THE WELLCARE GROUP OF COMPANIES
EDI TRANSACTION SET
837P X12 HEALTH CARE
FFS CLAIM PROFESSIONAL
ASC X12N VERSION **5010A1**
COMPANION GUIDE

Inbound
837 Professional
Claims Submission

Table of Contents

REVISION HISTORY

Date	Rev #	Author	Description
06/11/2010	1.0 Review	Craig Smitman	State Review
02/25/2011	1.01 Update	Craig Smitman	Updated Verbiage for errata dates
02/25/2011	1.01 Update	Craig Smitman	Updated the Clearinghouse verbiage
02/25/2011	1.01 Update	Craig Smitman	Updated the File Size Requirements
06/14/2011	1.02 Update	Craig Smitman	Updated the Verbiage for COB – MOOP
06/20/2011	1.02 Update	Craig Smitman	Updated the Verbiage to add the all "The Plans" and added a page that has all The Plans names on it.
12/19/2011	2.0 Review / Update	Lee Falk	Updated Guide with Business Requirements
12/27/2011	2.01 Update	Craig Smitman	Updated the Guide with KY Requirements and small revisions
06/10/2013	2.02 Update	Lee Falk	Updated the verbiage for Taxonomy code, COB and paper requirements
09/16/2013	2.03 Update	Craig Smitman	Updated some verbiage in the guide
09/17/2013	2.04 Update	Craig Smitman / Damaryes Escribano	Added ICD-10 Mandate Business Rule and updated the Paper Claim Submission verbiage
10/04/2013	2.05 Update	Craig Smitman / GA Market	Updated the ICD-10 Verbiage to add Date of Service as part of the Mandate.
12/06/2013	2.06 Update	Craig Smitman	Removed the Encounter File Upload for Direct Submitters section since this FFS Guide.
08/06/2014	2.07 Update	Craig Smitman / Tiffany Hilleary	Updated the ICD-10 Start Date and added New States for Windsor and removed EAS Logo. Updated the E-Mail in the Contact Roster
08/30/2015	2.08 Update	Craig Smitman / Fran Meadows	Removed KY Requirements
10/29/2015	2.09 Update	Craig Smitman	Updated the Guide with IA Requirements
08/03/2016	2.10 Update	Craig Smitman	Update the Guide with NE Requirements Removed the IA Requirements Removed Windsor Logo
08/12/2016	2.11 Update	Craig Smitman / Edouard Desruisseaux / Tiffany Hilleary	Updated the WellCare Group of Companies, State Affiliation and Added Referring Provider State License and Spinal Manipulation Service Notes
09/07/2016	2.12 Update	Craig Smitman / Edouard Desruisseaux	Made a change the NE in the Referring Provider State License Note. Changed NTE to REF.

CONTACT ROSTER

Trading Partners and Providers: for questions, concerns or testing information, please email the following:	
EDI Coordinator/Testing	
EDIAnalyst@wellcare.com	Multi group supported email distribution

INTRODUCTION

The WellCare Group of Companies ("The Plan") used the standard format for Claims Data reporting from Providers and Trading Partners (TPs). The Plan X12N 837 Professional Claim "Companion Guide" is intended for use by The Plan's Providers and Trading Partners (TPs) in conjunction with HIPAA ANSI ASC X12N Technical Report Type 3 Electronic Transaction Standard (Version –TR3) and its related errata X222A1 Implementation Guide.

The Reference HIPAA TR3 for this Companion Guide is the ANSI ASC X12N 837P TR3 Version – 005010X222 and its related errata X222A1

- UAT 5010 X222A1 Start Date – 09/01/2011 for inbound FFS claims
- Production 5010 X222A1 Start Date – 01/01/2012 for inbound FFS claims
- Production 5010 X222A1 Mandate Date – 04/01/2012 for inbound FFS claims

The Plan's Companion Guides have been written to assist those Providers and Vendors who will be implementing the X12 837 Healthcare Claim Professional transactions but does not contradict, disagree, oppose, or otherwise modify the HIPAA Technical Report Type 3 (TR3) in a manner that will make its implementation by users to be out of compliance.

Using this Companion Guide does not mean that a claim will be paid. It does not imply payment policies of payers or the benefits that have been purchased by the employer or subscriber. This Companion Guide clarifies the HIPAA-designated standard usage and must be used in conjunction with the following document:

The 837 Professional Healthcare Claim TR3 Implementation Guides (IG)

To purchase the IG, contact Washington Publishing Company at **www.wpc-edi.com**.

This Companion Guide contains data clarifications derived from specific business rules that apply exclusively to claims processing for The Plan. Field requirements are located in the ASC X12N 837I (005010X222A1) TR3 Implementation Guide.

Submitters are advised that updates will be made to the Companion Guides on a continual basis to include new revisions to the web sites below. Submitters are encouraged to check our website periodically for updates to the Companion Guides.

The WellCare Group of Companies (The Plan)

'Ohana Health Plan, a plan offered by WellCare Health Insurance of Arizona, Inc.

WellCare Health Insurance of Illinois, Inc.

WellCare Health Insurance of New York, Inc.

WellCare Health Plans of New Jersey, Inc.

WellCare of Nebraska, Inc.

WellCare of Louisiana, Inc.

WellCare of New York, Inc.

WellCare of Connecticut, Inc.

WellCare of Georgia, Inc.

Harmony Health Plan of Illinois, Inc.

Easy Choice California

WellCare of Texas, Inc.

Healthy Connections Prime

Missouri Care, Inc.

WellCare of South Carolina, Inc.

Easy Choice Health Plan

WellCare of Kentucky, Inc.

WellCare Health Plans of Kentucky, Inc.

WellCare of Ohio, Inc.

WellCare of Florida, Inc., operating in Florida as Staywell and Staywell Kids

State Affiliations

This Guide covers further clarification to Providers and TPs on how to report claims to The Plan. The Plan provides services in the following states:

Arizona – Medicare
Arkansas – Medicare
California – Medicare/Medicaid
Connecticut – Medicare/Medicaid
Florida – Medicare/Medicaid
Georgia – Medicare/Medicaid
Hawaii – Medicare/Medicaid
Illinois – Medicare/Medicaid
Indiana – Medicare
Kentucky – Medicaid/Medicare
Louisiana – Medicare
Mississippi – Medicare
Missouri – Medicare/Medicaid
Nebraska – Medicaid
New York – Medicare/Medicaid
New Jersey – Medicare/Medicaid
Ohio – Medicare
South Carolina – Medicaid / Medicare
Texas – Medicaid
Tennessee – Medicare

Front-End WEDI SNIP Validation

The Front-End System, utilizing EDIFECS Validation Engine, will be performing the Workgroup for Electronic Data Interchange (WEDI) Strategic National Implementation Process (SNIP) Validation. Any claims that do not pass WEDI SNIP Validations will be rejected. Below are a few examples of the Health Plans SNIP level requirements:

WEDI SNIP Level 1: EDI Syntax Integrity Validation

- Syntax errors also referred to as Integrity Testing, which is at the file level. This level will verify that valid EDI syntax for each type of transaction has been submitted. When these errors are received the entire file will be rejected back to the submitter. Errors can occur at the file level, batch level within a file or individual claim level. It is therefore possible that an entire file or just part of a file could be rejected and sent back to the submitter when one of these errors is encountered.

