County of Los Angeles
Department of Mental Health

Contract Providers Transition Project (CPTP)

837I Companion Guide – Short Doyle II

Version 5.3

September 2011

DOCUMENT REVISION HISTORY

Version	Release Date	Revised by	Comments/Indicate Sections Revised
V 1.0	06/13/2006	Dee Eng	
V 3.0 (IS 2.0)	11/27/2006	Dee Eng	Updated for Implementation of Integrated System Version 2.0
V 3.1	01/30/2008	Dee Eng	Added requirement for Transaction Set Header, segment ST02, must be numeric to receive a 997
V 4.0	04/15/2008	Dee Eng	Updated loops 2010A for HIPAA NPI Requirements
V 4.1 (IS 2.0 & NPI)	08/27/2008	Dee Eng	Updated Loop 2330B NM109 to be the value of '01192' when Medicare is the payer.
Release Version 4.1 Revised for .gov links	08/12/2009	Marta Ghazarian	Minor Updates
Release Version 5.0 Short Doyle II updates	03/12/2010	Karen Bollow	All Sections updated for Short Doyle II Modifications
V 5.1	07/02/2010	Dee Eng	Modifications for Evidence Based Practice
V 5.2	06/09/2011	Dee Eng	Required Rendering Provider Taxonomy Code
V 5.3	09/07/2011	Gordon Bunch	Detailed Adjustments for local Contract Providers in Loop 2320 CAS and AMT segments **[Effective 10/13/11]**

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837I (HEALTH CARE CLAIM: INSTITUTIONAL) COMPANION GUIDE **2**

DMH Integrated System Project
Companion Guides Legend

Usage Notes	DMH Validation	DMH Business Rules	Example
This Companion Guide addresses specific DMH business process requirements for HIPAA transactions that are conformable with the HIPAA requirements. It is assumed that trading partners are familiar with the HIPAA Implementation Guides and, as such, this guide does not attempt to instruct trading partners in the creation of an entire HIPAA transaction. However, samples of entire transaction will be given to trading partners during registration / orientation process. This Companion Guide is subject to change. Please visit our website at http://dmh.lacounty.gov/hipaa/edi_homepage.html for the latest version. LAC-DMH CIOB HIPAA EDI UNIT promotes Trading Partners readiness for these transactions. Please contact us at (213) 351-1335.	This column identifies which segments and fields are required by DMH. While some of these segments are not required by HIPAA they may be required by DMH to process claims. It is strongly recommended to reference these Companion Guides in conjunction with the WPC Implementation Guides. Pay downloads of Washington Publishing Company's HIPAA EDI Implementation Guides can be obtained at www.wpc-edi.com 270 - 004010X092 276 - 004010X093 834 - 004010X095 837P - 004010X098 & 004010X098A1 837I - 004010X096 835 - 004010X091 277U - 004040X167 Data Element Dictionary 004010DED	This column describes how the segment / field are to be used in order to meet the DMH business process requirements. Explanations are given much consideration to Fee-For-Service and Local Contract Providers, under different claim scenarios.	This column gives an example of the data that can be populated in the field. If the value is darkened / bolded, must use that value.
	R = Required		
	S= Situational		

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Loop	Seg ID	Ref. Des.	Field Name	DMH Valid.	DMH Business Rules	Example
Interchange Control Header						
HEADER	ISA	ISA05	Interchange ID Qualifier	M	Always use ZZ.	**ZZ**
HEADER	ISA	ISA06	Interchange Sender ID	M	Use the Interchange Sender ID assigned to the provider by DMH during registration process.	000000020000000
HEADER	ISA	ISA07	Interchange ID Qualifier	M	Always use ZZ.	**ZZ**
HEADER	ISA	ISA08	Interchange Receiver ID	M	Always use 000000010000000 for DMH Interchange Receiver ID.	**000000010000000**
HEADER	ISA	ISA13	Interchange Control Number	M	IS2.0: This field is required by HIPAA and is recommended to be a unique value for each file. To identify each file for a submitter, DMH business process ensures the value for the file is unique. The Interchange Control Number, ISA13, must be Identical to the associated Interchange Trailer IEA02 As per HIPAA this must be a length of nine (9)	123456789 - Unique value that is a length of 9
Transaction Set Header						
HEADER	ST	ST02	Transaction Set Control Number	R	In order to receive a 997 transaction from BizTalk, this field must be numeric for the length of 4 (minimum) to 9 (maximum).	1234, 0011, 12345, 123456789, etc.

