Santa Clara County

HIPAA 837P Companion Guide

Refers to the ASC X12N 837 Professional (Version 005010X222A1)

Version 1.04

Disclosure Statement

This document represents Santa Clara County implementation instructions for electronic claim transactions. It is believed to be compliant with all ASC X12 intellectual property requirement

Document Revision History

Version	Release Date	Comments
1.0	6/10/2019	Initial Document Release
1.01	10/10/2019	
1.02	07/02/2020	Updated Subscriber Identifier and Units of Measurement
1.03	11/17/2020	Updated to include Evidence Based Practices
1.04	8/8/2022	Updated Submitter ID (Loop 1000A NM109) New 837 Claim Snapshots Updated to include notation for Evidence Based Practices (NTE01, NTE02) Updated Identification Code Qualifier (20100AA NM108) Add National Drug Code (NDC) Identification Information (Loop 2410) Added Note for Zip and Postal Codes to Include +4 Digits (2010AA N4, 2010BA N4, 2010BB N4, 2310C N4, 2330BA N4, 1000A N4, 1000B N4)

Preface

This Companion Guide to the version 5010 ASC X12N Implementation Guides and associated errata adopted under HIPAA clarifies and specifies the data content when exchanging electronically with Santa Clara County. Transmissions based on this companion guide, used in tandem with the v5010 ASC X12N Implementation Guides, are compliant with both ASC X12 syntax and those guides. This Companion Guide is intended to convey information that is within the framework of the ASC X12N Implementation Guides adopted for use under HIPAA. The Companion Guide is not intended to convey information that in any way exceeds the requirements or Santa Clara County of data expressed in the Implementation Guides.

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

This Companion Guide is subject to change. If you have any questions, please contact Santa Clara County.

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1. Introduction

1.1 Scope

This companion guide is intended to be used by Santa Clara County certified contracted providers (CCP) in support of the following ASC X12 transaction implementations mandated under HIPAA:

- ASC X12 Health Care Claim: Professional (837) as specified in guide 005010X222 and 005010X222A1 (837P)

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

1.2 Overview

Section 2 provides information about establishing a trading partner relationship with Santa Clara County.

Section 3 provides a Process Flow of the claiming transactions.

Section 4 identifies EDI related contacts within Santa Clara County.

Section 5 provides the Santa Clara County technical requirements for file exchange and the envelope segments.

Section 6 provides the Santa Clara County specific business rules and limitations.

Section 7 identifies the Santa Clara County acknowledgment transactions.

Section 8 provides operational information.

Section 9 provides the Santa Clara County requirements and Santa Clara County for the 837 claiming transactions.

Section 10 provides sample 837 transactions

1.3 References

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

2. Getting Started

2.1 Trading Partner Registration

Trading Partners

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

You can find additional information on registering for EDI by contacting Santa Clara County at following address:

