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

# Blue Shield of California Promise Health Plan

# Beacon

## 837 Professional Companion Guide

For Health Care Claim/Encounter (837P)

Transactions based on ASC X12 Implementation Guides, Version 005010X222A1
Effective Date: 1/1/2019

Version Number 1.5
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# Document History:

| Version | Release Date | Description |
|---|---|---|
| 1.0 | 4/26/2018 | Creation Date |
| 1.1 | 5/17/2018 | Addition: Appendix A Encounter Type<br>Addition: Appendix B Facility<br>Type Updated: File Name<br>Convention<br>Updated: Response File Name |
| 1.2 | 7/31/2018 | Updated: Contact phone number<br>Updated: Response file name<br>Updated: 2430 CAS |
| 1.3 | 9/21/2018 | Replaced Care 1st with BSC Promise<br>Updated 1.2 Contact Information<br>Updated 2.3 Testing<br>Updated 2.5 Processing Schedule<br>Updated 6.1 Loop 1000B<br>Updated 6.3 Notes/Comments<br>Updated 6.4 Loop 2010BB<br>Updated 6.6 Loop 2430 |
| 1.4 | 10/2/19 | Updated multiple fields for Beacon requirements to submit member cost share information. |
| 1.5 | 4/16/2020 | Added: Loop 2400 HCP02 Note<br>Added: Loop 2430 SVD01, SVD02<br>Added: Appendix C |

# Table of Contents

# 1. Introduction

## 1.1 Scope

This companion guide provides information on the submission of Medi-Cal, Medicare, and Cal MediConnect professional 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 Blue Shield of California Promise Health Plan professional claim or encounter data companion guide versions.

This companion guide is to be used in conjunction with the 5010 Implementation Guide ASC X12N / 005010X222A1 -- Health Care Claim Professional (837P). The instructions in this companion guide are not intended to replace or be standalone requirements from the Implementation Guide (837P). Requirements that are identical to the Implementation Guide (837P) 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 | "837P" for 837 Professional |
| **TRANSACTION-TYPE-CODE** | Code specifying the type of transaction | Must match the value submitted in BHT06 |
| **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.<br>"**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 837P file submitted to BSC Promise. The TA1 report provides information to the Trading Partner on whether the file was successfully received. The 837P 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 837P 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.

## 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 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 837P are required to adhere to the following:

4.2.1 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.

4.2.2 In the 2400 loop (service level), use a "Y" in field SV111 ("Yes/No Condition Response Code") if there was an EPSDT involvement in the service.

4.2.3 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 | 837P Expected Value |
|---|---|---|
| **2300/ CRC – EPSDT Referral** | CRC01<br>Code Qualifier | "ZZ"<br>Mutually Defined<br>EPSDT Screening referral information |
| | CRC02<br>Certification Condition Code Applies Indicator | "Y"<br>If EPSDT referral given. If no EPSDT referral was given, do not populate |
| | CRC03<br>CRC04<br>*<br>CRC05<br>*<br>Condition Indicator<br><br>*Use CRC04 and CRC05 when a second and third condition code is necessary | "AV": Available-Not Used<br>Patient refused referral<br>"NU": Not Used<br>If CRC02 = "N", then "NU" must be used in CRC03<br>"S2": Under Treatment<br>"ST": New Services Requested |
| **2400/ SV1** | SV111<br>EPSDT Indicator | "Y"<br>Indicates EPSDT involvement |
| | SV101-03, 04, 05 or 06<br>Procedure Modifier | "EP"<br>Modifier to identify EPSDT Supplemental Services |

## 4.3 Physician Administered Drug (PAD) 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 SV101-3, 4, 5 or 6).

## 4.4 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 (date 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 | Adjudication or Payment Date | 2430 | DTP*573 DTP03 | Adjudication Date must be less than or equal to file submission date |
| | 4 | Admission Date | 2300 | DTP*435 DTP03 | Admission Date must be less than or equal to To Service Date |
| | 5 | Discharge Date | 2300 | DTP*096 DTP03 | Discharge Date must be greater than or equal to To Service Date |
| | 6 | Patient Death Date | 2000B | PAT06 | Death Date must be greater than or equal to To Service Date |
| | 7 | 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 |

