Delaware Medicaid Enterprise System

Health Care Claim:
Professional, Institutional, Dental (837) Transaction
Standard Companion Guide

Companion to Health Care Claims
ASC X12N 837 005010X222
ASC X12N 837 005010X223
ASC X12N 837 005010X224
Implementation Guides

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Disclosure Statement

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Preface

This Companion Guide to the Health Care Claims (837s) adopted under Health Insurance Portability and Accountability Act (HIPAA) clarifies and specifies the data content when exchanging electronically with Delaware Medicaid Enterprise System (DMES). Transmissions based on this Companion Guide, used in tandem with the **ASC X12N 837 005010X222 and the associated errata 005010X222A1; ASC X12N 837 005010X223 and the associated errata 005010X223A1 and 005010X223A2; ASC X12N 837 005010X224 and the associated errata 005010X224A1 and 005010X224A2 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.

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1. INTRODUCTION

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 carries provisions for administrative simplification. This requires the Secretary of the Department of Health and Human Services (DHHS) to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. HIPAA directs the Secretary to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard HIPAA serves to:

- Create better access to health insurance
- Limit fraud and abuse
- Reduce administrative costs

The HIPAA regulations at 45 CFR 162.915 require that covered entities not enter into transition partner agreement that would do any of the following:

- Change the definition, data condition, or use of a data element or segment in a standard
- Add any data elements or segments to the maximum defined data set
- Use any code or data elements that are marked “not used” in the standard’s implementation specification or are not in the standard’s implementation specifications
- Change the meaning or intent of the standards implementation specifications

SCOPE

The Companion Guide is to be used with, and to supplement the requirements in the HIPAA ASC X12 Implementation Guides, without contradicting those requirements. Implementation Guides define the national data standards, electronic format, and values for each data element within an electronic transaction. The purpose of the Companion Guide is to provide trading partners with a guide to communicate Delaware Medicaid Enterprise System (DMES) specific information required to exchange transactions successfully.

The Companion Guide is intended for the business and technical users, within or on behalf of trading partners, responsible for the testing and setup of electronic claim status request and response transactions to DMES.

OVERVIEW

This section of the Companion Guide will provide guidance for establishing a relationship with DMES for the business purpose of doing Health Care Claims (837s).

REFERENCES

This section specifies additional on-line sources of helpful information related to electronic data interchange and X12 transactions.

Washington Publishing Company (WPC) at http://wpc-edi.com/

ASC X12 at www.X12.org

ACA Section 1104 information is at the CMS website. For information on ACA Administrative Simplification information, follow this link:

https://www.cms.gov/regulations-and-guidance/HIPAA-Administrative-Simplification/affordable-care-act/operatingrulesforHIPAATransactions.html

ADDITIONAL INFORMATION

It is assumed that the trading partner has purchased and is familiar with the ASC X12 Type 3 Technical Report (TR3) being referenced in this Companion Guide. TR3s can be purchased from the ASC X12 store at http://store.x12.org/store/.

2. GETTING STARTED

WORKING WITH DELAWARE DMES

The Electronic Data Interchange (EDI) Department is available to assist trading partners when questions arise.

TRADING PARTNER REGISTRATION

Trading Partner registration is completed through the secure provider portal. All required fields must be completed and an electronic signature must be included.

CERTIFICATION AND TESTING OVERVIEW

All covered entities who submit electronic transactions are required to certify. This includes Clearing houses, Software Vendors, Provider Groups, and Managed Care Organizations (MCOs). If you submit your claims through one of these agencies, they will certify on your behalf. However, if you submit claims, you will need to certify. If you submit your claims through an MCO, you should receive information from the MCO regarding certification requirements.

3. TESTING WITH THE PAYER

Testing is required for Health Care Claims (837s).

4. CONNECTIVITY WITH THE PAYER/COMMUNICATIONS

You must register and access the provider portal in order to upload EDI files.
To register/logon to the provider portal:

https://medicaid.dhss.delaware.gov

5. CONTACT INFORMATION

Please contact the Delaware EDI Department at 800-999-3371 Option 0, Option 2 or send any inquiries via email to DelawareECSGroup@dxc.com

APPLICABLE WEBSITES

https://medicaid.dhss.delaware.gov

6. CONTROL SEGMENTS/ENVELOPES

ISA-IEA

This section describes the use of the interchange control segments. It includes a description of expected sender and receiver codes, authorization information, and delimiters.

