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**South Carolina Department of Health and Human Services**

HIPAA Transaction  
Standard Companion Guide

Refers to the Implementation Guides Based on X12 version 005010A1

Companion Guide Version Number: 2.4

January 2013

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## **Preface**

This Companion Guide to the ASC X12N Implementation Guides adopted under HIPAA clarifies and specifies the data content when exchanging electronically with South Carolina Department of Health and Human Services. Transmissions based on this companion guide, used in tandem with the X12N Implementation Guides, are compliant with both X12 syntax and those guides. This Companion Guide is intended to convey information that is within the framework of the ASC X12N Implementation Guides adopted for use under HIPAA. The Companion Guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the Implementation Guides.

2013

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## Table of Contents

Disclosure Statement.....	2
Preface .....	3
1. Introduction .....	7
Scope.....	8
Overview .....	8
HIPAA Legislation .....	8
Compliance according to HIPAA .....	8
Compliance according to ASC X12 .....	9
References .....	9
2. Getting Started.....	9
Working with SCDHHS .....	9
Trading Partner Registration.....	9
Providers .....	9
Vendors/Clearinghouses.....	9
Transition from Test to Production Status.....	11
3. Connectivity with the Payer/ Communications .....	12
EDI Customer Service/Technical Assistance .....	12
Provider Service Number .....	13
Applicable Websites / Email .....	13
4. Control Segments / Envelopes.....	13
5. Payer Specific Business Rules and Limitations.....	13
ISA and Case Requirements .....	13
Delimiter Rules.....	14
6. Acknowledgments/Reports .....	14
7. Trading Partner Agreements.....	14
Trading Partners.....	14
Providers .....	15
Vendors/Clearinghouses.....	15
Completion of the S.C. Medicaid Trading Partner Agreement .....	15
8. Transaction Specific Information .....	16
Appendix .....	31

**South Carolina Department Health & Human Services 837 Professional Companion Guide**

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1. Frequently Asked Questions ..... 31

2. Change Summary ..... 31

## 1. Introduction

This section describes how X12N Implementation Guides (IGs) adopted under HIPAA will be detailed with the use of a table. The table contains a row for each segment that South Carolina Department of Health and Human Services (SCDHHS) has something additional, over and above, the information in the IGs. That information can:

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

In addition to the row for each segment, one or more additional rows are used to describe SCDHHS usage for composite and simple data elements and for any other information. The following table is an example:

SHADED Rows represent “ <b>segments</b> ” in the X12N Implementation Guide.
NON-SHADED rows represent “ <b>data elements</b> ” in the X12N Implementation Guide.

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
HDR	ISA	Interchange Control Header		1	R	Loop Repeat	Values	Requirement Description
HDR	ISA01	Authorization Information Qualifier	ID	2-2	R		00, 03	
HDR	ISA03	Security Information Qualifier	ID	2-2	R		00, 01	
HDR	ISA05	Interchange ID Qualifier	ID	2-2	R		01, 14, 20, 27, 28, 29, 30, 33, ZZ	Use ‘ZZ’ – Mutually Defined

## Scope

This 837 Health Care Claim: Professional Companion Guide (CG) is to be used in addition to the X12 Implementation Guide, adopted for use under HIPAA.

This Companion Guides contains two types of data; instructions for electronic communications with SCDHHS (Communications/Connectivity Instructions) and supplemental information for creating transactions for SCDHHS while ensuring compliance with the associated ASC X12 IG (Transaction Instructions).

The Transaction Instruction component is included in the CG when SCDHHS 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.

## Overview

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.

### 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 transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard HIPAA serves to:

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

### 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).

### **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.

## **References**

The CORE v5010 Master Companion Guide Template has been adapted from the CAQH/WEDI Best Practices Companion Guide Template originally published January 1, 2003.

## **2. Getting Started**

### **Working with SCDHHS**

Should you intend to conduct electronic transactions with South Carolina Medicaid, you must first complete and return a Trading Partner Agreement (TPA) to South Carolina Medicaid Provider Outreach. The TPA delineates the responsibilities of both the provider and SCDHHS.

Once South Carolina Medicaid Provider Outreach staff receives your completed TPA, they will contact you to give instructions on how to proceed. Should you intend to create files and send them yourself; the S.C. Medicaid EDI Support Center staff will set up an electronic mailbox for you, assign you a user I.D. and password, and notify you that you may submit a transaction for testing. The testing process evaluates both the format of content of your transaction to ensure it is HIPAA compliant.

