



County of Los Angeles  
Department of Mental Health

Contract Providers Transition Project  
(CPTP)

837I 5010 Companion Guide

**Version 0.1**

**DRAFT**

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## DOCUMENT REVISION HISTORY

<b>Version</b>	<b>Release Date</b>	<b>Revised by</b>	<b>Comments/Indicate Sections Revised</b>
V 0.1	06/27/2011	Zeno Jacobi	5010 initial Draft release

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### DMH Integrated System Project Companion Guides Legend

Usage Notes	DMH Validation	DMH Business Rules	Example
<p>This Companion Guide addresses specific DMH business process requirements for HIPAA transactions that are conformable with the HIPAA requirements.</p> <p>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.</p> <p>However, samples of entire transaction will be given to trading partners during registration / orientation process.</p> <p>This Companion Guide is subject to change. Please visit our website at <a href="http://dmh.lacounty.gov/hipaa/edi_homepage.html">http://dmh.lacounty.gov/hipaa/edi_homepage.html</a> for the latest version.</p> <p>LAC-DMH CIOB HIPAA EDI UNIT promotes Trading Partners readiness for these transactions. Please contact us at (213) 351-1335.</p>	<p>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.</p> <p>It is strongly recommended to reference these Companion Guides in conjunction with the WPC Implementation Guides.</p> <p>Pay downloads of Washington Publishing Company's HIPAA EDI Implementation Guides can be obtained at <a href="http://www.wpc-edi.com">www.wpc-edi.com</a></p> <p>837P - 005010X222A1                      837I - 005010X223A2                      835 - 005010X221A1                      277CA - 005010X214</p>	<p>This column describes how the segment / field are to be used in order to meet the DMH business process requirements.</p> <p>Explanations are given much consideration to Fee-For-Service and Local Contract Providers, under different claim scenarios.</p>	<p>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.</p>
	R = Required		
	S= Situational		

**837I 5010 (Health Care Claim: Institutional) Companion Guide**

DMH Integrated System		837I Institutional Claims V5010 Companion Guide				06/27/2011 V 0.1	
Valid Character Rules: Letters: 'A' thru 'Z' and 'a' thru 'z'. Numbers: '0' thru '9'. Symbols: Dash: '-', Number sign '#', Period '.' and Ampersand '& Delimiters: Segment: Tilde '~' Field: Asterisk '*' Component Element Separator Colon: ':' Repetition Separator: '^'							
Loop	Seg ID	Ref. Des.	Field Name	DMH Valid.	DMH Business Rules	Example	
<b>Interchange Control Header</b>							
HEADER	ISA	ISA05	Interchange ID Qualifier	R	Always use ZZ.	ZZ	
HEADER	ISA	ISA06	Interchange Sender ID	R	Use the Interchange Sender ID assigned to the provider by DMH during registration process.	000000020000000	
HEADER	ISA	ISA07	Interchange ID Qualifier	R	Always use ZZ.	ZZ	
HEADER	ISA	ISA08	Interchange Receiver ID	R	Always use 000000010000000 for DMH Interchange Receiver ID.	000000010000000	
HEADER	ISA	ISA11	Interchange Control Standard ID (Repetition Separator)	R	Always use "^ "	^	
HEADER	ISA	ISA13	Interchange Control Number	R	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	
<b>Functional Group Header</b>							
HEADER	GS	GS01	Functional Identifier Code	R	Required Value "HC"	HC	

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Loop	Seg ID	Ref. Des.	Field Name	DMH Valid.	DMH Business Rules	Example
HEADER	GS	GS02	Application Sender Code	R	Use the Application Sender Code assigned to the provider by DMH during registration process. It is an 8-byte A/N character field.	0000012
HEADER	GS	GS03	Application Receiver Code	R	Always use 00000001 for DMH Application Receiver ID. It is an 8-byte A/N character field.	00000001
HEADER	GS	GS04	Date	R	Use the Current Date	CCYYMMDD
HEADER	GS	GS05	Time	R	Use the Current Time	HHMM
HEADER	GS	GS06	Group Control Number	R	Please use a valid numeric value. It is recommended that a unique number is used for each 837I submission in this field. This number will be echoed in 997 responses and can be used to link 837I to the appropriate 997 response.	
HEADER	GS	GS08	Version/ Release/ Industry Identifier Code	R	Always use 005010X223A2	005010X223A2
Transaction Set Header						
HEADER	ST	ST01	Transaction Set Identifier	R	Required value "837"	837
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.
HEADER	ST	ST03	Implementation Convention Reference	R	Required value for the 837I Transaction '005010X223A2'	005010X223A2

