ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)

837 Standard Companion Guide Transaction Information

Instructions related to Transactions based on ASC X12 Implementation Guides, version 005010

Companion Guide Version Number: 1.3
October 2016

Preface

Companion Guides (CG) may contain two types of data, instructions for electronic communications with the publishing entity (Communications/Connectivity Instructions) and supplemental information for creating transactions for the publishing entity while ensuring compliance with the associated ASC X12 IG (Transaction Instructions). Either the Communications/Connectivity component or the Transaction Instruction component must be included in every CG. The components may be published as separate documents or as a single document.

The Communications/Connectivity component is included in the CG when the publishing entity wants to convey the information needed to commence and maintain communication exchange.

The Transaction Instruction component is included in the CG when the publishing entity wants to clarify the IG instructions for submission of specific electronic transactions. The Transaction Instruction component content is limited by ASCX12's copyrights and Fair Use statement

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Transaction Instruction (TI)

1. TI Introduction

1.1 Background

1.1.1 Overview of HIPAA Legislation

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 carry provisions for administrative simplification. This requires the Secretary of the Department of Health and Human Services (HHS) 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 translations 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

1.1.2 Compliance according to HIPAA

The HIPAA regulations at 45 CFR 162.915 require that covered entities not enter into a trading 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 specifications or are not in the standard’s implementation specification(s).
- Change the meaning or intent of the standard’s implementation specification(s).

1.1.3 Compliance according to ASC X12

ASC X12 requirements include specific restrictions that prohibit trading partners from:

- Modifying any defining, explanatory, or clarifying content contained in the implementation guide.
- Modifying any requirement contained in the implementation guide.

1.2 Intended Use

The Transaction Instruction component of this companion guide must be used in conjunction with an associated ASC X12 Implementation Guide. The instructions in this companion guide are not intended to be stand-alone requirements documents. This companion guide conforms to all the requirements of any associated ASC X12 Implementation Guides and is in conformance with ASC X12's Fair Use and Copyright statements.

ASC X12 TR3 Implementation Guides can be obtained by visiting http://store.x12.org/store/.

2. Included ASC X12 Implementation Guides

Unique ID	Name
005010X222	Health Care Claim: Professional (837)
005010X223	Health Care Claim: Institutional (837)
005010X224	Health Care Claim: Dental (837)

3. Instruction Tables

3.1 837 Health Care Claim: Professional – Encounters

Loop	Reference Element	Description 837-P 5010 A1 ENC	Note	AHCCCS Usage/Expected Value (Codes/Notes/Comments)
				Glossary: **NOT USED BY AHCCCS** - AHCCCS does not use the segment or element for processing or updating of the adjudication system. The field may still be required by a Validator. - Follow TR3 guidelines.
				Blue = Header segments
				Light Blue = Billing Provider Detail Segments
				Green = Subscriber Detail Segments
				Yellow = Claim Level Segments
				Orange = Line Level Segments
				Bright Green = Specific guidance or use provided to Trading Partner (TP); included in Instruction Table of the Companion Guide (CG)
				Unless otherwise noted, these Notes apply to Paid and Denied encounter files as applicable.
___	**ISA**	**INTERCHANGE CONTROL HEADER**		
	ISA06	Interchange Sender ID		Expect HP Tax ID+6 spaces
	ISA08	Interchange Receiver ID		Expect AHCCCS866004791

Loop	Reference Element	Description 837-P 5010 A1 ENC	Note	AHCCCS Usage/Expected Value (Codes/Notes/Comments)
___	**GS**	**FUNCTIONAL GROUP HEADER**		
	GS02	Application Sender Code		Expect 6-digit HP ID + 3-digit TSN For RBHAs: RBHA 6-digit Provider ID + 3-digit TSN
	GS03	Application Receiver Code		Expect AHCCCS866004791 or AHCCCSDENIED "AHCCCS8660047919"=Use for new day encounters (approved, replaced, voids) "AHCCCSDENIED"=Use for Denied encounter files (.deny; input mode 6)
	GS08	Version Identifier Code	Code Change	Expect 005010X222A1
___	**ST**	**TRANSACTION SET HEADER**		
	ST03	Implementation Convention Reference	New Element	Expect 005010X222A1
___	**BHT**	**BEGINNING OF HIERARCHICAL TRANSACTION**		
	BHT06	Claim or Encounter ID		Expect 'RP' Reporting
1000A	**NM1**	**SUBMITTER NAME**		
1000A	NM109	Submitter Identifier		Expect 6-digit HP ID + 3-digit TSN + 1-digit Input Mode For RBHAs: 079999 + 3-digit TSN + 1-digit Input Mode Input Mode: 2=Adjudicated/New Day Encounter 6=Denied (for use with .deny files) For Health Plans: 1000A/NM109=2330B/NM109=2430/SVD01
1000A	**PER**	**SUBMITTER EDI CONTACT INFORMATION**		**2nd occurrence is for BBA attestation in PER04**
1000A	PER01	Contact Function Code		Expect 'IC' Information Contact
1000A	PER02	Submitter Contact Name		NOT USED BY AHCCCS
1000A	PER03	Communication Number Qualifier	Code 'ED' EDI Number - Deleted	Expect 'EM' Email
1000A	PER04	Communication Number	Increase from 80 - 256	Expect BBA attestation: TOMYKNOWLEDGEINFORMATIONANDBELIEFTHEDATAINTHISFILEISACCURATECOMPLETEANDTRUE.CERTIFIER@CERTIFIED.COM
1000A	PER05	Communication Number Qualifier	Code Deleted	Expect 'EM' Email
1000A	PER06	Communication Number	Increase from 80 - 256	Expect Contact Email
1000A	PER07	Communication Number Qualifier	Code Deleted	Expect 'TE' Telephone
1000A	PER08	Communication Number	Increase from 80 - 256	Expect Contact Phone
1000B	**NM1**	**RECEIVER NAME**		
1000B	NM103	Receiver Name	Increase from 35 - 60	Expect 'AHCCCS'

