# STATE OF HAWAII

# DEPARTMENT OF HUMAN SERVICES

# MED-QUEST DIVISION

## Companion Document and Transaction Specifications for HIPAA 837 Claim Transactions

**Version 1.5**
**MARCH 2004**

# DRAFT

# DRAFT

## Revision History

| Date | Version | Description | Author |
|---|---|---|---|
| 04/16/2003 | 1.0 | Draft for posting to the Med-QUEST Web Site | Med-QUEST Systems Office |
| 07/08/2003 | 1.1 | Final Companion Document for 837 Claims implementation | Med-QUEST Systems Office |
| 09/09/2003 | 1.2 | 837 Claims Companion Document with revised acknowledgement procedures and a corrected DHS/Med-QUEST Federal Tax ID | Med-QUEST Systems Office |
| 11/04/2003 | 1.3 | Draft for posting to the Med-QUEST Web Site | Med-QUEST Systems Office |
| 12/12/2003 | 1.4 | Draft for posting to the Med-QUEST Web Site | Med-QUEST Systems Office |
| 03/05/2004 | 1.5 | Draft for posting to the Med-QUEST Web Site | Med-QUEST Systems Office |

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# Table of Contents

# 1. Introduction

## 1.1 Document Purpose

**Companion Documents**

HIPAA Transaction Companion Documents are available to electronic trading partners (health plans, program contractors, providers, third party processors, and billing services) to clarify information on HIPAA-compliant electronic interfaces with Med-QUEST. The following Companion Documents are being produced:

- 834 Enrollment and 820 Capitation Transactions
- 270 Eligibility Verification and 271 Eligibility Response Transactions
- *837 Claims Transactions*
- 837 and NCPDP Encounter Transactions
- 835 Electronic FFS Claims Remittance Advice Transaction
- 276 Claim Status Request and 277 Response Transactions
- 277 Unsolicited Claim Status Transaction (Encounters)
- 278 Prior Authorization Transaction

The ASC X12 837 Claim Transactions for professional, dental, and institutional claims are covered in this document.

**HIPAA Overview**

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) require the federal Department of Health and Human Services to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. The Act also addresses the security and privacy of health data. The long-term purpose of these standards is to improve the efficiency and effectiveness of the nation's health care system by encouraging widespread use of standard electronic data interchanges in health care.

The intent of the law is that all electronic transactions for which standards are specified must be conducted according to the standards. These standards were reviewed through a process that included significant public and private sector input prior to publication in the Federal Register as Final Rules with legally binding implementation time frames.

Covered entities are required to accept transmissions in the standard format and must not delay a transaction or adversely affect an entity that wants to conduct standard transactions electronically. For HIPAA, both Med-QUEST and its fee-for-service providers are covered entities.

**Document Objective**

This Claims Companion Document provides information related to electronic submission of 837 Claims Transactions to Med-QUEST by contracted providers and billing agents. Three distinct claim transaction formats are documented:

- 837 Professional
- 837 Dental
- 837 Institutional

For each of these formats, this Companion Guide tells claim submitters how to prepare and maintain a HIPAA compliant claim submission interface, including detailed information on populating claim data elements for submission to Med-QUEST. The Companion Guide supplements the HIPAA Implementation Guide for each transaction type with information specific to Med-QUEST and its trading partners.

**Intended Users**

Companion Documents are intended for the technical staffs of all types of providers and billing agents that are responsible for electronic transaction exchanges. They also offer a statement of HIPAA Transaction and Code Set Requirements from a Med-QUEST perspective.

Only providers that submit claims to Med-QUEST electronically are subject to HIPAA Transaction and Code Set requirements.

**Relationship to HIPAA Implementation Guides**

Companion Documents supplement the HIPAA Implementation Guides for each of the HIPAA transactions. Rules for format, content, and field values can be found in the Implementation Guides. This document describes the Med-QUEST FTP environment and, for 837 Claim Transactions, edit and interchange conventions. It also provides specific information on the fields and values required for transactions sent to Med-QUEST.

Companion Documents are intended to supplement rather than replace the standard HIPAA Implementation Guide for each transaction set. Information in these documents is not intended to:

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

**Disclaimer**

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

Substantial effort has been taken to minimize information conflicts. However, Med-QUEST, the Med-QUEST Systems Office, or its employees will not be liable or responsible for any errors or expenses resulting from the use of information in this document. If you believe there is an error in the document, please notify the Med-QUEST Systems Office immediately.

## 1.2 Contents of this Companion Document

| | |
|---|---|
| **Introduction** | Section 1 provides general information on Companion Documents and HIPAA and outlines the information included in the remainder of the document. |
| **Transaction Overview** | Section 2 provides an overview of the transaction or transactions included in this Companion Document including information on:<br>▪ The purpose of the transaction(s)<br>▪ The standard Implementation Guide for the transaction(s)<br>▪ Replaced and impacted Med-QUEST files and processes<br>▪ Transmission schedules |
| **Technical Infrastructure** | Section 3 provides a brief statement of the technical interfaces required for trading partners to communicate with Med-QUEST via electronic transactions. Readers are referred to the Med-QUEST Electronic Claim Submission and Electronic Remittance Advice Requirements document for operational information. |
| **Transaction Standards** | Section 4 provides information relating to the transactions included in this Companion Document including:<br>▪ General HIPAA transaction standards<br>▪ Data interchange conventions applicable to the transactions<br>▪ Procedures for acknowledgment transactions<br>▪ Procedures for handling rejected transmissions and transactions |
| **Transaction Specifications** | Section 5 provides specific information relating to the transaction(s) in this Companion Document including:<br>▪ A statement of the purpose of transaction specifications between Med-QUEST and other covered entities<br>▪ Med-QUEST-specific data requirements for the transaction(s) at the data element level<br>The Data Requirements portion of each Transaction Specification defines in detail how HIPAA Transactions are formatted and populated for exchanges with Med-QUEST. This section covers transaction data elements about which Med-QUEST provides information not to be found in the standard Implementation Guide. |

# 2. 837 Claim Transactions

## 2.1 Transaction Overview

**Claim Submission**

The HIPAA compliant 837 Claim Transactions are designed for use by health care providers to electronically submit fee-for-service claims to health care payers. Med-QUEST has adopted the HIPAA-mandated 837 Claim Transactions for use by fee-for-service providers that are paid directly by the Agency. Providers and other entities that submit claims to Med-QUEST electronically are required to use the 837's formats and code sets.

The 837 Transaction has three separate formats for professional, dental, and institutional claims. Each of the formats has hundreds of data elements that describe medical services. Med-QUEST pharmacy claims are processed by a contracted pharmacy benefit manager (PBM) and are not submitted directly to Med-QUEST for adjudication.

Electronic claim submission by providers or their billing agents and claim adjudication by Med-QUEST are not changed by HIPAA mandates. What have changed significantly are the formats of the submitted claims and the code sets used to describe claim data. In the HIPAA compliant environment, Med-QUEST accepts claims in 837 formats and relies on a translator to bring them into its Hawaii Prepaid Medical Management Information System (HPMMIS) for adjudication and reporting.

**Claim Adjudication**

Within the Med-QUEST System, claim adjudication and reporting will continue with modifications (state-only HCPCS Procedure Codes, for example, will no longer be recognized). 837 formats can accommodate many more data elements than the Electronic Claim Submission File formerly used by Med-QUEST. The Agency has enhanced its data retention and reporting capabilities and will use supplementary claim data (including coordination of benefits data) for reporting and analysis. Basic claim data elements, including identifiers, dates, Diagnosis Codes, and Procedure Codes, remain unchanged.

Following claim adjudication, two additional HIPAA transaction sets tell submitting providers adjudication results and current claim statuses. They are the 835 Claim Remittance Advice Transaction and the 276/277 Claim Status Request and Response Transactions. The 835 Transaction supplements the pre-HIPAA Med-QUEST electronic Remittance Advice and tells providers adjudication results and payment amounts by claim and service line. The 276/277 Transaction Set permits providers to inquire as to the current status of selected claims whether or not they have completed adjudication.

**Processes Replaced or Impacted**

Replaced Processes

- None

Impacted Processes

- Claims from contracted fee-for-service providers now have HIPAA compliant transaction formats and code sets.
- Submitters of electronic claims receive remittance advices from Med-QUEST with the HIPAA compliant 835 Transaction.

The impacted processes will continue to function but will be changed so that they meet all HIPAA data and/or format compliance requirements.

## 2.2 837 Claims Transactions

**Purpose**

The purpose of the three types of 837 Claims Transactions is to enable medical providers of all types (with the exception of pharmacy) to submit claims for payment for services. To some extent, 837 Transactions reflect HCFA-1500, UB-92, and American Dental Association (ADA) claim formats, with the addition of many supplementary and specialized data structures.

Med-QUEST uses HIPAA compliant 837 Transactions for both fee for service claims and encounters. This Companion Document deals only with claims submitted directly to Med-QUEST.

Contracted fee-for-service providers or their billing agents transmit 837 Claim Transactions in batch mode through the Med-QUEST File Transfer Protocol (FTP) Server. Med-QUEST follows the procedures described in Sections 4.5, Acknowledgement Procedures, and 4.6, Rejected Transmissions and Transactions, to acknowledge, accept, or reject electronic 837 Claim Transactions.

**Standard Implementation Guides**

The Standard Implementation Guides for Claim Transactions are:

- 837 Health Care Claim: Professional (004010X098)
- 837 Health Care Claim: Dental (004010X097)
- 837 Health Care Claim: Institutional (004010X096)

For 837 Transactions, Med-QUEST incorporates all approved Addenda. Transmission Type Codes for production transactions that follow standards as modified by Addenda are:

- ASC X12N 837 Professional (004010X098A1)
- ASC X12N 837 Dental (004010X097A1)
- ASC X12N 837 Institutional (004010X096A1)

**Submission Schedule**

Claim submitters can transmit 837 Transactions or "batches" of claims to Med-QUEST at any time during the day or night. Med-QUEST processes claims every evening, one batch at a time.

Med-QUEST sends 835 Remittance Advice Transactions to claim submitters that request them on a weekly basis. They are issued at the same time as claim payments. Providers can use 276 Claim Status Request Transactions to inquire about the current status of a claim at any time and receive 277 Claim Status Response Transactions in return.

# 3. Technical Infrastructure and Procedures

## 3.1 Technical Environment

**Med-QUEST Data Center Communications Requirements**

Trading partners connect to Med-QUEST by going from the Internet through a Virtual Private Network (VPN) Tunnel to the Med-QUEST File Transfer Protocol (FTP) Server. In standard software-to-hardware VPN connections, VPN client software is installed and configured on each machine at the client site that requires FTP access. Software to establish provider computers as VPN Clients is available from the sources documented in the Med-QUEST Electronic Claim Submission and Electronic Remittance Advice Requirements document. Detailed information on FTP and VPN setups also appears in that manual.

**Technical Assistance and Help**

The Provider Inquiry Unit or Call Center maintained by Affiliated Computer Services (ACS), the Med-QUEST Fiscal Agent, provides technical assistance related to questions about electronic claims submission or data communications interfaces. All calls result in Ticket Number assignment and problem tracking. Contact information is:

- **Telephone Number:** Oahu: (808) 952-5570
  Neighbor Islands: (800) 882-4378
- **Hours:** 7:30 AM – 5:00 PM Hawaii Time, Mondays through Fridays
- **Information required for initial call:**
  - Topic of Call (VPN setup, FTP procedures, etc.)
  - Name of caller
  - Organization of caller
  - Telephone number of caller
  - Nature of problem (connection, receipt status, etc.)
- **Information required for follow up call(s):**
  - Ticket Number assigned by the Provider Call Center

## 3.2 Directory and File Naming Conventions

**FTP Directory Naming Convention**

The current structure on the FTP server is designed to provide logical access to all files, ease troubleshooting searches, and simplify security for account set ups and maintenance. Current FTP Directory file naming conventions are as follows:

**FTP\Submitter ID\Claims\(ECSin\ECSout)\(Prod\Test)**

- Submitter ID – The 5 digit Submitter ID assigned by Med-QUEST.
- Claims – The default directory name indicating 837 Claims Transactions.
- ECSin – The default directory name indicating inbound data.
- ECSout – The default directory name indicating outbound data.
- Prod – The default directory name indicating it is the production environment.
- Test – The default directory name indicating it is the test environment.

**File Naming Conventions**

**837 Transaction**

The 837 Transaction has three separate formats for professional, dental, and institutional claims. Refer to Section 5, 837 Transaction Specifications, for more information.

CLM.MMDDYY.HHMMSS.837

- CLM is the file type.
- MMDDYY is the date processed.
- HHMMSS is the time processed.
- 837 is the Transaction type.

### TA1 Interchange Acknowledgement Transactions

Trading partners can use the TA1 Transaction to acknowledge receipt of transmissions or interchanges of X12 Transactions and to tell Med-QUEST of problems in the ISA/IEA Interchange Envelope. Refer to Section 4.5, Acknowledgement Procedures, for additional information.

MMDDYY.000000000.TA1

- MMDDYY is the process date.
- 000000000 is the unique 9 character Interchange Control Number created for every file Med-QUEST sends to the trading partner regardless of the transaction type.
- TA1 is the acknowledgement type.

### 997 Functional Acknowledgement Transactions

A 997 can be sent as an acknowledgement for each GS/GE Envelope or Functional Group of one or more transactions within the interchange or to report on some types of syntactical errors. Refer to Section 4.5, Acknowledgement Procedures, for additional information.

MMDDYY.000000000.997

- MMDDYY is the process date.
- 000000000 is the unique 9 character Interchange Control Number created for every file that Med-QUEST sends to the trading partner regardless of the transaction type.
- 997 is the acknowledgement type.

### 824 Implementation Guide Reporting Transactions

For transmissions that are valid on the interchange level, the translator edits transactions and uses 824 Implementation Guide Reporting Transactions to report problems. Refer to Section 4.5, Acknowledgement Procedures, for additional information.

MMDDYY.000000000.824

- MMDDYY is the process date.
- 000000000 is the unique 9 character Interchange Control Number created for every file Med-QUEST sends to the trading partner regardless of the transaction type.
- 824 is the acknowledgement type.

# 4. Transaction Standards

## 4.1 General Information

**HIPAA Requirements**

HIPAA standards are specified in Implementation Guides for each transaction set and in authorized Implementation Guide Addenda. The second draft Addenda Documents for the three types of 837 Transactions have been published in final form in February 2003. In this Companion Document, Med-QUEST uses Version 4010 of 837 Transactions as modified by final Addenda.

An overview of requirements specific to each transaction can be found in each Implementation Guide. Implementation Guides contain information related to:

- The format and content of interchanges and functional groups of transactions
- The format and content of the Header, Detail, and Trailer Segments specific to the transaction
- Code sets and values authorized for use in the transaction

Companion Documents can be seen as a bridge between Implementation Guides and claim requirements specific to Med-QUEST. For claims, this Companion Document, in combination with the Implementation Guides, tells how to prepare data in HIPAA standard formats for submission to Med-QUEST.

