837 Professional Medical and Drug

Pennsylvania Specific Encounter Submission Notes

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Overview

This packet contains detailed instructions for preparing 837 Professional Medical and Drug encounter transaction records for all of the different types of services that can be submitted to PROMISe™ in the 837 Professional format. **Please disregard any instructions that do not pertain to the services for which you are submitting.**

One of the terms derived out of *HIPAA* is *payer variability*. As each payer works to make its system HIPAA-compliant, there is a realization and an allowance that payers require information and values/formats specific to their systems. As such, each payer requires that transactions be completed with specific data. This was developed to communicate the Pennsylvania Medical Assistance-specific information required to successfully submit the 837 Professional transaction.

This should be used in conjunction with the CMS *HIPAA Implementation Guide* found at http://www.wpc-edicom. The CMS *HIPAA Implementation Guide* is the main source of information about the transaction sets.

This communicates the Pennsylvania Medical Assistance interpretation/application of the data elements that support encounter transaction submissions and the methods utilized to convey data that are not included in the *CMS HIPAA Implementation Guide*, but are required for processing Pennsylvania Department of Human Services encounter transactions; and Clarification for certain, less obvious, but still standard, uses of the transaction.

Appendix B addresses specific data values needed to process successfully in PROMISe for the following Service Programs:

MBHTH – Behavioral health encounters

MPHTH – Physical health encounters

EPOMS – County CCR submitters

The appendix also addresses the multiple loops and segments used to determine a crossover claim type in PROMISe™.

General Information

PROMIS*e*™ is using 5010 X12 standards. These standards are in compliance with the CMS mandate effective January 1, 2012.

837 File Limits:

Production: Incoming 837 files cannot exceed 75,000 records.
Test: Incoming 837 files cannot exceed 100.
Note: 837 Professional and Professional Drug are two separate encounter types but may come in the same file.

837 File Format:

File	Name	Key
837 Batch Encounters	837JJJSS.MM.zip	837 = constant, JJJ = Julian date, SS - two digit sequence number, MM - plan code

FTP files consist of a base file (vendor data file) zipped into a carrier file. The base file and the zip file are named exactly the same, including the use of upper and lower case letters. If the base file is 837JJJSS.MM, the carrier file is 837JJJSS.MM.zip.

837 Response File Format:

File	Name	Key
277 (Unsolicited) Batch Claim/Encounter Status	UJJSSSSS.MM.zip - production UJJTSSSS.MM.zip – UAT TEST only	U = Constant value, JJ = Last two digits of the Julian day, SSSSS = Sequence number TSSSS = T Sequence number test only
ZZZ Full File Reject Report sent in response to 837 files submitted.	Original file name.zzz.zip See page 16 of Onboarding document for troubleshooting instruction.	This report is sent from the translator in response to incoming HIPAA transaction files.
999 Formatting Reject Report sent in response to 837 files submitted.	Original file name.999.zip See page 16 of Onboarding document for troubleshooting instruction.	This report is sent from the translator in response to incoming HIPAA transaction files.
Transaction Status Summary Report sent in response to 837 files submitted.	Original file name.txn.zip See page 16 of Onboarding document for troubleshooting instructions.	This report is sent from the translator in response to incoming HIPAA transaction files.

Unsolicited HIPAA 277 Response Files

Only one U277 file is generated per plan per processing day. Multiple 837 input files will be included in the single U277. The U277 will include all 837 encounters processed on the previous calendar day from 12:01 AM to 11:59 PM.

Managed Care Encounter Data

The managed care organization (MCO) will be treated as a previous payer and as the submitter.

- The MCO identifies the transaction as an encounter by reporting 'RP' (Reporting) in BHT06 (Transaction Type Code).
- The MCO identifies themselves as the submitter by putting their PROMIS*e*™ MPI Number and Service Location Code into Loop 1000A, Data Element NM109 (Submitter Primary Identifier).
- The MCO identifies themselves as a previous payer by putting their payer information in Loops 2320 and 2330B.
- The MCO identifies their adjudication information by using Loops 2320 and 2430. Pennsylvania PROMIS*e*™ is expecting the value 'HM' in Loop 2320, Data Element SBR09 (Claim Filing Indicator) when the payer is an MCO.
- The MCO must send their MCO-specific internal control number (ICN) in Loop 2330B, Segment REF (Other Payer Claim Control Number), using REF01='F8' as the qualifier.

Loop 2300, Segment CLM, Data Element CLM01 must also contain the MCO's internal control number (ICN). The number that the MCO transmits in this position is echoed back in the 277 Claim Status Response, Detail Level, Loop 2200D (Claim Submitter's Trace Number). TRN02 will be set to the Patient Account Number submitted on the original claim in Loop 2300, Segment CLM, Data Element CLM01.

- The MCO reports sub-capitation arrangements by using the Contract Information segment (CN1) in Loop 2300.
- The MCO must report a claim adjudication date in the 2330B Loop, DTP segment, even when service line adjudication dates are reported in Loop 2430 at the service line level. If there are multiple adjudication dates at the service line level the most recent adjudication date at the service line level should be reported in Loop 2330B.

Newborn Eligibility Claims	In 5010 it is assumed that the subscriber is also the patient. The patient loop does not have a segment to send an MAID. If a patient loop is sent, we will set a newborn indicator. The submitter identifies newborns by using Loops 2000C (Patient Hierarchical Level) and 2010CA (Patient Name).
Ambulance and Transportation Claims	• The submitter must use Loop 2300 segments CR1 (Ambulance Transport Information) and CRC (Ambulance Certification). • Loop 2400 segments CR1 and CRC must be submitted if the information on the service line (Loop 2400) is different from the claim (Loop 2300).
EPSDT Claims	• The submitter must supply the appropriate EPSDT codes in Loop 2300 Segment NTE (Claim Note). • For service lines, the indicator for EPSDT is in Loop 2400 segment SV1 (Service Line), Data Element SV111 (EPSDT indicator). The EPSDT codes applying to the service line may be sent in Loop 2400 segment NTE (Line Note).
General Claim	Pennsylvania PROMIS*e*™ will capture any of the Loops and Segments that are included in the CMS HIPAA Implementation Guide and are sent in the transaction. Where not specifically mentioned in this Transaction Guide, the Loops, Segments, and Data Elements must be used in accordance with the CMS HIPAA Implementation Guide. The transaction must pass HIPAA compliance edits before it can be processed in PROMIS*e*™.
Other Payer Information	PROMIS*e*™ expects the other payer data to be submitted in accordance with the implementation guides for the 837 Professional and 835 Electronic Remittance Advice. Since the 837 Professional is a claim type where payers adjudicate and price individual service lines, the coinsurance, deductible, and copay and other deductions that other payers assigned to the service lines must be reported in the 2430 Loop for the service lines.

Field Name	5010 Values, Functions	PROMISe™ Specific Instructions
ISA: Interchange Control Header		
ISA01: Authorization Information Qualifier	"00" or "03"	Use "00"
ISA02: Authorization Information		Use 10 spaces
ISA03: Security Information Qualifier	"00" or "01"	Use "00"
ISA04: Security Information		Use 10 spaces
ISA05: Interchange ID Qualifier		Use "ZZ"
ISA06: Interchange Sender ID		MCO's assigned BBS ID
ISA07: Interchange ID Qualifier		Use "ZZ"
ISA08: Interchange Receiver ID		Production – "345529167" Testing – "445562154" AKA – DHS BBS ID
ISA09: Interchange Date	YYMMDD format	
ISA10: Interchange Time	HHMM format	
ISA11: Interchange Control Standards Identifier		Suggested Value '^' PROMISe™ does not expect to use the repeating data functionality in 837s.
ISA12: Interchange Control Version Number	"00501"	
ISA13: Interchange Control Number		
ISA14: Acknowledgement Requested		
ISA15: Usage Indicator		
ISA16: Component Element Separator		
GS: Functional Group Header		
GS01: Functional Identifier Code		
GS02: Application Sender's Code		

Field Name	5010 Values, Functions	PROMISe™ Specific Instructions
GS03: Application Receiver's Code		Production - use "345529167" Testing - use "445562154"
GS04: Date		
GS05: Time	HHMM recommended format	HHMM recommended format
GS06: Group Control Number		
GS07: Responsible Agency Code		
GS08: Version, Release, Industry Identifier Code	"005010X222A1"	
ST01: Transaction Set Identifier Code		
ST02: Transaction Set Control Number		
ST03: Implementation Convention Reference	"005010X222A1"	
BHT01: Hierarchical Structure Code		
BHT02: Transaction Set Purpose Code		
BHT03: Originator Application Transaction Identifier		
BHT04: Transaction Set Creation Date		
BHT05: Transaction Set Creation Time		
BHT06: Transaction Type Code		Use "RP" for Encounters
LOOP 1000A: SUBMITTER NAME		
NM101: Entity Identifier Code	"41"	
NM102: Entity Type Qualifier	"1", "2"	
NM103: Name Last or Organizational Name		
NM104: Name First		
NM105: Name Middle		
NM108: Identification Code Qualifier	"46"	
NM109: Submitter Primary Identification Number		MCO or County MPI /Service location Code

