



5010 Simplified Gap Analysis Professional Claims

Based on ASC X12 837 v5010 TR3 X222A1

Version 2.0 August 2010



This information is provided by Emdeon for education and awareness use only. Even though Emdeon believes that all the information in this document is correct as of July 2010, Emdeon does not warrant the accuracy, completeness, or fitness for any particular purpose of this information. All use is at the reader's own risk. The information provided here is for reference use only and does not constitute the rendering of legal, financial, or other professional advice or recommendations by Emdeon.

© 2010, Emdeon Business Services, LLC, 3055 Lebanon Pike Suite 1000, Nashville, TN 37214.

All Rights Reserved. Printed in the USA.



OVERVIEW

PURPOSE

Claim submitters typically enter the billing information into a Practice Management System or billing system that provides data entry screens. The format that is transmitted out of that system may not be known by the person using the system. This makes it difficult for the billing office to determine their gaps with regards to the HIPAA data content. The purpose of this document is to provide a tool that removes the formatting from the data content included in the X12 005010 HIPAA Technical Report 3 (TR3) X222A1. The information is presented in logical groupings rather than in the order of the TR3.

ROLE OF CLEARINGHOUSE

The Administrative Simplification Act allows the clearinghouse to take in non-standard formats and translate them into the standard format. In order to ensure that the standard format is compliant, the clearinghouse must receive the required data content from the provider regardless of the format that the provider is using to transmit the data. This document outlines the rules for the data content to help claim submitters determine what they need to do to reach a state of compliance for the type of services that they perform.

ROLE OF SOFTWARE VENDOR

As stated above, the clearinghouse can only translate the data content into the standard format if the content is present in the transaction. The software vendor must ensure that the provider can enter the required data into the system for transmission either directly to the payer or through a clearinghouse. If the software does not have the ability to generate the ASC X12 837 (005010X222A1), the claims cannot be sent directly to the payer and must go through a clearinghouse for translation. The provider should use this document to determine whether the software being used in the collection of data for electronic submission meets the HIPAA requirements. If gaps are found, the provider should work with their vendor to ensure that the gaps will be accounted for prior to the mandated date.

TECHNICAL REPORT 3 (TR3)

This document should be used along with the X12 5010 Professional TR3 X222A1. To obtain your copy of the TR3 and Errata visit the X12 Web Site at:

<http://www.X12.org>
Health Care Claims: Professional 837
ASC X12 837 (005010X222A1)

TEXT LEGEND



White Text - Green Background

Indicates a grouping of information. The groups of information are outlined in the section of this overview titled Grouping of Information.

Black Text - Orange Background

Indicates a subgroup of information that is REQUIRED on all claims regardless of the provider or procedures being rendered.

White Text - Orange Background

Indicates a subgroup of information that is SITUATIONALLY REQUIRED based on the services or situation presented in the claim.

Black Text - White Background

Indicates a Data Element that is SITUATIONALLY REQUIRED based on the services or situation presented in the claim. The * indicates that there is also a code change for this element.

Red Text - White Background

Indicates a Data Element that is REQUIRED whenever the subgroup of information is used. The * indicates that there is also a code change for this element.

Black Text - Green Background

Indicates a Data Element new in 005010 X222A1 that is SITUATIONALLY REQUIRED based on the services or situation presented in the claim.

Red Text - Green Background

Indicates a Data Element new in 005010 X222A1 that is REQUIRED based on the services or situation presented in the claim.

Black Text - Gray Background

Indicates a Data Element removed in 005010 X222A1 that was in the 004010 X098A1.

Black Text - Yellow Background

Indicates a Data Element changed in 005010 X222A1 with the Errata.

GROUPING OF INFORMATION

OVERVIEW

The information in this document has been divided into logical groups of information. The intent is to present the information in a similar manner to the data entry screens and claim forms typically used by claim submitters

BATCH LEVEL INFORMATION

Reflects the data pertaining to the Billing Provider and Pay-to Address.

