SUBSTANCE USE DISORDER TREATMENT SERVICES PROVIDER MANUAL
ADDENDUM

Sage – The Patient Information Management System: Services, Data, and Claims

System Transformation to Advance Recovery and Treatment, Los Angeles County's Substance Use Disorder Organized Delivery System

COMPANION GUIDE

HIPAA 837I

Health Insurance Portability and Accountability Act Industry-wide standards for health care electronic billing, data privacy and security provisions for medical information

May 2020 (Version 1.1)

Disclosure Statement

This document represents the Los Angeles County Department of Public Health, Substance Abuse Prevention and Control implementation instructions for electronic claim transactions. It is believed to be compliant with all ASC X12 intellectual property requirement.

Document Revision History

Version	Release Date	Comments
1.0	10/10/2019	Sage Project – Initial Document Release
1.1	5/15/2020	Updated for Institutional Claims, Loops and Segments
1.		

Preface

This Companion Guide to the version 5010 ASC X12N Implementation Guides and associated errata adopted under Health Insurance Portability and Accountability Act (HIPAA) clarifies and specifies the data content when exchanging electronically with Los Angeles County "LAC" Substance Abuse Prevention Control Department "SAPC". Transmissions based on this Companion Guide, used in tandem with the v5010 ASC X12N Implementation Guides, are compliant with both ASC X12 syntax and those guides. This Companion Guide is intended to convey information that is within the framework of the ASC X12N Implementation Guides adopted for use under HIPAA. The Companion Guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the Implementation Guides.

This Companion Guide addresses specific SAPC business processes required for transmitting claims data to the SAPC Sage System. In addition to the SAPC business requirements, all 837 Institutional transactions submitted to Sage must be compatible with all HIPAA requirements. It is assumed that trading partners are familiar with ASC X12 transactions and does not attempt to instruct trading partners in the creation of an entire HIPAA transaction.

This Companion Guide is subject to change. If you have any questions, please contact SAPC at sapc_support@ph.lacounty.gov.

COUNTY OF LOS ANGELES
Public Health
Substance Abuse Prevention and Control

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Section 1. Introduction

Scope

This Companion Guide is intended to be used by SAPC contracted providers in support of the following ASC X12 transaction implementations mandated under HIPAA:

- ASC X12 Health Care Claim: Institutional (837) as specified in guide 005010X223 and 005010X223A2 (837I)

These guides are available for purchase from ASC X12 at http://store.X12.org/

Overview

Section 2 provides information about establishing a trading partner relationship with SAPC.

Section 3 provides a Process Flow of the claiming transactions.

Section 4 identifies Electronic Data Interchange (EDI) related contacts within SAPC.

Section 5 provides operational information.

Section 6 provides the SAPC specific business rules and limitations.

Section 7 provides the SAPC technical requirements for file exchange and the envelope segments.

Section 8 provides the SAPC requirements and usage for the 837 claiming transactions.

Section 9 identifies the SAPC acknowledgment transactions.

Appendix A provides 837I Billing Combination.

Appendix B provides sample 837 transactions.

References

This information must be used in conjunction with the ASC X12 Implementation Guides. They are available at http://www.wpc-edi.com/.

Section 2. Getting Started

Trading Partner Registration

Trading Partners

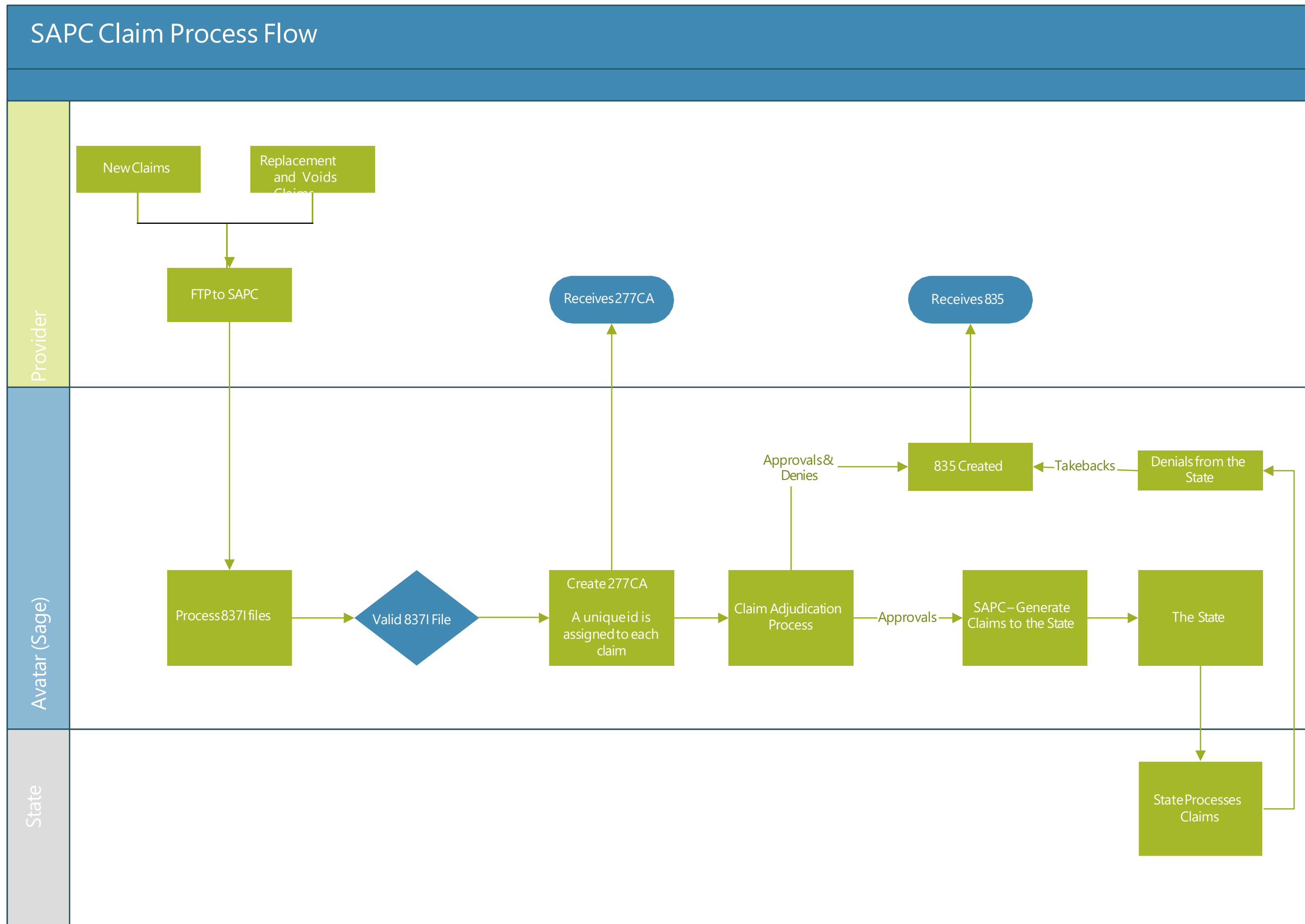
An EDI Trading Partner is defined as any SAPC customer (provider, billing service, software vendor, financial institution, etc.) that transmits to, or receives from SAPC any standardized electronic data (i.e. HIPAA claim or remittance advice transactions).

