Health Net/Centene

- Trading Partner guidelines for 837 5010 professional and institutional submissions.
- To be added to HN 837 companion guides.

Items covered by this document

- ✓ ST / SE Standards
- ✓ ISA / GS Standards (encounter)
- ✓ Provider Id – Mandatory Required Fields

ST / SE Standards

All ST / SE standards are applied by our Clearinghouse FinThrive at Health Net's direction.

- Health Net requires at least one ST and one SE record per Submitter ID within a submission.
- This means that Health Net requires one ST and one SE for each unique occurrence of the 1000A NM109 Submitter ID field.
- We have noted that some submitters are sending a unique instance of ST/SE records for every claim/encounter within the submission. Our Translator is able to process a unique instance ST/SE combination.

FinThrive ISA / GS Standards to Health Net only.

Our standards are shown below.

837 Inbound Transaction (Health Net is the Receiver)

X12 Data Element	Description	Values Used	Comments
Clearinghouse Rule – for receiver id			
ISA07	Receiver Qualifier	30 or ZZ	30 or ZZ
ISA08	Receiver Id	As agreed, upon	Health Net of CA Tax Id (~~———~~)
Clearinghouse Rule – for GS03 field			
GS03	Receiver's Code	As agreed, upon	Identifies HN health plan encounters submission

Professional 837

Provider ID – Professional (See tables below)

1. **Billing Provider Name, NPI** and **Taxonomy** is required in Loop 2010AA. The Billing Provider state and zip code is required when the address is in the United States.
   Medicare Atypical Only: Professional NPI (1999999984) and DME NPI (199999999)
   Medi-Cal Atypical Only: Atypical Taxonomy Code, no Billing NPI, 2010 BB REF*G2 must contains 9 digits
2. **Referring Provider Name** and **NPI** is required in loop 2310A if referred. Required on DME Services
3. **Rendering Provider Name, NPI** and **Taxonomy** is required in loop 2310B if different that Billing Provider
4. **Service Facility Name** and **NPI** is required in loop 2310 if different than the Billing Provider.

Billing Provider **REQUIRED**

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2000A	PRV	PRV01	BI	Provider Code
2000A	PRV	PRV02	PXC	Reference Qualifier
2000A	PRV	PRV03		Billing Provider Taxonomy Code
2010AA	NM1	NM103		Billing Provider Last Name/Org Name
2010AA	NM1	NM104		First Name **Required** if NM102 = 1 (Person and has First Name)
2010AA	NM1	NM108	XX	Qualifier
2010AA	NM1	NM109		Billing Provider NPI
2010AA	REF	REF01	EI or SY	ID Qualifier
2010AA	REF	REF02		Tax ID No. /Social Security No.
2010AA	REF	N301		Billing Provider Address
2010AA	REF	N401		Billing Provider City
2010AA	N4	N402		Billing Provider State
2010AA	N4	N403	9 digits	Billing Provider Zip Code Note: Last 4 digits cannot be 0000 or 9999; the new default value is 9998.

Referring Provider (Claim Level) Entity Type 1 = Person **REQUIRED if Referred or DME**

Loop Id	Segment Id	Reference Designator			Values	Descriptions
2310A	NM1	NM108			XX	Qualifier
2310A	NM1	NM109				Referring Provider NPI
2310A	REF	REF01			G2	Provider Commercial Number
2310A	REF	REF02			9999	Referring Provider Tribal Indicator - Used to identify a Tribal Provider

Rendering Provider (Claim Level) Entity Type 1 = Person **REQUIRED if different than Billing Provider in Loop 2010AA**

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2310B	NM1	NM103		Rendering Provider Last Name/Org Name
2310B	NM1	NM104		First Name **Required** if NM102 = 1 (Person and has First Name)
2310B	NM1	NM108	XX	Qualifier
2310B	NM1	NM109		Rendering Provider NPI
2310B	PRV	PRV01	PE	Provider Code
2310B	PRV	PRV02	PXC	Reference Qualifier
2310B	PRV	PRV03		Rendering Provider Taxonomy Code

2310B	REF	REF01	G2	Provider Commercial Number
2310B	REF	REF02	9999	Rendering Provider Tribal Indicator - Used to identify a Tribal Provider

Service Facility (Claim Level) **REQUIRED if different than Billing Provider Loop 2010AA)**

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2310C	NM1	NM103		Laboratory of Facility Name
2310C	NM1	NM108	XX	Qualifier
2310C	NM1	NM109		Service Facility NPI
2310C	N3	N301		Billing Provider Address
2310C	N4	N402		Billing Provider State
2310C	N4	N403	9 digits	Billing Provider Zip Code Note: Last 4 digits cannot be 0000 or 9999; the new default value is 9998.

Professional Requirements:

Total Claim Charge Amount, Admission Date, Patient responsibility, Allowed Amount, Anesthesia Qualifier, Co-Pay, Co-insurance, Deductible, Ambulance Transport, In and Out of Network Indicator, UD Modifier, National Drug Code (*PAD*), DRG, Newborn Submission, Duplicate logic, Twin Logic, Same Procedure Code submission and VAR (*Void/Adjustment/Replacement*)- Professional (***See requirement details below***)

1. **Total Claim Charge Amount** (Loop 2300 CLM02) Medicare encounter cannot be less than 0 or greater than 99,999.99. Medi-Cal cannot be less than 0 or any amount over 1 million.

