HAWAII DEPARTMENT OF HUMAN SERVICES
MED-QUEST DIVISION

Companion Document
and
Transaction Specifications
for HIPAA
837 Claim Transactions

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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 Claim Transactions*
- 835 Electronic FFS Claims Remittance Advice Transaction
- 276/277 Claim Status Request and Response Transactions
- 278 Prior Authorization Transaction
- NCPDP Encounter Transactions

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.

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Document Objective

This Claims Companion Document provides information related to electronic submission of 837 Claim 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 are intended to supplement the HIPAA Implementation Guides for each of the HIPAA transactions. Rules for data format, content, and field values can be found in the Implementation Guides. This document describes the technical interface environment with Med-QUEST, including connectivity requirements, protocols, and electronic interchange procedures. It provides specific information on the fields and values required for transactions that are sent to or received from Med-QUEST.

Companion Documents are intended to supplement but not to replace the standard Implementation Guides for each HPIAA Transaction Set. Information in Companion 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.

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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.

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1.2. Contents of this Companion Document

Introduction	Section 1 provides general information on Companion Documents and HIPAA and outlines the information to be 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: ▪ The purpose of the transaction(s) ▪ The standard Implementation Guide for the transaction(s) ▪ Replaced and impacted Med-QUEST files and processes ▪ Transmission schedules
Technical Infrastructure	Section 3 provides technical information on transmitting electronic data to and receiving electronic data from Med-QUEST including information on: ▪ Setting up a communications link ▪ File Transfer Protocol (FTP) procedures ▪ Security requirements and procedures, including encryption ▪ File naming conventions
Transaction Standards	Section 4 provides information relating to the transaction(s) in this Companion Document including: ▪ General HIPAA transaction standards ▪ Testing criteria and procedures ▪ Front end edits applicable to incoming transactions ▪ Procedures for generating and responding to required acknowledgment transactions ▪ Procedures for handling rejected transmissions and transactions
Transaction Specifications	Section 5 provides specific information relating to the transaction(s) in this Companion Document including: ▪ A statement of the purpose of transaction specifications between Med-QUEST and other covered entities ▪ Med-QUEST-specific data requirements for the transaction(s) at the data element level 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.

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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 and non-payable encounters 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.

Electronic claim submission by providers or their billing agents and claim receipt and 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 newly installed translator to bring them into the 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 limited 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 addition 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

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276/277 Transaction Set permits providers to inquire as to the current status of particular 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 process will continue to function but will be changed so that they meet all HIPAA data and/or format compliance requirements.

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2.2. 837 Claim Transactions

Purpose

The purpose of the three 837 Claim 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 4.4, Acknowledgement Procedures, and 4.5, 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
- 837 Health Care Claim: Dental
- 837 Health Care Claim: Institutional

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)

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Submission Schedule

Claim submitters can transmit 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 electronic claim submitters on a weekly basis. The are issued at the same times 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.

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3. Technical Infrastructure and Procedures

3.1. Technical Environment

MED-QUEST Data Center Communications Requirements	**Med-QUEST is currently evaluating and refining its electronic data communication procedures. Trading partners will receive information when procedures are final.**
Technical Assistance and Help	The Med-QUEST Systems Office provides technical assistance related to non-testing related questions about electronic claims submission or data communications interfaces. Contact information is: ▪ Telephone Number: 808-**nnn-nnnn** ▪ Hours: 8:00 AM to 5:00 PM (MST), Monday through Friday ▪ Information required for initial call: o Topic of Call ("VPN setup", "FTP procedures", etc.) o Name of caller o Organization of caller o Telephone number of caller o Nature of problem (dial-up, receipt status, etc.) ▪ Information required for follow up call(s): o Ticket Number assigned by the Med-QUEST Systems Office

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3.2. File Transfer Protocol (FTP) Procedures

Data Communications Interface Request Procedure

An entity has to complete the following forms to receive authorization for access to the Med-QUEST FTP server:

- Med-QUEST Electronic Data Exchange Request Form
- Med-QUEST User Affirmation Statement
- Data-specific Authorization Forms

These forms are described in the remainder of this section and are available in Appendix A. All installation, testing, and implementation schedules will be under the control of the Med-QUEST Systems Office.

Med-QUEST Electronic Data Exchange Request Form

This form is completed by the submitting entity and provides a summary of the information exchanged between the entity and MED-QUEST. This form contains information about:

- The name and ID Numbers of the contracted entity that submits claims
- Who is authorized to add or change the data being provided or received from Med-QUEST
- Who are the users authorized to access the data
- What entity will be actually submitting the data, if that entity is different from the contracted entity
- What type of data will be accessible to the contracted entity (e.g., Roster files, Encounter or Claim files, Provider Reference Files, or electronic Remittance Advice data)
- How the data exchange will occur (e.g., by tape, FTP via VPN, Internet or e-mail)
- The entity's current user ID and password

MED-QUEST User Affirmation Statement

The Med-QUEST User Affirmation Statement outlines the responsibilities associated with access to Med-QUEST data. It requires all employees in a contracted entity who are authorized to access data using the electronic connection to affirm that they understand and will comply with these responsibilities. Confidentiality of individual health care data and compliance with HIPAA Privacy and Security Mandates are major considerations.

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Software-to-Hardware Communications Interface	**Med-QUEST is currently evaluating and refining its electronic data communication procedures. Trading partners will receive information when procedures are final.**
Hardware-to-Hardware Communications Interface	**Med-QUEST is currently evaluating and refining its electronic data communication procedures. Trading partners will receive information when procedures are final.**
File Transfer Procedures	**Med-QUEST is currently evaluating and refining its electronic data communication procedures. Trading partners will receive information when procedures are final.**

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3.3. Security Procedures

Security Requirements

Entities that utilize this service will be required to meet various physical and system security requirements as defined by Med-QUEST. Security requirements include:

- All users must sign a User Affirmation Statement regarding security and data confidentiality.
- Entities will be held responsible for the actions of their staffs.
- Program contractors and health plans and their subcontractors and staff are expected to and will be required to comply with all Federal, State of Hawaii, and Med-QUEST policies and procedures regarding data confidentiality, security, and user access.

Adding/Changing Access

Entities that wish to add users who are authorized to access data through the VPN tunnel must:

- Have the new user complete and sign a Med-QUEST User Affirmation Statement.
- Mail and/or fax a copy of the signed User Affirmation Statement to the Med-QUEST Systems Office.
- Receive notification from Med-QUEST when the new user's account has been established, including, if necessary, the new user's User ID and password.

File Encryption Procedures

Med-QUEST is currently evaluating and refining its electronic data communication procedures. Trading partners will receive information when procedures are final.

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3.4. File and Directory Naming Conventions

FTP Directories

The directory 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. The current naming conventions are as follows:

- FTP\Cust_ID\System\SubsystemIN(OUT)\TEST(PROD)\

Directory Names:

- Cust_ID - A three character alphabetic value assigned by MED-QUEST that represents a commonly recognized acronym for the claim submitter. For example, a submitter called Maricopa Provider Group could be abbreviated "MAR".
- System. The HPMMIS Subsystem that the data pertains to such as Health Plan, Recipient, Encounter, Reference, or Provider.
- Subsystem. The type of information in the file such as Roster, TPL, etc.
- IN/OUT. IN identifies a directory where the entity sends the file to Med-QUEST. OUT identifies a directory where MED-QUEST sends the file to the entity.
- TEST/PROD. TEST is for files to be used in the test region. PROD is for production files.

Production Files

837 Claim Transactions (Professional, Dental, and Institutional)

- FTP\Cust_ID\CLAIMS\CLAIMSIN\PROD\

Test Files

837 Claim Transactions (Professional, Dental, and Institutional)

- FTP\Cust_ID\CLAIMS\CLAIMSIN\TEST\

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4. Transaction Standards

4.1. General Information

HIPAA Requirements

HIPAA standards are specified in Implementation Guides for each transaction set and in authorized 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 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 Guide, tells how to prepare data in HIPAA standard formats for submission to Med-QUEST.