Loop	Reference Element	Description 837-P 5010 A1 ENC	Note	AHCCCS Usage/Expected Value (Codes/Notes/Comments)
1000B	NM109	Receiver Primary Identifier		Expect '866004791'
2010AA	**NM1**	**Billing Provider Name**	Name Change	
2010AA	N403	Billing Provider Postal Zone or ZIP Code	Usage changed to Situational	Expect Billing Provider 9-digit Zip code Health plans are encouraged to submit the full 9-digit zip code; however, a value of '0000' or '9999' is acceptable until the actual zip+4 code is identified and reported on future encounter submissions.
2010BA	**NM1**	**SUBSCRIBER NAME**		
2010BA	NM109	Subscriber Primary Identifier	Usage changed to Required	Expect AHCCCS ID (A*, x(9)) For RBHAs: Expect AHCCCS ID (A*, x(9)), State Only ID (S*, X(9)), or CIS ID x(10).
2010BB	**NM1**	**PAYER NAME**		
2010BB	NM103	Payer Name	Increase from 35 - 60	Expect 'AHCCCS'
2010BB	NM108	Identification Code Qualifier		Expect "PI"
2010BB	NM109	Payer Identifier		Expect 866004791
2010BB	**REF**	**BILLING PROVIDER SECONDARY IDENTIFICATION**	New Segment Moved from 2010AA/REF	Atypical Provider
2010BB	REF01	Reference Identification Qualifier		Expect "G2"
2010BB	REF02	Payer Additional Identifier		Expect 6-digit AHCCCS Provider Registration ID when provider is not eligible for NPI
2300	**CLM**	**CLAIM INFORMATION**		
2300	CLM01	Patient Account Number	The maximum number of characters to be supported for this field is '20'.	Expect Patient Account Number This value is not returned in the 277CA This value is returned in the 277U 2200D/TRN02 1st and 2nd occurrence
2300	CLM05-3	Claim Frequency Code	Code Deleted	Expect Claim Frequency Code For Replacements, use '7' (Replacement of prior claim) For Voids, use '8' (Void/Cancel prior claim)
2300	**REF**	**REFERRAL NUMBER**	New Segment Required when a referral number is assigned by the payer or Utilization Management Organization (UMO) AND a referral is involved.	SEGMENT NOT USED BY AHCCCS See 2330B/REF OTHER PAYER REFERRAL NUMBER
2300	**REF**	**PRIOR AUTHORIZATION**	New Segment Required when an authorization number is assigned by the payer or UMO AND the services on this claim were preauthorized.	SEGMENT NOT USED BY AHCCCS See 2330B/REF OTHER PAYER PRIOR AUTHORIZATION NUMBER

Loop	Reference Element	Description 837-P 5010 A1 ENC	Note	AHCCCS Usage/Expected Value (Codes/Notes/Comments)
2300	**REF**	**PAYER CLAIM CONTROL NUMBER**	Required when CLM05-3 (Claim Frequency Code) indicates this claim is a replacement or void to a previously adjudicated claim. Same for Header and Detail	
2300	REF01	Reference Identification Qualifier	F8=Original Reference Number	Expect 'F8'
2300	REF02	Claim Original Reference Number		Expect Original CRN If submitting a void transaction, the AHCCCS CRN of the encounter to be adjusted must be included in this field. AHCCCS only accepts professional (837P) and dental (837D) replacements or voids at the header, which replaces or voids all previously submitted lines associated with the first 12 digits of the CRN. When replacing or voiding at the header only the first 12 digits of the CRN should be submitted. For replacements the encounter must reflect the plan's final disposition of all claim lines.
2300	**REF**	**MEDICAL RECORD NUMBER**	Required when the provider needs to identify for future inquiries, the actual medical record of the patient identified in either Loop ID-2010BA or Loop ID-2010CA for this episode of care.	
2300	REF02	Medical Record Number	Increase from 30 - 50	2300/REF*EA Medical Record number reported in 277U 2200D/REF*EA
2300	**CR1**	**AMBULANCE TRANSPORT INFORMATION**	Required on all claims involving ambulance transport services.	
2300	CR104	Ambulance Transport Reason Code	A=Patient was transported to nearest facility for care of symptoms, complaints, or both B=Patient was transported for the benefit of a preferred physician C=Patient was transported for the nearness of family members E=Patient Transferred to Rehabilitation Facility	Expect A, B, C, D, or E Or Default to value 'A' when not known
2300	CR105	Unit or Basis for Measurement Code	DH=Miles	Expect 'DH' Or Default to 'DH' when CR104 is not known
2300	CR106	Transport Distance 9(4)	0 (zero) is a valid value when ambulance services do not include a charge for mileage.	Expect Transport Distance Or Default to '0' when not known
2300	CR109	Round Trip Purpose Description	Required when the ambulance service is for a round trip.	AHCCCS Transportation services are separate legs and are not tracked for "round trip". Will leave open for usage as determined by the HP.
2310B	**REF**	**RENDERING PROVIDER SECONDARY IDENTIFICATION**		Atypical Provider
2310B	REF01	Reference Identification Qualifier		Expect 'G2'

