County of Los Angeles
Department of Mental Health

Contract Providers Transition Project (CPTP)

837P Companion Guide – Short Doyle II

Version 5.2

June 2011

DOCUMENT REVISION HISTORY

Version	Release Date	Revised by	Comments/Indicate Sections Revised
11/18/03	1/9/2004	Dee Eng	HEADER GS03 corrected typo error from 10000000 to 00000001 in the business rules column.
11/18/03	1/9/2004	Dee Eng	HEADER BHT02 was eliminated since DMH ignores this field.
11/18/03	1/9/2004	Dee Eng	1000A NM1 PER03 to PER06 was eliminated since they are optional.
11/18/03	1/9/2004	Dee Eng	1000A NM109 changed to use the production value assigned to the submitters.
11/18/03	1/9/2004	Dee Eng	1000B NM109 changed to use dmh production value 00000001.
11/18/03	1/9/2004	Dee Eng	2010AA REF01 simplified the legend for B3 and FH in the example column.
11/18/03	1/9/2004	Dee Eng	2300 CLM01 in the business rules column eliminated the void claims paragraph.
11/18/03	1/9/2004	Dee Eng	2300 CLM05-3 in the example column eliminated the legend for "8" - void claim.
11/18/03	1/9/2004	Dee Eng	2330 A REF02 simplified the legend in the example column to be 2000-01.
11/18/03	1/9/2004	Dee Eng	2400 SV101-4 in the business rules column corrected typo from "third" to "second".
11/18/03	1/9/2004	Dee Eng	2400 SV101-5 in the business rules column corrected typo from "first" to "third".
V 1.0	1/9/2004	Dee Eng	Given the 837P Companion Guide a version number (V 1.0) and the date (01/09/04) of the version.
V 1.1	1/29/2004	Dee Eng	2300 CLM01 changed name to Claim Submitter's Identifier and business rule Patient Account to Claim.
V 1.2	5/28/2004	Dee Eng	2330B NM109 changed temporary Medicare id from 10202 to official PI identifier 31146.
V 1.3	8/6/2004	Dee Eng	2400 SV103 added : For psychological testing procedural code 96100, use only MJ.

V 2.0	10/18/2004	Dee Eng	Significant changes have been made to this Companion Guide to over-clarify business rules; while no alteration has been induced to these rules. Also changed (M = Mandatory, O = Optional) to (R = Required, S = Situational) in the DMH Validation column to be in accordance with the Implementation Guide standard. Also added some example values to be used in different fields.
V 2.1	11/12/2004	Dee Eng	2330A NM109 To clarify the use of CIN versus SSN.
V 2.2	6/6/2005	Dee Eng	On the Companion Guides Legend page, put in the new LAC-DMH HIPAA website URL. Correct typo on Pay-to Provider loop from 2010AA to 2010AB. Correct typo on 2330A REF01 1G to IG.
V 2.3	7/25/2005	Dee Eng	Updated info for loop 2300 CLM05-3.
V 3.0 (IS 2.0)	11/27/2006	Dee Eng	Updated info for Implementation of Integrated System version 2.0 (IS 2.0).
V 3.1 (IS 2.0)	1/23/2008	Dee Eng	Added more info on loop 2400, segments SV101-2 and SV104.
V 3.2 (IS 2.0)	1/29/2008	Dee Eng	Added requirement for Transaction Set Header, segment ST02, must be numeric to receive a 997.
V 4.0 (IS 2.0 & NPI)	4/15/2008	Dee Eng	Updated Loops 2010AA and 2310B for HIPAA NPI requirement.
V 4.1 (IS 2.0 & NPI)	6/2/2008	Dee Eng	Updated Loop 2330A NM109 to require CIN# must be used by FFS Providers, effective 6-12-2008. Also enhanced the wording for Local Contract Providers.
V 4.2 (IS 2.0 & NPI)	8/27/2008	Dee Eng	Updated Loop 2330B NM109 to the value of '01192' when Medicare is the payer.
V 5.0 (Short Doyle II)	03/12/2010	Dee Eng	Updated for Short Doyle II Modifications.
V 5.1 (Evidence Based Practice)	07/02/2010	Dee Eng	Updated for Evidence Based Practice Modifications
V5.2 (Required Provider Taxonomy Code)	06/09/2011	Dee Eng	Update for Required Rendering Provider Taxonomy

