service Claims

- The provider ID, service location and recipient information must be identical on the void as it appears on the claim that is being voided.
- If a void is submitted with an NPI, that NPI must cross-walk to the same IHCP LPI and service location that appears on the claim being voided.
- The provider ID and service location information must be identical on the replacement as it appears on the claim that is being replaced.
- If a replacement is submitted with an NPI, that NPI must cross-walk to the same IHCP LPI and service location that appears on the claim being replaced.
- The type of claim on the void or replacement must be the same type on the claim being voided or replaced.
- The replacement cannot be older than one year from the last activity that took place on the claim being replaced.
- The void or replacement request must be done against the most recent occurrence of the bill.
- The void or replacement request must be for an IHCP claim that is found in the database.
- A void cannot be processed against a claim that denied in the IndianaAIM system.
- A replacement request cannot be performed against a claim that denied due to a previous void request.

Section 2: Data Exchange Technical Specifications and Interchange Control Structure

Overview

Appendix A, Section A.1.1 of each National Electronic Data Interchange Transaction Set Implementation Guide (ASC X12N~) (IG), the Health Insurance Portability and Accountability Act (HIPAA), provides details about the rules for ensuring integrity and maintaining the efficiency of data exchange. Data files are transmitted in an *electronic envelope*. The communication envelope consists of an interchange envelope and functional groups.

The following table defines the use of the inbound 837I control structure as it relates to communication with the Indiana Health Coverage Programs (IHCP).

Inbound Transactions

Table 2.1 – Interchange Control Header

| Segment Name | Interchange Control Header | | | | | | | | | | | | | | |
|---|--|------------------------|--|-----------|------|-----------|---|----------|------------------------|---|-------|-----------------------|---|-------|--------------------|
| Segment ID | ISA | | | | | | | | | | | | | | |
| Loop ID | N/A | | | | | | | | | | | | | | |
| Usage | Required | | | | | | | | | | | | | | |
| Segment Notes | <p>All positions within each data element in the ISA segment must be filled. Delimiters are specified in the interchange header segment.</p> <p>The character immediately following the segment ID, ISA, defines the data elements separator. The last character in the segment defines the component element separator, and the segment terminator is the byte that immediately follows the component element separator. The following are examples of the separators.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="background-color: #d3d3d3;">Character</th> <th style="background-color: #d3d3d3;">Name</th> <th style="background-color: #d3d3d3;">Delimiter</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">*</td> <td>Asterisk</td> <td>Data Element Separator</td> </tr> <tr> <td style="text-align: center;">:</td> <td>Colon</td> <td>Sub-element Separator</td> </tr> <tr> <td style="text-align: center;">~</td> <td>Tilde</td> <td>Segment Terminator</td> </tr> </tbody> </table> | | | Character | Name | Delimiter | * | Asterisk | Data Element Separator | : | Colon | Sub-element Separator | ~ | Tilde | Segment Terminator |
| Character | Name | Delimiter | | | | | | | | | | | | | |
| * | Asterisk | Data Element Separator | | | | | | | | | | | | | |
| : | Colon | Sub-element Separator | | | | | | | | | | | | | |
| ~ | Tilde | Segment Terminator | | | | | | | | | | | | | |
| While it is not required that submitters use these specific delimiters, they are the ones that the IHCP uses for all outbound transactions. | | | | | | | | | | | | | | | |
| Example | <pre>ISA* 00** 00*.....* ZZ* P123 .* ZZ*IHCP.....* 930602* 1253* U* 00401* 000000905* 1* P* :~</pre> | | | | | | | | | | | | | | |

Table 2.2 – Element ID ISA01-ISA016

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|---|---|
| ISA01 | R | Authorization Information Qualifier 00 – No Authorization Information Present | |
| ISA02 | R | Authorization Information Insert 10 blanks | Always blank. Insert 10 blank spaces. |
| ISA03 | R | Security Information Qualifier 00 – No Security Information Present | |
| ISA04 | R | Security Information Insert 10 blanks | Always blank. Insert 10 blank spaces. |
| ISA05 | R | Interchange ID Qualifier ZZ – Mutually Defined | |
| ISA06 | R | Interchange Sender ID | For batch transactions, this is the four-byte sender ID (four to eight characters) assigned by the IHCP. For interactive transactions, this is the eight-byte assigned terminal ID (IN followed by six digits). This field has a required length of 15 bytes; therefore, the field must be blank filled to the right. |
| ISA07 | R | Interchange ID Qualifier ZZ – Mutually Defined | |
| ISA08 | R | Interchange Receiver ID IHCP | This field has a required length of 15 bytes; therefore, the field must be blank filled to the right. |
| ISA09 | R | Interchange Date | Format: YYMMDD. |
| ISA10 | R | Interchange Time | Format: HHMM. |
| ISA11 | R | Interchange Control Standards Identifier U – U.S. EDI Community of ASC X12, TDCC, and UCS | |
| ISA12 | R | Interchange Control Version Number 00401 – Draft Standards for Trial Use Approved for Publication by ASC X12 Procedures Review Board through October 1997 | |
| ISA13 | R | Interchange Control Number | The interchange control number (ICN) is created by the submitter and must be identical to the associated Interchange Trailer (IEA02). This is a numeric field and must be zero-filled. This number should be unique and the IHCP recommends that it be incremented by one with each ISA segment. |

(Continued)

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|---|---|
| ISA14 | R | Acknowledgment Requested 0 – No acknowledgment requested 1 – Interchange Acknowledgment Requested | The IHCP always creates an acknowledgment file for each file received. |
| ISA15 | R | Usage Indicator P – Production Data T – Test Data | During testing the usage indicator entered must be T . After testing approval, P must be entered for production transactions. |
| ISA16 | R | Component Element Separator | The component element separator is a delimiter and not a data element. This field provides the delimiter used to separate component data elements within a composite data structure; this value must be different than the data element separator and the segment terminator. |

Table 2.3 – Functional Group Header

| Segment Name | Functional Group Header |
|---------------|---|
| Segment ID | GS |
| Loop ID | N/A |
| Usage | Required |
| Segment Notes | |
| Example | GS*HC*P123*IHCP*20020606*105531*5*X*004010X096A1~ |

Table 2.4 – Element ID GS01-GS08

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|---|--|
| GS01 | R | Functional Identifier Code HC – Health Care Claim (837) | Use the appropriate identifier to designate the type of transaction data to follow the GS segment. |
| GS02 | R | Application Sender’s Code | For batch transactions, this is the four-byte sender ID assigned by the IHCP. For interactive transactions, this is the eight-byte assigned terminal ID (IN followed by six digits). |
| GS03 | R | Application Receiver’s Code IHCP | |
| GS04 | R | Date | Format: CCYYMMDD. |
| GS05 | R | Time | Format: HHMMSS |
| GS06 | R | Group Control Number | Assigned number originated and maintained by the sender. This must match the number in the corresponding GE02 data element on the GE group trailer segment. |
| GS07 | R | Responsible Agency Code X – Accredited Standards Committee X12 | |
| GS08 | R | Version/Release/Industry Identifier Code 004010X096A1 – 837I | Use the appropriate identifier to designate the identifier code for the type of transaction data to follow the GS segment. Refer to specific transaction IG for proper value. |

Table 2.5 – Functional Group Trailer

| Segment Name | Functional Group Trailer |
|---------------|--------------------------|
| Segment ID | GE |
| Loop ID | N/A |
| Usage | Required |
| Segment Notes | |
| Example | GE*1*5~ |

Table 2.6 – Element ID GE01-GE02

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|-------------------------------------|---|
| GE01 | R | Number of Transaction Sets Included | Use the number of transaction sets included in this functional group. |
| GE02 | R | Group Control Number | Group control number GE02 in this trailer must be identical to the same data element in the associated functional group header, GS06. |

Table 2.7 – Interchange Control Trailer

| Segment Name | Interchange Control Trailer |
|---------------|-----------------------------|
| Segment ID | IEA |
| Loop ID | N/A |
| Usage | Required |
| Segment Notes | |
| Example | IEA*1*000000905~ |

Table 2.8 – Element ID IEA01-IEA02

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|--------------------------------------|--|
| IEA01 | R | Number of Included Functional Groups | Use the number of functional groups included in this interchange envelope. |
| IEA02 | R | Interchange Control Number | Interchange control number (ICN) IEA02 in this trailer must be identical to the same data element in the associated interchange control header, ISA13, including padded zeros. |

Sample Inbound Interchange Control

```
ISA* 00* .....* 00*.....* ZZ* P123    ..* ZZ*IHCP.....* 930602*
1253* U* 00401* 000000905* 1* P* :~
GS*HS*P123*IHCP*20020606*105531*5*X*004010X092A1~
ST - 270 TRANSACTION SET HEADER
DETAIL SEGMENTS
SE - 270 TRANSACTION SET TRAILER
GE*1*5~
GS*HC*P123*IHCP*20020606*105531*5*X*004010X096A1~
ST - 837 TRANSACTION SET HEADER
DETAIL SEGMENTS
SE - 837 TRANSACTION SET TRAILER
GE*1*5~
IEA*2*000000905~
```

Figure 2.1 – Inbound Interchange Control, 270 and 837I Transactions

Section 3: Institutional Claims and Encounters

Segment Usage – 837 Institutional

The following matrix lists all segments available for submission using the 4010 version of the *National Electronic Data Interchange Transaction Set Implementation Guide: Health Care Claim: Institutional: 837: ASC X12N 837 (004010X096) and (004010X096A1) Addenda*. It includes a *Usage* column identifying segments that are required (**R**), situational (**S**), or not used (**N/A**) by the Indiana Health Coverage Programs (IHCP). A required segment element must appear on all transactions. Failure to include a required segment results in a compliance error. A situational segment is not required on every type of transaction; however, a situational segment may be required under certain circumstances. Any data in a segment identified in the *Usage* column with an **X** is ignored by the IHCP. Any segment identified in the *Usage* column as required, or situational, is explained in detail in this section. Any element identified as, *Not Used by the IHCP*, is not required for processing by the IHCP.

Refer to the *IHCP Provider Manual* for specific billing requirements.

Table 3.1 –Segment Usage

| Segment ID | Loop ID | Segment Name | IHCP Usage R –Required S- Situational X – Not Used |
|------------|---------|---|---|
| ST | N/A | Transaction Set Header | R |
| BHT | N/A | Beginning of Hierarchical Transaction | R |
| REF | N/A | Transmission Type Identification | R |
| NM1 | 1000A | Submitter Name | R |
| PER | 1000A | Submitter Electronic Data Interchange (EDI) Contact Information | R |
| NM1 | 1000B | Receiver Name | R |
| HL | 2000A | Billing/Pay-To Hierarchical Level (HL) | R |
| PRV | 2000A | Billing/Pay-To Specialty Information | S |
| CUR | 2000A | Foreign Currency Information | X |
| NM1 | 2010AA | Billing Provider Name | R |
| N3 | 2010AA | Billing Provider Address | R |
| N4 | 2010AA | Billing Provider City/State/ZIP Code | R |
| REF | 2010AA | Billing Provider Secondary Information | R |
| REF | 2010AA | Credit/Debit Card Billing Information | X |
| PER | 2010AA | Billing Provider Contact Information | X |
| NM1 | 2010AB | Pay-to Provider Name | X |
| N3 | 2010AB | Pay-to Provider Address | X |
| N4 | 2010AB | Pay-to Provider City/State/ZIP Code | X |
| REF | 2010AB | Pay-to Provider Secondary Information | X |

| Segment ID | Loop ID | Segment Name | IHCP Usage R – Required S- Situational X – Not Used |
|------------|---------|---------------------------------------|--|
| HL | 2000B | Subscriber Hierarchical Level | R |
| SBR | 2000B | Subscriber Information | R |
| PAT | 2000B | Patient Information | X – deleted per <i>Addenda</i> |
| NM1 | 2010BA | Subscriber Name | R |
| N3 | 2010BA | Subscriber Address | R |
| N4 | 2010BA | Subscriber City/State/ZIP Code | R |
| DMG | 2010BA | Subscriber Demographic Information | R |
| REF | 2010BA | Subscriber Secondary Information | X |
| REF | 2010BA | Property and Casualty Claim Number | X |
| NM1 | 2010BB | Credit/Debit Card Account Holder Name | X |
| REF | 2010BB | Credit/Debit Card Information | X |
| NM1 | 2010BC | Payer Name | R |
| N3 | 2010BC | Payer Address | X |
| N4 | 2010BC | Payer City/State/ZIP Code | X |
| REF | 2010BC | Payer Secondary Information | X |
| NM1 | 2010BD | Responsible Party Name | X |
| N3 | 2010BD | Responsible Party Address | X |
| N4 | 2010BD | Responsible Party City/State/ZIP Code | X |
| HL | 2000C | Patient Hierarchical Level | S |
| PAT | 2000C | Patient Information | S |
| NM1 | 2010CA | Patient Name | S |
| N3 | 2010CA | Patient Address | S |
| N4 | 2010CA | Patient City/State/ZIP Code | S |
| DMG | 2010CA | Patient Demographic Information | S |
| REF | 2010CA | Patient Secondary Information Number | S |
| REF | 2010CA | Property and Casualty Claim Number | S |
| CLM | 2300 | Claim Information | R |
| DTP | 2300 | Discharge Hour | X |
| DTP | 2300 | Statement Dates | R |
| DTP | 2300 | Admission Date/Hour | S |
| CL1 | 2300 | Institutional Claim Code | S |
| PWK | 2300 | Claim Supplemental Information | S |
| CN1 | 2300 | Contract Information | S |
| AMT | 2300 | Payer Estimated Amount Due | R |
| AMT | 2300 | Patient Estimated Amount Due | X |
| AMT | 2300 | Patient Paid Amount | S |

| Segment ID | Loop ID | Segment Name | IHCP Usage R – Required S- Situational X – Not Used |
|------------|---------|--|--|
| AMT | 2300 | Credit/Debit Card Maximum Amount | X |
| REF | 2300 | Adjusted Repriced Claim Number | X |
| REF | 2300 | Repriced Claim Number | X |
| REF | 2300 | Claim Identification Number for Clearinghouses and Other Transmission Intermediaries | X |
| REF | 2300 | Document Identification Code | X |
| REF | 2300 | Original Reference Number (ICN/DCN) | S |
| REF | 2300 | Investigational Device Exemption Number | X |
| REF | 2300 | Service Authorization Exception Code | X |
| REF | 2300 | Peer Review Organization (PRO) Approval Number | X |
| REF | 2300 | Prior Authorization or Referral Number | S |
| REF | 2300 | Medical Record Number | S |
| REF | 2300 | Demonstration Project Identifier | X |
| K3 | 2300 | File Information | S |
| NTE | 2300 | Claim Note | S |
| NTE | 2300 | Billing Note | X |
| CR6 | 2300 | Home Health Care Information | X |
| CRC | 2300 | Home Health Functional Liabilities | X |
| CRC | 2300 | Home Health Activities Permitted | X |
| CRC | 2300 | Home Health Mental Status | X |
| HI | 2300 | Principal, Admitting, E-code, and Patient Reason for Visit Diagnosis Information | R |
| HI | 2300 | Diagnosis Related Group (DRG) Information | X |
| HI | 2300 | Other Diagnosis Information | S |
| HI | 2300 | Principal Procedure Information | S |
| HI | 2300 | Other Procedure Information | S |
| HI | 2300 | Occurrence Span Information | S |
| HI | 2300 | Occurrence Information | S |
| HI | 2300 | Value Information | S |
| HI | 2300 | Condition Information | S |
| HI | 2300 | Treatment Code Information | X |
| QTY | 2300 | Claim Quantity | S |
| HCP | 2300 | Claim Pricing/Repricing Information | X |
| CR7 | 2305 | Home Health Care Plan Information | X |
| HSD | 2305 | Home Care Services Delivery | X |
| NM1 | 2310A | Attending Physician Name | S |

