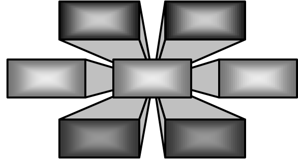
Introduction ANSI X12 Standards

HIPAA Implementation Guides
Down and Dirty

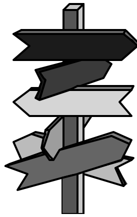
Dan Petrosky April 7,2005

004010



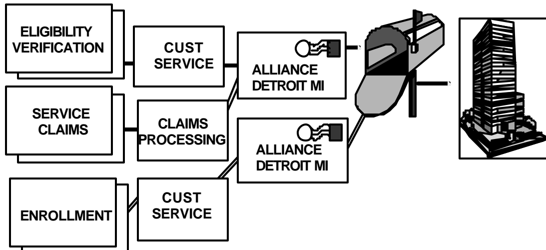
Who needs to understand them?

Session Objectives



- Standards support business activity
- Introduce standards documentation
- Introduce standards implementation guidelines
- Develop sample 837 transaction set

NORMAL BUSINESS

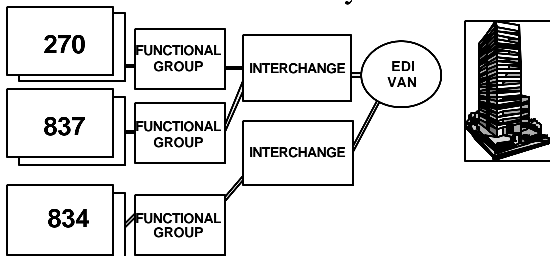


Introduction ANSI X12 Standards

PAPER vs EDI

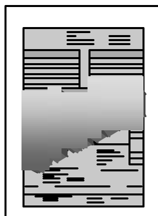
Document -	Transaction
Little Envelope -	Functional Group
Big Envelope -	Interchange
Postal Service -	VAN
Courier Delivery -	Point-to-Point
Human Audit -	Machine Audit

EDI Delivery



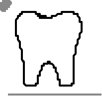
Standards Language

Document -	Transaction
Line -	Segment
Phrase -	Composite Element
Word-	Simple Element
Code -	Identifier
Punctuation -	Delimiters
Grammar -	Syntax



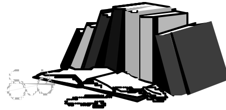
SIMPLE AND COMPOSITE
DATA ELEMENTS

```
N1*PR*ABC INS CO*PI*ABC47~
TOO*JP*8*F:L~
```



Levels of Standards Documentation

- ANSI X12 Standards Documentation
- Industry Implementation Guidelines
- Trading Partner Profiles



Section I - Transaction Set Tables

Table 1 Header	ST BHT
Table 2 Detail	HL
Table 3 Summary	SE

Related information usually appears together.

STANDARD

837 Health Care Claim Functional Group ID: **HC**

Table 1 – Header

POS#	SEG ID	NAME	REQ. DES	MAX USE	LOOP REPEAT
005	**ST**	Transaction Set Header	M	1	
010	**BHT**	Beginning of Hierarchical Transaction	M	1	
		LOOP ID – 1000			10
020	**NM1**	Individual or Organization Name	O	1	
045	**PER**	Administration Communication Contact	O	2	

Table 2 – Detail

POS#	SEG ID	NAME	REQ. DES	MAX USE	LOOP REPEAT
		LOOP ID – 2000			>1
001	**HL**	Hierarchical Level	M	1	
003	**PRV**	Provider Information	O	1	
		LOOP ID – 2010			10
015	**NM1**	Individual or Organization Name	O	1	
040	**PER**	Administration Communication Contact	O	2	
555	**SE**	Transaction Set Trailer	M	1	

IMPLEMENTATION

837 Health Care Claim: Professional

Table 1 – Header

PG	POS#	SEG ID	NAME	USAGE	REPEAT	LOOP REPEAT
62	005	**ST**	Transaction Set Header	R	1	
63	010	**BHT**	Beginning of Hierarchical Transaction	R	1	
			LOOP ID – 1000A SUBMITTER NAME			1
67	020	**NM1**	Submitter Name	R	1	
71	045	**PER**	Submitter EDI Contact Information	R	2	

Table 2 – Detail – Billing/Pay-To Provider

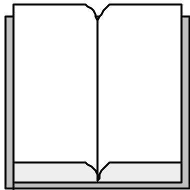
PG	POS#	SEG ID	NAME	USAGE	REPEAT	LOOP REPEAT
			LOOP ID – 2000A BILLING/PAY-TO-PROVIDER			>1
77	001	**HL**	Billing/Pay-to-Provider Hierarchical Level	R	1	
			LOOP ID – 2010AA BILLNG PROVIDER NAME			1
84	015	**NM1**	Billing Provider Name	R	1	

Table 2 – Detail – Subscriber

PG	POS#	SEG ID	NAME	USAGE	REPEAT	LOOP REPEAT
573	555	**SE**	Transaction Set Trailer	R	1	

Transaction Set Tables

- Permitted segments
  - Required order
    - Presence requirement
      - How many
        - Loops



IMPLEMENTATION STANDARD

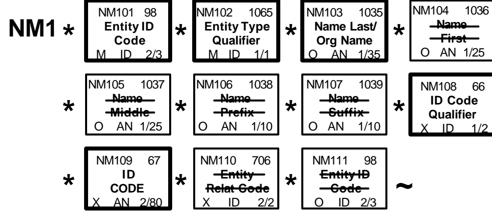
RECEIVER NAME

NM1 Individual or Organization Name

Level: Header

Syntax: **1. P0809**

If either NM108 or NM109 is present, then the other is required.



IMPLEMENTATION STANDARD

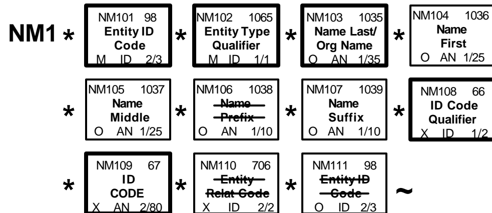
BILLING PROVIDER NAME

NM1 Individual or Organization Name

Level: Header

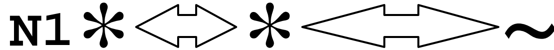
Syntax: **1. P0809**

If either NM108 or NM109 is present, then the other is required.



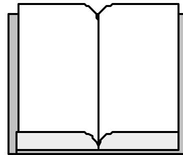
SEGMENT

- An ordered collection of elements
- Elements are variable length
- Elements are delimited by element separators
- Segment ends with segment terminator

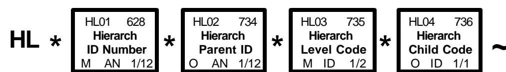


Data Element Dictionary

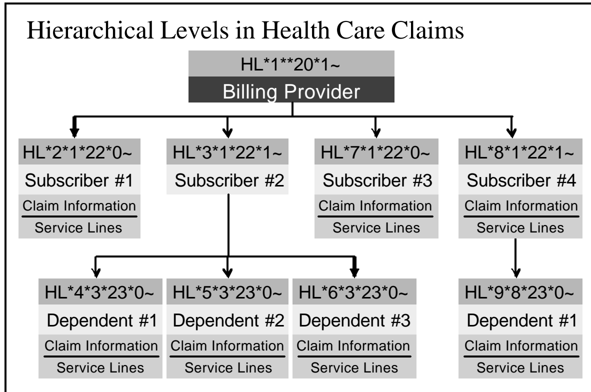
- Listed numerically
- Same in all segments
- Data & position vary
- Length min & max
- Code lists
- Type of data



HL **Hierarchical Level**



HL01	**628**	**Hierarchical ID Number** The first HL01=1, in subsequent HL segments the value is incremented by 1.
HL02	**734**	**Hierarchical Parent Number** The HL02 identifies the HL01 that is the parent of this HL segment.
HL03	**735**	**Hierarchical Level Code** "20" = Billing Provider "22" = Subscriber – Child to Billing Provider "23" = Dependent – Child to Subscriber
HL04	**736**	**Hierarchical Child Code** "0" No Subordinate HL Segment "1" Additional Subordinate HL Data Segment



Valid Element Types

- AN - Alphanumeric
- B - Binary
- Nn - Numeric (n decimals)
- R - Decimal (explicit)
- ID - Code
- DT - Date
- TM - Time

OK!

AN 6/6 - Exactly 6 characters long
R 7/10 - From 7 to 10 digits long

LENGTH

Sign & decimal are not counted in length.

QUALIFIER & VALUE

- Pairs elements (qualifier & value)
- Flexible transaction definitions
- Reuse elements

Reese

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STANDARDS EVOLVE

- Working papers
- Three times a year
- Draft standards
- ANSI standards
- Version & release

001000	ANSI - 1983
002000	ANSI - 1986
002040	Draft X12 May 89
003000	ANSI - 1992
003020	Draft X12 Oct 91
003021	Draft X12 Feb 92
004000	ANSI - 1997
004010	Draft X12 Oct 97

CHANGES

- Simplify data.
- Eliminate transactions.
- Utilize status information rather than batch data.
- Reengineer business processes.
- Exchange information more frequently.