Field Name	5010 Values, Functions	PROMISe™ Specific Instructions
PER Submitter Contact EDI Contact Information		
LOOP 1000B: RECEIVER NAME		
NM101: Entity Identifier Code	"40"	
NM102: Entity Type Qualifier	"2"	
NM103: Receiver Name Last or Organizational Name		Use "Department of Human Services"
NM108: Identification Code Qualifier	"46"	
NM109: Receiver Primary Identification Number		Use "236003113"
LOOP 2000A: BILLING PROVIDER HIERARCHICAL LEVEL		
HL Provider Hierarchical Level		
PRV01: Provider Code	"BI"	
PRV02: Reference Identification Qualifier	"PXC"	
PRV03: Provider Specialty Code		PROMISe™ needs the Taxonomy Code for all provider entities who have a Taxonomy Segment
CUR – Foreign Currency Information		PROMISe™ Does not use this segment
LOOP 2010AA: BILLING PROVIDER NAME	LOOP 2010AA: BILLING PROVIDER: Send all required elements. If NPI is being reported it is sent in this loop. PA MPI and service location ID are reported in loop 2010BB. (See FAQ #5 for more details)	
NM101: Entity Identifier Code	"85"	
NM102: Entity Type Qualifier	"1", "2"	
NM103: Billing Provider Last or Organizational Name		
NM104: Billing Provider First Name		
NM105: Billing Provider Middle Name		
NM107: Billing Provider Name Suffix		

Field Name	5010 Values, Functions	PROMISe™ Specific Instructions
NM108: Identification Code Qualifier	"XX" = NPI Situational	
NM109: Billing Provider Identifier	Situational	See Appendix B
N301: Billing Provider Address 1		
N302: Billing Provider Address 2		
N401: Billing Provider's City		
N402: Billing Provider State or Province Code	Situational	
N403: Billing Provider Postal or Zip Code	Situational	PROMISe™ needs the zip code and extension for all provider entities who have an address segment.
N404: Billing Provider Country Code		
REF01: Reference Identification Qualifier	"EI" = FEIN (Required for Billing Providers who are non-persons) "SY"= SSN (Required for Billing Providers who are persons) max length 30	This segment is required for all Billing Providers.
REF02: Billing Provider Tax Identifier		
REF01: Referenced Identification Qualifier	"0B" = License "IG" = UPIN	
REF02: Billing Provider UPIN/License Information		
PER Billing Provider Contact Information		PROMISe™ does not use contact (PER) segments
LOOP 2010AB: PAY-TO ADDRESS NAME PROMISe™ will not use the Pay- To Address Loop		

Field Name	5010 Values, Functions	PROMISe™ Specific Instructions
LOOP 2010AC: PAY-TO PLAN NAME		PROMISe™ will not use the Pay- To Plan Loop
LOOP 2000B: SUBSCRIBER HIERARCHICAL LEVEL		
HL Subscriber Hierarchical Level		
SBR01: Payer Responsibility Sequence Number Code		
SBR02: Relationship Code	"18"	
SBR03: Subscriber Group or Policy Number		
SBR04: Subscriber Group Name		"WM" for women's medical services and non-invasive contraceptive supplies "BC" for breast cancer screenings "FP" for all other Title XX services
SBR05: Insurance Type Code		
SBR09: Claim Filing Indicator Code		PROMISe™ values are "MC" for Medicaid "TV" for Title V "OF" for Title XX
PAT05: Date Time Period Format Qualifier	"D8"	
PAT06: Date of Death		
PAT07: Unit or Basis of Measurement Code	"01" = Pounds	
PAT08: Patient Weight		
PAT09: Pregnancy Indicator	"Y" or not sent	
LOOP 2010BA: SUBSCRIBER NAME		
NM101: Entity Identifier Code	"IL"	
NM102: Entity Type Qualifier	"1"	
NM103: Subscriber Last Name		
NM104: Subscriber First Name		
NM105: Subscriber Middle Name		

Field Name	5010 Values, Functions	PROMISe™ Specific Instructions
NM107: Subscriber Name Suffix		
NM108: Identification Code Qualifier	"MI" = Member Identification Required	
NM109: Subscriber Primary Identifier	Required	This is the PROMISe™ recipient ID
N301: Subscriber Address 1		
N302: Subscriber Address 2		
N401: Subscriber City Name		
N402: Subscriber State or Province Code	Situational	
N403: Subscriber Postal or Zip Code	Situational	
N404: Subscriber Country Code		
DMG01: Date Time Period Format Qualifier	"D8"	
DMG02: Subscriber Birth Date		
DMG03: Subscriber Gender Code	"M", "F", "U"	
REF01: Referenced Identification Qualifier		
REF02: Subscriber Supplemental Identifier		
REF Property Casualty Claim Number		PROMISe™ does not use this segment
PER Property and Casualty Subscriber Contact Information		PROMISe™ does not use contact (PER) segments
Loop 2010BB: Payer: Send all required elements. PA MPI and service location ID are reported in this loop. If NPI is being reported it is sent in Loop 2010AA. (See FAQ #5 for more details)		
NM101: Entity Identifier Code	"PR"	
NM102: Entity Type Qualifier	"2"	
NM103: Payer Name		

Field Name	5010 Values, Functions	PROMISe™ Specific Instructions
NM108: Identification Code Qualifier	"PI", "XV"	
NM109: Payer Primary Identifier		
N301: Payer Address 1		PROMISe™ does not use the Payer Address Segments in Loop 2010BB.
N302: Payer Address 2		PROMISe™ does not use the Payer Address Segments in Loop 2010BB.
N401: Payer City Name	Segment Required	PROMISe™ does not use the Payer Address Segments in Loop 2010BB.
N402: Payer State or Province Code	Situational	PROMISe™ does not use the Payer Address Segments in Loop 2010BB.
N403: Payer Postal or Zip Code	Situational	PROMISe™ does not use the Payer Address Segments in Loop 2010BB.
N404: Payer Country Code		PROMISe™ does not use the Payer Address Segments in Loop 2010BB.
REF01: Referenced Identification Qualifier	“2U”,”EI”, “FY”, “NF”	
REF02: Payer Additional Identifier		
REF01: Referenced Identification Qualifier	"G2" = Commercial Provider Number "LU" = Location	Use "G2" for Atypical Providers' Legacy (MAID)
REF02: Billing Provider Secondary Identification		Atypical Billing Providers will send their Legacy (MAID) here
LOOP 2000C: PATIENT HIERARCHICAL LEVEL	.	
HL Patient Hierarchical Level		

Field Name	5010 Values, Functions	PROMISe™ Specific Instructions
PAT01: Patient's Relationship To Insured		PROMISe™ only accepts value "19"
PAT05: Date Time Period Format Qualifier	“D8”	
PAT06: Patient Death Date		
PAT07: Unit or Basis of Measurement Code	"01" = Pounds	
PAT08: Patient Weight		
PAT09: Pregnancy Indicator	"Y" or not sent	
LOOP 2010CA: PATIENT NAME		
NM101: Entity Identifier Code	"QC"	
NM102: Entity Type Qualifier	"1"	
NM103: Patient Last Name		
NM104: Patient First Name		
NM105: Patient Middle Name		
NM107: Patient Name Suffix		
N301: Patient Address 1		
N302: Patient Address 2		
N401: Patient City Name		
N402: Patient State Code	Situational	
N403 : Patient Postal or Zip Code	Situational	
N404: Patient Country Code		
DMG01: Date Time Period Format Qualifier	“D8”	
DMG02: Patient Birth Date		
DMG03: Patient Gender Code	“F”, “M”, “U”	
REF Property Casualty Claim Number		PROMISe™ does not use this segment

Field Name	5010 Values, Functions	PROMISe™ Specific Instructions
PER Property and Casualty Patient Contact Information		PROMISe™ does not use contact (PER) segments
LOOP 2300: CLAIM INFORMATION		
CLM01: Patient Account Number		See Appendix B.
CLM02: Total Usual Charge		
CLM05: 1 Facility Type Code		See Appendix B.
CLM05: 2 Facility Code Qualifier	"B" = Place of Service Codes for Professional or Dental	See Appendix B.
CLM05: 3 Claim Frequency Code		See Appendix B.
CLM06: Provider or Supplier Signature Indicator	“Y”, “N”	
CLM07: Medicare Assignment Code		This value should be "A" for all PROMISe™ enrolled Billing Providers
CLM08: Benefits Assignment Certification Indicator	"Y", "N"	
CLM09: Release of Information Code		
CLM10: Patient Signature Source Code		
CLM11: 1 Related Causes Code		
CLM11: 2 Related Causes Code		
CLM11: 4 Auto Accident State or Province Code		
CLM11: 5 Country Code		
CLM12: Special Program Code		

Field Name	5010 Values, Functions	PROMISe™ Specific Instructions
CLM20: Delay Reason Code		
DTP01: Date/Time Qualifier	"431"	
DTP02: Date Time Period Format Qualifier	"D8"	
DTP03: Date - Onset of Current Illness or Symptom		
DTP01: Date/Time Qualifier	"454"	
DTP02: Date Time Period Format Qualifier	"D8"	
DTP03: Date - Initial Treatment		
DTP01: Date/Time Qualifier	"304"	
DTP02: Date Time Period Format Qualifier	"D8"	
DTP03: Date - Last Seen		
DTP01: Date/Time Qualifier	"453"	
DTP02: Date Time Period Format Qualifier	"D8"	
DTP03: Date - Acute Manifestation		
DTP01: Date/Time Qualifier	"439"	
DTP02: Date Time Period Format Qualifier	"D8", "DT"	
DTP03: Date - Accident		
DTP01: Date/Time Qualifier	"484"	
DTP02: Date Time Period Format Qualifier	"D8"	
DTP03: Date - Last Menstrual Period		
DTP01: Date/Time Qualifier	"455"	
DTP02: Date Time Period Format Qualifier	"D8"	
DTP03: Date - Last X-Ray		
DTP01: Date/Time Qualifier	"471"	
DTP02: Date Time Period Format Qualifier	"D8"	
DTP03: Date - Hearing and Vision Prescription		