Table of Contents

COMPANION GUIDES LEGEND **1**
837P (PROFESSIONAL CLAIMS) COMPANION GUIDE **2**

DMH Integrated System Project
Companion Guides Legend

Usage Notes	DMH Validation	DMH Business Rules	Example
This Companion Guide addresses specific DMH business process requirements for HIPAA transactions that are conformable 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 at http://dmh.lacounty.gov/hipaa/edi_homepage.html for the latest version. LAC-DMH CIOB HIPAA EDI UNIT promotes Trading Partners readiness for these transactions. Please contact us at (213) 351-1335.	This column identifies which segments and fields are required by DMH. While some of these segments are not required by HIPAA they may be required by DMH to process claims. It is strongly recommended to reference these Companion Guides in conjunction with the WPC Implementation Guides. Pay downloads of Washington Publishing Company's HIPAA EDI Implementation Guides can be obtained at www.wpc-edi.com 270 - 004010X092 276 - 004010X093 834 - 004010X095 837P - 004010X098 & 004010X098A1 837I - 004010X096 835 - 004010X091 277U - 004040X167 Data Element Dictionary 004010DED	This column describes how the segment / field is to be used in order to meet the DMH business process requirements. Explanations are given much consideration to Fee-For-Service and Local Contract Providers, under different claim scenarios.	This column gives an example of the data that can be populated in the field. If the value is darkened / bolded, must use that value.
	R = Required		
	S= Situational		

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Loop	Segment ID	Ref. Des.	Field Name	DMH Validation	DMH Business Rules	Example
Interchange Control Header						
HEADER	ISA	ISA05	Interchange ID Qualifier	R	Always use ZZ	**ZZ**
HEADER	ISA	ISA06	Interchange Sender ID	R	Use the Interchange Sender ID assigned to the provider by DMH during registration process. It is a 15-byte A/N character field.	000001020000000
HEADER	ISA	ISA07	Interchange ID Qualifier	R	Always use ZZ	**ZZ**
HEADER	ISA	ISA08	Interchange Receiver ID	R	Always use 000000010000000 for DMH Interchange Receiver ID. It is a 15-byte A/N character field.	**000000010000000**
HEADER	ISA	ISA13	Interchange Control Number	R	IS2.0: This field is required by HIPAA and is recommended to be a unique value for each file. To identify each file for a submitter, DMH business process ensures the value for the file is unique. The Interchange Control Number, ISA13, must be Identical to the associated Interchange Trailer IEA02 As per HIPAA this must be a length of nine (9)	123456789 - Unique value that is a length of 9
Transaction Set Header						

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Loop	Segment ID	Ref. Des.	Field Name	DMH Validation	DMH Business Rules	Example
HEADER	ST	ST02	Transaction Set Control Number	R	In order to receive a 997 transaction from BizTalk, this field must be numeric for the length of 4 (minimum) to 9 (maximum).	1234, 0011, 12345, 123456789, etc.
Functional Group Header						
HEADER	GS	GS02	Application Sender's Code	R	Use the Application Sender Code assigned to the provider by DMH during registration process. It is an 8-byte A/N character field.	00000102
HEADER	GS	GS03	Application Receiver's Code	R	Always use 00000001 for DMH Application Receiver ID. It is an 8-byte A/N character field.	**00000001**
Beginning of Hierarchical Transaction						
HEADER	BHT	BHT06	Claim or Encounter Indicator	R	DMH does not validate this segment, but as all claims sent to DMH are adjudicated always use 'CH'.	**CH**
Transmission Type Identification						
HEADER	REF	REF01	Reference ID Qualifier	R		**87**
HEADER	REF	REF02	Transmission Type Code	R	Testing for certification, value should be 004010X098DA1 .	**004010X098A1**(production) 004010X098DA1 (testing for certification)
Submitter Name						

