



County of Los Angeles
Department of Mental Health

Contract Providers Transition Project
(CPTP)

837P 5010 Companion Guide

Version 1.7

July 2013

DOCUMENT REVISION HISTORY

Version	Release Date	Revised by	Comments/Indicate Sections Revised
5010 V 1.0	06/27/2011	Zena Jacobi	Initial Version of the 837P 5010 Companion Guide
5010 V 1.1	08/31/2011	Gordon Bunch	Updates in Loop 2320 CAS and AMT segments - Detailed Adjustments for local Contract Providers.
5010 V 1.2	11/03/2011	Gordon Bunch	Updated Business Rule for loop 2300 CLM20 [Effective 11/07/11] .
5010 V 1.3	12/05/2011	Karen Bollow	Removed reference to IS Codes Manual for Duplicate Override Code.
5010 V 1.4	12/12/2011	Karen Bollow	Added Remaining Liability segment and corrected the Health Care Diagnosis Code Reference Description.
5010 V 1.5	02/06/2012	Karen Bollow	Removed Ampersand "&" as a valid character. Added clarification to the Remaining Liability segment regarding detailed adjustments.
5010 V 1.6	Summer 2012	Karen Bollow	Added modifiers for Telephone (SC) and Tele-psychiatry (GT). These modifiers are scheduled to be implemented in summer 2012.
5010 V 1.7	09/12/2013	Karen Bollow	New Medicare intermediary payor identification.

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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 http://dmh.lacounty.gov/hipaa/edi_homepage.html 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 www.wpc-edi.com</p> <p>837P - 005010X222A1 837I - 005010X223A2 835 - 005010X221A1 277CA - 005010X214</p>	<p>This column describes how the segment / field is 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		

837P Version 5010 (Professional Claims) Companion Guide

DMH Integrated System		837P Professional Claims V5010 Companion Guide				07/15/2013 V 1.7
Valid Character Rules: Letters: 'A' thru 'Z' and 'a' thru 'z'. Numbers: '0' thru '9'. Symbols: Dash: '-', Number sign '#', and Period '.' Delimiters: Segment: Tilde '~' Field: Asterisk '*' Component Element Separator Colon ':' Repetition Separator: '^'						
Loop	Segment ID	Ref Des	Field Name	DMH Validation	DMH Business Rules	Example
Interchange Control Header						
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. It is a 15-byte A/N character field.	000001020000000
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. It is a 15-byte A/N character field.	000000010000000
HEADER	ISA	ISA09	Interchange Date	R	Required Format YYMMDD Use a valid date the required format	Required Format YYMMDD
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

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Loop	Segment ID	Ref Des	Field Name	DMH Valid ation	DMH Business Rules	Example
HEADER	ISA	ISA15	Usage Indicator	R	P' = Production 'T' = Test	P or T
Functional Group Header						
HEADER	GS	GS01	Functional Identifier Code	R	Required Value "HC"	HC
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	Use a valid numeric value. It is recommended that a unique number is used for each 837P submission in this field. This number will be echoed in 997 responses and can be used to link 837P to the appropriate 997 response.	
HEADER	GS	GS08	Version/ Release/ Industry Identifier Code	R	Must be set to '005010X222A1'	005010X222A1
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.

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Loop	Segment ID	Ref Des	Field Name	DMH Validation	DMH Business Rules	Example
HEADER	ST	ST03	Implementation Convention Reference	R	Required value for the 837P Transaction '005010X222A1'	005010X222A1
Beginning of Hierarchical Transaction						
HEADER	BHT	BHT02	Transaction Set Purpose Code	R	Required value "00"	00
HEADER	BHT	BHT06	Transaction Type Code	R	DMH does not validate this segment, but as all claims sent to DMH are adjudicated always use 'CH'.	CH
Submitter Name						
1000A	NM1	NM108	Identification Code Qualifier	R	Must use 46	46
1000A	NM1	NM109	Submitter Primary ID#	R	Assigned to provider by DMH during registration process. It is an 8-byte character field.	00000102
Receiver Name						
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 in production. It is an 8-byte A/N character field.	00000001
Billing Provider Name						
2010AA	NM1	NM108	Identification Code Qualifier	S	HIPAA requires this field, 'XX' is used in combination with NPI.	XX