Field Name	5010 Values, Functions	PROMISe™ Specific Instructions
DTP01: Date/Time Qualifier	"360" = Disability From Date "361" = Disability To Date	
DTP02: Date Time Period Format Qualifier	"D8"	
DTP03: Date - Disability Dates		
DTP01: Date/Time Qualifier	"297"	
DTP02: Date Time Period Format Qualifier	"D8"	
DTP03: Date - Last Worked		
DTP01: Date/Time Qualifier	"296"	
DTP02: Date Time Period Format Qualifier	"D8"	
DTP03: Date - Authorized to Return to Work		
DTP01: Date/Time Qualifier	"435"	
DTP02: Date Time Period Format Qualifier	"D8"	
DTP03: Date – Admission		
DTP01: Date/Time Qualifier	"096"	
DTP02: Date Time Period Format Qualifier	"D8"	
DTP03: Date – Discharge		
DTP01: Date/Time Qualifier	"090" or "091"	
DTP02: Date Time Period Format Qualifier	"D8"	
DTP03: Date - Assumed or Relinquished Care Dates		
DTP Property and Casualty Date of First Contact		PROMISe™ will not use this segment
DTP Repricer Received Date		PROMISe™ will not use this segment
PWK01: Attachment Report Type Code		
PWK02: Report Transmission Code		

Field Name	5010 Values, Functions	PROMISe™ Specific Instructions
PWK05: Identification Code Qualifier		
PWK06: Attachment Control Number		
CN101: Contract Type Code	Added “01” – DRG	See Appendix B.
CN102: Contract Amount		
CN103: Contract Percentage		
CN104: Contract Code		
CN105: Terms Discount Percentage		
CN106: Contract Version Number		
AMT01: Amount Qualifier Code	“F5”	Use on 837P to Drug
AMT02: Patient Amount Paid		Use on 837P to Drug
REF01: Reference Identification Qualifier	“4N”	
REF02: Service Authorization Exception Code		
REF01: Reference Identification Qualifier	“F5”	
REF02: Medicare Section 4081 Indicator		
REF01: Reference Identification Qualifier	“EW”	
REF02: Mammography Certification Number		
REF01: Reference Identification Qualifier	"9F" = Referral Number	
REF02: Referral Number		This is the location for Referral Codes
REF01: Reference Identification Qualifier	"G1" = Prior Authorization Number	Use on 837P to Drug
REF02: Prior Authorization Number		Use on 837P to Drug
REF01: Reference Identification Qualifier	"F8"	
REF02: Payer Claim Control Number		See Appendix B.
REF01: Reference Identification Qualifier	"X4"	
REF02: Clinical Laboratory Improvement Amendment Number		

Field Name	5010 Values, Functions	PROMISe™ Specific Instructions
REF Repriced Claim Number		PROMISe™ does not use this segment
REF Adjusted Repriced Claim Number		PROMISe™ does not use this segment
REF01: Reference Identification Qualifier	"LX"	
REF02: Investigational Device Exemption Identifier		
REF01: Reference Identification Qualifier	"D9"	
REF02: Claim Identifier for Transmission Intermediaries		
REF01: Reference Identification Qualifier	"EA"	
REF02: Medical Record Number		
REF01: Reference Identification Qualifier	"P4"	
REF02: Demonstration Project Identifier		
REF01: Reference Identification Qualifier	"1J" = Care Plan Oversight	
REF02: Care Plan Oversight	NA	
K301: Fixed Format Information		
NTE01: Note Reference Code	"ADD", "CER", "DCP", "DGN", "TPO"	Stored only when qualifier = "ADD"
NTE02: Claim Note Text		
CR101: Unit or Basis of Measurement Code	"LB"	
CR102: Patient Weight		
CR104: Ambulance Transport Reason Code		
CR105: Unit or Basis for Measurement Code	"DH"	
CR106: Transport Distance		
CR109: Round Trip or Purpose Description		
CR110: Stretcher Purpose Description		
CR208: Patient Condition Code		
CR210: Patient Condition Description		

Field Name	5010 Values, Functions	PROMISe™ Specific Instructions
CR211: Patient Condition Description		
CRC01: Code Category	"07"	
CRC02: Certification Condition Indicator	"Y" or "N"	
CRC03: Condition Code		
CRC04: Condition Code		
CRC05: Condition Code		
CRC06: Condition Code		
CRC07: Condition Code		
CRC01: Code Category		
CRC02: Certification Condition Indicator	"Y" or "N"	
CRC03: Condition Code		
CRC04: Condition Code		
CRC05: Condition Code		
CRC06: Condition Code		
CRC07: Condition Code		
CRC01: Code Category	"75"	
CRC02: Certification Condition Indicator	"Y" or "N"	
CRC03: Condition Code	"IH"	
CRC01: Code Category	"ZZ"	
CRC02: Certification Condition Indicator	"Y" or "N"	
CRC03: Condition Code		
CRC04: Condition Code		
CRC05: Condition Code		
HI01: 1 Code List Qualifier Code	"BK" = ICD9 Primary Diagnosis "ABK" = ICD10 Primary Diagnosis	http://dhs.pa.gov/cs/groups/webcontent/documents/document/c_213855.pdf
HI01: 2 Diagnosis Type Code		
HI02: 1 Code List Qualifier Code	"BF" = ICD9 Secondary Diagnosis "ABF" = ICD10 Secondary Diagnosis	http://dhs.pa.gov/cs/groups/webcontent/documents/document/c_213855.pdf
HI02: 2 Diagnosis Type Code		
HI03: 1 Code List Qualifier Code	"BF" = ICD9 Secondary Diagnosis "ABF" = ICD10 Secondary Diagnosis	See Appendix B
HI03: 2 Diagnosis Type Code		

Field Name	5010 Values, Functions	PROMISe™ Specific Instructions
HI04: 1 Code List Qualifier Code	"BF" = ICD9 Secondary Diagnosis "ABF" = ICD10 Secondary Diagnosis	See Appendix B
HI04: 2 Diagnosis Type Code		
HI05: 1 Code List Qualifier Code	"BF" = ICD9 Secondary Diagnosis "ABF" = ICD10 Secondary Diagnosis	See Appendix B
HI05: 2 Diagnosis Type Code		
HI06: 1 Code List Qualifier Code	"BF" = ICD9 Secondary Diagnosis "ABF" = ICD10 Secondary Diagnosis	See Appendix B
HI06: 2 Diagnosis Type Code		
HI07 : 1 Code List Qualifier Code	"BF" = ICD9 Secondary Diagnosis "ABF" = ICD10 Secondary Diagnosis	See Appendix B
HI07: 2 Diagnosis Type Code		
HI08: 1 Code List Qualifier Code	"BF" = ICD9 Secondary Diagnosis "ABF" = ICD10 Secondary Diagnosis	See Appendix B
HI08: 2 Diagnosis Type Code		
HI09: 1 Code List Qualifier Code	"BF" = ICD9 Secondary Diagnosis "ABF" = ICD10 Secondary Diagnosis	See Appendix B
HI09: 2 Diagnosis Type Code		

Field Name	5010 Values, Functions	PROMISe™ Specific Instructions
HI10: 1 Code List Qualifier Code	"BF" = ICD9 Secondary Diagnosis "ABF" = ICD10 Secondary Diagnosis	See Appendix B
HI10: 2 Diagnosis Type Code		
HI11: 1 Code List Qualifier Code	"BF" = ICD9 Secondary Diagnosis "ABF" = ICD10 Secondary Diagnosis	See Appendix B
HI11: 2 Diagnosis Type Code		
HI12 : 1 Code List Qualifier Code	"BF" = ICD9 Secondary Diagnosis "ABF" = ICD10 Secondary Diagnosis	See Appendix B
HI12: 2 Diagnosis Type Code		
HI01 : 1 Code List Qualifier Code	"BP" = Anesthesia Related Principal Procedure	
HI01: 2 Anesthesia Related Principal Procedure		
HI01 : 1 Code List Qualifier Code	"BO" = Anesthesia Related Procedure	
HI01: 2 Anesthesia Related Procedure		
HI01 : 1 Code List Qualifier Code	"BG" = Condition Code	
HI01: 2 Condition Code		
HI02 : 1 Code List Qualifier Code	"BG" = Condition Code	
HI02: 2 Condition Code		
HI03: 1 Code List Qualifier Code	"BG" = Condition Code	
HI03: 2 Condition Code		
HI04: 1 Code List Qualifier Code	"BG" = Condition Code	
HI04: 2 Condition Code		
HI05 : 1 Code List Qualifier Code	"BG" = Condition Code	
HI05: 2 Condition Code		
HI06 : 1 Code List Qualifier Code	"BG" = Condition Code	

Field Name	5010 Values, Functions	PROMISe™ Specific Instructions
HI06: 2 Condition Code		
HI07 : 1 Code List Qualifier Code	"BG" = Condition Code	
HI07: 2 Condition Code		
HI08 : 1 Code List Qualifier Code	"BG" = Condition Code	
HI08: 2 Condition Code		
HI09 : 1 Code List Qualifier Code	"BG" = Condition Code	
HI09: 2 Condition Code		
HI10 : 1 Code List Qualifier Code	"BG" = Condition Code	
HI10: 2 Condition Code		
HI11: 1 Code List Qualifier Code	"BG" = Condition Code	
HI11: 2 Condition Code		
HI12 : 1 Code List Qualifier Code	"BG" = Condition Code	
HI12: 2 Condition Code		
HCP Repricer Information		PROMISe™ does not use this segment.
LOOP 2310A: Referring Provider Name		
NM101: Entity Identifier Code	"DN", "P3"	
NM102: Entity Type Qualifier	"1"	
NM103: Referring Provider Last Name		
NM104: Referring Provider First Name		
NM105: Referring Provider Middle Name		
NM107: Referring Provider Name Suffix		
NM108: Identification Code Qualifier	"XX" = NPI Situational	
NM109: Referring Provider Primary Identifier	Situational	See Appendix B

