




5010 Simplified Gap Analysis Institutional Claims

Based on ASC X12 837 v5010 TR3 X223A1

Version 1.1 December 2009



This information is provided by Emdeon for education and awareness use only. While Emdeon believes that all the information in this document is correct as of December 2009, 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.

© 2009, Emdeon Corporation, 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 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) X223A1. 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 (005010X223A1), 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 Institutional TR3 X223A1. To obtain your copy of the TR3 visit the X12 Web Site at:

<http://store.X12.org>
Health Care Claims: Institutional 837
ASC X12 837 (005010X223A1)

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.
Red Text and 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 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 X223A1 that is SITUATIONALLY REQUIRED based on the services or situation presented in the claim.
Red Text Light Green Background	Indicates a Data Element new in 005010 X223A1 that is REQUIRED based on the services or situation presented in the claim.
Black Text Grey Background	Indicates a Data Element removed in 005010 X223A1 that was in the 004010 X096A1.

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.



Batch Level Information

Billing Provider

Taxonomy Code

Currency Code

Organization Name

NPI

Address 1

Address 2

City Name

State / Province Code

Postal Zone or Zip Code

Country Code

Country Subdivision Code

EIN

Secondary Identifiers

State License Number

Blue Cross Number

Blue Shield Number

Medicare Number

Medicaid Number

Medicaid Number

CHAMPUS Id Number

UPIN

Facility ID Number

PPO Number

HMO Number

Clinic Number

Commercial Number

Site Number

Location Number

SSN

State industrial Acc Number

Contact Name

Communication Number

Email

Telephone Extension

FAX

Telephone

Pay-to Address

Taxonomy Code

Organization Name

Primary Identifier

NPI

EIN

SSN

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

Facility ID Number

PPO Number

HMO Number

Clinic Number

Commercial Number

Site Number

Location Number

UPIN

State Industrial Acc Number

High Level Information

Subscriber (Employer)

Payer Responsibility Code*

Group or Policy Number

Group Name

Claim Filing Indicator Code*

Last/Org Name

First Name

Middle Name or Initial

Name Suffix

Primary Identifier

Member ID

Standard Unique Health Identifier*

Secondary Identifiers

HIS Health Record Number

Member ID

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*

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

IHS Number

Member Id

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

Billing Provider Payer Assigned ID

Billing Provider Location Number

Assignment or Plan Participation Code*

Benefits Assignment Indicator*

Release of Information Code*

Referral Number

Prior Authorization Number

Payer Claim Control Number

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

Facility Type Code

Claim Frequency Code

Provider or Supplier Signature Indicator

Explanation of Benefits Indicator

Delay Reason Code*

I Discharge Time

Statement From and To Date

I Admission Date and Hour

I Admission Type Code

Admission Source Code

Patient Status Code

Payer Estimated Claim Due Amount

Patient Responsibility Amount

Patient Amount Paid

Service Authorization Exception Code

Investigational Device Exemption Identifier

Medical Record Number

Demonstration Project Identifier

Peer Review Authorization Number

Document Control Identifier

Fixed Format Information

Claim Note Text

Billing Note Text

Principal Diagnosis Type Code*

Principal Diagnosis Code

Present on Admission Indicator

I Admitting Diagnosis

O Patient Reason for Visit (3)

E-Code Diagnosis Type Code*

External Cause of Injury Code (12)

Present on Admission Indicator (12)

Diagnosis Related Group (DRG) Code

Other Diagnosis Type Code*

Other Diagnosis (12)

Present on Admission Indicator (12)

Principal Procedure Type Code*

I Principal Procedure Code

I Principal Procedure Date

Other Procedure Type Code*

I Other Procedure Code (12)

I Procedure Date (12)

Occurrence Span Code (12)

Occurrence Span Code Date (12)

Occurrence Code (12)

Occurrence Code Date (12)

Value Code (12)

Value Code Amount (12)

Condition Code (12)