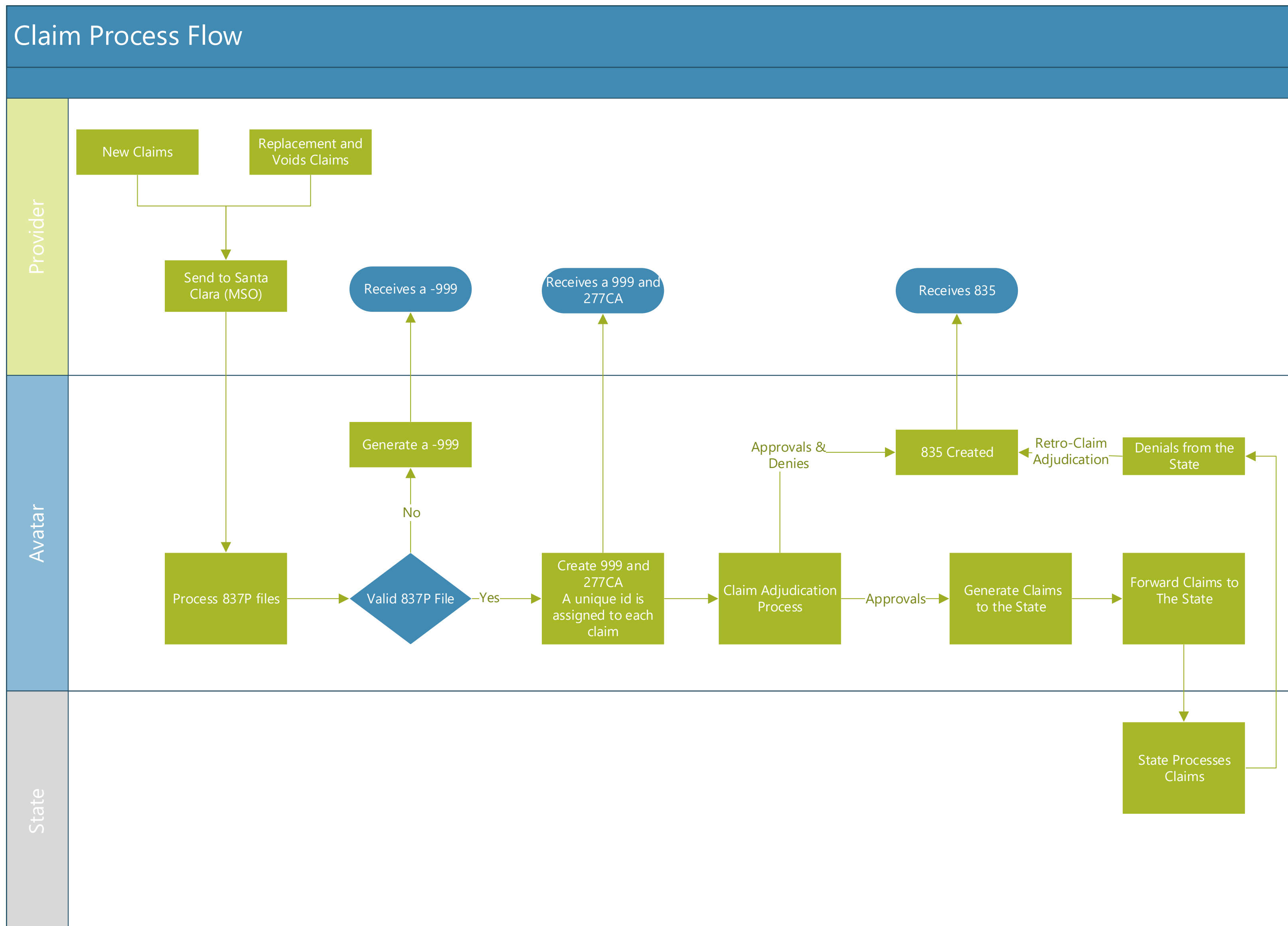
Attn: BHSD TSS

County of Santa Clara

828 South Bascom Ave., Suite 280

San Jose, CA 95128

3. Process Flow



4. Contact Information

4.1 EDI Customer Service/Technical Assistance

Attn: XXXX

County of Santa Clara
828 South Bascom Ave., Suite 280
San Jose, CA 95128

5. Operational Information

5.1 Hours of Operation

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

6. Santa Clara County Business Rules and Limitations

6.1 Business rules for inbound 837P Transactions.

1. All clients must be created in Santa Clara County prior to claiming. The client must be identified by a unique Client ID assigned by Santa Clara County. The client ID number must be prefixed with the letters 'CSC' in loop 2010BA/NM109 Subscriber Primary Identifier field.
2. Financial Eligibility must be entered for each client prior to claiming. The following fields are required:
    - Client's Relationship to Subscriber
    - Subscriber's First Name
    - Subscriber's Last Name
    - Subscriber's Gender
    - Subscriber's Date of Birth
    - Subscriber's Address Information
    - Subscriber's Client Index Number (CIN)
    - Verified Eligibility with a date prior to the date of service on the claim
    - Subscriber's Assignment of Benefits
    - Subscriber's Release of Information
3. All Contracting Provider Programs must be set up in Santa Clara County.
4. Santa Clara County requires an authorization for all services in the 2400/REF02 segment. A provider will put only one authorization on a claim line
    - Provider Authorizations, or P-Auths, are specific to a Contracting Provider and to a Funded Program/Funding Source. Generally, Provider Authorizations will be published by Santa Clara County for each fiscal year. These Authorizations always start with the letter 'P' and can be billed without further authorization subject to rules established by Santa Clara County.

    - Member Authorizations or Service Authorization are specific to a client and a Contracting Provider. They authorize specific services for a specific duration of time. Member Authorizations are also tied to a

Funded Program/Funding Source, however when claiming only send the Member Authorization. Member Authorizations can be requested through ProviderConnect Enterprise or ProviderConnect Portal. Member Authorizations are always all numeric.

5. The Rendering Provider, or Practitioner, must be set up and associated in Santa Clara County with the Provider prior to billing. All Rendering Providers must have an NPI set up in Santa Clara County. The NPI number will be used to match the clinician on the inbound claim with the clinician associated with the Provider in Santa Clara County. Rendering Provider updates should be communicated to Santa Clara County on a timely basis.
6. The Rendering Provider's Discipline will be determined based on the information stored in Santa Clara County. Santa Clara County will not utilize the Rendering Provider's taxonomy in the PRV segment. Any updates to the Practitioner's Discipline will need to be communicated to Santa Clara County on a timely basis.
7. Group Claims
    - Services for group claims are subject to the group billing calculation established by Medi-Cal. The calculation is results of group minutes (including documentation and travel time) times the per minute price divided by the number of participants. The amount reported on the claim must be the results of this calculation. Providers can only claim the portion of the service that applies to the client being claimed.
8. Modifier – each service should contain the correct modifier. Santa Clara County will validate the HCPCS/CPT code and Modifier(s) against the services associated with the Authorization. Services that do not match the HCPCS/CPT code in the Authorization will be denied. Each modifier must be separated by a colon ':'.
9. All services must be reported in 'UN' (units), 'DA' (days) or 'MJ' (minutes) as the Unit or Basis of Measurement Code in SV103. For Residential claims, one day equals 1 unit.
10. The following elements are used by Santa Clara County to identify and validate the client:
    - Client ID – 2010BA/NM109 Subscriber Primary Identifier. The Subscriber Primary number will be assigned by Santa Clara County during the admission process. The Subscriber Primary number will always have a prefix of 'CSC'.
    - Gender – 2010BA/DMG03 Subscriber Gender Code.
    - Date of Birth – 2010BA/DMG02 Subscriber Birth Date.
11. Services per claim
    - Santa Clara County allows one service line per claim.
12. Santa Clara County Health Care Claim Payment/Advice (835)
    - Providers will receive an 835 for all Approved and Denied claims at the time that the claim is adjudicated, and the provider receives payment.
    - Per the national HIPAA 835 guide, Santa Clara County uses the Claim Status Code values 1, 2 and 3 (CLP02) when adjudicating original claims, regardless of whether the claim was approved or denied. Santa Clara County does not return the Claim Status Code 4 when a claim is denied.
13. Retro-Claim Adjudication
    - Santa Clara County claims that are subsequently denied by the state will result in a second 835, known as a retro- claim adjudication. Retro- claim adjudication 835s follow all the standard HIPAA 835 requirements for reversals and corrections.
14. Replacement Claims
    - Replacement claims must reference the Santa Clara County Original Reference Number in the REF segment of the 2100 loop of the 835. This reference number is used by Santa Clara County to match the replacement claim to the original claims. Example: REF*F8*123456.
    - You can only replace an original claim one time. If you need to make an additional replacement, replace the replacement claim, not the original.
    - Any amount differences between the original amount approved and paid by Santa Clara County will be adjusted on the next 835.
15. Voided Claims

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

7. File Exchange/File Structure/Control Segments

7.1 File Requirements

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

7.2 ISA-IEA on Inbound Transactions

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

7.3 GS-GE on Inbound Transactions

Santa Clara County accepts only one Functional Group per Interchange

GS - Function Group Header		
GS01	Functional Identifier Code	HC = Health Care Claim 837
GS02	Application Senders Code	The Provider's Federal Tax ID Number
GS03	Applications Receiver Code	Santa Clara County's Federal Tax ID Number 946000533
GS08	Version / Release / Industry Identifier Code	005010X222A1 = Standards Approved for Publication by ASC X12

7.4 ST-SE on Inbound Transactions

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

8. Transaction Specific Information

Health Care Claim Processional (837P)