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Loop	Seg ID	Ref. Des.	Field Name	DMH Valid.	DMH Business Rules	Example
<b>Beginning Of Hierarchical Transaction</b>						
HEADER	BHT	BHT02	Transaction	R	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.	00, 18
<b>Submitter Name</b>						
1000A	NM1	NM108	Identification Code Qualifier	R	Must use 46.	46
1000A	NM1	NM109	Submitter Primary ID#	R	Electronic Transmitter Identification Number (ETIN) assigned to provider by DMH during registration process.	00000002
<b>Submitter EDI Contact Name</b>						
1000A	NM1	PER03	Communication Number Qualifier	S	If available, populate this field with the appropriate HIPAA qualifier for the submitters telephone or email address	TE
1000A	NM1	PER04	Communication Number Qualifier	S	If available, populate this field with the submitter's telephone number or email address.	2135551212
1000A	NM1	PER05	Communication Number Qualifier	S	If available populate this field with the appropriate HIPAA qualifier for the submitters telephone or email address	EM
1000A	NM1	PER06	Communication Number Qualifier	S	If available, populate this field with the submitter's telephone number or email address.	subdept@subcompany.com

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Loop	Seg ID	Ref. Des.	Field Name	DMH Valid.	DMH Business Rules	Example
<b>Receiver Name</b>						
1000B	NM1	NM103	Receiver Name	R	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	R	Must use 46.	46
1000B	NM1	NM109	Receiver Primary Identifier	R	The receiver must always be DMH. Always use 00000001	00000001
<b>Billing Provider Name</b>						
2010AA	NM1	NM108	Identification Code Qualifier	S	HIPAA requires this field, 'XX' is used with combination for NPI.	XX
2010AA	NM1	NM109	Billing Provider Identifier	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.	Billing Provider NPI
2010AA	REF	REF01	Reference Identification Qualifier	R	When NPI is used, must ALSO provide 'EI' for Employer's Identification Number	EI - Employer's Identification Number
2010AA	REF	REF02	Billing Provider Additional Identifier	R	Use the Billing Providers EIN	950002390

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Loop	Seg ID	Ref. Des.	Field Name	DMH Valid.	DMH Business Rules	Example
<b>Subscriber Information</b>						
2000B	SBR	SBR01	Payer Responsibility Sequence Number	R	Set to the appropriate payment responsibility for DMH. DMH is always the payer of last resort. Please see the explanations and examples in the 2320 Other Subscriber Information loop entry in this Companion Guide under the heading Coordination of Benefit Scenarios.	<b>P Primary S Secondary T Tertiary A Payer 4 B Payer 5 C Payer 6 D Payer 7 E Payer 8 F Payer 9 G Payer 10 H Payer 11</b>
2000B	SBR	SBR02	Relationship Code	R	DMH subscribers are always the patient. Therefore, never send the 2000C loop. Always set this field to 18.	<b>18</b>
2000B	SBR	SBR04	Name	R	Use the appropriate Plan ID. If the Plan ID is not valid the claim will be rejected.  FFS Providers: may only bill to the Managed Care Fund (1001). If any other Plan ID is found the claim will be rejected.	1000
2000B	SBR	SBR09	Claim Filing Indicator Code	S	LAC-DMH requires this value. Always use '11'.	<b>11</b>
<b>Subscriber Name</b>						
2010BA	NM1	NM102	Entity Type Qualifier	R	Subscriber is always the patient. Always set to 1.	<b>1</b>
2010BA	NM1	NM108	Identification Code Qualifier	R	Always use Member ID qualifier (MI).	<b>MI</b>
2010BA	NM1	NM109	Subscriber Primary Identifier	R	Set to the 7 digit DMH client ID. If the client id is not valid, the claim will be rejected.	0123456

