



Standard Companion Guide Transaction Information

**Instructions related to Transactions based on ASC
X12 Implementation Guides, version 005010**

Final

**837P Companion Guide Version Number: 2.3
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Preface

Companion Guides (CG) may contain two types of data, instructions for electronic communications with the publishing entity (Communications/Connectivity Instructions) and supplemental information for creating transactions for the publishing entity while ensuring compliance with the associated ASC X12 IG (Transaction Instructions). Either the Communications/Connectivity component or the Transaction Instruction component must be included in every CG. The components may be published as separate documents or as a single document.

The Communications/Connectivity component is included in the CG when the publishing entity wants to convey the information needed to commence and maintain communication exchange.

The Transaction Instruction component is included in the CG when the publishing entity wants to clarify the IG instructions for submission of specific electronic transactions. The Transaction Instruction component content is limited by ASCX12's copyrights and Fair Use statement.

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Transaction Instruction (TI)

1 TI Introduction

1.1 Background

1.1.1 Overview of HIPAA Legislation

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 carries provisions for administrative simplification. This requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. HIPAA directs the Secretary to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard HIPAA serves to:

- Create better access to health insurance
- Limit fraud and abuse
- Reduce administrative costs

1.1.2 Compliance according to HIPAA

The HIPAA regulations at 45 CFR 162.915 require that covered entities not enter into a trading partner agreement that would do any of the following:

- Change the definition, data condition, or use of a data element or segment in a standard.
- Add any data elements or segments to the maximum defined data set.
- Use any code or data elements that are marked “not used” in the standard’s implementation specifications or are not in the standard’s implementation specification(s).
- Change the meaning or intent of the standard’s implementation specification(s).

1.1.3 Compliance according to ASC X12

ASC X12 requirements include specific restrictions that prohibit trading partners from:

- Modifying any defining, explanatory, or clarifying content contained in the implementation guide.
- Modifying any requirement contained in the implementation guide.

1.2 Intended Use

The Transaction Instruction component of this companion guide must be used in conjunction with an associated ASC X12 Implementation Guide. The instructions in this companion guide are not intended to be stand-alone requirements documents. This companion guide conforms to all the requirements of any associated ASC X12 Implementation Guides and is in conformance with ASC X12's Fair Use and Copyright statements.

2 Included ASC X12 Implementation Guides

This table lists the X12N Implementation Guides for which specific transaction Instructions apply and which are included in Section 3 of this document.

Unique ID	Name
[005010X222A1	Health Care Claim: Professional (837)]

3 Instruction Tables

These tables contain one or more rows for each segment for which a supplemental instruction is needed.

Legend
SHADED rows represent “segments” in the X12N implementation guide.
NON-SHADED rows represent “data elements” in the X12N implementation guide.

3.1 837P 005010X222A1 Health Care Claim: Professional

005010X222A1 Health Care Claim: Professional

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
HDR	ISA	Interchange Control Header		1	R	1		
HDR	ISA01	Authorization Information Qualifier	ID	2-2	R		00, 03	Use Value '00'
HDR	ISA03	Security Information Qualifier	ID	2-2	R		00, 01	Use Value '00'
HDR	ISA05	Interchange ID Qualifier	ID	2-2	R		01, 14, 20, 27, 28, 29, 30, 33, ZZ	Use Value 'ZZ' – Mutually Defined
HDR	ISA06	Interchange Sender ID	AN	15-15	R			Use the SC Medicaid Assigned Submitter Number
HDR	ISA07	Interchange ID Qualifier	ID	2-2	R		01, 14, 20, 27, 28, 29, 30, 33, ZZ	Use Value 'ZZ' – Mutually Defined
HDR	ISA08	Interchange Receiver ID	AN	15-15	R			Use Value 'SCMEDICAID' –
HDR	ISA11	Repetition Separator	AN	1-1	R			Hardcode Caret ^
HDR	ISA14	Acknowledgement Requested	ID	1-1	R		0, 1	If your Trading Partner Agreement indicates that you will receive an Interchange Acknowledgement (TA1). Use '1' for Interchange