Session Summary

- ✍Standards are based on business requirements.
- ✍There are multiple details to coordinate.
- ✍One person should not make all decisions.
- ✍The business process will change over time.

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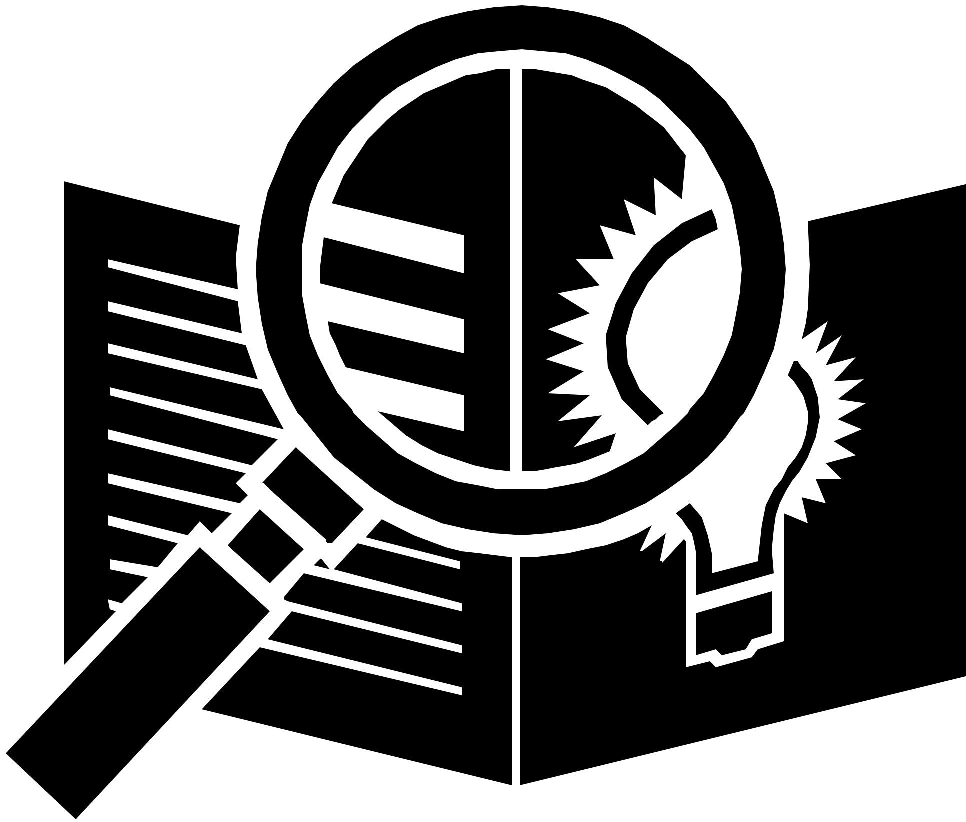

REFERENCE 1

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IMPLEMENTATION

837 Health Care Claim: Professional

1. The 837 transaction is designed to transmit one or more claims for each billing provider. The hierarchy of the looping structure is billing provider, subscriber, patient, claim level, and claim service line level. Billing providers who sort claims using this hierarchy will use the 837 more efficiently because information that applies to all lower levels in the hierarchy will not have to be repeated within the transaction.

2. This standard is also recommended for the submission of similar data within a pre-paid managed care context. Referred to as capitated encounters, this data usually does not result in a payment, though it is possible to submit a “mixed” claim that includes both pre-paid and request for payment services. This standard will allow for the submission of data from providers of health care products and services to a Managed Care Organization or other payer. This standard may also be used by payers to share data with plan sponsors, employers, regulatory entities and Community Health Information Networks.

3. This standard can, also, be used as a transaction set in support of the coordination of benefits claims process. Additional looped segments can be used within both the claim and service line levels to transfer each payer’s adjudication information to subsequent payers.

Table 1 - Header

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
62	005	ST	Transaction Set Header	R	1	
63	010	BHT	Beginning of Hierarchical Transaction	R	1	
66	015	REF	Transmission Type Identification	R	1	
			LOOP ID - 1000A SUBMITTER NAME			1
67	020	NM1	Submitter Name	R	1	
70	025	N2	Additional Submitter Name Information	S	1	
71	045	PER	Submitter EDI Contact Information	R	2	
			LOOP ID - 1000B RECEIVER NAME			1
74	020	NM1	Receiver Name	R	1	
76	025	N2	Receiver Additional Name Information	S	1	

Table 2 - Detail, Billing/Pay-to Provider Hierarchical Level

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
			LOOP ID - 2000A BILLING/PAY-TO PROVIDER HIERARCHICAL LEVEL			>1
77	001	HL	Billing/Pay-to Provider Hierarchical Level	R	1	
79	003	PRV	Billing/Pay-to Provider Specialty Information	S	1	
81	010	CUR	Foreign Currency Information	S	1	
			LOOP ID - 2010AA BILLING PROVIDER NAME			1
84	015	NM1	Billing Provider Name	R	1	
87	020	N2	Additional Billing Provider Name Information	S	1	
88	025	N3	Billing Provider Address	R	1	
89	030	N4	Billing Provider City/State/ZIP Code	R	1	
91	035	REF	Billing Provider Secondary Identification	S	8	
94	035	REF	Credit/Debit Card Billing Information	S	8	
96	040	PER	Billing Provider Contact Information	S	2	
			LOOP ID - 2010AB PAY-TO PROVIDER NAME			1
99	015	NM1	Pay-to Provider Name	S	1	
102	020	N2	Additional Pay-to Provider Name Information	S	1	

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
103	025	N3	Pay-to Provider Address	R	1	
104	030	N4	Pay-to Provider City/State/ZIP Code	R	1	
106	035	REF	Pay-to-Provider Secondary Identification	S	5	

Table 2 - Detail, Subscriber Hierarchical Level

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
			LOOP ID - 2000B SUBSCRIBER HIERARCHICAL LEVEL			>1
108	001	HL	Subscriber Hierarchical Level	R	1	
110	005	SBR	Subscriber Information	R	1	
114	007	PAT	Patient Information	S	1	
			LOOP ID - 2010BA SUBSCRIBER NAME			1
117	015	NM1	Subscriber Name	R	1	
120	020	N2	Additional Subscriber Name Information	S	1	
121	025	N3	Subscriber Address	S	1	
122	030	N4	Subscriber City/State/ZIP Code	S	1	
124	032	DMG	Subscriber Demographic Information	S	1	
126	035	REF	Subscriber Secondary Identification	S	4	
128	035	REF	Property and Casualty Claim Number	S	1	
			LOOP ID - 2010BB PAYER NAME			1
130	015	NM1	Payer Name	R	1	
133	020	N2	Additional Payer Name Information	S	1	
134	025	N3	Payer Address	S	1	
135	030	N4	Payer City/State/ZIP Code	S	1	
137	035	REF	Payer Secondary Identification	S	3	
			LOOP ID - 2010BC RESPONSIBLE PARTY NAME			1
139	015	NM1	Responsible Party Name	S	1	
142	020	N2	Additional Responsible Party Name Information	S	1	
143	025	N3	Responsible Party Address	R	1	
144	030	N4	Responsible Party City/State/ZIP Code	R	1	
			LOOP ID - 2010BD CREDIT/DEBIT CARD HOLDER NAME			1
146	015	NM1	Credit/Debit Card Holder Name	S	1	
149	020	N2	Additional Credit/Debit Card Holder Name Information	S	1	
150	035	REF	Credit/Debit Card Information	S	2	

Table 2 - Detail, Patient Hierarchical Level

For purposes of this documentation, the claim detail information is presented only in the dependent level. Specific claim detail information can be given in either the subscriber or the dependent hierarchical level. Because of this the claim information is said to “float.” Claim information is positioned in the same hierarchical level that describes its owner-participant, either the subscriber or the dependent. In other words, the claim information, loop 2300, is placed following loop 2010BD in the subscriber hierarchical level when the patient is the subscriber, or it is placed at the patient/dependent hierarchical level when the patient is the dependent of the subscriber as shown here. When the patient is the subscriber, loops 2000C and 2010CA are not sent. See 2.3.2.1, HL Segment, for details.