Size of Transmissions/ Batches

Transmission sizes are limited based on two factors:

- The number of segments/records allowed by HIPAA standards.
- Med-QUEST file transfer limitations

HIPAA recommendations for the maximum file size of each transaction set are specified in the appropriate Implementation Guide or its authorized Addenda. For the 837 Transaction, the Implementation Guide's recommendation is for a maximum of 5,000 CLM Claim Information Segments, generally equivalent to 5,000 claims. Med-QUEST file transfer standards are set by the Information Services Division based on the type of data contained in the transaction set.

For the 837 Claim Transactions, Med-QUEST is currently finalizing its file transfer standards.

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4.2. Testing Procedures

Testing Procedures

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

Internal Transaction Validation

Med-QUEST encourages 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 prior to starting testing with trading partners. The seven basic testing categories are:

1. Integrity Testing
   This kind of testing validates the basic syntactical integrity of the health plan'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).

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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.

These categories also relate to the kinds of "tests" or edits to which the Med-QUEST translator subjects incoming 837 Claim Transactions. Refer to Section 4.3, Edits for 837 Claims, for more information.

Validation of the Electronic Data Exchange Process with Trading Partners

After a health plan has been certified as HIPAA compliant for a transaction set, Med-QUEST and each health plan perform further testing. Testing with trading partners ensures that transactions can be passed through the Med-QUEST translator (and, in some cases, the health plan translator) and successfully read by the receiving trading partner without distortion of the data on the transactions. Med-QUEST provides specific procedures for testing with trading partners to health plans prior to the start of testing for each HIPAA Transaction Set.

Test Data

Med-QUEST believes that, when possible, using real-life production data will enhance the overall value of the compliance testing process. However, 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.

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Testing Procedures	**The testing procedures for individual transaction sets will be finalized at a later date. Testing procedures will be provided to covered entities prior to the start of testing for each transaction set.**
Acceptance Procedures	**The procedures for accepting testing results for individual transactions will be finalized at a later date. Acceptance procedures will be provided to covered entities prior to the start of testing for each transaction set.**

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4.3. Edits for 837 Claim Transactions

Overview of the Edit Process

Med-QUEST is currently evaluating and refining the front-end edits to be performed by its translator. Trading partners will receive information when procedures are final.

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4.4. Acknowledgment Procedures

Overview of Acknowledgment Processes	**Med-QUEST is currently evaluating and refining the acknowledgement procedures to be performed by its translator. Trading partners will receive information when procedures are final.**

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4.5 Rejected Transmissions and Transactions

Overview of Rejection Process	**Med-QUEST is currently evaluating and refining the acceptance and rejection processes to be performed by its translator. Trading partners will receive information when procedures are final.**

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5. Transaction Specifications

5.1. 837 Transaction Specifications

Purpose

Transaction specifications are designed, in combination with the HIPAA Implementation Guides, to identify data to be transmitted between Med-QUEST trading partners and to specify 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.

To a greater extent than encounters, Med-QUEST claims fit the model offered by the 837 Claim Transaction. 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 response components of the process are heavily impacted by new electronic transactions. 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 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.

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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 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 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 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.

- The Claim Level Adjustment and Service Line Adjustment CAS Segments appear within Other Payer Loops on 837 Transactions. They are used to show "adjustments" caused by differences between Billed and Paid Amounts made by previous payers.

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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.

Valid Values
When data element values are listed in the Implementation Guide, the values 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.

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837 PROFESSIONAL CLAIM TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
N/A	REF	REF02	Transmission Type Code	Code identifying the type of transaction or transmission included in the transaction set		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: Pilot Testing: 004010X098DA1 Production: 004010X098A1
1000A	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	46	Electronic Transmitter Identification Number (ETIN)
1000A	NM1	NM109	Submitter Identifier	Code or number identifying the entity submitting the claim		Med-QUEST identifies submitting providers and billing agents with a six-digit number consisting of a single zero followed by the five-digit Electronic Supplier Number assigned by the Med-QUEST Systems Office.
1000B	NM1	NM103	Receiver Name	Name of organization receiving the transaction	MED-QUEST	The transaction receiver
1000B	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	46	Electronic Transmitter Identification Number (ETIN)
1000B	NM1	NM109	Receiver Primary Identifier	Primary identification number for the receiver of the transaction		The Federal Tax ID for Hawaii DHS.
2000A	PAT	PAT07	Unit or Basis for Measurement Code	Code specify the units in which a value is being expressed, or manner in which a measurement has been taken	01	Actual Pounds Med-QUEST requires the patient weight on ambulance claims.
2000A	PAT	PAT08	Patient Weight	Numeric value of weight		On ambulance claims, the weight of the patient in pounds. Note that the 837 Professional Addenda has changed the usage of the Patient Weight element significantly. Weight is no longer birth weight in grams.
2010AA	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	24 or 34	Employer's Identification Number or Social Security Number 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		The billing provider's EIN or SSN.

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837 PROFESSIONAL CLAIM TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2010AA	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	1D or 1C	Medicaid Provider Number or Medicare Provider Number Use the qualifier for the Medicare Provider Number only on Medicare crossover claims.
2010AA	REF	REF02	Billing Provider Additional Identifier	Identifies another or additional distinguishing code number associated with the billing provider		The Med-QUEST ID and Location Code of the billing provider or, for Medicare crossover claims only, the billing provider's Medicare Provider Number. When billing with a Med-QUEST group Billing Number, insert two leading zeros in front of the group's six-digit Med-QUEST Provider ID and submit without a Location Code. In this situation, rendering providers will be different from billing providers. Medicare Provider Numbers do not need this adjustment.
2000B	SBR	SBR01	Payer Responsibility Sequence Number Code	Code identifying the insurance carrier's level of responsibility for a payment of a claim	T	Tertiary – used to indicate that MED-QUEST is the payer of last resort.
2000B	SBR	SBR02	Individual Relationship Code	Code indicating the relationship between two individuals or entities	18	Self
2000B	SBR	SBR09	Claim Filing Indicator Code	Code identifying type of claim or expected adjudication process	11	Other Non-Federal Programs
2010BA	NM1	NM109	Subscriber Primary Identifier	Primary identification number of the subscriber to the coverage		Med-QUEST Recipient ID
2010BB	NM1	NM103	Payer Name	Name identifying the payer organization	MED-QUEST	The "destination payer" according to the Implementation Guide. For claims, unlike encounters, the destination payer is also the direct payer of fee-for-service claims.
2010BB	NM1	NM109	Payer Identifier	Number identifying the payer organization		The Federal Tax ID for Hawaii DHS.
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		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.

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837 PROFESSIONAL CLAIM TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
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 Standard Format		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. Med-QUEST processes each service line's Place of Service separately. 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	1 7 8	Original Replacement (Replacement of prior claim) Void (Void/Cancel of prior claim) 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. Changes can not 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.
2300	CLM	CLM06	Provider or Supplier Signature Indicator	An indicator that the provider of service reported on this claim acknowledges the performance of the service and authorizes payment, and that a signature is on file in the provider's office	Y	Signature on File A signature is required for a provider to register with Med-QUEST.
2300	CLM	CLM07	Medicare Assignment Code	An indication, used by Medicare or other government programs, that the provider accepted assignment	A	Assigned When applicable, Medicare assignment is required by Med-QUEST as a condition of coverage.

