ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)

Companion Document
and
Transaction Specifications
for HIPAA
837 Claim Transactions

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Revision History

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1. Introduction

1.1. Document Purpose

Companion Documents

HIPAA Transaction Companion Documents are available to electronic trading partners (health plans, program contractors, providers, third party processors, and billing services) to clarify information on HIPAA-compliant electronic interfaces with AHCCCS. The following Companion Documents are being produced:

- 834 Enrollment and 820 Capitation Transactions
- 270 Eligibility Verification and 271 Eligibility Response Transactions
- *837 Claims Transactions*
- 837 and NCPDP Encounter Transactions
- 835 Electronic FFS Claims Remittance Advice Transaction
- 276 Claim Status Request and 277 Response Transactions
- 277 Unsolicited Claim Status Transaction (Encounters)
- 278 Prior Authorization Transaction

The ASC X12 837 Claim Transactions for professional, dental, and institutional claims are covered in this document.

HIPAA Overview

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) require the federal Department of Health and Human Services to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. The Act also addresses the security and privacy of health data. The long-term purpose of these standards is to improve the efficiency and effectiveness of the nation's health care system by encouraging widespread use of standard electronic data interchanges in health care.

The intent of the law is that all electronic transactions for which standards are specified must be conducted according to the standards. These standards were reviewed through a process that included significant public and private sector input prior to publication in the Federal Register as Final Rules with legally binding implementation time frames.

Covered entities are required to accept transmissions in the standard format and must not delay a transaction or adversely affect an entity that wants to conduct standard transactions electronically. For HIPAA, both AHCCCS and its fee-for-service providers are covered entities.

Document Objective

This Claims Companion Document provides information related to electronic submission of 837 Claims Transactions to AHCCCS by contracted providers and billing agents. Three distinct claim transaction formats are documented:

- 837 Professional
- 837 Dental
- 837 Institutional

For each of these formats, this Companion Guide tells claim submitters how to prepare and maintain a HIPAA compliant claim submission interface, including detailed information on populating claim data elements for submission to AHCCCS. The Companion Guide supplements the HIPAA Implementation Guide for each transaction type with information specific to AHCCCS and its trading partners.

Intended Users

Companion Documents are intended for the technical staffs of all types of providers and billing agents that are responsible for electronic transaction exchanges. They also offer a statement of HIPAA Transaction and Code Set Requirements from an AHCCCS perspective.

Only providers that submit claims to AHCCCS electronically are subject to HIPAA Transaction and Code Set requirements.

Relationship to HIPAA Implementation Guides

Companion Documents supplement the HIPAA Implementation Guides for each of the HIPAA transactions. Rules for format, content, and field values can be found in the Implementation Guides. This document describes the AHCCCS FTP environment and, for 837 Claim Transactions, edit and interchange conventions. It also provides specific information on the fields and values required for transactions sent to AHCCCS.

Companion Documents are intended to supplement rather than replace the standard HIPAA Implementation Guide for each transaction set. Information in these documents is not intended to:

- Modify the definition, data condition, or use of any data element or segment in the standard Implementation Guides.
- Add any additional data elements or segments to the defined data set.
- Utilize any code or data values that are not valid in the standard Implementation Guides.
- Change the meaning or intent of any implementation specifications in the standard Implementation Guides.

Disclaimer

This Companion Document is a technical document describing the specific technical and procedural requirements for interfaces between AHCCCS and its trading partners. It does not supersede either the health plan contracts or the specific procedure manuals for various operational processes. If there are conflicts between this document and health plan contracts or operational procedure manuals, the contract or procedure manual will prevail.

Substantial effort has been taken to minimize information conflicts. However, AHCCCS, the Information Services Division, or its employees will not be liable or responsible for any errors or expenses resulting from the use of information in this document. If you believe there is an error in the document, please notify the AHCCCS Information Services Division immediately.

1.2. Contents of this Companion Document

Introduction	Section 1 provides general information on Companion Documents and HIPAA and outlines the information included in the remainder of the document.
Transaction Overview	Section 2 provides an overview of the transaction or transactions included in this Companion Document including information on: ▪ The purpose of the transaction(s) ▪ The standard Implementation Guide for the transaction(s) ▪ Replaced and impacted AHCCCS files and processes ▪ Transmission schedules
Technical Infrastructure	Section 3 provides a brief statement of the technical interfaces required for trading partners to communicate with AHCCCS via electronic transactions. Readers are referred to the AHCCCS Electronic Claim Submission and Electronic Remittance Advice Requirements document for operational information.
Transaction Standards	Section 4 provides information relating to the transactions included in this Companion Document including: ▪ General HIPAA transaction standards ▪ Data interchange conventions applicable to the transactions ▪ Procedures for acknowledgment transactions ▪ Procedures for handling rejected transmissions and transactions
Transaction Specifications	Section 5 provides specific information relating to the transaction(s) in this Companion Document including: ▪ A statement of the purpose of transaction specifications between AHCCCS and other covered entities ▪ AHCCCS-specific data requirements for the transaction(s) at the data element level The Data Requirements portion of each Transaction Specification defines in detail how HIPAA Transactions are formatted and populated for exchanges with AHCCCS. This section covers transaction data elements about which AHCCCS provides information not to be found in the standard Implementation Guide.

2. 837 Claim Transactions

2.1. Transaction Overview

Claim Submission

The HIPAA compliant 837 Claim Transactions are designed for use by health care providers to electronically submit fee-for-service claims to health care payers. AHCCCS has adopted the HIPAA-mandated 837 Claim Transactions for use by fee-for-service providers that are paid directly by the Agency. Providers and other entities that submit claims to AHCCCS electronically are required to use the 837's formats and code sets.

The 837 Transaction has three separate formats for professional, dental, and institutional claims. Each of the formats has hundreds of data elements that describe medical services. AHCCCS pharmacy claims are processed by a contracted pharmacy benefit manager (PBM) and are not submitted directly to AHCCCS for adjudication.

Electronic claim submission by providers or their billing agents and claim adjudication by AHCCCS are not changed by HIPAA mandates. What have changed significantly are the formats of the submitted claims and the code sets used to describe claim data. In the HIPAA compliant environment, AHCCCS accepts claims in 837 formats and relies on a translator to bring them into its Prepaid Medical Management Information System (PMMIS) for adjudication and reporting.

Claim Adjudication

Within the AHCCCS System, claim adjudication and reporting will continue with modifications (state-only HCPCS Procedure Codes, for example, will no longer be recognized). 837 formats can accommodate many more data elements than the Electronic Claim Submission File formerly used by AHCCCS. The Agency has enhanced its data retention and reporting capabilities and will use supplementary claim data (including coordination of benefits data) for reporting and analysis. Basic claim data elements, including identifiers, dates, Diagnosis Codes, and Procedure Codes, remain unchanged.

Following claim adjudication, two additional HIPAA transaction sets tell submitting providers adjudication results and current claim statuses. They are the 835 Claim Remittance Advice Transaction and the 276/277 Claim Status Request and Response Transactions. The 835 Transaction supplements the pre-HIPAA AHCCCS electronic Remittance Advice and tells providers adjudication results and payment amounts by claim and service line. The 276/277 Transaction Set permits providers to inquire as to the current status of selected claims whether or not they have completed adjudication.

Processes Replaced or Impacted

Replaced Processes

- None

Impacted Processes

- Claims from contracted fee-for-service providers now have HIPAA compliant transaction formats and code sets.
- Submitters of electronic claims receive remittance advices from AHCCCS with the HIPAA compliant 835 Transaction.

The impacted processes will continue to function but will be changed so that they meet all HIPAA data and/or format compliance requirements.

2.2. 837 Claims Transactions

Purpose

The purpose of the three types of 837 Claims Transactions is to enable medical providers of all types (with the exception of pharmacy) to submit claims for payment for services. To some extent, 837 Transactions reflect HCFA-1500, UB-92, and American Dental Association (ADA) claim formats, with the addition of many supplementary and specialized data structures.

AHCCCS uses HIPAA compliant 837 Transactions for both fee for service claims and encounters. This Companion Document deals only with claims submitted directly to AHCCCS.

Contracted fee-for-service providers or their billing agents transmit 837 Claim Transactions in batch mode through the AHCCCS File Transfer Protocol (FTP) Server. AHCCCS follows the procedures described in Sections 4.5, Acknowledgement Procedures, and 4.6, Rejected Transmissions and Transactions, to acknowledge, accept, or reject electronic 837 Claim Transactions.

Standard Implementation Guides

The Standard Implementation Guides for Claim Transactions are:

- 837 Health Care Claim: Professional (004010X098)
- 837 Health Care Claim: Dental (004010X097)
- 837 Health Care Claim: Institutional (004010X096)

For 837 Transactions, AHCCCS incorporates all approved Addenda. Transmission Type Codes for production transactions that follow standards as modified by Addenda are:

- ASC X12N 837 Professional (004010X098A1)
- ASC X12N 837 Dental (004010X097A1)
- ASC X12N 837 Institutional (004010X096A1)

Submission Schedule

Claim submitters can transmit 837 Transactions or "batches" of claims to AHCCCS at any time during the day or night. AHCCCS processes claims every evening, one batch at a time.

AHCCCS sends 835 Remittance Advice Transactions to claim submitters that request them on a weekly basis. They are issued at the same time as claim payments. Providers can use 276 Claim Status Request Transactions to inquire about the current status of a claim at any time and receive 277 Claim Status Response Transactions in return.

3. Technical Infrastructure and Procedures

3.1 Technical Environment

AHCCCS Data Center Communications Requirements

Trading partners connect to AHCCCS by going from the Internet through a Virtual Private Network (VPN) Tunnel to the AHCCCS File Transfer Protocol (FTP) Server. In standard software-to-hardware VPN connections, VPN client software is installed and configured on each machine at the client site that requires FTP access. Software to establish provider computers as VPN Clients is available from the sources documented in the AHCCCS Electronic Claim Submission and Electronic Remittance Advice Requirements document. Detailed information on FTP and VPN setups also appears in that manual.

Technical Assistance and Help

The AHCCCS Information Services Division (ISD) Customer Support Center provides technical assistance related to questions about electronic claims submission or data communications interfaces. All calls result in Ticket Number assignment and problem tracking. Contact information is:

- **Telephone Number:** (602) 417-4451
- **Hours:** 8:00 AM – 5:00 PM Arizona Time, Mondays through Fridays
- **Information required for initial call:**
  - Topic of Call (VPN setup, FTP procedures, etc.)
  - Name of caller
  - Organization of caller
  - Telephone number of caller
  - Nature of problem (connection, receipt status, etc.)
- **Information required for follow up call(s):**
  - Ticket Number assigned by the Customer Support Center

3.2 Directory and File Naming Conventions

FTP Directory Naming Convention

The current structure on the FTP server is designed to provide logical access to all files, ease troubleshooting searches, and simplify security for account set ups and maintenance. Current FTP Directory file naming conventions are as follows:

FTP\Submitter ID\Claims\(ECSin\ECSout)\(Prod\Test)

- Submitter ID – The 5 digit Submitter ID assigned by AHCCCS.
- Claims – The default directory name indicating 837 Claims Transactions.
- ECSin – The default directory name indicating inbound data.
- ECSout – The default directory name indicating outbound data.
- Prod – The default directory name indicating it is the production environment.
- Test – The default directory name indicating it is the test environment.

File Naming Conventions

837 Transaction

The 837 Transaction has three separate formats for professional, dental, and institutional claims. Refer to Section 5, 837 Transaction Specifications, for more information.

CLM.MMDDYY.HHMMSS.837

- CLM is the file type.
- MMDDYY is the date processed.
- HHMMSS is the time processed.
- 837 is the Transaction type.

TA1 Interchange Acknowledgement Transactions

Trading partners can use the TA1 Transaction to acknowledge receipt of transmissions or interchanges of X12 Transactions and to tell AHCCCS of problems in the ISA/IEA Interchange Envelope. Refer to Section 4.5, Acknowledgement Procedures, for additional information.

MMDDYY.000000000.TA1

- MMDDYY is the process date.
- 000000000 is the unique 9 character Interchange Control Number created for every file AHCCCS sends to the trading partner regardless of the transaction type.
- TA1 is the acknowledgement type.

997 Functional Acknowledgement Transactions

A 997 can be sent as an acknowledgement for each GS/GE Envelope or Functional Group of one or more transactions within the interchange or to report on some types of syntactical errors. Refer to Section 4.5, Acknowledgement Procedures, for additional information.

MMDDYY.000000000.997

- MMDDYY is the process date.
- 000000000 is the unique 9 character Interchange Control Number created for every file AHCCCS sends to the trading partner regardless of the transaction type.
- 997 is the acknowledgement type.

824 Implementation Guide Reporting Transactions

For transmissions that are valid on the interchange level, the translator edits transactions and uses 824 Implementation Guide Reporting Transactions to report problems. Refer to Section 4.5, Acknowledgement Procedures, for additional information.

MMDDYY.000000000.824

- MMDDYY is the process date.
- 000000000 is the unique 9 character Interchange Control Number created for every file AHCCCS sends to the trading partner regardless of the transaction type.
- 824 is the acknowledgement type.