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Loop	Seg ID	Ref. Des.	Field Name	DMH Valid.	DMH Business Rules	Example
Functional Group Header						
HEADER	GS	GS02	Application Sender's Code	M	Use the Application Sender Code assigned to the provider by DMH during registration process.	00000002
HEADER	GS	GS03	Application Receiver's Code	M	Always use 10000000 for DMH Application Receiver ID.	**00000001**
Beginning Of Hierarchical Transaction						
HEADER	BHT	BHT02	Transaction	M	This field is required by HIPAA, but DMH does not validate nor use this field in any business process. DMH checks claim frequency (2300_CLM05-3) to determine the type of claim and only allows a claim frequency of original ("1"), resubmit ("7") or void ("8"). Therefore, even if BHT02 contains "18" (Reissue) and the claim frequency is Original, the patient account number (2300_CLM01) must be unique and the claim is processed as an original claim. DMH ignores this field.	00, 18
Transmission Type Identification						
HEADER	REF	REF01	Reference ID Qualifier	M		87
HEADER	REF	REF02	Transmission Type Code	M	Test value should be 004010X096DA1.	004010X096A1(production) and 004010X096DA1 (testing and certification)
Submitter Name						
1000A	NM1	NM108	Identification Code Qualifier	M	Must use 46.	**46**
1000A	NM1	NM109	Submitter Primary ID#	M	Electronic Transmitter Identification Number (ETIN) assigned to provider by DMH during registration process.	00000002

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Loop	Seg ID	Ref. Des.	Field Name	DMH Valid.	DMH Business Rules	Example
Submitter EDI Contact Name						
1000A	NM1	PER03	Communication Number Qualifier	O	If available, populate this field with the appropriate HIPAA qualifier for the submitters telephone or email address	TE
1000A	NM1	PER04	Communication Number Qualifier	O	If available, populate this field with the submitters telephone number or email address.	2135551212
1000A	NM1	PER05	Communication Number Qualifier	O	If available populate this field with the appropriate HIPAA qualifier for the submitters telephone or email address	EM
1000A	NM1	PER06	Communication Number Qualifier	O	If available, populate this field with the submitters telephone number or email address.	subdept@subcompany.com
Receiver Name						
1000B	NM1	NM103	Receiver Name	M	This value is not used or validated by DMH and is provided for informational purposes only.	**LAC DEPARTMENT OF MENTAL HEALTH**
1000B	NM1	NM108	Identification Code Qualifier	M	Must use 46.	**46**
1000B	NM1	NM109	Receiver Primary Identifier	M	The receiver must always be DMH. Always use 00000001	**00000001**
Billing Provider Name						
2010AA	NM1	NM108	Identification Code Qualifier	S	HIPAA requires this field, ' XX' is used with combination for NPI.	**XX**
2010AA	NM1	NM109	Pay-to Provider Identifier	S	LAC-DMH ensures the qualifier and identifier combination are valid. LAC-DMH will also apply the NPI check digit algorithm to ensure valid NPI format. IMPORTANT: Use Service Location NPI here when it's a Satellite or Public school site.	Billing Provider NPI or Service Location NPI (ONLY for Satellite of Public School site) 1123456789