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
			LOOP ID - 2000C PATIENT HIERARCHICAL LEVEL			>1
152	001	HL	Patient Hierarchical Level	S	1	
154	007	PAT	Patient Information	R	1	

			LOOP ID - 2010CA PATIENT NAME			**1**
157	**015**	**NM1**	Patient Name	**R**	**1**	
160	**020**	**N2**	Additional Patient Name Information	**S**	**1**	
161	**025**	**N3**	Patient Address	**R**	**1**	
162	**030**	**N4**	Patient City/State/ZIP Code	**R**	**1**	
164	**032**	**DMG**	Patient Demographic Information	**R**	**1**	
166	**035**	**REF**	Patient Secondary Identification	**S**	**5**	
168	**035**	**REF**	Property and Casualty Claim Number	**S**	**1**	
			LOOP ID - 2300 CLAIM INFORMATION			**100**
170	**130**	**CLM**	Claim Information	**R**	**1**	
180	**135**	**DTP**	Date - Order Date	**S**	**1**	
182	**135**	**DTP**	Date - Initial Treatment	**S**	**1**	
184	**135**	**DTP**	Date - Referral Date	**S**	**1**	
186	**135**	**DTP**	Date - Date Last Seen	**S**	**1**	
188	**135**	**DTP**	Date - Onset of Current Illness/Symptom	**S**	**1**	
190	**135**	**DTP**	Date - Acute Manifestation	**S**	**5**	
192	**135**	**DTP**	Date - Similar Illness/Symptom Onset	**S**	**10**	
194	**135**	**DTP**	Date - Accident	**S**	**10**	
196	**135**	**DTP**	Date - Last Menstrual Period	**S**	**1**	
197	**135**	**DTP**	Date - Last X-ray	**S**	**1**	
199	**135**	**DTP**	Date - Estimated Date of Birth	**S**	**1**	
200	**135**	**DTP**	Date - Hearing and Vision Prescription Date	**S**	**1**	
201	**135**	**DTP**	Date - Disability Begin	**S**	**5**	
203	**135**	**DTP**	Date - Disability End	**S**	**5**	
205	**135**	**DTP**	Date - Last Worked	**S**	**1**	
206	**135**	**DTP**	Date - Authorized Return to Work	**S**	**1**	
208	**135**	**DTP**	Date - Admission	**S**	**1**	
210	**135**	**DTP**	Date - Discharge	**S**	**1**	
212	**135**	**DTP**	Date - Assumed and Relinquished Care Dates	**S**	**2**	
214	**155**	**PWK**	Claim Supplemental Information	**S**	**10**	
217	**160**	**CN1**	Contract Information	**S**	**1**	
219	**175**	**AMT**	Credit/Debit Card Maximum Amount	**S**	**1**	
220	**175**	**AMT**	Patient Amount Paid	**S**	**1**	
221	**175**	**AMT**	Total Purchased Service Amount	**S**	**1**	
222	**180**	**REF**	Service Authorization Exception Code	**S**	**1**	
224	**180**	**REF**	Mandatory Medicare (Section 4081) Crossover Indicator	**S**	**1**	
226	**180**	**REF**	Mammography Certification Number	**S**	**1**	
227	**180**	**REF**	Prior Authorization or Referral Number	**S**	**2**	
229	**180**	**REF**	Original Reference Number (ICN/DCN)	**S**	**1**	
231	**180**	**REF**	Clinical Laboratory Improvement Amendment (CLIA) Number	**S**	**3**	
233	**180**	**REF**	Repriced Claim Number	**S**	**1**	
235	**180**	**REF**	Adjusted Repriced Claim Number	**S**	**1**	
236	**180**	**REF**	Investigational Device Exemption Number	**S**	**1**	
238	**180**	**REF**	Claim Identification Number for Clearing Houses and Other Transmission Intermediaries	**S**	**1**	
240	**180**	**REF**	Ambulatory Patient Group (APG)	**S**	**4**	
241	**180**	**REF**	Medical Record Number	**S**	**1**	
242	**180**	**REF**	Demonstration Project Identifier	**S**	**1**	
244	**185**	**K3**	File Information	**S**	**10**	
246	**190**	**NTE**	Claim Note	**S**	**1**	
248	**195**	**CR1**	Ambulance Transport Information	**S**	**1**	
251	**200**	**CR2**	Spinal Manipulation Service Information	**S**	**1**	
257	**220**	**CRC**	Ambulance Certification	**S**	**3**	
260	**220**	**CRC**	Patient Condition Information: Vision	**S**	**3**	
263	**220**	**CRC**	Homebound Indicator	**S**	**1**	

265	231	HI	Health Care Diagnosis Code	S	1	
271	241	HCP	Claim Pricing/Repricing Information	S	1	
			LOOP ID - 2305 HOME HEALTH CARE PLAN INFORMATION			6
276	242	CR7	Home Health Care Plan Information	S	1	
278	243	HSD	Health Care Services Delivery	S	3	
			LOOP ID - 2310A REFERRING PROVIDER NAME			2
282	250	NM1	Referring Provider Name	S	1	
285	255	PRV	Referring Provider Specialty Information	S	1	
287	260	N2	Additional Referring Provider Name Information	S	1	
288	271	REF	Referring Provider Secondary Identification	S	5	
			LOOP ID - 2310B RENDERING PROVIDER NAME			1
290	250	NM1	Rendering Provider Name	S	1	
293	255	PRV	Rendering Provider Specialty Information	R	1	
295	260	N2	Additional Rendering Provider Name Information	S	1	
296	271	REF	Rendering Provider Secondary Identification	S	5	
			LOOP ID - 2310C PURCHASED SERVICE PROVIDER NAME			1
298	250	NM1	Purchased Service Provider Name	S	1	
301	271	REF	Purchased Service Provider Secondary Identification	S	5	
			LOOP ID - 2310D SERVICE FACILITY LOCATION			1
303	250	NM1	Service Facility Location	S	1	
306	260	N2	Additional Service Facility Location Name Information	S	1	
307	265	N3	Service Facility Location Address	R	1	
308	270	N4	Service Facility Location City/State/ZIP	R	1	
310	271	REF	Service Facility Location Secondary Identification	S	5	
			LOOP ID - 2310E SUPERVISING PROVIDER NAME			1
312	250	NM1	Supervising Provider Name	S	1	
315	260	N2	Additional Supervising Provider Name Information	S	1	
316	271	REF	Supervising Provider Secondary Identification	S	5	
			LOOP ID - 2320 OTHER SUBSCRIBER INFORMATION			10
318	290	SBR	Other Subscriber Information	S	1	
323	295	CAS	Claim Level Adjustments	S	5	
332	300	AMT	Coordination of Benefits (COB) Payer Paid Amount	S	1	
333	300	AMT	Coordination of Benefits (COB) Approved Amount	S	1	
334	300	AMT	Coordination of Benefits (COB) Allowed Amount	S	1	
335	300	AMT	Coordination of Benefits (COB) Patient Responsibility Amount	S	1	
336	300	AMT	Coordination of Benefits (COB) Covered Amount	S	1	
337	300	AMT	Coordination of Benefits (COB) Discount Amount	S	1	
338	300	AMT	Coordination of Benefits (COB) Per Day Limit Amount	S	1	
339	300	AMT	Coordination of Benefits (COB) Patient Paid Amount	S	1	
340	300	AMT	Coordination of Benefits (COB) Tax Amount	S	1	
341	300	AMT	Coordination of Benefits (COB) Total Claim Before Taxes Amount	S	1	
342	305	DMG	Subscriber Demographic Information	S	1	
344	310	OI	Other Insurance Coverage Information	R	1	
347	320	MOA	Medicare Outpatient Adjudication Information	S	1	
			LOOP ID - 2330A OTHER SUBSCRIBER NAME			1
350	325	NM1	Other Subscriber Name	R	1	
353	330	N2	Additional Other Subscriber Name Information	S	1	
354	332	N3	Other Subscriber Address	S	1	
355	340	N4	Other Subscriber City/State/ZIP Code	S	1	

357	355	REF	Other Subscriber Secondary Identification	S	3	
			LOOP ID - 2330B OTHER PAYER NAME			1
359	325	NM1	Other Payer Name	R	1	
362	330	N2	Additional Other Payer Name Information	S	1	
363	345	PER	Other Payer Contact Information	S	2	
366	345	DTP	Claim Adjudication Date	S	1	
368	355	REF	Other Payer Secondary Identifier	S	2	
370	355	REF	Other Payer Prior Authorization or Referral Number	S	2	
372	355	REF	Other Payer Claim Adjustment Indicator	S	2	
			LOOP ID - 2330C OTHER PAYER PATIENT INFORMATION			1
374	325	NM1	Other Payer Patient Information	S	1	
376	355	REF	Other Payer Patient Identification	S	3	
			LOOP ID - 2330D OTHER PAYER REFERRING PROVIDER			2
378	325	NM1	Other Payer Referring Provider	S	1	
380	355	REF	Other Payer Referring Provider Identification	R	3	
			LOOP ID - 2330E OTHER PAYER RENDERING PROVIDER			1
382	325	NM1	Other Payer Rendering Provider	S	1	
384	355	REF	Other Payer Rendering Provider Secondary Identification	R	3	
			LOOP ID - 2330F OTHER PAYER PURCHASED SERVICE PROVIDER			1
386	325	NM1	Other Payer Purchased Service Provider	S	1	
388	355	REF	Other Payer Purchased Service Provider Identification	R	3	
			LOOP ID - 2330G OTHER PAYER SERVICE FACILITY LOCATION			1
390	325	NM1	Other Payer Service Facility Location	S	1	
392	355	REF	Other Payer Service Facility Location Identification	R	3	
			LOOP ID - 2330H OTHER PAYER SUPERVISING PROVIDER			1
394	325	NM1	Other Payer Supervising Provider	S	1	
396	355	REF	Other Payer Supervising Provider Identification	R	3	
			LOOP ID - 2400 SERVICE LINE			50
398	365	LX	Service Line	R	1	
400	370	SV1	Professional Service	R	1	
408	385	SV4	Prescription Number	S	1	
410	420	PWK	DMERC CMN Indicator	S	1	
412	425	CR1	Ambulance Transport Information	S	1	
415	430	CR2	Spinal Manipulation Service Information	S	5	
421	435	CR3	Durable Medical Equipment Certification	S	1	
423	445	CR5	Home Oxygen Therapy Information	S	1	
427	450	CRC	Ambulance Certification	S	3	
430	450	CRC	Hospice Employee Indicator	S	1	
432	450	CRC	DMERC Condition Indicator	S	2	
435	455	DTP	Date - Service Date	R	1	
437	455	DTP	Date - Certification Revision Date	S	1	
439	455	DTP	Date - Referral Date	S	1	
440	455	DTP	Date - Begin Therapy Date	S	1	
442	455	DTP	Date - Last Certification Date	S	1	
444	455	DTP	Date - Order Date	S	1	
445	455	DTP	Date - Date Last Seen	S	1	
447	455	DTP	Date - Test	S	2	
449	455	DTP	Date - Oxygen Saturation/Arterial Blood Gas Test	S	3	
451	455	DTP	Date - Shipped	S	1	