HIGH LEVEL INFORMATION

Reflects the data pertaining to the subscriber and patient. This information would apply to the entire claim.

CLAIM/BILL INFORMATION

Applies to the entire claim and all service lines within the claim. Some of the data can be overridden at the service line level. Information in this group is applicable to most claims regardless of the provider or procedures being performed.

SPECIALTY CLAIM/BILL INFORMATION

Applies to specific claim types as indicated in the subgroup heading. Required data in these subgroups are only required for the specific claim type.

SERVICE LINE INFORMATION

The data in this group is specific to the procedure or service that is being rendered. If some of the data in this group is carried at the claim level, the service line information should only be entered when different from the claim. Information in this group is applicable to most claims regardless of the provider or procedures being performed.

SPECIALTY SERVICE LINE INFORMATION

The data in this group is used for specific claim types as indicated in the subgroup heading. Required data in these subgroups is only required for the specific claim type.



GROUPING OF INFORMATION

SECONDARY BILLING

COB Claim/Line Information

Used for submitting claims to a secondary payer(s). The information should be cross walked from the remittance advice of the payer(s) and should reflect the adjudication information.

OTHER INFORMATION

Repriced Claim/Line Information

Used only by third party repricers to carry the repricing information for adjudication purposes and must never be submitted by a provider.

Clearinghouse/Van Information

Added by the clearinghouse or VAN for tracking purposes.

Subrogation

Used by Medicaid to submit claims to a Health Plan for reimbursement.

WORKERS' COMPENSATION

Subscriber Information

Workers' Compensation Bills are different from Group Health Claims when reporting Subscriber Information. In Workers' Compensation Bills the Subscriber is the Employer of the Patient.

Other Information

Based on State Jurisdiction data elements listed in the specialty section for Workers' Compensation Bills may be required. Providers should check with the State Department of Workers' Compensation for the jurisdiction of the bill to determine the requirements.

5010 GAP ANALYSIS SIMPLIFIED FOR PROFESSIONAL CLAIM 837 VERSION 5010 X222A1

Batch Level Information

Billing Provider

Taxonomy code

Currency Code

Entity Type Qualifier

Last/Org Name

First Name

Middle Name or Initial

Name Suffix

NPI

Address 1

Address 2

City Name

State / Province Code

Postal Zone or Zip Code

Country Code

Country Subdivision Code

Blue Cross Number

Blue Shield Number

Medicare Number

Medicaid Number

CHAMPUS Id Number

Facility ID Number

PPO Number

HMO Number

Clinic Number

Commercial Number

Site Number

Location Number

USIN

State Industrial Acc Number

Tax Identification Number

EIN

SSN

UPIN/License Information

State License Number

UPIN

Contact Name

Communication Number

Email

Telephone Extension

FAX

Telephone

Pay-to Address

Taxonomy code

Last/Org Name

First Name

Middle Name or Initial

Name Suffix

Primary Identifier

EIN

SSN

NPI

Address 1

Address 2

City Name

State / Province Code

Postal Zone or Zip Code

Country Code

Country Subdivision Code

Secondary Identifiers

State License Number

Blue Cross Number

Blue Shield Number

Medicare Number

Medicaid Number

UPIN

CHAMPUS Id Number

Facility ID Number

PPO Number

HMO Number

Clinic Number

Commercial Number

Site Number

Location Number

USIN Number

State Industrial Acc Number

High Level Information

Subscriber (Employer)

Payer Responsibility Code *

Group or Policy Number

Group Name

Insurance Type Code

Claim Filing Indicator Code *

Last/Org Name

First Name

Middle Name or Initial

Name Suffix

Primary Identifier

Standard Unique Health Identifier

Member Identification Number

HIPAA Individual Identifier

Secondary Identifiers

Member Id

IHS Number

Insurance Policy Number

SSN

Other Subscriber Information

Individual Relationship Code

Date of Birth

Gender

Address 1

Address 2

City Name

State / Province Code

Postal Zone or Zip Code

Country Code

Country Subdivision Code

Patient

Individual Relationship Code *

Patient Death Date

Patient Weight

Pregnancy Indicator

Last Name

First Name

Middle Name or Initial

Name Suffix

Primary Identifier

Member Identification Number

HIPAA Individual Identifier

Address 1

Address 2

City Name

State or Province Code

Postal Zone or Zip Code

Country Code

Country Subdivision Code

Date of Birth

Gender

Secondary Identifiers

Member Id

IHS Number

Insurance Policy Number

SSN

Payer (11 Repeats)

