Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

blue california
Promise Health Plan
Effective 1/1/2019

Blue Shield of California Promise Health Plan

Beacon

837 Institutional Companion Guide

For Health Care Claim/Encounter (837I)

Transactions based on ASC X12 Implementation Guides, Version 005010X223A2

Effective Date: 1/1/2019

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Document History:

Version	Release Date	Description
1.0	5/17/2018	Creation Date
1.1	7/31/2018	Updated: Contact phone number Updated: Response File Name Updated: 2300 AMT01 Updated: 2430 CAS
1.2	9/24/2018	Replaced Care 1st with BSC Promise Updated 1.2 Contact Information Updated 2.3 Testing Updated 2.5 Processing Schedule Updated 6.1 Loop 1000B Updated 6.3 Notes/Comments Updated 6.4 Loop 2010BB Updated 6.6 Loop 2430
1.3	10/2/2019	Updated multiple fields for Beacon requirements to submit member cost share
1.4	4/6/2020	Added: Loop 2400 HCP01, HCP02 Added: Loop 2430 SVD01, SVD02 Added: Appendix C Updates could require systems changes

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1. Introduction

1.1 Scope

This companion guide provides information on the submission of Medi-Cal, Medicare, and Cal MediConnect institutional claims and/or encounters. This guide is issued to Trading Partners with Blue Shield of California Promise Health Plan (Care1st Health Plan until 12/31/2018), hereafter referred to as "BSC Promise". Effective 1/1/2019, this companion guide will supersede any other previously-issued Care1st Health Plan Institutional claim or encounter data companion guide versions.

This companion guide is to be used in conjunction with the 5010 Implementation Guide ASC X12N / 005010X223A2 -- Health Care Claim Institutional (837I). The instructions in this companion guide are not intended to replace or be standalone requirements from the Implementation Guide (837I). Requirements that are identical to the Implementation Guide (837I) are not included in this companion guide.

1.2 Contact Information

Trading Partners needing assistance with electronic submissions and processing of an 837 file, contact EDI Platform Services at:

Email: EDI_PHP@blueshieldca.com

Phone 800-480-1221

1.3 References

Trading Partners may obtain access to the Implementation Guides at: http://www.x12.org/.

2. Submitting Encounters to BSC Promise

2.1 Initial Setup

Prior to the implementation of a new Trading Partner to submit claim or encounter data, BSC Promise will provide the following information to the Trading Partner:

2.1.1 File transmission location details
2.1.2 Secure login information
2.1.3 Submitter ID information
2.1.4 Test plan, with information on testing criteria
2.1.5 Any other pertinent information needed to submit Production data

2.2 Claim or Encounter Data Submission File Naming Convention

BSC Promise has a standardized file naming convention for file submission. All Trading Partners must adhere to the file naming convention.

All files must be named using capitalized letters only (case sensitive).

The maximum number of characters allowed in the file is **60 characters** (including the optional "_R" and ".DAT").

2.2.1 BSC Promise File Naming Convention

SENDER-ID_FILE-FORMAT_TRANSACTION-TYPE-CODE_ YYYYMMDD_NNNN_R.DAT

Element	Description	Requirement
SENDER-ID	Code assigned to each Trading Partner by BSC Promise	Must match the ISA06 segment
FILE-FORMAT	Code assigned to each submission based on transaction format	"837I" for 837 Institutional
TRANSACTION-TYPE-CODE	Code specifying the type of transaction	Must match the value submitted in
YYYYMMDD	Date of submission	
NNNN	Unique, sequential, numeric transaction identifier used to differentiate between files submitted on the same day by the same submitter	Must be 4 digits and padded with leading zeros so it is 4 digits long.
R	**R** is optional and only used for the submitter to differentiate regular submissions from special submissions	"**R**" may include one or more characters. "**R**" only allows alpha and numeric characters; no symbol, no control character, no space, no tab

2.3 Testing with BSC Promise

Trading Partners should work with EDI Platform Services team to test file submissions. Trading Partners must notify EDI Platform Services prior to submitting a file for testing. Email notifications should be sent to: EDI_PHP@blueshieldca.com.

For test files, ISA15 must be populated with "T".

2.4 File Size Limitations

Claim or Encounter data files submitted to BSC Promise should not exceed the limits listed below:

File Size Limitations	
Maximum number of transactions (ST-SE) per file	5,000
Maximum number of claims or encounters per transaction (ST-SE)	5,000
Maximum number of claims or encounters per file	5,000

2.5 BSC Promise Processing Schedule

Files from Trading Partners are accepted 24 hours a day, 7 days a week. Trading Partners are notified prior to any scheduled system maintenance. Files are to be submitted after system maintenance is completed.