452	455	DTP	Date - Onset of Current Symptom/Illness	S	1
454	455	DTP	Date - Last X-ray	S	1
456	455	DTP	Date - Acute Manifestation	S	1
458	455	DTP	Date - Initial Treatment	S	1
460	455	DTP	Date - Similar Illness/Symptom Onset	S	1
462	460	QTY	Anesthesia Modifying Units	S	5
464	462	MEA	Test Result	S	20
466	465	CN1	Contract Information	S	1
468	470	REF	Repriced Line Item Reference Number	S	1
469	470	REF	Adjusted Repriced Line Item Reference Number	S	1
470	470	REF	Prior Authorization or Referral Number	S	2
472	470	REF	Line Item Control Number	S	1
474	470	REF	Mammography Certification Number	S	1
475	470	REF	Clinical Laboratory Improvement Amendment (CLIA) Identification	S	1
477	470	REF	Referring Clinical Laboratory Improvement Amendment (CLIA) Facility Identification	S	1
478	470	REF	Immunization Batch Number	S	1
479	470	REF	Ambulatory Patient Group (APG)	S	4
480	470	REF	Oxygen Flow Rate	S	1
482	470	REF	Universal Product Number (UPN)	S	1
484	475	AMT	Sales Tax Amount	S	1
485	475	AMT	Approved Amount	S	1
486	475	AMT	Postage Claimed Amount	S	1
487	480	K3	File Information	S	10
488	485	NTE	Line Note	S	1
489	488	PS1	Purchased Service Information	S	1
491	491	HSD	Health Care Services Delivery	S	1
495	492	HCP	Line Pricing/Repricing Information	S	1
			LOOP ID - 2420A RENDERING PROVIDER NAME		**1**
501	500	NM1	Rendering Provider Name	S	1
504	505	PRV	Rendering Provider Specialty Information	R	1
506	510	N2	Additional Rendering Provider Name Information	S	1
507	525	REF	Rendering Provider Secondary Identification	S	5
			LOOP ID - 2420B PURCHASED SERVICE PROVIDER NAME		**1**
509	500	NM1	Purchased Service Provider Name	S	1
512	525	REF	Purchased Service Provider Secondary Identification	S	5
			LOOP ID - 2420C SERVICE FACILITY LOCATION		**1**
514	500	NM1	Service Facility Location	S	1
517	510	N2	Additional Service Facility Location Name Information	S	1
518	514	N3	Service Facility Location Address	R	1
519	520	N4	Service Facility Location City/State/ZIP	R	1
521	525	REF	Service Facility Location Secondary Identification	S	5
			LOOP ID - 2420D SUPERVISING PROVIDER NAME		**1**
523	500	NM1	Supervising Provider Name	S	1
526	510	N2	Additional Supervising Provider Name Information	S	1
527	525	REF	Supervising Provider Secondary Identification	S	5
			LOOP ID - 2420E ORDERING PROVIDER NAME		**1**
529	500	NM1	Ordering Provider Name	S	1
532	510	N2	Additional Ordering Provider Name Information	S	1
533	514	N3	Ordering Provider Address	S	1
534	520	N4	Ordering Provider City/State/ZIP Code	S	1

Page	Pos.	Seg.	Name	Req	Max Use	Repeat
536	525	REF	Ordering Provider Secondary Identification	S	5	
538	530	PER	Ordering Provider Contact Information	S	1	
			LOOP ID - 2420F REFERRING PROVIDER NAME			**2**
541	500	NM1	Referring Provider Name	S	1	
544	505	PRV	Referring Provider Specialty Information	S	1	
546	510	N2	Additional Referring Provider Name Information	S	1	
547	525	REF	Referring Provider Secondary Identification	S	5	
			LOOP ID - 2420G OTHER PAYER PRIOR AUTHORIZATION OR REFERRAL NUMBER			**4**
549	500	NM1	Other Payer Prior Authorization or Referral Number	S	1	
552	525	REF	Other Payer Prior Authorization or Referral Number	R	2	
			LOOP ID - 2430 LINE ADJUDICATION INFORMATION			**25**
554	540	SVD	Line Adjudication Information	S	1	
558	545	CAS	Line Adjustment	S	99	
566	550	DTP	Line Adjudication Date	R	1	
			LOOP ID - 2440 FORM IDENTIFICATION CODE			**5**
567	551	LQ	Form Identification Code	S	1	
569	552	FRM	Supporting Documentation	R	99	
572	555	SE	Transaction Set Trailer	R	1	

STANDARD

837 Health Care Claim

Functional Group ID: HC

This Draft Standard for Trial Use contains the format and establishes the data contents of the Health Care Claim Transaction Set (837) for use within the context of an Electronic Data Interchange (EDI) environment. This transaction set can be used to submit health care claim billing information, encounter information, or both, from providers of health care services to payers, either directly or via intermediary billers and claims clearinghouses. It can also be used to transmit health care claims and billing payment information between payers with different payment responsibilities where coordination of benefits is required or between payers and regulatory agencies to monitor the rendering, billing, and/or payment of health care services within a specific health care/insurance industry segment.

For purposes of this standard, providers of health care products or services may include entities such as physicians, hospitals and other medical facilities or suppliers, dentists, and pharmacies, and entities providing medical information to meet regulatory requirements. The payer refers to a third party entity that pays claims or administers the insurance product or benefit or both. For example, a payer may be an insurance company, health maintenance organization (HMO), preferred provider organization (PPO), government agency (Medicare, Medicaid, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), etc.) or an entity such as a third party administrator (TPA) or third party organization (TPO) that may be contracted by one of those groups. A regulatory agency is an entity responsible, by law or rule, for administering and monitoring a statutory benefits program or a specific health care/insurance industry segment.

Table 1 - Header

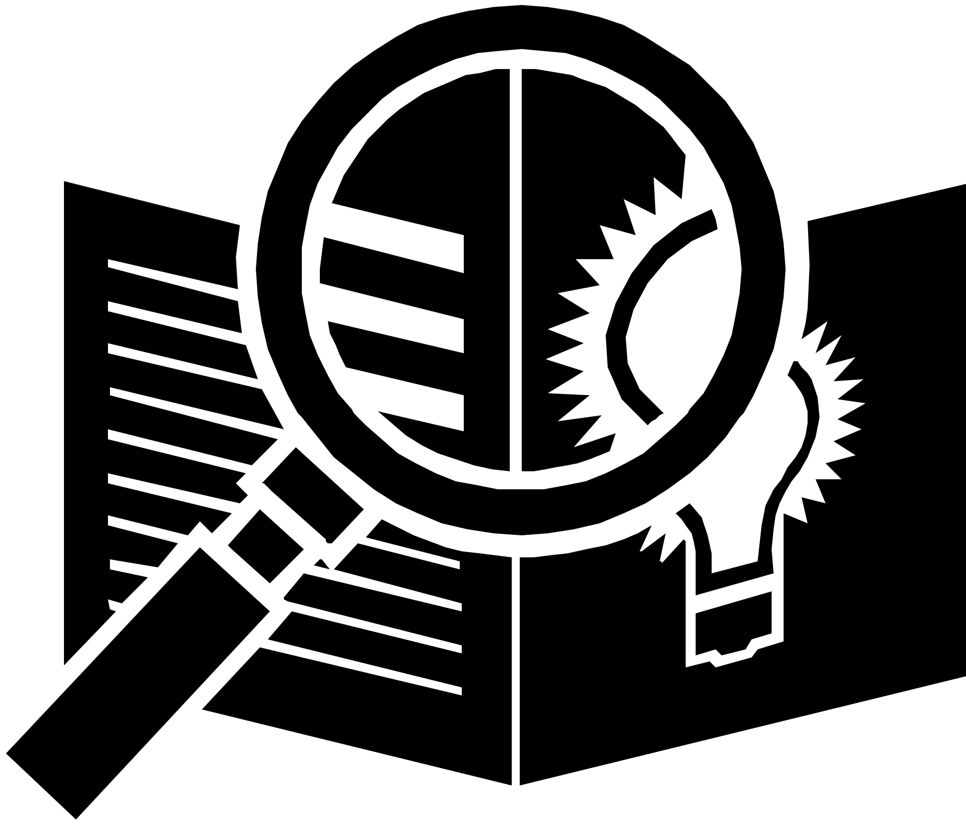
POS. #	SEG. ID	NAME	REQ. DES.	MAX USE	LOOP REPEAT
005	ST	Transaction Set Header	M	1	
010	BHT	Beginning of Hierarchical Transaction	M	1	
015	REF	Reference Identification	O	3	
		LOOP ID - 1000			10
020	NM1	Individual or Organizational Name	O	1	
025	N2	Additional Name Information	O	2	
030	N3	Address Information	O	2	
035	N4	Geographic Location	O	1	
040	REF	Reference Identification	O	2	
045	PER	Administrative Communications Contact	O	2	