4. Transaction Standards

4.1 General Information

HIPAA Requirements

HIPAA standards are specified in Implementation Guides for each transaction set and in authorized Implementation Guide Addenda. The second draft Addenda Documents for the three types of 837 Transactions have been published in final form in February 2003. In this Companion Document, AHCCCS uses Version 4010 837 Transactions as modified by final Addenda.

An overview of requirements specific to each transaction can be found in each Implementation Guide. Implementation Guides contain information related to:

- The format and content of interchanges and functional groups of transactions
- The format and content of the Header, Detail, and Trailer Segments specific to the transaction
- Code sets and values authorized for use in the transaction

Companion Documents can be seen as a bridge between Implementation Guides and claim requirements specific to AHCCCS. For claims, this Companion Document, in combination with the Implementation Guides, tells how to prepare data in HIPAA standard formats for submission to AHCCCS.

Size of Transmissions/ Batches

Implementation Guides for 837 Transactions recommend a maximum of 5,000 claims per transaction. If submitters have more than 5,000 claims, they should be submitted within separate 837 Transactions.

4.2 Data Interchange Conventions

Overview of Data Interchange

When receiving 837 Claim Transactions from providers, AHCCCS follows standards developed by the Accredited Standards Committee (ASC) of the American National Standards Institute (ANSI). These standards involve Interchange (ISA/IEA) and Functional Group (GS/GE) Segments or "outer envelopes". All 837 Transactions are enclosed in transmission level ISA/IEA envelopes and, within transmissions, functional group level GS/GE envelopes. The segments and data elements used in outer envelopes are documented in Appendix B of Implementation Guides and later in this section.

Transaction Specifications that say how individual data elements are populated by AHCCCS on ISA/IEA and GS/GE envelopes are shown in the table beginning on the next page. This document assumes that security considerations involving user identifiers, passwords, and encryption procedures are handled by the AHCCCS FTP Server and not through the ISA Segment.

The ISA/IEA Interchange Envelope, unlike most ASC X12 data structures, has fixed fields of a fixed length. Blank fields cannot be left out.

Envelope Specifications Tables

Definitions of table columns follow:

Loop ID
The Implementation Guide's identifier for a data loop within a transaction. Always "NA" in this situation because segments in outer envelopes have segments and elements but not loops.

Segment ID
The Implementation Guide's identifier for a data segment.

Element ID
The Implementation Guide's identifier for a data element within a segment.

Element Name
A data element name as shown in the Implementation Guide. When the industry name differs from the Data Element Dictionary name, the more descriptive industry name is used.

Element Definition/Length
How the data element is defined in the Implementation Guide. For ISA and IEA Segments only, fields are of fixed lengths and are present whether or not they are populated. For this reason, field lengths are provided in this

column after element definitions.

Valid Values
The valid values from the Implementation Guide that are used by AHCCCS.

Definition/Format
Definitions of valid values used by AHCCCS and additional information about AHCCCS data element requirements.

ISA/IEA INTERCHANGE CONTROL ENVELOPE TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition/Length**	**Valid Values**	**Definition/Format**
ISA INTERCHANGE HEADER						
NA	ISA	ISA01	AUTHORIZATION INFORMATION QUALIFIER	Code to identify the type of information in the Authorization Information Element/2 Characters	00	No Authorization Information Present
NA	ISA	ISA02	AUTHORIZATION INFORMATION	Information used for additional identification or authorization of the interchange sender or the data in the interchange; the type of information is set by the Authorization Information Qualifier/10 characters		Leave field blank – not used by AHCCCS.
NA	ISA	ISA03	SECURITY INFORMATION QUALIFIER	Code to identify the type of information in the Security Information/2 characters	00	No Security Information present
NA	ISA	ISA04	SECURITY INFORMATION	This field is used for identifying the security information about the interchange sender and the data in the interchange; the type of information is set by the Security Information Qualifier/10 characters		Leave field blank – not used by AHCCCS.
NA	ISA	ISA05	INTERCHANGE ID QUALIFIER	Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified/2 characters	ZZ	Mutually Defined
NA	ISA	ISA06	INTERCHANGE SENDER ID	Identification code published by the sender for other parties to use as the receiver ID to route data to them; the sender always codes this value in the sender ID element/15 characters		The five-digit Claim Submitter ID assigned by AHCCCS
NA	ISA	ISA07	INTERCHANGE ID QUALIFIER	Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified/2 characters	ZZ	Mutually Defined
NA	ISA	ISA08	INTERCHANGE RECEIVER ID	Identification code published by the receiver of the data; When sending, it is used by the sender as their sending ID, thus other parties sending to them will use this as a receiving ID to route data to them/15 characters		“AHCCCS” followed by the nine-digit AHCCCS Federal Tax ID number (866004791)
NA	ISA	ISA09	INTERCHANGE DATE	Date of the interchange/6 characters		The Interchange Date in YYMMDD format
NA	ISA	ISA10	INTERCHANGE TIME	Time of the interchange/4 characters		The Interchange Time in HHMM format

ISA/IEA INTERCHANGE CONTROL ENVELOPE TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition/Length**	**Valid Values**	**Definition/Format**
NA	ISA	ISA11	INTERCHANGE CONTROL STANDARDS IDENTIFIER	Code to identify the agency responsible for the control standard used by the message that is enclosed by the interchange header and trailer/1 character	U	U.S. EDI Community of ASC X12, TDCC, and UCS
NA	ISA	ISA12	INTERCHANGE CONTROL VERSION NUMBER	This version number covers the interchange control segments/5 characters	00401	Draft Standards for Trial Use Approved for Publication by ASC X12 Procedure Review Board through October 1997
NA	ISA	ISA13	INTERCHANGE CONTROL NUMBER	A control number assigned by the interchange sender/9 characters		The claim submitter assigns the Interchange Control Number in the rightmost six characters of this nine-character field. ISA13 must be unique within all transmissions (i.e., files) submitted to AHCCCS by the same entity. AHCCCS tracks this number to guard against duplicate file submissions. ISA13 must also be identical to the control number in Interchange Trailer element IEA02.
NA	ISA	ISA14	ACKNOWLEDGE-MENT REQUESTED	Code sent by the sender to request an Interchange Acknowledgement (TA1)/1 character	0	No Acknowledgement Requested AHCCCS does not request or expect TA1 Interchange Acknowledgement Segments from its trading partners.
NA	ISA	ISA15	USAGE INDICATOR	Code to indicate whether data enclosed is test, production or information/1 character	P or T	Production Data or Test Data
NA	ISA	ISA16	COMPONENT ELEMENT SEPARATOR	The delimiter value used to separate components of composite data elements/1 character	|	A “pipe” (the symbol above the backslash on most keyboards) is the value used by AHCCCS for component separation. Segment and element level delimiters are defined by usage in the ISA Segment and do not require separate ISA elements to identify them. Delimiter values, by definition, cannot be used as data, even within free-form messages. The following separator or delimiter values are used by AHCCCS on outgoing transactions:

ISA/IEA INTERCHANGE CONTROL ENVELOPE TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition/Length**	**Valid Values**	**Definition/Format**
						Segment Delimiter - “~’ (tilde – hexadecimal value X”7E”) Element Delimiter - “{“ (left rounded bracket – hexadecimal value X”7B”) Composite Component Delimiter (ISA16) - “|” (pipe – hexadecimal value X”7C”) These values are used because they are not likely to occur within transaction data.
IEA INTERCHANGE TRAILER						
NA	IEA	IEA01	NUMBER OF INCLUDED FUNCTIONAL GROUPS	A count of the number of functional groups included in an interchange/5 characters		The number of functional groups of transactions in the interchange
NA	IEA	IEA02	INTERCHANGE CONTROL NUMBER	A control number assigned by the interchange sender/9 characters		A control number identical to the header-level Interchange Control Number in ISA13.

GS/GE FUNCTIONAL GROUP ENVELOPE TRANSACTION SPECIFICATIONS							
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition/Length**	**Valid Value**	**Definition/Format**	**Source**
GS FUNCTIONAL GROUP HEADER							
NA	GS	GS01	FUNCTIONAL IDENTIFIER CODE	Code identifying a group of application related transaction sets	HC	Health Care Claim (837)	HIPAA Code Set
NA	GS	GS02	APPLICATION SENDER'S CODE	Code identifying party sending transmission; codes agreed to by trading partners		Repeat the Sender Identifier used in the ISA Segment.	Transmission sender
NA	GS	GS03	APPLICATION RECEIVER'S CODE	Codes identifying party receiving transmission. Codes agreed to by trading partners		Repeat the Receiver Identifier used in the ISA Segment.	Transmission sender
NA	GS	GS04	DATE	Date expressed as CCYYMMDD		The functional group creation date.	Transmission sender
NA	GS	GS05	TIME	Time on a 24-hour clock in HHMM format.		The functional group creation time.	Transmission sender
NA	GS	GS06	GROUP CONTROL NUMBER	Assigned number originated and maintained by the sender		A control number for the functional group of transactions.	Transaction sender
NA	GS	GS07	RESPONSIBLE AGENCY CODE	Code used in conjunction with Element GS08 to identify the issuer of the standard	X	Accredited Standards Committee X12	HIPAA Code Set
NA	GS	GS08	VERSION/ RELEASE/ INDUSTRY IDENTIFIER CODE	Code that identifies the version of the transaction(s) in the functional group		004010X098A1 (Professional) 004010X097A1 (Dental) 004010X096A1 (Institutional) AHCCCS uses Addenda versions of all HIPAA Transactions. These Version Numbers incorporate the final Addenda.	HIPAA Code Set
GE FUNCTIONAL GROUP TRAILER							
NA	GE	GE01	NUMBER OF TRANSACTION SETS INCLUDED	The number of transactions in the functional group ended by this trailer segment			Transmission sender
NA	GE	GE02	GROUP CONTROL NUMBER	Assigned number originated and maintained by the sender		This number must match the control number in GS06.	Transmission sender

4.3. Testing Procedures

Testing Procedures

Each AHCCCS trading partner is responsible for ensuring that its transactions are compliant with HIPAA mandates based on the types of testing described below.

AHCCCS encourages providers and other entities to use a third party tool to certify that the entity can produce and accept HIPAA compliant transactions. Success is determined by the ability to pass the seven types of compliance tests listed below. The initial four of the seven types of testing are also used as categories for edits performed by the AHCCCS translator. The testing types have been developed by the Workgroup for Electronic Data Interchange (WEDI), a private sector organization concerned with implementation of electronic transactions. They are:

1. Integrity Testing
   This kind of testing validates the basic syntactical integrity of the provider's EDI file.

2. Implementation Guide-Requirements Testing
   This kind of testing involves requirements imposed by the transaction's HIPAA Implementation Guide, including validation of data element values specified in the Guide.

3. Balancing Testing
   Balancing verification requires that summary-level data be numerically consistent with corresponding detail level data, as defined in the transaction's Implementation Guide.

4. Inter-Segment Situation Testing
   Situation testing validates inter-segment situations specified in the Implementation Guide (e.g., for accident claims, an Accident Date must present).

5. External Code Set Testing
   This kind of testing validates code set values for HIPAA mandated codes defined and maintained outside of Implementation Guides. HCPCS Procedure Codes and NDC Drug Codes are examples.

6. Product Type or Line of Service Testing
   This kind of testing validates specific requirements defined in the Implementation Guide for specialized services such as durable medical equipment (DME).

7. Trading Partner-Specific Testing
   Testing of trading partner requirements involves Implementation Guide requirements for transactions to or from Medicare, Medicaid and Indian Health Services. For AHCCCS trading partners, trading partner requirement testing includes testing of the approaches that AHCCCS has taken to accommodate necessary data within HIPAA compliant transactions and code sets.

Test Data and Privacy

AHCCCS believes that, when possible, using real-life production data enhances the overall value of the compliance testing process. If a covered entity elects to use production data in testing, it must ensure that it remains in compliance with all federal and state privacy regulations. Data (e.g., names and identification numbers) that would make it possible to identify particular individuals should be removed or encrypted.

AHCCCS expects that patient identifiable information will be encrypted or eliminated from test data submitted to the certification testing system unless the testing system is in compliance with all HIPAA regulations concerning security, privacy, and business associate specifications.

4.4 Syntactical Edits for 837 Claims Transactions

Overview of the Syntactical Edit Process

Edits performed by the AHCCCS translator on 837 Claims Transactions ensure that incoming transactions comply with the standards documented in each transaction's HIPAA Implementation Guide. Only 837 Transactions of claims that have passed translator edits can have their claims translated and adjudicated. The translator's edits are prior to and in addition to edits performed by PMMIS. AHCCCS processes and procedures for resolution of claims pended and denied by PMMIS remain unchanged.

AHCCCS uses the 997 Functional Acknowledgement Transaction to acknowledge each functional group of 837 Transactions that has passed translator edits and the 824 Implementation Guide Reporting Transaction to inform 837 submitters of "syntactical" problems. Syntactical errors differ from "semantic" errors in that they involve data structures rather than meanings of data elements. In general, the AHCCCS translator handles syntactical edits and PMMIS handles semantic edits.

