Los Angeles County
Department of
Mental Health

HIPAA 837 Transaction Standard
Companion Guide for IBHIS Client
Service Based and Community Outreach
Service (COS) Claims Processing

Refers to the ASC X12 version 005010
Implementation Guides
Disclosure Statement
This document represents the Los Angeles County Department of Mental Health implementation instructions for HIPAA required transactions. It is believed to be compliant with all ASC X12 intellectual property requirement.

2014 Los Angeles County Department of Mental Health
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## DOCUMENT REVISION HISTORY

<table>
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<tr>
<th>Version</th>
<th>Release Date</th>
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<tr>
<td>1.0</td>
<td>11/20/2013</td>
<td>Initial document release</td>
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<td>Section 6: Updated Business Rules Section 8.1: 837P/2400/SV103 Residential and PHF rules added Section 8.1: 837P/2420C added Service Facility Location rules Section 8.3: Added 837I Inpatient loop and segment information Section 9.2.1: Added 837I Medi-Cal example Section 9.2.2: Added 837I Indigent example Section 9.2.3: Added 837I Medi-Medi example</td>
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Section 6.1: Added an exception for county funded procedures that do not use the HX modifier  
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Section 6.1, 9.1, 9.3: Added rules requiring Inpatient, Residential, PHF and Day Treatment services to report one claim per day  
Section 6.2: Added a Business Rule regarding the Medicare HMO Risk indicator  
Section 6.2: Added the Business Rules for populating the diagnosis code on outbound transactions to the state  
Added Section 6.3: Generation of Outbound 835 Files to Contract Providers  
Added Section 7.2: Linking an 837 to the 277CA  
Section 7.3: Renumbered and added 277CA Rejection reasons  
Added Section 8 Operational Information and renumbered subsequent sections  
Section 9.2: COS Claims use the DMH IBHIS COS Dictionary Values file for valid codes  
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Added Section 10.3 with 835 examples |
| 1.10     | 8/11/2014  | Section 7.3: Added 277CA Rejection reasons relating to ICD-9 and ICD-10 usage  
Section 9.2: Added an ICD-10 value for COS claims for services after the ICD-10 compliance date  
Section 10.3: Added additional 835 examples |
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Section 6.1, 9.1, 9.3: Requirements for Katie A claims  
Section 6.1: Current versus Future mapping of outbound claim info  
Section 9.1: Clarified diagnosis code requirements for 837P claims  
Section 9.1: Crisis Stabilization to use MJ as the Units qualifier  
Section 9.2: Removed decimal point from ICD-10 example for COS claims  
Section 9.3: Added diagnosis code requirements for 837I claims |
| 1.12     | 06/08/2016 | Section 3: Process Flow changes after claims adjudication.  
Section 6.1: MSO Denied claims  
Section 6.1, 9.1: Included Life Support business rules and 837P claiming requirements  
Section 6.1: Clarification that 24-hour service claims will deny if the admit and discharge is on the same day  
Section 6.2: Medicare Risk HMO indicator, Healthy Families Indicator, Financial Eligibility Changes.  
Section 7.3: Added 277CA Rejection reasons relating to Coordination of Benefits segments  
Section 9: Transaction set 2300 NTE and 2320 SBR09. |
| 1.13     | 04/27/2017 | Section 6.1: Business rule 12 modified to remove the reference to Gurantor 18 and 11.  
Section 6.1: Added Business rule 16 for Cost Based Payment Method (UCC).  
Section 7.3: Modified the rejection reason for code A7:255 to include invalid Diagnosis Code.  
Section 9: 2330B Other payor primary identifier.  
Section 10.1.9: Corrected the COS example to reflect correct Zip code. |
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| 1.14 | **Section 6.1**: Use of TAR Number in FFS2 Claims. Non Medi-Cal Residential (CPT) and In Patient (Revenue) Codes. Replacement Claim Rule.  
**Section 7.3**: New Claim Rejection Code.  
**Section 9.1**: Allowable EBP Codes Reference  
**Section 9.2**: Program Area Codes made optional for COS claim.  
**Section 10.4**: 999 Example.  
**Section 10.5**: 277 Example. |
Preface
This Companion Guide to the version 005010 (v5010) ASC X12N Implementation Guides and associated errata adopted under HIPAA clarifies and specifies the data content when exchanging electronically with Los Angeles County Department of Mental Health (LACDMH). Transmissions based on this companion guide, used in tandem with the v5010 ASC X12N Implementation Guides, are compliant with both ASC X12 syntax and those guides. This Companion Guide is intended to convey information that is within the framework of the ASC X12N Implementation Guides adopted for use under HIPAA. The Companion Guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the Implementation Guides.

This Companion Guide addresses specific DMH business process requirements for transmitting claim data to the LACDMH Integrated Behavioral Health Information System (IBHIS) system. In addition to the LACDMH business requirements, all 837 transactions transmitted from the providers to LACDMH must be compatible 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 for the latest version:
Legal Entities: http://lacdmh.lacounty.gov/hipaa/IBHIS_EDI_Guides.htm
Fee-for-Service Providers: http://lacdmh.lacounty.gov/hipaa/ffs_IBHIS_EDI_Guides.htm
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1 INTRODUCTION

1.1 Scope
This companion guide is intended to be used by Los Angeles County Department of Mental Health (LACDMH) contracted providers in support of the following ASC X12 transaction implementations mandated under HIPAA:

- ASC X12 Health Care Claim: Professional (837) as specified in guide 005010X222 and 005010X222A1 (837P)
- ASC X12 Health Care Claim: Institutional (837) as specific in guide 005010X223 and 005010X223A2 (837I)

These guides are available from ASC X12 at [http://store.X12.org](http://store.X12.org)

1.2 Overview
Section 2 provides information about establishing a trading partner relationship with LACDMH.
Section 3 provides a Process Flow of the claiming transactions.
Section 4 identifies EDI related contacts within LACDMH.
Section 5 provides the LACDMH technical requirements for file exchange and the envelope segments.
Section 6 provides the LACDMH specific business rules and limitations.
Section 7 identifies the LACDMH acknowledgment transactions.
Section 8 provides operational information.
Section 9 provides the LACDMH requirements and usage for the 837 claiming transactions.
Section 10 provides sample 837/835/999/277 transactions

1.3 References
This information must be used in conjunction with the ASC X12 implementation guides that are available at [http://store.X12.org](http://store.X12.org)

2 GETTING STARTED

2.1 Trading Partner Registration
Trading Partners
An EDI Trading Partner is defined as any LACDMH customer (provider, billing service, software vendor, financial institution, etc.) that transmits to, or receives from LACDMH any standardized electronic data (i.e. HIPAA claim or remittance advice transactions).
You can find additional information on registering for EDI:

Legal Entities: [http://lacdmh.lacounty.gov/hipaa/IBHIS_EDI_homepage.htm](http://lacdmh.lacounty.gov/hipaa/IBHIS_EDI_homepage.htm)
Fee-for-Service providers: [http://lacdmh.lacounty.gov/hipaa/ffs_IBHIS_EDI_Guides.htm](http://lacdmh.lacounty.gov/hipaa/ffs_IBHIS_EDI_Guides.htm)
3 PROCESS FLOW

Provider
- Sends 837 file
- Receives TA1
- Corrects errors

DMH BizTalk
- Receives 837 file
- Generates TA1; technical acknowledgment
- Forwards 837 files that have received accepted TA1

Avatar
- Processes 837 files
- Generates a -999
- 999 is Implementation acknowledgment
- Assigns a unique claim ID for each Accepted claim

LACDMH Claims
- Generates an 835
- Executes DMH business validations against each claim

Medi-Cal
- Monthly EOB Processing
- Forwards claims to State

State Approval
- State Approval
- State Denial

Denial
- Denial
- Forward claims to State

Technical Acknowledgment
- Technical Acknowledgment

File is accepted means provider received a Positive TA1 (even with noted errors)
File is rejected means provider received a Negative TA1; needs to be resubmitted

Resubmit Denied Claims
- Resubmit Denied Claims
- Receives a -999
- Receives an 835
- Generates an 835
- Forwards an 835

Forwards a -999
- Forwards a -999 and 277CA

Forwards a +999
- Forwards a +999 and 277CA

Forwards 837 files that have received accepted TA1
- Receives an 835
- Receives a +999 and 277CA
- Receives TA1
- Sends 837 file

Successfully
- Successful?

rejected
- accepted

999 is Implementation acknowledgment
- 999 is Implementation acknowledgment
4 CONTACT INFORMATION

4.1 EDI Customer Service/Technical Assistance
LAC DMH Helpdesk – 213-351-1335

4.2 Provider Service Number
LAC DMH Helpdesk – 213-351-1335

4.3 Applicable websites/e-mail
IBHIS Legal Entity EDI Website: http://lacdmh.lacounty.gov/hipaa/IBHIS_EDI_homepage.htm
IBHIS Fee-for-Service Providers EDI Website: http://lacdmh.lacounty.gov/hipaa/ffs_IBHIS_EDI_homepage.htm
Provider Manuals & Directories: http://dmh.lacounty.gov/wps/portal/dmh/admin_tools/prov_manuals

5 FILE EXCHANGE/FILE STRUCTURE/CONTROL SEGMENTS

5.1 File Exchange
See the IBHIS Secure File Exchange Instructions for details on how to upload claim files and how to download the transaction response files. The instructions can be found on the following webpages:
Legal Entity: http://lacdmh.lacounty.gov/hipaa/IBHIS_EDl_Guides.htm
Fee-for-Service: http://lacdmh.lacounty.gov/hipaa/ffs_IBHIS_EDl_Guides.htm

5.2 File Requirements
837 claim files cannot contain carriage returns. The data must be wrapped as in a true EDI file.

5.3 ISA-IEA on Inbound transactions

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<th>Reference</th>
<th>Name</th>
<th>Notes/Comments</th>
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<tr>
<td>ISA01</td>
<td>Authorization Information Qualifier</td>
<td>LACDMH expects ‘00’.</td>
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<tr>
<td>ISA03</td>
<td>Security Information Qualifier</td>
<td>LACDMH expects ‘00’.</td>
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<tr>
<td>ISA05</td>
<td>Interchange ID Qualifier</td>
<td>LACDMH expects ‘14’.</td>
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<tr>
<td>ISA06</td>
<td>Interchange Sender ID</td>
<td>LACDMH expects the provider’s Duns plus suffix. Enter the 9-digit DUNS number, followed by 6 spaces.</td>
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<tr>
<td>ISA07</td>
<td>Interchange ID Qualifier</td>
<td>LACDMH expects ‘14’.</td>
<td></td>
</tr>
<tr>
<td>ISA08</td>
<td>Interchange Receiver ID</td>
<td>Enter LA County’s 9-digit DUNS number, followed by 6 spaces. The required value for LACDMH is ‘132486189’.</td>
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<td>ISA16</td>
<td>Component Element Separator</td>
<td>In order to process procedure codes that contain modifiers, LACDMH only accepts ‘:’ as the Component Element Separator</td>
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5.4 GS-GE on Inbound transactions
LACDMH accepts only one Functional Group per Interchange.

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<td>GS02</td>
<td>Application Sender’s Code</td>
<td>Enter the 9-digit DUNS number, with no trailing spaces.</td>
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<td>GS03</td>
<td>Application Receiver’s Code</td>
<td>Enter the 9-digit DUNS number, with no trailing spaces.</td>
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6 LACDMH BUSINESS RULES AND LIMITATIONS

6.1 Business rules for Inbound 837 Transactions

1. LACDMH requires an authorization for all services. There are 3 types of authorizations. A provider will put only 1 authorization on a claim line. If a service requires individual Member Authorization, the claim will only have the Member Authorization. Otherwise, Legal Entities will use the Provider Authorization and Fee-for-Service providers will use the Funding Source Authorization.

- Provider Authorizations, or P-Auths, are specific to a Legal Entity/Contracting Provider and to a Funded Program/Funding Source. Generally, Provider Authorizations will cover a complete Fiscal Year. A report with a Legal Entity’s Provider Authorizations will be included in the Legal Entity’s EFT extracts.

- Provider Authorizations begin with a ‘P’, followed by a number.

- Member Authorizations are specific to a client and to a Contracting Provider. They authorize specific services for a specific duration of time. Member Authorizations are also tied to a Funded Program/Funding Source, however when claiming only send the Member Authorization. The initiation of a Member Authorization will vary based on the type of services provided.

- Day Treatment and Fee-for-Service over-threshold authorizations will be requested through ProviderConnect, a web portal to the IBHIS system. Providers will see the authorization number when they make the request, however the authorization cannot be used on claims until the authorization request has been approved. Providers will also be able to see the authorization status on ProviderConnect.

- Professional services rendered by a Fee-For-Service provider in a Fee-For-Service Hospital setting will obtain the Treatment Authorization Request(TAR) number from the Hospital. The professional claims submitted for these services should contain the TAR number as the authorization number in claim. This is a 11 digit number.

- Member Authorizations are all numeric.

- Funding Source Authorizations will be used by Fee-for-Service providers for under-threshold and medication support services. Under-threshold Funding Source authorizations will cover a four-month (trimester) period of time and providers will use a different Funding Source authorization for each trimester. Further information on which Funding Source authorization to use will be provided in Fee-for-Service Provider Bulletins.

- Funding Source Authorizations begin with an ‘F’, followed by a number.

2. Legal Entity providers must use Medi-Cal Authorizations for claims that are billable to Medi-Cal.

3. The Rendering Provider on the claim must be associated with the Legal Entity or FFS provider in the IBHIS Contracting Provider table.

4. The Practitioner’s Discipline will be determined based on the information stored in the IBHIS Practitioner/Performing Provider table. IBHIS validates that the Practitioner (837 Rendering Provider) is allowed to perform the procedure code on the claim, based on the discipline stored in the IBHIS Practitioner/Performing Provider table.


7. Use the County Funded Procedure Code Modifier when submitting most claims using non-Medi-Cal outpatient or CalWORKs Provider Authorizations. As of June 2015, G9007 is the only non-Medi-Cal procedure code that does not use the HX modifier.

- The duplicate (76, 59), telephone (SC) and telepsych (GT) modifiers are not used when sending claims using non-Medi-Cal authorizations that use the HX County Funded modifier.

- The County Funded Procedure Code Modifier, HX, is not used on Life Support claims. It is used on Outpatient, Residential and Inpatient claims.

8. LACDMH 835s

- System creates 835 segregated by Fiscal Year.
• Providers will receive an 835 for all Denied claims at the time that the claim is adjudicated and an 835 for all approved claims when the provider receives payment.

9. Retroclaim adjudication.
• DMH Approved Medi-Cal billable claims are subsequently submitted to State for adjudication. Medi-Cal claims that are subsequently denied by the state will result in a 2nd 835, known as a retroclaim adjudication. Retroclaim adjudication 835s follow all of the standard HIPAA 835 requirements for reversals and corrections. See the HIPAA 835 v5010 Technical Report, section 1.10.2.8 – Reversals and Corrections for further information.
• Retroclaim adjudications will also be reported in all SIFT reports that provide claim level data.

10. Replacement Claims:
• Send Replacement claims when you’ve received a Retroclaim adjudication for a Medi-Cal denial and need to correct the claim and have it resubmitted to the state. You can send a Replacement claim after each Retroclaim adjudication/Medi-Cal denial.
• Do not send Replacement claims in response to LACDMH denials, i.e. any claim that was not paid in the initial adjudication cycle. Send in a new Original claim to correct claiming errors.
• You can only replace an original claim one time. If you need to make an additional replacement, replace the replacement claim, not the original.
• You need to wait for the receipt of your original payment 835 before submitting a replacement to DMH.

• Claims for Residential, PHF and Life Support services must be reported using the 837 Professional format.
• Residential, PHF and Life Support claims must report claims in UNITS using ‘UN’ as the Unit or Basis of Measurement Code in SV103. The Units are the number of days you are claiming for.