								Acknowledgement Requested If your Trading Partner Agreement does not indicate that you will receive an Interchange Acknowledgement (TA1). Use '0' for No Interchange Acknowledgement Requested
HDR	ISA15	Usage Indicator	ID	1-1	R		P, T	'Provider should use 'T' until testing of the Trading Partner is approved
HDR	ISA16	Component Element Separator	AN	1-1	R			Default :

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
HDR	GS	FUNCTIONAL GROUP HEADER		1	R	>1		
HDR	GS02	Application Sender Code	AN	2-15	R			Use the SC Medicaid Assigned Submitter ID
HDR	GS03	Application Receiver Code	AN	2-15	R			Use Value 'SCMEDICAID'

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
HDR	BHT	BEGINNING OF HIERARCHICAL TRANSACTION	1	R	1			
HDR	BHT02	Transaction Set Purpose Code	ID	2-2	R		00, 18	Use Value '00' - Original
HDR	BHT05	Transaction Set Creation Time	TM	4-8	R		HHMM, HHMMSS, HHMMSSD, CCYYMMDD	Format is HHMM
HDR	BHT06	Claim or Encounter ID	ID	2-2	R		31, CH, RP	Use value 'CH' – Chargeable 'RP' – Reporting for Encounters

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
1000A	NM1	SUBMITTER NAME		1	R	1		
1000A	NM109	Submitter Identifier	AN	2-80	R			Use your SC Medicaid Trading Partner ID. FOR TRANSPORTATION BROKERS ONLY: Use Value 'TT'

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
1000B	NM1	RECEIVER NAME		1	R	1		
1000B	NM103	Receiver Name	AN	1-60	R			Use value 'SC Medicaid'.
1000B	NM109	Receiver Primary Identifier	AN	2-80	R			Use value 'SC Medicaid'.

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
2000A	PRV	BILLING PROVIDER SPECIALTY INFORMATION	1	S				
2000A	PRV03	Provider Taxonomy Code	AN	1-50	R			Submit the Provider Taxonomy that was used for the SC Medicaid Provider Enrollment.

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
2010AA	NM1	BILLING PROVIDER NAME		1	R	1		
2010AA	NM108	Identification Code Qualifier	ID	1-2	S		XX	Use value 'XX' for NPI if typical provider. Else use value in Segment 2010BB.
2010AA	NM109	Billing Provider Identifier	AN	2-80	S			NPI for Billing Provider if typical provider. Else use value in Segment 2010BB.

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
2010AA	NM1	BILLING PROVIDER NAME		1	R	1		
2010AA	NM108	Identification Code Qualifier	ID	1-2	S		XX	Use value 'XX' for NPI if typical provider. Else use value in Segment 2010BB.
2010AA	NM109	Billing Provider Identifier	AN	2-80	S			NPI for Billing Provider if typical provider. Else use value in Segment 2010BB.

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
2010AA	N4	BILLING PROVIDER CITY/STATE/ZIP CODE	1	R				
2010AA	N403	Billing Provider Postal Zone or ZIP Code	ID	3-15	S			Submit Full 9 Digit Zip Code.

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
2000B	SBR	SUBSCRIBER INFORMATION		1	R			
2000B	SBR09	Claim Filing Indicator Code	ID	1-2	S		11, 12, 13, 14, 15, 16, 17, AM, BL, CH, CI, DS, FI, HM, LM, MA, MB, MC, OF, TV, VA, WC, ZZ	Use Value 'MC' - Medicaid or "13" if Pharmacy provider.

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
2010BA	NM1	SUBSCRIBER NAME		1	R	1		
2010BA	NM108	Identification Code Qualifier	ID	1-2	R		II, MI	Use value 'MI' – Member Identification Number.
2010BA	NM109	Subscriber Primary Identifier	AN	2-80	R			Use the recipient's 10 Digit SC Medicaid Identification Number. This data element is required when NM102 equals one (1).