Table 2 - Detail

POS. #	SEG. ID	NAME	REQ. DES.	MAX USE	LOOP REPEAT
		LOOP ID - 2000			>1
001	HL	Hierarchical Level	M	1	
003	PRV	Provider Information	O	1	
005	SBR	Subscriber Information	O	1	
007	PAT	Patient Information	O	1	
009	DTP	Date or Time or Period	O	5	
010	CUR	Currency	O	1	
		LOOP ID - 2010			10
015	NM1	Individual or Organizational Name	O	1	
020	N2	Additional Name Information	O	2	

025	N3	Address Information	O	2	
030	N4	Geographic Location	O	1	
032	DMG	Demographic Information	O	1	
035	REF	Reference Identification	O	20	
040	PER	Administrative Communications Contact	O	2	
		LOOP ID - 2300			**100**
130	CLM	Health Claim	O	1	
135	DTP	Date or Time or Period	O	150	
140	CL1	Claim Codes	O	1	
145	DN1	Orthodontic Information	O	1	
150	DN2	Tooth Summary	O	35	
155	PWK	Paperwork	O	10	
160	CN1	Contract Information	O	1	
165	DSB	Disability Information	O	1	
170	UR	Peer Review Organization or Utilization Review	O	1	
175	AMT	Monetary Amount	O	40	
180	REF	Reference Identification	O	30	
185	K3	File Information	O	10	
190	NTE	Note/Special Instruction	O	20	
195	CR1	Ambulance Certification	O	1	
200	CR2	Chiropractic Certification	O	1	
205	CR3	Durable Medical Equipment Certification	O	1	
210	CR4	Enteral or Parenteral Therapy Certification	O	3	
215	CR5	Oxygen Therapy Certification	O	1	
216	CR6	Home Health Care Certification	O	1	
219	CR8	Pacemaker Certification	O	1	
220	CRC	Conditions Indicator	O	100	
231	HI	Health Care Information Codes	O	25	
240	QTY	Quantity	O	10	
241	HCP	Health Care Pricing	O	1	
		LOOP ID - 2305			**6**
242	CR7	Home Health Treatment Plan Certification	O	1	
243	HSD	Health Care Services Delivery	O	12	
		LOOP ID - 2310			**9**
250	NM1	Individual or Organizational Name	O	1	
255	PRV	Provider Information	O	1	
260	N2	Additional Name Information	O	2	
265	N3	Address Information	O	2	
270	N4	Geographic Location	O	1	
271	REF	Reference Identification	O	20	
275	PER	Administrative Communications Contact	O	2	
		LOOP ID - 2320			**10**
290	SBR	Subscriber Information	O	1	
295	CAS	Claims Adjustment	O	99	
300	AMT	Monetary Amount	O	15	
305	DMG	Demographic Information	O	1	
310	OI	Other Health Insurance Information	O	1	
315	MIA	Medicare Inpatient Adjudication	O	1	
320	MOA	Medicare Outpatient Adjudication	O	1	
		LOOP ID - 2330			**10**
325	NM1	Individual or Organizational Name	O	1	
330	N2	Additional Name Information	O	2	
332	N3	Address Information	O	2	
340	N4	Geographic Location	O	1	
345	PER	Administrative Communications Contact	O	2	

Pos.	ID	Segment Name	Req. Des.	Max. Use	Loop Repeat
350	DTP	Date or Time or Period	O	9	
355	REF	Reference Identification	O	3	
		LOOP ID - 2400			>1
365	LX	Assigned Number	O	1	
370	SV1	Professional Service	O	1	
375	SV2	Institutional Service	O	1	
380	SV3	Dental Service	O	1	
382	TOO	Tooth Identification	O	32	
385	SV4	Drug Service	O	1	
400	SV5	Durable Medical Equipment Service	O	1	
405	SV6	Anesthesia Service	O	1	
410	SV7	Drug Adjudication	O	1	
415	HI	Health Care Information Codes	O	25	
420	PWK	Paperwork	O	10	
425	CR1	Ambulance Certification	O	1	
430	CR2	Chiropractic Certification	O	5	
435	CR3	Durable Medical Equipment Certification	O	1	
440	CR4	Enteral or Parenteral Therapy Certification	O	3	
445	CR5	Oxygen Therapy Certification	O	1	
450	CRC	Conditions Indicator	O	3	
455	DTP	Date or Time or Period	O	15	
460	QTY	Quantity	O	5	
462	MEA	Measurements	O	20	
465	CN1	Contract Information	O	1	
470	REF	Reference Identification	O	30	
475	AMT	Monetary Amount	O	15	
480	K3	File Information	O	10	
485	NTE	Note/Special Instruction	O	10	
488	PS1	Purchase Service	O	1	
490	IMM	Immunization Status Code	O	>1	
491	HSD	Health Care Services Delivery	O	1	
492	HCP	Health Care Pricing	O	1	
		LOOP ID - 2410			>1
494	LIN	Item Identification	O	1	
495	CTP	Pricing Information	O	1	
496	REF	Reference Identification	O	1	
		LOOP ID - 2420			10
500	NM1	Individual or Organizational Name	O	1	
505	PRV	Provider Information	O	1	
510	N2	Additional Name Information	O	2	
514	N3	Address Information	O	2	
520	N4	Geographic Location	O	1	
525	REF	Reference Identification	O	20	
530	PER	Administrative Communications Contact	O	2	
		LOOP ID - 2430			>1
540	SVD	Service Line Adjudication	O	1	
545	CAS	Claims Adjustment	O	99	
550	DTP	Date or Time or Period	O	9	
		LOOP ID - 2440			>1
551	LQ	Industry Code	O	1	
552	FRM	Supporting Documentation	M	99	
555	SE	Transaction Set Trailer	M	1	



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2010, Loop ID-2420, etc.). For example, loop 2310 has five possible uses identified: referring provider, rendering provider, purchased service provider, service facility location, and supervising provider. These loops are labeled 2310A, 2310B, 2310C, 2310D, and 2310E . Each of these 2310 loops is an equivalent loop. Because they do not specify an HL, it is not necessary to use them in any particular order. In a similar fashion, it is acceptable to send subloops 2010BB, 2010BD, 2010BA, and 2010BC in that order as long as they all belong to the same subloop. However, it is not acceptable to send subloop 2330 before loop 2310 because these are not equivalent subloops.

In a similar manner, if a single loop has many iterations (repetitions) of a particular segment all the iterations of that segment are equivalent. For example there are many DTP segments in the 2300 loop. These are equivalent segments. It is not required that Order Date be sent before Initial Treatment date. However, it is required that the DTP segment in the 2300 loop come after the CLM segment because it carried in a different position within the 2300 loop.

Translators should distinguish between equivalent subloops and segments by qualifier codes (e.g., the value carried in NM101 in loops 2010BA, 2010 BB, and 2010BC; the values in the DTP01s in the 2300 loop), not by the position of the subloop or segment in the transaction. The number of times a loop or segment can be repeated is indicated in the detail information on that portion of the transaction.

2.2.1 Required and Situational Loops

Loop usage within ASC X12 transactions and their implementation guides can be confusing. Care must be used to read the loop requirements in terms of the context or location within the transaction.

The usage designator of a loop's beginning segment indicates the usage of the loop. If a loop is used, the first segment of that loop is required even if it is marked Situational. An example of this is the 2010AB - Pay-to Provider loop.

In the 837 Professional Implementation Guide loops that are required on all claims/encounters are the Header, 1000A - Submitter Name, 1000B - Receiver Name, 2000A - Billing/Pay-to Provider Hierarchical Level, 2010AA - Billing Provider Name, 2000B - Subscriber Hierarchical Level, 2010BA -Subscriber Name, 2010BB - Payer Name, 2300 - Claim Level Information, and 2400 Service Line. The use of all other loops is dependent upon the nature of the claim/encounter.

If the usage of the first segment in a loop is marked Required, the loop must occur at least once unless it is nested in a loop that is not being used. An example of this is Loop ID-2330A - Other Subscriber Name. Loop 2330A is required only when Loop ID-2320 - Other Subscriber Information is used, i.e., if the claim involves coordination of benefits information. A parallel situation exists with the Loop ID-2330B - Other Payer Name. A note on the Required initial segment of a nested loop will indicate dependency on the higher level loop.