Covered Days

Coinsurance Days

Lifetime Reserve Days

Non-covered Days

Supplemental Information (Repeat 10)

Attachment Report Type Code*

Attachment Transmission Code*

Attachment Control Number

Attachment Description

Contract Information

Contract Type Code

Contract Amount

Contract Percentage

Contract Code

Terms Discount Percentage

Contract Version Identifier

Rendering Provider

Last Name

First Name

Middle Name or Initial

Name Suffix

Primary Identifier

NPI

Secondary Identifiers

State License Number

UPIN

Commercial Number

Location Number

Attending Physician

Last Name

First Name

Middle Name or Initial

Name Suffix

Primary Identifier

EIN

SSN

NPI

Provider Taxonomy 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

State Industrial Acc Number

Claim/Bill Information

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

Facility ID Number

Clinic Number

Commercial Number

Site Number

Location Number

Network ID

State Industrial Acc Number

Supervising Provider Information

Last Name

First Name

Middle Name or Initial

Name Suffix

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 Number

State Industrial Acc Number

Other Operating Physician Information

Last Name

First Name

Middle Name or Initial

Name Suffix

Primary Identifier

NPI

Secondary Identifiers

State License Number

UPIN

Commercial Number

Location Number

Referring Provider Information

Last Name

First Name

Middle Name or Initial

Name Suffix

Primary Identifier

NPI

Secondary Identifiers

State License Number

UPIN

Commercial Number

Other Provider

Last Name

First Name

Middle Name

Name Suffix

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

State Industrial Acc Number

Specialty Claim/Bill Information

Related Causes

Auto Accident State Code

EPSDT Claims

Certification Condition Indicator

EPSDT Condition Code (1)

EPSDT Condition Code (2)

Worker Comp/Disability/P&C Claims

Property Casualty Claim Number

Home Health Claims

Prognosis Indicator

Service From Date

Certification Period

Diagnosis Date

Skilled Nursing Facility Indicator

Medicare Coverage Indicator

Certification Type Indicator

Surgery Date

Surgical Procedure Type Code

Surgical Procedure Code

Provider Order Date

Last Visit Date

Provider Contact Date

Last Discharge Date

Last Admission Date

Patient Discharge Facility Type Code

Diagnosis Date - 1

Diagnosis Date - 2

Diagnosis Date - 3

Diagnosis Date - 4

Code Category

Certification Condition Indicator

Functional Limitation Code (5)

Code Category

Certification Condition Indicator

Activities Permitted Code (5)

Code Category

Certification Condition Indicator

Mental Status Code (5)

Discipline Type Code

Visits Prior to Recertification Date Count

Certification Period Projected Visit Count

Number of Visits

Frequency Period

Frequency Count

Duration of Visits Units

Duration of Visits

Calendar Pattern Code

Delivery Pattern Time Code

Home Health Treatment Plan

Treatment Code (12)

Service Line Information

Generic Claims

Service Line Revenue Code

Procedure Type Code*
 Procedure Code
 Procedure Modifier 1
 Procedure Modifier 2
 Procedure Modifier 3
 Procedure Modifier 4

Description

Line Item Charge Amount

Unit Type Code*

Service Unit Count

Unit Rate
 Non-covered Charge Amount

○ Service Date

Assessment Date
 Line Item Control Number

Service Tax Amount
 Facility Tax Amount

Supplemental Information (Repeat 10)

Attachment Report Type Code*

Attachment Transmission Code*

Attachment Control Number

Rendering Provider

Last Name

First Name
 Middle Name or Initial
 Name Suffix
 Primary Identifier
 NPI
 Secondary Identifiers
 State License Number
 UPIN
 Commercial Number
 Location Number

Attending Physician

Last/Org Name
 First Name
 Middle Name
 Name Suffix
 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
 State Industrial Acc Number

Supervising Provider Information

Last Name

First Name
 Middle Name or Initial
 Name Suffix
 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