**Size of Transmissions/ Batches**

Implementation Guides for 837 Transactions recommend a maximum of 5,000 claims per transaction. If submitters have more than 5,000 claims, they should be submitted within separate 837 Transactions.

## 4.2 Data Interchange Conventions

**Overview of Data Interchange**

When receiving 837 Claim Transactions from providers, Med-QUEST follows standards developed by the Accredited Standards Committee (ASC) of the American National Standards Institute (ANSI). These standards involve Interchange (ISA/IEA) and Functional Group (GS/GE) Segments or "outer envelopes". All 837 Transactions are enclosed in transmission level ISA/IEA envelopes and, within transmissions, functional group level GS/GE envelopes. The segments and data elements used in outer envelopes are documented in Appendix B of Implementation Guides and later in this section.

Transaction Specifications that say how individual data elements are populated by Med-QUEST on ISA/IEA and GS/GE envelopes are shown in the table beginning on the next page. This document assumes that security considerations involving user identifiers, passwords, and encryption procedures are handled by the Med-QUEST FTP Server and not through the ISA Segment.

The ISA/IEA Interchange Envelope, unlike most ASC X12 data structures, has fixed fields of a fixed length. Blank fields cannot be left out.

**Envelope Specifications Tables**

Definitions of table columns follow:

Loop ID
The Implementation Guide's identifier for a data loop within a transaction. Always "NA" in this situation because segments in outer envelopes have segments and elements but not loops.

Segment ID
The Implementation Guide's identifier for a data segment.

Element ID
The Implementation Guide's identifier for a data element within a segment.

Element Name
A data element name as shown in the Implementation Guide. When the industry name differs from the Data Element Dictionary name, the more descriptive industry name is used.

Element Definition/Length
How the data element is defined in the Implementation Guide. For ISA and IEA Segments only, fields are of fixed lengths and are present whether or

not they are populated. For this reason, field lengths are provided in this column after element definitions.

Valid Values
The valid values from the Implementation Guide that are used by Med-QUEST.

Definition/Format
Definitions of valid values used by Med-QUEST and additional information about Med-QUEST data element requirements.

| ISA/IEA INTERCHANGE CONTROL ENVELOPE TRANSACTION SPECIFICATIONS | | | | | | |
|---|---|---|---|---|---|---|
| **Loop ID** | **Seg ID** | **Element ID** | **Element Name** | **Element Definition/Length** | **Valid Values** | **Definition/Format** |
| **ISA INTERCHANGE HEADER** | | | | | | |
| NA | ISA | ISA01 | AUTHORIZATION INFORMATION QUALIFIER | Code to identify the type of information in the Authorization Information Element/2 Characters | 00 | No Authorization Information Present |
| NA | ISA | ISA02 | AUTHORIZATION INFORMATION | Information used for additional identification or authorization of the interchange sender or the data in the interchange; the type of information is set by the Authorization Information Qualifier/10 characters | | Leave field blank – not used by Med-QUEST. |
| NA | ISA | ISA03 | SECURITY INFORMATION QUALIFIER | Code to identify the type of information in the Security Information/2 characters | 00 | No Security Information present |
| NA | ISA | ISA04 | SECURITY INFORMATION | This field is used for identifying the security information about the interchange sender and the data in the interchange; the type of information is set by the Security Information Qualifier/10 characters | | Leave field blank – not used by Med-QUEST. |
| NA | ISA | ISA05 | INTERCHANGE ID QUALIFIER | Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified/2 characters | ZZ | Mutually Defined |
| NA | ISA | ISA06 | INTERCHANGE SENDER ID | Identification code published by the sender for other parties to use as the receiver ID to route data to them; the sender always codes this value in the sender ID element/15 characters | | The five-digit Claim Submitter ID assigned by Med-QUEST |
| NA | ISA | ISA07 | INTERCHANGE ID QUALIFIER | Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified/2 characters | ZZ | Mutually Defined |
| NA | ISA | ISA08 | INTERCHANGE RECEIVER ID | Identification code published by the receiver of the data; When sending, it is used by the sender as their sending ID, thus other parties sending to them will use this as a receiving ID to route data to them/15 characters | | "MQD" followed by the nine-digit DHS/Med-QUEST Federal Tax ID number (996001089) |
| NA | ISA | ISA09 | INTERCHANGE DATE | Date of the interchange/6 characters | | The Interchange Date in YYMMDD format |
| NA | ISA | ISA10 | INTERCHANGE TIME | Time of the interchange/4 characters | | The Interchange Time in HHMM format |

| ISA/IEA INTERCHANGE CONTROL ENVELOPE TRANSACTION SPECIFICATIONS | | | | | | |
|---|---|---|---|---|---|---|
| **Loop ID** | **Seg ID** | **Element ID** | **Element Name** | **Element Definition/Length** | **Valid Values** | **Definition/Format** |
| NA | ISA | ISA11 | INTERCHANGE CONTROL STANDARDS IDENTIFIER | Code to identify the agency responsible for the control standard used by the message that is enclosed by the interchange header and trailer/1 character | U | U.S. EDI Community of ASC X12, TDCC, and UCS |
| NA | ISA | ISA12 | INTERCHANGE CONTROL VERSION NUMBER | This version number covers the interchange control segments/5 characters | 00401 | Draft Standards for Trial Use Approved for Publication by ASC X12 Procedure Review Board through October 1997 |
| NA | ISA | ISA13 | INTERCHANGE CONTROL NUMBER | A control number assigned by the interchange sender/9 characters | | The claim submitter assigns the Interchange Control Number in the rightmost six characters of this nine-character field. ISA13 must be unique within all transmissions (i.e., files) submitted to Med-QUEST by the same entity. Med-QUEST tracks this number to guard against duplicate file submissions. ISA13 must also be identical to the control number in Interchange Trailer element IEA02. |
| NA | ISA | ISA14 | ACKNOWLEDGE-MENT REQUESTED | Code sent by the sender to request an Interchange Acknowledgement (TA1)/1 character | 0 | No Acknowledgement Requested<br><br>Med-QUEST does not request or expect TA1 Interchange Acknowledgement Segments from its trading partners. |
| NA | ISA | ISA15 | USAGE INDICATOR | Code to indicate whether data enclosed is test, production or information/1 character | P or T | Production Data or<br>Test Data |
| NA | ISA | ISA16 | COMPONENT ELEMENT SEPARATOR | The delimiter value used to separate components of composite data elements/1 character | \| | A “pipe” (the symbol above the backslash on most keyboards) is the value used by Med-QUEST for component separation. Segment and element level delimiters are defined by usage in the ISA Segment and do not require separate ISA elements to identify them.<br><br>Delimiter values, by definition, cannot be used as data, even within free-form messages. The following separator or delimiter values are used by Med-QUEST |

| ISA/IEA INTERCHANGE CONTROL ENVELOPE TRANSACTION SPECIFICATIONS | | | | | | |
|---|---|---|---|---|---|---|
| **Loop ID** | **Seg ID** | **Element ID** | **Element Name** | **Element Definition/Length** | **Valid Values** | **Definition/Format** |
| | | | | | | on outgoing transactions:<br>Segment Delimiter - "~' (tilde – hexadecimal value X"7E")<br>Element Delimiter - "{" (left rounded bracket – hexadecimal value X"7B")<br>Composite Component Delimiter (ISA16) - "\|" (pipe – hexadecimal value X"7C")<br>These values are used because they are not likely to occur within transaction data. |
| **IEA INTERCHANGE TRAILER** | | | | | | |
| NA | IEA | IEA01 | NUMBER OF INCLUDED FUNCTIONAL GROUPS | A count of the number of functional groups included in an interchange/5 characters | | The number of functional groups of transactions in the interchange |
| NA | IEA | IEA02 | INTERCHANGE CONTROL NUMBER | A control number assigned by the interchange sender/9 characters | | A control number identical to the header-level Interchange Control Number in ISA13. |

| GS/GE FUNCTIONAL GROUP ENVELOPE TRANSACTION SPECIFICATIONS | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Loop ID** | **Seg ID** | **Element ID** | **Element Name** | **Element Definition/Length** | **Valid Value** | **Definition/Format** | **Source** |
| **GS FUNCTIONAL GROUP HEADER** | | | | | | | |
| NA | GS | GS01 | FUNCTIONAL IDENTIFIER CODE | Code identifying a group of application related transaction sets | HC | Health Care Claim (837) | HIPAA Code Set |
| NA | GS | GS02 | APPLICATION SENDER'S CODE | Code identifying party sending transmission; codes agreed to by trading partners | | Repeat the Sender Identifier used in the ISA Segment. | Transmission sender |
| NA | GS | GS03 | APPLICATION RECEIVER'S CODE | Codes identifying party receiving transmission. Codes agreed to by trading partners | | Repeat the Receiver Identifier used in the ISA Segment. | Transmission sender |
| NA | GS | GS04 | DATE | Date expressed as CCYYMMDD | | The functional group creation date. | Transmission sender |
| NA | GS | GS05 | TIME | Time on a 24-hour clock in HHMM format. | | The functional group creation time. | Transmission sender |
| NA | GS | GS06 | GROUP CONTROL NUMBER | Assigned number originated and maintained by the sender | | A control number for the functional group of transactions. | Transaction sender |
| NA | GS | GS07 | RESPONSIBLE AGENCY CODE | Code used in conjunction with Element GS08 to identify the issuer of the standard | X | Accredited Standards Committee X12 | HIPAA Code Set |
| NA | GS | GS08 | VERSION/ RELEASE/ INDUSTRY IDENTIFIER CODE | Code that identifies the version of the transaction(s) in the functional group | | 004010X098A1 (Professional)<br>004010X097A1 (Dental)<br>004010X096A1 (Institutional)<br><br>Med-QUEST uses Addenda versions of all HIPAA Transactions. These Version Numbers incorporate the final Addenda. | HIPAA Code Set |
| **GE FUNCTIONAL GROUP TRAILER** | | | | | | | |
| NA | GE | GE01 | NUMBER OF TRANSACTION SETS INCLUDED | The number of transactions in the functional group ended by this trailer segment | | | Transmission sender |
| NA | GE | GE02 | GROUP CONTROL NUMBER | Assigned number originated and maintained by the sender | | This number must match the control number in GS06. | Transmission sender |

## 4.3 Testing Procedures

**Testing Procedures**

Each Med-QUEST trading partner is responsible for ensuring that its transactions are compliant with HIPAA mandates based on the types of testing described below.

Med-QUEST encourages providers and other entities to use a third party tool to certify that the entity can produce and accept HIPAA compliant transactions. Success is determined by the ability to pass the seven types of compliance tests listed below. The initial four of the seven types of testing are also used as categories for edits performed by the Med-QUEST translator. The testing types have been developed by the Workgroup for Electronic Data Interchange (WEDI), a private sector organization concerned with implementation of electronic transactions. They are:

1. Integrity Testing
   This kind of testing validates the basic syntactical integrity of the provider's EDI file.

2. Implementation Guide-Requirements Testing
   This kind of testing involves requirements imposed by the transaction's HIPAA Implementation Guide, including validation of data element values specified in the Guide.

3. Balancing Testing
   Balancing verification requires that summary-level data be numerically consistent with corresponding detail level data, as defined in the transaction's Implementation Guide.

4. Inter-Segment Situation Testing
   Situation testing validates inter-segment situations specified in the Implementation Guide (e.g., for accident claims, an Accident Date must present).

5. External Code Set Testing
   This kind of testing validates code set values for HIPAA mandated codes defined and maintained outside of Implementation Guides. HCPCS Procedure Codes and NDC Drug Codes are examples.

6. Product Type or Line of Service Testing
   This kind of testing validates specific requirements defined in the Implementation Guide for specialized services such as durable medical equipment (DME).

7. Trading Partner-Specific Testing
   Testing of trading partner requirements involves Implementation Guide requirements for transactions to or from Medicare, Medicaid and Indian Health Services. For Med-QUEST trading partners, trading partner requirement testing includes testing of the approaches that Med-QUEST has taken to accommodate necessary data within HIPAA compliant transactions and code sets.

**Test Data and Privacy**

Med-QUEST believes that, when possible, using real-life production data enhances the overall value of the compliance testing process. If a covered entity elects to use production data in testing, it must ensure that it remains in compliance with all federal and state privacy regulations. Data (e.g., names and identification numbers) that would make it possible to identify particular individuals should be removed or encrypted.

Med-QUEST expects that patient identifiable information will be encrypted or eliminated from test data submitted to the certification testing system unless the testing system is in compliance with all HIPAA regulations concerning security, privacy, and business associate specifications.

## 4.4 Syntactical Edits for 837 Claims Transactions

**Overview of the Syntactical Edit Process**

Edits performed by the Med-QUEST translator on 837 Claim Transactions ensure that incoming transactions comply with the standards documented in each transaction's HIPAA Implementation Guide. Only 837 Transactions of claims that have passed translator edits can have their claims translated and adjudicated. The translator's edits are prior to and in addition to edits performed by HPMMIS. Med-QUEST processes and procedures for resolution of claims pended and denied by HPMMIS remain unchanged.

Med-QUEST uses the 997 Functional Acknowledgement Transaction to acknowledge each functional group of 837 Transactions that has passed translator edits and the 824 Implementation Guide Reporting Transaction to inform 837 submitters of "syntactical" problems. Syntactical errors differ from "semantic" errors in that they involve data structures rather than meanings of data elements. In general, the Med-QUEST translator handles syntactical edits and HPMMIS handles semantic edits.

The 997 and 824 are ASC X12 Transactions that are not explicitly required by HIPAA rules but are available to perform acknowledgement and error notification functions electronically. The 997 is documented in Appendix B of every HIPAA Implementation Guide. The 824 has its own ASC (but non-HIPAA) Implementation Guide. A final version of it is available at cost ($45.00) from the Washington Publishing Company. Call Washington Publishing's Order Desk at (301) 949-9740 for information on payment procedures.

Four types of edits are handled by the Med-QUEST translator and reported on 824 Transactions. They are:

1. Integrity Edits
   This kind of edit validates the basic syntactical integrity of the incoming EDI file.

2. Implementation Guide-Requirements Edits
   This kind of edit involves requirements imposed by the transaction's HIPAA Implementation Guide, including validation of data element values specified in the Guide.

3. Balancing Edits
   Balancing verification requires that summary-level data be numerically consistent with corresponding detail level data, as defined in the transaction's Implementation Guide.

4. Inter-Segment Situation Edits
   Edits to validate inter-segment situations specified in the Implementation Guide (e.g., for accident claims, an Accident Date must be present).

In addition to carrying error codes, the 824 Transaction shows the relative location of erroneous data structures with error position designators. For a large transaction, each of the generic edit code values can be repeated in many code to element combinations.