3. Acknowledgement and Response Files

3.1 Transmission of Response Files to Trading Partners

Acknowledgement and response files will be sent to the Trading Partners at the designated location communicated during the initial set up of claim and/or encounter submissions.

3.2 Validation Logic

Validation is performed at all levels including, but not limited to, the Header level, Claim Detail level, Member Level, Payer detail and Service Line level. However, record status is determined at the claim level. If one line in a claim or encounter is rejected, the entire claim or encounter is rejected.

3.3 TA1 – Interchange Acknowledgement

A TA1 acknowledgement report will be generated for each 837I file submitted to BSC Promise. The TA1 report provides information to the Trading Partner on whether the file was successfully received. The 837I file does not progress to the next step if a rejection occurs at this level.

The TA1 acknowledgement report will mirror the submitted file name with an added designation, as follows:

SENDER-ID_FILE-FORMAT_TRANSACTION-TYPE-CODE_YYYYMMDD_NNNN_R.RCPCCYYMMDDHHMMSS.DAT.TA1

Where:

RCP is a fixed value which represents receipt
CCYYMMDDHHMMSS is the file receipt date

3.4 999 – Functional Group Acknowledgement

A 999 acknowledgement report will be generated for each 837I file that was accepted at the TA1 level. The 999 report provides information to Trading Partners on whether functional groups were accepted or rejected, including validation on syntactical errors and any functional group errors. The claims or encounters within this transaction do not progress to the 277CA level if a rejection occurs at this level. The transaction will progress to the 277CA validation if it is accepted or accepted with error.

The 999 acknowledgement report will mirror the submitted file name with an added designation, as follows:

SENDER-ID_FILE-FORMAT_TRANSACTION-TYPE-CODE_YYYYMMDD_NNNN_R.RCPCCYYMMDDHHMMSS.DAT.999

Where:

RCP is a fixed value which represents receipt
CCYYMMDDHHMMSS is the file receipt date

3.5 277CA – Claim Acknowledgement

The Health Care Claim Acknowledgment 277CA transaction report will be created for claims or encounters within a transaction that are "accepted" or "accepted with errors" at the 999 level. The 277CA report provides accepted or rejected status at the claim or encounter level, including validation on BSC Promise custom Validation Checks as outlined in Sections 4, 5 and 6 of this document.

The 277 CA report will mirror the submitted file name with an added designation, as follows:

SENDER-ID_FILE-FORMAT_TRANSACTION-TYPE-CODE_YYYYMMDD_NNNN_R.RCPCCYYMMDDHHMMSS.DAT_ HHmmsssSSSS.277

Where:

RCP is a fixed value which represents receipt
CCYYMMDDHHMMSS is the file receipt date
HHmmsssSSSS is the system time that the acknowledgement/response file was generated

4. Claim or Encounter Submission Instructions

4.1 National Coding Standards

Trading Partners must adhere to all national coding standards including procedure, modifier, and diagnostic codes.

Any claims or encounters submitted with a date of service on or after October 1, 2015 must use ICD-10 diagnosis codes. Diagnostic codes must be coded to the highest specificity. External cause codes should not be used as a primary diagnosis code.

Local codes will not be accepted.

4.2 Child Health and Disability Program (CHDP) and Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT) Submission

Effective June 30, 2018, BSC Promise does not process PM160 paper forms. All Medi-Cal Trading Partners should submit CHDP electronically using National Standard HIPPA 837 Formats. Please refer to the DHCS website for further information on converting local codes to CPT 4 National Codes.

For EPSDT that are part of CHDP, submissions in the 837I are required to adhere to the following:

4.3.1 Use the CRC segment ("Conditions Indicator") in the 2300 loop to indicate if an EPSDT referral was given for diagnostic or corrective treatment. The CRC segment should indicate the referral only, not the actual diagnostic or corrective treatment. The CRC referenced diagnostic or corrective treatment should be included on a separate submission.

4.3.2 Encounters for EPSDT Diagnostic or corrective treatments will be submitted differently: Identify the EPSDT Supplemental Services by reporting the "EP" procedure modifier with the appropriate CPT code(s) for services rendered.

