County of Los Angeles
Department of Mental Health

Contract Providers Transition Project (CPTP)

837I 5010 Companion Guide

Version 1.8

June 2015

DOCUMENT REVISION HISTORY

Version	Release Date	Revised by	Comments/Indicate Sections Revised
V 1.0	**09/07/2011**	**Zena Jacobi**	**5010 initial Final release**
V 1.1	**11/03/2011**	**Gordon Bunch**	Updated Business Rule for loop 2300 CLM20 **[Effective 11/07/11]**.
V1.2	**12/05/2011**	**Karen Bollow**	Added links to the IS Codes Manual for Facility Type and Delay Reason. Added a new Billing Note for Residential Claims.
V1.3	**12/12/2011**	**Karen Bollow**	Added Remaining Liability Segment and corrected the Share of Cost reference description field.
V1.4	**02/06/2012**	**Karen Bollow**	Removed Ampersand "&" as a valid character. Added clarification to the Remaining Liability segment regarding detailed adjustments.
V1.5	**06/06/2012**	**Karen Bollow**	Expanded the Claim Note description section for loop 2300 NTE02.
V1.6	**09/12/2013**	**Karen Bollow**	New Medicare intermediary payer identification.
V1.7	**09/12/2013**	**Karen Bollow**	Modified Medicare intermediary payer identification to match the payer identification on the 837P.
V1.8	**06/05/2015**	**Zena Jacobi**	Adding Health Maintenance Organization (HMO) Medicare Risk (value 16) as a Claim Filing Indicator Code in the Other Health Care provider Coordination of Benefits loop

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837I 5010 (HEALTH CARE CLAIM: INSTITUTIONAL) 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 837P - 005010X222A1 837I - 005010X223A2 835 - 005010X221A1 277CA - 005010X214	This column describes how the segment / field are 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		

837I 5010 (Health Care Claim: Institutional) Companion Guide

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Loop	Seg ID	Ref. Des.	Field Name	DMH Valid.	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.	000000020000000
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.	**000000010000000**
HEADER	ISA	ISA11	Interchange Control Standard ID (Repetition Separator)	R	Always use "^ "	**^**
HEADER	ISA	ISA13	Interchange Control Number	R	This field is required by HIPAA and is recommended to be a unique value for each file. To identify each file for a submitter, DMH business process ensures the value for the file is unique. The Interchange Control Number, ISA13, must be Identical to the associated Interchange Trailer IEA02 As per HIPAA this must be a length of nine (9)	123456789 - Unique value that is a length of 9
Functional Group Header						
HEADER	GS	GS01	Functional Identifier Code	R	Required Value "HC"	**HC**

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Loop	Seg ID	Ref. Des.	Field Name	DMH Valid.	DMH Business Rules	Example
HEADER	GS	GS02	Application Sender Code	R	Use the Application Sender Code assigned to the provider by DMH during registration process. It is an 8-byte A/N character field.	0000012
HEADER	GS	GS03	Application Receiver Code	R	Always use 00000001 for DMH Application Receiver ID. It is an 8-byte A/N character field.	**00000001**
HEADER	GS	GS04	Date	R	Use the Current Date	**CCYYMMDD**
HEADER	GS	GS05	Time	R	Use the Current Time	**HHMM**
HEADER	GS	GS06	Group Control Number	R	Please use a valid numeric value. It is recommended that a unique number is used for each 837I submission in this field. This number will be echoed in 997 responses and can be used to link 837I to the appropriate 997 response.	
HEADER	GS	GS08	Version/ Release/ Industry Identifier Code	R	Always use 005010X223A2	**005010X223A2**
Transaction Set Header						
HEADER	ST	ST01	Transaction Set Identifier	R	Required value "837"	**837**
HEADER	ST	ST02	Transaction Set Control Number	R	In order to receive a 997 transaction from BizTalk, this field must be numeric for the length of 4 (minimum) to 9 (maximum).	1234, 0011, 12345, 123456789, etc.
HEADER	ST	ST03	Implementation Convention Reference	R	Required value for the 837I Transaction '005010X223A2'	**005010X223A2**

