REPORT - HIPAA 837I to EDB mapped fields only

Loop	SegID	HIPAA Name	DT	Req	File	Field	DT	Comment	CommentType
		Health Care Claim: Institutional						One EDB encounter record is created for each service line level on the incoming 837 encounter.	Processing Logic
	ST	**Transaction Set Header**		**R**					
	ST 01	Transaction Set Identifier Code	ID3	R				verify "837"	Translation
	BHT	**Beginning of Hierarchical Transaction**		**R**					
	BHT02	Transaction Set Purpose Code	ID2	R				If "18"-reissue, handle as reversal & correction	Map Codes
	BHT06	Claim or Encounter Identifier	ID2	R				Store in MMIS to flag whether FFS or encounter; if both, must detect which	Map Codes
	REF	**Transmission Type Identification**		**R**					
	REF01	Reference Identification Qualifier	ID3	R				Verify "87"	Translation
	REF02	Transmission Type Code	AN30	R				Use to access correct version of translation	Translation
1000A	***NM1***	***Submitter Name***		***R***					
1000A	**NM1**	**Submitter Name**		**R**					
1000A	NM101	Entity Identifier Code	ID3	R				Verify "41"	Translation
1000A	NM108	Identification Code Qualifier	ID2	R				Verify "46"	Translation
1000A	NM109	Submitter Identifier	AN80	R				Store in MMIS to verify that submitter is approved for provider	Processing Logic

Loop	SegID	HIPAA Name	DT	Req	File	Field	DT	Comment	CommentType
1000A	**PER**	**Submitter EDI Contact Information**		**R**					
1000B	***NM1***	***Receiver Name***		***R***					
1000B	**NM1**	**Receiver Name**		**R**					
1000B	NM108	Information Receiver Identification Number	ID2	R				verify "46"	Translation
1000B	NM109	Receiver Primary Identifier	AN80	R				Validate against MAA's ETIN number	Translation
2000A	***HL***	***Billing/Pay-To Provider Hierarchical Level***		***R***				For translator, we should estim. the max # providers per tx	Translation
2000A	**HL**	**Billing/Pay-To Provider Hierarchical Level**		**R**					
2000A	**PRV**	**Billing/Pay-To Provider Specialty Information**		**S**					
2000A	PRV03	Provider Taxonomy Code	AN30	R				Add taxonomy code to claim; saved as variable to populate subsequest claims	HIPAA Required
2000A	**CUR**	**Foreign Currency Information**		**S**					
2010AA	***NM1***	***Billing Provider Name***		***R***				Use 2010AB-Pay-to-Prov, unless only 2010AA-Billing-Prov is sent	Translation
2010AA	**NM1**	**Billing Provider Name**		**R**					
2010AA	NM101	Entity Identifier Code	ID3	R				Verify "85"	Translation
2010AA	NM103	Billing Provider Last or Organizational Name	AN35	R				If incoming prov name differs from prov-file, save it for a report & possible update.	Nice to Have
2010AA	NM108	Identification Code Qualifier	ID2	R				Use if NM108="XX"; send NPI to MMIS new field	Translation
2010AA	**N 3**	**Billing Provider Address**		**R**					

Loop	SegID	HIPAA Name	DT	Req	File	Field	DT	Comment	CommentType
2010AA	**N 4**	**Billing Provider City/State/ZIP Code**		**R**					
2010AA	**REF**	**Billing Provider Secondary Identification**		**S**					
2010AA	REF01	Reference Identification Qualifier	ID3	R				Verify "1D" = Medicaid # or "1G"=UPIN or "1C"-Medicare #	Translation
2010AA	**REF**	**Credit/Debit Card Billing Information**		**S**					
2010AA	**PER**	**Billing Provider Contact Information**		**S**					
2010AB	***NM1***	***Pay-To Provider Name***		***S***					
2010AB	**NM1**	**Pay-To Provider Name**		**S**					
2010AB	NM101	Entity Identifier Code	ID3	R				Verify "87"	Translation
2010AB	NM108	Identification Code Qualifier	ID2	R				verify "XX"-NPI	Translation
2010AB	**N 3**	**Pay-To Provider Address**		**R**					
2010AB	**N 4**	**Pay-To Provider City/State/ZIP Code**		**R**					
2010AB	**REF**	**Pay-To Provider Secondary Identification**		**S**					
2010AB	REF01	Reference Identification Qualifier	ID3	R				Verify "1D" = Medicaid number or "1G"=UPIN	Translation
2000B	***HL***	***Subscriber Hierarchical Level***		***R***				For translator, we should approximate what is the max # subscribers per provider: rec. max. 5000?	Translation

Loop	SegID	HIPAA Name	DT	Req	File	Field	DT	Comment	CommentType
2000B	**HL**	**Subscriber Hierarchical Level**		**R**				MMIS only needs patient, not subscriber. If SBR02="18" use subscriber loop 2000B, skip patient loop, & go to loop 2300, else use patient loop 2000C	Translation
2000B	HL 01	Hierarchical ID Number	AN12	R				Verify "2"	Translation
2000B	HL 02	Hierarchical Parent ID Number	AN12	S				Verify "1"	Translation
2000B	HL 03	Hierarchical Level Code	ID2	R				Verify "22"	Translation
2000B	**SBR**	**Subscriber Information**		**R**					
2000B	SBR09	Claim Filing Indicator Code	ID2	S				Store in MMIS for use in 835-CLP06; in this field?	Match Back
2000B	**PAT**	**Patient Information**		**S**					
2000B	PAT07	Unit or Basis for Measurement Code	ID2	S				Verify "GR"; weight if < 29 days old (RECIP-AGE); can translator convert grams to pounds?	Translation
2000B	PAT08	Patient Weight	R10	S				MAA might want a new field in MMIS for this.	Case Management
2010BA	***NM1***	***Subscriber Name***		***R***					
2010BA	**NM1**	**Subscriber Name**		**R**					
2010BA	NM101	Entity Identifier Code	ID3	R				Verify "IL"	Translation
2010BA	NM108	Identification Code Qualifier	ID2	S				Verify "MI"-Payor's member ID	Translation
2010BA	NM109	Subscriber Primary Identifier	AN80	S				Match back required	Match Back
2010BA	**N 3**	**Subscriber Address**		**S**					
2010BA	**N 4**	**Subscriber City/State/ZIP Code**		**S**					