| Segment ID | Loop ID | Segment Name | IHCP Usage R – Required S- Situational X – Not Used |
|------------|---------|--|--|
| PRV | 2310A | Attending Physician Specialty Information | S |
| REF | 2310A | Attending Physician Secondary Information | X |
| NM1 | 2310B | Operating Physician Name | S |
| PRV | 2310B | Operating Physician Specialty Information | X – deleted per <i>Addenda</i> |
| REF | 2310B | Operating Physician Secondary Information | X |
| NM1 | 2310C | Other Provider Name | S |
| PRV | 2310C | Other Provider Specialty Information | X – deleted per <i>Addenda</i> |
| REF | 2310C | Other Provider Secondary Information | X |
| NM1 | 2310D | Referring Provider Name | X – deleted per <i>Addenda</i> |
| PRV | 2310D | Referring Provider Specialty Information | X – deleted per <i>Addenda</i> |
| REF | 2310D | Referring Provider Secondary Information | X – deleted per <i>Addenda</i> |
| NM1 | 2310E | Service Facility Name | X |
| PRV | 2310E | Service Facility Specialty Information | X – deleted per <i>Addenda</i> |
| N3 | 2310E | Service Facility Address | X |
| N4 | 2310E | Service Facility City/State/ZIP Code | X |
| REF | 2310E | Service Facility Secondary Information | X |
| SBR | 2320 | Other Subscriber Information | S |
| CAS | 2320 | Claim Level Adjustment | S |
| AMT | 2320 | Payer Prior Payment | S |
| AMT | 2320 | Coordination of Benefits (COB) Total Allowed Amount | S |
| AMT | 2320 | Coordination of Benefits (COB) Total Submitted Charges | X |
| AMT | 2320 | Diagnosis Related Group (DRG) Outlier Amount | X |
| AMT | 2320 | Coordination of Benefits (COB) Total Medicare Paid Amount | S |
| AMT | 2320 | Medicare Paid Amount – 100 percent | X |
| AMT | 2320 | Medicare Paid Amount – 80 percent | X |
| AMT | 2320 | Coordination of Benefits (COB) Medicare A Trust Fund Paid Amount | X |
| AMT | 2320 | Coordination of Benefits (COB) Medicare B Trust Fund Paid Amount | X |
| AMT | 2320 | Coordination of Benefits (COB) Total Non-covered Amount | X |
| AMT | 2320 | Coordination of Benefits (COB) Total Denied Amount | S |
| DMG | 2320 | Other Subscriber Demographic Information | S |
| OI | 2320 | Other Insurance Coverage Information | X |
| MIA | 2320 | Medicare Inpatient Adjudication Information | X |
| MOA | 2320 | Medicare Outpatient Adjudication Information | X |

| Segment ID | Loop ID | Segment Name | IHCP Usage R – Required S- Situational X – Not Used |
|------------|---------|---|--|
| NM1 | 2330A | Other Subscriber Name | S |
| N3 | 2330A | Other Subscriber Address | S |
| N4 | 2330A | Other Subscriber City/State/ZIP Code | S |
| REF | 2330A | Other Subscriber Secondary Information | S |
| NM1 | 2330B | Other Payer Name | S |
| N3 | 2330B | Other Payer Address | S |
| N4 | 2330B | Other Payer City/State/ZIP Code | S |
| DTP | 2330B | Claim Adjudication Date | S |
| REF | 2330B | Other Payer Secondary Identification and Reference Number | S |
| REF | 2330B | Other Payer Prior Authorization or Referral Number | S |
| NM1 | 2330C | Other Payer Patient Information | S |
| REF | 2330C | Other Payer Patient Identification Number | S |
| NM1 | 2330D | Other Payer Attending Provider | X |
| REF | 2330D | Other Payer Attending Provider Identification | X |
| NM1 | 2330E | Other Payer Operating Provider | X |
| REF | 2330E | Other Payer Operating Provider Identification | X |
| NM1 | 2330F | Other Payer Other Provider | X |
| REF | 2330F | Other Payer Other Provider Identification | X |
| NM1 | 2330G | Other Payer Referring Provider | X |
| REF | 2330G | Other Payer Referring Provider Identification | X |
| NM1 | 2330H | Other Payer Service Facility Provider | X |
| REF | 2330H | Other Payer Service Facility Provider Identification | X |
| LX | 2400 | Service Line Number | R |
| SV2 | 2400 | Institutional Service Line | R |
| SV4 | 2400 | Prescription Number | X – deleted per <i>Addenda</i> |
| PWK | 2400 | Line Supplemental Information | S |
| DTP | 2400 | Service Line Date | S |
| STP | 2400 | Assessment Date | X |
| AMT | 2400 | Service Tax Amount | X |
| AMT | 2400 | Facility Tax Amount | X |
| LIN | 2410 | Drug Identification – New segment per <i>Addenda</i> | S |
| CTP | 2410 | Drug Pricing – New segment per <i>Addenda</i> | S |
| REF | 2410 | Prescription Number | X |
| NM1 | 2420A | Attending Physician Name | X |
| PRV | 2420A | Attending Physician Specialty Information | X – deleted per <i>Addenda</i> |

| Segment ID | Loop ID | Segment Name | IHCP Usage R – Required S- Situational X – Not Used |
|------------|---------|---|--|
| REF | 2420A | Attending Physician Secondary Information | X |
| NM1 | 2420B | Operating Physician Name | X |
| PRV | 2420B | Operating Physician Specialty Information | X – deleted per <i>Addenda</i> |
| REF | 2420B | Operating Physician Secondary Information | X |
| NM1 | 2420C | Other Provider Name | X |
| PRV | 2420C | Other Provider Specialty Information | X – deleted per <i>Addenda</i> |
| REF | 2420C | Other Provider Secondary Information | X |
| NM1 | 2420D | Referring Provider Name | X – deleted per <i>Addenda</i> |
| PRV | 2420D | Referring Provider Specialty Information | X – deleted per <i>Addenda</i> |
| REF | 2420D | Referring Provider Secondary Information | X – deleted per <i>Addenda</i> |
| SVD | 2430 | Service Line Adjudication Information | S |

Segment and Data Element Description

This section contains tables representing segments required or situational for the Indiana Health Information Portability and Accountability Act (HIPAA) implementation of the 837I. Each segment table contains rows and columns describing different segment elements.

Table 3.2 – Segment and Data Element Description

| Segment/Data Element | Description |
|------------------------------------|--|
| Segment Name | The industry-assigned segment name identified in the IG. |
| Segment ID | The industry-assigned segment ID identified in the IG. |
| Loop ID | The loop where the segment should appear. |
| Usage | This identifies the segment as required or situational. |
| Segment Notes | A brief description of the purpose or use of the segment. |
| Example | An example of complete segment. |
| Element ID | The industry-assigned segment ID as identified in the IG. |
| Usage | Identifies the data element as R -required, S -situational, or X -not used based on the IHCP guidelines. |
| Guide Description and Valid Values | Industry name associated with the data element. If no industry name exists, this is the IG data element name. This column also lists in BOLD the values and code sets to use. |
| Comments | Description of the contents of the data elements, including field lengths. |

Table 3.3 – Transaction Set Header

| Segment Name | Transaction Set Header |
|---------------|--------------------------------------|
| Segment ID | ST |
| Loop ID | N/A |
| Usage | Required |
| Segment Notes | This segment begins the transaction. |
| Example | ST*837*7656543~ |

Table 3.4 – Element ID ST01-ST02

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|---|---|
| ST01 | R | Transaction Set Identifier Code 837 | |
| ST02 | R | Transaction Set Control Number | This number is assigned locally by the sender and should match the value in the corresponding SE segment. |

Table 3.5 – Beginning of Hierarchical Transaction

| Segment Name | Beginning of Hierarchical Transaction |
|---------------|---|
| Segment ID | BHT |
| Loop ID | N/A |
| Usage | Required |
| Segment Notes | This segment provides the bill date and indicator to determine whether the claim submitted is a fee for service or encounter claim. |
| Example | BHT*0019*00*X2FF1*20020901*1230*CH~ |

Table 3.6 – Element ID BHT01-BHT06

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|---|--|
| BHT01 | R | Hierarchical Structure Code 0019 – Information Source | |
| BHT02 | R | Transaction Set Purpose Code 00 – Original 19 – Reissue | See the IG for specific usage. This field has no affect on the processing of this transaction. |
| BHT03 | R | Originator Application Transaction Identifier | This value is assigned by the sender. Not used by the IHCP. |
| BHT04 | R | Transaction Set Creation Date | Format: CCYYMMDD. This is the bill date for all claims that follow. |
| BHT05 | R | Transaction Set Creation Time | Not used by the IHCP |

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|--|--|
| BHT06 | R | Claim or Encounter Identifier CH – Chargeable RP – Reporting | Use CH for fee-for-service (FFS) claims. Use RP for encounter claims. |

Table 3.7 – Transaction Type Identification

| Segment Name | Transaction Type Identification |
|---------------|--|
| Segment ID | REF |
| Loop ID | N/A |
| Usage | Required |
| Segment Notes | This segment identifies the X12N version and the production versus test status of the transaction. |
| Example | REF*87*004010X096A1~ |

Table 3.8 – Element ID REF01 – REF02

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|---|---|
| REF01 | R | Reference Identification Qualifier 87 – Functional Category | |
| REF02 | R | Transmission Type Code 004010X096A1 – Production 004010X096DA1 – Test | This value assumes the 4010 implementation version. Contents of this field must be updated with subsequent version upgrades as they are named. The ISA segment determines submission is for production or test. While this data element must be submitted to be complaint, the value here is ignored by the IHCP. |

Table 3.9 – Submitter Name

| Segment Name | Submitter Name |
|---------------|--|
| Segment ID | NM1 |
| Loop ID | 1000A |
| Usage | Required |
| Segment Notes | This segment identifies the submitter and must include the IHCP-assigned sender ID ETIN. |
| Example | NM1*41*2*Clearinghouse Inc.*****46*A23I~ |

Table 3.10 – Element ID NM101-NM111

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|--|---|
| NM101 | R | Entity Identifier Code 41 – Submitter | |
| NM102 | R | Entity Type Qualifier 1 – Person 2 – Non-Person Entity | |
| NM103 | R | Submitter Last Name or Organization Name | |
| NM104 | S | Submitter First Name | |
| NM105 | S | Submitter Middle Name | |
| NM106 | N/A | Name Prefix | Not used |
| NM107 | N/A | Name Suffix | Not used |
| NM108 | R | Identification Code Qualifier 46 – ETIN | |
| NM109 | R | Submitter Identifier | Use the sender ID assigned by EDS Electronic Solutions. |
| NM110 | N/A | Entity Relationship Code | Not used |
| NM111 | N/A | Entity Identifier Code | Not used |

Table 3.11 – Submitter EDI Contact Information

| Segment Name | Submitter EDI Contact Information |
|---------------|--|
| Segment ID | PER |
| Loop ID | 1000A |
| Usage | Required |
| Segment Notes | This segment is required by the IG and must be submitted to be compliant; however, data submitted is not captured by the IHCP. See the IG for details. |

Table 3.12 – Receiver Name

| Segment Name | Receiver Name |
|---------------|--|
| Segment ID | NM1 |
| Loop ID | 1000B |
| Usage | Required |
| Segment Notes | This segment is required by the IG and must be submitted to be compliant; however, data submitted is not captured by the IHCP. See the IG for details. |

Table 3.13 – Billing/Pay-to-Provider Hierarchical Level

| Segment Name | Billing/Pay-to Provider Hierarchical Level |
|---------------|--|
| Segment ID | HL |
| Loop ID | 2000A |
| Usage | Required |
| Segment Notes | This segment and following billing/pay-to provider loops must repeat for every billing provider submitting claims. |
| Example | HL*1**20*1~ |

Table 3.14 – Element ID HL01-HL04

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|---|----------|
| HL01 | R | Hierarchical ID Number 1 | |
| HL02 | N/A | Hierarchical Parent ID Number | Not used |
| HL03 | R | Hierarchical Level Code 20 – Information Source | |
| HL04 | R | Hierarchical Child Code 1 | |

Table 3.15 – Billing/Pay-to Provider Specialty Information

| Segment Name | Billing/Pay-to Provider Specialty Information |
|---------------|---|
| Segment ID | PRV |
| Loop ID | 2000A |
| Usage | Situational |
| Segment Notes | This segment provides the taxonomy code of the billing provider. The taxonomy code entered may be needed for a successful NPI to Legacy Provider Identifier (LPI) crosswalk. The crosswalk must successfully identify a unique billing provider for the claim to be accepted. Segment usage changed from Required to Situational per the Addenda. |
| Example | PRV*BI*ZZ*404FX0500D~ |

Table 3.16 – Element ID PRV01-PRV06

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|--|--|
| PRV01 | S | Provider Code BI – Billing | |
| PRV02 | S | Reference Identification Qualifier ZZ – Mutually Defined | |
| PRV03 | S | Provider Taxonomy Code | Use the taxonomy code of the billing provider. |
| PRV04 | N/A | | Not used |
| PRV05 | N/A | | Not used |
| PRV06 | N/A | | Not used |

Table 3.17 – Billing Provider Name

| Segment Name | Billing Provider Name |
|----------------------|---|
| Segment ID | NM1 |
| Loop ID | 2010AA |
| Usage | Required |
| Segment Notes | <p>This segment is required by the IG and must be submitted to be compliant. See the IG for details.</p> <p>This segment contains the National Provider Identifier (NPI) information. If the NPI is used in the NM108/NM109 of this loop, then either the Employer’s Identification Number or the Social Security Number (SSN) of the provider must be carried in the Billing Provider Secondary Identification segment (REF). However, the IHCP will continue to use the Tax ID or SSN on file for the IHCP billing LPI and will ignore the Tax ID or SSN submitted.</p> <p>Only atypical providers may submit the EIN or SSN in this segment.</p> <p>The NPI will be returned on the Biller Summary Report (BSR) and the 835 transaction.</p> |
| Example | <p>Segment with NPI:</p> <p>NM1*85*2*JONES HOSPITAL****XX*1234567890~</p> |

