Companion Document

837I

837 Institutional Health Care Claim

This companion document is for informational purposes only to describe certain aspects and expectations regarding the transaction and is not a complete guide. The details contained in this document are supplemental and should be used in conjunction with the ASC X12 Standards for Electronic Data Interchange Technical Report Type 3 (TR3) as published by the Washington Publishing Company.

Section 1 – 837I Institutional Health Care Claim: Basic Instructions

Section 2 – 837I Institutional Health Care Claim: Enveloping

Section 3 – 837I Institutional Health Care Claim: Charts for Situational Rules

Any questions?

Contact E-Solutions
www.empireblue.com/edi, LiveChat

Section 1 - Basic Instructions

1.1 X12 and HIPAA Compliance Checking, and Business Edits

EDI interchanges submitted to Empire for processing pass through compliance edits. 5010 acknowledgments and reports for accepted/rejected files will be placed in the submitter's trading partner mailbox for pickup. *EDI Representative will review these reports thoroughly with submitters.

- TA1 Interchange Acknowledgment. Empire returns TA1 X12 and proprietary reports to the submitter of inbound 837 files containing envelope errors in the ISA and GS segments.
- Level 1. Empire returns a 999 Interchange Acknowledgment to the submitter for every inbound 837 transaction received. Each transaction passes through edits to ensure that it is X12 compliant. If the X12 syntax or any other aspect of the 837 is not X12 compliant, the 999 FA will also report the Level 1 errors in AK segments and indicate that the entire transaction set has been rejected.
- Level 2. In addition to HIPAA TR3 edits, Empire applies business edits to ensure that the necessary information is populated and complete for efficient processing. When encountering HIPAA compliance (including balancing), code set or business errors, Empire returns: 1) 277 Claims Acknowledgement (CA) and 2) 864 Level 2 Status Report to the submitter identifying which claim(s) have failed.

1.2 HIPAA Compliant Codes

Use HIPAA-compliant codes from current versions of the following:

- Physician's Current Procedure Terminology (CPT)
- Health Care Financing Administration Common Procedural Coding System (HCPCS)
- International Classification of Diseases Clinical Mod (ICD-9-CM) Diseases
- National Uniform Billing Committee (NUBC) Codes
- Diagnosis Related Group Number (DRG)
- Provider Taxonomy Codes
- National Drug Code

* ICD-10 Codes will not be accepted any earlier than October 1, 2015.

1.3 Diagnosis Codes

According to the 837I TR3, a transaction is not X12 compliant if decimal points are used in diagnosis codes. Therefore, should a diagnosis code contain a decimal point, Empire will return a 999 to the submitter indicating that the transaction has been rejected.

1.4 Procedure Codes and Modifiers

All valid CPT and HCPCS codes and modifiers are accepted for claim adjudication. Refer to your billing guidelines or provider contract for submission of these codes. If submitted codes are invalid, a 277CA

and an 864 Level 2 Status Report will be returned to the submitter identifying which claim(s) have failed.

1.5 Uppercase Letters, Special Characters, and Delimiters

As specified in the TR3, the basic character set includes uppercase letters, digits, spaces, and other special characters.

Inbound Delimiters		
	Suggested Value	
Data Element Separator	*	Asterisk
Sub-Element Separator	:	Colon
Segment Terminator	~	Tilde
Repetition Separator	^	Caret

- All alpha characters must be submitted in UPPERCASE letters only.
- Suggested delimiters for the transaction are assigned as part of the trading partner set up. EDI Representative will discuss options with trading partners, if applicable.
- To avoid syntax errors, hyphens, parentheses and spaces are not recommended to be used in values for identifiers.

  Examples: Recommended: Zip Code 123456789 Medical Record # 1234567
- Since originally submitted values may be returned on outbound transactions, Empire encourages trading partners to not use the following special characters as part of the value: asterisk (*), less than/greater than signs (<, >), colon (:), and slash (/). This minimizes the risk for a special character to be recognized as a delimiter.

  Example: Provider assigns a Patient Control Number '12*3456789'. Although an asterisk (*) is a valid special character, it adversely affects processing since it is also a common delimiter. The value '12*3456789' may process incorrectly as two separate values '12' and '3456789'.