  Examples of these errors include but are not limited to:
  - Invalid date or time
  - Invalid telephone number
  - The data element is too long (i.e., the claim form field expects a numerical figure 9 characters long but reads 10 or more characters)
  - Field 'Name' is required on the Reject Response Transaction (i.e. Field 'ID' is missing. It is required when Reject Response is "R")
  - A slash is not allowed as a value for dates (i.e., date of service is expected to be in a numerical format of CCYYMMDD. MM/DD/CCYY is incorrect.)

WEDI SNIP Level 2: HIPAA Syntactical Requirement Validation

- This level is for HIPAA syntax errors. This level is also referred to as Requirement Testing. This level will verify that the transaction sets adhere to HIPAA Implementation guides.

  Examples of these errors include but are not limited to:
  - Social Security Number is not valid.
  - Procedure Date is required when ICD are reported.
  - Claim number limit per transaction has been exceeded.
  - 'Name' is required when ID is not sent.
  - Revenue Code should not be used when it is already used as a Procedure Code.
  - NPI number is invalid for 'Name'.
  - State code is required for an auto accident.
  - Employer Identification Number (EIN) is invalid.
  - Missing/invalid Patient information. Member identification missing or invalid. Patient's city, state, or ZIP is missing or invalid.
  - Invalid character or data element. The data element size is invalid or has invalid character limits.
  - Missing NPI. WellCare requires NPI numbers on claims as of May 23, 2008 in accordance with HIPAA guidelines. An NPI must be a valid 10-digit number.
  - Legacy ID still on claim. Legacy numbers include Provider IDs, Medicaid and Medicare IDs, UPIN and State License numbers. All legacy numbers need to be removed from claims.

WEDI SNIP Level 3: Balancing Validation

- This level is for balancing of the claim. This level will validate the transactions submitted for balanced field totals and financial balancing of claims.

  Examples of these errors include but are not limited to:
  - Total charge amount for services does not equal sum of lines charges.
  - Service line payment amount failed to balance against adjusted line amount.

WEDI SNIP Level 4: Situational Requirements

- This level is for Situation Requirements/Testing. This level will test specific inter-segment situations as defined in the implementation guide, where if A occurs, then B must be populated.

  Examples of these errors include but are not limited to:
  - If the claim is for an auto accident, the accident date must be present.
  - Patient Reason for Visit is required on unscheduled outpatient visits.
  - Effective date of coverage is required when adding new coverage for a member.
  - Physical address of service location is required for all places of service billed.
  - Referral number is required when a referral is involved.
  - Subscriber Primary ID is required when Subscriber is the Patient.
  - Payer ID should match to the previously defined Primary Identifier of Other Payer.

WEDI SNIP Level 5: External Code Set Validation

- This level not only validates the code sets, but also ensures the usage is appropriate for any particular transaction and appropriate with the coding guidelines that apply to the specific code set.

  Examples of these errors include but are not limited to:
  - Validated CPT code
  - ICD Codes
  - ZIP code
  - National Drug Code (NDC)
  - Taxonomy Code validation
  - State code
  - Point of Origin for Admission or Status Codes
  - Adjustment Reason Codes and their appropriate use within the transaction

WEDI SNIP Level 7: Custom Health Plan Edits

- This level is intended for specific business requirements by the Health Plan that are not covered within the WEDI SNIP or the Implementation Guide.

Paper Claim Submission

For Optical Character Recognition (OCR) from paper to EDI, all paper claims must meet the criteria below to be submitted as a "Clean EDI Claim" for The Plan EDI Gateway and Core Systems Adjudication.

- The Health Plan requires a "Clean EDI Claim" submission for all paper claims.
  - This means that the claims must be in the nationally accepted HIPAA paper format along with the standard coding guidelines with no further information, adjustments, or alteration in order to be processed and paid by the Health Plan.

- Paper claims must be submitted on the original "Red and White Claims" CMS-1500 Claim Forms or their successor with "drop out" red ink.
  - Beginning 4/1/2014, The Plan will only accept CMS-1500 claims forms on the 02/12 version.
  - The Plan will be following the same release schedule as outlined by CMS for the use of the new CMS-1500 claim form as defined in the June 27, 2013 MLN Connects Provider eNews on the **www.cms.gov** site.

- In addition to CMS mandating the use of Red Claims, the Health Plan requires certain standards, since all paper claims are read through OCR software. This technology allows The Plan to process claims with greater accuracy and speed.
  - All forms should be printed or typed in **large**, capitalized black font.
  - The font theme should be **Arial** with a point size of **10, 11, or 12**.

- After OCR, all paper claims are subjected to WEDI SNIP Validation.

- The Health Plan will not accept the following:
  - Handwritten claims
  - Faxed or altered claim forms
  - Black and white copied forms
  - Outdated CMS claim forms

Electronic Submission

The Plan can only process one (1) ISA GS and IEA GE Segments per File sent. The Plan can process Multiple ST & SE Transactions of the Same Transaction Type with in the ISA GS and IEA GE Segments

Professional Fee-for-Service (FFS) Claims submitted using the TS3 format must be in a separate file from all Encounter reporting.

When sending Professional FFS Claims, The Plan expects the BHT06 to be:

- FFS Claims Identifier (BHT06) has to be set to "**CH**" (Chargeable).
- Encounters Claims Identifier (BHT06) has to be set to "**RP**" (Reporting). See the *Encounter Companion Guides* for complete details on files and validation requirements.
- The Plan will not process "**31**" (Subrogation Demand) Claims. These claims will be rejected.

File Size Requirements

The following list outlines the file sizes by transaction type:

Transaction Type	Testing Purposes	Production Purposes
837 formats – FFS claims	50-100 claims	< 5000 claims per ST/SE. 10 ST/SE per file.

Submission Frequency

We process files 24 hours a day, 7 days a week, 365 days per year.

Fee-for-Service Clearinghouse Submitters

All Fee-for-Service (FFS) Providers and Vendors must send their claims through a Clearinghouse. See The Plan's *Quick Reference Guide* (QRG) for the preferred clearinghouse's contact information along with the Payer ID number. Also, most clearinghouses can exchange data with one another, and generally have a TP agreement with each other. Please contact your clearinghouse for The Plan Payer ID to use for claim routing and any other pertinent IDs.

THE PLAN SPECIFIC INFORMATION

Highlighted Business Rules

Patient (Dependent):

The Plan will reject and will not pay any (FFS) claims, which have indicated that the patient is the dependent. These loops consist of the following:

- Patient Hierarchical (2000C) Loop
- Patient Name (2010CA) Loop

All Newborn and Dependents must have Medicaid or Medicare ID as per the States and CMS requirements. The Members' IDs must be in the Subscriber Loops that consist of the following:

- Subscriber Hierarchical (2000B) Loop
- Subscriber Name (2010BA) Loop
- Payer Name (2010BB) Loop

Provider:

- The Billing Provider Name in Loop 2010AA may be a health care provider, a billing service, or some other representative of the provider that will receive the payment in the 835 transaction for FFS Claims.

