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DEPARTMENT OF
MENTAL HEALTH
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Los Angeles County Department of Mental Health

HIPAA 837 Transaction Standard Companion Guide for Integrated Behavioral Information Systems (IBHIS) Client Service Based and Community Outreach Service (COS) Claims Processing

Refers to the ASC X12 version 005010 Implementation Guides

Disclosure Statement

This document represents the Los Angeles County Department of Mental Health (LACDMH) implementation instructions for Health Insurance Portability and Accountability Act (HIPAA) required transactions. It is believed to be compliant with all ASC X12 intellectual property requirement.

Document Revision History

Version	Release Date	Comments/ Indicate Sections Revised
1.0	11/20/2013	▪ Initial document release
1.1	12/04/2013	▪ Section 5.3: Added info re ISA06, ISA08 ▪ Section 6.1: Added information re authorizations ▪ Section 10.1: Added examples
1.2	01/03/2014	▪ Corrected typos ▪ Section 8.1: Corrected 1000B NM109 value ▪ Section 9: Corrected ISA02 and ISA04 for all examples
1.3	01/27/2014	▪ Section 6: Updated Business Rules ▪ Section 8.1: 837P/2330B/NM109 ▪ Section 8.1: 837P/2400 – Refers to the Addendum Guide to Procedure Codes for IBHIS ▪ Section 8.1: 837P/2430 Loop requirements ▪ Section 8.2: Added 837P COS loop and segment information ▪ Section 10.1.9: Added COS example
1.4	2/6/2014	▪ Section 6: Updated Business Rules ▪ Section 8.1 & 8.2 – V Code diagnoses must use a capital V ▪ Section 10.1.9: Revised the COS example – number of minutes
1.5	3/5/2014	▪ Section 6: Updated Business Rules ▪ Section 8.1: 837P/2400/Procedure Code Modifier comment ▪ Section 8.2: 837P/2400/Procedure Code Modifier comment ▪ Section 9: Modified SE Segment Count on a number of the examples ▪ Section 10.1.5: Added an OHC/Medicare/Medi-Cal example
1.6	4/7/2014	▪ Section 6: Updated Business Rules ▪ Section 9.1: 837P/2400/SV103 Residential and PHF rules added ▪ Section 9.1: 837P/2420C added Service Facility Location rules ▪ Section 8.3: Added 837I Inpatient loop and segment information ▪ Section 10.2.1: Added 837I Medi-Cal example ▪ Section 10.2.2: Added 837I Indigent example ▪ Section 10.2.3: Added 837I Medi-Medi example
1.7	5/6/2014	▪ Section 3: Updated Process Flow ▪ Section 6: Business Rules clarifications including additional Residential claim clarifications ▪ Section 6: Added Replacement claim rules ▪ Section 6, 8.1, 8.2, 8.3: Restrict claims to 1 service line per claim ▪ Section 7.2: Added 277CA Rejection Codes ▪ Section 8.1: Added Service Date clarifications for Residential claims ▪ Section 8.1, 8.3: OHC Payer ID clarification ▪ Section 10.1.8: Added a Residential claim example
1.8	9/12/2014	▪ Section 7.2: Added a 277CA Rejection reason ▪ Section 8.1, 8.3: Additional OHC Payer ID clarification
1.9	6/25/2015	▪ Section 6.1: Added a link to QA Bulletin 14-04 IBHIS Addendum Guide to Service & Procedure Codes ▪ Section 6.1: Added an exception for county funded procedures that do not use the HX modifier ▪ Section 6.1: Added a Business Rule regarding Replacement claims ▪ Section 6.1, 9.1, 9.3: Added rules requiring Inpatient, Residential, PHF and Day Treatment services to report one claim per day ▪ Section 6.2: Added a Business Rule regarding the Medicare HMO Risk indicator

		▪ Section 6.2: Added the Business Rules for populating the diagnosis code on outbound transactions to the state ▪ Added Section 6.3: Generation of Outbound 835 Files to Contract Providers ▪ Added Section 7.2: Linking an 837 to the 277CA ▪ Section 7.3: Renumbered and added 277CA Rejection reasons ▪ Added Section 8 Operational Information and renumbered subsequent sections ▪ Section 9.2: COS Claims use the DMH IBHIS COS Dictionary Values file for valid codes ▪ Section 10.1.6, 10.1.8, 10.2.1, 10.2.2, 10.2.3: 837 Examples revised to reflect 1 service date per claim on Day Treatment, Residential and Inpatient. ▪ Added Section 10.3 with 835 examples
1.10	8/11/2014	▪ Section 7.3: Added 277CA Rejection reasons relating to ICD-9 and ICD-10 usage ▪ Section 9.2: Added an ICD-10 value for COS claims for services after the ICD-10 compliance date ▪ Section 10.3: Added additional 835 examples
1.11	1/5/2016	▪ Section 6.1: CalWORKs to use the HX modifier and will not use the CalWORKs guarantor ▪ Section 6.1, 9.1, 9.3: Requirements for Katie A claims ▪ Section 6.1: Current versus Future mapping of outbound claim info ▪ Section 9.1: Clarified diagnosis code requirements for 837P claims ▪ Section 9.1: Crisis Stabilization to use MJ as the Units qualifier ▪ Section 9.2: Removed decimal point from ICD-10 example for COS claims ▪ Section 9.3: Added diagnosis code requirements for 837I claims
1.12	06/08/2016	▪ Section 3: Process Flow changes after claims adjudication. ▪ Section 6.1: MSO Denied claims ▪ Section 6.1, 9.1: Included Life Support business rules and 837P claiming requirements ▪ Section 6.1: Clarification that 24-hour service claims will deny if the admit and discharge is on the same day ▪ Section 6.2 : Medicare Risk HMO indicator, Healthy Families Indicator, Financial Eligibility Changes. ▪ Section 7.3: Added 277CA Rejection reasons relating to Coordination of Benefits segments ▪ Section 9: Transaction set 2300 NTE and 2320 SBR09.
1.13	04/27/2017	▪ Section 6.1: Business rule 12 modified to remove the reference to Guarantor 18 and 11. ▪ Section 6.1: Added Business rule 16 for Cost Based Payment Method (UCC). ▪ Section 7.3: Modified the rejection reason for code A7:255 to include invalid Diagnosis Code. ▪ Section 9 : 2330B Other payer primary identifier. ▪ Section 10.1.9 : Corrected the COS example to reflect correct Zip code.
1.14	04/24/2018	▪ Section 6.1 : Use of TAR Number in FFS2 Claims. Non Medi-Cal Residential (CPT) and In Patient (Revenue) Codes. Replacement Claim Rule. ▪ Section 7.3 : New Claim Rejection Code. ▪ Section 9.1 : Allowable EBP Codes Reference ▪ Section 9.2 : Program Area Codes made optional for COS claim. ▪ Section 10.4: 999 Example. ▪ Section 10.5: 277 Example.
1.15	05/30/2019	▪ Section 7.3 : New Rejection Code (A7:481) ▪ Section 7.4 : This new section is added to report the possible -999 reasons
1.16	11/05/2019	▪ Section 7.3 : New Rejection Codes (A3:0, A7:0, A7:672) ▪ All reference links are updated to point to the new ‘Provider Central’ website.
1.17	09/18/2020	▪ Section 6.1 : Updated Business Rule on an MSO denied Replacement claim ▪ Section 7.3 : New Rejection Code (A7:787)
1.18	06/16/2021	▪ Section 5:1: Updated IBHIS Secure File Exchange Instructions.

