




# **5010 Simplified Gap Analysis Professional Claims**

**Based on ASC X12 837 v5010 TR3 X222**

Version 1.1 December 2009



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# 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 physician's 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 differences between the X12N 004010 Implementation Guide and the X12 005010 HIPAA Technical Report 3 (TR3) X222. 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 (005010x222), 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 X222. To obtain your copy of the TR3 visit the X12 Web Site at:

<http://www.X12.org>  
Health Care Claims: Professional 837  
ASC X12 837 (005010X222)

# TEXT LEGEND



<b>White Text</b> <b>Green Background</b>	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.
<b>Red Text and Red Text *</b> <b>White Background</b>	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 and 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.
Black Text Light Green Background	Indicates a Data Element new in 005010 X222 that is SITUATIONALLY REQUIRED based on the services or situation presented in the claim.
<b>Red Text</b> <b>Light Green Background</b>	Indicates a Data Element new in 005010 X222 that is REQUIRED based on the services or situation presented in the claim.
Black Text Grey Background	Indicates a Data Element removed in 005010 X222 that was in the 004010 X098A1.

# 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 X222

## 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  
 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

### 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

# Specialty Claim/Bill Information

## 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

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

### Durable Medical Equipment Claims

**Procedure Code**

**Length of Medical Necessity**

**DME Rental Amount**

**DME Purchase Price**

**Rental Unit Price Indicator**

## Specialty Service Line Information

### 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

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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