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.

DOCUMENT REVISION HISTORY

Version	Release Date	Comments/ Indicate Sections Revised
1.0	11/20/2013	Initial document release
1.1	12/04/2013	Section 5.3: Added info re ISA06, ISA08 Section 6.1: Added information re authorizations Section 9.1: Added examples
1.2	01/03/2014	Corrected typos Section 8.1: Corrected 1000B NM109 value Section 9: Corrected ISA02 and ISA04 for all examples
1.3	01/27/2014	Section 6: Updated Business Rules Section 8.1: 837P/2330B/NM109 Section 8.1: 837P/2400 – Refers to the Addendum Guide to Procedure Codes for IBHIS Section 8.1: 837P/2430 Loop requirements Section 8.2: Added 837P COS loop and segment information Section 9.1.7: Added COS example
1.4	2/6/2014	Section 6: Updated Business Rules Section 8.1 & 8.2 – V Code diagnoses must use a capital V Section 9.1.7: Revised the COS example – number of minutes
1.5	3/5/2014	Section 6: Updated Business Rules Section 8.1: 837P/2400/Procedure Code Modifier comment Section 8.2: 837P/2400/Procedure Code Modifier comment Section 9: Modified SE Segment Count on a number of the examples Section 9.1.5: Added an OHC/Medicare/Medi-Cal example
1.6	4/7/2014	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
1.7	5/6/2014	Section 3: Updated Process Flow Section 6: Business Rules clarifications including additional Residential claim clarifications Section 6: Added Replacement claim rules Section 6, 8.1, 8.2, 8.3: Restrict claims to 1 service line per claim Section 7.2: Added 277CA Rejection Codes Section 8.1: Added Service Date clarifications for Residential claims Section 8.1, 8.3: OHC Payer ID clarification Section 9.1.8: Added a Residential claim example
1.8	9/12/2014	Section 7.2: Added a 277CA Rejection reason Section 8.1, 8.3: Additional OHC Payer ID clarification

1.9	6/25/2015	Section 6.1: Added a link to QA Bulletin 14-04 IBHIS Addendum Guide to Service & Procedure Codes Section 6.1: Added an exception for county funded procedures that do not use the HX modifier Section 6.1: Added a Business Rule regarding Replacement claims 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 Section 10.1.6, 10.1.8, 10.2.1, 10.2.2, 10.2.3: 837 Examples revised to reflect 1 service date per claim on Day Treatment, Residential and Inpatient. 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
1.11	1/5/2016	Section 6.1: CalWORKs to use the HX modifier and will not use the CalWORKs guarantor 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.