Loop	Reference Element	Description 837-P 5010 A1 ENC	Note	AHCCCS Usage/Expected Value (Codes/Notes/Comments)
2310B	REF02	Rendering Provider Secondary Identifier		Expect 6-digit AHCCCS Provider Registration ID when provider is not eligible for NPI
2310C	**N3**	**SERVICE FACILITY LOCATION ADDRESS**	Loop Change If service facility location is in an area where there are no street addresses, enter a description of where the service was rendered (for example, “crossroad of State Road 34 and 45” or “Exit near Mile marker 265 on Interstate 80”.)	**PO Box or Lock Box not allowed for the Service Facility Address** **Must supply the physical address information**
2310C	N301	Laboratory or Facility Address Line		Expect Laboratory or Facility Address Line "PO Box" or "Lock Box" is not allowed
2310C	**N4**	**SERVICE FACILITY LOCATION CITY/STATE/ZIP**	Loop Change	
2310C	N403	Laboratory or Facility Postal Zone ZIP Code	Usage changed to Situational	Expect Laboratory or Facility 9-digit Zip code Health plans are encouraged to submit the full 9-digit zip code; however, a value of ‘0000’ or ‘9999’ is acceptable until the actual zip+4 code is identified and reported on future encounter submissions.
2310E	**N3**	**AMBULANCE PICK UP LOCATION ADDRESS**	If the ambulance pickup location is in an area where there are no street addresses, enter a description of where the service was rendered (for example, “crossroad of State Road 34 and 45” or “Exit near Mile marker 265 on Interstate 80”.)	
2310E	N301	Ambulance Pick Up Address Line		PO Box address should not be used. Use physical pick up address.
2330A	**NM1**	**OTHER SUBSCRIBER NAME**	If the patient can be uniquely identified to the Other Payer indicated in this iteration of Loop ID-2320 by a unique Member Identification Number, then the patient is the subscriber or is considered to be the subscriber and is identified in this Other Subscriber’s Name Loop ID-2330A.	
2330A	NM109	Other Insured Identifier		Expect Other Insured Identifier or AHCCCS ID
2330B	**NM1**	**OTHER PAYER NAME**		

Loop	Reference Element	Description 837-P 5010 A1 ENC	Note	AHCCCS Usage/Expected Value (Codes/Notes/Comments)
2330B	NM109	Other Payer Primary Identifier	When sending Line Adjudication Information for this payer, the identifier sent in SVD01 (Payer Identifier) of Loop ID-2430 (Line Adjudication Information) must match this value.	For Health plans, expect 6-character HP ID + 3-character TSN + 1-digit Input Mode For RBHAs: RBHA 6-digit Provider ID + 3-digit TSN + 1-digit Input Mode For Medicare, expect 'MA' or 'MB' For TPL/Other Insurance, expect 'OI' For Health plans: 1000A/NM109=2330B/NM109=2430/SVD01 Other Payer Primary Identifier cannot be more than 9 bytes and must be unique between payers
2330B	**REF**	**OTHER PAYER PRIOR AUTHORIZATION NUMBER**	Name Change Note: Prior Auth and Referral Number split from 4010	
2330B	REF01	Reference Identification Qualifier	G1=Prior Authorization Number Code 9F Deleted (see next REF segment)	Expect 'G1'
2330B	REF02	Other Payer Prior Authorization Number	Increase from 30 - 50	Expect Payer Prior Authorization number
2330B	**REF**	**OTHER PAYER REFERRAL NUMBER**	New Segment Note: Prior Auth and Referral Number split from 4010	
2330B	REF01	Reference Identification Qualifier	9F=Referral Number	Expect '9F'
2330B	REF02	Other Payer Referral Number		Expect Other Payer Referral Number
2330B	**REF**	**OTHER PAYER CLAIM CONTROL NUMBER**	New Segment	
2330B	REF01	Reference Identification Qualifier	F8=Original Reference Number	Expect 'F8'
2330B	REF02	Other Payer Claim Control Number		Expect Health Plan Claim ID When the Payer is the Health plan limited to 30 bytes This value is returned in the 277U 2200D/REF*1K 2nd occurrence This value is not returned in the 277CA
2400	**SV1**	**PROFESSIONAL SERVICE**		
2400	SV107	COMPOSITE DIAGNOSIS CODE POINTER	Usage changed to Required Allowed values are 1-12 If SV107-1 is present, use the number represented here to determine which diagnosis from the HI segment should be moved. Note: Only 4 Diagnosis code pointers to now 12 (prior 8) Diagnosis codes in 2300/HI segment	Expect to have the alpha letters A-L from the CMS1500 form cross-walked to a numeric equivalent for use in the 837 Encounter. Per the TR3, the only acceptable values that can be used for a Diagnosis code pointer is 1-12.

Loop	Reference Element	Description 837-P 5010 A1 ENC	Note	AHCCCS Usage/Expected Value (Codes/Notes/Comments)
2400	**CN1**	**CONTRACT INFORMATION**		This segment must always be sent for each line to capture the Health plan Allowed amount
2400	CN101	Contract Type Code	01 Diagnosis Related Group (DRG) 02 Per Diem 03 Variable Per Diem 04 Flat 05 Capitated 06 Percent 09 Other (use for FFS)	For non-BHS plans, expect any value For BHS plans, expect '05' or '09' 05 Capitated 09 Other (use for FFS)
2400	CN102	Contract Amount	S9(7).99	Expect Health plan Allowed amount Allowed Amount: What would have paid under FFS before other payer
2400	**REF**	**PRIOR AUTHORIZATION**	Required when service line involved a prior authorization number that is different than the number reported at the claim level (Loop ID-2300).	**SEGMENT NOT USED BY AHCCCS**
2400	REF01	Reference Identification Qualifier	G1=Prior Authorization Number Code Deleted	NOT USED BY AHCCCS
2400	REF02	Prior Authorization or Referral Number	Increase from 30 - 50	NOT USED BY AHCCCS
2400	**REF**	**REFERRAL NUMBER**	New Segment Required when this service line involved a referral number that is different than the number reported at the claim level (Loop-ID 2300).	**SEGMENT NOT USED BY AHCCCS**
2400	REF01	Reference Identification Qualifier	9F Referral Number	NOT USED BY AHCCCS
2400	REF02	Referral Number		NOT USED BY AHCCCS
2410	**CTP**	**DRUG QUANTITY**		
2410	CTP04	National Drug Unit Count	when CTP05-1 = UN - 9(3).9, F2 - 9(7).999 ML - 9(2).99 GR - 9(2).99 ME - 9(5).999	The maximum length allowed for a whole number is eight digits (99999999). When a decimal is used, the maximum number of digits allowed to the right of the decimal is three (99999999.999).
2420A	**NM1**	**RENDERING PROVIDER NAME**	Required when the Rendering Provider NM1 information is different than that carried in the Loop ID-2310B Rendering Provider. OR Required when Loop ID-2310B Rendering Provider is not used AND this particular line item has different Rendering Provider information than that which is carried in Loop ID-2010AA Billing Provider.	**SEGMENT NOT USED BY AHCCCS** - Different Rendering Provider at the Line Level is not used by AHCCCS. If needed submit separate claim.