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Loop	Seg ID	Ref. Des.	Field Name	DMH Valid.	DMH Business Rules	Example
2010AA	REF	REF01	Reference Identification Qualifier	R	This segment is used to identify the billing provider and service location. These identification values are assigned to providers by DMH during the registration process. Always use 'B3' to identify the billing provider. Always use 'FH' to identify the service location. If the billing provider and service location are the same, there still must be two REF segments. When NPI is used, must ALSO provide 'EI' for Employer's Identification number or 'SY' for Social Security number. There are three 2010AA, REF segments must be used.	**B3** - Assigned billing provider id and **FH** - Assigned Service location ID and **EI** - Employer's Identification number or **SY** - Social Security number
2010AA	REF	REF02	Billing Provider Additional Identifier	R	Use the appropriate assigned identification values for billing provider, service location and EIN / SSN when use with NPI.	2390 555998888
Subscriber Information						
2000B	SBR	SBR01	Payer Responsibility Sequence Number	M	Set to the appropriate payment responsibility for DMH. DMH is always the payer of last resort and as such its payment responsibility is after all other payers (Private Insurance, Medicare and/or Medi-Cal) of the claim. Typically this value is usually set to 'T'.	P - If DMH is the only payer and there are no DMH plans specified in 2320 (i.e. there are no 2320 loops). S - If there is just one other payer (e.g. Medi-Cal or a DMH plan) specified) in 2320) T - If there are two other payers (e.g. Medicare and Medi-Cal) specified in the 2320 loop.

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Loop	Seg ID	Ref. Des.	Field Name	DMH Valid.	DMH Business Rules	Example
2000B	SBR	SBR02	Relationship Code	M	DMH subscriber's are always the patient. Therefore, never send the 2000C loop. Always set this field to 18.	**18**
Patient Information						
2000B	PAT	PAT06	Date of Death	0	Date of Death cannot be prior to the birthdate in 2010BA_DMG_Birthdate. If the birthdate is not provided in the 837i, the IS ensures the date of death is not prior to the birthdate that the IS has stored, if any, for the client.	20030120
Subscriber Name						
2010BA	NM1	NM102	Entity Type Qualifier	M	Subscriber is always the patient. Always set to 1.	**1**
2010BA	NM1	NM108	Identification Code Qualifier	M	Always use Member ID qualifier (MI).	**MI**
2010BA	NM1	NM109	Subscriber Primary Identifier	M	Set to the 7 digit DMH client ID. If the client id is not valid, the claim will be rejected.	0123456
Payer Name						
2010BC	NM1	NM108	Identification Code Qualifier	M		PI
2010BC	NM1	NM109	Payer Identifier	M	The payer is always DMH. Always use 953893470.	**953893470**
Payer Address						
2010BC	N3	N301	Payer Address Line	O	The address is not used by DMH and is provided for informational purposes only.	**500 S. VERMONT AVENUE**
Payer City State ZIP CODE						
2010BC	N4	N401	Payer City Name	O	The address is not used by DMH and is provided for informational purposes only.	**LOS ANGELES**
2010BC	N4	N402	Payer State Code	O	The address is not used by DMH and is provided for informational purposes only.	**CA**

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Loop	Seg ID	Ref. Des.	Field Name	DMH Valid.	DMH Business Rules	Example
2010BC	N4	N403	PayerPostalZoneOrZIPCode	O	The address is not used by DMH and is provided for informational purposes only.	**90020**
2010BC	N4	N404	Country Code	O	The address is not used by DMH and is provided for informational purposes only.	**US**
Claim Information						
2300	CLM	CLM01	Patient Account Number	M	This value must be unique for all claims received by a submitter, which includes original, replacement and void claims. The combination of Submitter ID (1000A_NM109) and Patient Account Number (2300-CLM01) must be unique for all claims. Any duplicates will be rejected. For replacement claims, use 2300_REF_OriginalReferenceNumberICNDCN and set 2300_REF01__ReferenceIdentificationQualifier attribute to the claim id that is being replaced. The IS only accepts replacement claims if the claim in this attribute was already denied. For void claims, use 2300_REF_OriginalReferenceNumberICNDCN and set 2300_REF01__ReferenceIdentificationQualifier attribute to the claim id that is being voided. The IS only accepts voided claims if the claim in this attribute has not been denied.	