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Loop	Segment ID	Ref. Des.	Field Name	DMH Validation	DMH Business Rules	Example
1000A	NM1	NM108	Identification Code Qualifier	R	Must use 46	**46**
1000A	NM1	NM109	Submitter Primary ID#	R	Assigned to provider by DMH during registration process. It is an 8-byte character field.	00000102
Receiver Name						
1000B	NM1	NM103	Receiver Name	R	This value is not used or validated by DMH and is provided for informational purposes only.	**LAC DEPARTMENT OF MENTAL HEALTH**
1000B	NM1	NM108	Identification Code Qualifier	R	Must use 46	**46**
1000B	NM1	NM109	Receiver Primary Identifier	R	The receiver must always be DMH. Always use 00000001 in production. It is an 8-byte A/N character field.	**00000001**
Billing Provider Name						
2010AA	NM1	NM108	Identification Code Qualifier	S	HIPAA requires this field, ' XX' is used with combination for NPI.	**XX**
2010AA	NM1	NM109	Pay-to Provider Identifier	S	LAC-DMH ensures the qualifier and identifier combination are valid. LAC-DMH will also apply the NPI check digit algorithm to ensure valid NPI format. IMPORTANT: Use Service Location NPI here when it's a Satellite or Public school site.	Billing Provider NPI or Service Location NPI (ONLY for Satellite or Public School site) 1123456789

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Loop	Segment ID	Ref. Des.	Field Name	DMH Validation	DMH Business Rules	Example
2010AA	REF	REF01	Reference Identification Qualifier	R	This segment is used to identify the billing provider and service location. These identification values are assigned to providers by DMH during the registration process. Always use 'B3' to identify the billing provider. Always use 'FH' to identify the service location. If the billing provider and service location are the same, there still must be two REF segments. When NPI is used, must ALSO provide 'EI' for Employer's Identification number or 'SY' for Social Security number. There are three 2010AA, REF segments must be used.	**B3 –** Assigned billing provider id and **FH** – Assigned Service Location ID and **EI** – Employer's Identification number or **SY** – Social Security Number
2010AA	REF	REF02	Billing Provider Additional Identifier	R	Use the appropriate assigned identification values for billing provider, service location and EIN / SSN when use with NPI.	2390 555998888
Subscriber Information						
2000B	SBR	SBR01	Payer Responsibility Sequence Number	R	Set to the appropriate payment responsibility for DMH. DMH is always the payer of last resort and as such its payment responsibility is after all other payers (Private Insurance, Medicare and/or Medi-Cal) of the claim. Use 'S' for Fee-For-Service claim. Use also 'S' for Local Plan Contract Providers, 1-plan Medi-Cal	**P , S, T**

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Loop	Segment ID	Ref. Des.	Field Name	DMH Validation	DMH Business Rules	Example
					claim. Use 'T' for Local Plan Contract Providers Medi-Medi claim.	
2000B	SBR	SBR02	Relationship Code	R	LAC-DMH requires this value. Always use '18'.	**18**
2000B	SBR	SBR09	Claim Filing Indicator Code	S	LAC-DMH requires this value. Always use '11'.	**11**
Patient Information						
2000B	PAT	PAT06	Date of Death	S	Date of Death cannot be prior to the birth date in 2010BA_DMG_Birthdate. If the birth date is not provided in the 837, the IS ensures the date of death is not prior to the birth date provided during enrollment (834 transaction).	20030120
2000B	PAT	PAT09	Yes/No Condition or Response Code	S	PAT09 indicates whether the Client has a pregnancy aid code. DMH requires this segment if aid code is a pregnancy aid code, otherwise do not send this segment.	**Y**
Subscriber Name						
2010BA	NM1	NM102	Entity Type Qualifier	R	Subscriber is always the patient. Always set to 1.	**1**
2010BA	NM1	NM108	Identification Code Qualifier	R	Always use Member ID qualifier (MI).	**MI**
2010BA	NM1	NM109	Subscriber Primary Identifier	R	Set to the 7-byte A/N character DMH client ID (MIS#). If the client id is not valid, the claim will be rejected.	0123456