You can find additional information on registering for EDI by contacting SAPC at following address:

Attn: SAPC EDI Coordinator
County of Los Angeles, SAPC
1000 South Fremont Avenue, Building A-9 East, 3rd Floor
Alhambra, CA 91803

(626) 299-4551
sapc_support@ph.lacounty.gov

Section 3. Process Flow



Section 4. Contract Information

EDI Customer Service/Technical Assistance

SAPC EDI Coordinator
(626) 299-4551
sapc_support@ph.lacounty.gov

County of Los Angeles, SAPC
1000 South Fremont Avenue, Building A-9 East, 3rd Floor
Alhambra, CA 91803

Section 5. Operational Information

Hours of Operation

Unless otherwise notified claims processing will occur between 8:00AM to 5:00PM PST, Monday through Friday.

Section 6. SAPC/Sage Business Rules and Limitations

Business rules for inbound 837I Transactions

1. All clients must be created in Sage prior to claiming. The client must be identified by a unique Client ID assigned by Sage. The client ID number must be prefixed with the letters 'MSO' in loop 2010BA/NM109 Subscriber Primary Identifier field.

2. Financial Eligibility must be entered in Sage for each client prior to claiming. Each client must have the correct guarantors associated with the client's admission. In addition, the following fields must be completed prior to claiming:

    - Client's Relationship to Subscriber
    - Subscriber's First Name
    - Subscriber's Last Name
    - Subscriber's Gender
    - Subscriber's Date of Birth
    - Subscriber's Address Information
    - Subscriber's Client Index Number (CIN), if DMC Enrolled. If Patient is non-DMC, leave blank.
    - Verified Eligibility with a date prior to the date of service on the claim
    - Subscriber's Assignment of Benefits
    - Subscriber's Release of Information

3. A diagnosis must be entered on the "Provider Diagnosis ICD 10" form on SAGE.

4. All provider facilities must be set up in Sage. Each facility is required to have a unique NPI number for electronic billing. The NPI number will be used to identify the facility providing services to the client.

5. SAPC requires an authorization for all services in the 2400/REF02 segment. Provider will put only one authorization on a claim line.

- Member Authorizations or Service Authorizations are specific to a client and a Contracting Provider. They are used to authorize all treatment services. Member Authorizations are also tied to a Funded Program/Funding Source and will ensure verifications are conducted during patient enrollment. Member Authorizations are requested via the Sage system. Member Authorizations are always all numeric. Providers should only submit claims on approved member authorizations in the 837I file, as claims on Member Authorizations that are not approved will automatically be denied.

6. The Rendering Provider, or Practitioner, must be set up and associated in Sage with the Provider prior to billing. All Rendering Providers must have a NPI set up in Sage. The NPI number will be used to match the clinician on the inbound claim with the clinician associated with the Provider in Sage. Rendering Provider updates should be communicated to SAPC on a timely basis.

7. The Rendering Provider's Discipline will be determined based on the information stored in Sage. SAPC will not utilize the Rendering Provider's taxonomy in the PRV segment. Any updates to the Practitioner's Discipline will need to be communicated to SAPC on a timely basis.

8. Modifier – each service should contain the correct modifier. Sage will validate the Revenue Code and Modifier(s) against the services associated with the Authorization. Services that do not match the Revenue Code in the Authorization will be denied. Each modifier must be separated by a colon ':'. Modifier must be in the order:
   - ASAM Level of care
   - Age
   - Perinatal Status

9. All Institutional services - 3.7 WM and 4.0 WM claims must be reported in 'UN' (units) as the Unit or Basis of Measurement Code in SV204. For Residential day rate claims, one day equals 1 unit.

10. All Institutional services - Room and Board claims must be reported in 'DA' (days) as the Unit or Basis of Measurement Code in SV204. For Residential day rate claims, one day equals 1 day.

11. The following elements are used by Sage to identify and validate the client:

    - Client ID – 2010BA/NM109 Subscriber Primary Identifier. The Subscriber Primary number will be assigned by SAPC during the admission process. The Subscriber Primary number must have a prefix of 'MSO' in front of client ID to avoid billing errors.
    - Gender – 2010BA DMG03 Subscriber Gender Code.
    - Date of Birth – 2010BA DMG02 Subscriber Birth Date.

12. Services per claim

    - SAPC allows one service line per claim.

13. SAPC Health Care Claim Payment/Advice (835)

    - Providers will receive an 835 for all Approved and Denied claims at the time that

the claim is adjudicated, and the provider receives payment.

- Providers will receive a separate 835 with just denied claims.
- Per the national HIPAA 835 guide, Sage uses the Claim Status Code values 1, 2 and 3 (CLP02) when adjudicating original claims, regardless of whether the claim was approved or denied. Sage does not return the Claim Status Code 4 when a claim is denied.

14. Retro Claim Adjudication

- Drug Medi-Cal claims that are subsequently denied by the State will result in a second 835, known as a retro claim adjudication. Retro claim adjudication 835s follow all the standard HIPAA 835 requirements for reversals and corrections.

15. Replacement Claims

- Replacement claims must reference the Sage Original Reference Number in the REF segment of the 2100 loop of the 835. This reference number is used by Sage to match the replacement claim to the original claims.
  Example: REF*F8*123456.
- You can only replace an original claim one time. If you need to make an additional replacement, replace the replacement claim, not the original.
- Any amount differences between the original amount approved and paid by Sage will be adjusted on the next 835.

16. Voided Claims

- A void of an approved claim will result in a retro claim adjudication ("takeback") on the subsequent 835.
- Do not send voided claims in response to SAPC/Sage denials, i.e. any claim that was not paid in the initial adjudication cycle.
- Voided claims can only be submitted after the claim has been adjudicated in Sage and the Provider has received an 835 with the Sage assigned claim ID number.

Section 7. File Exchange/File Structure/Control Segments

File Exchange

Test and Production 837I files should be placed on secured File Transfer Protocol (FTP) in your agency's specific 837 folder. SAPC will provide a User Name and Password for this secure site. 277CA and 835 files will be returned in the same site in your agency's 835 folder accessible. It is provider's responsibility to email the SAPC EDI Coordinator when files are uploaded.

File Requirements

837 claims file cannot contain carriage returns. The data must be wrapped as in a true EDI file.

ISA-IEA on Inbound Transactions

ISA – Interchange Control Header		
ISA01	Authorization Information Qualifier	SAPC expects '00'
ISA03	Security Information Qualifier	SAPC expects '00'
ISA05	Interchange ID Qualifier	SAPC expects '30'
ISA06	Interchange Sender ID	The Provider's Federal Tax ID with no dash followed by 6 spaces
ISA07	Interchange ID Qualifier	SAPC expects '30'
ISA08	Interchange Receiver ID	SAPC's Federal Tax ID Number with no dash followed by 6 spaces
ISA11	Repetition Separator	Must be present
ISA16	Component Element Separator	All outbound EDI will use the colon (":") as the Component Element Separator

GS-GE on Inbound Transactions

SAPC accepts only one Functional Group per Interchange

GS – Function Group Header		
GS01	Functional Identifier Code	HC = Health Care Claim 837
GS02	Application Senders Code	The Provider's Federal Tax ID Number
GS03	Applications Receiver Code	Sage's Federal Tax ID Number
GS08	Version / Release / Industry Identifier Code	005010X223A2 = Standards Approved for Publication by ASC X12

ST-SE on Inbound Transactions

ST – Transaction Set Header		
ST01	Transaction Set Identifier Code	837 = Health Care Claim
ST02	Transaction Set Control Number	ST Segment Counter starting at 1 for every ISA/GS Segment
ST03	Implementation Convention Reference	This field contains the same value as GS08