<b>DMH Integrated System</b>		<b>8371 Institutional Claims V5010 Companion Guide</b>			<b>06/27/2011 V 0.1</b>	
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Loop	Seg ID	Ref. Des.	Field Name	DMH Valid.	DMH Business Rules	Example
<b>Payer Name</b>						
2010BB	NM1	NM108	Identification Code Qualifier	R	Always use PI.	PI
2010BB	NM1	NM109	Payer Identifier	R	The payer is always DMH. Always use 953893470.	953893470
<b>Payer Address</b>						
2010BB	N3	N301	Payer Address Line	S	The address is not used by DMH and is provided for informational purposes only.	550 S. VERMONT AVENUE
<b>Payer City State ZIP CODE</b>						
2010BB	N4	N401	Payer City Name	S	The address is not used by DMH and is provided for informational purposes only.	LOS ANGELES
2010BB	N4	N402	Payer State Code	S	The address is not used by DMH and is provided for informational purposes only.	CA
2010BC	N4	N403	Payer ZIP Code	S	The address is not used by DMH and is provided for informational purposes only.	90020
2010BC	N4	N404	Country Code	S	The address is not used by DMH and is provided for informational purposes only.	US

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<b>Claim Information</b>						
2300	CLM	CLM01	Patient Account Number	R	<p>This value must be unique each time. Please refer to the 5010 837I Implementation Guide for details. It is an alpha-numeric field with maximum length of 20 bytes. This value must be unique for all claims received by a submitter, which includes original, replacement and void claims.</p> <p>The combination of Submitter ID (1000A_NM109) and Patient Account Number (2300-CLM01) must be unique for all claims. Any duplicates will be rejected.</p> <p>For replacement claims, use 2300_REF_OriginalReferenceNumberICN/DCN 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.</p> <p>For void claims, use 2300_REF_OriginalReferenceNumberICN/DCN 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.</p>	X1234567-000089-0109

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Loop	Seg ID	Ref. Des.	Field Name	DMH Valid.	DMH Business Rules	Example
2300	CLM	CLM05-1	Facility Type Code	R	DMH accepts the following Facility Type codes: 11 Hospital Inpatient (Including Medicare Part A) 12 Hospital Inpatient (Medicare Part B only) 18 Hospital - Swing Beds 21 Skilled Nursing Inpatient (Including Medicare Part A) 22 Skilled Nursing Inpatient (Medicare Part B only) 28 Skilled Nursing - Swing Beds 41 Religious Non-Medical Health Care Institutions – Hospital Inpatient 65 Intermediate Care – Level I 66 Intermediate Care – Level II 86 Residential Facility  DMH validates that the Billing Provider is contracted to provide the billed procedure code with modifiers in the specified facility types. If the procedure code, modifiers and facility type are not found for that billing provider, the claim will be rejected.	11
2300	CLM	CLM05-3	Claim Frequency Code	R	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_OriginalReferenceNumberICN/DCN for use with replacement and void claims.	1 - Original Claim 7 - Replacement Claim 8 - Void claim
2300	CLM	CLM07	Provider Accept Assignment Code	R	Must submit 'A' to indicate the provider accepts assignment per the HIPAA 5010 definition.	A
2300	CLM	CLM08	Benefits Assignment Certification Indicator	R	Must submit 'Y'.	Y

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Loop	Seg ID	Ref. Des.	Field Name	DMH Valid.	DMH Business Rules	Example
2300	CLM	CLM09	Release of Information Code	R	Local Contract Providers: all values allowed.  FFS Providers: Must submit 'Y' to indicate Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim per the HIPAA 5010 definition.	Y,I
2300	CLM	CLM20	Delay Reason Code	S	Use this code for claims submitted more than 6 months after the service date.  Refer to the IS Codes manual for a list of valid codes.	1
<b>Statement Dates</b>						
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	
<b>Admission Date and Hour</b>						
2300	DTP	DTP02	Date Time Qualifier	R	DMH requires an admit date and time for all institutional claims.	DT
2300	DTP	DTP03	Admission Date and Hour	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
<b>Institutional Claim Code</b>						
2300	CL1	CL101	Admission Priority/Type Code	R	Enter the code representing the Admission Priority Code. DMH accepts the following values: 1     Emergency 2     Urgent 3     Elective 9     Information not Available	2

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Loop	Seg ID	Ref. Des.	Field Name	DMH Valid.	DMH Business Rules	Example
2300	CL1	CL102	Admission Source Code	R	Enter the code representing the Admission Source Code. DMH accepts all currently effective, assigned values.	1
2300	CL1	CL103	Patient Status Code	R	Enter the code representing the Patient (Discharge) Status. DMH accepts the following values: 01 Discharge to Home or Self Care 02 Discharged/Transferred to General Hospital for Inpatient Care 04 Discharged/transferred to intermediate care facility or assisted living facility 07 Left Against Medical Advice or Discontinued Care 20 Expired 21 Discharged/transferred to Court/Law Enforcement 30 Still Patient 43 Discharged/transferred to a Federal Health Care Facility 50 Hospice – Home 51 Hospice – Medical Facility (Certified) Providing Hospice Level of Care 65 Discharged/transferred to a Psychiatric Hospital or Psychiatric District Part Unit of a Hospital 70 Discharged/transferred to another Type of Health Care Institution not Defined Elsewhere in this Code List.	01
<b>Patient Estimated Amount Due</b>						
2300	AMT	AMT01	Amount Qualifier Code	S		F3

