ASC X12N/005010X223 HEALTH CARE CLAIM INSTITUTIONAL (837)

This Addendum to the Companion Guide is intended as an addition to the ASCX12 Implementation Guides adopted under HIPAA to clarify and specify situational data elements and plan-specific values that must be included in transactions that are transmitted electronically to South Dakota Medicaid. Transactions based on the information contained in this document, used in tandem with the X12 Implementation Guides, will help ensure compliance with both X12 syntax and usage.

Page No.	Loop ID	Reference	Name	Codes	Length	Notes / Comments
C.7	None	GS	Functional Group			
C.8	None	GS08	Version / Release	005010X223A2		South Dakota Medicaid will only support Health Care Claim Institutional transactions that incorporate the changes identified in the addenda published June 2010, modifying the transactions that were originally published as 005010X223 published May 2006.
76	1000B		Receiver Name			This loop indicates the identity of the entity you are submitting electronic transactions to.
77	1000B	NM109	Receiver Primary Identifier	SD48MED		All transactions should contain the ID "SD48MED" to identify SD Medicaid as the claim receiver. Any transaction received without this ID will be rejected.
80	2000A	PRV	Billing Provider Specialty Information			The 2000A Loop PRV Segment is required by SD Medicaid.
80	2000A	PRV01	Provider Code	BI		A value of BI (Billing) is required.
80	2000A	PRV03	Reference Identification		10	Billing Provider Taxonomy Code.
84	2010AA		Billing Provider Name			The billing entity does not have to be a health care provider, however the NPI submitted must be known to SD Medicaid and also listed as a billing entity for the Rendering Provider. Must be a street address.
86	2010AA	NM108	Identification Code Qualifier	XX		The Identification Code Qualifier must have a value of XX.
86	2010AA	NM109	Billing Provider Primary Identifier		10	Health Care Financing Administration National Provider Identifier (NPI).
89	2010AA	N403	Billing Provider ZIP Code		9	The nine character ZIP code is required (no hyphens).
94	2010AB		Pay-to Address Name			Required when the address for payment is different than what was sent in the 2010AA Loop. If the Billing Provider wishes to utilize a Post Office Box or Lock Box the address must then be sent in this Loop.
98	2010AB	N403	Pay-to Provider ZIP Code		9	If applicable, a nine character ZIP code is required (no hyphens).
107	2000B		Subscriber Level			This loop identifies the individual Subscriber (SD Medicaid Recipient) receiving services.
108	2000B	HL04	Hierarchical Child Code	0		SD Medicaid does not support or process claims at the Dependent level. A value of 0 should always be used.
111	2000B	SBR09	Claim Filing Indicator Code	MC		A value of MC (Medicaid) is required.
112	2010BA		Subscriber Name			This loop identifies the full name and address of the individual Subscriber (SD Medicaid Recipient) receiving services.
114	2010BA	NM108	Identification Code Qualifier	MI		A value of MI (Member Identification Number) is required.
114	2010BA	NM109	Subscriber Primary Identifier		14	This element should contain the South Dakota Medicaid Recipient ID that was assigned to the individual Subscriber (SD Medicaid Recipient).
122	2010BB		Payer Name			This loop identifies the Payer.
123	2010BB	NM108	Identification Code Qualifier	PI		A value of PI (Payer Identification) is required.
123	2010BB	NM109	Payer Identifier	SD48MED		All Medicaid claim transactions should contain the ID "SD48MED" to identify SD Medicaid as the Payer. Any transaction received without this ID will be denied.
131	2000C		Patient Level			This loop identifies the Subscriber's Dependents. SD Medicaid does not process Dependent related data from the 2000C Loop. The Subscriber must be the Patient and should be fully contained in the 2000B Loop data for SD Medicaid to process correctly. Any data sent within this loop will be ignored.
160	2300	AMT	Patient Estimated Amount Due			If submitted on a Nursing Home claim the value sent in AMT02 must match the cost share amount on record for the Subscriber (SD Medicaid Recipient).
184 220	2300	HI	Diagnosis Information			Up to 8 diagnosis codes are supported by SD Medicaid at this time. E-codes cannot be used as the Principal / Admitting / Reason For Visit diagnosis.
193	2300	HI	External Cause of Injury			This segment is not supported by SD Medicaid at this time.
218	2300	HI	Diagnosis Related Group Information			This segment is not supported by SD Medicaid at this time.
319	2310A		Attending Provider Name			This loop is required and identifies the individual who has overall responsibility for rendering services to the Subscriber. This is required to be a Type 1 NPI.
319	2310A	NM108	Identification Code Qualifier	XX		The Identification Code Qualifier must have a value of XX.
319	2310A	NM109	Attending Provider Primary Identifier		10	Health Care Financing Administration National Provider Identifier (NPI).