## 4.5 Acknowledgment Procedures

**Overview of Electronic Acknowledgment Processes**

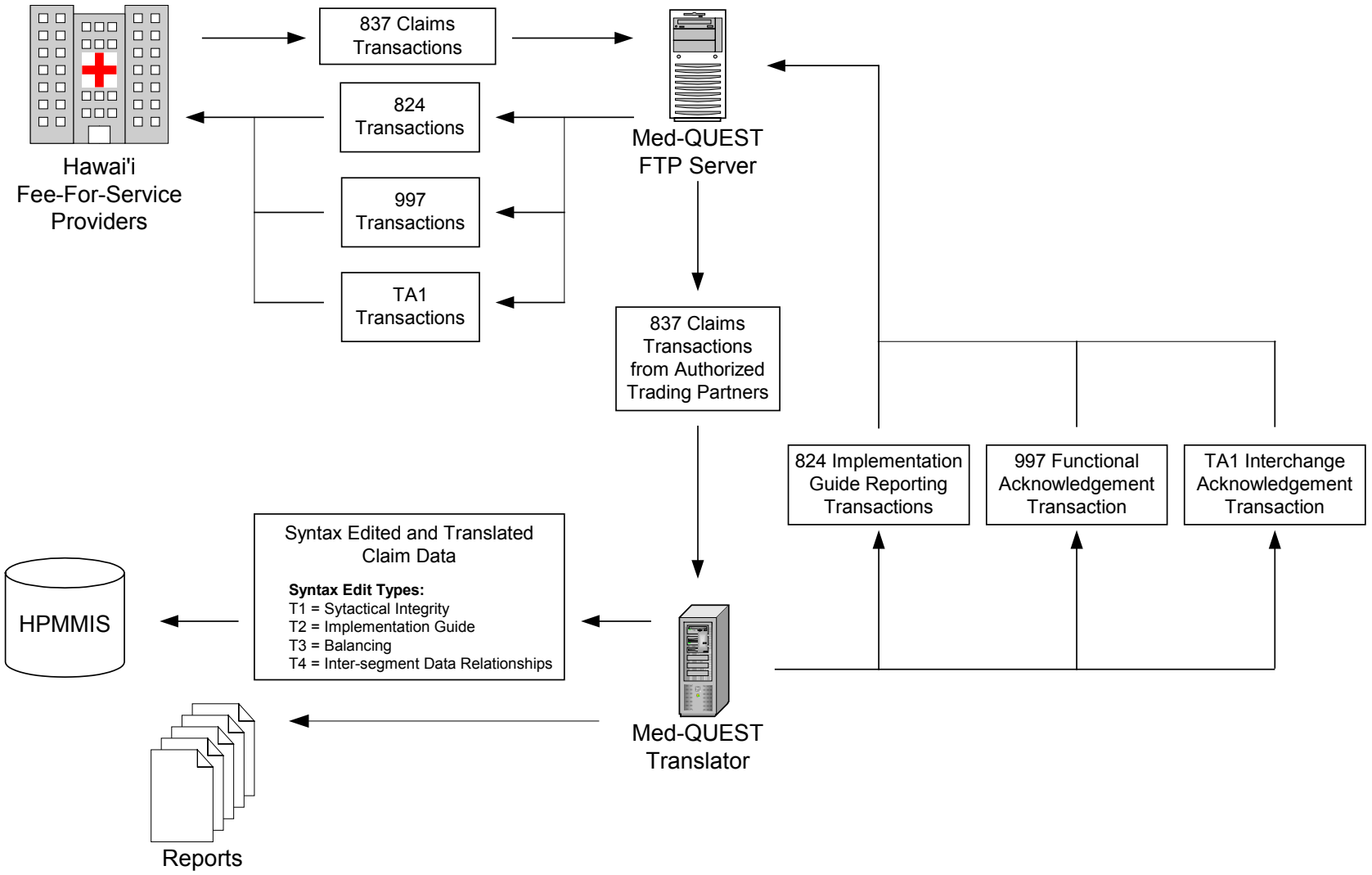
The diagram on the next page, Med-QUEST Interchange Flow for 837 Claim Transactions, shows how the Med-QUEST translator accepts, acknowledges, and reports problems on 837 Claims from billing providers. The Med-QUEST electronic acknowledgement and error reporting process affects all of the three types of 837 Claim Transactions (Professional, Dental, and Institutional).

As shown at the top of the diagram, claim submitters transmit 837 Transactions to the Med-QUEST File Transfer Protocol (FTP) Server. The Med-QUEST translator uploads authorized electronic transmissions from the Server into the translator. At this point, the translator checks data in the ISA/IEA outer envelope of the interchange (i.e., transmission or file). It returns a TA1 Application Acknowledgement Segment to the claim submitter if there are errors in the outer envelope. When this happens, data within the transmission is not processed further.

For transmissions that are valid on the interchange level, the translator edits transactions and uses 824 Implementation Guide Reporting Transactions to report problems. The syntactical edits reported on the 824 are required to ensure that complex electronic transactions are assembled and formatted correctly. Any syntactical error in a transmission results in rejection of all claims within the transmission. For syntactically valid functional groups of transactions, 997s are returned as electronic acknowledgements.

Finally comes the actual translation of syntactically valid data from the 837 Transaction to HPMMIS. Elements from 837 Transactions are moved to HPMMIS Tables for claim adjudication and reporting. Values of HIPAA code sets are converted to Med-QUEST code set values and/or reformatted for use in claim adjudication and reporting.

## Med-QUEST Interchange Flow - 837 Transaction




*HPMMIS - Hawaii Prepaid Medical Management Information System

## 4.6 Rejected Transmissions and Transactions

**Overview of Rejection Process**

Upon receiving an electronic transmission from a claim submitter, the Med-QUEST translator's first action is to check for presence and validity of data in the transaction's outer envelope of ISA and IEA Interchange Header and Trailer Segments. If ISA/IEA data is valid, processing continues. If the segments have, the entire file is rejected with a TA1 Interchange Acknowledgement Transaction with a descriptive error code. The submitter must correct the problem in the outer envelope and resubmit all transactions in the transmission.

Next come the translator's syntactical edits on the transaction or transactions within the outer envelope. When an incoming functional group of one or more 837 Transactions has passed the translator's syntactical edits, Med-QUEST returns a 997 Functional Acknowledgement Transaction with a Functional Group Acknowledge Code (AK901) of "A" (Accepted) to signify acceptance. For functional groups with errors, one or more 824 Implementation Guide Reporting Transactions reject each 837 Transaction (ST through SE) within the functional group with an Application Acknowledgement Code (OTI01) beginning with "R" (Reject).

Any error detected by the translator results in rejection of the entire transmission, even when the transmission has multiple transactions, some good and some bad. For rejected transactions, Med-QUEST makes use of standard 824 error location designators to identify each erroneous data structure. The translator reports all transaction errors that it can identify. It does not stop editing when it detects a problem.

# 5. Transaction Specifications

## 5.1 837 Transaction Specifications

**Purpose**

Transaction specifications are designed, in combination with HIPAA Implementation Guides, to identify data to be transmitted between Med-QUEST trading partners and to identify its type and format. Data structures that are fully covered by the HIPAA Implementation Guide are not mentioned in this section. Only transaction data with submission requirements specific to Med-QUEST claims is included.

The data element level Transaction Specifications in this section show in an Adjudication Usage column whether each element listed is required, required if applicable, or optional. Because the Transaction Specifications are limited to data elements not fully covered in Implementation Guides, they are not a complete list of the data elements required by Med-QUEST for claim adjudication. Some required claim data elements, primarily identification and control fields, are adequately covered in one of the 837 Implementation Guides and do not appear in this document. Fields required by Med-QUEST are described in the Med-QUEST Fee-for-Service Provider Manual and in other Med-QUEST documents.

Med-QUEST claims fit the business model offered by the 837 Claim Transaction quite well. Providers submit fee-for-service claims to Med-QUEST and the Agency responds by editing and adjudicating the claims, paying the provider the amounts determined by HPMMIS, and reporting adjudication results on remittance advices. Under HIPPA, both the claim submission and the remittance advice components of the process are heavily impacted by new electronic transactions. However, the internal rules and algorithms that Med-QUEST uses to adjudicate claims are not directly affected.

Within the Transaction Specifications Section, this document has separate subsections for Professional, Dental, and Institutional 837s. The three 837 formats are quite distinct.

**Relationship to HIPAA Implementation Guides**

Transaction specifications are intended to supplement the data in the Implementation Guides for each transaction set with specific information pertaining to the trading partners using the transaction set.

The information in the Transaction Specifications portion of this Companion Document is not intended to:

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

## 5.2 Claim Transaction Specifications – Professional 837 Claims

**Overview**

Professional 837 Claim Transactions from Med-QUEST fee-for-service providers contain data to enable Med-QUEST to adjudicate professional claims, plus a number of additional fields, including fields with coordination of benefits data, that are desirable for reporting and are of interest to Med-QUEST. The purpose of these Transaction Specifications are to identify critical data elements and data element values that Med-QUEST needs in Claim Transactions and to let providers know how to populate and transmit electronic claim data for Med-QUEST.

The specifications in this section apply only to 837 Professional Claim Transactions that providers send to Med-QUEST, not to encounters submitted by health plans. Only data elements that are used by Med-QUEST in ways that require explanations that go beyond information in standard HIPAA Implementation Guides are included.

**General Transaction Specifications**

Professional 837 Claim Transaction Specifications that are not specific to an individual data element are discussed below.

- With the exception of data elements in the Transaction Header Segment, all Professional 837 Claim Loops, Segments, and Elements are of variable length. Segments within loops and elements within segments occur only when data is present. There are no blank or null fields. In some situations, zero field values are acceptable.

- On claims submitted to Med-QUEST, 837 loops, segments, and data elements that involve coordination of benefits with other payers are used to show payments made by third party carriers, including Medicare and commercial health insurance companies. Med-QUEST is both the destination payer and the maker of direct payments to fee-for-service providers and their agents. Med-QUEST requests that all Coordination Of Benefits (COB) payment information be provided at the line level.

- Med-QUEST providers must transmit home health data on professional rather than institutional 837 Claims. Both professional and institutional 837s can accommodate home health services but only professional home health claims are processed by Med-QUEST. Claims submitted on inappropriate formats are denied by Med-QUEST.

**Transaction Specifications Table**

The Professional 837 Claim Transaction Specifications for individual data elements are shown in the table starting on the next page. Definitions of table columns follow.

Loop ID
The Implementation Guide's identifier for a data loop within a transaction.

Segment ID
The Implementation Guide's identifier for a data segment within a loop.

Element ID
The Implementation Guide's identifier for a data element within a segment.

Element Name
A data element name as shown in the Implementation Guide. When the Industry Name differs from the Data Element Dictionary name, the more descriptive Industry Name is used.

Element Definition
How the data element is defined in the Implementation Guide.

Adjudication Usage
An indication of how a data element is used in Med-QUEST claim adjudication.
R = Required on all transactions of this type by either the transaction's HIPAA Implementation Guide or by current HPMMIS processing.
R/A = Required if applicable – Accident Date, for example, is required if a claim's medical services result from an accident.
O = Optional – Present or not present at the discretion of the trading partner.

Valid Values
The valid values from the Implementation Guide that are used by Med-QUEST.

Definition/Format
Definitions of valid values used by Med-QUEST and additional information about Med-QUEST data element requirements.

| 837 PROFESSIONAL CLAIM TRANSACTION SPECIFICATIONS | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Loop ID** | **Seg ID** | **Element ID** | **Element Name** | **Element Definition** | **Adjud Usage** | **Valid Values** | **Definition/Format** |
| N/A | REF | REF02 | Transmission Type Code | Code identifying the type of transaction or transmission included in the transaction set | R | | Values specified for this element differ in the original Implementation Guide and the Addenda. Med-QUEST has adopted Addenda features and is using Addenda values. Current valid values for submitting claims to Med-QUEST are:<br><br>Pilot Testing: 004010X098DA1<br>Production: 004010X098A1 |
| 1000A | NM1 | NM108 | Identification Code Qualifier | Code designating the system/method of code structure used for Identification Code | R | 46 | Electronic Transmitter Identification Number (ETIN) |
| 1000A | NM1 | NM109 | Submitter Identifier | Code or number identifying the entity submitting the claim | R | | Med-QUEST identifies submitting providers and billing agents with the five-digit Electronic Supplier Number assigned by the Med-QUEST Systems Office. |
| 1000B | NM1 | NM103 | Receiver Name | Name of organization receiving the transaction | R | Med-QUEST | The transaction receiver |
| 1000B | NM1 | NM108 | Identification Code Qualifier | Code designating the system/method of code structure used for Identification Code | R | 46 | Electronic Transmitter Identification Number (ETIN) |
| 1000B | NM1 | NM109 | Receiver Primary Identifier | Primary identification number for the receiver of the transaction | R | 996001089 | DHS/Med-QUEST Federal Tax ID |
| 2010AA | NM1 | NM108 | Identification Code Qualifier | Code designating the system/method of code structure used for Identification Code | R | 24 or 34 | Employer's Identification Number or Social Security Number<br><br>The qualifier for the Federal Tax ID used by the billing provider. |
| 2010AA | NM1 | NM109 | Billing Provider Identifier | The code that identifies the billing provider | R | | The billing provider's EIN or SSN. |
| 2010AA | REF | REF01 | Reference Identification Qualifier | Code qualifying the reference identification | R | 1D<br>1C | Medicaid Provider Number<br>Medicare Provider Number |

| 837 PROFESSIONAL CLAIM TRANSACTION SPECIFICATIONS | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Loop ID** | **Seg ID** | **Element ID** | **Element Name** | **Element Definition** | **Adjud Usage** | **Valid Values** | **Definition/Format** |
| 2010AA | REF | REF02 | Billing Provider Additional Identifier | Identifies another or additional distinguishing code number associated with the billing provider | R | | For all claims except Medicare crossovers, the Med-QUEST ID and Location Code of the rendering provider. Submit this number with two leading zeros. The format is 00aaaaaall when aaaaaa is the Med-QUEST Provider ID and ll the Location Code.<br><br>This REF02 Provider ID field should always be populated, both when the Billing Provider is the same as the Servicing or Rendering Provider and when the IDs are different.<br><br>On Medicare crossovers, use the Medicare Provider ID without leading zeros. |
| 2000B | SBR | SBR02 | Individual Relationship Code | Code indicating the relationship between two individuals or entities | R | 18 | Self |
| 2000B | SBR | SBR09 | Claim Filing Indicator Code | Code identifying type of claim or expected adjudication process | R | MC | Medicaid |