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837 PROFESSIONAL CLAIM TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2300	CLM	CLM08	Benefits Assignment Certification Indicator	A code showing whether the provider has a signed form authorizing the third party payer to pay the provider	Y	Benefits are Assigned Required by Med-QUEST as a condition of coverage.
2300	CLM	CLM09	Release of Information Code	Code indicating whether the provider has on file a signed statement permitting the release of medical data to other organizations	Y	Provider has a signed statement permitting release of medical billing data related to a claim. Required by Med-QUEST as a condition of coverage.
2300	CLM	CLM10	Patient Signature Source Code	Code indication how the patient/subscriber authorization signatures were obtained and how they are being retained by the provider	B	Signed signature authorization form or forms for both HCFA-1500 Claim Form block 12 and block 13 are on file Required by Med-QUEST as a condition of coverage.
2300	CLM	CLM20	Delay Reason Code	Code indicating the reason why a request was delayed		When a claim is submitted later than allowed by Med-QUEST rules, enter the Delay Reason Code from the Implementation Guide that best describes the reason for the delay. Include a further explanation in the Claim Note Segment (Element NTE02) later in the 2300 Loop.
2300	AMT	AMT01	Amount Qualifier Code	Code to qualify an amount	F5	Patient Amount Paid
2300	AMT	AMT02	Patient Amount Paid	The amount paid by the patient		Med-QUEST uses the Patient Amount Paid AMT Segment for Share of Cost Amounts paid by the subscriber. They are reported at the header level and are not included in the Total Claim Charge Amount (CLM02 earlier in the 2300 Loop).
2300	REF	REF01	Reference Identification Qualifier	Code qualifying the Reference Identification	G1	Prior Authorization Number 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		The Prior Authorization Number

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837 PROFESSIONAL CLAIM TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2300	REF	REF01	Reference Identification Qualifier	Code qualifying the Reference Identification	F8	Original Reference Number
2300	REF	REF02	Claim Original Reference Number	Number assigned by a processor to identify a claim		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	P4	Project Code
2300	REF	REF02	Demonstration Project Identifier	A code identify a demonstration project	Y	Yes, the claim involves participation in the SSD Demonstration Project
2300	NTE	NTE01	Note Reference Code	A category of claim note	ADD	Additional Information Use this NTE Segment to add an explanation of the delay in claim submission when CLM20 Delay Reason Code is present for claims submitted later than permitted by Med-QUEST submission rules.
2300	NTE	NTE02	Claim Note Text	A free-form description to clarify the related data elements and their content		When a Delay Reason Code (CLM20) is present, the submitter explanation for the delay. Maximum length is 80 characters.
2310A	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	24 or 34	Employer’s Identification Number or Social Security Number Use the 2310A Loop when the referring provider is at the claim rather than the service line level. Unless overridden by a service line referring provider, 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		The referring provider’s Federal Tax ID or Social Security Number.
2310A	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	1D or IC	Medicaid Provider Number or Medicare Provider Number Use the qualifier for Medicare Provider Number only on Medicare crossover claims.

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837 PROFESSIONAL CLAIM TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2310A	REF	REF02	Referring Provider Secondary Identifier	Additional identification number for the provider referring the patient for service		The Med-QUEST ID and Location Code of the referring provider or, for Medicare crossover claims only, the Medicare Provider Number. Submit this number with two leading zeros. The format is 00aaaaaall when aaaaaa is MED-QUEST Provider ID and ll the Location Code. Medicare Provider Numbers do not need this adjustment.
2310B	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	24 or 34	Employer's Identification Number or Social Security Number Use the 2310B Loop when the rendering provider is at the claim rather than the service line level and is different from the billing provider in Loop 2010AA. Unless overridden by a service line rendering provider, this loop's rendering provider will be the rendering provider for all service lines.
2310B	NM1	NM109	Rendering Provider Identifier	The identifier assigned by the Payer to the provider who performed the service		The rendering provider's Federal Tax ID or Social Security Number.
2310B	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	1D or IC	Medicaid Provider Number or Medicare Provider Number Use the qualifier for Medicare Provider Number only on Medicare crossover claims.
2310B	REF	REF02	Rendering Provider Secondary Identifier	Additional identifier for the provider providing care to the patient		The MED-QUEST ID and Location Code of the rendering provider.or, for Medicare crossover claims only, the Medicare Provider Number. Submit this number with two leading zeros. The format is 00aaaaaall when aaaaaa is the MED-QUEST Provider ID and ll the Location Code. Medicare Provider Numbers do not need this adjustment.
2310D	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	24 or 34	Employer's Identification Number or Social Security Number
2310D	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		The laboratory's or facility's Federal Tax ID or Social Security Number.

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837 PROFESSIONAL CLAIM TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2310D	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	1D or IC	Medicaid Provider Number or Medicare Provider Number Use the qualifier for Medicare Provider Number only on Medicare crossover claims.
2310D	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		The MED-QUEST ID and Location Code of the laboratory or facility or, for Medicare crossover claims only, the Medicare Provider Number. If the 2310D Laboratory or Facility Loop is submitted, treat the Lab or Facility ID like other MED-QUEST Provider IDs. Submit the ID Number and Location with two leading zeros. The format is 00aaaaaall when aaaaaa is the MED-QUEST Provider ID and ll the Location Code. Medicare Provider Numbers do not need this adjustment.
2310E	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	24 or 34	Employer's Identification Number or Social Security Number
2310E	NM1	NM109	Supervising Provider Identifier	The Identification Number for the Supervising Provider		The supervising provider's Federal Tax ID or Social Security Number.
2310E	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	1D or IC	Medicaid Provider Number or Medicare Provider Number Use the qualifier for Medicare Provider Number only on Medicare crossover claims.
2310E	REF	REF02	Supervising Provider Secondary Identifier	Additional identifier for the provider supervising care rendered to the patient		The Med-QUEST ID and Location Code of the supervising provider or, for Medicare crossover claims only, the Medicare Provider Number. If the 2310E Supervising Provider Loop is submitted, treat the Supervising Provider ID like other Med-QUEST Provider IDs. Submit the ID Number and Location with two leading zeros. The format is 00aaaaaall when aaaaaa is the Med-QUEST Provider ID and ll the Location Code. Medicare Provider Numbers do not need this adjustment

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837 PROFESSIONAL CLAIM TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2320	SBR	SBR01	Payer Responsibility Sequence Number Code	Code identifying the insurance carrier's level of responsibility for a payment of a claim	P or S or T	Primary or Secondary or Tertiary 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. 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	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		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		A Group or Policy Name associated with SBR03.
2320	CAS	CAS01	Claim Adjustment Group Code	Code identifying the general category of payment adjustment		On 837 Transactions, “adjustments” are changes from other payer’s Billed to Paid Amounts at the claim or service line level. A CAS Segment is needed if the amount that the health plan pays the provider is different from the amount charged due to a claim-level adjustment. 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	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.

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837 PROFESSIONAL CLAIM TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
						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. 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		The difference between the claim level Charged Amount and Paid Amount associated with the Adjustment Reason Code in CAS02. A negative 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		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 negative number when the Paid Quantity is less than the Charged Quantity.
2320	MOA	MOA02	Claim HCPCS Payable Amount	Sum of payable line item amounts for HCPCS codes billed on this claim		The Medicare Outpatient Adjudication MOA Segment is required if data for it is available from an electronic remittance advice (835 Transaction). 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. 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.

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837 PROFESSIONAL CLAIM TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2400	SV1	SV101-1	Product or Service ID Qualifier	Code identifying the type/source of the descriptive number used in Product/Service ID (234)	HC	Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes 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, only HCPCS Procedure Codes are used to identify professional services.
2400	SV1	SV101-3	Procedure Modifier	This identifies special circumstances related to the performance of the service		The first Procedure Code Modifier Med-QUEST uses this Procedure Code Modifier in adjudication.
2400	SV1	SV101-4	Procedure Modifier	This identifies special circumstances related to the performance of the service		The second Procedure Code Modifier 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		The third Procedure Code Modifier 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		The fourth Procedure Code Modifier Med-QUEST does not use this Procedure Code Modifier in adjudication.
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	Y	Yes, the service is the result of an EPSDT referral Required if a Medicaid service is the result of a screening referral. This service referenced by this service line element differs from the data on the referral itself in the claim level EPSDT CRC Segment. This new segment has been introduced by the 837 Professional Addenda. SV111 indicates a service that results from an EPSDT referral, not the original EPSDT evaluation.