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

RECEIVER NAME - LOOP 1000B			
NM1 - Receiver Name			
NM101	Entity Identifier Code	40	40 = Receiver
NM102	Entity Type Qualifier	2	2 = Non-Person Entity
NM103	Receiver Name		Santa Clara County
NM104	Name First		
NM108	Identification Code Qualifier	46	46 = Electronic Transmitter Identification Number (ETIN)
NM109	Receiver Primary Identifier		CSC001
BILLING PROVIDER HIERARCHICAL LEVEL			
HL - Billing Provider Hierarchical Level (2000A)			
HL01	Hierarchical ID Number		The first HL01 within each ST-SE envelope must begin with 1 and be incremented by one each time an HL is used in the transaction. Only numeric values are allowed in HL01
HL02	Hierarchical Parent ID Number		Hierarchical ID number of the HL segment to which the current HL segment is subordinate
HL03	Hierarchical Level Code	20	Information Source
HL04	Hierarchical Child Code	1	Additional Subordinate HL Data Segment in This Hierarchical Structure.
Billing Provider Name (2010AA)			
NM101	Entity Identifier Code	85	85 = Billing Provider
NM102	Billing Provider Entity Type Qualifier		1 = Person 2 = Non-Person Entity
NM103	Billing Provider Last or Organization Name		
NM104	Billing Provider First Name		
NM105	Billing Provider Middle Name		
NM107	Billing Provider Name Suffix		
NM108	Identification Code Qualifier		XX
NM109	Billing Provider Identifier		NPI Number
N3 - Billing/Provider Address Information			
N301	Billing Provider Address Line		
N302	Billing Provider Address Line		
N4 - Billing/Provider City/State/Zip Code			
N401	Billing Provider City Name		
N402	Billing Provider State or Province Code		
N403	Billing Provider Postal Zone or ZIP Code		Zip Code+4 (ex. 951282651)
N404	Country Code		
N407	Country Subdivision Code		

REF - Billing Provider Tax Information			
REF01	Reference Identification Qualifier	EI	EI = Employer's Identification Number SY = Social Security Number
REF02	Reference Identification		Tax ID
PER - Billing Provider Contact Information			
PER01	Contact Function Code	IC	IC = Information Contact
PER02	Billing Provider Contact Name		
PER03	Communication Number Qualifier	TE	TE = Telephone
PER04	Communication Number		
PER05	Communication Number Qualifier		
PER06	Communication Number		
PER07	Communication Number Qualifier		
PER08	Communication Number		
SUBSCRIBER HIERARCHICAL LEVEL - LOOP 2000B			
HL - Billing Provider Hierarchical Level (2000B)			
HL01	Hierarchical ID Number	2	HL Segment Counter starting at 1 for the initial HL segment and increment by one in each subsequent HL segment within the ST/SE
HL02	Hierarchical Parent ID Number		Hierarchical ID number of the HL segment to which the current HL segment is subordinate
HL03	Hierarchical Level Code	22	22 = Subscriber
HL04	Hierarchical Child Code		Hierarchical Child Code indicates whether there are subordinates (or child) HL segments related to the current HL segment
SBR - Subscriber Information			
SBR01	Payer Responsibility Sequence Number Code		See Table
SBR02	Individual Relationship Code	18	18 = Client's relationship to subscriber
SBR03	Insured Group or Policy Number		
SBR04	Insured Group Name		
SBR05	Insurance Type Code		
SBR09	Claim Filing Indicator Code	MC	MC = Medi-Cal

PAT - Patient Information			
PAT01	Individual Relationship Code		
PAT02	Patient Location Code		
PAT03	Employment Status Code		
PAT04	Patient Location Code		
PAT05	Date Time Period Format Qualifier		
PAT06	Date Time Period		
PAT07	Unit or Basis for Measurement Code		
PAT08	Weight		
PAT09	Yes/No Condition or Response Code		

SUBSCRIBER NAME - LOOP 2010BA			
NM1 - Subscriber Name			
NM101	Entity Identifier Code	IL	
NM102	Entity Type Qualifier		
NM103	Subscriber Last Name		
NM104	Subscriber First Name		
NM105	Subscriber Middle Name		
NM107	Subscriber Name Suffix		
NM108	Identification Code Qualifier	MI	
NM109	Subscriber Primary Identifier		The Santa Clara subscriber identifier is an alpha numeric field comprise of 'CSC' concatenated with the Client ID. If the submitted value is invalid the claim will be rejected Example: if the client ID is 12345, the subscriber primary identifier must be entered as 'CSC12345'
N3 - Subscriber Address			
N301	Subscriber Address Line		
N302	Subscriber Address Line		

N4 - Subscriber City/State/Zip Code			
N401	Subscriber City Name		
N402	Subscriber State Code		
N403	Subscriber Postal Zone or ZIP Code		Zip Code+4 (ex. 951282651)
N404	Country Code		
N407	Country Subdivision Code		
DMG - Subscriber Demographic Information			
DMG01	Date Time Period Format Qualifier	D8	
DMG02	Subscriber Birth Date		
DMG03	Subscriber Gender Code		
REF - Subscriber Secondary Information			
REF01	Reference Identification Qualifier		
REF02	Reference Identification		

PAYER NAME - LOOP 2010BB			
NM1 - Payer Name			
NM101	Entity Identifier Code	PR	Payer
NM102	Entity Type Qualifier	2	Non-Person Entity
NM103	Payer Name		SANTA CLARA COUNTY
NM108	Identification Code Qualifier		PI
NM109	Payer Identifier		MSO001
N3 - Payer Address			
N301	Payer Address Line		828 South Bascom Ave., Suite 280
N302	Payer Address Line		
N4 - Payer City/State/Zip Code			
N401	Payer City Name		SAN JOSE
N402	Payer State Code		CA
N403	Payer Postal Zone or ZIP Code		951282651
N404	Country Code		
N407	Country Subdivision Code		

CLM - Claim Information			
CLM01	Claim Submitter's ID		
CLM02	Total Claim Charge Amount		
CLM03	Not Used		Not Used
CLM04	Not Used		Not Used
CLM05-1	Facility Code Value		
CLM05-2	Facility Code Qualifier		
CLM05-3	Claim Frequency Code		
CLM06	Provider or Supplier Signature Indicator		
CLM07	Medicare Assignment Code		
CLM08	Benefits Assignment Certification Indicator		
CLM09	Release of Information Code		
CLM10	Patient Signature Source Code		
CLM11-**1**	Related Causes Code		
CLM11-**2**	Related Causes Code		
CLM11-**3**	Related Causes Code		
CLM11-**4**	Auto Accident State or Province Code		
CLM11-**5**	Country Code - Not Used		Not Used
CLM12	Special Program Indicator - Not Used		Not Used
CLM16	Participation Agreement		Not Used
CLM20	Delay Reason Code		
DTP - Date - Admission			
DTP01	Date/Time Qualifier	435	
DTP02	Date Time Period Format Qualifier		
DTP03	Date Time Period		
DTP - Date - Discharge			
DTP01	Date/Time Qualifier	096	
DTP02	Date Time Period Format Qualifier		
DTP03	Date Time Period		
AMT - Patient Amount Paid			
AMT01	Amount Qualifier Code	F5	F5 = Patient Amount Paid
AMT02	Patient Amount Paid		Total Amount Paid By Client