Field Name	5010 Values, Functions	PROMISe™ Specific Instructions
REF01: Reference Identification Qualifier	"0B" = License Number "1G" = UPIN "G2" = Commercial Provider Number	G2 Qualifier here means PROMISe™ Legacy (MAID) Identifier
REF02: Referring Provider Secondary Identifier		
LOOP 2310B: Rendering Provider Name		
NM101: Entity Identifier Code	"82"	
NM102: Entity Type Qualifier	"1", "2"	
NM103: Rendering Provider Last Name		
NM104: Rendering Provider First Name		
NM105: Rendering Provider Middle Name		
NM107: Rendering Provider Name Suffix		
NM108: Identification Code Qualifier	"XX" = NPI Situational	
NM109: Rendering Provider Primary Identifier	Situational	
PRV01: Provider Code	"PE"	
PRV02: Reference Identification Qualifier	"PXC"	
PRV03: Provider Specialty Code		PROMISe™ needs the Taxonomy Code for all provider entities who have a Taxonomy Segment
REF01: Reference Identification Qualifier	"0B" = License Number "1G" = UPIN "G2" = Commercial Provider Number "LU" = Location	G2 Qualifier here means PROMISe™ Legacy (MAID) Identifier
REF02: Rendering Provider Secondary Identification		

Field Name	5010 Values, Functions	PROMISe™ Specific Instructions
LOOP 2310C: Service Facility Location Name		
NM101: Entity Identifier Code	"77" = Facility	
NM102: Entity Type Qualifier	"2"	
NM103: Laboratory or Facility Name		
NM108: Identification Code Qualifier	"XX" = NPI Situational	
NM109: Laboratory or Facility Primary Identifier	Situational	
N301: Laboratory or Facility Address Line 1		
N302: Laboratory or Facility Address Line 2		
N401: Laboratory or Facility City Name		
N402: Laboratory or Facility State or Province Code	Situational	
N403: Laboratory or Facility Postal Zone or Zip Code	Situational	
N404: Laboratory or Facility Country Code		PROMISe™ needs the zip code and extension for all provider entities that have an address segment.
REF01: Reference Identification Qualifier	"0B" = License Number "G2" = Commercial Provider Number "LU" = Location	G2 Qualifier here means PROMISe™ Legacy (MAID) Identifier
REF02: Service Facility Locations Secondary Identification		
PER Service Facility Contact Information		PROMISe™ does not use contact (PER) segments

Field Name	5010 Values, Functions	PROMISe™ Specific Instructions
LOOP 2310D: Supervising Provider Name		
NM101: Entity Identifier Code	"DQ"	
NM102: Entity Type Qualifier	"1"	
NM103: Supervising Provider Last Name		
NM104: Supervising Provider First Name		
NM105: Supervising Provider Middle Name		
NM107: Supervising Provider Name Suffix		
NM108: Identification Code Qualifier	"XX" = NPI Situational	
NM109: Supervising Provider Identifier	Situational	
REF01: Reference Identification Qualifier	"0B" = License Number "1G" = UPIN "G2" = Commercial Provider Number "LU" = Location	G2 Qualifier here means PROMISe™ Legacy (MAID) Identifier
REF02: Supervising Provider Secondary Identifier		
LOOP 2310E: Ambulance Pick-Up Location		
NM101: Entity Identifier Code	"PW" = Ambulance Pickup Location	
NM102: Entity Type Qualifier	"2" = Non-person entity	
NM103: Pickup Location Name		
N301: Ambulance Pickup Address Line		
N302: Ambulance Pickup Address Line		
N401: Ambulance Pickup City		
N402: Ambulance Pickup State		

Field Name	5010 Values, Functions	PROMISe™ Specific Instructions
N403 : Ambulance Pickup Zip Code		
N404: Ambulance Pickup Country Code		
LOOP 2310F: Ambulance Drop-Off Location		
NM101: Entity Identifier Code	"45" = Ambulance Drop-Off Location	
NM102: Entity Type Qualifier	"2" = Non-person entity	
N103: Ambulance Drop-Off Location		
N301: Ambulance Drop-Off Address Line		
N302: Ambulance Drop-Off Address Line		
N401: Ambulance Drop-Off City		
N402: Ambulance Drop-Off State		
N403: Ambulance Drop-Off Zip Code		
N404: Ambulance Drop-Off Country Code		
LOOP 2320: Other Subscriber Information	The MCO identifies themselves as a previous payer by putting their payer information in Loops 2320 and 2330B. The MCO identifies their adjudication information by using Loops 2320 and 2430.	
SBR01: Payer Responsibility Sequence Number Code		
SBR02: Individual Relationship Code		
SBR03: Insured Group or Policy Number		
SBR04: Other Insured Group Name		

Field Name	5010 Values, Functions	PROMISe™ Specific Instructions
SBR05: Insurance Type Code		
SBR09: Claim Filing Indicator Code		Use “HM” for CCR Counties or Managed Care Organizations submitting encounters to PROMISe™. Use “16” for HMO Medicare Risk Use “CI for commercial HMOs
CAS01: Claim Adjustment Group Code		
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		

Field Name	5010 Values, Functions	PROMISe™ Specific Instructions
CAS13: Adjustment Quantity		
CAS14: Adjustment Reason Code		
CAS15: Adjustment Amount		
CAS16: Adjustment Quantity		
CAS17: Adjustment Reason Code		
CAS18: Adjustment Amount		
CAS19: Adjustment Quantity		
AMT01: Amount Qualifier Code	"D"	
AMT02: Payer Paid Amount		
AMT01: Amount Qualifier Code	"A8" = Non-Covered Actual	
AMT02: Noncovered Charges - Actual		
AMT01: Amount Qualifier Code	"EAF" = Remaining Patient Liability	
AMT02: Remaining Patient Liability		
OI03: Benefits Assignment Certification Indicator		
OI04: Patient Signature Source Code		
OI06: Release of Information Code	“I”, “Y”	
MOA01: Reimbursement Rate		
MOA02: HCPCS Payable Amount		
MOA03: Remark Code		
MOA04: Remark Code		
MOA05: Remark Code		
MOA06: Remark Code		
MOA07: Remark Code		
MOA08: End Stage Renal Disease Payment Amount		
MOA09: Non-Payable Professional Component Billed Amount		
LOOP 2330A: Other Subscriber Name		

Field Name	5010 Values, Functions	PROMISe™ Specific Instructions
NM101: Entity Identifier Code	"IL"	
NM102: Entity Type Qualifier	“1”, “2”	
NM103: Other Insured Last Name		
NM104: Other Insured First Name		
NM105: Other Insured Middle Name		
NM107: Other Insured Name Suffix		
NM108: Identification Code Qualifier	"MI" = Member Identification "ZZ" = Mutually defined	
NM109: Other Insured Identifier		See Appendix B
N301: Other Insured Address Line		
N302: Other Insured Address Line		
N401: Other Insured City Name		
N402: Other Insured State Code	Situational	
N403: Other Insured Postal Zone or ZIP Code	Situational	
N404: Country Code		
REF01: Reference Identification Qualifier	"IG" = Insurance Policy Number "SY" = Social Security Number	
REF02: Other Insured Additional Identifier		
LOOP 2330B: Other Payer Name	The MCO identifies themselves as a previous payer by putting their payer information in Loops 2320 and 2330B.	
NM101: Entity Identifier Code	"PR"	
NM102: Entity Type Qualifier	"2"	
NM103: Other Payer Last or Organization Name		

Field Name	5010 Values, Functions	Description of 5010 Change	PROMISe™ Specific Instructions
NM108: Identification Code Qualifier	“PI”, “XV”		
NM109: Other Payer Primary Identifier			See Appendix B
N301: Other Payer Address Line		Segment Added	
N302: Other Payer Address Line		Segment Added	
N401: Other Payer City Name		Segment Added	
N402: Other Payer State Code		Segment Added	
N403: Other Payer Postal Zone or ZIP Code		Segment Added	
N404: Country Code		Segment Added	
DTP01: Date Time Qualifier	"573"		
DTP02: Date Time Period Format Qualifier	“D8”		
DTP03: Claim Check or Remittance Date			See Appendix B.
REF01: Reference Identification Qualifier	"2U" = Payer Identification Number "EI" = Employer’s Identification Number "FY" = Claim Office Number "NF" = National Association of Insurance Commissioners (NAIC) Code	Qualifier for Federal Taxpayer ID changed from TJ to EI	
REF02: Other Payer Secondary Identifier			
REF01: Reference Identification Qualifier	“G1”		
REF02: Other Payer Prior Authorization Number			
REF01: Reference Identification Qualifier	“9F”		
REF02: Other Payer Referral Number			
REF01: Reference Identification Qualifier	“T4”		
REF02: Other Payer Claim Adjustment Indicator			