If you plan to use a clearinghouse to conduct your transactions, it will not be necessary to set up a mailbox for you, nor for you to test with S.C. Medicaid.

### **Trading Partner Registration**

#### **Providers**

Trading Partner Agreement Enrollment Instructions for Providers can be found on the scdhhs.gov website or <http://www.scdhhs.gov/resource/hipaa-5010-project-status>

#### **Vendors/Clearinghouses**

Trading Partner Agreement Enrollment Instructions for Vendors and Clearinghouses can be found on the scdhhs.gov website: <http://www.scdhhs.gov/resource/hipaa-5010-project-status>

The Trading Partner Agreement Enrollment (TPA) form may be found online at:

<http://www.scdhhs.gov/resource/hipaa-5010-project-status>

**Testing with the Payer**

Becoming HIPAA compliant will require that most healthcare payers, clearinghouses and providers make significant changes to their existing Electronic Data Interchange (EDI) processes. Process change inevitably includes testing for results validation. This testing can be one of the most time consuming efforts in the development cycle. SC Medicaid expects the following approach will optimize test time and expedite our Trading Partners’ transition from test to production status.

The following must be performed for each different transaction type that a Trading Partner is approved to submit to SC Medicaid.

The Trading Partner must complete testing for each of the transactions it will implement and shall not be allowed to exchange data with SCDHHS in production mode until testing is satisfactorily passed as determined by SCDHHS. Successful testing means the ability to successfully pass HIPAA compliance checking and to process PHI transmitted by Trading Partner to SCDHHS. SCDHHS will accept certification from any third-party testing and certification entity that has been identified by the Workgroup for Electronic Data Interchange, Strategic National Implementation Process (WEDI/SNIP) in lieu of a Trading Partner being tested by SCDHHS. Such certification must be at least level 4 as defined by WEDI.

Test Step	Description
<b>Test Plan</b>	The SC Medicaid EDI Support Center and the Trading Partner will agree to a predefined set of test data with expected results. The matrix will vary by transaction and Trading Partner. Also, we will develop a plan for test-to production transition that considers volume testing and transaction acceptance ratios.
<b>Security</b>	The SC Medicaid EDI Support Center will verify approved Trading Partners have a valid User ID and password.
<b>Connectivity and Transmission Integrity</b>	<p>SC Medicaid Axiom translator-supported connectivity protocols are outlined in the “Understanding Access to SC Medicaid” section of this manual. This first level of testing is complete when the Trading Partner has successfully sent to and received from SC Medicaid Axiom translator a test file via one of the SC Medicaid Axiom translator-supported connectivity options.</p> <p>The SC Medicaid EDI Support Center suggests the Trading Partner limit transactions to small volume (one percent of estimated daily transactions) for this test phase.</p>

<b>Transaction Validation</b>	The SC Medicaid EDI Support Center will verify that approved Trading Partners are submitting transactions allowed per our enrollment applications.
<b>Data Integrity</b>	<p>Data integrity is determined by X12 and HIPAA Implementation Guide (IG) Level 4 compliance edits performed by the SC Medicaid Axiom translator.</p> <p>The SC Medicaid EDI Support Center will ask a Trading Partner to first submit low volume files. When these are successfully processed, the SC Medicaid EDI Support Center will ask for larger volume files (five percent of estimated daily transactions).</p> <p>The SC Medicaid Axiom translator returns transmission acknowledgement and edit result response transactions from this process.</p> <p>The Trading Partner should correct transactions reported as errors and resubmit them.</p> <p>Data integrity testing is successfully completed when the Trading Partner’s data has no compliance errors; i.e., achieves 100% acceptance.</p>
<b>Acknowledgement and Response Transactions</b>	<p>Trading Partners must demonstrate the ability to receive acknowledgement and response transactions.</p> <p>The SC Medicaid Axiom translator expects Trading Partners will also implement balancing or reconciliation processes and report transmission discrepancies to us immediately.</p>
<b>Results Analysis</b>	SC Medicaid EDI Support Center and the Trading Partner will review acknowledgement and response transactions for consistency with the predefined expected results.

**Transition from Test to Production Status**

The Trading Partner must complete testing for each of the transactions it will implement and will not be allowed to exchange data with SC Medicaid in production mode until testing is satisfactorily passed. SC Medicaid will accept certification from any third-party testing and certification entity that has been identified by the Workgroup for Electronic Data Interchange, Strategic National Implementation Process (WEDI/SNIP) in lieu of a Trading Partner being tested by SC Medicaid. Such certification must be at least level 4 as defined by WEDI.

