HIPAA Transaction Instructions
Standard Companion Guide

Refers to Transactions Based on ASC X12 version 005010

Companion Guide Version: 3.4
October 2016

This Companion Guide was modified by Central California Alliance for Health for Alliance-specific purposes.

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 (TI) 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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1 Introduction

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

1.2 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)

1.3 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

1.4 Intended Use

The Transaction Instruction (TI) 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.

Please note that the following list is not all-inclusive and is intended as an example. It should be specific to the entity creating the companion guide. It is not intended to include only HIPAA-adopted implementation guides.

Unique ID	Name
[005010X222	Health Care Claim: Professional (837)]
[005010X223	Health Care Claim: Institutional (837)]
[005010X279	Health Care Eligibility Benefit Inquiry and Response (270/271)]
[005010X221	Health Care Claim Payment/ Advice (835)]
[005010X212	Health Care Claim Status Request and Response (276/277)]

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 005010X222 Health Care Claim: Professional

Loop ID	Reference	Name	Codes	Notes/Comments
	BHT	Beginning of Hierarchical Transaction		
	BHT09	Subscriber Primary Identifier	31	Alliance doesn't support receipt of Subrogation Demand claim transactions.
1000A	NM1	Submitter Name		
1000A	NM109	Submitter Identifier		Provider's NPI or Clearinghouse ID#
1000B	NM1	Receiver Name		
1000B	NM103	Receiver Name		Use "Central California Alliance for Health" to identify the Alliance.
1000B	NM109	Receiver Primary Identifier		Use "770395311" to identify the Alliance.
2000A	PRV	Billing Provider Specialty Information		Alliance uses provider taxonomy during claim adjudication and requires this segment when the billing provider performed any of the services within this file.
2000A	CUR	Foreign Currency Information		Alliance can't process currencies other than US Dollars.
2010AA	REF	Billing Provider UPIN/License Information		Alliance doesn't use UPIN or State License numbers to identify providers.
2010AC	NM1	Pay-To-Plan Name		Alliance doesn't support receipt of subrogation payment requests electronically.
2000B	SBR	Subscriber Information		
2000B	SBR01	Payer Responsibility	P – Primary S – Secondary T – Tertiary	Anything other than the qualifier of P is considered a crossover claim.
2000B	SBR09	Claim Filing Indicator Code		Required data elements per TR3 Guide.
2010BA	REF	Subscriber Secondary Identification		Alliance doesn't use the social security number for additional identification.

Loop ID	Reference	Name	Codes	Notes/Comments
2010BB	NM1	Payer Name		
2010BB	NM103	Payer Name		Use “Central California Alliance for Health”.
2010BB	NM109	Payer Identifier		Use “770395311”.
2010BB	REF	Payer Secondary Identification		Alliance doesn’t use a secondary identifier.
2010BB	REF	Billing Provider Secondary Identification		Alliance doesn’t support proprietary identifiers for atypical providers.
2000C	HL	Patient Hierarchical Level		Dependents can only be submitted to Alliance in the case of a baby that has not yet received a unique identifier.
2000C	PAT	Patient Information		
2000C	PAT01	Individual Relationship Code	19 - Child	This is the only relationship support by Alliance’s business.
2300	DTP	Date – Last Menstrual Period (LMP)	484	Alliance requires the LMP date to be populated in this field only when reporting LMP.
2300	DTP	Date – Initial Treatment Date		Alliance does not need initial treatment date for adjudication.
2300	DTP	Date – Last Seen Date		Alliance does not need last seen date for adjudication.
2300	DTP	Date – Last Worked		Alliance doesn’t need last worked date for adjudication.
2300	DTP	Date – Authorized Return to Work		Alliance doesn’t need the authorized return to work date for adjudication.
2300	REF	Service Authorization Exception Code		Alliance does not use this information.
2300	REF	Prior Authorization		Prior authorization field has to be mapped at claim header only. The Alliance no longer accepts this field at the claim level.
2300	REF	Claim Identifier for Transmission Intermediaries		Alliance does/doesn’t capture and return this number in the claim acknowledgement.
2300	REF	Demonstration Project Identifier		Alliance doesn’t participate in demonstration projects at this time.
2300	CR2	Spinal Manipulation Service Information		This information doesn’t impact the Alliance adjudication system.
2300	CRC	Patient Condition Information: Vision		This information doesn’t impact the Alliance adjudication system.
2300	HI	Anesthesia Related Procedure		Alliance does not use this information in adjudication at this time.