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
2010BB	NM1	PAYER NAME		1	R	1		
2010BB	NM103	Payer Name	AN	1-60	R			Use value 'SC Medicaid'.
2010BB	NM108	Identification Code Qualifier	ID	1-2	R		PI, XV	Use value 'PI' – Payer Identification.
2010BB	NM109	Payer Identifier	AN	2-80	R			Use value 'SCXIX'.

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
2010BB	N3	PAYER ADDRESS		1	S			
2010BB	N301	Payer Address Line	AN	1-55	R			Use value '1801 Main St'.

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
2010BB	N4	PAYER CITY/STATE/ZIP CODE		1	R			
2010BB	N401	Payer City Name	AN	2-30	R			Use value 'Columbia'.
2010BB	N402	Payer State Code	ID	2-2	S			Use value 'SC'.
2010BB	N403	Payer Postal Zone or ZIP Code	ID	3-15	S			Use value '29201'.

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
2010BB	REF	BILLING PROVIDER SECONDARY IDENTIFICATION	2	S				
2010BB	REF01	Reference Identification Qualifier	ID	2-3	R		G2, LU	Atypical providers enter value "G2" Provider Commercial Number (SC Medicaid Proprietary ID) Required when NM109 in Loop 2010AA is not used and an identification number other than the NPI is necessary for the receiver to identify the provider.
2010BB	REF02	Payer Additional Identifier	AN	1-50	R			Atypical providers enter SC Medicaid Proprietary ID.

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
2300	CLM	CLAIM INFORMATION		1	R	100		
2300	CLM07	Provider Accept Assignment Code	ID	1-1	R		A, B, C	Use value "A" = Assigned
2300	CLM08	Yes/No Condition or Response Code	ID	1-1	R		N, W, Y	Use value "Y" = Yes

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
2300	REF	PRIOR AUTHORIZATION		1	S			
2300	REF01	Reference Identification Qualifier	ID	2-3	R		G1	Use Value G1
2300	REF02	Prior Authorization	AN	1-50	R			Use Prior Authorization Number

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
2300	REF	Referral		1	S			
2300	REF01	Reference Identification Qualifier	ID	2-3	R		9F	Use Value "9F"
2300	REF02	Referral Number	AN	1-50	R			Referral Number

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
2300	NTE	CLAIM NOTE		1	S			
2300	NTE01	Note Reference Code	ID	3-3	R		ADD, CER, DCP, DGN, TPO	TRANSPORTATION BROKERS ONLY: Use Value 'ADD' – Additional Information
2300	NTE02	Claim Note Text	AN	1-80	R			TRANSPORTATION BROKERS ONLY:

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
2300	CRC	EPSDT REFERRAL		1	S			
2300	CRC03	Condition Code	ID	2-3	R		AV, NU, S2, ST	<p>S2 Under Treatment = Patient is currently under treatment for referred diagnostic or corrective health problem.</p> <p>(MMIS Value = 1 - Well child care with treatment of an identified problem treated by the physician]</p> <p>ST New Services Requested = Patient is referred to another provider for diagnostic or corrective treatment for at least one health problem identified during an initial or periodic screening service (not including dental referrals) OR Patient is scheduled for another appointment with screening</p>