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Loop	Segment ID	Ref Des	Field Name	DMH Validation	DMH Business Rules	Example
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 1123456789
2010AA	REF	REF01	Reference Identification Qualifier	R	When NPI is used, must ALSO provide 'EI' for Employer's Identification Number or 'SY' for Social Security Number.	EI - Employer's Identification Number or SY - Social Security Number
2010AA	REF	REF02	Billing Provider Additional Identifier	R	Use the Billing Providers EIN or SSN.	950002390 555998888
Subscriber Information						
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.	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
2000B	SBR	SBR02	Relationship Code	R	LAC-DMH requires this value. Always use '18'.	18

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Loop	Segment ID	Ref Des	Field Name	DMH Valid ation	DMH Business Rules	Example
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'.	11
Patient Information						
2000B	PAT	PAT06	Date of Death	S	Date of Death cannot be prior to the birthdate in 2010BA_DMGM_Birthdate. If the birthdate is not provided in the 837, the IS ensures the date of death is not prior to the birthdate in the IS.	20030120
2000B	PAT	PAT09	Yes/No Condition or Response Code	S	PAT09 indicates whether or not a client has a pregnancy aid code. If the client does not have the pregnancy aid code do not send.	Y
Subscriber Name						
2010BA	NM1	NM102	Entity Type Qualifier	R	Subscriber is always the patient. Always set to 1.	1
2010BA	NM1	NM108	Identification Code Qualifier	R	Always use Member ID qualifier (MI).	MI
2010BA	NM1	NM109	Subscriber Primary Identifier	R	Set to the 7-byte A/N character DMH client ID (MIS#). If the client id is not valid, the claim will be rejected.	0123456
Payer Name						
2010BB	NM1	NM108	Identification Code Qualifier	R	Always use PI.	PI

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Loop	Segment ID	Ref Des	Field Name	DMH Validation	DMH Business Rules	Example
2010BB	NM1	NM109	Payer Identifier	R	The payer is always DMH. Always use 953893470	953893470
Payer Address						
2010BB	N3	N301	Payer Address Line	S	Please use the address indicated in the examples column.	550 S. VERMONT AVENUE
Payer City State ZIP CODE						
2010BB	N4	N401	Payer City Name	S	Payer City	LOS ANGELES
2010BB	N4	N402	Payer State Code	S	Payer State	CA
2010BB	N4	N403	Payer ZIP Code	S	Payer Zip Code	90020
2010BB	N4	N404	Country Code	S	Payer Country	US
Payer Secondary Identification						
2010BB	REF	REF01	Reference Identification Qualifier	S	Required for FFS Providers FFS Providers: Used to indicate qualifier FFS Provider Service Location.	FY
2010BB	REF	REF02	Reference Identifier	S	Required for FFS Providers FFS Providers: Used to indicate FFS Service Location Number	120111
Claim Information						
2300	CLM	CLM01	Claim Submitter's Identifier	R	This value must be unique each time. It is an alpha-numeric field with maximum length of 20 bytes.	A1234567-000089-0109
2300	CLM	CLM02	Monetary Amount	R	Indicate the charge amount.	200

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Loop	Segment ID	Ref Des	Field Name	DMH Validation	DMH Business Rules	Example
2300	CLM	CLM05-1	Place of Service Code	R	DMH will always use this field to determine the place of service. If the place of service was via telephone, set this value to '11'. If this field is not present, the claims will be rejected.	23
2300	CLM	CLM05-3	Claim Frequency Code	R	DMH accepts Original, '1', Replacement, '7' and Void, "8" claim frequency codes. Please contact EDI testing and Certification Unit for details.	1, 7, 8
2300	CLM	CLM06	Provider Signature Indicator	R	Must submit 'Y' to indicate the provider has a signature is on file.	Y
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
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