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Loop	Seg ID	Ref. Des.	Field Name	DMH Valid.	DMH Business Rules	Example
Beginning Of Hierarchical Transaction						
HEADER	BHT	BHT02	Transaction	R	This field is required by HIPAA, but DMH does not validate nor use this field in any business process. DMH checks claim frequency (2300_CLM05-3) to determine the type of claim and only allows a claim frequency of original ("1"), resubmit ("7") or void ("8"). Therefore, even if BHT02 contains "18" (Reissue) and the claim frequency is Original, the patient account number (2300_CLM01) must be unique and the claim is processed as an original claim.	00, 18
Submitter Name						
1000A	NM1	NM108	Identification Code Qualifier	R	Must use 46.	**46**
1000A	NM1	NM109	Submitter Primary ID#	R	Electronic Transmitter Identification Number (ETIN) assigned to provider by DMH during registration process.	00000002
Submitter EDI Contact Name						
1000A	NM1	PER03	Communication Number Qualifier	S	If available, populate this field with the appropriate HIPAA qualifier for the submitters telephone or email address	TE
1000A	NM1	PER04	Communication Number Qualifier	S	If available, populate this field with the submitter's telephone number or email address.	2135551212
1000A	NM1	PER05	Communication Number Qualifier	S	If available populate this field with the appropriate HIPAA qualifier for the submitters telephone or email address	EM
1000A	NM1	PER06	Communication Number Qualifier	S	If available, populate this field with the submitter's telephone number or email address.	subdept@subcompany.com

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Loop	Seg ID	Ref. Des.	Field Name	DMH Valid.	DMH Business Rules	Example
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	**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	Billing Provider Identifier	R	LAC-DMH ensures the qualifier and identifier combination are valid. LAC-DMH will also apply the NPI check digit algorithm to ensure valid NPI format.	Billing Provider NPI
2010AA	REF	REF01	Reference Identification Qualifier	R	When NPI is used, must ALSO provide 'EI' for Employer's Identification Number	**EI** - Employer's Identification Number
2010AA	REF	REF02	Billing Provider Additional Identifier	R	Use the Billing Providers EIN	950002390

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Loop	Seg ID	Ref. Des.	Field Name	DMH Valid.	DMH Business Rules	Example
Subscriber Information						
2000B	SBR	SBR01	Payer Responsibility Sequence Number	R	Set to the appropriate payment responsibility for DMH. DMH is always the payer of last resort. Please see the explanations and examples in the 2320 Other Subscriber Information loop entry in this Companion Guide under the heading Coordination of Benefit Scenarios.	**P Primary** **S Secondary** **T Tertiary** **A Payer 4** **B Payer 5** **C Payer 6** **D Payer 7** **E Payer 8** **F Payer 9** **G Payer 10** **H Payer 11**
2000B	SBR	SBR02	Relationship Code	R	DMH subscribers are always the patient. Therefore, never send the 2000C loop. Always set this field to 18.	**18**
2000B	SBR	SBR04	Name	R	Use the appropriate Plan ID. If the Plan ID is not valid the claim will be rejected. FFS Providers: may only bill to the Managed Care Fund (1001). If any other Plan ID is found the claim will be rejected.	1000
2000B	SBR	SBR09	Claim Filing Indicator Code	S	LAC-DMH requires this value. Always use '11'.	**11**
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 digit DMH client ID. If the client id is not valid, the claim will be rejected.	0123456

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Loop	Seg ID	Ref. Des.	Field Name	DMH Valid.	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.	**550 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**
2010BC	N4	N403	Payer ZIP Code	S	The address is not used by DMH and is provided for informational purposes only.	**90020**
2010BC	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	Seg ID	Ref. Des.	Field Name	DMH Valid.	DMH Business Rules	Example
Claim Information						
2300	CLM	CLM01	Patient Account Number	R	This value must be unique each time. Please refer to the 5010 837I Implementation Guide for details. It is an alpha-numeric field with maximum length of 20 bytes. This value must be unique for all claims received by a submitter, which includes original, replacement and void claims. The combination of Submitter ID (1000A_NM109) and Patient Account Number (2300-CLM01) must be unique for all claims. Any duplicates will be rejected. For replacement claims, use 2300_REF_OriginalReferenceNumberICN/DCN and set 2300_REF01__ReferenceIdentificationQualifier attribute to the claim id that is being replaced. The IS only accepts replacement claims if the claim in this attribute was already denied. For void claims, use 2300_REF_OriginalReferenceNumberICN/DCN and set 2300_REF01__ReferenceIdentificationQualifier attribute to the claim id that is being voided. The IS only accepts voided claims if the claim in this attribute has not been denied.	X1234567-000089-0109