Loop	SegID	HIPAA Name	DT	Req	File	Field	DT	Comment	CommentType
2010BA	**DMG**	**Subscriber Demographic Information**		**S**					
2010BA	DMG02	Subscriber Birth Date	AN35	R				convert CCYYMMDD to YYMMDD	Translation
2010BA	DMG03	Subscriber Gender Code	ID1	R				Internal "1" = "M", and "2" = "F"	Translation
2010BA	**REF**	**Subscriber Secondary Identification**		**S**					
2010BA	REF01	Reference Identification Qualifier	ID3	R				Verify "1W"	Translation
2010BA	**REF**	**Property and Casualty Claim Number**		**S**					
2010BB	***NM1***	***Credit/Debit Card Account Holder Name***		***S***					
2010BB	**NM1**	**Credit/Debit Card Account Holder Name**		**S**					
2010BB	**REF**	**Credit/Debit Card Information**		**S**					
2010BC	***NM1***	***Payer Name***		***R***					
2010BC	**NM1**	**Payer Name**		**R**				Based on this, we may want to route the claim to L&I, SSPS, MMIS.	Processing Logic
2010BC	NM101	Entity Identifier Code	ID3	R				Verify "PR"	Translation
2010BC	NM108	Identification Code Qualifier	ID2	R				"PI"=Payor Identification or "XV"=National PlanID (when avail.)	Translation
2010BC	NM109	Payer Identifier	AN80	R				Validate MAA ID num	Translation
2010BC	**N 3**	**Payer Address**		**S**					
2010BC	**N 4**	**Payer City/State/ZIP Code**		**S**					
2010BC	**REF**	**Payer Secondary Identification**		**S**					

Loop	SegID	HIPAA Name	DT	Req	File	Field	DT	Comment	CommentType
2010BD	*NM1*	*Responsible Party Name*		*S*					
2010BD	**NM1**	**Responsible Party Name**		**S**					
2010BD	**N 3**	**Responsible Party Address**		**R**					
2010BD	**N 4**	**Responsible Party City/State/ZIP Code**		**R**					
2000C	*HL*	*Patient Hierarchical Level*		*S*					
2000C	**HL**	**Patient Hierarchical Level**		**S**					
2000C	HL 01	Hierarchical ID Number	AN12	R				Verify "3"	Translation
2000C	HL 02	Hierarchical Parent ID Number	AN12	S				Verify "2"	Translation
2000C	HL 03	Hierarchical Level Code	ID2	R				Verify "23"	Translation
2000C	**PAT**	**Patient Information**		**R**					
2010CA	*NM1*	*Patient Name*		*R*					
2010CA	**NM1**	**Patient Name**		**R**					
2010CA	NM101	Entity Identifier Code	ID3	R				Verify "QC"	Translation
2010CA	**N 3**	**Patient Address**		**R**					
2010CA	**N 4**	**Patient City/State/ZIP Code**		**R**					
2010CA	**DMG**	**Patient Demographic Information**		**R**					
2010CA	**REF**	**Patient Secondary Identification Number**		**S**					
2010CA	**REF**	**Property and Casualty Claim Number**		**S**					
2300	*CLM*	*Claim information*		*R*					

Loop	SegID	HIPAA Name	DT	Req	File	Field	DT	Comment	CommentType
2300	**CLM**	**Claim information**		**R**					
2300	CLM01	Patient Account Number	AN38	R	Encouter Data	Plan Record ID	X(20)	Match back required; support up to 38 bytes	HIPAA Required
2300	CLM02	Total Claim Charge Amount	R18	R	Encouter Data	Line Billed Charges	9(7)V99		
2300	CLM05	Facility Type Code	AN2	R	Encouter Data	Place of Service	X(1)	Expand to 2 digits and convert to standard values	Match Back
2300	CLM05	Claim Frequency Code	ID1	R	Encouter Data	Claim Status	X(1)	New field: original, corrected, replacement, void	HIPAA Required
2300	CLM07	Medicare Assignment Code	ID1	S				"A" = yes; "C" = no; If "C" and it's a Medicare x-over, then deny claim	Map Codes
2300	CLM11	Related Causes Information		S				Req'd if accident or emplmt related	HIPAA Required
2300	CLM11	Related Causes Code	ID3	R				Add new field to claim for 3 of these.	HIPAA Required
2300	CLM11	Auto Accident State or Province Code	ID2	S				Add new field to claim using state postal codes	HIPAA Required
2300	CLM11	Country Code	ID3	S				Add new field to claim using latest ISO 3166 codes	HIPAA Required
2300	CLM12	Special Program Indicator	ID3	S				Use?	System Questions
2300	CLM20	Delay Reason Code	ID2	S				Maybe add to claim (timely site variable)	Case Management
2300	**DTP**	**Discharge Hour**		**S**					
2300	DTP01	Date Time Qualifier	ID3	R				verify "096"	Translation
2300	DTP03	Discharge Hour	AN35	R				just get hour, not minutes	Translation
2300	**DTP**	**Statement Dates**		**R**					
2300	DTP01	Date Time Qualifier	ID3	R				verify "434"	Translation
2300	DTP03	Statement From or To Date	AN35	R	Encouter Data	Hospital Discharge Date	9(6)		