1.14	04/24/2018	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

Table of Contents

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/

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/

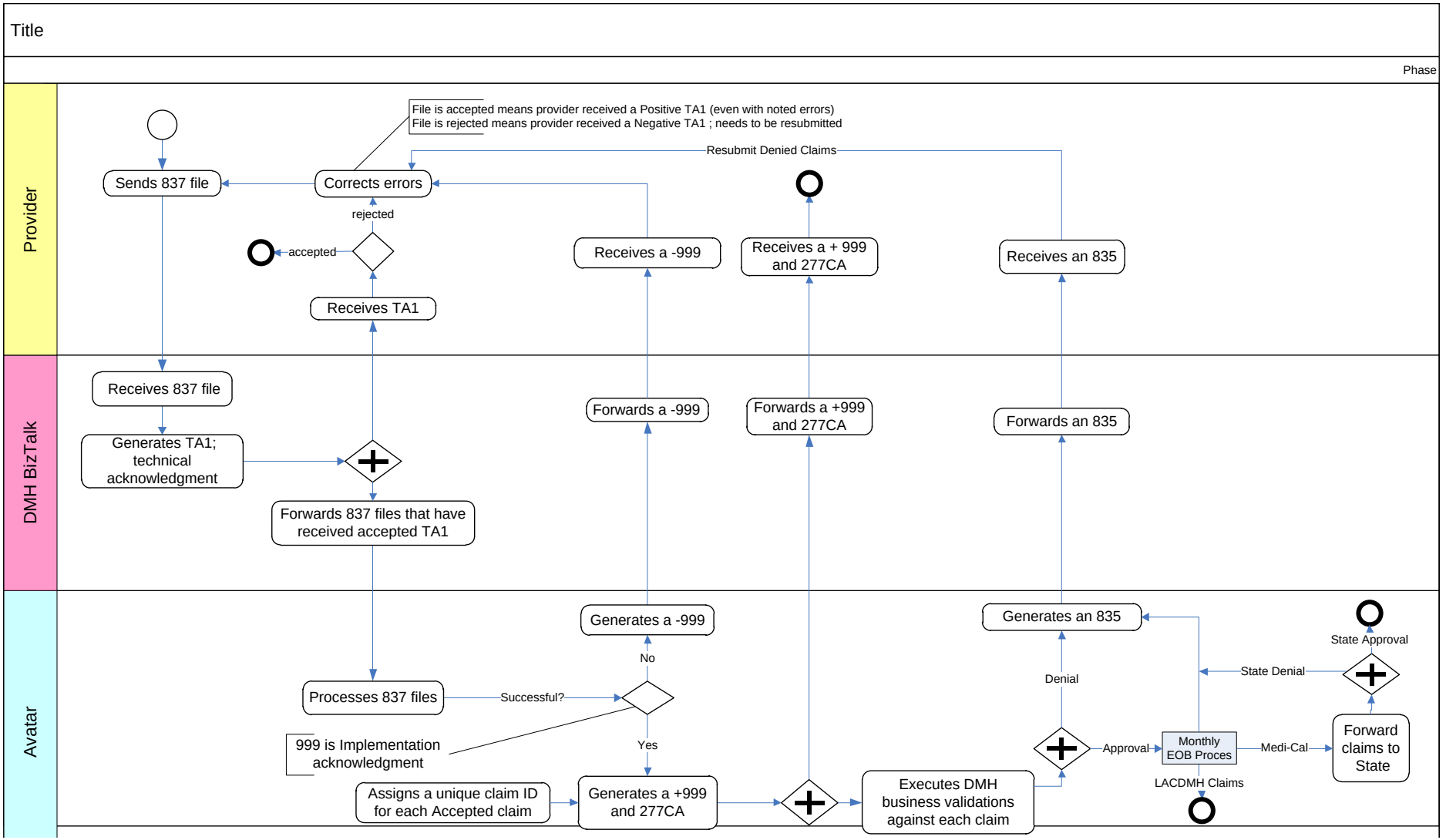
2 GETTING STARTED

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
Fee-for-Service providers: http://lacdmh.lacounty.gov/hipaa/ffs_IBHIS_EDI_Guides.htm

3 PROCESS FLOW



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_EDI_Guides.htm
Fee-for-Service: http://lacdmh.lacounty.gov/hipaa/ffs_IBHIS_EDI_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

Loop ID	Reference	Name	Notes/Comments
	ISA01	Authorization Information Qualifier	LACDMH expects '00'.
	ISA03	Security Information Qualifier	LACDMH expects '00'.
	ISA05	Interchange ID Qualifier	LACDMH expects '14'.
	ISA06	Interchange Sender ID	LACDMH expects the provider's Duns plus suffix. Enter the 9-digit DUNS number, followed by 6 spaces.
	ISA07	Interchange ID Qualifier	LACDMH expects '14'.
	ISA08	Interchange Receiver ID	Enter LA County's 9-digit DUNS number, followed by 6 spaces. The required value for LACDMH is '132486189 '.
	ISA16	Component Element Separator	In order to process procedure codes that contain modifiers, LACDMH only accepts ':' as the Component Element Separator

5.4 GS-GE on Inbound transactions

LACDMH accepts only one Functional Group per Interchange.

Loop ID	Reference	Name	Notes/Comments
	GS02	Application Sender's Code	Enter the 9-digit DUNS number, with no trailing spaces.
	GS03	Application Receiver's Code	Enter the 9-digit DUNS number, with no trailing spaces.

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.
5. Group claims - Refer to the explanation found in the Group Claim Bulletin located on the IBHIS EDI News/Alerts webpage: http://lacdmh.lacounty.gov/hipaa/IBHIS_EDI_News.htm.
6. Refer to the Addendum Guide to Procedure Codes for IBHIS located at 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-psychiatry (GT) and/or County Funded (HX). QA Bulletin 14-04 IBHIS Addendum Guide to Service & Procedure Codes (http://file.lacounty.gov/dmh/cms1_218857.pdf) contains further information regarding the guide and the use of duplicate override modifiers.
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 calims 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.
11. Residential, PHF and Life Support Claims.
    - 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 fleld 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:

Inbound 837P/I Claim Rejections	Claim Status Codes on IBHIS 277CA
Missing Admission Diagnosis on an Inpatient/837I claim	A6:232
Evidence Based Practice (EBP) code is missing	A6:442
Client's date of birth not match	A7:0
Void or Replacement Claim with invalid Payer Claim Control #	A7:0
Void or Replacement Claim where Client ID/MSO # on the Void or Replacement does not match the Client ID/MSO # of the original claim	A7:0
Date of Service is a future date	A7:0
Procedure code not defined in IBHIS MSO CPT table	A7:21 & A7:454
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.	A7:3
Client ID with the 'MSO' prefix but does not exist in IBHIS	A7:33
Client ID without the 'MSO' prefix	A7:33
Total claim charge amount not equal sum of line item charge amount	A7:178
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)	A7:232
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 & 837I 2300 HI01-2)	A7:254

