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.

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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

Preface

This Companion Guide to the version 005010 (v5010) ASC X12N Implementation Guides and associated errata adopted under HIPAA clarifies and specifies the data content when exchanging electronically with Los Angeles County Department of Mental Health (LACDMH). Transmissions based on this companion guide, used in tandem with the v5010 ASC X12N Implementation Guides, are compliant with both ASC X12 syntax and those guides. This Companion Guide is intended to convey information that is within the framework of the ASC X12N Implementation Guides adopted for use under HIPAA. The Companion Guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the Implementation Guides.

This Companion Guide addresses specific DMH business process requirements for transmitting claim data to the LACDMH Integrated Behavioral Health Information System (IBHIS) system. In addition to the LACDMH business requirements, all 837 transactions transmitted from the providers to LACDMH must be compatible with the HIPAA requirements. It is assumed that trading partners are familiar with the HIPAA Implementation Guides and, as such, this guide does not attempt to instruct trading partners in the creation of an entire HIPAA transaction.
However, samples of entire transaction will be given to trading partners during registration/orientation process.
This Companion Guide is subject to change. Please visit our website for the latest version:
Legal Entities: http://lacdmh.lacounty.gov/hipaa/IBHIS_EDI_Guides.htm
Fee-for-Service Providers: http://lacdmh.lacounty.gov/hipaa/ffs_IBHIS_EDI_Guides.htm

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1 INTRODUCTION

1.1 Scope

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

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

These guides are available from ASC X12 at http://store.X12.org/

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 the LACDMH requirements and usage for the 837 claiming 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/