2. **Admission Date** is required on all inpatient medical visits. Admission date must be equal to or less than from Service line From Date.

3. **Patient responsibility** amount AMT*F5 is required if Loop 2430 contains CAS PR 1, 2 or 3. If Loop 2430 does not contain CAS*PR* (1, 2 or 3) do not send.

4. **Allowed Amount** - This is a CMS requirement. The HCP*10 (loop 2400) segment at the line level is required on all capitated encounters submission. HCP02 Allowed Amount must be 0 or greater.

5. **Anesthesia Qualifier Requirement (**Loop 2400 SV103) must be **MJ** when procedure code qualifier (SV101-03, 04, 05, 06) is an anesthesia **Service Line Quantity Qualifier (**Loop 2400 SV103) must be **MJ** when procedure code qualifier (SV101-03, 04, 05, 06) is an anesthesia modifier (AA, AD, QK, QX, QY or QZ). Per CMS services that contain an **anesthesia procedure code must be submitted with the appropriate anesthesia modifier in the first position**. Additional modifiers QS, G8 and G9 are to be placed in the second position. ***Additional Modifier QS will be added to our logic third quarter of 2024.

6. **Patient coinsurance, copayment and deductible** is required on all professional (*Medicare, Commercial & ACA*) encounters in **Loop 2430** in the x12 837 **CAS*PR*1, 2 or 3** segment when patient responsibility is greater than 0. The total CAS PR values must match Loop 2300 AMT*F5 value.

7. **Ambulance Transport** is required on all professional encounters when billing for ambulance or non-emergency transportation. (**CLM05-01 is '41' or '42'**).

8. **In and Out of Network** is required in Loop 2300 HCP15 in the x12 837 when known.

9. Service lines that have a **340B physician-administered drug** should include the "**UD**" modifier in the procedure code qualifier positions (Loop 2400 SV101).

10. **National Drug Code (NDC)** (Loop 2410 LIN03) is required on all outpatient Physician-Administered Drugs (PADs). A PAD is any covered drug provided or administered to a patient which is billed by a provider other than a pharmacy. Includes any method of administration and is not limited to injectable drugs.

11. **National Drug Code (NDC) Loop 2410 CPT04** unit count quantity is required to be greater than 0 (zero).

12. **DRG Codes** are not allowed in Medi-Cal capitated encounter records. They will be rejected by DHCS if submitted.

13. **Newborn Submission**

Current Guideline to submit Newborn encounters is within 30 days of birth.

- CM = Commercial, MC = Medicare, ACA = Affordable Care Act, ** ML = MediCal

** Guideline to submit Newborn encounters month of birth plus next month. – Effective Date: 10/23/2023

- ML = MediCal

Newborn can be submitted as a subscriber in Loop 2010BA, Subscriber Name field and in ID field a father's ID or a mother's ID can be submitted depending on the product line:

- Father's ID or Mother's ID (CM, MC, ACA)
- Mother's ID (ML)

Below is the example:

Newborn can be billed as a subscriber:

If the Newborn does NOT have eligibility from the date of birth

HL*2*1*22*1~
SBR*S**1145A******HM~
NM1*IL*1* Newborn Last Name*Newborn First Name****MI*Subscriber ID (ML- Mother's CIN ID) ~
N3*100 DOWNTOWN RD~
N4*ELK GROVE*CA*922209999~
DMG*D8*Newborn DOB*Newborn Gender type~
CLM*12340*100***13>B>1*Y*A*Y*Y~
LX*1~
DTP*472*D8*Date of Service~

OR

Newborn is billed as a dependent

In loop 2000C Patient Information **PAT*19** Individual Relationship Segment (child/dependent) and in loop 2010CA **NM1*QC**, submit newborn information in this segment and Subscriber can be submitted as a father or a mother depending on the product line:

- Father's Information or Mother's Information (CM, MC, ACA)
- Mother's Information (ML)

Or in some cases the first name can be submitted under PAT*19 as a "BABY" and the last name as BOY or GIRL.

Below is the example:

HL*2*1*22*1~
SBR*S**1145A******HM~
NM1*IL*1*Subscriber Last Name*Subscriber First Name****MI*Subscriber ID ~
NM1*PR*2*HEALTH NET*****PI* 954402957~
HL*3*2*23*0~
PAT*19~
NM1*QC*1*Newborn Last Name* Newborn First Name ~
N3*100 DOWNTOWN RD~
N4*ELK GROVE*CA*922209999~

DMG*D8*Newborn DOB*Newborn Gender type~
CLM*12340*100***13>B>1*Y*A*Y*Y~
LX*1~
DTP*472*D8*Date of Service~

OR
Newborn is billed as a subscriber:
If the Newborn has eligibility from the date of birth
Submit the newborn as the subscriber in Loop 2010BA Subscriber Name NM1 segment.