| 837 PROFESSIONAL CLAIM TRANSACTION SPECIFICATIONS | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Loop ID** | **Seg ID** | **Element ID** | **Element Name** | **Element Definition** | **Adjud Usage** | **Valid Values** | **Definition/Format** |
| 2000B | PAT | PAT07 | Unit or Basis for Measurement Code | Code specifying the units in which a value is being expressed, or the manner in which a measurement has been taken | R/A | 01 | Actual Pounds<br><br>Use of Patient Weight is quite different in the original Implementation Guide and in the Addenda. In the 837 Professional Addenda adopted by Med-QUEST, Patient Weight is in pounds rather than grams and no longer represents a birth weight. Instead, it is, in the words of the Addenda:<br>Required on:<br>(1) claims/encounters involving EPO (epoetin) for patients on dialysis<br>(2) Medicare Durable Medical Equipment Regional Carriers certificate of medical necessity (DMERC CMN) 02.03 and 10.02<br>Med-QUEST suggests that providers submit a Patient Weight on EPO claims. The second requirement appears to be for Medicare only. |
| 2000B | PAT | PAT08 | Patient Weight | Numeric value of weight | R/A | | The patient's weight in pounds if appropriate - see above. |
| 2010BA | NM1 | NM108 | Identification Code Qualifier | Code designating the system or method of code structure used for the Identification Code | R | MI | Member Identification Number |
| 2010BA | NM1 | NM109 | Subscriber Primary Identifier | Primary identification number of the subscriber to the coverage | R | | Med-QUEST Recipient ID |
| 2010BB | NM1 | NM103 | Payer Name | Name identifying the payer organization | R | Med-QUEST | The "destination payer" according to the Implementation Guide. |
| 2010BB | NM1 | NM108 | Identification Code Qualifier | Code designating the system/method of code structure used for Identification Code | R | PI | Payer Identification |
| 2010BB | NM1 | NM109 | Payer Identifier | Number identifying the payer organization | R | 996001089 | The DHS/Med-QUEST Federal Tax Id Number |

| 837 PROFESSIONAL CLAIM TRANSACTION SPECIFICATIONS | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Loop ID** | **Seg ID** | **Element ID** | **Element Name** | **Element Definition** | **Adjud Usage** | **Valid Values** | **Definition/Format** |
| 2300 | CLM | CLM01 | Patient Account Number | Unique identification number assigned by the provider to the claim patient to facilitate posting of payment information and identification of the billed claim | R | | This is the Patient Account Number used by the provider that performed the service. For HIPAA, the maximum length of the field is 20 characters. |
| 2300 | CLM | CLM05-1 | Facility Type Code | Code identifying the type of facility where services were performed | R | | Place of Service can be submitted at the claim level. However, it is stored at the service line level on HPMMIS Professional Claim Tables. Place of Service Codes submitted at the claim level apply to all service lines unless overridden by a different Place of Service at the line level (SV105 in Loop 2400).<br><br>A few of the CLM05-1 valid values on the 837 Transaction differ from the Place of Service values used by Med-QUEST in the pre-HIPAA environment. Under HIPAA, Med-QUEST accepts only the valid HIPAA values listed in the 837 Professional Implementation Guide. |
| 2300 | CLM | CLM05-3 | Claim Frequency Code | Code specifying the frequency of the claim This is the third position of the Uniform Billing Claim Form Bill Type | R | 1<br>7<br>8 | Original<br>Replacement (Replacement of prior claim)<br>Void (Void/Cancel of prior claim)<br><br>A value of “6” (Corrected) was originally included in the Implementation Guide but deactivated by Designated Standards Maintenance Organizations (DSMOs). It is no longer valid.<br><br>Changes cannot be made to existing adjudicated claims (as identified by CRN) with the new CLM05-3 coding scheme. Instead, a claim must be “replaced” (CLM05-3 = “7”). Replacements void prior claims (identified by CRN) before adding the replacement claim with a new CRN. |

| 837 PROFESSIONAL CLAIM TRANSACTION SPECIFICATIONS | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Loop ID** | **Seg ID** | **Element ID** | **Element Name** | **Element Definition** | **Adjud Usage** | **Valid Values** | **Definition/Format** |
| 2300 | CLM | CLM11-1<br>CLM11-2<br>CLM11-3 | Related Causes Code | Code identifying an accompanying cause of an illness, injury or an accidents | R/A | AA<br>OA<br>AP<br>EM | Auto Accident<br>Other Accident<br>Another Party Responsible<br>Employment<br><br>Med-QUEST requires one of these values if the situation it describes is present. Up to three Related Causes Codes can be submitted per claim (CLM11-1, CLM11-2, and CLM11-03). |
| 2300 | CLM | CLM11-4 | Auto Accident State or Province Code | Code (Standard State/Province) as defined by appropriate government agency | R/A | | Required if any of the up to three Related Causes Code occurrences submitted has a value of “AA” (Auto Accident). |
| 2300 | CLM | CLM11-5 | Country Code | Code identifying the country | R/A | | Required if any of the up to three Related Causes Code occurrences submitted has a value of “AA” (Auto Accident) and the accident occurred outside the United States. |
| 2300 | CLM | CLM12 | Special Program Indicator | Code indicating the special program under which services related to the patient were performed. | R/A | 01 | Early & Periodic Screening, Diagnosis, and Treatment (EPSDT) or Child Health Assessment Program (CHAP)<br><br>Use this value for EPSDT examinations and screenings. Services that result from EPSDT referrals are indicated at the service line level by Element SV111 EPSDT Indicator in Loop 2400. |
| 2300 | DTP | DTP01 | Date Time Qualifier | Code specifying the type of data or time, or both date and time | R/A | 439 | Accident Date<br><br>The Accident Date DTP Segment is required if the claim resulted from an accident (CLM11-1, -2, or -3 = “AA”, “OA” or “AP”). |
| 2300 | DTP | DTP02 | Date Time Period Format Qualifier | Code indicating the date format, the time format, or date and time format | R/A | D8 | Date expressed in format CCYYMMDD |
| 2300 | DTP | DTP03 | Accident Date | The date of the accident | R/A | | The date of the accident if the claim results from an accident (CLM11-1, -2 or -3 = “AA”, “OA” or “AP”). |

| 837 PROFESSIONAL CLAIM TRANSACTION SPECIFICATIONS | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Loop ID** | **Seg ID** | **Element ID** | **Element Name** | **Element Definition** | **Adjud Usage** | **Valid Values** | **Definition/Format** |
| 2300 | REF | REF01 | Reference Identification Qualifier | Code qualifying the Reference Identification | R/A | G1 | Prior Authorization Number<br><br>Although this REF Segment can also be used for Referral Numbers, Med-QUEST is only concerned with PA Numbers for services that were authorized by Med-QUEST. Use this segment when the prior authorization is at the claim rather than the service line level. |
| 2300 | REF | REF02 | Prior Authorization Number | The Med-QUEST assigned Prior Authorization Number for all services on the claim | R/A | | The Prior Authorization Number |
| 2300 | REF | REF01 | Reference Identification Qualifier | Code qualifying the Reference Identification | R/A | F8 | Original Reference Number<br><br>This REF Segment is required if a claim voids or replaces another claim. |
| 2300 | REF | REF02 | Claim Original Reference Number | Number assigned by a processor to identify a claim | R/A | | For replacement and void claims (CLM05-3 = “7” or “8”), the Med-QUEST Claim Reference Number (CRN) of the prior claim being replaced or voided. |
| 2300 | REF | REF01 | Reference Identification Qualifier | Code qualifying the Reference Identification | R/A | P4 | Project Code<br><br>The Department of Human Services Social Services Division (DHS/SSD) is responsible for Medicaid Waiver Programs in Hawaii. SSD claims for Medicaid Waiver services are identified by a “W” in the Demonstration Project Identifier element. |
| 2300 | REF | REF02 | Reference Identification | Demonstration Project Identifier | R/A | W | Used to denote Social Services Division Waiver Program Claims. |

| 837 PROFESSIONAL CLAIM TRANSACTION SPECIFICATIONS | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Loop ID** | **Seg ID** | **Element ID** | **Element Name** | **Element Definition** | **Adjud Usage** | **Valid Values** | **Definition/Format** |
| 2310A | NM1 | NM108 | Identification Code Qualifier | Code designating the system/method of code structure used for Identification Code | R/A | 24<br>34 | Employer's Identification Number<br>Social Security Number<br><br>Use the 2310A Loop when a referring provider is present at the claim level. Unless overridden by a service line referring provider in the 2410F Loop, this loop's referring provider will be the referring provider for all service lines. |
| 2310A | NM1 | NM109 | Referring Provider Identifier | The identification number for the referring physician | R/A | | The referring provider's Federal Tax ID or Social Security Number. |
| 2310A | REF | REF01 | Reference Identification Qualifier | Code qualifying the reference identification | R/A | 1D<br>1C | Medicaid Provider Number<br>Medicare Provider Number |
| 2310A | REF | REF02 | Referring Provider Secondary Identifier | Additional identification number for the provider referring the patient for service | R/A | | For all claims except Medicare crossovers, the Med-QUEST ID and Location Code of the rendering provider. Submit this number with two leading zeros. The format is 00aaaaaall when aaaaaa is the Med-QUEST Provider ID and ll the Location Code.<br><br>On Medicare crossovers, use the Medicare Provider ID without leading zeros. |

| 837 PROFESSIONAL CLAIM TRANSACTION SPECIFICATIONS | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Loop ID** | **Seg ID** | **Element ID** | **Element Name** | **Element Definition** | **Adjud Usage** | **Valid Values** | **Definition/Format** |
| 2310B | NM1 | NM108 | Identification Code Qualifier | Code designating the system/method of code structure used for Identification Code | R/A | 24 or<br>34 | Employer's Identification Number or<br>Social Security Number<br><br>Use the 2310B Loop for the rendering provider at the claim level when the rendering provider is different from the billing provider in Loop 2010AA. If billing and rendering providers are the same, the 2310B Loop is not needed.<br><br>Although the 837 Transaction supports different Rendering Providers at the service line level, Med-QUEST policy requires a single Rendering Provider per claim. Med-QUEST denies claims with a Rendering Provider at the service line level that is different than the Rendering Provider at the claim level. |
| 2310B | NM1 | NM109 | Rendering Provider Identifier | The identifier assigned by the Payer to the provider who performed the service | R/A | | The rendering provider's Federal Tax ID or Social Security Number. |
| 2310B | REF | REF01 | Reference Identification Qualifier | Code qualifying the reference identification | R/A | 1D<br>1C | Medicaid Provider Number<br>Medicare Provider Number |
| 2310B | REF | REF02 | Rendering Provider Secondary Identifier | Additional identifier for the provider providing care to the patient | R/A | | For all claims except Medicare crossovers, the Med-QUEST ID and Location Code of the rendering provider. Submit this number with two leading zeros. The format is 00aaaaaall when aaaaaa is the Med-QUEST Provider ID and ll the Location Code.<br><br>On Medicare crossovers, use the Medicare Provider ID without leading zeros. |
| 2320 | SBR | SBR01 | Payer Responsibility Sequence Number Code | Code identifying the insurance carrier's level of responsibility for a payment of a claim | R/A | P<br>S<br>T | Primary<br>Secondary<br>Tertiary<br><br>Other carrier Loop 2320 can occur up to ten times for up to ten payers other than Med- |

| 837 PROFESSIONAL CLAIM TRANSACTION SPECIFICATIONS | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Loop ID** | **Seg ID** | **Element ID** | **Element Name** | **Element Definition** | **Adjud Usage** | **Valid Values** | **Definition/Format** |
| | | | | | | | QUEST. 2320 is an "umbrella loop" that contains within it Loops 2330A through 2330E. All of these loops can be repeated as needed for each payer. Other payer loops occur at the service line level as well. |
| 2320 | SBR | SBR03 | Insured Group or Policy Number | The identification number, control number, or code assigned by the carrier or administrator to identify the group under which the individual is covered | R/A | | A Group or Policy Number associated with the other coverage. |
| 2320 | SBR | SBR04 | Other Insured Group Name | Name of the group or plan through which the insurance is provided to the other insured | R/A | | A Group or Policy Name associated with SBR03. |
| 2320 | CAS | CAS01 | Claim Adjustment Group Code | Code identifying the general category of payment adjustment | R/A | | On 837 Transactions, "adjustments" are changes from other carrier Billed to Paid Amounts at the claim or service line level. A CAS Segment is needed if the amount that the other carrier paid the provider is different from the amount charged due to a claim-level pricing adjustment.<br><br>If the change from Charged to Paid Amount is at the service line level, use the CAS Segment in Loop 2430 rather than this one. The service line adjustment does not need to be accommodated at the claim level |
| 2320 | CAS | CAS02 | Adjustment Reason Code | Code that indicates the reason for the adjustment | R/A | Many Code Set Values | Hundreds of Adjustment Reason Code values are maintained on the Washington Publishing Company's Web Site (www.wpc-edi.com). Submit the code value or values that best describe the reason for the difference between the Charged Amount and the Paid Amount.<br><br>These are the same Adjustment Reason Codes that appear on the 835 Claim Remittance Advice Transaction. The 837 Transaction is designed to pick them up from the other payer's 835. If other |

| 837 PROFESSIONAL CLAIM TRANSACTION SPECIFICATIONS | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Loop ID** | **Seg ID** | **Element ID** | **Element Name** | **Element Definition** | **Adjud Usage** | **Valid Values** | **Definition/Format** |
| | | | | | | | carriers transmit 835 Remittance Advice Transactions to submitting providers, data from these transactions can be the source of the Adjustment Reason Code(s) on the 2320 Loop.<br><br>The “adjustment trio”, consisting of Adjustment Reason Code, Adjustment Amount, and Adjustment Quantity, occurs up to six times within each CAS Segment.<br><br>Med-QUEST requests that all Coordination Of Benefits (COB) payment information be provided at the line level where possible. |
| 2320 | CAS | CAS03 | Adjustment Amount | Adjustment amount for the associated reason code | R/A | | The difference between the claim level Charged Amount and Paid Amount associated with the Adjustment Reason Code in CAS02. A positive number when the Paid Amount is less than the Charged Amount. |
| 2320 | CAS | CAS04 | Adjustment Quantity | Numeric quantity associated with the related reason code for coordination of benefits | O | | The difference between the billed and paid units of service for all service lines when the difference is the result of claim level adjudication and is associated with the Adjustment Reason Code in CAS02. A positive number when the Paid Quantity is less than the Charged Quantity. |

| 837 PROFESSIONAL CLAIM TRANSACTION SPECIFICATIONS | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Loop ID** | **Seg ID** | **Element ID** | **Element Name** | **Element Definition** | **Adjud Usage** | **Valid Values** | **Definition/Format** |
| 2320 | MOA | MOA02 | Claim HCPCS Payable Amount | Sum of payable line item amounts for HCPCS codes billed on this claim | R/A | | The Medicare Outpatient Adjudication MOA Segment is required if data for it is available from an electronic remittance advice (835 Transaction).<br><br>This segment is used for outpatient adjudication information, including standard HIPAA Remark Codes, generated by Medicare or another carrier. In this context, all professional services are considered outpatient. Institutional 837s have both MOA and MIA (Medicare Inpatient Adjudication) Segments but the Professional 837 has only the MOA Segment.<br><br>All data elements within the MOA Segment are situational. They reflect adjudication by Medicare or another payer and should be included if available to the submitter. |
| 2400 | SV1 | SV101-1 | Product or Service ID Qualifier | Code identifying the type/source of the descriptive number used in Product/Service ID | R | HC | Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes<br><br>A variety of additional qualifier values are listed in the implementation guide, including qualifiers for NDC Drug and HIEC Home Infusion Codes. Alternative code sets are available if Med-QUEST adopts them in the future. At present, however, Med-QUEST uses only HCPCS Procedure Codes to identify professional services. |
| 2400 | SV1 | SV101-3 | Procedure Modifier | This identifies special circumstances related to the performance of the service | R/A | | The first Procedure Code Modifier<br><br>Med-QUEST uses this Procedure Code Modifier in adjudication. |