Loop/Segment	Reference Designator	837I Expected Value
2300/CRC – EPSDT Referral	**CRC01** Code Qualifier	"**ZZ**" Mutually Defined EPSDT Screening referral information.
	CRC02 Certification Condition Code Applies Indicator	"**Y**" If EPSDT referral given. If no EPSDT referral was given, do not populate
	CRC03 **CRC04*** **CRC05*** Condition Indicator **Use CRC04 and CRC05 when a second and third condition code is necessary*	"**AV**": Available-Not Used Patient refused referral "**NU**": Not Used if CRC02 = "N",then "NU"must be used in CRC03 "**S2**": Under Treatment "**ST**" : New Services Requested
2400/SV2	**SV202-03,04,05,06** Procedure Modifier	"**EP**" Modifier to identify EPSDT Supplemental Services

4.4 Physician Administered Drug (PAD) Encounter Submissions – 340B

For the Medi-Cal line of business, services that include the use of 340B physician administered drugs should be reported accurately with the proper procedure code, National Drug Code, drug unit, and drug quantity to BSC Promise. The "UD" modifier must be included in one of the four available modifier positions (2400 SV202-03, 04, 05 or 06).

4.5 Date Validation Checks

BSC Promise requires Trading Partners to submit complete and accurate data. As part of this initiative, BSC Promise has implemented several customized Date Verification checks, including the following:

Edit Level	ID	Date Field	Loop / Segment	Field / Data Element	Business Rule
File	1	Submission Date (the date the file was uploaded to BSC Promise)		System generated	
	2	Transaction Set Creation Date		BHT04	Transaction Set Creation Date must be less than or equal to the file submission date
Detail	3	Admission Date	2300	DTP*435 DTP03 (may be DT or D8)	Admission Date must be less than or equal to To Statement Date.
					Admission Date must be populated for inpatient encounters
	4	Procedure Date	2300	Principal BBR/BR HI01-4 Other BBQ/BQ HI01-4, HI02-4, thru HI12-4	Procedure Date must be greater than or equal to From Statement Date
					Procedure Date must be less than or equal to To Statement Date
	5	Service Date	2400	DTP*472 DTP03 (may be D8 or RD8)	From Service Date must be less than or equal to To Service Date
					To Service Date must be less than or equal to Adjudication Date
	6	Statement Date	2300	DTP*434*RD8 DTP03	From Statement Date must be less than or equal to To Statement Date
					To Statement Date must be less than or equal to the file submission date

4.6 Present on Admission (POA)

For Inpatient claims or encounters, the Present on Admission indicator must be properly reported for all diagnosis codes. The POA is located in loop 2300 segment HI01-09; the 01 incrementally increases for each additional diagnosis reported. As indicated below, report "Y" for Present at the time of inpatient admission, "N" for Not present at the time of inpatient admission, "U" if the documentation is insufficient to determine if the condition was present on admission, "W" if the provider was unable to clinically determine if the condition was present on admission and do not populate if the POA does not apply.

Loop / Segment	Value	Description
2300/ HI01 - 09	Y	Present at time of Inpatient Admission
	N	Not present at time of inpatient admission
	U	Insufficient documentation to determine of condition present on admission
	W	Provider unable to clinically determine of condition present on admission
	<Do not populate>	POA does not apply

4.7 Duplicate Claims or Encounters

All submissions will be evaluated by duplicate validation checks at the File and Record Level.

Duplicate File validation check is to verify the uniqueness of the file submitted. The combination of Submitter ID (ISA06) and Interchange Control Number (ISA13) will be used. If the combination is not unique, the file will be rejected.

Additionally, the uniqueness of a record will be validated against received records that were accepted in the prior 7 days. Claim data elements that are used for duplicate checks are as follows:

- Billing Provider Data
- Patient Data
- Claim Level Data
- Other Subscriber Information
- Service Line Data

4.8 Void and Replacement of a Claim or Encounter

Claims or Encounters that have been submitted and accepted can be subsequently corrected by either a void or a replacement action. When a Trading Partner needs to submit a Replacement or Void claim or encounter to a previously accepted claim or encounter, the following data must be provided:

1) The submitter (ISA06) of the correcting claim or encounter must be the same as the submitter of the claim or encounter being corrected.
2) The Claim Control Number (CLM01) must be unique.
3) A value of either "7" (replacement) or "8" (void) must be placed in the Claim Frequency Code in CLM05-03.
4) In the correcting claim or encounter, the Claim Control Number of the original accepted claim or encounter must be populated in the Payer Claim Control Number REF segment in the 2300 loop (REF*F8).

5. Control Segment/Envelopes

5.1 ISA/IEA

Interchange Control (ISA/IEA) must be utilized as portrayed in the National Electronic Data Interchange Transaction Set Implementation Guides. BSC Promise will work with Trading Partners to determine the submitter ID prior to testing for all electronic transactions. BSC Promise will accept only one ISA/IEA header per file.