Loop	Reference Element	Description 837-P 5010 A1 ENC	Note	AHCCCS Usage/Expected Value (Codes/Notes/Comments)
2420A	**REF**	**RENDERING PROVIDER SECONDARY IDENTIFICATION**	Required on or after the mandated NPI Implementation Date when NM109 in this loop is not used and an identification number other than the NPI is necessary for the receiver to identify the provider.	Atypical Provider
2420A	REF01	Reference Identification Qualifier		Expect 'G2'
2420A	REF02	Rendering Provider Secondary Identifier		Expect 6-digit AHCCCS Provider Registration ID when provider is not eligible for NPI
2420C	**REF**	**SERVICE FACILITY LOCATION SECONDARY IDENTIFICATION**	Required on or after the mandated NPI implementation date when the entity is not a Health Care provider (a.k.a. an atypical provider), and an identifier is necessary for the claims processor to identify the entity.	Atypical Provider
2420C	REF01	Reference Identification Qualifier		Expect 'G2'
2420C	REF02	Service Facility Location Secondary Identifier		Expect 6-digit AHCCCS Provider Registration ID when provider is not eligible for NPI
2420F	**NM1**	**REFERRING PROVIDER NAME**	Required when this service line involves a referral and the referring provider differs from that reported at the claim level (loop 2310A)	**SEGMENT NOT USED BY AHCCCS** Submit Referring Provider at Header Only
2430	**SVD**	**LINE ADJUDICATION INFORMATION**	Required when the claim has been previously adjudicated by payer identified in Loop ID-2330B and this service line has payments and/or adjustments applied to it.	AHCCCS currently allows for one 2430 Loop per payer, per line.
2430	SVD01	Other Payer Primary Identifier	This identifier indicates the payer responsible for the reimbursement described in this iteration of the 2430 loop. The identifier indicates the Other Payer by matching the appropriate Other Payer Primary Identifier (Loop ID-2330B, element NM109).	For Health Plan: 6-digit HP ID + 3-digit TSN + 1-digit Input Mode For RBHAs: RBHA 6-digit Provider ID + 3-digit TSN + 1-digit Input Mode For Medicare, expect 'MA' or 'MB' For TPL/Other Insurance, expect 'OI' For Health plans: For Health plans: 1000A/NM109=2330B/NM109=2430/SVD01
2430	**CAS**	**LINE ADJUSTMENT**	Required when the payer identified in Loop 2330B made line level adjustments which caused the amount paid to differ from the amount originally charged.	ENC captures 6 trios

Loop	Reference Element	Description 837-P 5010 A1 ENC	Note	AHCCCS Usage/Expected Value (Codes/Notes/Comments)
2430	CAS03	Adjustment Amount	S9(7).99	Net Allowed Amount (Approved Amount): Final value of the encounter if paid as FFS after all other payments have been considered Capitated = Amount Paid $0, use CAS*CO*24 segment FFS - Final Net Allowed Amount would not be sent; it is the same as the HP Paid Amount which was already reported

3.2 837 Health Care Claim: Institutional - Encounters

Loop	Reference Element	Description 837-I 5010 A2 ENC	837 Note	AHCCCS Usage/Expected Value (Codes/Notes/Comments)
				Glossary: NOT USED BY AHCCCS - AHCCCS does not use the segment or element for processing or updating of the adjudication system. The field may still be required by a Validator. - Follow TR3 guidelines.
				Blue = Header segments
				Light Blue = Billing Provider & Pay To Segments
				Green = Subscriber & Payer Segments
				Yellow = Claim Level Segments
				Purple = Other Subscriber & Other Payer Segments
				Orange = Line Level Segments
				Bright Green = Specific guidance or use provided to Trading Partner (TP); included in Instruction Table of the Companion Guide (CG)
				Unless otherwise noted, these Notes apply to Paid, Denied and Partial encounter files as applicable.
	ISA	**INTERCHANGE CONTROL HEADER**		
	ISA06	Interchange Sender ID		Expect HP Tax ID+6 spaces
	ISA08	Interchange Receiver ID		Expect AHCCCS866004791
	GS	**FUNCTIONAL GROUP HEADER**		
	GS02	Application Sender Code		Expect 6-digit HP ID+3-digit TSN For RBHAs: RBHA 6-digit Provider ID+3-digit TSN
	GS03	Application Receiver Code		Expect AHCCCS866004791, AHCCCSDENIED, or AHCCCSPARTIAL "AHCCCSDENIED"=Use for Denied encounter files (.deny; input mode 6) "AHCCCS8660047919"=Use for new day encounters (approved, replaced, voids) "AHCCCSPARTIAL"=Use for non-covered lines due to invalid code sets
	GS08	Version Identifier Code	Code Change	Expect 005010X223A2
	ST	**TRANSACTION SET HEADER**		
	ST03	Implementation Convention Reference	New Element	Expect 005010X223A2