1.6 Decimal "R" Data Element Types

"R" data element types contain a decimal point; involving monetary amounts, units, visits, weights, and frequency. Empire recommends using decimal points for monetary amounts, and whole numbers for other types of "R" data elements. Except for monetary amounts, if "R" data element type includes a decimal and numbers after the decimal, Empire adjudicates the claim based on the whole number. Numbers after the decimal will not be considered.

1.7 Numeric Values, Monetary Amounts and Units

- Empire pays all claims in US dollars and therefore, accepts monetary amounts in US dollars only. If codes related to foreign currencies are used, then a 277CA and an 864 Level 2 Status Report will be returned to the submitter identifying which claim(s) have failed.
- Empire recognizes units in whole numbers only.
- Empire recognizes units in values of less than 9999 and greater than or equal to zero.
- If a negative service line charge or negative units are used, then a 277CA and an 864 Level 2 Status

Report will be returned to the submitter identifying which claim(s) have failed.

SV203 Monetary Amount - Line Item Charge Amount
SV205 Quantity - Service Unit Count

1.8 Address Information

- P.O. mailboxes / Lock Boxes are not allowed in the Billing Provider loop. If submitted in the Billing Provider loop, a 277CA and an 864 Level 2 Status Report will be returned to the submitter identifying which claim(s) have failed.
- The Pay-to Address loop does support P.O. Box / Lock Box addresses. Therefore, if payment is expected to be remitted to a P.O. Box / Lock Box, submit the P.O. Box / Lock Box address.
- Full 9-digit zip codes are required in the Billing Provider and Service Facility Location loops. If 5-digit zip codes are used in these loops, a 277CA and an 864 Level 2 Status Report will be returned to the submitter identifying which claim(s) have failed.

1.9 Coordination of Benefits

Specific 837 data elements work together to coordinate benefits between Empire and Medicare or other carriers. Following the Provider-to-Payer-to-Provider model;

- The provider sends the 837 to the primary payer.
- The primary payer adjudicates the claim and sends an 835 Payment Advice to the provider. The 835 includes the claim adjustment reason code and/or remark code for the claim.
- Upon receipt of the 835, the provider sends a second 837 with COB information populated in Loops 2320, 2330A-I, and/or 2430 to the secondary payer. The secondary payer adjudicates the claim and sends an 835 Payment Advice to the provider.

Empire recognizes submission of an 837 transaction to a sequential payer populated with data from the previous payer's 835. Based on the information provided and the level of policy, the claim will be adjudicated without the paper copy of the Explanation of Benefits from Medicare or the primary carrier.

When more than one payer is involved on a claim, data elements for all prior payers must be present (i.e., if a tertiary payer is involved, then all the data elements from the primary and secondary payers must also be present.

If data elements from previous payer(s) are omitted, Empire will fail the particular claim.

1.10 Claim and COB Balancing

For COB claims, balancing is performed at both claim and service line on the payment charges for each payer. If not balanced, a 277CA and an 864 Level 2 Status Report will be returned to the submitter identifying which claim(s) have failed.

- Loop 2300 CLM02 (Total Claim Charge) must equal the sum of Loop 2400 SV203 (Line Item Charge).
- Loop 2320 AMT02 (COB Payer Paid Amount) must equal the sum of Loop 2430 SVD02 (Line Adjudication Information) less the sum of Loop 2300 CAS (Claim Level Adjustments).

- Loop 2400 SV203 (Line Item Charge Amount) must equal the sum of Loop 2430 SVD02 (Line Adjudication Information) plus the sum of Loop 2430 CAS (Claim Level Adjustments).

1.11 Sending Unsolicited Attachments to Support a Claim

Loop 2300 PWK segment is required when paper documentation (attachments) supports a claim.

In order to expedite processing of a claim:

- Mail the attachment the same day the claim is submitted
- Do not send a copy of the claim with the attachment
- Do not send unnecessary attachments (i.e., do not send a copy of the member's ID card)
- Include the attachment control # in the upper right hand corner of the supporting documentation

Mailing Address for FEP -

Federal Employee Program
PO Box 3876
Church Street Station
New York, NY 10008

1.12 Taxonomy Codes (PRV)

The Healthcare Provider Taxonomy code set divides health care providers into hierarchical groupings by type, classification, and specialization, and assigns a code to each grouping. The Taxonomy consists of two parts: individuals (e.g., physicians) and non-individuals (e.g., ambulatory health care facilities). All codes are 10-alphanumeric positions in length. Health care providers select the taxonomy code(s) that most closely represents their education, license, or certification. If a health care provider has more than one taxonomy code associated with it, a health plan may prefer that the health care provider use one over another when submitting claims for certain services.