The 997 and 824 are ASC X12 Transactions that are not explicitly required by HIPAA rules but are available to perform acknowledgement and error notification functions electronically. The 997 is documented in Appendix B of every HIPAA Implementation Guide. The 824 has its own ASC (but non-HIPAA) Implementation Guide. A final version of it is available at cost ($45.00) from the Washington Publishing Company. Call Washington Publishing's Order Desk at (301) 949-9740 for information on payment procedures.

Four types of edits (in addition to preliminary edits that involve only ISA/IEA outer envelopes) are handled by the AHCCCS translator and reported on 824 Transactions. They are:

1. Integrity Edits
   This kind of edit validates the basic syntactical integrity of the incoming EDI file.

2. Implementation Guide-Requirements Edits
   This kind of edit involves requirements imposed by the transaction's HIPAA Implementation Guide, including validation of data element values specified in the Guide.

3. Balancing Edits
   Balancing verification requires that summary-level data be numerically consistent with corresponding detail level data, as defined in the transaction's Implementation Guide.

4. Inter-Segment Situation Edits
   Edits to validate inter-segment situations specified in the Implementation Guide (e.g., for accident claims, an Accident Date must be present).

In addition to carrying error codes, the 824 Transaction shows the relative location of erroneous data structures with error position designators. For a large transaction, each of the generic edit code values can be repeated in many code to element combinations.

4.5 Acknowledgment Procedures

Overview of Electronic Acknowledgment Processes

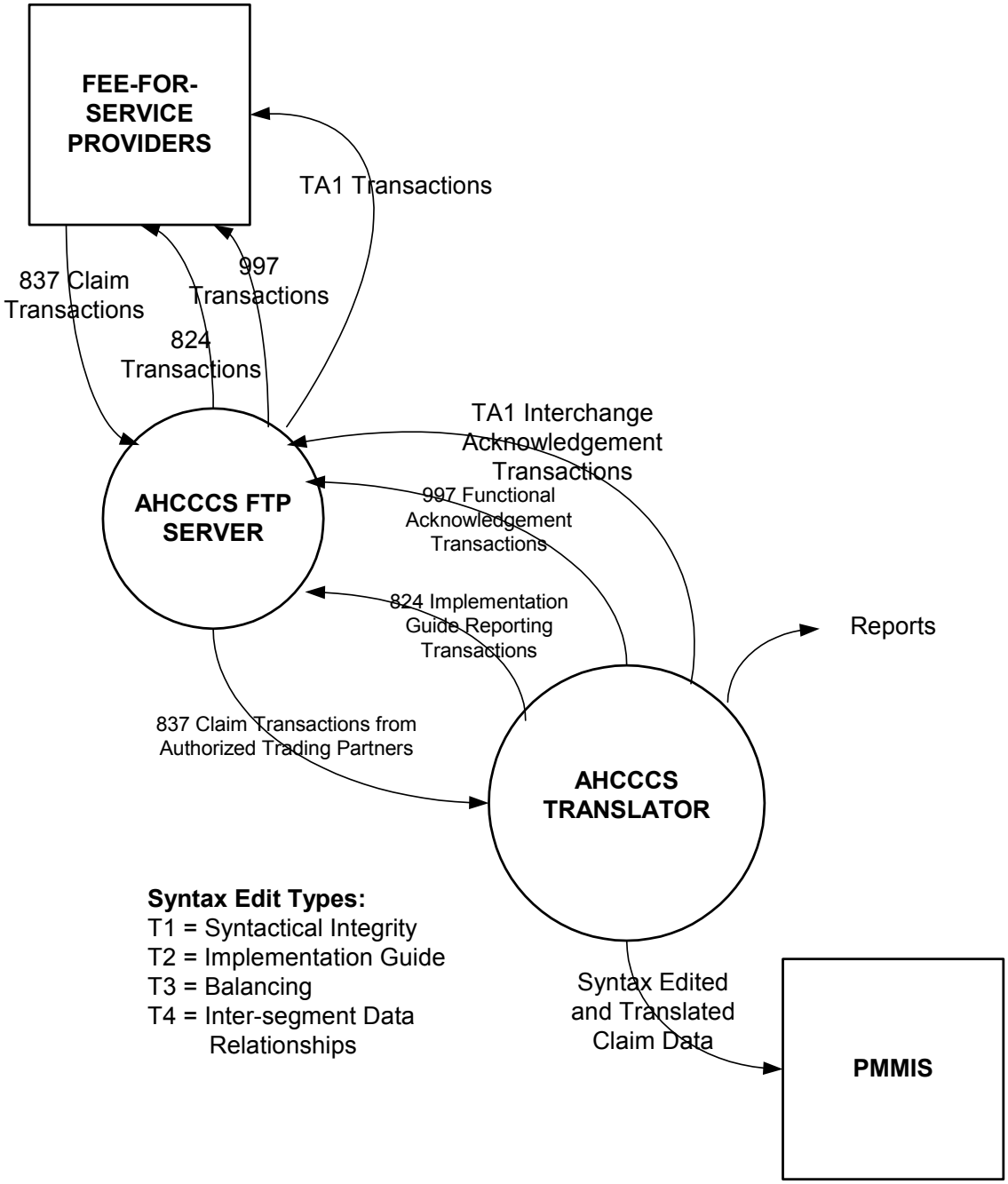
The diagram on the next page, AHCCCS Interchange Flow for 837 Claim Transactions, shows how the AHCCCS translator accepts, acknowledges, and reports problems on 837 Claims from billing providers. The AHCCCS electronic acknowledgement and error reporting process affects all three types of 837 Claim Transactions (Professional, Dental, and Institutional).

As shown at the top of the diagram, claim submitters transmit 837 Transactions to the AHCCCS File Transfer Protocol (FTP) Server. The AHCCCS translator uploads authorized electronic transmissions from the Server into the translator. At this point, the translator checks data in the ISA/IEA outer envelope of the interchange (i.e., transmission or file). It returns a TA1 Application Acknowledgement Segment to the claim submitter if there are errors in the outer envelope. When this happens, data within the transmission is not processed further.

For transmissions that are valid on the interchange level, the translator edits transactions and uses 824 Implementation Guide Reporting Transactions to report problems. The syntactical edits reported on the 824 are required to ensure that complex electronic transactions are assembled and formatted correctly. Any syntactical error in a transmission results in rejection of all claims within the transmission. For syntactically valid functional groups of transactions, 997s are returned as electronic acknowledgements.

Finally comes the actual translation of syntactically valid data from the 837 Transaction to PMMIS. Elements from 837 Transactions are moved to PMMIS Tables for claim adjudication and reporting. Values of HIPAA code sets are converted to AHCCCS code set values and/or reformatted for use in claim adjudication and reporting.

AHCCCS Interchange Flow for 837 Claim Transactions



4.6 Rejected Transmissions and Transactions

Overview of Rejection Process

Upon receiving an electronic transmission from a claim submitter, the AHCCCS translator's first action is to check for presence and validity of data in the transaction's outer envelope of ISA and IEA Interchange Header and Trailer Segments. If ISA/IEA data is valid, processing continues. If the segments have errors, the entire file is rejected with a TA1 Interchange Acknowledgement Transaction with a descriptive error code. The submitter must correct the problem in the outer envelope and resubmit all transactions in the transmission.

Next come the translator's syntactical edits on the transaction or transactions within the outer envelope. When an incoming functional group of one or more 837 Transactions has passed the translator's syntactical edits, AHCCCS returns a 997 Functional Acknowledgement Transaction with a Functional Group Acknowledge Code (AK901) of "A" (Accepted) to signify acceptance. For functional groups with errors, one or more 824 Implementation Guide Reporting Transactions reject each 837 Transaction (ST through SE) within the functional group with an Application Acknowledgement Code (OTI01) beginning with "R" (Reject).

Any error detected by the translator results in rejection of the entire transmission, even when the transmission has multiple transactions, some good and some bad. For rejected transactions, AHCCCS makes use of standard 824 error location designators to identify each erroneous data structure. The translator reports all transaction errors that it can identify. It does not stop editing when it detects a problem.

5. Transaction Specifications

5.1. 837 Transaction Specifications

Purpose

Transaction specifications are designed, in combination with HIPAA Implementation Guides, to identify data to be transmitted between AHCCCS trading partners and to identify its type and format. Data structures that are fully covered by the HIPAA Implementation Guide are not mentioned in this section. Only transaction data with submission requirements specific to AHCCCS claims is included.

The data element level Transaction Specifications in this section show in an Adjudication Usage column whether each element listed is required, required if applicable, or optional. Because the Transaction Specifications are limited to data elements not fully covered in Implementation Guides, they are not a complete list of the data elements required by AHCCCS for claim adjudication. Some required claim data elements, primarily identification and control fields, are adequately covered in one of the 837 Implementation Guides and do not appear in this document. Fields required by AHCCCS are described in the AHCCCS Fee-for-Service Provider Manual and in other AHCCCS documents.

AHCCCS claims fit the business model offered by the 837 Claim Transaction quite well. Providers submit fee-for-service claims to AHCCCS and the Agency responds by editing and adjudicating the claims, paying the provider the amounts determined by PMMIS, and reporting adjudication results on remittance advices. Under HIPPA, both the claim submission and the remittance advice components of the process are heavily impacted by new electronic transactions. However, the internal rules and algorithms that AHCCCS uses to adjudicate claims are not directly affected.

Within the Transaction Specifications Section, this document has separate subsections for Professional, Dental, and Institutional 837s. The three 837 formats are quite distinct.

Relationship to HIPAA Implementation Guides

Transaction specifications are intended to supplement the data in the Implementation Guides for each transaction set with specific information pertaining to the trading partners using the transaction set.

The information in the Transaction Specifications portion of this Companion Document is not intended to:

- Modify the definition, data condition, or use of any data element or segment in the standard Implementation Guides.
- Add any additional data elements or segments to the defined data set.
- Utilize any code or data values that are not valid in the standard Implementation Guides.
- Change the meaning or intent of any implementation specifications in the standard Implementation Guides.

5.2. Claim Transaction Specifications – Professional 837 Claims

Overview

Professional 837 Claim Transactions from AHCCCS fee-for-service providers contain data to enable AHCCCS to adjudicate professional claims, plus a number of additional fields, including fields with coordination of benefits data, that are desirable for reporting and are of interest to AHCCCS. The purpose of these Transaction Specifications are to identify critical data elements and data element values that AHCCCS needs in Claim Transactions and to let providers know how to populate and transmit electronic claim data for AHCCCS.

The specifications in this section apply only to 837 Professional Claim Transactions that providers send to AHCCCS, not to encounters submitted by health plans. Only data elements that are used by AHCCCS in ways that require explanations that go beyond information in standard HIPAA Implementation Guides are included.

General Transaction Specifications

Professional 837 Claim Transaction Specifications that are not specific to an individual data element are discussed below.

- With the exception of data elements in the Transaction Header Segment, all Professional 837 Claim Loops, Segments, and Elements are of variable length. Segments within loops and elements within segments occur only when data is present. There are no blank or null fields. In some situations, zero field values are acceptable.

- On claims submitted to AHCCCS, 837 loops, segments, and data elements that involve coordination of benefits with other payers are used to show payments made by third party carriers, including Medicare and commercial health insurance companies. AHCCCS is both the destination payer and the maker of direct payments to fee-for-service providers and their agents. AHCCCS requests that all Coordination Of Benefits (COB) payment information be provided at the line level.

- AHCCCS providers must transmit home health data on professional rather than institutional 837 Claims. Both professional and institutional 837s can accommodate home health services but only professional home health claims are processed by AHCCCS. Claims submitted on inappropriate formats are denied by AHCCCS.

Transaction Specifications Table

The Professional 837 Claim Transaction Specifications for individual data elements are shown in the table starting on the next page. Definitions of table columns follow.

Loop ID
The Implementation Guide's identifier for a data loop within a transaction.

Segment ID
The Implementation Guide's identifier for a data segment within a loop.

Element ID
The Implementation Guide's identifier for a data element within a segment.

Element Name
A data element name as shown in the Implementation Guide. When the Industry Name differs from the Data Element Dictionary name, the more descriptive Industry Name is used.

Element Definition
How the data element is defined in the Implementation Guide.

Adjudication Usage
An indication of how a data element is used in AHCCCS claim adjudication.
R = Required on all transactions of this type by either the transaction's HIPAA Implementation Guide or by current PMMIS processing.
R/A = Required if applicable – Accident Date, for example, is required if a claim's medical services result from an accident.
O = Optional – Present or not present at the discretion of the trading partner.

Valid Values
The valid values from the Implementation Guide that are used by AHCCCS.

Definition/Format
Definitions of valid values used by AHCCCS and additional information about AHCCCS data element requirements.

