UnitedHealthcare

Standard Encounter EDI Implementation Guide
UHC Payer IDs 95958, 98789

837 5010 Professional (837P)

ASC X12N Version 005010X222A1

Health Care Claim: Professional

HIPAA Transaction Companion Guide
837 Professional Health Care Claim
Refers to the Implementation Guides
Based on X12 version 005010
Companion Guide Version Number: 1.0

Preface

This is the Companion Guide (CG) to the ASC X12N Implementation Guides (IG) and clarifies and specifies the data content when exchanging electronically with UnitedHealthcare. Transmissions based on this companion guide, used in tandem with the ASC X12N IGs, are compliant with both ASC X12 syntax and those guides. This CG is intended to convey information that is within the framework of the ASC X12N Implementation Guides. This CG is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the IGs.

Table of Contents

1 INTRODUCTION

This section describes how ASC X12N Implementation Guides (IGs) will be detailed with the use of a table. The tables contain a row for each segment that UnitedHealthcare has something additional, over and above, the information in the IGs. That information can:

1. Limit the repeat of loops, or segments.
2. Limit the length of a simple data element.
3. Specify a sub-set of the IGs internal code listings.
4. Clarify the use of loops, segments, composite and simple data elements.
5. Any other information tied directly to a loop, segment, composite or simple data element pertinent to trading electronically with UnitedHealthcare.

In addition to the row for each segment, one or more additional rows are used to describe UnitedHealthcare's usage for composite and simple data elements and for any other information. Notes and comments should be placed at the deepest level of detail. For example, a note about a code value should be placed on a row specifically for that code value, not in a general note about the segment.

SCOPE

This document is to be used in conjunction with the IG (HIPAA 5010 837) Health Care Claim Encounters: Professional (sometimes referred to as Professional Claim or 837P Claim in this document) for the purpose of submitting encounter claims electronically. This CG is not intended to replace the IG.

OVERVIEW

This CG will replace, in total, any previous UnitedHealthcare CG versions for Health Care Professional Claim and must be used in conjunction with the IG instructions. This CG is intended to provide guidance during the implementation of electronic Professional Encounter transactions that meet UnitedHealthcare processing standards, by identifying pertinent structural and data related requirements and recommendations. Updates to this companion guide can occur periodically and are available online. CG documents are posted in the Electronic Data Interchange (EDI) section of our Resource Library on the Companion Guides page: 837P located at: UnitedHealthcare Standard Encounter Companion Guide UHC Payer ID 95958 & 98789

REFERENCES

Please refer to the ASC X12 Consolidated Guide Healthcare Claim 837P (005010X222A1). The ANSI ASC X12N 837 Health Care Claims (837) transaction is for professional encounters. This document is intended to comply with the data standards set out by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its associated rules. IGs can be viewed on the X12 website via "Glass" (with a license). For more information, please go to: https://x12.org/products

ADDITIONAL INFORMATION

The American National Standards Institute (ANSI) is the coordinator for information on national and international standards. In 1979 ANSI chartered the Accredited Standards Committee (ASC) X12 to develop uniform standards for electronic interchange of business transactions and eliminate the problem of non-standard electronic data communication. The objective of the ASC X12 Committee is to develop standards to facilitate electronic interchange relating to all types of business transactions. The ANSI X12 standards is recognized by the United States as the standard for North America. EDI adoption has been proved to reduce the administrative

burden on providers. Please note that this is UnitedHealthcare's approach to 837 Professional Claim transactions. After careful review of the existing IG for Version 005010X222A1, we have compiled the UnitedHealthcare specific CG. We are not responsible for any changes and updates made to the IG.

2 GETTING STARTED

WORKING WITH UNITEDHEALTHCARE

UnitedHealthcare exchanges transactions with clearinghouses and direct submitters, also referred to as Trading Partners. All transactions must go through the managed data gateway for UnitedHealthcare EDI transactions called OptumInsight.