It is strongly recommended that the taxonomy be populated in PRV segments for all applicable claims that you are filing. Refer to the CMS website for a listing of codes, www.wpc-edi.com/taxonomy.

1.13 Medicaid Reclamation / Subrogation Claims

Situations exist when a Patient who has BCBS as primary and Medicaid as secondary (last payer), indicates to the provider that he has Medicaid insurance only. The service is rendered and the provider bills Medicaid as primary. Medicaid pays the claim as the sole payer ("pays out of turn") and later determines that the patient actually had primary insurance.

In order to reclaim monies, states submit claims to the primary insurance after reconciliation of eligibility files between BCBS and Medicaid. Exempt from NPI, trading partners on behalf of states must submit specific data elements in Loops 2010AA, 2010AC, 2010BB, 2310A, 2310E and 2320 for Medicaid reclamation.

Section 2 - Enveloping

EDI envelopes control and track communications between you and Empire. One envelope may contain many transaction sets grouped into the following:

- Interchange Control Header (ISA)
- Functional Group Header (GS)
- Functional Group Trailer (GE)
- Interchange Control Trailer (IEA)

837 Institutional Health Care Claim–Envelope Specific to Empire NY (TR3, Appendix C)

ISA—Interchange Control Header	
ISA01	00
ISA02	*refer to TR3*
ISA03	00
ISA04	*refer to TR3*
ISA05	ZZ
ISA06	*SENDER ID*
	EDI assigned Left-justified followed by spaces
ISA07	ZZ
ISA08	EMPIRENY
ISA09	*refer to TR3*
ISA10	*refer to TR3*
ISA11	*^ (5E)*
ISA12	00501
ISA13	*refer to TR3*
ISA14	1
ISA15	*refer to TR3*
ISA16	*: (3A)*

GS—Functional Group Header	
GS01	HC
GS02	*SENDER ID*
	EDI assigned Left-justified followed by no zeroes or spaces
GS03	EMPIRENY
GS04	*refer to TR3*
GS05	*refer to TR3*
GS06	*refer to TR3*
GS07	X
GS08	005010X223A2

GE—Functional Group Trailer	
GE01	*refer to TR3*
GE02	*refer to TR3*

IEA—Interchange Control Trailer	
IEA01	*refer to TR3*
IEA02	*refer to TR3*

NOTE. Critical Batching and Editing Information
****Transactions must be batched in separate functional group by GS03.***
****Unique group control number (GS06) MUST NOT be duplicated within 365 days by Trading Partner ID (GS02); files containing duplicate or previously received group control numbers will be rejected.***

837 Institutional Health Care Claim–Envelope Specific to Empire NY Medicaid Reclamation (TR3, Appendix C)

ISA—Interchange Control Header	
ISA01	00
ISA02	*refer to TR3*
ISA03	00
ISA04	*refer to TR3*
ISA05	ZZ
ISA06	*SENDER ID*
	EDI assigned Left-justified followed by spaces
ISA07	ZZ
ISA08	MEDICAIDREC
ISA09	*refer to TR3*
ISA10	*refer to TR3*
ISA11	*^ (5E)*
ISA12	00501
ISA13	*refer to TR3*
ISA14	1
ISA15	*refer to TR3*
ISA16	*: (3A)*

GS—Functional Group Header	
GS01	HC
GS02	*SENDER ID*
	EDI assigned Left-justified followed by no zeroes or spaces
GS03	MEDICAIDRECNY
GS04	*refer to TR3*
GS05	*refer to TR3*
GS06	*refer to TR3*
GS07	X
GS08	005010X223A2

GE—Functional Group Trailer	
GE01	*refer to TR3*
GE02	*refer to TR3*

IEA—Interchange Control Trailer	
IEA01	*refer to TR3*
IEA02	*refer to TR3*

NOTE. Critical Batching and Editing Information
****Transactions must be batched in separate functional group by GS03.***
****Unique group control number (GS06) MUST NOT be duplicated within 365 days by Trading Partner ID (GS02); files containing duplicate or previously received group control numbers will be rejected.***

Section 3 - Charts for Situational Rules

Listed below are loops, segments, and data elements required for proper adjudication by Empire per the situational rules in the 837I TR3.