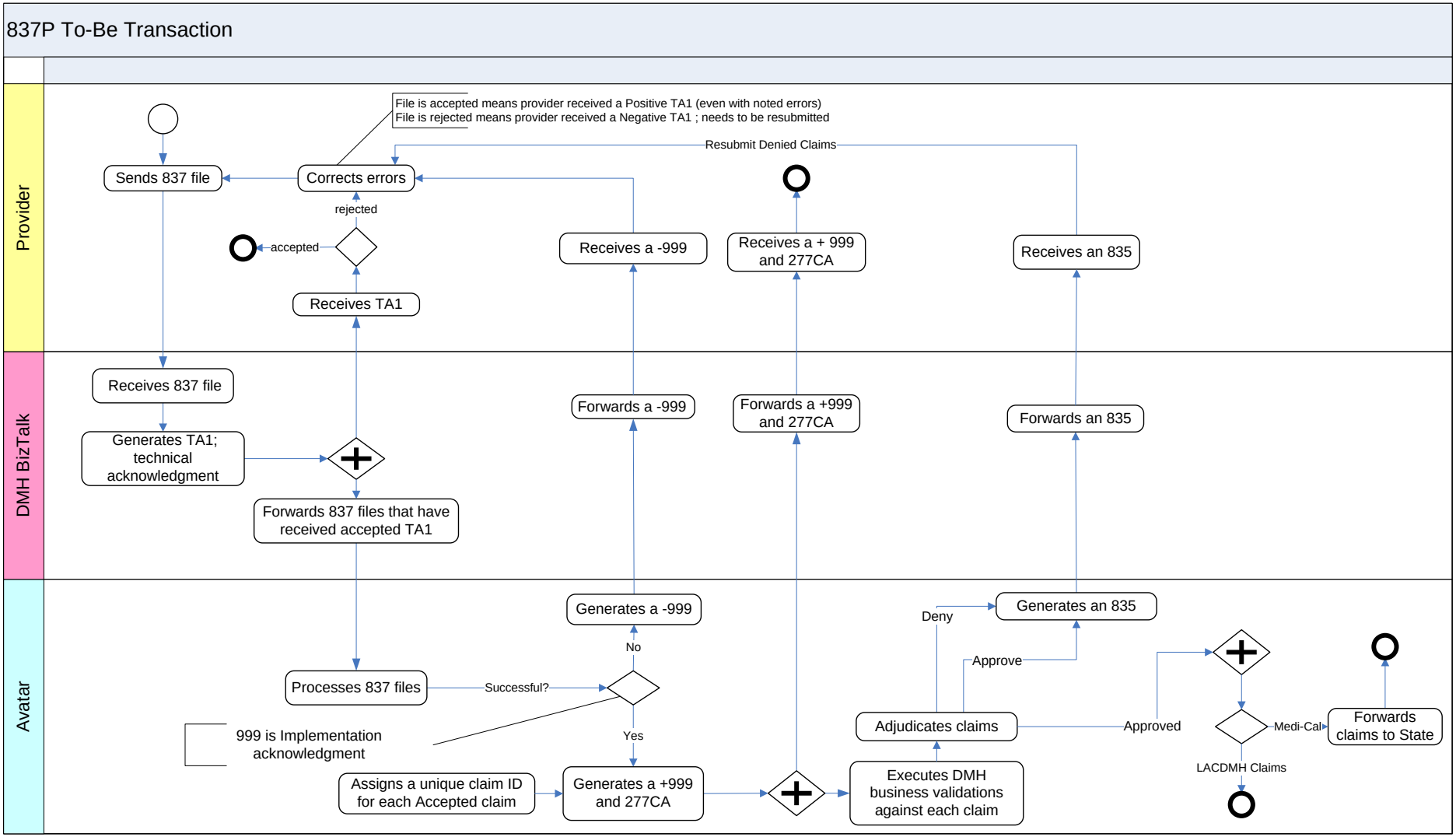
2 GETTING STARTED

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.
     - 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).
7. Use the County Funded Procedure Code Modifier when submitting claims using non-Medi-Cal outpatient Funding Source authorizations.
   - 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 CalWORKs, Residential or Inpatient claims.
8. Retroclaim adjudication.
   - Providers will receive an 835 for all claims at the time that the claim is adjudicated and the provider receives payment. 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.
9. Claims for residential and PHF services must be reported using the 837 Professional format.
10. 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 and psychiatric health facility (PHF).
- Inpatient, residential and PHF claims that include the discharge date will be denied unless the admit and discharge dates are the same date of service
- IBHIS validates that claims with Medi-Cal Funding Source authorizations have an established Medi-Cal Guarantor in their Financial Eligibility (Medi-Cal (10), Healthy Families (11) or Katie A Medi-Cal (18)). 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.
- IBHIS validates that claims with CalWORKs authorizations have the CalWORKs Guarantor (17) in their Financial Eligibility.
- IBHIS validates that the Payer ID on claims with Medicare and/or Other Health Care matches the Payer ID of one of the clients Financial Eligibility guarantors.
  - Payer ID – 2330B NM109 Other Payer Primary Identifier

11. 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.

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 based on the Guarantor information stored in the IBHIS Financial Eligibility form. Katie A sub-class clients must be set up with the Katie A. MediCal Guarantor (#18) for all applicable time periods. EDI Providers will update the Financial Eligibility information via the Client Web Services or Fee-for-Service providers will update Financial Eligibility information using ProviderConnect.
4. The Healthy Families SED indicator will be transmitted to the state based on the Guarantor information stored in the IBHIS Financial Eligibility form. Healthy Families clients should be set up with the MediCal Healthy Families Guarantor (#11). EDI Providers will update the financial eligibility information via the Client Web Services or Fee-for-Service providers will update Financial Eligibility information using ProviderConnect.
5. 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.
6. Financial Eligibility information is entered via Client Web Services. 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 entered in Financial Eligibility for Medi-Cal (Medi-Cal, Healthy Families or Katie A Medi-Cal guarantors) and for Medicare/OHC when the claim was previously adjudicated by another payer:

- 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.

7. 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

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.
2. LACDMH provides Implementation Acknowledgment transactions (999) for all inbound Functional Groups (i.e. 837s).
3. LACDMH provides the Health Care Claim Acknowledgment transaction (277CA) for all claims. Only accepted claims will be assigned an IBHIS claim ID.
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.

8 TRANSACTION SPECIFIC INFORMATION

8.1 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.

Loop ID	Reference	Name	Codes	Notes/Comments
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.
Health Care Diagnosis Code				
2300	HI01-02, HI02-02, HI03-02, … HI12-02	Diagnosis Code		For any V-code diagnosis, the V must be sent in as an uppercase V.
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.
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		Include the published Payer ID from the Guarantor dictionary. The Guarantor dictionary can be found in the **DMH IBHIS Dictionary Values** document located on the IBHIS Technical Specifications webpage: Legal Entities: http://lacdmh.lacounty.gov/hipaa/IBHIS_EDI_Technical_Specifications.htm Fee-for-Service Providers: http://lacdmh.lacounty.gov/hipaa/ffs_IBHIS_EDI_Technical_Specifications.htm

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 – use 'MJ' / Minutes Day Treatment/Residential/PHF – use 'UN' / Units
2400	SV104	Service Unit Count		Set to the number of units or minutes. Use the procedure code that matches to the appropriate face to face time. Enter minutes as the total of face to face + other time. 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.
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.
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.