Table 3.18 – Element ID NM101-NM111

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|--|---|
| NM101 | R | Entity Identifier Code 85 – Billing Provider | |
| NM102 | R | Entity Type Qualifier 2 – Non-Person Entity | |
| NM103 | R | Name Last or Organization Name | |
| NM104 | N/A | Name First | Not used |
| NM105 | N/A | Name Middle | Not used |
| NM106 | N/A | Name Prefix | Not used |
| NM107 | N/A | Name Suffix | Not used |
| NM108 | R | Identification Code Qualifier XX – NPI 24 – Employer’s Identification Number 34 – Social Security Number | XX - NPI required for healthcare providers. Either the Employer’s Identification Number or the SSN of the provider must be carried in the REF segment in this loop. Atypical, non-healthcare providers may continue to send either their EIN or SSN |
| NM109 | R | Identification Code | If XX is sent in NM108, enter the 10-digit NPI. If 24 or 34 is sent, enter the nine digit number |
| NM110 | N/A | Entity Relationship Code | Not used |
| NM111 | N/A | Entity Identifier Code | Not used |

Table 3.19 – Billing Provider Address

| Segment Name | Billing Provider Address |
|---------------|--|
| Segment ID | N3 |
| Loop ID | 2010AA |
| Usage | Required |
| Segment Notes | This segment is required by the IG and must be submitted to be compliant; however, data submitted is not captured by the IHCP. |

Table 3.20 – Billing Provider City/State/ZIP Code

| Segment Name | Billing Provider City/State/ZIP Code |
|---------------|---|
| Segment ID | N4 |
| Loop ID | 2010AA |
| Usage | Required |
| Segment Notes | This segment is required by the IG and must be submitted to be compliant. See the IG for details. This is the Billing Provider's Office Location City, State, and ZIP Code. The ZIP Code +4 may be needed for a successful NPI to Legacy Provider Identifier (LPI) crosswalk. The crosswalk must successfully identify a unique billing provider in order for the claim to be accepted. |

Table 3.21 – Element Id N401-N403

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|------------------------------------|--|
| N401 | R | Billing Provider City | Billing Provider's Office Location City |
| N402 | R | Billing Provider State | Billing Provider's Office Location two character State |
| N403 | R | Billing Provider ZIP Code | Billing Provider's Office Location nine-digit ZIP Code |

Table 3.22 – Billing Provider Secondary Identification

| Segment Name | Billing Provider Secondary Identification |
|---------------|---|
| Segment ID | REF |
| Loop ID | 2010AA |
| Usage | Required |
| Segment Notes | <p>This segment is used for multiple purposes. The primary usage is to submit the Employer's Identification Number or the SSN when XX-NPI is used in the Billing Provider Name segment (NM108-109) of this loop. The IHCP billing provider LPI and service location, can be submitted in a repeat of this segment when submitting claims to the IHCP for an atypical provider.</p> <p>Managed care organizations (MCOs) submitting encounter claims must include their MCO ID and location code in a repeat of this segment.</p> <p>When submitting atypical provider claims to Medicare that are expected to crossover to the IHCP, the IHCP LPI and service location with the 1D qualifier can be included in a repeat of this segment along with submitting the Medicare provider number with the IC qualifier. Medicare will automatically crossover the claim with both the Medicare and the IHCP provider numbers to the IHCP. Failure to submit the IHCP LPI and service location when submitting to Medicare could result in claim denial by the IHCP. The denied claim may not be reported to the provider if the Medicaid provider number is missing.</p> |
| Examples | <p>Claims submitted by atypical providers to the IHCP: REF*1D*100999250A~</p> |
| | <p>Claims containing NPI submitted by provider to the IHCP: REF*EI*675438789~</p> |
| | <p>Encounter claims submitted by MCO: REF*B3*2008889902~</p> |
| | <p>Claims submitted by atypical providers to Medicare, expecting to crossover to the IHCP: REF*1C*236450~ REF*1D*100999250A~</p> |

Table 3.23 – Element ID REF01-REF04

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|--|---|
| REF01 | R | Reference Identification Qualifier ID – Medicaid Provider Number B3 – Preferred Provider Organization Number EI – Employer’s Identification Number SY – Social Security Number | B3 is used only by MCOs. EI or SY must be used when the 10-digit NPI is sent in the Billing Provider Name segment of this loop. An additional 2010AA REF segment should be sent with the ID qualifier and IHCP LPI/service location for atypical providers |
| REF02 | R | Billing Provider Additional Identifier | When sending the <i>ID</i> qualifier, use the 10-digit IHCP provider number (nine numeric plus one alpha location code). When sending the <i>B3</i> qualifier, use the MCO ID (nine numeric plus one alpha region code). Invalid IHCP provider numbers and MCO IDs are rejected and reported on the BSR. When sending the <i>EI</i> qualifier, use the Employer Identification Number used on the 1099. When sending the <i>SY</i> qualifier, use the SSN used on the 1099. |
| REF03 | N/A | Description | Not used |
| REF04 | N/A | Reference Identifier | Not used |

Table 3.24 – Subscriber Hierarchical Level

| Segment Name | Subscriber Hierarchical Level |
|---------------|--|
| Segment ID | HL |
| Loop ID | 2000B |
| Usage | Required |
| Segment Notes | This segment and following subscriber loops must repeat for every subscriber claim submitted. This Includes claims for IHCP members and HCI. See the IG for additional information about creating HL segments. |
| Example | HL*2*1*22*0~ |

Table 3.25 – Element ID HL01-HL04

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|--|---|
| HL01 | R | Hierarchical ID Number | The number increments by one for each member regardless of program eligibility. |
| HL02 | R | Hierarchical Parent ID Number | This HL segment is always subordinate to the Billing Pay-to Provider HL. The value in this field must match the Billing/Pay-to Provider Hierarchical ID number. |
| HL03 | R | Hierarchical Level Code 22 – Subscriber | |
| HL04 | R | Hierarchical Child Code 0 – No Subordinate HL Segments in This Hierarchical Structure | Because the member is always the patient, there should be no subordinate HLs to this HL segment. |

Table 3.26 – Subscriber Information

| Segment Name | Subscriber Information |
|---------------|---|
| Segment ID | SBR |
| Loop ID | 2000B |
| Usage | Required |
| Segment Notes | This segment identifies the intended payer of this claim. Valid payers include Medicaid, the IHCP, and HCI. |
| Example | SBR*T*18*****MC~ |

Table 3.27 – Element ID SBR01-SBR09

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|--|---|
| SBR01 | R | Payer Responsibility Sequence Number Code T – Tertiary P – Primary | This data element is not captured by the IHCP for processing; however, it is recommended that submitters use T for Medicaid claims, as the IHCP is traditionally the payer of last resort. For HCI claims, P for Primary payer is recommended. |
| SBR02 | R | Patients Relationship to Insured 18 – Self | Not used by the IHCP; however, required for compliance. |
| SBR03 | S | Insured Group or Policy Number | Not used by the IHCP |
| SBR04 | S | Insured Group Name | Not used by the IHCP |
| SBR05 | N/A | Insurance Type Code | Not used |
| SBR06 | N/A | Coordination of Benefits Code | Not used |
| SBR07 | N/A | Yes/No Condition or Response Code | Not used |
| SBR08 | N/A | Employment Status Code | Not used |
| SBR09 | R | Claim Filing Indicator Code MC – Medicaid | Not used by the IHCP; however, required for compliance. |

Table 3.28 – Subscriber Name

| Segment Name | Subscriber Name |
|---------------|---|
| Segment Name | NM1 |
| Loop ID | 2010BA – Subscriber Name |
| Usage | Required |
| Segment Notes | This segment contains the IHCP member name and ID number. For HCI claims, it contains the recipient's name and SSN. |
| Example | NM1*IL*1*DOE*JOE*X***MI*123456989999~ |

Table 3.29 – Element ID NM101-NM111

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|---|--|
| NM101 | R | Entity Identifier Code IL – Insured or Subscriber | |
| NM102 | R | Entity Type Qualifier 1 – Person | |
| NM103 | R | Subscriber's Last Name | Use the last name of the IHCP member. |
| NM104 | R | Subscriber's First Name | Use the first name of the IHCP member. |
| NM105 | S | Subscriber's Middle Initial | Not used by the IHCP |
| NM106 | N/A | Name Prefix | Not used |
| NM107 | S | Subscriber Name Suffix | Not used by the IHCP |
| NM108 | R | Identification Code Qualifier MI – Member Identification Number ZZ – Mutually Defined | IHCP claims are coded with MI . HCI claims are coded with ZZ . |
| NM109 | R | Subscriber Primary Identifier | Use the 12-digit IHCP member ID for Medicaid claims. For HCI claims, use the nine-digit recipient's SSN. Do not format the SSN with dashes. |
| NM110 | N/A | Entity Relationship Code | Not used |
| NM111 | N/A | Entity Identifier Code | Not used |

Table 3.30 – Subscriber Address

| Segment Name | Subscriber Address |
|---------------|--|
| Segment ID | N3 |
| Loop ID | 2010BA – Subscriber Name |
| Usage | Required |
| Segment Notes | This segment is required by the IG and must be submitted to be compliant; however, data submitted is not captured by the IHCP. See the IG for details. |

Table 3.31 – Subscriber City/State/ZIP Code

| Segment Name | Subscriber City/State/ZIP Code |
|---------------|--|
| Segment ID | N4 |
| Loop ID | 2010BA – Subscriber Name |
| Usage | Required |
| Segment Notes | This segment is required by the IG and must be submitted to be compliant; however, data submitted is not captured by the IHCP. See the IG for details. |

Table 3.32 – Subscriber Demographic Information

| Segment Name | Subscriber Demographic Information |
|---------------|---|
| Segment ID | DMG |
| Loop ID | 2010BA – Subscriber Name |
| Usage | Required |
| Segment Notes | This segment is required by the IG and must be submitted to be compliant. Data submitted is not captured by the IHCP for Medicaid claims. For HCI inpatient claims, the recipient's gender and birth date are required for inpatient claim pricing. |
| Example | DMG*D8*19430706*M~ |

Table 3.33 – Element ID DMG01-DMG03

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|--|----------|
| DMG01 | R | Date/Time Period Format Qualifier D8 —Date Expressed in format CCYYMMDD | |
| DMG02 | R | Date/Time Period | |
| DMG03 | R | Gender Code | |

Table 3.34 – Payer Name

| Segment Name | Payer Name |
|---------------|--|
| Segment ID | NM1 |
| Loop ID | 2010BC |
| Usage | Required |
| Segment Notes | This segment identifies EDS as the destination payer for Medicaid claims and HCI for HCI claims. |
| Example | NM1*PR*2*EDS*****PI*EDS~ |

Table 3.35 – Element ID NM101-NM111

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|---|---|
| NM101 | R | Entity Identifier Code PR – Payer | |
| NM102 | R | Entity Type Qualifier 2 – Non-Person Entity | |
| NM103 | R | Payer Name EDS HCI | |
| NM104 | N/A | Name First | Not used |
| NM105 | N/A | Name Middle | Not used |
| NM106 | N/A | Name Last | Not used |
| NM107 | N/A | Name Suffix | Not used |
| NM108 | R | Identification Code Qualifier PI | |
| NM109 | R | Payer Identifier EDS HCI | Use EDS for IHCP claims. Use HCI for HCI claims. |
| NM110 | N/A | Entity Relationship Code | Not used |
| NM111 | N/A | Entity Identifier Code | Not used |

Table 3.36 – Patient Hierarchical Level

| Segment Name | Patient Hierarchical Level |
|---------------|---|
| Segment ID | HL |
| Loop ID | 2000C |
| Usage | Situational |
| Segment Notes | The IG requires this segment if the 2000C Loop is used and must be submitted to be compliant. Data submitted is not captured by the IHCP. See the IG for details. |

Table 3.37 – Patient Information

| Segment Name | Patient Information |
|---------------|---|
| Segment ID | PAT |
| Loop ID | 2000C – Patient Information |
| Usage | Situational |
| Segment Notes | The IG requires this segment if the 2000C Loop is used and must be submitted to be compliant. Data submitted is not captured by the IHCP. See the IG for details. |

Table 3.38 – Patient Name

| Segment Name | Patient Name |
|---------------|--|
| Segment Name | NM1 |
| Loop ID | 2010CA – Patient Name |
| Usage | Situational |
| Segment Notes | The IG requires this segment if the 2000C Loop is used and must be submitted to be compliant. It is not recommended that a patient loop be coded for the IHCP claims. However, if it is coded, the NM109 of the subscriber must equal the NM109 of the patient or the claim rejects in the pre-adjudication reports. |
| Example | NM1*QC*1*DOE*JOE*X***MI*123456989999~ |

Table 3.39 – Element ID NM101-NM111

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|---|--|
| NM101 | R | Entity Identifier Code QC – Patient | |
| NM102 | R | Entity Type Qualifier 1 – Person | |
| NM103 | R | Subscriber's Last Name | Not used by the IHCP |
| NM104 | R | Subscriber's First Name | Not used by the IHCP |
| NM105 | S | Subscriber's Middle Initial | Not used by the IHCP |
| NM106 | N/A | Name Prefix | Not used |
| NM107 | S | Subscriber Name Suffix | Not used by the IHCP |
| NM108 | R | Identification Code Qualifier MI – Member Identification Number ZZ – Mutually Defined | IHCP claims are coded with MI . HCI claims are coded with ZZ . |
| NM109 | R | Subscriber Primary Identifier | If this segment is coded, the 12-digit IHCP member ID for of the patient must match the ID submitted in the 2010BA Loop. For HCI claims, use the nine-digit recipient's SSN. Do not format the SSN with dashes. |
| NM110 | N/A | Entity Relationship Code | Not used |
| NM111 | N/A | Entity Identifier Code | Not used |

Table 3.40 – Patient Address

| Segment Name | Patient Address |
|---------------|--|
| Segment ID | N3 |
| Loop ID | 2010CA – Patient Address |
| Usage | Patient |
| Segment Notes | The IG requires this segment if the 2010CA Loop is used and must be submitted to be compliant. Data submitted is not captured by the IHCP. See the IG for details. |

Table 3.41 – Patient City/State/ZIP Code

| Segment Name | Patient City/State/ZIP Code |
|---------------|--|
| Segment ID | N4 |
| Loop ID | 2010CA – Patient City/State/ZIP Code |
| Usage | Patient |
| Segment Notes | The IG requires this segment if the 2010CA Loop is used and must be submitted to be compliant. Data submitted is not captured by the IHCP. See the IG for details. |

Table 3.42 – Patient Demographic Information

| Segment Name | Patient Demographic Information |
|---------------|--|
| Segment ID | DMG |
| Loop ID | 2010CA – Patient Demographic Information |
| Usage | Required |
| Segment Notes | The IG requires this segment if the 2010CA Loop is used and must be submitted to be compliant. Data submitted is not captured by the IHCP. See the IG for details. |

Table 3.43 – Claim Information

| Segment Name | Claim Information |
|---------------|--|
| Segment ID | CLM |
| Loop ID | 2300 |
| Usage | Required |
| Segment Notes | This segment begins submission of the individual claim information. The IHCP processes a maximum of 5000 CLM segments per ST-SE. |
| Example | CLM*3343E66*2555.51***11:A:1*Y**Y*Y*****Y~ |