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837 PROFESSIONAL CLAIM TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2400	SV1	SV115	Co-Pay Status Code	A code indicating the status of the co-payment requirements for this service	0	Exempt from co-payment Enter this value for all Med-QUEST recipients. In the future, some programs administered by MED-QUEST may include co-payments and require a different value.
2400	REF	REF01	Reference Identification Qualifier	Code qualifying the Reference Identification	G1	Prior Authorization Number 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		The Prior Authorization Number for the service line.
2410	LIN	LIN02	Product or Service ID Qualifier	Code identifying the type or source of the descriptive number used in Product ID Field.	N4	National Drug Code in 5-4-2 Format 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. This usage differs from use of an NDC Code as a procedure in Loop 2400 (allowed by HIPAA but not by Med-QUEST).
2420A	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	24 or 34	Employer's Identification Number or Social Security Number Use the 2420A Loop when the rendering provider is at the service line rather than the claim level and is different from the claim-level rendering provider in Loop 2310B. The service line rendering provider overrides the rendering provider, if any, in Loop 2310B.
2420A	NM1	NM109	Rendering Provider Identifier	The identifier assigned by the Payer to the provider who performed the service		The rendering provider's Federal Tax ID or Social Security Number.

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837 PROFESSIONAL CLAIM TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2420A	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	1D or IC	Medicaid Provider Number or Medicare Provider Number Use the qualifier for Medicare Provider Number only on Medicare crossover claims.
2420A	REF	REF02	Rendering Provider Secondary Identifier	Additional identifier for the provider providing care to the patient		The service line Med-QUEST ID and Location Code of the rendering provider or, for Medicare crossover claims only, the Medicare Provider Number. Submit this number with two leading zeros. The format is 00aaaaaall when aaaaaa is the MED-QUEST Provider ID and ll the Location Code. This adjustment is not needed for Medicare Provider Numbers.
2420D	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	24 or 34	Employer's Identification Number or Social Security Number
2420D	NM1	NM109	Supervising Provider Identifier	The Identification Number for the Supervising Provider		The supervising provider's Federal Tax ID or Social Security Number.
2420D	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	1D or IC	Medicaid Provider Number or Medicare Provider Number Use the qualifier for Medicare Provider Number only on Medicare crossover claims.
2420D	REF	REF02	Supervising Provider Secondary Identifier	Additional identifier for the provider supervising care rendered to the patient		The service line Med-QUEST ID and Location Code of the supervising provider, or, for Medicare crossover claims only, the Medicare Provider Number. If the 2420D service line Supervising Provider Loop is submitted, treat the Supervising Provider ID like other MED-QUEST Provider IDs. Submit the ID Number and Location with two leading zeros. The format is 00aaaaaall when aaaaaa is the MED-QUEST Provider ID and ll the Location Code. Provider IDs on Medicare crossover claims do not require this adjustment.

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837 PROFESSIONAL CLAIM TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2420E	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	1D or IC	Medicaid Provider Number or Medicare Provider Number Use the qualifier for Medicare Provider Number only on Medicare crossover claims.
2420E	REF	REF02	Ordering Provider Secondary Identifier	Additional identifier for the provider ordering services for the patient		The Med-QUEST ID and Location Code of the ordering provider, or, for Medicare crossover claims only, the Medicare Provider Number. If the 2420D service line Ordering Provider Loop is submitted, treat the Ordering Provider ID like other Med-QUEST Provider IDs. Submit the ID Number and Location with two leading zeros. The format is 00aaaaaall when aaaaaa is the Med-QUEST Provider ID and ll the Location Code. Medicare Provider IDs on crossover claims do not require this adjustment.
2420F	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	1D or IC	Medicaid Provider Number or Medicare Provider Number Use the qualifier for Medicare Provider Number only on Medicare crossover claims.
2420F	REF	REF02	Referring Provider Secondary Identifier	Additional identification number for the provider referring the patient for service		The service line Med-QUEST Provider ID Number and Location Code of the referring provider or, for Medicare crossover claims only, the Medicare Provider Number. Submit this number with two leading zeros. The format is 00aaaaaall when aaaaaa is the Med-QUEST Provider ID and ll the Location Code. Medicare Provider IDs on crossover claims do not require this adjustment.
2430	SVD	SVD01	Other Payer Primary Identifier	An identification number for the other payer		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." This number in this field needs to match NM109 in the Loop 2330B that identifies the other payer.

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837 PROFESSIONAL CLAIM TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2430	CAS	CAS02	Adjustment Reason Code	Code that indicates the reason for the adjustment	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. These are the same Adjustment Reason Codes that appear on the 835 Claim Remittance Advice Transaction. The "adjustment trio" of Adjustment Reason Code, Adjustment Amount, and Adjustment Quantity occur up to six times within the CAS Segment.
2430	CAS	CAS03	Adjustment Amount	Adjustment amount for the associated reason code		The difference between the service line level Charged Amount and Paid Amount associated with the Adjustment Reason Code in CAS02. A negative 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		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 negative number when the Paid Quantity is less than the Charged Quantity.

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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 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.

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 rather than as a pseudo Procedure Modifier) are covered in these specifications.

The specifications in this section apply only to 837 Dental Claim Transactions that fee for service providers submit to Med-QUEST. Only data elements that are used by Med-QUEST in ways that require explanations that go beyond information in standard Implementation Guides are included.

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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.

- The 837 Dental Claim format does not have a data element that indicates whether a tooth is temporary or permanent. The recipient's Age (calculated from the Date of Birth) is now used to make this distinction.

- 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.

- Although a 2310D Assistant Surgeon Loop has been added by Addenda to the 837 Dental Transaction, this loop should not be used on Med-QUEST dental claims. Assistant surgeons should bill on professional 837s. Dental claims with Assistant Surgeon Loops will be denied.

- Although the 837 Dental Claim format permits up to 32 Tooth Numbers (TOO Segments) per dental service line, only a single TOO Tooth Information Segment per service is allowed by Med-QUEST. 837 Dental Transactions submitted with more than one TOO Segment per service line will be denied.

- 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.

- The Claim Level Adjustment and Service Line Adjustment CAS Segments appear within Other Payer Loops on 837 Transactions. They are used to show "adjustments" caused by differences between Billed and Paid Amounts made by previous payers.

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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.

Valid Values
When data element values are listed in the Implementation Guide, the values 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.

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837 DENTAL CLAIM TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
N/A	REF	REF02	Transmission Type Code	Code identifying the type of transaction or transmission included in the transaction set		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: Pilot Testing: 004010X097DA1 Production: 004010X097A1
1000A	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	46	Electronic Transmitter Identification Number (ETIN)
1000A	NM1	NM109	Submitter Identifier	Code or number identifying the entity submitting the claim		Med-QUEST identifies submitting providers and billing agents with a six-digit number consisting of a single zero followed by the five-digit Electronic Supplier Number assigned by the Med-QUEST Systems Office.
1000B	NM1	NM103	Receiver Name	Name of organization receiving the transaction	MED-QUEST	The transaction receiver
1000B	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code (67)	46	Electronic Transmitter Identification Number (ETIN)
1000B	NM1	NM109	Receiver Primary Identifier	Primary identification number for the receiver of the transaction		The DHS Federal Tax ID
2010AA	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	24 or 34	Employer's Identification Number or Social Security Number 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		The Federal Tax ID used by the billing provider.
2010AA	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	1D or 1C	Medicaid Provider Number or Medicare Provider ID Use the Medicare Provider ID Qualifier only on Medicare crossover claims.