TRADING PARTNER REGISTRATION

Entities that have been delegated to pay claims (termed encounters when transmitted to the health plan) on behalf of UnitedHealthcare, can submit via an approved clearinghouse. Approval to submit encounters must be obtained from our Inbound Encounters Team by contacting encountercollection@uhc.com

CERTIFICATION AND TESTING OVERVIEW

All trading partners are required to submit 837P Claim transactions to UnitedHealthcare via the ASC X12 837 (Version 005010X222A1), and receive corresponding EDI responses, must complete testing to ensure that their systems and connectivity are working correctly before any production transactions can be processed. For testing EDI transactions (encounters) with UnitedHealthcare, please reach out to encountercollection@uhc.com

3 TESTING WITH THE PAYER

All new and established provider groups are required to test their ASC X12 (837P) 5010 files when submitting encounters for a new contract or an updated contract where financial risk has changed. Additional test files are required for the following: implementing a new claims or encounters management platform, adding a new line of business, changing to a different clearinghouse or claims/encounters system, and any mapping/logic changes. For new delegates, we will coordinate the clearinghouse connection with FinThrive (finthrive.com).

Prior to testing, special set up is required at UnitedHealthcare and your clearinghouse for your test files (and your production files) to process successfully. UnitedHealthcare Inbound Encounters Operations team will provide a unique 12-character submitter ID. This 12-character submitter ID is required to be submitted in Loop 2010BB, REF G*2 Segment.

Pre-Go Live Contract Date: Prior to your contract effective date, our clearinghouses will work with you to run your de-identified test data (pre-go live testing) to check for upload connectivity, formatting, and sequencing prior to using adjudicated claims data.

The Inbound Encounter Operations team will also coordinate a series of meetings with your organization prior to your contract go-live date. These meetings will provide an opportunity to review specific 837 EDI requirements to ensure that your encounter data files will meet our requirements for timeliness, completeness, and accuracy. The Inbound Encounter Operations team will coordinate a series of meetings with your organization to complete this process.

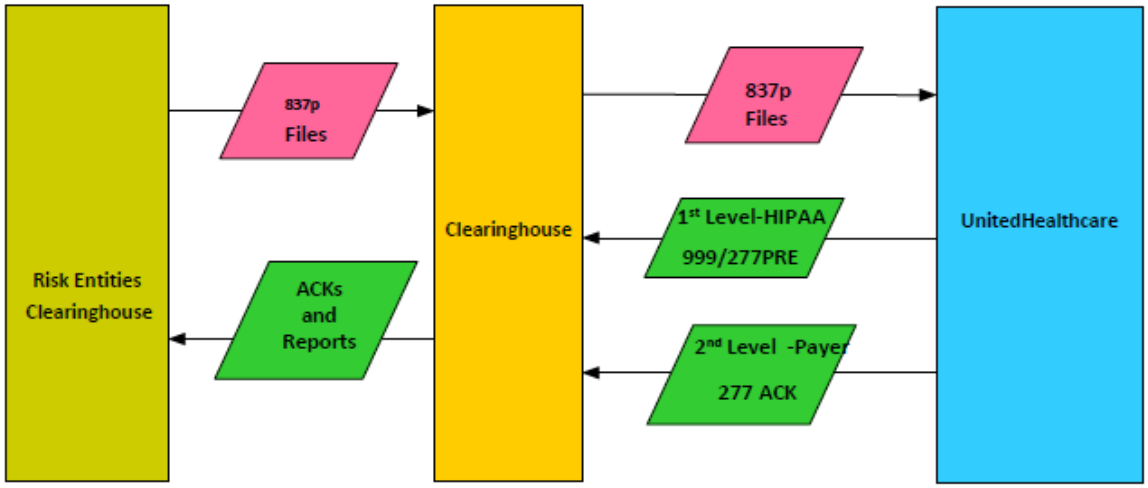
Post-Go Live Contract Date: UnitedHealthcare Inbound Encounter Operations expects that the test files should include claims that have been adjudicated from your claim's platform. We will coordinate with FinThrive post go live to confirm the production files meet the error rate acceptance criteria before the files

are released in production. The Inbound Encounter Operations team will coordinate a series of meetings with your organization to complete this process.