ISA01 - Value “00” is expected in this data element.
ISA02 - No data is expected in this data element.
ISA03 - Value “00” is expected in this data element
ISA04 - No data is expected in this data element.
ISA05 - Value “ZZ” is expected in this data element.
ISA06 -The DXC Technology (DXC) Electronic Transaction Identification Number (ETIN) assigned to the submitter is expected in this data element. This is the same as your Trading Partner ID.
ISA07 - Value “ZZ” is expected in this data element.
ISA08 – The DXC ETIN “345724166” is expected in this data element.
ISA12 - Value “00501” is expected in this data element.
ISA14 - Value “1” is expected in this data element if you wish to receive a TA1 response.
ISA15 - Value “P” is expected for production data and value “T” is expected for test data.
ISA16 - A colon (:) is expected as the component element separator.

GS-GE

This section describes the use of the functional group control segments. It includes a description of expected application sender and receiver codes. Also included in this section is a description of how DMES expects functional groups to be sent and how DMES will send functional groups. This section will describe how similar transaction sets will be packaged and DMES use of functional group control numbers.

GS08 - Value “005010X222A1” for Professional, “005010X223A2” for Institutional, or “005010X224A2” for Dental” is expected in this data element.

ST-SE

This section describes the use of transaction set control numbers.

ST03 - Value “005010X222A1” for Professional, “005010X223A2” for Institutional, or “005010X224A2” for Dental is expected in this data element.

Transactions (ST-SE envelopes) are limited to a maximum of 5000 CLM segments.

7. PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS

Payer specific business rule information regarding DMES can be found at the website:

https://medicaid.dhss.delaware.gov

8. ACKNOWLEDGEMENTS AND/OR REPORTS

The acknowledgement process will create the TA1 (if ISA14 has a value of ‘1’) and the 999 acknowledgement for the inbound transactions.

9. TRADING PARTNER AGREEMENTS

An Electronic Data interchange (EDI) Trading Partner is defined as any DMES customer (provider, billing service, software vendor, employer group, financial institution, etc.) that transmits to, or receives electronic data from DMES.

Payers have EDI Trading Partner Agreements (TPAs) 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.

10. TRANSACTION SPECIFIC INFORMATION

This section describes how ASC X12N Implementation Guides (IGs) adopted under HIPAA will be detailed with the use of a table. The tables contain a row for each segment DMES has additional information, over and above, the information in the IGs. The 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 DMES

In addition to the row for each segment, one or more additional rows are used to describe DMES 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.

All DMES members are considered “subscribers” so they all have individual loops. See the Implementation Guide for additional information.

ETIN –This is the number that is assigned to the provider/submitter to identify their electronic transaction uniquely. This may also be referred to as the Trading Partner ID.

NAMING YOUR FILES

When uploading files, it is requested that the submitter name their files using the following format for processing and tracking purposes:

1. FFS- fee for service.
2. <SubmitterId> is the trading partner ID [a/k/a submitter ID] assigned. This is to be used by all providers, vendors and clearinghouses submitting batch transactions.
3. <filename> is assigned, preferable meaningful to receiver such as ‘837P fee for service’.
4. <datetime> using a datetime value ccccmmddhhmm allows the filename to be uniquely identified and helps to avoid duplicate files.
5. <filetypeext> is a file type extension, so that the file can be identified.
    i. .txt

FFS-<SubmitterId>-<filename><datetime>.<filetypeext>

FFS-1234-837Pfeeforservice201510101308.txt

2. MCO is assigned preferably meaningful to a receiver such as ‘encounter’ followed by a unique ID. This is to be used by Managed Care Organizations submitting encounter claims.

MCO_<SubmitterId>_<filename>_<transaction type>_<datetime>.<ext>

MCO_xxxxxxxxx_ENCOUNTER_x_201611101308.837

<transaction type>

1 - **P** – Professional

2 - I – Institutional

3 – D - Dental

<datetime> using a datetime value ccccmmddhhmm allows the filename to be uniquely identified and helps to avoid duplicate files.

<ext> is a file type extension.