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Loop	Seg ID	Ref. Des.	Field Name	DMH Valid.	DMH Business Rules	Example
2300	AMT	AMT02	Patient Paid Amount	S	Enter the estimated Patient Amount Due.	Can be zero (0.00)
Original Reference Number ICN/DCN						
2300	REF	REF01	Reference ID Qualifier	S	For Replacement and Void claims this segment is required	F8
2300	REF	REF02	Claim Original Reference Number	S	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.  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

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Loop	Seg ID	Ref. Des.	Field Name	DMH Valid.	DMH Business Rules	Example
<b>Claim Note for Reporting EBP Codes</b>						
2300	NTE	NTE01	Note Reference Code	R	Use DCP for reporting the Evidence Based Practice (EBP) codes.	<b>DCP</b>
2300	NTE	NTE02	Description	R	Use codes from list provided only. Use 99 for unknown. Up to 3 codes can be used. Separate each code by a hyphen (-). Each code is 2-byte alpha-numeric. Alpha is in uppercase, numeric has leading zero. Claim will fail if this segment is not present, for invalid codes or if not in the list of valid EBP codes.	NTE*DCP*99~ NTE*DCP*01-10~ NTE*DCP*56-4K-01~
<b>Claim Note for Other Indicators</b>						
2300	NTE	NTE01	Note Reference Code	S	Code identifying the functional area or purpose for which note applies.	<b>UPI</b>
2300	NTE	NTE02	Description	S	Description indicates the claim is a Healthy Families, EPSDT screen referral, Pregnancy or Emergency claim.  Use one segment for each indicator when multiple conditions apply.	<b>SED (Healthy Families) EPSDT screen referral EMERGENCY PREGNANCY</b>
<b>Attending Provider</b>						
2310A	NM1	NM101	Entity Identifier Code	R	The attending provider loop is always required.	<b>71</b>
2310A	NM1	NM108	Identification Code Qualifier	R	This field is required by HIPAA - NPI use	<b>XX</b>

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Loop	Seg ID	Ref. Des.	Field Name	DMH Valid.	DMH Business Rules	Example
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.  The claim will reject if there are multiple instances of the Attending Provider NPI in the IS Rendering Provider table.	Attending Physician NPI 1123456789
<b>Attending Provider Specialty Information</b>						
2310A	PRV	PRV03	Provider Taxonomy Code	R	Enter the valid Taxonomy for the Rendering Provider. DMH ensures the Taxonomy is valid I.S. Taxonomy.	2084P0800X
<b>Other Subscriber Information</b>						
2320	SBR	SBR01	Payer Resp. Seq. Number Code	R	Coordination of Benefit Scenarios  OHC / Medicare/ Medical / LACDMH <b>P S T A (2000B Loop)</b>  Medicare / Medical / LACDMH <b>P S T (2000B Loop)</b>  Medical / LACDMH <b>P S (2000B Loop)</b>  LACDMH (Sole Payer) <b>P (2000B Loop only)</b>  <b>Note: 2320/2330 loops are NOT used when LACDMH is the sole payer.</b>	<b>P Primary</b> <b>S Secondary</b> <b>T Tertiary</b> <b>A Payer 4</b> <b>B Payer 5</b> <b>C Payer 6</b> <b>D Payer 7</b> <b>E Payer 8</b> <b>F Payer 9</b> <b>G Payer 10</b> <b>H Payer 11</b>