837 PROFESSIONAL CLAIM TRANSACTION SPECIFICATIONS							
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Adjud Usage**	**Valid Values**	**Definition/Format**
N/A	REF	REF02	Transmission Type Code	Code identifying the type of transaction or transmission included in the transaction set	R		Values specified for this element differ in the original Implementation Guide and the Addenda. AHCCCS has adopted Addenda features and is using Addenda values. Current valid values for submitting claims to AHCCCS are: Pilot Testing: 004010X098DA1 Production: 004010X098A1
1000A	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	R	46	Electronic Transmitter Identification Number (ETIN)
1000A	NM1	NM109	Submitter Identifier	Code or number identifying the entity submitting the claim	R		AHCCCS identifies submitting providers and billing agents with the five-digit Electronic Supplier Number assigned by the AHCCCS Information Services Division (ISD).
1000B	NM1	NM103	Receiver Name	Name of organization receiving the transaction	R	AHCCCS	The transaction receiver
1000B	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	R	46	Electronic Transmitter Identification Number (ETIN)
1000B	NM1	NM109	Receiver Primary Identifier	Primary identification number for the receiver of the transaction	R	866004791	AHCCCS Federal Tax ID
2010AA	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	R	24 or 34	Employer's Identification Number or Social Security Number The qualifier for the Federal Tax ID used by the billing provider.
2010AA	NM1	NM109	Billing Provider Identifier	The code that identifies the billing provider	R		The billing provider's EIN or SSN.
2010AA	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	R	1D 1C	Medicaid Provider Number Medicare Provider Number

837 PROFESSIONAL CLAIM TRANSACTION SPECIFICATIONS							
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Adjud Usage**	**Valid Values**	**Definition/Format**
2010AA	REF	REF02	Billing Provider Additional Identifier	Identifies another or additional distinguishing code number associated with the billing provider	R		For all claims except Medicare crossovers, the AHCCCS ID and Location Code of the rendering provider. Submit this number with two leading zeros. The format is 00aaaaaall when aaaaaa is the AHCCCS Provider ID and ll the Location Code. This REF02 Provider ID field should always be populated, both when the Billing Provider is the same as the Servicing or Rendering Provider and when the IDs are different. On Medicare crossovers, use the Medicare Provider ID without leading zeros.
2000B	SBR	SBR02	Individual Relationship Code	Code indicating the relationship between two individuals or entities	R	18	Self
2000B	SBR	SBR09	Claim Filing Indicator Code	Code identifying type of claim or expected adjudication process	R	MC	Medicaid

837 PROFESSIONAL CLAIM TRANSACTION SPECIFICATIONS							
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Adjud Usage**	**Valid Values**	**Definition/Format**
2000B	PAT	PAT07	Unit or Basis for Measurement Code	Code specifying the units in which a value is being expressed, or the manner in which a measurement has been taken	R/A	01	Actual Pounds Use of Patient Weight is quite different in the original Implementation Guide and in the Addenda. In the 837 Professional Addenda adopted by AHCCCS, Patient Weight is in pounds rather than grams and no longer represents a birth weight. Instead, it is, in the words of the Addenda: Required on: (1) claims/encounters involving EPO (epoetin) for patients on dialysis (2) Medicare Durable Medical Equipment Regional Carriers certificate of medical necessity (DMERC CMN) 02.03 and 10.02 AHCCCS suggests that providers submit a Patient Weight on EPO claims. The second requirement appears to be for Medicare only.
2000B	PAT	PAT08	Patient Weight	Numeric value of weight	R/A		The patient's weight in pounds if appropriate - see above.
2010BA	NM1	NM108	Identification Code Qualifier	Code designating the system or method of code structure used for the Identification Code	R	MI	Member Identification Number
2010BA	NM1	NM109	Subscriber Primary Identifier	Primary identification number of the subscriber to the coverage	R		AHCCCS Recipient ID
2010BB	NM1	NM103	Payer Name	Name identifying the payer organization	R	AHCCCS	The "destination payer" according to the Implementation Guide.
2010BB	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	R	PI	Payer Identification
2010BB	NM1	NM109	Payer Identifier	Number identifying the payer organization	R	866004791	The AHCCCS Federal Tax Id Number

837 PROFESSIONAL CLAIM TRANSACTION SPECIFICATIONS							
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Adjud Usage**	**Valid Values**	**Definition/Format**
2300	CLM	CLM01	Patient Account Number	Unique identification number assigned by the provider to the claim patient to facilitate posting of payment information and identification of the billed claim	R		This is the Patient Account Number used by the provider that performed the service. For HIPAA, the maximum length of the field is 20 characters.
2300	CLM	CLM05-1	Facility Type Code	Code identifying the type of facility where services were performed	R		Place of Service can be submitted at the claim level. However, it is stored at the service line level on PMMIS Professional Claim Tables. Place of Service Codes submitted at the claim level apply to all service lines unless overridden by a different Place of Service at the line level (SV105 in Loop 2400). A few of the CLM05-1 valid values on the 837 Transaction differ from the Place of Service values used by AHCCCS in the pre-HIPAA environment. Under HIPAA, AHCCCS accepts only the valid HIPAA values listed in the 837 Professional Implementation Guide.
2300	CLM	CLM05-3	Claim Frequency Code	Code specifying the frequency of the claim This is the third position of the Uniform Billing Claim Form Bill Type	R	1 7 8	Original Replacement (Replacement of prior claim) Void (Void/Cancel of prior claim) A value of “6” (Corrected) was originally included in the Implementation Guide but deactivated by Designated Standards Maintenance Organizations (DSMOs). It is no longer valid. Changes cannot be made to existing adjudicated claims (as identified by CRN) with the new CLM05-3 coding scheme. Instead, a claim must be “replaced” (CLM05-3 = “7”). Replacements void prior claims (identified by CRN) before adding the replacement claim with a new CRN.

837 PROFESSIONAL CLAIM TRANSACTION SPECIFICATIONS							
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Adjud Usage**	**Valid Values**	**Definition/Format**
2300	CLM	CLM11-1 CLM11-2 CLM11-3	Related Causes Code	Code identifying an accompanying cause of an illness, injury or an accidents	R/A	AA OA AP EM	Auto Accident Other Accident Another Party Responsible Employment AHCCCS requires one of these values if the situation it describes is present. Up to three Related Causes Codes can be submitted per claim (CLM11-1, CLM11-2, and CLM11-03).
2300	CLM	CLM11-4	Auto Accident State or Province Code	Code (Standard State/Province) as defined by appropriate government agency	R/A		Required if any of the up to three Related Causes Code occurrences submitted has a value of “AA” (Auto Accident).
2300	CLM	CLM11-5	Country Code	Code identifying the country	R/A		Required if any of the up to three Related Causes Code occurrences submitted has a value of “AA” (Auto Accident) and the accident occurred outside the United States.
2300	CLM	CLM12	Special Program Indicator	Code indicating the special program under which services related to the patient were performed.	R/A	01	Early & Periodic Screening, Diagnosis, and Treatment (EPSDT) or Child Health Assessment Program (CHAP) Use this value for EPSDT examinations and screenings. Services that result from EPSDT referrals are indicated at the service line level by Element SV111 EPSDT Indicator in Loop 2400.
2300	DTP	DTP01	Date Time Qualifier	Code specifying the type of data or time, or both date and time	R/A	439	Accident Date The Accident Date DTP Segment is required if the claim resulted from an accident (CLM11-1, -2, or -3 = “AA”, “OA” or “AP”).
2300	DTP	DTP02	Date Time Period Format Qualifier	Code indicating the date format, the time format, or date and time format	R/A	D8	Date expressed in format CCYYMMDD
2300	DTP	DTP03	Accident Date	The date of the accident	R/A		The date of the accident if the claim results from an accident (CLM11-1, -2 or -3 = “AA”, “OA” or “AP”).

837 PROFESSIONAL CLAIM TRANSACTION SPECIFICATIONS							
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Adjud Usage**	**Valid Values**	**Definition/Format**
2300	REF	REF01	Reference Identification Qualifier	Code qualifying the Reference Identification	R/A	G1	Prior Authorization Number Although this REF Segment can also be used for Referral Numbers, AHCCCS is only concerned with PA Numbers for services that were authorized by AHCCCS. Use this segment when the prior authorization is at the claim rather than the service line level.
2300	REF	REF02	Prior Authorization Number	The AHCCCS assigned Prior Authorization Number for all services on the claim	R/A		The Prior Authorization Number
2300	REF	REF01	Reference Identification Qualifier	Code qualifying the Reference Identification	R/A	F8	Original Reference Number This REF Segment is required if a claim voids or replaces another claim.
2300	REF	REF02	Claim Original Reference Number	Number assigned by a processor to identify a claim	R/A		For replacement and void claims (CLM05-3 = “7” or “8”), the AHCCCS Claim Reference Number (CRN) of the prior claim being replaced or voided.
2310A	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	R/A	24 34	Employer’s Identification Number Social Security Number Use the 2310A Loop when a referring provider is present at the claim level. Unless overridden by a service line referring provider in the 2410F Loop, this loop’s referring provider will be the referring provider for all service lines.
2310A	NM1	NM109	Referring Provider Identifier	The identification number for the referring physician	R/A		The referring provider’s Federal Tax ID or Social Security Number.
2310A	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	R/A	1D 1C	Medicaid Provider Number Medicare Provider Number

837 PROFESSIONAL CLAIM TRANSACTION SPECIFICATIONS							
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Adjud Usage**	**Valid Values**	**Definition/Format**
2310A	REF	REF02	Referring Provider Secondary Identifier	Additional identification number for the provider referring the patient for service	R/A		For all claims except Medicare crossovers, the AHCCCS ID and Location Code of the rendering provider. Submit this number with two leading zeros. The format is 00aaaaaall when aaaaaa is the AHCCCS Provider ID and ll the Location Code. On Medicare crossovers, use the Medicare Provider ID without leading zeros.
2310B	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	R/A	24 or 34	Employer's Identification Number or Social Security Number Use the 2310B Loop for the rendering provider at the claim level when the rendering provider is different from the billing provider in Loop 2010AA. If billing and rendering providers are the same, the 2310B Loop is not needed. Although the 837 Transaction supports different Rendering Providers at the service line level, AHCCCS policy requires a single Rendering Provider per claim. AHCCCS denies claims with a Rendering Provider at the service line level that is different then the Rendering Provider at the claim level.
2310B	NM1	NM109	Rendering Provider Identifier	The identifier assigned by the Payer to the provider who performed the service	R/A		The rendering provider's Federal Tax ID or Social Security Number.
2310B	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	R/A	1D 1C	Medicaid Provider Number Medicare Provider Number

837 PROFESSIONAL CLAIM TRANSACTION SPECIFICATIONS							
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Adjud Usage**	**Valid Values**	**Definition/Format**
2310B	REF	REF02	Rendering Provider Secondary Identifier	Additional identifier for the provider providing care to the patient	R/A		For all claims except Medicare crossovers, the AHCCCS ID and Location Code of the rendering provider. Submit this number with two leading zeros. The format is 00aaaaaall when aaaaaa is the AHCCCS Provider ID and ll the Location Code. On Medicare crossovers, use the Medicare Provider ID without leading zeros.
2320	SBR	SBR01	Payer Responsibility Sequence Number Code	Code identifying the insurance carrier's level of responsibility for a payment of a claim	R/A	P S T	Primary Secondary Tertiary Other carrier Loop 2320 can occur up to ten times for up to ten payers other than AHCCCS. 2320 is an “umbrella loop” that contains within it Loops 2330A through 2330E. All of these loops can be repeated as needed for each payer. Other payer loops occur at the service line level as well.
2320	SBR	SBR03	Insured Group or Policy Number	The identification number, control number, or code assigned by the carrier or administrator to identify the group under which the individual is covered	R/A		A Group or Policy Number associated with the other coverage.
2320	SBR	SBR04	Other Insured Group Name	Name of the group or plan through which the insurance is provided to the other insured	R/A		A Group or Policy Name associated with SBR03.

837 PROFESSIONAL CLAIM TRANSACTION SPECIFICATIONS							
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Adjud Usage**	**Valid Values**	**Definition/Format**
2320	CAS	CAS01	Claim Adjustment Group Code	Code identifying the general category of payment adjustment	R/A		On 837 Transactions, “adjustments” are changes from other carrier Billed to Paid Amounts at the claim or service line level. A CAS Segment is needed if the amount that the other carrier paid the provider is different from the amount charged due to a claim-level pricing adjustment. If the change from Charged to Paid Amount is at the service line level, use the CAS Segment in Loop 2430 rather than this one. The service line adjustment does not need to be accommodated at the claim level
2320	CAS	CAS02	Adjustment Reason Code	Code that indicates the reason for the adjustment	R/A	Many Code Set Values	Hundreds of Adjustment Reason Code values are maintained on the Washington Publishing Company’s Web Site (www.wpc-edi.com). Submit the code value or values that best describe the reason for the difference between the Charged Amount and the Paid Amount. These are the same Adjustment Reason Codes that appear on the 835 Claim Remittance Advice Transaction. The 837 Transaction is designed to pick them up from the other payer’s 835. If other carriers transmit 835 Remittance Advice Transactions to submitting providers, data from these transactions can be the source of the Adjustment Reason Code(s) on the 2320 Loop. The “adjustment trio”, consisting of Adjustment Reason Code, Adjustment Amount, and Adjustment Quantity, occurs up to six times within each CAS Segment. AHCCCS requests that all Coordination Of Benefits (COB) payment information be provided at the line level where possible.