Loop ID	Reference	Name	Codes	Notes/Comments
ISA	**ISA**	Interchange Control Header		
	ISA05	Interchange ID Qualifier	ZZ	Mutually Defined
	ISA06	Interchange Sender ID	PHPBEACONSPEC	
	ISA07	Interchange ID Qualifier	30	
	ISA08	Interchange Receiver ID	954468482	
	ISA11	Repetition Separator	^	
	ISA16	Component Element Separator	:	

5.2 GS/GE

The Functional Group Header (GS) is intended to group similar transaction sets within the same interchange. BSC Promise will accept only one GS/GE header per file.

Loop ID	Reference	Name	Codes	Notes/Comments
GS	**GS**	Functional Group Header		
	GS01	Functional Identifier Code	HC	
	GS02	Application Sender's Code	PHPBEACONSPEC	Value must match value in ISA06.
	GS03	Application Receiver's Code	954468482	

5.3 BHT

Loop ID	Reference	Name	Codes	Notes/Comments
BHT	**BHT**	Beginning of Hierarchical Transaction		
	BHT06	Claim or Encounter ID	RP	RP = Reportable for encounter records.

6. Transaction Specific Information

Under the Usage column in the following tables, "R" indicates Required and "S" indicates Situational.

6.1 Header Detail

Loop ID	Reference	Name	USAGE	Codes	Notes/Comments
1000A	**NM1**	Submitter Name	R		
	NM109	Submitter Identifier	R	PHPBEACONSPEC	Original Provider's Submitter ID
1000B	**NM1**	Receiver Name	R		
	NM103		R	BSC Promise Health Plan	
	NM109	Receiver Primary Identifier	R	954468482	

6.2 Billing Provider Detail

Loop ID	Reference	Name	USAGE	Codes	Notes/Comments
2000A	**PRV**	Billing Specialty Provider Info	R		Taxonomy code is required
2010AA	**NM1**	Billing Provider Name	R		
	NM101	Entity Identifier Code	R	85	Billing Provider
	NM108	Identification Code Qualifier	S	XX	For Atypical Providers NM108 should not be populated
	NM109	Identification Code	S		For Atypical Providers NM109 should not be populated; otherwise populate with NPI. The NPI is validated against the NPPES registry
	REF	Rendering Provider Secondary Identification	S		Required if the rendering provider is an Atypical provider **Note**: Encounters received for Atypical providers without State License Number will be rejected.
	REF01	Reference Identification Qualifier	R	0B	State License Number

6.3 Subscriber Detail

Each beneficiary is viewed as an individual subscriber. As such, each member must be identified in the Subscriber loop (2010BA). The Patient loop (2010CA) should not be used.

Loop ID	Reference	Name	USAGE	Codes	Notes/Comments
2000B	**SBR**	**Other Subscriber Information**	**R**		**Required to allow Beacon to submit member cost share information for claims they have adjudicated**
	SBR01	Payor Responsibility Sequence Number Code	R	S	S: Secondary **Note**: Only submit Beacon's payer adjudication information
2010BA	**NM1**	**Subscriber Name**	**R**		
	NM108	Identification Code Qualifier	R	MI	
	NM109	Subscriber Primary Identifier	R	Subscriber ID	FACETS ID, MBI, CIN, HICN, BSC Promise Member ID are acceptable. FACETS ID is recommended. **Note**: If BSC Promise Member ID is used with an asterisk (i.e., 1234567*01), then an asterisk (*) cannot be used as a delimiter

6.4 Payer Detail

Loop ID	Reference	Name	USAGE	Codes	Notes/Comments
2010BB	**NM1**	Payer Name	R		
	NM101	Entity Identifier Code	R	PR	
	NM103	Name Last Or Organization Name	R	BSC Promise Health Plan	
	NM108	Identification Code Qualifier	R	PI	
	NM109	Identification Code	R	954468482	

6.5 Claim Level Detail

Loop ID	Reference	Name	USAGE	Codes	Notes/Comments
2300	**CLM**	**Claim Information**	**R**		
	CLM01	Claim Control Number	R		Must be unique value per Submitter, no more than 12 characters
	CLM05-3	Claim Frequency Code	R	1, 2, 3, 4, 7, 8	1: Original encounter submission 2: Interim – First Claim 3: Interim – Continuing Claim 4: Interim – Last Claim 7: Replacement submission 8: Void submission
	CN1	**Contract Information**	**S**		**Required for Medicare**
	REF	**Payer Claim Control Number**	**S**		**Required for void and Replacements**
	REF01	Reference Identification Qualifier	R	F8	
	REF02	Claim Original Reference Number	R		Populate with the originally submitted CLM01 that the Trading Partner intends to take action on
	AMT	**Patient Amount Paid**	**S**		**Required for Medicare**
	AMT01	Amount Qualifier Code	R	F3	Patient Responsibility Amount
	K3	**File Information**	**S**		**Required if an MSO was used for submission**
	K301	Fixed Format Information	R	MSO Group Name	