Table 3.44 – Element ID CLM01-CLM20

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|--|---|
| CLM01 | R | Patient Account Number | Use patient account number of up to 20 characters. |
| CLM02 | R | Total Claim Charge Amount | Use the sum of all service line or detail charges up to 10 bytes. The IHCP accepts the maximum HIPAA format of 99999999.99 |
| CLM03 | N/A | Claim Filing Indicator Code | Not used |
| CLM04 | N/A | Non-Institutional Claim Type Code | Not used |
| CLM05 | R | Health Care Service Location Information | This is a composite data element. |
| CLM05-1 | R | Facility Type Code | Use the first two digits of the type of bill code. |
| CLM05-2 | R | Facility Type Code Qualifier A – Uniform Billing Claim Form Bill Type | |
| CLM05-3 | R | Claim Frequency Code | Use the third digit of the type of bill code. Note: The third digit of type of bill code represents the action requested. For a void this value is 8 ; for a replacement it is 7 . |
| CLM06 | R | Provider Signature Indicator N – No Y – Yes | This data element indicates whether the billing provider signature is on file in the billing office. |
| CLM07 | S | Medicare Assignment Code | Not used by the IHCP |
| CLM08 | R | Benefits Assignment Certification Indicator | Not used by the IHCP |
| CLM09 | R | Release of Information Code | Not used by the IHCP |
| CLM10 | N/A | Patient Signature Source Code | Not used |
| CLM11 | N/A | Property and Casualty Related Cause Codes | Not used |
| CLM12 | S | Special Program Indicator | Not used by the IHCP |
| CLM13 | N/A | Yes/No Condition or Response Code | Not used |
| CLM14 | N/A | Level of Service Code | Not used |
| CLM15 | N/A | Yes/No Condition or Response Code | Not used |
| CLM16 | N/A | Provider Agreement Code | Not used |
| CLM17 | N/A | Claim Status Code | Not used |
| CLM18 | R | Explanation of Benefits Indicator N – No Y – Yes | Not used by the IHCP |
| CLM19 | N/A | Claim Submission Code | Not used |
| CLM20 | S | Delay Reason Code | Not used by the IHCP |

Table 3.45 – Statement Dates

| Segment Name | Statement Dates |
|---------------|---|
| Segment ID | DTP |
| Loop ID | 2300 |
| Usage | Required |
| Segment Notes | This segment provides the Statement Covers Period or the <i>From</i> and <i>Through</i> dates of service. |
| Example | DTP*434*RD8*20011019-20011118~ |

Table 3.46 – Element ID DTP01-DTP03

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|---|--|
| DTP01 | R | Date/Time Qualifier 434 – Statement | |
| DTP02 | R | Date/Time Period Format Qualifier RD8 – Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD D8 – Date Expressed in Format CCYYMMDD | If D8 is submitted as the qualifier, the date submitted is used as both <i>From</i> and <i>Through</i> dates. |
| DTP03 | R | Date/Time Period | Use the <i>From</i> and <i>Through Dates of Service</i> from the Statement Covers Period. |

Table 3.47 – Admission Date/Time

| Segment Name | Admission Date/Time |
|---------------|--|
| Segment ID | DTP |
| Loop ID | 2300 |
| Usage | Situational |
| Segment Notes | This segment relays admission date and time information. |
| Example | DTP*435*DT*200107271400~ |

Table 3.48 – Element ID DTP01-DTP03

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|--|--|
| DTP01 | R | Date/Time Qualifier 435 – Admission | |
| DTP02 | R | Date/Time Period Format Qualifier DT – Date and Time Expressed in format CCYYMMDDHHMM | |
| DTP03 | R | Date/Time Period | Use the date and time the IHCP member was admitted. For example, 200107271400 represents an admit date of 7/27/2001 and an admit hour of 2 p.m. Value 99 is invalid for HHMM. |

Table 3.49 – Institutional Claim Code

| Segment Name | Institutional Claim Code |
|---------------|---|
| Segment ID | CL1 |
| Loop ID | 2300 |
| Usage | Situational |
| Segment Notes | This segment conveys admission type and patient status. |
| Example | CL1*3**02~ |

Table 3.50 – Element ID CL101-CL103

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|---|---|
| CL101 | S | Admission Type Code 1 – Emergency 2 – Urgent 3 – Elective 4 – Newborn | For the IHCP processing, 9 is not a valid code. |
| CL102 | S | Admission Source Code | Not used by the IHCP |
| CL103 | S | Patient Status Code | See the <i>IHCP Provider Manual</i> for valid Patient Status Codes and definitions. |

Table 3.51 – Claim Supplemental Information

| Segment Name | Claim Supplemental Information |
|---------------|--|
| Segment ID | PWK |
| Loop ID | 2300 |
| Usage | Situational |
| Segment Notes | This segment is used when additional information is required to process the claim, and the information is mailed to the IHCP. This segment is ignored if BHT06 = <i>RP</i> or the claim is a Medicare submitted crossover claim. |
| Example | PWK*AS*BM***AC*86576*ADMISSION COMMENTS~ |

Table 3.52 – Element ID PWK01-PWK09

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|--|--|
| PWK01 | R | Attachment Report Type Code | See the IG for list of valid values. |
| PWK02 | R | Attachment Transmission Code BM – By mail | Even though all Attachment Transmission Codes are accepted, claims that suspend because of an attachment requirement are only resolved by sending the attachment by mail. |
| PWK03 | N/A | Report Copies Needed | Not used |
| PWK04 | N/A | Entity Identifier Code | Not used |
| PWK05 | R | Identification Code Qualifier AC – Attachment Control Number | |
| PWK06 | R | Attachment Control Number | A unique attachment control number of up to 30 characters must be used and must match the number associated with the paper documentation sent by mail. This number is used to link the claim with the paper documentation and must be unique per billing location across all claims. |
| PWK07 | S | Attachment Description | |
| PWK08 | N/A | Actions Indicated | Not used |
| PWK09 | N/A | Request Category Code | Not used |

Table 3.53 – Contract Information

| Segment Name | Contract Information |
|---------------|---|
| Segment ID | CN1 |
| Loop ID | 2300 |
| Usage | Situational |
| Segment Notes | This segment is used by MCOs to identify an encounter from a network provider who has a capitated payment arrangement with the MCO. Do not send this segment except for a capitated provider. |
| Example | CN1*05~ |

Table 3.54 – Element ID CN101-CN106

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|---|--|
| CN101 | R | Contract Type Code 05 – Capitated | A value of 05 indicates the provider has a capitated payment arrangement. |
| CN102 | S | Contract Amount | Not used by the IHCP |
| CN103 | S | Contract Percentage | Not used by the IHCP |
| CN104 | S | Contract Code | Not used by the IHCP |
| CN105 | S | Term Discount Percentage | Not used by the IHCP |
| CN106 | S | Contract Version Identifier | Not used by the IHCP |

Table 3.55 – Payer Estimated Amount Due

| Segment Name | Payer Estimated Amount Due |
|---------------|---|
| Segment ID | AMT |
| Loop ID | 2300 |
| Usage | Situational |
| Segment Notes | This segment is required for IHCP claims. It is an estimate of the amount to be paid by Medicaid. |
| Example | AMT*C5*1500~ |

Table 3.56 – Element ID AMT01-AMT03

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|---|---|
| AMT01 | R | Amount Code Qualifier C5 – Claim Amount Due – Estimated | |
| AMT02 | R | Estimated Claim Due Amount | Use the estimated amount due for the claim. This is the equivalent of the C payer amount due on the <i>UB-04</i> . The IHCP accepts the maximum HIPAA format of 99999999.99 |
| AMT03 | N/A | Credit/Debit Flag Code | Not used |

Table 3.57 – Patient Paid Amount

| Segment Name | Patient Paid Amount |
|---------------|--|
| Segment ID | AMT |
| Loop ID | 2300 |
| Usage | Situational |
| Segment Notes | This segment reports any prior payment other than third party liability TPL and is deducted from the allowed amount. |
| Example | AMT*F5*110.3~ |

Table 3.58 – Element ID AMT01-AMT03

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|--|--|
| AMT01 | R | Amount Qualifier Code F5 – Patient Paid Amount | |
| AMT02 | R | Estimated Claim Due Amount | Use the estimated amount due for the claim. This is the equivalent of the C payer amount due on the <i>UB04</i> . The IHCP accepts the maximum HIPAA format of 99999999.99 |
| AMT03 | N/A | Credit/Debit Flag Code | Not used |

Table 3.59 – Original Reference Number ICN/DCN

| Segment Name | Original Reference Number ICN/DCN |
|---------------|--|
| Segment ID | REF |
| Loop ID | 2300 |
| Usage | Situational |
| Segment Notes | This segment is required only if the CLM05-3 Claim Frequency Code Type of Bill in the 2300 Loop is a 7 - Replacement or an 8 - Void. This segment identifies the original IHCP ICN/DCN of the desired claim to be voided or replaced. This is reflected as the original claim on the 835. |
| Example | REF*F8*2004394623999~ |

Table 3.60 – Element ID REF01-REF04

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|--|---|
| REF01 | R | Reference Identification Qualifier F8 – Referral Number | |
| REF02 | R | Reference Identification – Claim Original Reference Number ICN/DCN | The IHCP ICN of the claim needing to be voided or replaced. |
| REF03 | N/A | Description | Not used |
| REF04 | N/A | Reference Identifier | Not used |

Table 3.61 – Prior Authorization or Referral Number

| Segment Name | Prior Authorization or Referral Number |
|---------------|---|
| Segment ID | REF |
| Loop ID | 2300 |
| Usage | Situational |
| Segment Notes | This segment identifies the PMP certification code. |
| Example | REF*9F*3E~ |

Table 3.62 – Element ID REF01-REF04

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|---|--|
| REF01 | R | Reference Identification Qualifier 9F – Referral Number | |
| REF02 | R | Prior Authorization Number | Use the two-character PMP certification code. This code is not used by MCOs. |
| REF03 | N/A | Description | Not used |
| REF04 | N/A | Reference Identifier | Not used |

Table 3.63 – Medical Record Number

| Segment Name | Medical Record Number |
|---------------|--|
| Segment ID | REF |
| Loop ID | 2300 |
| Usage | Situational |
| Segment Notes | The segment submits a medical record number. |
| Examples | REF*EA*D234345~ |

Table 3.64 – Element ID REF01-REF02

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|---|--|
| REF01 | R | Reference Identification Qualifier EA – Medical Record Number | |
| REF02 | R | Medical Record Number | Use the medical record number of the IHCP member. The IHCP accepts the full HIPAA length of 30 characters. Previously, only the first 20 characters were accepted. |

Table 3.65– File Information

| Segment Name | File Information |
|---------------|--|
| Segment ID | K3 |
| Loop ID | 2300 |
| Usage | Situational |
| Segment Notes | This segment is utilized to send Present on Admission – POA indicators for Inpatient claims. |
| Example | K3*POAYNYNX~ |

Table 3.66 – Element ID K301 – K303

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|------------------------------------|--|
| K301 | R | Fixed Format Information | <p>Data Element Structure</p> <ul style="list-style-type: none"> • Positions 1-3= POA • Position 4= represents the present on admission (POA) indicator for the principal diagnosis code. • Position 5 begins the reporting of POA indicators for all “other” diagnosis codes if applicable. • A “Z” or an “X” must be reported to indicate the end of reporting of the POA indicators for the “other” diagnosis codes. • The byte following the “Z” or “X” value represents the POA indicator for a submitted e-code if applicable. If the segment ends in a “Z” or an “X” value, than the e-code was not submitted. <p>POA Codes: Y = Yes N = No U = unknown W = clinically undetermined. I- Represents a “space” or “blank” and means the diagnosis code is exempt from reporting of present on admission. X or Z- Indicates the end of reporting of POA indicators for the other diagnosis codes.</p> |
| K302 | N/A | Record Format Code | Not used |
| K303 | N/A | COMPOSIT UNIT OF MEASURE | Not used |

Table 3.67 – Claim Note

| Segment Name | Claim Note |
|---------------|---|
| Segment ID | NTE |
| Loop ID | 2300 |
| Usage | Situational |
| Segment Notes | This segment provides additional narrative information about this claim. The IHCP accepts the HIPAA maximum of 10 claim notes |
| Example | NTE*NTR*PATIENT REQUIRES TUBE FEEDING~ |

Table 3.68 – Element ID NTE01-NTE02

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|------------------------------------|---|
| NTE01 | R | Note Reference Code | See the IG for list of valid values. |
| NTE02 | R | Claim Note Text | Use up to 80 characters of narrative description. |

Table 3.659 – Principal, Admitting, E-code and Patient Reason for Visit Diagnosis Information

| Segment Name | Principal, Admitting, E-code, and Patient Reason for Visit Diagnosis Information |
|---------------|---|
| Segment ID | HI |
| Loop ID | 2300 |
| Usage | Required |
| Segment Notes | This segment reports the principal and admitting diagnosis codes and the E-Code. If the decimal is submitted with the diagnosis code or E-Code and it does not comply with the diagnosis <i>ICD-9</i> code, the claim is initially be accepted; however, it will deny when processed in <i>IndianaAIM</i> . See the <i>Other Diagnosis Information</i> segment for reporting other diagnosis codes. |
| Example | HI*BK:51881*BJ:51881~ |

Table 3.70 – Element ID HI01-HI12

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|---|--|
| HI01 | R | Health Care Code Information | This is a composite data element. |
| HI01-1 | R | Code List Qualifier Code BK – Principal Diagnosis | |
| HI01-2 | R | Principal Diagnosis Code | Use the appropriate <i>ICD-9</i> diagnosis code. |
| HI01-3 | N/A | Date/Time Period Format Qualifier | Not used |
| HI01-4 | N/A | Date/Time Period | Not used |
| HI01-5 | N/A | Monetary Amount | Not used |
| HI01-6 | N/A | Quantity | Not used |
| HI01-7 | N/A | Version Identifier | Not used |
| HI02 | S | Health Care Code Information | This is a composite data element. |
| HI02-1 | R | Code List Qualifier Code BJ – Admitting Diagnosis | Only required for Inpatient and LTC |
| HI02-2 | R | Admitting Diagnosis Code | Use the appropriate <i>ICD-9</i> diagnosis code. |
| HI02-3 | N/A | Date/Time Period Format Qualifier | Not used |
| HI02-4 | N/A | Date/Time Period | Not used |
| HI02-5 | N/A | Monetary Amount | Not used |
| HI02-6 | N/A | Quantity | Not used |
| HI02-7 | N/A | Version Identifier | Not used |
| HI03 | S | Health Care Code Information | This is a composite data element. |
| HI03-1 | R | Code List Qualifier Code BN – US DHHS, Office of Vital Statistics E-Code | |
| HI03-2 | R | E-Code | Use the appropriate <i>ICD-9</i> diagnosis code. |
| HI03-3 | N/A | Date/Time Period Format Qualifier | Not used |
| HI03-4 | N/A | Date/Time Period | Not used |
| HI03-5 | N/A | Monetary Amount | Not used |
| HI03-6 | N/A | Quantity | Not used |
| HI03-7 | N/A | Version Identifier | Not used |
| HI04 | N/A | Health Care Code Information | Not used |
| HI05 | N/A | Health Care Code Information | Not used |
| HI06 | N/A | Health Care Code Information | Not used |
| HI07 | N/A | Health Care Code Information | Not used |
| HI08 | N/A | Health Care Code Information | Not used |
| HI09 | N/A | Health Care Code Information | Not used |
| HI10 | N/A | Health Care Code Information | Not used |
| HI11 | N/A | Health Care Code Information | Not used |
| HI12 | N/A | Health Care Code Information | Not used |