State Industrial Acc Number

Other Operating Physician Information

Last Name

First Name
 Middle Name or Initial
 Name Suffix
 Primary Identifier
 NPI
 Secondary Identifiers
 State License Number
 UPIN
 Commercial Number
 Location Number

Service Line Information

Referring Provider Information

- Last Name**
- First Name
- Middle Name or Initial
- Name Suffix
- Primary Identifier
 - NPI
- Secondary Identifiers
 - State License Number
 - UPIN
 - Commercial Number

Other Provider

Last Name
First Name
Middle Name or Initial
Name Suffix
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
- State Industrial Acc Number

Specialty Service Line Information

Drug Claims

National Drug Code

Drug Unit Price

National Drug Unit Count

Drug Unit Type

Prescription Number

Secondary Billing Information

COB Claim Information

CAS Code (5)

Adjustment Reason Code (6)

Adjustment Amount (6)

Adjustment Quantity (6)

Payer Paid Amount*

Remaining Patient Liability

Total Allowed Amount

Total Submitted Charge Amount

DRG Outlier Amount

Total Medicare Paid Amount

Medicare Paid at 100% Amount

Medicare Paid at 80% Amount

Paid From Part A Medicare Trust Fund Amount

Paid From Part B Medicare Trust Fund Amount

Total Non-Covered Charge Amount

Total Denied Amount

| Covered Days or Visits Count

| Lifetime Reserve Days Count

| Lifetime Psychiatric Days Count

| Claim DRG Amount

| MIA Claim Payment Remark Code (5)

| Claim Disproportionate Share Amount

| Claim MSP Pass-through Amount

| Claim PPS Capital Amount

| PPS-Capital FSP DRG Amount

| PPS-Capital HSP DRG Amount

| PPS-Capital DSH DRG Amount

| Old Capital Amount

| PPS-Capital IME Amount

| PPS-OHS DRG Amount

| Cost Report Day Count

| PPS-OFS DRG Amount

| Claim PPS Capital Outlier Amount

| Claim Indirect Teaching Amount

| Nonpayable Professional Component Amount

| PPS-Capital Exception Amount

| Reimbursement Rate

○ HCPCS Payable Amount

○ MOA Claim Payment Remark Code (5)

○ Claim ESRD Payment Amount

○ Nonpayable Professional Component Amount

Adjudication or Payment Date

Other Payer Claim Adjustment Indicator

Other Payer Claim Control Number

COB Line Information

Service Line Paid Amount

Product or Service ID Qualifier

Procedure Code

Procedure Modifier 1

Procedure Modifier 2

Procedure Modifier 3

Procedure Modifier 4

Procedure Code Description

Service Line Revenue Code

Paid Service Unit Count

Bundled Line Number

CAS Group Code (5)

Adjustment Reason Code (6)

Adjustment Amount (6)

Adjustment Quantity (6)

Adjudication or Payment Date

Remaining Patient Liability

Other Information

Repriced Claim Information

Repricer Received Date
 Repriced Claim Number
 Adjusted Repriced Claim Number

Pricing Methodology

Repriced Allowed Amount

Repriced Savings Amount
 Repricing Organization Identifier
 Repricing Per Diem or Flat Rate Amount
 Repriced Approved DRG Code
 Repriced Approved Amount

Repriced Approved Revenue Code
 Repriced Approved Procedure Type Code
 Repriced Approved HCPCS Code

Repriced Approved Unit Type Code
 Repriced Approved Service Unit Count

Reject Reason Code
 Policy Compliance Code
 Exception Code

Repriced Line Information

Repriced Line Item Reference Number
 Adjusted Repriced Line Number
 Line Note Text

Pricing Methodology

Repriced Allowed Amount

Repriced Savings Amount
 Repriced Organization Identifier
 Repricing Per Diem or Flat Rate Amount

Repriced Approved APG Code
 Repriced Approved APG Amount
 Repriced Approved Revenue Code
 Repriced Procedure Type Code*

Repriced Procedure Code
 Repriced Approved Unit Type Code
 Repriced 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 Plan ID

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 Identification Number