837 PROFESSIONAL CLAIM TRANSACTION SPECIFICATIONS							
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Adjud Usage**	**Valid Values**	**Definition/Format**
2320	CAS	CAS03	Adjustment Amount	Adjustment amount for the associated reason code	R/A		The difference between the claim level Charged Amount and Paid Amount associated with the Adjustment Reason Code in CAS02. A positive number when the Paid Amount is less than the Charged Amount.
2320	CAS	CAS04	Adjustment Quantity	Numeric quantity associated with the related reason code for coordination of benefits	O		The difference between the billed and paid units of service for all service lines when the difference is the result of claim level adjudication and is associated with the Adjustment Reason Code in CAS02. A positive number when the Paid Quantity is less than the Charged Quantity.
2320	MOA	MOA02	Claim HCPCS Payable Amount	Sum of payable line item amounts for HCPCS codes billed on this claim	R/A		The Medicare Outpatient Adjudication MOA Segment is required if data for it is available from an electronic remittance advice (835 Transaction). This segment is used for outpatient adjudication information, including standard HIPAA Remark Codes, generated by Medicare or another carrier. In this context, all professional services are considered outpatient. Institutional 837s have both MOA and MIA (Medicare Inpatient Adjudication) Segments but the Professional 837 has only the MOA Segment. All data elements within the MOA Segment are situational. They reflect adjudication by Medicare or another payer and should be included if available to the submitter.

837 PROFESSIONAL CLAIM TRANSACTION SPECIFICATIONS							
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Adjud Usage**	**Valid Values**	**Definition/Format**
2400	SV1	SV101-1	Product or Service ID Qualifier	Code identifying the type/source of the descriptive number used in Product/Service ID	R	HC	Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes A variety of additional qualifier values are listed in the implementation guide, including qualifiers for NDC Drug and HIEC Home Infusion Codes. Alternative code sets are available if AHCCCS adopts them in the future. At present, however, AHCCCS uses only HCPCS Procedure Codes to identify professional services.
2400	SV1	SV101-3	Procedure Modifier	This identifies special circumstances related to the performance of the service	R/A		The first Procedure Code Modifier AHCCCS uses this Procedure Code Modifier in adjudication.
2400	SV1	SV101-4	Procedure Modifier	This identifies special circumstances related to the performance of the service	R/A		The second Procedure Code Modifier AHCCCS uses this Procedure Code Modifier in adjudication.
2400	SV1	SV101-5	Procedure Modifier	This identifies special circumstances related to the performance of the service	R/A		The third Procedure Code Modifier AHCCCS does not use this Procedure Code Modifier in adjudication.
2400	SV1	SV101-6	Procedure Modifier	This identifies special circumstances related to the performance of the service	R/A		The fourth Procedure Code Modifier AHCCCS does not use this Procedure Code Modifier in adjudication.
2400	SV1	SV105	Service Unit Count	Numeric value of quantity	R		AHCCCS uses seven-digit Units values without decimal points.

837 PROFESSIONAL CLAIM TRANSACTION SPECIFICATIONS							
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Adjud Usage**	**Valid Values**	**Definition/Format**
2400	SV1	SV105	Facility Code Value	Code identifying the type of facility where services were performed; the first and second positions of the Uniform Bill Type code or the Place of Service code from the Electronic Media Claims National Standard Format	R/A		Place of Service Codes submitted at the service line level override different Place of Service Codes at the claim level (Loop 2300, Element CLM05-1). AHCCCS processes each service line's Place of Service separately. A few of the SV105 valid values on the 837 Transaction differ from the Place of Service values used by AHCCCS in the pre-HIPAA environment. Under HIPAA, AHCCCS accepts only the valid HIPAA values listed in the 837 Professional Implementation Guide.
2400	SV1	SV111	EPSDT Indicator	An indicator of whether or not Early and Periodic Screening for Diagnosis and Treatment of children services are involved with this detail line	R/A	Y	Yes, the service is the result of an EPSDT referral Required if a Medicaid service is the result of a screening referral. The service referenced on this service line element differs from the EPSDT screening identified by the claim level Special Program Indicator (CLM12) in Loop 2300. SV111 indicates a service that results from an EPSDT referral, not the original EPSDT evaluation.
2410	LIN	LIN02	Product or Service ID Qualifier	Code identifying the type or source of the descriptive number used in Product ID Field.	O	N4	National Drug Code in 5-4-2 Format Information on drugs supplied or prescribed in association with HCPCS Procedure Codes is of interest to AHCCCS. The LIN Segment is newly introduced by the 837 Professional Addendum to associate prescription information more closely with professional procedures. AHCCCS retains a single NDC Code per service line.

837 PROFESSIONAL CLAIM TRANSACTION SPECIFICATIONS							
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Adjud Usage**	**Valid Values**	**Definition/Format**
2410F	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	R/A	24 or 34	Employer's Identification Number or Social Security Number Use the 2410F Loop when a referring provider is present at the service line level that differs from the referring provider present in Loop 2310A, if any, at the claim level.
2410F	NM1	NM109	Referring Provider Identifier	The identification number for the referring physician	R/A		The referring provider's Federal Tax ID or Social Security Number.
2410F	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	R/A	1D IC	Medicaid Provider Number Medicare Provider Number
2410F	REF	REF02	Referring Provider Secondary Identifier	Additional identification number for the provider referring the patient for service	R/A		For all claims except Medicare crossovers, the AHCCCS ID of the referring provider. Insert two zeros in front of the six-digit AHCCCS Provider ID. On Medicare crossovers, used the Medicare Provider ID without leading zeros.
2430	SVD	SVD01	Other Payer Primary Identifier	An identification number for the other payer	R/A		According to this Implementation Guide, the 2430 Loop is "required if claim has been previously adjudicated by payer identified in Loop 2330B and service line has adjustments applied to it." This number in this field needs to match NM109 in the Loop 2330B that identifies the other payer.

837 PROFESSIONAL CLAIM TRANSACTION SPECIFICATIONS							
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Adjud Usage**	**Valid Values**	**Definition/Format**
2430	CAS	CAS02	Adjustment Reason Code	Code that indicates the reason for the adjustment	R/A	Many Code Set Values	Hundreds of Adjustment Reason Code values are maintained on the Washington Publishing Company's Web Site (www.wpc-edi.com). Enter the code value that best describes the reason for the difference between the Service Line Charged Amount and the Paid Amount. These are the same Adjustment Reason Codes that appear on the 835 Claim Remittance Advice Transaction. The "adjustment trio" of Adjustment Reason Code, Adjustment Amount, and Adjustment Quantity occur up to six times within the CAS Segment. AHCCCS requests that all Coordination Of Benefits (COB) payment information be provided at the line level where possible.
2430	CAS	CAS03	Adjustment Amount	Adjustment amount for the associated reason code	R/A		The difference between the service line level Charged Amount and Paid Amount associated with the Adjustment Reason Code in CAS02. A positive number when the Paid Amount is less than the Charged Amount.
2430	CAS	CAS04	Adjustment Quantity	Numeric quantity associated with the related reason code for coordination of benefits	O		The difference between the billed and paid units of service at the service line level when the difference is the result of line level adjudication and is associated with the Adjustment Reason Code in CAS02. A positive number when the Paid Quantity is less than the Charged Quantity.

5.3. Claim Transaction Specifications – Dental 837 Claims

Overview

Dental 837 Claim Transactions from AHCCCS providers and billing agents contain data to enable AHCCCS to adjudicate dental claims, plus a number of additional fields, including fields with coordination of benefits data, that are desirable for reporting and are of interest to AHCCCS. The purpose of these Transaction Specifications are to identify critical data elements and data element values that AHCCCS needs in claim transactions and to let providers know how to populate and transmit claim data for AHCCCS.

In the pre-HIPAA environment, AHCCCS received claims for dental services in the same format that it used for professional claims. For claims submitted electronically, this is no longer the case. To achieve HIPAA compliance, AHCCCS expects its fee-for-service dental providers to submit electronic claims using the 837 Dental Standard. Detailed changes required by the new orientation (for example, submitting Tooth Surface as a discrete data element) are covered in these specifications.

The specifications in this section apply only to 837 Dental Claim Transactions that providers send to AHCCCS, not to encounters submitted by health plans. Only data elements that are used by AHCCCS in ways that require explanations that go beyond information in standard HIPAA Implementation Guides are included.

General Transaction Specifications

Dental 837 Claim Transaction specifications that are not specific to a particular data element are discussed below.

- With the exception of data elements in the Transaction Header Segment, all Dental 837 Claim Loops and Segments are of variable length. Segments within loops and elements within segments occur only when data is present. There are no blank or null fields. In some situations, zero field values are acceptable.

- On claims submitted to AHCCCS, 837 loops, segments, and data elements that involve coordination of benefits with other payers are used to show payments made by third party carriers, including Medicare and commercial health insurance companies. AHCCCS requests that all Coordination Of Benefits (COB) payment information be provided at the line level where possible.

- Although the Dental 837 Transaction supports predetermination of dental benefits, AHCCCS does not use it in this manner. AHCCCS will deny any 837 Dental claims submitted for predetermination of dental benefits.

- Dental services that require pre-authorization (not predetermination of benefits) will continue to be handled with prior authorization requests. The 837 Dental format, as revised by the 2002 Addenda, accommodates PA Numbers in the same way as professional claims.

Transaction Specifications Table

The Dental 837 Claim Transaction Specifications for individual data elements are shown in the table starting on the next page. Definitions of table columns follow.

Loop ID
The Implementation Guide's identifier for a data loop within a transaction.

Segment ID
The Implementation Guide's identifier for a data segment within a loop.

Element ID
The Implementation Guide's identifier for a data element within a segment.

Element Name
A data element name as shown in the Implementation Guide. When the industry name differs from the Data Element Dictionary name, the more descriptive industry name is used.

Element Definition
How the data element is defined in the Implementation Guide.

Adjudication Usage
An indication of how a data element is used in AHCCCS claim adjudication.
R = Required on all transactions of this type by either the transaction's HIPAA Implementation Guide or by current PMMIS processing.
R/A = Required if applicable – Accident Date, for example, is required if a claim's medical services result from an accident.
O = Optional – Present or not present at the discretion of the trading partner.

Valid Values
The valid values from the Implementation Guide that are used by AHCCCS.

Definition/Format
Definitions of valid values used by AHCCCS and additional information about AHCCCS data element requirements.

837 DENTAL CLAIM TRANSACTION SPECIFICATIONS							
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Adjud Usage**	**Valid Values**	**Definition/Format**
N/A	REF	REF02	Transmission Type Code	Code identifying the type of transaction or transmission included in the transaction set	R		Values specified for this element differ in the original Implementation Guide and the Addenda. AHCCCS has adopted Addenda features and is using Addenda values. Valid values are: Pilot Testing: 004010X097DA1 Production: 004010X097A1
1000A	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	R	46	Electronic Transmitter Identification Number (ETIN)
1000A	NM1	NM109	Submitter Identifier	Code or number identifying the entity submitting the claim	R		AHCCCS identifies submitting providers and billing agents with the five-digit Electronic Supplier Number assigned by the AHCCCS Information Services Division (ISD).
1000B	NM1	NM103	Receiver Name	Name of organization receiving the transaction	R	AHCCCS	The transaction receiver
1000B	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	R	46	Electronic Transmitter Identification Number (ETIN)
1000B	NM1	NM109	Receiver Primary Identifier	Primary identification number for the receiver of the transaction	R	866004791	AHCCCS Federal Tax ID
2010AA	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	R	24 or 34	Employer's Identification Number or Social Security Number Enter the qualifier for the Federal Tax ID used by the billing provider.
2010AA	NM1	NM109	Billing Provider Identifier	Identification number for the provider or organization in whose name the bill is submitted and to whom payment should be made	R		The Federal Tax ID used by the billing provider.
2010AA	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	R	1D 1C	Medicaid Provider Number Medicare Provider Number

837 DENTAL CLAIM TRANSACTION SPECIFICATIONS							
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Adjud Usage**	**Valid Values**	**Definition/Format**
2010AA	REF	REF02	Billing Provider Additional Identifier	Identifies another or additional distinguishing code number associated with the billing provider	R		For all claims except Medicare crossovers, the AHCCCS ID and Location Code of the rendering provider. Submit this number with two leading zeros. The format is 00aaaaaall when aaaaaa is the AHCCCS Provider ID and ll the Location Code. This REF02 Provider ID field should always be populated, both when the Billing Provider is the same as the Servicing or Rendering Provider and when the IDs are different. On Medicare crossovers, use the Medicare Provider ID without leading zeros.
2000B	SBR	SBR02	Individual Relationship Code	Code indicating the relationship between two individuals or entities	R	18	Self
2000B	SBR	SBR09	Claim Filing Indicator Code	Code identifying type of claim or expected adjudication process	R	MC	Medicaid
2010BA	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	R	MI	Member ID
2010BA	NM1	NM109	Subscriber Primary Identifier	Primary identification number of the subscriber to the coverage	R		AHCCCS Recipient ID
2010BB	NM1	NM103	Payer Name	Name identifying the payer organization	R	AHCCCS	The name of the “destination payer” according to the Implementation Guide.
2010BB	NM1	NM109	Payer Identifier	Number identifying the payer organization	R	866004791	The AHCCCS Federal Tax ID
2300	CLM	CLM01	Patient Account Number	Unique identification number assigned by the provider to the claim patient to facilitate posting of payment information and identification of the billed claim	R		The Patient Account Number used by the rendering provider