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837 DENTAL CLAIM TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2010AA	REF	REF02	Billing Provider Additional Identifier	Identifies another or additional distinguishing code number associated with the billing provider		The Med-QUEST ID and Location Code of the billing provider or, on Medicare crossover claims only, the Medicare Provider ID. When billing with a group Billing Number, insert two leading zeros in front of the group's six-digit Med-QUEST Provider ID and submit without a Location Code. In this situation, rendering providers will be different from billing providers. No such adjustments are required for Medicare Provider IDs.
2000B	SBR	SBR01	Payer Responsibility Sequence Number Code	Code identifying the insurance carrier's level of responsibility for a payment of a claim	T	Tertiary – used to indicate that MED-QUEST is the payer of last resort.
2000B	SBR	SBR02	Individual Relationship Code	Code indicating the relationship between two individuals or entities	18	Self
2000B	SBR	SBR09	Claim Filing Indicator Code	Code identifying type of claim or expected adjudication process	11	Other Non-Federal Programs
2010BA	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	MI	Member ID
2010BA	NM1	NM109	Subscriber Primary Identifier	Primary identification number of the subscriber to the coverage		The MED-QUEST Recipient ID
2010BB	NM1	NM103	Payer Name	Name identifying the payer organization	MED-QUEST	The name of the "destination payer" according to the Implementation Guide. For claims, unlike encounters, MED-QUEST is both the destination payer and the entity that makes direct payments to fee-for-service providers.
2010BB	NM1	NM109	Payer Identifier	Number identifying the payer organization		The DHS 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		The Patient Account Number used by the rendering provider

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837 DENTAL CLAIM TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
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 Standard Format		Code values are listed in the Implementation Guide and in the Addendum for the 837 Dental Transaction. The Addendum states that "only codes contained in the document available from code source 237 are to be supported in this transaction and take precedence over any and all codes listed here." Code Source 237 is CMS. The Implementation Guide provides an address, Web Site, and contact person. The six codes listed in the Implementation Guide are not as extensive as the Facility Type Codes listed for Professional and Institutional 837s. MED-QUEST understands the statement quoted above to mean that all valid Facility Type Code values can be used on Dental 837s. Place of Service is submitted at the claim level but stored at the service line level in HPMMIS. Place of Service at the claim level applies to all service lines unless overridden by a different Place of Service Code at the line level.
2300	CLM	CLM05-3	Claim Submission Reason Code	Code identifying reason for claim submission	1 7 8	Original (New admit thru discharge claim) Replacement (Replacement of prior claim) Void (Void/Cancel of prior claim) A value of "6" (Corrected) was originally included in the Implementation Guide but deactivated by Designated Standards Maintenance Organizations (DSMOs). 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	CLM06	Provider or Supplier Signature Indicator	An indicator that the provider of service reported on this claim acknowledges the performance of the service and authorizes payment, and that a signature is on file in the provider's office	Y	Signature on File A signature is required for a provider to register with MED-QUEST.

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837 DENTAL CLAIM TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2300	CLM	CLM07	Medicare Assignment Code	An indication, used by Medicare or other government programs, that the provider accepted assignment	A	Assigned When applicable, Medicare assignment is required by MED-QUEST as a condition of coverage.
2300	CLM	CLM08	Benefits Assignment Certification Indicator	A code showing whether the provider has a signed form authorizing the third party payer to pay the provider	Y	Benefits are Assigned Required by MED-QUEST as a condition of coverage.
2300	CLM	CLM09	Release of Information Code	Code indicating whether the provider has on file a signed statement permitting the release of medical data to other organizations	Y	Provider has a signed statement permitting release of medical billing data related to a claim. Required by MED-QUEST as a condition of coverage.
2300	CLM	CLM20	Delay Reason Code	Code indicating the reason why a request was delayed		When a claim is submitted later than allowed by Med-QUEST rules, enter the Delay Reason Code from the Implementation Guide that best describes the reason for the delay. Include a further explanation in the Claim Note Segment (Element NTE02) later in the 2300 Loop.
2300	AMT	AMT01	Amount Qualifier Code	Code to qualify an amount	F5	Patient Amount Paid
2300	AMT	AMT02	Patient Amount Paid	The amount paid by the patient		Med-QUEST uses the Patient Amount Paid AMT Segment for Share of Cost Amounts paid by the subscriber. They are reported at the header level and are not included in the Total Claim Charge Amount (CLM02 earlier in the 2300 Loop).
2300	REF	REF01	Reference Identification Qualifier	Code qualifying the Reference Identification	G1	Prior Authorization Number 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		The Prior Authorization Number

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837 DENTAL CLAIM TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2300	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	F8	Original Reference Number 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		For replacement and void claims, the MED-QUEST Claim Reference Number (CRN) of the prior claim being replaced or voided.
2300	NTE	NTE01	Note Reference Code	A category of claim note	ADD	Additional Information Use this NTE Segment to add an explanation of the delay in claim submission when CLM20 Delay Reason Code is present for claims submitted later than permitted by Med-QUEST submission rules.
2300	NTE	NTE02	Claim Note Text	A free-form description to clarify the related data elements and their content		When a Delay Reason Code (CLM20) is present, the submitter explanation for the delay. Maximum length is 80 characters.
2310A	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	24 or 34	Employer’s Identification Number or Social Security Number Use the 2310A Loop when the referring provider is at the claim rather than the service line level. Unless overridden by a service line referring provider, this loop’s referring provider will be the referring provider for all service lines.
2310A	NM1	NM109	Referring Provider Identifier	The identifier assigned by the Payer to the referring provider		The referring provider’s Federal Tax ID or Social Security Number.
2310A	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	1D or 1C	Medicaid Provider Number or Medicare Provider ID Use the Medicare Provider ID Qualifier only on Medicare crossover claims.

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837 DENTAL CLAIM TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2310A	REF	REF02	Referring Provider Secondary Identifier	Additional identification number for the provider referring the patient for service		The Med-QUEST ID and Location Code of the referring provider or, on Medicare crossover claims only, the referring provider's Medicare Provider ID. Insert two leading zeros in front of the six-digit Med-QUEST Provider ID and add a Location Code to create a ten-digit field. No such adjustments are required for Medicare Provider IDs.
2310B	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	24 or 34	Employer's Identification Number or Social Security Number Use the 2310B Loop when the rendering provider is at the claim rather than the service line level. Unless overridden by a service line rendering provider, this loop's rendering provider will be the rendering provider for all service lines.
2310B	NM1	NM109	Rendering Provider Identifier	The identifier assigned by the Payer to the provider who performed the service		The rendering provider's Federal Tax ID or Social Security Number.
2310B	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	1D or 1C	Medicaid Provider Number or Medicare Provider ID Use the Medicare Provider ID Qualifier only on Medicare crossover claims.
2310B	REF	REF02	Rendering Provider Secondary Identifier	Additional identifier for the provider providing care to the patient		The Med-QUEST ID and Location Code of the rendering provider or, on Medicare crossover claims only, the rendering provider's Medicare Provider ID. Insert two leading zeros in front of the six-digit Med-QUEST Provider ID and add a Location Code to create a ten-digit field. No such adjustments are required for Medicare Provider IDs.
2310C	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	24 or 34	Employer's Identification Number or Social Security Number
2310C	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		The laboratory or facility's Federal Tax ID or Social Security Number.

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837 DENTAL CLAIM TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2310C	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	1D or 1C	Medicaid Provider Number or Medicare Provider ID Use the Medicare Provider ID Qualifier only on Medicare crossover claims.
2310C	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		The Med-QUEST ID and Location Code of the laboratory or facility or, on Medicare crossover claims only, the lab or facilty's Medicare Provider ID. Insert two leading zeros in front of the six-digit Med-QUEST Provider ID and add a Location Code to create a ten-digit field. No such adjustments are required for Medicare Provider IDs.
2320	SBR	SBR01	Payer Responsibility Sequence Number Code	Code identifying the insurance carrier's level of responsibility for a payment of a claim	P or S or T	Primary or Secondary or Tertiary 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. 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	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		A Group or Policy Number associated with the other coverage.
2320	SBR	SBR04	Policy Name	The name of the policy providing coverage		A Group or Policy Name associated with SBR03.

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837 DENTAL CLAIM TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2320	CAS	CAS01	Claim Adjustment Group Code	Code identifying the general category of payment adjustment		Enter the code value in the Implementation Guide that best describes the reason for any difference between the Charged Amount and the Paid Amount. On 2320 Loops, a CAS Segment is needed if the amount that the other payer has paid the provider is 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.
2320	CAS	CAS02	Adjustment Reason Code	Code that indicates the reason for the adjustment	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 describes the reason for the difference between the Charged Amount and the Paid Amount. 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 payer 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. 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		The difference between the claim level Charged Amount and Paid Amount associated with the Adjustment Reason Code in CAS02. A negative 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		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 negative number when the Paid Quantity is less than the Charged Quantity.