1.19	09/20/2021	▪ Section 6.1 : Added Business Rules on IHBS and TBS Member Authorizations ▪ Section 9.2 : Health Care Claim Professional (837P) COS rule for Wraparound Clients ▪ Section 10.1.9 : Add Client ID requirement for Wraparound client on COS Loop 2300
1.20	04/29/2022	▪ Section 6.1 : Added Business Rules on Inbound 837 Transactions for Therapeutic Foster Care (TFC) services ▪ All referenced/embedded hyperlinks were validated for functionality and accuracy to ensure each link redirects to ProviderCentral' website accordingly.
1.21	05/23/2022	▪ Los Angeles County Department of Mental Health address updated to 510 S. Vermont Ave. ▪ APPENDICES : Phone number referenced under Payer Identification (1000A) updated to 2139476347.
1.22	09/30/2022	▪ Section 6.1 : Added Business Rule 17 for Place of Service codes 02 and 10 in Loop 2420C (Service Facility Location) and Loop 2300 (Claim Information). ▪ Section 9.1 : 837P/2420C Added Service Facility Location rules for Place of Service '02 Telehealth' and '10 Telehealth Provided in Patients Home'.
1.23	04/28/2023	▪ Section 1.1 : Updated with introduction to California Advancing and Innovating Medi-Cal (CalAIM) Payment Reform, effective July 1, 2023. ▪ Section 1.3 : Added reference to DHCS CalAIM MedCCC Library. ▪ Section 6.1 : Added new section for CalAIM Highlights and Overview. ▪ Section 6.2 : Updated with CalAIM Business Rules for Inbound 837 Transactions. ▪ Section 9.1 : Updated Loop 2400 (SV103) with CalAIM Unit of Measurement Code 'UN'. ▪ Section 10.1 : Added CalAIM 837P example under 10.1.10. ▪ Section 10.1 : Added CalAIM 835 example under 10.3.6.
1.24	10/11/2024	▪ Section 6.2 : Updated Business Rule 6 link to SMHS Billing Manual and QA Guide to Procedure Codes ▪ Section 6.2 : Updated Business Rule 10 Replacement claims instructions ▪ Section 6.2 : Updated Business Rule 14 on one service per claim rule. ▪ Section 6.2 : Updated Business Rule 17 for Place of Service codes 02 and 10 in Loop 2420C (Service Facility Location) and Loop 2300 (Claim Information). ▪ Section 6.2 : Updated Business Rule 19 for T1013 (Sign Language or Oral Interpretation) and 90785 (Interactive Complexity). ▪ Section 6.2 : Updated Business Rule 20 for claims provided by a Clinical Trainee (Student) ▪ Section 10.1.11 : Added Clinical Trainee (Student) example
1.25	9/15/2026	▪ Section 6.2 : Added Business Rule 13 for Inbound 837 Transactions for COS 231 Claims ▪ Section 6.2 : Added Business Rule 21 for Evidence-Based Practices (EBP) Monthly Bundled Rules from State DHCS ▪ Section 9.1 : Updated to use "11" when the payer in this iteration of the 837P 2320 loop is Medi-Cal. ▪ Section 9.2 : Updated Claim Note Text on Loop 2300 for COS 231 with Potential Client ID from SRTS or COS 231 DMH/IBHIS Client ID requirement. ▪ Section 9.3 : Updated to use "11" when the payer in this iteration of the 837I 2320 loop is Medi-Cal. ▪ Section 10.1.9 : Updated Client ID requirement to use MJ as the Units Qualifier on Community Outreach Services Loop 2400 example ▪ Section 10.1.12 : Added 837 Professional Claim Snippet (H2033 Example Full Rate) ▪ Section 10.1.13 : Added 837 Professional Claim Snippet (H2033 Example Partial Rate) ▪ Section 10.3.7 : Added 835 Professional Claim Snippet (H2033 Example Full Rate) ▪ Section 10.3.8 : Added 835 Professional Claim Snippet (H2033 Example Partial Rate)

Preface

This Companion Guide to the version 005010 (v5010) ASC X12N Implementation Guides and associated errata adopted under HIPAA clarifies and specifies the data content when exchanging electronically with Los Angeles County Department of Mental Health (LACDMH). 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 usages of data expressed in the Implementation Guides.