12. Successful claims processing is dependent on consistency between 837 claim data and the client data that is established through the Client Web Services interface. The following inconsistencies will result in claim denials:
• The client ID, gender and date of birth on the claim must match the client ID, gender and date of birth in IBHIS.
  • Client ID – 2010BA/NM109 Subscriber Primary Identifier
  • Gender – 2010BA DMG03 Subscriber Gender Code
  • Date of Birth – 2010BA DMG02 Subscriber Birth Date
• IBHIS validates that the client has a Legal Entity or FFS episode for the date of service on Outpatient and Day Treatment claims.
• IBHIS validates that the client has a unique episode at the program of service level for all 24-hour services and that the service/statement dates are within the episode. 24-hour services include Inpatient, Residential, psychiatric health facility (PHF) and Life Support.
• Inpatient, Residential, PHF and Life Support (24-hour) claims that include the discharge date will be denied. This rule also applies when the date of service, admit and discharge dates are the same date.
• IBHIS validates that claims with Medi-Cal Funding Source authorizations have an established Medi-Cal Guarantor in their Financial Eligibility (Medi-Cal (10)). The Medi-Cal Guarantor must be set with Eligibility Verified set to Yes.
• IBHIS validates that claims with non-Medi-Cal Funding Source authorizations have the LA County Guarantor (16) in their Financial Eligibility.

13. COS Claims - COS claims will be processed the same as any other 837 claim:
• COS claims are delivered to the same file location as any other 837 file.
• COS claims can be included in the same 837 transaction as an 837 that contains direct service claims.
• COS claims will be reported via the standard 999, 277CA and 835 response files.
• Void/Replacement functionality will be available in the same way that any 837 for direct services is Replaced or Voided.
• They will be listed on all SIFT reports that provide claim level data.
• COS claims must be reported with the total # of minutes for all practitioners involved in providing the service. DMH IBHIS rate tables have been modified to pay by the minute, rather than by the hour.

14. LACDMH allows one service line per claim.
15. LACDMH requires each Inpatient (837I), Residential (837P), PHF (837P) and Day Treatment (837P) day to be reported as a single claim, i.e. there must be one service line per claim and one day per service line.

16. Claiming Services that are subject to Cost Based Payment Method, such as claims submitted for services rendered at an Urgent Care Center (UCC) program that follows the cost based payment model. Payment based on the cost and not based on the services submitted.

• Provider must acquire a separate DUNS number for the Cost Based Program/Urgent Care Facility.
• Provider must complete a separate TPA under the new DUNS number and there will be a separate integration folder available for claiming.
• LACDMH require the claims to be submitted on 837P format using the DUNS number acquired for the UCC facility in the ISA06, GS02 and 1000A/NM109 fields.
• The clients served under the UCC can share the same outpatient episode created under the Legal Entity. If no outpatient episode exist under the Legal Entity, one must be created.
• LACDMH will issue separate provider authorizations for UCC based on the available funding sources allocated for UCC.
• Claims must be submitted with measurement code MJ in the SV103 field and number of hours in SV104. 
  Eg: If 60 minutes of service are rendered, the claim must be submitted with MJ in SV103 and 1 in SV04. 
  If 120 minutes of service are rendered, the claim must be submitted with MJ in SV103 and 2 in SV04.
• The minimum measurement that can be submitted on a claim is 1.
• The maximum measurement that can be submitted on a Med-Cal claim is 20 and on a non Medi-Cal claim is 24.
6.2 Generation of Outbound 837 Medi-Cal Claims

1. The Practitioner’s Taxonomy will be transmitted to the state based on the information stored in the IBHIS Practitioner/Performing Provider table.

2. The Pregnancy Indicator will be transmitted to the state based on the information stored in the IBHIS Client Condition – Pregnancy table. EDI Providers will update the pregnancy information via Client Web Services or Fee-for-Service providers will update client pregnancy information using ProviderConnect.

3. The Katie A. Demonstration Project Identifier will be transmitted to the state when it has been received from the Inbound 837 to LA County.

4. The Health Maintenance Organization (HMO) Medicare Risk indicator will be transmitted to the state when it has been received from the inbound 837 to LA County.

5. The Healthy Families SED indicator will be transmitted to the state based on the information received from the Inbound 837 to LA County.

6. Claims are only sent to the state when the Financial Eligibility/Eligibility Verified flag is set to Yes via Client Web Services. Providers indicate to LA County DMH which claims are to be sent to the state by using Medi-Cal Authorizations on their EDI claims.

7. Financial Eligibility for Medi-Cal and LA County is generated on behalf of the Trading Partner via Client Services when a client is admitted or updated. The client’s demographic information that’s sent to the state comes from the Financial Eligibility information stored in IBHIS as the subscriber information. The following data elements will be sent on outbound 837P and 837I Medi-Cal claims based on the information created for Financial Eligibility for Medi-Cal:
   - Client's Relationship To Subscriber - Self
   - Subscriber First Name
   - Subscriber Last Name
   - Subscriber Address
   - Subscriber Zip
   - Subscriber City
   - Subscriber State
   - Subscriber Policy # - CIN #
   - Subscriber Assignment of Benefits
   - Subscriber Release of Information
   - Subscriber’s Gender

Guarantor Order – will be calculated based on whether there were prior payer adjudications that were submitted on the inbound 837

The following data elements will be sent on outbound 837P and 837I claims from the inbound claims when the claim was previously adjudicated by Medicare/OHC and included the Medicare/OHC loop:
   - Guarantor Order
   - Client's Relationship To Subscriber
   - Subscriber First Name
   - Subscriber Last Name
   - Subscriber Address
   - Subscriber Zip
   - Subscriber City
   - Subscriber State
   - Subscriber Policy # (CIN for Medi-Cal, HIC for Medicare, subscriber ID for OHC)
   - Subscriber Assignment of Benefits
   - Subscriber Release of Information
   - Subscriber’s Gender

Client Date of Birth will also be sent on outbound 837 Medi-Cal claims.

8. The following data elements will be sent on outbound 837I Medi-Cal claims based on the information entered via the Client Web Services Admit and Discharge Client routines:
   - Admission Date and Time
- Discharge Date and Time
- Type of Admission
- Source of Admission
- Type of Discharge

9. 837P claims transmitted to the state send the diagnosis code which was received on the inbound 837P claim.

10. 837I claims transmitted to the state send the principal diagnosis code which was received on the inbound 837I claim and send the admitting diagnosis based on the admitting diagnosis entered via the Client Web Services diagnosis calls. System expects an admitting diagnosis with a diagnosis date on or before the episode admission date.

6.3 Generation of Outbound 835 Files to Contract Providers

1. Per the national HIPAA 835 guide, IBHIS uses the Claim Status Code values 1, 2 and 3 (CLP02) when adjudicating original claims, regardless of whether the claim was approved or denied. IBHIS does not return the Claim Status Code 4 when a claim is denied.
7 ACKNOWLEDGEMENTS AND/OR REPORTS

7.1 Acknowledgements
1. LACDMH returns an Interchange Acknowledgment (TA1) segment when requested, based on the value transmitted in ISA14. LACDMH recommends that the provider request for the acknowledgement receipt (value 1) for all submissions.
2. LACDMH provides Implementation Acknowledgment transactions (999) for all inbound Functional Groups (i.e. 837s). Please refer to examples at section 10.4 for more information.
3. LACDMH provides the Health Care Claim Acknowledgment transaction (277CA) for all claims. Only accepted claims will be assigned an IBHIS claim ID. Please refer to examples at section 10.5 for more information.
4. LACDMH does not request the Interchange Acknowledgments (TA1) segment on outbound interchanges.
5. LACDMH accepts, but does not require or process, Implementation Acknowledgment (999) transactions for all outbound Functional Groups.

7.2 Linking an 837 to the 277CA
As per the HIPAA Technical Report for the 277CA transaction, the 277CA file reports the 837’s BHT03 Originator Application Transaction Identifier value in the Claim Transaction Batch Number (2200B – TRN02) of the 277CA. In order to successfully link an 837 to the correct 277CA, the 837 must contain a unique value in the BHT03 for every 837 file generated. LACDMH recommends you to use a unique BHT03 value for all your submissions.

7.3 277CA Claim Status Codes
The following scenarios will result in claim rejections that will be seen on the IBHIS 277CA:

<table>
<thead>
<tr>
<th>Inbound 837P/I Claim Rejections</th>
<th>Claim Status Codes on IBHIS 277CA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Missing Admission Diagnosis on an Inpatient/837I claim</td>
<td>A6:232</td>
</tr>
<tr>
<td>Evidence Based Practice (EBP) code is missing</td>
<td>A6:442</td>
</tr>
<tr>
<td>Client’s date of birth not match</td>
<td>A7:0</td>
</tr>
<tr>
<td>Void or Replacement Claim with invalid Payer Claim Control #</td>
<td>A7:0</td>
</tr>
<tr>
<td>Void or Replacement Claim where Client ID/MSO # on the Void or Replacement does not match the Client ID/MSO # of the original claim</td>
<td>A7:0</td>
</tr>
<tr>
<td>Date of Service is a future date</td>
<td>A7:0</td>
</tr>
<tr>
<td>Procedure code not defined in IBHIS MSO CPT table</td>
<td>A7:21 &amp; A7:454</td>
</tr>
<tr>
<td>A replacement or void claim request will be rejected when the request is submitted prior to the receipt of payment advice (835) for the original claim.</td>
<td>A7:3</td>
</tr>
<tr>
<td>Client ID with the ‘MSO’ prefix but does not exist in IBHIS</td>
<td>A7:33</td>
</tr>
<tr>
<td>Client ID without the ‘MSO’ prefix</td>
<td>A7:33</td>
</tr>
<tr>
<td>Total claim charge amount not equal sum of line item charge amount</td>
<td>A7:178</td>
</tr>
<tr>
<td>A claim will be rejected if a valid ICD-9 or ICD-10 qualifier (ABJ or BJ) is sent, based on the date of service, but the diagnosis code itself (ICD-9 or ICD-10) is not valid in the Admitting Diagnosis field (837I - 2300 HI01-2)</td>
<td>A7:232</td>
</tr>
<tr>
<td>A claim will be rejected if a valid ICD-9 or ICD-10 qualifier (ABK or BK) is sent, based on the date of service, but the diagnosis code itself (ICD-9 or ICD-10) is not valid in the Principal Diagnosis field (837P &amp; 837I 2300 HI01-2)</td>
<td>A7:254</td>
</tr>
</tbody>
</table>
### Inbound 837P/I Claim Rejections

<table>
<thead>
<tr>
<th>Claim Status Codes on IBHIS 277CA</th>
</tr>
</thead>
<tbody>
<tr>
<td>A7:255</td>
</tr>
<tr>
<td>A7:400</td>
</tr>
<tr>
<td>A7:477</td>
</tr>
<tr>
<td>A7:477</td>
</tr>
<tr>
<td>A7:478</td>
</tr>
<tr>
<td>A7:479</td>
</tr>
<tr>
<td>A7:509</td>
</tr>
<tr>
<td>A7:521</td>
</tr>
<tr>
<td>A7:578</td>
</tr>
<tr>
<td>A7:673</td>
</tr>
<tr>
<td>A7:732</td>
</tr>
</tbody>
</table>

A claim will be rejected if a claim contains mixture of services with DOS (outpatient) or discharge/thru date (inpatient) before and after the cutover date and/or both ICD-9 and ICD-10 qualifiers are submitted on the claim.

Claim is out of balance – service line paid amount + all service line adjustment amounts do not equal the line item charge amount

Diagnosis Code Not Defined in IBHIS Diagnosis Table

A claim will be rejected if an ICD-9 diagnosis indicator is received and the service date (outpatient) or discharge/thru date (inpatient) are on or after the ICD-10 cutover date.

A claim will be rejected if an ICD-10 diagnosis indicator is received and the service date (outpatient) or discharge/thru date (inpatient) prior to the ICD-10 cutover date.

Submitter ID NOT found

Other Payer Primary ID is missing or invalid or the value sent in the 2330 loop does not match the value sent in the 2430 loop

A claim will be rejected if a valid ICD-9 or ICD-10 qualifier (ABN or BN) is sent, based on the date of service, but the diagnosis code itself (ICD-9 or ICD-10) is not valid in the External Cause of Injury field (837I - 2300 HI01-2)

Claim adjustment reason code in the CAS segment is invalid or was not active on the Coordination of Benefits Adjudication/Payment Date (2430:DTP03)

Medicare is the secondary payer and the Medicare Coordination of Benefits Insurance Type Code is missing or invalid (2320:SBR05)

A claim will be rejected if a valid ICD-9 or ICD-10 qualifier (APR or PR) is sent, based on the date of service, but the diagnosis code itself (ICD-9 or ICD-10) is not valid in the Patient Reason for Visit field (837I - 2300 HI01-2)

A claim will be rejected if a claim contains mixture of services with DOS (outpatient) or discharge/thru date (inpatient) before and after the cutover date and/or both ICD-9 and ICD-10 qualifiers are submitted on the claim.

### 8 OPERATIONAL INFORMATION

#### 8.1 HOURS OF OPERATION

Unless otherwise notified claims processing will be online 7 days a week, 24 hours a day.
9 TRANSACTION SPECIFIC INFORMATION