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Loop	Seg ID	Ref. Des.	Field Name	DMH Valid.	DMH Business Rules	Example
2300	CLM	CLM05-1	Facility Type Code	R	DMH validates that the Billing Provider is contracted to provide the billed procedure code with modifiers in the specified facility types. If the procedure code, modifiers and facility type are not found for that billing provider, the claim will be rejected. Refer to the IS Codes Manual for a list of valid Facility Type Codes. URL to locate IS Codes Manual: http://lacdmh.lacounty.gov/hipaa/index.html	11
2300	CLM	CLM05-3	Claim Frequency Code	R	DMH only accepts original ('1'), replacement ('7'), or void ('8') claims. If corrected ('6') claims are received, they will be rejected. Please see 2300_REF_OriginalReferenceNumberICN/DCN for use with replacement and void claims.	**1** - Original Claim **7** - Replacement Claim **8** - Void claim
2300	CLM	CLM07	Provider Accept Assignment Code	R	Must submit 'A' to indicate the provider accepts assignment per the HIPAA 5010 definition.	**A**
2300	CLM	CLM08	Benefits Assignment Certification Indicator	R	Must submit 'Y'.	**Y**
2300	CLM	CLM09	Release of Information Code	R	Local Contract Providers: all values allowed. FFS Providers: Must submit 'Y' to indicate Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim per the HIPAA 5010 definition.	**Y,I**

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Loop	Seg ID	Ref. Des.	Field Name	DMH Valid.	DMH Business Rules	Example
2300	CLM	CLM20	Delay Reason Code	S	Use this code for claims submitted more than 6 months after the service date. If the claim is more than 6 months late and a delay reason code is not specified, the claim is rejected. Refer to the IS Codes Manual for a list of valid codes. URL to locate IS Codes Manual: http://lacdmh.lacounty.gov/hipaa/index.html	1
Statement Dates						
2300	DTP	DTP02	Date Time Qualifier	R	This is required by HIPAA. DMH does not use this segment	
2300	DTP	DTP03	Statement From Or To Date	R	This is required by HIPAA. DMH does not use this segment	
Admission Date and Hour						
2300	DTP	DTP02	Date Time Qualifier	R	DMH requires an admit date and time for all institutional claims.	**DT**
2300	DTP	DTP03	Admission Date and Hour	R	Specify the episode admit date and time. (CCYYMMDDHHMM) DMH ensures an episode exists for the client, service location, admit date and service dates.	200510011130

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Loop	Seg ID	Ref. Des.	Field Name	DMH Valid.	DMH Business Rules	Example
Institutional Claim Code						
2300	CL1	CL101	Admission Priority/Type Code	R	Enter the code representing the Admission Priority Code. DMH accepts the following values: 1 Emergency 2 Urgent 3 Elective 9 Information not Available	2
2300	CL1	CL102	Admission Source Code	R	Enter the code representing the Admission Source Code. DMH accepts all currently effective, assigned values.	1
2300	CL1	CL103	Patient Status Code	R	Enter the code representing the Patient (Discharge) Status. DMH accepts the following values: 01 Discharge to Home or Self Care 02 Discharged/Transferred to General Hospital for Inpatient Care 04 Discharged/transferred to intermediate care facility or assisted living facility 07 Left Against Medical Advice or Discontinued Care 20 Expired 21 Discharged/transferred to Court/Law Enforcement 30 Still Patient 43 Discharged/transferred to a Federal Health Care Facility 50 Hospice – Home 51 Hospice – Medical Facility (Certified) Providing Hospice Level of Care 65 Discharged/transferred to a Psychiatric Hospital or Psychiatric District Part Unit of a Hospital 70 Discharged/transferred to another Type of Health Care Institution not Defined Elsewhere in this Code List.	01