Loop ID	Reference	Name	Codes	Notes/Comments
2310A	REF	Referring Provider Secondary Identifier		Alliance doesn't provide proprietary identifiers to atypical providers.
2310B	PRV	Rendering Provider Specialty Information		Alliance Adjudication is impacted by the provider taxonomy code.
2310B	REF	Rendering Provider Secondary Identification		Alliance doesn't provide proprietary identifiers to atypical providers.
2310C	REF	Service Facility Location Secondary Identification		Alliance doesn't provide proprietary identifiers to atypical providers.
2310D	REF	Supervising Provider Secondary Identification		Alliance doesn't provide proprietary identifiers to atypical providers.
2320	SBR	Other Subscriber Information		
2320	SBR01	Payer Responsibility	P – Primary S – Secondary T – Tertiary	
2320	CAS	Claim Level Adjustments		Alliance uses these segments for secondary claims.
2320	SBR09	Claim Filing Indicator	MA – Medicare Part A MB – Medicare Part B Insurance	Required data elements per TR3 Guide.
2320	AMT	Coordination of Benefits Total Non-covered Amount		Alliance does not have a cost avoidance policy that allows bypassing any prior payers.
2330	REF	Prior Authorization		Prior authorization field has to be mapped at claim header only. The Alliance no longer accepts this field at the claim level.
2400	SV1	Professional Service		
2400	SV101-01	Product or Service ID Qualifier	"HC" - HCPCS	Alliance can only adjudicate HCPCS Procedure Codes
2400	CRC	Condition Indicator/Durable Medical Equipment		Alliance doesn't use this information for adjudication.
2400	DTP	Date – Last Seen Date		Alliance does not need last seen date for adjudication.
2400	DTP	Date – Initial Treatment Date		Alliance does not need initial treatment date for adjudication.
2400	NTE	Line Note		This field is informational and is mapped to a remarks field.
2400	PS1	Purchased Service Information		Alliance does not need this information for adjudication.

Loop ID	Reference	Name	Codes	Notes/Comments
2420A	PRV	Rendering Provider Specialty Information		Alliance Adjudication is impacted by the provider taxonomy code.
2420A	REF	Rendering Provider Secondary Identification		Alliance doesn't provide proprietary identifiers to atypical providers.
2420B	REF	Purchased Service Provider Secondary Identification		Alliance doesn't provide proprietary identifiers to atypical providers.
2420C	REF	Service Facility Location Secondary Identification		Alliance doesn't provide proprietary identifiers to atypical providers.
2420D	REF	Supervising Provider Secondary Identification		Alliance doesn't provide proprietary identifiers to atypical providers.
2420E	REF	Ordering Provider Secondary Identification		Alliance doesn't provide proprietary identifiers to atypical providers.
2420F	REF	Referring Provider Secondary Identification		Alliance doesn't provide proprietary identifiers to atypical providers.
2430	CAS	Claim Line Adjustments	CAS*PR*1*	Alliance uses CAS PR*1 when reporting a deductible amount.
2430	CAS	Claim Line Adjustments	CAS*PR*2*	Alliance uses CAS PR*2 when reporting a co-insurance amount.
2430	CAS	Claim Line Adjustments	CAS*PR*3*	Alliance uses CAS PR*3 when reporting a co-payment amount.
2430	CAS	Claim Line Adjustments	CAS*CO*45*	Alliance uses CAS*CO* 45 when reporting a non-covered amount (contractual obligations).
2430	CAS	Claim Line Adjustments	CAS*CO*253*	Alliance uses CAS*CO* 253 when reporting a sequestration amount (contractual obligations).
2440	LQ	Form Identification Code		Alliance does use information in this loop.

3.2 005010X223 Health Care Claim: Institutional

Loop ID	Reference	Name	Codes	Notes/Comments
	BHT	Beginning of Hierarchical Transaction		
	BHT09	Claim Identifier	31 – Subrogation Demand	Alliance doesn't support receipt of Subrogation Demand claim transactions.
1000A	NM1	Submitter Name		