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Loop	Segment ID	Ref. Des.	Field Name	DMH Validation	DMH Business Rules	Example
Payer Name						
2010BB	NM1	NM108	Identification Code Qualifier	R	Always use PI.	**PI**
2010BB	NM1	NM109	Payer Identifier	R	The payer is always DMH. Always use 953893470	**953893470**
Payer Address						
2010BB	N3	N301	Payer Address Line	S	The address is not used by DMH and is provided for informational purposes only.	500 S. VERMONT AVENUE
Payer City State ZIP CODE						
2010BB	N4	N401	Payer City Name	S	The address is not used by DMH and is provided for informational purposes only.	LOS ANGELES
2010BB	N4	N402	Payer State Code	S	The address is not used by DMH and is provided for informational purposes only.	CA
2010BB	N4	N403	PayerPostalZoneOrZIPCode	S	The address is not used by DMH and is provided for informational purposes only.	90020
2010BB	N4	N404	Country Code	S	The address is not used by DMH and is provided for informational purposes only.	US

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Loop	Segment ID	Ref. Des.	Field Name	DMH Validation	DMH Business Rules	Example
Claim Information						
2300	CLM	CLM01	Claim Submitter's Identifier	R	This value must be unique each time. Please refer to the last two paragraphs on page 171 of the 837P IG version 004010X098 for detail. It is an alpha-numeric field with maximum length of 20 bytes.	A1234567-000089-0109
2300	CLM	CLM02	Monetary Amount	R	Put in the claim amount.	200
2300	CLM	CLM05-1	Place of Service Code	R	DMH will always use this field to determine the place of service. If the place of service was via telephone, set this value to '11'. If this field is not present, the claims will be rejected.	23
2300	CLM	CLM05-3	Claim Frequency Code	R	DMH accepts Original, '1', Replacement, '7' and Void, "8" claim frequency codes. Please contact EDI testing and Certification Unit for details.	**1 , 7, 8**
2300	CLM	CLM06	Yes/No Condition or Response Code	R	Required by DMH	**Y**
2300	CLM	CLM07	Provider Accept Assignment Code	R	If the provider is Medicare -certified set to 'A'. If the provider is not Medicare certified set to 'C'. This mapping is consistent with Medi-Cal requirements	**A, C**
2300	CLM	CLM08	Yes/No Condition or Response Code	R	Required by DMH	**Y**

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Loop	Segment ID	Ref. Des.	Field Name	DMH Validation	DMH Business Rules	Example
2300	CLM	CLM09	Release of Information Code	R	Required by DMH	**Y**
2300	CLM	CLM10	Patient Signature Source Code	S	Required by DMH	**B**
2300	CLM	CLM20	Delay Reason Code	S	Use this code for claims submitted more than 6 months after the service date. If the claim is more than 6 months late and a delay reason code is not specified, the claim is rejected. Contact EDI certification unit to obtain the code(s) for your particular scenario. IS 2.0 (FFS providers only) Valid late codes are 1, 3, 8 and 11. And if 11 is sent, a TAR number must be present.	1,7
Share of Cost (SOC)						
2300	AMT	AMT01	Amount Qualifier Code	S	Code to qualify amount	**F5**
2300	AMT	AMT02	Other Payer Patient Paid Amount	S	Patient SOC Amount obligated	SOC Obligated Amt
Original Reference Number ICNDCN						
2300	REF	REF01	Reference ID Qualifier	S	For Replacement and Void claims this segment is required	F8