This Companion Guide addresses specific DMH business process requirements for transmitting claim data to the LACDMH Integrated Behavioral Health Information System (IBHIS) system. In addition to the LACDMH business requirements, all 837 transactions transmitted from the providers to LACDMH must be compatible with the HIPAA requirements. It is assumed that trading partners are familiar with the HIPAA Implementation Guides and, as such, this guide does not attempt to instruct trading partners in the creation of an entire HIPAA transaction. However, samples of the entire transaction will be given to trading partners during registration/orientation process.

This Companion Guide is subject to change.

Please visit https://dmh.lacounty.gov/pc/cp/ti/ for the latest information.

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1 INTRODUCTION

1.1 Scope

This Companion Guide is intended to be used by Los Angeles County Department of Mental Health (LACDMH) contracted providers 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)
- ASC X12 Health Care Claim: Institutional (837) as specific in guide 005010X223 and 005010X223A2 (837I)

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

California Advancing and Innovating Medi-Cal (CalAIM)

Effective July 1, 2023, all Medi-Cal billable claims submitted with date of service July 1, 2023 or later must follow CalAIM specific business rules, which are mandated by the State of California Department of Health Care Services (DHCS).

1.2 Overview

Section 2 provides information about establishing a trading partner relationship with LACDMH.
Section 3 provides a Process Flow of the claiming transactions.
Section 4 identifies EDI related contacts within LACDMH.
Section 5 provides the LACDMH technical requirements for file exchange and the envelope segments.
Section 6 provides the LACDMH specific business rules and limitations.
Section 7 identifies the LACDMH acknowledgment transactions.
Section 8 provides operational information.
Section 9 provides the LACDMH requirements and usage for the 837 claiming transactions.
Section 10 provides sample 837/835/999/277 transactions

1.3 References

This information must be used in conjunction with the ASC X12 implementation guides that are available at http://store.X12.org/

The **SMHS Medi-Cal Billing Manual** can be accessed via the DHCS MedCCC Library at https://www.dhcs.ca.gov/services/MH/Pages/MedCCC-Library.aspx.

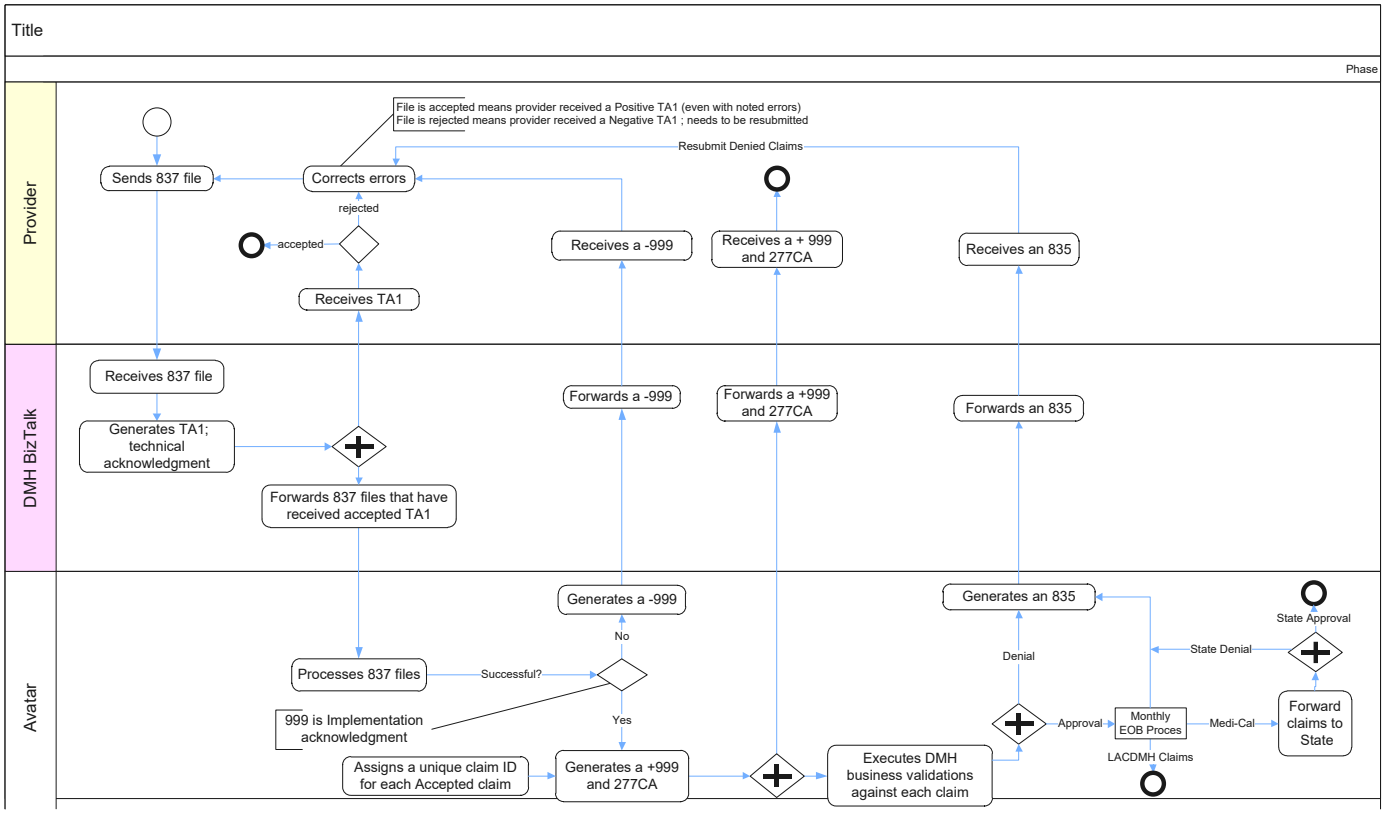
2 GETTING STARTED

2.1 Trading Partner Registration

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

You can find additional information on registering for EDI at https://dmh.lacounty.gov/pc/cp/.