- The Taxonomy Code within the Billing Provider Hierarchical Level (2000A) Loop (PRV) Segment is required for all FFS claim submissions and Encounter Submissions. The Taxonomy reported on the claim must match the Billing Provider's specialty, which is maintained by the Workgroup for Electronic Data Interchange (WEDI).

- Providers who perform care or services must be identified within the Rendering Provider Loop (2310B), when the Rendering Provider is not the same in the Billing Provider's Name (2010AA) Loop. If the Billing Provider (2010AA) and the Rendering Provider are the same, do not populate Loop 2310B. When using the 2310B Loop, The Plan requires that the Taxonomy Code is populated in the PRV Segment. The Taxonomy code must match the Rendering Provider's specialty, which is maintained by the Workgroup for Electronic Data Interchange (WEDI).

- The Plan requires the name and physical address where services were rendered in Service Facility Location Name in Loop 2310C, when the location of the health care service is different than the address within the Billing Provider Loop 2010AA. This loop must not contain a P.O. box in the Address (N3) Segment.

Patient Control Number:

The Plan requires that the Patient Control Number in the Claim Information (2300) Loop (CLM01) Segment be unique for each claim submitted.

Subscriber Gender:

The Plan will reject any claim that has the Subscriber Gender Code in the Subscriber Demographic Information (2010BA) loop as "U" – Unknown. This element must be "F" – Female or "M" – Male.

ICD-10 Mandate

As of Oct. 1, 2015, ICD-9 Diagnosis Codes cannot be used for services provided on or after this date. We will only accept ICD-10 Diagnosis Codes on all claims for Service Dates on or after Oct. 1, 2015, and we will reject any claims that have both ICD-9 and ICD-10 codes on the same claim after such date. Please refer to the CMS website for more information about ICD-10 diagnosis codes at **www.cms.gov**. Please see the NUCC guide for billing details. Please see 837 IG for EDI for correct qualifier to use with the ICD-10 diagnosis codes.

Prior Authorizations and/or Referral Numbers

The Plan requires all submitters to send the Prior Authorizations and/or Referral Numbers when assigned by The Plan. The Plan will deny any services as "Not Covered" if the services require an Authorization and/or Referral.

Valid National Provider Identifiers (NPI)

All submitters are required to use the National Provider Identification (NPI) numbers that are now required in the ANSI ASC X12N 837 as per the 837 Professional (TR3) Implementation Guide for all appropriate loops with the exception of atypical providers. Atypical providers must pre-register with The Plan before submitting claims to avoid NPI rejections. Atypical providers are classified as non-health care providers such as taxi drivers, carpenters, and personal care providers.

Corrected Claim Submission

Replacement (Adjustment) Claim or Void/Cancel Claim via EDI

When submitting a "Corrected Claim", use the appropriate Claim Frequency Type Code in the CLM05-3 segment. Please indicate whether for Replacement (Adjustment) of prior claim "7" or a Void/Cancel of prior Claim "8".

Also, per the Implementation Guide – when "7" or "8" is used as Claim Frequency Type Code for Replacement or Void/Cancel of Prior Claim Submission, the Claim Level information in Loop 2300 and segment REF with an F8 qualifier must contain The Plan's Claim Control Number (WCN) or The Plan's Van Trace, (formally known as the Original Reference Number). These numbers can be found in the 277CA (Claims Acknowledgement), which The Plan sends along with the 999 and the corresponding 277U (if requested).

To submit a corrected or voided claim via paper:

- For Institutional claims, provider must include the original WellCare claim number and bill frequency code per industry standards.
- For Professional claims, the provider must include the original WellCare claim number and bill frequency code per industry standards. When submitting a corrected or voided claim, enter the appropriate bill frequency code left justified in the left-hand side of Box 22.
-

Any missing, incomplete or invalid information in any field may cause the claim to be rejected.

Please Note: If you handwrite, stamp, or type "Corrected Claim" on the claim form without entering the appropriate Frequency Code "7" or "8" along with the Original Claim Number as indicated above, the claim will be considered a first-time claim submission.

The Correction Process involves two transactions:

1. The original claim will be reversed and noted with an adjustment reason code RV059 "Payment Reversal – payment lost/voided/missed." This process will deduct the prior payment. The Payment Reversal for this process may generate a negative amount, which may be offset from future payments rather than on the EOP that is sent out for the newly submitted corrected claim.

2. The corrected claim will be processed with the newly submitted information and noted with an adjustment code CL025 "Adjusted per corrected bill." This process will pay out the newly calculated amount on a new claim with a new claim number.

The Void Process involves two claims:

The original claim will be reversed and the subsequent claim submitted with an 8 (Void/cancel of prior claim) will be processed as a zero payment and noted with an adjustment reason code RV059 "Payment Reversal – Payment lost/voided/missed." This process will deduct the prior payment or zero net amount if applicable.

Coordination of Benefits (COB) and Adjudication Information – MOOP

All submitters that adjudicate Claims for The Plan HMO or have COB information from other payers are required to send in all the Coordination of Benefits and Adjudication Loops as per the Coordination of Benefits 1.4.1 section within the 837 Professional (TR3) Implementation Guide.

Providers and Vendors must have the 837 Professional (TR3) Implementation Guide in conjunction with this Companion Guide to create the loops below correctly.

The required loops and segments that are needed to be sent for a Compliant COB are as follows:

- Other Subscriber Information (2320) Loop
- Other Subscriber Name (2330A) Loop
- Line Adjudication Information (2430) Loop
    - For out-of-pocket amounts, use Loop ID 2430 220 Position 300 Data Element 782 for Patient Responsibility
    - This includes coinsurance, co-pays and deductibles – Please refer to Code Set 139 for the correct Claim Adjustment Reason Code

National Drug Code (NDC) – Medicaid Claim Submission Only

Per the 837 Professional (TR3) Implementation Guide, all Submitters are required to supply the National Drug Code (NDC) for all HCPCS J-codes submitted on the claim. The NDC must be reported in Loop 2410 Segment LIN03. Also, per the Implementation Guide, the Drug Quantity and Price also must be reported within the CTP segment. The Plan uses the First Data Bank (FDB) and CMS to validate the NDC codes for the source of truth.

Transportation Vendors

All Transportation Vendors must now use the Ambulance Pickup (2310E) and Drop-Off Location (2310F) Loops.

- Only one claim can be submitted per one-way trip.
- The physical address is required for the pickup/drop-off location.
- Any P.O. box information within this segment will be rejected.
- Please use the default diagnostic codes for the following states
    - FL – V700
    - OH – 7999
    - IL – 7999
    - MO – V609

FTP PROCESS for Production, Encounters, and Test files

Secure File Transfer Protocol

MOVEit® is The Plan's preferred file transfer method of transferring electronic transactions over the Internet. It has the FTP option or online web interface.

Secure File Transfer Protocol (SFTP) is specifically designed to handle large files and sensitive data. The Plan uses Secure Sockets Layer (SSL) technology, the standard internet security, and SFTP ensures unreadable data transmissions over the internet without a proper digital certificate.