Loop ID	Reference	Name	USAGE	Codes	Notes/Comments
2310D	**NM1**	Rendering Provider Name	S		Required if the rendering provider is different from the billing provider
	NM108	Identification Code qualifier	S	XX	For Atypical Providers, NM108 should not be populated
	NM109	Rendering Provider Identifier	S		For Atypical Providers NM109 should not be populated; otherwise populate with NPI. The NPI is validated against the NPPES registry
	PRV	Rendering Provider Specialty Information	R		Taxonomy code is required for rendering provider
	REF	Rendering Provider Secondary Identification	S		Required if the rendering provider is an Atypical provider **Note**: Encounters received for Atypical providers without State License Number will be rejected.
	REF01	Reference Identification Qualifier	R	0B	State License Number

Loop ID	Reference	Name	USAGE	Codes	Notes/Comments
2320	**SBR**	**Other Subscriber Information**	**R**		**Required to allow Beacon to submit member cost share information for claims they have adjudicated**
	SBR01	Payor Responsibility Sequence Number Code	R	P	P: Primary
2320	**AMT01 AMT02**	**COB Payer Paid Amount**	S	D	D: Payor Amount Paid AMT02: Monetary Amount
	AMT01 AMT02	**COB Total Non-Covered Amount**	S	A8	A8: Noncovered Charges AMT02: Monetary Amount
	AMT01 AMT02	**Remaining Patient Liability**	S	EAF	EAF: Amount Owed AMT02: Monetary Amount
	OI	**Other Insurance Coverage Information**	R		All information contained in the OI segment applies only to the payer identified in Loop ID-2330B in this iteration of Loop ID-2320
	OI03	Yes/No Condition or Response Code*	R	N, Y	N: No Y: Yes
	OI04	Patient Signature Source Code	S	P	P: Signature generated by provider because the patient was not physically present for services
	OI06	Release of Information Code*	R	Y	Y: Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim

*These are examples of used codes. Values and Qualifiers will be applied based on how the provider adjusted the services, including any services that were denied. For the entire list of Values and Qualifiers, refer to your 837P Implementation Guide: ASC X12 Standards for Electronic Data Interchange, Technical Report Type 3.

6.6 Service Line Detail

Loop ID	Reference	Name	USAGE	Codes	Notes/Comments
2400	**SV2**	**Institutional Service Line**	**R**		
	SV201	Service Line Revenue Code	R		Populate with 4-digit Revenue code. If Revenue Code is 2 digits, add leading zeros. E.G. '23' = '0023'
	SV202	Composite Procedure Medical Identifier	S		
	SV202-01	Product or Service ID Qualifier	R		For LA County Medi-Cal submissions, populate with HP if revenue code is '0022', '0023', '0024'. If revenue code is not '0022', '0023' or '0024', and the service is outpatient, populate with 'HC'
	SV202-02	Procedure Code	R		Populate with valid HCPC code if SV202-01 is 'HC'. For LA County Medi-Cal submissions, populate with valid HIPPS code if SV202-01 is 'HP'.
	SV202-07	Description	S		Required for Medicare if a Not Otherwise Classified procedure code is submitted in SV202-02
	SV204	Unit or Basis for Measurement Code	R	DA, UN	If the revenue code submitted is a Room and Board Revenue code, then populate with 'DA' and the corresponding line days in SV205. Otherwise, use 'UN' and populate the corresponding quantity in SV205

Loop ID	Reference	Name	USAGE	Codes	Notes/Comments
2400	**HCP***	**Line Pricing/Re-pricing Information**	**S**		Required for Medicare and Cal MediConnect For Medi-Cal: If cost share information is available, submit appropriately. If cost share information is not available, do not submit this segment. Required when the claim has been previously adjudicated by payer identified in Loop ID-2330B and this service line has payments and/or adjustments applied to it.
	HCP01	Pricing Methodology	S		Note: See Implementation Guide for codes
	HCP02	Monetary Amount	S		Allowed Amount
	HCP03	Reject Reason Code	S	T1	Populate with 'T1' if out of network. If in network, do not populate