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Loop	Seg ID	Ref. Des.	Field Name	DMH Valid.	DMH Business Rules	Example
2300	CLM	CLM20	Delay Reason Code	M	Use this code for claims submitted more than 6 months after the service date. For LP providers do not use reason codes 3,5,6,9 or 11. If these are used for LP providers, the claim will be rejected.	1
2300	CLM	CLM05-1	Place of Service Code	M	DMH uses this field to determine the place of service. If this field is not present, the claims will be rejected.	23
2300	CLM	CLM05-3	Claim Frequency Code	M	DMH only accepts original ('1'), replacement ('7'), or void ('8') claims. If corrected ('6') claims are received, they will be rejected. Please see 2300_REF_OriginalReferenceNumberICNDCN for use with replacement and void claims.	**1** - Original Claim **7** - Replacement Claim **8** - Void claim
2300	CLM	CLM07	Provider Accept Assignment Code	R	IS2.0 If the provider is Medicare Certified set to 'A' If the provider is not Medicare Certified set to 'C'. This mapping is consistent with Medi-Cal requirements	**A,C**
Statement Dates						
2300	DTP	DTP02	Date Time Qualifier	R	This is required by HIPAA. DMH does not use this segment	
2300	DTP	DTP03	Statement From Or To Date	R	This is required by HIPAA. DMH does not use this segment	
Admission Date and Hour						
2300	DTP	DTP02	Date Time Qualifier	R	DMH requires an admit date and time for all institutional claims.	**DT**

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Loop	Seg ID	Ref. Des.	Field Name	DMH Valid.	DMH Business Rules	Example
2300	DTP	DTP03	Statement From Or To Date	R	Specify the episode admit date and time. (CCYYMMDDHHMM) DMH ensures an episode exists for the client, service location, admit date and service dates.	200510011130
Share of Cost (SOC)						
2300	AMT	AMT01	Amount Qualifier Code	0	Code to qualify amount	**F5**
2300	AMT	AMT02	Patient Paid Amount	0	Patient SOC amount obligated	SOC obligated amount
Original Reference Number ICNDCN						
2300	REF	REF01	Reference ID Qualifier	O	For Replacement and Void claims this segment is required	**F8**

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Loop	Seg ID	Ref. Des.	Field Name	DMH Valid.	DMH Business Rules	Example
2300	REF	REF02	Claim Original Reference Number	O	For Replacement claims, specify the submitter's claim ID for the claim that is being replaced. The IS ensures that the claim ID specified in this attribute has already been denied. For Void claims, specify the submitter's claim ID for the claim that is being voided. The IS ensures that the claim ID specified in this attribute has not already been denied. IS2.0 For Replacement and Voided claims the IS assigned claims identifier (IS Claim Number) for the claim to be replaced/voided must be used in this field. The IS will accept Void on a claim that was approved or denied by DMH adjudication. Replacement and Voids are not allowed on claims that were denied by DMH Business Rules	Claim ID to be replaced or voided IS2.0 Internal IS claim identifier
Claim Note for Reporting EBP Codes						
2300	NTE	NTE01	Note Reference Code	R	Use when required by State law for health data reporting.	**DCP**

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Loop	Seg ID	Ref. Des.	Field Name	DMH Valid.	DMH Business Rules	Example
2300	NTE	NTE02	Description	R	Use Codes from list provided only. Use 99 for unknown. Up to 3 codes can be used and separate each code by a hyphen (-). The code is 2-byte alpha-numeric. Alpha is in uppercase, numeric has leading zero. Claim will fail if this REF segment is not present. Claim will also fail for invalid code format.	**NTE*DCP*01-7R-61~** **NTE*DCP*99~** **NTE*DCP*01-10~**
Claim Note for all indicators						
2300	NTE	NTE01	Note Reference Code	O	Code identifying the functional area or purpose for which the note applies	**UPI**
2300	NTE	NTE02	Description	O	Description indicates the claim is a Health Families, EPSDT screen referral, Pregnancy, Emergency, Duplicate Override. Use one segment for each indicator when aid-code and/or duplicate override is/are applicable.	**SED** (Healthy Families) **EPSDT screen referral** **EMERGENCY** **PREGNANCY** **76** (duplicate override code)
Attending Physician						
2310A	NM1	NM101	Entity Identifier Code	R	The rendering provider is always required even if it is the same as the billing provider and/or the pay to provider.	**82**
2310A	NM1	NM108	Identification Code Qualifier	R	This field is required by HIPAA - NPI use	**XX**
2310A	NM1	NM109	Referring Provider Primary ID	R	LAC-DMH ensures the qualifier and identifier combination are valid. LAC-DMH will also apply the NPI check digit algorithm to ensure valid NPI format.	Attending Physician NPI 1123456789