9.1 HEALTH CARE CLAIM: PROFESSIONAL (837P)

<table>
<thead>
<tr>
<th>Loop ID</th>
<th>Reference</th>
<th>Name</th>
<th>Codes</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>BHT02</td>
<td></td>
<td>Transaction Set Purpose Code</td>
<td>00</td>
<td>LACDMH expects to receive this code value.</td>
</tr>
<tr>
<td>BHT06</td>
<td></td>
<td>Transaction Type Code</td>
<td>CH</td>
<td>LACDMH expects to receive this code value.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Beginning of Hierarchical</td>
<td></td>
<td>Transaction</td>
</tr>
<tr>
<td>1000A</td>
<td>NM109</td>
<td>Submitter Identifier</td>
<td></td>
<td>Enter the 9-digit DUNS number, with no trailing spaces.</td>
</tr>
<tr>
<td>1000B</td>
<td>NM103</td>
<td>Receiver Name</td>
<td></td>
<td>LACDMH expects to receive ‘LAC DEPARTMENT OF MENTAL HEALTH’</td>
</tr>
<tr>
<td>1000B</td>
<td>NM109</td>
<td>Receiver Primary Identifier</td>
<td></td>
<td>LACDMH expects to receive ‘LACDMH’.</td>
</tr>
<tr>
<td>2000A</td>
<td>PRV03</td>
<td>Billing Provider Specialty</td>
<td></td>
<td>LACDMH adjudication is not impacted by the provider Taxonomy Code</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2000B</td>
<td>SBR01</td>
<td>Payer Responsibility Sequence Number</td>
<td>Set to the appropriate payment responsibility for the claim. The value will be the highest level following adjudication by a previous payer. For example, a Medi-Medi claim that contains the Medicare Other Payer loop will be represented as a Secondary claim when reported to LACDMH. A straight MediCal or Indigent claim will be represented as a Primary claim.</td>
<td></td>
</tr>
<tr>
<td>2010BA</td>
<td>NM102</td>
<td>Entity Type Qualifier</td>
<td>1</td>
<td>A LACDMH subscriber is always a person.</td>
</tr>
<tr>
<td>2010BA</td>
<td>NM108</td>
<td>Identification Code Qualifier</td>
<td>MI</td>
<td></td>
</tr>
<tr>
<td>2010BA</td>
<td>NM109</td>
<td>Subscriber Primary Identifier</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2010BB</td>
<td>NM103</td>
<td>Payer name</td>
<td></td>
<td>The destination payer is always LACDMH. LACDMH expects to receive ‘LAC DEPARTMENT OF MENTAL HEALTH’</td>
</tr>
<tr>
<td>2010BB</td>
<td>NM108</td>
<td>Identification Code Qualifier</td>
<td>PI</td>
<td>LACDMH expects to receive this code value.</td>
</tr>
<tr>
<td>2010BB</td>
<td>NM109</td>
<td>Payer identifier</td>
<td></td>
<td>‘953893470’</td>
</tr>
<tr>
<td>2300</td>
<td>CLM01</td>
<td>Patient Control Number</td>
<td></td>
<td>LACDMH requires that this be a unique identifier.</td>
</tr>
<tr>
<td>2300</td>
<td>CLM05-1</td>
<td>Place of Service Code</td>
<td></td>
<td>If the place of service was via telephone, set this value to ‘11’.</td>
</tr>
<tr>
<td>Share of Cost (SOC)</td>
<td>2300</td>
<td>AMT01</td>
<td>Amount Qualifier Code</td>
<td>F5</td>
</tr>
<tr>
<td>---------------------</td>
<td>------</td>
<td>-------</td>
<td>-----------------------</td>
<td>----</td>
</tr>
<tr>
<td></td>
<td>2300</td>
<td>AMT02</td>
<td>Patient Paid Amount</td>
<td></td>
</tr>
<tr>
<td>Original Reference Number ICN/DCN</td>
<td>2300</td>
<td>REF01</td>
<td>Reference ID Qualifier</td>
<td>F8</td>
</tr>
<tr>
<td></td>
<td>2300</td>
<td>REF02</td>
<td>Claim Original Reference Number</td>
<td></td>
</tr>
<tr>
<td>Replacement and Void claims can only be submitted after the claim has been adjudicated in IBHIS and the provider has received an 835 with the IBHIS assigned claim ID number. Report the IBHIS assigned claim identifier, for the claim to be replaced/voided in this field.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Katie A Identifier</td>
<td>2300</td>
<td>REF01</td>
<td>Reference ID Qualifier</td>
<td>P4</td>
</tr>
<tr>
<td></td>
<td>2300</td>
<td>REF02</td>
<td>Demonstration Project Identifier</td>
<td>KTA</td>
</tr>
<tr>
<td>To identify all specialty mental health services provided to Katie A. subclass members, providers shall identify all claims for services provided to clients identified as Katie A. subclass members by supplying the Loop 2300 REF-Demonstration Project Identifier (DPI) segment with the value &quot;KTA&quot; as the Demonstration Project Identifier (data element REF02).</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Claim Note(Healthy Families)</td>
<td>2300</td>
<td>NTE01</td>
<td>Note Reference</td>
<td>ADD</td>
</tr>
<tr>
<td></td>
<td>2300</td>
<td>NTE02</td>
<td>Description</td>
<td>SED</td>
</tr>
<tr>
<td>Indicates Healthy Families</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Care Diagnosis Code</td>
<td>2300</td>
<td>HI01-01</td>
<td>Code List Qualifier Code</td>
<td></td>
</tr>
<tr>
<td>For dates of service prior to the ICD-10 compliance date must use “BK”. For dates of service on or after the ICD-10 compliance date must use “ABK”.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2300</td>
<td>HI01-02, HI02-02, HI03-02, ... HI12-02</td>
<td>Diagnosis Code</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use UPPERCASE, for any letters in an ICD-9 or ICD-10 code. Use ICD-9 codes for any dates of service prior to 10/1/2015. Use ICD-10 codes for any dates of service on or after 10/1/2015.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2320 SBR - Other Subscriber Information</td>
<td>Only submit the 2320 Other Subscriber Loop for payers that have previously adjudicated the claim and/or have financial responsibility on the claim prior to being sent to LACDMH.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2320</td>
<td>SBR01</td>
<td>Payer Responsibility Sequence Number</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Set to the appropriate payment responsibility for the claim.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2320</td>
<td>SBR09</td>
<td>Claim Filing Indicator Code</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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 16 when the payer in this iteration of the 2320 loop is a Medicare HMO plan. Use appropriate code for all other payers.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Field</td>
<td>Code</td>
<td>Description</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------</td>
<td>------</td>
<td>-----------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AMT01</td>
<td></td>
<td>Amount Qualifier Code D: Use D to report amount paid by Medicare/OHC. This</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>amount will be used for balancing processing. Must supply even if the amount</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>is zero.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AMT02</td>
<td></td>
<td>COB Payer Paid Amount: For Local Plan Contracted and FFS providers, that</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>have previously sent claims and received remit advices from Medicare and/or</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>private insurance, this field must be populated with the amount paid by</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medicare and/or private insurance, even if it is zero.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NM109</td>
<td></td>
<td>Other Payer Primary Identifier: An identification number for the other</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>payer, such as ‘01182’ for Medicare.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LX01</td>
<td></td>
<td>Line Counter: Set to 1. LACDMH allows one service line per claim.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Procedure Code</td>
<td>Description</td>
<td>Details</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------</td>
<td>-------------</td>
<td>---------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SV101-03 thru  SV101-06</td>
<td>Procedure Code Modifier</td>
<td>Refer to the Addendum Guide to Procedure Codes for IBHIS located at <a href="http://dmh.lacounty.gov/wps/portal/dmh/admin_tools/prov_manuals">http://dmh.lacounty.gov/wps/portal/dmh/admin_tools/prov_manuals</a> for a complete list of Procedure Codes in IBHIS (including the modifiers for Duplicate Overrides (59 &amp; 76), Telephone (SC), Tele-psychiatry (GT) and/or County Funded (HX)). Modifiers must be submitted in the order listed in the Addendum Guide to Procedure Codes for IBHIS. See State DMH Info Notice 10-23 at [<a href="http://www.dmh.ca.gov/dmhdocs/docs/not">http://www.dmh.ca.gov/dmhdocs/docs/not</a> ices10/10-23.pdf](<a href="http://www.dmh.ca.gov/dmhdocs/docs/not">http://www.dmh.ca.gov/dmhdocs/docs/not</a> ices10/10-23.pdf) for further billing info on Telephone and Tele-psychiatry.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SV103</td>
<td>Unit or Basis of Measurement Code</td>
<td>UN MJ Outpatient Services claimed by the minute – use ‘MJ’ / Minutes Crisis Stabilization claimed by the hour – use ‘MJ’ / Minutes Day Treatment/Residential/PHF/Life Support – use ‘UN’ / Units</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SV104</td>
<td>Service Unit Count</td>
<td>Set to the number of units or minutes or hours. Use the procedure code that matches to the appropriate face to face time. Enter minutes as the total of face to face + other time. Crisis Stabilization claims must represent the number of hours claimed for. Must be 1 for Day Treatment, Residential, PHF and Life Support claims. For Local Contract Provider Group claims, refer to the explanation found in the Group Claim Bulletin located on the IBHIS EDI News/Alerts webpage: [<a href="http://lacdmh.lacounty.gov/hipaa/IBHIS_E">http://lacdmh.lacounty.gov/hipaa/IBHIS_E</a> DI_News.htm](<a href="http://lacdmh.lacounty.gov/hipaa/IBHIS_E">http://lacdmh.lacounty.gov/hipaa/IBHIS_E</a> DI_News.htm).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SV109</td>
<td>Emergency Indicator</td>
<td>Y 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.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

DTP – Service Date

<p>| Date Time Qualifier | 472 |</p>
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2400 DTP02</td>
<td>Date Time Period Format Qualifier</td>
<td>Use D8 for all services, including Day Treatment, Residential, PHF and Life Support</td>
</tr>
<tr>
<td>2400 DTP03</td>
<td>Service Date</td>
<td>Submit the service date</td>
</tr>
<tr>
<td>2400 REF01</td>
<td>Prior Authorization Qualifier</td>
<td>Report the Provider, Member or Fee-for-Service Authorization # in the Prior Authorization field.</td>
</tr>
<tr>
<td>2400 REF02</td>
<td>Prior Authorization Number</td>
<td></td>
</tr>
<tr>
<td>2400 NTE01</td>
<td>Note Reference Code</td>
<td>Use DCP for reporting the Evidence Based Practice (EBP) code.</td>
</tr>
<tr>
<td>2400 NTE02</td>
<td>Claim Note Text</td>
<td>Enter the primary EBP or Service Strategy. Any applicable EBP, other than 99-Unknown, should be prioritized over a Service Strategy. Enter only 1 code. Each code is 2-byte alpha-numeric. Alpha characters must be uppercase. All numeric codes must be 2 digits. Include a leading zero, if needed, to make a 2 digit code. Claims will reject if this segment is not present. Allowable EBP Codes are located at: <a href="http://lacdmh.lacounty.gov/hipaa/IBHIS_EDI_Guides.htm">http://lacdmh.lacounty.gov/hipaa/IBHIS_EDI_Guides.htm</a></td>
</tr>
<tr>
<td>2400 NM101</td>
<td>Entity Identifier Code</td>
<td>77</td>
</tr>
<tr>
<td>2400 NM102</td>
<td>Entity Type Qualifier</td>
<td>2</td>
</tr>
<tr>
<td>2400 NM103</td>
<td>Facility Name</td>
<td>Enter the name or description where the service was delivered</td>
</tr>
<tr>
<td>2400 N301</td>
<td>Facility Address Line</td>
<td>Enter the street address where the service was delivered</td>
</tr>
<tr>
<td>2400 N401</td>
<td>Facility City Name</td>
<td>Enter the city where the service was delivered</td>
</tr>
<tr>
<td>2400 N402</td>
<td>Facility State</td>
<td>Enter the state where the service was delivered</td>
</tr>
<tr>
<td>2400 N403</td>
<td>Facility Zip</td>
<td>Enter the zip code where the service was delivered. Note: you must enter the full nine digit zip code in this field</td>
</tr>
</tbody>
</table>

Service Facility Location – send the 2420C Service Facility Location loop when the health care service was delivered in a location other than the billing provider office. DO NOT ENTER an NPI for the Service Facility Location.

Loop 2430 Line Adjudication Information – IBHIS requires the 2430 loop and required 2430 segments whenever a claim was adjudicated by a prior payer and there is a 2320 Other Subscriber Loop on the claim.

SVD – Line Adjudication Information – the SVD segment is required whenever a claim was adjudicated by a prior payer and there is a 2320 Other Subscriber Loop on the claim.

CAS – Line Adjustment

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2430 CAS01</td>
<td>Claim Line Adjustments</td>
<td>Required when the payer identified in Loop 2330B made payment adjustments which caused the amount paid to differ from the amount originally charged. Medicare/OHC adjustments must be reported at the Service Line level.</td>
</tr>
</tbody>
</table>
## 9.2 Health Care Claim: Professional (837P) COS

### Community Outreach Services

<table>
<thead>
<tr>
<th>Loop ID</th>
<th>Reference</th>
<th>Name</th>
<th>Codes</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>BHT02</td>
<td>NM109</td>
<td>Submitter Identifier</td>
<td></td>
<td>Enter the 9-digit DUNS number, with no trailing spaces.</td>
</tr>
<tr>
<td>BHT06</td>
<td>NM109</td>
<td>Receiver Primary Identifier</td>
<td></td>
<td>LACDMH expects to receive 'LAC DEPARTMENT OF MENTAL HEALTH'.</td>
</tr>
</tbody>
</table>

### Billing Provider Specialty Information

<table>
<thead>
<tr>
<th>Loop ID</th>
<th>Reference</th>
<th>Name</th>
<th>Codes</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>BHT02</td>
<td>NM109</td>
<td>Billing Provider Specialty</td>
<td></td>
<td>LACDMH adjudication is not impacted by the provider Taxonomy Code</td>
</tr>
</tbody>
</table>

### Subscriber Information

<table>
<thead>
<tr>
<th>Loop ID</th>
<th>Reference</th>
<th>Name</th>
<th>Codes</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>N102</td>
<td>NM108</td>
<td>Name Last</td>
<td>MI</td>
<td></td>
</tr>
<tr>
<td>N103</td>
<td>NM109</td>
<td>Name First</td>
<td>U</td>
<td></td>
</tr>
<tr>
<td>N108</td>
<td>NM109</td>
<td>Subscriber Primary Identifier</td>
<td></td>
<td>For COS claims, use 'MSO8888888' as the Subscriber ID</td>
</tr>
<tr>
<td>N301</td>
<td>N401</td>
<td>Address</td>
<td></td>
<td>Must use &quot;550 S VERMONT AVE&quot;</td>
</tr>
<tr>
<td>N401</td>
<td>N402</td>
<td>City Name</td>
<td></td>
<td>Must use &quot;LOS ANGELES&quot;</td>
</tr>
<tr>
<td>N402</td>
<td>N403</td>
<td>State</td>
<td></td>
<td>Must use &quot;CA&quot;</td>
</tr>
<tr>
<td>N403</td>
<td>DMG01</td>
<td>Date Time Format Qualifier</td>
<td>D8</td>
<td>Date of Birth</td>
</tr>
<tr>
<td>N404</td>
<td>DMG02</td>
<td>Date Time</td>
<td></td>
<td>Must use &quot;20130701&quot;</td>
</tr>
<tr>
<td>N405</td>
<td>DMG03</td>
<td>Gender Code</td>
<td>U</td>
<td>Must use &quot;U&quot;</td>
</tr>
</tbody>
</table>

### Payer Information

<table>
<thead>
<tr>
<th>Loop ID</th>
<th>Reference</th>
<th>Name</th>
<th>Codes</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>N103</td>
<td>NM108</td>
<td>Identification Code Qualifier</td>
<td>PI</td>
<td>LACDMH expects to receive this code value.</td>
</tr>
<tr>
<td>N109</td>
<td>NM109</td>
<td>Payer identifier</td>
<td>'953893470'</td>
<td></td>
</tr>
</tbody>
</table>

### Claim Information

<table>
<thead>
<tr>
<th>Loop ID</th>
<th>Reference</th>
<th>Name</th>
<th>Codes</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLM01</td>
<td>CLM05-1</td>
<td>Place of Service Code</td>
<td></td>
<td>Use any appropriate Place of Service code.</td>
</tr>
<tr>
<td>CLM01</td>
<td>CLM05-3</td>
<td>Claim Frequency Code</td>
<td></td>
<td>DMH accepts Original, '1', Replacement, '7' and Void, '8' claim frequency codes.</td>
</tr>
</tbody>
</table>
### Original Reference Number ICN/DCN

<table>
<thead>
<tr>
<th>Code</th>
<th>REF01</th>
<th>Reference ID Qualifier</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>2300</td>
<td>REF02</td>
<td>Claim Original Reference Number</td>
<td>F8</td>
</tr>
</tbody>
</table>

Replacement and Void claims can only be submitted after the claim has been adjudicated in IBHIS and the provider has received an 835 with the IBHIS assigned claim ID number. Report the IBHIS assigned claim identifier, for the claim to be replaced/voided in this field.

### Health Care Diagnosis Code

<table>
<thead>
<tr>
<th>Code</th>
<th>HI01-01</th>
<th>Code List Qualifier Code</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>2300</td>
<td>HI01-02</td>
<td>Diagnosis Code</td>
<td>F8</td>
</tr>
</tbody>
</table>

For dates of service prior to the ICD-10 compliance date must use “BK”. For dates of service on or after the ICD-10 compliance date must use “ABK”.

### Rendering Provider

<table>
<thead>
<tr>
<th>Code</th>
<th>NM101</th>
<th>Entity Identifier Code</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>2310</td>
<td>NM102</td>
<td>Entity Type Qualifier</td>
<td>1</td>
</tr>
<tr>
<td>2310</td>
<td>NM103</td>
<td>Name Last</td>
<td>Last Name of the Primary COS Provider</td>
</tr>
<tr>
<td>2310</td>
<td>NM104</td>
<td>Name First</td>
<td>First Name of the Primary COS Provider</td>
</tr>
<tr>
<td>2310</td>
<td>NM108</td>
<td>Identification Code Qualifier</td>
<td>XX</td>
</tr>
<tr>
<td>2310</td>
<td>NM109</td>
<td>Identification Code</td>
<td>Primary COS Provider’s NPI #</td>
</tr>
</tbody>
</table>

### LX – Service Line Number

<table>
<thead>
<tr>
<th>Code</th>
<th>LX01</th>
<th>Line Counter</th>
<th>Value</th>
</tr>
</thead>
</table>

Set to 1. LACDMH allows one service line per claim.