***See **Appendix C** for examples

Loop ID	Reference	Name	USAGE	Codes	Notes/Comments
2410	**LIN**	Drug Identification	S		
	LIN02	Product Service ID/ Qualifier	R	N4	
	LIN03	National Drug Code	R	National Drug Cod in 5-4-2 Format	11 bytes
	REF	Prescription or Compound Drug Association	S		Required when a prescription number is available

Loop ID	Reference	Name	USAGE	Codes	Notes/Comments
2420C	**NM1**	Rendering Provider Name	S		Required if the rendering provider is different than that at the claim level, or required when the rendering provider is blank at the claim level, but the rendering provider on the service level is different than the billing provider
	NM101	Entity Identifier Code	R	82	Rendering Provider
	NM108	Identification Code Qualifier	S	XX	For Atypical Providers NM108 should not be populated.
	NM109	Rendering Provider Identifier	S		For Atypical Providers NM109 should not be populated; otherwise populate with NPI. The NPI is validated against the NPPES registry.
	REF	Rendering Provider Secondary Identification	S		Required if a provider is a typical provider. **Note**: Encounters received for Atypical providers without State License Number will be rejected.
	REF01	Reference Identification Qualifier	R	0B	State License Number

Loop ID	Reference	Name	USAGE	Codes	Notes/Comments
2430	**SVD****	Line Adjudication Information	S		Required for Medicare and Cal MediConnect For Medi-Cal: If cost share information is available, submit appropriately. If cost share information is not available, do not submit this segment. Required when the claim has been previously adjudicated by payer identified in Loop ID-2330B and this service line has payments and/or adjustments applied to it. **Note**: Only submit Beacon's payer adjudication information
	SVD01	Identification Code	S		Must match Loop 2330B NM109
	SVD02	Monetary Amount	S		Paid Amount Note: Loop 2400 SV103 Line Item Charge Amount Loop minus (-) Loop 2340 CAS Monetary Amount(s) = SVD02

*For the entire list of Claims Adjustment Group Codes and Adjustment Reason Codes (CARC), refer to Washington Publishing Company: http://www.wpc-edi.com/reference/

See **Appendix C for example

Loop ID	Reference	Name	USAGE	Codes	Notes/Comments
2430	**CAS****	Line Level Adjustments	S		Required for Medicare and Cal MediConnect For Medi-Cal: If cost share information is available, submit appropriately. If cost share information is not available, do not submit this segment. Required for all lines of business when at least one of the following members out of pocket responsibility is applied: co-insurance, deductible, or co-pay; and any denied services. **Note**: Claim Adjustment Group Code and Claim Adjustment Reason Code will be applied based on how the provider adjusted the services, including any services that were denied.
	CAS01	Claim Adjustment Group Code*	R	CO, PR	CO: Contractual Obligations PR: Patient Responsibility
	CAS02	Claim Adjustment Reason Code*	R	1, 2, 3	1: Deductible Amount 2: Co-Insurance Amount 3: Co-pay Amount
	AMT01 AMT02	**Remaining Patient Liability**	S	EAF	EAF: Amount Owed AMT02: Monetary Amount

*For the entire list of Claims Adjustment Group Codes and Adjustment Reason Codes (CARC), refer to Washington Publishing Company: http://www.wpc-edi.com/reference/

See **Appendix C for examples

Appendix A Claim Type

There are five Claim Types:

1) Pharmacy

The Claim Type of the encounter data submitted in the file type NCPDP 4.2 is "Pharmacy" with a value of "01".

2) Long Term Care

The Claim Type of claim or encounter data submitted in the file type 837I depending upon its Facility Type and/or the Room & Board Indicator of the Revenue Code is "Long Term Care" with a value of "02".

3) Hospital Inpatient

The Claim Type of claim or encounter data submitted in the file type 837I depending upon its Facility Type is "Hospital Inpatient" with a value of "03".

4) Outpatient

The Claim Type of claim or encounter data submitted in the file type 837I depending upon its Facility Type and/or the Room & Board Indicator of the Revenue Code is "Outpatient" with a value of "04".

5) Physician

The Claim Type of claim or encounter data submitted in the file type 837P is "Physician" with a value of "05".

Claim Types

Claim Type	Description	File Type
01	Pharmacy	NCPDP
02	Long Term Care	837I
03	Hospital Inpatient	837I
04	Outpatient	837I
05	Physician	837P

Appendix B Facility Type

Facility Type will be determined by the first two digits of Bill Types.

Claim Type will be determined by File type, Facility Type (first two digits of the Bill Types), Room & Board Indicator of the Revenue Codes.