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837 DENTAL CLAIM TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2320	OI	OI03	Benefits Assignment Certification Indicator	A code showing whether the provider has a signed form authorizing the third party payer to pay the provider	Y or N	Yes or No Benefit assignment is required for MED-QUEST coverage. Value is always “Y” in the initial 2320 Loop. Can be “Y” or “N” in subsequent 2320 iterations.
2320	OI	OI04	Patient Signature Source Code	Code indication how the patient/subscriber authorization signatures were obtained and how they are being retained by the provider	Y or N	Yes or No A patient authorization signature is required for MED-QUEST coverage. Value is always “Y” in the initial 2320 Loop. Can be “Y” or “N” in subsequent 2320 iterations.
2320	OI	OI06	Release of Information Code	Code indicating whether the provider has on file a signed statement permitting the release of medical data to other organizations	Y or N	Yes or No A release of information authorization is required for MED-QUEST coverage. Value is always “Y” in the initial 2320 Loop. Can be “Y” or “N” in subsequent 2320 iterations.
2330A	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	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		The Subscriber ID assigned by the other payer.
2330B	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	PI	Payer Identifier
2330B	NM1	NM109	Other Payer Primary Identifier	An identification number for the other payer		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		The number of the service line, beginning with 1 for the first line. For 837 Dental Claims, the maximum number of lines is 50. MED-QUEST no longer accept s dental claims with more than 50 lines.

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837 DENTAL CLAIM TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2400	SV3	SV301-1	Produce or Service ID Qualifier	Code identifying the type/source of the descriptive number used in Produce/Service ID	AD	American Dental Association Code CDT (Current Dental Terminology) ADA Procedure Codes have been made part of Level II HCPCS Codes.
2400	SV3	SV301-2	Procedure Code	The ADA Dental Procedure Code		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		According to the 837 Dental Addenda, Dental Procedure Code Modifiers must be valid ADA Procedure Code Modifiers. Submitters of dental claims can no longer use modifiers with other values.
2400	SV3	SV304-1 – SV304-5	Oral Cavity Designation Code	Code identifying the oral cavity in which service is rendered		Quadrants are now submitted as Oral Cavity Designation Codes listed in the 837 Dental Implementation Guide.
2400	SV3	SV306	Procedure Count	Number of Procedures		This element is for the service units reported by the provider to the health plan. The units reported by the health plan to Med-QUEST are captured in loop 2430.
2400	TOO	TOO01	Code List Qualifier Code	Code identifying a specific industry code list	JP	National Standard Tooth Numbering System Although up to 32 TOO Segments per dental service line are permitted by the Dental 837 Implementation Guide, Med-QUEST uses and allows only a single TOO Segment.
2400	TOO	TOO02	Tooth Number	The ADA Tooth Number Code		The ADA code for Tooth Number affected by the surface
2400	TOO	TOO03-1 – TOO03-5	Tooth Surface	Code identifying the area of the tooth that was treated		The 837 Dental Transaction can accommodate up to five occurrences of Tooth Surface Codes in association with a Tooth Number.
2400	REF	REF01	Reference Identification Qualifier	Code qualifying the Reference Identification	G1	Prior Authorization Number 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		The Prior Authorization Number

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837 DENTAL CLAIM TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2420A	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	24 or 34	Employer's Identification Number or Social Security Number Use the 2420A Loop when the rendering provider is at the service line rather than the claim level and is different from the claim-level rendering provider in Loop 2310B. The service line rendering provider overrides the rendering provider, if any, in Loop 2310B.
2420A	NM1	NM109	Rendering Provider Identifier	The identifier assigned by the Payer to the provider who performed the service		The rendering provider's Federal Tax ID or Social Security Number.
2420A	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	1D or 1C	Medicaid Provider Number or Medicare Provider ID Use the Medicare Provider ID Qualifier only on Medicare crossover claims.
2420A	REF	REF02	Rendering Provider Secondary Identifier	Additional identifier for the provider providing care to the patient		The Med-QUEST ID and Location Code of the service line level rendering provider or, on Medicare crossover claims only, the rendering provider's Medicare Provider ID. Insert two leading zeros in front of the six-digit Med-QUEST Provider ID and add a Location Code to create a ten-digit field. No such adjustments are required for Medicare Provider IDs.
2420B	NM1	NM103	Other Payer Last or Organization Name	The name of the other payer organization		The name of the 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		The other payer's identification number. It must be the same as a payer's ID Number in a claim level 2330B Loop.

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837 DENTAL CLAIM TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2430	SVD	SVD01	Other Payer Primary Identifier	An identification number for the other payer		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." 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		Required if the other 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. 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	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. These are the same Adjustment Reason Codes that appear on the 835 Claim Remittance Advice Transaction.
2430	CAS	CAS03	Adjustment Amount	Adjustment amount for the associated reason code		The difference between the service line level Charged Amount and Paid Amount associated with the Adjustment Reason Code in CAS02. A negative 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		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 negative number when the Paid Quantity is less than the Charged Quantity.

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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 and billing agents 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 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.

- The Claim Level Adjustment and Service Line Adjustment CAS Segments appear within Other Payer Loops on 837 Transactions. They are used to show "adjustments" caused by differences between Billed and Paid Amounts made by previous payers.

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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.

Valid Values
When data element values are listed in the Implementation Guide, the values 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.

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837 INSTITUTIONAL CLAIM TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
N/A	REF	REF02	Transmission Type Code	Code identifying the type of transaction or transmission included in the transaction set		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: Pilot Testing: 004010X096DA1 Production: 004010X096A1
1000A	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	46	Electronic Transmitter Identification Number (ETIN)
1000A	NM1	NM109	Submitter Identifier	Code or number identifying the entity submitting the claim		Med-QUEST identifies submitting providers and billing agents with a six-digit number consisting of a single zero followed by the five-digit Electronic Supplier Number assigned by the Med-QUEST Systems Office.
1000B	NM1	NM103	Receiver Name	Name of organization receiving the transaction	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	46	Electronic Transmitter Identification Number (ETIN)
1000B	NM1	NM109	Receiver Primary Identifier	Primary identification number for the receiver of the transaction		The Federal Tax ID used by DHS.
2010AA	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	24 or 34	Employer's Identification Number or Social Security Number 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		The Federal Tax ID or Social Security Number used by the billing provider.
2010AA	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	1D or 1C	Medicaid Provider Number or Medicare Provider ID Use the Medicare Provider ID Qualifier only on Medicare crossover claims.

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837 INSTITUTIONAL CLAIM TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2010AA	REF	REF02	Billing Provider Additional Identifier	Identifies another or additional distinguishing code number associated with the billing provider		The Med-QUEST ID and Location Code of the billing provider or, on Medicare crossover claims only, the billing provider's Medicare Provider ID. If the billing provider is the same as the rendering provider, insert two leading zeros in front of the six-digit Med-QUEST Provider ID and add a Location Code to create a ten-digit field. If the billing provider is a provider group with an ID different from the ID of the rendering provider, do not use the Location Code. No such adjustments are required for Medicare Provider IDs.
2000B	SBR	SBR01	Payer Responsibility Sequence Number Code	Code identifying the insurance carrier's level of responsibility for a payment of a claim	T	Tertiary – used to indicate that Med-QUEST is the payer of last resort.
2000B	SBR	SBR02	Individual Relationship Code	Code indicating the relationship between two individuals or entities	18	Self
2000B	SBR	SBR09	Claim Filing Indicator Code	Code identifying type of claim or expected adjudication process	11	Other Non-Federal Programs
2010BA	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	MI	Member Identification Number
2010BA	REF	REF02	Subscriber Supplemental Identifier	Identifies another or additional distinguishing code number associated with the subscriber		The member's Med-QUEST ID
2010BC	NM1	NM103	Payer Name	Name identifying the payer organization	MED-QUEST	The "destination payer" according to the Implementation Guide.
2010BC	NM1	NM109	Payer Identifier	Number identifying the payer organization		The Federal Tax ID Number of DHS
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		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		The first two characters of the Uniform Billing (UB) Type of Bill field on institutional claims.