837 DENTAL CLAIM TRANSACTION SPECIFICATIONS							
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Adjud Usage**	**Valid Values**	**Definition/Format**
2300	CLM	CLM05-1	Facility Type Code	Code identifying the type of facility where services were performed	R		Place of Service can be submitted at the claim level. However, it is stored at the service line level on PMMIS Dental Claim Tables. Place of Service Codes submitted at the claim level apply to all service lines unless overridden by a different Place of Service at the line level (SV105 in Loop 2400). A few of the CLM05-1 valid values on the 837 Transaction differ from the Place of Service values used by AHCCCS in the pre-HIPAA environment. Under HIPAA, AHCCCS accepts only the valid HIPAA values listed in the 837 Professional Implementation Guide.
2300	CLM	CLM05-3	Claim Submission Reason Code	Code identifying reason for claim submission	R	1 7 8	Original (New admit thru discharge claim) Replacement (Replacement of prior claim) Void (Void/Cancel of prior claim) A value of “6” (Corrected) was originally included in the Implementation Guide but deactivated by Designated Standards Maintenance Organizations (DSMOs). Changes cannot be made to existing adjudicated claims (as identified by CRN) with the new CLM05-3 coding scheme. Instead, a claim must be “replaced” (CLM05-3 = “7”). Replacements are intended to void prior claims (identified by CRN) before adding the replacement with a new CRN.
2300	CLM	CLM12	Special Program Indicator	Code indicating the special program under which services related to the patient were performed.	R/A	01	Early & Periodic Screening, Diagnosis, and Treatment (EPSDT) or Child Health Assessment Program (CHAP) Use this value for EPSDT examinations and screenings.

837 DENTAL CLAIM TRANSACTION SPECIFICATIONS							
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Adjud Usage**	**Valid Values**	**Definition/Format**
2300	REF	REF01	Reference Identification Qualifier	Code qualifying the Reference Identification	R/A	G1	Prior Authorization Number Although this REF Segment can also be used for Referral Numbers, AHCCCS is only concerned with PA Numbers for services that were authorized by AHCCCS. Use this segment when the prior authorization is at the claim rather than the service line level.
2300	REF	REF02	Prior Authorization Number	The AHCCCS assigned Prior Authorization Number for all services on the claim	R/A		The Prior Authorization Number
2300	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	R/A	F8	Original Reference Number Required for replacement and void claims (CLM05-3 = “7” or “8”).
2300	REF	REF02	Claim Original Reference Number	Number assigned by a processor to identify a claim	R/A		For replacement and void claims, the AHCCCS Claim Reference Number (CRN) of the prior claim being replaced or voided.
2310A	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	R/A	24 or 34	Employer’s Identification Number or Social Security Number Use the 2310A Loop when there is a referring provider. On Dental 837 Transactions, referring providers only appear at the claim rather than the service line level. The 2310A Loop carries data on the referring provider for all dental service lines.
2310A	NM1	NM109	Referring Provider Identifier	The identifier assigned by the Payer to the referring provider	R/A		The referring provider’s Federal Tax ID or Social Security Number.
2310A	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	R/A	1D	Medicaid Provider Number

837 DENTAL CLAIM TRANSACTION SPECIFICATIONS							
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Adjud Usage**	**Valid Values**	**Definition/Format**
2310A	REF	REF02	Referring Provider Secondary Identifier	Additional identification number for the provider referring the patient for service	R/A		For all claims except Medicare crossovers, the AHCCCS ID and Location Code of the rendering provider. Submit this number with two leading zeros. The format is 00aaaaaall when aaaaaa is the AHCCCS Provider ID and ll the Location Code. On Medicare crossovers, use the Medicare Provider ID without leading zeros.
2310B	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	R/A	24 or 34	Employer's Identification Number or Social Security Number Use the 2310B Loop when the rendering provider is different from the billing provider in Loop 2010AA. Although the 837 Transaction supports different Rendering Providers at the service line level, AHCCCS policy requires a single Rendering Provider per claim. AHCCCS denies claims with a Rendering Provider at the service line level that is different than the Rendering Provider at the claim level.
2310B	NM1	NM109	Rendering Provider Identifier	The identifier assigned by the Payer to the provider who performed the service	R/A		The rendering provider's Federal Tax ID or Social Security Number.
2310B	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	R/A	1D IC	Medicaid Provider Number Medicare Provider Number

837 DENTAL CLAIM TRANSACTION SPECIFICATIONS							
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Adjud Usage**	**Valid Values**	**Definition/Format**
2310B	REF	REF02	Rendering Provider Secondary Identifier	Additional identifier for the provider providing care to the patient	R/A		Use the 2310B Loop for rendering provider at the claim level when the rendering provider is different from the billing provider in Loop 2010AA. If billing and rendering providers are the same, the 2310B Loop is not needed. For all claims except Medicare Crossovers, use the AHCCCS ID and Location Code of the rendering provider. Insert two zeros in front of the six-digit AHCCCS Provider ID and two-digit Location Code. On Medicare crossovers, use the Medicare Provider ID without leading zeros. Although the 837 Dental Transaction supports different rendering providers at the service line level, AHCCCS policy requires a single rendering provider per claim. AHCCCS denies claims with a Rendering Provider at the service line level.
2320	SBR	SBR01	Payer Responsibility Sequence Number Code	Code identifying the insurance carrier's level of responsibility for a payment of a claim	R/A	P S T	Primary Secondary Tertiary The 2320 Other Subscriber Information Loop is for information on payers other than AHCCCS that have adjudicated the claim. Element SBR01 can have any of the above values. Loop 2320 can occur up to ten times for up to ten payers other than AHCCCS. 2320 is an “umbrella loop” that contains within it Loops 2330A through 2330E. All of these loops can be repeated as needed for each payer. Other payer loops occur at the service line level as well.
2320	SBR	SBR03	Insured Group or Policy Number	The identification number, control number, or code assigned by the carrier or administrator to identify the group under which the individual is covered	R/A		A Group or Policy Number associated with the other coverage.

837 DENTAL CLAIM TRANSACTION SPECIFICATIONS							
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Adjud Usage**	**Valid Values**	**Definition/Format**
2320	SBR	SBR04	Policy Name	The name of the policy providing coverage	R/A		A Group or Policy Name associated with SBR03.
2320	CAS	CAS01	Claim Adjustment Group Code	Code identifying the general category of payment adjustment	R/A		The code value in the Implementation Guide that best describes the reason for any difference between the Charged Amount and the Paid Amount. On the 2320 Loop, a CAS Segment is needed if the amount that the other payer paid the provider was different from the amount charged. If the change from Charged to Paid Amount is at the service line level, use the CAS Segment in Loop 2430 rather than this one.
2320	CAS	CAS02	Adjustment Reason Code	Code that indicates the reason for the adjustment	R/A	Many Code Set Values	Hundreds of Adjustment Reason Code values are maintained on the Washington Publishing Company's Web Site (www.wpc-edi.com). Submit the code value or values that best describe the reason for the difference between the Charged Amount and the Paid Amount. These are the same Adjustment Reason Codes that appear on the 835 Claim Remittance Advice Transaction. The 837 Transaction is designed to pick them up from the other payer's 835. If a health plan transmits 835 Remittance Advice Transactions to providers, data from these transactions can be the source of the Adjustment Reason Code(s) on the 2320 Loop. The "adjustment trio", consisting of Adjustment Reason Code, Adjustment Amount, and Adjustment Quantity, occurs up to six times within each CAS Segment. AHCCCS requests that all Coordination Of Benefits (COB) payment information be provided at the line level where possible.

837 DENTAL CLAIM TRANSACTION SPECIFICATIONS							
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Adjud Usage**	**Valid Values**	**Definition/Format**
2320	CAS	CAS03	Adjustment Amount	Adjustment amount for the associated reason code	R/A		The difference between the claim level Charged Amount and Paid Amount associated with the Adjustment Reason Code in CAS02. A positive number when the Paid Amount is less than the Charged Amount.
2320	CAS	CAS04	Adjustment Quantity	Numeric quantity associated with the related reason code for coordination of benefits	O		The difference between the billed and paid units of service for all service lines when the difference is the result of claim level adjudication and is associated with the Adjustment Reason Code in CAS02. A positive number when the Paid Quantity is less than the Charged Quantity.
2330B	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	R/A	PI	Payer Identifier
2330B	NM1	NM109	Other Payer Primary Identifier	An identification number for the other payer	R/A		Any identification number assigned to the other payer. AHCCCS will not perform validity edits on this identifier.
2400	LX	LX01	Assigned Number	Number assigned for differentiation within a transaction set	R		The number of the service line, beginning with 1 for the first line. For 837 Dental Claims, the maximum number of lines is 50. AHCCCS no longer accept s dental claims with more than 50 lines.
2400	SV3	SV301-1	Product or Service ID Qualifier	Code identifying the type/source of the descriptive number used in Product/Service ID	R	AD	American Dental Association Code CDT (Current Dental Terminology) ADA Procedure Codes have been made part of Level II HCPCS Codes.
2400	SV3	SV301-2	Procedure Code	The ADA Dental Procedure Code	R		ADA Procedure Codes have been made part of Level II HCPCS Codes.
2400	SV3	SV301-3 – SV301-6	Procedure Code Modifier	ADA Procedure Code Modifier	R/A		According to the 837 Dental Addenda, Dental Procedure Code Modifiers must be valid ADA Procedure Code Modifiers. The American Dental Association has not yet made Modifier Codes final. Submitters of dental claims can no longer use modifiers with non-ADA values and should not submit modifiers until final values are established.

837 DENTAL CLAIM TRANSACTION SPECIFICATIONS							
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Adjud Usage**	**Valid Values**	**Definition/Format**
2400	SV3	SV304-1 – SV304-5	Oral Cavity Designation Code	Code identifying the oral cavity in which service is rendered	R/A		Quadrants are now submitted as Oral Cavity Designation Codes with code values listed in the 837 Dental Implementation Guide.
2400	SV3	SV306	Procedure Count	The number of service units	R		AHCCCS uses seven-digit Units values without decimal points.
2400	TOO	TOO01	Code List Qualifier Code	Code identifying a specific industry code list	R/A	JP	National Standard Tooth Numbering System
2400	TOO	TOO02	Tooth Number	The ADA Tooth Number Code	R/A		The ADA code for Tooth Number affected by the surface or surfaces. Although up to 32 occurrences of Tooth Number can be submitted per dental service line on the 837 Dental Transaction, only a single occurrence is allowed by AHCCCS. Claims submitted with more than Tooth Number per dental service line will be denied.
2400	TOO	TOO03-1 – TOO03-5	Tooth Surface	Code identifying the area of the tooth that was treated	R/A		The 837 Dental Transaction can accommodate up to five occurrences of Tooth Surface Codes in association with each Tooth Number.
2400	REF	REF01	Reference Identification Qualifier	Code qualifying the Reference Identification	R/A	G1	Prior Authorization Number Although this REF Segment can also be used for Referral Numbers, AHCCCS is only concerned with PA Numbers for services that were authorized by AHCCCS. Use this segment when the prior authorization is at the service line rather than the claim level.
2400	REF	REF02	Prior Authorization Number	The AHCCCS assigned Prior Authorization Number for all services on the claim	R/A		The Prior Authorization Number
2420B	NM1	NM103	Other Payer Last or Organization Name	The name of the other payer organization	R/A		The name of the other payer organization that handled the referral or prior authorization. The 2420B Loop is needed to associate the Service Line Referral Number with the appropriate other payer 2330B Loop within the claim level 2320 Loop.

837 DENTAL CLAIM TRANSACTION SPECIFICATIONS							
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Adjud Usage**	**Valid Values**	**Definition/Format**
2420B	NM1	NM109	Other Payer Referral Number	The non-destination (COB) payer's service line level referral number	R/A		The other payer's identification number. It must be the same as a payer's ID Number in a claim level 2330B Loop.
2430	SVD	SVD01	Other Payer Primary Identifier	An identification number for the other payer	R/A		According to this Implementation Guide, the 2430 Loop is "required if claim has been previously adjudicated by payer identified in Loop 2330B and service line has adjustments applied to it." This number in this field needs to match NM109 in the Loop 2330B that identifies the other payer.
2430	CAS	CAS01	Claim Adjustment Group Code	Code identifying the general category of payment adjustment	R/A		Required if the payer identified in loop 2330B made line level adjustments that caused the amount paid to differ from the amount originally charged. In this situation, enter the code value that best describes the reason for the different between the Charged Amount and the Paid Amount for this service line. The "Adjustment Trio" of Adjustment Reason, Amount, and Quantity can occur up to six times per CAS Segment and CAS Segments have up to 99 iterations at the service line level. Five hundred and ninety-four Claim Adjustment Codes for the health plan and other carriers can be accommodated.