4 CONNECTIVITY WITH THE PAYER/COMMUNICATIONS

PROCESS FLOWS

PROCESS FLOW: BATCH 837 PROFESSIONAL ENCOUNTERS



TRANSMISSION ADMINISTRATIVE PROCEDURES

UnitedHealthcare supports both batch and real-time 837P Claim transmissions.

5 CONTACT INFORMATION

Inbound Encounter Operations Team

Delegated entities should contact our UnitedHealthcare Inbound Encounter Operations Team at encountercollection@uhc.com

6 APPLICABLE WEBSITES

This section contains information about useful web sites and email addresses.

www.uhcprovider.com – for all UnitedHealthcare delegate protocols

https://x12.org/products - IGs are available to view on the X12 website via “Glass” (with a license)

UnitedHealthcare Standard Encounter Companion Guide UHC Payer ID 95958 & 98789 –the most current version of this CG.

encountercollection@uhc.com – Email contact for the Inbound Encounter Operations Team

7 CONTROL SEGMENTS/ENVELOPES ISA-IEA

The table below represents only those fields that UnitedHealthcare requires a specific value in or has additional guidance on what the value should be. The table does not represent all the fields necessary for a successful transaction; the IG should be reviewed for that information.

LOOP ID	REFERENCE	NAME	VALUES	NOTES/COMMENTS
None	**ISA**	**ISA Interchange Control Header**		
	ISA05	Interchange ID Qualifier	ZZ	ZZ = Mutually Defined
	ISA06	Interchange Sender ID	Optum User ID	Assigned by Clearinghouse
	ISA08	Interchange Receiver ID	Optum User ID	Assigned by Clearinghouse

GS-GE

EDI transactions of a similar nature and destined for one trading partner may be gathered into a functional group, identified by a functional group header segment (GS) and a functional group trailer segment (GE). Each GS segment marks the beginning of a functional group. There can be many functional groups within an interchange envelope. The number of GS/GE functional groups that exist in a transmission may vary. The below table represents only those fields that UnitedHealthcare requires a specific value in or has additional guidance on what the value should be. The table does not represent all the fields necessary for a successful transaction; the IG should be reviewed for that information.

LOOP ID	Reference	NAME	Values	Notes/Comments
None	**GS**	**Functional Group Header**		
	GS03	Application Receiver's Code	95958 or 98789	Inbound Encounter Operations team will advise on appropriate value
	GS08	Version/Release Industry Identifier Code	005010X222A1	Version expected to be received by UnitedHealthcare

ST-SE

The beginning of each individual transaction is identified using a transaction set header segment (ST).

The end of every transaction is marked by a transaction set trailer segment (SE). For real time transactions, there will always be one ST and SE combination. An 837 file can only contain 837 transactions.

The below table represents only those fields that UnitedHealthcare requires a specific value in or has additional guidance on what the value should be. The table does not represent all the fields necessary for a successful transaction; TR3 should be reviewed for that information.

LOOP ID	Reference	NAME	Codes	Notes/Comments
None	ST	Transaction Set Header		Required Header
	ST03	Implementation Convention Reference	005010X222A1	Version expected to be received by UnitedHealthcare

8 CONTROL SEGMENT HIERARCHY

ISA - Interchange Control Header segment GS

-Functional Group Header segment

ST - Transaction Set Header segment First 837 Transaction

SE - Transaction Set Trailer segment

ST - Transaction Set Header segment Second 837 Transaction

SE - Transaction Set Trailer segment

ST - Transaction Set Header segment Third 837 Transaction

SE - Transaction Set Trailer segment GE - Functional Group Trailer segment

IEA - Interchange Control Trailer segment

9 CONTROL SEGMENT NOTES

The ISA data segment is a fixed length record, and all fields must be supplied. Fields not populated with actual data must be filled with space.