Registered users are assigned a secure mailbox where all reports are posted. Upon enrollment, they will receive a login and password.

In order to send files to The Plan, submitters need to have an FTP client that supports AUTH SSL encryption.

The AUTH command allows The Plan to specify the authentication mechanism name to be used for securing the FTP session. Sample FTP client examples are:

- WS_FTP PRO® (The commercial version supports automation and scripting). WS_FTP PRO® has instructions on how to connect to a WS_FTP Server using SSL.
- Core FTP Lite® (The free version supports manual transfers). Core FTP Lite® has instructions on how to connect to a WS_FTP Server. Additionally, The Plan can help you with setup.

Reporting States Notes

Illinois Notes

Transportation:
Transportation claims, emergency and non-emergency, must report specific information about the trip in the NTE 2300 Loop. The State code, Vehicle License Number, Origin Time, and Destination Time must be reported in Loop 2300 Claim Note, NTE02 element. The information contained in this field will apply to all service sections unless overridden in the 2400 Loop.

NTE01: Value "ADD"
NTE02: State or Province Code, Vehicle License Number, Origin Time, Destination Time
Example: NTE*ADD* IL,12345678,1155,1220 and must follow this format

Each field must be separated with a comma.

The length for each field is listed below:

Length	Description
2	State or Province Code (Use Code source 22: States and Outlying Areas of the U.S.
8	Vehicle License Number
4	Origin Time Time expressed in 24-hour clock time as follows: HHMM, where H = hours (00-23), M = minutes (00-59).
4	Destination Time Time expressed in 24-hour clock time as follows: HHMM, where H = hours (00-23), M = minutes (00-59).

NOTE: The State or Province Code, Origin Time and Destination Time fields **must** contain the length per field as listed above. Vehicle license number may vary from 1 to a maximum of 8 characters. If the license plate number is less than 8 characters, left justify and space fill.

Transportation Modifiers – Emergency Transportation Claims
Place Codes for origin and destination will be reported using Procedure Modifiers, and they will be reported with each procedure code billed. The one-digit modifiers are combined to form a two-digit modifier that identifies the transportation provider's place of origin with the first digit, and the destination with the second digit.

Modifier	Description
D	Diagnostic or therapeutic site, other than P or H when used as an origin code
E	Residential facility
H	Hospital
N	Skilled nursing facility
P	Physician's office
R	Residence
S	Scene of accident or acute event
X	Destination code only, intermediate stops at physician's office on the way to the hospital

Transportation Modifiers – Non-Emergency Transportation Claims
Place Codes for origin and destination will be reported using Procedure Modifiers, and they will be reported with each procedure code billed. The one-digit modifiers are combined to form a two-digit modifier that identifies the transportation provider's place of origin with the first digit, and the destination with the second digit.

Non-emergency transportation claims must contain HIPAA compliant modifiers. This will require the provider to **map the HFS proprietary codes to the HIPAA codes accepted by HFS** as shown below. The allowable values of these Modifiers for Illinois Medicaid are:

HFS Proprietary Code	HIPAA Modifier Accepted by HFS	Description
E F G	D	Diagnostic or therapeutic site, other than P or H
B C	H	Hospital
A	P	Physician's office
H I K	R	Residence

For example, if the patient is transported from his home ("K") to a physician's office ("A"), the "K" will be changed to an "R" and the "A" changed to a "P", so the modifier reported on the 837P will be "RP".
NOTE: Continue to report HFS' proprietary codes ("KA" in this example) on **paper** claims.

Taxonomy:
The providers must report the billing provider taxonomy code in *PRV03 o*f the 2000A Loop. For HFS, the provider taxonomy code will be used to derive the Department's unique categories of service. For additional detail on Taxonomy codes, refer to ***Appendix 5 of Chapter 300 Provider Handbook for Electronic Processing***.

Florida State Notes

Private Transportation:
Private Transportation providers are currently required to submit start and stop time information on the claim. This offers a means to distinguish between services submitted for the same recipient on the same day. The X12N 837 Professional transaction does not provide the capability for providers to submit start and stop times. Private Transportation claims will use two modifiers instead of start and stop times.

The values are:

D Diagnostic or therapeutic site other than "P" or "H"

E Residential, domiciliary, custodial facility (nursing home, not a skilled nursing facility)

G Hospital-based dialysis facility (hospital or hospital-related)

H Hospital

I Site of transfer (for example, airport or helicopter pad) between types of ambulance

J Non-hospital-based dialysis facility

N Skilled nursing facility (SNF)

P Physician's office (includes HMO non-hospital facility, clinic, etc.)

R Residence

S Scene of accident or acute event

X Intermediate stop at physician's office in route to the hospital (includes HMO non-hospital facility, clinic, etc.)

Note: Modifier X can only be used as a designation code in the second modifier position.

The Origin and Destination codes will be billed together as a two-character modifier to provide combinations to uniquely identify services billed on the same day. If the provider needs to utilize the same procedure code and origin/destination modifier for the same recipient on the same day, a second modifier will be billed with the value of '76' (Repeat Procedure by Same Physician).

Note about Round Trip: A round trip means that the patient was picked up, taken somewhere, and returned to the same place they were picked up. There are only two legs to a round trip, going out and coming back. If you made a trip with three legs (going out, going somewhere else, coming back) that is not a round trip.

A. To bill a round trip if you bill for a base rate and mileage:

(1) Round trips will be billed with Ambulance Transport Code "X" in Loop 2300 CR1

(2) Bill only one line for mileage (unless you have a known exception). The modifier for origin and destination should reflect the pickup point and the stop point (e.g., home to doctor is a modifier of RP).

(3) If you bill a base rate, you will send that line item once. For wheelchair van and stretcher van, submit total charges of two times your base rate on this line item.

B. To bill a round trip if you bill for a base rate only:

(1) Round Trips will be billed with Ambulance Transport Code 'X' in Loop2300 CR103.

(2) Bill only one line item for base rate. The modifier for origin and destination should reflect the pick-up point and the stop point (e.g., Home to Doctor is a modifier of RP). For wheelchair van and stretcher van, submit total charges of two times your base rate on this line item.

Note about multi-leg trips: For a trip that had multiple segments and is not a round trip as described above, each segment must be billed as a separate line item.

A. To bill a multi-leg trip if you bill for a base rate and mileage:

(1) Multi-leg trips will be billed with Ambulance Transport Code "I" in Loop 2300 CR103.

(2) Bill one line item for each segment of mileage. The modifier for origin and destination should reflect the start point and the stop point for that leg of the trip.

(3) Bill one line item for each segment of base rate. The modifier for origin and destination should reflect the start point and the stop point for that leg of the trip.

B. To bill a multi-leg trip if you bill for a base rate only:

(1) Multi-leg trips will be billed with Ambulance Transport Code in Loop 2300 CR103.

(2) Bill one line item for each segment of base rate. The modifier for origin and destination should reflect the start point and the stop point for that leg of the trip.