								<p>provider for diagnostic or corrective treatment for at least one health problem identified during an initial or periodic screening service (not including dental referrals)</p> <p>[MMIS Value = 2 = Well child care with a referral made for an identified problem to another provider]</p>
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Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
2300	HI	HEALTH CARE DIAGNOSIS CODE		1	R			
2300	HI-1-1	Diagnosis Type Code	ID	1-3	R		ABK, BK	-Use Value 'BK' – Principal Diagnosis (ICD-9) October 1, 2013 = ICD-10 implementation. At that time, Value ABK - Principal Diagnosis (ICD-10) will be used. The diagnosis listed in this element is assumed to be the principal diagnosis.
2300	H-2-1	Diagnosis Type Code	ID	1-3	R		ABK, BK	-Use Value 'BK' – Principal Diagnosis (ICD-9) October 1, 2013 = ICD-10 implementation. At that time, Value ABK - Principal Diagnosis (ICD-10) will be used. The diagnosis listed in this element is assumed to be the principal diagnosis.
2300	HI-3-1	Diagnosis Type Code	ID	1-3	R		ABK, BK	-Use Value 'BK' – Principal Diagnosis (ICD-9) October 1, 2013 = ICD-10 implementation. At that time, Value ABK - Principal Diagnosis (ICD-10) will be used. The diagnosis listed

								in this element is assumed to be the principal diagnosis.
2300	HI-4-1	Diagnosis Type Code	ID	1-3	R		ABK, BK	-Use Value 'BK' – Principal Diagnosis (ICD-9) October 1, 2013 = ICD-10 implementation. At that time, Value ABK - Principal Diagnosis (ICD-10) will be used. The diagnosis listed in this element is assumed to be the principal diagnosis.
2300	HI-5-1	Diagnosis Type Code	ID	1-3	R		ABK, BK	-Use Value 'BK' – Principal Diagnosis (ICD-9) October 1, 2013 = ICD-10 implementation. At that time, Value ABK - Principal Diagnosis (ICD-10) will be used. The diagnosis listed in this element is assumed to be the principal diagnosis.
2300	HI-6-1	Diagnosis Type Code	ID	1-3	R		ABK, BK	-Use Value 'BK' – Principal Diagnosis (ICD-9) October 1, 2013 = ICD-10 implementation. At that time, Value ABK - Principal Diagnosis (ICD-10) will be used. The diagnosis listed in this element is assumed to be the principal diagnosis.
2300	HI-7-1	Diagnosis Type Code	ID	1-3	R		ABK, BK	-Use Value 'BK' – Principal Diagnosis (ICD-9) October 1, 2013 = ICD-10 implementation. At that time, Value ABK - Principal Diagnosis (ICD-10) will be used. The diagnosis listed in this element is assumed to be the principal diagnosis.
2300	HI-8-1	Diagnosis Type Code	ID	1-3	R		ABK, BK	-Use Value 'BK' – Principal Diagnosis (ICD-9) October 1, 2013 = ICD-10 implementation. At that time, Value ABK - Principal Diagnosis (ICD-10) will be used.

								The diagnosis listed in this element is assumed to be the principal diagnosis.
2300	HI-9-1	Diagnosis Type Code	ID	1-3	R		ABK, BK	-Use Value 'BK' – Principal Diagnosis (ICD-9) October 1, 2013 = ICD-10 implementation. At that time, Value ABK - Principal Diagnosis (ICD-10) will be used. The diagnosis listed in this element is assumed to be the principal diagnosis.
2300	HI-10-1	Diagnosis Type Code	ID	1-3	R		ABK, BK	-Use Value 'BK' – Principal Diagnosis (ICD-9) October 1, 2013 = ICD-10 implementation. At that time, Value ABK - Principal Diagnosis (ICD-10) will be used. The diagnosis listed in this element is assumed to be the principal diagnosis.
2300	HI-11-1	Diagnosis Type Code	ID	1-3	R		ABK, BK	-Use Value 'BK' – Principal Diagnosis (ICD-9) October 1, 2013 = ICD-10 implementation. At that time, Value ABK - Principal Diagnosis (ICD-10) will be used. The diagnosis listed in this element is assumed to be the principal diagnosis.
2300	HI-12-1	Diagnosis Type Code	ID	1-3	R		ABK, BK	-Use Value 'BK' – Principal Diagnosis (ICD-9) October 1, 2013 = ICD-10 implementation. At that time, Value ABK - Principal Diagnosis (ICD-10) will be used. The diagnosis listed in this element is assumed to be the principal diagnosis.