HI - Health Care Diagnosis Code			
HI01	Principal Diagnosis	ABK	ABK=Principal Diagnosis DSM-5/ ICD-10 Codes
HI01	Diagnosis Code		Industry Code
HI02	Diagnosis Type Code	ABF	ABF=Diagnosis ICD-10 Codes
HI02	Diagnosis Code		Industry Code
HI03	Diagnosis Type Code	ABF	ABF=Diagnosis ICD-10 Codes
HI03	Diagnosis Code		Industry Code
HI04	Diagnosis Type Code	ABF	ABF=Diagnosis ICD-10 Codes
HI04	Diagnosis Code		Industry Code
HI05	Diagnosis Type Code	ABF	ABF=Diagnosis ICD-10 Codes
HI05	Diagnosis Code		Industry Code
HI06	Diagnosis Type Code	ABF	ABF=Diagnosis ICD-10 Codes
HI06	Diagnosis Code		Industry Code
HI07	Diagnosis Type Code	ABF	ABF=Diagnosis ICD-10 Codes
HI07	Diagnosis Code		Industry Code
HI08	Diagnosis Type Code	ABF	ABF=Diagnosis ICD-10 Codes
HI08	Diagnosis Code		Industry Code
NM1 Rendering Provider Name (2310B)			
NM101	Entity Identifier Code		82
NM102	Entity Type Qualifier		1 = Person / 2 = Non-Person Entity
NM103	Referring Provider Last Name		
NM104	Referring Provider First Name		
NM105	Referring Provider Middle Name		
NM107	Referring Provider Name Suffix		
NM108	Identification Code Qualifier		
NM109	Referring Provider Identifier		Clinical NPI Number
NM112	Name Last or Organization Name		
Service Facility Location Name (2310C) - Required when Service Location is Office or Home			
NM101	Entity Identifier Code		77
NM102	Entity Type Qualifier		1 = Person / 2 = Non-Person Entity
NM103	Rendering Provider Last or Organization Name		Client's Program For The Episode
NM108	Identification Code Qualifier	XX	
NM109	Identification Code		Location NPI
N3 - Service Facility Location Address			
N301	Laboratory or Facility Address Line		
N302	Laboratory or Facility Address Line		

N4 - Service Facility Location City/State/Zip			
N401	Laboratory or Facility City Name		
N402	Laboratory or Facility State or Province Code		
N403	Laboratory or Facility Postal Zone or ZIP Code		Zip Code+4 (ex. 951282651)
N404	Country Code		
N407	Country Subdivision Code		
OTHER SUBSCRIBER INFORMATION - LOOP 2320 - Medi-Cal is Secondary Ins			
SBR - Other Subscriber Information			
SBR01	Payer Responsibility Sequence Number Code		
SBR02	Individual Relationship Code		
SBR03	Insured Group or Policy Number		
SBR04	Other Insured Group Name		
SBR05	Insurance Type Code		
AMT - Coordination of Benefits (COB) Total Non-Covered Amount			
AMT01	Amount Qualifier Code	D	Payor Amount Paid
AMT02	Monetary Amount		
AMT03	Credit/Debit Flag Code		
AMT - Remaining Patient Liability			
AMT01	Amount Qualifier Code	EAF	Patient Liability
AMT02	Monetary Amount		
AMT03	Credit/Debit Flag Code		
OI - Other Insurance Coverage Information			
OI03	Benefits Assignment Certification Indicator		
OI04	Patient Signature Source Code		
OI06	Release of Information Code		

OTHER SUBSCRIBER NAME - LOOP 2330BA

NM1 - Other Subscriber Name			
NM101	Entity Identifier Code	IL	
NM102	Entity Type Qualifier		
NM103	Subscriber Last Name		
NM104	Subscriber First Name		
NM105	Subscriber Middle Name		
NM107	Subscriber Name Suffix		
NM108	Identification Code Qualifier		
NM109	Subscriber Primary Identifier		
N3 - Other Subscriber Address			
N301	Payer Address Line		
N302	Payer Address Line		
N4 - Other Subscriber City/State/Zip Code			
N401	Payer City Name		
N402	Payer State Code		
N403	Payer Postal Zone or ZIP Code		Zip Code+4 (ex. 951282651)
N404	Country Code		
N407	Country Subdivision Code		

OTHER PAYER - LOOP 2330B

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

Service Line Number (Loop 2400)

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

SV1 - Professional Service			
SV101	Procedure Modifier	HC	HC = HCPCS Codes **This must be HC for processing into MSO.**
SV101	Procedure Code		**This must be defined in the MSO CPT code table, or the service is rejected on MSO inbound.**
SV101	Product or Service ID Qualifier		
SV101	Procedure Modifier		
SV101	Procedure Modifier		
SV101	Procedure Modifier		
SV102	Line-Item Charge Amount		Total Service Charge
SV103	Unit or Basis for Measurement Code		UN = Units MJ = Minutes DA = Days
SV104	Service Unit Count		Total Service Units If Units Based Service
SV105	Place of Service Code		
SV107	Diagnosis Code Pointer		Diagnosis Code Pointer Based on Client's Diagnosis **If an invalid diagnosis reference is encountered, the entire claim will be rejected by MSO inbound.**
SV107	Diagnosis Code Pointer		Diagnosis Code Pointer Based on Client's Diagnosis **If an invalid diagnosis reference is encountered, the entire claim will be rejected by MSO inbound.**
SV107	Diagnosis Code Pointer		Diagnosis Code Pointer Based on Client's Diagnosis **If an invalid diagnosis reference is encountered, the entire claim will be rejected by MSO inbound.**
SV107	Diagnosis Code Pointer		Diagnosis Code Pointer Based on Client's Diagnosis **If an invalid diagnosis reference is encountered, the entire claim will be rejected by MSO inbound.**
SV109	Emergency Indicator		
SV111	EPSDT Indicator		
SV112	Family Planning Indicator		
SV115	Co-Pay Status Code		