1.The first element separator (byte 4) in the ISA segment defines the element separator to be used through the entire interchange.

2.The ISA segment terminator (byte 106) defines the segment terminator used throughout the entire interchange.

3.ISA16 defines the component element

10 FILE DELIMITERS

UnitedHealthcare requests that you use the following delimiters on your 837 files. If used as delimiters, these characters (*: ~ ^) must not be submitted within the data content of the transaction sets. Please contact UnitedHealthcare if there is a need to use a delimiter other than the following:

1. Data Element: The recommended data element delimiter is an asterisk (*)
2. Data Segment: The recommended data segment delimiter is a tilde (~)
3. Component Element: ISA16 defines the component element delimiter is to be used throughout the entire transaction. The recommended component-element delimiter is a colon (:)
4. Repetition Separator: ISA11 defines the repetition separator to be used throughout the entire transaction. The recommended repetition separator is a caret (^)

11 PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS

Following these guidelines will help you submit your encounters successfully to UnitedHealthcare.

SERVICES	GUIDELINES
Non-Encounter Fee for Service Claims	Fee for Service claims should be submitted under UHC Payer ID 87726, the UHC Standard 837 Companion Guide will apply.
Delegated Encounters	Delegated Encounters should be submitted under UHC Payer ID 95958 or 98789. Please contact encountercollection@uhc.com to confirm appropriate Payer ID.
Interest Payments	Under the capitated delegated agreement with UnitedHealthcare to submit encounter data, any finalized claim in part or in its entirety that contains interest payments must display these payments using a claim adjustment reason code (CARC) 225 – Payment or Interest Paid by Payer. This code should only be used for plan-to-plan encounter reporting. According to Section 1.1.1.1 of the 005010X222A1, balancing with the claim payment involves the subtraction of adjustments from the service line payment total. A positive dollar amount for interest would reduce the payment of the claim. A negative dollar amount would increase the payment on the claim. As a result, reporting the payment of interest by a prior payer in the 837 would require a “negative dollar” amount to balance. CARC 225 payments should not be equal to zero.
Lifetime Events	A lifetime event is described as a medical procedure that can only occur once in a lifetime. Such events include but are not limited to Hysterectomy, Prostatectomy, Appendectomy, and Amputations, etc. Lifetime events must be reported with a unit value of only 1.
Rejected Encounters	Encounter rejections that appear on clearinghouse reports or via the 277 ACK and have not been

	accepted by UnitedHealthcare should be corrected and resubmitted electronically.
Required Member Cost Share / Revenue Reporting	For Commercial and Medicare Advantage plans, UnitedHealthcare requires contracted providers to submit current, complete and accurate encounter data including member cost share/revenue daily to effectively track member cost share. *CMS Guidelines:* *Federal Register: Medicare Program; Maximum Out-of-Pocket (MOOP) Limits and Service Category Cost Sharing Standards*
Sequestration	As required by federal law under a sequestration order dated March 1, 2013, Medicare Fee-For-Service claims with dates of service or dates of discharge on or after April 1, 2013, incur a two percent reduction in Medicare payment. [Source: Center for Medicare and Medicaid Services]. Under the capitated delegated agreement with UnitedHealthcare to submit encounter data, any finalized claim in part or in entirety that contains a reduction in payment due to “sequestration” should be reported to UnitedHealthcare using claim adjustment reason code (CARC) 253 – Sequestration. Sequestration reduction should be presented at the service line level.
Duplicate Encounter Submissions	HIPAA validation requires the use of Group Code ‘OA’ in combination with CARC Code ‘18’. [Exact duplicate claim/service] to flag service lines that are an exact duplicate of a previous encounter submission. Note: *Do not use OA18 on replacements when the service line level has cost share applied on the history encounter. This causes cost share to be removed from the members accumulators in error.* Please reach out to encountercollection@uhc.com for further guidance.
Submission of CARC Code B11	UnitedHealthcare recommends the use of CARC code B11 to identify encounters that have been denied due to claim/service has been transferred to the proper payer/processor for processing. Any claim adjudicated using CARC code B11 on all service lines should be submitted to UHC. Please reach out to encountercollection@uhc.com for further guidance.
In Network / Out of Network	All encounter submissions must reflect whether the services provided to the member is “in network” or “out of network.” Any finalized claim or encounter