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Loop	Seg ID	Ref. Des.	Field Name	DMH Valid.	DMH Business Rules	Example
Original Reference Number ICN/DCN						
2300	REF	REF01	Reference ID Qualifier	S	For Replacement and Void claims this segment is required	F8
2300	REF	REF02	Claim Original Reference Number	S	For Replacement claims, specify the submitter's claim ID for the claim that is being replaced. The IS ensures that the claim ID specified in this attribute has already been denied. For Void claims, specify the submitter's claim ID for the claim that is being voided. The IS ensures that the claim ID specified in this attribute has not already been denied. 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
Claim Note for Reporting EBP Codes						
2300	NTE	NTE01	Note Reference Code	R	Use DCP for reporting the Evidence Based Practice (EBP) codes.	**DCP**

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Loop	Seg ID	Ref. Des.	Field Name	DMH Valid.	DMH Business Rules	Example
2300	NTE	NTE02	Description	R	Use codes from list provided only. Use 99 for unknown. Up to 3 codes can be used. Separate each code by a hyphen (-). Each code is 2-byte alpha-numeric. Alpha is in uppercase, numeric has leading zero. Claim will fail if this segment is not present, for invalid codes or if not in the list of valid EBP codes.	NTE*DCP*99~ NTE*DCP*01-10~ NTE*DCP*56-4K-01~
Claim Note for Other Indicators						
2300	NTE	NTE01	Note Reference Code	S	Code identifying the functional area or purpose for which note applies.	**UPI**
2300	NTE	NTE02	Description	S	Description indicates the claim is a **SED** (Healthy Families), **EPSDT Screen Referral**, **EMERGENCY** or **PREGNANCY** claim. Important Notes: Use one segment for each indicator when multiple conditions apply. An 837I Inpatient claim can ONLY use **SED**. An 837I Residential claim can use all these four descriptions. These descriptions are case sensitive when input into the 837I. Please follow exactly the same format as shown. Failure to do so will NOT trigger a negative 997 and a negative 835.	**SED** **EPSDT Screen Referral** **EMERGENCY** **PREGNANCY**
Billing Note for Residential Claim						
2300	NTE	NTE01	Note Reference Code	S	Code identifying the functional area or purpose for which note applies.	**ADD**

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Loop	Seg ID	Ref. Des.	Field Name	DMH Valid.	DMH Business Rules	Example
2300	NTE	NTE02	Description	S	An indicator that the provider of service reported on this claim acknowledges the performance of the service and authorizes payment, and that a signature is on file in the provider's office. This segment is required on all Residential claims and the value of this field must be "SIGNATURE ON FILE". If not required, do not send.	**SIGNATURE ON FILE**
Share of Cost (SOC) - Value Information – to report patient paid amount						
2300	HI	HI01-01	Code List Qualifier Code	S	DMH expects to receive "BE" value when reporting patient paid amount.	**BE**
2300	HI	HI01-02	Value Code	S	DMH expects to receive "FC" value when reporting patient paid amount.	**FC**
2300	HI	HI01-05	Value Code Amount	S	Enter dollar amount the patient has paid.	125.43
Attending Provider						
2310A	NM1	NM101	Entity Identifier Code	R	The attending provider loop is always required.	**71**
2310A	NM1	NM108	Identification Code Qualifier	R	This field is required by HIPAA - NPI use	**XX**

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Loop	Seg ID	Ref. Des.	Field Name	DMH Valid.	DMH Business Rules	Example
2310A	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. The claim will reject if there are multiple instances of the Attending Provider NPI in the IS Rendering Provider table.	Attending Physician NPI 1123456789
Attending Provider Specialty Information						
2310A	PRV	PRV03	Provider Taxonomy Code	R	Enter the valid Taxonomy for the Rendering Provider. DMH ensures the Taxonomy is valid I.S. Taxonomy.	2084P0800X
Other Subscriber Information						