Section 8. Transaction Specific Information

Health Care Claim Institutional (837I)

Segment ID	HIPAA Field Name	Default Value	Comments
Submitter Name - Loop 1000A			
NM1 – Submitter Name			
NM101	Entity Identifier Code	41	41 = Submitter
NM102	Entity Type Qualifier	2	2 = Non-Person Entity
NM103	Submitter Last or Organization Name		
NM104	Submitter First Name		
NM105	Submitter Middle Name		
NM108	Identification Code Qualifier	46	Established Trading Partners
NM109	Submitter Identifier		Federal Tax ID
PER – Submitter EDI Contact Information			
PER01	Contact Function Code	IC	IC = Information Contact
PER02	Submitter Contact Name		
PER03	Communication Number Qualifier	TE	TE = Telephone Number
PER04	Communication Number		
PER05	Communication Number Qualifier		
PER06	Communication Number		
PER07	Communication Number Qualifier		
PER08	Communication Number		

RECEIVER NAME - LOOP 1000B

NM1 – Receiver Name			
NM101	Entity Identifier Code	40	40 = Receiver
NM102	Entity Type Qualifier	2	2 = Non-Person Entity
NM103	Receiver Name		Los Angeles County SAPC
NM104	Name First		
NM108	Identification Code Qualifier	46	
NM109	Receiver Primary Identifier		SAPC001

BILLING PROVIDER HIERARCHICAL LEVEL

HL – Billing Provider Hierarchical Level (2000A)			
HL01	Hierarchical ID Number		The first HL01 within each ST-SE envelope must begin with 1, and be incremented by one each time an HL is used in the transaction. Only numeric values are allowed in HL01
HL02	Hierarchical Parent ID Number		Hierarchical ID number of the HL segment to which the current HL segment is subordinate
HL03	Hierarchical Level Code	20	Information Source
HL04	Hierarchical Child Code	1	Additional Subordinate HL Data Segment in This Hierarchical Structure.
Billing Provider Name (2010AA)			
NM101	Entity Identifier Code	85	85 = Billing Provider
NM102	Billing Provider Entity Type Qualifier		1 = Person 2 = Non-Person Entity
NM103	Billing Provider Last or Organization Name		
NM104	Billing Provider First Name		
NM105	Billing Provider Middle Name		
NM107	Billing Provider Name Suffix		
NM108	Identification Code Qualifier		
NM109	Billing Provider Identifier		NPI Number
N3 – Billing/Provider Address Information			
N301	Billing Provider Address Line		
N302	Billing Provider Address Line		
N4 – Billing/Provider City/State/Zip Code			
N401	Billing Provider City Name		
N402	Billing Provider State or Province Code		
N403	Billing Provider Postal Zone or ZIP Code		
N404	Country Code		
N407	Country Subdivision Code		

REF – Billing Provider Tax Information			
REF01	Reference Identification Qualifier	EI	EI = Employer's Identification Number SY = Social Security Number
REF02	Reference Identification		Tax ID
PER – Billing Provider Contact Information			
PER01	Contact Function Code	IC	IC = Information Contact
PER02	Billing Provider Contact Name		
PER03	Communication Number Qualifier	TE	TE = Telephone
PER04	Communication Number		
PER05	Communication Number Qualifier		
PER06	Communication Number		
PER07	Communication Number Qualifier		
PER08	Communication Number		

SUBSCRIBER HIERARCHICAL LEVEL - LOOP 2000B

HL – Billing Subscriber Hierarchical Level (2000B)			
HL01	Hierarchical ID Number	2	HL Segment Counter starting at 1 for the initial HL segment and increment by one in each subsequent HL segment within the ST/SE
HL02	Hierarchical Parent ID Number		Hierarchical ID number of the HL segment to which the current HL segment is subordinate
HL03	Hierarchical Level Code	22	22 = Subscriber
HL04	Hierarchical Child Code		Hierarchical Child Code indicates whether or not there are subordinates (or child) HL segments related to the current HL segment
SBR – Subscriber Information			
SBR01	Payer Responsibility Sequence Number Code		See EDI Guide for Table
SBR02	Individual Relationship Code	18	18 = Client's relationship to subscriber
SBR03	Insured Group or Policy Number		
SBR04	Insured Group Name		
SBR05	Insurance Type Code		
SBR09	Claim Filing Indicator Code	MC	MC = Medi-Cal

SUBSCRIBER NAME - LOOP 2010BA

NM1 – Subscriber Name

NM101	Entity Identifier Code	IL
NM102	Entity Type Qualifier	1
NM103	Subscriber Last Name	
NM104	Subscriber First Name	
NM105	Subscriber Middle Name	
NM107	Subscriber Name Suffix	
NM108	Identification Code Qualifier	MI
NM109	Subscriber Primary Identifier	SAPC Assigned Subscriber Patient ID Number and not the Patient's CIN. Note: This segment must begin with MSO followed by the patient ID number. Example: MSO315411.

PAT – Patient Information

PAT01	Individual Relationship Code	
PAT02	Patient Location Code	
PAT03	Employment Status Code	
PAT04	Patient Location Code	
PAT05	Date Time Period Format Qualifier	
PAT06	Date Time Period	
PAT07	Unit or Basis for Measurement Code	
PAT08	Weight	
PAT09	Yes/No Condition or Response Code	The "Y" code indicates that the patient is pregnant. The pregnancy indicator is required where the client is known to the provider to be either pregnant or postpartum as defined in 22 CCR § 51341.1(b) (18). The indicator will be used for statistical purposes, and for adjudicating claims for which the client's perinatal eligibility is relevant.

N3 – Subscriber Address

N301	Subscriber Address Line	
N302	Subscriber Address Line	

N4 – Subscriber City/State/Zip Code			
N401	Subscriber City Name		
N402	Subscriber State Code		
N403	Subscriber Postal Zone or ZIP Code		
N404	Country Code		
N407	Country Subdivision Code		
DMG – Subscriber Demographic Information			
DMG01	Date Time Period Format Qualifier	D8	
DMG02	Subscriber Birth Date		
DMG03	Subscriber Gender Code		
REF – Subscriber Secondary Information			
REF01	Reference Identification Qualifier		
REF02	Reference Identification		

PAYER NAME - LOOP 2010BB

NM1 – Payer Name			
NM101	Entity Identifier Code	PR	Payer
NM102	Entity Type Qualifier	2	Non-Person Entity
NM103	Payer Name		SAPC
NM108	Identification Code Qualifier		PI
NM109	Payer Identifier		SAPC001 Or 680290013
N3 – Payer Address			
N301	Payer Address Line		1000 FREMONT AVE
N302	Payer Address Line		
N4 – Payer City/State/Zip Code			
N401	Payer City Name		ALHAMBRA
N402	Payer State Code		CA
N403	Payer Postal Zone or ZIP Code		918039998
N404	Country Code		
N407	Country Subdivision Code		