Georgia State Notes

Transportation:

In the CR104 Segment GA requires for Ambulance Claims:
'A' – Patient was transported to nearest facility for care of symptoms, complaints, or both. May be used to indicate that the patient was transferred to a residential facility
'B' – Patient was transported for the benefit of a preferred physician
'C' – Patient was transported for the nearness of family members
'D' – Patient was transported for the care of a specialist or for availability of specialized equipment
'E' – Patient Transferred to Rehabilitation Facility

In the CR105 Segment that State of GA requires that an Ambulance Unit of Basis For Measurement Code has to be "DH" for Miles.

Nebraska State Notes

Providers Not Eligible for NPI (Atypical):

Nebraska Medicaid defines a provider ineligible for an NPI as an atypical provider, such as: MHCP (Medically Handicapped Children's Program) clinics, MIPS (Medicaid in Public Schools), Personal Care Aides, Mental Health Personal Care Aides/Community Treatment Aides, Mental

Health Home Health Care Aides and Non-Emergency Transportation providers and Community Support Workers.

Vision Services:
When using V2799 to claim for frame front/chassis, temple, hinge, nose pad, or eyeglasses case replacement; enter description of replacement. For Telehealth services, enter the site where the patient is receiving the Telehealth service.

Referring Provider State License:
The State License Number needs to be reported in the REF 2310A Loop.

- State license number must be the two-digit alphabetical state code abbreviation, followed by the state license number. For example, NE123456

DESIGNATOR DESCRIPTION

M – Mandatory: The designation of mandatory is absolute in the sense that there is no dependency on other data elements. This designation may apply to either simple data elements or composite data structures. If the designation applies to a composite data structure then at least one value of a component data element in that composite data structure shall be included in the data segment.

R – Required: At least one of the elements specified in the condition must be present.

S – Situational: If a Segment or Field is marked as "Situational", it is only sent if the data condition stated applies.

Further Claim Field Descriptions

Refer to the IG for the initial mapping information. The grid below further clarifies additional information The Plan requires.

Interchange Control Header:						
Pos	**Id**	**Segment Name**	**Req**	**Max Use**	**Repeat**	**Notes**
	ISA06	Interchange Sender ID	M	1		For Direct submitters, use unique ID assigned by The Plan. Example: 123456 followed by spaces to complete the 15-digit element For Clearinghouse submitters, use ID as per the clearinghouse
	ISA08	Interchange Receiver ID	M	1		For Direct submitters, use "**WELLCARE**" **Note:** Please make sure the Receiver ID is **left-justified** with **trailing spaces** for a total of 15 characters. Do not use leading ZEROS. For Clearinghouse submitters, use ID as per the clearinghouse

Functional Group Header:						
	GS02	Senders Code	M	1		For Direct submitters, use your existing Plan Submitter ID **or** the Trading Partner ID provided during the enrollment process. For Clearinghouse submitters, use ID as per the clearinghouse
	GS03	Receivers Code	M	1		For Direct submitters Use WellCare ID "**WELLCARE**" For Clearinghouse submitters, use ID as per the clearinghouse
Header:						
Pos	**Id**	**Segment Name**	**Req**	**Max Use**	**Repeat**	**Notes**
0100	**BHT06**	Claim/Encounter Identifier	R	1		Use value the value of "**CH**" – Chargeable (FFS) or "**RP**" – Reporting (Encounters) Claims. The Plan will reject any Claims that have "**31**' – Subrogation Demand.
LOOP ID - 1000A – Submitter Name					**1**	
0200	**NM109**	Submitter Identifier	R			For Direct submitters, use "**ETIN**" i.e., Use the Plan Submitter ID or 6-digit trading partner ID assigned during the EDI enrollment process. For Clearinghouse submitters, use ID as per the clearinghouse
LOOP ID - 1000B – Receiver Name					**1**	
0200	**NM103**	Receiver Name	R	1		For Direct submitters, use value "**WELLCARE HEALTH PLANS, INC**" (e.g., WellCare Health Plans of Georgia, WellCare Health Plans of New York) For Clearinghouse submitters, use ID as per the clearinghouse
0200	**NM109**	Receiver Primary ID	R	1		For Direct submitters, use the value of Payer ID For Clearinghouse submitters, use ID as per the clearinghouse

Detail:

Pos	Id	Segment Name	Req	Max Use	Repeat	Notes
LOOP ID - 2000A – Billing/Pay-To Provider Hierarchical Level					>1	
0030	PRV03	Billing Provider Specialty Information	S	1		**All States** The correct Billing Provider Taxonomy Code **must** be sent.
LOOP ID - 2010AA – Billing Provider Name					1	
0150	**NM108**	Billing Provider Primary Type	R	1		**All States** All non-Atypical submitters **must** have value of "**XX**". All Atypical submitters **must** not use this element.
0150	**NM109**	Billing Provider ID	R	1		**All States** All non-Atypical submitters **must** have NPI. All Atypical Submitters **must** Not use this element.
0350	REF**01**	Billing Provider Tax Identification	R	1		**All States** All Atypical and non-Atypical submitters are required to use the value of "**EI**".
0350	REF**02**	Billing Provider Tax Identification	R	1		**All States** All submitters are required to send in their "**TAX ID**".
0350	REF**01**	Billing Provider UPIN/License Information	R	2		**All States** Only Atypical submitters may use this REF segment.
0350	REF**02**	Billing Provider UPIN/License Information	R	2		**All States** Only Atypical submitters may use this REF segment.
LOOP ID - 2000B – Subscriber Hierarchical Level					>1	
0050	**SBR01**	Payer Responsibility Sequence Number Code	R	1		Use the value of "**P**" if The Plan is the primary payer.
0050	**SBR09**	Claim Filing Indicator Code		1		Value equal to Medicaid or Medicare filing.
0070	**PAT09**	Pregnancy Indicator	S	1		Use indicator of "**Y**" if subscriber is pregnant.
LOOP ID - 2010BA – Subscriber Name					1	
0150	NM1**08**	Subscriber Primary Identification code Qualifier	S-R	1		Use the value "**MI**".
0150	NM1**09**	Subscriber Primary Identifier	S-R	1		Subscriber Medicaid/Medicare ID, The Plan ID
0320	DMG**03**	Subscriber Demographic Information	S-R	1		**All States** All submitters **must** send in "**F**" – Female or "**M**" – Male only
LOOP ID - 2010BB – Payer Name					1	
0150	**NM108**	Identification code Qualifier				Use value "**PI**".
0150	**NM109**	Identification code				Use value Payer ID.
LOOP ID - 2300 – Claim information					100	
1300	**CLM01**	Claim Submitters Identifier	R	1		**All States:** All submitters are required to send Unique IDs for each claim sent.