Loop	Reference Element	Description 837-I 5010 A2 ENC	837 Note	AHCCCS Usage/Expected Value (Codes/Notes/Comments)
	BHT	**BEGINNING OF HIERARCHICAL TRANSACTION**		
	BHT06	Claim or Encounter ID	Code Added	Expect 'RP' Reporting
1000A	**NM1**	**SUBMITTER NAME**		
1000A	NM109	Submitter Identifier		Expect 6-digit HP ID+3-digit TSN+1-digit Input Mode For RBHAs: 079999+TSN+1-digit Input Mode Input Mode: 2=Adjudicated/New Day Encounter 6=Denied (for use with .deny files) For Health Plans: 1000A/NM109=2330B/NM109=2430/SVD01
1000A	**PER**	**SUBMITTER EDI CONTACT INFORMATION**		**2nd occurrence is for BBA attestation in PER04**
1000A	PER03	Communication Number Qualifier	Code ED deleted	Expect 'EM' Email
1000A	PER04	Communication Number	Increase from 80 - 256	Expect BBA attestation: TOMYKNOWLEDGEINFORMATIONANDBELIEFTHEDATAINTHISFILEISACCURATECOMPLETEANDTRUE.CERTIFIER@CERTIFIED.COM
1000A	PER05	Communication Number Qualifier	Code deleted	Expect 'EM' Email
1000A	PER06	Communication Number	Increase from 80 - 256	Expect Contact Email
1000A	PER07	Communication Number Qualifier	Code deleted	Expect 'TE' Telephone
1000A	PER08	Communication Number	Increase from 80 - 256	Expect Contact Phone
1000B	**NM1**	**RECEIVER NAME**		
1000B	NM103	Receiver Name	Increase from 35 - 60	Expect 'AHCCCS'
1000B	NM109	Receiver Primary Identifier		Expect '866004791'
2010BA	**NM1**	**SUBSCRIBER NAME**		
2010BA	NM109	Subscriber Primary Identifier	Usage change to Required	Expect AHCCCS ID (A*, x(9)) For RBHAs: Expect AHCCCS ID (A*, x(9)), State Only ID (S*, X(9)), or CIS ID x(10).
2010BB	**NM1**	**PAYER NAME**	Loop Change	
2010BB	NM103	Payer Name	Increase from 35 - 60	Expect 'AHCCCS'
2010BB	NM108	Identification Code Qualifier		Expect "PI"
2010BB	NM109	Payer Identifier		Expect 866004791
2010BB	**REF**	**BILLING PROVIDER SECONDARY IDENTIFICATION**	Segment Added	
2010BB	REF01	Reference Identification Qualifier		Expect 'G2'
2010BB	REF02	Payer Additional Identifier		Expect 6-digit AHCCCS Provider Registration ID when provider is not eligible for NPI

Loop	Reference Element	Description 837-I 5010 A2 ENC	837 Note	AHCCCS Usage/Expected Value (Codes/Notes/Comments)
2300	**CLM**	**CLAIM INFORMATION**		
2300	CLM01	Patient Control Number	The maximum number of characters to be supported for this field is '20'.	Expect Patient Account Number This value is not returned in the 277CA This value is returned in the 277U 2200D/TRN02 1st and 2nd occurrence
2300	CLM05-1	Facility Type Code		The first and second positions of the Uniform Bill Type Code for Institutional Services
2300	CLM05-2	Facility Code Qualifier	A=Uniform Billing Claim Form Bill Type	Expect 'A'
2300	CLM05-3	Claim Frequency Code		This is the third position of the Uniform Billing Claim Form Bill Type For Replacements, use '7' (Replacement of prior claim) For Voids, use '8' (Void/Cancel prior claim)
2300	**CN1**	**CONTRACT INFORMATION**		This segment must always be sent to capture the Health plan Allowed amount
2300	CN101	Contract Type Code		For non-BHS plans, expect any value For BHS plans, expect '05' or '09' 05 Capitated 09 Other (use for FFS)
2300	CN102	Contract Amount		Expect Health plan Allowed amount
2300	**REF**	**REFERRAL NUMBER**	New Segment	SEGMENT NOT USED BY AHCCCS See 2330B/REF OTHER PAYER REFERRAL NUMBER
2300	**REF**	**PRIOR AUTHORIZATION**	# Repeats change to 1	SEGMENT NOT USED BY AHCCCS See 2330B/REF OTHER PAYER PRIOR AUTHORIZATION NUMBER
2300	**REF**	**PAYER CLAIM CONTROL NUMBER**	Name Change	
2300	REF01	Reference Identification Qualifier		Expect 'F8'
2300	REF02	Claim Original Reference Number	Increase from 30 - 50	Expect Payer Claim Control Number If submitting a void transaction, the AHCCCS CRN of the encounter to be adjusted must be included in this field.
2300	**REF**	**MEDICAL RECORD NUMBER**		
2300	REF01	Reference Identification Qualifier		Expect 'EA'
2300	REF02	Medical Record Number	Increase from 30 - 50	2300/REF*EA Medical Record number reported in 277U 2200D/REF*EA

Loop	Reference Element	Description 837-I 5010 A2 ENC	837 Note	AHCCCS Usage/Expected Value (Codes/Notes/Comments)
2300	**REF**	**DEMONSTRATION PROJECT IDENTIFIERS**	Required when it is necessary to identify claims which are atypical in ways such as content, purpose, and/or payment, as could be the case for a demonstration or other special project, or a clinical trial	**Submit when identifying encounters related to a Structured Payment Contract**
2300	REF01	Reference Identification Qualifier		Expect 'P4'
2300	REF02	Medical Record Number	Submit MCO VBP Contract ID (field must be between 3 and 30 characters in length)	Submit MCO VBP Contract ID (field must be between 3 and 30 characters in length)
2300	**HI**	**DIAGNOSIS RELATED GROUP (DRG) INFORMATION**		Required when an inpatient hospital is under DRG contract with a payer and the contract requires the provider to identify the DRG to the payer.
2300	HI01	HEALTH CARE CODE INFORMATION		
2300	HI01-1	Qualifier	DR=Diagnosis Related Group (DRG) Name Change	Expect 'DR'
2300	HI01-2	DRG Code		Expect MCO's Qualified Diagnosis Related Group code - not the provider's DRG. Format **without** hyphen: **DRG(3)SOI(1) ex. 0201**
2300	**HI**	**VALUE INFORMATION**	Includes use of value codes: 80 - Covered Days 82 - Coinsurance Days 83 - Lifetime Reserve Days	Required when there is a Value Code that applies to this claim Birth weight should be submitted in this loop when required (14 days and under). 2300/HIXX-2 - Value Code = '54' 2300/HIXX-5 - Value Code Amount - Birth weight in format per standard
2300	HI01	HEALTH CARE CODE INFORMATION		
2300	HI01-1	Qualifier	BE=Value	Expect 'BE'
2300	HI01-2	Value Code	Includes use of value codes: 80 - Covered Days 82 - Coinsurance Days 83 - Lifetime Reserve Days	Expect Value code
2300	HI01-5	Value Code Amount	Name Change	Expect Value code amount
2310E	**N3**	**SERVICE FACILITY LOCATION ADDRESS**	Name Change	**PO Box or Lock Box not allowed for the Service Facility Address** **Must supply the physical address information**
2310E	N301	Laboratory or Facility Address Line		Expect Laboratory or Facility Address Line "PO Box" or "Lock Box" is not allowed
2320	**CAS**	**CLAIM LEVEL ADJUSTMENTS**		01/08/13: AHCCCS expects Co-pay amounts to be reported at the 2430/CAS segment for Institutional files.