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Loop	Seg ID	Ref. Des.	Field Name	DMH Valid.	DMH Business Rules	Example
Attending Physician Specialty Information						
2310A	PRV	PRV03	Provider Taxonomy Code	R	Enter the Taxonomy for the Rendering Provider. DMH ensures the Taxonomy is a valid I.S. Taxonomy.	2084P0800X
Attending Physician Secondary Information						
2310A	REF	REF01	Reference ID Qualifier	M	This segment is used to identify the attending physician identification that was assigned to providers by DMH during the registration process. Always use 'N5' to identify the attending physician. If the attending physician is the same as the billing provider and/or pay-to provider, there still must be REF segment. All other REF segments without "N5" in REF01 are ignored by DMH.	**N5** - to specify rendering provider
2310A	REF	REF02	Rendering Provider Secondary ID	M	Use the assigned identification value for the rendering provider. DMH uses this value to identify the rendering provider.	240
Service Facility Location ----- IMPORTANT - Loop 2310E is situational, currently LAC-DMH is NOT using this loop for Service Location NPI.						
2310E	NM1	NM101	Entity Identifier Code	R	When used for NPI, enter "FA'.	**FA**
2310E	NM1	NM102	Entity type qualifier	R	Per HIPAA	**2**
2310E	NM1	NM108	Identification Code Qualifier	R	This field is required by HIPAA - NPI use	**XX**

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Loop	Seg ID	Ref. Des.	Field Name	DMH Valid.	DMH Business Rules	Example
2310E	NM1	NM109	Identifier code	R	LAC-DMH ensures the qualifier and identifier combination are valid. LAC-DMH will also apply the NPI check digit algorithm to ensure valid NPI format. State DMH will have the final validation of the NPI.	Service Location NPI 1123456789
2310E	N3	N301	Address information	R	Street number and name	1234 West Hill Lane
2310E	N4	N401	City Name	R	Name of the city	Los Angeles
2310E	N4	N402	State or Province Code	R	Name of the State	CA
2310E	N4	N403	Postal Code	R	Zip Code	90020

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Loop	Seg ID	Ref. Des.	Field Name	DMH Valid.	DMH Business Rules	Example
Other Subscriber Information						
2320			**Other Subscriber Information**	0	The 2320 loop is used to identify all the other payers of the claim as well as the DMH plans that are to be charged for the claim. For example, if Medi-Cal is a payer and the County General Fund plan is to be charged, the 837p will have 2 instances of the 2320 loop. The 2330B loop is used to identify the payer. Therefore when specifying which DMH plans to charge the claim against, 2330B must contain DMH. The 2330A loop is used to identify the subscriber's identification for the payer referenced in 2330B. When specifying DMH plans, 2330B must contain DMH. Note that DMH does not require any plans to be specified in the 837i. If no plans are specified, DMH automatically charges County General Fund for Local Plan providers (Directly Operated and Contracted) and Managed Care Fund for FFS providers. IS2.0 DMH business rules only allow 1 plan to be specified IS2.0 DMH business rules only allow up to 5 occurrences of Other Insurance payers	
2320	SBR	SBR02	Individual Relationship Code	M	If the other payer is Medicare,Medical or DMH, set this value to 18. If the payer is Insurance, and the patient is not the	18 - When the Payer is Medi-Cal, Medicare or DMH