Below is the example:
HL*2*1*22*1~
SBR*S**1145A******HM~
NM1*IL*1*Subscriber Last Name*Subscriber First Name****MI*Subscriber ID~
N3*100 DOWNTOWN RD~
N4*ELK GROVE*CA*922209999~
DMG*D8*Subscriber DOB*Subscriber Gender type~
CLM*12340*100***13>B>1*Y*A*Y*Y~
LX*1~
DTP*472*D8*Date of Service~

14. **Duplicate logic (MediCal LOB Only)** *to align with DHCS duplicate logic guideline, bolded in **red** below are the fields added – **Effective 10/23/23***
    - Member ID
    - Date(s) of Service – 2400 DTP*472 DTP03 *(can be a range)*
    - Rendering Provider *(NM1*82)* NPI, none present then Billing provider *(NM1*85)* NPI
    - Procedure Code – 2400 SV101-2 ***First time submission, can be sent more than once (Effective 11/18/2024)***
    - Procedure Modifier(s) – 2400 SV101-3,4,5,6
    - NDC Drug code – 2410 LIN03 – *(Drug code is used when it is present).*
    - Place of service
    - Frequency code
    - Remittance/Processed date *(DTP*573)* greater
    - To appropriately represent encounters for the same service that can be performed multiple times in a day, these modifiers **59, 76, 77 and XS** can be used to override the duplicate validation logic. ***Use of these modifiers is strictly monitored by DHCS***.

Duplicate logic (Medicare LOB) - – *Effective 04/29/24*

- Member ID
- Date(s) of Service – 2400 DTP*472 DTP03 (can be a range)
- Rendering Provider (NM1*82) NPI, none present then Billing provider (NM1*85) NPI
- **Paid Amount** - 2320 AMT02 field, AMT01 =" D", AMT02 = Paid Amount
- Procedure Code 2400 SV101-2
- Procedure Modifier(s) – 2400 SV101-3,4,5,6
- **Line Level Billed Amount**- 2400 SV102
- **Line level Paid Amount** -2430 SVD02
- NDC Drug code – 2410 LIN03 – Drug code is used when it is present.
- Place of Service
- Frequency code
- Remittance/Processed date (DTP*573) greater

Duplicate logic (Commercial & Dual LOB)

- Member ID
- Date(s) of Service – 2400 DTP*472 DTP03 *(can be a range)*
- Rendering Provider *(NM1*82)* NPI, none present then Billing provider *(NM1*85)* NPI
- Procedure Code – 2400 SV101-2
- Procedure Modifier(s) – 2400 SV101-3,4,5,6
- NDC Drug code – 2410 LIN03 – *(Drug code is used when it is present).*
- Place of service
- Frequency code
- Remittance/Processed date *(DTP*573)* greater

15. **Twin Logic**: Member's ID, Date of Birth (DOB) and the First name.

16. If the **same procedure code** is submitted more than once on the same date of service, than it must contain a unique modifier or NDC code.

17. **VAR** (*Void/Adjustment/Replacement*) **requirement:** A claim Frequency Code is required on all professional capitated encounters at the claim level Loop 2300 CLM05-03 segment) with a greater process date in service line loop 2430 DTP*573 than the previously accepted.
    a. Frequency code 1 indicates the original encounter
    b. Frequency code 7 indicates a replacement to a previously submitted encounter
    c. Frequency code 8 indicates a voided encounter

Claim Information (Claim Level)

Loop Id	Segment Id		Reference Designator	Values	Descriptions
2300	CLM		CLM05-03	1,7,8	Frequency Type Code 1 = Original 7 = Replacement/Adjustment 8 = Void

Patient Amount Paid (Claim Level) - REQUIRED if Loop 2430 Patient Responsibility is greater than 0)

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2300	AMT	AMT01	F5	Qualifier
2300	AMT	AMT02	Greater than 0	Monetary Amount – Patient Responsibility Amount greater than Zero (0). *Value of 0 cannot be accepted, if zero, please remove segment.* It AMT*F5* is greater than zero (0) must send CAS*PR*(1, 2 or 3) in Loop 2430.

Payer Claim Control Number (Claim Level) REQUIRED if Frequency Code 7 or 8 is sent in CLM05-03)

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2300	REF	REF01	F8	Original Reference ID Number
2300	REF	REF02		Payer Original Claim Control Number

Ambulance Transport Information (Claim Level) REQUIRED when CLM05-01 is '41' or '42')

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2300	CR1	CR101	LB	Unit or Basis for Measurement Code (Pound) – Required if known
2300	CR1	CR102		Patient Weight - Required if known

2300	CR1	CR104	(A, B, C, D, or E)	Ambulance Transport Reason
2300	CR1	CR105	DH	Unit or Basis for Measurement Code (Miles)
2300	CR1	CR106		Transport Distance

Condition Information (Claim Level) **REQUIRED when condition information applies to claim)**

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2300	HI	HI01	BG	Qualifier
2300	HI	HI02		Condition Code

Claim Pricing Repricing Information (Claim Loop) **REQUIRED if known**

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2300	HCP	15	3, 6	In and Out of Network Indicator 1 or 3 = Out of Network 6 = In Network

Admission Date (Claim Level) **REQUIRED on Inpatient claims, = to or less than Statement From Date**

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2300	DTP	DTP01	435	Admission Qualifier
2300	DTP	DTP02	D8 (CCYYMMDD)	Date Time Period Format Qualifier
2300	DTP	DTP03		Admission Date and Hour

Ambulance Transport Pick-Up Location (Claim Level) **REQUIRED when CLM05-01 is '41')**

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2310E	NM1	NM101	PW	Entity Identifier Code
2310E	NM1	NM102	2	Entity Type Qualifier (Non-Person)
2310E	N3	N301		Pick-up Address
2310E	N4	N401		Pick-up City
2310E	N4	N402		Pick-up State if in USA or Canada
2310E	N4	N403		Pick-up Zip Code if in USA or Canada
2310E	N4	N404		Pick-up Country if outside USA or Canada