Loop ID	Reference	Name	Codes	Notes/Comments
1000A	NM109	Submitter Identifier		Provider's NPI or Clearinghouse ID#
1000B	NM1	Receiver Name		
1000B	NM103	Receiver Name		Use "Central California Alliance for Health" to identify the Alliance.
1000B	NM109	Receiver Primary Identifier		Use "770395311" to identify the Alliance.
2000A	PRV	Billing Provider Specialty Information		Alliance uses provider taxonomy during claim adjudication.
2000A	CUR	Foreign Currency Information		Alliance can't process currencies other than US Dollars.
2010AC	NM1	Pay-To-Plan Name		Alliance doesn't support receipt of subrogation payment requests electronically.
2000B	SBR	Subscriber Information		
2000B	SBR09	Claim Filing Indicator Code		Required data elements per TR3 Guide.
2010BA	REF	Subscriber Secondary Identification		Alliance doesn't use the social security number for additional identification.
2010BB	NM1	Payer Name		
2010BB	NM103	Payer Name		Use "Central California Alliance for Health".
2010BB	NM109	Payer Identifier		Use "770395311".
2010BB	REF	Payer Secondary Identification		Alliance doesn't use a secondary identifier.
2010BB	REF	Billing Provider Secondary Identification		Alliance doesn't support proprietary identifiers for atypical providers.
2000C	HL	Patient Hierarchical Level		Dependents can only be submitted to Alliance in the case of a baby that has not yet received a unique identifier.
2000C	PAT	Patient Information		
2000C	PAT01	Individual Relationship Code	19 - Child	This is the only relationship support by Alliance's business.
2300	DTP	Admission Date/Hour		This field is required per DHCS for LTC Inpatient claims
2300	REF	Service Authorization Exception Code		Alliance doesn't use this information.
2300	REF	Prior Authorization		Prior authorization field has to be mapped at claim header only. The Alliance no longer accepts this field at the claim level.

Loop ID	Reference	Name	Codes	Notes/Comments
2300	REF	Claim Identifier for Transmission Intermediaries		Alliance does/doesn't capture and return this number in the claim acknowledgement.
2300	REF	Demonstration Project Identifier		Alliance doesn't participate in demonstration projects.
2300	NTE	Claim Note		This field is informational only and is mapped to a remarks field.
2300	NTE	Billing Note		This field is informational only and is mapped to a remarks field.
2300	HI	Diagnosis Related Group Information		Alliance contracts do not require providers to identify the DRG.
2300	HI	Treatment Code Information		Alliance contracts do not require that providers report treatment information.
2310A	PRV	Attending Provider Specialty Information		Alliance adjudication uses specialty information.
2310A	REF	Attending Provider Secondary Identifier		Alliance doesn't provide proprietary identifiers to atypical providers.
2310B	REF	Operating Physician Secondary Identification		Alliance doesn't provide proprietary identifiers to atypical providers.
2310C	REF	Other Operating Physician Secondary Identification		Alliance doesn't provide proprietary identifiers to atypical providers.
2310D	REF	Rendering Provider Secondary Identification		Alliance doesn't provide proprietary identifiers to atypical providers.
2310E	REF	Service Facility Location Secondary Identification		Alliance doesn't provide proprietary identifiers to atypical providers.
2310F	REF	Referring Provider Secondary Identifier		Alliance doesn't provide proprietary identifiers to atypical providers.
2320	SBR	Other Subscriber Information		
2320	SBR09	Claim Filing Indicator	MA – Medicare Part A MB – Medicare Part B Insurance	Required data elements per TR3 Guide.
2320	AMT	Coordination of Benefits Total Non-covered Amount		Alliance does not have a cost avoidance policy that allows bypassing any prior payers.
2330	REF	Prior Authorization		Prior authorization field has to be mapped at claim header only. The Alliance no longer accepts this field at the claim level.
2400	SV2	Institutional Service Line		

Loop ID	Reference	Name	Codes	Notes/Comments
2400	SV202-01	Product or Service ID Qualifier	HC – HCPCS Codes	Alliance only adjudicates HCPCS codes.
2400	SV207	Line Item Denied Charge or Non-covered Charge Amount		Alliance doesn't use this during adjudication.
2400	DTP	Service Date		Alliance adjudication is not impacted by drug duration or the date that a prescription was written.
2400	AMT	Service Tax Amount		There are no requirements to report Service Tax Amounts.
2400	AMT	Facility Tax Amount		There are no requirements to report Service Tax Amounts.
2410	LIN	Drug Identification		There are no government regulation mandates that prescribed drugs and biologics are reported with NDC numbers that apply to claims submitted to Alliance.
2420A	REF	Operating Physician Secondary Identification		Alliance doesn't provide proprietary identifiers to atypical providers.
2420B	REF	Other Operating Physician Secondary Identification		Alliance doesn't provide proprietary identifiers to atypical providers.
2420C	REF	Rendering Provider Secondary Identification		Alliance doesn't provide proprietary identifiers to atypical providers.
2420D	REF	Referring Provider Secondary Identification		Alliance doesn't provide proprietary identifiers to atypical providers.