| 837 PROFESSIONAL CLAIM TRANSACTION SPECIFICATIONS | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Loop ID** | **Seg ID** | **Element ID** | **Element Name** | **Element Definition** | **Adjud Usage** | **Valid Values** | **Definition/Format** |
| 2400 | SV1 | SV101-4 | Procedure Modifier | This identifies special circumstances related to the performance of the service | R/A | | The second Procedure Code Modifier<br><br>Med-QUEST uses this Procedure Code Modifier in adjudication. |
| 2400 | SV1 | SV101-5 | Procedure Modifier | This identifies special circumstances related to the performance of the service | R/A | | The third Procedure Code Modifier<br><br>Med-QUEST does not use this Procedure Code Modifier in adjudication. |
| 2400 | SV1 | SV101-6 | Procedure Modifier | This identifies special circumstances related to the performance of the service | R/A | | The fourth Procedure Code Modifier<br><br>Med-QUEST does not use this Procedure Code Modifier in adjudication. |
| 2400 | SV1 | SV104 | Service Unit Count | Numeric value of quantity | R | | Med-QUEST uses seven-digit Unit values to the left of the decimal, and the two to the right of the decimal. |
| 2400 | SV1 | SV105 | Facility Code Value | Code identifying the type of facility where services were performed; the first and second positions of the Uniform Bill Type code or the Place of Service code from the Electronic Media Claims National Standard Format | R/A | | Place of Service Codes submitted at the service line level override different Place of Service Codes at the claim level (Loop 2300, Element CLM05-1). Med-QUEST processes each service line's Place of Service separately.<br><br>A few of the SV105 valid values on the 837 Transaction differ from the Place of Service values used by Med-QUEST in the pre-HIPAA environment. Under HIPAA, Med-QUEST accepts only the valid HIPAA values listed in the 837 Professional Implementation Guide. |

| 837 PROFESSIONAL CLAIM TRANSACTION SPECIFICATIONS | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Loop ID** | **Seg ID** | **Element ID** | **Element Name** | **Element Definition** | **Adjud Usage** | **Valid Values** | **Definition/Format** |
| 2400 | SV1 | SV111 | EPSDT Indicator | An indicator of whether or not Early and Periodic Screening for Diagnosis and Treatment of children services are involved with this detail line | R/A | Y | Yes, the service is the result of an EPSDT referral<br><br>Required if a Medicaid service is the result of a screening referral. The service referenced on this service line element differs from the EPSDT screening identified by the claim level Special Program Indicator (CLM12) in Loop 2300.<br><br>SV111 indicates a service that results from an EPSDT referral, not the original EPSDT evaluation. |
| 2410 | LIN | LIN02 | Product or Service ID Qualifier | Code identifying the type or source of the descriptive number used in Product ID Field. | O | N4 | National Drug Code in 5-4-2 Format<br><br>Information on drugs supplied or prescribed in association with HCPCS Procedure Codes is of interest to Med-QUEST. The LIN Segment is newly introduced by the 837 Professional Addendum to associate prescription information more closely with professional procedures. Med-QUEST retains a single NDC Code per service line. |
| 2410F | NM1 | NM108 | Identification Code Qualifier | Code designating the system/method of code structure used for Identification Code | R/A | 24 or 34 | Employer's Identification Number or Social Security Number<br><br>Use the 2410F Loop when a referring provider is present at the service line level that differs from the referring provider present in Loop 2310A, if any, at the claim level. |
| 2410F | NM1 | NM109 | Referring Provider Identifier | The identification number for the referring physician | R/A | | The referring provider's Federal Tax ID or Social Security Number. |
| 2410F | REF | REF01 | Reference Identification Qualifier | Code qualifying the reference identification | R/A | 1D<br>IC | Medicaid Provider Number<br>Medicare Provider Number |

| 837 PROFESSIONAL CLAIM TRANSACTION SPECIFICATIONS | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Loop ID** | **Seg ID** | **Element ID** | **Element Name** | **Element Definition** | **Adjud Usage** | **Valid Values** | **Definition/Format** |
| 2410F | REF | REF02 | Referring Provider Secondary Identifier | Additional identification number for the provider referring the patient for service | R/A | | For all claims except Medicare crossovers, the Med-QUEST ID of the referring provider. Insert two zeros in front of the six-digit Med-QUEST Provider ID.<br><br>On Medicare crossovers, used the Medicare Provider ID without leading zeros. |
| 2430 | SVD | SVD01 | Other Payer Primary Identifier | An identification number for the other payer | R/A | | According to this Implementation Guide, the 2430 Loop is “required if claim has been previously adjudicated by payer identified in Loop 2330B and service line has adjustments applied to it.”<br><br>This number in this field needs to match NM109 in the Loop 2330B that identifies the other payer. |
| 2430 | CAS | CAS02 | Adjustment Reason Code | Code that indicates the reason for the adjustment | R/A | Many Code Set Values | Hundreds of Adjustment Reason Code values are maintained on the Washington Publishing Company’s Web Site (www.wpc-edi.com). Enter the code value that best describes the reason for the difference between the Service Line Charged Amount and the Paid Amount.<br><br>These are the same Adjustment Reason Codes that appear on the 835 Claim Remittance Advice Transaction.<br><br>The “adjustment trio” of Adjustment Reason Code, Adjustment Amount, and Adjustment Quantity occur up to six times within the CAS Segment.<br><br>Med-QUEST requests that all Coordination Of Benefits (COB) payment information be provided at the line level where possible. |

| 837 PROFESSIONAL CLAIM TRANSACTION SPECIFICATIONS | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Loop ID** | **Seg ID** | **Element ID** | **Element Name** | **Element Definition** | **Adjud Usage** | **Valid Values** | **Definition/Format** |
| 2430 | CAS | CAS03 | Adjustment Amount | Adjustment amount for the associated reason code | R/A | | The difference between the service line level Charged Amount and Paid Amount associated with the Adjustment Reason Code in CAS02. A positive number when the Paid Amount is less than the Charged Amount. |
| 2430 | CAS | CAS04 | Adjustment Quantity | Numeric quantity associated with the related reason code for coordination of benefits | O | | The difference between the billed and paid units of service at the service line level when the difference is the result of line level adjudication and is associated with the Adjustment Reason Code in CAS02. A positive number when the Paid Quantity is less than the Charged Quantity. |

## 5.3 Claim Transaction Specifications – Dental 837 Claims

**Overview**

Dental 837 Claim Transactions from Med-QUEST providers and billing agents contain data to enable Med-QUEST to adjudicate dental claims, plus a number of additional fields, including fields with coordination of benefits data, that are desirable for reporting and are of interest to Med-QUEST. The purpose of these Transaction Specifications are to identify critical data elements and data element values that Med-QUEST needs in claim transactions and to let providers know how to populate and transmit claim data for Med-QUEST.

In the pre-HIPAA environment, Med-QUEST received claims for dental services in the same format that it used for professional claims. For claims submitted electronically, this is no longer the case. To achieve HIPAA compliance, Med-QUEST expects its fee-for-service dental providers to submit electronic claims using the 837 Dental Standard. Detailed changes required by the new orientation (for example, submitting Tooth Surface as a discrete data element) are covered in these specifications.

The specifications in this section apply only to 837 Dental Claim Transactions that providers send to Med-QUEST, not to encounters submitted by health plans. Only data elements that are used by Med-QUEST in ways that require explanations that go beyond information in standard HIPAA Implementation Guides are included.

**General Transaction Specifications**

Dental 837 Claim Transaction specifications that are not specific to a particular data element are discussed below.

- With the exception of data elements in the Transaction Header Segment, all Dental 837 Claim Loops and Segments are of variable length. Segments within loops and elements within segments occur only when data is present. There are no blank or null fields. In some situations, zero field values are acceptable.

- On claims submitted to Med-QUEST, 837 loops, segments, and data elements that involve coordination of benefits with other payers are used to show payments made by third party carriers, including Medicare and commercial health insurance companies. Med-QUEST requests that all Coordination Of Benefits (COB) payment information be provided at the line level where possible.

- Although the Dental 837 Transaction supports predetermination of dental benefits, Med-QUEST does not use it in this manner. Med-QUEST will deny any 837 Dental claims submitted for predetermination of dental benefits.

- Dental services that require pre-authorization (not predetermination of benefits) will continue to be handled with prior authorization requests. The 837 Dental format, as revised by the 2002 Addenda, accommodates PA Numbers in the same way as professional claims.

**Transaction Specifications Table**

The Dental 837 Claim Transaction Specifications for individual data elements are shown in the table starting on the next page. Definitions of table columns follow.

Loop ID
The Implementation Guide's identifier for a data loop within a transaction.

Segment ID
The Implementation Guide's identifier for a data segment within a loop.

Element ID
The Implementation Guide's identifier for a data element within a segment.

Element Name
A data element name as shown in the Implementation Guide. When the industry name differs from the Data Element Dictionary name, the more descriptive industry name is used.

Element Definition
How the data element is defined in the Implementation Guide.

Adjudication Usage
An indication of how a data element is used in Med-QUEST claim adjudication.
R = Required on all transactions of this type by either the transaction's HIPAA Implementation Guide or by current HPMMIS processing.
R/A = Required if applicable – Accident Date, for example, is required if a claim's medical services result from an accident.
O = Optional – Present or not present at the discretion of the trading partner.

Valid Values
The valid values from the Implementation Guide that are used by Med-QUEST.

Definition/Format
Definitions of valid values used by Med-QUEST and additional information about Med-QUEST data element requirements.

| 837 DENTAL CLAIM TRANSACTION SPECIFICATIONS | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Loop ID** | **Seg ID** | **Element ID** | **Element Name** | **Element Definition** | **Adjud Usage** | **Valid Values** | **Definition/Format** |
| N/A | REF | REF02 | Transmission Type Code | Code identifying the type of transaction or transmission included in the transaction set | R | | Values specified for this element differ in the original Implementation Guide and the Addenda. Med-QUEST has adopted Addenda features and is using Addenda values. Valid values are:<br>Pilot Testing: 004010X097DA1<br>Production: 004010X097A1 |
| 1000A | NM1 | NM108 | Identification Code Qualifier | Code designating the system/method of code structure used for Identification Code | R | 46 | Electronic Transmitter Identification Number (ETIN) |
| 1000A | NM1 | NM109 | Submitter Identifier | Code or number identifying the entity submitting the claim | R | | Med-QUEST identifies submitting providers and billing agents with the five-digit Electronic Supplier Number assigned by the Med-QUEST Systems Office (ISD). |
| 1000B | NM1 | NM103 | Receiver Name | Name of organization receiving the transaction | R | Med-QUEST | The transaction receiver |
| 1000B | NM1 | NM108 | Identification Code Qualifier | Code designating the system/method of code structure used for Identification Code | R | 46 | Electronic Transmitter Identification Number (ETIN) |
| 1000B | NM1 | NM109 | Receiver Primary Identifier | Primary identification number for the receiver of the transaction | R | 996001089 | DHS/Med-QUEST Federal Tax ID |
| 2010AA | NM1 | NM108 | Identification Code Qualifier | Code designating the system/method of code structure used for Identification Code | R | 24 or 34 | Employer's Identification Number or Social Security Number<br><br>Enter the qualifier for the Federal Tax ID used by the billing provider. |
| 2010AA | NM1 | NM109 | Billing Provider Identifier | Identification number for the provider or organization in whose name the bill is submitted and to whom payment should be made | R | | The Federal Tax ID used by the billing provider. |
| 2010AA | REF | REF01 | Reference Identification Qualifier | Code qualifying the reference identification | R | 1D<br>1C | Medicaid Provider Number<br>Medicare Provider Number |

| 837 DENTAL CLAIM TRANSACTION SPECIFICATIONS | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Loop ID** | **Seg ID** | **Element ID** | **Element Name** | **Element Definition** | **Adjud Usage** | **Valid Values** | **Definition/Format** |
| 2010AA | REF | REF02 | Billing Provider Additional Identifier | Identifies another or additional distinguishing code number associated with the billing provider | R | | For all claims except Medicare crossovers, the Med-QUEST ID and Location Code of the rendering provider. Submit this number with two leading zeros. The format is 00aaaaaall when aaaaaa is the Med-QUEST Provider ID and ll the Location Code.<br><br>This REF02 Provider ID field should always be populated, both when the Billing Provider is the same as the Servicing or Rendering Provider and when the IDs are different.<br><br>On Medicare crossovers, use the Medicare Provider ID without leading zeros. |
| 2000B | SBR | SBR02 | Individual Relationship Code | Code indicating the relationship between two individuals or entities | R | 18 | Self |
| 2000B | SBR | SBR09 | Claim Filing Indicator Code | Code identifying type of claim or expected adjudication process | R | MC | Medicaid |
| 2010BA | NM1 | NM108 | Identification Code Qualifier | Code designating the system/method of code structure used for Identification Code | R | MI | Member ID |
| 2010BA | NM1 | NM109 | Subscriber Primary Identifier | Primary identification number of the subscriber to the coverage | R | | Med-QUEST Recipient ID |
| 2010BB | NM1 | NM103 | Payer Name | Name identifying the payer organization | R | Med-QUEST | The name of the “destination payer” according to the Implementation Guide. |
| 2010BB | NM1 | NM109 | Payer Identifier | Number identifying the payer organization | R | 996001089 | The DHS/Med-QUEST Federal Tax ID |
| 2300 | CLM | CLM01 | Patient Account Number | Unique identification number assigned by the provider to the claim patient to facilitate posting of payment information and identification of the billed claim | R | | The Patient Account Number used by the rendering provider |

| 837 DENTAL CLAIM TRANSACTION SPECIFICATIONS | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Loop ID** | **Seg ID** | **Element ID** | **Element Name** | **Element Definition** | **Adjud Usage** | **Valid Values** | **Definition/Format** |
| 2300 | CLM | CLM05-1 | Facility Type Code | Code identifying the type of facility where services were performed | R | | Place of Service can be submitted at the claim level. However, it is stored at the service line level on HPMMIS Dental Claim Tables. Place of Service Codes submitted at the claim level apply to all service lines unless overridden by a different Place of Service at the line level (SV105 in Loop 2400).<br><br>A few of the CLM05-1 valid values on the 837 Transaction differ from the Place of Service values used by Med-QUEST in the pre-HIPAA environment. Under HIPAA, Med-QUEST accepts only the valid HIPAA values listed in the 837 Professional Implementation Guide. |
| 2300 | CLM | CLM05-3 | Claim Submission Reason Code | Code identifying reason for claim submission | R | 1<br>7<br>8 | Original (New admit thru discharge claim)<br>Replacement (Replacement of prior claim)<br>Void (Void/Cancel of prior claim)<br><br>A value of “6” (Corrected) was originally included in the Implementation Guide but deactivated by Designated Standards Maintenance Organizations (DSMOs).<br><br>Changes cannot be made to existing adjudicated claims (as identified by CRN) with the new CLM05-3 coding scheme. Instead, a claim must be “replaced” (CLM05-3 = “7”). Replacements are intended to void prior claims (identified by CRN) before adding the replacement with a new CRN. |
| 2300 | CLM | CLM12 | Special Program Indicator | Code indicating the special program under which services related to the patient were performed. | R/A | 01 | Early & Periodic Screening, Diagnosis, and Treatment (EPSDT) or Child Health Assessment Program (CHAP)<br><br>Use this value for EPSDT examinations and screenings. |