Ambulance Transport Drop-Off (Claim Level) **REQUIRED when CLM05-01 is '41'**

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2310F	NM1	NM101	45	Entity Identifier Code
2310F	NM1	NM102	2	Entity Type Qualifier (Non-Person)
2310F	NM1	NM103		Last Name or Organization Name of Ambulance transport drop-off location (Required if known)

Other Subscriber Information (Claim Level) **REQIRED to send Patient Responsibility and Adjustment Reason Codes**

Loop Id	Segment Id	Reference Designator	Values	Descriptions

2000B	SBR	SBR01	S	S = Secondary
2000B	SBR	SBR02	18	Required if loop 2000C is NOT present
2000B	SBR	SBR09		Insurance Type Code 16 = HMO Medicare Risk CI = Commercial HM = Health Maintenance Org
2320	SBR	SBR01	P	Payer Responsibility Sequence Number Code
2320	AMT	AMT01	D	Payor Amount Paid Qualifier
2320	AMT	AMT02	0 or greater	Payer Paid Amount (0 or greater) Must balance to the sum of the SVD service line(s) amount in Loop 2340 NOTE: If Loop 2320 CAS is present Loop 2430 SVD02 minus (-) Loop 2320 CAS Monetary Amount(s) = AMT D
2320	OI	OI03	N, Y, W	Yes/No Condition or Response Crosswalk of CLM08
2320	OI	OI06	I, Y	Release of Information Code Crosswalk of CLM09
2320	MOA	MOA02		HCPCS Payable Amount Required to report Medicare 100% Allowed Amount

Other Subscriber Information (Claim Level)

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2330A	NM1	NM1		Other Subscriber Name
2330A	NM1	NM108		Identification Code Qualifier
2330A	NM1	NM109		Identification Code Delegated Medical Groups Member ID / Subscriber ID
2330B	NM1	NM103		Payer Name Last or Organization Name
2330B	NM1	NM108	PI	Identification Code Qualifier
2330B	NM1	NM109		Identification Code

Line Pricing / Repricing Information (Claim Level)

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2400	SV1	SV101-03,04,05,06	UD	Service lines that have a 340B physician-administered drug should include the “UD” modifier in one of the four available modifier positions.
2400	K3	K301	EHB	Essential Health Benefit Indicator
2400	HCP	HCP01	10	Other Pricing - Required on Medicare encounters
2400	HCP	HCP02	0 or greater	Service Line Allowed Amount – Required on Medicare encounters

Line Adjudication Information (Line Level) **REQUIRED when Patient Responsibility is greater than 0)**

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2430	SVD	SVD01		Other Payer Primary Identifier (same as Loop 2330B NM109)
2430	SVD	SVD02	0 or greater	Monetary Amount – Cannot be a negative number - Required on Medicare encounters NOTE: Loop 2400 SV103 (Prof) Line-Item Charge Amount Loop minus (-) Loop 2340 CAS Monetary Amount(s) = SVD02
2430	SVD	SVD03		Procedure Code

2430	SVD	SVD05		Quantity
2430	CAS	CAS01	CO, CR, OA, PI, PR	Line Adjustment Group Code CO = Contractual Obligation CR = Correction and Reversals OA = Other Adjustment PI = Payer Initiated Reductions **PR = Patient Responsibility** NOTE: When submitting **Member Cost Share** use code **PR** and include the appropriate Claim Adjustment Reason Code in (CAS02) as listed below.
2430	CAS	CAS02, CAS05, CAS08, CAS11, CAS14, CAS17		Line Adjustment Reason Code CAS*PR*1,2,3 **Member Cost Share (PR qualifier), reason codes:** 1 = Deductible Amount 2 = Coinsurance Amount 3 = Co-payment Amount Claim Adjustment Reason Codes are available via Washington Publishing: http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/
2430	CAS	CAS03, CAS06, CAS09 CAS12, CAS15, CAS18		Monetary Amount
2430	DTP	DTP01	573	Payment Date
2430	DTP	DTP02	D8	
2430	DTP	DTP03		CCYYMMDD Payment/Remittance Date

Drug Identification (Line Level) **REQUIRED if procedure code requires a Physician-Administered Drug (PAD)**

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2410	LIN	LIN02	N4	Qualifier
2410	LIN	LIN03		11digit National Drug Code without hyphens
2410	CTP	CTP04	Greater than 0	National Drug Unit Count
2410	CTP	CTP05		Composite Unit of Measure
2410	CTP	CTP05-1	F2, GR, ME, ML, UN	Unit or Basis for Measurement code

Institutional 837

Provider ID scenarios – Institutional (See tables below)

1. **Billing Provider Name, NPI and Taxonomy** is required in loop 2010AA. The Billing Provider state and zip code is required when the address is in the United States.
   MEDICARE Atypical Only: Institutional NPI (1999999976) and DME NPI (1999999992 –Inst)
   Medi-Cal Atypical Only: Atypical Taxonomy Code, no Billing NPI, 2010 BB REF*G2 must contains 9 digits

2. **Attending Provider Name NPI and Taxonomy** must be provided in the loop 2310A when the encounter record contains any service other than non-scheduled transportation.

3. **Service Facility Name** and **NPI** is required in loop 2310E if different than Billing Provider.

4. **Referring Provider Name** and **NPI** is required in loop 2310F when known. Required on DME

5. **Rendering Provider Name** and **NPI** is required in Loop 2310D if different than Attending Provider.