Loop	SegID	HIPAA Name	DT	Req	File	Field	DT	Comment	CommentType
2300	**DTP**	**Admission Date/Hour**		**S**					
2300	DTP01	Date Time Qualifier	ID3	R				verify "435"	Translation
2300	DTP03	Admission Date and Hour	AN35	R	Encouter Data	Hospital Admission Date	9(6)	get hour, not minutes	Translation
2300	**CL1**	**Institutional Claim Code**		**S**					
2300	CL101	Admission Type Code	ID1	S				map codes	Translation
2300	CL102	Admission Source Code	ID1	S				map codes	Translation
2300	CL103	Patient Status Code	ID2	S				need to map codes	Map Codes
2300	**PWK**	**Claim Supplemental Information**		**S**					
2300	PWK01	Attachment Report Type Code	ID2	R				Add to claim	Case Management
2300	PWK02	Attachment Transmission Code	ID2	R				Add to claim	Case Management
2300	PWK06	Attachment Control Number	AN80	S				Add to claim	Case Management
2300	**CN1**	**Contract Information**		**S**					
2300	**AMT**	**Payer Estimated Amount Due**		**S**					
2300	AMT01	Amount Qualifier Code	ID3	R				verify "C5"	Translation
2300	**AMT**	**Patient Estimated Amount Due**		**S**					
2300	AMT01	Amount Qualifier Code	ID3	R				verify "F3"	Translation
2300	AMT02	Patient Responsibility Amount	R18	R				add to claim for COB	Electronic COB
2300	**AMT**	**Patient Paid Amount**		**S**					
2300	AMT01	Amount Qualifier Code	ID3	R				Verify "F5"	Translation

Loop	SegID	HIPAA Name	DT	Req	File	Field	DT	Comment	CommentType
2300	**AMT**	**Credit/Debit Card Maximum Amount**		**S**					
2300	**REF**	**Adjusted Repriced Claim Number**		**S**					
2300	**REF**	**Repriced Claim Number**		**S**					
2300	**REF**	**Claim Identification Number For Clearinghouses and Other Transmission ? Intermediaries**		**S**					
2300	**REF**	**Document Identification Code**		**S**					
2300	**REF**	**Original Reference Number (ICN/DCN)**		**S**					
2300	REF01	Reference Identification Qualifier	ID3	R				Verify "F8" When CLM05-3=7-replacement, REF02 can be used to justify timelines. Automate. Issue for OPS.	Policy Issues
2300	REF02	Claim Original Reference Number	AN30	R				store & return in 835	Match Back
2300	**REF**	**Investigational Device Exemption Number**		**S**					
2300	**REF**	**Service Authorization Exception Code**		**S**				Ask PA, Lisa Cline	System Questions
2300	**REF**	**Peer Review Organization (PRO) Approval Number**		**S**					
2300	**REF**	**Prior Authorization or Referral Number**		**S**					
2300	REF01	Reference Identification Qualifier	ID3	R				Verify "G1"	Translation

Loop	SegID	HIPAA Name	DT	Req	File	Field	DT	Comment	CommentType
2300	REF02	Prior Authorization Number	AN30	R				MMIS has 1; X12 has 2; UB92 has 3	System Questions
2300	**REF**	**Medical Record Number**		**S**					
2300	REF01	Reference Identification Qualifier	ID3	R				Verify "EA"	Translation
2300	REF02	Medical Record Number	AN30	R	Encouter Data	Hospital Patient Control Number	X(20)	need longer field; store & return in 835 loop 2100 040 REF01=EA	Match Back
2300	**REF**	**Demonstration Project Identifier**		**S**					
2300	REF02	Demonstration Project Identifier	AN30	R				May use for new local code when legislture mandates	Case Management
2300	**K 3**	**File Information**		**S**					
2300	K 301	Fixed Format Information	AN80	R				Store: do we want a claim indicator for legislative emergency, perhaps in expand-area of claim	Case Management
2300	**NTE**	**Claim Note**		**S**					
2300	NTE01	Note Reference Code	ID3	R				Store code with text	Case Management
2300	NTE02	Claim Note Text	AN80	R				Keep: HH needs to use this for plan of care summary	Case Management
2300	**NTE**	**Billing Note**		**S**					
2300	NTE01	Note Reference Code	ID3	R				verify "ADD"	Translation
2300	NTE02	Billing Note Text	AN80	R				add to claim for any additional adjudication info	Case Management
2300	**CR6**	**Home Health Care Information**		**S**				Home health encounters are done, but no home health data is captured.	HIPAA Required
2300	CR601	Prognosis Code	ID1	R				useful for review in a report to HH	Case Management
2300	CR602	Service From Date	DT8	R				if any service date is before CR602, deny claim without review	Case Management