DTP - Date - Service Date			
DTP01	Date Time Qualifier	472	472 = Service
DTP02	Date Time Period Format Qualifier		D8 = Date expressed in CCYYMMDD, RD8 = Range of dates expressed in CCYYMMDD-CCYYMMDD
DTP03	Service Date		**This is required for the service to file in the MSO 'Claim Processing (HCFA)' option ('Service Detail' tab).**
REF - Prior Authorization - Required			
REF01	Reference Identification Qualifier	G1	G1 = Prior Authorization Number
REF02	Prior Authorization or Referral Number		Prior Authorization or Referral Number
Line Note			
NTE01	Note Reference	DCP	Use DCP for reporting the Evidence Based Practice (EBP) code.
NTE02	Description		Enter the primary EBP or Service Strategy. Any applicable EBP, other than 99-Unknown, should be prioritized over a Service Strategy. Enter only 1 code. Each code is 2-byte alpha-numeric. Alpha characters must be uppercase. All numeric codes must be 2 digits. Include a leading zero, if needed, to make a 2-digit code. Claims will reject if this segment is not present. *The County has not identified the values for the EBP options at this time. Until the values are defined and shared, please leave this section blank.
NATIONAL DRUG CODE (NDC) IDENTIFICATION INFORMATION – LOOP 2410			
LIN - Drug Identification (Loop 2410)			
LIN01			
LIN02	Product/Service ID Qualifier	N4	Qualifier
LIN03	Product/Service ID		11 digit NDC without hyphens or spaces
CTP – Drug Quantity			
CTP01			
CTP02			
CTP03			
CTP04	National Drug Unit Count		Quantity (number of units)
CTP05	Measurement Code		Composite Unit of Measure
CTP05-1	F2, - International Unit, GR – Gram, ML – Milliliter, UN – Unit, ME - Milligram		Unit or Basis of measurement code

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

9. Acknowledgement and Reports

9.1 Acknowledgements

- Santa Clara County returns an Interchange Acknowledgment (TA1) segment when requested, based on the value transmitted in ISA14.
- Santa Clara County provides Implementation Acknowledgment transactions (999) for all inbound Functional Groups (i.e., 837s).
- Santa Clara County provides the Health Care Claim Acknowledgment transaction (277CA) for all claims. Only accepted claims will be assigned a SANTA CLARA COUNTY claim ID.
- Santa Clara County does not request the Interchange Acknowledgments (TA1) segment on outbound interchanges.
- Santa Clara County accepts, but does not require or process, Implementation Acknowledgment (999) transactions for all outbound Functional Groups.

9.2 Linking an 837 to the 277CA

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

9.3 277CA Claim Status Codes

The following are most common rejection Claim Status Codes returned on the Santa Clara County 277CA:

Inbound 837P Claim Rejections	Claim Status Codes on Santa Clara County 277CA
Client's date of birth does not match	A7:0
Void or Replacement Claim with invalid Payer Claim Control #	A7:0
Void or Replacement Claim where Client ID/MSO # on the Void or Replacement does not match the Client ID/MSO # of the original claim	A7:0
Date of Service is a future date	A7:0
Procedure code not defined in SANTA CLARA COUNTY MSO HCPC/CPT table	A7:21 & A7:454
Client ID with the 'MSO' prefix but does not exist in SANTA CLARA COUNTY	A7:33
Client ID without the 'MSO' prefix	A7:33
Total claim charge amounts not equal sum of line-item charge amount	A7:178
Claim is out of balance – service line paid amount + all service line adjustment amounts do not equal the line-item charge amount	A7:400
Diagnosis Code Not Defined in SANTA CLARA COUNTY Diagnosis Table	A7:477
A claim will be rejected if an ICD-9 diagnosis indicator is received and the service date (outpatient) or discharge/thru date (inpatient) are on or after the ICD-10 cutover date.	A7:477
Submitter ID NOT found	A7:478

Other Payer Primary ID is missing or invalid or the value sent in the 2330 loop does not match the value sent in the 2430 loop	A7:479

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

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

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

10. Remittance (835)

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

REF - Version Identification		
REF01	Reference Identification Qualifier	F2
REF02	Reference Identification	AVATAR MSO 2017
DTM - Production Date		
DTM01	Date/Time Qualifier	405
DTM02	Date	
PAYER IDENTIFICATION - LOOP 1000A		
N1 - Payer Identification		
N101	Entity Identifier Code	
N102	Name	SANTA CLARA COUNTY
N103	Identification Code Qualifier	
N104	Identification Code	
N3 - Payer Address		
N301	Address Information	
N302	Address Information	
N4 - Payer City, State, ZIP		
N401	City Name	
N402	State or Province Code	
N403	Postal Code	Zip Code+4 (ex. 951282651)
N404	Country Code	
N405	Location Qualifier	
N406	Location Identifier	
N407	Country Subdivision Code	
REF - Additional Payer Identification		
REF01	Reference Identification Qualifier	2U=Payer Identification Number EO=Submitter Identification Number HI=Health Industry Number (HIN) NF=National Association of Insurance Commissioners (NAIC) Code
REF02	Reference Identification	

PER - Payer Contact Information		
PER01	Contact Function Code	CX=Payers Claim Office
PER02	Name	
PER03	Communication Number Qualifier	TE=Telephone
PER04	Communication Number	
PER05	Communication Number Qualifier	EM=Electronic Mail
PER06	Communication Number	
PER07	Communication Number Qualifier	
PER08	Communication Number	
PER - Payer Technical Contact Information		
PER01	Contact Function Code	BL - Technical Department
PER02	Name	
PER03	Communication Number Qualifier	EM=Electronic Mail TE=Telephone UR=Uniform Resource Locator (URL)
PER04	Communication Number	
PER05	Communication Number Qualifier	EM=Electronic Mail EX=Telephone Extension FX=Facsimile TE=Telephone UR=Uniform Resource Locator (URL)
PER06	Communication Number	
PER07	Communication Number Qualifier	EM=Electronic Mail EX=Telephone Extension FX=Facsimile UR=Uniform Resource Locator (URL)
PER08	Communication Number	
PAYEE IDENTIFICATION - LOOP 1000B		
N1 - Payee Identification		
N101	Entity Identification Code	PE
N102	Name	
N103	Identification Code Qualifier	
N104	Identification Code	
N3 - Payee Address		
N301	Address Information	
N302	Address Information	