| 837 DENTAL CLAIM TRANSACTION SPECIFICATIONS | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Loop ID** | **Seg ID** | **Element ID** | **Element Name** | **Element Definition** | **Adjud Usage** | **Valid Values** | **Definition/Format** |
| 2300 | REF | REF01 | Reference Identification Qualifier | Code qualifying the Reference Identification | R/A | G1 | Prior Authorization Number<br><br>Although this REF Segment can also be used for Referral Numbers, Med-QUEST is only concerned with PA Numbers for services that were authorized by Med-QUEST. Use this segment when the prior authorization is at the claim rather than the service line level. |
| 2300 | REF | REF02 | Prior Authorization Number | The Med-QUEST assigned Prior Authorization Number for all services on the claim | R/A | | The Prior Authorization Number |
| 2300 | REF | REF01 | Reference Identification Qualifier | Code qualifying the reference identification | R/A | F8 | Original Reference Number<br><br>Required for replacement and void claims (CLM05-3 = “7” or “8”). |
| 2300 | REF | REF02 | Claim Original Reference Number | Number assigned by a processor to identify a claim | R/A | | For replacement and void claims, the Med-QUEST Claim Reference Number (CRN) of the prior claim being replaced or voided. |
| 2310A | NM1 | NM108 | Identification Code Qualifier | Code designating the system/method of code structure used for Identification Code | R/A | 24 or 34 | Employer’s Identification Number or Social Security Number<br><br>Use the 2310A Loop when there is a referring provider. On Dental 837 Transactions, referring providers only appear at the claim rather than the service line level. The 2310A Loop carries data on the referring provider for all dental service lines. |
| 2310A | NM1 | NM109 | Referring Provider Identifier | The identifier assigned by the Payer to the referring provider | R/A | | The referring provider’s Federal Tax ID or Social Security Number. |
| 2310A | REF | REF01 | Reference Identification Qualifier | Code qualifying the reference identification | R/A | 1D | Medicaid Provider Number |

| 837 DENTAL CLAIM TRANSACTION SPECIFICATIONS | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Loop ID** | **Seg ID** | **Element ID** | **Element Name** | **Element Definition** | **Adjud Usage** | **Valid Values** | **Definition/Format** |
| 2310A | REF | REF02 | Referring Provider Secondary Identifier | Additional identification number for the provider referring the patient for service | R/A | | For all claims except Medicare crossovers, the Med-QUEST ID and Location Code of the rendering provider. Submit this number with two leading zeros. The format is 00aaaaaall when aaaaaa is the Med-QUEST Provider ID and ll the Location Code.<br><br>On Medicare crossovers, use the Medicare Provider ID without leading zeros. |
| 2310B | NM1 | NM108 | Identification Code Qualifier | Code designating the system/method of code structure used for Identification Code | R/A | 24 or 34 | Employer's Identification Number or Social Security Number<br><br>Use the 2310B Loop when the rendering provider is different from the billing provider in Loop 2010AA.<br><br>Although the 837 Transaction supports different Rendering Providers at the service line level, Med-QUEST policy requires a single Rendering Provider per claim. Med-QUEST denies claims with a Rendering Provider at the service line level that is different than the Rendering Provider at the claim level. |
| 2310B | NM1 | NM109 | Rendering Provider Identifier | The identifier assigned by the Payer to the provider who performed the service | R/A | | The rendering provider's Federal Tax ID or Social Security Number. |
| 2310B | REF | REF01 | Reference Identification Qualifier | Code qualifying the reference identification | R/A | 1D<br>IC | Medicaid Provider Number<br>Medicare Provider Number |

| 837 DENTAL CLAIM TRANSACTION SPECIFICATIONS | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Loop ID** | **Seg ID** | **Element ID** | **Element Name** | **Element Definition** | **Adjud Usage** | **Valid Values** | **Definition/Format** |
| 2310B | REF | REF02 | Rendering Provider Secondary Identifier | Additional identifier for the provider providing care to the patient | R/A | | Use the 2310B Loop for rendering provider at the claim level when the rendering provider is different from the billing provider in Loop 2010AA. If billing and rendering providers are the same, the 2310B Loop is not needed.<br><br>For all claims except Medicare Crossovers, use the Med-QUEST ID and Location Code of the rendering provider. Insert two zeros in front of the six-digit Med-QUEST Provider ID and two-digit Location Code. On Medicare crossovers, use the Medicare Provider ID without leading zeros.<br><br>Although the 837 Dental Transaction supports different rendering providers at the service line level, Med-QUEST policy requires a single rendering provider per claim. Med-QUEST denies claims with a Rendering Provider at the service line level. |
| 2320 | SBR | SBR01 | Payer Responsibility Sequence Number Code | Code identifying the insurance carrier's level of responsibility for a payment of a claim | R/A | P<br>S<br>T | Primary<br>Secondary<br>Tertiary<br><br>The 2320 Other Subscriber Information Loop is for information on payers other than Med-QUEST that have adjudicated the claim. Element SBR01 can have any of the above values.<br><br>Loop 2320 can occur up to ten times for up to ten payers other than Med-QUEST. 2320 is an “umbrella loop” that contains within it Loops 2330A through 2330E. All of these loops can be repeated as needed for each payer. Other payer loops occur at the service line level as well. |

| 837 DENTAL CLAIM TRANSACTION SPECIFICATIONS | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Loop ID** | **Seg ID** | **Element ID** | **Element Name** | **Element Definition** | **Adjud Usage** | **Valid Values** | **Definition/Format** |
| 2320 | SBR | SBR03 | Insured Group or Policy Number | The identification number, control number, or code assigned by the carrier or administrator to identify the group under which the individual is covered | R/A | | A Group or Policy Number associated with the other coverage. |
| 2320 | SBR | SBR04 | Policy Name | The name of the policy providing coverage | R/A | | A Group or Policy Name associated with SBR03. |
| 2320 | CAS | CAS01 | Claim Adjustment Group Code | Code identifying the general category of payment adjustment | R/A | | The code value in the Implementation Guide that best describes the reason for any difference between the Charged Amount and the Paid Amount.<br><br>On the 2320 Loop, a CAS Segment is needed if the amount that the other payer paid the provider was different from the amount charged. If the change from Charged to Paid Amount is at the service line level, use the CAS Segment in Loop 2430 rather than this one. |

| 837 DENTAL CLAIM TRANSACTION SPECIFICATIONS | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Loop ID** | **Seg ID** | **Element ID** | **Element Name** | **Element Definition** | **Adjud Usage** | **Valid Values** | **Definition/Format** |
| 2320 | CAS | CAS02 | Adjustment Reason Code | Code that indicates the reason for the adjustment | R/A | Many Code Set Values | Hundreds of Adjustment Reason Code values are maintained on the Washington Publishing Company's Web Site (www.wpc-edi.com). Submit the code value or values that best describe the reason for the difference between the Charged Amount and the Paid Amount.<br><br>These are the same Adjustment Reason Codes that appear on the 835 Claim Remittance Advice Transaction. The 837 Transaction is designed to pick them up from the other payer's 835. If a health plan transmits 835 Remittance Advice Transactions to providers, data from these transactions can be the source of the Adjustment Reason Code(s) on the 2320 Loop.<br><br>The "adjustment trio", consisting of Adjustment Reason Code, Adjustment Amount, and Adjustment Quantity, occurs up to six times within each CAS Segment.<br><br>Med-QUEST requests that all Coordination Of Benefits (COB) payment information be provided at the line level where possible. |
| 2320 | CAS | CAS03 | Adjustment Amount | Adjustment amount for the associated reason code | R/A | | The difference between the claim level Charged Amount and Paid Amount associated with the Adjustment Reason Code in CAS02. A positive number when the Paid Amount is less than the Charged Amount. |
| 2320 | CAS | CAS04 | Adjustment Quantity | Numeric quantity associated with the related reason code for coordination of benefits | O | | The difference between the billed and paid units of service for all service lines when the difference is the result of claim level adjudication and is associated with the Adjustment Reason Code in CAS02. A positive number when the Paid Quantity is less than the Charged Quantity. |

| 837 DENTAL CLAIM TRANSACTION SPECIFICATIONS | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Loop ID** | **Seg ID** | **Element ID** | **Element Name** | **Element Definition** | **Adjud Usage** | **Valid Values** | **Definition/Format** |
| 2330B | NM1 | NM108 | Identification Code Qualifier | Code designating the system/method of code structure used for Identification Code | R/A | PI | Payer Identifier |
| 2330B | NM1 | NM109 | Other Payer Primary Identifier | An identification number for the other payer | R/A | | Any identification number assigned to the other payer. Med-QUEST will not perform validity edits on this identifier. |
| 2400 | LX | LX01 | Assigned Number | Number assigned for differentiation within a transaction set | R | | The number of the service line, beginning with 1 for the first line.<br><br>For 837 Dental Claims, the maximum number of lines is 50. Med-QUEST no longer accept s dental claims with more than 50 lines. |
| 2400 | SV3 | SV301-1 | Product or Service ID Qualifier | Code identifying the type/source of the descriptive number used in Product/Service ID | R | AD | American Dental Association Code CDT (Current Dental Terminology)<br><br>ADA Procedure Codes have been made part of Level II HCPCS Codes. |
| 2400 | SV3 | SV301-2 | Procedure Code | The ADA Dental Procedure Code | R | | ADA Procedure Codes have been made part of Level II HCPCS Codes. |
| 2400 | SV3 | SV301-3 – SV301-6 | Procedure Code Modifier | ADA Procedure Code Modifier | R/A | | According to the 837 Dental Addenda, Dental Procedure Code Modifiers must be valid ADA Procedure Code Modifiers. The American Dental Association has not yet made Modifier Codes final. Submitters of dental claims can no longer use modifiers with non-ADA values and should not submit modifiers until final values are established. |
| 2400 | SV3 | SV304-1 – SV304-5 | Oral Cavity Designation Code | Code identifying the oral cavity in which service is rendered | R/A | | Quadrants are now submitted as Oral Cavity Designation Codes with code values listed in the 837 Dental Implementation Guide. |
| 2400 | SV3 | SV306 | Procedure Count | The number of service units | R | | Med-QUEST uses seven-digit Units values without decimal points. |
| 2400 | TOO | TOO01 | Code List Qualifier Code | Code identifying a specific industry code list | R/A | JP | National Standard Tooth Numbering System |

| 837 DENTAL CLAIM TRANSACTION SPECIFICATIONS | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Loop ID** | **Seg ID** | **Element ID** | **Element Name** | **Element Definition** | **Adjud Usage** | **Valid Values** | **Definition/Format** |
| 2400 | TOO | TOO02 | Tooth Number | The ADA Tooth Number Code | R/A | | The ADA code for Tooth Number affected by the surface or surfaces.<br><br>Although up to 32 occurrences of Tooth Number can be submitted per dental service line on the 837 Dental Transaction, only a single occurrence is allowed by Med-QUEST. Claims submitted with more than Tooth Number per dental service line will be denied. |
| 2400 | TOO | TOO03-1 – TOO03-5 | Tooth Surface | Code identifying the area of the tooth that was treated | R/A | | The 837 Dental Transaction can accommodate up to five occurrences of Tooth Surface Codes in association with each Tooth Number. |
| 2400 | REF | REF01 | Reference Identification Qualifier | Code qualifying the Reference Identification | R/A | G1 | Prior Authorization Number<br><br>Although this REF Segment can also be used for Referral Numbers, Med-QUEST is only concerned with PA Numbers for services that were authorized by Med-QUEST. Use this segment when the prior authorization is at the service line rather than the claim level. |
| 2400 | REF | REF02 | Prior Authorization Number | The Med-QUEST assigned Prior Authorization Number for all services on the claim | R/A | | The Prior Authorization Number |
| 2420B | NM1 | NM103 | Other Payer Last or Organization Name | The name of the other payer organization | R/A | | The name of the other payer organization that handled the referral or prior authorization. The 2420B Loop is needed to associate the Service Line Referral Number with the appropriate other payer 2330B Loop within the claim level 2320 Loop. |
| 2420B | NM1 | NM109 | Other Payer Referral Number | The non-destination (COB) payer's service line level referral number | R/A | | The other payer’s identification number. It must be the same as a payer’s ID Number in a claim level 2330B Loop. |

| 837 DENTAL CLAIM TRANSACTION SPECIFICATIONS | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Loop ID** | **Seg ID** | **Element ID** | **Element Name** | **Element Definition** | **Adjud Usage** | **Valid Values** | **Definition/Format** |
| 2430 | SVD | SVD01 | Other Payer Primary Identifier | An identification number for the other payer | R/A | | According to this Implementation Guide, the 2430 Loop is "required if claim has been previously adjudicated by payer identified in Loop 2330B and service line has adjustments applied to it."<br><br>This number in this field needs to match NM109 in the Loop 2330B that identifies the other payer. |
| 2430 | CAS | CAS01 | Claim Adjustment Group Code | Code identifying the general category of payment adjustment | R/A | | Required if the payer identified in loop 2330B made line level adjustments that caused the amount paid to differ from the amount originally charged. In this situation, enter the code value that best describes the reason for the different between the Charged Amount and the Paid Amount for this service line.<br><br>The "Adjustment Trio" of Adjustment Reason, Amount, and Quantity can occur up to six times per CAS Segment and CAS Segments have up to 99 iterations at the service line level. Five hundred and ninety-four Claim Adjustment Codes for the health plan and other carriers can be accommodated. |
| 2430 | CAS | CAS02 | Adjustment Reason Code | Code that indicates the reason for the adjustment | R/A | Many Code Set Values | Hundreds of Adjustment Reason Code values are maintained on the Washington Publishing Company's Web Site (www.wpc-edi.com). Enter the code value that best describes the reason for the difference between the Service Line Charged Amount and the Paid Amount.<br><br>These are the same Adjustment Reason Codes that appear on the 835 Claim Remittance Advice Transaction.<br><br>Med-QUEST requests that all Coordination Of Benefits (COB) payment information be provided at the line level where possible. |

| 837 DENTAL CLAIM TRANSACTION SPECIFICATIONS | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Loop ID** | **Seg ID** | **Element ID** | **Element Name** | **Element Definition** | **Adjud Usage** | **Valid Values** | **Definition/Format** |
| 2430 | CAS | CAS03 | Adjustment Amount | Adjustment amount for the associated reason code | R/A | | The difference between the service line level Charged Amount and Paid Amount associated with the Adjustment Reason Code in CAS02. A positive number when the Paid Amount is less than the Charged Amount. |
| 2430 | CAS | CAS04 | Adjustment Quantity | Numeric quantity associated with the related reason code for adjustment of benefits | O | | The difference between the billed and paid units of service at the service line level when the difference is the result of line level adjudication and is associated with the Adjustment Reason Code in CAS02. A positive number when the Paid Quantity is less than the Charged Quantity. |

## 5.4 Claim Transaction Specifications – Institutional 837 Claims

**Overview**

Institutional 837 Claim Transactions from Med-QUEST providers contain data to enable Med-QUEST to adjudicate institutional claims, plus a number of additional fields, including fields with coordination of benefits data, that are desirable for reporting and are used by Med-QUEST. The purposes of these Transaction Specifications are to identify critical data elements and data element values that Med-QUEST needs in Claim Transactions and to let providers know how to populate and transmit claim data for Med-QUEST.