When the test results have been satisfied, the Trading Partner’s submission status will be changed from test to production. At this time, the Trading Partner can begin to send production transaction data to SC Medicaid.

### 3. Connectivity with the Payer/ Communications

#### EDI Gateway

McaidNET is the EDI gateway to SC Medicaid. Effective 03/01/2009, no new modem accounts will be created. Effective 07/01/2009, the modem server will no longer be available. The following are communication packages that will be supported:

- SecureFTP
- WS\_FTP Pro v8.0 or higher

McaidNET is defaulted to send uncompressed files.

**Note:** McaidNET supports file transfers via secure File Transfer Protocol (FTP). Specifications on these options are included later in this manual.

SC Medicaid accepts the following ASC X12N Version 5010 (Errata) transactions, required with the implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA):

- Dental Claim: ASC X12N 837D 005010X224A2 - Health Care Claim: Dental
- Professional Claim: ASC X12N 837P 005010X222A - Health Care Claim: Professional
- Institutional Claim: ASC X12N 837I 005010X223A2 - Health Care Claim: Institutional
- Health Claim Status: ASC X12N 276/277 005010X212 - Health Care Claim Status Request
- Eligibility for a Health Plan: ASC X12N 270/271 005010X279A1 - Health Care Eligibility Benefit Inquiry
- Premium Payment: ASC X12N 820 005010X218A1
- Enrollment: ASC X12N 834 005010X220A1
- Claim Payment: ASC X12N 835 005010X221A1

The McaidNET platform is available 24 hours a day, seven days a week, with the exception of infrequent maintenance performed on Sundays.

If you have any questions regarding the McaidNET platform, please call the SC Medicaid EDI Support Center toll-free at 1-888-289-0709, Option 1 then Option 1.

Access the Communications Manual online: <http://www.scdhhs.gov/resource/hipaa-5010-project-status>

#### Contact Information

#### EDI Customer Service/Technical Assistance

The South Carolina Medicaid EDI Support Center can assist you with your questions about HIPAA-related transactions, code sets and related provider training opportunities.

Call 1-888-289-0709 or Email [EDIG.OPS-MCAID@palmettogba.com](mailto:EDIG.OPS-MCAID@palmettogba.com)

### **Provider Service Number**

The South Carolina Provider Service department can assist you with your questions at 1-888-289-0709 or by submitting an inquiry at [Provider Inquiry](#).

### **Applicable Websites / Email**

Provider Services: <http://www.scdhhs.gov/organizations>

Contact a Provider Service Representative: <http://www.scdhhs.gov/contact-us>

To ensure receipt and processing of claims for services, providers are reminded that all hardcopy Medicaid claims and corrected Edit Correction Forms (ECF) must be mailed to:

Medicaid Claims Receipt  
Post Office Box 1412  
Columbia, South Carolina 29202-1412

Updates to provider information should be mailed to:

Medicaid Provider Enrollment  
Post Office Box 8809  
Columbia, South Carolina 29202-8809

Updates and changes will continue to be posted to our website at [www.scdhhs.gov](http://www.scdhhs.gov) as we continue to improve the services that we provide to both Medicaid providers and beneficiaries. Please continue to review your Medicaid Policy manual for additional policy changes and updates.

## **4. Control Segments / Envelopes**

ASC X12 transaction envelopes (i.e., ISA, IEA, GS and GE segments) should be populated per instructions found in the South Carolina Communications Manual. Transactions returned by SC Medicaid to the Trading Partner will be enveloped consistent with the specifications described in Example 1B. ASC X12 transaction record formats are available as downloads from the Washington Publishing Company (WPC) Web site (<http://wpc-edi.com/>).

## **5. Payer Specific Business Rules and Limitations**

### **ISA and Case Requirements**

1. Trading Partners must envelope (ISA-IEA) different transactions separately.

2. SC Medicaid’s compliance edits reject the ISA-IEA content when any transaction within that ISAIEA is not 100% compliant.
3. SC Medicaid’s processes will perform a case conversion (to UPPERCASE) on all EDI data.