### SV1 - Professional Service

<table>
<thead>
<tr>
<th>Code</th>
<th>SV101-02 thru SV101-06</th>
<th>Procedure Code</th>
<th>Procedure Code Modifier</th>
</tr>
</thead>
</table>

Must use one of the identified COS codes and modifier if applicable. Refer to the Addendum Guide to Procedure Codes for IBHIS located at [http://dmh.lacounty.gov/wps/portal/dmh/admin_tools/prov_manuals](http://dmh.lacounty.gov/wps/portal/dmh/admin_tools/prov_manuals) for a complete list of Procedure Codes in IBHIS (including the modifiers for Duplicate Overrides (59 & 76), Telephone (SC), Tele-mentality (GT) and/or County Funded (HX).

Modifiers must be submitted in the order listed in the Addendum Guide to Procedure Codes for IBHIS.

<table>
<thead>
<tr>
<th>Code</th>
<th>SV103</th>
<th>Unit or Basis of Measurement Code</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>2400</td>
<td></td>
<td>COS services must use “MJ” - minutes</td>
<td></td>
</tr>
</tbody>
</table>

For COS services, Use the total # of minutes for all practitioners involved in providing the service. Documentation time should be included. Travel time is excluded.
<table>
<thead>
<tr>
<th>REF - Prior Authorization</th>
<th>2400</th>
<th>REF01</th>
<th>Prior Authorization Qualifier</th>
<th>G1</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2400</td>
<td>REF02</td>
<td>Prior Authorization Number</td>
<td>Use the appropriate non-Medi-Cal P-Authorization number</td>
</tr>
<tr>
<td>NTE Claim Note</td>
<td>2400</td>
<td>NTE01</td>
<td>Note Reference Code</td>
<td>DCP Use DCP for reporting the Evidence Based Practice (EBP) code.</td>
</tr>
<tr>
<td></td>
<td>2400</td>
<td>NTE02</td>
<td>Claim Note Text</td>
<td>99 COS Claims must use “99” Claims will reject if this segment is not present.</td>
</tr>
<tr>
<td>LQ – Form Identification Code</td>
<td>2440</td>
<td>LQ01</td>
<td>Code List Qualifier Code</td>
<td>AS Must use “AS”</td>
</tr>
<tr>
<td></td>
<td>2440</td>
<td>LQ02</td>
<td>Industry Code</td>
<td>IBHISCOS Must use “IBHISCOS”</td>
</tr>
<tr>
<td>FRM – Supporting Documentation</td>
<td>2440</td>
<td>FRM01</td>
<td>Assigned Identification</td>
<td>D26</td>
</tr>
<tr>
<td></td>
<td>2440</td>
<td>FRM01</td>
<td>Assigned Identification</td>
<td>D12</td>
</tr>
<tr>
<td></td>
<td>2440</td>
<td>FRM01</td>
<td>Assigned Identification</td>
<td>D43</td>
</tr>
<tr>
<td></td>
<td>2440</td>
<td>FRM01</td>
<td>Assigned Identification</td>
<td>D01</td>
</tr>
<tr>
<td></td>
<td>2440</td>
<td>FRM03</td>
<td>Reference Identification</td>
<td>Required on every COS claim. See dictionary D.1 in the DMH IBHIS COS Dictionary Values file for Age Category Codes (<a href="http://lacdmh.lacounty.gov/hipaa/IBHIS_EDI_Technical_Specifications.htm">http://lacdmh.lacounty.gov/hipaa/IBHIS_EDI_Technical_Specifications.htm</a>)</td>
</tr>
<tr>
<td></td>
<td>2440</td>
<td>FRM01</td>
<td>Assigned Identification</td>
<td>D23</td>
</tr>
<tr>
<td></td>
<td>2440</td>
<td>FRM01</td>
<td>Assigned Identification</td>
<td>D25</td>
</tr>
<tr>
<td></td>
<td>2440</td>
<td>FRM01</td>
<td>Assigned Identification</td>
<td>Contacts</td>
</tr>
<tr>
<td></td>
<td>2440</td>
<td>FRM03</td>
<td>Reference Identification</td>
<td>Number of persons contacted</td>
</tr>
</tbody>
</table>
### 9.3 Health Care Claim: Inpatient (837I)

<table>
<thead>
<tr>
<th>Loop ID</th>
<th>Reference</th>
<th>Name</th>
<th>Codes</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>BHT02</td>
<td></td>
<td>Transaction Set Purpose Code</td>
<td>00</td>
<td>LACDMH expects to receive this code value.</td>
</tr>
<tr>
<td>BHT06</td>
<td></td>
<td>Transaction Type Code</td>
<td>CH</td>
<td>LACDMH expects to receive this code value.</td>
</tr>
<tr>
<td></td>
<td>1000A</td>
<td>Submitter Identifier</td>
<td></td>
<td>Enter the 9-digit DUNS number, with no trailing spaces.</td>
</tr>
<tr>
<td></td>
<td>1000B</td>
<td>Receiver Name</td>
<td></td>
<td>LACDMH expects to receive ‘LAC DEPARTMENT OF MENTAL HEALTH’</td>
</tr>
<tr>
<td></td>
<td>1000B</td>
<td>Receiver Primary Identifier</td>
<td></td>
<td>LACDMH expects to receive ‘LACDMH’.</td>
</tr>
<tr>
<td></td>
<td>2000A</td>
<td>Billing Provider Specialty Information</td>
<td></td>
<td>LACDMH adjudication is not impacted by the provider Taxonomy Code</td>
</tr>
<tr>
<td></td>
<td>2000B</td>
<td>Payer Responsibility Sequence Number</td>
<td>Set to the appropriate payment responsibility for the claim. The value will be the highest level following adjudication by a previous payer. For example, a Medi-Medi claim that contains the Medicare Other Payer loop will be represented as a Secondary claim when reported to LACDMH. A straight MediCal or Indigent claim will be represented as a Primary claim.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2010BA</td>
<td>Entity Type Qualifier</td>
<td>1</td>
<td>A LACDMH subscriber is always a person.</td>
</tr>
<tr>
<td></td>
<td>2010BA</td>
<td>Identification Code Qualifier</td>
<td>MI</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2010BA</td>
<td>Subscriber Primary Identifier</td>
<td></td>
<td>The LACDMH subscriber identifier is an alpha numeric field comprised of ‘MSO’ concatenated with the ClientID. If the submitted value is invalid the claim will be rejected. Example: if the client ID is 12345, the subscriber primary identifier must be entered as ‘MSO12345’.</td>
</tr>
<tr>
<td></td>
<td>2010BB</td>
<td>Payer name</td>
<td></td>
<td>The destination payer is always LACDMH. LACDMH expects to receive ‘LAC DEPARTMENT OF MENTAL HEALTH’</td>
</tr>
<tr>
<td></td>
<td>2010BB</td>
<td>Identification Code Qualifier</td>
<td>PI</td>
<td>LACDMH expects to receive this code value.</td>
</tr>
<tr>
<td></td>
<td>2010BB</td>
<td>Payer identifier</td>
<td>‘953893470’</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2300</td>
<td>Patient Control Number</td>
<td></td>
<td>LACDMH requires that this be a unique identifier.</td>
</tr>
</tbody>
</table>
### Loop ID 2300

<table>
<thead>
<tr>
<th>Reference</th>
<th>Name</th>
<th>Codes</th>
<th>Notes/Comments</th>
</tr>
</thead>
</table>
| CLM05-3  | Claim Frequency Code          |                            | Enter the appropriate code:  
|           |                               |                            | 1 - Admit & Discharge Claim –charges for an entire episode  
|           |                               |                            | 2 - Interim 1st Claim  
|           |                               |                            | 3 - Interim Continuing Claim  
|           |                               |                            | 4 - Interim Last Claim  
|           |                               |                            | 5 - Late Charge Only  
|           |                               |                            | 7 - Replacement of Prior Claim  
|           |                               |                            | 8 - Void/Cancel of prior Claim |

### DTP – Statement Dates

<table>
<thead>
<tr>
<th>Reference</th>
<th>Name</th>
<th>Codes</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTP01</td>
<td>Date/Time Qualifier</td>
<td>434</td>
<td></td>
</tr>
<tr>
<td>DTP02</td>
<td>Date Time Period Format Qualifier</td>
<td>RD8</td>
<td></td>
</tr>
<tr>
<td>DTP03</td>
<td>Statement From and To Date</td>
<td></td>
<td>Enter the Service Date you are claiming for. You must use the date range format, but the From and To dates must be the same date.</td>
</tr>
</tbody>
</table>

### REF - Prior Authorization

<table>
<thead>
<tr>
<th>Reference</th>
<th>Name</th>
<th>Codes</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>REF01</td>
<td>Prior Authorization Qualifier</td>
<td>G1</td>
<td>Report the Provider or Member Authorization # in the Prior Authorization field.</td>
</tr>
<tr>
<td>REF02</td>
<td>Prior Authorization Number</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Original Reference Number ICN/DCN

<table>
<thead>
<tr>
<th>Reference</th>
<th>Name</th>
<th>Codes</th>
<th>Notes/Comments</th>
</tr>
</thead>
</table>
| REF01     | Reference ID Qualifier        | F8    | Replacement and Void claims can only be submitted after the claim has been adjudicated in IBHIS and the provider has received an 835 with the IBHIS assigned claim ID number.  
| REF02     | Claim Original Reference Number |       | Report the IBHIS assigned claim identifier, for the claim to be replaced/voided in this field. |

### Katie A Identifier

<table>
<thead>
<tr>
<th>Reference</th>
<th>Name</th>
<th>Codes</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>REF01</td>
<td>Reference ID Qualifier</td>
<td>P4</td>
<td></td>
</tr>
<tr>
<td>REF02</td>
<td>Demonstration Project Identifier</td>
<td>KTA</td>
<td>To identify all specialty mental health services provided to Katie A. subclass members, providers shall identify all claims for services provided to clients identified as Katie A. subclass members by supplying the Loop 2300 REF-Demonstration Project Identifier (DPI) segment with the value “KTA” as the Demonstration Project Identifier (data element REF02).</td>
</tr>
</tbody>
</table>

### NTE Claim Note

<table>
<thead>
<tr>
<th>Reference</th>
<th>Name</th>
<th>Codes</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>NTE01</td>
<td>Note Reference Code</td>
<td>DCP</td>
<td>Use DCP for reporting the Evidence Based Practice (EBP) code.</td>
</tr>
<tr>
<td>Loop ID</td>
<td>Reference</td>
<td>Name</td>
<td>Codes</td>
</tr>
<tr>
<td>---------</td>
<td>-----------</td>
<td>---------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>2300</td>
<td>NTE02</td>
<td>Claim Note Text</td>
<td></td>
</tr>
<tr>
<td>2300</td>
<td>NTE01</td>
<td>Note Reference</td>
<td>ADD</td>
</tr>
<tr>
<td>2300</td>
<td>NTE02</td>
<td>Description</td>
<td>SED</td>
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<td>2300</td>
<td>HI01-01</td>
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<td>ABK</td>
</tr>
<tr>
<td>2300</td>
<td>HI01-01</td>
<td>Diagnosis Type Code</td>
<td>BK</td>
</tr>
<tr>
<td>2300</td>
<td>HI01-02</td>
<td>Principal Diagnosis Code</td>
<td>F3111</td>
</tr>
<tr>
<td>2300</td>
<td>HI01-02</td>
<td>Principal Diagnosis Code</td>
<td>29570</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Admitting Diagnosis Code</td>
<td></td>
</tr>
<tr>
<td>2300</td>
<td>HI01-01</td>
<td>Diagnosis Type Code</td>
<td>ABJ</td>
</tr>
<tr>
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<td>HI01-01</td>
<td>Diagnosis Type Code</td>
<td>BJ</td>
</tr>
<tr>
<td>2300</td>
<td>HI01-02</td>
<td>Admitting Diagnosis Code</td>
<td>F3111</td>
</tr>
<tr>
<td>2300</td>
<td>HI01-02</td>
<td>Admitting Diagnosis Code</td>
<td>29570</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Share of Cost (SOC) – Value Information – To report patient paid amount</td>
<td></td>
</tr>
<tr>
<td>2300</td>
<td>HI01-01</td>
<td>Code List Qualifier Code</td>
<td>BE</td>
</tr>
<tr>
<td>2300</td>
<td>HI01-02</td>
<td>Value Code</td>
<td>FC</td>
</tr>
<tr>
<td>2300</td>
<td>HI01-05</td>
<td>Value Code Amount</td>
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<td></td>
<td>Attending Provider</td>
<td></td>
</tr>
<tr>
<td>2310A</td>
<td>NM101</td>
<td>Entity Identifier Code</td>
<td>71</td>
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<tr>
<td>2310A</td>
<td>NM108</td>
<td>Identification Code Qualifier</td>
<td>XX</td>
</tr>
<tr>
<td>2300</td>
<td>NM109</td>
<td>Attending Provider Primary Identifier</td>
<td></td>
</tr>
<tr>
<td>2320 SBR - Other Subscriber Information</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loop ID</td>
<td>Reference</td>
<td>Name</td>
<td>Codes</td>
</tr>
<tr>
<td>---------</td>
<td>-----------</td>
<td>-------------------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>2320</td>
<td>SBR01</td>
<td>Payer Responsibility Sequence Number</td>
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</tr>
<tr>
<td>2320</td>
<td>SBR09</td>
<td>Claim Filing Indicator Code</td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
### AMT - Coordination of Benefits COB Payer Paid Amount

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2320</td>
<td><strong>AMT01</strong> Amount Qualifier Code &lt;br&gt;<strong>D</strong>&lt;br&gt;Use <strong>D</strong> to report amount paid by Medicare/OHC. This amount will be used for balancing processing. Must supply even if the amount is zero.</td>
</tr>
<tr>
<td>2320</td>
<td><strong>AMT02</strong> COB Payer Paid Amount&lt;br&gt;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, even if it is zero.</td>
</tr>
</tbody>
</table>

### NM1 - Other Payer Name

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2330B</td>
<td><strong>NM109</strong> Other Payer Primary Identifier&lt;br&gt;An identification number for the other payer, such as '01182' for Medicare.</td>
</tr>
</tbody>
</table>

### LX – Service Line Number

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2400</td>
<td><strong>LX01</strong> Line Counter&lt;br&gt;Set to 1. LACDMH allows one service line per claim.</td>
</tr>
</tbody>
</table>

### SV2 – Inpatient Service Line

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2400</td>
<td><strong>SV202-01</strong> Product or Service ID Qualifier&lt;br&gt;HC&lt;br&gt;LACDMH expects to receive this code value.</td>
</tr>
<tr>
<td>2400</td>
<td><strong>SV202-02</strong> Procedure Code &lt;br&gt;Refer to the Addendum Guide to Procedure Codes for IBHIS located at <a href="http://dmh.lacounty.gov/wps/portal/dmh/admin_tools/prov_manuals">http://dmh.lacounty.gov/wps/portal/dmh/admin_tools/prov_manuals</a> for a complete list of Procedure Codes in IBHIS. &lt;br&gt;Modifiers must be submitted in the order listed in the Addendum Guide to Procedure Codes for IBHIS.</td>
</tr>
<tr>
<td>2400</td>
<td><strong>SV202-03</strong> thru <strong>SV202-06</strong> Procedure Code Modifier &lt;br&gt;Refer to the Addendum Guide to Procedure Codes for IBHIS located at <a href="http://dmh.lacounty.gov/wps/portal/dmh/admin_tools/prov_manuals">http://dmh.lacounty.gov/wps/portal/dmh/admin_tools/prov_manuals</a> for a complete list of Procedure Codes in IBHIS. &lt;br&gt;Modifiers must be submitted in the order listed in the Addendum Guide to Procedure Codes for IBHIS.</td>
</tr>
<tr>
<td>2400</td>
<td><strong>SV204</strong> Unit or Basis of Measurement Code&lt;br&gt;DA&lt;br&gt;Inpatient Services – use ‘DA’ / Days</td>
</tr>
<tr>
<td>2400</td>
<td><strong>SV205</strong> Service Unit Count&lt;br&gt;Must be 1</td>
</tr>
</tbody>
</table>

### Loop 2430 Line Adjudication Information – IBHIS requires the 2430 loop and required 2430 segments whenever a claim was adjudicated by a prior payer and there is a 2320 Other Subscriber Loop on the claim. 