1300	**CLM05-3**	Claim Frequency Type Code	R	1		**All States** Use "**1**" on original Claim/Encounter submissions. Use "**7**" for Claim/Encounter Replacement (Adjustment). Use "**8**" for Claim/Encounter Void. For both "**7**" and "**8**", include the original **WellCare Claim Number (WCN)**, as indicated in Loop 2300 **REF02 (Original Reference Number**). This number can be found on The Plan's 277CA along with the 999 and the corresponding 277U (if requested).
1350	**DTP**	Last Menstrual Period	S-R	1		**All States** All submitters **must** send this segment when the Pregnancy Indicator is in the PAT09 in the 2000B loop is set to "**Y**" – Yes.
1800	**REF02**	Prior Authorization Number	S-R	1		**State Notes** **GA, LA** Submitters are required to submit the "**G1**" in the **REF01** and Auth Number in the **REF02**. **HI** Submitters are required to submit the "**G1**" in the **REF01**. Although this REF Segment can also be used for referral numbers, Med-QUEST is only concerned with PA numbers for services that were authorized by Med-QUEST. Use this segment when the PA is at the claim rather than the service line level. **All States** This is now a single segment for just the PA number. All submitters are required to send this segment when The Plan has assigned a PA number.
1800	**REF02**	Referral Number	S-R	1		**State Notes** **GA, LA** Submitters are required to submit the "**9F**" in the **REF01** and referral number in the **REF02**. **All States** This is now a single segment for just the referral number. All submitters are required to send this segment when The Plan has assigned a referral number.
1800	**REF02**	Code qualifying the Reference Identification	S-R	1		**State Note** **HI** Submitters must submit **"P4"** in the **REF01** when The Department of Human Services Social Services Division (DHS/SSD) is responsible for Medicaid Waiver Programs in

						Hawaii. SSD claims for Medicaid Waiver services are identified by a "W" in the Demonstration Project Identifier element.
1800	**REF02**	Payer Claim Control Number (formally known as Original Reference Number) (ICN/DCN)	S-R	1		**All States** All submitters must submit an "**F8**" in the **REF01** when **CLM05-3** (Claim Submission Reason Code) = "**7**", or "**8**" along with **the WellCare Control Number (WCN)**. This number can be found on The Plan's 277CA along with the 999 and the corresponding 277U (if requested).
1900	**NTE01**	Note Reference Code	S-R	20		**All States** For **MAS** procedure codes, use "**ADD**" in the **NTE01** **State Note** **OH** Medicaid Co-Payments exclusions – Send in "**ADD**" in the **NTE01.** **IL** Must use "**ADD**" when the services require additional information to be reported.
1900	**NTE02**	Description	S-R			**All States** For **MAS** procedure codes, see CMS documentation. **State Notes:** **OH** When Medicaid co-payment exclusion applies, the 10-character code (see below) **must** be the first item in the **NTE02**. There **must** always be a single space between the word COPAY and the fourth character exclusion code. • COPAY EMER (Emergency) • COPAY HSPC (Hospice) • COPAY PREG (Pregnancy) **IL** For all claims that are special priced, include the appropriate required detail in this section. For emergency and non-emergency transportation claims, this element will contain the State, Vehicle License Number, Origin Time, and Destination Time. See section on Transportation claims under the Payer Specific Business Rules and Limitations section for more detail.
1950	**CR104**	Ambulance Transport Reason Code	S-R	1		**State Notes** **FL** Enter the Ambulance Transport Reason Code. **Note:** Refer to the 837 Professional Implementation Guide for the valid code values.

						GA Ambulance Transport Reason Codes **'A'** – Patient was transported to nearest facility for care of symptoms, complaints, or both. May be used to indicate that the patient was transferred to a residential facility. **'B'** – Patient was transported for the benefit of a preferred physician **'C'** – Patient was transported for the nearness of family members **'D'** – Patient was transported for the care of a specialist or for availability of specialized equipment **'E'** – Patient Transferred to Rehabilitation Facility
1950	**CR105**	Ambulance Unit or Basis for Measurement Code	S-R	1		**State Note** **FL** 'DH' – Miles.
1950	**CR106**	Ambulance Transport Distance	S-R	1		**State Notes** **FL** Florida Medicaid will process only the whole number when units are entered with decimals. **Example**: Units entered on the transaction 3.75 will be processed as 3 units. **GA** Quantity **IL** Transportation providers must report the number of "loaded" miles.
2200	**CR210**	Spinal Manipulation Service Information	S-R	1		**State Note** **NE** Report the treatment number(s) billed on this claim
2200	**CRC01**	Ambulance Certification – Code Category	S-R	1		**All States** '**07**' – Ambulance Certification The CRC segment is required if CR1 is used.
2200	**CRC02**	Ambulance Certification – Certification Condition Code Applies Indicator	S-R	1		**All States** **'Y**' – Yes '**N**' – No CRC02 is a Certification Condition Code applies indicator. A "**Y**" value indicates the condition codes in CRC03 through CRC07 apply; an "**N**" value indicates the condition codes in CRC03 through CRC07 do not apply.
2200	**CRC03**	Ambulance Certification – Condition Indicator	S-R	1		**State Note** **GA** '**01**' – Patient was admitted to a hospital '**04**' – Patient was moved by stretcher '**05**' – Patient was unconscious or in shock '**06**' – Patient was transported in an emergency situation '**07**' – Patient had to be physically restrained '**08**' – Patient had visible

						hemorrhaging '**09**' – Ambulance service was medically necessary '**12**' – Patient is confined to a bed or chair
2200	**CRC01**	EPSDT Referral – Code Category	S-R	1		**State Notes** **FL,GA** **'ZZ**' – Mutually Defined Enter this for Child Health Checkup Screening referral information
2200	**CRC02**	EPSDT Referral – Certification Condition Indicator	S-R	1		**State Notes** **FL,GA** '**Y**' – Yes '**N**' – No For Child Health Checkup screenings enter "**Y**" if the patient is referred to another provider as a result of the screening. Enter '**N**' if no referral is made. If '**N**' is entered here, enter '**NU**' in 2300, CRC03
2200	**CRC03**	EPSDT Referral – Condition Code	S-R	1		**State Notes** **FL,GA** Enter one of the following valid values. For Child Health Checkup Exam Result: '**AV**' – Patient Refused Referral '**NU'** – Not Used (Patient Not Referred) '**S2**' – Under Treatment '**ST**' – New Services Requested
LOOP ID – 2310A – Referring Provider Name					**1**	
2500	**NM108**	Referring Provider Name	S-R	1		**All States** All non-Atypical submitters **must** have value of "**XX**". All Atypical submitters **must** not use this element.
2500	**NM109**	Referring Provider ID	R	1		**All States** All non-Atypical submitters **must** have NPI. All Atypical submitters **must** not use this element.
2710	**REF01**	Referring Reference Identification Qualifier	S	5		**All States** Only Atypical submitters can use this segment. **State Note** **NE** Medicaid will only process "**0B**".
2710	**REF02**	Referring Provider Secondary Identification	S	5		**All States** Only Atypical submitters can use this segment **State Note** **NE** State license number must be the two-digit alphabetical state code abbreviation, followed by the state license number: for example, NE123456