Field Name	5010 Values, Functions	Description of 5010 Change	PROMISe™ Specific Instructions
REF01: Reference Identification Qualifier	“F8”		MCOs and counties use qualifier F8
REF02: Other Payer Claim Control Number			MCO or county generated ICN
LOOP 2330C: Other Payer Referring Provider			
NM101: Entity Identifier Code	"DN" = Other Payer Referring Provider "P3" = Other Payer Primary Care Provider		
NM102: Entity Type Qualifier	"1"		
NM103: Other Payer Referring Provider Last Name			
REF01: Reference Identification Qualifier	"0B" = License Number "1G" = UPIN "G2" = Commercial Provider Number	List of allowed qualifiers changed	
REF02: Other Payer Referring Provider Identifier			
LOOP 2330D: Other Payer Rendering Provider			
NM101: Entity Identifier Code	"82"		
NM102: Entity Type Qualifier	"1" , "2"		
NM103: Rendering Provider Last or Organization Name			
REF01: Reference Identification Qualifier	"0B" = License Number "1G" = UPIN "G2" = Commercial Provider Number "LU" = Location	List of allowed qualifiers changed	
REF02: Other Payer Rendering Provider Secondary Identifier			
LOOP 2330E: Other Payer Service Facility Location			
NM101: Entity Identifier Code	"77"	Loop Name Changed Entity Type Qualifier only allowed value now is "77"	

Field Name	5010 Values, Functions	Description of 5010 Change	PROMISe™ Specific Instructions
NM102: Entity Type Qualifier	"1" , "2"		
REF01: Reference Identification Qualifier	"0B" = License Number "G2" = Commercial Provider Number "LU" = Location	List of allowed qualifiers changed	
REF02: Other Payer Service Facility Secondary Identifier			
LOOP 2330F: Other Payer Supervising Provider			
NM101: Entity Identifier Code	"DQ"		
NM102: Entity Type Qualifier	"1"		
REF01: Reference Identification Qualifier	"0B" = License Number "1G" = UPIN "G2" = Commercial Provider Number "LU" = Location		
REF02: Other Payer Supervising Provider Identifier			
LOOP 2330G: Other Payer Billing Provider			
NM101: Entity Identifier Code	“85”	New Loop Added	
NM102: Entity Type Qualifier	"1" , "2"	New Loop Added	
REF01: Reference Identification Qualifier		New Loop Added	
REF02: Other Payer Billing Provider Identifier		New Loop Added	
LOOP 2400: Service Line Number			
LX01: Assigned Number			
SV101: COMPOSITE MEDICAL PROCEDURE IDENTIFIER			
SV101-01: Product or Service ID Qualifier		Code List Changed	
SV101-02: Procedure Code			
SV101-03: Procedure Modifier			
SV101-04: Procedure Modifier			

Field Name	5010 Values, Functions	Description of 5010 Change	PROMISe™ Specific Instructions
SV101-05: Procedure Modifier			
SV101-06: Procedure Modifier			
SV102: Line Item Charge Amount			
SV103: Unit or Basis for Measurement Code	“MJ”, “UN”		
SV104: Service Unit Count	“MJ” = 9(4) “UN” = 9(3)V9		
SV105: Place of Service Code			
SV107: COMPOSITE DIAGNOSIS CODE POINTER	Required	Data Element usage changed from situational to required	
SV107-01: Diagnosis Code Pointer			
SV107-02: Diagnosis Code Pointer			
SV107-03: Diagnosis Code Pointer			
SV107-04: Diagnosis Code Pointer			
SV109: Emergency Indicator	“Y” or nothing		
SV111: EPSDT Indicator	“Y” or nothing		
SV112: Family Planning Indicator	“Y” or nothing		
SV115: Co-Pay Status Code	"0"		
SV501-1: Product/Service ID Qualifier	"HC"		
SV501-2: Product/Service ID			
SV502: Unit or Basis of Measurement Code	"DA"		
SV503: Quantity			
SV504: DME Rental Price	Required	Data Element usage changed from situational to required	
SV505: DME Purchase Price	Required	Data Element usage changed from situational to required	
SV506: Frequency Code	"1" weekly, "4" monthly, "6" daily"		
PWK01: Attachment Report Type Code		Code List Changed	
PWK02: Attachment Transmission Code			

Field Name	5010 Values, Functions	Description of 5010 Change	PROMISe™ Specific Instructions
PWK05: Identification Code Qualifier	“AC”		
PWK06: Identification Code			
PWK01: Attachment Report Type Code	“CT”		
PWK02: Attachment Transmission Code			
CR101: Unit or Basis for Measurement Code	"LB"		
CR102: Patient Weight			
CR104: Ambulance Transport Reason Code	A,B,C,D,E		
CR105: Unit or Basis for Measurement Code	“DH”		
CR106: Transport Distance			
CR109: Round Trip Purpose Description			
CR110: Stretcher Purpose Description			
CR301: Certification Type Code	“I”, “R”, “S”		
CR302: Unit or Basis for Measurement Code	“MO”		
CR303: Durable Medical Equipment Duration			
CRC01: Code Category	"07"		
CRC02: Certification Condition Indicator			
CRC03: Condition Code			
CRC04: Condition Code			
CRC05: Condition Code			
CRC06: Condition Code			
CRC07: Condition Code			
CRC01: Code Category	"70"		
CRC02: Hospice Employed Provider Indicator	“N”, “Y”		
CRC03: Condition Indicator	"65"		
CRC01: Code Category			
CRC02: Certification Condition Indicator			
CRC03: Condition Indicator			
CRC04: Condition Indicator			
CRC01: Code Category	"09" = Durable Medical Equipment Certification	Segment Added	

Field Name	5010 Values, Functions	Description of 5010 Change	PROMISe™ Specific Instructions
CRC02 Certification Condition Indicator	"N" = No "Y" = Yes	Segment Added	
CRC03: Condition Indicator	"38" = Certification signed by the physician is on file at the supplier's office, "ZV" = Replacement Item	Segment Added	
CRC04: Condition Indicator	"38" = Certification signed by the physician is on file at the supplier's office, "ZV" = Replacement Item	Segment Added	
DTP01: Date Time Qualifier	"472" – Service Date		Use on 837P to Drug
DTP02: Date Time Period Format Qualifier	"D8", "RD8"		Use on 837P to Drug
DTP03: Date - Service Date	CCYYMMDD, CCYYMMDD-CCYYMMDD		Use on 837P to Drug
DTP01: Date Time Qualifier	"471" = Prescription Date	Segment Added	Use on 837P to Drug
DTP02: Date Time Period Format Qualifier	"D8"	Segment Added	Use on 837P to Drug
DTP03: Date - Prescription Date			Use on 837P to Drug
DTP01: Date Time Qualifier	"607"		
DTP02: Date Time Period Format Qualifier	"D8"		
DTP03: Date - Certification Revision/Recertification Date			
DTP01: Date Time Qualifier	"463"		
DTP02: Date Time Period Format Qualifier	"D8"		
DTP03: Date - Begin Therapy Date			
DTP01: Date Time Qualifier	"461"		
DTP02: Date Time Period Format Qualifier	"D8"		
DTP03: Date - Last Certification Date			
DTP01: Date Time Qualifier	"304"		
DTP02: Date Time Period Format Qualifier	"D8"		

Field Name	5010 Values, Functions	Description of 5010 Change	PROMISe™ Specific Instructions
DTP03: Date - Last Seen Date			
DTP01: Date Time Qualifier	"304"		
DTP02: Date Time Period Format Qualifier	"D8"		
DTP03: Date - Test Performed Date			
DTP01: Date Time Qualifier	"011"		
DTP02: Date Time Period Format Qualifier	"D8"		
DTP03: Date - Shipped Date			
DTP01: Date Time Qualifier	"455"		
DTP02: Date Time Period Format Qualifier	"D8"		
DTP03: Date - Last X-ray Date			
DTP01: Date Time Qualifier	"454"		
DTP02: Date Time Period Format Qualifier	"D8"		
DTP03: Date - Initial Treatment Date			
QTY01: Quantity Qualifier	"PT" = Patients	Segment Added	
QTY02: Ambulance Patient Count		Segment Added	
QTY01 - Quantity Qualifier	"FL" = Units	Segment Added	
QTY02: Obstetric Anesthesia Additional Units		Segment Added	
MEA01: Measurement Reference Identification Code			
MEA02: Measurement Qualifier			
MEA03: Test Results			
CN101: Contract Type Code			See Appendix B.
CN102: Contract Amount			
CN103: Contract Percentage			
CN104: Contract Code			
CN105: Terms Discount Percentage			
CN106: Contract Version Identifier			

Field Name	5010 Values, Functions	Description of 5010 Change	PROMISe™ Specific Instructions
REF: Repriced Line Item Reference Number			PROMISe™ does not use this segment.
REF Adjusted Repriced Line Item Reference Number			PROMISe™ does not use this segment.
REF01: Reference Identification Qualifier	"G1"		
REF02: Prior Authorization			
REF01: Reference Identification Qualifier	"6R"		
REF02: Line Item Control Number			
REF01: Reference Identification Qualifier	"EW"		
REF02: Mammography Certification Number			
REF01: Reference Identification Qualifier	"X4"		
REF02: Clinical Laboratory Improvement Amendment Number			
REF01: Reference Identification Qualifier	"F4"		
REF02: Referring CLIA Number			
REF01: Reference Identification Qualifier	"BT"		
REF02: Immunization Batch Number			
REF01: Reference Identification Qualifier	"9F"		
REF02: Referral Number			
AMT01: Amount Qualifier Code	"T"		
AMT02: Sales Tax Amount			
AMT01: Amount Qualifier Code	"F4"		
AMT02: Postage Claimed Amount			
K301: Fixed Format Information			
NTE01: Note Reference Code	"ADD" = Additional Information "DCP" = Goals, Rehabilitation, or Discharge Plans	Qualifier Added	Only qualifier "ADD" will be used by PROMISe™