837

837 Professional

Loop	Element	Name	Instructions
	BHT	**Beginning of Hierarchical Transactions**	
	BHT06	Transaction Type Code	CH - Providers billing fee-for-service RP - MCO submitting encounters
2000A	**PRV**	**Billing Provider Specialty information**	**This segment is now required for all DMAP claims.**
	PRV03	Provider Taxonomy Code	The taxonomy the provider is enrolled with DE Medicaid should be submitted
2010BA	**NM1**	**Subscriber Name**	
	NM108	Identification Code Qualifier	MI - Member Identification Number
	NM109	Subscriber Client ID Number	This is the ten-digit Delaware Medical Assistance Identification number as listed on the Delaware Medical Assistance program card
2010BB	**NM1**	**Payer Name**	
	NM109	Payer Identifier	Enter DE_TXIX
	REF	**Billing Provider Secondary Identification**	This is the Atypical DE Provider Number
	REF01	Reference Identification Qualifier	G2 - Provider Commercial Number or Atypical Provider Number
	REF02	Atypical Provider Number	The DMAP Atypical Provider Number submitted here when an NPI is not billed in the 2010AA NM109 loop and segment
2300	**CLM**	**Claim Information**	
	CLM01	Patient Control Number	Maximum 20 Bytes, Number will be returned on 835 Transactions
	CLM02	Monetary Amount or Total Claim Charge	Maximum of 10 digits including the cents data elements
	REF	**Payer Claim Control Number**	
	REF02	Payer Claim Control Number or ICN	Enter the DMAP assigned 13-digit ICN when voiding/replacing a previously paid claim
	REF	**Medical Record Number**	
	REF02	Medical Record Number	Maximum length of 30 bytes supported
	PWK	**Claim Supplemental Information**	Required on claims with attachments
	PWK06	Attachment Control Number	The formula for the Attachment Control Number is Provider NPI (or Atypical ID Number) plus Member ID plus From Date of Service plus Sequence Number (4 numeric digits)

			The Sequence Number needs to be unique for each Attachment Control Number assigned.
2310B	**NM1**	Rendering Provider Name	
	NM103	Name Last or Organization Name	**Encounter Claims only:** The Rendering Provider's service location is determined from the NM103 field for encounter claims. The MCO will place the Medicaid ID (MCD ID) of the Rendering provider in the NM103 element then followed by a space, and then rest of the name that will fit in the data element. If the name is too big, the name is truncated.
2310B	**PRV**	Rendering Provider Specialty Information	
	PRV03	Reference Identification	DMAP uses rendering provider taxonomy in adjudication.
2320	**SBR**	**Other Subscriber Information**	For MCO Encounter claims, the MCO will be considered an Other Payer and the MCO payment information will be included in this loop
	SBR09	Claim filing indicator code	MB - Medicare Part B- this is expected if Medicare is the primary Other payer HM - Health Maintenance Organization- if the claim is an encounter claim being submitted by a Managed Care Organization (MCO) and the Other Payer data reflects the MCO payment information, this "HM" value must be used 16 - Health Maintenance Organization (HMO) Medicare Risk – This will be used for Medicare Advantage Plans Otherwise, select the claim filing indicator that is appropriate for the Other Payer
	CAS	**Claim Level Adjustments**	
	CAS03, CAS06, CAS09, CAS12, CAS15, CAS18	Monetary Amount	Maximum of 10 digits including the cents
	AMT	**Coordination of Benefits (COB) Payer Paid Amount**	
	AMT02	Monetary Amount	Maximum of 10 digits including the cents
	AMT	**Coordination of Benefits (COB) Total**	