Billing Provider (Claim Level REQUIRED)

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2000A	PRV	PRV01	BI	Provider Code
2000A	PRV	PRV02	PXC	Reference Qualifier
2000A	PRV	PRV03		Billing Provider Taxonomy Code
2010AA	NM1	NM103		Billing Provider Name Last or Organization Name
2010AA	NM1	NM108	XX	Qualifier
2010AA	NM1	NM109		Billing Provider NPI
2010AA	REF	REF01	EI	Employer's ID No. Qualifier
2010AA	REF	REF02		Tax ID
2010AA	N3	N301		Billing Provider Address
2010AA	N4	N401		Billing Provider City
2010AA	N4	N402		Billing Provider State
2010AA	N4	N403	9 digits	Billing Provider Zip Code Note: Last 4 digits cannot be 0000 or 9999; the new default value is 9998.

Attending Physician (Claim Level) **REQUIRED when the claim contains any services other than non-scheduled transportation**

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2310A	NM1	NM103		Attending Provider Name Last or Organization Name
2310A	NM1	NM104		First Name REQUIRED when person has a first name
2310A	NM1	NM108	XX	Qualifier
2310A	NM1	NM109		Referring Provider NPI
2310A	PRV	PRV01	AT	Provider Code
2310A	PRV	PRV02	PXC	Reference Qualifier
2310A	PRV	PRV03		Rendering Provider Taxonomy Code

Operating Physician (Claim Level) **Entity Type 1 = Person**

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2310B	NM1	NM108	XX	Qualifier
2310B	NM1	NM109		Operating Provider NPI

Rendering Provider (Claim Level) **Entity Type 1 = Person REQUIRED if different than Attending**

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2310D	NM1	NM103		Provider Name Last or Organization Name
2310D	NM1	NM104		First Name REQUIRED when person has a first name
2310D	NM1	NM108	XX	Qualifier
2310D	NM1	NM109		Rendering Provider NPI
2310D	REF	REF01	G2	Provider Commercial Qualifier

2310D	REF	REF02	9999	Rendering Provider Tribal Indicator - Used to identify a Tribal Provider.

Service Facility (Claim Level) **REQUIRED if different than Billing Provider Loop 2010AA**

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2310E	NM1	NM103		Laboratory of Facility Name
2310E	NM1	NM108	XX	Qualifier
2310E	NM1	NM109		Service Facility NPI
2310E	N3	N301		Billing Provider Address
2310E	N4	N402		Billing Provider State
2310E	N4	N403	9 digits	Billing Provider Zip Code Note: Last 4 digits cannot be 0000 or 9999; the new default value is 9998.

Referring Provider (Claim Level) **Entity Type 1 = Person**

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2310F	NM1	NM108	XX	Qualifier
2310F	NM1	NM109		Referring Provider NPI
2310F	REF	REF01	G2	Provider Commercial Qualifier
2310F	REF	REF02	9999	Referring Provider Tribal Indicator - Used to identify a Tribal Provider

Institutional Requirements:

Total Claim Charge Amount, Patient Responsibility, Admission Date, Discharge Hours, Admitting Diagnosis, Patient Reason for Visit Code, Present on Admission, In and Out of Network Indicator, Allowed Amount, Patient Responsibility, National Drug Code (PAD), and HIPPS Codes

1. **Total Claim Charge Amount** (Loop 2300 CLM02) Medicare encounter cannot be less than 0 or greater than 99,999,999.99. Medi-Cal cannot be less than 0 any amount over 1 million.

2. The **patient responsibility amount** AMT*F3 is required if Loop 2430 CAS PR 1, 2 or 3 is on any service line in Loop 2430. If no Loop 2430 CAS PR 1, 2 or 3 is submitted do not send.

3. **Admission Date and Admitting Diagnosis Code** is required on all inpatient visits. Patient Reason for Visit is required on certain outpatient visits. Admission date must be equal to or less than Statement from Date.

4. **Discharge Hours** is required in Loop 2300 in the X12 837 DTP*096 segment, when an inpatient service is submitted. This is a **DHCS** requirement.

5. **Present on Admission (POA)** Indicator is required on Inpatient claims Principal Diagnosis, Other Diagnosis, and External Cause of Injury Diagnosis Codes.

6. **In and Out of Network** is required in Loop 2300 HCP15 in the x12 837 when known.

7. **Allowed Amount** - This is a CMS requirement. The HCP*10 segment at the line level (Loop 2400) is required on all capitated encounters submission. HCP02 Allowed Amount must be 0 or greater.

8. **Patient coinsurance, copayment and deductible** is required in Loop 2430 in the x12 837 **CAS*PR*1, 2 or 3** segment when Patient Responsibility is greater than 0. The total CAS PR values must match AMT*F3

9. Service lines that have a **340B physician administered drug** should include the "**UD**" modifier in modifier position (Loop 2400 SV202).

10. The **National Drug Code (NDC)** Loop 2410 LIN03 is required on all outpatient Physicians-Administered Drugs (PADs). A PAD is any covered drug provided or administered to a patient which is billed by a provider other than a pharmacy. Includes any method of administration and is not limited to injectable drugs.

11. **National Drug Code (NDC) Loop 2410 CPT04** unit count quantity is required to be greater than 0 (zero).