Field Name	5010 Values, Functions	Description of 5010 Change	PROMISe™ Specific Instructions
NTE02: Line Note Text			
NTE Third Party Organization Note		Segment Added	PROMISe™ does not use this segment.
PS101: Purchased Service Provider Identifier		Segment Added	
PS102: Purchased Service Charge Amount			
HCP Line Pricing/Repricing Information			PROMISe™ does not use this segment.
LOOP 2410: Drug Identification			
LIN02: Product/Service ID Qualifier	"N4"		Use on 837P to Drug
LIN03: National Drug Code			Use on 837P to Drug
CTP04: National Drug Unit Count			Use on 837P to Drug
CTP05-1: Unit or Basis of Measurement Code	"GR" crosswalks to "GM" “ML” crosswalks to "ML" "UN" crosswalks to "EA"		Use on 837P to Drug
REF01: Reference Identification Qualifier	"XZ" = Pharmacy Prescription Number "VY" = Link Sequence Number	Added new qualifier	Use "XZ" for 837P to Drug
REF02: Prescription Or Compound Drug Association Number	The first 12 digits are used for Rx Number. The 13th digit is used for Refill Number.		Use on 837P to Drug
LOOP 2420A: Rendering Provider Name			
NM101: Entity Identifier Code	"82"		
NM102: Entity Type Qualifier	“1”, “2”		
NM103: Rendering Provider Last or Organization Name			
NM104: Rendering Provider First Name			
NM105: Rendering Provider Middle Name			
NM107: Rendering Provider Name Suffix			

Field Name	5010 Values, Functions	Description of 5010 Change	PROMISe™ Specific Instructions
NM108: Identification Code Qualifier	"XX" = NPI Situational	Changed from required to situational. Can only be sent if the Rendering Provider primary ID is an NPI	
NM109: Rendering Provider Identifier	Situational	Changed from required to situational. Can only be sent if the Rendering primary ID is an NPI	
PRV01: Provider Code	"PE"		
PRV02: Reference Identification Qualifier	"PXC"	Changed qualifier for Taxonomy Codes	PROMISe™ needs taxonomy codes for all provider entities who have a taxonomy code
PRV03: Provider Taxonomy Code			
REF01: Reference Identification Qualifier	"0B" = License Number "1G" = UPIN "G2" = Commercial Provider Number "LU" = Location	List of allowed qualifiers changed	G2 Qualifier here means PROMISe™ Legacy (MAID) Identifier
REF02: Rendering Provider Secondary Identifier			
LOOP 2420B: Purchased Service Provider Name			
NM101: Entity Identifier Code	"QB"		
NM102: Entity Type Qualifier	"1", "2"		
NM108: Identification Code Qualifier	"XX" = NPI Situational	Changed from required to situational. Can only be sent if the Purchased Service Provider primary ID is an NPI	
NM109: Purchased Service Provider Identifier	Situational	Changed from required to situational. Can only be sent if the Purchased Service Provider primary ID is an NPI	
REF01: Reference Identification Qualifier	"0B" = License Number "1G" = UPIN "G2" = Commercial Provider Number	List of allowed qualifiers changed	G2 Qualifier here means PROMISe™ Legacy (MAID) Identifier

Field Name	5010 Values, Functions	Description of 5010 Change	PROMISe™ Specific Instructions
REF02: Purchased Service Provider Secondary Identifier			
LOOP 2420C: Service Facility Location Name			
NM101: Entity Identifier Code	"77"	Entity Type Qualifier only allowed value now is "77"	
NM102: Entity Type Qualifier	"2"		
NM103: Laboratory or Facility Name			
NM108: Identification Code Qualifier	"XX" = NPI Situational	Changed from required to situational. Can only be sent if the Facility primary ID is an NPI	
NM109: Laboratory or Facility Primary Identifier	Situational	Changed from required to situational. Can only be sent if the Facility primary ID is an NPI	
N301: Laboratory or Facility Address Line			
N302: Laboratory or Facility Address Line			
N401: Laboratory or Facility City Name			
N402: Laboratory or Facility State or Province Code	Situational	Usage changed from required to situational. However, the note still requires this data element to be sent.	
N403: Laboratory or Facility Postal Zone or ZIP Code	Situational	Usage changed from required to situational. However, the note still requires this data element to be sent.	
N404: Country Code			
REF01: Reference Identification Qualifier	"G2" = Commercial Provider Number "LU" = Location	List of allowed qualifiers changed	G2 Qualifier here means PROMISe™ Legacy (MAID) Identifier
REF02: Service Facility Location Secondary Identifier			
LOOP 2420D: Supervising Provider Name			
NM101: Entity Identifier Code	"DQ"		

Field Name	5010 Values, Functions	Description of 5010 Change	PROMISe™ Specific Instructions
NM102: Entity Type Qualifier	"1"		
NM103: Supervising Provider Last Name			
NM104: Supervising Provider First Name			
NM105: Supervising Provider Middle Name			
NM107: Supervising Provider Name Suffix			
NM108: Identification Code Qualifier	"XX" = NPI Situational	Changed from required to situational. Can only be sent if the Supervising Provider primary ID is an NPI	
NM109: Supervising Provider Identifier	Situational	Changed from required to situational. Can only be sent if the Supervising Provider primary ID is an NPI	
REF01: Reference Identification Qualifier	"0B" = License Number "1G" = UPIN "G2" = Commercial Provider Number	List of allowed qualifiers changed	G2 Qualifier here means PROMISe™ Legacy (MAID) Identifier
REF02: Supervising Provider Secondary Identifier			
LOOP 2420E: Ordering Provider Name			
NM101: Entity Identifier Code	"DK"		
NM102: Entity Type Qualifier	"1"		
NM103: Ordering Provider Last Name			
NM104: Ordering Provider First Name			
NM105: Ordering Provider Middle Name			
NM107: Ordering Provider Name Suffix			
NM108: Identification Code Qualifier	"XX" = NPI Situational	Changed from required to situational. Can only be sent if the Ordering Provider primary ID is an NPI	
NM109: Ordering Provider Identifier	Situational	Changed from required to situational. Can only be sent if the Ordering primary ID is an NPI	

Field Name	5010 Values, Functions	Description of 5010 Change	PROMISe™ Specific Instructions
N301: Ordering Provider Address Line			
N302: Ordering Provider Address Line			
N401: Ordering Provider City Name			
N402: Ordering Provider State Code	Situational	Usage changed from required to situational. However, the note still requires this data element to be sent.	
N403: Ordering Provider Postal Zone or ZIP Code	Situational	Usage changed from required to situational. However, the note still requires this data element to be sent.	
N404: Country Code			
REF01: Reference Identification Qualifier	"0B" = License Number "1G" = UPIN "G2" = Commercial Provider Number	List of allowed qualifiers changed	G2 Qualifier here means PROMISe™ Legacy (MAID) Identifier
REF02: Ordering Provider Secondary Identifier			
PER Ordering Provider Contact Information		New Segment Added	PROMISe™ does not use contact (PER) segments
LOOP 2420F: Referring Provider Name			
NM101: Entity Identifier Code	"DN", "P3"		
NM102: Entity Type Qualifier	"1"		
NM103: Referring Provider Last Name			
NM104: Referring Provider First Name			
NM105: Referring Provider Middle Name			
NM107: Referring Provider Name Suffix			
NM108: Identification Code Qualifier	"XX" = NPI Situational	Changed from required to situational. Can only be sent if the Referring Provider primary ID is an NPI	
NM109: Referring Provider Identifier	Situational	Changed from required to situational. Can only be sent if the Referring primary ID is an NPI	

Field Name	5010 Values, Functions	Description of 5010 Change	PROMISe™ Specific Instructions
REF01: Reference Identification Qualifier	"0B" = License Number "1G" = UPIN "G2" = Commercial Provider Number	List of allowed qualifiers changed	G2 Qualifier here means PROMISe™ Legacy (MAID) Identifier
REF02: Referring Provider Secondary Identifier			
LOOP 2420G: Ambulance Pick-Up Location			
NM101: Entity Identifier Code	"PW" = Ambulance Pickup Location	Loop Added	
NM102: Entity Type Qualifier	"2" = Non-person entity	Loop Added	
NM103: Pickup Location Name		Loop Added	
N301: Ambulance Pickup Address Line		Loop Added	
N302: Ambulance Pickup Address Line		Loop Added	
N401: Ambulance Pickup City		Loop Added	
N402: Ambulance Pickup State		Loop Added	
N403 : Ambulance Pickup Zip Code		Loop Added	
N404: Ambulance Pickup Country Code		Loop Added	
LOOP 2420H: Ambulance Drop-Off Location			
NM101: Entity Identifier Code	"45" = Ambulance Drop-Off Location	Loop Added	
NM102: Entity Type Qualifier	"2" = Non-person entity	Loop Added	
NM103: Pickup Location Name		Loop Added	
N301: Ambulance Drop-Off Address Line		Loop Added	
N302: Ambulance Drop-Off Address Line		Loop Added	
N401: Ambulance Drop-Off City		Loop Added	
N402: Ambulance Drop-Off State		Loop Added	
N403: Ambulance Drop-Off Zip Code		Loop Added	
N404: Ambulance Drop-Off Country Code		Loop Added	