Loop	SegID	HIPAA Name	DT	Req	File	Field	DT	Comment	CommentType
2300	CR604	Home Health Certification Period	AN35	S				useful for review	Case Management
2300	CR605	Diagnosis Date	DT8	R				useful for review	Case Management
2300	CR606	Skilled Nursing Facility Indicator	ID1	R				if "Y", deny claim without review	Case Management
2300	CR607	Medicare Coverage Indicator	ID1	R				useful for review	Case Management
2300	CR608	Certification Type Code	ID1	R				useful for review	Case Management
2300	CR609	Surgery Date	DT8	S				useful for review	Case Management
2300	CR611	Surgical Procedure Code	AN15	S				useful for review	Case Management
2300	CR612	Physician Order Date	DT8	S				useful for review	Case Management
2300	CR613	Last Visit Date	DT8	S				useful for review	Case Management
2300	CR616	Last Admission Period	AN35	S				useful for review	Case Management
2300	CR617	Patient Discharge Facility Type Code	ID1	R				useful for review	Case Management
2300	CR618	Diagnosis Date	DT8	S				useful for review (4 times)	Case Management
2300	**CRC**	**Home Health Functional Limitations**		**S**					
2300	CRC01	Code Category	ID2	R				verify "75"	Translation
2300	CRC02	Certification Condition Indicator	ID1	R				useful for review	Case Management
2300	CRC03	Functional Limitation Code	ID2	R				useful for review (5 times)	Case Management
2300	**CRC**	**Home Health Activities Permitted**		**S**					
2300	CRC01	Certification Condition Indicator	ID2	R				verify "76"	Translation

Loop	SegID	HIPAA Name	DT	Req	File	Field	DT	Comment	CommentType
2300	CRC02	Functional Limitation Code	ID1	R				useful for review	Case Management
2300	CRC03	Activities Permitted Code	ID2	R				useful for review (5 times)	Case Management
2300	**CRC**	**Home Health Mental Status**		**S**					
2300	CRC01	Certification Condition Indicator	ID2	R				verify "77"	Translation
2300	CRC02	Functional Limitation Code	ID1	R				useful for review	Case Management
2300	CRC03	Mental Status Code	ID2	R				useful for review (5 times)	Case Management
2300	**HI**	**Principal, Admitting, E-Code and Patient Reason For Visit Diagnosis ? Information**		**R**					
2300	HI 01	Code List Qualifier Code	ID3	R				Verify "BK"-Principal Diagnosis	Translation
2300	HI 01	Industry Code	AN30	R				No principal diag. at encounter level, only at line level.	HIPAA Required
2300	HI 02	Code List Qualifier Code	ID3	R				verify "BJ"-admitting diag	Translation
2300	HI 03	Industry Code	AN30	R				Store E-Codes	Case Management
2300	**HI**	**Diagnosis Related Group (DRG) Information**		**S**					
2300	HI 01	Diagnosis Related Group (DRG) Code	AN30	R	Encouter Data	DRG	9(3)	Don't use incoming	Translation
2300	**HI**	**Other Diagnosis Information**		**S**					
2300	HI 01	Code List Qualifier Code	ID3	R				verify "BF"-Diagnosis	Translation
2300	HI 01	Other Diagnosis	AN30	R	Encouter Data	Other Diagnosis Codes1	X(7)	MMIS field occurs 9 times; there can be 12 in the 837. add more?	Policy Issues

Loop	SegID	HIPAA Name	DT	Req	File	Field	DT	Comment	CommentType
2300	HI 02	Other Diagnosis	AN30	R	Encouter Data	Other Diagnosis Codes2	X(7)		
2300	HI 03	Other Diagnosis	AN30	R	Encouter Data	Other Diagnosis Codes3	X(7)		
2300	HI 04	Other Diagnosis	AN30	R	Encouter Data	Other Diagnosis Codes5	X(7)		
2300	HI 05	Other Diagnosis	AN30	R	Encouter Data	Other Diagnosis Codes6	X(7)		
2300	HI 06	Other Diagnosis	AN30	R	Encouter Data	Other Diagnosis Codes7	X(7)		
2300	HI 07	Other Diagnosis	AN30	R	Encouter Data	Other Diagnosis Codes8	X(7)		
2300	**HI**	**Principal Procedure Information**		**S**					
2300	HI 01	Code List Qualifier Code	ID3	R				verify "BP"-Principal Procedure	Translation
2300	HI 01	Principal Procedure Code	AN30	R	Encouter Data	Primary Procedure	X(5)		
2300	**HI**	**Other Procedure Information**		**S**					
2300	HI 01	Code List Qualifier Code	ID3	R				verify "BO"-other procedures	Translation
2300	HI 01	Procedure Code	AN30	R	Encouter Data	Other Surgical Procedure Codes1	X(5)		
2300	HI 01	Procedure Date	AN35	S				Add fields for all 12 procedure codes and procedure dates. This is at the claim level.	Policy Issues
2300	HI 02	Procedure Code	AN30	R	Encouter Data	Other Surgical Procedure Codes2	X(5)		
2300	HI 03	Procedure Code	AN30	R	Encouter Data	Other Surgical Procedure Codes3	X(5)		
2300	HI 04	Procedure Code	AN30	R	Encouter Data	Other Surgical Procedure Codes4	X(5)		
2300	HI 05	Procedure Code	AN30	R	Encouter Data	Other Surgical Procedure Codes5	X(5)		
2300	**HI**	**Occurrence Span Information**		**S**					

Loop	SegID	HIPAA Name	DT	Req	File	Field	DT	Comment	CommentType
2300	**HI**	**Occurrence Information**		**S**					
2300	HI 01	Code List Qualifier Code	ID3	R				verity "BH"-occurrance code	Translation
2300	HI 03	Occurrence Code	AN30	R				add fields for up to 12 occurence codes and occurence dates.	Policy Issues
2300	**HI**	**Value Information**		**S**					
2300	**HI**	**Condition Information**		**S**					
2300	HI 01	Health Care Code Information		R				add fields for up to 12 condition codes	Policy Issues
2300	HI 01	Code List Qualifier Code	ID3	R				Verify "BG"	Translation
2300	**HI**	**Treatment Code Information**		**S**					
2300	**QTY**	**Claim Quantity**		**S**					
2300	QTY02	Claim Days Count	R15	R				If code "LA"-lifetime reserve days, add field to MMIS	Nice to Have
2300	**HCP**	**Claim Pricing/Repricing Information**		**S**					
2305	***CR7***	***Home Health Care Plan Information***		***S***					
2305	**CR7**	**Home Health Care Plan Information**		**S**					
2305	CR701	Discipline Type Code	ID2	R				if "MS" deny without review	Case Management
2305	CR702	Visits Prior to Recertification Date Count	N09	R				store recert date plus disciplines & accumulate this for each discipline & recert period; zeroing it when get new recert date	Case Management
2305	**HSD**	**Health Care Services Delivery**		**S**					
2305	HSD01	Visits	ID2	S				verify "VS"	Translation