Inbound 837P/I Claim Rejections	Claim Status Codes on IBHIS 277CA
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 or invalid Diagnosis Code submitted on the claim	A7:255
Claim is out of balance – service line paid amount + all service line adjustment amounts do not equal the line item charge amount	A7:400
Diagnosis Code Not Defined in IBHIS Diagnosis Table	A7:477
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.	A7:477
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.	A7:477
Submitter ID NOT found	A7:478
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	A7:479
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)	A7:509
Claim adjustment reason code in the CAS segment is invalid or was not active on the Coordination of Benefits Adjudication/Payment Date (2430:DTP03)	A7:521
Medicare is the secondary payer and the Medicare Coordination of Benefits Insurance Type Code is missing or invalid (2320:SBR05)	A7:578
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)	A7:673
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.	A7:732

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)

Loop ID	Reference	Name	Codes	Notes/Comments
Beginning of Hierarchical Transaction				
	BHT02	Transaction Set Purpose Code	00	LACDMH expects to receive this code value.
	BHT06	Transaction Type Code	CH	LACDMH expects to receive this code value.
Submitter Name				
1000A	NM109	Submitter Identifier		Enter the 9-digit DUNS number, with no trailing spaces.
Receiver Name				
1000B	NM103	Receiver Name		LACDMH expects to receive 'LAC DEPARTMENT OF MENTAL HEALTH'
1000B	NM109	Receiver Primary Identifier		LACDMH expects to receive 'LACODMH'.
Billing Provider Specialty Information				
2000A	PRV03	Billing Provider Specialty Information		LACDMH adjudication is not impacted by the provider Taxonomy Code
SBR - Subscriber Information				
2000B	SBR01	Payer Responsibility Sequence Number		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.
Subscriber Name				
2010BA	NM102	Entity Type Qualifier	1	A LACDMH subscriber is always a person.
2010BA	NM108	Identification Code Qualifier	MI	
2010BA	NM109	Subscriber Primary Identifier		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'.
Payer Name				
2010BB	NM103	Payer name		The destination payer is always LACDMH. LACDMH expects to receive 'LAC DEPARTMENT OF MENTAL HEALTH'
2010BB	NM108	Identification Code Qualifier	PI	LACDMH expects to receive this code value.
2010BB	NM109	Payer identifier		'953893470'
Claim Information				
2300	CLM01	Patient Control Number		LACDMH requires that this be a unique identifier.
2300	CLM05-1	Place of Service Code		If the place of service was via telephone, set this value to '11'.
2300	CLM05-3	Claim Frequency Code		DMH accepts Original, '1', Replacement, '7' and Void, '8' claim frequency codes.

Share of Cost (SOC)				
2300	AMT01	Amount Qualifier Code	F5	
2300	AMT02	Patient Paid Amount		Patient SOC Amount obligated
Original Reference Number ICN/DCN				
2300	REF01	Reference ID Qualifier	F8	
2300	REF02	Claim Original Reference Number		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.
Katie A Identifier				
2300	REF01	Reference ID Qualifier	P4	
2300	REF02	Demonstration Project Identifier	KTA	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).
Claim Note(Healthy Families)				
2300	NTE01	Note Reference	ADD	Additional Information
2300	NTE02	Description	SED	Indicates Healthy Families
Health Care Diagnosis Code				
2300	HI01-01	Code List Qualifier Code		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”.
2300	HI01-02, HI02-02, HI03-02, … HI12-02	Diagnosis Code		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.
2320 SBR - Other Subscriber Information 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**.				
2320	SBR01	Payer Responsibility Sequence Number		Set to the appropriate payment responsibility for the claim.
2320	SBR09	Claim Filing Indicator Code		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.

AMT - Coordination of Benefits COB Payer Paid Amount				
2320	AMT01	Amount Qualifier Code	D	Use **D** to report amount paid by Medicare/OHC. This amount will be used for balancing processing. Must supply even if the amount is zero.
2320	AMT02	COB Payer Paid Amount		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.
NM1 - Other Payer Name				
2330B	NM109	Other Payer Primary Identifier		An identification number for the other payer, such as '01182' for Medicare.
LX – Service Line Number				
2400	LX01	Line Counter		Set to 1. LACDMH allows one service line per claim.