Field Name	5010 Values, Functions	Description of 5010 Change	PROMISe™ Specific Instructions
LOOP 2430: Service Line Adjudication Information	The MCO identifies their adjudication information by using Loops 2320 and 2430.		
SVD01: Other Payer Primary Identifier			
SVD02: Service Line Paid Amount			
SVD03: COMPOSITE MEDICAL PROCEDURE IDENTIFIER			
SVD03-01: Product or Service ID Qualifier	“ER”, “HC”, “IV”, “WK”		
SVD03-02: Procedure Code			
SVD03-03: Procedure Modifier			
SVD03-04: Procedure Modifier			
SVD03-05: Procedure Modifier			
SVD03-06: Procedure Modifier			
SVD03-07: Procedure Code Description			
SVD05: Paid Service Unit Count			
SVD06: Bundled Line Or Unbundled Number			See Appendix B.
CAS01: Claim Adjustment Group Code			See Appendix B.
CAS02: Adjustment Reason Code			See Appendix B.
CAS03: Adjustment Amount			See Appendix B.
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			

Field Name	5010 Values, Functions	Description of 5010 Change	PROMISe™ Specific Instructions
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			
DTP01: Date Time Qualifier	"573"		
DTP02: Date Time Period Format Qualifier	"D8"		
DTP03: Line Check or Remittance Date			
AMT01: Amount Qualifier Code	"EAF"	Segment Added	
AMT02: Amount Remaining Patient Liability		Segment Added	
LOOP 2440: Form Identification Code			
LQ01: Code List Qualifier Code			
LQ02: Form Identifier			
FRM01: Question Number/Letter			
FRM02: Question Response			
FRM03: Question Response			
FRM04: Question Response			
FRM05: Question Response			
SE01: Transaction Segment Count			
SE02: Transaction Set Control Number			

Insurance Carrier Codes

For the most current list of Carrier codes visit:

https://dpwintra.dpw.state.pa.us/HealthChoices/custom/general/codes/tplreference.asp

Appendix B – Service Program Transaction Guide

Brief Description of Loop/Element	Multiple Loops and Segments Used by PROMIS*e*™ to Determine Crossover Claim Types* 837 Professional Encounter
MBHTH **MPHTH**	BHT06 = "RP" 837 Professional Claim with Medicare Part B as a Payer in Loop 2320 (Loop 2320, SBR09="MB") AND Medicare Part B Claim Amount Paid is greater than zero OR Medicare Part B Claim Level Coinsurance is greater than zero (OR Medicare Part B Claim Level Deductible is greater than zero OR First Service Line Medicare Part B Service Level amount paid is greater than zero OR First Service Line Medicare Service Level Coinsurance amount is greater than zero OR First Service Line Medicare Service Level Deductible amount is greater than zero
	Note: The determination is completed when any one of the OR conditions (Medicare Paid Amount, Medicare Coinsurance Amount, Medicare Deductible Amount) evaluates to true.
EPOMS	No crossover claim types accepted.

*****This information is included to assist those entities submitting encounters in trouble-shooting professional crossover claim type submissions.

Brief Description of Loop/Element	**NM1 – BILLING PROVIDER NAME** **Loop 2010AA**, pages 87 - 90 837 Professional Encounter
MBHTH	Encounters are processed with the DHS issued MPI and service location ID as sent on the PRV414 and PRV415 files to MCOs. When sending NPI identifiers, the NPI must be used as provided on the MPI/service location crosswalk file PRV430. PROMIS*e*™ uses taxonomy codes and zip code + four to resolve a single NPI to one of the many PROMIS*e*™ service location codes that the provider uses. Therefore, it is essential that providers who are sending National Provider IDs (NPI) also provide the taxonomy code and zip code + four that matches their enrollment for the specific service location code that is intended where those codes are available.
MPHTH	The following exception applies to **professional drug encounters only**: **NM108** will contain qualifier 'XX'. **NM109** will contain the billing provider NPI. If the NPI check digit calculates correctly, the NPI will pass billing provider editing; the NPI will not have to be present on the PRV430 NPI crosswalk. For **all other professional encounters**: Encounters are processed with the DHS issued MPI and service location ID as sent on the PRV414 and PRV415 files to MCOs, or the PRV416 file to counties. When sending NPI identifiers, the NPI must be used as provided on the MPI/service location crosswalk file PRV430. PROMIS*e*™ uses taxonomy codes and zip code + four to resolve a single NPI to one of the many PROMIS*e*™ service location codes that the provider uses. Therefore, it is essential that providers who are sending National Provider IDs (NPI) also provide the taxonomy code and zip code + four that matches their enrollment for the specific service location code that is intended where those codes are available.
EPOMS	Encounters are processed with the DHS issued MPI and service location ID as sent on the PRV416 file to counties.

Brief Description of Loop/Element	**CLM: CLAIM INFORMATION** **Loop 2300**, pages 158 - 163 837 Professional Encounter
MBHTH	**CLM01** *must* contain the submitter's Patient Account Number (PAN). The number that the submitter transmits in this position is echoed back to the submitter in the translator accept/reject reports, U277 Claim Status Response, and the 835 Remittance Advice. **CLM05-1** is the Facility Type Code (place of service). Valid values are available to submitters from OMHSAS on the BHSRCC. **CLM05-3** is the Claim Frequency Code. If the encounter is not an adjustment, Loop 2300, Segment CLM, Data Element CLM05-3 (Claim Frequency Code) can contain the value '0' (Non-Payment/Zero Claim), '1' (Admission to Discharge Bill), '2' (Initial Interim Bill), '3' (Interim Continuing Bill), '4' (Interim Last Claim). If the encounter is a **correction to a suspended encounter**, CLM05-3 will contain the value '7' (Replacement). See Loop 2300, REF for additional information when using this claim frequency code. If the encounter is an **adjustment to a paid encounter**, CLM05-3 will contain the value '7' (Replacement). See Loop 2300, REF for additional information when using this claim frequency code. If the encounter is a **cancellation of a previous paid encounter**, CLM05-3 will contain the value '8'(Void). See Loop 2300, REF for additional information when using this claim frequency code.

Brief Description of Loop/Element	**CLM: CLAIM INFORMATION** **Loop 2300,** pages 158 - 163 837 Professional Encounter (Medical)
MPHTH	**CLM01** *must* contain the submitter's Patient Account Number (PAN). The number that the submitter transmits in this position is echoed back to the submitter in the translator accept/reject reports, U277 Claim Status Response, and the 835 Remittance Advice. **CLM05-1** is the Facility Type Code (place of service). Valid values are posted at http://www.dhs.pa.gov/provider/promise/placeofservicecrosswalk/#.V03qMq3ruHs **CLM05-3** is the Claim Frequency Code. If the encounter is an **Admit through Discharge encounter**, CLM05-3 will contain the value '1' (a.k.a.: Original/New Day) If the encounter is a **correction to a suspended encounter**, CLM05- 3 will contain the value '7' (Replacement). See Loop 2300, REF for additional information when using this claim frequency code. If the encounter is an **adjustment to a paid encounter**, CLM05-3 will contain the value '7' (Replacement). See Loop 2300, REF for additional information when using this claim frequency code. If the encounter is a **cancellation of a previous paid encounter**, CLM05-3 will contain the value '8' (Void). See Loop 2300, REF for additional information when using this claim frequency code.

Brief Description of Loop/Element	**CLM: CLAIM INFORMATION** **Loop 2300,** pages 158 - 163 837 Professional Encounter (Drug)
MPHTH	**CLM01** *must* contain the submitter's Patient Account Number (PAN). The number that the submitter transmits in this position is echoed back to the submitter in the translator accept/reject reports, U277 Claim Status Response, and the 835 Remittance Advice. **CLM05-1** is the Facility Type Code (place of service). Valid values are posted at http://www.dhs.pa.gov/provider/promise/placeofservicecrosswalk/#.V03qMq3ruHs If the encounter is reporting Long Term Care or ICFMR, CLM05-1 will contain the value '32' (Nursing Facility) or '54' (Intermediate Care Facility/Mentally Retarded) **CLM05-3** is the Claim Frequency Code. If the encounter is an **Admit through Discharge encounter**, CLM05-3 will contain the value '1' (a.k.a.: Original/New Day) If the encounter is a **correction to a suspended encounter**, CLM05-3 will contain the value '8' (Void). See Loop 2300, REF for additional information when using this claim frequency code.

Brief Description of Loop/Element	**CLM: CLAIM INFORMATION** **Loop 2300,** pages 158 - 163 837 Professional Encounter
EPOMS	**CLM01** *must* contain the submitter's Patient Account Number (PAN). The number that the submitter transmits in this position is echoed back to the submitter in the translator accept/reject reports, U277 Claim Status Response, and the 835 Remittance Advice. **CLM05-1** is the Facility Type Code (place of service). Valid values are available to CCR submitters from OMHSAS for EPOMS.

Brief Description of Loop/Element	**CN1: CONTRACT INFORMATION** **Loop 2300** claim level, pages 186 - 187 837 Professional Encounter
MBHTH	No business rule exceptions for use, follow IG guidance.
MPHTH	Not applicable on MCO denied encounters. MCO paid/approved encounters must have a CN1 segment at the header or the detail. The value sent in this loop will apply to each line. **If different CN1 values are need for different service lines, use the CN1 in loop 2400 at the LX level to designate the value for each service line.** The following values *cannot* be sent on professional claim level, CN101: 01 Diagnosis Related Group (DRG) 02 Per Diem 3 Variable Per Diem The following value must be sent in the CN101 when MCO, Medicare or TPL payment amounts are sent: 4 Flat The following values can only be sent in the CN101 when no MCO payment amount is sent (regardless of any Medicare or TPL payment amounts sent):
	5 Capitated 6 Percent See also Loop 2430, CAS for appropriate claim adjustment reason codes for CN101 values 04, 05, 06.
EPOMS	Used to indicate alternative payment arrangements when no paid amount is reported by the county. In CN101 report value: 05 Capitated If the county reports an amount paid, no value is sent in CN101.