The specifications in this section apply only to 837 Institutional Claim Transactions that providers send to Med-QUEST, not to encounters submitted by health plans. Only data elements that are used by Med-QUEST in ways that require explanations that go beyond information in standard HIPAA Implementation Guides are included.

**General Transaction Specifications**

Institutional 837 Claim Transaction Specifications that are not specific to an individual data element are discussed below.

- With the exception of data elements in the Transaction Header Segment, all Institutional 837 Claim Loops and Segments are of variable length. Segments within loops and elements within segments occur only when data is present. There are no blank or null fields. In some situations, zero field values are acceptable.

- On claims submitted to Med-QUEST, 837 loops, segments, and data elements that involve coordination of benefits with other payers are used to show payments made by third party carriers, including Medicare and commercial health insurance companies.

**Transaction Specifications Table**

The Institutional 837 Claim Transaction Specifications for individual data elements are shown in the table starting on the next page. Definitions of table columns follow.

Loop ID
The Implementation Guide's identifier for a data loop within a transaction.

Segment ID
The Implementation Guide's identifier for a data segment within a loop.

Element ID
The Implementation Guide's identifier for a data element within a segment.

Element Name
A data element's name as shown in the Implementation Guide. When the Industry Name differs from the Data Element Dictionary name, the more descriptive Industry Name is used.

Element Definition
How the data element is defined in the Implementation Guide.

Adjudication Usage
An indication of how a data element is used in Med-QUEST claim adjudication.
R = Required on all transactions of this type by either the transaction's HIPAA Implementation Guide or by current HPMMIS processing.
R/A = Required if applicable – Accident Date, for example, is required if a claim's medical services result from an accident.
O = Optional – Present or not present at the discretion of the trading partner.

Valid Values
The valid values from the Implementation Guide that are used by Med-QUEST.

Definition/Format
Definitions of valid values used by Med-QUEST and additional information about Med-QUEST data element requirements.

| 837 INSTITUTIONAL CLAIM TRANSACTION SPECIFICATIONS | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Loop ID** | **Segment ID** | **Element ID** | **Element Name** | **Element Definition** | **Adjud Usage** | **Valid Values** | **Definition/Format** |
| N/A | REF | REF02 | Transmission Type Code | Code identifying the type of transaction or transmission included in the transaction set | R | | Values specified for this element differ in the original Implementation Guide and the Addenda. Med-QUEST has adopted Addenda features and is using Addenda values. Valid values are:<br>Pilot Testing: 004010X096DA1<br>Production: 004010X096A1 |
| 1000A | NM1 | NM108 | Identification Code Qualifier | Code designating the system/method of code structure used for Identification Code | R | 46 | Electronic Transmitter Identification Number (ETIN) |
| 1000A | NM1 | NM109 | Submitter Identifier | Code or number identifying the entity submitting the claim | R | | Med-QUEST identifies submitting providers and billing agents with the five-digit Electronic Supplier Number (ESN) assigned by the Med-QUEST Systems Office (ISD).. |
| 1000B | NM1 | NM103 | Receiver Name | Name of organization receiving the transaction | R | Med-QUEST | The transaction receiver |
| 1000B | NM1 | NM108 | Information Receiver Identification Number | The identification number of the individual or organization who expects to receive information in response to a query | R | 46 | Electronic Transmitter Identification Number (ETIN) |
| 1000B | NM1 | NM109 | Receiver Primary Identifier | Primary identification number for the receiver of the transaction | R | 996001089 | DHS/Med-QUEST Federal Tax ID |
| 2010AA | NM1 | NM108 | Identification Code Qualifier | Code designating the system/method of code structure used for Identification Code | R | 24 or 34 | Employer's Identification Number or Social Security Number<br><br>Enter the qualifier for the Federal Tax ID or Social Security Number used by the billing provider. |
| 2010AA | NM1 | NM109 | Billing Provider Identifier | Identification number for the provider or organization in whose name the bill is submitted and to whom payment should be made | R | | The Federal Tax ID or Social Security Number used by the billing provider. |
| 2010AA | REF | REF01 | Reference Identification Qualifier | Code qualifying the reference identification | R | 1D | Medicaid Provider Number |

| 837 INSTITUTIONAL CLAIM TRANSACTION SPECIFICATIONS | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Loop ID** | **Segment ID** | **Element ID** | **Element Name** | **Element Definition** | **Adjud Usage** | **Valid Values** | **Definition/Format** |
| 2010AA | REF | REF02 | Billing Provider Additional Identifier | Identifies another or additional distinguishing code number associated with the billing provider | R | | For all claims except Medicare crossovers, the Med-QUEST ID and Location Code of the rendering provider. Submit this number with two leading zeros. The format is 00aaaaaall when aaaaaa is the Med-QUEST Provider ID and ll the Location Code.<br><br>The REF02 Provider ID field should always be populated, both when the Billing Provider is the same as the Servicing or Rendering Provider and when the IDs are different.<br><br>On Medicare crossovers, use the Medicare Provider ID without leading zeros. |
| 2000B | SBR | SBR02 | Individual Relationship Code | Code indicating the relationship between two individuals or entities | R | 18 | Self |
| 2000B | SBR | SBR09 | Claim Filing Indicator Code | Code identifying type of claim or expected adjudication process | R | MC | Medicaid |
| 2010BA | NM1 | NM108 | Identification Code Qualifier | Code designating the system or method of code structure used for the Identification Code | R | MI | Member Identification Number |
| 2010BA | NM1 | NM109 | Subscriber Primary Identifier | Primary identification number of the subscriber to the coverage | R | | Med-QUEST Recipient ID |
| 2010BC | NM1 | NM103 | Payer Name | Name identifying the payer organization | R | Med-QUEST | The “destination payer” according to the Implementation Guide. |
| 2010BC | NM1 | NM109 | Payer Identifier | Number identifying the payer organization | R | 996001089 | The DHS/Med-QUEST Federal Tax ID Number |
| 2300 | CLM | CLM01 | Patient Account Number | Unique identification number assigned by the provider to the claim patient to facilitate posting of payment information and identification of the billed claim | R | | This is the Patient Account Number used by the provider that performed the service. For HIPAA, the maximum length of the field is 20 characters. |
| 2300 | CLM | CLM05-1 | Facility Type Code | Code identifying the type of facility where services were performed; the first and second positions of the Uniform Bill Type code or the Place of Service code from the Electronic Media Claims National | R | | The first two characters of the Uniform Billing (UB) Type of Bill field on institutional claims. |

| 837 INSTITUTIONAL CLAIM TRANSACTION SPECIFICATIONS | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Loop ID** | **Segment ID** | **Element ID** | **Element Name** | **Element Definition** | **Adjud Usage** | **Valid Values** | **Definition/Format** |
| | | | | Standard Format | | | |
| 2300 | CLM | CLM05-2 | Facility Code Qualifier | Code identifying the type of facility referenced | R | A | Uniform Billing Claim Form Bill Type |
| 2300 | CLM | CLM05-3 | Claim Frequency Code | Code specifying the frequency of the claim. This is the third position of the Uniform Billing Claim Form Bill Type. | R | | The Claim Frequency Code is the third character of the UB Type of Bill field on institutional claims.<br><br>A value of “6” (Corrected) was originally included in 837 Implementation Guides but deactivated by Designated Standards Maintenance Organizations (DSMOs). It is no longer valid.<br><br>Changes cannot be made to existing adjudicated claims (as identified by CRN) with the new CLM05-3 coding scheme. Instead, a claim must be “replaced” (CLM05-3 = “7”). Replacements are intended to void prior claims (identified by CRN) before adding the replacement with a new CRN.<br><br>Under HIPAA, Med-QUEST continues to accept interim inpatient claims with appropriate Claim Frequency Codes. |
| 2300 | CLM | CLM18 | Explanation of Benefits Indicator | Indicator of whether a paper explanation of benefits (EOB) is requested | R | | Med-QUEST does not provide paper EOBs and will not respond to any value in this required institutional element. Recommend “N” (Paper EOB Not Requested) in CLM18. |
| 2300 | DTP | DTP01 | Date Time Qualifier | Code specifying the type or date or time, or both date and time | R/A | 096 | Discharge<br><br>Only the Discharge Hour is present on this DTP Segment. The Discharge Date on a discharge claim is the Through Date in the Statement Date DTP Segment when the Claim Frequency Code (CLM05-3) indicates a discharge. Although it is required by HIPAA, Med-QUEST does not use the Discharge Hour in claim adjudication. |

| 837 INSTITUTIONAL CLAIM TRANSACTION SPECIFICATIONS | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Loop ID** | **Segment ID** | **Element ID** | **Element Name** | **Element Definition** | **Adjud Usage** | **Valid Values** | **Definition/Format** |
| 2300 | DTP | DTP02 | Date Time Period Format Qualifier | Code indicating the date format, time format, or date and time format | R/A | TM | Time expressed in format HHMM |
| 2300 | DTP | DTP03 | Discharge Hour | The time at which the patient was discharged from a facility | R/A | | Although the Discharge Time must include minutes on the 837 Transaction, minutes are truncated for Med-QUEST claim adjudication. Enter “00” if discharge minutes are unknown.<br><br>The Discharge Date, if present, appears as the Statement Through Date in the next DTP Segment. This date can be considered a Discharge Date when the Claim Frequency Code (CLM05-3) has a value that indicates a discharge. |
| 2300 | DTP | DTP01 | Statement Date or Range Qualifier | Indicator of a Statement Date or Range DTP Segment | R | 434 | Statement<br><br>The Statement Date can be either a single date or a date range. Normally, it is a single date on outpatient claims and a date range on inpatient claims. In combination with a Claim Frequency Code (CLM05-3) that indicates a discharge, the Through Date of the Statement Date Range serves as the Discharge Date. |
| 2300 | DTP | DTP01 | Date/Hour Qualifier | Code specifying type of date or time or both date and time | R | 435 | Admission |
| 2300 | DTP | DTP02 | Date/Time Period Format Qualifier | Code indicating the date format, the time format or the date and time format | R | DT | Date and time expressed in format CCYYMMDDHHMM. |
| 2300 | DTP | DTP03 | Admission Date and Time | Admission Date and Hour | R | | Although the admission time must include minutes on the 837 Transaction, minutes are truncated for Med-QUEST claim adjudication. Enter “00” if admission minutes are unknown. |

| 837 INSTITUTIONAL CLAIM TRANSACTION SPECIFICATIONS | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Loop ID** | **Segment ID** | **Element ID** | **Element Name** | **Element Definition** | **Adjud Usage** | **Valid Values** | **Definition/Format** |
| 2300 | REF | REF01 | Reference Identification Qualifier | Code qualifying the reference identification | R/A | F8 | Original Reference Number<br><br>This REF Segment is required on replacement and void claims. The Original Reference Number is the Med-QUEST CRN assigned to the claim being replaced or voided (when CLM05-3 = “7” or “8”). |
| 2300 | REF | REF02 | Claim Original Reference Number | Number assigned by a processor to identify a claim | R/A | | The Med-QUEST assigned Claim Reference Number (CRN) for the claim being replaced or voided. |
| 2300 | REF | REF01 | Reference Identification Qualifier | Code qualifying the Reference Identification | R/A | G1 | Prior Authorization Number<br><br>Although this REF Segment can also be used for Referral Numbers, Med-QUEST is only concerned with PA Numbers for services that were authorized by Med-QUEST. |
| 2300 | REF | REF02 | Prior Authorization Number | The Med-QUEST assigned Prior Authorization Number for all services on the claim | R/A | | The Prior Authorization Number |
| 2300 | REF | REF01 | Reference Identification Qualifier | Code qualifying the Reference Identification | R/A | P4 | Project Code<br><br>The Department of Human Services Social Services Division (DHS/SSD) is responsible for Medicaid Waiver Programs in Hawaii. SSD claims for Medicaid Waiver services are identified by a “W” in the Demonstration Project Identifier element. |
| 2300 | REF | REF02 | Reference Identification | Demonstration Project Identifier | R/A | W | Used to denote Social Services Division Waiver Program Claims. |

| 837 INSTITUTIONAL CLAIM TRANSACTION SPECIFICATIONS | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Loop ID** | **Segment ID** | **Element ID** | **Element Name** | **Element Definition** | **Adjud Usage** | **Valid Values** | **Definition/Format** |
| 2300 | HI | HI01-1 | Code List Qualifier Code | Code qualifying the Reference Identification – Other Diagnosis Codes | R/A | BF | Diagnosis<br><br>These are diagnoses in addition to the required Principal Diagnosis Codes in a previous segment. The 837 Transaction can accommodate up to 24 occurrences of Other Diagnoses on institutional claims. However, only the initial eight (in the first of the two possible HI Segments) are used by Med-QUEST in claim adjudication. |
| 2300 | HI | HI01-1 | Code List Qualifier Code | Code identifying Principal Procedures – Principal Procedure Codes | R/A | BR | International Classification of Diseases Clinical Modification (ICD-9-CM) Principal Procedure<br><br>Med-QUEST expects ICDC-9 Procedure Codes to be submitted in the claim-level 2300 Loop for impatient services. HCPCS outpatient procedures are submitted at the service line level in the 2400 Loop of the Institutional 837. |
| 2300 | HI | HI01-1 | Code List Qualifier Code | Code qualifying the Reference Identification – Other Procedure Codes | R/A | BQ | International Classification of Diseases Clinical Modification (ICD-9-CM) Procedure<br><br>Med-QUEST expects ICD-9-CM Procedure Codes to be used for inpatient procedures and for HCPCS Codes to be used at the service line level for outpatient procedures.<br><br>The 837 Transaction can accommodate up to 24 occurrences of Other Procedures on institutional claims. However, only the initial five are used by Med-QUEST in claim adjudication. |
| 2300 | HI | HI01-1 | Code List Qualifier Code | Code qualifying the Reference Identification – Occurrence Span Codes | R/A | BI | Occurrence Span<br><br>The 837 Transaction can accommodate up to 24 occurrences of Occurrence Span Codes on institutional claims. However, only the initial two (in the first of the two possible HI Segments) are used by Med-QUEST in claim adjudication. |