	with services rendered by an out of network provider should be reported using claim adjustment reason code (CARC) 242 – Services Not Provided by Network/Primary Care Provider, at the service line level (Loop 2430 CAS) OR at the claim header level (Loop 2320 CAS).

FORMATS	LOOP	SEG-FLD	FIELD Description	CARC Code
837p	2320	CAS02	• Use this segment to report OON at the claim header level	242
	2430	CAS02	• Use this segment to report OON at the service line level	242

Secondary Claims	When another insurance plan is the primary payer, and the delegate is the secondary payer then the primary payer's claim adjudication information COB will be submitted on the encounter identifying the primary adjudication information with CARC 23.

FORMATS	LOOP	SEG-FLD	FIELD Description	CODE
837p	2000B	SBR01	• This is the destination payer	P = Primary S = Secondary T = Tertiary
	2320	SBR01	• This is the non-destination payer	
	2320	CAS02	• Please use CARC 23 for service lines with other payers	23
	2430	CAS02	• Please use CARC 23 for service lines with other payers	23

EXAMPLE	Destination vs. Non-Destination	CODE
One Payer (fee for service claim)	2000B *(destination)*	P = Primary
Two Payers (delegated encounter)	2000B *(destination)*	S = Secondary
	2320 *(non-destination)*	P = Primary
Three Payers (delegated encounter with dual coverage member)	2000B *(destination)*	T = Tertiary
	2320 *(non-destination)*	S = Secondary
	2320 *(non-destination)*	P = Primary

Voids and Replacements	A replacement encounter should be sent to UnitedHealthcare when a previously adjudicated claim requires data correction or a payment adjustment. A replacement encounter should contain a claim frequency code of [7] in Loop 2300 CLM05-3 segment.

	A void encounter should be sent to UnitedHealthcare when the previously submitted encounter should be eliminated. A void encounter must match the original encounter except for the claim frequency type code and if applicable, the patient control number (PCN). A void encounter should not contain "negative" values and must contain a claim frequency code of [8] in Loop 2300 CLM05-3 segment. The replacement or void encounter is required to be submitted with the Original Reference Number PCN in Loop 2300 REF segment. The REF01 = F8 and the REF02 = **Original PCN**. If the required information is not submitted the encounter will be rejected back to the submitter.
Maintaining or Removing Member Cost share on Replacements	Maintain Member Cost Share When submitting replacements that maintain member cost share submit Adjusted Group Code "PR" and the Claim Adjustment Reason Code with a "1 or 2 or 3" as it applies to the amount of member cost share. Remove Member Cost Share When submitting replacements to remove member cost share submit the replacement omitting the Adjusted Group Code "PR" and the Claim Adjustment Reason Code with a "1 or 2 or 3" from the prior submission to remove the member cost share.

FORMATS	LOOP	SEG-FLD	FIELD DESCRIPTION	CODE
837P	2300	CLM05-3	ClaimFrequency Type Code 7 or 8	7 or 8
	2300	REF02 (F8)	Originalclaim number	Claim Number from Original Submission

12 VALIDATION OF ENCOUNTERS

UnitedHealthcare applies two levels of editing to inbound HIPAA 837 files and claims:

1. Level 1 HIPAA Compliance:
   Claims passing Level 1 Compliance are assigned a UnitedHealthcare Payer Claim Control Number and are "accepted" for front-end processing.