LOOP ID – 2310B – Rendering Provider Name					**1**	
2500	**NM108**	Rendering Provider Name	S-R	1		**All States** All non -typical submitters **must** have value of "**XX**". All Atypical submitters **must** not use this element.
2500	**NM109**	Rendering Provider ID	R	1		**All States** All non-Atypical submitters **must** have NPI. All Atypical submitters **must** not use this element.
2550	**PRV03**	Rendering Taxonomy Code	S-R	1		**All States** All submitters **must** send the Rending Provider Taxonomy Code as per the 837. **State Notes** **CT GA IN LA** Submitters are required to send in the Taxonomy Codes. **MO** Submitters are required to send in the Taxonomy Codes if submitter has multiple MO HealthNet Legacy Provider IDs
2710	**REF01**	Rendering Reference Identification Qualifier	S	3		**All States** Only Atypical submitters can use this segment
2710	**REF02**	Rendering Provider Secondary Identification	S	3		**All States** Only Atypical submitters can use this segment
LOOP ID – 2310C Service Facility Location					**1**	
2500	**NM1**	Service Facility Location	S-R	1		**All States** All Submitters **must** use this loop when the physical location where the service took place is different than the address in the Billing Provider Name (2010AA) Loop. This loop must not contain a P.O. box in the Address (N3) Segment.
2650	**N301**	Service Facility Location Address	R	1		**All States** All submitters **must** send in physical address. The Plan will reject any claims that contain a P.O. box in this segment.
LOOP ID – 2310E Ambulance Pickup Location					**1**	
2500	**NM1**	Ambulance Pickup Location	S-R	1		**All States** All Transportation submitters **must** use this loop.
2650	**N301**	Ambulance Pickup Location Address	R	1		**All States** All Transportation submitters **must** send in physical address. The Plan will reject any claims that contain a P.O. box in this segment. **NOTE:** If the ambulance pickup location is in an area where there are no street addresses, enter a description of where the service was rendered (for example, 'crossroad of State Road 34 and 45' or 'Exit near Mile marker 265 on Interstate 80'.)

2700	**N4**	Ambulance Pickup Location City, State ZIP Code	R	1		**All States** All Transportation submitters **must** send this in.
LOOP ID – 2310F - Ambulance Drop-Off Location					**1**	
2500	**NM1**	Ambulance Drop-Off Location	S-R	1		**All States** All Transportation submitters **must** use this loop.
2650	**N301**	Ambulance Drop-Off Location Address	R	1		**All States** All Transportation submitters **must** send in physical address. The Plan will reject any claims that contain a P.O. box in this segment. **NOTE:** If the ambulance pickup location is in an area where there are no street addresses, enter a description of where the service was rendered (for example, 'crossroad of State Road 34 and 45' or 'Exit near Mile marker 265 on Interstate 80'.)
2700	**N4**	Ambulance Drop-Off Location City, State Zip Code	R	1		**All States** All Transportation submitters **must** send this in.
LOOP ID – 2320 – Other Subscriber Information					**10**	
2900	**SBR01**	Payer Responsibility Sequence Number Code	R	1		**All States** All Vendor/Provider submitters that adjudicate claims for The Plan must make themselves the Primary "**P**". In the SBR01 Element in the Subscriber Information (2000B) **must** be sent to the next available Payer Responsibility Number Code
2950	**CAS02**	Claim Adjustment Reason	S	5		**State Note** **GA** Interest paid on the claim should be reported in a CAS segment. Please use Code "**225**" for interest payments **NOTE:** Do not report interest paid as a separate line item on the claim/encounter.
3000	**AMT02**	Coordination of Benefits (COB) Payer Paid Amount	S	1		**All States** All Vendor/Provider submitters that adjudicate claims for The Plan must send this segment. This element **must** be the amount paid by the Vendor to the Provider.
LOOP ID – 2330B Other Payer Name			S		**1**	
2250	**NM103**	Name Last or Organization Name	R	1		**All States** All Vendor/Provider submitters that adjudicate claims for The Plan **must** send this segment. The Vendor/Provider submitters who are paying the claim/encounter **must** be in this element.
2250	**NM109**	Identification Code	R	1		**All States** All Vendor/Provider submitters that adjudicate claims for The

						Plan **must** send this segment. The Vendor/Provider submitters who are paying the claim/encounter **must** have ID. This will be used in the Line Adjudication Information (2430) Loop in the SVD01.
2950	**CAS02**	Claim Adjustment Reason	S	5		**State Note** **GA** Interest paid on the claim should be reported in a CAS Segment. Please use Code "**225**" for interest payments **NOTE:** Do not report interest paid as a separate line item on the claim/encounter.
LOOP ID – 2400 – Line Note					**1**	
4850	**NTE02**	Line Note Text	S	1		**State Note** **NE** For vision services: When using V2799 to claim for frame front/chassis, temple, hinge, nose pad, or eyeglasses case replacement, enter description of replacement. For Telehealth services, enter the site where the patient is receiving the Telehealth service. **IL** For all claims that are special priced, include the appropriate required detail in this section. For emergency and non-emergency transportation claims, this element will contain the State, Vehicle License Number, Origin Time, and Destination Time. See section on Transportation claims under the Payer Specific Business Rules and Limitations section for more detail.
LOOP ID – 2420A – Rendering Provider Name					**1**	
5050	**PRV03**	Taxonomy Code	S-R	1		**State Notes** **MO, IL** Submitters are required to send in the Taxonomy Codes if submitter has multiple MO HealthNet Legacy Provider IDs
LOOP ID – 2420F – Referring Provider Name					**1**	
255	**PRV03**	Taxonomy Code	S-R	1		**State Notes** **MO, IL** Submitters are required to send in the Taxonomy Codes if submitter has multiple MO HealthNet Legacy Provider IDs
LOOP ID – 2430 Line Adjudication Information					**15**	
5400	**SVD01**	Identification Code	S-R	1		**All States** All Vendor/Provider submitters that adjudicate claims for The Plan **must** send this segment The Vendor/Provider submitters who are paying the claim/encounter **must** have ID. This will be the same as in the Other Payer Name (2330B) Identification Code in the NM109.

5400	**SVD02**	Monetary Amount	R	1		**All States** All Vendor/Provider submitters that adjudicate claims for The Plan **must** send this segment. This is how much was paid by the Vendor/Provider after Check Run.
5450	**CAS02**	Claim Adjustment Reason Code	R	1		**All States** All Vendor/Provider submitters that adjudicate claims for The Plan **must** send this segment. This **must** be a HIPAA-compliant reason code.
5450	**CAS03**	Monetary Amount	R	1		**All States** All Vendor/Provider submitters that adjudicate claims for The Plan **must** send this Segment This is the Difference between what the Vendor/Provider paid and how much was billed.
5500	**DTP03**	Date Time Period	R	1		**All States** All Vendor/Provider submitters that adjudicate claims for The Plan **must** send this segment The Vendor/Provider **must** use the check date for the payment date.