Table 3.71 – Other Diagnosis Information

| Segment Name | Other Diagnosis Information |
|---------------|--|
| Segment ID | HI |
| Loop ID | 2300 |
| Usage | Situational |
| Segment Notes | This segment conveys additional diagnosis codes not submitted on previous HI segments. All 24 other diagnosis codes are recognized. Previously, the first eight values submitted were recognized by the IHCP. If the decimal is submitted with the diagnosis codes, and it does not comply with the diagnosis <i>ICD-9</i> codes, the claim is initially accepted; however, it will deny when processed in <i>IndianaAIM</i> . |
| Example | HI*BF*7070*BF:5789*BF:42731*BF:78039*BF:5119*BF:2761*BF:03811*BF:4280~ |

Table 3.72 – Element ID HI01-HI01-7

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|---|--|
| HI01 | R | Health Care Code Information | This is a composite data element. The seven data elements in this composite occur 12 times in this segment. Only the first occurrence is used in this illustration. See the IG for complete details. |
| HI01-1 | R | Code List Qualifier Code BF – Other Diagnosis | |
| HI01-2 | R | Other Diagnosis Code | Use the appropriate <i>ICD-9</i> diagnosis code. |
| HI01-3 | N/A | Date/Time Period Format Qualifier | Not used |
| HI01-4 | N/A | Date/Time Period | Not used |
| HI01-5 | N/A | Monetary Amount | Not used |
| HI01-6 | N/A | Quantity | Not used |
| HI01-7 | N/A | Version Identifier | Not used |

Table 3.73 – Principal Procedure Information

| Segment Name | Principal Procedure Information |
|---------------|---|
| Segment ID | HI |
| Loop ID | 2300 |
| Usage | Situational |
| Segment Notes | This segment conveys the principal surgical procedure code and date information. If the decimal is submitted with the principal procedure code and it does not comply with the <i>ICD-9</i> code, the claim is initially accepted; however, it will deny when processed in <i>IndianaAIM</i> . See the <i>Other Procedure Code Information</i> segment for reporting other procedure codes. |
| Example | HI*BR:8894:D8:20021001~ |

Table 3.74 – Element ID HI01-HI12

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|---|---|
| HI01 | R | Health Care Code Information | This is a composite data element. |
| HI01-1 | R | Code List Qualifier BR – International Classification of Diseases Clinical Modification <i>ICD-9-CM</i> Principle Procedure | |
| HI01-2 | R | Principal Procedure Code | Use the four-byte principal surgical procedure code. |
| HI01-3 | R | Date/Time Period Format Qualifier D8 – Date Expressed in Format CCYYMMDD | |
| HI01-4 | R | Date/Time Period | Use principal surgical procedure code date. |
| HI01-5 | N/A | Monetary Amount | Not used |
| HI01-6 | N/A | Quantity | Not used |
| HI01-7 | N/A | Version Identifier | Not used |
| HI02 | N/A | Health Care Code Information | Not used |
| HI03 | N/A | Health Care Code Information | Not used |
| HI04 | N/A | Health Care Code Information | Not used |
| HI05 | N/A | Health Care Code Information | Not used |
| HI06 | N/A | Health Care Code Information | Not used |
| HI07 | N/A | Health Care Code Information | Not used |
| HI08 | N/A | Health Care Code Information | Not used |
| HI09 | N/A | Health Care Code Information | Not used |
| HI10 | N/A | Health Care Code Information | Not used |
| HI11 | N/A | Health Care Code Information | Not used |
| HI12 | N/A | Health Care Code Information | Not used |

Table 3.75 – Other Procedure Information

| Segment Name | Other Procedure Information |
|---------------|---|
| Segment ID | HI |
| Loop ID | 2300 |
| Usage | Situational |
| Segment Notes | This segment conveys additional surgical procedure codes and dates not submitted on the previous HI segment. The segment may be repeated two times; thus, the maximum number of procedures reported is 24. The IHCP recognizes all 24 other procedures submitted. Previously, only the first five values were recognized. If the decimal is submitted and it does not comply with the <i>ICD-9</i> code, the claim is initially accepted; however, it will deny when processed in IndianaAIM. |
| Example | HI*BQ:8894:D8:20021001*BQ:7883:20021001~ |

Table 3.76 – Element ID HI01-HI01-7

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|--|--|
| HI01 | S | Health Care Code Information | This is a composite data element. The seven data elements in this composite occur 12 times in this segment. Only the first occurrence is used in this illustration. See the IG for complete details. |
| HI01-1 | R | Code List Qualifier Code BQ – International Classification of Diseases Clinical Modification <i>ICD-9 CM</i> Procedure | BQ is the only valid value recognized by the IHCP. |
| HI01-2 | R | Procedure Code | Use the four-byte surgical procedure code. |
| HI01-3 | R | Date/Time Period Format Qualifier D8 – Date Expressed in Format CCYYMMDD | |
| HI01-4 | R | Date/Time Period | Use the surgical procedure code date. |
| HI01-5 | N/A | Monetary Amount | Not used |
| HI01-6 | N/A | Quantity | Not used |
| HI01-7 | N/A | Version Identifier | Not used |

Table 3.77 – Occurrence Span Information

| Segment Name | Occurrence Span Information |
|---------------|---|
| Segment ID | HI |
| Loop ID | 2300 |
| Usage | Situational |
| Segment Notes | This segment conveys occurrence codes and span dates. The segment may be repeated two times. The maximum number of occurrence span code/dates used for processing is 12. Occurrence span codes/dates are typically used only on home health claims. Only the first two occurrence code values are recognized by the IHCP. |
| Example | HI*BI:51:RD8:20021001-20021005~ |

Table 3.78 – Element ID HI01-HI01-7

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|--|--|
| HI01 | S | Health Care Code Information | This is a composite data element. The seven data elements in this composite occur 12 times in this segment. Only the first occurrence is used in this illustration. See the IG for complete details. |
| HI01-1 | R | Code List Qualifier Code BI – Occurrence Span | |
| HI01-2 | R | Occurrence Span Code | Use the two-byte occurrence span code. See the <i>IHCP Provider Manual</i> for a list of valid values and descriptions. |
| HI01-3 | R | Date/Time Period Format Qualifier RD8 – Date Expressed in Format CCYYMMDD- CCYYMMDD | |
| HI01-4 | R | Date/Time Period | Use the occurrence span <i>From</i> and <i>Through</i> date. |
| HI01-5 | N/A | Monetary Amount | Not used |
| HI01-6 | N/A | Quantity | Not used |
| HI01-7 | N/A | Version Identifier | Not used |

Table 3.79 – Occurrence Information

| Segment Name | Occurrence Information |
|---------------|---|
| Segment ID | HI |
| Loop ID | 2300 |
| Usage | Situational |
| Segment Notes | This segment conveys occurrence codes and dates. The segment may be repeated two times. The maximum number of occurrence codes used for processing is 12. Only the first eight occurrence codes are recognized by the IHCP. Occurrence span codes and dates are typically used only on home health and outpatient claims. |
| Example | HI*BH:51:D8:20011118~ |

Table 3.80 – Element ID HI01-HI01-7

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|---|--|
| HI01 | S | Health Care Code Information | This is a composite data element. The seven data elements in this composite occur 12 times in this segment. Only the first occurrence is used in this illustration. See the IG for complete details. |
| HI01-1 | R | Code List Qualifier Code BH – Occurrence | |
| HI01-2 | R | Occurrence Span Code | Use the two-character occurrence code. See the <i>IHCP Provider Manual</i> for a list of valid values and descriptions. |
| HI01-3 | R | Date/Time Period Format Qualifier D8 – Date Expressed in Format CCYYMMDD | |
| HI01-4 | R | Date/Time Period | Use the occurrence code date. |
| HI01-5 | N/A | Monetary Amount | Not used |
| HI01-6 | N/A | Quantity | Not used |
| HI01-7 | N/A | Version Identifier | Not used |

Table 3.81 – Value Information

| Segment Name | Value Information |
|---------------|--|
| Segment ID | HI |
| Loop ID | 2300 |
| Usage | Situational |
| Segment Notes | This segment conveys value codes and dollar amounts. The segment may be repeated two times. The maximum number of value code/amounts reported used for processing is 12. |
| Example | HI*BE:80:::125~ |

Table 3.82 – Element ID HI01-HI01-7

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|---|--|
| HI01 | S | Health Care Code Information | This is a composite data element. The seven data elements in this composite occur 12 times in this segment. Only the first occurrence is used in this illustration. See the IG for complete details. |
| HI01-1 | R | Code List Qualifier Code BE – Value | |
| HI01-2 | R | Value Code | Use the two-byte value code. See the <i>IHCP Provider Manual</i> for a list of valid values and descriptions. |
| HI01-3 | N/A | Date/Time Period Format Qualifier | Not used |
| HI01-4 | N/A | Date/Time Period | Not used |
| HI01-5 | R | Value Code Amount | Use the value code amount. IHCP format 9999999.99 |
| HI01-6 | N/A | Quantity | Not used |
| HI01-7 | N/A | Version Identifier | Not used |

Table 3.83 – Condition Information

| Segment Name | Condition Information |
|---------------|--|
| Segment ID | HI |
| Loop ID | 2300 |
| Usage | Situational |
| Segment Notes | This segment conveys condition codes. The segment may be repeated two times. The maximum number of condition codes used for processing is seven. |
| Example | HI *BG : C1 ~ |

Table 3.84 – Element ID HI01-HI01-7

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|---|---|
| HI01 | S | Health Care Code Information | This is a composite data element. The seven data elements in this composite occur 12 times in this segment; however, only the first occurrence is used in this illustration. See the IG for complete details. |
| HI01-1 | R | Code List Qualifier Code BG – Condition | |
| HI01-2 | R | Condition Code | Use the two-byte condition code. See the <i>IHCP Provider Manual</i> for a list of valid values and descriptions. |
| HI01-3 | N/A | Date/Time Period Format Qualifier | Not used |
| HI01-4 | N/A | Date/Time Period | Not used |
| HI01-5 | N/A | Monetary Amount | Not used |
| HI01-6 | N/A | Quantity | Not used |
| HI01-7 | N/A | Version Identifier | Not used |

Table 3.85 – Claim Quantity

| Segment Name | Claim Quantity |
|---------------|---|
| Segment ID | QTY |
| Loop ID | 2300 |
| Usage | Situational |
| Segment Notes | This segment reports covered days for inpatient and LTC claims. |
| Example | QTY*CA*30*DA~ |

Table 3.86 – Element ID QTY01-QTY04

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|--|--|
| QTY01 | R | Quantity Qualifier CA – Covered-Actual | |
| QTY02 | R | Claim Days Count | Use the covered days for services billed on the claim. |
| QTY03 | R | Composite Unit of Measure | This is a composite data element. |
| QTY03-1 | R | Unit or Basis for Measurement Code DA – Days | |
| QTY03-2 | N/A | Exponent | Not used |
| QTY03-3 | N/A | Multiplier | Not used |
| QTY03-4 | N/A | Unit of Basis for Measurement Code | Not used |
| QTY03-5 | N/A | Exponent | Not used |
| QTY03-6 | N/A | Multiplier | Not used |
| QTY03-7 | N/A | Unit of Basis for Measurement Code | Not used |
| QTY03-8 | N/A | Exponent | Not used |
| QTY03-9 | N/A | Multiplier | Not used |
| QTY03-10 | N/A | Unit of Basis for Measurement Code | Not used |
| QTY03-11 | N/A | Exponent | Not used |
| QTY03-12 | N/A | Multiplier | Not used |
| QTY03-13 | N/A | Unit of Basis for Measurement Code | Not used |
| QTY03-14 | N/A | Exponent | Not used |
| QTY03-15 | N/A | Multiplier | Not used |
| QTY04 | N/A | Free form message | Not used |

Table 3.87 – Attending Physician Name

| Segment Name | Attending Physician Name |
|----------------------|--|
| Segment ID | NM1 |
| Loop ID | 2310A |
| Usage | Situational |
| Segment Notes | This segment conveys attending physician information for claims requiring the attending physician data. If using this loop to provide attending physician information, this segment is required by the IG and must be submitted to be compliant. See the IG for details. |
| Example | When submitted with NPI: NM1*71*1*JONES*JANE****XX*1234567890~ |

Table 3.88 – Element ID NM101-NM111

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|--|--|
| NM101 | R | Entity Identifier Code 71 – Attending Physician | |
| NM102 | R | Entity Type Qualifier 1 - Person 2 – Non-Person Entity | |
| NM103 | R | Name Last or Organization Name | |
| NM104 | S | Name First | |
| NM105 | S | Name Middle | |
| NM106 | N/A | Name Prefix | Not used |
| NM107 | S | Name Suffix | |
| NM108 | R | Identification Code Qualifier XX – NPI 24 – Employer’s Identification Number 34 – Social Security Number | XX - NPI required for healthcare providers. |
| NM109 | R | Identification Code | If XX is sent in NM108, enter the 10-digit NPI. |
| NM110 | N/A | Entity Relationship Code | Not used |
| NM111 | N/A | Entity Identifier Code | Not used |

Table 3.89 – Attending Physician Specialty Information

| Segment Name | Attending Physician Specialty Information |
|----------------------|---|
| Segment ID | PRV |
| Loop ID | 2310A |
| Usage | Situational |
| Segment Notes | This segment conveys taxonomy information for the attending physician when claims require the attending physician data. |
| Example | PRV*AT*ZZ*424BF0411F~ |

Table 3.90 – Element ID PRV01-PRV06

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|--|--|
| PRV01 | R | Provider Code AT – Attending | |
| PRV02 | R | Reference Identification Qualifier ZZ – Mutually Defined | |
| PRV03 | R | Provider Taxonomy Code | Use the provider taxonomy code for the attending physician, if applicable. |
| PRV04 | N/A | State or Province Code | Not used |
| PRV05 | N/A | Provider Specialty Information | Not used |
| PRV06 | N/A | Provider Organization Code | Not used |

Table 3.91 – Attending Physician Secondary Information

| Segment Name | Attending Physician Secondary Information |
|---------------|---|
| Segment ID | REF |
| Loop ID | 2310A |
| Usage | Situational |
| Segment Notes | With the NPI Stage 3 implementation, the information received in this segment will be ignored. This segment contains the state license number of the attending physician. The segment may repeat five times. Only the segment containing the 0B qualifier is captured. |
| Example | REF*0B*01234543~ |

Table 3.92 – Element ID REF01-REF04

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|--|---|
| REF01 | R | Reference Identification Qualifier 0B – State License Number | |
| REF02 | R | Attending Physician Secondary Identifier | Use the state license number of the attending physician. The IHCP accepts the eight-digit license number. |
| REF03 | N/A | Description | Not used |
| REF04 | N/A | Reference Identifier | Not used |