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Loop	Segment ID	Ref Des	Field Name	DMH Validation	DMH Business Rules	Example
2300	CLM	CLM20	Delay Reason Code	S	Use this code for claims submitted more than 6 months after the service date. If the claim is more than 6 months late and a delay reason code is not specified, the claim is rejected. Refer to the IS Codes Manual for a list of valid codes.	1, 7
Share of Cost (SOC)R						
2300	AMT	AMT01	Amount Qualifier Code	S	Code to qualify amount.	F5
2300	AMT	AMT02	Other Payer Patient Paid Amount	S	Patient SOC Amount obligated	SOC obligated amount
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 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 Internal IS claim identifier

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Loop	Segment ID	Ref Des	Field Name	DMH Validation	DMH Business Rules	Example
Prior Authorization or Referral Number						
2300	REF	REF01	Reference ID Qualifier	S	FFS providers: an authorization number is required if the procedure code requires authorization. Otherwise, DMH does not validate this field. FFS providers: A TAR number must be present if late code 11 is sent.	G1 - For FFS authorization
2300	REF	REF02	Prior Authorization or Referral Number	S	FFS providers: an authorization number is required if the procedure code requires authorization. Otherwise, DMH does not validate this field. FFS providers: submit the TAR # in this field. A TAR number must be present if late code 11 is sent.	89199361741
Claim Note (Healthy Family Indicator)						
2300	NTE	NTE01	Note Reference Code	S	Code identifying the functional area or purpose for which note applies.	ADD
2300	NTE	NTE02	Description	S	The description that applies to the claim.	SED (Indicates Healthy Families claim)
Health Care Diagnosis Code						
2300	HI	HI01-01	Diagnosis Type Code	S	DMH processing does not require diagnosis, but it is required for some other payers, (e.g. Medi-Cal). Therefore if the claim contains payers other than DMH, it is recommended that the primary diagnosis is included in the claim.	BK ICD-9 Codes
2300	HI	HI01-02	Diagnosis Code	S	Do not send decimal points.	29570

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Loop	Segment ID	Ref Des	Field Name	DMH Validation	DMH Business Rules	Example
Rendering Provider						
2310B	NM1	NM101	Entity Identifier Code	R	The Rendering Provider loop is always required.	82
2310B	NM1	NM108	Identification Code Qualifier	R	This field is required by HIPAA - NPI use	XX
2310B	NM1	NM109	Referring Provider Primary ID	R	Rendering Provider NPI 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 Rendering Provider NPI in the IS Rendering Provider table.	1123456789
Rendering Provider Specialty Information						
2310B	PRV	PRV03	Provider Taxonomy Code	R	Enter the valid Taxonomy for the Rendering Provider. DMH ensures the Taxonomy is valid I.S. Taxonomy.	2084P0800X
Service Facility Location Name						
2310C	NM1	NM101	Entity Identifier Code	S	Loop is required when services were provided in a Satellite or School.	77
2310C	NM1	NM103	Name Last or Organization Name	S	Enter the Satellite or School name.	ABC Clinic
2310C	NM1	NM108	Identification Code Qualifier	S	Enter a valid Identification Code Qualifier.	XX

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Loop	Segment ID	Ref Des	Field Name	DMH Validation	DMH Business Rules	Example
2310C	NM1	NM109	Identification Code	S	Enter the Satellite or School NPI.	1123456789
Other Subscriber Information						
2320	SBR	SBR01	Payer Resp. Seq. Number Code	R	Coordination of Benefit Scenarios OHC / Medicare/ Medi-Cal / LACDMH P S T A (2000B Loop) Medicare / Medi-Cal / LACDMH P S T (2000B Loop) Medi-Cal / LACDMH P S (2000B Loop) LACDMH (Sole Payer) P (2000B Loop only) Note: 2320/2330 loops are NOT used when LACDMH is the sole payer.	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