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Loop	Segment ID	Ref. Des.	Field Name	DMH Validation	DMH Business Rules	Example
2300	REF	REF02	Claim Original Reference Number	S	IS2.0 For Replacement and Voided claims the IS assigned claims identifier (IS Claim Number) for the claim to be replaced/voided must be used in this field. The IS will accept Void on a claim that was approved or denied by DMH adjudication. Replacement and Voids are not allowed on claims that were denied by DMH Business Rules	Claim ID to be replaced or voided IS2.0 Internal IS claim identifier
Prior Authorization or Referral Number						
2300	REF	REF01	Reference ID Qualifier	S	For FFS providers, an authorization number is required if the procedure code requires authorization. Otherwise, DMH does not validate this field. IS 2.0 (FFS providers only) A TAR number must be present if late code 11 is sent.	**G1** - For FFS authorization
2300	REF	REF02	Prior Authorization or Referral Number	S	For FFS providers, an authorization number is required if the procedure code requires authorization. Otherwise, DMH does not validate this field. For FFS providers, put the TAR # in this field. IS 2.0 (FFS providers only) A TAR number must be present if late code 11 is sent.	
Claim Note (Healthy Family Indicator)						
2300	NTE	NTE01	Note Reference Code	S	Code identifying the functional area or purpose for which the note applies	**ADD**

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Loop	Segment ID	Ref. Des.	Field Name	DMH Validation	DMH Business Rules	Example
2300	NTE	NTE02	Description	S	Description indicates the claim is a Healthy Families claim	**SED**
Health Care Diagnosis Code						
2300	HI	HI01	Diagnosis Type Code	S	DMH processing does not require diagnosis, but it is required for some other payers, (e.g. Medi-Cal). Therefore if the claim contains payers other than DMH, it is recommended that the primary diagnosis is included in the claim.	**BK** ICD-9 Codes
2300	HI	HI02	Diagnosis Code	S	Do not send decimal points.	29570
Rendering Provider						
2310B	NM1	NM101	Entity Identifier Code	R	The rendering provider is always required even if it is the same as the billing provider and/or the pay to provider.	**82**
2310B	NM1	NM108	Identification Code Qualifier	R	This field is required by HIPAA - NPI use	**XX**
2310B	NM1	NM109	Referring Provider Primary ID	R	LAC-DMH ensures the qualifier and identifier combination are valid. LAC-DMH will also apply the NPI check digit algorithm to ensure valid NPI format.	Rendering Provider NPI 1123456789

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Loop	Segment ID	Ref. Des.	Field Name	DMH Validation	DMH Business Rules	Example
Rendering Provider Specialty Information						
2310B	PRV	PRV03	Provider Taxonomy Code	R	Enter the Taxonomy for the Rendering Provider. DMH ensures the Taxonomy is a valid I.S. Taxonomy. For FFS rendering provider, the taxonomy is optional.	2084P0800X
Rendering Provider Secondary Information						
2310B	REF	REF01	Reference ID Qualifier	R	This segment is used to identify the rendering provider identification that was assigned to providers by DMH during the registration process. Always use 'N5' to identify the rendering provider. If the rendering provider is the same as the billing provider and/or pay-to provider, there still must be REF segment. All other REF segments without "N5" in REF01 are ignored by DMH.	**N5 -** to specify rendering provider
2310B	REF	REF02	Rendering Provider Secondary ID	R	Use the assigned identification value for the rendering provider. DMH uses this value to identify the rendering provider.	24009
Service Facility Location ----- IMPORTANT - This is a situation loop, LAC-DMH currently is NOT using 2310D for Service Location NPI.						
2310D	NM1	NM101	Entity Identifier Code	R	When used for NPI, enter "FA'.	**FA**
2310D	NM1	NM102	Entity type qualifier	R	Per HIPAA	**2**