### SVD – Line Adjudication Information – the SVD segment is required whenever a claim was adjudicated by a prior payer and there is a 2320 Other Subscriber Loop on the claim. 

### CAS – Line Adjustment

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2430</td>
<td><strong>CAS01 – CAS04</strong> Claim Line Adjustments &lt;br&gt;Required when the payer identified in Loop 2330B made payment adjustments which caused the amount paid to differ from the amount originally charged. Medicare/OHC adjustments must be reported at the Service Line level.</td>
</tr>
</tbody>
</table>
10 APPENDICES

10.1 837P EXAMPLES

10.1.1 STRAIGHT MEDI-CAL

Interchange (L_ISA)
ISA*00* 00* 14*996508079 14*132486189
*131121*0822:*00501*131121802*1*T:*~

Functional Group (L_GS)
GS*HC*996508079*132486189*20131121*082252*131121802*X*005010X222A1~

Transaction 837P (837P)
ST*837*0000000001*005010X222A1~
BHT*0019*00*131121802A*20131121*082252*CH~

Submitter Name (1000A)
NM1*41*2*LE88333 FAMILY MENTAL HEALTH SERVICES CLINIC
*****46*996508079~ ←=Submitter's DUNS
PER*IC*BILLING DEPARTMENT*TE*5554443333~

Receiver Name (1000B)
NM1*40*2*LAC DEPARTMENT OF MENTAL HEALTH******46*LACODMH~

Billing Provider Hierarchical Level (2000A)
HL*1**20*1~

Billing Provider Name (2010AA)
NM1*85*2*1234Z FMHSC PGM-LOCATION-Z LE88333******XX*9926907927~ ←=Contracting Provider Program NPI
N3*305 GRANDE AVE STE 202~
N4*LOS ANGELES*CA*900024160~
REF*El*999916918~
PER*IC*BILLING MANAGER*TE*5554443333~

Subscriber Hierarchical Level (2000B)
HL*2*1*22*0~
SBR*P*18********11~ ←=LACDMH is the destination payer, it is Primary

Subscriber Name (2010BA)
NM1*IL*1*MEDICALDOE*MEDICALJOHN****MI*MSO9888331~ ←=Client's ID & 'MSO' is required
N3*613 8TH STREET~
N4*LOS ANGELES*CA*90012~
DMG*D8*19860821*M~

Payer Name (2010BB)
NM1*PR*2*LAC DEPARTMENT OF MENTAL HEALTH******PI*953893470~ ←=LACDMH Payer ID
N3*550 S Vermont Ave~
N4*Los Angeles*CA*90012~

Claim Information (2300)
CLM*131121802A-01*297.6***11:B:1*Y*A*Y*I~
HI*ABK:F339~

Rendering Provider Name (2310B)
NM1*82*1*BRIGHT*FUTURO******XX*1899992078~ ←=Performing Provider NPI
Service Line Number (2400)
LX*1~
SV1*HC:90887*297.6*MJ*120***1~ \(\Leftarrow \) MJ for minutes
DTP*472*D8*20131118~
REF*G1*P71~ \(\Leftarrow \) Provider Authorization number
NTE*DCP*01~ \(\Leftarrow \) EBP (Evidence Based Practice) Code

Transaction 837P (837P)
SE*29*000000001~

Functional Group (L_GS)
GE*1*131121802~

Interchange (L_Isa)
IEA*1*131121802~

10.1.2 INDIGENT

Interchange (L_Isa)
ISA*00*00*14*996508079*131121*08222*00501*131121802*T:*~

Functional Group (L_GS)
GS*HC*996508079*132486189*20131121*082252*131121802*X*005010X222A1~

Transaction 837P (837P)
ST*837*0000000001*005010X222A1~
BHT*0019*00*131121802A*20131121*082252*CH~

Submitter Name (1000A)
NM1*41*2*LE88333 FAMILY MENTAL HEALTH SERVICES CLINIC*****46*996508079~ \(\Leftarrow \) Submitter’s DUNS
PER*IC*BILLING DEPARTMENT*TE*5554443333~

Receiver Name (1000B)
NM1*40*2*LAC DEPARTMENT OF MENTAL HEALTH*****46*LACODMH~

Billing Provider Hierarchical Level (2000A)
HL*1**20*1~

Billing Provider Name (2010AA)
NM1*85*2*1234Z FMHSC PGM-LOCATION-Z LE88333******XX*9926907927~ \(\Leftarrow \) Contracting Provider Program NPI
N3*305 GRANDE AVE STE 202~
N4*LOS ANGELES*CA*900024160~
REF*EI*999916918~
PER*IC*BILLING MANAGER*TE*5554443333~

Subscriber Hierarchical Level (2000B)
HL*2*1**22*0~
SBR*P*18**********11~ \(\Leftarrow \) LACDMH is the destination payer, it is Primary

Subscriber Name (2010BA)
NM1*IL*1*INDIGENTDOE*INDIGENTJANE****MI*MSO9884330~ \(\Leftarrow \) Client’s ID & ‘MSO’ is required
N3*972 3RD AVE~
N4*LOS ANGELES*CA*90022~
DMG*D8*19560326*F~

Payer Name (2010BB)
NM1*PR*2*LAC DEPARTMENT OF MENTAL HEALTH*****PI*953893470~ £==LACDMH Payer ID
N3*550 S Vermont Ave~
N4*Los Angeles*CA*90012~

Claim Information (2300)
CLM*131121802A-01*297.6****11:B:1*Y*A*Y*I~
HI*ABK:F339~

Rendering Provider Name (2310B)
NM1*82*1*BRIGHT*FUTURO****XX*1899992078~ £==Performing Provider NPI

Service Line Number (2400)
LX*1~
SV1*HC:T1017:HE:HS:HX*297.6*MJ*120***1~ £==MJ for minutes, Procedure code is NOT Medi-
Cal Billable
DTP*472*D8*20131118~
REF*G1*P51~ £==Provider Authorization number
NTE*DCP*01~ £==EBP (Evidence Based Practice) Code

Transaction 837P (837P)
SE*29*000000001~

Functional Group (L_GS)
GE*1*131121802~

Interchange (L_ISA)
IEA*1*131121802~

10.1.3 MEDI-MEDI

Interchange (L_ISA)
ISA*00*00*14*996508079*14*132486189
*131121*08221!00501*131121802*1*T*:~

Functional Group (L_GS)
GS*HC*996508079*132486189*20131121*082252*131121802*X*005010X222A1~

Transaction 837P (837P)
ST*837*0000000001*005010X222A1~
BHT*0019*00*131121802A*20131121*082252*CH~

Submitter Name (1000A)
NM1*41*2*LE88333 FAMILY MENTAL HEALTH SERVICES CLINIC
*****46*996508079~ £==Submitter’s DUNS
PER*IC*BILLING DEPARTMENT*TE*5554443333~

Receiver Name (1000B)
NM1*40*2*LAC DEPARTMENT OF MENTAL HEALTH*****46*LACODMH~

Billing Provider Hierarchical Level (2000A)
HL*1***20*1~
**Billing Provider Name (2010AA)**
NM1*85*2*12342 FMHSC PGM-LOCATION-Z LE88333*****XX*9926907927~

---Contracting Provider Program NPI
N3*305 GRANDE AVE STE 202~
N4*LOS ANGELES*CA*900024160~
REF*EI*999916918~
PER*IC*BILLING MANAGER*TE*5554443333~

**Subscriber Hierarchical Level (2000B)**
HL*2*1*22*0~
SBR*S*18********11~

---LACDMH is the destination payer, it is Secondary because this is a Medicare, Medi-Cal claim

**Subscriber Name (2010BA)**
NM1*IL*1*MEDICAREDOE*MEDICAREJOHN*****MI*MSO9888400~

---Client’s ID & ‘MSO’ is required
N3*11 7TH STREET~
N4*LOS ANGELES*CA*90012~
DMG*D8*19450413*M~

**Payer Name (2010BB)**
NM1*PR*2*LAC DEPARTMENT OF MENTAL HEALTH*****PI*953893470~

---LACDMH Payer ID
N3*550 S Vermont Ave~
N4*Los Angeles*CA*90012~

**Claim Information (2300)**
CLM*131121802A-01*297.6****11:B:1*Y*A*Y*I~
HI*BK:29602~

**Rendering Provider Name (2310B)**
NM1*82*1*BRIGHT*FUTURO*****XX*1899992078~

---Performing Provider NPI

**Other Subscriber Information (2320)**
SBR*P*18********MB~

---Primary Payer is Medicare Part B
AMT*D*96.6~

---Payor Amount Paid, amount zero is acceptable
OI***Y***I~

**Other Subscriber Name (2330A)**
NM1*IL*1*MEDICAREDOE*MEDICAREJOHN*****MI*12345678A~

---Client’s HIC (Medicare Beneficiary ID)
N3*11 7TH STREET~
N4*LOS ANGELES*CA*90012~

**Other Payer Name (2330B)**
NM1*PR*2*MEDICARE*****PI*01182~

---Medicare Part B Southern California Payer ID is 01182

**Service Line Number (2400)**
LX*1~
SV1*HC:90887*297.6*MJ*120****1~

---MJ for minutes
DTP*472*D8*20130918~
REF*G1*P11~

---Provider Authorization number
NTE*DCP*01~

---EBP (Evidence Based Practice) Code

**Line Adjudication Information (2430)**
SVD*01182*96.6*HC:90887**120~

---Line Adjudication Information from Medicare Part B Southern California Payer ID 01182
CAS*CO*45*201~

---Line Adjustment by Medicare Part B Southern California Payer ID 01182
### 10.1.4 OHC-MEDICAL

#### Interchange (L_ISA)

ISA|00* | *00* | *14*996508079 | *14*132486189
   |131121*0822*!00501*131121802*1*T*:~

#### Functional Group (L_GS)

GS|HC|996508079*132486189*20131121*082252*131121802*X*005010X222A1~

#### Transaction 837P (837P)

ST|837*000000001*005
   |010X222A1~

BHT|0019*00*131121802A*20131121*082252*CH~

#### Submitter Name (1000A)

NM1|41*2|LE88333 FAMILY MENTAL HEALTH SERVICES CLINIC
   |*****46
   |996508079~ ←Submitter’s DUNS
   |PER*IC*BILLING DEPARTMENT*TE*5554443333~

#### Receiver Name (1000B)

NM1|40*2|LAC DEPARTMENT OF MENTAL HEALTH****46*LACODMH~

#### Billing Provider Hierarchical Level (2000A)

HL|1**20*1~

#### Billing Provider Name (2010AA)

NM1|85*2|1234Z FMHSC PGM-LOCATION-Z LE88333*****XX|9926907927~ ←Contracting Provider Program NPI
   |N3*305 GRANDE AVE STE 202~
   |N4*LOS ANGELES*CA*900024160~
   |REF*EI*999916918~
   |PER*IC*BILLING MANAGER*TE*5554443333~

#### Subscriber Hierarchical Level (2000B)

HL|2*1*22*0~
   |SBR*S*18*******11~ ←LACDMH is the destination payer, it is Secondary because this is a OHC, Medi-Cal claim

#### Subscriber Name (2010BA)

NM1|IL*1|OHCDOE*OHJCJANE****MI*MSO9888621~ ←Client’s ID & ‘MSO’ is required
   |N3*311 9TH STREET~
   |N4*LOS ANGELES*CA*90012~
   |DMG*D8*19840721*F~

#### Payer Name (2010BB)

NM1|PR*2|LAC DEPARTMENT OF MENTAL HEALTH*****PI*953893470~ ←LACDMH Payer ID
   |N3*550 S Vermont Ave~
N4*Los Angeles*CA*90012~

Claim Information (2300)
CLM*131121802A-01*297.6****11:B:1*Y*A*Y*I~
HI*ABK:F339~

Rendering Provider Name (2310B)
NM1*82*1*BRIGHT*FUTURO*****XX*1899992078~ ⏎==Performing Provider NPI

Other Subscriber Information (2320)
SBR*P*18******CI~ ⏎==Primary Payer is a Commercial Payor
AMT*D*96.6~ ⏎==Payor Amount Paid, amount zero is acceptable
OI***Y***I~

Other Subscriber Name (2330A)
NM1*IL*1*OHCDOE*OHCJANE*****MI*AET633-8~ ⏎==Client's Aetna HMO membership ID
N3*311 9TH STREET~
N4*LOS ANGELES*CA*90012~

Other Payer Name (2330B)
NM1*PR*2*Aetna HMO*****PI*60054~ ⏎==OHC payor is Aetna HMO with Payer ID 60054

Service Line Number (2400)
LX*1~
SV1*HC:90887*297.6*MJ*120****1~ ⏎==MJ for minutes
DTP*472*D8*20131018~
REF*G1*P21~ ⏎==Provider Authorization number
NTE*DCP*01~ ⏎==EBP (Evidence Based Practice) Code

Line Adjudication Information (2430)
SVD*60054*96.6*HC:90887****120~ ⏎==Line Adjudication Information from Aetna HMO ID 60054
CAS*CO*45*201~ ⏎==Line Adjustment by Aetna HMO
DTP*573*D8*20131030~ ⏎==Line Check or Remittance Date

Transaction 837P (837P)
SE*39*000000001~

Functional Group (L_GS)
GE*1*131121802~

Interchange (L_ISA)
IEA*1*131121802~

10.1.5 OHC-MEDI-MEDI

Interchange (L_ISA)
ISA*00* ~*00* ~*14*996508079 ~*14*132486189 ~*131121*0822*!*00501*131121802*1*T:*~

Functional Group (L_GS)
GS*HC*996508079*132486189*20131121*082252*131121802*X*005010X222A1~

Transaction 837P (837P)
ST*837*000000001*005010X222A1~
BHT*0019*00*131121802A*20131121*082252*CH~

Submitter Name (1000A)
NM1*41*2*LE88333 FAMILY MENTAL HEALTH SERVICES CLINIC
Receiver Name (1000B)
NM1*40*2*LAC DEPARTMENT OF MENTAL HEALTH*****46*LACODMH~

Billing Provider Hierarchical Level (2000A)
HL*1**20*1~

Billing Provider Name (2010AA)
NM1*85*2*1234Z FMHSC PGM-LOCATION-Z LE88333******XX*9926907927~ ⇐=Contracting Provider Program NPI
N3*305 GRANDE AVE STE 202~
N4*LOS ANGELES*CA*900024160~
REF*EI*999916918~
PER*IC*BILLING MANAGER*TE*5554443333~

Subscriber Hierarchical Level (2000B)
HL*2*1*22*0~
SBR*T*18*******11~ ⇐=LACDMH is the destination payer, it is Tertiary because this is an OHC Medi-Medi claim

Subscriber Name (2010BA)
NM1*IL*1*OHCMMDOE*OHCMMJANE****MI*MSO9811621~ ⇐=Client's ID & 'MSO' is required
N3*311 9TH STREET~
N4*LOS ANGELES*CA*90012~
DMG*D8*19840721*F~