ATTACHMENT A

Glossary

Term	Definition
HIPAA	In 1996, Congress passed into federal law the Health Insurance Portability and Accountability Act (HIPAA) in order to improve the efficiency and effectiveness of the entire health care system. The provisions of HIPAA, which apply to health plans, health care providers, and healthcare clearinghouses, cover many areas of concern including, preventing fraud, waste and abuse, preventing pre-existing condition exclusions in health care coverage, protecting patients' rights through privacy and security guidelines and mandating the use of a national standard for EDI transactions and code sets.
SSL **(Secure Sockets Layer)**	SSL is a commonly used protocol for managing the security of a message transmission through the Internet. SSL uses a program layer located between the HTTP and TCP layers. The "sockets" part of the term refers to the sockets method of passing data back and forth between a client and a server program in a network or between program layers in the same computer. SSL uses the public- and private-key encryption system from RSA, which also includes the use of a digital certificate.
Secure FTP (SFTP)	Secure FTP, as the name suggests, involves a number of optional security enhancements such as encrypting the payload or including message digests to validate the integrity of the transported files to name two examples. Secure FTP uses Port 21 and other Ports, including SSL.
AUTH SSL	AUTH SSL is the explicit means of implementing secure communications as defined in RFC 2228. AUTH SSL provides a secure means of transmitting files when used in conjunction with an FTP server and client that both support AUTH SSL.
Required Segment	A required segment is a segment mandated by HIPAA as mandatory for exchange between Trading Partners.
Situational Segment	A situational segment is a segment mandated by HIPAA as optional for exchange between Trading Partners.
Required Data Element	A mandatory data element is one that must be transmitted between Trading Partners with valid data.
Situational Data Element	A situational data element may be transmitted if data is available. If another data element in the same segment exists and follows the current element the character used for missing data should be entered.
N/U (Not Used)	An N/U (Not Used) data element is included in the shaded areas if the Implementation Guide is NOT USED according to the standard, and no attempt should be made to include these in transmissions.
ATTENDING PROVIDER	The primary individual provider who attended to the client/member during an in-patient hospital stay. This must be identified in 837I.

Term	Definition
BILLING PROVIDER	The Billing Provider entity may be a health care provider, a billing service, or some other representative of the provider.
IMPLEMENTATION GUIDE (IG)	Instructions for developing the standard ANSI ASC X12N Health Care Claim 837 transaction sets. The Implementation Guides are available from Washington Publishing Company.
PAY-TO PROVIDER	This entity may be a medical group, clinic, hospital, other institution, or the individual provider who rendered the service.
REFERRING PROVIDER	Identifies the individual provider who referred the client or prescribed ancillary services/items such as Lab, Radiology or Durable Medical Equipment (DME).
RENDERING PROVIDER	The primary individual provider who attended to the client/member. They must be identified in 837P.
TRADING PARTNERS (TPs)	Includes all of the following: payers, switch vendors, software vendors, providers, billing agents, clearinghouses
FFS	Fee-for-Service Claims
DATE FORMAT	All dates are eight 8-character dates in the format CCYYMMDD. The only date data element that varies from the above standard is the Interchange Date data element located in the ISA segment. The Interchange Date data element is a six 6-character date in the YYMMDD format.
DELIMITERS	A delimiter is a character used to separate 2 data elements or sub-elements, or to terminate a segment. Delimiters are specified in the interchange header segment, ISA The ISA segment is a 105 byte fixed length record. The data element separator is byte number 4; the component element separator is byte number 105; and the segment terminator is the byte that immediately follows the component element separator. Once specified in the interchange header, delimiters are not to be used in a data element value elsewhere in the transaction. The following characters are used as data delimiters for all transaction segments:

CHARACTER	PURPOSE
* Asterisk	Data Element Separator
: Colon	Sub-Element Separator
^ Caret	Repetition Separator
~ Tilde	Segment Terminator

ATTACHMENT B
999 Interpretations

The examples below show an accepted and a Rejected X12 N 999. On The Plan FTP site in the respective Provider directory the X12N 997 files, when opened, will display as one complete string without carriage returns or line feeds. In the examples below, we added carriage returns at the end of each segment.

Accepted 999

```
ISA~00~       ~00~       ~ZZ~123456789     ~ZZ~987654321     ~111211~2345~^~00501~000000001~0~P~+'
GS~FA~123456789~133052274~987654321~2345~1~X~005010X231A1'
ST~999~0001~005010X231A1'
AK1~HC~77123~005010X222A1'
AK2~837~0001~005010X222A1'
IK5~A'
AK9~A~1~1~1'
SE~6~0001'
GE~1~1'
IEA~1~000000001'
```

Rejected 999

```
ISA~00~       ~00~       ~ZZ~123456789     ~ZZ~987654321     ~111227~1633~^~00501~000000001~0~P~+'
GS~FA~123456789~987654321~20111227~1633~1~X~005010X231A1'
ST~999~0001~005010X231A1'
AK1~HC~3264~005010X222A1'
AK2~837~000000060~005010X222A1'
IK3~SV5~32~2400~8'
CTX~CLM01+0116.0090738.01'
IK4~4~782~I9'
IK4~6~594~I9'
IK3~SV5~43~2400~8'
CTX~CLM01+0116.0090738.01'
IK4~4~782~I9'
IK4~6~594~I9'
IK5~R~I5'
AK9~R~1~1~0'
SE~14~0001'
GE~1~1'
IEA~1~000000001'
```

Partial 999

```
ISA~00~       ~00~       ~ZZ~123456789     ~ZZ~987654321     ~111115~2119~^~00501~000000001~0~P~+'
GS~FA~123456789~RHCLM117~20111115~2119~1~X~005010X231A1'
ST~999~0001~005010X231A1'
AK1~HC~184462723~005010X222A1'
AK2~837~000000001~005010X222A1'
IK5~A'
AK2~837~000000002~005010X222A1'
IK5~A'
AK2~837~000000003~005010X222A1'
IK5~A'
AK2~837~000000004~005010X222A1'
IK5~A'
AK2~837~000000005~005010X222A1'
IK5~A'
AK2~837~000000006~005010X222A1'
IK5~A'
....
AK2~837~000000126~005010X222A1'
IK5~A'
AK2~837~000000127~005010X222A1'
IK5~A'
AK2~837~000000128~005010X222A1'
IK3~NM1~22~2310~8'
```

CTX~CLM01+001-375436/483311'
IK4~4~1036~I9'
IK3~NM1~40~2310~8'
CTX~CLM01+001-375436/483312'
IK4~4~1036~I9'
IK3~NM1~58~2310~8'
CTX~CLM01+001-375436/483313'
IK4~4~1036~I9'
IK3~NM1~76~2310~8'
CTX~CLM01+001-387563/483314'
IK4~4~1036~I9'
IK3~NM1~94~2310~8'
IK5~E~I5'
AK2~837~000000129~005010X222A1'
IK5~A'
AK2~837~000000130~005010X222A1'
IK5~A'
AK2~837~000000131~005010X222A1'
IK5~A'
...
AK2~837~000000277~005010X222A1'
IK5~A'
AK2~837~000000278~005010X222A1'
IK5~A'
AK2~837~000000279~005010X222A1'
IK3~NM1~46~2310~8'
CTX~CLM01+599440'
IK4~4~1036~I9'
IK3~NM1~72~2310~8'
CTX~CLM01+599450'
IK4~4~1036~I9'
IK5~E~I5'
AK2~837~000000280~005010X222A1'
IK5~A'
AK2~837~000000281~005010X222A1'
IK5~A'
AK2~837~000000282~005010X222A1'
IK5~A'
...
AK2~837~000000729~005010X222A1'
IK5~A'
AK2~837~000000730~005010X222A1'
IK5~A'
AK2~837~000000731~005010X222A1'
IK5~A'
AK9~P~731~731~730'
SE~1696~0001'
GE~1~1'
IEA~1~000000001'