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Loop	Segment ID	Ref. Des.	Field Name	DMH Validation	DMH Business Rules	Example
2310D	NM1	NM108	Identification Code Qualifier	R	This field is required by HIPAA - NPI use	**XX**
2310D	NM1	NM109	Identifier code	R	LAC-DMH ensures the qualifier and identifier combination are valid. LAC-DMH will also apply the NPI check digit algorithm to ensure valid NPI format.	Service Location NPI 1123456789
2310D	N3	N301	Address information	R	Street number and name	1234 West Hill Lane
2310D	N4	N401	City Name	R	Name of the city	Los Angeles
2310D	N4	N402	State or Province Code	R	Name of the State	CA
2310D	N4	N403	Postal Code	R	Zip Code	90020
Other Subscriber Information						
2320	SBR	SBR01	Payer Resp. Seq. Number Code	R	FFS providers & Local Contract providers, use 'P' in the first instance of 2320 loop. Local Contract Providers, in the second instance of loop 2320, use 'T' for 1-plan Medi-Cal claim; use 'S' for Medi-Medi claim. And also for Local Contract Providers, use 'T' in the third instance of loop 2320 for Medi-Medi claim.	**P, S, T**

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Loop	Segment ID	Ref. Des.	Field Name	DMH Validation	DMH Business Rules	Example
2320	SBR	SBR02	Individual Relationship Code	R	Use '18' in all instances of loop 2320.	**18**
2320	SBR	SBR05	Insurance Type Code	R	FFS Providers, use 'MC'. Local Contract Providers, use 'OT' in all instances of 2320 loop for 1-plan- Medi-Cal or Medi-Medi scenarios.	**MC** = Medi-Cal **MB =** Medicare **OT** = Other
2320	SBR	SBR09	Claim Filing Indicator Code	S	FFS Providers, use 'MC'. Local Contract Providers, use 'MC' in the first instance of 2320 loop and "11" for the second instance under the 1-plan-Medi-Cal scenario. Local Contract Providers, use 'MB' in the first instance of 2320 loop and 'MC' for the second instance, and '11' for the third instance, under the Medi-Medi scenario.	**MC** = Medi-Cal **MB =** Medicare **11** = Other Non-Federal Programs
Coordination of Benefits COB Payer Paid Amount						
2320	AMT	AMT01	Amount Qualifier Code	S		D
2320	AMT	AMT02	COB Payer Paid Amount	S	For Local Plan Contracted and FFS providers, that have previously sent claims and received remit advices from Medicare and/or private insurance, this field must be populated with the amount paid by Medicare and/or private insurance (not Medi-Cal) , even if it is zero. When Medi-Cal is the payer this segment is not required. If it is included, set the value to zero as DMH always forwards claims to Medi-Cal and receives payment from Medi-Cal.	61.28 The amount can be zero (0.00)

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Loop	Segment ID	Ref. Des.	Field Name	DMH Validation	DMH Business Rules	Example
					DMH uses this value during adjudication.	
Other Payer Patient Information						
2330A	NM1	NM108	Identification Code Qualifier	R	Always use qualifier Member ID - MI	**MI**
2330A	NM1	NM109	Other Subscriber Primary Identifier	R	**For FFS Providers only -** Effective 6-12-2008 MUST use CIN# . If SSN or other identifier is used, claim will be rejected. **For Local Contract Providers only -** Use CIN# when the payer in 2330B NM109 is Medi-Cal (PI=01). Use MIS# when the payer in 2330B NM109 is LACDMH (PI=953893470). Use client's MEDICARE ID under the Medi-Medi scenario where in 2330B NM109 the primary	12345678A , 0006991, 987654321D

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Loop	Segment ID	Ref. Des.	Field Name	DMH Validation	DMH Business Rules	Example
					payer is Medicare (PI=01192).	
Other Subscriber Secondary Information						
2330A	REF	REF01	Reference Identification Qualifier	S	When DMH is the payer (2330B), this segment is used to identify the DMH plans to charge the claim against. Always use "IG" when identifying DMH plans. For Local Contract Providers, use this in the 2nd instance of loop 2330A under the 1-plan-Medi-Cal scenario, and under the Medi-Medi scenario, use in the 3rd instance.	**IG**