SV1 - Professional Service				
2400	SV101-02	Procedure Code		Group claims - Refer to the explanation found in the Group Claim Bulletin located on the IBHIS EDI News/Alerts webpage: Legal Entities: http://lacdmh.lacounty.gov/hipaa/IBHIS_EDI_News.htm Fee-for-Service Providers: http://lacdmh.lacounty.gov/hipaa/ffs_IBHIS_EDI_News.htm
2400	SV101-03 thru SV101-06	Procedure Code Modifier		Refer to the Addendum Guide to Procedure Codes for IBHIS located at 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-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 http://www.dmh.ca.gov/dmhdocs/docs/notices10/10-23.pdf for further billing info on Telephone and Tele-psychiatry.
2400	SV103	Unit or Basis of Measurement Code	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
2400	SV104	Service Unit Count		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: http://lacdmh.lacounty.gov/hipaa/IBHIS_EDI_News.htm.
2400	SV109	Emergency Indicator	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.
DTP – Service Date				
2400	DTP01	Date Time Qualifier	472	

2400	DTP02	Date Time Period Format Qualifier	D8	Use D8 for all services, including Day Treatment, Residential, PHF and Life Support
2400	DTP03	Service Date		Submit the service date
REF - Prior Authorization				
2400	REF01	Prior Authorization Qualifier	G1	
2400	REF02	Prior Authorization Number		Report the Provider, Member or Fee-for-Service Authorization # in the Prior Authorization field.
NTE Claim Note				
2400	NTE01	Note Reference Code	DCP	Use DCP for reporting the Evidence Based Practice (EBP) code.
2400	NTE02	Claim Note Text		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: http://lacdmh.lacounty.gov/hipaa/IBHIS_EDI_Guides.htm
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				
2420C	NM101	Entity Identifier Code	77	
2420C	NM102	Entity Type Qualifier	2	
2420C	NM103	Facility Name		Enter the name or description where the service was delivered
2420C	N301	Facility Address Line		Enter the street address where the service was delivered
2420C	N401	Facility City Name		Enter the city where the service was delivered
2420C	N402	Facility State		Enter the state where the service was delivered
2420C	N403	Facility Zip		Enter the zip code where the service was delivered Note: you must enter the full nine digit zip code in this field
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				
2430	CAS01 – CAS04	Claim Line Adjustments		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.

9.2 HEALTH CARE CLAIM: PROFESSIONAL (837P) COS

Community Outreach Services

Loop ID	Reference	Name	Codes	Notes/Comments
Beginning of Hierarchical Transaction				
	BHT02	Transaction Set Purpose Code	00	LACDMH expects to receive this code value.
	BHT06	Transaction Type Code	CH	LACDMH expects to receive this code value.
Submitter Name				
1000A	NM109	Submitter Identifier		Enter the 9-digit DUNS number, with no trailing spaces.
Receiver Name				
1000B	NM103	Receiver Name		LACDMH expects to receive 'LAC DEPARTMENT OF MENTAL HEALTH'
1000B	NM109	Receiver Primary Identifier		LACDMH expects to receive 'LACODMH'.
Billing Provider Specialty Information				
2000A	PRV03	Billing Provider Specialty Information		LACDMH adjudication is not impacted by the provider Taxonomy Code
SBR - Subscriber Information				
2000B	SBR01	Payer Responsibility Sequence Number	P	DMH is always primary for COS services.
Subscriber Name				
2010BA	NM102	Entity Type Qualifier	1	For COS claims, the subscriber/patient will be identified as a person, even when the COS service was related to a group of people.
2010BA	NM103	Name Last	COS	Must use "COS"
2010BA	NM104	Name First	Service	Must Use "SERVICE"
2010BA	NM108	Identification Code Qualifier	MI	
2010BA	NM109	Subscriber Primary Identifier		For COS claims, use 'MSO8888888' as the Subscriber ID
2010BA	N301	Address		Must use "550 S VERMONT AVE"
2010BA	N401	City Name		Must use "LOS ANGELES"
2010BA	N402	State		Must use "CA"
2010BA	N403	Zip Code		Must use "900201912"
2010BA	DMG01	Date Time Format Qualifier	D8	Date of Birth
2010BA	DMG02	Date Time		Must use "20130701"
2010BA	DMG03	Gender Code	U	Must use "U"
Payer Name				
2010BB	NM103	Payer name		The destination payer is always LACDMH. LACDMH expects to receive 'LAC DEPARTMENT OF MENTAL HEALTH'
2010BB	NM108	Identification Code Qualifier	PI	LACDMH expects to receive this code value.
2010BB	NM109	Payer identifier		'953893470'
Claim Information				
2300	CLM01	Patient Control Number		LACDMH requires that this be a unique identifier.
2300	CLM05-1	Place of Service Code		Use any appropriate Place of Service code.
2300	CLM05-3	Claim Frequency Code		DMH accepts Original, '1', Replacement, '7' and Void, '8' claim frequency codes.