837 Institutional Health Care Claim

TR3	Segment	Reference Designator(s)	Value	Definitions and Notes Specific to Empire NY
P.67	**ST** Transaction Set Header	**ST03** Implementation Convention Ref	***005010X223A2***	005010X223A2 - Health Care Claim, Institutional
P.68	**BHT** Beginning of Hierarchical Trx	**BHT06** Transaction Type Code	***CH***	CH - Chargeable
			31	required for Medicaid Reclamation
Loop ID 1000A—Submitter Name				
P.71	**NM1** Submitter Name	**NM109** Identification Code	***(Submitter Identifier) UPPERCASE***	▪ EDI assigned Sender ID. ▪ Equals the value entered in ISA06 and GS02.
P.73	**PER** *Submitter EDI Contact Information - Refer to TR3*			
Loop ID 1000B—Receiver Name				
P.76	**NM1** Receiver Name	**NM109** Identification Code	***00303***	Code represents Empire Blue Cross
Loop ID 2000A—Billing Provider Hierarchical Level				
P.78	**HL** *Billing Provider Hierarchical Level - Refer to TR3*			
P.80	**PRV** *Billing Provider Specialty Information - Refer to TR3*			
P.81	**CUR** Foreign Currency Information	**CUR02** Currency Code	***USD***	USD - US dollars ▪ Monetary amounts recognized in US dollars only.
Loop ID 2010AA—Billing Provider Name				
P.84	**NM1** *Billing Provider Name - Refer to TR3*			(Medicaid Reclamation)
P.87	**N3** Billing Provider Address	**N301** Address Information	***(Billing Provider Address Line)***	(Medicaid Reclamation) Enter the physical address to uniquely identify the provider. Submitting PO Box/Lock Box address will result in claim failure, and return of 277CA and Level 2 Status report.
P.88	**N4** *Billing Prov City, State, ZIP Code - Refer to TR3*			(Medicaid Reclamation)
P.90	**REF** Billing Provider Tax Identification #	**REF02** Reference Identification	***(Billing Provider Tax Identification #)***	(Medicaid Reclamation)
P.91	**PER** *Billing Provider Contact Information - Refer to TR3*			
Loop ID 2010AB—Pay-To Address Name				
P.94	**NM1** *Pay-to Address Name - Refer to TR3*			
P.96	**N3** Pay-to Address	**N301** Address Information	***(Pay-to Provider Address Line)***	Enter the address to uniquely identify the provider. Submit PO Box address in Pay-to, if applicable.
P.97	**N4** *Pay-To Address City, State, ZIP Code - Refer to TR3*			
Loop ID 2010AC—Pay-To Plan Name				
P.99	**NM1** Pay-to Plan Name	**NM103** Name Last or Organization Name	***(Pay-to Plan Organizational Name)***	(Medicaid Reclamation)
P.101	**N3** *Pay-to Plan Address - Refer to TR3*			
P.102	**N4** *Pay-to Plan City, State, ZIP Code - Refer to TR3*			
P.104	**REF** *Pay-to Plan Secondary Identification - Refer to TR3*			

Although loops, segments and/or data elements required for Medicaid Reclamation are clarified in the definition and notes as (Medicaid Reclamation), they are not exclusive to Medicaid Reclamation type of claims only.