Table 3.93 – Operating Physician Name

| Segment Name | Operating Physician Name |
|---------------|--|
| Segment ID | NM1 |
| Loop ID | 2310B |
| Usage | Situational |
| Segment Notes | This segment conveys operating physician information when operating physician data is required. If using this loop to provide operating physician information, this segment is required by the IG and must be submitted to be compliant. See the IG for details. |
| Example | When submitted with the NPI: NM1*72*1*SMITH*ROBERT****XX*1234567890~ |

Table 3.94 – Element ID NM101-NM111

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|--|--|
| NM101 | R | Entity Identifier Code 72 – Operating Physician | |
| NM102 | R | Entity Type Qualifier 1 - Person | |
| NM103 | R | Name Last or Organization Name | |
| NM104 | R | Name First | |
| NM105 | S | Name Middle | |
| NM106 | N/A | Name Prefix | Not used |
| NM107 | S | Name Suffix | |
| NM108 | R | Identification Code Qualifier XX – NPI 24 – Employer’s Identification Number 34 – Social Security Number | XX - NPI required for healthcare providers. |
| NM109 | R | Identification Code | If XX is sent in NM108, enter the 10-digit NPI. |
| NM110 | N/A | Entity Relationship Code | Not used |
| NM111 | N/A | Entity Identifier Code | Not used |

Table 3.95 – Operating Physician Secondary Information

| Segment Name | Operating Physician Secondary Information |
|---------------|---|
| Segment ID | REF |
| Loop ID | 2310B |
| Usage | Situational |
| Segment Notes | With the NPI Stage 3 implementation, the information received in this segment will be ignored. This segment contains the state license number of the operating physician. The segment may repeat five times. Only the segment containing the qualifier of 0B is captured. |
| Example | REF*0B*01234543~ |

Table 3.96 – Element ID REF01-REF04

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|--|---|
| REF01 | R | Reference Identification Qualifier 0B – State License Number | |
| REF02 | R | Operating Physician Secondary Identifier | Use the state license number of the operating physician. The IHCP accepts the eight-digit license number. |
| REF03 | N/A | Description | Not used |
| REF04 | N/A | Reference Identifier | Not used |

Table 3.97 – Other Provider Name

| Segment Name | Other Provider Name |
|---------------|--|
| Segment ID | NM1 |
| Loop ID | 2310C |
| Usage | Situational |
| Segment Notes | This segment conveys PMP information on claims when PMP data is required. If using this loop to provide PMP information, this segment is required by the IG and must be submitted to be compliant. See the IG for details. |
| Example | When submitted with NPI: NM1*73*1*DOE*JOHN****XX*1234567890~ |

Table 3.98 – Element ID NM101-NM111

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|--|--|
| NM101 | R | Entity Identifier Code 73 – Other Physician | |
| NM102 | R | Entity Type Qualifier 1 - Person 2 – Non-Person Entity | |
| NM103 | R | Name Last or Organization Name | |
| NM104 | S | Name First | |
| NM105 | S | Name Middle | |
| NM106 | N/A | Name Prefix | Not used |
| NM107 | S | Name Suffix | |
| NM108 | R | Identification Code Qualifier 24 – Employer’s Identification Number 34 – Social Security Number XX – NPI | If XX - NPI is used, then either the Employer’s Identification Number or the SSN of the provider must be carried in the REF segment in this loop. This value will be required when the NPI is mandated for use. |
| NM109 | R | Identification Code | If XX is sent in NM108, enter the 10-digit NPI. |
| NM110 | N/A | Entity Relationship Code | Not used |
| NM111 | N/A | Entity Identifier Code | Not used |

Table 3.99 – Other Provider Secondary Information

| Segment Name | Other Provider Secondary Information |
|---------------|--|
| Segment ID | REF |
| Loop ID | 2310C |
| Usage | Situational |
| Segment Notes | With the NPI Stage 3 implementation, the information received in this segment will be ignored. This segment contains the state license number of the PMP. The segment may repeat five times. Only the segment containing the qualifier of 0B is captured. This is not used by MCOs. |
| Example | REF*0B*01234543~ |

Table 3.100 – Element ID REF01-REF04

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|--|---|
| REF01 | R | Reference Identification Qualifier 0B – State License Number | |
| REF02 | R | Other Provider Secondary Identifier | Use the state license number of the IHCP member’s PMP. The IHCP accepts the eight-digit license number. |
| REF03 | N/A | Description | Not used |
| REF04 | N/A | Reference Identifier | Not used |

Table 3.101 – Other Subscriber Information

| Segment Name | Other Subscriber Information |
|---------------|--|
| Segment ID | SBR |
| Loop ID | 2320 |
| Usage | Situational |
| Segment Notes | The IG requires this segment if the 2320 Loop is used and must be submitted to be compliant. IHCP verifies that the Claim Filing Indicator Code correctly represents whether the other insurance carrier for the subscriber is a Medicare payer. |
| Example | SBR*S*01*GR00786*****OF~ |

Table 3.102 – Element ID SBR01-SBR09

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|---|---|
| SBR01 | R | Payer Responsibility Sequence Number Code | Not used by IHCP. |
| SBR02 | R | Individual Relationship Code | |
| SBR03 | S | Reference Identification | |
| SBR04 | S | Name | |
| SBR05 | N/A | Insurance Type Code | |
| SBR06 | N/A | Coordination of Benefits Code | |
| SBR07 | N/A | Yes/No Condition or Response Code | |
| SBR08 | N/A | Employment Status Code | |
| SBR09 | S | Claim Filing Indicator Code | The Claim Filing Indicator Code is used to identify Medicare crossover claims. If the claim is a crossover, the Claim Filing Indicator must be set to MA - Medicare Part A or MB - Medicare Part B. |

Table 3.103 – Claim Level Adjustment

| Segment Name | Claim Level Adjustment |
|---------------|--|
| Segment ID | CAS |
| Loop ID | 2320 |
| Usage | Situational |
| Segment Notes | This segment submits Medicare deductible, coinsurance, and blood deductible amounts for Medicare Part A claims. For non-Medicare or non-crossover claims, this segment submits all adjustment amounts. . The combination of Adjustment Reason Code, Adjustment Amount, and Adjustment Quantity is reported six times on this segment. The following illustration shows only the first iteration. See the IG for complete details about CAS05-19. |
| Example | CAS*PR*1*153.2~ |

Table 3.104 – Element ID CAS01-CAS04

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|------------------------------------|---|
| CAS01 | R | Claim Adjustment Group Code | |
| CAS02 | R | Adjustment Reason Code | All adjustments and adjustment amounts are captured by IHCP for claims that were previously adjudicated by another payer for example, MCO, Medicare, or TPL claims. |
| CAS03 | R | Adjustment Amount | Use the dollar amount associated with the reason code identified in CAS02. The IHCP accepts the maximum HIPAA format of 99999999.99 |
| CAS04 | S | Adjustment Quantity | Use the quantity associated with the reason code identified in CAS02. IHCP format 9999999.999. |

Table 3.105 – Payer Prior Payment

| Segment Name | Payer Prior Payment |
|---------------|--|
| Segment ID | AMT |
| Loop ID | 2320 |
| Usage | Situational |
| Segment Notes | This segment reports the amount paid by the other insurer. Medicare paid amounts are captured on the following segment COB Total Medicare Paid Amount. For HIP encounter claims, this segment should be used to send the amount of the claim payment attributed to the State's and member's POWER account. This is the total of member and state POWER account contribution used on the claim. |
| Example | AMT*C4*75~ |

Table 3.106 – Element ID AMT01-AMT03

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|---|---|
| AMT01 | R | Amount Qualifier Code C4 – Prior Payment – Actual | |
| AMT02 | R | Other Payer Patient Paid Amount | Use the TPL amount paid by the other insurer. When the other payer is an MCO, use the MCO paid amount here. When the other payer is a HIP insurer, send the amount deducted from the State’s and member’s contribution to the POWER account here. The IHCP accepts the maximum HIPAA format of 99999999.99 |
| AMT03 | N/A | Credit/Debit Flag Code | Not used |

Table 3.107 – Total Allowed Amount

| Segment Name | Total Allowed Amount |
|---------------|---|
| Segment ID | AMT |
| Loop ID | 2320 |
| Usage | Situational |
| Segment Notes | This segment reports the amount allowed by the other insurer. |
| Example | AMT*B6*85~ |

Table 3.108 – Element ID AMT01-AMT03

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|---|---|
| AMT01 | R | Amount Qualifier Code B6 – Allowed – Actual | |
| AMT02 | R | Allowed Amount | Use the total claim allowed amount by the other insurer. The IHCP accepts the maximum HIPAA format of 99999999.99 |
| AMT03 | N/A | Credit/Debit Flag Code | Not used |

Table 3.109 – Coordination of Benefits COB Total Medicare Paid Amount

| Segment Name | Coordination of Benefits COB Total Medicare Paid Amount |
|---------------|---|
| Segment ID | AMT |
| Loop ID | 2320 |
| Usage | Situational |
| Segment Notes | This segment contains the Medicare paid amount. For Medicare payments, if an amount is supplied in the C4 segment, but the N1 segment is missing or the amount is zero, the claim rejects on the BSR. |
| Example | AMT*N1*606.15~ |

Table 3.110 – Element ID AMT01-AMT03

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|---|--|
| AMT01 | R | Amount Qualifier Code N1 – Net Worth | |
| AMT02 | R | Total Medicare Paid Amount | Use the Medicare paid amount. The IHCP accepts the maximum HIPAA format of 99999999.99 |
| AMT03 | N/A | Credit/Debit Flag | Not used |

Table 3.111 – Total Denied Charge Amount

| Segment Name | Total Denied Charge Amount |
|---------------|--|
| Segment ID | AMT |
| Loop ID | 2320 |
| Usage | Situational |
| Segment Notes | This segment contains the Total Denied Amount. |
| Example | AMT*YT*32~ |

Table 3.112– Element ID AMT01-AMT03

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|--------------------------------------|---|
| AMT01 | R | Amount Qualifier Code YT – Denied | |
| AMT02 | R | Claim Total Denied Charge Amount | Use the other payer total denied charge amount by the other insurer. The IHCP accepts the maximum HIPAA format of 99999999.99 |
| AMT03 | N/A | Credit/Debit Flag Code | Not used |

Table 3.113 – Other Subscriber Demographic Information

| Segment Name | Other Subscriber Demographic Information |
|---------------|--|
| Segment ID | DMG |
| Loop ID | 2320 |
| Usage | Situational |
| Segment Notes | Segment contains other payer's subscriber information. |
| Example | DMG*D8*19550101*F~ |

Table 3.114 – Element ID DMG01-DMG09

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|------------------------------------|----------|
| DMG01 | R | Date/Time Period Format Qualifier | |
| DMG02 | R | Other Insured Birth Date | |
| DMG03 | R | Other Insured Gender Code | |
| DMG04 | N/A | Marital Status Code | Not Used |
| DMG05 | N/A | Race or Ethnicity Code | Not Used |
| DMG06 | N/A | Citizenship Status Code | Not Used |
| DMG07 | N/A | Country Code | Not Used |
| DMG08 | N/A | Basis of Verification Code | Not Used |
| DMG09 | N/A | Quantity | Not Used |

Table 3.115 – Other Insurance Coverage Information

| Segment Name | Other Insurance Coverage Information |
|---------------|--|
| Segment ID | OI |
| Loop ID | 2320 |
| Usage | Required, if the 2320 Loop is used. |
| Segment Notes | The IG requires this segment if the 2320 Loop is used and must be submitted to be compliant. Data submitted is not captured by the IHCP. See the IG for details. |

Table 3.116 – Other Subscriber Name

| Segment Name | Other Subscriber Name |
|---------------|---|
| Segment ID | NM1 |
| Loop ID | 2330A |
| Usage | Required if 2320 Loop is used |
| Segment Notes | This segment specifies information about other subscribers. See the IG for details. |
| Example | NM1*IL*1*DOE*JOHN*T***34*123456789~ |

Table 3.117 – Element ID NM101-NM109

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|---|-------------------|
| NM101 | R | Entity Identifier Code IL – Insured or Subscriber | |
| NM102 | R | Entity Type Qualifier | Not used by IHCP. |
| NM103 | R | Other Payer’s Subscriber Name | |
| NM104 | R | Other Payer’s Subscriber First Name | |
| NM105 | R | Other Payer’s Subscriber Middle Name | |
| NM106 | N/A | Name Prefix | Not used |
| NM107 | R | Other Payer’s Subscriber Name Suffix | |
| NM108 | R | Identification Code Qualifier | Not used by IHCP. |
| NM109 | R | Other Insured Identifier | |

Table 3.118 – Other Subscriber Address

| Segment Name | Other Subscriber Address |
|----------------------|--|
| Segment ID | N3 |
| Loop ID | 2330A |
| Usage | Situational |
| Segment Notes | This segment specifies information about other subscriber’s address. See the IG for details. |
| Example | N3*4320 WASHINGTON ST SUITE 100~ |

Table 3.119 – Element ID N301-N302

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|------------------------------------|----------|
| N301 | R | Other Payer’s Subscriber Address 1 | |
| N302 | R | Other Payer’s Subscriber Address 2 | |

Table 3.120 – Other Subscriber City/State/ZIP Code

| Segment Name | Other Subscriber City/State/ZIP Code |
|----------------------|--|
| Segment ID | N4 |
| Loop ID | 2330A |
| Usage | Situational Required when N3 segment is present. |
| Segment Notes | This segment specifies information about other subscriber’s address. See the IG for details. |
| Example | N4*PALISADES*OR*23119~ |

Table 3.121 – Element ID N401-N403

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|------------------------------------|----------|
| N401 | R | Other Payer's Subscriber City | |
| N402 | R | Other Payer's Subscriber State | |
| N403 | R | Other Payer's Subscriber ZIP Code | |

Table 3.122 – Other Subscriber Secondary Information

| Segment Name | Other Subscriber Secondary Information |
|---------------|---|
| Segment ID | REF |
| Loop ID | 2330A |
| Usage | Situational |
| Segment Notes | This segment specifies information about other subscriber's additional identifiers. See the IG for details. |
| Example | REF*SY*030385074~ |

Table 3.123 – Element ID REF01-REF04

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|---|---|
| REF01 | R | Reference Identification Qualifier IG - Insurance Policy Number SY – Social Security number | |
| REF02 | R | Reference Identification | IHCP only uses the insurance policy number and SSN of the other subscriber. |
| REF03 | N/A | Description | Not used |
| REF04 | N/A | Reference Identifier | Not used |

Table 3.124 – Other Subscriber Name

| Segment Name | Other Subscriber Name |
|---------------|--|
| Segment ID | NM1 |
| Loop ID | 2330A |
| Usage | Required if 2320 Loop is used |
| Segment Notes | The IG requires this segment if the 2320 Loop is used and must be submitted to be compliant. Data submitted is not captured by the IHCP. See the IG for details. |