3 PROCESS FLOW



4 CONTACT INFORMATION

4.1 EDI Customer Service/Technical Assistance

LAC DMH Helpdesk – 213-351-1335

4.2 Provider Service Number

LAC DMH Helpdesk – 213-351-1335

4.3 Applicable website/e-mail

Contract Providers:
https://dmh.lacounty.gov/pc/cp/
Provider Manuals & Directories:
https://dmh.lacounty.gov/for-providers/administrative-tools/provider-manuals-directories/

5 FILE EXCHANGE/FILE STRUCTURE/CONTROL SEGMENTS

Note: The following screenshots are provided for your reference; however, the screen layout and configuration may vary depending on the file transfer client being configured.

5.1 Test Environment Configuration Details

1. Open the **File Transfer Protocol over SSL** (FTPS) client you are using at the organization.
2. Create a **new** site connection.
3. In order to connect to the **IBHIS Electronic File Transfer** (EFT) site, please configure the settings below.

Host address:	b2beftqa.dmh.lacounty.gov
Username:	Legal Entity Number (e.g., 00999) **Note:** Leading 0's must be included.
	FFS Network Provider Number – DMH Issued ID **Note:** This number can be obtained from the TPA Request Application field
Protocol:	FTPS TLS/SSL Implicit
Port:	4990

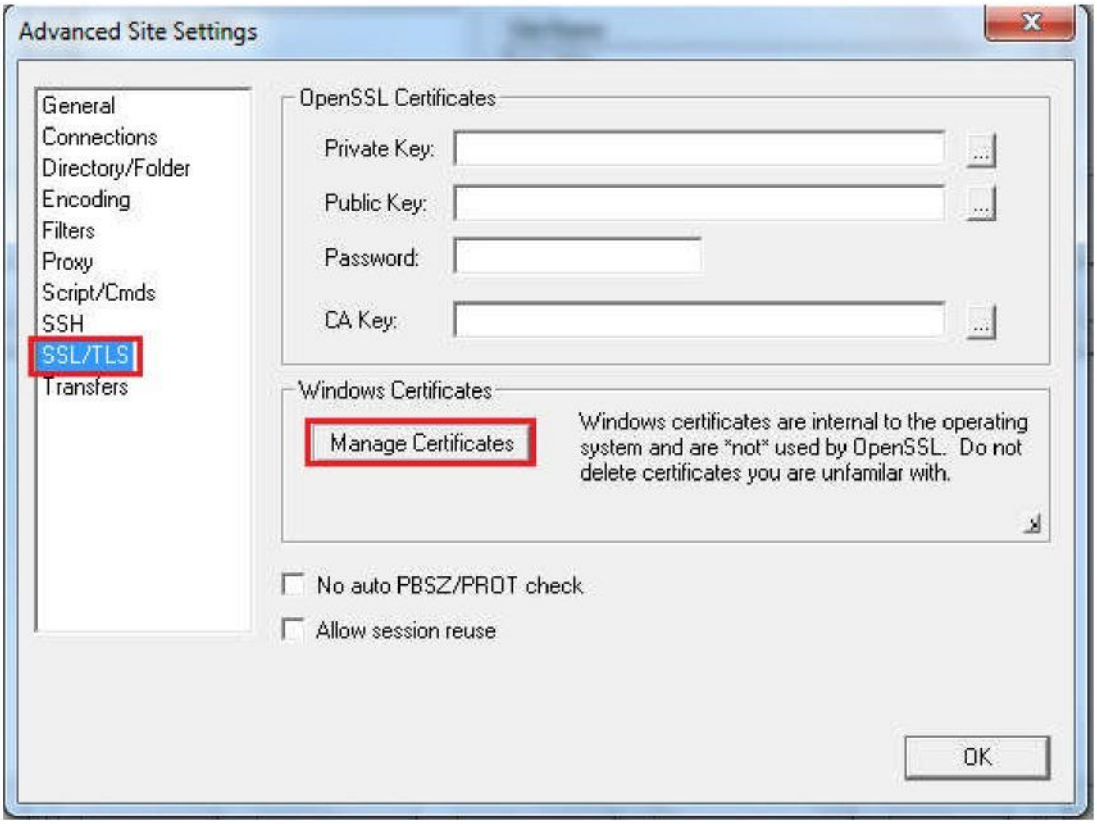
4. Select the **Certificate** issued by Los Angeles County Department of Mental Health

5.2 File Exchange

Refer to the **IBHIS Secure File Exchange Instructions** for details on how to upload Claim files and how to download the Transaction Response files. Visit the Provider Central site for the latest Technical Information.