Facility Type and Claim Type

File Type	Type of Bill – 1st 2 Digits	Facility Type	Room & Board Indicator of Revenue Code	Claim Type
837P				05
NCPDP				01
837I	11	Hospital Inpatient (Including Medicare Part A)		03
837I	12	Hospital Inpatient (Medicare Part B only)		04
837I	13	Hospital Outpatient		04
837I	14	Hospital Laboratory Services Provided to Non- patients		04
837I	18	Hospital Swing Beds		02
837I	21	Skilled Nursing Inpatient (Including Medicare Part A)		02
837I	22	Skilled Nursing Inpatient (Medicare Part B only)		04
837I	23	Skilled Nursing Outpatient		04
837I	28	Skilled Nursing Swing Beds	One of the Revenue Codes is a bed code	02
837I	28	Skilled Nursing Swing Beds	No revenue codes are bed codes	04
837I	32	Home Health-Inpatient(Plan of treatment under Part B only)		04
837I	33	Home Health Outpatient		04
837I	34	Home Health-Other (for medical and surgical services not under a plan of treatment)		04

File Type	Type of Bill – 1st 2 Digits	Facility Type	Room & Board Indicator of Revenue Code	Claim Type
837I	41	Religious Non-Medical Health Care Institutions Hospital Inpatient (formerly referred to as Christian Science) - Inpatient (Including Medicare Part A)		03
837I	43	Religious Non-Medical Health Care Institutions Hospital Inpatient (formerly referred to as Christian Science) - Outpatient		04
837I	65	Intermediate Care - Level I	One of the Revenue Codes is a bed code	02
837I	65	Intermediate Care - Level I	No revenue codes are bed codes	04
837I	66	Intermediate Care Intermediate Care - Level II	One of the Revenue Codes is a bed code	02
837I	66	Intermediate Care Intermediate Care - Level II	No revenue codes are bed codes	04
837I	69	Intermediate Care Reserved for National Assignment		02
837I	71	Clinic - Rural Health		04
837I	72	Clinic - Hospital Based or Independent		04
837I	73	Clinic - Free Standing		04
837I	74	Clinic - Outpatient Rehabilitation Facility		04
837I	75	Clinic - Comprehensive Outpatient Rehabilitation		04
837I	76	Clinic - Community Mental Health Center		04
837I	77	Clinic - Federally Qualified Health Center (FQHC)		04
837I	78	Licensed Freestanding Emergency Medical Facility		04
837I	79	Clinic - Other		04

File Type	Type of Bill – 1st 2 Digits	Facility Type	Room & Board Indicator of Revenue Code	Claim Type
837I	81	Hospice (non-hospital based)		04
837I	82	Hospice (hospital based)		04
837I	83	Ambulatory Surgery Center		04
837I	84	Free Standing Birthing Center		04
837I	85	Critical Access Hospital		04
837I	86	Residential Facility	One of the Revenue Codes is a bed code	02
837I	86	Residential Facility	No revenue codes are bed codes	04
837I	89	Special Facility - Other	One of the Revenue Codes is a bed code	02
837I	89	Special Facility - Other	No revenue codes are bed codes	04

Appendix C Cost Share Information

Data Elements	Loop	Segment Position	Example
Allowed Amount	2400	HCP02	HCP*10*100~
Paid Amount	2430	SVD02	SVD*IPA*60~
Any other Adjudicated Amounts (Not part of balancing, only shown here as an example that CAS segments are used for non-Member Out of Pockets as well)	2430	CAS03 where CAS02, CAS05, etc. does not = 1, 2, 3, 66, 241, 247, 248	CAS*CO*45*50~
Member Out of Pockets			
Deductible	2430	CAS03 where CAS02, CAS05, etc. = 1, 66, 247	CAS*PR*1*10
Coinsurance	2430	CAS03 where CAS02, CAS05, etc. = 2, 248	CAS*PR*2*10
Copayment	2430	CAS03 where CAS02, CAS05, etc. = 3, 241	CAS*PR*3*10
Any other Patient Responsibility Amounts	2430	CAS03 where CAS01, CAS04, etc. = PR	CAS*PR*96*10

Scenario A: No member out of pocket dollars: Paid at 100% of Allowance

LX*1~
SV1*HC>88305>>>>>TISSUE EXAM BY PATHOLOGIST*3000*UN*12***1~ *[BILLED AMOUNT: $3000]*
DTP*472*D8*20200219~
REF*6R*403834930921~
HCP*10*883.73~ *[ALLOWED AMOUNT: $888.73]*
SVD*IPA*883.73*HC>88305**12~ *[PAID AMOUNT: $888.73]*
CAS*CO*45*2116.27~ *[OTHER ADJUDICATED AMOUNTS: $2116.27]*
DTP*573*D8*20200318~