		Non-Covered Amount	
	AMT02	Monetary Amount	Maximum of 10 digits including the cents
	AMT	**Remaining Patient Liability Amount**	
	AMT02	Monetary Amount	Maximum of 10 digits including the cents
2330B	**NM1**	**Other Payer Name**	
	NM108	Identification Code Qualifier	PI - Payer Identification
	NM109	Identification Code	When the claim is an encounter and this iteration of the COB loop uses the 'HM' claim filing indicator to identify the MCO, this data element will contain the DMAP Atypical Provider number, otherwise, the rules below are used Value expected in data element is the National Electronic Insurance Code (NEIC) These codes can be found at: http://www.emdeon.com/payerlists or https://medicaidpublications.dhss.delaware.gov/dotnetnuke/search?EntryId=34 (Insurance_carrier_crosswalk)
2400	**SV1**	**Professional Service**	
	SV101	Composite Medical Procedure Identifier	
	SV101-2	Procedure Code	If a drug is being billed, an appropriate J-code or other drug related HCPCS code must be used
	SV102	Monetary Amount	Maximum of 10 digits including the cents data elements
	PWK	**Claim Supplemental Information**	Required on claims with attachments
	PWK06	Attachment Control Number	The formula for the Attachment Control Number is Provider NPI (or Atypical ID Number) plus Member ID plus From Date of Service plus Sequence Number (4 numeric digits) The Sequence Number needs to be unique for each Attachment Control Number assigned
2410	**LIN**	**Drug Identification**	Required when Loop 2400 procedure code is a drug-related HCPCS code
2420A	**NM1**	**Rendering Provider Name**	
	NM103	**Name Last or Organization Name**	**Encounter Claims only:** If submitted at the detail, the Rendering Provider's service location is determined from the NM103 field. The MCO will place the Medicaid ID (MCD ID) of the Rendering provider in the NM103 element then followed by a space, and then rest of the name that will

			fit in the data element. If the name is too big, the name is truncated.
2430	**SVD**	**Line Adjudication Information**	If there is an Other Payer payment at the claim level in 2320, detail payments are required in this 2430 loop
	SVD02	Monetary Amount or Service Line Paid Amount	Maximum of 10 digits including the cents data elements
	CAS	**Line Adjustment**	
	CAS03, CAS06, CAS09, CAS12, CAS15, CAS18	Monetary Amount	Maximum of 10 digits including the cents
	AMT	**Remaining Patient Liability**	
	AMT02	Monetary Amount	Maximum of 10 digits including the cents

837 Institutional

Loop	Element	Name	Instructions
	BHT	**Beginning of Hierarchical Transactions**	
	BHT06	Transaction Type Code	CH - Providers billing fee-for-service RP - MCO submitting encounters
2000A	**PRV**	**Billing Provider Specialty Information**	This is required for all DMAP claims
	PRV03	Provider Taxonomy Code	The taxonomy the provider is enrolled with DE Medicaid should be submitted
2010BA	**NM1**	**Subscriber Name**	
	NM108	Identification Code Qualifier	MI - Member Identification Number
	NM109	Subscriber Client ID	Ten digit Delaware Medical Assistance Identification Number as listed on the Delaware Medical Assistance program card
2010BB	**NM1**	**Payer Name**	
	NM109	Payer Identifier	Enter DE_TXIX
	REF	**Billing Provider Secondary Identification**	Atypical DE Provider Number
	REF01	Reference Identification Qualifier	G2 - Provider Commercial Number or Atypical Provider Number
	REF02	Atypical Provider Number	
2300	**CLM**	**Claim Information-Header**	
	CLM01	Patient Control Number	Maximum of 20 bytes Number will be returned on 835 transaction
	CLM02	Monetary Amount or Total Claim Charge Amount	Maximum of 10 digits including the cents data elements
	REF	**Medical Record Number**	
	REF02	Medical Record Number	Maximum of 30 bytes supported
	PWK	**Claim Supplemental Information**	Required on claims with attachments
	PWK06	Attachment Control Number	The formula for the Attachment Control Number is Provider NPI (or Atypical ID Number) plus Member ID plus From Date of Service plus Sequence Number (4 numeric digits) The Sequence Number needs to be unique for each Attachment Control Number assigned
2310A	**PRV**	**Attending Provider Specialty Information**	
	PRV03	Provider Taxonomy	DMES uses attending provider taxonomy in

		Code	adjudication
2310D	NM1	Rendering Provider Name	
	NM103	Name Last or Organization Name	**Encounter Claims only:** The Rendering Provider's service location is determined from the NM103 field. The MCO will place the Medicaid ID (MCD ID) of the Rendering provider in the NM103 element then followed by a space, and then rest of the name that will fit in the data element. If the name is too big, the name is truncated.
2320	**SBR**	**Other Subscriber Information**	For MCO Encounter claims, the MCO will be considered an Other Payer and the MCO payment information will be included in this loop
	SBR09	Claim Filing Indicator Code	MA - Medicare Part A – this is expected if Medicare Part A is the primary Other Payer MB - Medicare Part B – this is excepted if Medicare Part B is the primary Other Payer HM – Health Maintenance Organization – if the claim is an encounter claim being submitted by a Managed Care Organization (MCO) and the Other Payer data reflects the MCO payment information, this 'HM' value must be used. 16 - Health Maintenance Organization (HMO) Medicare Risk – This will be used for Medicare Advantage Plans Otherwise, select, the claim filing indicator that is appropriate for the Other Payer
	CAS	**Claim Level Adjustments**	
	CAS03, CAS06, CAS09, CAS12, CAS15, CAS18	Monetary Amount	Maximum of 10 digits including the cents
	AMT	**Coordination of Benefits (COB) Payer Paid Amount**	
	AMT02	Monetary Amount	Maximum of 10 digits including the cents
	AMT	**Remaining Patient Liability Amount**	
	AMT02	Monetary Amount	Maximum of 10 digits including the cents
	AMT	**Coordination of Benefits (COB) Total**	