N4 - Payee City, State, Zip Code		
N401	City Name	
N402	State or Province Code	
N403	Postal Code	Zip Code+4 (ex. 951282651)
N404	Country Code	
N405	Location Qualifier	
N406	Location Identifier	
N407	Country Subdivision Code	
REF - Payee Additional Identification		
REF01	Reference Identification Qualifier	TJ - Federal Tax ID
REF02	Reference Identification	

LOOP 2000		
LX - Header Number		
LX01	Assigned Number	
CLAIM PAYMENT INFORMATION - LOOP 2100		
CLP - Claim Payment Information		
CLP01	Claim Submitter's Identifier	
CLP02	Claim Status Code	1=Processed as Primary 2=Processed as Secondary 3=Processed as Tertiary 4=Denied 19=Processed as Primary, Forwarded to Additional Payer(s) 20=Processed as Secondary, Forwarded to Additional Payer(s) 21=Processed as Tertiary, Forwarded to Additional Payer(s) 22=Reversal of Previous Payment 23=Not Our Claim, Forwarded to Additional Payer(s) 25=Predetermination Pricing Only - No Payment
CLP03	Monetary Amount	
CLP04	Monetary Amount	

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

DTM01	Date/Time Qualifier	232=Claim Statement Period Start 233=Claim Statement Period End
DTM02	Date	
AMT - Claim Supplemental Information		
AMT01	Amount Qualifier Code	AU=Coverage Amount D8=Discount Amount F5=Patient Amount Paid
AMT02	Monetary Amount	
SERVICE PAYMENT INFORMATION - LOOP 2110		
SVC - Service Payment Information		
SVC01	COMPOSITE MEDICAL PROCEDURE IDENTIFIER	
SVC01-1	Product/Service ID Qualifier	HC - HCPC/CPT Codes
SVC01-2	Product/Service ID	
SVC01-3	Procedure Modifier	
SVC01-4	Procedure Modifier	
SVC01-5	Procedure Modifier	
SVC01-6	Procedure Modifier	
SVC01-7	Description	
SVC02	Monetary Amount	
SVC03	Monetary Amount	
SVC04	Product/Service ID	
SVC05	Quantity	
SVC06	COMPOSITE MEDICAL PROCEDURE IDENTIFIER	
SVC06-01	Product/Service ID Qualifier	
SVC06-02	Product/Service ID	
SVC06-03	Procedure Modifier	
SVC06-04	Procedure Modifier	
SVC06-05	Procedure Modifier	
SVC06-06	Procedure Modifier	
SVC06-07	Description	
SVC07	Quantity	

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

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

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

11. Appendix A

11.1. 837P Examples

```
ISA*00*          *00*          *30*941496052*30*946000533*220617*1126*!*00501*171126031*1*T*:~
GS*HC*941496052*946000533*20220617*112631*171126031*X*005010X222A1~
ST*837*000000001*005010X222A1~
BHT*0019*00*12345H*20220617*112631*CH~
NM1*41*2*MOMENTUM FOR MENTAL HEALTH*****46*30700~
PER*IC*BILLING DEPARTMENT*TE*6264409803~
NM1*40*2*Santa Clara County*****46*CSC001~
HL*1**20*1~
NM1*85*2*MOMENTUM FOR MENTAL HEALTH*****46*1154426807~
N3*2001 The Alameda~
N4*SAN JOSE*CA*951261136~
REF*EI*~
PER*IC*BILLING MANAGER*TE*4082929353~
HL*2*1*22*0~
SBR*P*18**SANTA CLARA COUNTY*****MC~
NM1*IL*1*MOMENTUM*MICHELLE****MI*CSC2623~
N3*123 APPLE STREET~
N4*SAN FRANCISCO*CA*908019998~
DMG*D8*19650101*F~
NM1*PR*2*SANTA CLARA COUNTY*****PI*MSO001~
N3*828 SOUTH BASCOM AVENUE~
N4*SAN JOSE*CA*961160000~
CLM*26031*152.4***11:B:1*Y*A*Y*Y~
HI*ABK:F3181~
NM1*82*1*WAYNE*HEATHER****XX*1407311459~
PRV*PE*PXC*2084P0800X~
LX*1~
SV1*HC:T1017:HE*152.40*MJ*60*11**1~
DTP*472*D8*20210923~
REF*G1*P133~
NTE*DCP*55~
SE*30*000000001~
GE*1*171126031~
IEA*1*171126031~
```

Annotations:

- 30700 — CCP ID #
- 1154426807 — Treating Facility's NPI
- CSC2623 — 'CSC' and CSC Client ID
- 1407311459 — Rendering Provider's NPI
- REF*G1*P133~ — Authorization Number assigned by CSC
- NTE*DCP*55~ — Evidenced Based Practice

11.1.2. OHC (Other Health Care)-Santa Clara County - PENDING

```
ISA*00*          *00*          *30*951234567      *30*681234567      *190529*0926*!*00501*290926008*1*T*:~
GS*HC*951234567*681234567*20190529*092608*2992608*X*005010X222A1~
ST*837*000000001*005010X222A1~
BHT*0019*00*12345H*20190529*092608*CH~
NM1*41*2*CERTIFIED CONTRACTING PROVIDER*****46*951234567~
PER*IC*BILLING DEPARTMENT*TE*8005559803~
NM1*40*2*SANTA CLARA COUNTY*****46*CSC001~
HL*1**20*1~
NM1*85*2*CONTRACTING PROVIDER*****XX*1659566404~
N3*1234 32ND STREET~
N4*SAN JOSE*CA*951281234~
REF*EI*741609108~
PER*IC*BILLING MANAGER*TE*8005558577~
HL*2*1*22*0~
SBR*S*18**CSC001*****MC~
NM1*IL*1*CLIENT*TEST****MI*CSC124479~
N3*125 SAN CARLOS AVE*APT 123~
N4*SAN JOSE*CA*787231234~
DMG*D8*19800101*M~
NM1*PR*2*DMH*****PI*01 DMH MENTAL HEALTH SERVICES~
N3*1901 16TH STREET~
N4*SACRAMENTO*CA*95814~
CLM*26008*125***11:B:1*Y*A*Y*Y~
HI*ABK:F319~
NM1*82*1*THERAPIST*JIM****XX*1245319599~
SBR*P*18**AETNA INSURANCE - RISK HMO*****CI~
AMT*D*105~
AMT*EAF*20~
OI***Y***Y~
NM1*IL*1*CLIENT*TEST****MI*CSC124479~
N3*125 SAN CARLOS AVE*APT 123~
N4*SAN JOSE*CA*787231234~
NM1*PR*2*AETNA INSURANCE - RISK HMO*****PI*60054~
LX*1~
SV1*HC:99203:U8*125*MJ*60***1~
DTP*472*D8*20190501~
REF*G1*27279~
NTE*DCP*55~
SVD*60054*105*HC:99203:U8**2~
CAS*CO*45*20~
DTP*573*D8*20190525~
SE*40*000000001~
GE*1*2992608~
IEA*1*290926008~
```

Drug Medi-Cal is identified as the secondary insurance in SBR01

The OHC payer is identified as the Primary.