Scenario B: Member out of pocket: Member Out of Pocket Amounts + Paid Amount = Allowance

Variation 1: ($5 + $76.73 = $81.73)
LX*1~
SV1*HC>99214>>>>>OFFICEOUTPATIENT VISIT, EST*178.14*UN*1***1~ *[BILLED AMOUNT: $178.14]*
DTP*472*D8*20200206~
REF*6R*403837896971~
HCP*10*81.73~ *[ALLOWED AMOUNT: $81.73]*
SVD*IPA*76.73*HC>99214**1~ *[PAID AMOUNT: $76.73]*
CAS*CO*45*96.41~ *[OTHER ADJUDICATED AMOUNTS: $96.41]*
CAS*PR*3*5~ *[ADJUDICATED AMOUNT APPLIED TO PATIENT RESPONSIBILITY "PR" FOR COPAY AMOUNT: $5]*
DTP*573*D8*20200227~

Variation 2: ($222.32 + $871.47 = $ 1093.79)
LX*1~
SV1*HC>E0483>RR>KX>KJ>>HI FREQ CHST WALL AIR-PULSE GEN EA*1642.5*UN*1***1~ *[BILLED AMOUNT: $1642.5]*
DTP*472*D8*20200207~
REF*6R*4038357099Z1~
HCP*10*1093.79~ *[ALLOWED AMOUNT: $1093.79]*
SVD*IPA*871.47*HC>E0483**1~ *[PAID AMOUNT: $871.47]*
CAS*OA*45*548.71~ *[OTHER ADJUDICATION AMOUNT: $548.71]*
CAS*PR*2*222.32~ *[ADJUDICATED AMOUNT APPLIED TO PATIENT RESPONSIBILITY "PR" FOR COINSURANCE AMOUNT: $222.32]*
DTP*573*D8*20200228~

Variation 3: ($35 + $35 = $70)
LX*1
SV1*HC>99212*80*UN*1***1 *[BILLED AMOUNT: $80]*
DTP*472*D8*20200129
REF*6R*398877979Z1
HCP*10*70~ *[ALLOWED AMOUNT: $70]*
SVD*95414204477*35*HC>99212**1 *[PAID AMOUNT: $35]*
CAS*CO*45*10 *[OTHER ADJUDICATION AMOUNT: $10]*
CAS*PR*3*35 *[ADJUDICATED AMOUNT APPLIED TO PATIENT RESPONSIBILITY "PR" FOR COPAYMENT AMOUNT: $35]*
DTP*573*D8*20200228

Scenario C: Service is denied, Billed Amount equals Patient Responsibility

LX*1~
SV1*HC>90691*313*UN*1***1>2~ *[BILLED AMOUNT: $313]*
DTP*472*D8*20191230~
REF*6R*P1281605630-2~
LIN**N4*49281079020~
CTP****.5*ML~
HCP*00*0*~ *[ALLOWED AMOUNT: $0]*
SVD*002*0*HC>90691**1~ *[PAID AMOUNT: $0]*
CAS*PR*96*313~ *[ADJUDICATED AMOUNT APPLIED TO PATIENT RESPONSIBILITY "PR": $313]*
DTP*573*D8*20200228~

Scenarios specific to Medi-Cal on the next page…

Scenario D: Services are for Medi-Cal member and cost share information is available however configured as zero dollars applied.

LX*1~
SV1*HC>90691*313*UN*1***1>2~ *[BILLED AMOUNT: $313]*
DTP*472*D8*20191230~
REF*6R*P1281605630-2~
LIN**N4*49281079020~
CTP****.5*ML~
HCP*00*0*~ *[ALLOWED AMOUNT: $0]*
SVD*002*0*HC>90691**1~ *[PAID AMOUNT: $0]*
CAS*CO*24*313~ *[OTHER ADJUDICATED AMOUNT APPLIED: $313]*
DTP*573*D8*20200228~

Scenario E: Services are for Medi-Cal member and cost share information is not available

LX*1~
SV1*HC>90691*313*UN*1***1>2~ *[BILLED AMOUNT: $313]*
DTP*472*D8*20191230~
REF*6R*P1281605630-2~
LIN**N4*49281079020~
CTP****.5*ML~
*[No HCP, SVD, CAS and DTP*573 segments are submitted]*