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2320	SBR	SBR01	Payer Resp. Seq. Number Code	R	Coordination of Benefit Scenarios OHC / Medicare/ Medical / LACDMH **P S T A (2000B Loop)** Medicare / Medical / LACDMH **P S T (2000B Loop)** Medical / LACDMH **P S (2000B Loop)** LACDMH (Sole Payer) **P (2000B Loop only)** **Note: 2320/2330 loops are NOT used when LACDMH is the sole payer.**	**P Primary** **S Secondary** **T Tertiary** **A Payer 4** **B Payer 5** **C Payer 6** **D Payer 7** **E Payer 8** **F Payer 9** **G Payer 10** **H Payer 11**
2320	SBR	SBR09	Claim Filing Indicator Code	R	Use MC when the payer in this iteration of the 2320 loop is Medi-Cal. Use MB when the payer in this iteration of the 2320 loop is Medicare. Use 16 when the payer in this iteration of the 2320 loop is a Medicare HMO plan. Use 11 for all other payers.	**MC** = Medi-Cal **MB =** Medicare **16** = HMO Medicare Risk **11** = Other Non-Federal Programs

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Loop	Seg ID	Ref. Des.	Field Name	DMH Valid.	DMH Business Rules	Example
Claim Level Adjustments – CAS segment is not applicable for Fee-For-Service Providers, do not send						
2320	CAS	CAS01	Claim Adjustment Group Code	S	For use when OHC or Medicare is used. Code identifying the general category of payment adjustment.	**CODE DEFINITION** **CO Contractual Obligations** **CR Correction and Reversals** **OA Other adjustments** **PI Payer Initiated Reductions** **PR Patient Responsibility**

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Loop	Seg ID	Ref. Des.	Field Name	DMH Valid.	DMH Business Rules	Example
2300	CAS	CAS02	Claim Adjustment Reason Code	S	Code identifying the detailed reason the adjustment was made.	Please use the code from 835 or paper remittance advice returned from OHC or Medicare. Washington Publishing Company's Claim Adjustment Reason Codes are used by payers.
2320	CAS	CAS03	Monetary Amount	S	CAS03 is the amount of adjustment.	Remittance amount not paid. Amount denied by OHC or Medicare. Please use the exact amount returned in 835 or paper remittance advice from OHC or Medicare.
Coordination of Benefits COB Payer Prior Payment						
2320	AMT	AMT01	Amount Qualifier Code	S	Use **D** to report amount paid by Medicare/OHC. This amount will be used for balancing processing. Must supply even if the amount is zero.	**D**

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Loop	Seg ID	Ref. Des.	Field Name	DMH Valid.	DMH Business Rules	Example
2320	AMT	AMT02	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 the payer, 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. DMH uses this value during adjudication. **Detailed Adjustments note** Total claim amount (CLM02) must equal sum of paid amount (AMT02 in loop 2320) and all adjustment amounts (CAS in 2320). Otherwise the claim will be denied because the claim is not in balance.	50.50 The amount can be zero (0.00)
Remaining Liability						
2320	AMT	AMT01	Amount Qualifier Code	S	Use **EAF** to report the remaining liability after adjudication by Medicare or OHC. DMH requires this segment when the payer in this loop has adjudicated the claim.	**EAF**

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Loop	Seg ID	Ref. Des.	Field Name	DMH Valid.	DMH Business Rules	Example
2320	AMT	AMT02	Remaining Liability	S	For Local Plan Contracted and FFS providers, that have previously sent claims and received remit advices from Medicare and/or private insurance, this field must be populated with the provider's judgment of the remaining liability. When Medi-Cal is the payer this segment should not be sent. The amount in this segment will not be used for the calculation of COB detailed Adjustments balancing.	49.50
Other Insurance Coverage Information						
2320	OI	OI03	Benefits Assignment Certification Indicator	R	Must submit 'Y'.	**Y**
2320	OI	OI06	Release of Information Code	R	Local Contract Providers: all values allowed. FFS Providers: Must submit 'Y' to indicate Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim per the HIPAA 5010 definition.	**Y, I**
Other Payer Subscriber Information						
2330A	NM1	NM108	Identification Code Qualifier	R	Always use qualifier Member ID - MI	**MI**