322	2310A	PRV	Attending Provider Specialty Information			The 2310A Loop PRV Segment should be included when the Taxonomy of the Attending Provider is different than that submitted for the Billing Provider in the 2000A Loop PRV Segment.
322	2310A	PRV01	Provider Code	AT		A value of AT (Attending) is required.
322	2310A	PRV03	Reference Identification		10	Attending Provider Taxonomy Code.
341	2310E		Service Facility Location Name			This loop is required when the Service Location is different than that submitted in the 2010AA Loop. If a Provider has multiple Payee ID Numbers with the same Billing NPI, Attending NPI, and Taxonomy the 9 character ZIP code is used to differentiate between them.
341	2310E	NM108	Identification Code Qualifier	XX		The Identification Code Qualifier must have a value of XX.
341	2310E	NM109	Laboratory or Facility Primary Identifier		10	Health Care Financing Administration National Provider Identifier (NPI).
345	2310E	N403	Laboratory or Facility ZIP Code		9	If applicable, a nine character ZIP code is required (no hyphens).
349	2310F		Referring Provider Name			This loop identifies the individual or organization that referred the Subscriber to the Attending Provider.
349	2310F	NM102	Entity Type Qualifier	1		A value of 1 (Person) is required.
349	2310F	NM104	Referring Provider First Name		1-35	If reporting a facility or organization it is recommended that this element be populated.
349	2310F	NM108	Identification Code Qualifier	XX		The Identification Code Qualifier must have a value of XX.
349	2310F	NM109	Referring Provider Primary Identifier		10	Health Care Financing Administration National Provider Identifier (NPI).
354	2320		Other Subscriber Information			This loop contains information about the paying and other Insurance Carriers for the Subscriber (SD Medicaid Recipient), the Subscriber of these other Insurance Carriers, and the School or Employer Information for the Subscriber (SD Medicaid Recipient) at the claim level.
358	2320	CAS02 CAS05 CAS08 CAS11 CAS14 CAS17	Claim Adjustment Reason Code		1-5	Deductible should be reported using an adjustment reason code of 1. Co-insurance should be reported using an adjustment reason code of 2. Psych deductible should be reported using an adjustment reason code of 122.
423	2400		Service Line			This loop contains service line level information.
424	2400	SV202-1	Product or Service ID Qualifier	HC		SD Medicaid uses the Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes.
424	2400	SV202-7	Description		1-80	Required when SV202-2 is a non-specific Procedure Code. Non-specific codes may include in their descriptors terms such as: Not Otherwise Classified (NOC); Not Otherwise Specified (NOS); Unlisted; Unspecified; Unclassified; Other; Miscellaneous; Prescription Drug, Generic; or Prescription Drug, Brand Name.
476	2430		Line Adjudication Information			This loop is to convey service line adjudication information for coordination of benefits between the initial payers of a health care claim and all subsequent payers at the service line level.
480	2430	CAS02 CAS05 CAS08 CAS11 CAS14 CAS17	Adjustment Reason Code		1-5	Deductible should be reported using an adjustment reason code of 1. Co-insurance should be reported using an adjustment reason code of 2. Psych deductible should be reported using an adjustment reason code of 122.