Loop	Reference Element	Description 837-I 5010 A2 ENC	837 Note	AHCCCS Usage/Expected Value (Codes/Notes/Comments)
2320	CAS03	Adjustment Amount		Net Allowed Amount (Approved Amount): Final value of the encounter if paid as FFS after all other payments have been considered Capitated = Amount Paid $0, use CAS*CO*24 segment FFS - Final Net Allowed Amount would not be sent; it is the same as the HP Paid Amount which was already reported
2330B	**NM1**	**OTHER PAYER NAME**		
2330B	NM109	Other Payer Primary Identifier	When sending Line Adjudication Information for this payer, the identifier sent in SVD01 (Payer Identifier) of Loop ID-2430 (Line Adjudication Information) must match this value.	For Health plans, expect 6-character HP ID + 3-character TSN + 1-digit Input Mode For RBHAs: RBHA 6-digit Provider ID + 3-digit TSN + 1-digit Input Mode For Medicare, expect 'MA' or 'MB' For TPL/Other Insurance, expect 'OI' For Health plans: 1000A/NM109=2330B/NM109=2430/SVD01 Other Payer Primary Identifier cannot be more than 9 bytes and must be unique between payers
2330B	**REF**	**OTHER PAYER PRIOR AUTHORIZATION NUMBER**		
2330B	REF01	Reference Identification Qualifier	Code Change	Expect 'G1'
2330B	REF02	Other Payer Prior Authorization Number	Increase from 30 - 50	Expect Prior Authorization Number
2330B	**REF**	**OTHER PAYER REFERRAL NUMBER**	New Segment	
2330B	REF01	Reference Identification Qualifier		Expect '9F'
2330B	REF02	Other Payer Referral Number		Expect Referral Number
2330B	**REF**	**OTHER PAYER CLAIM CONTROL NUMBER**	Required when it is necessary to identify the Other Payer's Claim Control Number in a payer-to-payer COB situation. OR Required when the Other Payer's Claim Control Number is available.	
2330B	REF01	Reference Identification Qualifier		Expect 'F8'
2330B	REF02	Other Payer Claim Control Number		Expect Health Plan Claim ID When the Payer is the Health plan limited to 30 bytes This value is returned in the 277U 2200D/REF*1K 2nd occurrence This value is not returned in the 277CA

Loop	Reference Element	Description 837-I 5010 A2 ENC	837 Note	AHCCCS Usage/Expected Value (Codes/Notes/Comments)
2400	**LX**	**SERVICE LINE**	Name Change	**Currently only allows for 99 lines until a solution is identified to accept 999 lines. Claims with more than 99 lines must manually be split prior to submission.**
2400	**SV2**	**INSTITUTIONAL SERVICE LINE**		
2400	SV205	Service Units/Days	The maximum length for this field is 8 digits excluding the decimal. When a decimal is used, the maximum number of digits allowed to the right of the decimal is three. Name Change	The maximum length allowed for a whole number is eight digits (99999999). When a decimal is used, the maximum number of digits allowed to the right of the decimal is three (99999999.999).
2410	**LIN**	**DRUG IDENTIFICATION**	# Loop Repeats change to 1	Drug Information, including Hemophilia drugs, to be supplied in this segment along with 2410/CTP or 2400/SV2
2410	LIN02	Product or Service ID Qualifier		Expect 'N4'
2410	LIN03	National Drug Code		Expect NDC code
2410	**CTP**	**DRUG QUANTITY**	Part of Drug Rebate project for AZ/HI	
2410	CTP04	National Drug Unit Count	Expect unit count	The maximum length allowed for a whole number is eight digits (99999999). When a decimal is used, the maximum number of digits allowed to the right of the decimal is three (99999999.999).
2410	CTP05	COMPOSITE UNIT OF MEASURE		
2410	CTP05-1	Unit or Basis For Measurement Code	F2 International Unit GR Gram ME Milligram ML Milliliter UN Unit Code Added	Expect Measurement code
2430	**SVD**	**LINE ADJUDICATION INFORMATION**		Currently only allow for one 2430 Loop per payer, per line.
2430	SVD01	Other Payer Primary Identifier	This identifier indicates the payer responsible for the reimbursement described in this iteration of the 2430 loop. The identifier indicates the Other Payer by matching the appropriate Other Payer Primary Identifier (Loop ID-2330B, element NM109).	For Health Plan: 6-digit HP ID + 3-digit TSN + 1-digit Input Mode For RBHAs: RBHA 6-digit Provider ID + 3-digit TSN + 1-digit Input Mode For Medicare, expect 'MA' or 'MB' For TPL/Other Insurance, expect 'OI' For Health plans: For Health plans: 1000A/NM109=2330B/NM109=2430/SVD01