The coordination benefits (COB) amount paid

Other Payer Name – NM109 contains the Payer's ID

Service Line Adjudication Information: Identifies the payer, amount paid by the payer for the service, the claim adjustment reason code (CARC), and the Remittance Date

11.1.3 Santa Clara County Claim with Patient Payment

```
ISA*00*          *00*          *30*941496052*30*946000533*220617*1126*!*00501*171126031*1*T*:~
GS*HC*941496052*946000533*20220617*112631*171126031*X*005010X222A1~
ST*837*000000001*005010X222A1~
BHT*0019*00*12345H*20220617*112631*CH~
NM1*41*2*MOMENTUM FOR MENTAL HEALTH*****46*30700~
PER*IC*BILLING DEPARTMENT*TE*6264409803~
NM1*40*2*Santa Clara County*****46*CSC001~
HL*1**20*1~
NM1*85*2*MOMENTUM FOR MENTAL HEALTH*****46*1154426807~
N3*2001 The Alameda~
N4*SAN JOSE*CA*951261136~
REF*EI*~
PER*IC*BILLING MANAGER*TE*4082929353~
HL*2*1*22*0~
SBR*P*18**SANTA CLARA COUNTY*****MC~
NM1*IL*1*MOMENTUM*MICHELLE****MI*CSC2623~
N3*123 APPLE STREET~
N4*SAN FRANCISCO*CA*908019998~
DMG*D8*19650101*F~
NM1*PR*2*SANTA CLARA COUNTY*****PI*MSO001~
N3*828 SOUTH BASCOM AVENUE~
N4*SAN JOSE*CA*961160000~
CLM*26031*152.4***11:B:1*Y*A*Y*Y~
AMT*F5*20~
HI*ABK:F3181~
NM1*82*1*WAYNE*HEATHER****XX*1407311459~
PRV*PE*PXC*2084P0800X~
LX*1~
SV1*HC:T1017:HE*152.40*MJ*60*11**1~
DTP*472*D8*20210923~
REF*G1*P133~
NTE*DCP*55~
SE*30*000000001~
GE*1*171126031~
IEA*1*171126031~
```

$20.00 Patient Payment

11.2. Voids and Replacements

11.2.1 Replacement Claim of an Approved Claim

```
ISA*00*          *00*          *30*941496052*30*946000533*220617*1126*!*00501*171126031*1*T*:~
GS*HC*941496052*946000533*20220617*112631*171126031*X*005010X222A1~
ST*837*000000001*005010X222A1~
BHT*0019*00*12345H*20220617*112631*CH~
NM1*41*2*MOMENTUM FOR MENTAL HEALTH*****46*30700~
PER*IC*BILLING DEPARTMENT*TE*6264409803~
NM1*40*2*Santa Clara County*****46*CSC001~
HL*1**20*1~
NM1*85*2*MOMENTUM FOR MENTAL HEALTH*****46*1154426807~
N3*2001 The Alameda~
N4*SAN JOSE*CA*951261136~
REF*EI*~
PER*IC*BILLING MANAGER*TE*4082929353~
HL*2*1*22*0~
SBR*P*18**SANTA CLARA COUNTY*****MC~
NM1*IL*1*MOMENTUM*MICHELLE****MI*CSC2623~
N3*123 APPLE STREET~
N4*SAN FRANCISCO*CA*908019998~
DMG*D8*19650101*F~
NM1*PR*2*SANTA CLARA COUNTY*****PI*MSO001~
N3*828 SOUTH BASCOM AVENUE~
N4*SAN JOSE*CA*961160000~
CLM*26031*152.4***11:B:7*Y*A*Y*Y~
REF*F8*3656~
HI*ABK:F3181~
NM1*82*1*WAYNE*HEATHER****XX*1407311459~
PRV*PE*PXC*2084P0800X~
LX*1~
SV1*HC:T1017:HE*152.40*MJ*60*11**1~
DTP*472*D8*20210923~
REF*G1*P133~
NTE*DCP*55~
SE*30*000000001~
GE*1*171126031~
IEA*1*171126031~
```

CLM05-3 must have a value of 7 (Replacement)

REF02 -Payer Claim Control Number from the 835 of the claims being replaced

11.2.2 Void an Approved Claim

```
ISA*00*          *00*          *30*941496052*30*946000533*220617*1126*!*00501*171126031*1*T*:~
GS*HC*941496052*946000533*20220617*112631*171126031*X*005010X222A1~
ST*837*000000001*005010X222A1~
BHT*0019*00*12345H*20220617*112631*CH~
NM1*41*2*MOMENTUM FOR MENTAL HEALTH*****46*30700~
PER*IC*BILLING DEPARTMENT*TE*6264409803~
NM1*40*2*Santa Clara County*****46*CSC001~
HL*1**20*1~
NM1*85*2*MOMENTUM FOR MENTAL HEALTH*****46*1154426807~
N3*2001 The Alameda~
N4*SAN JOSE*CA*951261136~
REF*EI*~
PER*IC*BILLING MANAGER*TE*4082929353~
HL*2*1*22*0~
SBR*P*18**SANTA CLARA COUNTY*****MC~
NM1*IL*1*MOMENTUM*MICHELLE****MI*CSC2623~
N3*123 APPLE STREET~
N4*SAN FRANCISCO*CA*908019998~
DMG*D8*19650101*F~
NM1*PR*2*SANTA CLARA COUNTY*****PI*MSO001~
N3*828 SOUTH BASCOM AVENUE~
N4*SAN JOSE*CA*961160000~
CLM*26031*152.4***11:B:8*Y*A*Y*Y~
REF*F8*3656~
HI*ABK:F3181~
NM1*82*1*WAYNE*HEATHER****XX*1407311459~
PRV*PE*PXC*2084P0800X~
LX*1~
SV1*HC:T1017:HE*152.40*MJ*60*11**1~
DTP*472*D8*20210923~
REF*G1*P133~
NTE*DCP*55~
SE*30*000000001~
GE*1*171126031~
IEA*1*171126031~
```