12. **Skilled Nursing Facility and Home Health** Medicare and CMC services only must be submitted in the 837-institutional format with at least one HIPPS code on the encounter. SNFs and HHAs encounters must contain a valid (HP) HIPPS code when REV code 0022, 0023, 0024 are present. Effective **01/15/24** - Health Net will be accepting HIPPS codes on the **Medi-Medi** product line to algin with DHCS guidelines. As per DHCS a Medi-Medi/Crossover recipient is identified as eligible for both Medicare and Medi-Cal product type in which case Medicare is responsible for a portion of the encounter and Medi-Cal is responsible for any remaining coverage. 1. If a Medi-Medi/Crossover encounter is submitted, and the member is a Health Net Medicare member, then the encounter will be accepted and processed as Medicare. 2. If a Medi-Medi/Crossover encounter is submitted and the member is not a Health Net Medicare member, then the Claim Filing Indicator on the encounter must be **SBR09 = **MA, MB or 16** in either Loop 2000B, loop 2320, or both in order to accept the HIPPS Codes, otherwise the encounter will be rejected

13. **Duplicate logic process – (Commercial & Dual LOB)**
    - Member ID
    - Statement Date (Loop 2400-line level date *DTP*472 (can be a range),* if not present, then Loop 2300 claim level date *DTP*434*)
    - Attending Provider *(NM1*71)* NPI (except non-scheduled transportation services submitted with the REV codes – 540-549 then Billing provider *(NM1*85)* NPI is required)
    - Procedure Code, – 2400 SV201-2
    - Procedure Modifier(s) – 2400 SV201-3,4,5,6
    - NDC Drug code – 2410 LIN03 – Drug code is used when it is present.
    - Bill Type
    - Frequency code
    - Remittance/Processed date *(DTP*573)* greater

14. **Duplicate logic process - (MediCal lob only)** *to align with DHCS duplicate logic guideline, bolded in **red** below are the fields added – Effective 10/23/23.*
    - Member ID
    - Statement Date (Loop 2400-line level date *DTP*472 (can be a range),* if not present, then Loop 2300 claim level date *DTP*434*)
    - Attending Provider *(NM1*71)* NPI (except non-scheduled transportation services submitted with the REV codes – 540-549 then Billing provider *(NM1*85)* NPI is required)
    - **Rendering Provider** *(NM1*82)*
    - **Revenue Code (Outpatient & Inpatient) – 2400 SV201**
    - **Admission Date/Hour - 2300 DTP*435/DTP03** ***(can be a date or a date/time)***
    - **Discharge Hour - 2300 DTP*096 / DTP03**
    - Procedure Code, – 2400 SV201-2
    - Procedure Modifier(s) – 2400 SV201-3,4,5,6
    - NDC Drug code – 2410 LIN03 – Drug code is used when it is present.
    - Bill Type
    - Frequency code
    - Remittance/Processed date *(DTP*573)* greater
    - **Diagnosis Code - (ICM-10 CM) Z38.30 - Z38.8 (**Diagnosis applies to multiple newborns only)**

    - To appropriately represent encounters for the same service that can be performed multiple times in a day, these modifiers **59, 76, 77 and XS** can be used to override the duplicate validation logic. *Use of these modifiers is strictly monitored by DHCS.*

Duplicate logic (Medicare LOB) - – *Effective 02/12/24*

Medicare Institutional Outpatient Duplicate logic - CHANGES

Member ID
Statement Date (2400 DTP*472 DTP03 (can be a range) if not present Loop 2300 DTP*434)
Attending Provider (NM1*71) NPI (except non-scheduled transportation services submitted with the REV codes – 540-549 then Billing provider (NM1*85) NPI is required)
Paid Amount (2320 AMT02 field, AMT01 =" D", AMT02 = Paid Amount)
Revenue Code – 2400 SV201 – Outpatient ONLY
Procedure Code 2400 SV201-2
Procedure Modifier(s) – 2400 SV201-3,4,5,6
Line Level Billed Amount - 2400 SV203
Line Level Paid Amount - 2430 SVD02
NDC Drug code – 2410 LIN03 – Drug code is used when it is present.
Bill Type
Frequency code
Remittance/Processed date (DTP*573) greater

Medicare Institutional Inpatient Duplicate Logic: NO CHANGES

Member ID
Statement Date (2400 DTP*472 DTP03 (can be a range) if not present Loop 2300 DTP*434)
Attending Provider (NM1*71) NPI (except non-scheduled transportation services submitted with the REV codes – 540-549 then Billing provider (NM1*85) NPI is required)
Procedure Code 2400 SV201-2
Procedure Modifier(s) – 2400 SV201-3,4,5,6
NDC Drug code – 2410 LIN03 – Drug code is used when it is present.
Bill Type
Frequency code
Remittance/Processed date (DTP*573) greater

****Multiple Newborn**

- To report the same service that was performed for the mother and the baby or babies, these modifiers **25, XE, XP, and XU** can be used to override the newborn duplicate validation logic.

15. **Twin Logic**: Member's ID, Date of Birth (DOB) and the First name.