2. Level 2 Front-End Validation:
   Member match
   Provider match
   Payer Level Edits
   WEDI SNIP Level 1-5 validation
   Level 1 HIPAA Compliance

3. Encounters passing front-end validation are accepted into the UnitedHealthcare system for processing.

4. Encounters that do not pass front-end validation will be rejected and returned to the submitter via 277 responses.

13 ACKNOWLEDGEMENTS AND/OR REPORTS

Acknowledgements:

TA1 – Transaction Acknowledgement

This file informs the submitter that the transaction arrived and provides information about the syntactical quality of the Envelope of the submitted X12 file. UnitedHealthcare real-time will only respond with a TA1 when the X12 contains Envelope errors. The submitted 837 will need to be corrected and resubmitted.

999 – Functional Acknowledgement

This file informs the submitter that the transaction arrived and provides information about the syntactical quality of the Functional Groups in a submitted X12 file. UnitedHealthcare will respond with a 999 when the X12 contains Functional errors. The submitted 837 will need to be corrected and resubmitted.

277PRE

This file informs the submitter with more detail about why the claim failed validation. The 277PRE is generated when encounters in the batch file failed Level 1 validation. If no claims failed Level 1 validation, then the 277PRE is not created.

277ACK

This file informs the submitter of the disposition of their encounters through Level 2 Front End Validation, it reports both accepted and rejected claims.

Report Inventory

The clearinghouse will advise what available reporting they can provide. This could include reporting on clearinghouse and payer edits accessible via a portal, or via a 277ACK response file.

The clearinghouse will acknowledge receipt of the electronic file transaction via the pre-277 acknowledgement. The clearinghouse will in addition acknowledge and identify all the errors in the content of the electronic file transaction via the 277. Please contact your clearinghouse for additional instructions on how to ingest a 277ACK. The ingestion of a 277 Acknowledgement (277ACK) is highly recommended to meet the UnitedHealthcare Inbound Encounters timeliness, completeness, and accuracy performance metrics.

14 TRADING PARTNER AGREEMENTS

Payers have EDI Trading Partner Agreements that accompany the standard implementation guide to ensure the integrity of the electronic transaction process. The Trading Partner Agreement is related to the electronic exchange of information, whether the agreement is an entity or a part of a larger agreement, between each party to the agreement.

TRADING PARTNERS

An EDI Trading Partner is defined as any UnitedHealthcare customer (provider, delegated entity, billing service, software vendor, clearinghouse, employer group, financial institution, etc.) that transmits to or receives electronic data from UnitedHealth Group.

15 TRANSACTION SPECIFIC INFORMATION

The table below represents only those fields that UnitedHealthcare requires a specific value in or has additional guidance on what the value sent in the response means. The table does not represent all the fields that will be returned in a successful transaction. The IG should be reviewed for that information.

Loop	Reference	Names	Values	Notes/Comments
None	**BHT**	**Beginning of Hierarchical Transaction**		
	BHT06	Transaction Type Code	RP	**RP** = Capitated Encounters Use RP when submitting Encounters
1000A	**Submitter Detail**			
	PER	Submitter Contact		
	PER02	Contact Name	Submitter Contact Name	The submitting clearinghouse populates this information
1000B	**Receiver Detail**			
	NM1	Receiver Name		
	NM103	Name Last or Organization Name	UNITEDHEALTHCARE WEST	The submitting clearinghouse populates this information
	NM109	Identification Code	95958, 98789	Inbound Encounter Operations team will advise on appropriate value
2010AA	**Billing Provider Name**			
	NM108	Billing Provider ID Qualifier	XX	NPI Identifier
	NM109	Billing Provider Identifier		Must be populated with the 10-digit NPI and formatted