## 4.5 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

## 4.6 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 Claim Control Number (CLM01) must be unique.
2) A value of either "7" (replacement) or "8" (void) must be placed in the Claim Frequency Code in CLM05-03.
3) 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<br>**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<br>**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.<br>**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 | 1,7,8 | 1: Original encounter submission<br>7: Replacement submission<br>8: Void submission |
| | **CN1** | Contract Information | S | | Required for Medicare |
| | **REF** | Payer Claim Control Number | S | | Required for replacements or voids (CLM05-3 = 7 or 8) |
| | REF01 | Reference Identification Qualifier | R | F8 | |
| | REF02 | Claim Original Reference Number | R | | Populate with the originally submitted CLM01 that the submitter intends to take action on |
| | **AMT** | Patient Amount Paid | R | | Required for Medicare |
| | **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 |
|---|---|---|---|---|---|
| **2310B** | **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<br>**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<br>AMT02: Monetary Amount |
| | **AMT01 AMT02** | **COB Total Non-Covered Amount** | S | A8 | A8: Noncovered Charges<br>AMT02: Monetary Amount |
| | **AMT01 AMT02** | **Remaining Patient Liability** | S | EAF | EAF: Amount Owed<br>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<br>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** | **SV1** | **Professional Service** | **R** | | |
| | SV101-07 | Description | S | | Required for Medicare if a non-specific procedure code is submitted in SV101-02 |
| | **HCP**** | **Line Pricing/Re-pricing Information** | **S** | | Required for Medicare and Cal MediConnect<br><br>For Medi-Cal:<br>If cost share information is available, submit appropriately. If cost share information is not available, do not submit this segment.<br><br>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 | 00, 10 | 00: Zero Pricing (Not covered under Contract)<br>10: Other Pricing |
| | HCP02 | Monetary Amount | S | | Allowed Amount |
| | HCP13 | Reject Reason Code | S | T1 | Populate with T1 if out of network. If in network, do not populate |
| **2410** | **LIN** | **Drug Identification** | **S** | | |
| | LIN02 | Product Service ID/Qualifier | R | N4 | |
| | LIN03 | National Drug Code | R | National Drug Code In 5-4-2 Format | 11 Bytes |
| | **REF** | **Prescription or Compound Drug Association Number** | **S** | | **Required when a prescription number is available** |

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

** See **Appendix C** for examples

| Loop ID | Reference | Name | USAGE | Codes | Notes/Comments |
|---|---|---|---|---|---|
| 2420A | **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. |
| | **PRV** | Rendering Provider Specialty Information | S | | Required if different from Billing |
| | PRV01 | Provider Code | R | PE | Performing |
| | **REF** | Rendering Provider Secondary Identification | S | | Required if a provider is a typical provider.<br>**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<br><br>For Medi-Cal:<br>If cost share information is available, submit appropriately. If cost share information is not available, do not submit this segment.<br><br>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.<br>**Note**: Only submit Beacon's payer adjudication information |
| | SVD01 | Identification Code | S | | Must match Loop 2330B NM109 |
| | SVD02 | Monetary Amount | S | | Paid Amount<br><br>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<br><br>For Medi-Cal:<br>If cost share information is available, submit appropriately. If cost share information is not available, do not submit this segment.<br><br>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.<br><br>**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<br>PR: Patient Responsibility |
| | CAS02 | Claim Adjustment Reason Code* | R | 1, 2, 3 | 1: Deductible Amount<br>2: Co-Insurance Amount<br>3: Co-pay Amount |
| | **AMT01<br>AMT02** | **Remaining Patient Liability** | S | EAF | EAF: Amount Owed<br>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 Claims 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) | | 03 |
| 837I | 43 | Religious Non-Medical Health Care Institutions Hospital Inpatient (formerly referred to as Christian Science) | | 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 |

| File Type | Type of Bill – 1st 2 Digits | Facility Type | Room & Board Indicator of Revenue Code | Claim Type |
|---|---|---|---|---|
| 837I | 79 | Clinic - Other | | 04 |
| 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<br><br>(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*4038349309Z1~
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*403835709971~
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*398877979671
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]*