837 DENTAL CLAIM TRANSACTION SPECIFICATIONS							
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Adjud Usage**	**Valid Values**	**Definition/Format**
2430	CAS	CAS02	Adjustment Reason Code	Code that indicates the reason for the adjustment	R/A	Many Code Set Values	Hundreds of Adjustment Reason Code values are maintained on the Washington Publishing Company's Web Site (www.wpc-edi.com). Enter the code value that best describes the reason for the difference between the Service Line Charged Amount and the Paid Amount. These are the same Adjustment Reason Codes that appear on the 835 Claim Remittance Advice Transaction. AHCCCS requests that all Coordination Of Benefits (COB) payment information be provided at the line level where possible.
2430	CAS	CAS03	Adjustment Amount	Adjustment amount for the associated reason code	R/A		The difference between the service line level Charged Amount and Paid Amount associated with the Adjustment Reason Code in CAS02. A positive number when the Paid Amount is less than the Charged Amount.
2430	CAS	CAS04	Adjustment Quantity	Numeric quantity associated with the related reason code for adjustment of benefits	O		The difference between the billed and paid units of service at the service line level when the difference is the result of line level adjudication and is associated with the Adjustment Reason Code in CAS02. A positive number when the Paid Quantity is less than the Charged Quantity.

5.4. Claim Transaction Specifications – Institutional 837 Claims

Overview

Institutional 837 Claim Transactions from AHCCCS providers contain data to enable AHCCCS to adjudicate institutional claims, plus a number of additional fields, including fields with coordination of benefits data, that are desirable for reporting and are used by AHCCCS. The purposes of these Transaction Specifications are to identify critical data elements and data element values that AHCCCS needs in Claim Transactions and to let providers know how to populate and transmit claim data for AHCCCS.

The specifications in this section apply only to 837 Institutional Claim Transactions that providers send to AHCCCS, not to encounters submitted by health plans. Only data elements that are used by AHCCCS in ways that require explanations that go beyond information in standard HIPAA Implementation Guides are included.

General Transaction Specifications

Institutional 837 Claim Transaction Specifications that are not specific to an individual data element are discussed below.

- With the exception of data elements in the Transaction Header Segment, all Institutional 837 Claim Loops and Segments are of variable length. Segments within loops and elements within segments occur only when data is present. There are no blank or null fields. In some situations, zero field values are acceptable.

- On claims submitted to AHCCCS, 837 loops, segments, and data elements that involve coordination of benefits with other payers are used to show payments made by third party carriers, including Medicare and commercial health insurance companies.

Transaction Specifications Table

The Institutional 837 Claim Transaction Specifications for individual data elements are shown in the table starting on the next page. Definitions of table columns follow.

Loop ID
The Implementation Guide's identifier for a data loop within a transaction.

Segment ID
The Implementation Guide's identifier for a data segment within a loop.

Element ID
The Implementation Guide's identifier for a data element within a segment.

Element Name
A data element's name as shown in the Implementation Guide. When the Industry Name differs from the Data Element Dictionary name, the more descriptive Industry Name is used.

Element Definition
How the data element is defined in the Implementation Guide.

Adjudication Usage
An indication of how a data element is used in AHCCCS claim adjudication.
R = Required on all transactions of this type by either the transaction's HIPAA Implementation Guide or by current PMMIS processing.
R/A = Required if applicable – Accident Date, for example, is required if a claim's medical services result from an accident.
O = Optional – Present or not present at the discretion of the trading partner.

Valid Values
The valid values from the Implementation Guide that are used by AHCCCS.

Definition/Format
Definitions of valid values used by AHCCCS and additional information about AHCCCS data element requirements.

837 INSTITUTIONAL CLAIM TRANSACTION SPECIFICATIONS							
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Adjud Usage**	**Valid Values**	**Definition/Format**
N/A	REF	REF02	Transmission Type Code	Code identifying the type of transaction or transmission included in the transaction set	R		Values specified for this element differ in the original Implementation Guide and the Addenda. AHCCCS has adopted Addenda features and is using Addenda values. Valid values are: Pilot Testing: 004010X096DA1 Production: 004010X096A1
1000A	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	R	46	Electronic Transmitter Identification Number (ETIN)
1000A	NM1	NM109	Submitter Identifier	Code or number identifying the entity submitting the claim	R		AHCCCS identifies submitting providers and billing agents with a five-digit number consisting of the five-digit Electronic Supplier Number (ESN) assigned by the AHCCCS Information Services Division (ISD).
1000B	NM1	NM103	Receiver Name	Name of organization receiving the transaction	R	AHCCCS	The transaction receiver
1000B	NM1	NM108	Information Receiver Identification Number	The identification number of the individual or organization who expects to receive information in response to a query	R	46	Electronic Transmitter Identification Number (ETIN)
1000B	NM1	NM109	Receiver Primary Identifier	Primary identification number for the receiver of the transaction	R	866004791	AHCCCS Federal Tax ID
2010AA	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	R	24 or 34	Employer's Identification Number or Social Security Number Enter the qualifier for the Federal Tax ID or Social Security Number used by the billing provider.
2010AA	NM1	NM109	Billing Provider Identifier	Identification number for the provider or organization in whose name the bill is submitted and to whom payment should be made	R		The Federal Tax ID or Social Security Number used by the billing provider.
2010AA	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	R	1D	Medicaid Provider Number

837 INSTITUTIONAL CLAIM TRANSACTION SPECIFICATIONS							
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Adjud Usage**	**Valid Values**	**Definition/Format**
2010AA	REF	REF02	Billing Provider Additional Identifier	Identifies another or additional distinguishing code number associated with the billing provider	R		For all claims except Medicare crossovers, the AHCCCS ID and Location Code of the rendering provider. Submit this number with two leading zeros. The format is 00aaaaaall when aaaaaa is the AHCCCS Provider ID and ll the Location Code. The REF02 Provider ID field should always be populated, both when the Billing Provider is the same as the Servicing or Rendering Provider and when the IDs are different. On Medicare crossovers, use the Medicare Provider ID without leading zeros.
2000B	SBR	SBR02	Individual Relationship Code	Code indicating the relationship between two individuals or entities	R	18	Self
2000B	SBR	SBR09	Claim Filing Indicator Code	Code identifying type of claim or expected adjudication process	R	MC	Medicaid
2010BA	NM1	NM108	Identification Code Qualifier	Code designating the system or method of code structure used for the Identification Code	R	MI	Member Identification Number
2010BA	NM1	NM109	Subscriber Primary Identifier	Primary identification number of the subscriber to the coverage	R		AHCCCS Recipient ID
2010BC	NM1	NM103	Payer Name	Name identifying the payer organization	R	AHCCCS	The “destination payer” according to the Implementation Guide.
2010BC	NM1	NM109	Payer Identifier	Number identifying the payer organization	R	866004791	The AHCCCS Federal Tax ID Number
2300	CLM	CLM01	Patient Account Number	Unique identification number assigned by the provider to the claim patient to facilitate posting of payment information and identification of the billed claim	R		This is the Patient Account Number used by the provider that performed the service. For HIPAA, the maximum length of the field is 20 characters.
2300	CLM	CLM05-1	Facility Type Code	Code identifying the type of facility where services were performed; the first and second positions of the Uniform Bill Type code or the Place of Service code from the Electronic Media Claims National Standard Format	R		The first two characters of the Uniform Billing (UB) Type of Bill field on institutional claims.

837 INSTITUTIONAL CLAIM TRANSACTION SPECIFICATIONS							
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Adjud Usage**	**Valid Values**	**Definition/Format**
2300	CLM	CLM05-2	Facility Code Qualifier	Code identifying the type of facility referenced	R	A	Uniform Billing Claim Form Bill Type
2300	CLM	CLM05-3	Claim Frequency Code	Code specifying the frequency of the claim. This is the third position of the Uniform Billing Claim Form Bill Type.	R		The Claim Frequency Code is the third character of the UB Type of Bill field on institutional claims. A value of “6” (Corrected) was originally included in 837 Implementation Guides but deactivated by Designated Standards Maintenance Organizations (DSMOs). It is no longer valid. Changes cannot be made to existing adjudicated claims (as identified by CRN) with the new CLM05-3 coding scheme. Instead, a claim must be “replaced” (CLM05-3 = “7”). Replacements are intended to void prior claims (identified by CRN) before adding the replacement with a new CRN. Under HIPAA, AHCCCS continues to accept interim inpatient claims with appropriate Claim Frequency Codes.
2300	CLM	CLM18	Explanation of Benefits Indicator	Indicator of whether a paper explanation of benefits (EOB) is requested	R		AHCCCS does not provide paper EOBs and will not respond to any value in this required institutional element. Recommend “N” (Paper EOB Not Requested) in CLM18.
2300	DTP	DTP01	Date Time Qualifier	Code specifying the type or date or time, or both date and time	R/A	096	Discharge Only the Discharge Hour is present on this DTP Segment. The Discharge Date on a discharge claim is the Through Date in the Statement Date DTP Segment when the Claim Frequency Code (CLM05-3) indicates a discharge. Although it is required by HIPAA, AHCCCS does not use the Discharge Hour in claim adjudication.

837 INSTITUTIONAL CLAIM TRANSACTION SPECIFICATIONS							
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Adjud Usage**	**Valid Values**	**Definition/Format**
2300	DTP	DTP02	Date Time Period Format Qualifier	Code indicating the date format, time format, or date and time format	R/A	TM	Time expressed in format HHMM
2300	DTP	DTP03	Discharge Hour	The time at which the patient was discharged from a facility	R/A		Although the Discharge Time must include minutes on the 837 Transaction, minutes are truncated for AHCCCS claim adjudication. Enter "00" if discharge minutes are unknown. The Discharge Date, if present, appears as the Statement Through Date in the next DTP Segment. This date can be considered a Discharge Date when the Claim Frequency Code (CLM05-3) has a value that indicates a discharge.
2300	DTP	DTP01	Statement Date or Range Qualifier	Indicator of a Statement Date or Range DTP Segment	R	434	Statement The Statement Date can be either a single date or a date range. Normally, it is a single date on outpatient claims and a date range on inpatient claims. In combination with a Claim Frequency Code (CLM05-3) that indicates a discharge, the Through Date of the Statement Date Range serves as the Discharge Date.
2300	DTP	DTP01	Date/Hour Qualifier	Code specifying type of date or time or both date and time	R	435	Admission
2300	DTP	DTP02	Date/Time Period Format Qualifier	Code indicating the date format, the time format or the date and time format	R	DT	Date and time expressed in format CCYYMMDDHHMM.
2300	DTP	DTP03	Admission Date and Time	Admission Date and Hour	R		Although the admission time must include minutes on the 837 Transaction, minutes are truncated for AHCCCS claim adjudication. Enter "00" if admission minutes are unknown.

837 INSTITUTIONAL CLAIM TRANSACTION SPECIFICATIONS							
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Adjud Usage**	**Valid Values**	**Definition/Format**
2300	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	R/A	F8	Original Reference Number This REF Segment is required on replacement and void claims. The Original Reference Number is the AHCCCS CRN assigned to the claim being replaced or voided (when CLM05-3 = “7” or “8”).
2300	REF	REF02	Claim Original Reference Number	Number assigned by a processor to identify a claim	R/A		The AHCCCS assigned Claim Reference Number (CRN) for the claim being replaced or voided.
2300	REF	REF01	Reference Identification Qualifier	Code qualifying the Reference Identification	R/A	G1	Prior Authorization Number Although this REF Segment can also be used for Referral Numbers, AHCCCS is only concerned with PA Numbers for services that were authorized by AHCCCS.
2300	REF	REF02	Prior Authorization Number	The AHCCCS assigned Prior Authorization Number for all services on the claim	R/A		The Prior Authorization Number
2300	HI	HI01-1	Code List Qualifier Code	Code qualifying the Reference Identification – Other Diagnosis Codes	R/A	BF	Diagnosis These are diagnoses in addition to the required Principal Diagnosis Codes in a previous segment. The 837 Transaction can accommodate up to 24 occurrences of Other Diagnoses on institutional claims. However, only the initial eight (in the first of the two possible HI Segments) are used by AHCCCS in claim adjudication.
2300	HI	HI01-1	Code List Qualifier Code	Code identifying Principal Procedures – Principal Procedure Codes	R/A	BR	International Classification of Diseases Clinical Modification (ICD-9-CM) Principal Procedure AHCCCS expects ICDC-9 Procedure Codes to be submitted in the claim-level 2300 Loop for impatient services. HCPCS outpatient procedures are submitted at the service line level in the 2400 Loop of the Institutional 837.