				correctly. NPI's begin with 1, 2, 3 or 4.
	N4	Billing Provider City, State, Zip Code		
	N403	Zip Code		The full nine (9) digits of the Zip Code are required.
	REF	Billing Provider Tax Identification		
	REF01	Reference ID Qualifier	EI	EI = Employer's Identification Number
Loop	**Reference**	**Names**	**Values**	**Notes/Comments**
	REF02	Reference ID		Billing Provider Tax ID. 9 digits with no separators
2010AB	**Pay to Address Name –This Loop only required when the address for payment is different than that of the billing provider**			
	NM101	Entity Identifier Code	87	Pay to Provider
	NM102	Entity Type Qualifier	1 or 2	Person or Non-Person
	N301	Address Information	Address	P.O. Box Allowed
	N401	City Name		
	N402	State or Province Code		
	N403	Postal Code	Zip Code + 4	

2010AC	**Pay to Plan Name – This Loop only required when sending encounters for Subrogation claims**			
	NM101	Entity Identifier Code	PE	Used to indicate the subrogated payee
	NM102	Entity Type Qualifier	2	Non-Person Entity
	NM103	Name Last or Organization Name		
Loop	**Reference**	**Names**	**Values**	Notes/Comments
	NM108	Identification Code Qualifier	PI	
	NM109	Identification Code	95958, 98789	
	N301	Address Information	Address	
	N401	City Name		
	N402	State or Province Code		
	N403	Postal Code	Zip Code + 4	
	REF01	Reference Identification Qualifier	EI	
	REF02	Reference Identification	Tax ID Number	
2000B	**Subscriber Information**			
	SBR	**Subscriber Information**		
	SBR01	Payer Responsibility Sequence Number Code	S	S = Secondary
2010BA	**Subscriber Name**		If a UnitedHealthcare patient is a Dependent, then the dependent information must be submitted in Loop 2000C and 2010CA. If the claim is for the Subscriber only, then Loop 2000C and 2010CA are not required. If the 2010CA Loop is sent, it may cause a rejection.	
	NM1	Subscriber Name		
	NM108	Subscriber Id Qualifier	MI	MI is the only valid value currently. Claims received with value II will be rejected.

	NM109	Subscriber Primary Identifier		The Member ID of the Subscriber is required for NM109; however, if the patient is a Dependent, their unique Member ID must be entered here regardless of the Name in NM103/NM104.
2010BB	**Payer Name**			
	NM1	Payer Name		
	NM103	Last Name or Organization Name	UnitedHealthcare	Payer Name
	NM108	Identification Code Qualifier	PI	PI = Payer Identifier
	NM109	Identification Code	Encounter Payer id 95958 or 98789.	Inbound Encounter Operations team will advise on the appropriate value.
	REF	**Billing Provider Secondary Identification**		
	REF01	Reference ID Qualifier	G2	G2 = Provider Commercial Number
	REF02	Reference ID		A 12-alphanumeric submitter id is required and provided by the Inbound Encounter Operations team.
Loop	**Reference**	**Names**	**Values**	**Notes/Comments**
2300	**Claim Loop**			
	CLM	Claim Information		
	CLM01	Patient Control Number		The delegates own internal claim number.
	CLM02	Total Claim Charge Amount		Must balance to the sum of the SV1 service lines in Loop 2400.
	CLM05-3	Claim Frequency Type Code	1 (1-5, 9), 7, 8	1=Original claim submission 7=Replacement 8=Void 9 = Final Interim Bill
	PWK	**Supplemental Information**		