CLM – Claim Information – Loop 2300			
CLM01	Claim Submitter's ID		
CLM02	Total Claim Charge Amount		
CLM03	Not Used		Not Used
CLM04	Not Used		Not Used
CLM05-1	Facility Code Value		
CLM05-2	Facility Code Qualifier		
CLM05-3	Claim Frequency Code		
CLM06	Provider or Supplier Signature Indicator		
CLM07	Provider Accept Assignment Code	A, B, C	
CLM08	Benefits Assignment Certification Indicator		
CLM09	Release of Information Code		
CLM10	Patient Signature Source Code		
CLM11-1	Related Causes Code		
CLM11-2	Related Causes Code		
CLM11-3	Related Causes Code		
CLM11-4	Auto Accident State or Province Code		
CLM11-5	Country Code – Not Used		Not Used
CLM12	Special Program Indicator – Not Used		Not Used
CLM16	Participation Agreement		Not Used
CLM20	Delay Reason Code		
DTP – Date – Statement			
DTP01	Date/Time qualifier	434	
DTP02	Date Time Period Format Qualifier	RD8	
DTP03	Date Time Period		
DTP – Date – Admission			
DTP01	Date/Time Qualifier	435	
DTP02	Date Time Period Format Qualifier	D8/DT	
DTP03	Date Time Period		
DTP – Date – Discharge			
DTP01	Date/Time Qualifier	096	
DTP02	Date Time Period Format Qualifier	D8	
DTP03	Date Time Period		
CL1 - Institutional Claim Code			
CL101	Admission Type Code		1 digit
CL102	Admission Source Code		1 digit
CL103	Patient Status Code		2 digits
AMT – Patient Amount Paid			
AMT01	Amount Qualifier Code	F5	F5 = Patient Amount Paid
AMT02	Patient Amount Paid		Total Amount Paid By Client

HI – Health Care Diagnosis Code			
HI01	Principal Diagnosis	ABK	ABK=Principal Diagnosis DSM-5/ ICD-10 Codes
HI01	Diagnosis Code		Industry Code
HI – Admitting Diagnosis Code			
HI01	Principal Diagnosis	ABJ	ABJ=Diagnosis ICD-10Codes
HI01	Diagnosis Code		Industry Code
HI – Other Diagnosis Information			
HI01	Diagnosis Type Code	ABF	ABF=Diagnosis ICD-10 Codes
Hi01	Diagnosis Code		Industry Code
DPI - Demonstration Project Identifier			
REF01	Project Code	P4	Project Code for all claims
REF02	DPI Code	WM37 WM37P WM37Y WM37PY WM40 WM40P WM40Y WM40PY	Will change depending on LOC and age group Example: REF:P4:WM37
HI – Principal Procedure Information			
HI01	Principal Diagnosis	BBR	BBR=Principal Diagnosis
HI01	PCS Code	HZ2ZZZZ	HZ2ZZZZ describes WM37 and WM40
HI01	Date Time Period Format Qualifier	D8	
HI01	Principal Procedure Date		Statement Start Date
NM1 Rendering Provider Name (2310B)			
NM101	Entity Identifier Code		71
NM102	Entity Type Qualifier		1 = Person / 2 = Non-Person Entity
NM103	Rendering Provider Last Name		
NM104	Rendering Provider First Name		
NM105	Rendering Provider Middle Name		
NM107	Rendering Provider Name Suffix		
NM108	Identification Code Qualifier		
NM109	Rendering Provider Identifier		Clinical NPI Number
NM112	Name Last or Organization Name		
Service Facility Location Name (2310C) – Required when Service Location is Office or			
NM101	Entity Identifier Code		77

NM102	Entity Type Qualifier		1 = Person / 2 = Non-Person Entity
NM103	Rendering Provider Last or Organization Name		Client's Program For The Episode
NM108	Identification Code Qualifier	XX	
NM109	Identification Code		Location NPI
N3 – Service Facility Location Address			
N301	Laboratory or Facility Address Line		
N302	Laboratory or Facility Address Line		
N4 – Service Facility Location City/State/Zip			
N401	Laboratory or Facility City Name		
N402	Laboratory or Facility State or Province Code		
N403	Laboratory or Facility Postal Zone or ZIP Code		
N404	Country Code		
N407	Country Subdivision Code		

OTHER SUBSCRIBER INFORMATION – LOOP 2320 – Medi-Cal is Secondary Ins			
SBR – Other Subscriber Information			
SBR01	Payer Responsibility Sequence Number Code		
SBR02	Individual Relationship Code		
SBR03	Insured Group or Policy Number		
SBR04	Other Insured Group Name		
SBR05	Insurance Type Code		
AMT – Coordination of Benefits (COB) Total Non-Covered Amount			
AMT01	Amount Qualifier Code	D	Payor Amount Paid
AMT02	Monetary Amount		
AMT03	Credit/Debit Flag Code		
AMT – Remaining Patient Liability			
AMT01	Amount Qualifier Code	EAF	Patient Liability
AMT02	Monetary Amount		
AMT03	Credit/Debit Flag Code		
OI – Other Insurance Coverage Information			
OI03	Benefits Assignment Certification Indicator		
OI04	Patient Signature Source Code		
OI06	Release of Information Code		

ANOTHER SUBSCRIBER NAME - LOOP

NM1 – Other Subscriber Name			
NM101	Entity Identifier Code	IL	
NM102	Entity Type Qualifier		
NM103	Subscriber Last Name		
NM104	Subscriber First Name		
NM105	Subscriber Middle Name		
NM107	Subscriber Name Suffix		
NM108	Identification Code Qualifier		
NM109	Subscriber Primary Identifier		
N3 – Other Subscriber Address			
N301	Payer Address Line		
N302	Payer Address Line		
N4 – Other Subscriber City/State/Zip Code			
N401	Payer City Name		
N402	Payer State Code		
N403	Payer Postal Zone or ZIP Code		
N404	Country Code		
N407	Country Subdivision Code		

OTHER PAYER - LOOP 2330B

NM1 – Other Payer Name			
NM101	Entity Identifier Code	PR	PR = Payer
NM102	Entity Type Qualifier	2	2 = Non Person Entity
NM103	Other Payer Last or Organization Name		
NM108	Identification Code Qualifier		
NM109	Other Payer Primary Identifier		

Service Line Number (Loop 2400)

LX – Service Line Number			
LX01	Assigned Number		LX Segment Counter starting at 1 for the initial LX segment and increment by one in each subsequent LX segment within Claim Information

SV2 – Institutional Service			
SV201	Service Line Revenue Code	0953	DHCS DMC Institutional services described exclusively with Revenue Code "0953"
SV202	Procedure Modifier	HC	HC=HCPCS Codes **This must be HC for processing into MSO**
SV202	Revenue Code	0953	
SV202	ASAM level of service for Withdrawal Management (WM) 3.7 or 4.0 and indicates Pregnant/Perinatal (P) or Youth 12-20 (Y)	37 37Y 37P 37PY 40 40Y 40P 40PY	These are Demonstration Project Identifier (DPI) codes for processing services in the Sage system. Ex. 0953:37Y
SV203	Line Item Charge Amount		Total Service Charge
SV204	Unit or Basis for Measurement Code	UN	UN = Units
SV205	Service Unit Count		Total Service Units If Units Based Service
SV207	Monetary Amount		Any claims greater than $10,000,000.00 would be returned
SV2 – Institutional Service - Room and Board			
SV201	Service Line Revenue Code	9000	DHCS DMC Institutional services described exclusively with "9000"
SV202	Procedure Modifier	HC	HC=HCPCS Code
SV202	Revenue Code	9000	
SV203	Line Item Charge Amount		Total Service Charge
SV204	Unit or Basis for Measurement Code	DA	DA= Day
SV205	Service Day Count		Total Service Days If Days
SV207	Monetary Amount		Any claims greater than $10,000,000.00 would be returned

* **Appendix A: A complete list of Revenue Codes by ASAM of Case.**

*Note: In a future revision to this Companion Guide a complete list of Revenue Codes is available on the rates and standards matrix from SAPC's Public Webpage: HTTP://PUBLICHEALTH.LACOUNTY.GOV/SAPC/NETWORKPROVIDERS/REGULATIONS.HTM