Payer Name

Primary Identifier

Payer Identification

CMS Plan ID

Address 1

Address 2

City Name

State / Province Code

Postal Zone or Zip Code

Country Code

Country Subdivision Code

Secondary Identifiers

EIN

Claim Office Number

NAIC Number

TIN

Billing Provider Secondary Identifiers

Location Number

Payer Assigned ID

Assignment or Plan Participation Code *

Benefits Assignment Indicator *

Release of Information Code *

Patient Signature Source Code *

Prior Authorization Number

Referral Number

Payer Claim Control Number

Contact Name

Communication Number

EDI Access Number

E-Mail

Facsimile

Telephone

Telephone Ext

High Level Information

Responsible Party

Last/Org Name

First Name

Middle Name or Initial

Name Suffix

Address 1

Address 2

City Name

State / Province Code

Postal Zone or Zip Code

Country Code

Claim/Bill Information

Generic Claims

Patient Control Number
Total Claim Charge Amount
Place Of Service Code
Claim Frequency Code
Provider or Supplier Signature Indicator

Participation Agreement

Delay Reason Code

Onset of Current Illness or Injury Date

Initial Treatment Date

Last Seen Date

Last Menstrual Period Date

Similar Illness or Symptom Date

Admission Date

Discharge Date

Relinquished Care Date

Assumed Care Date

Patient Amount Paid

Service Authorization Exception Code

CLIA NUMBER

IDE Identifier

Medical Record Number

Demonstration Project Identifier

State / Regulatory Information

Claim Note Text

Homebound Indicator

Diagnosis Type Code

Diagnosis Code (1)

Diagnosis Code (2-8)

Diagnosis Code (9-12)

Condition Code (1- 12)

Supplemental Information (Repeat 10)

Attachment Report Type Code *

Attachment Transmission Code *

Attachment Control Number

Contract Information

Contract Type Code

Contract Amount

Contract Percentage

Contract Code

Terms Discount Percentage

Contract Version Identifier

Rendering Provider

Last/Org Name

First Name

Middle Name or Initial

Name Suffix

Primary Identifier

EIN

SSN

NPI

Provider Taxonomy Code

Secondary Identifiers

State License Number

Blue Shield Number

Medicare Number

Medicaid Number

UPIN

Champus Number

Commercial Number

Location Number

Network ID

State Industrial Acc Number

Service Facility Location

Organization Name

Primary Identifier

EIN

SSN

NPI

Address 1

Address 2

City Name

State / Province Code

Postal Zone or Zip Code

Country Code

Country Subdivision Code

Secondary Identifiers

State License Number

Blue Cross Number

Blue Shield Number

Medicare Number

Medicaid Number

UPIN

Champus Number

Commercial Number

Location Number

Network ID

CLIA Number

State Industrial Acc Number

Claim/Bill Information

Referring / PCP Providers (2 Repeats)

Last Name

First Name

Middle Name or Initial

Name Suffix

Primary Identifier

EIN

SSN

NPI

Provider Taxonomy Code

Secondary Identifiers

State License Number

Blue Shield Number

Medicare Number

Medicaid Number

UPIN

Champus Number

Commercial Number

Location Number

Network ID

State Industrial Acc Number

Specialty Claim/Bill Information

CMS Claims

Special Program Indicator *
 Medicare Section 4081 Indicator
 APG Number
 Care Plan Oversight Number

Related Causes

Auto Accident
 Another Party Responsible
 Employment Related
 Other Accident
 Related-Causes Code
 Auto Accident State/Prov Code
 Auto Accident Country Code
 Accident Date
 Accident Hour