### Delimiter Rules

1. The delimiters for the inbound X12 transaction sets will be:  
CR/LF Carriage return and line feed for segment terminator (upon request the ~ Tilde can be used for those partners unable to process the CR/LF)
2. The delimiters set by SC Medicaid for the outbound X12 transaction sets will be:  
CR/LF Carriage return and line feed for segment terminator (upon request the ~ Tilde can be used for those partners unable to process the CR/LF)

## 6. Acknowledgments/Reports

SCDHHS will send an Acknowledgment Medic Report- an HTML summary of the transaction via 999 and 997.

### Sample of Medic Report

This report contains health care information and should be handled in accordance with appropriate security and privacy procedures. The report relies on potentially non-compliant structures and may contain errors or other erroneous output.

File Summary	
Sender ID:	<b>Applicable information populates here.</b>
Receiver ID:	
File Name:	
File Path:	
Report Date / Time:	

Claim #	Provider ID	Sub Last	Amount	Status
Claims Total:	<b>Applicable information populates here.</b>			
Claims Excluded:				
Claims Included:				
Value of Claims:				
Value of Claims Excluded:				
Value of Claims Included:				

InStream Detail Report (with EDI) for file (Options: Severity >= 3)	Claim File Number populates here.
---	-----------------------------------

Errors will be listed here.

## 7. Trading Partner Agreements

### Trading Partners

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

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

### Providers

Trading Partner Agreement Enrollment Instructions for Providers can be found on the scdhhs.gov website or <http://www.scdhhs.gov/resource/hipaa-5010-project-status>

### Vendors/Clearinghouses

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## Completion of the S.C. Medicaid Trading Partner Agreement

### Page 1

**I.A.1., Name:** Provider or organization name. The name must match the S.C. Medicaid Provider Number in I.A.2. For instance, if you have an organization name, you must provide a group ID; if you have an individual name, you must provide an individual ID. If you have both an individual and a group ID, you must complete two separate TPAs, one for each ID.

**I.A.2., S.C. Medicaid Provider Number:** The 6-digit provider ID. If you do not yet have a provider ID, you must contact South Carolina Medicaid Enrollment and apply for one before submitting a TPA to the EDI division. You may contact Enrollment at 803-788-7622, ext: 41650 to request an enrollment packet and to sign up for Electronic Funds Transfer.

**I.A.4., Address:** The provider's billing or street address.

**I.A.5., Contact Name:** The provider's enrollment officer, or anyone who can answer questions about the completed TPA.

**I.A.6, 7, & 8, Contact Phone, E-mail and Fax:** Please complete all information. If we cannot reach you by phone, we will try to contact you via e-mail and fax.

### Page 5

**Signing for EDI Partner:** An original signature is required; stamps, copies, or faxes are not accepted. The signature must be either that of the provider or the

provider's authorized representative.

#### Page 6

**Provider Name, Medicaid ID#, address, and phone:** Must all be the same as the information provided on page 1.

**NPI #:** The National Provider ID for the provider ID listed. Do not leave this blank -we will not process the TPA without the NPI.

**Name and Title:** Must be the name and title of the person who signs pages 5 and 8.

**The Provider will submit claim:** If you would like a Web Tool ID, indicate the number of user IDs needed. Each person must have their own user ID.

**Other company or software:** If you are using a third party to submit your claims, list the name of your clearinghouse or software vendor. If you have your own S.C. Medicaid Submitter ID, you can list it here.

#### Page 8

**Signature:** Must be the same individual who signed page 5 and who was reflected under "Name and Title" section on page 6.

#### Appendix B

**Sharing Your NPI:** If the TPA is for an individual provider, please complete the Individual Provider section only. If the TPA is for a group ID, complete the Group section only. It is very important that the NPI that you provide is for the provider ID listed.

**Note:** the TPA will not be processed without the NPI information. Information for obtaining and NPI number is located on page 1 of the TPA.

#### Additional Information:

- [Trading Partner Agreement Enrollment Instructions for Providers](#)
- [Trading Partner Agreement Enrollment Instructions for Vendors and Clearinghouses](#)
- [Trading Partner Agreement 10/30/12](#)