Brief Description of Loop/Element	**REF: PAYER CLAIM CONTROL NUMBER** **Loop 2300**, page 196 837 Professional Encounter
MBHTH **MPHTH**	If the claim frequency code in CLM05-3 is '7' or '8', REF01 will contain the value 'F8', REF02 will contain the Last PROMIS*e*™ 13-digit Approved or Adjustment ICN.
EPOMS	If the claim frequency code in CLM05-3 is '8', REF01 will contain the value 'F8', REF02 will contain the Last PROMIS*e*™ 13-digit Approved or Adjustment ICN.

Brief Description of Loop/Element	**HI: ALL HI SEGMENTS IN LOOP** **Loop 2300**, pages 226 - 238 837 Professional Encounter
MBHTH	Providers must not mix ICD9 and ICD10 Diagnosis Codes in the same claim. Valid values are available to submitters from OMHSAS on the BHSRCC.
MPHTH	Providers must not mix ICD9 and ICD10 Diagnosis Codes in the same claim. (See FAQ #6 for more information)
EPOMS	Providers must not mix ICD9 and ICD10 Diagnosis Codes in the same claim Valid values are available to submitters from OMHSAS for EPOMS.

Brief Description of Loop/Element	**NM1: REFERRING PROVIDER NAME** **Loop 2310A**, pages 257 - 259 837 Professional Encounter
MBHTH	No business rule exceptions for use, follow IG guidance.
MPHTH	The following exception applies to **professional drug encounters only** (Region 24- Professional Drug): **NM108** will contain qualifier 'XX'. **NM109** will contain the prescriber provider NPI. If the NPI check digit calculates correctly, the NPI will pass billing provider editing; the NPI will not have to be present on the PRV430 NPI crosswalk. For **all other professional encounters**: Encounters are processed with the DHS issued MPI and service location ID as sent on the PRV414 and PRV415 files to MCOs, or the PRV416 file to counties. When sending NPI identifiers, the NPI must be used as provided on the MPI/service location crosswalk file PRV430.
EPOMS	No business rule exceptions for use, follow IG guidance.

Brief Description of Loop/Element	**DTP: CLAIM CHECK OR REMITTANCE DATE** **Loop 2330B**, page 325 837 Professional Encounter
MBHTH **MPHTH** **EPOMS**	The MCO must report a claim adjudication date in the 2330B Loop, DTP segment, even when service line adjudication dates are reported in Loop 2430 at the service line level. If there are multiple adjudication dates at the service line level the most recent adjudication date at the service line level should be reported in Loop 2330B.

Brief Description of Loop/Element	**SVD: LINE ADJUDICATION INFORMATION** **Loop 2430**, pages 480 – 483 837 Professional Encounter
MBHTH	No business rule exceptions for use, follow IG guidance
MPHTH	Data element SVD06 must be used with CAS02 values '97' and '59'. SVD06 is only used for bundling of service lines. It references the LX Assigned Number of the service line into which this service line was bundled.
EPOMS	No business rule exceptions for use, follow IG guidance

Service Line Bundling

In the example below, service lines 1, 2, and 3, are bundled. Lines 1 and 2 are the non-paid lines of the bundled group. Line 3 is the paid line of the bundled group.

LX*1
SV1*HC:A***0***UN*1***1**N
DTP*472*RD8*20090301-20090301
CN1*04
SVD*PAYERID***0***HC:C**1***3**

CAS*CO***97***0***1
DTP*573*D8*20090312

LX*2
SV1*HC:B***0***UN*1***1**N
DTP*472*RD8*20090301-20090301
CN1*04
SVD*PAYERID***0***HC:C**1***3**

CAS*CO***97***0***1
DTP*573*D8*20090312

LX*3
SV1*HC:C***200***UN*1***1**N
DTP*472*RD8*20090301-20090301
CN1*04
SVD*PAYERID***50***HC:C**1*

CAS*CO***59***150***1
DTP*573*D8*20090312

LX*1and LX*2 have a billed amount of **$0**, a paid amount of **$0**, and an adjusted amount of **$0**, with a claim adjustment reason code (CARC) of **'97'**. The use of '97' indicates this line is paid with/on another line. The SVD06 pointer indicates lines 1 and 2 are paid on line **3**.

The billed amounts from all bundled lines are summed in LX*3 as **$200.** The MCO indicates **$50** was paid for these bundled services. **CARC '59' indicates this is the paid line of a bundled group so the financial transaction must be on the paid line.** The MCO adjusted off **$150** and has kept the rule that the paid amount and the adjusted amount must equal the billed amount (**50** +**150** = **200**).

For additional information regarding paid, unpaid and bundling CAS visit:
https://dpwintra.dpw.state.pa.us/HealthChoices/custom/program/encounter/promise/documents/5010_matrix_table.xls

Brief Description of Loop/Element	**CAS - LINE ADJUSTMENT** **Loop 2430**, pages 484 – 489 837 Professional Encounter
MBHTH	No business rule exceptions for use, follow IG guidance. **To indicate MCO recipient co-pay amount:** In segment CAS01 send value 'PR'. In segment CAS02 send value '3'. In segment CAS03 send the dollar value of the co-pay.
MPHTH	CAS is required on all physical health professional encounters at the service line. **If CN101 has a value '04' and the service line is not bundled:** In segment CAS01 send value 'CO'. In segment CAS02 send value '24'. In segment CAS03 send the adjustment amount. **If CN101 has a value '04' and the service line is a non-paid line of a bundled group:** In segment CAS01 send value 'CO'. In segment CAS02 send value '97'. In segment CAS03 send the dollar value of zero, '0'. **If CN101 has a value '04' and the service line is a paid line of a bundled group:** In segment CAS01 send value 'CO'. In segment CAS02 send value '59'. In segment CAS03 send the adjustment amount.

See "Service Line Bundling" with Loop 2430, SVD.

If the service line is denied by the MCO,

(continued on next page)

there will be no CN1 value.

In segment CAS01 send value 'CO'

In segment CAS02 send one of the following appropriate values:

'29' MCO denied, claim submitted after filing deadline

'96' MCO denied, service not covered

'15' or '62' MCO denied, service not referred/authorized

'22' MCO denied, other coverage

In segment CAS03 send the dollar value of zero, '0'.

If CN101 has a value '05' indicating capitated service:

In segment CAS01 send value 'CO'.

In segment CAS02 send value '24'.

In segment CAS03 send the dollar value of zero, '0'.

If CN101 has a value '06' indicating service paid by percent:

In segment CAS01 send value 'CO'.

In segment CAS02 send value '24'.

In segment CAS03 send the dollar value of zero, '0'.

To indicate MCO recipient co-pay amount:

In segment CAS01 send value 'PR'.

In segment CAS02 send value '3'.

	In segment CAS03 send the dollar value of the co-pay. When sending the MCO co-pay, the MPHTH specified values will come first, followed by the MCO co-pay: CAS*CO*24*47.81 CAS*PR*3*2 PROMISe™ will regard the amount with the qualifier PR and CAS02 value of 3 as the MCO co-pay amount.
EPOMS	No business rule exceptions for use, follow IG guidance.

FREQUENTLY ASKED QUESTIONS (FAQ)

1. Q: What does F2:21 deny on the service line for a "void request" on a U277 indicate?
   A: If the U277 is in response to a void request on a previously paid encounter, the void response will indicate F0 at the header and F2:21 at the service line. The U277 response for a void request will be:

   - F0:293 for Behavioral Health encounters or
   - F0:335 for Physical Health encounters

   The service line will be returned with the default deny, which is the same for Behavioral and Physical Health encounters, F2:21. This response indicates the void transaction is successful and requires no action.

2. Q: Who do we contact if we have encounter questions?
   A: Physical Health MCO email PH_Encounter@pa.gov
   Behavioral Health MCO email OMHSAS-837Issues@pa.gov

3. Q: Why did we receive ESC *4280 for a zero paid drug?*
   A: ESC 4280 will deny drug encounters that are $0 plan paid, $0 TPL paid and $0 co-pay. Currently, PROMISe™ does not capture CN1 capitated (05) for drug encounters.

4. Q: How do we submit bundled encounters?
   A: Use CARC- CAS Detail of '97' to submit any non-paid lines '59' for paid line. For additional information visit:
   https://dpwintra.dpw.state.pa.us/HealthChoices/custom/program/encounter/promise/documents/bundling_service_lines_how_to.doc

5. Q: Where can I obtain additional information regarding the new ACA requirement that explains the secondary identifier must be present for the billing and rendering ID fields?
   A: See Quick Tips on Submission of Secondary ID for Rendering and Billing Provider ID at
   http://www.dhs.pa.gov/cs/groups/webcontent/documents/communication/c_233618.pdf

6. Q: Where do we find information on ICD-9 and ICD-10?
   A: See link at http://www.dhs.pa.gov/provider/icd10information/P_012571#.VmmqVa3ruHs

7. Q: Is there a limit to the number of details accepted by PROMISe on a Professional?
   A. Professional has a max of 50 details. Professional drugs only have 1 line of detail.