EPSDT Claims

Certification Condition Indicator
EPSDT Condition Code (1)
 EPSDT Condition Code (2)

Worker Comp/Disability/P&C Claims

Subscriber (Employer) Information Contact
 Subscriber (Employer) Telephone Number
 Subscriber (Employer) Telephone Extension
 Patient Secondary Identifier
 Member Id
 SSN

Property Casualty Claim Number
 Patient Contact Name
 Patient Telephone Number
 Patient Telephone Extension
 Disability
 Initial Disability Period Start
 Initial Disability Period End

Last Worked Date
 Work Return Date

First Visit or Consultation
 Service Facility Contact Name
 Service Facility Telephone Number
 Service Facility Telephone Extension

Mammography Claims

Mammography Certification Number

Spinal Manipulations Claims

Acute Manifestation Date
 Last X-Ray Date
 Patient Condition Code
 Patient Condition Description (2)
 X-Ray Availability Indicator

Hearing and Vision Claims

Prescription Date
 Code Category
 Vision Condition Code (5)

Anesthesia Claims

Related Surgical Procedure (2)

Ambulance Claims

Patient Weight
 Transport Code
 Transport Reason Code
 Transport Distance
 Round Trip Purpose Description
 Stretcher Purpose Description
 Certification Condition Indicator (3)
 Condition Code (5)

Pick-up Address 1
 Pick-up Address 2
 Pick-up City Name
 Pick-up Location State / Province Code
 Pick-up Postal Zone or Zip Code
 Pick-up Country Code
 Pick-up Country Subdivision Code
 Drop-off Location Organization Name
 Drop-off Location Address 1
 Drop-off Location Address 2
 Drop-off Location City Name
 Drop-off Location State / Province Code
 Drop-off Location Postal Zone or Zip Code
 Drop-off Location Country Code
 Drop-off Location Country Subdivision Code

Purchased Service Claims

Total Purchased Service Amount

Specialty Claim/Bill Information

Purchase Service Provider

Last/Org Name

Name First

Middle Name or Initial

Primary Identifier

EIN

SSN

NPI

Secondary Identifiers

State License Number

Blue Cross Number

Blue Shield Number

Medicare Number

Medicaid Number

UPIN

Champus Number

Commercial Number

Location Number

Network ID

USIN

State Industrial Acc Number

Home Health Treatment Plan

Discipline Type Code

Total Visits Rendered Count

Certification Period Projected Visit Count

Number Of Visits

Modulus UBM Code

Modulus Amount

Number of Periods

Calendar Pattern Code

Delivery Pattern Time Code

Supervising Provider Information

Last Name

First Name

Middle Name or Initial

Name Suffix

Primary Identifier

EIN

SSN

NPI

Secondary Identifiers

State License Number

Blue Shield Number

Medicare Number

Medicaid Number

UPIN

Champus Number

Commercial Number

Location Number

Network ID

State Industrial Acc Number

Service Line Information

Generic Claims

Procedure Code

Procedure Modifier 1

Procedure Modifier 2

Procedure Modifier 3

Procedure Modifier 4

Procedure Code Description

Line Item Charge Amount

Service Unit Type Code

Service Unit Count

Place of Service Code

Diagnosis Code Pointer 1

Diagnosis Code Pointer 2

Diagnosis Code Pointer 3

Diagnosis Code Pointer 4

Emergency Indicator

Family Planning Indicator

Copay Status Code

Service Date

Prescription Date

Treatment or Therapy Date

Shipped Date

Onset Date

Initial Treatment Date

Similar Illness or Symptom Date

Prior Authorization Number

Line Item Control Number

CLIA NUMBER

Referring CLIA Number

Immunization Batch Number

Universal Product Number

Vendor Product Number

Referral Number

Sales Tax Amount

Postage Claimed Amount

State / Regulatory Information

7/6/2010

Line Note Text

Supplemental Information (Repeat 10)