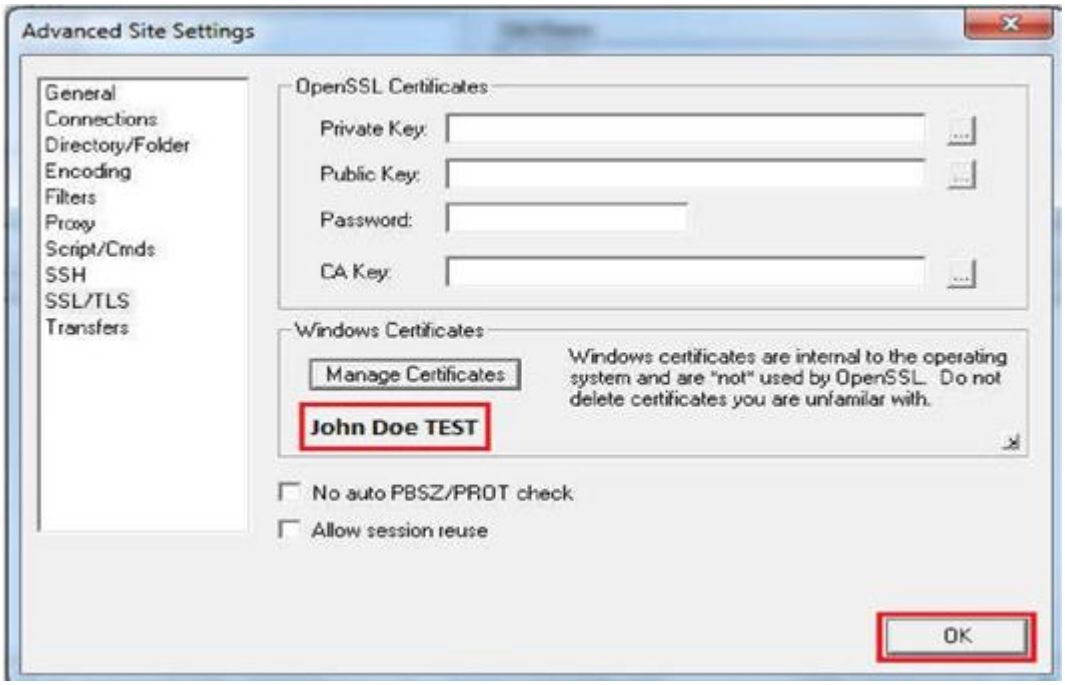
For example, when using CoreFTP:

1. **Site Name** should be the entry for the **Connection Details** (i.e., IBHIS_Test or IBHIS_Prod).
2. Select **Windows SSL**
3. Click **Advanced**
4. **Advanced Site Settings** window, select the **SSL/TLS** option on the left pane.
5. Click **Manage Certificates**

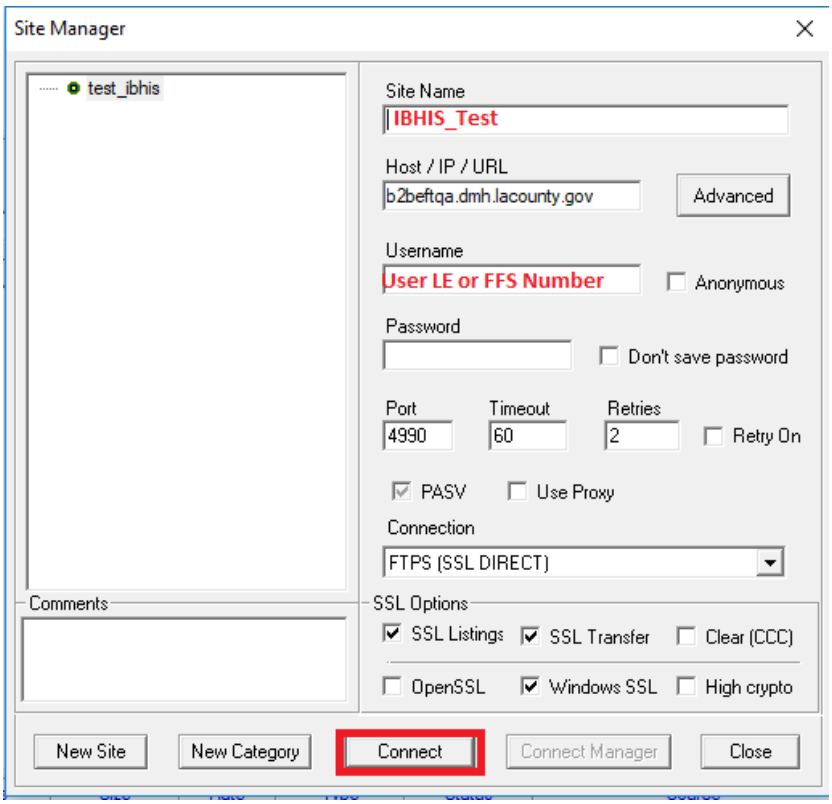


6. Select the Certificate appropriate to the Environment you are connecting to. For example, select the **John Doe TEST** certificate for the connectivity to the **Test Environment**. Likewise, select the **John Doe PROD** certificate for the connectivity to the **Production Environment**.

7. The following screen will display the certificate name. Click OK.



8. **Site Manager** will display the Site Name, Host/IP/URL, etc. (see below). Click **Connect**.