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Loop	Seg ID	Ref. Des.	Field Name	DMH Valid.	DMH Business Rules	Example
2320	SBR	SBR09	Claim Filing Indicator Code	R	Use MC when the payer in this iteration of the 2320 loop is Medi-Cal. Use MB when the payer in this iteration of the 2320 loop is Medicare. Use 11 for all other payers.	<b>MC</b> = Medi-Cal <b>MB</b> = Medicare <b>11</b> = Other Non-Federal Programs
<b>Coordination of Benefits COB Payer Paid Amount</b>						
2320	AMT	AMT01	Amount Qualifier Code	S	Use the appropriate qualifier. LACDMH is expecting 'D'.	<b>D</b>
2320	AMT	AMT02	Payer Paid Amount	S	For Local Plan Contracted and FFS providers, that have previously sent claims and received remit advices from Medicare and/or private insurance, this field must be populated with the amount paid by the payer, 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.	50.50 The amount can be zero (0.00)
<b>Other Insurance Coverage Information</b>						
2320	OI	OI03	Benefits Assignment Certification Indicator	R	Must submit 'Y'.	<b>Y</b>
2320	OI	OI06	Release of Information Code	R	Local Contract Providers: all values allowed.  FFS Providers: Must submit 'Y' to indicate Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim per the HIPAA 5010 definition.	<b>Y, I</b>

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Loop	Seg ID	Ref. Des.	Field Name	DMH Valid.	DMH Business Rules	Example
<b>Other Payer Subscriber Information</b>						
2330A	NM1	NM108	Identification Code Qualifier	R	Always use qualifier Member ID - MI	MI
2330A	NM1	NM109	Other Subscriber Primary Identifier	R	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 Medi-Cal is the Payer, set this field to the subscriber's Medi-Cal ID (CIN #).  When Medicare is the Payer, set this field to the subscriber's Medicare ID (HIC #).  When Other Insurance is the Payer, set this field to the subscriber's Insurance ID.	12345678A , 912345678A
<b>Other Payer Name</b>						
2330B	NM1	NM108	Identification Code Qualifier	R	Use 'PI'	Use "PI"
2330B	NM1	NM109	Other Payer Primary ID	R	Set to PI identification value for the payer. DMH uses this value to identify the payer. 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.	Medi-Cal = '01'. This value is as per Medi-Cal's mapping instructions.  Medicare = '01192'.
<b>Other Payer Claim Adjudication Date</b>						
2330B	DTP	DTP01	Date/Time Qualifier	S	Date Claim Paid	573

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Valid Character Rules: Letters: 'A' thru 'Z' and 'a' thru 'z'. Numbers: '0' thru '9'. Symbols: Dash: '-', Number sign '#', Period '.' and Ampersand '& Delimiters: Segment: Tilde '~' Field: Asterisk '*' Component Element Separator Colon ':' Repetition Separator: '^'						
Loop	Seg ID	Ref. Des.	Field Name	DMH Valid.	DMH Business Rules	Example
2330B	DTP	DTP02	DateTime 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 will cause HIPAA syntax errors.	20101205
<b>Service Line</b>						
2400	LX	LX01	Line Counter	R	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
<b>Institutional Service</b>						
2400	SV2	SV202-1	Product Or Service ID Qualifier	R	Must be HC.	HC
2400	SV2	SV202-2	Procedure Code	R	Use the appropriate HIPAA procedure code for the service. If the procedure code is invalid, the Claim is rejected.	0101
2400	SV2	SV202-3 thru SV202-6	Procedure Code Modifier	S	Use the appropriate Procedure Code Modifier(s). Note that when indicating the Duplicate Override Modifier (76) it must be the last modifier in the chain of modifiers.  IS Codes manuals are available from the IS Home Page: <a href="http://dmh.lacounty.gov/hipaa/index.html">http://dmh.lacounty.gov/hipaa/index.html</a>	Example: SV2*0100*HC:0100:HE:HT:76*
2400	SV2	SV204	Unit or Basis for Measurement Code	R	Set to the HIPAA allowable unit measurement code for the procedure code. DMH processes DA only.	DA
2400	SV2	SV205	Service Unit Count	R	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

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 Delimiters: Segment: Tilde '~' Field: Asterisk '\*' Component Element Separator Colon: ':' Repetition Separator: '^'

Loop	Seg ID	Ref. Des.	Field Name	DMH Valid.	DMH Business Rules	Example
<b>Service Date</b>						
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	<b>RD8</b>
2400	DTP	DTP03	Service Date	R	<p>Specify the service begin and end date.</p> <p>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.</p> <p>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.</p> <p>When the service spans multiple days, do not include the Discharge Date in the service date. DMH does not adjudicate for discharge date.</p> <p>DMH ensures an episode exists for the client, service location, admit date and service dates.</p>	<p>20051008-20051015 - Multiple Day service - In this example, please note that the admit date is 20051008 and the discharge date is 20051016 which cannot be included, so the last date of service is reported as 20051015.</p> <p>20050903-20050903 - Single day service</p>