	PWK01	Report Type Code	N/A	Reserved for Ancillary Supplemental codes. More information can be provided by the Inbound Encounter Operations team.
	DTP	**Date Admission**		
		Submit Admission Date on all ambulance claims or when patient was known to be admitted to the hospital.		
	K3	**File Information**		
		Optional segment utilized to submit additional information such as provider claim ID's.		
	HI	**Health Care Information Codes**		
		Submit only ICD10 codes. Claims or Encounters received with value ICD9 codes will be rejected.		
2320	**Other Subscriber Information**			
	SBR	**Other Subscriber Information**		
	SBR01	Payer Responsibility Sequence Number Code	P, S, T	P = Primary S = Secondary T = Tertiary
	AMT	**Coordination of Benefits (COB) Payer Amount Paid**		
	AMT01	Monetary Amount	D	D = Payer Amount Paid
	AMT02	Payer Paid Amount		Value is Contracted Rate or Medicare Fee Schedule Rate or Calculated Capitation Rate less any applicable patient responsibility submitted in CAS Segment
Loop	**Reference**	**Name**	**Value**	**Notes/Comments**
2330A	**Other Subscriber Name**			
	NM1	Other Subscriber Name		
	NM108	Identification Code Qualifier	MI	MI is the only valid value currently. Claims received with value II will be rejected.
	NM109			Member ID / Subscriber ID

2330B	**Other Payer Name**			
	NM1	Other Payer Name		
	NM103	Name Last or Organization Name		Name of Delegated Medical Group
	NM108	Identification Code Qualifier		
	NM109	Identification Code	Delegate provides their own Payer ID Must match 2430 SVD01 segment.	Unique ID that identifies the delegate who processed the claim
2400	**Service Line Information**			
	SV1	Professional Service		
	SV103	Unit or Basis for measurement code	MJ	Submit code MJ when reporting anesthesia minutes in Loop 2400 SV104.
	SV104	Quantity		Units Submit a maximum unit quantity of 999 per occurrence of Loop 2400 SV1. When unit quantity is greater than 999, submit multiple occurrences with up to 999 units per occurrence. Minutes Submit quantity as minutes for time-based anesthesia services, using MJ qualifier in Loop 2400 SV103.
2400	**Third Party Organization Notes**			
	NTE	Surprise Medical Billing Identifier	State NTE*TPO*SMB*N872-[two-digit state code] Federal – Air Ambulance NTE*TPO*NSA-N859	For Commercial insured members only: Submission requirement for submitted encounters when the claim is adjudicated under the state or federal Surprise Medical Billing Guidelines. Please contact your assigned encounter business analyst.
	HCP	**Line Pricing/Repricing Information**		
		Submit line pricing for repriced claims.		

		Providers do not submit this data. This data is to be submitted by re-pricers only.		
2430	**Line Adjudication Information**		**Member Cost Share amounts made at the Line Level must be submitted in Loop 2430 (Line Level).**	
	SVD	**Line Adjudication Information**		
Loop	**Reference**	**Name**	**Value**	**Notes/Comments**
	SVD01	Identification Code		Value reported here must match value utilized in Loop 2330B NM109.
	SVD02	Monetary Amount		Value is Contracted Rate or Medicare Fee Schedule Rate or Calculated Capitation Rate less any applicable patient responsibility submitted in CAS Segment as identified below. If the line level adjudication is present and the service line has no charge submit SVD02 = $0
	CAS	**Line Level Adjustments**		
	CAS01	Claim Adjustment Group Code		All of the Claim Adjustment Group Codes are allowed. Note: When submitting Member Cost Share use code PR and include the appropriate Claim Adjustment Reason Code in (CAS02) as listed below.
	CAS02	Claim Adjustment Reason Code		When submitting member cost Share using the PR qualifier, specify the appropriate reason code: 1 = Deductible Amount 2 = Coinsurance Amount 3 = Co-payment Amount Claim Adjustment Reason Codes: https://x12.org/codes
	DTP	**Remittance Date**		

	DTP03	Adjudication or Payment Date		All delegated encounters are required to report the date where the claim was finalized under the delegates internal system.

16 APPENDICES

Change Summary

Date	Description	Version
06/25/2025	Complete re-write of companion guide, Previous version 7.1	1.0