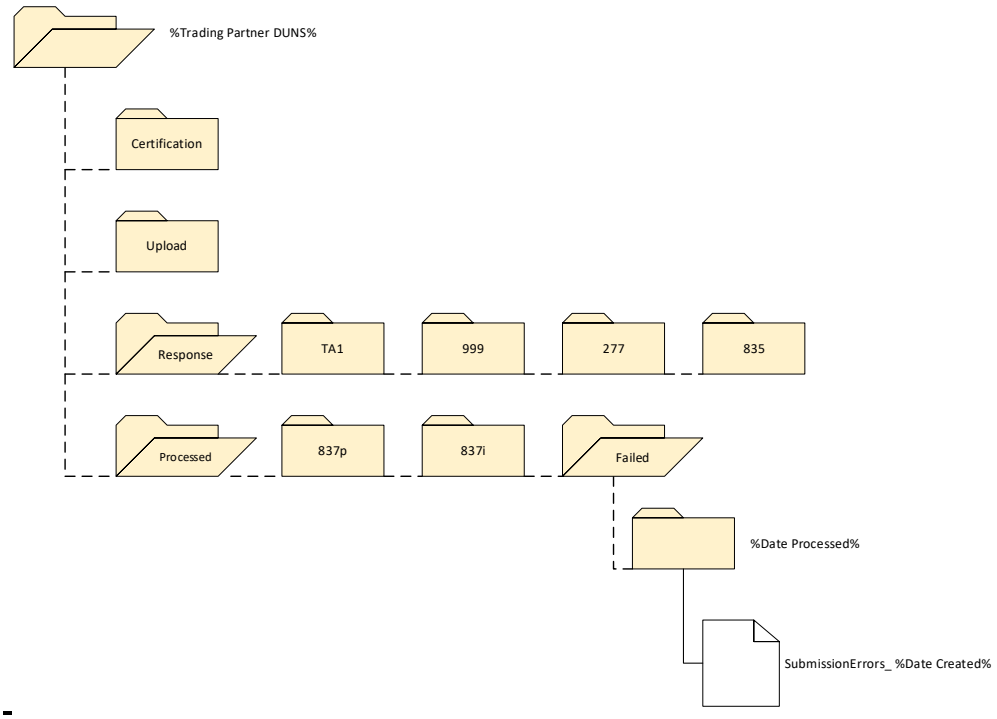
Once successfully connected to the IBHIS test environment, the following folders will be available:

Certification:	Directory for uploading Client Web Services Certification documents.
Upload:	Directory for uploading EDI files.
Response:	Directory for EDI response files.
Processed:	Directory for EDI files accepted and processed

Sub Folders under "Response" and "Processed" folders:

- **Response Folder**
  - TA1 – This is where the TA1 response files reside
  - 999 – This is where the 999 response files reside
  - 277 – This is where the 277 response files reside
  - 835 – This is where the 835 response files reside

- **Processed Folder**
  - 837p – This is where the 837p processed files reside
  - 837i – This is where the 837i processed files reside
  - Failed – This where the failed files reside



"Failed" Subfolder under the "Processed" Folder

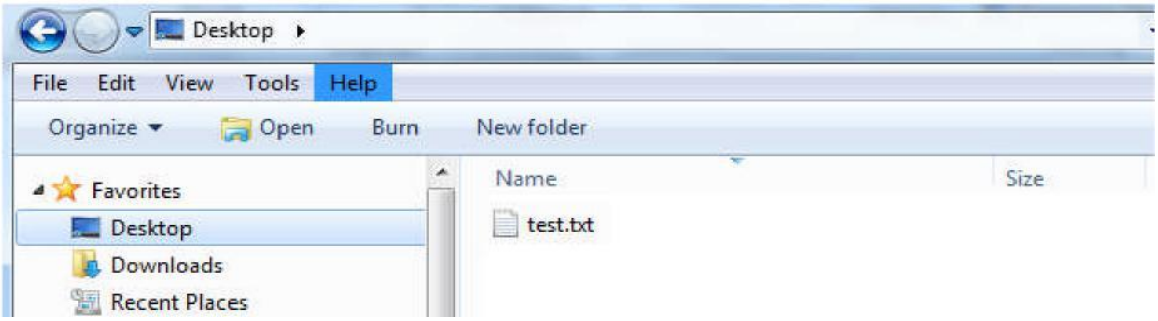
If the file fails fatally and is not processable, then the file will be placed in the **Failed** subfolder. **Submission Errors** can be found by Processing Date in the text file named **SubmissionErrors_%Date Processed%.** This text file is created, as needed, on a daily basis which provides details as to why an EDI file is **Rejected**. This file, named **SubmissionErrors_%Date Created%,** can be located by using its processing date.

Resolving Directory Issues

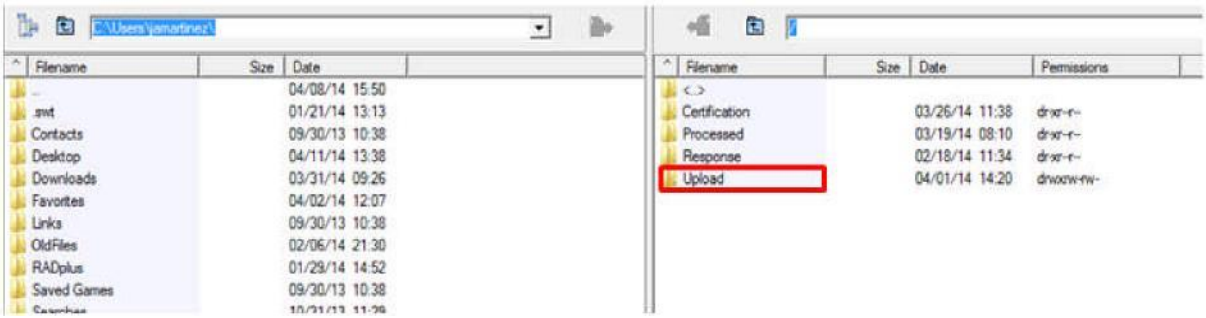
If you experience issues related to the directories above, please notify the **LACDMH Help Desk** at (213) 351-1335 or open a ticket using the HEAT Self Service Portal.