Original Reference Number ICN/DCN				
2300	REF01	Reference ID Qualifier	F8	
2300	REF02	Claim Original Reference Number		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				
2300	HI01-01	Code List Qualifier Code		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”.
2300	HI01-02	Diagnosis Code		For dates of service prior to the ICD-10 compliance date must use “V7109”. For dates of service on or after the ICD-10 compliance date must use “Z0389”.
Rendering Provider				
2310	NM101	Entity Identifier Code	82	
2310	NM102	Entity Type Qualifier	1	
2310	NM103	Name Last		Last Name of the Primary COS Provider
2310	NM104	Name First		First Name of the Primary COS Provider
2310	NM108	Identification Code Qualifier	XX	
2310	NM109	Identification Code		Primary COS Provider’s NPI #
LX – Service Line Number				
2400	LX01	Line Counter		Set to 1. LACDMH allows one service line per claim.
SV1 - Professional Service				
2400	SV101-02 SV101-03 thru SV101-06	Procedure Code Procedure Code Modifier		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 for a complete list of Procedure Codes in IBHIS (including the modifiers for Duplicate Overrides (59 & 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.
2400	SV103	Unit or Basis of Measurement Code	MJ	COS services must use “MJ” - minutes
2400	SV104	Service Unit Count		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.

REF - Prior Authorization				
2400	REF01	Prior Authorization Qualifier	G1	
2400	REF02	Prior Authorization Number		Use the appropriate non-Medi-Cal P-Authorization number
NTE Claim Note				
2400	NTE01	Note Reference Code	DCP	Use DCP for reporting the Evidence Based Practice (EBP) code.
2400	NTE02	Claim Note Text	99	COS Claims must use “99” Claims will reject if this segment is not present.
LQ – Form Identification Code				
2440	LQ01	Code List Qualifier Code	AS	Must use “AS”
2440	LQ02	Industry Code	IBHISCOS	Must use “IBHISCOS”
FRM – Supporting Documentation				
2440	FRM01	Assigned Identification	D26	
2440	FRM03	Reference Identification		Required on every COS claim. See dictionary D.26 in the DMH IBHIS COS Dictionary Values file for Service Type Codes (http://lacdmh.lacounty.gov/hipaa/IBHIS_EDI_Technical_Specifications.htm)
2440	FRM01	Assigned Identification	D12	
2440	FRM03	Reference Identification		Required on every COS claim. See dictionary D.12 in the DMH IBHIS COS Dictionary Values file for Ethnicity Codes (http://lacdmh.lacounty.gov/hipaa/IBHIS_EDI_Technical_Specifications.htm)
2440	FRM01	Assigned Identification	D43	
2440	FRM03	Reference Identification		Required on every COS claim. See dictionary D.43 in the DMH IBHIS COS Dictionary Values file for Primary Language Codes (http://lacdmh.lacounty.gov/hipaa/IBHIS_EDI_Technical_Specifications.htm)
2440	FRM01	Assigned Identification	D01	
2440	FRM03	Reference Identification		Required on every COS claim. See dictionary D.1 in the DMH IBHIS COS Dictionary Values file for Age Category Codes (http://lacdmh.lacounty.gov/hipaa/IBHIS_EDI_Technical_Specifications.htm)
2440	FRM01	Assigned Identification	D23	
2440	FRM03	Reference Identification		Optional on COS claim. See dictionary D.23 in the DMH IBHIS COS Dictionary Values file for Program Area Codes (http://lacdmh.lacounty.gov/hipaa/IBHIS_EDI_Technical_Specifications.htm)
2440	FRM01	Assigned Identification	D25	
2440	FRM03	Reference Identification		Required on every COS claim. See dictionary D.25 in the DMH IBHIS COS Dictionary Values file for Service Recipient Type Codes (http://lacdmh.lacounty.gov/hipaa/IBHIS_EDI_Technical_Specifications.htm)
2440	FRM01	Assigned Identification	Contacts	
2440	FRM03	Reference Identification		Number of persons contacted