Attachment Report Type Code

Attachment Transmission Code

Attachment Control Number

Contract Information

Contract Type Code

Contract Amount

Contract Percentage

Contract Code

Terms Discount Percentage

Contract Version Identifier

Rendering Provider

Last/Org Name

First Name

Middle Name or Initial

Name Suffix

Primary Identifier

EIN

SSN

NPI

Taxonomy Code

Secondary Identifiers

State License Number

Blue Shield Number

Medicare Number

Medicaid Number

UPIN

Champus Number

Commercial Number

Location Number

Network ID

State Industrial Acc Number

Service Facility Location

Organization Name

Primary Identifier

EIN

SSN

NPI

Address 1

Address 2

City Name

State / Province Code

Postal Zone or Zip Code

Country Code

Country Subdivision Code

Secondary Identifiers

State License Number

Blue Cross Number

Blue Shield Number

Medicare Number

Medicaid Number

UPIN

Champus Number

Commercial Number

Location Number

Network ID

CLIA Number

State Industrial Acc Number

Service Line Information

Referring / PCP Providers (2 Repeats)

Last Name

First Name

Middle Name or Initial

Primary Identifier

EIN

SSN

NPI

Referring Provider Taxonomy Code

Secondary Identifiers

State License Number

Blue Shield Number

Medicare Number

Medicaid Number

UPIN

Champus Number

Commercial Number

Location Number

Network ID

State Industrial Acc Number

Specialty Service Line Information

CMS Claims

Hospice Employee Provider Ind.

APG Number

EPSDT Claims

EPSDT Indicator

Mammography Claims

Mammography Certification Number

Spinal Manipulations Claims

Nature of Condition Code

Patient Condition Description

Patient Condition Description

X-Ray Availability Indicator

Last X-Ray Date

Acute Manifestation Date

Anesthesia Claims

Obstetric Additional Units

Ambulance Claims

Patient Weight

Transport Code

Transport Reason Code

Transport Distance

Round Trip Purpose Description

Stretcher Purpose Description

Certification Condition Indicator (3)

Condition Code (5) *

Patient Count

Pick-up Address 1

Pick-up Address 2

Pick-up City Name

Pick-up State / Province Code

Pick-up Postal Zone or Zip Code

Pick-up Country Code

Pick-up Country Subdivision Code

Drop-off Location Organization Name

Drop-off Address 1

Drop-off Address 2

Drop-off City Name

Drop-off State / Province Code

Drop-off Postal Zone or Zip Code

Drop-off Country Code

Drop-off Country Subdivision Code

Home Health Claims

Quantity (Number of Visits)

Sample Selection Modulus

Duration of Visits, Number of Units

Delivery Pattern Time Code

Purchased Service Claims

Purchased Service Charge Amount

Purchase Service Provider

Primary Identifier

EIN

SSN

NPI

Secondary Identifiers

State License Number

Blue Cross Number

Blue Shield Number

Medicare Number

Medicaid Number

UPIN

Champus Number

Commercial Number

Location Number

Network ID

USIN

State Industrial Acc Number

Home Oxygen Therapy Claims

Oxygen Certification Type Code

Oxygen Treatment Period Count

Oxygen Arterial Blood Gas Quantity

Oxygen Saturation Quantity

Oxygen Test Condition Code

Oxygen Test Finding Code

Oxygen Test Finding Code

Oxygen Test Findings Code

Test Performed

Arterial Blood Gas Test

Oxygen Saturation Test

Oxygen Flow Rate

Specialty Service Line Information

Durable Medical Equipment Claims

Procedure Code

Length of Medical Necessity

DME Rental Amount

DME Purchase Price

Rental Unit Price Indicator

DMERC Claims

Certificate of Medical Necessity Code

Certification Type Code

Duration

Condition Indicator (5) *

Certification Revision/Recertification Date

Begin Therapy Date

Last Certification Date

DMERC Forms

Form Identification Code

Form Identifier

Question Number/Letter

Question Response (4)

Test Results (MEA - 5 Repeats)