		Non-Covered Amount	
	AMT02	Monetary Amount	Maximum of 10 digits including the cents
2330B	**NM1**	**Other Payer Name**	
	NM108	Identification Code Qualifier	PI - Payer Identification
	NM109	Identification Code	When the claim is an encounter and this iteration of the COB loop uses the 'HM' claim filing indicator to identify the MCO, this data element will contain the DMAP Atypical Provider number, otherwise, the rules below are used Value expected in data element is the National Electronic Insurance Code (NEIC) These codes can be found at: http://www.emdeon.com/payerlists or https://medicaidpublications.dhss.delaware.gov/dotnetnuke/search?EntryId=34 Insurance_carrier_crosswalk

2400	**SV2**	**Institutional Service Line**	
	SV201	Service Line Revenue Code	
	SV203	Line Item Charge Amount	Maximum of 10 digits including the cents data elements
	PWK	**Claim Supplemental Information**	Required on claims with attachments
	PWK06	Attachment Control Number	The formula for the Attachment Control Number is Provider NPI (or Atypical ID Number) plus Member ID plus From Date of Service plus Sequence Number (4 numeric digits) The Sequence Number needs to be unique for each Attachment Control Number assigned
2410	**LIN**	**Drug Identification**	*(Note: Required when Loop 2400 procedure code is a drug-related HCPCS code.)*
2420C	**NM1**	**Rendering Provider Name**	
	NM103	**Name Last or Organization Name**	**Encounter Claims only:** If submitted at the detail, the Rendering Provider's service location is determined from the NM103 field. The MCO will place the Medicaid ID (MCD ID) of the Rendering provider in the NM103 element then followed by a space, and then rest of the name that will fit in the data element. If the name is too big, the name is truncated.
2430	**SVD**	**Line Adjudication Information**	If there is an Other Payer payment at the claim level in 2320, and the claim is not an inpatient, inpatient crossover, or nursing home claim, detail payments are required in this 2430 loop
	SVD02	Service Line Paid Amount	Maximum of 10 digits including the cents data elements
	CAS	**Line Adjustment**	On claim submissions where an Other Payer is primary and has approved the claim and the claim is not an inpatient, inpatient crossover, or nursing home claim, the paid amount, paid date, and claim adjustment reasons /amounts are required at this level
	CAS03, CAS06, CAS09, CAS12, CAS15, CAS18	Monetary Amount	Maximum of 10 digits including the cents

837 Dental

Loop	Element	Name	Instructions
	BHT	**Beginning of Hierarchical Transactions**	
	BHT06	Transaction Type Code	CH - Providers billing fee-for-service RP - MCO submitting encounters
2010BA	**NM1**	**Subscriber Name**	
	NM108	Identification Code Qualifier	MI - Member Identification Number
	NM109	Subscriber Client ID Number	This is the ten-digit Delaware Medical Assistance Identification number as listed on the Delaware Medical Assistance Program card
2010BB	**NM1**	**Payer Name**	
	NM109	Payer Identifier	Enter DE_TXIX
2300	**CLM**	**Claim Information**	
	CLM01	Patient Control Number	Maximum 20 Bytes, Number will be returned on 835 Transactions
	CLM02	Monetary Amount or Total Claim Charge	Maximum of 10 digits including the cents data elements
	PWK	**Claim Supplemental Information**	Required on claims with attachments
	PWK06	Attachment Control Number	The formula for the Attachment Control Number is Provider NPI (or Atypical ID Number) plus Member ID plus From Date of Service plus Sequence Number (4 numeric digits) The Sequence Number needs to be unique for each Attachment Control Number assigned
2310A	**PRV**	**Referring Provider Specialty Information**	*(Required if referring provider is sent on claim)*
	PRV03	Provider Taxonomy Code	DMES uses referring provider taxonomy in adjudication
2310B	**NM1**	Rendering Provider Name	
	NM103	Name Last or Organization Name	**Encounter Claims only:** The Rendering Provider’s service location is determined from the NM103 field for encounter claims. The MCO will place the Medicaid ID (MCD ID) of the Rendering provider in the NM103 element then followed by a space, and then rest of the name that will fit in the data element. If the name is too big, the name is truncated.
2310B	**PRV**	**Rendering Provider Specialty Information**	
	PRV03	Provider Taxonomy Code	DMES uses rendering provider taxonomy in adjudication