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
2310B	REF	RENDERING PROVIDER SECONDARY IDENTIFICATION	4	S				
2310B	REF01	Reference Identification Qualifier	ID	2-3	R		0B, 1G, G2, LU	Use value "G2" - Provider Commercial Number for atypical providers ONLY.
2310B	REF02	Rendering Provider Secondary Identifier	AN	1-50	R			Use the rendering provider's SC Medicaid provider number for atypical providers ONLY.

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
2320	CAS	CLAIM LEVEL ADJUSTMENTS		1	S	5		
2320	CAS01	Claim Adjustment Group Code	AN	1-2	R		PR	Claim adjustment data will be reported at the claim level in 2320. Loop 2430 line level adjustment data will not be used.

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
2430	CAS	LINE ADJUSTMENTS		1	S	5		
2430	CAS01	Claim Adjustment Group Code	AN	1-2	R		PR	Claim adjustment data will be reported at the claim level in 2320. This loop will not be used.

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
2330A	NM1	OTHER SUBSCRIBER NAME		1	R	1		
2330A	NM108	Identification Code Qualifier	ID	1-2	R		II, MI	Use Value "MI" = Member Identification Number The subscriber's identification number as assigned by the payer.
2330A	NM109	Other Insured Identifier	AN	2-80	R			Other Insured Identifier

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
2330B	NM1	OTHER PAYER NAME		1	R	1		Submitters are required to send all known information on other payers in this Loop ID-2330.
2330B	NM108	Identification Code Qualifier	ID	1-2	R		PI, XV	Use value - "PI" = Payor Identification
2330B	NM109	Other Payer Primary Identifier	AN	2-80	R			This number must be identical to SVD01 (Loop ID-2430) for COB. Use the carrier codes assigned by SC Medicaid to identify other insurance carriers.

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
2330B	NM1	OTHER PAYER NAME		1	R	1		Submitters are required to send all known information on other payers in this Loop ID-2330.
2330B	NM108	Identification Code Qualifier	ID	1-2	R		PI, XV	Use value - "PI" = Payor Identification
2330B	NM109	Other Payer Primary Identifier	AN	2-80	R			This number must be identical to SVD01 (Loop ID-2430) for COB. Use

									the carrier codes assigned by SC Medicaid to identify other insurance carriers.
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Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
2400	SV1	PROFESSIONAL SERVICE		1	R			
2400	SV101	Composite Medical Procedure Identifier			R			
2400	SV101-1	Product or Service ID Qualifier	ID	2-2	R		ER, HC, IV, WK	Value "HC" = Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
2400	SV5	DURABLE MEDICAL EQUIPMENT SERVICE	1	S				
2400	SV501-1	Procedure Identifier	ID	2-2	R		HC	Use Value 'HC' - Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
2420A	REF	RENDERING PROVIDER SECONDARY IDENTIFICATION	20	S				
2420A	REF01	Reference Identification Qualifier	ID	2-3	R		OB, 1G, G2, LU	Use value "G2" - Provider Commercial Number
2420A	REF02	Rendering Provider Secondary Identifier	AN	1-50	R			Use the rendering provider's SC Medicaid provider number for atypical

4 TI Change Summary

Version	Issue Date	Modified By	Comments / Reason
1.0	05/02/2011	William Douglas	Original document 05/03 /2011
1.1	06/15/2011	William Douglas	Updates for ISA14
2.0	06/30/2011	William Douglas	Comments from Review and updates to ISA 16 should be a : and ISA11 should be ^
2.1	10/31/11	Tracie O'Donnell	Updated 1000B NM109 with "Use value 'SC Medicaid'."
2.2	01/20/2012	Charley Cosby	Updated info – Adjustment amounts should be reported at claim level in 2320 and 2430, line level adjustments are not used.
2.3	02/23/2012	Charley Cosby	Changed wording in 2320 to clarify 2430 not used.