| 837 INSTITUTIONAL CLAIM TRANSACTION SPECIFICATIONS | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Loop ID** | **Segment ID** | **Element ID** | **Element Name** | **Element Definition** | **Adjud Usage** | **Valid Values** | **Definition/Format** |
| 2300 | HI | HI01-1 | Code List Qualifier Code | Code qualifying the Reference Identification – Occurrence Codes | R/A | BH | Occurrence<br><br>The 837 Transaction can accommodate up to 24 occurrences of Occurrence Codes on institutional claims. However, only the initial eight (in the first of the two possible HI Segments) are used by Med-QUEST in claim adjudication. |
| 2300 | HI | HI01-1 | Code List Qualifier Code | Code qualifying the Reference Identification – Value Codes | R/A | BE | Value<br><br>The 837 Transaction can accommodate up to 24 occurrences of Value Codes on institutional claims. However, only the initial 12 (those in the first of two possible HI Segments) are used by Med-QUEST in claim adjudication. |
| 2300 | HI | HI01-1 | Code List Qualifier Code | Code qualifying the Reference Identification – Condition Codes | R/A | BG | Condition<br><br>The 837 Transaction can accommodate up to 24 occurrences of Occurrence Codes on institutional claims. However, only the initial eight (in the first of the two possible HI Segments) are used by Med-QUEST in claim adjudication. |
| 2300 | HI | HI01-1 | Code List Qualifier Code | Code qualifying the Reference Identification – Treatment Codes | R/A | TC | Treatment Codes<br><br>The 837 Transaction can accommodate up to 24 occurrences of home health Treatment Codes on institutional claims. However, Treatment Codes are not used by Med-QUEST claim adjudication. |
| 2300 | QTY | QTY01 | Quantity Qualifier | Code specifying the type of quantity | R/A | CA<br>CD<br>LA<br>NA | Covered – Actual<br>Co-insured - Actual<br>Life-time Reserve - Actual<br>Number of Non-covered Days<br><br>Med-QUEST requires a value of “NA” when non-covered days are reported. Data in segments with other QTY01 values will not be used for adjudication. |

| 837 INSTITUTIONAL CLAIM TRANSACTION SPECIFICATIONS | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Loop ID** | **Segment ID** | **Element ID** | **Element Name** | **Element Definition** | **Adjud Usage** | **Valid Values** | **Definition/Format** |
| 2300 | QTY | QTY02 | Claim Days Count | The number of categorized days associated with the claim, such as lifetime reserve days, covered days | R/A | | The number of non-covered days |
| 2300 | QTY | QTY03-1 | Unit or Basis for Measurement Code | Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken | R/A | DA | Days<br><br>Use whole numbers without decimal points. Med-QUEST does not process partial days. |
| 2310A | NM1 | NM108 | Identification Code Qualifier | Code designating the system/method of code structure used for Identification Code | R/A | 24 or 34 | Employer's Identification Number<br>Social Security Number |
| 2310A | NM1 | NM109 | Attending Physician Primary Identifier | Primary identification number of the physician responsible for care of the patient | R/A | | The attending physician's Federal Tax ID or Social Security Number |
| 2310A | REF | REF01 | Reference Identification Qualifier | Code qualifying the reference identification | R/A | 1D<br>1C | Medicaid Provider Number<br>Medicare Provider Number |
| 2310A | REF | REF02 | Attending Physician Secondary Identifier | Secondary identification number of the physician responsible for the care of the patient | R/A | | For all claims except Medicare crossovers, the Med-QUEST Provider ID. Insert two digits in front of the six-digit Med-QUEST Provider ID.<br><br>On Medicare crossovers, use the Medicare Provider ID without leading zeros. |
| 2310E | NM1 | NM108 | Identification Code Qualifier | Code designating the system/method of code structure used for Identification Code | R/A | 24 | Employer's Identification Number<br><br>Submit the 2310E Laboratory or Facility Loop only if the ID of the facility is different from the ID of the billing provider in Loop 2010AA. |
| 2310E | NM1 | NM109 | Laboratory or Facility Primary Identifier | Identification number of laboratory or other facility performing laboratory testing on the claim where the health care service was performed/rendered | R/A | | The facility's Federal Tax ID |

| 837 INSTITUTIONAL CLAIM TRANSACTION SPECIFICATIONS | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Loop ID** | **Segment ID** | **Element ID** | **Element Name** | **Element Definition** | **Adjud Usage** | **Valid Values** | **Definition/Format** |
| 2310E | REF | REF01 | Reference Identification Qualifier | Code qualifying the reference identification | R/A | 1D<br>1C | Medicaid Provider Number<br>Medicare Provider Number |
| 2310E | REF | REF02 | Laboratory or Facility Secondary Identifier | Additional identifier for the laboratory or facility performing tests billed on the claim where the health care service was performed/rendered | R/A | | Use this loop to identify the facility if its ID is different from the ID of the Billing Provider.<br><br>For all claims except Medicare crossovers, this is the Med-QUEST Provider ID and Location Code of the facility. Insert two zeros in front of the Med-QUEST Provider ID.<br><br>On Medicare crossovers, use the Medicare Provider ID without leading zeros. |
| 2320 | SBR | SBR01 | Payer Responsibility Sequence Number Code | Code identifying the insurance carrier's level of responsibility for a payment of a claim | R/A | P<br>S<br>T | Primary<br>Secondary<br>Tertiary<br><br>The 2320 Other Subscriber Information Loop is for information on payers other than Med-QUEST that have adjudicated the claim. Element SBR01 can have any of the above values.<br><br>Loop 2320 can occur up to ten times for up to ten payers other than Med-QUEST. 2320 is an "umbrella loop" that contains within it Loops 2330A through 2330E. All of these loops can be repeated as needed for each payer. Other payer loops occur at the service line level as well. |
| 2320 | SBR | SBR02 | Individual Relationship Code | Code indicating the relationship between two individuals or entities | R/A | | Any of the values listed in the Implementation Guide can be used, depending on the patient's relationship to the primary subscriber covered by the other payer. |

| 837 INSTITUTIONAL CLAIM TRANSACTION SPECIFICATIONS | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Loop ID** | **Segment ID** | **Element ID** | **Element Name** | **Element Definition** | **Adjud Usage** | **Valid Values** | **Definition/Format** |
| 2320 | SBR | SBR03 | Insured Group or Policy Number | The identification number, control number, or code assigned by the carrier or administrator to identify the group under which the individual is covered | R/A | | A Group or Policy Number associated with the other payer's coverage. |
| 2320 | SBR | SBR04 | Other Insured Group Name | Name of the group or plan through which the insurance is provided to the other insured | R/A | | A Group or Policy Name associated with SBR03. |
| 2320 | CAS | CAS01 | Claim Adjustment Group Code | Code identifying the general category of payment adjustment | R/A | | On 837 Transactions, "adjustments" are changes from Billed to Paid Amounts at the claim or service line level. A CAS Segment is needed if the amount that the other carrier pays the provider is different from the amount charged.<br><br>If the change from Charged to Paid Amount is at the service line level, use the CAS Segment in Loop 2430 rather than this one. The service line adjustment does not need to be accommodated at the claim level |

| 837 INSTITUTIONAL CLAIM TRANSACTION SPECIFICATIONS | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Loop ID** | **Segment ID** | **Element ID** | **Element Name** | **Element Definition** | **Adjud Usage** | **Valid Values** | **Definition/Format** |
| 2320 | CAS | CAS02 | Adjustment Reason Code | Code that indicates the reason for the adjustment | R/A | Many Code Set Values | Hundreds of Adjustment Reason Code values are maintained on the Washington Publishing Company's Web Site (www.wpc-edi.com). Submit the code value or values that best describe the reason for the difference between the Charged Amount and the Paid Amount.<br><br>These are the same Adjustment Reason Codes that appear on the 835 Claim Remittance Advice Transaction. The 837 Transaction is designed to pick them up from the other payer's 835. If other carriers transmit 835 Remittance Advice Transactions to submitting providers, data from these transactions can be the source of the Adjustment Reason Code(s) on the 2320 Loop.<br><br>The "adjustment trio", consisting of Adjustment Reason Code, Adjustment Amount, and Adjustment Quantity, occurs up to six times within each CAS Segment. |
| 2320 | CAS | CAS03 | Adjustment Amount | Adjustment amount for the associated reason code | R/A | | The difference between the claim level Charged Amount and Paid Amount associated with the Adjustment Reason Code in CAS02. A positive number when the Paid Amount is less than the Charged Amount. |
| 2320 | CAS | CAS04 | Adjustment Quantity | Numeric quantity associated with the related reason code for coordination of benefits | O | | The difference between the billed and paid units of service for all service lines when the difference is the result of claim level adjudication and is associated with the Adjustment Reason Code in CAS02. A positive number when the Paid Quantity is less than the Charged Quantity. |

| 837 INSTITUTIONAL CLAIM TRANSACTION SPECIFICATIONS | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Loop ID** | **Segment ID** | **Element ID** | **Element Name** | **Element Definition** | **Adjud Usage** | **Valid Values** | **Definition/Format** |
| 2320 | MIA | MIA01 | Covered Days or Visits Count | The quantity of covered days or visits | R/A | | The Medicare Inpatient Adjudication MIA Segment is required if data for it is available from an electronic remittance advice (835 Transaction).<br><br>This segment is used for inpatient adjudication Information, including standard HIPAA Remark Codes, generated by Medicare or another carrier. Institutional 837s have both MIA and MOA (Medicare Outpatient Adjudication) Segments.<br><br>With the exception of Element MIA01 which is required if the MIA Segment is present, data elements within the MIA Segment are situational. They reflect adjudication by Medicare or another payer and should be included if available to the submitter. |
| 2320 | MOA | MOA01 | Reimbursement Rate | Rate used when payment is based upon a percentage of applicable charges | R/A | | The Medicare Outpatient Adjudication MOA Segment is required if data for it is available from an electronic remittance advice (835 Transaction).<br><br>This segment is used for outpatient adjudication Information, including standard HIPAA Remark Codes generated by Medicare or another carrier. The MIA Segment carries similar data, including Remark Codes, for inpatient claims.<br><br>All data elements within the MOA Segment are situational. They reflect adjudication by Medicare or another payer and should be included if available to the submitter. |
| 2330A | NM1 | NM108 | Identification Code Qualifier | Code designating the system/method of code structure used for Identification Code | R/A | MI | Member Identification Number |
| 2330A | NM1 | NM109 | Other Insured Identifier | An identification number, assigned by the third party payer, to identify the additional insured individual | R/A | | The Subscriber ID assigned by the other payer. |

| 837 INSTITUTIONAL CLAIM TRANSACTION SPECIFICATIONS | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Loop ID** | **Segment ID** | **Element ID** | **Element Name** | **Element Definition** | **Adjud Usage** | **Valid Values** | **Definition/Format** |
| 2330B | NM1 | NM108 | Identification Code Qualifier | Code designating the system/method of code structure used for Identification Code | R/A | PI | Payer identification |
| 2330B | NM1 | NM109 | Other Payer Primary Identifier | An identification number for the other payer | R/A | | Any identification number assigned to the other payer. |
| 2330B | REF | REF01 | Reference Identification Qualifier | Code qualifying the reference identification | R/A | F8 | Original Reference Number<br><br>Use code F8 to indicate the payer's claim number assigned to this claim by the other payer referenced in this iteration of Loop 2330B. |
| 2330B | REF | REF02 | Other Payer Secondary Identifier | Additional identifier for the other payer organization | R/A | | The other payer's claim control number for the claim. This is not the CRN that Med-QUEST assigns to the claim. |
| 2400 | LX | LX01 | Assigned Number | Number assigned for differentiation within a transaction set | R | | The other carrier's Claim Line Number, not the Claim Line Number assigned by Med-QUEST. The Institutional 837 Transaction supports up to 999 lines. |
| 2400 | SV2 | SV201 | Service Line Revenue Code | The Revenue Code maintained by the National Uniform Billing Committee (NUBC) | R/A | | This is the Revenue Code used to bill inpatient services. Not expected for outpatient. |
| 2400 | SV2 | SV202-1 | Product or Service ID Qualifier | Code identifying the type/source of the descriptive number used in Product/Service ID | R/A | | Claim submitters use HCPCS Procedure Codes (Qualifier "HC") in this segment for outpatient institutional services. At this time, "HC" is the only Qualifier value used by Med-QUEST.<br><br>One or more HCPCS Procedure Code is required for all outpatient institutional claims. |

| 837 INSTITUTIONAL CLAIM TRANSACTION SPECIFICATIONS | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Loop ID** | **Segment ID** | **Element ID** | **Element Name** | **Element Definition** | **Adjud Usage** | **Valid Values** | **Definition/Format** |
| 2430 | SVD | SVD01 | Payer Identifier | Number identifying the payer organization | R/A | | The 2430 Service Line Adjudication Information Loop is required if this claim had been previously adjudicated by a payer identified in Other Payer Name Loop 2330B and this service line has adjustments (differences between charged and paid amounts) applied to it.<br><br>There is no HIPAA standard for the payer identifier. For Med-QUEST claims, it must match a payer identifier in an Other Payer Name 2330B Loop. |
| 2430 | SVD | SVD03-1 | Product or Service ID Qualifier | Code identifying the type/source of the descriptive number used in Product/Service ID | R/A | HC | Health Care Financing Administration Common Procedural Coding Systems (HCPCS) Codes<br><br>HCPCS Codes are required on outpatient institutional claims for outpatient services paid by other carriers. |
| 2430 | CAS | CAS01 | Claim Adjustment Group Code | Code identifying the general category of payment adjustment | R/A | CO<br>CR<br>OA<br>PI<br>PR | Contractual Obligations<br>Correction and Reversals<br>Other Adjustments<br>Payer Initiated Reductions<br>Patient Responsibility<br><br>Enter the code value that best describes the reason for the different between the Charged Amount and the Paid Amount for this service line. This CAS Segment is used only when another payer has made an adjustment is for payment at the service line level.<br><br>The trio of Adjustment Reason, Amount, and Quantity can occur up to six times per CAS Segment and CAS Segments have up to 99 iterations per service line. |

| 837 INSTITUTIONAL CLAIM TRANSACTION SPECIFICATIONS | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Loop ID** | **Segment ID** | **Element ID** | **Element Name** | **Element Definition** | **Adjud Usage** | **Valid Values** | **Definition/Format** |
| 2430 | CAS | CAS02 | Adjustment Reason Code | Code that indicates the reason for the adjustment | R/A | Many Code Set Values | Hundreds of Adjustment Reason Code values are maintained on the Washington Publishing Company's Web Site (www.wpc-edi.com). Enter the code value that best describes the reason for the difference between the Charged Amount and the Paid Amount. |
| 2430 | CAS | CAS03 | Adjustment Amount | Adjustment amount for the associated reason code | R/A | | The difference between the service line level Charged Amount and Paid Amount associated with the Adjustment Reason Code in CAS02. A positive number when the Paid Amount is less than the Charged Amount. |
| 2430 | CAS | CAS04 | Adjustment Quantity | Numeric quantity associated with the related reason code for coordination of benefits | O | | The difference between the billed and paid units of service when the difference is the result of line level adjudication and is associated with the Adjustment Reason Code in CAS02. A positive number when the Paid Quantity is less than the Charged Quantity. |