837 Institutional Health Care Claim				
TR3	**Segment**	**Reference Designator(s)**	**Value**	**Definitions and Notes Specific to Empire NY**
Loop ID 2010AC—Pay-To Plan Name (cont'd)				
P.106	**REF** Pay-to Plan Tax Identification #	**REF02** Reference Identification	***(Pay-to Plan Tax Identification #)***	(Medicaid Reclamation)
Loop ID 2000B—Subscriber Hierarchical Level				
P.107	**HL**	*Subscriber Hierarchical Level - Refer to TR3*		
P.109	**SBR**	*Subscriber Information - Refer to TR3*		
Loop ID 2010BA—Subscriber Name				
P.112	**NM1** Subscriber Name	**NM109** Identification Code	***Enter the ID Number exactly as it appears on the front of the ID card, WITHOUT suffix or dependent number.***	
				Must be left justified.
				Do not submit leading spaces.
				Do not submit all alpha characters.
				Do not submit embedded spaces or special characters.
				Subscriber ID body must begin immediately following the alpha prefix. No space after prefix.
				Do not submit ID body containing all 1's, 2's, 3's, 4's, 5's, 6's, 7's, 8's, 9's, 0's, 123456789, 1234567890 or literals equal to UNKNOWN, UNK, INDIVIDUAL, SELF, or NONE.
				Do not submit lowercase alpha characters.
P.115	**N3**	*Subscriber Address - Refer to TR3*		
P.116	**N4**	*Subscriber City, State, ZIP Code - Refer to TR3*		
P.118	**DMG**	*Subscriber Demographic Information - Refer to TR3*		
P.120	**REF**	*Subscriber Secondary Identification - Refer to TR3*		
P.121	**REF**	*Property and Casualty Claim Number - Refer to TR3*		
Loop ID 2010BB—Payer Name				
P.122	**NM1** Payer Name	**NM108** ID Code Qualifier	***PI***	PI - Payer Identification
		NM109 Identification Code	***(Payer Primary Identifier)***	00303 - represents Empire Blue Cross
P.124	**N3**	*Payer Address - Refer to TR3*		
P.125	**N4**	*Payer City, State, ZIP Code - Refer to TR3*		
P.127	**REF**	*Payer Secondary Identification - Refer to TR3*		
P.129	**REF** Billing Provider Secondary Identification	**REF01** Ref ID Qualifier	***G2***	G2 - Provider Commercial Number
		REF02 Ref Identification	***(Billing Prov Secondary ID)***	(Medicaid Reclamation)
Loop ID 2000C—Patient Hierarchical Level				
P.131	**HL**	*Patient Hierarchical Level - Refer to TR3*		
P.133	**PAT**	*Patient Information - Refer to TR3*		
Loop ID 2010CA—Patient Name				
P.135	**NM1** Patient Name	**NM109** Identification Code	Must be 1) left justified, 2) not contain leading spaces, 3) not contain all alpha characters, 4) not contain embedded spaces or special characters, 5) not contain low values • No space after prefix; Patient ID body must begin immediately following the alpha prefix. • The ID body must not contain all 1's, 2's, 3's, 4's, 5's, 6's, 7's, 8's, 9's, 0's, 123456789, 1234567890 or literals equal to UNKNOWN, UNK, INDIVIDUAL, SELF, NONE.	

Although loops, segments and/or data elements required for Medicaid Reclamation are clarified in the definition and notes as (Medicaid Reclamation), they are not exclusive to Medicaid Reclamation type of claims only.

837 Institutional Health Care Claim				
TR3	**Segment**	**Reference Designator(s)**	**Value**	**Definitions and Notes Specific to Empire NY**
Loop ID 2010CA—Patient Name (cont'd)				
P.137	**N3** *Patient Address - Refer to TR3*			
P.138	**N4** *Patient City, State, ZIP Code - Refer to TR3*			
P.140	**DMG** *Patient Demographic Information - Refer to TR3*			
P.142	**REF** *Property and Casualty Claim Number - Refer to TR3*			
Loop ID 2300—Claim Information				
P.143	**CLM** Claim Information	**CLM01** Claim Submitter's Identifier	***(Patient Control Number)***	▪ Maximum of 20 alphanumeric characters. ▪ Value is returned on outbound 835 and other transactions.
		CLM02 Monetary Amount	***(Total Claim Charge Amt)***	Value must equal the sum of submitted service line charges in Loop 2400 SV203.
		CLM05-1 Fac Code Value	***(Facility Type Code)***	Required for 33X and 34X outpatient type of bills.
		CLM05-3 Claim Frequency Type Code	***(Third Position of Uniform Billing Claim Form Bill Type)***	If '7' (replacement) or '8' (void/cancel) then the first 3 positions of following value must be submitted in Billing Note (Loop 2300 NTE02).
			DIA Diagnosis; ***POS*** Place of Service; ***UNT*** Units of Service; ***MDF*** Modifier; ***DEP*** Dependent Number Change; ***SOA*** Questioning Schedule of Allowance; ***MED*** Medical Necessity Appeal; ***AUT*** Authorization on File Appeal Denial; ***TFD*** Timely Filing Denial - Appeals; ***CDR*** Contractual Denial Review; ***OTH*** Other	
P.149	**DTP** *Discharge Hour - Refer to TR3*			
P.150	**DTP** Statement Dates	**DTP03** Date Time Period	***(Statement From or To Date)***	Valid medical codes will be based on the "Statement From Date"
P.151	**DTP** *Admission Date/Hour - Refer to TR3*			
P.152	**DTP** *Date-Repricer Received Date - Refer to TR3*			
P.153	**CL1** *Institutional Claim Code - Refer to TR3*			
P.154	**PWK** *Claim Supplemental Information - Refer to TR3*			
P.158	**CN1** *Contract Information - Refer to TR3*			
P.160	**AMT** *Patient Estimated Amount Due - Refer to TR3*			
P.161	**REF** *Service Authorization Exception Code - Refer to TR3*			
P.163	**REF** *Referral Number - Refer to TR3*			
P.164	**REF** *Prior Authorization - Refer to TR3*			
P.166	**REF** Payer Claim Control Number	**REF01** Ref ID Qualifier	***F8***	F8 - Original Reference Number
		REF02 Reference Identification	***(Claim Original Reference Number)***	Represents the claim number assigned by Empire. Providers should submit the original claim number indicated on the 835 when Loop 2300 CLM05-3 Claim Freq. Type Code equals '7' or '8'.
P.167	**REF** *Repriced Claim Number - Refer to TR3*			
P.168	**REF** *Adjusted Repriced Claim Number - Refer to TR3*			
P.169	**REF** *Investigational Device Exemption Number - Refer to TR3*			
P.170	**REF** Claim ID for Transmission Intermediaries	**REF01** Ref ID Qualifier	***D9***	D9 - Claim Number
		REF02 Reference Identification	***(Value Added Network Trace Number)***	Will be returned on Level 2 Status Report, if submitted.