837 INSTITUTIONAL CLAIM TRANSACTION SPECIFICATIONS							
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Adjud Usage**	**Valid Values**	**Definition/Format**
2300	HI	HI01-1	Code List Qualifier Code	Code qualifying the Reference Identification – Other Procedure Codes	R/A	BQ	International Classification of Diseases Clinical Modification (ICD-9-CM) Procedure AHCCCS expects ICD-9-CM Procedure Codes to be used for inpatient procedures and for HCPCS Codes to be used at the service line level for outpatient procedures. The 837 Transaction can accommodate up to 24 occurrences of Other Procedures on institutional claims. However, only the initial five are used by AHCCCS in claim adjudication.
2300	HI	HI01-1	Code List Qualifier Code	Code qualifying the Reference Identification – Occurrence Span Codes	R/A	BI	Occurrence Span The 837 Transaction can accommodate up to 24 occurrences of Occurrence Span Codes on institutional claims. However, only the initial two (in the first of the two possible HI Segments) are used by AHCCCS in claim adjudication.
2300	HI	HI01-1	Code List Qualifier Code	Code qualifying the Reference Identification – Occurrence Codes	R/A	BH	Occurrence The 837 Transaction can accommodate up to 24 occurrences of Occurrence Codes on institutional claims. However, only the initial eight (in the first of the two possible HI Segments) are used by AHCCCS in claim adjudication.
2300	HI	HI01-1	Code List Qualifier Code	Code qualifying the Reference Identification – Value Codes	R/A	BE	Value The 837 Transaction can accommodate up to 24 occurrences of Value Codes on institutional claims. However, only the initial 12 (those in the first of two possible HI Segments) are used by AHCCCS in claim adjudication.

837 INSTITUTIONAL CLAIM TRANSACTION SPECIFICATIONS							
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Adjud Usage**	**Valid Values**	**Definition/Format**
2300	HI	HI01-1	Code List Qualifier Code	Code qualifying the Reference Identification – Condition Codes	R/A	BG	Condition The 837 Transaction can accommodate up to 24 occurrences of Occurrence Codes on institutional claims. However, only the initial eight (in the first of the two possible HI Segments) are used by AHCCCS in claim adjudication.
2300	HI	HI01-1	Code List Qualifier Code	Code qualifying the Reference Identification – Treatment Codes	R/A	TC	Treatment Codes The 837 Transaction can accommodate up to 24 occurrences of home health Treatment Codes on institutional claims. However, Treatment Codes are not used by AHCCCS claim adjudication.
2300	QTY	QTY01	Quantity Qualifier	Code specifying the type of quantity	R/A	CA CD LA NA	Covered – Actual Co-insured - Actual Life-time Reserve - Actual Number of Non-covered Days AHCCCS requires a value of “NA” when non-covered days are reported. Data in segments with other QTY01 values will not be used for adjudication.
2300	QTY	QTY02	Claim Days Count	The number of categorized days associated with the claim, such as lifetime reserve days, covered days	R/A		The number of non-covered days
2300	QTY	QTY03-1	Unit or Basis for Measurement Code	Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken	R/A	DA	Days Use whole numbers without decimal points. AHCCCS does not process partial days.
2310A	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	R/A	24 or 34	Employer’s Identification Number Social Security Number
2310A	NM1	NM109	Attending Physician Primary Identifier	Primary identification number of the physician responsible for care of the patient	R/A		The attending physician’s Federal Tax ID or Social Security Number

837 INSTITUTIONAL CLAIM TRANSACTION SPECIFICATIONS							
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Adjud Usage**	**Valid Values**	**Definition/Format**
2310A	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	R/A	1D 1C	Medicaid Provider Number Medicare Provider Number
2310A	REF	REF02	Attending Physician Secondary Identifier	Secondary identification number of the physician responsible for the care of the patient	R/A		For all claims except Medicare crossovers, the AHCCCS Provider ID. Insert two digits in front of the six-digit AHCCCS Provider ID. On Medicare crossovers, use the Medicare Provider ID without leading zeros.
2310E	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	R/A	24	Employer's Identification Number Submit the 2310E Laboratory or Facility Loop only if the ID of the facility is different from the ID of the billing provider in Loop 2010AA.
2310E	NM1	NM109	Laboratory or Facility Primary Identifier	Identification number of laboratory or other facility performing laboratory testing on the claim where the health care service was performed/rendered	R/A		The facility's Federal Tax ID
2310E	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	R/A	1D 1C	Medicaid Provider Number Medicare Provider Number
2310E	REF	REF02	Laboratory or Facility Secondary Identifier	Additional identifier for the laboratory or facility performing tests billed on the claim where the health care service was performed/rendered	R/A		Use this loop to identify the facility if its ID is different from the ID of the Billing Provider. For all claims except Medicare crossovers, this is the AHCCCS Provider ID and Location Code of the facility. Insert two zeros in front of the AHCCCS Provider ID. On Medicare crossovers, use the Medicare Provider ID without leading zeros.
2320	SBR	SBR01	Payer Responsibility Sequence Number Code	Code identifying the insurance carrier's level of responsibility for a payment of a claim	R/A	P S T	Primary Secondary Tertiary

837 INSTITUTIONAL CLAIM TRANSACTION SPECIFICATIONS							
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Adjud Usage**	**Valid Values**	**Definition/Format**
							The 2320 Other Subscriber Information Loop is for information on payers other than AHCCCS that have adjudicated the claim. Element SBR01 can have any of the above values. Loop 2320 can occur up to ten times for up to ten payers other than AHCCCS. 2320 is an "umbrella loop" that contains within it Loops 2330A through 2330E. All of these loops can be repeated as needed for each payer. Other payer loops occur at the service line level as well.
2320	SBR	SBR02	Individual Relationship Code	Code indicating the relationship between two individuals or entities	R/A		Any of the values listed in the Implementation Guide can be used, depending on the patient's relationship to the primary subscriber covered by the other payer.
2320	SBR	SBR03	Insured Group or Policy Number	The identification number, control number, or code assigned by the carrier or administrator to identify the group under which the individual is covered	R/A		A Group or Policy Number associated with the other payer's coverage.
2320	SBR	SBR04	Other Insured Group Name	Name of the group or plan through which the insurance is provided to the other insured	R/A		A Group or Policy Name associated with SBR03.
2320	CAS	CAS01	Claim Adjustment Group Code	Code identifying the general category of payment adjustment	R/A		On 837 Transactions, "adjustments" are changes from Billed to Paid Amounts at the claim or service line level. A CAS Segment is needed if the amount that the other carrier pays the provider is different from the amount charged. If the change from Charged to Paid Amount is at the service line level, use the CAS Segment in Loop 2430 rather than this one. The service line adjustment does not need to be accommodated at the claim level

837 INSTITUTIONAL CLAIM TRANSACTION SPECIFICATIONS							
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Adjud Usage**	**Valid Values**	**Definition/Format**
2320	CAS	CAS02	Adjustment Reason Code	Code that indicates the reason for the adjustment	R/A	Many Code Set Values	Hundreds of Adjustment Reason Code values are maintained on the Washington Publishing Company's Web Site (www.wpc-edi.com). Submit the code value or values that best describe the reason for the difference between the Charged Amount and the Paid Amount. These are the same Adjustment Reason Codes that appear on the 835 Claim Remittance Advice Transaction. The 837 Transaction is designed to pick them up from the other payer's 835. If other carriers transmit 835 Remittance Advice Transactions to submitting providers, data from these transactions can be the source of the Adjustment Reason Code(s) on the 2320 Loop. The "adjustment trio", consisting of Adjustment Reason Code, Adjustment Amount, and Adjustment Quantity, occurs up to six times within each CAS Segment.
2320	CAS	CAS03	Adjustment Amount	Adjustment amount for the associated reason code	R/A		The difference between the claim level Charged Amount and Paid Amount associated with the Adjustment Reason Code in CAS02. A positive number when the Paid Amount is less than the Charged Amount.
2320	CAS	CAS04	Adjustment Quantity	Numeric quantity associated with the related reason code for coordination of benefits	O		The difference between the billed and paid units of service for all service lines when the difference is the result of claim level adjudication and is associated with the Adjustment Reason Code in CAS02. A positive number when the Paid Quantity is less than the Charged Quantity.

837 INSTITUTIONAL CLAIM TRANSACTION SPECIFICATIONS							
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Adjud Usage**	**Valid Values**	**Definition/Format**
2320	MIA	MIA01	Covered Days or Visits Count	The quantity of covered days or visits	R/A		The Medicare Inpatient Adjudication MIA Segment is required if data for it is available from an electronic remittance advice (835 Transaction). This segment is used for inpatient adjudication Information, including standard HIPAA Remark Codes, generated by Medicare or another carrier. Institutional 837s have both MIA and MOA (Medicare Outpatient Adjudication) Segments. With the exception of Element MIA01, which is required, if the MIA Segment is present, data elements within the MIA Segment are situational. They reflect adjudication by Medicare or another payer and should be included if available to the submitter.
2320	MOA	MOA01	Reimbursement Rate	Rate used when payment is based upon a percentage of applicable charges	R/A		The Medicare Outpatient Adjudication MOA Segment is required if data for it is available from an electronic remittance advice (835 Transaction). This segment is used for outpatient adjudication Information, including standard HIPAA Remark Codes generated by Medicare or another carrier. The MIA Segment carries similar data, including Remark Codes, for inpatient claims. All data elements within the MOA Segment are situational. They reflect adjudication by Medicare or another payer and should be included if available to the submitter.
2330A	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	R/A	MI	Member Identification Number
2330A	NM1	NM109	Other Insured Identifier	An identification number, assigned by the third party payer, to identify the additional insured individual	R/A		The Subscriber ID assigned by the other payer.

837 INSTITUTIONAL CLAIM TRANSACTION SPECIFICATIONS							
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Adjud Usage**	**Valid Values**	**Definition/Format**
2330B	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	R/A	PI	Payer identification
2330B	NM1	NM109	Other Payer Primary Identifier	An identification number for the other payer	R/A		Any identification number assigned to the other payer.
2330B	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	R/A	F8	Original Reference Number Use code F8 to indicate the payer's claim number assigned to this claim by the other payer referenced in this iteration of Loop 2330B.
2330B	REF	REF02	Other Payer Secondary Identifier	Additional identifier for the other payer organization	R/A		The other payer's claim control number for the claim. This is not the CRN that AHCCCS assigns to the claim.
2400	LX	LX01	Assigned Number	Number assigned for differentiation within a transaction set	R		The other carrier's Claim Line Number, not the Claim Line Number assigned by AHCCCS. The Institutional 837 Transaction supports up to 999 lines.
2400	SV2	SV201	Service Line Revenue Code	The Revenue Code maintained by the National Uniform Billing Committee (NUBC)	R/A		This is the Revenue Code used to bill inpatient services. Not expected for outpatient.
2400	SV2	SV202-1	Product or Service ID Qualifier	Code identifying the type/source of the descriptive number used in Product/Service ID	R/A		Claim submitters use HCPCS Procedure Codes (Qualifier "HC") in this segment for outpatient institutional services. At this time, "HC" is the only Qualifier value used by AHCCCS. One or more HCPCS Procedure Code is required for all outpatient institutional claims.

837 INSTITUTIONAL CLAIM TRANSACTION SPECIFICATIONS							
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Adjud Usage**	**Valid Values**	**Definition/Format**
2430	SVD	SVD01	Payer Identifier	Number identifying the payer organization	R/A		The 2430 Service Line Adjudication Information Loop is required if this claim had been previously adjudicated by a payer identified in Other Payer Name Loop 2330B and this service line has adjustments (differences between charged and paid amounts) applied to it. There is no HIPAA standard for the payer identifier. For AHCCCS claims, it must match a payer identifier in an Other Payer Name 2330B Loop.
2430	SVD	SVD03-1	Product or Service ID Qualifier	Code identifying the type/source of the descriptive number used in Product/Service ID	R/A	HC	Health Care Financing Administration Common Procedural Coding Systems (HCPCS) Codes HCPCS Codes are required on outpatient institutional claims for outpatient services paid by other carriers.
2430	CAS	CAS01	Claim Adjustment Group Code	Code identifying the general category of payment adjustment	R/A	CO CR OA PI PR	Contractual Obligations Correction and Reversals Other Adjustments Payer Initiated Reductions Patient Responsibility Enter the code value that best describes the reason for the different between the Charged Amount and the Paid Amount for this service line. This CAS Segment is used only when another payer has made an adjustment is for payment at the service line level. The trio of Adjustment Reason, Amount, and Quantity can occur up to six times per CAS Segment and CAS Segments have up to 99 iterations per service line.

837 INSTITUTIONAL CLAIM TRANSACTION SPECIFICATIONS							
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Adjud Usage**	**Valid Values**	**Definition/Format**
2430	CAS	CAS02	Adjustment Reason Code	Code that indicates the reason for the adjustment	R/A	Many Code Set Values	Hundreds of Adjustment Reason Code values are maintained on the Washington Publishing Company's Web Site (www.wpc-edi.com). Enter the code value that best describes the reason for the difference between the Charged Amount and the Paid Amount.
2430	CAS	CAS03	Adjustment Amount	Adjustment amount for the associated reason code	R/A		The difference between the service line level Charged Amount and Paid Amount associated with the Adjustment Reason Code in CAS02. A positive number when the Paid Amount is less than the Charged Amount.
2430	CAS	CAS04	Adjustment Quantity	Numeric quantity associated with the related reason code for coordination of benefits	O		The difference between the billed and paid units of service when the difference is the result of line level adjudication and is associated with the Adjustment Reason Code in CAS02. A positive number when the Paid Quantity is less than the Charged Quantity.