16. **Newborn Submission**

Current Guideline to submit Newborn encounters is within 30 days of birth.
- CM = Commercial, MC = Medicare, ACA = Affordable Care Act, ** ML = MediCal

** Guideline to submit Newborn encounters month of birth plus next month. – Effective Date: 10/23/23
- ML = MediCal

Newborn can be submitted as a subscriber in Loop 2010BA, Subscriber Name field and in ID field a father's ID or a mother's ID can be submitted depending on the product line:

- Father's ID or Mother's ID (CM, MC, ACA)
- Mother's ID (ML)

Below is the example:
Newborn can be billed as a subscriber:
If the Newborn does NOT have eligibility from the date of birth
HL*2*1*22*1~
SBR*S**1145A******HM~
NM1*IL*1* Newborn Last Name*Newborn First Name****MI*Subscriber ID (ML- Mother's id) ~

N3*100 DOWNTOWN RD~
N4*ELK GROVE*CA*922209999~
DMG*D8*Newborn DOB*Newborn Gender type~
CLM*12340*100***13>B>1*Y*A*Y*Y~
LX*1~
DTP*472*D8*Date of Service~
OR
Newborn is billed as a dependent

In loop 2000C Patient Information **PAT*19** Individual Relationship Segment (child/dependent) and in loop 2010CA **NM1*QC**, submit newborn information in this segment and Subscriber can be submitted as a father or a mother depending on the product line:

- Father's Information or Mother's Information (CM, MC, ACA)
- Mother's Information (ML)

Or in some cases the first name can be submitted under PAT*19 as a "BABY" and the last name as BOY or GIRL.

Below is the example:

HL*2*1*22*1~
SBR*S**1145A******HM~
NM1*IL*1*Subscriber Last Name*Subscriber First Name****MI*Subscriber ID ~
NM1*PR*2*HEALTH NET*****PI* 954402957~
HL*3*2*23*0~
PAT*19~
NM1*QC*1*Newborn Last Name* Newborn First Name ~
N3*100 DOWNTOWN RD~
N4*ELK GROVE*CA*922209999~
DMG*D8*Newborn DOB*Newborn Gender type~
CLM*12340*100***13>B>1*Y*A*Y*Y~
LX*1~
DTP*472*D8*Date of Service~

OR
Newborn is billed as a subscriber:
If the Newborn has eligibility from the date of birth
Submit the newborn as the subscriber in Loop 2010BA Subscriber Name NM1 segment.

Below is the example:
HL*2*1*22*1~
SBR*S**1145A******HM~
NM1*IL*1*Subscriber Last Name*Subscriber First Name****MI*Subscriber ID~
N3*100 DOWNTOWN RD~
N4*ELK GROVE*CA*922209999~
DMG*D8*Subscriber DOB*Subscriber Gender type~
CLM*12340*100***13>B>1*Y*A*Y*Y~
LX*1~
DTP*472*D8*Date of Service~

17. If the **same procedure code** is submitted more than once on the same date of service, than it must contain a unique modifier or NDC code.

18. **Allowed Amount** - This is a CMS requirement. The HCP*10 (Loop 2400) segment at the line level is required on all professional and institutional capitated encounters. HCP02 Allowed Amount must be 0 or greater.

19. **VAR** (*Void/Adjustment/Replacement*) **requirement:** A claim Frequency Code is required on all institutional capitated encounters at the claim level Loop 2300 CLM05-03 segment) with a greater process date in service line loop 2430 DTP*573 than the previously accepted. **DHCS** will only accept Frequency code – 1,7,8.
    a. Frequency code 1 indicates the original encounter
    b. Frequency code 6 indicates an adjustment to a previously submitted institutional encounter
    c. Frequency code 7 indicates a replacement to a previously submitted encounter
    d. Frequency code 8 indicates a voided encounter
    e. Frequency codes 1 – 9 are used in institutional encounters

Claim Information (Claim Level)

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2300	CLM	CLM05-03	1,2,3,4,6,7,8	Frequency Type Code 1 = Original 2 = Interim – First Claim 3 = Interim – Continuing Claim 4 = Interim – Last Claim 6 = Adjustment 7 = Replacement 8 = Void

Admission Date (Claim Level) REQUIRED on Inpatient claims, = to or less than 24 hours from Statement From Date

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2300	DTP	DTP01	435	Admission Qualifier
2300	DTP	DTP02	D8 (CCYYMMDD), DT (CCYYMMDDHHMM)	Date Time Period Format Qualifier
2300	DTP	DTP03		Admission Date and Hour

Patient Estimated Amount Due (Claim Level) REQUIRED if Loop 2430 Patient Responsibility is greater than 0

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2300	AMT	AMT01	F3	Qualifier
2300	AMT	AMT02		Monetary Amount – Patient Responsibility Amount greater than Zero (0). *Value of 0 cannot be accepted, if zero, please remove segment.* If AMT*F3* greater than zero (0) must send CAS*PR*(1, 2 or 3) in Loop 2430.

Payer Claim Control Number (Claim Level) REQUIRED if Frequency Code 6, 7 or 8 is sent in CLM05-03

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2300	REF	REF01	F8	Original Reference ID Number
2300	REF	REF02		Payer Original Claim Control Number

Principle Diagnosis (Claim Level) REQUIRED on all encounters

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2300	HI	-01	ABJ or BJ	Qualifier
2300	HI	-02		Admitting Diagnosis Code

2300	HI	-09	N , Y, U, W	Present on Admission Indicator

Admitting Diagnosis (Claim Level) **REQUIRED on inpatient encounter**

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2300	HI	-01	ABJ or BJ	Qualifier
2300	HI	-02		Admitting Diagnosis Code

Patient Reason for Visit (Claim Level) **REQUIRED on outpatient visits**

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2300	HI	-01	APR or PR	Qualifier
2300	HI	-02		Patient Reason for Visit

External Cause of Injury (Claim Level) **Report external cause of injury, poisoning, or adverse effect – series of 3 required**