Table 3.125 – Other Payer Name

| Segment Name | Other Payer Name |
|---------------|---|
| Segment ID | NM1 |
| Loop ID | 2330B |
| Usage | Required if 2320 Loop is used |
| Segment Notes | This segment specifies information about other payers. When submitting claims to Medicare that are expected to crossover to the IHCP, this segment must be included and contain the payer ID assigned to the IHCP by Medicare. The payer ID representing the IHCP is 70035 . |
| Examples | Claims submitted to the IHCP: NM1*PR*2*Family Insurance*****PI*01234~ |
| | Claims submitted by provider to Medicare, expecting to crossover to the IHCP: NM1*PR*2*Office Of Medicaid Policy & Planning*****PI*70035~ |

Table 3.126 – Element ID NM101-NM111

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|---|--|
| NM101 | R | Entity Identifier Code PR – Payer | |
| NM102 | R | Entity Type Qualifier 2 – Non-Person Entity | |
| NM103 | R | Other Payer Organization Name | |
| NM104 | N/A | Name First | Not used |
| NM105 | N/A | Name Middle | Not used |
| NM106 | N/A | Name Prefix | Not used |
| NM107 | N/A | Name Suffix | Not used |
| NM108 | R | Identification Code Qualifier PI – Payer Identification | |
| NM109 | R | Other Payer Primary Identifier For crossover claims, the valid payer identifier list can be located at: http://www.indianamedicaid.com/ihcp/Misc_PDF/Medicare_Payer_IDs.pdf When submitting claims to Medicare that are expected to crossover to the IHCP, use the payer id for the IHCP – 70035 . For encounter claims, the payer identifier should be from this list: 555763410– MDWise 455701400- Anthem 155723420 – ESP ACS | For Medicare payments, if the payer is a Medicare payer and the 2320 SBR09 Claim Filing Indicator is MA or MB , the claim is identified as a crossover claim. If the payer is in the Medicare list, but the Claim Filing Indicator does not indicate that the claim is a Medicare crossover claim, the payment is identified as a commercial payment and is summed into TPL. MCO payers are identified by using the NM109 payer ID. Any other payers are identified as TPL. |
| NM110 | N/A | Entity Relationship Code | Not used |
| NM111 | N/A | Entity Identifier Code | Not used |

Table 3.127 – Other Payer Address

| Segment Name | Other Payer Address |
|---------------|---|
| Segment ID | N3 |
| Loop ID | 2330A |
| Usage | Situational |
| Segment Notes | This segment specifies information about other payer’s address. See the IG for details. |
| Example | N3*4320 WASHINGTON ST SUITE 100~ |

Table 3.128 – Element ID N301-N302

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|------------------------------------|----------|
| N301 | R | Other Payer Address Line 1 | |
| N302 | R | Other Payer Address Line 2 | |

Table 3.129 – Other Payer City/State/ZIP Code

| Segment Name | Other Payer City/State/ZIP Code |
|---------------|---|
| Segment ID | N4 |
| Loop ID | 2330A |
| Usage | Situational <i>Required</i> when N3 segment is present. |
| Segment Notes | This segment specifies information about other payer’s address. |
| Example | N4*PALISADES*OR*23119~ |

Table 3.130 – Element ID N401-N404

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|------------------------------------|----------|
| N401 | R | Other Payer City Name | |
| N402 | R | Other Payer State | |
| N403 | R | Other Payer ZIP Code | |
| N404 | R | Other Payer Country Code | |

Table 3.131 – Claim Adjudication Date

| Segment Name | Claim Adjudication Date |
|---------------|--|
| Segment ID | DTP |
| Loop ID | 2330B |
| Usage | Situational |
| Segment Notes | This segment is required when the Line Adjudication Date is not used and the claim has been adjudicated. |
| Example | DTP*573*D8*19981226~ |

Table 3.132 – Element ID DTP01-DTP03

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|---|---|
| DTP01 | R | Date/Time Qualifier 573 - Date Claim Paid | |
| DTP02 | R | Date/Time Period Format Qualifier D8 – Date Expressed in Format CCYYMMDD | |
| DTP03 | R | Date/Time Period | Adjudication or Payment Date MCOs submit payment date. |

Table 3.133 – Other Payer Secondary Identification and Reference Number

| Segment Name | Other Payer Secondary Identification and Reference Number |
|---------------|---|
| Segment ID | REF |
| Loop ID | 2330B |
| Usage | Situational |
| Segment Notes | Utilize segment to send other payer’s claim number. IHCP utilizes the information to do replacements and voids of claims. |
| Example | REF*F8*465980789~ |

Table 3.134 – Element ID REF01-REF04

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|---|---|
| REF01 | R | Reference Identification Qualifier F8 – Original Reference Number | Use F8 to send the other payer’s claim number ICN or DCN. <i>Note: MCO must provide ICN in order to Void or Replace the claim in the future. This encounter claim is reflected on the 835 along with the equivalent IHCP ICN.</i> |
| REF02 | R | Reference Identification | Use the other payer’s ICN or DCN identified in NM109. |
| REF03 | N/A | Description | Not used |
| REF04 | N/A | Reference Identifier | Not used |

Table 3.135 – Other Payer Prior Authorization or Referral Number

| Segment Name | Other Payer Prior Authorization or Referral Number |
|---------------|---|
| Segment ID | REF |
| Loop ID | 2330B |
| Usage | Situational |
| Segment Notes | This segment specifies information about other payer’s referral or PA number. See the IG for details. |

Table 3.136 – Element ID REF01-REF04

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|---|-------------------------------|
| REF01 | R | Reference Identification Qualifier G1 - Prior Authorization Number 9F - Referral Number | |
| REF02 | R | Reference Identification | Referral Number or PA Number. |
| REF03 | N/A | Description | Not used |
| REF04 | N/A | Reference Identifier | Not used |

Table 3.137 – Other Payer Patient Identification Number

| Segment Name | Other Payer Patient Identification Number |
|---------------|---|
| Segment ID | REF |
| Loop ID | 2330C |
| Usage | Situational |
| Segment Notes | This segment specifies information about other payer’s patient identification. See the IG for details |
| Example | REF*SY*123521234~ |

Table 3.138– Element ID REF01-REF04

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|---|--|
| REF01 | R | Reference Identification Qualifier IG - Insurance Policy Number SY - Social Security number | |
| REF02 | R | Reference Identification | Other Payer Patient Secondary Identifier |
| REF03 | N/A | Description | Not used |
| REF04 | N/A | Reference Identifier | Not used |

Table 3.139 – Service Line Number

| Segment Name | Service Line Number |
|---------------|---|
| Segment ID | LX |
| Loop ID | 2400 |
| Usage | Required |
| Segment Notes | This segment contains the line item number that is incremented by one for each service line or detail. The IHCP processes a maximum of 450 LX segments 2400 Loops for each CLM segment. |
| Example | LX*1~ |

Table 3.140 – Element ID LX01

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|------------------------------------|--|
| LX01 | R | Assigned Number | The first service line should begin with the number 1 . Each subsequent service line/detail should be incremented by one. |

Table 3.141 – Institutional Service Line

| Segment Name | Institutional Service Line |
|---------------|---|
| Segment ID | SV2 |
| Loop ID | 2400 |
| Usage | Required |
| Segment Notes | This segment reports revenue code, procedure code, modifiers, charge amounts, and units. The IHCP only recognizes the first 450 service lines on a claim. The Total Claim Charge Amount from CLM02 must reflect the total of the first 450 details. Failure to comply results in denial of the claim for an out of balance condition. |
| Example | SV2*300*HC:80019*301*UN*5~ |

Table 3.142 – Element ID SV201-SV210

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|--|---|
| SV201 | R | Service Line Revenue Code | Use the appropriate revenue code for the service rendered. |
| SV202 | S | Composite Medical Procedure Identifier | This is a composite data element. |
| SV202-1 | R | Product/Service ID Qualifier HC – Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes | HC is the only valid value accepted by the IHCP. Per the addenda, National Drug Code (NDC) information now resides on the LIN/CTP segments in the 2410 Loop. |
| SV202-2 | R | Procedure Code | Use the five-digit HCPCS procedure code for the service rendered. |
| SV202-3 | S | HCPCS Modifier 1 | |
| SV202-4 | S | HCPCS Modifier 2 | |
| SV202-5 | S | HCPCS Modifier 3 | |
| SV202-6 | S | HCPCS Modifier 4 | |
| SV202-7 | N/A | Description | Not used |
| SV203 | R | Line Item Charge Amount | The IHCP accepts the maximum HIPAA format of 99999999.99 |
| SV204 | R | Unit or Basis of Measurement Code DA – Days UN – Units | |
| SV205 | R | Service Unit Count | The IHCP only recognizes up to a seven-digit whole number. Fractional quantities are not recognized. IHCP format 9999999.999 |
| SV206 | S | Service Line Rate | Not used by the IHCP |
| SV207 | S | Line Item Denied Charge or Non-Covered Charge Amount | Not used by the IHCP |
| SV208 | N/A | Yes/No Condition or Response Code | Not used |
| SV209 | N/A | Nursing Home Residential Status Code | Not used |
| SV210 | N/A | Level of Care Code | Not used |

Table 3.143 – Line Supplemental Information

| Segment Name | Line Supplemental Information |
|---------------|--|
| Segment ID | PWK |
| Loop ID | 2400 |
| Usage | Situational |
| Segment Notes | This segment is used when additional information is required to process the claim, and the information must be mailed to the IHCP. |
| Example | PWK*AS*BM***AC*1522353~ |

Table 3.144 – Element ID PWK01-PWK09

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|--|--|
| PWK01 | R | Attachment Report Type Code | See the IG for a list of valid values. |
| PWK02 | R | Attachment Transmission Code BM – By Mail | Even though all Attachment Transmission Codes are accepted, claims that suspend because of an attachment requirement are only resolved by sending the attachment by mail. |
| PWK03 | N/A | Report Copies Needed | Not used |
| PWK04 | N/A | Entity Identifier Code | Not used |
| PWK05 | R | Identification Code Qualifier AC – Attachment Control Number | |
| PWK06 | R | Attachment Control Number | A unique attachment control number of up to 30 characters must be used and must match the number associated with the paper documentation sent by mail. This number is used to link the claim with the paper documentation and must be unique per billing location across all claims. |
| PWK07 | S | Attachment Description | Not used by the IHCP |
| PWK08 | N/A | Actions Indicated | Not used |
| PWK09 | N/A | Request Category Code | Not used |

Table 3.145 – Service Line Date

| Segment Name | Service Line Date |
|---------------|--|
| Segment ID | DTP |
| Loop ID | 2400 |
| Usage | Situational |
| Segment Notes | This segment reports the detail date of service. Required for home health and outpatient claims. |
| Example | DTP*472*D8*20021130~ |

Table 3.146 – Element ID DTP01-DTP03

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|---|--|
| DTP01 | R | Date/Time Qualifier 472 – Service | |
| DTP02 | R | Date/Time Period Format Qualifier D8 – Date Expressed in Format CCYYDDMM RD8 – Date Expressed in Format CCYYMMDD-CCYYMMDD | If qualifier RD8 is used, the IHCP uses the first occurrence of CCYYMMDD as the detail date of service. |
| DTP03 | R | Service Date | |

Table 3.147 – Drug Identification

| Segment Name | Drug Identification |
|---------------|---|
| Segment ID | LIN |
| Loop ID | 2410 |
| Usage | Situational |
| Segment Notes | This segment contains the NDC if applicable. LIN04 through LIN31 are listed in this segment, but marked as not used and do not appear in this illustration. This newly created segment appears in the <i>IG Addenda</i> . Only the first occurrence of the segment submitted is recognized by the IHCP. |
| Example | LIN*N4*00045012424~ |

Table 3.148 – Element ID LIN01-LIN03

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|---|-----------------------|
| LIN01 | N/A | Assigned Identification | Not used |
| LIN02 | R | Product/Service ID Qualifier N4 – National Drug Code in 5-4-2 format | |
| LIN03 | R | National Drug Code | Use the 11-digit NDC. |

Table 3.149 – Drug Pricing

| Segment Name | Drug Pricing |
|---------------|---|
| Segment ID | CTP |
| Loop ID | 2410 |
| Usage | Situational |
| Segment Notes | This segment contains information necessary to price the NDC listed in the previous LIN segment. CTP05-2 through CTP05-15 and CTP06 through CTP11 are listed in this segment but marked as not used and do not appear in this illustration. This newly created segment appears in the <i>IG Addenda</i> . |
| Example | CTP***1.2*300*ML~ |

Table 3.150 – Element ID CTP01-CTP05-1

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|--|--|
| CTP01 | N/A | Class of Trade Code | Not used |
| CTP02 | N/A | Price Identifier Code | Not used |
| CTP03 | R | Drug Unit Price | Not used by the IHCP |
| CTP04 | R | National Drug Unit Count | Use the quantity associated with the NDC listed in LIN03. The IHCP format is 9999999.999 |
| CTP05 | R | Composite Unit of Measure | This is a composite data element. |
| CTP05-1 | R | Unit or Basis of Measurement Code GR – Gram ML – Milliliter UN – Unit F2 – International Units | Use the appropriate unit of measure. |

Table 3.151 – Service Line Adjudication Information

| Segment Name | Service Line Adjudication Information |
|---------------|---|
| Segment ID | SVD |
| Loop ID | 2430 |
| Usage | Situational |
| Segment Notes | This segment contains the detail other payer paid amount. See the <i>IHCP Provider Manual</i> for guidelines for using the detail paid amount. For HIP, the plans will report the total paid for the detail including the POWER account contribution. |
| Example | SVD*00130*678.9~ |

Table 3.152 – Element ID SVD01-SVD06

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|--|---|
| SVD01 | R | Payer Identification | This must match the value submitted in NM109 in the 2330B Loop. For crossover claims with Medicare payment submitted at the detail, refer to the companion guide values specified for NM109 in Loop 2330B. |
| SVD02 | R | Service Line Paid Amount | Use the detail Medicare, MCO and any other payer paid amount. The IHCP accepts the maximum HIPAA format of 99999999.99 For HIP, the plans will report the total paid for the detail including the POWER account contribution. |
| SVD03 | S | Composite Medical Procedure Identifier | This is a composite data element and is not used by the IHCP. |
| SVD03-1 | R | Product or Service ID Qualifier | Not used by the IHCP |
| SVD03-2 | R | Procedure Code | Not used by the IHCP |
| SVD03-3 | S | Procedure Modifier | Not used by the IHCP |
| SVD03-4 | S | Procedure Modifier | Not used by the IHCP |
| SVD03-5 | S | Procedure Modifier | Not used by the IHCP |
| SVD03-6 | S | Procedure Modifier | Not used by the IHCP |
| SVD03-7 | S | Procedure Code Description | Not used by the IHCP |
| SVD04 | R | Service Line Revenue Code | Not used by the IHCP |
| SVD05 | R | Adjustment Quantity | Not used by the IHCP |
| SVD06 | S | Bundled or Unbundled Line Number | Not used by the IHCP |

Table 3.153 – Service Line Adjustment

| Segment Name | Service Line Adjustment |
|---------------|--|
| Segment ID | CAS |
| Loop ID | 2430 |
| Usage | Situational |
| Segment Notes | This segment submits Medicare deductible, coinsurance, and blood deductible amounts for Medicare Part B claims. For non-crossover claims, this segment submits all adjustment amounts. The combination of Adjustment Reason Code, Adjustment Amount, and Adjustment Quantity is reported six times on this segment. The following illustration shows only the first iteration. See the IG for complete details about CAS05-19. |
| Example | CAS*PR*2*25.1~ |