Payer Name (2010BB)
NM1*PR*2*LAC DEPARTMENT OF MENTAL HEALTH*****PI*953893470~ ⇐=LACDMH Payer ID
N3*550 S Vermont Ave~
N4*Los Angeles*CA*90012~

Claim Information (2300)
CLM*131121802A-01*297.6***11:B:1*Y*A*Y*I~
HI*ABK:F3131~

Rendering Provider Name (2310B)
NM1*82*1*BRIGHT*FUTURO****XX*1899992078~ ⇐=Performing Provider NPI

Other Subscriber Information (2320)
SBR*P*18******CI~ ⇐=Primary Payer is Commercial Insurance
AMT*D*96.6~ ⇐=Payor Amount Paid, amount zero is acceptable
OI***Y***I~

Other Subscriber Name (2330A)
NM1*IL*1*OHCMMDOE*OHCMMJANE****MI*AET630-2~ ⇐=Client's HMO ID
N3*311 9TH STREET~
N4*LOS ANGELES*CA*90012~

Other Payer Name (2330B)
NM1*PR*2*Aetna HMO*****PI*60054~ ⇐=Aetna HMO Payer ID is 60054

Other Subscriber Information (2320)
SBR*S*18****47****MB~ ⇐=Secondary Payer is Medicare Part B
AMT*D*20~ ⇐=Payor Amount Paid, amount zero is acceptable
OI***Y***I~
Other Subscriber Name (2330A)
NM1*IL*1*OHCMMDOE*OHCMMJANE****MI*12345677G~ ➔==Client’s HIC (Medicare Beneficiary ID)
N3*311 9TH STREET~
N4*LOS ANGELES*CA*90012~

Other Payer Name (2330B)
NM1*PR*2*MEDICARE*****PI*01182~ ➔==Medicare Part B Southern California Payer ID is 01182

Service Line Number (2400)
LX*~
SV1*HC:90887*297.6*MJ*120***1~ ➔==MJ for minutes
DTP*472*D8*20131018~
REF*G1*P21~ ➔==Provider Authorization number
NTE*DCP*01~ ➔==EBP (Evidence Based Practice) Code

Line Adjudication Information (2430)
SVD*60054*96.6*HC:90887***120~ ➔==Line Adjudication Information from Aetna HMO Payer ID 60054
CAS*CO*45*201~ ➔==Line Adjustment by Aetna HMO Payer ID 60054
DTP*573*D8*20131030~ ➔== Line Check or Remittance Date

Line Adjudication Information (2430)
SVD*01182*20*HC:90887***120~ ➔==Line Adjudication Information from Medicare Part B Southern California Payer ID 01182
CAS*CO*45*181~ ➔==Line Adjustment by Medicare Part B Southern California Payer ID 01182
CAS*CO*23*96.6~ ➔==Line Adjustment by Medicare Payer ID 01182 showing OHC payment
DTP*573*D8*20131101~ ➔== Line Check or Remittance Date

Transaction 837P (837P)
SE*50*000000001~

Functional Group (L_GS)
GE*1*131121802~

Interchange (L_ISA)
IEA*1*131121802~

10.1.6 DAY TREATMENT/MEMBER AUTHORIZATION

Interchange (L_ISA)
ISA*00~
*00*14*996508079*14*132486189
*131121*08222*00501*1311218021*T~

Functional Group (L_GS)
GS*HC*996508079*132486189*20131121*082252*131121802X*005010X222A1~

Transaction 837P (837P)
ST*837*0000000001*005010X222A1~
BHT*0019*00*131121802A*20131121*082252*CH~

Submitter Name (1000A)
NM1*41*2*LE88333 FAMILY MENTAL HEALTH SERVICES CLINIC
*****46996508079~ ➔==Submitter’s DUNS
PER*IC*BILLING DEPARTMENT*TE*5554443333~

Receiver Name (1000B)
NM1*40*2*LAC DEPARTMENT OF MENTAL HEALTH*****46*LACDMH~

Billing Provider Hierarchical Level (2000A)
HL*1**20*1~

Billing Provider Name (2010AA)
NM1*85*1*1234Z FMHSC PGM-LOCATION-Z LE88333*****XX*9926907927~ ≡≡≡Contracting Provider Program NPI
N3*305 GRANDE AVE STE 202~
N4*LOS ANGELES*CA*900024160~
REF*El*999916918~
PER*IC*BILLING MANAGER*TE*5554443333~

Subscriber Hierarchical Level (2000B)
HL*2'1'22'0~
SBR*P*18*******11~ ≡≡≡LACDMH is the destination payer, it is Primary

Subscriber Name (2010BA)
NM1*IL*1*DAYTREATDOE*DAYTREATJANE****MI*MSO9778332~ ≡≡≡Client’s ID & ‘MSO’ is required
N3*656 5TH STREET~
N4*LOS ANGELES*CA*90012~
DMG*D8*19760721*F~

Payer Name (2010BB)
NM1*PR*2*LAC DEPARTMENT OF MENTAL HEALTH*****PI*953893470~ ≡≡≡LACDMH Payer ID
N3*550 S Vermont Ave~
N4*Los Angeles*CA*90012~

Claim Information (2300)
CLM*131121802A-01*189.33***11:B:1*Y*A*Y*I~
HI*ABK:*F3131~

Rendering Provider Name (2310B)
NM1*82*1*BRIGHT*FUTURO****XX*1899992078~ ≡≡≡Performing Provider NPI

Service Line Number (2400)
LX*1~
SV1*HC:H2012:HE: TG*189.33*UN*1***1~ ≡≡≡Must use UN for Day Treatment, must be 1 Unit
DTP*472*D8*20131101~ ≡≡≡Must represent 1 Day
REF*G1*44~ ≡≡≡Member Authorization number for Day Treatment
NTE*DCP*01~ ≡≡≡EBP (Evidence Based Practice) Code

Transaction 837P (837P)
SE*29*000000001~

Functional Group (L_GS)
GE*1*131121802~

Interchange (L_ISA)
IEA*1*131121802~

10.1.7 Fee-for-Service

Interchange (L_ISA)
ISA*00*00*14*122869839~14*132486189
*131015*0822*!*00501*131028431*1*T*:~
Functional Group (L_GS)
GS*HC*122869839*132486189*20131015*082252*131028431*X*005010X222A1~

Transaction 837P (837P)
ST*837*000000001*005010X222A1~
BHT*0019*00*131028431A*20131015*082252*CH~

Submitter Name (1000A)
NM1*41*2*JANET SMITH MFT*****46*122869839~ ➔Submitter's DUNS
PER*IC*BILLING DEPARTMENT*TE*5551231234~

Receiver Name (1000B)
NM1*40*2*LAC DEPARTMENT OF MENTAL HEALTH*****46*LACDMH~

Billing Provider Hierarchical Level (2000A)
HL*1***20*1~

Billing Provider Name (2010AA)
NM1*85*2*JANET SMITH OFFICE*****XX*9998825769~ ➔FFS Billing Provider NPI
N3*42 ATHER STREET~
N4*Long Beach*CA*908159998~
REF*El*951234569~
PER*IC*BILLING MANAGER*TE*5551231234~

Subscriber Hierarchical Level (2000B)
HL*2*1'22*0~
SBR*P*18*******11~ ➔LACDMH is the destination payer, it is Primary

Subscriber Name (2010BA)
NM1*IL*1*FFSDOE*FFSJHON*****MI*MSO9999159~ ➔Client’s ID & ‘MSO' is required
N3*1 FIRST STREET~
N4*LOS ANGELES*CA*90012~
DMG*D8*19300101*M~

Payer Name (2010BB)
NM1*PR*2*LAC DEPARTMENT OF MENTAL HEALTH*****PI*953893470~ ➔LACDMH Payer ID
N3*550 S Vermont Ave~
N4*Los Angeles*CA*90012~

Claim Information (2300)
CLM*131028431A-01*71****11:B:1*Y*A*Y*Y~
HI*ABK:F3131~

Rendering Provider Name (2310B)
NM1*82*1*SMITH*JANET****XX*9908825766~ ➔FFS Performing Provider NPI

Service Line Number (2400)
LX*1~
SV1*HC:90847*71*MJ*60***1~ ➔MJ for minutes
DTP*472*D8*20130718~
REF*G1*F13~ ➔Funding Source Authorization number for FFS clients
NTE*DCP*01~ ➔EBP (Evidence Based Practice) Code

Transaction 837P (837P)
SE*29*0000000001~

Functional Group (L_GS)
10.1.8 Residential Claims

Interchange (L_ISA)
ISA*00* "00* "14*996508079 "14*132486189
*140423*0822*!00501*131121802*1*T*:~=

Functional Group (L_GS)
GS*HC*996508079*132486189*20140423*082252*131121802*X*005010X222A1~

Transaction 837P (837P)
ST*837*000000001*005010X222A1~
BHT*0019*00*131121802A*20140423*082252*CH~

Submitter Name (1000A)
NM1*41*2*LE88333 FAMILY MENTAL HEALTH SERVICES CLINIC
*****46*996508079 ~ ➔Submitter's DUNS
PER*IC*BILLING DEPARTMENT*TE*5554443333~

Receiver Name (1000B)
NM1*40*2*LAC DEPARTMENT OF MENTAL HEALTH*****46*LACODMH~

Billing Provider Hierarchical Level (2000A)
HL*1**20*1~

Billing Provider Name (2010AA)
NM1*85*2*1234Z FMHSC PGM-LOCATION-Z LE88333*****XX*1926907927~ ➔Contracting Provider Program NPI
N3*305 GRANDE AVE STE 202~
N4*LOS ANGELES*CA*900024160~
REF*EI*999916918~
PER*IC*BILLING MANAGER*TE*5554443333~

Subscriber Hierarchical Level (2000B)
HL*2*11*22*0~
SBR*P*18*******11~ ➔LACDMH is the destination payer, it is Primary

Subscriber Name (2010BA)
NM1*IL*1*RESIDENTDOE*RESIDENTJOHN*****MI*MSO9899333~ ➔Client's ID & 'MSO' is required
N3*777 ANY STREET~
N4*LOS ANGELES*CA*90005~
DMG*ID*19900101*M~

Payer Name (2010BB)
NM1*PR*2*LAC DEPARTMENT OF MENTAL HEALTH*****PI*953893470~ ➔LACDMH Payer ID
N3*550 S Vermont Ave~
N4*Los Angeles*CA*90005~

Claim Information (2300)
CLM*131121802A-01*416.04 ***56:B:1*Y*A*Y*I~ ➔Service Location Code 56 is for Psychiatric Residential Treatment Center
HI*ABK:F339~
Rendering Provider Name (2310B)
NM1*82*1*BRIGHT*FUTURO****XX*1899992078~ \(\Leftarrow\) Performing Provider NPI

Service Line Number (2400)
LX*1~
SV1*HC:H0018*416.04*UN*1***1~ \(\Leftarrow\) H0018 is Procedure Code for Crisis Residential, UN for day(s). The number of units must be 1.

DTP*472*D8*20140101~ \(\Leftarrow\) Use D8 for a single date of service. DO NOT claim for the Discharge Date.
REF*G1*P322~ \(\Leftarrow\) Provider Authorization number
NTE*DCP*01~ \(\Leftarrow\) EBP (Evidence Based Practice) Code

Transaction 837P (837P)
SE*29*0000000001~

Functional Group (L_GS)
GE*1*131121802~

Interchange (L_ISA)
IEA*1*131121802~

10.1.9 COMMUNITY OUTREACH SERVICES

Interchange (L_ISA)
ISA*00*00*14*996508079*14*132486189*131121*0822*!00501*131121802*1*T:*~

Functional Group (L_GS)
GS*HC*996508079*132486189*20131121*082252*131121802*X*005010X222A1~

Transaction 837P (837P)
ST*837*0000000001*005010X222A1~
BHT*0019*00*131121802A*20131121*082252*CH~

Submitter Name (1000A)
NM1*41*2*LE88333 FAMILY MENTAL HEALTH SERVICES CLINIC*****46*996508079~ \(\Leftarrow\) Submitter’s DUNS
PER*IC*BILLING DEPARTMENT*TE*5554443333~

Receiver Name (1000B)
NM1*40*2*LAC DEPARTMENT OF MENTAL HEALTH*****46*LACDMH~

Billing Provider Hierarchical Level (2000A)
HL*1**20*1~

Billing Provider Name (2010AA)
NM1*85*2*1234Z FMHSC PGM-LOCATION-Z LE88333******XX*9926907927~ \(\Leftarrow\) Contracting Provider Program NPI
N3*305 GRANDE AVE STE 202~
N4*LOS ANGELES*CA*900024160~
REF*EI*999916918~
PER*IC*BILLING MANAGER*TE*5554443333~

Subscriber Hierarchical Level (2000B)
HL*2*1*22*0~
SBR*P*18******11~ \(\Leftarrow\) LACDMH is the destination payer, it is Primary
Subscriber Name (2010BA)
NM1*IL*1*COS*SERVICE*****MI*MSO88888888* Client’s ID/MSO88888888 is required
N3*550 S VERMONT AVE~
N4*LOS ANGELES*CA* 900201912~
DMG*D8*20130701*U~ Use 20130701 as the Date of Birth and U as the Gender

Payer Name (2010BB)
NM1*PR*2*LAC DEPARTMENT OF MENTAL HEALTH*****PI*953893470~ LACDMH Payer ID
N3*550 S Vermont Ave~
N4*Los Angeles*CA*90012~

Claim Information (2300)
CLM*131121802A-01*297.6****99:B:1*Y*A*Y*I~
HI*ABK*Z0389~ COS Diagnosis Code

Rendering Provider Name (2310B)
NM1*82*1*BRIGHT*FUTURO****XX*1899992078~ Primary COS Performing Provider NPI

Service Line Number (2400)
LX*1~
SV1*HC:200*297.6*MJ:120****1~ MJ for minutes*# of Minutes
DTP*472*D8*20131118~
REF*G1*P51~ Provider nonMedi-Cal Authorization number
NTE*DCP*99~ EBP (Evidence Based Practice) Code

Form Identification (2440)
LQ*AS*IBHISCOS~ COS (Community Outreach Services)

Supporting Documentation (2440)
FRM*D26**7~ Service Type Code (Dictionary D.26)
FRM*D12**1~ Ethnicity Code (Dictionary D.12)
FRM*D43**001~ Primary Language Code (Dictionary D.43)
FRM*D01**1~ Age Category Code (Dictionary D.1)
FRM*D23**2~ Program Area Code (Dictionary D.23)
FRM*D25**7~ Service Recipient Type Code (Dictionary D.25)
FRM*CONTACTS**10~ Number of Persons Contacted

Transaction 837P (837P)
SE*48*000000001~

Functional Group (L_GS)
GE*1*131121802~

Interchange (L_ISA)
IEA*1*131121802~

10.2 837I EXAMPLES

10.2.1 STRAIGHT MEDI-CAL

Interchange (L_ISA)
ISA*00* 00* 14*081234983 14*132486189
*140313*0822*00501*20140313604*1*T*~

Functional Group (L_GS)
GS*HC*081234983*132486189*20140313*082252*140313604*X*005010X223A2~

Transaction 837I (837I)
**Submitter Name (1000A)**
NM1*41*2*SUNSHINE MENTAL HEALTH HOSPITAL*****46*081234983~ ➔=Submitter’s DUNS
PER*IC*Billing Office*TE*8005552000~

**Receiver Name (1000B)**
NM1*40*2*LAC DEPARTMENT OF MENTAL HEALTH*****46*LACDMH~

**Billing Provider Hierarchical Level (2000A)**
HL*1**20*1~

**Billing Provider Name (2010AA)**
NM1*85*2*LONG SHORE CITY WARD*****XX*1005552001~ ➔=Contracting Provider Program NPI
N3*4321 FIRST STREET~
N4*LONG SHORE CITY*CA*900319998~
REF*El*951691234~