3.3 005010X279 Health Care Eligibility Benefit Inquiry (270)

Loop ID	Reference	Name	Codes	Notes/Comments
	BHT	Beginning of Hierarchical Transaction		
	BHT02	Transaction Set Purpose	01	Alliance doesn't support reporting of spend down in the 270 transaction and therefore doesn't support a spend down cancellation.
	BHT03	Submitter Transaction Identifier		Alliance does support real time eligibility.
	BHT06	Transaction Type Code	RT	Alliance doesn't support reporting of spend down in the 270 transaction.
2100A	NM1	Information Source Name		

Loop ID	Reference	Name	Codes	Notes/Comments
	NM103	Information Source Last or Organization Name		Use “Central California Alliance for Health” to identify the Alliance.
	NM108	Identification Code Qualifier	FI	Until a mandate for the National Plan ID, identify Alliance by tax identification number.
	NM109	Information Source Primary Identifier		Use “770395311” to identify the Alliance.
2100C	REF	Subscriber Additional Identification		Alliance has no alternate search options that need a subscriber additional identification.
2100C	N3	Subscriber Address		Alliance has no alternate search options that need a subscriber address.
2100C	N4	Subscriber City, State, ZIP Code		Alliance has no alternate search options that need a subscriber city, state and ZIP code.
2100C	PRV	Provider Information		Alliance does process this information in creating a response when the patient is enrolled in our HMO.
2100C	HI	Subscriber Health Care Diagnosis Code		Alliance does not support inquiries at this level of functionality.
2100C	DTP	Subscriber Date		Alliance responds to all inquiries with eligibility information based upon the date processed and doesn’t make use of this information.
2110C	EQ	Subscriber Eligibility or Benefit Inquiry		
	EQ01	Service Type Code	30	Alliance supports benefit information for the listed Service Type Codes.
	EQ02	Composite Medical Procedure Identifier		Alliance doesn’t support procedure specific benefit requests.
	EQ03	Coverage Level Code		Alliance does not support this functionality.
2000D	HL	Dependent Level		Alliance only supports dependents when a baby has been born to a covered mother and the baby has not yet received its own identification within our system. All 2000C loop notes apply to the related parts of the 2000D loop and are not repeated here.

3.4 005010X279 Health Care Eligibility Benefit Response (271)

Loop ID	Reference	Name	Codes	Notes/Comments
	BHT	Beginning of Hierarchical Transaction		
	BHT02	Transaction Set Purpose	06	Alliance doesn’t support reporting of spend down in the 270 transaction and therefore doesn’t support a spend down cancellation confirmation.

Loop ID	Reference	Name	Codes	Notes/Comments
	BHT03	Submitter Transaction Identifier		Alliance does return the BHT03 from the request (when present) in the 271.
	BHT05	Transaction Set Creation Time		This will be the time based upon the Pacific Time Zone.
2100A	NM1	Information Source Name		
	NM103	Information Source Last or Organization Name		Use “Central California Alliance for Health” to identify the Alliance.
	NM108	Identification Code Qualifier	FI	Until a mandate for the National Plan ID, Alliance uses the tax identification number.
	NM109	Information Source Primary Identifier		Alliance sends “770395311” to identify the Alliance.
2000C	TRN	Subscriber Trace Number		Alliance doesn’t assign an additional unique trace number for the response.
2100C	REF	Subscriber Additional Identification		Alliance doesn’t require additional identifiers on subsequent transactions and does not populate any beyond what is required from the 270 request.
2100C	HI	Subscriber Health Care Diagnosis Code		Alliance doesn’t use diagnosis information from a 270 to determine benefits, so this segment is not supported in the response.
2110C	EB	Subscriber Eligibility or Benefit Information		
	EB01	Eligibility or Benefit Information	1, 6, B, L	Alliance only sends the listed codes.
	EB02	Benefit Coverage Level Code	IND, ECH	Alliance only sends the listed codes. ECH is only used to identify benefits for a covered party and her baby, prior to the baby qualifying for separate benefits.
	EB03	Service Type Code		Alliance only returns the codes listed under the 270 transaction 2110C EQ01 above.
	EB04	Insurance Type Code		Alliance doesn’t require this information on subsequent transactions and does not send it in the 271.
	EB13	Composite Medical Procedure Identifier		Alliance doesn’t support Medical Procedure Code based 271 transactions or use a medical procedure from a 270 to determine benefit responses.
	EB14	Composite Diagnosis Code Pointer		Alliance doesn’t use diagnosis information from a 270 to determine benefits, so this composite is not supported in the response.
2110C	REF	Subscriber Additional Identification		Alliance doesn’t require additional identifiers on subsequent transactions and does not populate any beyond what is required from the 270 request.