## 8. Transaction Specific Information

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

1. Limit the repeat of loops, or segments
2. Limit the length of a simple data element

## South Carolina Department Health & Human Services 837 Professional Companion Guide

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

### 837P 005010X222A1 Health Care Claim: Professional

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
HDR	ISA	Interchange Control Header		1	R	1		
HDR	ISA01	Authorization Information Qualifier	ID	2-2	R		00, 03	Use Value '00'
HDR	ISA03	Security Information Qualifier	ID	2-2	R		00, 01	Use Value '00'
HDR	ISA05	Interchange ID Qualifier	ID	2-2	R		01, 14, 20, 27, 28, 29, 30, 33, ZZ	Use Value 'ZZ' – Mutually Defined
HDR	ISA06	Interchange Sender ID	AN	15-15	R			Use the SC Medicaid Assigned Submitter Number
HDR	ISA07	Interchange ID Qualifier	ID	2-2	R		01, 14, 20, 27, 28, 29, 30, 33, ZZ	Use Value 'ZZ' – Mutually Defined
HDR	ISA08	Interchange Receiver ID	AN	15-15	R			Use Value 'SCMEDICAID' –
HDR	ISA11	Repetition Separator	AN	1-1	R			Hardcode Caret ^
HDR	ISA14	Acknowledgement Requested	ID	1-1	R		0, 1	<p>If your Trading Partner Agreement indicates that you will receive an Interchange Acknowledgement (TA1). Use '1' for Interchange Acknowledgement Requested</p> <p>If your Trading Partner Agreement does not indicate that you will receive an Interchange Acknowledgement (TA1).</p>

## South Carolina Department Health & Human Services 837 Professional Companion Guide

								Use '0' for No Interchange Acknowledgement Requested
HDR	ISA15	Usage Indicator	ID	1-1	R		P, T	'Provider should use 'T' until testing of the Trading Partner is approved
HDR	ISA16	Component Element Separator	AN	1-1	R			Default :

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
HDR	GS	FUNCTIONAL GROUP HEADER		1	R	>1		
HDR	GS02	Application Sender Code	AN	2-15	R			Use the SC Medicaid Assigned Submitter ID
HDR	GS03	Application Receiver Code	AN	2-15	R			Use Value 'SCMEDICAID'

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
HDR	BHT	BEGINNING OF HIERARCHICAL TRANSACTION	1	R	1			
HDR	BHT02	Transaction Set Purpose Code	ID	2-2	R		00, 18	Use Value '00' - Original
HDR	BHT05	Transaction Set Creation Time	TM	4-8	R		HHMM, HHMMSS, HHMMSSD, CCYYMMDD	Format is HHMM
HDR	BHT06	Claim or Encounter ID	ID	2-2	R		31, CH, RP	Use value 'CH' – Chargeable 'RP' – Reporting for Encounters

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
1000A	NM1	SUBMITTER NAME		1	R	1		

## South Carolina Department Health & Human Services 837 Professional Companion Guide

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1000A	NM109	Submitter Identifier	AN	2-80	R			Use your SC Medicaid Trading Partner ID.  FOR TRANSPORTATION BROKERS ONLY: Use Value 'TT'
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Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
1000B	NM1	RECEIVER NAME		1	R	1		
1000B	NM103	Receiver Name	AN	1-60	R			Use value 'SC Medicaid'.
1000B	NM109	Receiver Primary Identifier	AN	2-80	R			Use value 'SC Medicaid'.

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
2000A	PRV	BILLING PROVIDER SPECIALTY INFORMATION	1	S				
2000A	PRV03	Provider Taxonomy Code	AN	1-50	R			Submit the Provider Taxonomy that was used for the SC Medicaid Provider Enrollment.

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
2010AA	NM1	BILLING PROVIDER NAME		1	R	1		
2010AA	NM108	Identification Code Qualifier	ID	1-2	S		XX	Use value 'XX' for NPI if typical provider.  Else use value in Segment 2010BB.
2010AA	NM109	Billing Provider Identifier	AN	2-80	S			NPI for Billing Provider if typical provider. Else use value in Segment 2010BB.

## South Carolina Department Health & Human Services 837 Professional Companion Guide

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Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
2010AA	NM1	<b>BILLING PROVIDER NAME</b>		1	R	1		
2010AA	NM108	Identification Code Qualifier	ID	1-2	S		XX	Use value 'XX' for NPI if typical provider.  Else use value in Segment 2010BB.
2010AA	NM109	Billing Provider Identifier	AN	2-80	S			NPI for Billing Provider if typical provider.  Else use value in Segment 2010BB.

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
2010AA	N4	<b>BILLING PROVIDER CITY/STATE/ZIP CODE</b>	1	R				
2010AA	N403	Billing Provider Postal Zone or ZIP Code	ID	3-15	S			Submit Full 9 Digit Zip Code.