CLM05-3 must have a value of 8 (Void)

REF02 -Payer Claim Control Number from the 835 of the claims being voided

11.3. 277CA Examples

11.3.1 277CA

```
CSC*00*          *00*          *ZZ*951234567      *ZZ*681234567      *190610*1256*^*00501*000000002*0*T*:~
GS*HN*951234567*681234556*20190610*125648*2*X*005010X214~
ST*277*0002*005010X214~
BHT*0085*08*2*20190610*125648*TH~
HL*1**20*1~
NM1*PR*2*SANTA CLARA COUNTY*****PI*681234556~
TRN*1*20190610125648~
DTP*050*D8*20190610~
DTP*009*D8*20190610~
HL*2*1*21*1~
NM1*41*2*CONTRACTING PROVIDER*****46*951234567~
TRN*2*000000001~
STC*A2:20*20190610*WQ*60~
QTY*90*1~
AMT*YU*60~
HL*3*2*19*1~
NM1*85*2*CONTRACTING LOCATION*****XX*1689710568~
TRN*1*0~
STC*A2:20**WQ*60~
QTY*QA*1~
AMT*YU*60~
HL*4*3*PT~
NM1*QC*1*CLIENT*TREATMENT****MI*SCC19369~
TRN*2*36044~
STC*A2:20*20190610*WQ*60~
REF*1K*1~
DTP*472*D8*20190421~
SE*26*0002~
GE*1*2~
IEA*1*000000002~
```

2200B Loop - Information Receiver Application Trace ID

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

2200B Loop - Information Receiver Application Trace ID

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

*A full list of Claim Status Category Codes is available at the following website

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

Claim Status Category Code

A2 – Acknowledgement/Accepted into Santa Clara County for adjudication

11.4. 835 Examples

11.4 1. Standard 835

Approved Claim

```
ISA*00*          *00*          *ZZ*681234567      *ZZ*951234567      *190605*0850*^*00501*050850015*0*T*:~
GS*HP*681234567*951234567*20190605*085015*2*X*005010X221A1~
ST*835*0010~
BPR*I*60*C*CHR***********20190605~
TRN*1*378560*1953893470~
REF*F2*AVATAR MSO 2019~
DTM*405*20190605~
N1*PR*SANTA CLARA COUNTY~
N3*2325 ENBORG LN~
N4*SAN JOSE*CA*951281234~
PER*BL*Avatar Support*TE*8665551234~
N1*PE*CONTRACTING PROVIDER*XX*1528263993~
REF*TJ*951234567~
LX*1~
CLP*Cx49814x1*1*60*60**16*1*11*1~
NM1*QC*1*CLIENT*TREATMENT****MI*SC11493~
REF*F8*14877~
DTM*232*20190605~
DTM*233*20190605~
AMT*AU*60~
SVC*HC:99223*60*60**6~
DTM*472*20190605~
REF*BB*P1245~
AMT*B6*60~
SE*23*0010~
GE*1*2~
IEA*1*050850015~
```

Denied Service

```
CLP*Cx49814x1*1*60*0**16*1*11*1~
NM1*QC*1*CLIENT*TREATMENT****MI*SC11493~
REF*F8*14877~
DTM*232*20190605~
DTM*233*20190605~
AMT*AU*60~
SVC*HC:99223*60*0**6~
DTM*472*20190605~
CAS*CO*96*60~
REF*BB*P1538~
LQ*HE*N216~
```

CAS02 - Service denied with Claim Adjustment Reason Code* (CARC) CO96 – Non-covered charge(s). At least one Remark Code must be Provider

LQ02 – Remark Code** N216 – We do not offer coverage for this type of service, or the patient is not enrolled in this portion of our benefit package

*Complete list of Claim Adjustment Reason Codes is available at:

http://www.x12.org/codes/claim-adjustment-reason-codes/

**Complete list of Remark Codes is available at:

http://www.wpc-edi.com/reference/codelists/healthcare/remittance-advice-remark-codes/

11.4.2 Takeback

```
ISA*00*          *00*          *ZZ*681234567      *ZZ*951234567      *190605*0850*^*00501*050850015*0*T*:~
GS*HP*681234567*951234567*20190605*085015*2*X*005010X221A1~
ST*835*0010~
BPR*I*0*C*NON************20190605~
TRN*1*34_DENIED_137*1953893470~
REF*F2*AVATAR MSO 2019~
DTM*405*20190605~
N1*PR*SANTA CLARA COUNTY~
N3*2325 ENBORG LN~
N4*SAN JOSE*CA*951281234~
PER*BL*Avatar Support*TE*8665551234~
N1*PE*CONTRACTING PROVIDER*XX*1528263993~
REF*TJ*951234567~
LX*1~
CLP*49814*22*-28*-28**MC*288*11*1~
NM1*QC*1*CLIENT*TREATMENT****MI*SC11493~
REF*F8*14877~
DTM*232*20190605~
DTM*233*20190605~
SVC*HC:99223*-28*-28**1~
DTM*472*20190605~
REF*BB*P1538~
AMT*B6*-28~
CLP*49814*1*28*0**HM*288*11*1~
NM1*QC*1*CLIENT*TREATMENT****MI*SC11493~
REF*F8*14877~
DTM*232*20190605~
DTM*233*20190605~
SVC*HC:99223*28*0**1~
DTM*472*20190605~
CAS*CO*177*28*1~
REF*BB*P1538~
PLB*1619008380*20190610*FB:34_DENIED_137*-28~
SE*32*0010~
GE*1*2~
IEA*1*050850015~
```

This 835 only contains a takeback due to a State Denials and is processed as a $0.00 payment with a future deduction listed in the PLB segment

The first loop of 2100 – 2110 segments contain a negative transaction to takeback funds previously paid for this claim.

The CLP and SVC segments contain a negative payment of -$28.00

The second loop of 2100 – 2110 segments contain the denial of the claim. The CAS segment contains the CARC from Drug Medi-Cal

PLB Segment shows the amount of a future takeback. This amount will be deducted from the next 835(s) until full amount has been consumed.