9.3 HEALTH CARE CLAIM: INPATIENT (837I)

Loop ID	Reference	Name	Codes	Notes/Comments
Beginning of Hierarchical Transaction				
	BHT02	Transaction Set Purpose Code	00	LACDMH expects to receive this code value.
	BHT06	Transaction Type Code	CH	LACDMH expects to receive this code value.
Submitter Name				
1000A	NM109	Submitter Identifier		Enter the 9-digit DUNS number, with no trailing spaces.
Receiver Name				
1000B	NM103	Receiver Name		LACDMH expects to receive 'LAC DEPARTMENT OF MENTAL HEALTH'
1000B	NM109	Receiver Primary Identifier		LACDMH expects to receive 'LACODMH'.
Billing Provider Specialty Information				
2000A	PRV03	Billing Provider Specialty Information		LACDMH adjudication is not impacted by the provider Taxonomy Code
SBR - Subscriber Information				
2000B	SBR01	Payer Responsibility Sequence Number		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.
Subscriber Name				
2010BA	NM102	Entity Type Qualifier	1	A LACDMH subscriber is always a person.
2010BA	NM108	Identification Code Qualifier	MI	
2010BA	NM109	Subscriber Primary Identifier		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'.
Payer Name				
2010BB	NM103	Payer name		The destination payer is always LACDMH. LACDMH expects to receive 'LAC DEPARTMENT OF MENTAL HEALTH'
2010BB	NM108	Identification Code Qualifier	PI	LACDMH expects to receive this code value.
2010BB	NM109	Payer identifier		'953893470'
Claim Information				
2300	CLM01	Patient Control Number		LACDMH requires that this be a unique identifier.

Loop ID	Reference	Name	Codes	Notes/Comments
2300	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				
2300	DTP01	Date/Time Qualifier	434	
2300	DTP02	Date Time Period Format Qualifier	RD8	
2300	DTP03	Statement From and To Date		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.
REF - Prior Authorization				
2300	REF01	Prior Authorization Qualifier	G1	
2300	REF02	Prior Authorization Number		Report the Provider or Member Authorization # in the Prior Authorization field.
Original Reference Number ICN/DCN				
2300	REF01	Reference ID Qualifier	F8	
2300	REF02	Claim Original Reference Number		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.
Katie A Identifier				
2300	REF01	Reference ID Qualifier	P4	
2300	REF02	Demonstration Project Identifier	KTA	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).
NTE Claim Note				
2300	NTE01	Note Reference Code	DCP	Use DCP for reporting the Evidence Based Practice (EBP) code.

Loop ID	Reference	Name	Codes	Notes/Comments
2300	NTE02	Claim Note Text		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: http://lacdmh.lacounty.gov/hipaa/IBHIS_EDI_Guides.htm
Billing Note (Healthy Families)				
2300	NTE01	Note Reference	ADD	Additional Information
2300	NTE02	Description	SED	Indicates Healthy Families
Principal Diagnosis Code				
2300	HI01-01	Diagnosis Type Code	ABK BK	Use ABK for Dates of Service of 10/1/15 and later Use BK for Dates of Service prior to 10/1/15
2300	HI01-02	Principal Diagnosis Code	 F3111 29570	Do not send decimal points. Send ICD-10 for Dates of Service of 10/1/15 and later Send ICD-9 for Dates of Service prior to 10/1/15
Admitting Diagnosis Code				
2300	HI01-01	Diagnosis Type Code	ABJ BJ	Use ABJ for Dates of Service of 10/1/15 and later Use BJ for Dates of Service prior to 10/1/15
2300	HI01-02	Admitting Diagnosis Code	 F3111 29570	Do not send decimal points. Send ICD-10 for Dates of Service of 10/1/15 and later Send ICD-9 for Dates of Service prior to 10/1/15
Share of Cost (SOC) – Value Information – To report patient paid amount				
2300	HI01-01	Code List Qualifier Code	BE	DMH expects to receive “BE” value when reporting the patient paid amount.
2300	HI01-02	Value Code	FC	DMH expects to receive “FC” value when reporting the patient paid amount.
2300	HI01-05	Value Code Amount		Enter dollar amount the patient has paid.
Attending Provider				
2310A	NM101	Entity Identifier Code	71	The Attending Provider loop is always required
2310A	NM108	Identification Code Qualifier	XX	Use XX to report the NPI in NM109
2300	NM109	Attending Provider Primary Identifier		Enter the Attending Provider’s NPI
2320 SBR - Other Subscriber Information 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**.				

Loop ID	Reference	Name	Codes	Notes/Comments
2320	SBR01	Payer Responsibility Sequence Number		Set to the appropriate payment responsibility for the claim.
2320	SBR09	Claim Filing Indicator Code		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.