Loop	SegID	HIPAA Name	DT	Req	File	Field	DT	Comment	CommentType
2305	HSD02	Number of Visits	R15	S				useful for review; store with CR701-discipline	Case Management
2305	HSD03	Frequency Period	ID2	S				useful for review; store with CR701-discipline	Case Management
2305	HSD04	Frequency Count	R6	S				useful for review; store with CR701-discipline	Case Management
2305	HSD05	Duration of Visits Units	ID2	S				useful for review; store with CR701-discipline	Case Management
2305	HSD06	Duration of Visits, Number of Units	N03	S				useful for review; store with CR701-discipline	Case Management
2305	HSD07	Ship, Delivery or Calendar Pattern Code	ID2	S				useful for review; store with CR701-discipline	Case Management
2305	HSD08	Delivery Pattern Time Code	ID1	S				useful for review; store with CR701-discipline	Case Management
2310A	***NM1***	***Attending Physician Name***		***S***					
2310A	**NM1**	**Attending Physician Name**		**S**				Only prov num, not name, accepted	Processing Logic
2310A	NM101	Entity Identifier Code	ID3	R				verify "71"	Translation
2310A	NM108	Identification Code Qualifier	ID2	R				Verify "XX"	Translation
2310A	NM109	Attending Physician Primary Identifier	AN80	R	Encouter Data	Performing Provider ID	9(7)	if there is no explicit "Attending Physician" here, use the "Billing Prov" in loop 2020AA NM1.	Translation
2310A	**PRV**	**Attending Physician Specialty Information**		**R**					
2310A	PRV01	Provider Code	ID3	R				verify "AT" or "SU"	Translation
2310A	PRV02	Reference Identification Qualifier	ID3	R				Verify "ZZ"-provider taxonomy	Translation

Loop	SegID	HIPAA Name	DT	Req	File	Field	DT	Comment	CommentType
2310A	**REF**	**Attending Physician Secondary Identification**		**S**					
2310A	REF01	Reference Identification Qualifier	ID3	R				Verify "1D" = Medicaid number or "1G"=UPIN	Translation
2310A	REF02	Attending Physician Secondary Identifier	AN30	R	Encouter Data	Performing Provider State License Number	X(10)		
2310B	***NM1***	***Operating Physician Name***		***S***					
2310B	**NM1**	**Operating Physician Name**		**S**				Add?	Nice to Have
2310B	NM108	Identification Code Qualifier	ID2	R				Verify "XX"	Translation
2310B	**PRV**	**Operating Physician Specialty Information**		**S**					
2310B	**REF**	**Operating Physician Secondary Identification**		**S**					
2310C	***NM1***	***Other Provider Name***		***S***					
2310C	**NM1**	**Other Provider Name**		**S**					
2310C	NM101	Entity Identifier Code	ID3	R				Verify "73"	Translation
2310C	NM108	Identification Code Qualifier	ID2	R				only Medicaid or NPI	Translation
2310C	NM109	Other Physician Identifier	AN80	R				Use?	Policy Issues
2310C	**PRV**	**Other Provider Specialty Information**		**R**					
2310C	PRV01	Provider Code	ID3	R				Verify "OT" or "PE"	Translation
2310C	PRV02	Reference Identification Qualifier	ID3	R				Verify "ZZ"-provider taxonomy	Translation
2310C	**REF**	**Other Provider Secondary Identification**		**S**					

Loop	SegID	HIPAA Name	DT	Req	File	Field	DT	Comment	CommentType
2310C	REF01	Reference Identification Qualifier	ID3	R				Verify "1D" = Medicaid number or "1G"=UPIN	Translation
2310D	***NM1***	***Referring Provider Name***		***S***					
2310D	**NM1**	**Referring Provider Name**		**S**					
2310D	NM101	Entity Identifier Code	ID3	R				Verify "DN"	Translation
2310D	NM108	Identification Code Qualifier	ID2	S				Verify "XX"-NPI	Translation
2310D	NM109	Referring Provider Identifier	AN80	S				add REFERRING-PROV-NUM in institutional-claim.	Nice to Have
2310D	**PRV**	**Referring Provider Specialty Information**		**S**					
2310D	PRV01	Provider Code	ID3	R				Verify "RF"	Translation
2310D	PRV02	Reference Identification Qualifier	ID3	R				Verify "ZZ"-provider taxonomy	Translation
2310D	**REF**	**Referring Provider Secondary Identification**		**S**					
2310D	REF01	Reference Identification Qualifier	ID3	R				Verify "1D" = Medicaid number or "1G"=UPIN	Translation
2310E	***NM1***	***Service Facility Name***		***S***					
2310E	**NM1**	**Service Facility Name**		**S**					
2310E	NM109	Laboratory or Facility Primary Identifier	AN80	S	Encouter Data	Billing Provider ID	9(7)		
2310E	**PRV**	**Service Facility Specialty Information**		**S**					
2310E	**N 3**	**Service Facility Address**		**R**					
2310E	**N 4**	**Service Facility City/State/Zip Code**		**R**					