3.3 837 Health Care Claim: Dental – Encounters

Loop	Reference Element	Description 837-D 5010 A2 ENC	Note	AHCCCS Usage/Expected Value (Codes/Notes/Comments)
				Glossary: **NOT USED BY AHCCCS** - AHCCCS does not use the segment or element for processing or updating of the adjudication system (PMMIS). The field may still be required by a Validator. - Follow TR3 guidelines.
				Blue = Header segments
				Light Blue = Billing Provider & Pay To Segments
				Green = Subscriber / Payer/ Patient Segments
				Yellow = Claim Level Segments
				Orange = Line Level Segments
				Bright Green = Specific guidance or use provided to Trading Partner (TP); included in Instruction Table of the Companion Guide (CG)
				Unless otherwise noted, these Notes apply to Paid and Denied encounter files as applicable.
	ISA	**Interchange Control Header**		
	ISA06	Interchange Sender ID		Expect HP Tax ID+6 spaces
	ISA08	Interchange Receiver ID		Expect AHCCCS866004791
	GS	**Functional Group Header**		
	GS02	Application Sender Code		Expect 6-digit HP ID + 3-digit TSN For RBHAs: RBHA 6-digit Provider ID + 3-digit TSN
	GS03	Application Receiver Code		Expect AHCCCS866004791 or AHCCCSDENIED "AHCCCS8660047919"=Use for new day encounters (approved, replaced, voids) "AHCCCSDENIED"=Use for Denied encounter files (.deny; input mode 6)
	GS08	Version Identifier Code		005010X224A2
	ST	**Transaction Set Header**		
	ST03	Implementation Convention Reference	Errata X224A2 New Element	005010X224A2
	BHT	**Beginning of Hierarchical Transaction**		
	BHT06	Claim or Encounter ID		Expect 'RP' Reporting
1000A	**NM1**	**Submitter Name**		

Loop	Reference Element	Description 837-D 5010 A2 ENC	Note	AHCCCS Usage/Expected Value (Codes/Notes/Comments)
1000A	NM109	Submitter Identifier		Expect 6-digit HP ID + 3-digit TSN + 1-digit Input Mode For RBHAs: 079999 + 3-digit TSN + 1-digit Input Mode Input Mode: 2=Adjudicated/New Day Encounter 6=Denied (for use with .deny files) For Health Plans: 1000A/NM109=2330B/NM109=2430/SVD01
1000A	**PER**	**Submitter EDI Contact Information**		**2nd occurrence is for BBA attestation in PER04**
1000A	PER01	Contact Function Code		Expect 'IC' Information Contact
1000A	PER02	Submitter Contact Name		NOT USED BY AHCCCS
1000A	PER03	Communication Number Qualifier		Expect 'EM' Email
1000A	PER04	Communication Number		Expect BBA attestation: TOMYKNOWLEDGEINFORMATIONANDBELIEFTHEDATAINTHISFILEISACCURATECOMPLETEANDTRUE.CERTIFIER@CERTIFIED.COM
1000A	PER05	Communication Number Qualifier		Expect 'EM' Email
1000A	PER06	Communication Number		Expect Contact Email
1000A	PER07	Communication Number Qualifier		Expect 'TE' Telephone
1000A	PER08	Communication Number		Expect Contact Phone
1000B	**NM1**	**Receiver Name**		
1000B	NM103	Receiver Name		Expect 'AHCCCS'
1000B	NM109	Receiver Primary Identifier		Expect 866004791
2010AA	**N4**	**Billing Provider City/State/Zip Code**		
2010AA	N403	Billing Provider Postal Zone or ZIP Code		Expect Billing Provider 9-digit Zip code Health plans are encouraged to submit the full 9-digit zip code; however, a value of '0000' or '9999' is acceptable until the actual zip+4 code is identified and reported on future encounter submissions.
2010BA	**NM1**	**Subscriber Name**		
2010BA	NM109	Subscriber Primary Identifier	Errata X224A2 - Usage changed to Situational	Expect AHCCCS ID (A*, x(9)) For RBHAs: Expect AHCCCS ID (A*, x(9)), State Only ID (S*, X(9)), or CIS ID x(10).
2010BB	**NM1**	**Payer Name**		
2010BB	NM103	Payer Name		Expect 'AHCCCS'
2010BB	NM108	Identification Code Qualifier		Expect "PI"

Loop	Reference Element	Description 837-D 5010 A2 ENC	Note	AHCCCS Usage/Expected Value (Codes/Notes/Comments)
2010BB	NM109	Payer Identifier		Expect 866004791
2010BB	**REF**	**Billing Provider Secondary Identification**	New Segment Moved from 2010AA/REF	Atypical Provider
2010BB	REF01	Reference Identification Qualifier		Expect "G2"
2010BB	REF02	Payer Additional Identifier		Expect 6-digit AHCCCS Provider Registration ID when provider is not eligible for NPI
2300	**CLM**	**Claim Information**		
2300	CLM01	Patient Control Number	The value carried in this element is limited to a maximum of 20 positions.	Expect Patient Account Number This value is not returned in the 277CA This value is returned in the 277U 2200D/TRN02 1st and 2nd occurrence
2300	CLM05-3	Claim Frequency Code		Expect Claim Frequency Code For Replacements, use '7' (Replacement of prior claim) For Voids, use '8' (Void/Cancel prior claim)
2300	**REF**	**Payer Claim Control Number**	Required when CLM05-3 (Claim Frequency Code) indicates this claim is a replacement or void to a previously adjudicated claim. Same for Header and Detail	
2300	REF01	Reference Identification Qualifier		Expect 'F8'
2300	REF02	Payer Claim Control Number		Expect Original CRN If submitting a void transaction, the AHCCCS CRN of the encounter to be adjusted must be included in this field. AHCCCS only accepts professional (837P) and dental (837D) replacements or voids at the header, which replaces or voids all previously submitted lines associated with the first 12 digits of the CRN. When replacing or voiding at the header only the first 12 digits of the CRN should be submitted. For replacements the encounter must reflect the plan's final disposition of all claim lines.
2300	**REF**	**Referral Number**		**SEGMENT NOT USED BY AHCCCS** **See 2330B/REF OTHER PAYER REFERRAL NUMBER**
2300	**REF**	**Prior Authorization**		**SEGMENT NOT USED BY AHCCCS** **See 2330B/REF OTHER PAYER PRIOR AUTHORIZATION NUMBER**
2310B	**REF**	**Rendering Provider Secondary Identification**		Atypical Provider