Table 3.154 – Element ID CAS01-CAS04

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|------------------------------------|---|
| CAS01 | R | Claim Adjustment Group Code | |
| CAS02 | R | Adjustment Reason Code | All adjustments and adjustment amounts are captured by IHCP for claims that were previously adjudicated by another payer for example, MCO, Medicare, or TPL claims. |
| CAS03 | R | Adjustment Amount | Use the dollar amount associated with the reason code identified in CAS02. The IHCP accepts the maximum HIPAA format of 99999999.99 |
| CAS04 | S | Adjustment Quantity | IHCP format 9999999.999 |

Table 3.155 – Service Adjudication Date

| Segment Name | Service Adjudication Date |
|---------------|--|
| Segment ID | DTP |
| Loop ID | 2430 |
| Usage | Situational |
| Segment Notes | This segment specifies the date when a service line was adjudicated. See the IG for details. |
| Example | DTP*573*D8*19981226~ |

Table 3.156 – Element ID DTP01-DTP03

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|---|---|
| DTP01 | R | Date/Time Qualifier 573 – Date Claim Paid | |
| DTP02 | R | Date/Time Period Format Qualifier D8 – Date Expressed in Format CCYYDDMM | |
| DTP03 | R | Service Adjudication or Payment Date | Payment or Adjudication Date MCOs submit payment date. |

Table 3.157 – Transaction Set Trailer

| Segment Name | Transaction Set Trailer |
|---------------|--|
| Segment ID | SE |
| Loop ID | N/A |
| Usage | Required |
| Segment Notes | This segment ends the transaction set. |
| Example | SE*837*7656543~ |

Table 3.158 – Element ID SE01-SE02

| Element ID | Usage | Guide Description and Valid Values | Comments |
|------------|-------|---|---|
| SE01 | R | Transaction Set Identifier Code 837 | |
| SE02 | R | Transaction Set Control Number | This number is assigned locally by the sender and should match the value in the preceding ST segment. |

Transaction Examples**Medicaid Primary – No COB**

```

ST*837*987654~
BHT*0019*00*X2FF1*20020901*1230*CH~
REF*87*004010X096A1~
NM1*41*2*ANDERSON MEDICAL GROUP*****46*P123~
PER*IC*ALICE WILSON*TE*3174880000~
NM1*40*2*IHCP*****46*IHCP~
HL*1**20*1~
NM1*85*2*ANDERSON MEDICAL GROUP*****XX*1234567890~
N3*4000 E MELROSE STREET~
N4*INDIANAPOLIS*IN*46204~
REF*EI*211311411~
REF*1D*100444000A~
HL*2*1*22*0~
SBR*P*18**IHCP*****MC~
NM1*IL*1*DOE*JACK****MI*100444555999~
N3*6000 WEST STREET~
N4*INDIANAPOLIS*IN*46410~
DMG*D8*19390529*M~
NM1*PR*2*EDS*****PI*EDS~
CLM*755555M*105951.4***11:A:1*Y**Y*Y*****N~
DTP*434*RD8*20021019-20021118~
DTP*435*DT*200210191400~
CL1*3**20~
PWK*AS*BM***AC*86576*Admission comments~
AMT*C5*105851.4~
AMT*F3*100~
REF*9F*12~
REF*EA*D234345~
HI*BK:51881*BJ:51881~
HI*BF:7070*BF:5789*BF:42731*BF:78039*BF:5119*BF:2761*BF:03811*BF:4280~
HI*BH:51:D8:20021118~
HI*BG:C1~
QTY*CA*30*DA~
NM1*71*2*ANDERSON*JOEL****XX*1234567890~
PRV*AT*ZZ*363LP0200N~
REF*0B*0123454321~
LX*1~
SV2*120**31500*UN*30*1050~
LX*2~
SV2*250**25276.85*UN*791~
LX*3~
SV2*258**4360.80*UN*150~
LX*4~
SV2*270**13148.10*UN*495~

```

```
LX*5~  
SV2*300**301*UN*5~  
LX*6~  
SV2*301**3118.25*UN*133~  
LX*7~  
SV2*305**240.60*UN*5~  
LX*8~  
SV2*306**497.15*UN*8~  
LX*9~  
SV2*307**45.40*UN*4~  
LX*10~  
SV2*320**632.75*UN*4~  
LX*11~  
SV2*410**26830.5*UN*96~  
SE*58*987654~
```

Figure 3.1 – 837I Transaction for Medicaid Primary and No COB

Medicaid Secondary to Medicare

```
ST*837*987654~  
BHT*0019*00*X2FF1*20020901*1230*CH~  
REF*87*004010X096A1~  
NM1*41*2*ANDERSON MEDICAL GROUP*****46*P123~  
PER*IC*ALICE WILSON*TE*3174880000~  
NM1*40*2*IHCP*****46*IHCP~  
HL*1**20*1~  
NM1*85*2*ANDERSON MEDICAL GROUP*****24*363915363~  
N3*4000 E MELROSE STREET~  
N4*INDIANAPOLIS*IN*46204~  
REF*1D*100444000A~  
HL*2*1*22*0~  
SBR*P*18**IHCP*****MC~  
NM1*IL*1*DOE*JACK****MI*100444555999~  
N3*6000 WEST STREET~  
N4*INDIANAPOLIS*IN*46410~  
DMG*D8*19390529*M~  
NM1*PR*2*EDS*****PI*EDS~  
CLM*755555M*105951.4***11:A:1*Y**Y*Y*****N~  
DTP*434*RD8*20021019-20021118~  
DTP*435*DT*200210191400~  
CL1*3**20~  
PWK*AS*BM***AC*86576*Admission comments~  
AMT*C5*61295.95~  
AMT*F3*100~  
REF*9F*12~
```

```

REF*EA*D234345~
HI*BK:51881*BJ:51881~
HI*BF:7070*BF:5789*BF:42731*BF:78039*BF:5119*BF:2761*BF:03811*BF:4280~
HI*BH:51:D8:20021118~
HI*BG:C1~
QTY*CA*30*DA~
NM1*71*2*ANDERSON*JOEL****34*212222122~
PRV*AT*ZZ*363LP0200N~
REF*0B*0123454321~
SBR*P*18*****MA~
CAS*PR*1*1153.2~
AMT*N1*44455.45~
DMG*D8*19251014*F~
OI***Y***Y~
NM1*IL*1*DOE*JACK****MI*7767654A~
NM1*PR*2*MEDICARE*****PI*00130~
LX*1~
SV2*120**31500*UN*30*1050~
LX*2~
SV2*250**25276.85*UN*791~
LX*3~
SV2*258**4360.80*UN*150~
LX*4~
SV2*270**13148.10*UN*495~
LX*5~
SV2*300**301*UN*5~
LX*6~
SV2*301**3118.25*UN*133~
LX*7~
SV2*305**240.60*UN*5~
LX*8~
SV2*306**497.15*UN*8~
LX*9~
SV2*307**45.40*UN*4~
LX*10~
SV2*320**632.75*UN*4~
LX*11~
SV2*410**26830.5*UN*96~
SE*65*987654~

```

Figure 3.2 – 837I Transaction for Medicaid Secondary to Medicare

Medicaid Tertiary to Medicare and Other Insurer

```

ST*837*987654~

```

```
BHT*0019*00*X2FF1*20020901*1230*CH~
REF*87*004010X096A1~
NM1*41*2*ANDERSON MEDICAL GROUP*****46*P123~
PER*IC*ALICE WILSON*TE*3174880000~
NM1*40*2*IHCP*****46*IHCP~
HL*1**20*1~
NM1*85*2*ANDERSON MEDICAL GROUP*****24*363915363~
N3*4000 E MELROSE STREET~
N4*INDIANAPOLIS*IN*46204~
REF*1D*100444000A~
HL*2*1*22*0~
SBR*P*18**IHCP*****MC~
NM1*IL*1*DOE*JACK****MI*100444555999~
N3*6000 WEST STREET~
N4*INDIANAPOLIS*IN*46410~
DMG*D8*19390529*M~
NM1*PR*2*EDS*****PI*EDS~
CLM*755555M*105951.4***11:A:1*Y**Y*Y*****N~
DTP*434*RD8*20021019-20021118~
DTP*435*DT*200210191400~
CL1*3**20~
PWK*AS*BM***AC*86576*Admission comments~
AMT*C5*62055.45~
AMT*F3*100~
REF*9F*12~
REF*EA*D234345~
HI*BK:51881*BJ:51881~
HI*BF:7070*BF:5789*BF:42731*BF:78039*BF:5119*BF:2761*BF:03811*BF:4280~
HI*BH:51:D8:20021118~
HI*BG:C1~
QTY*CA*30*DA~
NM1*71*2*ANDERSON*JOEL****34*212222122~
PRV*AT*ZZ*363LP0200N~
REF*0B*0123454321~
SBR*P*18*****MA~
CAS*PR*1*1153.2~
AMT*N1*44455.45~
DMG*D8*19251014*M~
OI***Y***Y~
NM1*IL*1*DOE*JACK****MI*7767654A~
NM1*PR*2*MEDICARE*****PI*00130~
SBR*P*18*****CI~
AMT*C4*17500~
DMG*D8*19251014*M~
```

```

OI***Y***Y~
NM1*IL*1*DOE*JACK****MI*7767654A~
NM1*PR*2*AETNA*****PI*98366~
LX*1~
SV2*120**31500*UN*30*1050~
LX*2~
SV2*250**25276.85*UN*791~
LX*3~
SV2*258**4360.80*UN*150~
LX*4~
SV2*270**13148.10*UN*495~
LX*5~
SV2*300**301*UN*5~
LX*6~
SV2*301**3118.25*UN*133~
LX*7~
SV2*305**240.60*UN*5~
LX*8~
SV2*306**497.15*UN*8~
LX*9~
SV2*307**45.40*UN*4~
LX*10~
SV2*320**632.75*UN*4~
LX*11~
SV2*410**26830.5*UN*96~
SE*71*987654~

```

Figure 3.3 – 837I Transaction for Medicaid Tertiary to Medicare and Other Insurer

Medicaid Secondary to Primary Insurer (TPL)

```

ST*837*987654~
BHT*0019*00*X2FF1*20020901*1230*CH~
REF*87*004010X096A1~
NM1*41*2*ANDERSON MEDICAL GROUP*****46*P123~
PER*IC*ALICE WILSON*TE*3174880000~
NM1*40*2*IHCP*****46*IHCP~
HL*1**20*1~
NM1*85*2*ANDERSON MEDICAL GROUP*****24*363915363~
N3*4000 E MELROSE STREET~
N4*INDIANAPOLIS*IN*46204~
REF*1D*100444000A~
HL*2*1*22*0~
SBR*P*18**IHCP*****MC~
NM1*IL*1*DOE*JACK****MI*100444555999~

```

N3*6000 WEST STREET~
N4*INDIANAPOLIS*IN*46410~
DMG*D8*19390529*M~
NM1*PR*2*EDS*****PI*EDS~
CLM*755555M*105951.4***11:A:1*Y**Y*Y*****N~
DTP*434*RD8*20021019-20021118~
DTP*435*DT*200210191400~
CL1*3**20~
PWK*AS*BM***AC*86576*Admission comments~
AMT*C5*88351.4~
AMT*F3*100~
REF*9F*12~
REF*EA*D234345~
HI*BK:51881*BJ:51881~
HI*BF:7070*BF:5789*BF:42731*BF:78039*BF:5119*BF:2761*BF:03811*BF:4280~
HI*BH:51:D8:20021118~
HI*BG:C1~
QTY*CA*30*DA~
NM1*71*2*ANDERSON*JOEL****34*212222122~
PRV*AT*ZZ*363LP0200N~
REF*0B*0123454321~
SBR*P*18***CI~**
AMT*C4*17500~
DMG*D8*19251014*M~
OI*Y***Y~**
NM1*IL*1*DOE*JACK**MI*7767654A~**
NM1*PR*2*AETNA***PI*98366~**
LX*1~
SV2*120**31500*UN*30*1050~
LX*2~
SV2*250**25276.85*UN*791~
LX*3~
SV2*258**4360.80*UN*150~
LX*4~
SV2*270**13148.10*UN*495~
LX*5~
SV2*300**301*UN*5~
LX*6~
SV2*301**3118.25*UN*133~
LX*7~
SV2*305**240.60*UN*5~
LX*8~
SV2*306**497.15*UN*8~
LX*9~

```

SV2*307**45.40*UN*4~
LX*10~
SV2*320**632.75*UN*4~
LX*11~
SV2*410**26830.5*UN*96~
SE*64*987654~

```

Figure 3.4 – 837I Transaction for Medicaid Secondary to Primary Insurer (TPL)

MCO Encounter Claim to Medicaid

```

ST*837*987655~
BHT*0019*00*ENCOUNTER WITH COB*20010901*1230*RP~
REF*87*004010X096A1~
NM1*41*2*MANAGED HEALTH SERVICES CENTRAL*****46*44444~
PER*IC*REQUIRED BUT WE DONT USE*TE*3174885059~
NM1*40*2*INDIANA HEALTH COVERAGE PROGRAM*****46*IHCP~
HL*1**20*1~
NM1*85*2*DR.  MARCUS WELBY*****24*123321123~
N3*4444 WEST STREET~
N4*INDIANAPOLIS*IN*12345~
REF*1A*123321123~
REF*1D*100000000A~
REF*B3*100467390N~
HL*2*1*22*0~
SBR*T*18**SBR03 OR 04 IS REQUIRED*****CI~
NM1*IL*1*PATIENT*JOE****MI*104455668899~
N3*1111 South Street~
N4*INDIANAPOLIS*IN*88888~
DMG*D8*19751010*M~
NM1*PR*2*EDS*****PI*EDS~
CLM*PAT12345*1000***13:A:1*Y**Y*M*****Y~
DTP*434*RD8*20021019-20021118~
AMT*C5*200~
HI*BK:25000*BJ:25000~
NM1*71*2* DR.  MARCUS WELBY * *****XX*1234567890~
PRV*SU*ZZ*363LP0200N~
SBR*S*18*****12~
CAS*PI*23*650~
CAS*CO*42*200~
AMT*C4*150~
DMG*D8*19751010*M~
OI***Y***Y~
NM1*IL*1*PATIENT*JOE****MI*104455668899~
NM1*PR*2*MANAGED HEALTH SERVICES CENTRAL*****PI*MHS~

```

```
REF*F8*1234567890123456~  
SBR*P*18*****CI~  
CAS*PR*1*250**2*100~  
AMT*C4*650~  
DMG*D8*19751010*M~  
OI***Y***Y~  
NM1*IL*1*PATIENT*JOE****MI*607840G~  
NM1*PR*2*ANTHEM INSURANCE*****PI*ANTHEM~  
LX*1~  
SV2*450**1000*UN*1~  
SVD*MHS*150**270*1~  
SVD*ANTHEM*650**270*1~  
SE*46*987655~
```

Figure 3.5 – 837I Transaction for MCO Encounter Claim to Medicaid

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