Loop	SegID	HIPAA Name	DT	Req	File	Field	DT	Comment	CommentType
2310E	**REF**	**Service Facility Secondary Identification**		**S**					
2310E	REF02	Laboratory or Facility Secondary Identifier	AN30	R	Encouter Data	Billing Provider Tax ID	X(10)		
2320	***SBR***	***Other Subscriber Information***		***S***				Not more than 2 other payers	Electronic COB
2320	**SBR**	**Other Subscriber Information**		**S**					
2320	SBR01	Payer Responsibility Sequence Number Code	ID1	R				Add to MMIS	Electronic COB
2320	SBR02	Individual Relationship Code	ID2	R				Add to MMIS	Electronic COB
2320	SBR03	Insured Group or Policy Number	AN30	S				Add to MMIS	Electronic COB
2320	SBR04	Other Insured Group Name	AN60	S				Add to MMIS	Electronic COB
2320	SBR09	Claim Filing Indicator Code	ID2	S				Add to MMIS	Electronic COB
2320	**CAS**	**Claim Level Adjustment**		**S**					
2320	CAS01	Claim Adjustment Group Code	ID2	R				Add to MMIS	Electronic COB
2320	CAS02	Adjustment Reason Code	ID5	R				Add to MMIS	Electronic COB
2320	CAS03	Adjustment Amount	R18	R				Add to MMIS	Electronic COB
2320	CAS04	Adjustment Quantity	R15	S				Add to MMIS	Electronic COB
2320	**AMT**	**Payer Prior Payment**		**S**					
2320	AMT01	Amount Qualifier Code	ID3	R				Verify "C4"	Translation

Loop	SegID	HIPAA Name	DT	Req	File	Field	DT	Comment	CommentType
2320	AMT02	Other Payer Patient Paid Amount	R18	R				Add to MMIS; If Inpatient, add Estimated Responsibility 1, 2, and 3 to TPL header total. (W1415234-THIRD-PARTY-PMT-AMT)	Electronic COB
2320	**AMT**	**Coordination of Benefits (COB) Total Allowed Amount**		**S**					
2320	AMT01	Amount Qualifier Code	ID3	R				Verify "B6"	Translation
2320	AMT02	Allowed Amount	R18	R				Add to MMIS	Electronic COB
2320	**AMT**	**Coordination of Benefits (COB) Total Submitted Charges**		**S**					
2320	AMT01	Amount Qualifier Code	ID3	R				Verify "T3"	Translation
2320	AMT02	Coordination of Benefits Total Submitted Charge Amount	R18	R				Add to MMIS	Electronic COB
2320	**AMT**	**Diagnostic Related Group (DRG) Outlier Amount**		**S**					
2320	AMT01	Amount Qualifier Code	ID3	R				Verify "ZZ"	Translation
2320	AMT02	Claim DRG Outlier Amount	R18	R				Add to MMIS	Electronic COB
2320	**AMT**	**Coordination of Benefits (COB) Total Medicare Paid Amount**		**S**					
2320	AMT01	Amount Qualifier Code	ID3	R				Verify "N1"	Translation
2320	**AMT**	**Medicare Paid Amount - 100%**		**S**					
2320	AMT01	Amount Qualifier Code	ID3	R				Verify "KF"	Translation
2320	AMT02	Medicare Paid at 100% Amount	R18	R				Add to MMIS	Electronic COB

Loop	SegID	HIPAA Name	DT	Req	File	Field	DT	Comment	CommentType
2320	**AMT**	**Medicare Paid Amount - 80%**		**S**					
2320	AMT01	Amount Qualifier Code	ID3	R				Verify "PG"	Translation
2320	AMT02	Medicare Paid at 80% Amount	R18	R				Add to MMIS	Electronic COB
2320	**AMT**	**Coordination of Benefits (COB) Medicare A Trust Fund Paid Amount**		**S**					
2320	AMT01	Amount Qualifier Code	ID3	R				Verify "AA"	Translation
2320	AMT02	Paid From Part A Medicare Trust Fund Amount	R18	R				Add to MMIS	Electronic COB
2320	**AMT**	**Coordination of Benefits (COB) Medicare B Trust Fund Paid Amount**		**S**					
2320	AMT01	Amount Qualifier Code	ID3	R				Verify "B1"	Translation
2320	AMT02	Paid From Part B Medicare Trust Fund Amount	R18	R				Add to MMIS	Electronic COB
2320	**AMT**	**Coordination of Benefits (COB) Total Non-covered Amount**		**S**					
2320	AMT01	Amount Qualifier Code	ID3	R				Verify "A8"	Translation
2320	AMT02	Non-Covered Charge Amount	R18	R				Add to MMIS	Electronic COB
2320	**AMT**	**Coordination of Benefits (COB) Total Denied Amount**		**S**					
2320	AMT01	Amount Qualifier Code	ID3	R				Verify "YT"	Translation