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Loop	Seg ID	Ref. Des.	Field Name	DMH Valid.	DMH Business Rules	Example
2330A	NM1	NM109	Other Subscriber Primary Identifier	R	This value must contain the subscriber's identifier for the payer. When DMH forwards claims to other payers, this value will be used in 2010BA_NM109. When Medi-Cal is the Payer, set this field to the subscriber's Medi-Cal ID (CIN #). When Medicare is the Payer, set this field to the subscriber's Medicare ID (HIC #). When Other Insurance is the Payer, set this field to the subscriber's Insurance ID.	12345678A , 912345678A
Other Payer Name						
2330B	NM1	NM108	Identification Code Qualifier	R	Use 'PI'	Use "PI"
2330B	NM1	NM109	Other Payer Primary ID	R	Set to PI identification value for the payer. DMH uses this value to identify the payer. If the value = '01' (zero one), the payer is Medi-Cal. If the value is '01182' the payer is Medicare. All other values are assumed to be private insurance.	Medi-Cal = '01'. This value is as per Medi-Cal's mapping instructions. Medicare = '**01182**'.

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Loop	Seg ID	Ref. Des.	Field Name	DMH Valid.	DMH Business Rules	Example
Other Payer Claim Adjudication Date						
2330B	DTP	DTP01	Date/Time Qualifier	S	Date Claim Paid	**573**
2330B	DTP	DTP02	DateTime Period Format Qualifier	S	A qualifier of D8 is normally used, but If the qualifier is RD8, DMH uses the first portion of the date (first 8 characters).	**D8**
2330B	DTP	DTP03	Date Time Period	S	Date the claim was adjudicated by the other payer. Note: date equals to or before service date will cause HIPAA syntax errors.	**20101205**
Service Line						
2400	LX	LX01	Line Counter	R	Set to 1. Just one service line per claim is allowed by DMH. Any claim with more than one service line will be rejected.	**1**
Institutional Service						
2400	SV2	SV202-1	Product Or Service ID Qualifier	R	Must be HC.	**HC**
2400	SV2	SV202-2	Procedure Code	R	Use the appropriate HIPAA procedure code for the service. If the procedure code is invalid, the Claim is rejected.	0101
2400	SV2	SV202-3 thru SV202-6	Procedure Code Modifier	S	Use the appropriate Procedure Code Modifier(s). IS Codes manuals are available from the IS Home Page: http://dmh.lacounty.gov/hipaa/index.html	Example: SV2*0100*HC:0100:HE:HT*
2400	SV2	SV204	Unit or Basis for Measurement Code	R	Set to the HIPAA allowable unit measurement code for the procedure code. DMH processes DA only.	**DA**

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Loop	Seg ID	Ref. Des.	Field Name	DMH Valid.	DMH Business Rules	Example
2400	SV2	SV205	Service Unit Count	R	Set to the number of days of service. DMH ensures that the number of days matches the service date range in 2400_DTP03__ServiceDate	15
Service Date						
2400	DTP	DTP02	Date Time Period Format Qualifier	R	DMH uses this segment to specify the service start and end date for all claims. Always use RD8	**RD8**
2400	DTP	DTP03	Service Date	R	Specify the service begin and end date. Service dates specified in the claim must be within a calendar month. If the service dates cross calendar months, the claim will be rejected. Therefore if a service spans calendar months, separate claims must be sent for the relevant service dates within each calendar month. The service date From and To portion can be the same when the service is for a single day or if the episode admit, service and discharge date are the same. When the service spans multiple days, do not include the Discharge Date in the service date. DMH does not adjudicate for discharge date. DMH ensures an episode exists for the client, service location, admit date and service dates.	20051008-20051015 - Multiple Day service - In this example, please note that the admit date is 20051008 and the discharge date is 20051016 which cannot be included, so the last date of service is reported as 20051015. 20050903-20050903 - Single day service