AMT - Coordination of Benefits COB Payer Paid Amount				
2320	AMT01	Amount Qualifier Code	D	Use **D** to report amount paid by Medicare/OHC. This amount will be used for balancing processing. Must supply even if the amount is zero.
2320	AMT02	COB Payer Paid Amount		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.
NM1 - Other Payer Name				
2330B	NM109	Other Payer Primary Identifier		An identification number for the other payer, such as '01182' for Medicare.
LX – Service Line Number				
2400	LX01	Line Counter		Set to 1. LACDMH allows one service line per claim.
SV2 – Inpatient Service Line				
2400	SV202-01	Product or Service ID Qualifier	HC	LACDMH expects to receive this code value.
2400	SV202-02	Procedure Code		Refer to the Addendum Guide to Procedure Codes for IBHIS located at http://dmh.lacounty.gov/wps/portal/dmh/admin_tools/prov_manuals for a complete list of Procedure Codes in IBHIS. Modifiers must be submitted in the order listed in the Addendum Guide to Procedure Codes for IBHIS.
2400	SV202-03 thru SV202-06	Procedure Code Modifier		Refer to the Addendum Guide to Procedure Codes for IBHIS located at http://dmh.lacounty.gov/wps/portal/dmh/admin_tools/prov_manuals for a complete list of Procedure Codes in IBHIS. Modifiers must be submitted in the order listed in the Addendum Guide to Procedure Codes for IBHIS.
2400	SV204	Unit or Basis of Measurement Code	DA	Inpatient Services – use 'DA' / Days
2400	SV205	Service Unit Count		Must be 1

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				
2430	CAS01 – CAS04	Claim Line Adjustments		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.

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*000000001*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*120*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*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~ ←===MJ for minutes**
DTP*472*D8*20131118~
REF*G1*P71~ ←===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~

10.1.2 INDIGENT

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
*******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*120*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*P*18*****11~ ←===LACDMH is the destination payer, it is Primary**

Subscriber Name (2010BA)
NM1*IL*1*INDIGENTDOE*INDIGENTJANE**MI*MSO9884330~ ←===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*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
*******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*120*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 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:90887120~ ←===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

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~

10.1.4 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*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*120*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*OHCJANE**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

*****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*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*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:90887120~←===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:90887120~←===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*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
*****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*120*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*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*LACODMH~

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*EI*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*FFSJOHN****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*000000001~

Functional Group (L_GS)

GE*1*131028431~

Interchange (L_ISA)
IEA*1*131028431~

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*120*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*1*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*D8*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~ ←===Performing Provider NPI**

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

DTP*472*D8*20140101~ ←===Use D8 for a single date of service. DO NOT claim for the Discharge Date.
REF*G1*P322~ ←===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~

10.1.9 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*000000001*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*120*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*P*18*****11~ ←===LACDMH is the destination payer, it is Primary**

Subscriber Name (2010BA)
NM1*IL*1*COS*SERVICE**MI*MSO8888888~ ←===Client's ID/'MSO8888888' 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*D267~ ←===Service Type Code (Dictionary D.26)**
FRM*D121~ ←===Ethnicity Code (Dictionary D.12)**
FRM*D43001~ ←===Primary Language Code (Dictionary D.43)**
FRM*D011~ ←===Age Category Code (Dictionary D.1)**
FRM*D232~ ←===Program Area Code (Dictionary D.23)**
FRM*D257~ ←===Service Recipient Type Code (Dictionary D.25)**
FRM*CONTACTS10~ ←===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*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*LACODMH~**

Billing Provider Hierarchical Level (2000A)
HL*120*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 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*RD8*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*!*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*LACODMH~

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
CL1*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)
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~

10.2.3 MEDI-MEDI

Interchange (L_ISA)
ISA*00* *00* *14*081234983 *14*132486189
***140313*0822*!*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*LACODMH~**

Billing Provider Hierarchical Level (2000A)
HL*120*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*S*18*****11~ ←===LACDMH is the destination payer, it is Secondary for a Medi/Medi claim**

Subscriber Name (2010BA)
NM1*IL*1*MMDOE*MMJANE**MI*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*1*X*005010X221A1~

Transaction 835 (835)

ST*835*1458~
BPR*I*242*C*CHK**********20150409~ ←===Total Actual Provider Payment Amount of $242.00
TRN*1*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~ **←===Total Actual Provider Payment Amount of $0.00 (no payment)**
TRN*1*FOR BATCH 2625*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*605647605~

Header Number (2000)
LX*1~

Claim Payment Information (2100)
CLP*150409822A-01*22*-242*-242**HM*4479*11*1~ **←===Claim Payment Amount of -$242.00. It is the payment reversal of the voided Avatar Claim ID 4479**
NM1*QC*1*LNTESTAE*FNTESTAE****MI*3012944~
REF*F8*4479~
DTM*232*20140615~
DTM*233*20140615~
AMT*AU*-242~

Service Payment Information (2110)
SVC*HC:90791*-242*-242**100~ **←===Line Item Provider Payment Amount of -$242.00. It is the payment reversal of the voided Avatar Claim ID 4479**
DTM*472*20140615~
REF*BB*P46~
AMT*B6*-242~