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Loop	Segment ID	Ref. Des.	Field Name	DMH Validation	DMH Business Rules	Example
2330A	REF	REF02	Other Insured Additional Identifier	S	If the payer is DMH (2330B) use this segment to identify the DMH Plan ID for which the claim is to be charged against. Immediately following the last character of the Plan ID, a suffix must be added to indicate the sequence in which plans should be charged. Suffix format is: "-01", "-02", etc, where "-01" indicates the first plan to charge against and "-02" indicates the second plan to charge against. If the plan id is not valid, the claim is rejected. FFS providers may only charge against Managed Care Fund. For these providers, if any other plan id is found the claim is rejected. IS2.0 DMH business rules only allow 1 plan to be specified	2000-01
Other Payer Name						
2330B	NM1	NM108	Identification Code Qualifier	R	Use 'PI'	**PI**

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Loop	Segment ID	Ref. Des.	Field Name	DMH Validation	DMH Business Rules	Example
2330B	NM1	NM109	Other Payer Primary ID	R	Set to PI identification value for the payer. DMH uses this value to identify the payer. If the value is 953893470, the payer is DMH, If the value = '01' (zero one), the payer is Medi-Cal. If the value is '01192' the payer is Medicare. All other values are assumed to be private insurance. FFS providers must always include Medi-Cal as an other payer.	DMH = **953893470** Medical = **'01**' . This value is as per Medi-Cal's 837p mapping instructions. Medicare = **01192**
Claim Adjudication Date of Other payers						
2330B	DTP	DTP01	Date/Time Qualifier	S	Date Claim Paid	**573**
2330B	DTP	DTP02	Date Time Period Format Qualifier	S	A qualifier of D8 is normally used, but If the qualifier is RD8, DMH uses the first portion of the date (first 8 characters).	D8
2330B	DTP	DTP03	Date Time Period	S	Date the claim was adjudicated by the other payer Note: date equals to or before service date can cause HIPAA syntax error.	20091205

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Loop	Segment ID	Ref. Des.	Field Name	DMH Validation	DMH Business Rules	Example
Other Payer Patient Information						
2330C	NM1	NM109	Other Payer Patient Primary ID	S	If the payer is private insurance and the patient is not the subscriber, the patient's identification value for the insurance company is put in this field. For all other providers (Local Plan Contracted and FFS) this value is not used by DMH.	Patient's private insurance identification value
Other Payer Rendering Provider Secondary Identification						
2330E	REF	REF01	Reference ID Qualifier	S	For Local Plan Directly Operated providers, DMH uses this segment to identify the rendering provider's Medicare ID. Always set this value to '1C' to indicate the Medicare rendering provider. of all other providers (Local Plan Contracted and FFS) DMH does not use this segment.	1C
2330E	REF	REF02	Identification Code Qualifier	S	For Local Plan Directly Operated providers and if the payer is Medicare, set this value to the rendering provider's Medicare id. This value is used by DMH when sending claims to Medicare. For Local Plan Contracted and FFS providers, DMH does not use this segment. DMH does not forward claims to Medicare for Local Plan Contracted or FFS providers.	When Medicare is the Payer - set to the rendering provider's Medicare identification value.