Loop	SegID	HIPAA Name	DT	Req	File	Field	DT	Comment	CommentType
2320	AMT02	Claim Total Denied Charge Amount	R18	R				Add to MMIS	Electronic COB
2320	**DMG**	**Other Subscriber Demographic Information**		**S**					
2320	DMG02	Other Insured Birth Date	AN35	R				Add to MMIS	Electronic COB
2320	DMG03	Other Insured Gender Code	ID1	R				Add to MMIS	Electronic COB
2320	**OI**	**Other Insurance Coverage Information**		**R**					
2320	**MIA**	**Medicare Inpatient Adjudication Information**		**S**					
2320	MIA04	Claim DRG Amount	R18	S				Add to MMIS	Electronic COB
2320	MIA05	Remark Code	AN30	S				Add to MMIS	Electronic COB
2320	MIA06	Claim Disproportionate Share Amount	R18	S				Add to MMIS	Electronic COB
2320	MIA07	Claim MSP Pass-through Amount	R18	S				Add to MMIS	Electronic COB
2320	MIA12	Old Capital Amount	R18	S				Add to MMIS	Electronic COB
2320	MIA18	Claim Indirect Teaching Amount	R18	S				Add to MMIS	Electronic COB
2320	MIA19	Nonpayable Professional Component Amount	R18	S				Add to MMIS	Electronic COB
2320	MIA20	Remark Code	AN30	S				Add to MMIS	Electronic COB
2320	MIA21	Remark Code	AN30	S				Add to MMIS	Electronic COB
2320	MIA22	Remark Code	AN30	S				Add to MMIS	Electronic COB
2320	MIA23	Remark Code	AN30	S				Add to MMIS	Electronic COB

Loop	SegID	HIPAA Name	DT	Req	File	Field	DT	Comment	CommentType
2320	**MOA**	**Medicare Outpatient Adjudication Information**		**S**					
2320	MOA01	Reimbursement Rate	R10	S				Add to MMIS	Electronic COB
2320	MOA02	Claim HCPCS Payable Amount	R18	S				Add to MMIS	Electronic COB
2320	MOA03	Remark Code	AN30	S				Add to MMIS	Electronic COB
2330A	***NM1***	***Other Subscriber Name***		***R***					
2330A	**NM1**	**Other Subscriber Name**		**R**					
2330A	NM103	Other Insured Last Name	AN35	R				Add to MMIS	Electronic COB
2330A	NM104	Other Insured First Name	AN25	S				Add to MMIS	Electronic COB
2330A	NM105	Other Insured Middle Name	AN25	S				Add to MMIS	Electronic COB
2330A	NM107	Other Insured Name Suffix	AN10	S				Add to MMIS	Electronic COB
2330A	NM109	Other Insured Identifier	AN80	R				Get Member ID, policy #, SSN	Electronic COB
2330A	**N 3**	**Other Subscriber Address**		**S**					
2330A	**N 4**	**Other Subscriber City/State/ZIP Code**		**S**					
2330A	**REF**	**Other Subscriber Secondary Information**		**S**					
2330A	REF01	Reference Identification Qualifier	ID3	R				Add to MMIS	Electronic COB
2330A	REF02	Other Insured Additional Identifier	AN30	R				Get Member ID, policy #, SSN	Electronic COB
2330B	***NM1***	***Other Payer Name***		***R***					
2330B	**NM1**	**Other Payer Name**		**R**					

Loop	SegID	HIPAA Name	DT	Req	File	Field	DT	Comment	CommentType
2330B	NM101	Entity Identifier Code	ID3	R				Verify "PR"	Translation
2330B	NM103	Other Payer Last or Organization Name	AN35	R				Add to MMIS	Electronic COB
2330B	NM108	Identification Code Qualifier	ID2	R				Verify "XV"-National Plan ID	Translation
2330B	NM109	Other Payer Primary Identifier	AN80	R				Add to MMIS	Electronic COB
2330B	**N 3**	**Other Payer Address**		**S**					
2330B	**N 4**	**Other Payer City/State/ZIP Code**		**S**					
2330B	**DTP**	**Claim Adjudication Date**		**S**					
2330B	DTP01	Date Time Qualifier	ID3	R				Verify "573"	Translation
2330B	DTP03	Adjudication or Payment Date	AN35	R				Send & store in MMIS	Electronic COB
2330B	**REF**	**Other Payer Secondary Identification and Reference Number**		**S**					
2330B	REF02	Other Payer Secondary Identifier	AN30	R				Add to MMIS	Electronic COB
2330B	**REF**	**Other Payer Prior Authorization or Referral Number**		**S**					
2330B	REF01	Reference Identification Qualifier	ID3	R				Verify "G1"	Translation
2330B	REF02	Other Payer Prior Authorization or Referral Number	AN30	R				Send & store in MMIS	Electronic COB
2330C	***NM1***	***Other Payer Patient Information***		***S***					

Loop	SegID	HIPAA Name	DT	Req	File	Field	DT	Comment	CommentType
2330C	NM1	Other Payer Patient Information		S					
2330C	REF	Other Payer Patient Identification Number		S					
2330D	*NM1*	*Other Payer Attending Provider*		*S*					
2330D	NM1	Other Payer Attending Provider		S					
2330D	REF	Other Payer Attending Provider Identification		R					
2330E	*NM1*	*Other Payer Operating Provider*		*S*					
2330E	NM1	Other Payer Operating Provider		S					
2330E	REF	Other Payer Operating Provider Identification		R					
2330F	*NM1*	*Other Payer Other Provider*		*S*					
2330F	NM1	Other Payer Other Provider		S					
2330F	REF	Other Payer Other Provider Identification		R					
2330G	*NM1*	*Other Payer Referring Provider*		*S*					
2330G	NM1	Other Payer Referring Provider		S					
2330G	REF	Other Payer Referring Provider Identification		R					
2330H	*NM1*	*Other Payer Service Facility Provider*		*S*					