**Subscriber Hierarchical Level (2000B)**
HL*2*1*22*0~
SBR*P**18********11~ ➔=LACDMH is the destination payer, it is Primary for a Medi-Cal claim

**Subscriber Name (2010BA)**
NM1*IL*1*MCDOE*MCJOHN*****MI*MSO923991~ ➔=Client’s ID & ‘MSO’ is required
N3*402736 ANY STREET~
N4*LOS ANGELES*CA*90005~
DMG*D8*19470721*M~

**Payer Name (2010BB)**
NM1*PR*2*LAC DEPARTMENT OF MENTAL HEALTH*****PI*953893470~ ➔=LACDMH Payer ID
N3*550 S Vermont Ave~
N4*Los Angeles*CA*90005~

**Claim Information (2300)**
CLM*140313604A-01*1360****11:A:2**A*Y*Y~ ➔= Ex: Claim Frequency Code is “2” – Interim 1st Claim
DTP*434*RD*8*20140109-20140109~ ➔=1st claim of the inpatient episode. Should be the date of admission
DTP*435*DT*201401090000~ ➔= Admission date, there is no discharge date/inpatient episode remains open
CL1*1*1*30~
REF*G1*P320~ ➔=Provider Medi-Cal Authorization number
NTE*DCP*01~ ➔=EBP (Evidence Based Practice) Code
HI*ABK:F319~
HI*ABJ:F3131~

**Attending Provider Name (2310A)**
NM1*71*1*SMITH*JUAN*****XX*1942312345~ ➔=Attending Provider NPI

**Service Line Number (2400)**
LX*1~
SV2*0100*HC:0100:HA*1360*DA*1~ ➔=Procedure Code and Modifiers. Days must be 1

**Transaction 837I (837I)**
SE*32’0001~

**Functional Group (L_GS)**
GE'1*140313604~

Interchange (L_ISA)
IEA'1*140313604~

10.2.2 INDIGENT
Interchange (L_ISA)
ISA'00*00*14*081234983*14*132486189
*140313*0822*1*00501*140313604*1*T*:~

Functional Group (L_GS)
GS*HC*081234983*132486189*20140313*082252*140313604*X*005010X223A2~

Transaction 837I (837I)
ST'837*0001*005010X223A2~
BHT'0019*00*140313604A*20140313*1418*CH~

Submitter Name (1000A)
NM1'41*2*SUNSHINE MENTAL HEALTH HOSPITAL*****46*081234983~<===Submitter’s DUNS PER*IC*Billing Office*TE*8005552000~

Receiver Name (1000B)
NM1'40*2*LAC DEPARTMENT OF MENTAL HEALTH*****46*LACDMH~

Billing Provider Hierarchical Level (2000A)
HL'1**20*1~

Billing Provider Name (2010AA)
NM1'85*2*LONG SHORE CITY WARD*****XX*1005552001~<===Contracting Provider Program NPI N3*4321 FIRST STREET~
N4*LONG SHORE CITY*CA*900319998~
REF*EI*951691234~

Subscriber Hierarchical Level (2000B)
HL'2*1*22*0~
SBR*P*18********11~<==LACDMH is the destination payer, it is Primary

Subscriber Name (2010BA)
NM1*IL*1*IDGDOE*IDGJOHN*****MI*MSO926001~<==Client’s ID & ‘MSO’ is required N3*992736 ANY STREET~
N4*LOS ANGELES*CA*90005~
DMG*D8*19670721*M~

Payer Name (2010BB)
NM1*PR*2*LAC DEPARTMENT OF MENTAL HEALTH*****PI*953893470~<==LACDMH Payer ID N3*550 S Vermont Ave~
N4*Los Angeles*CA*90005~

Claim Information (2300)
CLM'140313604A-01*1360****11:A:3**A*Y*Y~<== Ex: Claim Frequency Code is “3” – Interim
Continuing Claim
DTP*096*TM*0000~
DTP*434*RD8*20140110-20140110~<== Statement must be for one day, Statement from and to
Date is after the Admission date as this is a Continuing Claim
DTP*435*DT*201401090000~<== Admission date
CL*1**1*01~
REF*G1*P011~<==Provider Authorization number MUST NOT be from Medi-Cal Funding Source
NTE*DCP*01~ <=EBP (Evidence Based Practice) Code
HI*ABK:F3131~
HI*ABJ:F319~

Attending Provider Name (2310A)
NM*71*SMITH*JUAN*1942312345~ <=Attending Provider NPI

Service Line Number (2400)
LX*1~
SV2*0100*HC:0100:HA*1360*DA*1~ <=Procedure Code and Modifiers, Days must be 1

Transaction 837I (837I)
SE*32*0001~

Functional Group (L_GS)
GE*1*140313604~

Interchange (L_ISA)
IEA*1*140313604~

10.2.3 MEDI-MEDI
Interchange (L_ISA)
ISA*00*00*14*081234983*14*132486189
*140313*0822*00501*140313604*1*~

Functional Group (L_GS)
GS*HC*081234983*132486189*20140313*082252*140313604*X*005010X223A2~

Transaction 837I (837I)
ST*837*0001*005010X223A2~
BHT*0019*00*140313604A*20140313*1418*CH~

Submitter Name (1000A)
NM*41*2*SUNSHINE MENTAL HEALTH HOSPITAL*081234983~ <=Submitter’s DUNS
PER*IC*Billing Office*TE*8005552000~

Receiver Name (1000B)
NM*40*2*LAC DEPARTMENT OF MENTAL HEALTH*14*081234983~

Billing Provider Hierarchical Level (2000A)
HL*1*20~

Billing Provider Name (2010AA)
NM*85*LONG SHORE CITY WARD*1005552001~ <=Contracting Provider Program NPI
N3*4321 FIRST STREET~
N4*LONG SHORE CITY*CA*900319998~
REF*E1*951691234~

Subscriber Hierarchical Level (2000B)
HL*2*1220~
SBR*S18******11~ <=LACDMH is the destination payer, it is Secondary for a Medi/Medi claim

Subscriber Name (2010BA)
NM*IL*MMDOE*MMJANE*MSO9900011~ <=Client’s ID & ‘MSO’ is required
N3*883974 ANY STREET~
N4*LOS ANGELES*CA*90005~
DMG*D8*19691025*F~

**Payer Name (2010BB)**
NM1*PR*2*LAC DEPARTMENT OF MENTAL HEALTH*****PI*953893470~ ↔️==LACDMH Payer ID
N3*550 S Vermont Ave~
N4*Los Angeles*CA*90005~

**Claim Information (2300)**
CLM*140313604A-01*1360****11:A:3**A*Y*Y~ ↔️ Ex: Claim Frequency Code is “3” – Interim
Continuing Claim
DTP*434*RD8*20140116-20140116~ ↔️ Statement must be for one day (20140116-20140116),
Statement Dates 20140111-20140115 had been claimed previously, so this is an Interim Continuing
Claim
DTP*435*DT*201401110000~ ↔️ Admission Date, there is no discharge date/inpatient episode
remains open
CL1*1*1*30~
REF*G1*P320~ ↔️ Provider Medi-Cal Authorization number
NTE*DCP*01~ ↔️ EBP (Evidence Based Practice) Code
HI*ABK:F3131~
HI*ABJ:F319~

**Attending Provider Name (2310A)**
NM1*71*1*SMITH*JUAN****XX*1942312345~ ↔️ Attending Provider NPI

**Other Subscriber Name (2330A)**
SBR*P*18******MA~ ↔️ Primary Payer is Medicare Part A
AMT*D*360~ ↔️ Payor Amount Paid, amount zero is acceptable
OI***Y***Y~

**Other Subscriber Name (2330A)**
NM1*IL*1*MMDOE*MMJANE****MI*99000111D~ ↔️ Medicare Subscriber’s HIC
N3*883974 ANY STREET~
N4*LOS ANGELES*CA*90005~

**Other Payer Name (2330B)**
NM1*PR*2*MEDICARE*****PI*01182~ ↔️ Medicare Payer ID is 01182

**Service Line Number (2400)**
LX*1~
SV2*0100*HC:0100*HA*1360*DA*1~ ↔️ Procedure Code and Modifiers, Days must be 1

**Line Adjudication Information (2430)**
SVD*01182*360*HC:0100:HA*0100*2~ ↔️ Line Adjudication Information from Medicare PI 01182
CAS*CO*45*1000~ ↔️ Line Adjustment by Medicare PI 01182
DTP*573*D8*20140131~ ↔️ Line Check or Remittance Date

**Transaction 837I (837I)**
SE*42*0001~

**Functional Group (L_GS)**
GE*1*140313604~

**Interchange (L_ISA)**
IEA*1*140313604~
10.3 835 EXAMPLES

10.3.1 APPROVED ORIGINAL CLAIM/NO PROVIDER ADJUSTMENT

Interchange (L_ISA)
ISA*00* 00* 14*132486189 14*605705605 150409*1321*00501*000000062*0*P*

Functional Group (L_GS)
GS*HP*132486189*605705605*20150409*132125*X*005010X221A1*

Transaction 835 (835)
ST*835*1458*
BPR*I*242*CCHK**********20150409~ ➔=Total Actual Provider Payment Amount of $242.00
TRN*I*FOR BATCH 2614*1953893470~
REF*F2*AVATAR MSO 2015~
DTM*405*20150409~

Payer Identification (1000A)
N1*PR*LAC - DEPARTMENT OF MENTAL HEALTH~
N3*550 S. VERMONT AVE~
N4*LOS ANGELES*CA*90020~
PER*CX*KIMBERLY NALL*TE*2137384625*EM*KNALL@DMH.LACOUNTY.GOV~
PER*BL*LACDMH EDI HELP DESK*TE*2133511335~

Payee Identification (1000B)
N1*PE*MH CLINIC*XX*6054051605~
REF*TJ*951647605~

Header Number (2000)
LX*1~

Claim Payment Information (2100)
CLP*150409822A-01*1*242*242*HM*4479*11*1~ ➔=Claim Payment Amount of $242.00 for Avatar Claim ID 4479
NM1*QC*1*LNTESTAE*FNTESTAE****MI*3012944~
REF*F8*4479~ ➔= Avatar Claim ID 4479
DTM*232*20140615~
DTM*233*20140615~

Service Payment Information (2110)
SVC*HC:90791*242*242**100~ ➔=Line Item Provider Payment Amount of $242.00 for Avatar Claim ID 4479

DTM*472*20140615~
REF*BB*P46~
AMT*B6*242~

Transaction 835 (835)
SE*24*1458~

Functional Group (L_GS)
GE*1*1~

Interchange (L_ISA)
IEA*1*000000062~
10.3.2 Void & Approved Claims Resulting in NO Provider Payment & Provider Adjustment

The claim payment amount is less than the voided claim amount. PLB segment is included to ‘zero’ out the payment.

Interchange (L_ISA)
ISA*00* 00* 14*132486189 14*605705605 150409*1450!*00501*000000064*0*P:

Functional Group (L_GS)
GS*HP*132486189*605705605*20150409*145002*1*X*005010X221A1:

Transaction 835 (835)
ST*835*1460:
BPR*I*0*C*NON***********20150409~

Transaction Interchange (L_ISA)
Payer Identification (1000A)
N1*PR*LAC - DEPARTMENT OF MENTAL HEALTH~
N3*550 S. VERMONT AVE~
N4*LOS ANGELES*CA*90020~
PER*CX*KIMBERLY NALL*TE*2137384625*EM*KNALL@DMH.LACOUNTY.GOV~
PER*BL*LACDMH EDI HELP DESK*TE*2133511335~

Payee Identification (1000B)
N1*PE*MH CLINIC*XX*6054051605~
REF*TJ*605647605~

Header Number (2000)
LX*1:

Claim Payment Information (2100)
CLP*150409822A-01*22*-242*242**HM*4479*11*1~

Claim Payment Information (2100)
NM1*QC*1*LNTESTAE*FNTESTAE****MI*3012944~

Service Payment Information (2110)
SVC*HC:90791*-242*242**100~

Claim Payment Information (2100)
CLP*150409822A-01*1*242 0**HM*4479*11*1~

Claim Payment Information (2100)
NM1*QC*1*LNTESTAE*FNTESTAE****MI*3012944~

Service Payment Information (2110)
SVC*HC:90791*242*0**0**100~ ↩️ Line Item Provider Payment Amount of $0.00. It is the non-payment for the voided Avatar Claim ID 4479

DTM*472*20140615~
CAS*OA*115*242*100~
REF*BB*P46~

Claim Payment Information (2100)
CLP*150409823A-01*1*121*121**HM*4480*11*1~ ↩️ Claim Payment Amount of $121.00 for Avatar Claim ID 4480

NM1*QC*1*LNTESTAE*FNTESTAE***MI*3012944~
REF*F8*4480~
DTM*232*20140616~
DTM*233*20140616~
AMT*AU*121~

Service Payment Information (2110)
SVC*HC:90791*121*121**50~ ↩️ Line Item Provider Payment Amount of $121.00 for Avatar Claim ID 4480

DTM*472*20140616~
REF*BB*P46~
AMT*AU*121~

Transaction 835 (835)
PLB*6054051240*20150630*FB:FOR BATCH 2625*121~ ↩️ Provider Adjustment – Forwarding Balance amount of -$121 = (-$242.00 Claim ID 4479 payment reversal due to void + $121.00 Claim ID 4480)

SE*44*1460~

Functional Group (L_GS)
GE*1*1~

Interchange (L_ISA)
IEA*1*000000064~
10.3.3 Approved Original Claim with Previous Provider Adjustment

Interchange (L_ISA)
ISA"00* "00* 14*132486189 14*605705605 15*0409*1642*I*00501*000000065*0*P*: ~

Functional Group (L_GS)
GS*HP*132486189*605705605*20150409*164206*1*X*005010X221A1~

Transaction 835 (835)
ST*835*1461~
BPR*I 121*C*CHK**************20150409~ ➡️Total Actual Provider Payment Amount of $121.00
TRN*1*FOR BATCH 2626*1953893470~
REF*F2*AVATAR MSO 2015~
DTM*405*20150409~

Payer Identification (1000A)
N1*PR*LAC - DEPARTMENT OF MENTAL HEALTH~
N3*550 S. VERMONT AVE~
N4*LOS ANGELES*CA*90020~
PER*CX*KIMBERLY NALL*TE*2137384625*EM*KNALL@DMH.LACOUNTY.GOV~
PER*BL*LACDMH EDI HELP DESK*TE*2133511335~

Payee Identification (1000B)
N1*PE*MH CLINIC*XX*6054051605~
REF*TX*605647605~

Header Number (2000)
LX*1~

Claim Payment Information (2100)
CLP*150409826A-01*1*242*242*HM*4481*11*1~ ➡️Claim Payment Amount of $242.00 for Avatar Claim ID 4481
NM1*QC*1*LNTESTAE*FNTESTAE****MI*3012944~
REF*F8*4481~
DTM*232*20140617~
DTM*233*20140617~
AMT*AU*242~

Service Payment Information (2110)
SVC*HC:90791*242*242**100~ ➡️Line Item Provider Payment Amount of $242.00 for Avatar Claim ID 4481
DTM*472*20140617~
REF*BB*P46~
AMT*B6*242~

Transaction 835 (835)
PLB*6054051605*20150630*FB:FOR BATCH 2626*121~ ➡️Provider Adjustment (outstanding) – Forwarding Balance amount of $121
SE*25*1461~

Functional Group (L_GS)
GE*1*1~

Interchange (L_ISA)
IEA*1*000000065~
10.3.4 APPROVED ORIGINAL CLAIM FOLLOWED BY A CONTRACTOR VOID

835 for Original Claim

Interchange (L_ISA)
ISA*00*  *00*  *14*132486189  *14*992499189  *150806*1219*!00501*000000134*0*P*:

Functional Group (L_GS)
GS*HP*132486189*992499189*20150806*121922*1*X*005010X221A1~

Transaction 835 (835)
ST*835*1722~
BPR*I*242*C*CHK**************20150806~
TRN*1*FOR BATCH 3051*1953893470~
REF*F2*AVATAR MSO 2015~
DTM*405*20150806~

Payer Identification (1000A)
N1*PR*LAC - DEPARTMENT OF MENTAL HEALTH~
N3*550 S. VERMONT AVE~
N4*LOS ANGELES*CA*90020~
PER*CX*KIMBERLY NALL*TE*2137384625*EM*KNALL@DMH.LACOUNTY.GOV~
PER*BL*LACDMH EDI HELP DESK*TE*2133511335~

Payee Identification (1000B)
N1*PE*GET WELL MH CLINIC*XX*9994099940~
REF*TJ*999947899~

Header Number (2000)
LX*1~

Claim Payment Information (2100)
CLP*150806838A-01*1*242*242**HM*10374*11*1~

≈≈Approved claim; value in CLP01 is from Contractor's inbound 837 CLM01

NM1*QC*1*LNTESTAE*FNTESTAE****MI*3012944~
REF*F8*10374~

≈≈PCCN (Payer Claim Control Number) assigned by IBHIS

DTM*232*20150417~
DTM*233*20150417~
AMT*AU*242~

Service Payment Information (2110)
SVC*HC:90791*242*242**100~
DTM*472*20150417~
REF*BB*P300~
AMT*B6*242~

Transaction 835 (835)
SE*24*1722~

Functional Group (L_GS)
GE*1*1~

Interchange (L_ISA)
IEA*1*000000134~
**835 for Contractor Void Interchange (L_ISA)**

ISA*00* "00* "14*132486189 *14*992499189 *150806*1359*1*00501*000000135*0*P*:

**Functional Group (L_GS)**

GS*HP*132486189*992499189*20150806*135959*1*X*00501*000000135*

**Transaction 835 (835)**

ST*835*1725~

BPR*I*242*C*CHK**************20150806~ ➞There is a positive payment amount in this BPR. Other claims, not shown in this example, are being paid on this 835.