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
2000B	SBR	<b>SUBSCRIBER INFORMATION</b>		1	R			
2000B	SBR09	Claim Filing Indicator Code	ID	1-2	S		11, 12, 13, 14, 15, 16, 17, AM, BL, CH, CI, DS, FI, HM, LM, MA, MB, MC, OF, TV, VA, WC, ZZ	Use Value 'MC' - Medicaid or "13" if Pharmacy provider.

## South Carolina Department Health & Human Services 837 Professional Companion Guide

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Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
2010BA	NM1	<b>SUBSCRIBER NAME</b>		1	R	1		
2010BA	NM108	Identification Code Qualifier	ID	1-2	R		II, MI	Use value 'MI' – Member Identification Number.
2010BA	NM109	Subscriber Primary Identifier	AN	2-80	R			Use the recipient's 10 Digit SC Medicaid Identification Number.  This data element is required when NM102 equals one (1).

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
2010BB	NM1	<b>PAYER NAME</b>		1	R	1		
2010BB	NM103	Payer Name	AN	1-60	R			Use value 'SC Medicaid'.
2010BB	NM108	Identification Code Qualifier	ID	1-2	R		PI, XV	Use value 'PI' – Payer Identification.
2010BB	NM109	Payer Identifier	AN	2-80	R			Use value 'SCXIX'.

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
2010BB	N3	<b>PAYER ADDRESS</b>		1	S			
2010BB	N301	Payer Address Line	AN	1-55	R			Use value '1801 Main St'.

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
2010BB	N4	<b>PAYER CITY/STATE/ZIP CODE</b>		1	R			

## South Carolina Department Health & Human Services 837 Professional Companion Guide

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2010BB	N401	Payer City Name	AN	2-30	R			Use value 'Columbia'.
2010BB	N402	Payer State Code	ID	2-2	S			Use value 'SC'.
2010BB	N403	Payer Postal Zone or ZIP Code	ID	3-15	S			Use value '29201'.

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
2010BB	REF	<b>BILLING PROVIDER SECONDARY IDENTIFICATION</b>	2	S				
2010BB	REF01	Reference Identification Qualifier	ID	2-3	R		G2, LU	Atypical providers enter value "G2"=  Provider Commercial Number (SC Medicaid Proprietary ID)  Required when NM109 in Loop 2010AA is not used and an identification number other than the NPI is necessary for the receiver to identify the provider.
2010BB	REF02	Payer Additional Identifier	AN	1-50	R			Atypical providers enter SC Medicaid Proprietary ID.

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
2300	CLM	<b>CLAIM INFORMATION</b>		1	R	100		
2300	CLM07	Provider Accept Assignment Code	ID	1-1	R		A, B, C	Use value "A" = Assigned
2300	CLM08	Yes/No Condition or Response Code	ID	1-1	R		N, W, Y	Use value "Y" = Yes

## South Carolina Department Health & Human Services 837 Professional Companion Guide

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Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
2300	REF	PRIOR AUTHORIZATION		1	S			
2300	REF01	Reference Identification Qualifier	ID	2-3	R		G1	Use Value G1
2300	REF02	Prior Authorization	AN	1-50	R			Use Prior Authorization Number

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
2300	REF	Referral		1	S			
2300	REF01	Reference Identification Qualifier	ID	2-3	R		9F	Use Value "9F"
2300	REF02	Referral Number	AN	1-50	R			Referral Number

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
2300	NTE	CLAIM NOTE		1	S			
2300	NTE01	Note Reference Code	ID	3-3	R		ADD, CER, DCP, DGN, TPO	TRANSPORTATION BROKERS ONLY: Use Value 'ADD' – Additional Information
2300	NTE02	Claim Note Text	AN	1-80	R			TRANSPORTATION BROKERS ONLY:

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
2300	CRC	EPSDT REFERRAL		1	S			
2300	CRC03	Condition Code	ID	2-3	R		AV, NU, S2, ST	S2 Under Treatment = Patient is currently under treatment for referred diagnostic or corrective health problem.  (MMIS Value = 1 -

**South Carolina Department Health & Human Services 837 Professional Companion Guide**

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								<p>Well child care with treatment of an identified problem treated by the physician]</p> <p>ST New Services Requested = Patient is referred to another provider for diagnostic or corrective treatment for at least one health problem identified during an initial or periodic screening service (not including dental referrals) OR Patient is scheduled for another appointment with screening provider for diagnostic or corrective treatment for at least one health problem identified during an initial or periodic screening service (not including dental referrals)</p> <p>[MMIS Value = 2 = Well child care with a referral made for an identified problem to another provider]</p>
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Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
2300	HI	HEALTH CARE DIAGNOSIS CODE		1	R			
2300	HI-1-1	Diagnosis Type Code	ID	1-3	R		ABK, BK	-Use Value 'BK' – Principal Diagnosis (ICD-9) October 1, 2013 = ICD-10 implementation. At that time, Value ABK - Principal Diagnosis (ICD-10) will be used. The diagnosis listed in this element is assumed to be the principal diagnosis.