CN1 - Contract Information			
CN101	Contract Type Code		
CN102	Not Used		Not Used
CN103	Not Used		Not Used
CN104	Reference Identification		Contract Code Only when the Submitter is contractually obligated to supply this information on post-adjudicated claim
REF - Prior Authorization - Required			
REF01	Reference Identification Qualifier	G1	G1 = Prior Authorization Number
REF02	Prior Authorization or Referral Number		Prior Authorization or Referral Number
Line Note			
NTE01	Note Reference	DCP	ADD - Additional Information DCP - Goals, Rehabilitation Potential, Discharge Plans
NTE02	Description		Value

NATIONAL DRUG CODE (NDC) IDENTIFICATION INFORMATION - LOOP 2410			
LIN – Drug Identification			
LIN01			
LIN02	Product/Service ID Qualifier	N4	Qualifier
LIN03	National Drug CD		11 -digit NDC without hyphens or spaces
CTP – Drug Quantity			
CTP01			
CTP02			
CTP03			
CTP04	National Drug Unit Count		Quantity (number of units)
CTP05	Measurement code		Composite Unit of Measure
CTP05-1	F2 - International Unit GR - Gram ME - Milligram ML - Milliliter UN - Unit		Unit or Basis of Measurement

*A complete list of NDC Codes is available in our Rate Matrix:
http://publichealth.lacounty.gov/sapc/NetworkProviders/FinanceForms/RatesAndStandardsMatrix.pdf

EXAMPLE OF NATIONAL DRUG CODE:

LIN**N4*63323024910~
CTP****07*ML~

LINE ADJUDICATION INFORMATION - LOOP 2430 - OHC / MEDI-CAL Claims			
SVD - Line Adjudication Information			
SVD01	Other Payer Primary Identifier		
SVD02	Service Line Paid Amount		
SVD03	Product or Service ID Qualifier		
SVD03	Procedure Modifier		
SVD03	Procedure Modifier		
SVD03	Procedure Modifier		
SVD03	Procedure Code		
SVD03	Procedure Modifier		
SVD03	Procedure Code Description		
SVD05	Paid Service Unit Count		
SVD06	Bundled or Unbundled Line Number		
CAS - Line Adjustment			
CAS01	Claim Adjustment Group Code		PR/CO/OA
CAS02	Adjustment Reason Code		
CAS03	Adjustment Amount		
CAS04	Adjustment Quantity		
CAS05	Adjustment Reason Code		
CAS06	Adjustment Amount		
CAS07	Adjustment Quantity		
CAS08	Adjustment Reason Code		
CAS09	Adjustment Amount		
CAS10	Adjustment Quantity		
CAS11	Adjustment Reason Code		
CAS12	Adjustment Amount		
CAS13	Adjustment Quantity		
CAS14	Adjustment Reason Code		
CAS15	Adjustment Amount		
CAS16	Adjustment Quantity		
CAS17	Adjustment Reason Code		
CAS18	Adjustment Amount		
CAS19	Adjustment Quantity		
DTP - Line Check Or Remittance Date			
DTP01	Date Time Qualifier	573	573 = Date Claim Paid
DTP02	Date Time Period Format Qualifier	D8	D8 = Date expressed in CCYYMMDD
DTP03	Adjudication or Payment Date		

Section 9. Acknowledgement and Reports

Acknowledgements

- SAPC returns an Interchange Acknowledgment (TA1) segment when requested, based on the value transmitted in ISA14.
- SAPC provides the Health Care Claim Acknowledgment transaction (277CA) for claims. Ensure your eHR is configured to read 277CA. Only accepted claims will be assigned a SAGE claim ID.
- SAPC does not request the Interchange Acknowledgments (TA1) segment on outbound interchanges.
- SAPC accepts, but does not require or process, Implementation Acknowledgment (999) transactions for all outbound Functional Groups.

Linking an 837I to the 277CA

As per the HIPAA Technical Report for the 277CA transaction, the 277CA file reports the 837's BHT03 Originator Application Transaction Identifier value in the Claim Transaction Batch Number (2200B – TRN02) of the 277CA. In order to successfully link an 837 to the correct 277CA, the 837 must contain a unique value in the BHT03 for every 837 file generated.

277CA Claim Status Codes

The following are most common rejection Claim Status Codes returned on the Sage 277CA:

Inbound 837I Claim Rejections	Claim Status Codes on Sage
Client's date of birth not match	A7:0
Void or Replacement Claim with invalid Payer Claim Control #	A7:0
Void or Replacement Claim where Client ID/MSO # on the Void or Replacement does not match the Client ID/MSO # of the original claim	A7:0
Date of Service is a future date	A7:0
Procedure code not defined in SAGE MSO HCPC/CPT table	A7:21 & A7:454
Client ID with the 'MSO' prefix but does not exist in SAGE	A7:33
Client ID without the 'MSO' prefix	A7:33
Total claim charge amount not equal sum of line item charge amount	A7:178
Claim is out of balance – service line paid amount + all service line adjustment amounts do not equal the line item charge amount	A7:400
Diagnosis Code Not Defined in SAGE Diagnosis Table	A7:477
A claim will be rejected if an ICD-9 diagnosis indicator is received and the service date (outpatient) or discharge/thru date (inpatient) are on or after the ICD-10 cutover date.	A7:477
Submitter ID NOT found	A7:478
Other Payer Primary ID is missing or invalid or the value sent in the 2330 loop does not match the value sent in the 2430 loop	A7:479

A complete list of codes and modifiers are available at the following websites:

http://www.x12.org/codes/health-care-claim-status-category-codes/
http://www.x12.org/codes/health-care-claim-status-codes/

Section 10. Remittance (835)

BPR - Financial Information		
BPR01	Transaction Handling Code	C=Payment Accompanies Remittance Advice D=Make Payment Only H=Notification Only I=Remittance Information Only P=Pre-notification of Future Transfers U=Split Payment and Remittance X=Handling Party's Option to Split Payment and Remittance
BPR02	Monetary Amount	
BPR03	Credit/Debit Flag Code	C=Credit D=Debit
BPR04	Payment Method Code	ACH=Automated Clearing House (ACH) BOP=Financial Institution Option CHK=Check FWT=Federal Reserve Funds/Wire Transfer - Non-repetitive NON=Non-Payment Data
BPR05	Payment Format Code	
BPR06	(DFI) ID Number Qualifier	
BPR07	(DFI) Identification Number	
BPR08	Account Number Qualifier	
BPR09	Account Number	
BPR10	Originating Company Identifier	
BPR11	Originating Company Supplemental Code	
BPR12	(DFI) ID Number Qualifier	
BPR13	(DFI) Identification Number	
BPR14	Account Number Qualifier	
BPR15	Account Number	
BPR16	Date	
TRN - Re-association Trace Number		
TRN01	Trace Type Code	1
TRN02	Reference Identification	EFT or Check Number
TRN03	Originating Company Identifier	
TRN04	Reference Identification	

REF - Version Identification		
REF01	Reference Identification Qualifier	F2
REF02	Reference Identification	AVATAR MSO 2017
DTM - Production Date		
DTM01	Date/Time Qualifier	405
DTM02	Date	