Uploading a file via the LACDMH IBHIS EFT site

1. Navigate to the **folder location of the file** to be uploaded.



2. **Establish a connection** to the appropriate **LACDMH IBHIS Electronic File Transfer** (EFT) site.
3. Transfer the file to the **Upload** folder.
4. Once the file has been uploaded, **processing** will begin.
5. Once successfully processed, the **SubmissionErrors_%Date Created%**. Processing time may take up to 5 minutes.
6. Please navigate to the **Processed** directory to see the **results of the uploaded file**.



5.3 Production Environment Configuration Details

1. Open the **File Transfer Protocol over SSL** (FTPS) client you are using at the organization.
2. Create a **new** site connection.
3. In order to connect to the **IBHIS Electronic File Transfer** (EFT) site, please configure the settings below:

Host Address:	b2beft.dmh.lacounty.gov
Username:	Legal Entity Number (e.g., 00999) **Note:** Leading 0's must be included.
	FFS Network Provider Number – DMH Issued ID **Note:** Number can be obtained from the TPA Request Application field "Provider"
Protocol:	FTPS TLS/SSL Implicit
Port:	4990

LACDMH IBHIS EFT Site Folders

After connecting to the IBHIS EFT successfully, the window will display the following 3 folders:

- **Upload:** Directory for uploading EDI files.
- **Response:** Directory for EDI response files.

- **Processed:** Directory for EDI files accepted and processed.

Subfolders under "Response" and "Processed" Folders

Response Folder
TA1 – This is where the TA1 response files reside
999 – This is where the 999 response files reside
277 – This is where the 277 response files reside
835 – This is where the 835 response files reside

Processed Folder
837p – This is where the 837p processed files reside
837i – This is where the 837i processed files reside
Failed – This where the failed files reside

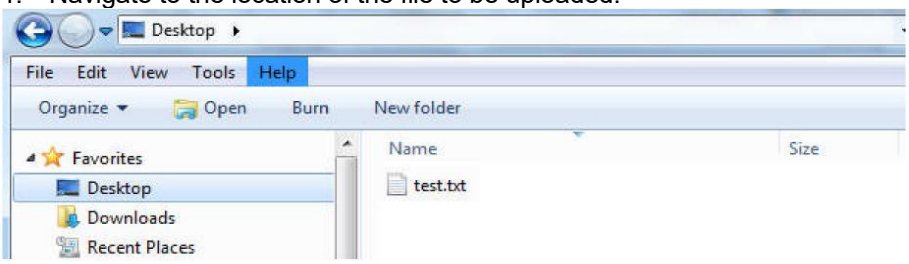
"Failed" Subfolder under "Processed" Folder

If the file is rejected, then the file will be placed in the **Failed** Folder. Submission Errors can be found by Processing Date in the text file named **SubmissionErrors_%Date Processed%**. This text file is created as needed on a daily basis and provides details as to why the EDI file was rejected. The file is located by processing date, and it is named **SubmissionErrors_%Date Created%.**

Resolving Directory Issues

If you experience issues related to directories above, please notify the LACDMH Help Desk at (213) 351-1335 or open a ticket using the HEAT Self Service Portal.

1. Navigate to the location of the file to be uploaded.



2. Establish a connection to the appropriate **LACDMH IBHIS Electronic File Transfer** (EFT) site.
3. Transfer the file to the **Upload** folder.
4. Once the file has been uploaded, **processing** will begin.
5. Once processed, the file will be moved to the **Processed directory**. Processing time may take up to 5 minutes.
6. Please navigate to the **Processed** directory to see the results of the uploaded file.

5.4 File Requirements

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

5.5 ISA-IEA on Inbound Transactions

Loop ID	Reference	Name	Notes/Comments
	ISA01	Authorization Information Qualifier	LACDMH expects '00'.

	ISA03	Security Information Qualifier	LACDMH expects '00'.
	ISA05	Interchange ID Qualifier	LACDMH expects '14'.
	ISA06	Interchange Sender ID	LACDMH expects the provider's Duns plus suffix. Enter the 9-digit DUNS number, followed by 6 spaces.
	ISA07	Interchange ID Qualifier	LACDMH expects '14'.
	ISA08	Interchange Receiver ID	Enter LA County's 9-digit DUNS number, followed by 6 spaces. The required value for LACDMH is '**132486189** '.
	ISA16	Component Element Separator	In order to process procedure codes that contain modifiers, LACDMH only accepts '**:**' as the Component Element Separator

5.6 GS-GE on Inbound transactions

LACDMH accepts only one Functional Group per Interchange.

Loop ID	Reference	Name	Notes/Comments
	GS02	Application Sender's Code	Enter the 9-digit DUNS number, with no trailing spaces.
	GS03	Application Receiver's Code	Enter the 9-digit DUNS number, with no trailing spaces.

6 LACDMH BUSINESS RULES AND LIMITATIONS

6.1 CalAIM Highlights and Overview

- Effective July 1, 2023, all claims with date of service of July 1, 2023 or later must follow the new CalAIM rules, per the CalAIM (CPT Coding) Payment Reform.
- Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding
    - System (HCPCS) Codes: These codes are used to capture uniform information for billing medical services and procedure. County Behavioral Health currently uses primarily HCPCS codes to bill Medi-Cal. Starting in July 1, 2023, a subset of services will be claimed using CPT codes.
    - The Payment Reform will end cost-based reimbursement and implement fee-for-service payments to county Behavioral Health (BH) plans to simplify county BH plan payments and reduce administrative burden (no more cost report) for the State, counties, and providers. –
    - The Financing mechanism will transition to Intergovernmental Transfers (IGTs) to finance Medi-Cal County BH plan payments in order to enable county BH plans to continue providing the non-federal share of cost for Medi-Cal services without certified public expenditures and cost-based reimbursement
    - CPT Coding Transition will improve reporting, align with other healthcare delivery systems and comply with CMS requirements for all state Medicaid programs to adopt CPT codes (where appropriate).
- Key changes are outlined below (but not limited to):
    - Unit of Measurement for all claims with date of service July 1, 2023 or later, must be submitted by Units of Service in units ('UN') instead of by the minute ('MJ'). All claims with date of service prior to July 1, 2023 should continue to be submitted with measurement code 'MJ'.