## South Carolina Department Health & Human Services 837 Professional Companion Guide

2300	H-2-1	Diagnosis Type Code	ID	1-3	R		ABK, BK	-Use Value 'BK' – Principal Diagnosis (ICD-9) October 1, 2013 = ICD-10 implementation. At that time, Value ABK - Principal Diagnosis (ICD-10) will be used. The diagnosis listed in this element is assumed to be the principal diagnosis.
2300	HI-3-1	Diagnosis Type Code	ID	1-3	R		ABK, BK	-Use Value 'BK' – Principal Diagnosis (ICD-9) October 1, 2013 = ICD-10 implementation. At that time, Value ABK - Principal Diagnosis (ICD-10) will be used. The diagnosis listed in this element is assumed to be the principal diagnosis.
2300	HI-4-1	Diagnosis Type Code	ID	1-3	R		ABK, BK	-Use Value 'BK' – Principal Diagnosis (ICD-9) October 1, 2013 = ICD-10 implementation. At that time, Value ABK - Principal Diagnosis (ICD-10) will be used. The diagnosis listed in this element is assumed to be the principal diagnosis.
2300	HI-5-1	Diagnosis Type Code	ID	1-3	R		ABK, BK	-Use Value 'BK' – Principal Diagnosis (ICD-9) October 1, 2013 = ICD-10 implementation. At that time, Value ABK - Principal Diagnosis (ICD-10) will be used. The diagnosis listed in this element is assumed to be the principal diagnosis.
2300	HI-6-1	Diagnosis Type Code	ID	1-3	R		ABK, BK	-Use Value 'BK' – Principal Diagnosis (ICD-9) October 1, 2013 = ICD-10 implementation. At that time, Value ABK - Principal Diagnosis (ICD-10) will be used. The diagnosis listed in this element is assumed to be the principal diagnosis.

## South Carolina Department Health & Human Services 837 Professional Companion Guide

2300	HI-7-1	Diagnosis Type Code	ID	1-3	R		ABK, BK	-Use Value 'BK' – Principal Diagnosis (ICD-9) October 1, 2013 = ICD-10 implementation. At that time, Value ABK - Principal Diagnosis (ICD-10) will be used. The diagnosis listed in this element is assumed to be the principal diagnosis.
2300	HI-8-1	Diagnosis Type Code	ID	1-3	R		ABK, BK	-Use Value 'BK' – Principal Diagnosis (ICD-9) October 1, 2013 = ICD-10 implementation. At that time, Value ABK - Principal Diagnosis (ICD-10) will be used. The diagnosis listed in this element is assumed to be the principal diagnosis.
2300	HI-9-1	Diagnosis Type Code	ID	1-3	R		ABK, BK	-Use Value 'BK' – Principal Diagnosis (ICD-9) October 1, 2013 = ICD-10 implementation. At that time, Value ABK - Principal Diagnosis (ICD-10) will be used. The diagnosis listed in this element is assumed to be the principal diagnosis.
2300	HI-10-1	Diagnosis Type Code	ID	1-3	R		ABK, BK	-Use Value 'BK' – Principal Diagnosis (ICD-9) October 1, 2013 = ICD-10 implementation. At that time, Value ABK - Principal Diagnosis (ICD-10) will be used. The diagnosis listed in this element is assumed to be the principal diagnosis.
2300	HI-11-1	Diagnosis Type Code	ID	1-3	R		ABK, BK	-Use Value 'BK' – Principal Diagnosis (ICD-9) October 1, 2013 = ICD-10 implementation. At that time, Value ABK - Principal Diagnosis (ICD-10) will be used. The diagnosis listed in this element is assumed to be the principal diagnosis.