837 Institutional Health Care Claim				
TR3	**Segment**	**Reference Designator(s)**	**Value**	**Definitions and Notes Specific to Empire NY**
Loop ID 2300—Claim Information (cont'd)				
P.172	**REF**	*Auto Accident State - Refer to TR3*		
P.173	**REF**	*Medical Record Number - Refer to TR3*		
P.174	**REF**	*Demonstration Project Identifier - Refer to TR3*		
P.175	**REF**	*PRO Approval Number - Refer to TR3*		
P.176	**K3**	*File Information - Refer to TR3*		
P.178	**NTE**	*Claim Note - Refer to TR3*		
P.180	**NTE**	*Billing Note - Refer to TR3*		
P.181	**CRC**	*EPSDT Referral - Refer to TR3*		
ICD-10 Codes will not be accepted any earlier than October 1, 2015.				
ICD-9-CM Guide requires diagnosis codes to the highest level of specificity. Code is invalid if it has not been coded to the full number of digits required for that code.				
P.184	**HI**	*Principal Diagnosis Information - Refer to TR3*		
P.187	**HI**	*Admitting Diagnosis - Refer to TR3*		
P.189	**HI**	*Patient's Reason for Visit - Refer to TR3*		
P.193	**HI**	*External Cause of Injury - Refer to TR3*		
P.218	**HI**	*DRG Information - Refer to TR3*		
P.220	**HI**	*Other Diagnosis Information - Refer to TR3*		
P.239	**HI**	*Principal Procedure Information - Refer to TR3*		
P.242	**HI**	*Other Procedure Information - Refer to TR3*		
P.258	**HI**	*Occurrence Span Information - Refer to TR3*		
P.271	**HI**	*Occurrence Information - Refer to TR3*		
P.284	**HI**	*Value Information - Refer to TR3*		
P.294	**HI**	*Condition Information - Refer to TR3*		
P.304	**HI**	*Treatment Code Information - Refer to TR3*		
P.313	**HCP**	*Claim Pricing/Repricing Information - Refer to TR3*		
Loop ID 2310A—Attending Physician Name				
Required for services (non-emergency ambulance transportation) populated in 2400, SV202-2				
P.319	**NM1**	*Attending Provider Name - Refer to TR3*		(Medicaid Reclamation)
P.322	**PRV**	*Attending Physician Specialty Information - Refer to TR3*		
P.324	**REF**	*Attending Prov Sec Identification - Refer to TR3*		(Medicaid Reclamation)
Loop ID 2310B—Operating Physician Name				
P.326	**NM1**	*Operating Physician Name - Refer to TR3*		
P.329	**REF**	*Operating Physician Secondary Identification - Refer to TR3*		
Loop ID 2310C—Other Operating Physician Name				
P.331	**NM1**	*Other Operating Physician Name - Refer to TR3*		
P.334	**REF**	*Other Operating Physician Secondary Identification - Refer to TR3*		
Loop ID 2310D—Rendering Provider Name				
P.336	**NM1**	*Rendering Provider Name - Refer to TR3*		
P.339	**REF**	*Rendering Provider Secondary Identification - Refer to TR3*		
Loop ID 2310E—Service Facility Location Name				
P.341	**NM1**	*Service Facility Location Name - Refer to TR3*		
P.344	**N3**	*Service Facility Location Address - Refer to TR3*		(Medicaid Reclamation)
P.345	**N4**	*Serv Fac Loc City, State, ZIP - Refer to TR3*		(Medicaid Reclamation)
P.347	**REF**	*Service Facility Location Secondary Identification - Refer to TR3*		
Loop ID 2310F—Referring Provider Name				
P.349	**NM1**	*Referring Provider Name - Refer to TR3*		
P.352	**REF**	*Referring Provider Secondary Identification - Refer to TR3*		