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Loop	Seg ID	Ref. Des.	Field Name	DMH Valid.	DMH Business Rules	Example
					subscriber, use a value other than 18.	
2320	SBR	SBR09	Insurance Type Code	M	Set to the appropriate type for the payer referenced in 2330B.	**MC** = Medi-Cal **MA** = Medicare Part A **11** = LAC-DMH **CI** = Commercial Insurance Co.
Claim Level Adjustments – CAS segment is not applicable for Fee-For-Service Providers, do not send						
2320	CAS	CAS01	Claim Adjustment Group Code	S	For use when OHC or Medicare is used. Code identifying the general category of payment adjustment.	**CODE DEFINITION** **CO Contractual Obligations** **CR Correction and Reversals** **OA Other adjustments** **PI Payer Initiated Reductions** **PR Patient Responsibility**
2300	CAS	CAS02	Claim Adjustment Reason Code	S	Code identifying the detailed reason the adjustment was made.	Please use the code from 835 or paper remittance advice returned from OHC or Medicare. Washington Publishing Company's Claim

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Loop	Seg ID	Ref. Des.	Field Name	DMH Valid.	DMH Business Rules	Example
						Adjustment Reason Codes are used by payers.
2320	CAS	CAS03	Monetary Amount	S	CAS03 is the amount of adjustment.	Remittance amount not paid. Amount denied by OHC or Medicare. Please use the exact amount returned in 835 or paper remittance advice from OHC or Medicare.
Coordination of Benefits COB Payer Prior Payment						
2320	AMT	AMT01	Amount Qualifier Code	S	Use **C4** to report amount paid by Medicare/OHC. This amount will be used for balancing processing. Must supply even the amount is zero.	**C4**

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Loop	Seg ID	Ref. Des.	Field Name	DMH Valid.	DMH Business Rules	Example
2320	AMT	AMT02	COB Payer Paid Amount	S	For Local Plan Contracted and FFS providers, that have previously sent claims and received remittance advices from Medicare and/or private insurance, this field must be populated with the amount paid by Medicare and/or private insurance (not Medi-Cal) , even if it is zero. When Medi-Cal is the payer this segment is not required. If it is included, set the value to zero as DMH always forwards claims to Medi-Cal and receives payment from Medi-Cal. DMH uses this value during adjudication. **Detailed Adjustments note** Total claim amount (CLM02) must equal sum of paid amount (AMT02 in loop 2320) and all adjustment amounts (CAS in 2320). Otherwise the claim will be denied for not in balance.	61.28 The amount can be zero (0.00)
Other Payer Patient Information						
2330A	NM1	NM108	Identification Code Qualifier	M	Always use qualifier Member ID - MI	**MI**

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Loop	Seg ID	Ref. Des.	Field Name	DMH Valid.	DMH Business Rules	Example
2330A	NM1	NM109	Other Subscriber Primary Identifier	M	This value must contain the subscriber's identifier for the payer. When DMH forwards claims to other payers, this value will be used in 2010BA_NM109. When Medical is the Payer, set this field to the subscriber's Medi-Cal ID. When Medicare is the Payer, set this field to the subscriber's Medicare ID. When Insurance is the Payer, set this field to the subscriber's Insurance ID. **In SD/MC II, when the payer in 2330B is Medi-Cal and the claim is Healthy Families, use CIN.**	
Other Subscriber Secondary Information						
2330A	REF	REF01	Reference Identification Qualifier	O	When DMH is the payer (2330B), this segment is used to identify the DMH plans to charge the claim against. Always use "1G" when identifying DMH plans. All other REF segments without "1G" in REF01 are ignored by DMH.	**1G**