Loop	Reference Element	Description 837-D 5010 A2 ENC	Note	AHCCCS Usage/Expected Value (Codes/Notes/Comments)
2310B	REF01	Reference Identification Qualifier		Expect 'G2'
2310B	REF02	Rendering Provider Secondary Identifier		Expect 6-digit AHCCCS Provider Registration ID when provider is not eligible for NPI
2310C	**N3**	**Service Facility Location Address**		**PO Box or Lock Box not allowed for the Service Facility Address** **Must supply the physical address information**
2310C	N301	Laboratory or Facility Address Line		Expect Laboratory or Facility Address Line "PO Box" or "Lock Box" is not allowed
2310C	**N4**	**Service Facility Location City/State/ Zip Code**		
2310C	N403	Laboratory or Facility Postal Zone Zip Code		Expect Laboratory or Facility 9-digit Zip code Health plans are encouraged to submit the full 9-digit zip code; however, a value of '0000' or '9999' is acceptable until the actual zip+4 code is identified and reported on future encounter submissions.
2330A	**NM1**	**Other Subscriber Name**		
2330A	NM109	Other Insured Identifier		Expect Other Insured Identifier or AHCCCS ID
2330B	**NM1**	**Other Payer Name**		
2330B	NM109	Other Payer Primary Identifier	When sending Line Adjudication Information for this payer, the identifier sent in SVD01 (Payer Identifier) of Loop ID-2430 (Line Adjudication Information) must match this value.	For Health plans, expect 6-character HP ID + 3-character TSN + 1-digit Input Mode For RBHAs: RBHA 6-digit Provider ID + 3-digit TSN + 1-digit Input Mode For Medicare, expect 'MA' or 'MB' For TPL/Other Insurance, expect 'OI' For Health plans: 1000A/NM109=2330B/NM109=2430/SVD01 Other Payer Primary Identifier cannot be more than 9 bytes and must be unique between payers
2330B	**REF**	**Other Payer Prior Authorization Number**		
2330B	REF01	Reference Identification Qualifier		Expect 'G1'
2330B	REF02	Other Payer Prior Authorization Number		Expect Payer Prior Authorization number
2330B	**REF**	**Other Payer Referral Number**	New segment	
2330B	REF01	Reference Identification Qualifier		Expect '9F'
2330B	REF02	Other Payer Referral Number		Expect Other Payer Referral Number

Loop	Reference Element	Description 837-D 5010 A2 ENC	Note	AHCCCS Usage/Expected Value (Codes/Notes/Comments)
2330B	**REF**	**Other Payer Claim Control Number**		
2330B	REF02	Other Payer Claim Control Number		Expect Health Plan Claim ID When the Payer is the Health plan limited to 30 bytes This value is returned in the 277U 2200D/REF*1K 2nd occurrence This value is not returned in the 277CA
2400	**CN1**	**Contract Information**	New segment Required when the submitter is contractually obligated to supply this information on post-adjudicated claims.	This segment must always be sent for each line to capture the Health plan Allowed amount
2400	CN101	Contract Type Code	01 Diagnosis Related Group (DRG) 02 Per Diem 03 Variable Per Diem 04 Flat 05 Capitated 06 Percent 09 Other (use for FFS)	For non-BHS plans, expect any value For BHS plans, expect '05' or '09' 05 Capitated 09 Other (use for FFS)
2400	CN102	Contract Amount		Expect Health plan Allowed amount Allowed Amount: What would have paid under FFS before other payer
2400	**REF**	**Prior Authorization**		**SEGMENT NOT USED BY AHCCCS**
2400	**REF**	**Referral Number**		**SEGMENT NOT USED BY AHCCCS**
2430	**SVD**	**Line Adjudication Information**		AHCCCS currently allows for one 2430 Loop per payer, per line.
2430	SVD01	Other Payer Primary Identifier	This identifier indicates the payer responsible for the reimbursement described in this iteration of the 2430 loop. The identifier indicates the Other Payer by matching the appropriate Other Payer Primary Identifier (Loop ID-2330B, element NM109).	For Health Plan: 6-digit HP ID + 3-digit TSN + 1-digit Input Mode For RBHAs: RBHA 6-digit Provider ID + 3-digit TSN + 1-digit Input Mode For Medicare, expect 'MA' or 'MB' For TPL/Other Insurance, expect 'OI' For Health plans: For Health plans: 1000A/NM109=2330B/NM109=2430/SVD01
2430	**CAS**	**Line Adjustment**		

Loop	Reference Element	Description 837-D 5010 A2 ENC	Note	AHCCCS Usage/Expected Value (Codes/Notes/Comments)
2430	CAS03	Adjustment Amount		Net Allowed Amount (Approved Amount): Final value of the encounter if paid as FFS after all other payments have been considered Capitated = Amount Paid $0, use CAS*CO*24 segment FFS - Final Net Allowed Amount would not be sent; it is the same as the HP Paid Amount which was already reported

4. TI Additional Information

4.1 Payer Specific Business Rules and Limitations

4.2 Frequently Asked Questions

None available at this time.

4.3 Other Resources

The following Websites provide information for where to obtain documentation for Medicare adopted EDI transactions, code sets and additional resources.

Resource	Web Address
ASC X12 TR3 Implementation Guides	http://store.x12.org
Washington Publishing Company Health Care Code Sets	http://www.wpc-edi.com/content/view/711/401/
To request changes to HIPAA adopted standards	http://www.hipaa-dsmo.org/

5. TI Change Summary

#	Location & Section	Revision
1.3		• Final Version • Removed EDI X12 Proprietary Data to conform to the ASC X12's Fair Use and Copyright standard