Although loops, segments and/or data elements required for Medicaid Reclamation are clarified in the definition and notes as (Medicaid Reclamation), they are not exclusive to Medicaid Reclamation type of claims only.

837 Institutional Health Care Claim				
TR3	**Segment**	**Reference Designator(s)**	**Value**	**Definitions and Notes Specific to Empire NY**
For COB claims, enter data elements in Loops 2320, 2330A, 2330B				
Loop ID 2320—Other Subscriber Information				
P.354	**SBR**	*Other Subscriber Information - Refer to TR3*		
P.358	**CAS**	*Claim Level Adjustments - Refer to TR3*		(Medicaid Reclamation)
P.364	**AMT**	*COB Payer Paid Amount - Refer to TR3*		(Medicaid Reclamation)
P.365	**AMT**	*Remaining Patient Liability - Refer to TR3*		
P.366	**AMT**	*COB Total Non-Covered Amount - Refer to TR3*		
P.367	**OI**	*Other Insurance Coverage Information - Refer to TR3*		
P.369	**MIA**	*Inpatient Adjudication Information - Refer to TR3*		
P.374	**MOA**	*Outpatient Adjudication Information - Refer to TR3*		
Loop ID 2330A—Other Subscriber Name				
P.377	**NM1**	*Other Subscriber Name - Refer to TR3*		
P.380	**N3**	*Other Subscriber Address - Refer to TR3*		
P.381	**N4**	*Other Subscriber City, State, ZIP Code - Refer to TR3*		
P.383	**REF**	*Other Subscriber Secondary Identification - Refer to TR3*		
Loop ID 2330B—Other Payer Name				
P.384	**NM1**	*Other Payer Name - Refer to TR3*		
P.386	**N3**	*Other Payer Address - Refer to TR3*		
P.387	**N4**	*Other Payer City, State, ZIP Code - Refer to TR3*		
P.389	**DTP**	*Claim Check or Remittance Date - Refer to TR3*		
P.390	**REF**	*Other Payer Secondary Identifier - Refer to TR3*		
P.392	**REF**	*Other Payer Prior Authorization Number - Refer to TR3*		
P.393	**REF**	*Other Payer Referral Number - Refer to TR3*		
P.394	**REF**	*Other Payer Claim Adjustment Indicator - Refer to TR3*		
P.395	**REF**	*Other Payer Claim Control Number - Refer to TR3*		
Loop ID 2330C—Other Payer Attending Provider				
P.396	**NM1**	*Other Payer Attending Provider - Refer to TR3*		
P.398	**REF**	*Other Payer Attending Provider Secondary Identification - Refer to TR3*		
Loop ID 2330D—Other Payer Operating Physician				
P.400	**NM1**	*Other Payer Operating Physician - Refer to TR3*		
P.402	**REF**	*Other Payer Operating Physician Secondary Identification - Refer to TR3*		
Loop ID 2330E—Other Payer Other Operating Physician				
P.404	**NM1**	*Other Payer Other Operating Physician - Refer to TR3*		
P.406	**REF**	*Other Payer Other Operating Physician Secondary Identification - Refer to TR3*		
Loop ID 2330F—Other Payer Service Facility Location				
P.408	**NM1**	*Other Payer Service Facility Location - Refer to TR3*		
P.410	**REF**	*Other Payer Service Facility Location Secondary Identification - Refer to TR3*		
Loop ID 2330G—Other Payer Rendering Provider Name				
P.412	**NM1**	*Other Payer Rendering Provider Name - Refer to TR3*		
P.414	**REF**	*Other Payer Rendering Provider Secondary Identification - Refer to TR3*		
Loop ID 2330H—Other Payer Referring Provider				
P.416	**NM1**	*Other Payer Referring Provider - Refer to TR3*		
P.418	**REF**	*Other Payer Referring Provider Secondary Identification - Refer to TR3*		
Loop ID 2330I—Other Payer Billing Provider				
P.420	**NM1**	*Other Payer Billing Provider - Refer to TR3*		
P.422	**REF**	*Other Payer Billing Provider Secondary Identification - Refer to TR3*		
Loop ID 2400—Service Line Number				
P.423	**LX**	*Service Line Number - Refer to TR3*		