PAYER IDENTIFICATION - LOOP 1000A		
N1 - Payer Identification		
N101	Entity Identifier Code	
N102	Name	COUNTY OF LOS ANGELES SAPC
N103	Identification Code Qualifier	
N104	Identification Code	
N3 - Payer Address		
N301	Address Information	
N302	Address Information	
N4 - Payer City, State, ZIP		
N401	City Name	
N402	State or Province Code	
N403	Postal Code	Must include Zip + 4 digit code
N404	Country Code	
N405	Location Qualifier	
N406	Location Identifier	
N407	Country Subdivision Code	
REF - Additional Payer Identification		
REF01	Reference Identification Qualifier	2U=Payer Identification Number EO=Submitter Identification Number HI=Health Industry Number (HIN) NF=National Association of Insurance Commissioners (NAIC) Code
REF02	Reference Identification	

PER - Payer Contact Information		
PER01	Contact Function Code	CX=Payers Claim Office
PER02	Name	
PER03	Communication Number Qualifier	TE=Telephone Number
PER04	Communication Number	
PER05	Communication Number Qualifier	EM=Email Address
PER06	Communication Number	
PER07	Communication Number Qualifier	
PER08	Communication Number	
PER - Payer Technical Contact Information		
PER01	Contact Function Code	BL - Technical Department
PER02	Name	
PER03	Communication Number Qualifier	EM=Email Address TE=Telephone Number UR=Uniform Resource Locator (URL)
PER04	Communication Number	
PER05	Communication Number Qualifier	EM=Email address EX=Telephone Extension FX=Facsimile TE=Telephone Number UR=Uniform Resource Locator (URL)
PER06	Communication Number	
PER07	Communication Number Qualifier	EM=Email address EX=Telephone Extension FX=Facsimile UR=Uniform Resource Locator (URL)
PER08	Communication Number	

PAYEE IDENTIFICATION - LOOP 1000B		
N1 - Payee Identification		
N101	Entity Identification Code	PE
N102	Name	
N103	Identification Code Qualifier	
N104	Identification Code	
N3 - Payee Address		
N301	Address Information	
N302	Address Information	

N4 - Payee City, State, Zip Code		
N401	City Name	
`N402	State or Province Code	
N403	Postal Code	Must include Zip + 4 digit code
N404	Country Code	
N405	Location Qualifier	
N406	Location Identifier	
N407	Country Subdivision Code	
REF - Payee Additional Identification		
REF01	Reference Identification Qualifier	TJ - Federal Tax ID
REF02	Reference Identification	

LOOP 2000	
LX - Header Number	
LX01	Assigned Number

CLAIM PAYMENT INFORMATION - LOOP 2100		
CLP - Claim Payment Information		
CLP01	Claim Submitter's Identifier	
CLP02	Claim Status Code	1=Processed as Primary 2=Processed as Secondary 3=Processed as Tertiary 4=Denied 19=Processed as Primary, Forwarded to Additional Payer(s) 20=Processed as Secondary, Forwarded to Additional Payer(s) 21=Processed as Tertiary, Forwarded to Additional Payer(s) 22=Reversal of Previous Payment 23=Not Our Claim, Forwarded to Additional Payer(s) 25=Predetermination Pricing Only - No Payment
CLP03	Monetary Amount	
CLP04	Monetary Amount	

CLP05	Monetary Amount	12=Preferred Provider Organization (PPO) 13=Point of Service (POS) 14=Exclusive Provider Organization (EPO) 15 =Indemnity Insurance 16=Health Maintenance Organization (HMO) Medicare Risk 17=Dental Maintenance Organization AM=Automobile Medical CH=Champus DS=Disability HM=Health Maintenance Organization LM=Liability Medical MA=Medicare Part A MB=Medicare Part B MC=Medicaid OF=Other Federal Program TV=Title V VA=Veterans Affairs Plan WC=Workers' Compensation Health Claim ZZ=Mutually Defined
CLP06	Claim Filing Indicator Code	
CLP07	Reference Identification	
CLP08	Facility Code Value	
CLP09	Claim Frequency Type Code	
CLP10	Patient Status Code	
CLP11	Diagnosis Related Group (DRG) Code	
CLP12	Quantity	
CLP13	Percentage as Decimal	
NM1 - Patient Name		
NM101	Entity Identifier Code	QC = Patient
NM102	Entity Type Qualifier	1 = Person
NM103	Name Last or Organization Name	
NM104	Name First	
NM105	Name Middle	
NM106	Name Prefix	
NM107	Name Suffix	
NM108	Identification Code Qualifier	MI=Member Identification Number
NM109	Identification Code	Client ID in Sage
REF - Other Claim Related Identification		
REF01	Reference Identification Qualifier	F8 - Original Reference Number
REF02	Reference Identification	This identifier is required for Corrected Claims, Voids and Replacement

DTM - Statement From or To Date		
DTM01	Date/Time Qualifier	232=Claim Statement Period Start 233=Claim Statement Period End
DTM02	Date	YYYYMMDD
AMT - Claim Supplemental Information		
AMT01	Amount Qualifier Code	AU=Coverage Amount D8=Discount Amount F5=Patient Amount Paid
AMT02	Monetary Amount	

SERVICE PAYMENT INFORMATION - LOOP 2110		
SVC - Service Payment Information		
SVC01	COMPOSITE MEDICAL PROCEDURE IDENTIFIER	
SVC01-1	Product/Service ID Qualifier	NU
SVC01-2	Product/Service ID	Revenue Codes
SVC01-3	Procedure Modifier	
SVC01-4	Procedure Modifier	
SVC01-5	Procedure Modifier	
SVC01-6	Procedure Modifier	
SVC01-7	Description	
SVC02	Monetary Amount	
SVC03	Monetary Amount	
SVC04	Product/Service ID	
SVC05	Quantity	
SVC06	COMPOSITE MEDICAL PROCEDURE IDENTIFIER	
SVC06-01	Product/Service ID Qualifier	
SVC06-02	Product/Service ID	
SVC06-03	Procedure Modifier	
SVC06-04	Procedure Modifier	
SVC06-05	Procedure Modifier	
SVC06-06	Procedure Modifier	
SVC06-07	Description	
SVC07	Quantity	

DTM - Service Date		
DTM01	Date/Time Qualifier	472
DTM02	Date	YYYYMMDD
CAS - Service Adjustment		
CAS01	Claim Adjustment Group Code	
CAS02	Claim Adjustment Reason Code	
CAS03	Monetary Amount	
CAS04	Quantity	
CAS05	Claim Adjustment Reason Code	
CAS06	Monetary Amount	
CAS07	Quantity	
CAS08	Claim Adjustment Reason Code	
CAS09	Monetary Amount	
CAS10	Quantity	
CAS11	Claim Adjustment Reason Code	
CAS12	Monetary Amount	
CAS13	Quantity	
CAS14	Claim Adjustment Reason Code	
CAS15	Monetary Amount	
CAS16	Quantity	
CAS17	Claim Adjustment Reason Code	
CAS18	Monetary Amount	
CAS19	Quantity	
REF - Service Identification		
REF01	Reference Identification Qualifier	BB - Authorization Number
REF02	Reference Identification	
AMT - Service Supplemental Amount		
AMT01	Amount Qualifier Code	B6=Allowed - Actual
AMT02	Monetary Amount	
LQ - Health Care Remark Codes		
LQ01	Code List Qualifier Code	
LQ02	Industry Code	