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837 INSTITUTIONAL CLAIM TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
				code or the Place of Service code from the Electronic Media Claims National Standard Format		
2300	CLM	CLM05-2	Facility Code Qualifier	Code identifying the type of facility referenced	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.		The Claim Frequency Code is the third character of the UB Type of Bill field on institutional claims. A value of “6” (Corrected) was originally included in some 837 Implementation Guides but deactivated by Designated Standards Maintenance Organizations (DSMOs). It is no longer valid. Changes can not 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. Under HIPAA, Med-QUEST continues to accept and adjudicate interim inpatient claims with appropriate Claim Frequency Codes.
CLM05-3	CLM	CLM06	Provider or Supplier Signature Indicator	An indicator that the provider of service reported on this claim acknowledges the performance of the service and authorizes payment, and that a signature is on file in the provider's office	Y	Signature on File A signature is required for a provider to register with MED-QUEST.
2300	CLM	CLM07	Medicare Assignment Code	An indication, used by Medicare or other government programs, that the provider accepted assignment	A	Assigned When applicable, Medicare assignment is required by MED-QUEST as a condition of coverage.

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837 INSTITUTIONAL CLAIM TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2300	CLM	CLM08	Benefits Assignment Certification Indicator	A code showing whether the provider has a signed form authorizing the third party payer to pay the provider	Y	Benefits are Assigned Required by MED-QUEST as a condition of coverage.
2300	CLM	CLM09	Release of Information Code	Code indicating whether the provider has on file a signed statement permitting the release of medical data to other organizations	Y	Provider has a signed statement permitting release of medical billing data related to a claim. Required by Med-QUEST as a condition of coverage.
2300	CLM	CLM18	Explanation of Benefits Indicator	Indicator of whether a paper explanation of benefits (EOB) is requested		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	CLM	CLM20	Delay Reason Code	Code indicating the reason why a request was delayed		When a claim is submitted later than allowed by Med-QUEST rules, enter the Delay Reason Code from the Implementation Guide that best describes the reason for the delay. Include a further explanation in the Claim Note Segment (Element NTE02) later in the 2300 Loop.
2300	DTP	DTP01	Date Time Qualifier	Code specifying the type or date or time, or both date and time	096	Discharge 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. Med-QUEST does not use the Discharge Hour in claim adjudication.
2300	DTP	DTP02	Date Time Period Format Qualifier	Code indicating the date format, time format, or date and time format	TM	Time expressed in format HHMM
2300	DTP	DTP03	Discharge Hour	The time at which the patient was discharged from a facility		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. 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.

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837 INSTITUTIONAL CLAIM TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2300	DTP	DTP01	Statement Date or Range Qualifier	Indicator of a Statement Date or Range DTP Segment	434	Statement The Statement Date DTP Segment is required. It 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	435	Admission
2300	DTP	DTP02	Date/Time Period Format Qualifier	Code indicating the date format, the time format or the date and time format	DT	Date and time expressed in format CCYYMMDDHHMM.
2300	DTP	DTP03	Admission Date and Time	Admission Date and Hour		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.
2300	AMT	AMT01	Amount Qualifier Code	Code to qualify an amount	F5	Patient Amount Paid
2300	AMT	AMT02	Patient Paid Amount	The amount paid by the patient		Med-QUEST uses the Patient Paid Amount AMT Segment for Share of Cost Amounts paid by the subscriber. They are reported at the header level and are not included in the Total Claim Charge Amount (CLM02 earlier in the 2300 Loop).
2300	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	F8	Original Reference Number 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		The Med-QUEST assigned Claim Reference Number (CRN) for the claim being replaced or voided.

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837 INSTITUTIONAL CLAIM TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2300	REF	REF01	Reference Identification Qualifier	Code qualifying the Reference Identification	G1	Prior Authorization Number 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		The Prior Authorization Number
2300	REF	REF01	Reference Identification Qualifier	Code qualifying the Reference Identification	P4	Project Code
2300	REF	REF02	Demonstration Project Identifier	A code identify a demonstration project	Y	Yes, the claim involves participation in the SSD Demonstration Project
2300	NTE	NTE01	Note Reference Code	A category of claim note	ADD	Additional Information Use this NTE Segment to add an explanation of the delay in claim submission when CLM20 Delay Reason Code is present for claims submitted later than permitted by Med-QUEST submission rules. On institutional 837s, use the Billing Note rather than the Claim Note Segment for the delay reason explanation. For institutional 837s only, the Claim Note segment is defined in a particular way by the Implementation Guide and cannot be used for delay explanations.
2300	NTE	NTE02	Billing Note Text	A free-form description to clarify the related data elements and their content		When a Delay Reason Code (CLM20) is present, the submitter's explanation for the delay. Maximum length is 80 characters.
2300	HI	HI01-1	Code List Qualifier Code	Code qualifying the Reference Identification – Other Diagnosis Codes	BF	Diagnosis 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.

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837 INSTITUTIONAL CLAIM TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2300	HI	HI01-1	Code List Qualifier Code	Code identifying Principal Procedures – Principal Procedure Codes	BP or BR	Health Care Financing Administration Common Procedural Coding System Principal Procedure or International Classification of Diseases Clinical Modification (ICD-9-CM) Principal Procedure Both HCPCS and ICD-9 Procedure Codes are valid on 837 Institutional Transactions. 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	BO or BQ	Health Carte Financing Administration Common Procedural Coding System (HCPCS) or International Classification of Diseases Clinical Modification (ICD-9-CM) Procedure One or both of these types of Procedure Codes are valid on Institutional 837s. 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. Only ICS-9-CM Procedures in this segment will be used by Med-QUEST for claim adjudication. The 837 Transaction can accommodate up to 24 occurrences of Other Procedures on institutional claims. However, only the initial five (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 – Occurrence Span Codes	BI	Occurrence Span 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.

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837 INSTITUTIONAL CLAIM TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2300	HI	HI01-1	Code List Qualifier Code	Code qualifying the Reference Identification – Occurrence Codes	BH	Occurrence 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	BE	Value 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	BG	Condition 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	TC	Treatment Codes 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	CA CD LA NA	Covered – Actual Co-insured - Actual Life-time Reserve - Actual Number of Non-covered Days 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.

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837 INSTITUTIONAL CLAIM TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**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		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	DA	Days
2310A	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	24 or 34	Employer's Identification Number Social Security Number
2310A	NM1	NM109	Attending Physician Primary Identifier	Primary identification number of the physician responsible for care of the patient		The attending physician's Federal Tax ID or Social Security Number
2310A	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	1D or 1C	Medicaid Provider Number or Medicare Provider ID Use the Medicare Provider ID Qualifier only on Medicare crossover claims.
2310A	REF	REF02	Attending Physician Secondary Identifier	Secondary identification number of the physician responsible for the care of the patient		The Med-QUEST ID and Location Code of the attending physician or, on Medicare crossover claims only, the attending physician's Medicare Provider ID. Insert two leading zeros in front of the six-digit Med-QUEST Provider ID and add a Location Code to create a ten-digit field. No such adjustments are required for Medicare Provider IDs.
2310B	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code (67)	24 or 34	Employer's Identification Number Social Security Number
2310B	NM1	NM109	Operating Physician Primary Identifier	Primary identifier of the physician performing the principle procedure		The operating physician's Federal Tax ID or Social Security Number

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837 INSTITUTIONAL CLAIM TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2310B	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	1D or 1C	Medicaid Provider Number or Medicare Provider ID Use the Medicare Provider ID Qualifier only on Medicare crossover claims.
2310B	REF	REF02	Operating Physician Secondary Identifier	Additional identifier for the physician performing the principal procedure		The Med-QUEST ID and Location Code of the operating physician or, on Medicare crossover claims only, the operating physician's Medicare Provider ID. Insert two leading zeros in front of the six-digit Med-QUEST Provider ID and add a Location Code to create a ten-digit field. No such adjustments are required for Medicare Provider IDs.
2310C	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code (67)	24 or 34	Employer's Identification Number Social Security Number
2310C	NM1	NM109	Other Physician Identifier	The name and/or number of the licensed physician other than the attending physician as defined by the payer organization		The other physician's Federal Tax ID or Social Security Number
2310C	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	1D or 1C	Medicaid Provider Number or Medicare Provider ID Use the Medicare Provider ID Qualifier only on Medicare crossover claims.
2310C	REF	REF02	Other Provider Secondary Identifier	Additional identification number of the other provider as defined by the payer organization		The Med-QUEST ID and Location Code of the other physician or, on Medicare crossover claims only, the other physician's Medicare Provider ID. Insert two leading zeros in front of the six-digit Med-QUEST Provider ID and add a Location Code to create a ten-digit field. No such adjustments are required for Medicare Provider IDs.