8.2 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				

Loop ID	Reference	Name	Codes	Notes/Comments
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	BK	
2300	HI01-02	Diagnosis Code	V7109	Must Use “V7109” Must be uppercase “V”
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

Loop ID	Reference	Name	Codes	Notes/Comments
2310	NM108	Identification Code Qualifier	XX	
2310	NM109	Identification Code		Primary COS Provider's NPI #

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 for Service Type Codes
2440	FRM01	Assigned Identification	D12	
2440	FRM03	Reference Identification		Required on every COS claim. See dictionary D.12 for Ethnicity Codes
2440	FRM01	Assigned Identification	D43	
2440	FRM03	Reference Identification		Required on every COS claim. See dictionary D.43 for Primary Language Codes
2440	FRM01	Assigned Identification	D01	
2440	FRM03	Reference Identification		Required on every COS claim. See dictionary D.1 for Age Category Codes

2440	FRM01	Assigned Identification	D23	
2440	FRM03	Reference Identification		Required on every COS claim. See dictionary D.23 for Program Area Codes
2440	FRM01	Assigned Identification	D25	
2440	FRM03	Reference Identification		Required on every COS claim. See dictionary D.25 for Service Recipient Type Codes
2440	FRM01	Assigned Identification	Contacts	
2440	FRM03	Reference Identification		Number of persons contacted

8.3 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'

Loop ID	Reference	Name	Codes	Notes/Comments
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	CLM05-3	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 Dates you are claiming for. Use a date range to indicate the From and Through date of the statement. When the statement is for a single date of service, the From and Through date are the same.
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.
NTE Claim Note				
2300	NTE01	Note Reference Code	DCP	Use DCP for reporting the Evidence Based Practice (EBP) code.
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.
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.

Loop ID	Reference	Name	Codes	Notes/Comments
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**.				
2320	SBR01	Payer Responsibility Sequence Number		Set to the appropriate payment responsibility for the claim.
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		Include the published Payer ID from the Guarantor dictionary. The Guarantor dictionary can be found in the **DMH IBHIS Dictionary Values** document located on the IBHIS Technical Specifications webpage: Legal Entities: http://lacdmh.lacounty.gov/hipaa/IBHIS_EDI_Technical_Specifications.htm Fee-for-Service Providers: http://lacdmh.lacounty.gov/hipaa/ffs_IBHIS_EDI_Technical_Specifications.htm
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.

Loop ID	Reference	Name	Codes	Notes/Comments
2400	SV204	Unit or Basis of Measurement Code	DA	Inpatient Services – use 'DA' / Days
2400	SV205	Service Unit Count		Set to the number of days of service.
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 APPENDICES

9.1 837P EXAMPLES

9.1.1 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*BK:311~

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~

9.1.2 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*BK:311~

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~

9.1.3 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 Payor 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 Payor ID 01182**
CAS*CO*45*201~ ←===Line Adjustment by Medicare Part B Southern California Payor 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~

9.1.4 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*BK:29602~

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 Payor 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:90887120~ ←===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~

9.1.5 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*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*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*BK:29602~

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 Payor 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 Payor 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 Payor ID 60054**
CAS*CO*45*201~ ←===Line Adjustment by Aetna HMO Payor 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 Payor ID 01182**
CAS*CO*45*181~ ←===Line Adjustment by Medicare Part B Southern California Payor ID 01182
CAS*CO*23*96.6~ ←===Line Adjustment by Medicare Payor 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~

9.1.6 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*BK:29600~

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**
DTP*472*D8*20131101~
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~

9.1.7 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*120*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*BK:311~

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~

9.1.8 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*90005~
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*BK:V7109~ ←===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~

9.2 837I EXAMPLES

9.2.1 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*20140109-20140110~ ←===1st claim of the inpatient episode for two days, from 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*BK:29620~
HI*BJ:29620~

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*2~ ←===Procedure Code and Modifiers

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

Functional Group (L_GS)
GE*1*140313604~

Interchange (L_ISA)
IEA*1*140313604~

9.2.2 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*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**

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:1**A*Y*Y~ ←=== Ex: Claim Frequency Code is "1" – charges for the entire episode**
DTP*096*TM*0000~
DTP*434*RD8*20140109-20140110~ ←===Entire claim of the inpatient episode for two days
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*BK:29620~
HI*BJ:29620~

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*2~ ←===Procedure Code and Modifiers

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

Functional Group (L_GS)
GE*1*140313604~

Interchange (L_ISA)
IEA*1*140313604~

9.2.3 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*20140116-20140117~ ←Statement is for two days (20140116-20140117), Statement from and to Date (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*BK:29620~
HI*BJ:29620~

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 Payor ID is 01182**

Service Line Number (2400)
LX*1~
SV2*0100*HC:0100:HA*1360*DA*2~ ←===Procedure Code and Modifiers

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~