PLB - Provider Adjustment		
PLB01	Reference Identification	
PLB02	Date	YYYYMMDD
PLB03	Adjustment Identifier	50=Late Charge 51=Interest Penalty Charge 72=Authorized Return 90=Early Payment Allowance AM=Applied to Borrower's Account AP=Acceleration of Benefits B2=Rebate B3=Recovery Allowance BD=Bad Debt Adjustment BN=Bonus C5=Temporary Allowance CR=Capitation Interest CS=Adjustment CT=Capitation Payment CV=Capital Pass thru CW=Certified Registered Nurse Anesthetist Pass thru DM=Direct Medical Education Pass thru E3=Withholding FB=Forwarding Balance FC=Fund Allocation GO=Graduate Medical Education Pass thru IP=Incentive Premium Payment IR=Internal Revenue Service Withholding IS=Interim Settlement J1=Non-reimbursable L3=Penalty L6=Interest Owed LE=Levy LS=Lump Sum OA=Organ Acquisition Pass thru OB=Offset for Affiliated Providers PI=Periodic Interim Payment PL=Payment Final RA=Retro-activity Adjustment RE=Return on Equity SL=Student Loan Repayment TL=Third Party Liability WO=Overpayment Recovery WU=Unspecified Recovery ZZ=Mutually Defined
PLB03-1	Adjustment Reason Code	**Required when a control, account or tracking number applies to this adjustment. **Use when necessary to assist the receiver in identifying, tracking or reconciling the adjustment. See sections 1.10.2.10 (Capitation and Related Payments), 1.10.2.5 (Advanced Payments and Reconciliation) and 1.10.2.12 (Balance Forward Processing) for further information. **IMPLEMENTATIONNAME: Provider Adjustment Identifier

PLB03-2	Reference Identification	**Required when a control, account or tracking number applies to this adjustment. **Use when necessary to assist the receiver in identifying, tracking or reconciling the adjustment. See sections 1.10.2.10 (Capitation and Related Payments), 1.10.2.5 (Advanced Payments and Reconciliation) and 1.10.2.12 (Balance Forward Processing) for further information. **IMPLEMENTATIONNAME: ProviderAdjustment Identifier
PLB04	Monetary Amount	**This is the adjustment amount for the preceding adjustment reason. **Decimal elements will be limited to a maximum length of 10 characters including reported or implied places for cents (implied value of 00 after the decimal point). This applies to all subsequent 782 elements. **IMPLEMENTATIONNAME: ProviderAdjustment Amount
PLB05	ADJUSTMENT IDENTIFIER	
PLB05-1	Adjustment Reason Code	
PLB05-2	Reference Identification	
PLB06	Monetary Amount	
PLB07	ADJUSTMENT IDENTIFIER	
PLB07-1	Adjustment Reason Code	
PLB07-2	Reference Identification	
PLB08	Monetary Amount	
PLB09	ADJUSTMENT IDENTIFIER	
PLB09-1	Adjustment Reason Code	
PLB09-2	Reference Identification	
PLB10	Monetary Amount	
PLB11	ADJUSTMENT IDENTIFIER	
PLB11-1	Adjustment Reason Code	
PLB11-2	Reference Identification	
PLB12	Monetary Amount	
PLB13	ADJUSTMENT IDENTIFIER	
PLB13-1	Adjustment Reason Code	
PLB13-2	Reference Identification	
PLB14	Monetary Amount	

837I BILLING COMBINATION

Withdrawal Management 3.7 and 4.0

Service	Revenue Code	PCS Code	DPI Segment
Withdrawal Management 3.7 Adult Perinatal	0953	HZ2ZZZZ*	WM37P
Withdrawal Management 3.7 Perinatal Youth	0953	HZ2ZZZZ*	WM37PY
Withdrawal Management 3.7 Adult Non-Perinatal	0953	HZ2ZZZZ*	WM37
Withdrawal Management 3.7 Youth Non-Perinatal	0953	HZ2ZZZZ*	WM37Y
Withdrawal Management 4.0 Adult Perinatal	0953	HZ2ZZZZ*	WM40P
Withdrawal Management 4.0 Perinatal Youth	0953	HZ2ZZZZ*	WM40PY
Withdrawal Management 4.0 Adult Non-Perinatal	0953	HZ2ZZZZ*	WM40
Withdrawal Management 4.0 Youth Non-Perinatal	0953	HZ2ZZZZ*	WM40Y

Appendix B

837I Examples

Drug Medi-Cal Claim

```
ISA*00*          *00*          *30*951234567      *30*680290013
*191024*1122*!*00501*231257023*1*T*:
GS*HC*951234567*680290013*20191024*1122*231257023*X*005010X223A2
ST*837*0001*005010X223A2
BHT*0019*00*751279*20191010*1122*CH
NM1*41*2* Recovery, INC.*****46*951234567                  Submitter's Federal Tax ID
PER*IC*TELEPHONE*TE*8181234567
NM1*40*2*LOS ANGELES COUNTY SAPC*****46*SAPC001
HL*1**20*1
NM1*85*2* RECOVERY LYNWOOD*****XX*1751934005              Treating Facility's NPI
N3*1234 32ND STREET
N4*Lynwood*CA*902629998
REF*EI*951234567
HL*2*1*22*0
SBR*P*18**ADP*****MC
NM1*IL*1*TESTLAST*TESTFIRST****MI*MSO159962                MSO and Sage Client ID
N3*1000 S FREMONT
N4*ALHAMBRA*CA*918030000
DMG*D8*19850101*M
NM1*PR*2*SAPC*****PI*SAPC001
N3*1000 S. FREEMONT AVE
N4*ALHAMBRA*CA*91803
CLM*18056*437.78***55:B:1*Y*A*Y*Y
DTP*434*RD8*20190910-20190910           (Statement Date)
DTP*435*D8*20190101                     (Admission Date)
CL1*3*1*03                              (Institutional Claim Code)
REF*G1*107679                           (Authorization Number Assigned by SAGE)
NTE*DCP*99
HI*ABK:F1510:::::::Y
HI*ABJ:F1020~                           (Admitting Diagnosis Code)
REF*P4*WM40P~                           (Demonstration Project Identifier)
HI*BBR:HZ2ZZZZ:D8:20190910~             (Principal Procedure Information)
NM1*71*1*COUNSLER*JIM*Y***XX*1245319599 (Rendering Provider's NPI)
PRV*AT*PXC*2084P0800X
LX*1
SV2*0953*HC:0953:37*437.78*UN*1***1     (Institutional Service - 3.7 WM and 4.0 WM)
REF*6R*18056
NTE*DCP*99
SE*35*0001
GE*1*231257023
IEA*1*231257023
```

Voids and Replacements

Replacement of an Approved Claim

HL*2*1*22*0~
SBR*P*18**ADP*****MC~
NM1*IL*1*AA*BB****MI*MSO123456~
N3*300 W Main ST~
N4*Alhambra*CA*91803~
DMG*D8*20010115*M~
NM1*PR*2*SAPC*****PI*SAPC001~
N3*1000 S. FREEMONT AVE~
N4*ALHAMBRA*CA*91803~
CLM*168105*437.78***11:A:7**A*Y*Y~ (CLM05-3 must have a value of 7 (Replacement))
REF*F8*1292664~ (REF02 -Payer Claim Control Number from the 835 of the claim being replaced)
DTP*434*RD8*20200120-20200125~
DTP*435*DT*202001150738~
CL1*1*1*01~
REF*G1*107877~
NTE*DCP*99~
HI*ABK:F1020~
HI*ABJ:F1020~
REF*P4*WM37Y~
HI*BBR:HZ2ZZZZ:D8:20200120~
NM1*71*1*Jordan*Evan*Y***XX*1760913920~
PRV*AT*PXC*2084P0800X~
LX*1~
SV2*0953*HC:0953:37Y*437.78*UN*1~