Loop ID	Reference	Name	Codes	Notes/Comments
2000D	HL	Dependent Level		Alliance only reports Dependent Level information for newborns that have not yet been entered into our system with separate coverage. Once entered, the newborn is a subscriber and is listed in the 2000C loop. Usage of this loop mirrors that of the related parts of the 2100C loop, and is not listed here separately.

3.5 005010X212 Health Care Claim Status Request (276)

Loop ID	Reference	Name	Codes	Notes/Comments
2100A	NM1	Payer Name		
	NM103	Payer Name		Use “Central California Alliance for Health” to identify the Alliance.
	NM108	Identification Code Qualifier	PI	Until a mandate for the National Plan ID, identify Alliance by Payer Identification.
	NM109	Payer Identifier		Use “770395311” to identify the Alliance by Tax ID.
2100B	NM1	Information Receiver Name		
	NM109	Information Receiver Identification Number		Provider’s NPI or Clearinghouse ID#
2200D	REF	Application or Location System Identifier		Alliance does not assign Application or Location System Identifiers
2200E	REF	Application or Location System Identifier		Alliance does not assign Application or Location System Identifiers

3.6 005010X212 Health Care Information Status Notification (277)

Loop ID	Reference	Name	Codes	Notes/Comments
2100A	NM1	Payer Name		
	NM103	Payer Name		Alliance sends “Central California Alliance for Health” to identify the Alliance.
	NM108	Identification Code Qualifier	FI	Until a mandate for the National Plan ID, Alliance uses a Payer identification number.
	NM109	Payer Identifier		Alliance uses “770395311” to identify the Alliance by tax ID.
2100A	PER	Payer Contact Information		Alliance will always provide claim status contact information.
2100B	NM1	Information Receiver Name		

Loop ID	Reference	Name	Codes	Notes/Comments
	NM109	Information Receiver Identification Number		Provider's NPI or Clearinghouse ID#
2200C	TRN	Provider of Service Trace Number		
	TRN02	Provider of Service Information Trace Identifier		When rejecting a Claim Status Request based upon errors at the provider level, Alliance will use Claims Control Number (CCN) as the Trace Identifier.
2200D	REF	Voucher Identifier		Alliance does not assign voucher identifiers
2200E	REF	Voucher Identifier		Alliance does not assign voucher identifiers

3.7 005010X221A1 Health Care Claim Payment/Advice (835)

Loop ID	Reference	Name	Codes	Notes/Comments
	BPR	Financial Information		
	BPR01	Transaction Handling Code	H, I	Alliance only uses the listed codes.
	BPR04	Payment Method Code	CHK, NON	Alliance only uses the listed codes.
	TRN	Re-association Trace Number		
	TRN03	Payer Identifier		Use "1770395311" to identify the Alliance.
	TRN04	Originating Company Supplemental Code		Alliance doesn't use this element.
1000A	N1	Payer Identification		
	N101	Payer Name		Alliance sends "Central California Alliance for Health".
1000A	REF	Additional Payer Identification		Alliance does not send this segment.
2000	LX	Header Number		Alliance does not sort claims and only sends one 2000 loop per 835.
2100	REF	Other Claim Related Identifiers		
	REF02	Other Claim Related Identifier	F8	Alliance does send this identifier with correction claims since the Alliance claim number changes during the re-adjudication process.
2110	REF	Healthcare Policy Identification		Alliance does not send this information at this time.

4 Additional Information

The following sections are under development.

4.1 Business Scenarios

This section is under development.

4.2 Payer Specific Business Rules and Limitations

This section is under development.