2320	**SBR**	**Other Subscriber Information**	For MCO Encounter claims, the MCO will be considered an Other Payer and the MCO payment information will be included in this loop
	SBR09	Claim filing indicator code	MB - Medicare Part B- this is expected if Medicare is the primary Other payer HM - Health Maintenance Organization- if the claim is an encounter claim being submitted by a Managed Care Organization (MCO) and the Other Payer data reflects the MCO payment information, this “HM” value must be used Otherwise, select the claim filing indicator that is appropriate for the Other Payer
	CAS	**Line Adjustment**	
	CAS03 CAS06 CAS09 CAS12 CAS15 CAS18	Monetary Amount	Maximum of 10 digits including the cents
	AMT	**Coordination of Benefits (COB) Payer Paid Amount**	
	AMT02	Monetary Amount	Maximum of 10 digits including the cents
	AMT	**Remaining Patient Liability Amount**	
	AMT02	Monetary Amount	Maximum of 10 digits including the cents
	AMT	**Coordination of Benefits (COB) Total Non-Covered Amount**	
	AMT02	Monetary Amount	Maximum of 10 digits including the cents
2330B	**NM1**	**Other Payer Name**	
	NM108	Identification Code Qualifier	PI - Payer Identification
	NM109	Identification Code	When the claim is an encounter and this iteration of the COB loop uses the ‘HM’ claim filing indicator to identify the MCO, this data element will contain the DMAP Atypical Provider number, otherwise, the rules below are used Value expected in data element is the National Electronic Insurance Code (NEIC) These codes can be found at: http://www.emdeon.com/payerlists or https://medicaidpublications.dhss.delaware.gov/dotnetnuke/search?EntryId=34 Insurance_carrier_crosswalk

2400	**SV3**	**Dental Service**	
	SV302	Line item charge amount	Maximum of 10 digits including the cents data elements
2420A	NM1	Rendering Provider Name	
	NM103	Name Last or Organization Name	**Encounter Claims only:** If submitted at the claim level, the Rendering Provider's service location is determined from the NM103 field. The MCO will place the Medicaid ID (MCD ID) of the Rendering provider in the NM103 element then followed by a space, and then rest of the name that will fit in the data element. If the name is too big, the name is truncated.
2430	**SVD**	**Line Adjudication Information**	If there is an Other Payer payment at the claim level in 2320, detail payments are required in this 2430 loop
	SVD02	Service Line Paid Amount	Maximum of 10 digits including the cents data elements
	CAS	**Line Adjustment**	
	CAS03, CAS06, CAS09, CAS12, CAS15, CAS18	Monetary Amount	Maximum of 10 digits including the cents

APPENDIX 1: Change Summary

Date	Change	Responsible Party
December 2016	Initial release for DMES	EDI Department
July 2017	Update to DXC Technology	EDI Department
October 2017	Section 1 INTRODUCTION - REFERENCES • Removed the sentence: Data Interchange Standards Association at www.disa.org Section 10 TRANSACTION SPECIFIC INFORMATION • Documentation-only update to 837 Professional Loop 2300 Element REF02 Name Payer Claim Control Number or ICN o Changed 15-digit ICN to 13-digit ICN	EDI Department
June 2018	Update for Encounter Claims 837P & 835D 2310B & 2430A (NM103) 8371 2310D & 2420C (NM103)	EDI Department
August 2018	837I	EDI Department

	2320 (SBR09) Added 16 Qualifier	
January 2019	All monetary, 9-digit references were updated to reflect acceptance of 10-digit figures.	EDI Department