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Loop	Segment ID	Ref. Des.	Field Name	DMH Validation	DMH Business Rules	Example
Service Line						
2400	LX	LX01	Line Counter	R	Set to 1. Just one service line per claim is allowed by DMH. Any claim with more than one service line will be rejected.	**1**
Professional Service						
2400	SV1	SV101-1	Product Or Service ID Qualifier	R	Can be HC, HE, HX, HB, etc. Please contact the EDI Testing Unit.	HC, HE, BX, HB, etc.
2400	SV1	SV101-2	Procedure Code	R	Use the appropriate HIPAA procedure code for the service. If the procedure code is invalid, the Claim is rejected. Group claims - Refer to the explanation found in the Group Claim Example.	90849 CPT Codes Link to a Group Claims example with explanation: http://dmh.lacounty.gov/hipaa/downloads/BulletinNo08-006_GroupClaims.pdf
2400	SV1	SV102	Monetary Amount	R	Put in the charge amount.	200
2400	SV1	SV103	Unit or Basis for Measurement Code	R	Put in the appropriate code	F2, MJ, UN

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Loop	Segment ID	Ref. Des.	Field Name	DMH Validation	DMH Business Rules	Example
2400	SV1	SV104	Service Unit Count	R	Set to the number of units or minutes. Use the procedure code that matches to the appropriate face to face time but the time should bill would be for face to face and other. In IS, the total amount of face to face is used to determine the appropriate procedure code but what is submitted to the State is the face to face and other time added together. For LPCP Group claims - Refer to the explanation found in the Group Claim Example. For FFS providers, the field must be 999 or less, otherwise the claim will be rejected.	15 Link to a Group Claims example with explanation: http://dmh.lacounty.gov/hipaa/downloads/BulletinNo08-006_GroupClaims.pdf
2400	SV1	SV107 - 4	Diagnosis Code Pointer	S	This value is not used by DMH, but may be used by other payers (e.g. Medi-Cal) and, as such, is recommended to be populated. For claims that include Medi-Cal as a payer (in 2320 loop) this field is used to point to the primary diagnosis specified in 2300 Healthcare Diagnosis Code loop.	1 thru 8. For example, a setting of 1 indicates the first diagnosis code in the 2300 Healthcare Diagnosis Code loop is the primary diagnosis.
2400	SV1	SV109	Yes/No Condition or Response Code	S	SV109 is the emergency aid code indicator; a "Y" value indicates the client has an emergency aid code. Put Y to turn it on. DO NOT do anything if client has no emergency aid code. Putting N in SV109 can cause HIPAA syntax error.	**Y**

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Loop	Segment ID	Ref. Des.	Field Name	DMH Validation	DMH Business Rules	Example
2400	SV1	SV111	Yes/No Condition or Response Code	S	SV111 is early and periodic screen for diagnosis and treatment of children (EPSDT). A 'Y' indicates the client has an EPSDT screening referral. Put Y to turn it on for an EPSDT claim. DO NOT do anything if it is not an EPSDT claim. Putting N in SV111 can cause HIPAA syntax error.	**Y**
Date Service Date						
2400	DTP	DTP02	Date Time Period Format Qualifier	R	A qualifier of D8 is normally used, but If the qualifier is RD8, DMH uses the first portion of the date (first 8 characters).	**D8**
2400	DTP	DTP03	Service Date	R	Set to the service date of the procedure. The service date cannot be more than a year old or the claim is rejected.. For example if the current date is 11/25/2003 and the service date is 11/24/2003, the claim will be rejected.	20031115
Reference Segment (REF) to provide EBP Codes						
2400	REF	REF01	Reference Id qualifier	R	Use when required by State law for health data reporting.	**BT**
2400	REF	REF02	Description	R	Use Codes from list provided only. Use 99 for unknown. Up to 3 codes can be used and separate each code by a hyphen (-). The code is	**REF*BT*99~** **REF*BT*01-10~** **REF*BT*56-4K-01~**

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Loop	Segment ID	Ref. Des.	Field Name	DMH Validation	DMH Business Rules	Example
					2-byte alpha-numeric. Alpha is in uppercase, numeric has leading zero. Claim will fail if this REF segment is not present. Claim will also fail for invalid code format.	

Line Note segment (NTE) to indicate duplicate override						
2400	NTE	NTE01	Note Reference Code	S	Required when override code is present. **Line note segment (NTE) is not required for FFS Providers**	**ADD**
2400	NTE	NTE02	Description	S	Duplicate override code	**76**