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837 INSTITUTIONAL CLAIM TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2310E	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	24	Employer's Identification Number
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		The facility's Federal Tax ID
2310E	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	1D or 1C	Medicaid Provider Number or Medicare Provider ID Use the Medicare Provider ID Qualifier only on Medicare crossover claims.
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		The Med-QUEST ID and Location Code of the laboratory or facility or, on Medicare crossover claims only, the lab or facility's Medicare Provider ID. Insert two leading zeros in front of the six-digit Med-QUEST Provider ID and add a Location Code to create a ten-digit field. No such adjustments are required for Medicare Provider IDs.
2320	SBR	SBR01	Payer Responsibility Sequence Number Code	Code identifying the insurance carrier's level of responsibility for a payment of a claim	P or S or T	Primary or Secondary or Tertiary 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. Loop 2320 can occur up to ten times for up to ten payers other than MED-QUEST. 2320 is an "umbrella loop" that

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837 INSTITUTIONAL CLAIM TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
						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		Coverage in the initial 2320 Loop is always for an individual (code "18" - Self). Any of the values listed in the Implementation Guide can be used, depending on the patient's relationship to the primary subscriber.
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		A Group or Policy Number associated with the coverage.
2320	SBR	SBR04	Other Insured Group Name	Name of the group or plan through which the insurance is provided to the other insured		A Group or Policy Name associated with SBR03.
2320	CAS	CAS01	Claim Adjustment Group Code	Code identifying the general category of payment adjustment		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. 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

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837 INSTITUTIONAL CLAIM TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2320	CAS	CAS02	Adjustment Reason Code	Code that indicates the reason for the adjustment	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. 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. 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		The difference between the claim level Charged Amount and Paid Amount associated with the Adjustment Reason Code in CAS02. A negative 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		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 negative number when the Paid Quantity is less than the Charged Quantity.

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837 INSTITUTIONAL CLAIM TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2320	MIA	MIA01	Covered Days or Visits Count	The quantity of covered days or visits		The Medicare Inpatient Adjudication MIA Segment is required if data for it is available from an electronic remittance advice (835 Transaction). 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. 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 health plan.
2320	MOA	MOA01	Reimbursement Rate	Rate used when payment is based upon a percentage of applicable charges		The Medicare Outpatient Adjudication MOA Segment is required if data for it is available from an electronic remittance advice (835 Transaction). 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. All data elements within both MIA and MOA Segments are situational. They will reflect adjudication by Medicare or another payer and should be included if available to the health plan. The MOA01 element carries the payer's Reimbursement Rate if payment is based on a percentage.
2330A	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code (67)	MI	Member Identification Number

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837 INSTITUTIONAL CLAIM TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2330A	NM1	NM109	Other Insured Identifier	An identification number, assigned by the third party payer, to identify the additional insured individual		The Subscriber ID assigned by the other payer.
2330B	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	PI	Payer identification
2330B	NM1	NM109	Other Payer Primary Identifier	An identification number for the other payer		Any identification number assigned to the other payer.
2330B	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	F8	Original Reference Number 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		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		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)		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		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. One or more HCPCS Procedure Code are required for all outpatient institutional claims. A service line procedure can also be included on inpatient claims if applicable.

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837 INSTITUTIONAL CLAIM TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2420A	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code (67)	24 or 34	Employer's Identification Number or Social Security Number
2420A	NM1	NM109	Attending Physician Primary Identifier	Primary identification number of the physician responsible for care of the patient		The attending physician's Federal Tax ID or Social Security Number
2420A	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	1D or 1C	Medicaid Provider Number or Medicare Provider ID Use the Medicare Provider ID Qualifier only on Medicare crossover claims.
2420A	REF	REF02	Attending Physician Secondary Identifier	Secondary identification number of the physician responsible for the care of the patient		The Med-QUEST ID and Location Code of the service line attending physician or, on Medicare crossover claims only, the attending physician's Medicare Provider ID. Insert two leading zeros in front of the six-digit Med-QUEST Provider ID and add a Location Code to create a ten-digit field. No such adjustments are required for Medicare Provider IDs.
2420B	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	24 or 34	Employer's Identification Number Social Security Number
2420B	NM1	NM109	Operating Physician Primary Identifier	Primary identifier of the physician performing the principal procedure		The operating physician's Federal Tax ID or Social Security Number
2420B	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	1D or 1C	Medicaid Provider Number or Medicare Provider ID Use the Medicare Provider ID Qualifier only on Medicare crossover claims.

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837 INSTITUTIONAL CLAIM TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2420B	REF	REF02	Operating Physician Secondary Identifier	Additional identifier for the physician performing the principal procedure		The Med-QUEST ID and Location Code of the service line operating physician or, on Medicare crossover claims only, the operating physician's Medicare Provider ID. Insert two leading zeros in front of the six-digit Med-QUEST Provider ID and add a Location Code to create a ten-digit field. No such adjustments are required for Medicare Provider IDs.
2420C	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	24 or 34	Employer's Identification Number Social Security Number
2420C	NM1	NM109	Other Provider Identifier	The number of the other licensed provider		The other physician's Federal Tax ID or Social Security Number
2420C	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	1D or 1C	Medicaid Provider Number or Medicare Provider ID Use the Medicare Provider ID Qualifier only on Medicare crossover claims.
2420C	REF	REF02	Other Provider Secondary Identifier	Additional identification number of the other provider as defined by the payer organization		The Med-QUEST ID and Location Code of the service line other physician or, on Medicare crossover claims only, the other physician's Medicare Provider ID. Insert two leading zeros in front of the six-digit Med-QUEST Provider ID and add a Location Code to create a ten-digit field. No such adjustments are required for Medicare Provider IDs.

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837 INSTITUTIONAL CLAIM TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2430	SVD	SVD01	Payer Identifier	Number identifying the payer organization		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. 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		Although additional code sets and formats are valid on outpatient institutional service lines of 837 Transactions, only HCPCS Procedure Codes (Qualifier “HC”) are currently used by MED-QUEST.
2430	CAS	CAS01	Claim Adjustment Group Code	Code identifying the general category of payment adjustment	CO CR OA PI PR	Contractual Obligations Correction and Reversals Other Adjustments Payer Initiated Reductions Patient Responsibility 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 there is an adjustment is for payment by another payer at the service line level. 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.
2430	CAS	CAS02	Adjustment Reason Code	Code that indicates the reason for the adjustment	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.

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837 INSTITUTIONAL CLAIM TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2430	CAS	CAS03	Adjustment Amount	Adjustment amount for the associated reason code		The difference between the service line level Charged Amount and Paid Amount associated with the Adjustment Reason Code in CAS02. A negative 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		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 negative number when the Paid Quantity is less than the Charged Quantity.

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Appendix A - Data Communications Interface Forms

A.1 Electronic Data Exchange Request Form

This form is not yet final.

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A.2 User Affirmation Statement

This form is not yet final.

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A.3 Data-Specific Authorization Forms

This form is not yet final.