Loop	SegID	HIPAA Name	DT	Req	File	Field	DT	Comment	CommentType
2330H	**NM1**	**Other Payer Service Facility Provider**		**S**					
2330H	**REF**	**Other Payer Service Facility Provider Identification**		**R**					
2400	***LX***	***Service Line Number***		***R***					
2400	**LX**	**Service Line Number**		**R**					
2400	LX 01	Assigned Number	N06	R	Encouter Data	Line Item Number	9(2)		
2400	**SV2**	**Institutional Service Line**		**R**					
2400	SV201	Service Line Revenue Code	AN48	R	Encouter Data	Revenue Code	9(4)	Store & send to MMIS	HIPAA Required
2400	SV202	Composite Medical Procedure Identifier		S				How to distinguish between enounter level and line level -- same 'principal proc' field in EDB encounter record	System Questions
2400	SV202	Product or Service ID Qualifier	ID2	R				Store & send back in 835 SVC01-1	Match Back
2400	SV202	Procedure Code	AN48	R	Encouter Data	National Drug Code	X(11)		
2400	SV202	Procedure Code	AN48	R	Encouter Data	Primary Procedure	X(5)		
2400	SV202	Procedure Modifier	AN2	S	Encouter Data	Procedure Code Modifier	X(2)	store all 4 modifiers from 837 SV102	Policy Issues
2400	SV202	Procedure Modifier	AN2	S				Should support up to 4 modifiers	Nice to Have
2400	SV203	Line Item Charge Amount	R18	R	Encouter Data	Line Billed Charges	9(7)V99		
2400	SV204	Unit or Basis for Measurement Code	ID2	R				must use standard international unit codes	HIPAA Required
2400	SV205	Service Unit Count	R15	R	Encouter Data	Units of Service	9(7)	need to store orig units from 837 SV104; add use of decimal units	HIPAA Required
2400	**SV4**	**Prescription Number**		**S**					

Loop	SegID	HIPAA Name	DT	Req	File	Field	DT	Comment	CommentType
2400	SV401	Prescription Number	AN30	R	Encouter Data	Prescription Number	X(7)	Store & send to MMIS	Case Management
2400	**PWK**	**Line Supplemental Information**		**S**					
2400	PWK01	Attachment Report Type Code	ID2	R				add to claim	Nice to Have
2400	PWK02	Attachment Transmission Code	ID2	R				add to claim	Nice to Have
2400	PWK06	Attachment Control Number	AN80	S				add to claim	Nice to Have
2400	**DTP**	**Service Line Date**		**S**					
2400	DTP03	Service Date	AN35	R				Add service dates at service line level for outpatient	HIPAA Required
2400	**DTP**	**Assessment Date**		**S**					
2400	**AMT**	**Service Tax Amount**		**S**					
2400	**AMT**	**Facility Tax Amount**		**S**					
2420A	***NM1***	***Attending Physician Name***		***S***				add all available providers to claim at service line level also	Policy Issues
2420A	**NM1**	**Attending Physician Name**		**S**				Store attending physician at service line level also.	HIPAA Required
2420A	**PRV**	**Attending Physician Specialty Information**		**R**					
2420A	**REF**	**Attending Physician Secondary Identification**		**S**					
2420B	***NM1***	***Operating Physician Name***		***S***					
2420B	**NM1**	**Operating Physician Name**		**S**					
2420B	**PRV**	**Operating Physician Specialty Information**		**S**					

Loop	SegID	HIPAA Name	DT	Req	File	Field	DT	Comment	CommentType
2420B	**REF**	**Operating Physician Secondary Identification**		**S**					
2420C	***NM1***	***Other Provider Name***		***S***					
2420C	**NM1**	**Other Provider Name**		**S**					
2420C	**PRV**	**Other Provider Specialty Information**		**S**					
2420C	**REF**	**Other Provider Secondary Identification**		**S**					
2420D	***NM1***	***Referring Provider Name***		***S***					
2420D	**NM1**	**Referring Provider Name**		**S**					
2420D	**PRV**	**Referring Provider Specialty Information**		**S**					
2420D	**REF**	**Referring Provider Secondary Identification**		**S**					
2430	***SVD***	***Service Line Adjudication Information***		***S***					
2430	**SVD**	**Service Line Adjudication Information**		**S**					
2430	SVD02	Service Line Paid Amount	R18	R				In MMIS at header level; in X12 at detail level. Roll up X12 line level amounts to determine header level total.	Translation
2430	**CAS**	**Service Line Adjustment**		**S**					
2430	**DTP**	**Service Adjudication Date**		**S**					
2430	**SE**	**Transaction Set Trailer**		**R**					

Comment Type Legend:

Case Management = "Nice to Have" fields for case reviewers.

Electronic COB = If we do electronic COB, these fields will be needed.

HIPAA Questions = Questions about interpreting the HIPAA Implementation Guides.

HIPAA Required = Required fields in HIPAA that don't seem to be in the legacy system.

Map Codes = Need to crosswalk local codes to standard codes.

Match Back = Fields received on an incoming transaction that must be returned in the response.

Nice to Have = Optional fields that are useful for other reasons.

Policy Issues = Decisions to be made by system experts.

Processing Logic = Logic that needs to be built into either the front end or MMIS.

System Questions = Questions about the legacy systems.

Translation = Only use to program translations.

Column Heading Legend:

"DT" = Data Type

COBOL Data Types Legend:

X(n) - Character data with length of n bytes

9(n) - Integer data with length of n bytes

S9(n) - Signed integer data with length of n bytes

9(n)V99 or 9(n)V9(2) - Numeric data with n decimal digits before the decimal point and 2 decimal digits after the decimal point

S9(n)V99 or S9(n)V9(2) - Signed numeric data with n decimal digits before the decimal point and 2 decimal digits after the decimal point

HIPAA Data Types Legend:

ANn - Free text with length of n bytes

IDn - Coded value with length of n bytes

Nn - Numeric data with length of n bytes

Rn - Real data with length of n bytes

DT8 - Date expressed as CCYYMMDD

TM8 - Time expressed as HHMMSSDD, where H = hours (00-23), M = minutes (00-59), S = integer seconds (00-59) and DD = decimal seconds ((00-99)