TRN*1*FOR BATCH 3054*1953893470~

REF*F2*AVATAR MSO 2015~

DTM*405*20150806~

**Payer Identification (1000A)**

N1*PR*LAC - DEPARTMENT OF MENTAL HEALTH~

N3*550 S. VERMONT AVE~

N4*LOS ANGELES*CA*90020~

PER*CX*KIMBERLY NALL*TE*2137384625*EM*KNALL@DMH.LACOUNTY.GOV~

PER*BL*LACDMH EDI HELP DESK*TE*2133511335~

**Payee Identification (1000B)**

N1*PE*GET WELL MH CLINIC*XX*9994099940~

REF*TJ*999947899~

**Header Number (2000)**

LX*1~

**Claim Payment Information (2100)**

CLP*150806838A-001*22*-242*-242**HM*10374*11*1~ ➞Payment reversal of a void claim; value in CLP01 is from Contractor's inbound 837 CLM01

NM1*QC*1*LNTESTAE*FNTESTAE****MI*3012944~

REF*F8*10374~ ➞PCCN (Payer Claim Control Number) assigned by IBHIS for the original claim

DTM*232*20150417~

DTM*233*20150417~

AMT*AU*-242~

**Service Payment Information (2110)**

SVC*HC:90791*-242*-242**100~ ➞Payment reversal of a void claim;

DTM*472*20150417~

REF*BB*P300~

AMT*B6*-242~
Claim Payment Information (2100)
CLP*150806838A-01*1*242*0**HM*10374*11*1~
  \[\leftarrow\text{This CLP loop shows the reason for non-payment}\]
NM1*QC*1*LNTESTAE*FNTESTAE****MI*3012944~
  REF*F8*10374~
  DTM*232*20150417~
  DTM*233*20150417~

Service Payment Information (2110)
SVC*HC:90791*242*0**0**100~
  DTM*472*20150417~
CAS*OA*115*242*100~ \[\leftarrow\text{Contractor void}\]
  REF*BB*P300~

Transaction 835 (835)
SE*43*1725~

Functional Group (L_GS)
GE*1*1~

Interchange (L_ISA)
IEA*1*000000135~
10.3.5 Approved Original; State Denial Followed by a Contractor Replacement Claim

835 for Original Claim

Interchange (L_ISA)
ISA*00*00*14*132486189*14*992499189*150805*1745*1*00501*000000131*0*P*:

Functional Group (L_GS)
GS*HP*132486189992499189*20150805*174510*1*X*005010X221A1~

Transaction 835 (835)
ST*835*1719~
BPR*I*242*C*CHK**************20150805~
TRN*1*FOR BATCH 3047*1953893470~
REF*F2*AVATAR MSO 2015~
DTM*405*20150805~

Payer Identification (1000A)
N1*PR*LAC - DEPARTMENT OF MENTAL HEALTH~
N3*550 S. VERMONT AVE~
N4*LOS ANGELES*CA*90020~
PER*CX*KIMBERLY NALL*TE*2137384625*EM*KNALL@DMH.LACOUNTY.GOV~
PER*BL*LACDMH EDI HELP DESK*TE*2133511335~

Payee Identification (1000B)
N1*PE*GET WELL MH CLINIC*XX*9994099940~
REF*TJ*999947899~

Header Number (2000)
LX*1~

Claim Payment Information (2100)
CLP*150805833A-01*1*242*242**HM*10365*11*1~

NM1*QC*1*LNTESTAE*FNTESTAE****MI*3012944~
REF*FF*10365~

Service Payment Information (2110)
SVC*HC:90791*242*242**100~

DTM*232*20150413~
DTM*233*20150413~
AMT*AU*242~

Transaction 835 (835)
SE*24*1719~

Functional Group (L_GS)
GE*1*1~

Interchange (L_ISA)
IEA*1*000000131~
835 for State Denial of Original Claim

Interchange (L_I3A)
ISA*:00* *00* *14*132486189 *14*992499189 *150805*19231!*00501*000000132*0*P*:

Functional Group (L_GS)
GS*HP*132486189*992499189*20150805*192350*1*X*005010X221A1:

Transaction 835 (835)
ST*835*1720:
BPR*1*242*C*CHK************20150805~

There is a positive payment amount in this BPR. Other claims, not shown in this example, are being paid on this 835.

TRN*1*FOR BATCH 3048*1953893470:
REF*F2*AVATAR MSO 2015:
DTM*405*20150805:

Payer Identification (1000A)
N1*PR*LAC - DEPARTMENT OF MENTAL HEALTH:
N3*550 S. VERMONT AVE:
N4*LOS ANGELES*CA*90020:
PER*CX*KIMBERLY NALL*TE*2137384625*EM*KNALL@DMH.LACOUNTY.GOV:
PER*BL*LACDMH EDI HELP DESK*TE*2133511335:

Payee Identification (1000B)
N1*PE*GET WELL MH CLINIC*XX*9994099940:
REF*J*999497899:

Header Number (2000)
LX*1:

Claim Payment Information (2100)
CLP*150805833A-01*22242242**HM*10365111*1~

Payment reversal due to the State denial, IBHIS PCCN 10365

NM1*QC*1*LNTESTAE*FNTESTAE****MI*3012944:
REF*F8*10365:
DTM*232*20150413:
DTM*233*20150413:
AMT*AU*242:

Service Payment Information (2110)
SVC*HC:90791*242*242**100:
DTM*472*20150413:
REF*BB*P300:
AMT*B6*242:

Claim Payment Information (2100)
CLP*150805833A-01*1*2420**HM*10365111*1~

IBHIS PCCN 10365; 2nd CLP gives the state’s reason for denial

NM1*QC*1*LNTESTAE*FNTESTAE****MI*3012944:
REF*F8*10365:
DTM*232*20150413:
DTM*233*20150413:

Service Payment Information (2110)
SVC*HC:90791*242*0**100:
DTM*472*20150413:
CAS*CO*97*242*100~

State denied Claim Adjustment Reason Group and Code
REF*BB*P300:
LQ*HE*M86~

State denied Remark Code

Transaction 835 (835)
SE*44*1720:

Functional Group (L_GS)
GE*1*1:
Interchange (L_I3A)
IEA*1*000000132:
835 for Replacement of Original Claim – Denied by the State

**Interchange (L_ISA)**
ISA*00*00*14*13248618914*9924991891508051959*00501*000000133*0*P:*~

**Functional Group (L_GS)**
GS*HP*132486189992499189201508051959521*1*X*005010X221A1~

**Transaction 835 (835)**
ST*835*1721~
BPR*1*242C*CHK**************20150805~

TRN*1*FOR BATCH 3049*1953893470~
REF*F*2*AVATAR MSO 2015~
DTM*405*20150805~

**Payer Identification (1000A)**
N1*PR*LAC - DEPARTMENT OF MENTAL HEALTH~
N3*550 S. VERMONT AVE~
N4*LOS ANGELES*CA*90020~
PER*CX*KIMBERLY NALL*TE*2137384625*EM*KNALL@DMH.LACOUNTY.GOV~
PER*BL*LACDMH EDI HELP DESK*TE*2133511335~

**Payee Identification (1000B)**
N1*PE*GET WELL MH CLINIC*XX*9994099940~
REF*T*J*999478999~

**Header Number (2000)**
LX*1~

**Claim Payment Information (2100)**
CLP*150805839A-01*1*242*242**HM*10367*11*7~

NM1*QC*1*LNTESTAE*FNTESTAE*****MI*3012944~
REF*F*8*10367~

**Service Payment Information (2110)**
SVC*HC:90791:76*242*242**100~

**Transaction 835 (835)**
SE*24*1721~

**Functional Group (L_GS)**
GE*1*1~

**Interchange (L_ISA)**
IEA*1*000000133~

---

There is a positive payment amount in this BPR; for the approved replacement claim.
10.4 999 EXAMPLE

10.4.1 REJECTED 999 FILE

Interchange (L_ISA)

ISA*00*  *00*  *14*132486189  *14*992499189  *170613*1013!*00501*995074028*1*P*:

Functional Group (L_GS)

GS*FA*132486189*992499189*20170613*1013*995074028*X*005010X231A1~

ST*999*0001*005010X231A1~

Functional Group Response :

AK1*HC*995074028*005010X222A1~ ←==AK102 is the GS06 from 837

Transaction Set Response Header

AK2*837*995074028*005010X222A1~ ←== AK202 is the ST02 from 837

Error Identification

IK3*CLM*20*2300*8~ ←== IK301- This element indicates the segment where the error occurred. (Error in CLM segment)
IK302 – This element contains the location of the segment in error from the ST segment in the 837 file. (Eg: 20 means 19 segments after ST)
IK303 – This element contains the loop number of the segment in error (Loop 2300)
IK304 – This element contains the error noted in segment.

IK4*1*1028*1~ ←== This Segment indicates the offending data that triggered the error and required only when a data element error.

( IK3 and IK4 exist only when the status of the transaction is a rejection)

Transaction Set Response Trailer

IK5*R*5~ ←== The IK5 reports that the file failed due to HIPAA error/Transaction set errors
IK501 – Status of transaction set – A- Accepted, R-Rejected

Functional Group Response Trailer

AK9*R*1*1*1~ ←== The AK9 report the errors between the ST and SE segments in the 837
AK901 – Functional Group Acknowledge Codes
( A- Accepted, R- Rejected)

SE*8*0001~
GE*1*995074028~
IEA*1*995074028~

10.4.2 ACCEPTED 999 FILE
Interchange (L_ISA)
ISA*00*  *00*  *14*132486189  *14*992499189  *170613*1013!*00501*995074028*1*P*: ~

Functional Group (L_GS)
GS*FA*132486189*992499189*20170613*1013*995074028*X*005010X231A1~
ST*999*0001*005010X231A1~

Functional Group Repsonse :
AK1*HC*32497*005010X222A1~ ===> AK102 is the GS06 from 837

Transaction Set Repsonse Header
AK2*837*1235*005010X222A1~ ===> AK202 is the ST02 from 837

Transaction Set Repsonse Trailer
IK5*A~  ===> IK501 – ‘A’ - Accepted

Functional Group Response Trailer
AK9*A*1*1*1~  ===> AK902 - 'A' - Accepted

SE*6*0001~
GE*1*32497~
IEA*1*000032497~

10.5 277 EXAMPLE

Look for the STC segment in the file. You will be able to see the Claim Status code and/or Claim Status Category Codes in the STC segments on the report.

STC01 - Health care claim status - Verify the rejections codes against the published codes in Page 17.
STC03 – U – Reject
STC03 – WQ – Accept
STC04 – Total Claim Charge Amount

Locate the QTY01 segment to determine the Total Rejected Claims or Total Rejected Quantity.
90=Acknowledged Quantity
AA=Unacknowledged Quantity
QA=Quantity Approved
QC=Quantity Disapproved

10.4.1 277 FILE WITH ACCEPTED AND REJECTED CLAIMS.

Interchange (L_ISA)
ISA*00*  *00*  *14*132486189  *14*992499189  *170613*1013!*00501*995074028*1*P*: ~

Functional Group (L_GS)
GS*HN*132486189*992499189*20170613*1013*995074028*X*005010X231A1~
Transaction Header

ST*277*0001*005010X231A1~
BHT*0085*08*3*20180321*105846*TH~

Loop 2000 A – Information Source Detail

HL*1**20*1~
NM1*PR*2*LAC Department of Mental Health*****PI*00000001~
TRN*1*20180321105846~
DTP*050*D8*20180321~
DTP*009*D8*20180321~

Loop 2000B – Information Receiver Detail

HL*2*1*21*1~
NM1*41*2*LE00XXX XXXXXXX *****46*138857268~
TRN*2*170203808A~

Loop 2000B – Receiver Level Summary

STC*A1:19:40*20180222*WQ*7625~
QTY*90*32~
QTY*AA*1~
AMT*YU*7400~
AMT*YY*225~

Loop 2000C - Billing Provider Level Summary

NM1*85*1*xxxx*xxxxx****XX*1952418212~
TRN*1*~
STC*A1:19:40**WQ*7625~
QTY*QA*32~
QTY*QC*1~
AMT*YU*7400~
AMT*YY*225~

2000D - Patient Level Detail.

NM1*QC*1*LNTESTAE*FNTESTAE****MI*MSO123456~
TRN*2*277203818B-01~
STC*A2:20*20180321*WQ*186.7~
REF*1K*625725~
DTP*472*D8*20161117~
HL*5*3*PT~
NM1*QC*1*LNTESTAE*FNTESTAE****MI*MSO123456~  =Client ID

TRN*2*277524828Au25z~  = CLM02 from 837.

STC*A7:33*20180321*U*173.4~  = STC01: A7:33 indicates the error message code. For an explanation of the error message code please see the LACDMH companion guide.
STC03: U Indicates that the claim was rejected.
STC04: The claim amount for the 837 in the CLM and SV1 or SV2.

REF*1K*277524828Au25z~  = Since the claim is rejected, DMH return the same CLM02 from 837.

DTP*472*D8*20180110~
HL*6*3*PT~

NM1*QC*1*LNTESTAE*FNTESTAE****MI*MSO12345~

TRN*2*277621819B-01~  = CLM02 from 837.

STC*A7:33*20180321*U*176.4~  = STC01: A7:33 indicates the error message code. For an explanation of the error message code please see the LACDMH companion guide.
STC03 : U Indicates that the claim was rejected.
STC04 : The claim amount for the 837 in the CLM and SV1 or SV2.

REF*1K*277621819B-01~  = Since the claim is rejected, DMH return the same CLM02 from 837.

DTP*472*D8*20170105~
SE*42*0003~
GE*1*3~
IEA*1*000000003~