updated 09/07/2011

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Valid Character Rule:
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Loop	Seg ID	Ref. Des.	Field Name	DMH Valid.	DMH Business Rules	Example
2330A	REF	REF02	Other Insured Additional Identifier	O	If the payer is DMH (2330B) use this segment to identify the DMH Plan ID for which the claim is to be charged against. Immediately following the last character of the Plan ID, a suffix must be added to indicate the sequence in which plans should be charged. Suffix format is: "-01", "-02", etc, where "-01" indicates the first plan to charge against and "-02" indicates the second plan to charge against. If the plan id is not valid, the claim is rejected. FFS providers may only charge against Managed Care Fund. For these providers, if any other plan id is found the claim is rejected. IS2.0 DMH business rules only allow 1 plan to be specified	2000-01 - AB1421 plan is the first plan to charge
Other Payer Name						
2330B	NM1	NM108	Identification Code Qualifier	M		Use "PI"
2330B	NM1	NM109	Other Payer Primary ID	M	Set to PI identification value for the payer. DMH uses this value to identify the payer. If the value is 953893470, the payer is DMH If the value = '01' (zero one), the payer is Medi-Cal. If the value is '01192' the payer is Medicare. All other values are assumed to be private insurance.	DMH = 953893470 Medical = '01' . This value is as per Medi-Cal's mapping instructions. Medicare = '01192'.

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Loop	Seg ID	Ref. Des.	Field Name	DMH Valid.	DMH Business Rules	Example
Claim Adjudication Date of Other payers						
2330B	DTP	DTP01	Date/Time Qualifier	S	Date Claim Paid	**573**
2330B	DTP	DTP02	Date Time Period Format Qualifier	S	A qualifier of D8 is normally used, but If the qualifier is RD8, DMH uses the first portion of the date (first 8 characters).	D8
2330B	DTP	DTP03	Date Time Period	S	Date the claim was adjudicated by the other payer Note: date equals to or before service date can cause HIPAA syntax error.	20091205
Service Line						
2400	LX	LX01	Line Counter	M	Set to 1. Just one service line per claim is allowed by DMH. Any claim with more than one service line will be rejected.	**1**
Professional Service						
2400	SV2	SV204	Unit or Basis for Measurement Code	M	Set to the HIPAA allowable unit measurement code for the procedure code. DMH processes DA only.	**DA**
2400	SV2	SV205	Service Unit Count	M	Set to the number of days of service. DMH ensures that the number of days matches the service date range in 2400_DTP03__ServiceDate	15
2400	SV2	SV201-1	Product Or Service ID Qualifier	M	Must be HC.	**HC**

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Loop	Seg ID	Ref. Des.	Field Name	DMH Valid.	DMH Business Rules	Example
2400	SV2	SV201-2	Procedure Code	M	Use the appropriate HIPAA procedure code for the service. If the procedure code is invalid, the Claim is rejected	0101
2400	SV2	SV201-3	Procedure Modifier	O	Use the appropriate HIPAA modifier code for the service. If the first modifier is invalid, the Claim is rejected.	HE
2400	SV2	SV201-4	Procedure Modifier	O	Use the appropriate HIPAA modifier code for the service. If the third modifier is invalid, the Claim is rejected.	
2400	SV2	SV201-5	Procedure Modifier	O	Use the appropriate HIPAA modifier code for the service. If the first modifier is invalid, the Claim is rejected.	
2400	SV2	SV201-6	Procedure Modifier	O	Use the appropriate HIPAA modifier code for the service. If the fourth modifier is invalid, the Claim is rejected.	
Service Date						
2400	DTP	DTP02	Date Time Period Format Qualifier	R	DMH uses this segment to specify the service start and end date for all claims. Always use RD8	**RD8**

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Segments delimiter: Tilde '~'. Fields delimiter: Asterisk '*'.

Loop	Seg ID	Ref. Des.	Field Name	DMH Valid.	DMH Business Rules	Example
2400	DTP	DTP03	Service Date	R	Specify the service begin and end date. Service dates specified in the claim must be within a calendar month. If the service dates cross calendar months, the claim will be rejected. Therefore if a service spans calendar months, separate claims must be sent for the relevant service dates within each calendar month. The service date From and To portion can be the same when the service is for a single day or if the episode admit, service and discharge date are the same. When the service spans multiple days, do not include the Discharge Date in the service date. DMH does not adjudicate for discharge date. DMH ensures an episode exists for the client, service location, admit date and service dates.	20051008-20051015 - Multiple Day service - In this example, please note that the admit date is 20051008 and the discharge date is 20051016 which cannot not be included, so the last date of service is 20051015. 20050903-20050903 - Single day service