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Loop	Segment ID	Ref Des	Field Name	DMH Validation	DMH Business Rules	Example
2320	SBR	SBR05	Insurance Type Code	S	This field is Situationally required when Medicare is the payer in this iteration of the 2320 loop and Medicare is not the Primary Payer. All values in the TR3 are valid.	12
2320	SBR	SBR09	Claim Filing Indicator Code	S	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.	MC = Medi-Cal MB = Medicare 11 = Other Non-Federal Programs

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Loop	Segment ID	Ref Des	Field Name	DMH Validation	DMH Business Rules	Example														
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														

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Loop	Segment ID	Ref Des	Field Name	DMH Validation	DMH Business Rules	Example
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 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 Paid Amount						
2320	AMT	AMT01	Amount Qualifier Code	S	Use D to report amount paid by Medicare/OHC. This amount will be used for balancing processing. Must supply even if the amount is zero.	D

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Loop	Segment ID	Ref Des	Field Name	DMH Validation	DMH Business Rules	Example
2320	AMT	AMT02	COB Payer Paid Amount	S	<p>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 Medicare and/or private insurance (not Medi-Cal), even if it is zero.</p> <p>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.</p> <p>DMH uses this value during adjudication.</p> <p>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 because the claim is not in balance.</p>	61.28 The amount can be zero (0.00)
Remaining Liability						
2320	AMT	AMT01	Amount Qualifier Code	S	Use EAF to report the remaining liability after adjudication by Medicare or OHC. DMH requires this segment when the payer in this loop has adjudicated the claim.	EAF

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Loop	Segment ID	Ref Des	Field Name	DMH Validation	DMH Business Rules	Example
2320	AMT	AMT02	Remaining Liability	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 provider's judgment of the remaining liability. When Medi-Cal is the payer this segment should not be sent. The amount in this segment will not be used for the calculation of COB Detailed Adjustments balancing.	138.72
Other Insurance Coverage Information						
2320	OI	OI03	Benefits Assignment Certification Indicator	R	Must submit 'Y'.	Y
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.	Y, I
Other Payer Subscriber Information						
2330A	NM1	NM108	Identification Code Qualifier	R	Always use qualifier Member ID – MI	MI
2330A	NM1	NM109	Other Subscriber Primary Identifier	R	Use CIN# when the payer in 2330B NM109 is Medi-Cal (2330B NM109 Payer ID = 01) Use client's MEDICARE ID under the Medi-Medi scenario where the payer is Medicare (2330B NM109 Payer ID = 01182)	12345678A , 912345678A

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Loop	Segment ID	Ref Des	Field Name	DMH Validation	DMH Business Rules	Example	
Other Payer Name							
2330B	NM1	NM108	Identification Code Qualifier	R	Use 'PI'	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', the payer is Medi-Cal. If the value is '01182' the payer is Medicare. All other values are assumed to be private insurance. FFS providers must always include Medi-Cal as a payer.	Medi-Cal = '01'. This value is as per Medi-Cal's 837P mapping instructions. Medicare = 01182	
Other Payer Claim Adjudication Date							
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 will cause HIPAA syntax errors.	20101205	
Service Line							
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	
Professional Service							
2400	SV1	SV101-1	Product Or Service ID Qualifier	R	Use HC.	HC	