Although loops, segments and/or data elements required for Medicaid Reclamation are clarified in the definition and notes as (Medicaid Reclamation), they are not exclusive to Medicaid Reclamation type of claims only.

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TR3	**Segment**	**Reference Designator(s)**	**Value**	**Definitions and Notes Specific to Empire NY**
Loop ID 2400—Service Line Number (cont'd)				
P.424	**SV2** Institutional Service Line	**SV201** Product/Service ID	***(Service Line Revenue Code)***	If the value ends in "9", then either Loop 2300 PWK (Claim Supplemental Information) or Loop 2300 NTE (Billing Note) is required.
		SV202-2 Product/Service ID	***(Procedure Code)***	Attending Provider (2310A) required for non-emergency ambulance transportation codes A0426, A0428 (without modifier QL).
P.429	**PWK**	*Line Supplemental Information - Refer to TR3*		
P.433	**DTP** Service Date	**DTP03** Date Time Period	***(Service Date)***	Date span does not apply to outpatient claims.
P.435	**REF**	*Line Item Control Number - Refer to TR3*		
P.437	**REF**	*Repriced Line Item Reference Number - Refer to TR3*		
P.438	**REF**	*Adjusted Repriced Line Item Reference Number - Refer to TR3*		
P.439	**AMT**	*Service Tax Amount - Refer to TR3*		
P.440	**AMT**	*Facility Tax Amount - Refer to TR3*		
P.441	**NTE**	*Third Party Organization Notes - Refer to TR3*		
P.442	**HCP**	*Line Pricing/Repricing Information - Refer to TR3*		
Loop ID 2410—Drug Identification				
P.449	**LIN** Drug Identification	**LIN03** Product/Service ID	***(National Drug Code)***	NDC # for prescribed drugs and biologics when required by government regulation.
P.452	**CTP**	*Drug Quantity - Refer to TR3*		
P.454	**REF**	*Prescription of Compound Drug Association Number - Refer to TR3*		
Loop ID 2420A—Operating Physician Name				
P.456	**NM1**	*Operating Physician Name - Refer to TR3*		
P.459	**REF**	*Operating Physician Secondary Identification - Refer to TR3*		
Loop ID 2420B—Other Operating Physician Name				
P.461	**NM1**	*Other Operating Physician Name - Refer to TR3*		
P.464	**REF**	*Other Operating Physician Secondary Identification - Refer to TR3*		
Loop ID 2420C—Rendering Provider Name				
P.466	**NM1**	*Rendering Provider Name - Refer to TR3*		
P.469	**REF**	*Rendering Provider Secondary Identification - Refer to TR3*		
Loop ID 2420D—Referring Provider Name				
P.471	**NM1**	*Referring Provider Name - Refer to TR3*		
P.474	**REF**	*Referring Provider Secondary Identification - Refer to TR3*		
Loop ID 2430—Line Adjudication Information				
P.476	**SVD**	*Line Adjudication Information - Refer to TR3*		
P.480	**CAS**	*Line Adjustment - Refer to TR3*		
P.486	**DTP**	*Line Check or Remittance Date - Refer to TR3*		
P.487	**AMT**	*Remaining Patient Liability - Refer to TR3*		
P.488	**SE**	*Transaction Set Trailer - Refer to TR3*		