Claim Payment Information (2100)
CLP*150409822A-01*1*242*0**HM*4479*11*1~ **←===Claim Payment Amount of $0.00. It is the non-payment for the voided Avatar Claim ID 4479**
NM1*QC*1*LNTESTAE*FNTESTAE****MI*3012944~
REF*F8*4479~
DTM*232*20140615~
DTM*233*20140615~

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*B6*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 *150409*1642*!*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*TJ*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*!*00501*000000135*0*P*:~

Functional Group (L_GS)

GS*HP*132486189*992499189*20150806*135959*1*X*005010X221A1~

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-01***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~ ←===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~ ←===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*!*00501*000000131*0*P*:~

Functional Group (L_GS)

GS*HP*132486189*992499189*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~ ←===**Approved claim; value in CLP01 is from Contractor's inbound 837 CLM01**

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

REF*F8*10365~ ←===**PCCN (Payer Claim Control Number) assigned by IBHIS**

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~

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_ISA)

ISA*00* *00* *14*132486189 *14*992499189 *150805*1923*!*00501*000000132*0*P*:~

Functional Group (L_GS)

GS*HP*132486189*992499189*20150805*192350*1*X*005010X221A1~

Transaction 835 (835)

ST*835*1720~

BPR*I*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*TJ*999947899~

Header Number (2000)

LX*1~

Claim Payment Information (2100)

CLP*150805833A-01*22*-242*-242**HM*10365*11*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*242*0**HM*10365*11*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**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_ISA)

IEA*1*000000132~

835 for Replacement of Original Claim – Denied by the State

Interchange (L_ISA)
ISA*00* *00* *14*132486189 *14*992499189 *150805*1959*!*00501*000000133*0*P*:
~
Functional Group (L_GS)
GS*HP*132486189*992499189*20150805*195952*1*X*005010X221A1~
Transaction 835 (835)
ST*835*1721~
BPR*I*242*C*CHK**********20150805~ ←===**There is a positive payment amount in this BPR; for the approved replacement claim**
TRN*1*FOR BATCH 3049*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***150805839A-01***1*1****242*242****HM*10367*11*7~ ←===**Approved replacement claim ("7"); value in CLP01 is from Contractor's inbound 837 CLM01 value**
NM1*QC*1*LNTESTAE*FNTESTAE****MI*3012944~
REF*F8*10367~ ←===**PCCN (Payer Claim Control Number) assigned by IBHIS**
DTM*232*20150413~
DTM*233*20150413~
AMT*AU*242~

Service Payment Information (2110)
SVC*HC:90791:76*242*242**100~
DTM*472*20150413~
REF*BB*P300~
AMT*B6*242~

Transaction 835 (835)
SE*24*1721~

Functional Group (L_GS)
GE*1*1~

Interchange (L_ISA)
IEA*1*000000133~

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 Reponse :

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

Transaction Set Repsonse 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 elemenent contains the location of the segement in error from the ST segment in the 837 file. (Eg : 20 means 19 segements 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 Reponse 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 Reponse :

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 Reponse 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~ **←===This is from the BHT03 in the 837 claim file From the 837 claim file (BHT*0019*00*170203808A*20170215*082252*CH~)**

Loop 2000B – Receiver Level Summary

STC*A1:19:40*20180222***WQ***7625~ **←===The transaction has been accepted**

QTY***90*32***~ **←===Number of Claims Accepted**
QTY***AA*1***~ **←===Number of Claims Rejected**
AMT***YU*7400***~ **←===Total Amount of Claims Accepted**
AMT***YY*225***~ **←===Total Amount of Claims Accepted**

Loop 2000C - Billing Provider Level Summary

NM1*85*1*xxxxx*xxxxxx****XX*1952418212~
TRN*1*0~
STC*A1:19:40**WQ*7625~ **←=== The transaction has been accepted**
QTY*QA*32~ **←===Number of Claims Accepted**
QTY*QC*1~ **←===Number of Claims Rejected**
AMT*YU*7400~ **←===Total Amount of Claims Accepted**
AMT*YY*225~ - **←===Total Amount of Claims Rejected**

2000D - Patient Level Detail.

NM1*QC*1*LNTESTAE*FNTESTAE****MI***MSO123456***~ **←===Client ID**

TRN*2*277203818B-01~ **←===CLM02 from 837.**

STC*A2:20*20180321***WQ*186.7***~ **←=== STC01: A2:20 indicates that the claim is accepted. STC03 : WQ Indicates that the claim was accepted. STC04 : The claim amount for the 837 in the CLM and SV1 or SV2.**

REF*1K***625725***~ **←=== Payor Assigned Claim Number (DMH PCCN)**
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~