Measurement Code

Measurement Type

Test Results

EPO Claims

Most Recent HGB or HCT

Most Recent Serum Creatin

Drug Claims

National Drug Code

Drug Unit Price

National Drug Unit Count

Drug Unit Type

Prescription Number

Ordering Provider Information

Last Name

First Name

Middle Name or Initial

Name Suffix

Primary Identifier

EIN

SSN

NPI

Address 1

Address 2

City Name

State / Province Code

Postal Zone or Zip Code

Country Code

Country Subdivision Code

Secondary Identifiers

State License Number

Blue Shield Number

Medicare Number

Medicaid Number

UPIN

Champus Number

Commercial Number

Location Number

Network ID

State Industrial Acc Number

Contact Name

Communication Number

Email

Telephone Extension

Fax

Telephone

Supervising Provider Information

Last Name

First Name

Middle Name or Initial

Name Suffix

Primary Identifier

EIN

SSN

NPI

Secondary Identifiers

State License Number

Blue Shield Number

Medicare Number

Medicaid Number

UPIN

Champus Number

Commercial Number

Location Number

Network ID

State Industrial Acc Number

Secondary Billing Information

COB Claim Information

CAS Group Code (5)

Reason Code (6)

Amount (6)

Quantity (6)

Payer Paid Amount

Approved Amount

Allowed Amount

Other Payer Patient Responsibility Amount

Other Payer Covered Amount

Other Payer Discount Amount

Other Payer Per Day Limit Amount

Other Payer Patient Paid Amount

Other Payer Tax Amount

Other Payer Pre-Tax Claim Total Amount

Non-Covered Charge Amount

Remaining Patient Liability

Reimbursement Rate

HCPCS Payable Amount

Claim Payment Remark Code (5)

ESRD Payment Amount

Non-payable Professional Component Amount

Adjudication or Payment Date

Other Payer Claim Adjustment Indicator

COB Line Information

Approved Amount

Service Line Paid Amount

Procedure Type Code

Procedure Code

Procedure Modifier 1

Procedure Modifier 2

Procedure Modifier 3

Procedure Modifier 4

Procedure Code Description

Paid Service Unit Count

Bundled or Unbundled Line Number

CAS Group Code (5)

Reason Code (6)

Amount (6)

Quantity (6)

Adjudication or Payment Date

Remaining Patient Liability

Other Information

Repriced Claim Information

Received Date
 Claim Reference Number
 Adjusted Claim Reference Number

Pricing Methodology

Allowed Amount

Savings Amount
 Organization Identifier
 Per Diem or Flat Rate Amount
 Approved APG Code
 Approved APG Amount
 Reject Reason Code
 Policy Compliance Code
 Exception Code

Repriced Line Information

Line Item Reference Number
 Adjusted Line Item Number
 TPO Note

Pricing Methodology

Allowed Amount

Savings Amount
 Organization Identifier
 Per Diem or Flat Rate Amount
 Approved APG Code
 Approved APG Amount
 Approved HCPCS Code
 Approved Service Unit Type Code
 Approved Service Unit Count
 Reject Reason Code
 Policy Compliance Code
 Exception Code

Credit-Debit Information

Secondary Identifiers
 System Number
 Bank Assigned Security Identifier
 Electronic Payment Reference Number
 Standard Industry Classification (SIC)
 Location Number
 Rate Code Number
 Store Number
 Terminal Code
 Cardholder Last/Org Name
 Cardholder First Name
 Cardholder Middle Name or Initial
 Cardholder Name Suffix
 Primary Identifier
 Authorization Number
 Acceptable Source Purchaser ID
 Maximum Amount

Clearinghouse/Van Information

Value Added Network Trace Number

Pay-to Plan (Subrogation Claims)

Organization Name

Primary Identifier

Payer ID
 CMS PlanID

Address 1

Address 2

City Name

State / Province Code
 Postal Zone or Zip Code

Country Code

Country Subdivision Code

Secondary Identifiers

Payer ID
 Claim Office Number

NAIC Number

Tax ID Number