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2300	HI	-01	ABN or BN	Qualifier
2300	HI	-02		External Cause of Injury Code
2300	HI	-09	N , Y, U, W	Present on Admission Indicator

Condition Code (Claim Level) **REQUIRED when condition information applies to claim**

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2300	HI	-01	BG	Condition Code Qualifier
2300	HI	-02		Condition Code

Claim Pricing Repricing Information (Claim Level) **REQUIRED if known**

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2300	HCP	15	3, 6	In and Out of Network Indicator 1 or 3 = Out of Network 6 = In Network

Other Subscriber Information (Claim Level)

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2000B	SBR	SBR01	S	S = Secondary
2000B	SBR	SBR02	CI or 16	Insurance Type Code 16 = HMO Medicare Risk CI = Commercial HM = Health Maintenance Org
2320	SBR	SBR01	P	Payer Responsibility Sequence Number Code
2320	AMT	AMT01	D	Payor Amount Paid Qualifier
2320	AMT	AMT02	0 or greater	Payer Paid Amount (0 or greater)

				Must balance to the sum of the SVD service line(s) amount in Loop 2340
2320	OI	OI03	N, Y, W	Yes/No Condition or Response NOTE: Crosswalk of Loop 2300 CLM08
2320	OI	OI06	I, Y	Release of Information Code NOTE: Crosswalk of Loop 2300 CLM09
2320	MOA	MOA02	0 or greater	HCPCS Payable Amount Required to report Medicare Allowed Amount

Other Subscriber Information (Claim Level)

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2330A	NM1	NM1		Other Subscriber Name
2330A	NM1	NM108		Identification Code Qualifier
2330A	NM1	NM109		Identification Code Delegated Medical Groups Member ID / Subscriber ID
2330B	NM1	NM103		Payer Name Last or Organization Name
2330B	NM1	NM108	PI	Identification Code Qualifier
2330B	NM1	NM109		Payer Identification Code
2330B	DTP	DTP01	573	Date Time Qualifier
2330B	DTP	DTP02	D8	Format Qualifier
2330B	DTP	DTP03		CCYYMMDD Payment/Process Date

Line Pricing / Repricing Information (Line Level) REQUIRED on Outpatient, Home Health or Inpatient SNF

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2400	SV2	SV201		Revenue Code
2400	SV2	SV202	**HC** - CPT/HCPCS code ER - Health Insurance Prospective Payment System **HP** - HIPPS IV - HIEC WK - DC-10	Procedure Code -- REQUIRED on outpatient HP Qualifier: Medicare/MediCal - SNFs and HHAs encounters must contain a valid (HP) HIPPS code when REV code 0022, 0023, or 0024 is present.
2400	SV2	SV202-03,04,05,06	UD	Service lines that have a 340B physician administered drug should include the "UD" modifier in one of the four available modifier positions.
2400	HCP	HCP		Other Subscriber Name
2400	HCP	HCP01	10	Other Pricing - Required on Medicare encounters
2400	HCP	HCP02	0 or greater	Service Line Allowed Amount - Required on Medicare encounters

Line Adjudication Information (Line Level) REQUIRED when Patient Responsibility is greater than 0

Loop Id	Segment Id	Reference Designator	Values	Descriptions

2430	SVD	SVD01		Payer Primary Identifier - Required on Medicare encounters NOTE: Must match Loop 2330B NM109 Payer Identification Code
2430	SVD	SVD02	0 or greater	Monetary Amount – Cannot be a negative number NOTE: Loop 2430 CAS03 and SVD02 must balance to Loop 2400 SV203 (Insti) Line-Item Charge Amount
2430	SVD	SVD03		Procedure Code
2430	SVD	SVD04		Revenue Code
2430	SVD	SVD05		Quantity
2430	CAS	CAS01	CO, CR, OA, PI, PR	Line Adjustment Group Code CO = Contractual Obligation CR = Correction and Reversals OA = Other Adjustment PI = Payer Initiated Reductions **PR = Patient Responsibility** NOTE: When submitting **Member Cost Share** use code **PR** and include the appropriate Claim Adjustment Reason Code in (CAS02) (1,2,3) as listed below.
2430	CAS	CAS02, CAS05, CAS08 CAS11, CAS14, CAS17		Line Adjustment Reason Code PR (1, 2, 3) **Member Cost Share (PR qualifier), appropriate reason codes:** 1 = Deductible Amount 2 = Coinsurance Amount 3 = Co-payment Amount Claim Adjustment Reason Codes are available via Washington Publishing: http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/
2430	CAS	CAS03, CAS06, CAS09 CAS12, CAS15, CAS18		Monetary Amount NOTE: Loop 2430 CAS03 and SVD02 must balance to Loop 2400 SV103 (Prof) or SV203 (Inst) Line-Item Charge Amount
2430	DTP	DTP01	573	Date Time Qualifier
2430	DTP	DTP02	D8	Format Qualifier
2430	DTP	DTP03		CCYYMMDD Payment Date

Drug Identification **(Line Level)** **REQUIRED if procedure code requires a Physician-Administered Drug (PAD)**

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2410	LIN	LIN02	N4	Qualifier
2410	LIN	LIN03		11 Digit National Drug Code without hyphens
2410	CTP	CTP03		Unit Price
2410	CTP	CTP04	Greater than 0	National Drug Unit Count
2410	CTP	CTP05		Composite Unit of Measure
2410	CTP	CTP05-1	F2, GR, ME, ML, UN	Unit or Basis for Measurement Code