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Valid Character Rules: Letters: 'A' thru 'Z' and 'a' thru 'z'. Numbers: '0' thru '9'. Symbols: Dash: '-', Number sign '#', and Period '!' Delimiters: Segment: Tilde '~' Field: Asterisk '*' Component Element Separator Colon ':' Repetition Separator: '^'						
Loop	Segment ID	Ref Des	Field Name	DMH Validation	DMH Business Rules	Example
2400	SV1	SV101-2	Procedure Code	R	Use the appropriate HIPAA procedure code for the service. If the procedure code is invalid, the Claim is rejected. Group claims - Refer to the explanation found in the Group Claim Bulletin: http://dmh.lacounty.gov/hipaa/downloads/BulletinNo08-006_GroupClaims.pdf	90849 CPT Codes
2400	SV1	SV101-3 thru SV101-6	Procedure Code Modifier	S	Use the appropriate Procedure Code Modifier(s). The Duplicate Override (76), Telephone (SC) and/or Tele-psychiatry (GT) modifiers must follow any other modifiers that are required per the Guide to Procedure Codes manual. Procedure codes that are not telephone allowable that contain the SC modifier will be denied. Claims that contain both the SC and GT modifiers will be denied. See State DMH Info Notice 10-23 at http://www.dmh.ca.gov/dmhdocs/docs/notices10/10-23.pdf for further billing info on Telephone and Tele-psychiatry.	SV1* HC:99211:HB:76*
2400	SV1	SV102	Monetary Amount	R	Put in the charge amount.	200
2400	SV1	SV103	Unit or Basis for Measurement Code	R	The only appropriate code in the 5010 implementation is 'UN' for LACDMH.	UN

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Loop	Segment ID	Ref Des	Field Name	DMH Validation	DMH Business Rules	Example
2400	SV1	SV104	Service Unit Count	R	Set to the number of units or minutes. Use the procedure code that matches to the appropriate face to face time but the unit time to bill is for face to face + other. In the IS, the total amount of face to face is used to determine the appropriate procedure code but what is submitted to the State is the face to face + other time added together. For Local Contract Provider Group claims - Refer to the explanation found in the Group Claim Bulletin: http://dmh.lacounty.gov/hipaa/downloads/BulletinNo08-006_GroupClaims.pdf For FFS Providers, the field must be 999 or less, otherwise the claim will be rejected.	15
2400	SV1	SV107 - 4	Diagnosis Code Pointer	S	This value is not used by DMH, but may be used by other payers (e.g. Medi-Cal) and, as such, is recommended to be populated. For claims that include Medi-Cal as a payer (in 2320 loop) this field is used to point to the primary diagnosis specified in 2300 Healthcare Diagnosis Code loop.	1 thru 8. For example, a setting of 1 indicates the first diagnosis code in the 2300 Healthcare Diagnosis Code loop
2400	SV1	SV109	Yes/No Condition or Response Code	S	SV109 is the Emergency Aid Code indicator. A 'Y' value indicates the client has an emergency aid code. If the client has no Emergency Aid code do not send.	Y

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Valid Character Rules: Letters: 'A' thru 'Z' and 'a' thru 'z'. Numbers: '0' thru '9'. Symbols: Dash: '-', Number sign '#', and Period '.' Delimiters: Segment: Tilde '~' Field: Asterisk '*' Component Element Separator Colon ':' Repetition Separator: '^'						
Loop	Segment ID	Ref Des	Field Name	DMH Validation	DMH Business Rules	Example
2400	SV1	SV111	Yes/No Condition or Response Code	S	SV111 is the Early and Periodic Screening for Diagnosis and Treatment for children (EPSDT) indicator. A 'Y' indicates the client has an EPSDT screening referral. Indicate 'Y' on an EPSDT claim.	Y
Service Date						
2400	DTP	DTP02	Date Time Period Format Qualifier	R	DMH accepts D8 only. DMH only accepts claims for a single service day and will deny claims that are submitted with a range of dates.	D8
2400	DTP	DTP03	Service Date	R	Set to the service date of the procedure. DMH only accepts claims for a single service day and will deny claims that are submitted with a range of dates. The service date cannot be more than a year old or the claim is rejected. For example if the current date is 11/25/2004 and the service date is 11/24/2003, the claim will be rejected.	20031115
Line Note						
2400	NTE	NTE01	Reference ID Qualifier	R	Use DCP for reporting the Evidence Based Practice (EBP) codes.	DCP
2400	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~