If the first segment is Situational, there will be a segment note addressing use of the loop. Any required segments in loops beginning with a Situational segment only occur when the loop is used. For an example of this see Loop ID-2010AB - Pay-to Provider. In the 2010AB loop, if the loop is used, the initial segment, NM1 - Pay-to Provider Name must be used. Use of the N2 and REF segments are optional, but the N3 and N4 segments are required.

2.3 Data Use by Business Use

The 837 is divided into two levels, or tables. The Header level, Table 1, contains transaction control information. The Detail level, Table 2, contains the detail information for the transaction's business function and is presented in 2.3.2, Table 2 - Detail Information.

2.3.1 Table 1 — Transaction Control Information

Table 1 is named the Header level (see figure 4, Header Level). Table 1 identifies the start of a transaction, the specific transaction set, and the transaction's business purpose. Additionally, when a transaction set uses a hierarchical data structure, a data element in the header BHT01 — the Hierarchical Structure Code — relates the type of business data expected to be found within each level.

Table 1 - Header

POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
005	ST	Transaction Set Header	R	1	
010	BHT	Beginning of Hierarchical Transaction	R	1	
015	REF	Transmission Type Identification	R	1	
		. . .			

Figure 4. Table 1 — Header Level

2.3.1.1 837 Table 1 — Header Level

The following is a coding example of Table 1 in the 837. Refer to Appendix A, ASC X12 Nomenclature, for descriptions of data element separators (e.g., *) and segment terminators (e.g., ~).

ST*837*0001~

837 = Transaction set identifier code
0001 = Transaction set control number

BHT*0019*00*98766Y*19970315*0001*CH~

0019 = Hierarchical structure code (information source, subscriber, dependent)
00 = Original
98766Y = Submitter's batch control number
19970315 = Date of file creation
0001 = Time of file creation
CH = Chargeable (claims)

REF*87*004010X098~

87 = Functional category
004010X098 = Professional Implementation Guide

The Transaction Set Header (ST) segment identifies the transaction set by using 837 as the data value for the transaction set identifier code data element, ST01. The transaction set originator assigns the unique transaction set control number ST02, shown in the previous example as 0001. In the example, the health care provider is the transaction set originator.

The Beginning of Hierarchical Transaction (BHT) segment indicates that the transaction uses a hierarchical data structure. The value of 0019 in the hierarchi-

cal structure code data element, BHT01, describes the order of the hierarchical levels and the business purpose of each level. See Section 2.3.1.2, Hierarchical Level Data Structure, for additional information about the BHT01 data element.

The BHT segment also contains the transaction set purpose code, BHT02, which indicates **original transaction** by using data value 00. The submitter's business application system generates the following fields: BHT03, originator's reference number; BHT04, date of transaction creation; BHT05, time of transaction creation. BHT02 is used to indicate the status of the transaction batch, i.e., is the batch an original transmission or a reissue (resubmitted) batch. BHT06 is used to indicate the type of billed service being sent: fee-for-service (claim) or encounter or a mixed bag of both.

Because the 837 is multi-functional, it is important for the receiver to know which business purpose is served, so the REF in the Header is used. A data value of 87 in REF 01 indicates the **functional category,** or type, of 837 being sent. Appropriate values for REF02 are as follows: 004010X098 for a Professional 837 transaction, 004010X097 for Dental, and 004010X096 for Institutional.

The Functional Group Header (GS) segment also identifies the business purpose of multi-functional transaction sets. See Appendix A, ASC X12 Nomenclature, for a detailed description of the elements in the GS segment.

2.3.1.2 Hierarchical Level Data Structure

The hierarchical level (HL) structure identifies and relates the participants involved in the transaction. The participants identified in the 837 Professional transaction are generally billing/pay-to provider, subscriber, and patient (when the patient is not the same person as the subscriber). The 0019 value in the BHT hierarchical structure code (BHT01) describes the appearance order of subsequent loops within the transaction set and refers to these participants, respectively, in the following terms:

- information source (billing provider)
- subscriber (can be the patient when the patient is the subscriber)
- dependent (patient, when the patient is not the subscriber)

The term “billing provider” indicates the information source HL. The term “patient” indicates the dependent HL.

2.3.2 Table 2 — Detail Information

Table 2 uses the hierarchical level structure. Each hierarchical level is comprised of a series of loops. Numbers identify the loops. The hierarchical level that identifies the participants and the relationship to other participants is Loop ID-2000. The individual or entity information is contained in Loop ID-2010.

2.3.2.1 HL Segment

The following information illustrates claim/encounter submissions when the patient is the subscriber and when the patient is not the subscriber.

NOTE
Specific claim detail information can be given in either the Subscriber or the Dependent hierarchical level. Because of this, the claim information is said to “float.”

Claim information is positioned in the same hierarchical level that describes its owner-participant, either the subscriber or the dependent. In other words, the claim information is placed at the subscriber hierarchical level when the patient is the subscriber, or it is placed at the patient/dependent hierarchical level when the patient is the dependent of the subscriber.

Claim/encounter submission when the **patient is the subscriber:**
Billing provider (HL03=20)
  Subscriber (HL03=22)
    Claim level information
    Line level information

Claim/encounter submission when the **patient is not the subscriber:**
Billing provider (HL03=20)
  Subscriber (HL03=22)
    Patient (HL03=23)
      Claim level information
      Line level information

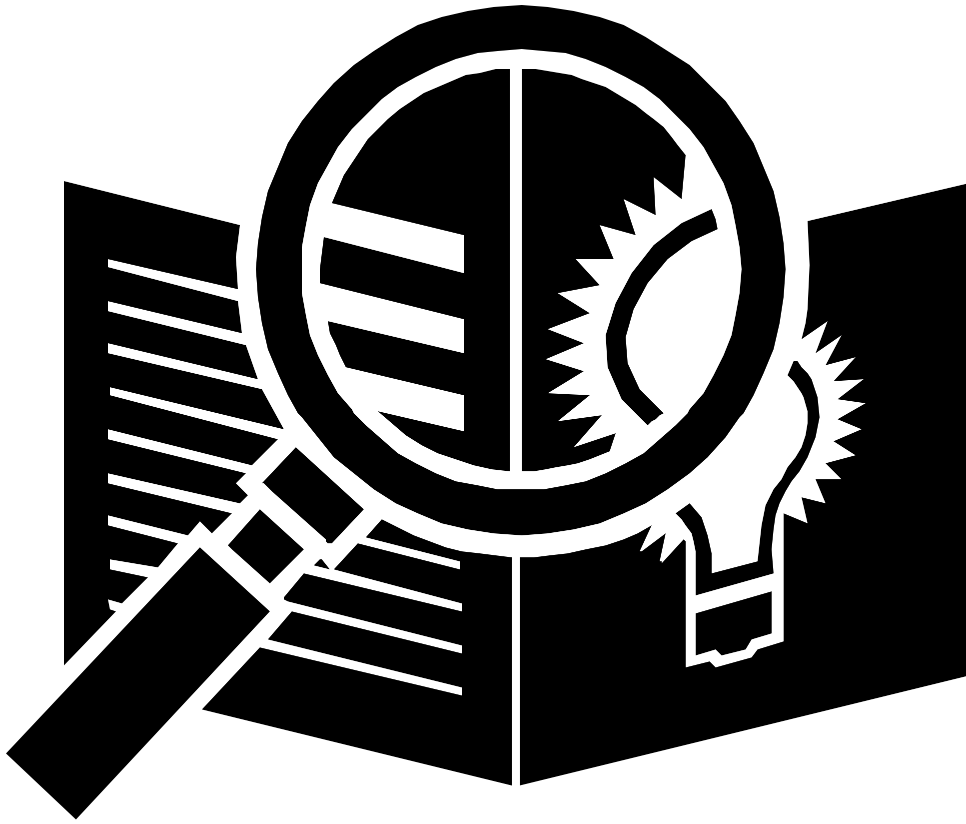
The Billing Provider or Subscriber HLs may contain multiple “child” HLs. A child HL indicates an HL that is nested within (subordinate to) the previous HL. Hierarchical levels may also have a “parent” HL. A parent HL is the HL that is one level out in the nesting structure. An example follows.

Billing provider HL	**Parent HL** to the Subscriber HL
Subscriber HL	**Parent HL** to the Patient HL; **Child HL** to the Billing Provider HL
Patient HL	**Child HL** to the Subscriber HL

For the subscriber HL, the billing provider HL is the parent. The patient HL is the child. The subscriber HL is contained within the billing provider HL. The patient HL is contained within the subscriber HL.