4.3 FAQ for 5010 837 Professional Claims - 005010X222

- Who can be considered a Billing Provider?
  In 5010, the billing provider must be a provider of health care services and can no longer be a billing service or clearinghouse. The Billing Provider field information must be that of a health care service provider.
- What are the Billing Provider Address Requirements?
  The billing provider address must be a physical street address and can no longer be a PO Box or Lock Box. In ANSI 5010 format, there is a Pay-To address in addition to the physical address if the provider prefers to send payments to another location. This Pay-To address can be a PO Box or Lock Box.
- What are the Zip Code Requirements?
  5010 requires a valid 9-digit zip code for Billing Provider address, Facility address, and Pay-To address. Claims submitted without valid 9-digit zip codes in the required locations of the Billing Provider address, Facility address, and Pay-To address will be rejected.
- Which segments are used for the Tax ID and the NPI for the Billing Provider?
  The Tax ID (Social Security number or TIN) is reported in the REF segment of the Billing Provider Loop. An NPI must be reported if the billing provider is eligible for one and will remain in segment NM109 of the Billing Provider Loop.
- What are the new requirements for Anesthesia Claims?
  In 5010 the SV104 segment must report time in minutes and not in units in order to pass compliance.
- What is required when reporting drugs using an NDC code (Loop 2410)?
  In 5010 the CTP line segment requires the reporting of the quantity of the drug. The CTP segment for NDC codes must be present with the quantity reported or the claim will be rejected.
- What are the new requirements for Diagnosis Codes (DX)?
  In 5010, the Diagnosis Codes (DX) are now required on all claims. The maximum number of Diagnosis Codes was increased to 12 in 5010 in preparation for the migration to ICD-10 Diagnosis Codes. This change also changes the range of Diagnosis Code Pointers to accept values 1-12.

4.4 FAQ for 5010 837 Institutional Claims - 005010X223

- Who can be considered a Billing Provider?
  In 5010, the billing provider must be a provider of health care services and can no longer be a billing service or clearinghouse. The Billing Provider field information must be that of a health care service provider.

- What are the Billing Provider Address Requirements?
  The billing provider address must be a physical street address and can no longer be a PO Box or Lock Box. In ANSI 5010 format, there is a Pay-To address in addition to the physical address if the provider prefers to send payments to another location. This Pay-To address can be a PO Box or Lock Box.
- What are the Zip Code Requirements?
  5010 requires a valid 9-digit zip code for Billing Provider address, Facility address, and Pay-To address. Claims submitted without valid 9-digit zip codes in the required locations of the Billing Provider address, Facility address, and Pay-To address will be rejected.
- Which segments are used for the Tax ID and the NPI for the Billing Provider?
  The Tax ID (Social Security number or TIN) is reported in the REF segment of the Billing Provider Loop. An NPI must be reported if the billing provider is eligible for one and will remain in segment NM109 of the Billing Provider Loop.
- What are the new requirements for Anesthesia Claims?
  In 5010 the SV104 segment must report time in minutes and not in units in order to pass compliance.
- What is required when reporting drugs using an NDC code (Loop 2410)?
  In 5010 the CTP line segment requires the reporting of the quantity of the drug. The CTP segment for NDC codes must be present with the quantity reported or the claim will be rejected.
- What are the changes and requirements for the HI Segment?
  - Principal Procedure Information - Loop 2300
    Code list Qualifier Code BP (CPT) no longer exists in 5010;
  - Other Procedure Information - Loop 2300
    Code list Qualifier Code BO (CPT) no longer exists in 5010;
  - Patient's Reason for Visit - Loop 2300
    In 5010 - Required when claim involves outpatient visits. If not required by this implementation guide, do not send. The ZZ code in 5010 will be changed to a PR code in the HI Segment - Patient's reason for Visit.
  - External Cause of Injury - Loop 2300
    In 5010 - Required when an External Cause of Injury is needed to describe an injury, poisoning, or adverse effect. If not required by this implementation guide, do not send. The BN code from Principal Diagnosis HI segment will map to the new segment.
- What are the changes and requirements for the CL Segment?
  In 5010, the Patient Status Code is required for both Inpatient and Outpatient Services.

4.5 Other Resources

This section is under development.

4.6 Change Summary

This section describes the differences between the current Companion Guide and the previous guide(s).

Version	Release Date	Changes Description
1.0	January 2012	First version of the document.
2.0	January 2012	Updated paragraph prior to the Preface. Date and version number updated.
3.0	February 2012	Added Section 4.3 Frequently Asked Questions for 5010 837 claims submission.
3.1	April 2012	Updated the notes/comments for the NTE section in the Professional transaction table.

Version	Release Date	Changes Description
3.2	April 2012	Updated the notes/comments for the NTE section in the Institutional transaction table.
3.3	April 2015	Added crossover loops and segments for 837 Transactions.
3.4	October 2016	Added Admission Date/Hour DTP requirement for inpatient claims per DHCS as of 08/10/2016; added Prior Authorization REF mapping requirements on claim header only – no longer accepted on claim level as of 10/01/2016.