Void an Approved Claim

```
HL*2*1*22*0~
SBR*P*18**ADP*****MC~
NM1*IL*1*Youth*Evan****MI*MSO160011~
N3*300 W Main ST~
N4*Alhambra*CA*91803~
DMG*D8*20010115*M~
NM1*PR*2*SAPC*****PI*SAPC001~
N3*1000 S. FREEMONT AVE~
N4*ALHAMBRA*CA*91803~
CLM*168105*437.78***11:A:8**A*Y*Y~     (CLM05-3 must have a value of 8 (Void))
REF*F8*1292664~                        (REF02 -Payer Claim Control Number from the 835 of the claim being voided)
DTP*434*RD8*20200120-20200125~
DTP*435*DT*202001150738~
CL1*1*1*01~
REF*G1*107877~
NTE*DCP*99~
HI*ABK:F1020~
HI*ABJ:F1020~
REF*P4*WM37Y~
HI*BBR:HZ2ZZZZ:D8:20200120~
NM1*71*1*Tom*Evans*Y***XX*1760913920~
PRV*AT*PXC*2084P0800X~
LX*1~
SV2*0953*HC:0953:37Y*437.78*UN*1~
```

277CA Examples

277CA

```
ISA*00*          *00*          *30*951234567      *30*680290013      *171107*0939*^*00501*000000003*1*T*:~
GS*HC*951234567*68029013*20171107*093907*3*X*005010X214~
ST*277*0003*005010X214~
BHT*0085*08*3*20171107*093907*TH~
HL*1**20*1~
NM1*AY*2*LA County Department of Health SAPC*****FI*680290013~
TRN*1*20171107093907~
DTP*050*D8*20171107~
DTP*009*D8*20171107~
HL*2*1*21*1~
NM1*41*2*RECOVERING, INC.*****46*951234567~
TRN*2*12345H~
STC*A2:20*20171107*WQ*60~
QTY*90*1~
AMT*YU*60~
HL*3*2*19*1~
NM1*85*2*RECOVERY LYNWOOD*****XX*1751934005~
TRN*1*0~
STC*A2:20**WQ*60~
QTY*QA*1~
AMT*YU*60~
HL*4*3*PT~
NM1*IL*1*CLIENT*TREATMENT****MI*MS010994~
TRN*2*36044~
STC*A2:20*20171107*WQ*60~
REF*1K*1~
DTP*472*D8*20170911~
SE*26*0003~
GE*1*3~
IEA*1*000000003~
```

2200B Loop - Information Receiver Application Trace ID

- TRN01 – Provider Reference ID from the 837I -- BHT03
- STC01 – Claim Status Category Code*
- QTY01 – 90=Acknowledged Quantity /AA=Unacknowledged Quantity
- AMT01—YU=Total Accepted Amount/ YY= Total Rejected Amount

2200D – Claim Status Tracking

- TRN02 – Provider's Claim ID from the 837I -- CLM01
- STC02 – Claim Status Category Code*
- REF02 – Claims Reference Assigned by Sage.
- DTP03 – Claim Level Service Date

*A full list of Claim Status Category Codes are available at the following website
http://www.x12.org/codes/health-care-claim-status-category-codes/

Claim Status Category Code
A2 – Acknowledgement/Accepted into Sage for adjudication

835 Examples

Standard 835

Approved Claim

```
ISA*00*          *00*          *ZZ*680290000      *ZZ*942219300      *200508*1108*!*00501*000000816*0*P*:~
GS*HP*680290000*942219300*20200508*110840*1*X*005010X221A1~
ST*835*7970~
BPR*I*0*C*NON************20200508~
TRN*1*20200508*1943303100~
REF*F2*AVATAR MSO 2020~
DTM*405*20200508~
N1*PR***LACDPH-SAPC~
N3*1000 SOUTH FREMONT~
N4*ALHAMBRA*CA*91803~
PER*CX**TE*18008751850*EM*SAPC_SUPPORT@PH.LACOUNTY.GOV~
PER*BL*SAPC EDI HELP DESK*EM*SAPC_SUPPORT@PH.LACOUNTY.GOV~
N1*PE*Provider Name*XX*1234567890~
REF*TJ*942219300~
LX*1~
CLP*50101*1*507.78*507.78**MC*1293253*11*1~
NM1*QC*1*FF*EE****MI*160000~
REF*F8*1293253~          (REF02 -Payer Claim Control Number (PCCN). This Control Number is required for Voids and Replacements)
DTM*232*20200113~
DTM*233*20200113~
AMT*AU*507.78~
SVC*NU:0953:40P*507.78*507.78**1~
DTM*472*20200113~
REF*BB*107872~
REF*6R*1~
AMT*B6*507.78~
PLB*1234567890*20200630*FB:20200508*507.78~
SE*26*7970~
GE*1*1~
IEA*1*000000816~
```

Denied Service

```
CLP*28102*1*437.78*0**MC*1293150*11*1~
NM1*QC*1*AA*BB****MI*159998~
REF*F8*1293150~
DTM*232*20200110~
DTM*233*20200110~
SVC*NU:0953:37*437.78*0**0**1~
DTM*472*20200110~
CAS*CO*181*437.78~  (CAS02 - Procedure code was invalid on the date of service (181) (CARC*) CO181)
REF*BB*107873~
REF*6R*1~
```

*Complete list of Claim Adjustment Reason Codes is available at:
http://www.x12.org/codes/claim-adjustment-reason-codes/
**Complete list of Remark Codes is available at:
http://www.wpc-edi.com/reference/codelists/healthcare/remittance-advice-remark-codes/

State Denial

```
ISA*00*          *00*          *30*680290013      *30*956000927      *200421*1036*^*00501*000063635*0*T*:~
GS*HP*680290013*956000927*20200421*103630*1*X*005010X221A1~
ST*835*0004~
BPR*H*0*C*NON************20200421~
TRN*1*INC-30172*1680317191*DRUG MEDI-CAL~
DTM*405*20200421~
N1*PR*DHCS Drug Medi-Cal~
N3*1500 Capitol Avenue MS 2629*PO Box 997413~
N4*Sacramento*CA*958997413~
PER*BL*County Customer Service Section
(FMAB)*TE*9163232043*EM*DMCSDMCIIHelpdesk@dhcs.ca.gov*UR*www.dhcs.ca.gov/services/Pages/SUD-
PPFD.aspx~
N1*PE*SUBSTANCE ABUSE PREVENTION AND CONTROL*XX*1700090834~
REF*TJ*956000927~
LX*1~
CLP*Cx3905270x1*4*437.78*.00**MC*149288693**3~
NM1*QC*1*AA*BB****HN*96325874A~
DTM*050*20200419~
SVC*NU:0953*437.78*.00**0.0000**1.000~
DTM*472*20200110~
CAS*CO*16*437.78**177**0*96**0*B7**0~   (Claim/service lacks information or has submission/billing error(s) which is
                                         needed for adjudication (CO16).)
REF*G3*,,N~
REF*6R*Cx3905270x65388.001~
LQ*HE*N327~
LQ*HE*MA39~
LQ*HE*N54~
LQ*HE*MA31~
LQ*HE*N216~  (LQ02 – Remark Code N216 – We do not offer coverage for this type of service or the patient is not
              enrolled in this portion of our benefit package.)
LQ*HE*N424~
LQ*HE*N570~
```