## South Carolina Department Health & Human Services 837 Professional Companion Guide

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2300	HI-12-1	Diagnosis Type Code	ID	1-3	R		ABK, BK	-Use Value 'BK' – Principal Diagnosis (ICD-9) October 1, 2013 = ICD-10 implementation. At that time, Value ABK - Principal Diagnosis (ICD-10) will be used. The diagnosis listed in this element is assumed to be the principal diagnosis.
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Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
<b>2310B</b>	<b>REF</b>	<b>RENDERING PROVIDER SECONDARY IDENTIFICATION</b>	<b>4</b>	<b>S</b>				
2310B	REF01	Reference Identification Qualifier	ID	2-3	R		0B, 1G, G2, LU	Use value "G2" - Provider Commercial Number for atypical providers ONLY.
2310B	REF02	Rendering Provider Secondary Identifier	AN	1-50	R			Use the rendering provider's SC Medicaid provider number for atypical providers ONLY.

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
2320	CAS	<b>CLAIM LEVEL ADJUSTMENTS</b>		1	S	5		
2320	CAS01	Claim Adjustment Group Code	AN	1-2	R		PR	Claim adjustment data can be reported at the claim level. 2430 data will be used if sent.

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
2430	CAS	<b>LINE ADJUSTMENTS</b>		1	S	5		
2430	CAS01	Claim Adjustment Group Code	AN	1-2	R		PR	Claim adjustment data can be reported in this loop.

**South Carolina Department Health & Human Services 837 Professional Companion Guide**

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Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
2330A	NM1	OTHER SUBSCRIBER NAME		1	R	1		
2330A	NM108	Identification Code Qualifier	ID	1-2	R		II, MI	Use Value "MI" = Member Identification Number The subscriber's identification number as assigned by the payer.
2330A	NM109	Other Insured Identifier	AN	2-80	R			Other Insured Identifier

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
2330B	NM1	OTHER PAYER NAME		1	R	1		Submitters are required to send all known information on other payers in this Loop ID-2330.
2330B	NM108	Identification Code Qualifier	ID	1-2	R		PI, XV	Use value - "PI" = Payor Identification
2330B	NM109	Other Payer Primary Identifier	AN	2-80	R			This number must be identical to SVD01 (Loop ID-2430) for COB.  Use the carrier codes assigned by SC Medicaid to identify other insurance carriers.

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
2330B	NM1	OTHER PAYER NAME		1	R	1		Submitters are required to send all known information on other payers in this Loop ID-2330.

## South Carolina Department Health & Human Services 837 Professional Companion Guide

2330B	NM108	Identification Code Qualifier	ID	1-2	R		PI, XV	Use value - " PI" = Payor Identification
2330B	NM109	Other Payer Primary Identifier	AN	2-80	R			This number must be identical to SVD01 (Loop ID-2430) for COB. Use the carrier codes assigned by SC Medicaid to identify other insurance carriers.

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
2400	SV1	<b>PROFESSIONAL SERVICE</b>		1	R			
2400	SV101	Composite Medical Procedure Identifier			R			
2400	SV101-1	Product or Service ID Qualifier	ID	2-2	R		ER, HC, IV, WK	Value "HC" = Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
2400	SV5	<b>DURABLE MEDICAL EQUIPMENT SERVICE</b>	1	S				
2400	SV501-1	Procedure Identifier	ID	2-2	R		HC	Use Value 'HC' - Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
2420A	REF	<b>RENDERING PROVIDER SECONDARY IDENTIFICATION</b>	20	S				

**South Carolina Department Health & Human Services 837 Professional Companion Guide**

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2420A	REF01	Reference Identification Qualifier	ID	2-3	R		OB, 1G, G2, LU	Use value "G2" - Provider Commercial Number
2420A	REF02	Rendering Provider Secondary Identifier	AN	1-50	R			Use the rendering provider's SC Medicaid provider number for atypical providers ONLY.

## Appendix

### 1. Frequently Asked Questions

To be updated as questions come in.

### 2. Change Summary

Version	Issue Date	Modified By	Comments / Reason
1.0	05/02/2011	William Douglas	Original document 05/03 /2011
1.1	06/15/2011	William Douglas	Updates for ISA14
2.0	06/30/2011	William Douglas	Comments from Review and updates to ISA 16 should be a : and ISA11 should be ^
2.1	10/31/11	Tracie O'Donnell	Updated 1000B NM109 with "Use value 'SC Medicaid'."
2.2	01/20/2012	Charley Cosby	Updated info – Adjustment amounts should be reported at claim level in 2320 and 2430, line level adjustments are not used.
2.3	07/12/2012	Charley Cosby	Removed reference to 2430 not being used. Provider can now send COB info in 2430 loop and it will be used.
2.4	01/01/2013	Tracie O'Donnell	Updated with Operating Rules Template