If the billing provider is submitting claims for more than one subscriber, each of whom may or may not have dependents, the HL structure between the transaction set header and trailer (ST–SE) could look like the following:

BILLING PROVIDER
  SUBSCRIBER #1 (Patient #1)
    Claim level information
    Line level information, as needed
SUBSCRIBER #2
  PATIENT #P2.1 (e.g., subscriber #2 spouse)
    Claim level information
    Line level information, as needed
  PATIENT #P2.2 (e.g., subscriber #2 first child)
    Claim level information
    Line level information, as needed
  PATIENT #P2.3 (e.g., subscriber #2 second child)
    Claim level information
    Line level information, as needed
SUBSCRIBER #3 (Patient #3)
  Claim level information
  Line level information, as needed
SUBSCRIBER #4 (Patient #4)
  Claim level information
  Line level information, as needed



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IMPLEMENTATION

RECEIVER NAME

Loop: **1000B — RECEIVER NAME** **Repeat:** **1**

Usage: **REQUIRED**

Repeat: **1**

Notes:
1. **Because this is a required segment, this is a required loop. See Appendix A for further details on ASC X12 syntax rules.**

Example: **NM1✻40✻2✻UNION MUTUAL OF OREGON✻✻✻✻✻46✻11122333~**

STANDARD

NM1 Individual or Organizational Name

Level: Header

Position: 020

Loop: 1000 **Repeat:** 10

Requirement: Optional

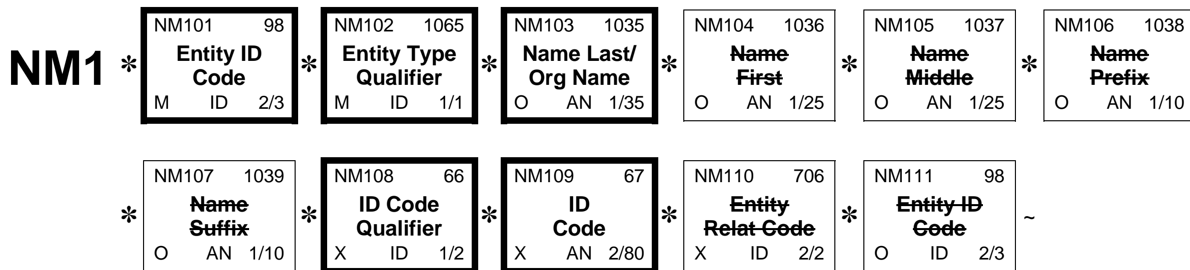
Max Use: 1

Purpose: To supply the full name of an individual or organizational entity

Set Notes:
1. Loop 1000 contains submitter and receiver information. If any intermediary receivers change or add data in any way, then they add an occurrence to the loop as a form of identification. The added loop occurrence must be the last occurrence of the loop.

Syntax:
1. **P0809**
   If either NM108 or NM109 is present, then the other is required.
2. **C1110**
   If NM111 is present, then NM110 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual CODE / DEFINITION **40** **Receiver**	**M**	**ID**	**2/3**
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. CODE / DEFINITION **2** **Non-Person Entity**	**M**	**ID**	**1/1**
REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name *INDUSTRY:* ***Receiver Name***	**O**	**AN**	**1/35**
NOT USED	**NM104**	**1036**	**Name First**	**O**	**AN**	**1/25**
NOT USED	**NM105**	**1037**	**Name Middle**	**O**	**AN**	**1/25**
NOT USED	**NM106**	**1038**	**Name Prefix**	**O**	**AN**	**1/10**
NOT USED	**NM107**	**1039**	**Name Suffix**	**O**	**AN**	**1/10**
REQUIRED	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) SYNTAX: P0809 CODE / DEFINITION **46** **Electronic Transmitter Identification Number (ETIN)**	**X**	**ID**	**1/2**
REQUIRED	**NM109**	**67**	**Identification Code** Code identifying a party or other code *INDUSTRY:* ***Receiver Primary Identifier*** *ALIAS:* ***Receiver Primary Identification Number*** SYNTAX: P0809 **NSF Reference:** **AA0-17.0, ZA0-04.0**	**X**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**

IMPLEMENTATION

BILLING PROVIDER NAME

Loop: **2010AA — BILLING PROVIDER NAME Repeat: 1**

Usage: **REQUIRED**

Repeat: **1**

Notes:
1. **Although the name of this loop/segment is "Billing Provider" the loop/segment really identifies the billing entity. The billing entity does not have to be a health care provider to use this loop. However, some payers do not accept claims from non-provider billing entities.**
2. **Because this is a required segment, this is a required loop. See Appendix A for further details on ASC X12 syntax rules.**

Example: **NM1✻85✻2✻CRAMMER, DOLE, PALMER, AND JOHNANSE✻✻✻✻✻24✻111223333~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 015

Loop: 2010 **Repeat:** 10

Requirement: Optional

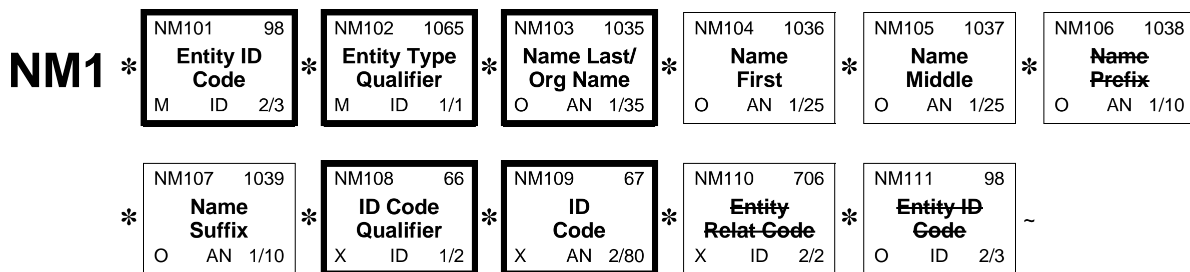
Max Use: 1

Purpose: To supply the full name of an individual or organizational entity

Set Notes:
1. Loop 2010 contains information about entities that apply to all claims in loop 2300. For example, these entities may include billing provider, pay-to provider, insurer, primary administrator, contract holder, or claimant.

Syntax:
1. **P0809**
   If either NM108 or NM109 is present, then the other is required.
2. **C1110**
   If NM111 is present, then NM110 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	**M**	**ID**	**2/3**
			CODE: **85** — **Billing Provider** **Use this code to indicate billing provider, billing submitter, and encounter reporting entity.**			
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103.	**M**	**ID**	**1/1**
			CODE: **1** — **Person**			
			CODE: **2** — **Non-Person Entity**			
REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name INDUSTRY: ***Billing Provider Last or Organizational Name*** ALIAS: ***Billing Provider Name*** **NSF Reference:** **BA0-18.0 or BA0-19.0**	**O**	**AN**	**1/35**
SITUATIONAL	**NM104**	**1036**	**Name First** Individual first name INDUSTRY: ***Billing Provider First Name*** ALIAS: ***Billing Provider Name*** **NSF Reference:** **BA0-20.0** **Required if NM102=1 (person).**	**O**	**AN**	**1/25**
SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial INDUSTRY: ***Billing Provider Middle Name*** ALIAS: ***Billing Provider Name*** **NSF Reference:** **BA0-21.0** **Required if NM102=1 and the middle name/initial of the person is known.**	**O**	**AN**	**1/25**
NOT USED	**NM106**	**1038**	**Name Prefix**	**O**	**AN**	**1/10**

IMPLEMENTATION

BILLING/PAY-TO PROVIDER HIERARCHICAL LEVEL

Loop: **2000A — BILLING/PAY-TO PROVIDER HIERARCHICAL LEVEL Repeat: >1**

Usage: **REQUIRED**

Repeat: **1**

Notes:

1. **Use the Billing Provider HL to identify the original entity who submitted the electronic claim/encounter to the destination payer identified in Loop ID-2010BB. The billing provider entity may be a health care provider, a billing service, or some other representative of the provider.**
2. **The NSF fields shown in Loop ID-2010AA and Loop ID-2010AB are intended to carry billing provider information, not billing service information. Refer to your NSF manual for proper use of these fields. If Loop 2010AA contains information on a billing service (rather than a billing provider), do not map the information in that loop to the NSF billing provider fields for Medicare claims.**
3. **The Billing/Pay-to Provider HL may contain information about the Pay-to Provider entity. If the Pay-to Provider entity is the same as the Billing Provider entity, then only use Loop ID-2010AA.**
4. **Because this is a required segment, this is a required loop. See Appendix A for further details on ASC X12 syntax rules.**
5. **Receiving trading partners may have system limitations regarding the size of the transmission they can receive. The developers of this implementation guide recommend that trading partners limit the size of the transaction (ST-SE envelope) to a maximum of 5000 CLM segments. While the implementation guide sets no specific limit to the number of Billing/Pay-to Provider Hierarchical Level loops, there is an implied maximum of 5000.**
6. **If the Billing or Pay-to Provider is also the Rendering Provider and Loop ID-2310A is not used, the Loop ID-2000 PRV must be used to indicate which entity (Billing or Pay-to) is the Rendering Provider.**

Example: **HL✻1✻✻20✻1~**

STANDARD

HL Hierarchical Level

Level: Detail

Position: 001

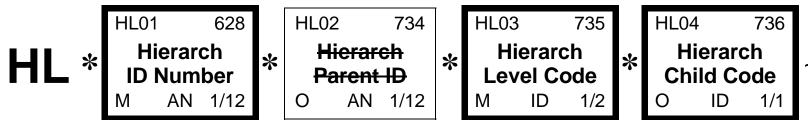
Loop: 2000 **Repeat:** >1

Requirement: Mandatory

Max Use: 1

Purpose: To identify dependencies among and the content of hierarchically related groups of data segments

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HL01**	**628**	**Hierarchical ID Number**	**M AN 1/12**
NOT USED	**HL02**	**734**	**Hierarchical Parent ID Number**	**O AN 1/12**
REQUIRED	**HL03**	**735**	**Hierarchical Level Code**	**M ID 1/2**
REQUIRED	**HL04**	**736**	**Hierarchical Child Code**	**O ID 1/1**

REQUIRED HL01 628 Hierarchical ID Number — M AN 1/12

A unique number assigned by the sender to identify a particular data segment in a hierarchical structure

COMMENT: HL01 shall contain a unique alphanumeric number for each occurrence of the HL segment in the transaction set. For example, HL01 could be used to indicate the number of occurrences of the HL segment, in which case the value of HL01 would be "1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction.

HL01 must begin with "1" and be incremented by one each time an HL is used in the transaction. Only numeric values are allowed in HL01.

NOT USED HL02 734 Hierarchical Parent ID Number — O AN 1/12

REQUIRED HL03 735 Hierarchical Level Code — M ID 1/2

Code defining the characteristic of a level in a hierarchical structure

COMMENT: HL03 indicates the context of the series of segments following the current HL segment up to the next occurrence of an HL segment in the transaction. For example, HL03 is used to indicate that subsequent segments in the HL loop form a logical grouping of data referring to shipment, order, or item-level information.

CODE	DEFINITION
20	**Information Source**

REQUIRED HL04 736 Hierarchical Child Code — O ID 1/1

Code indicating if there are hierarchical child data segments subordinate to the level being described

COMMENT: HL04 indicates whether or not there are subordinate (or child) HL segments related to the current HL segment.

CODE	DEFINITION
1	**Additional Subordinate HL Data Segment in This Hierarchical Structure.**

IMPLEMENTATION

SUBSCRIBER HIERARCHICAL LEVEL

Loop: **2000B — SUBSCRIBER HIERARCHICAL LEVEL Repeat: >1**

Usage: **REQUIRED**

Repeat: **1**

Notes:

1. **If the insured and the patient are the same person, use this HL to identify the insured/patient, skip the subsequent (PATIENT) HL, and proceed directly to Loop ID-2300.**
2. **The Subscriber HL contains information about the person who is listed as the subscriber/insured for the destination payer entity (Loop ID-2010BA). The Subscriber HL contains information identifying the subscriber (Loop ID-2010BA), his or her insurance (Loop ID-2010BB), and responsible party (Loop ID-2010BC). In addition, information about the credit/debit card holder is placed in this HL (Loop ID-2010BD). The credit/debit card holder may or may not be the subscriber. See Appendix G, Credit/Debit Card Use, for a description of using Loop ID-2010BD.**
3. **Because this is a required segment, this is a required loop. See Appendix A for further details on ASC X12 syntax rules.**
4. **Receiving trading partners may have system limitations regarding the size of the transmission they can receive. The developers of this implementation guide recommend that trading partners limit the size of the transaction (ST-SE envelope) to a maximum of 5000 CLM segments. While the implementation guide sets no specific limit to the number of Subscriber Hierarchical Level loops, there is an implied maximum of 5000.**

Example: **HL✻2✻1✻22✻1~**

STANDARD

HL Hierarchical Level

Level: Detail

Position: 001

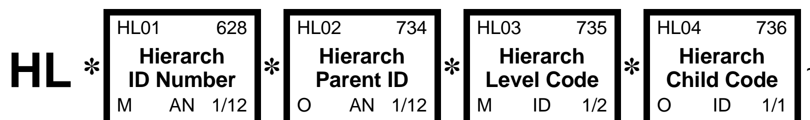
Loop: 2000 **Repeat:** >1

Requirement: Mandatory

Max Use: 1

Purpose: To identify dependencies among and the content of hierarchically related groups of data segments

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HL01**	**628**	**Hierarchical ID Number** A unique number assigned by the sender to identify a particular data segment in a hierarchical structure COMMENT: HL01 shall contain a unique alphanumeric number for each occurrence of the HL segment in the transaction set. For example, HL01 could be used to indicate the number of occurrences of the HL segment, in which case the value of HL01 would be “1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction.	**M AN 1/12**
REQUIRED	**HL02**	**734**	**Hierarchical Parent ID Number** Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to COMMENT: HL02 identifies the hierarchical ID number of the HL segment to which the current HL segment is subordinate.	**O AN 1/12**
REQUIRED	**HL03**	**735**	**Hierarchical Level Code** Code defining the characteristic of a level in a hierarchical structure COMMENT: HL03 indicates the context of the series of segments following the current HL segment up to the next occurrence of an HL segment in the transaction. For example, HL03 is used to indicate that subsequent segments in the HL loop form a logical grouping of data referring to shipment, order, or item-level information.	**M ID 1/2**

CODE	DEFINITION
22	**Subscriber**

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HL04**	**736**	**Hierarchical Child Code** Code indicating if there are hierarchical child data segments subordinate to the level being described COMMENT: HL04 indicates whether or not there are subordinate (or child) HL segments related to the current HL segment.	**O ID 1/1**

The claim loop (Loop ID-2300) can be used both when HL04 has no subordinate levels (HL04 = 0) or when HL04 has subordinate levels indicated (HL04 = 1).

In the first case (HL04 = 0), the subscriber is the patient and there are no dependent claims. The second case (HL04 = 1) happens when claims/encounters for both the subscriber and a dependent of theirs are being sent under the same billing provider HL (e.g., a father and son are both involved in the same automobile accident and are treated by the same provider). In that case, the subscriber HL04 = 1 because there is a dependent to this subscriber, but the 2300 loop for the subscriber/patient (father) would begin after the subscriber HL. The dependent HL (son) would then be run and the 2300 loop for the dependent/patient would be run after that HL. HL04=1 would also be used when a claim/encounter for a only a dependent is being sent.

CODE	DEFINITION
0	**No Subordinate HL Segment in This Hierarchical Structure.**
1	**Additional Subordinate HL Data Segment in This Hierarchical Structure.**

IMPLEMENTATION

PATIENT HIERARCHICAL LEVEL

Loop: **2000C — PATIENT HIERARCHICAL LEVEL Repeat: >1**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **This HL is required when the patient is a different person than the subscriber. There are no HLs subordinate to the Patient HL.**

2. **Because the usage of this segment is “Situational” this is not a syntactically required loop. If this loop is used, then this segment is a “Required” segment. See Appendix A for further details on ASC X12 syntax rules.**

3. **Receiving trading partners may have system limitations regarding the size of the transmission they can receive. The developers of this implementation guide recommend that trading partners limit the size of the transaction (ST-SE envelope) to a maximum of 5000 CLM segments. While the implementation guide sets no specific limit to the number of Patient Hierarchical Level loops, there is an implied maximum of 5000.**

Example: **HL✻3✻2✻23✻0~**

STANDARD

HL Hierarchical Level

Level: Detail

Position: 001

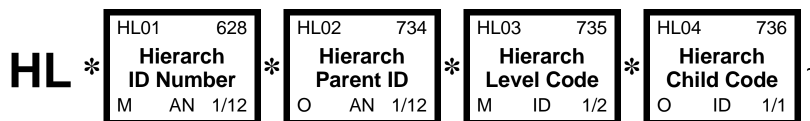
Loop: 2000 **Repeat:** >1

Requirement: Mandatory

Max Use: 1

Purpose: To identify dependencies among and the content of hierarchically related groups of data segments

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HL01**	**628**	**Hierarchical ID Number** A unique number assigned by the sender to identify a particular data segment in a hierarchical structure COMMENT: HL01 shall contain a unique alphanumeric number for each occurrence of the HL segment in the transaction set. For example, HL01 could be used to indicate the number of occurrences of the HL segment, in which case the value of HL01 would be “1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction.	**M AN 1/12**
REQUIRED	**HL02**	**734**	**Hierarchical Parent ID Number** Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to COMMENT: HL02 identifies the hierarchical ID number of the HL segment to which the current HL segment is subordinate.	**O AN 1/12**
REQUIRED	**HL03**	**735**	**Hierarchical Level Code** Code defining the characteristic of a level in a hierarchical structure COMMENT: HL03 indicates the context of the series of segments following the current HL segment up to the next occurrence of an HL segment in the transaction. For example, HL03 is used to indicate that subsequent segments in the HL loop form a logical grouping of data referring to shipment, order, or item-level information.	**M ID 1/2**

CODE	DEFINITION
23	**Dependent** **The code DEPENDENT is meant to convey that the information in this HL applies to the patient when the subscriber and the patient are not the same person.**

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HL04**	**736**	**Hierarchical Child Code** Code indicating if there are hierarchical child data segments subordinate to the level being described COMMENT: HL04 indicates whether or not there are subordinate (or child) HL segments related to the current HL segment.	**O ID 1/1**

CODE	DEFINITION
0	**No Subordinate HL Segment in This Hierarchical Structure.**