- The majority of the CPT codes already in use by LACDMH will be utilized alongside modifiers and add-on codes. HCPCs will continue to be used in some circumstances. Some HCPCs codes will be used in place of existing HCPCs codes (e.g. H0034 instead of H2010).
- Time or complexity have been added to primary procedure codes.
  - ex. 70 minutes of E&M service: 99215 (40-54 minutes) + G2212 (Prolong)
  - ex. 60 minutes of Assessment: 96130 (1 Hour) + 90785 (Interactive Complexity)
- Please refer to the Guide to Procedure Codes for detailed information on the HCPCS and CPT codes, Primary vs Add-on codes, Allowable Modifiers, Disciplines, Place of Service, Duration, Unit Limits, Lockout rules, etc.

- New and changes to Claim Adjustment Reason and Remark Codes and additional MSO denial rules for duplicates, duration, lockouts, and place of service.
  - Multiple services per claim is allowed for primary and add on services only.
  - Dependent On codes: Dependent procedures cannot be billed unless the provider first bills the primary procedure to the same beneficiary by the same rendering provider on the same date on the same claim.
  - Duplicate Services: If a provider renders two services to the same beneficiary on the same day, all encounters must be claimed as one service to ensure the additional encounters are not denied as duplicate services.
- Rates are set up based on Units and reimbursed by Provider Type (Discipline), at a fixed rate (shared by Finance).
  - DMH will convert the hourly rate to units (UN), based on the duration allowed on each service.
  - Service will still be validated against the location that is certified by the State.
  - Group services codes
    - Group Service Codes: H2017:HQ, H0034:HQ, 90849, 90853 and G2212:HQ (prolong code for groups).
    - When submitting claims for Group services, the Units of Service should be the same for all participants in the service. The charge amount should be the Total Charge for the unit divided by 4.5. If the claim is submitted with a Total Charge amount for each client in the group, LACDMH will pay only the charge which is equal to the Total Charge divided by 4.5 and the remaining amount will be returned back to the provider with an adjustment reason code CO*45.

6.2 Business rules for Inbound 837 Transactions

1. LACDMH requires authorization for all services. There are 3 types of authorizations. A provider will put only 1 authorization on a claim line. If a service requires individual **Member Authorization**, the claim will only have the Member Authorization. Otherwise, Legal Entities will use the **Provider Authorization** and Fee-For-Service (FFS) providers will use the **Funding Source Authorization** (F-AUTH).
   - Provider Authorizations, or **P-AUTHs**, are specific to a Legal Entity/Contracting Provider and to a Funded Program/Funding Source. Generally, **P-AUTHs** will cover a complete Fiscal Year. A report with a Legal Entity's **P-AUTHs** will be included in the Legal Entity's **EFT Extracts**.
   - Member Authorizations, or **M-AUTHs**, are specific to a client and to a Contracting Provider. They authorize specific services for a specific duration of time. **M-AUTHs** are also tied to a Funded Program/Funding Source, however when claiming only send the **M-AUTH**. The initiation of a Member Authorization will vary based on the type of services provided.
   - Provider Authorizations begin with a 'P', followed by a number, while **M-AUTHs** are all numeric.
   - Providers must select the appropriate Funding Source, Benefit Plan, Program, Procedure Code and Units Requested when submitting **M-AUTH** requests. Providers can view the authorization status and authorization number upon submission using ProviderConnect. The authorization number cannot be

used on any claims until the authorization request has been approved. Please refer to the Pre-Authorization for IHBS/TBS/TFC FAQs page for more information.

- Professional services rendered by a Fee-For-Service (FFS) provider in an FFS Hospital setting will obtain the Treatment Authorization Request (TAR) number from the FFS Hospital. Any professional claims submitted for these services should contain the TAR number, an 11-digit number, as the authorization number in the claim.
- FFS Providers will be provided Funding Source Authorizations for each fiscal year, which is provided, as needed. For more info, visit the Fee for Service Provider Bulletins page for the latest provider manuals and updates.
- The Funding Source Authorizations are given by LACDMH according to the disciplines of the providers. These Funding Source Authorizations will be used by FFS providers for Specialty Mental Health, Psychological Testing and Medication Support services. Funding Source Authorizations begin with an 'F', followed by a number. Further information on which Funding Source Authorization to use will be provided in the Fee-For-Service Provider Bulletins.

2. Legal Entity providers must use Medi-Cal Authorizations for claims that are billable to Medi-Cal.
3. The Rendering Provider on the claim must be associated with the Legal Entity or FFS provider in the IBHIS Contracting Provider table.
4. The Practitioner's Discipline will be determined based on the information stored in the IBHIS Practitioner/Performing Provider table. IBHIS validates that the Practitioner (837 Rendering Provider) is allowed to perform the procedure code on the claim, based on the discipline stored in the IBHIS Practitioner/Performing Provider table.
5. Group claims - Refer to the explanation found Bulletin 11-02: Group Claiming which can be found in the Quality Assurance Bulletins page.

6. Effective July 1, 2023, the SC and GT modifiers are only allowed for Healthcare Common Procedure Coding System (HCPCS) code that begin with a letter, except for G2212 and T1013. Modifiers SC and GT can be used when the service is provided via telephone or audio. If using this modifier, indicate that the service was provided in Place of Service 02 or 10 with the exception of mobile crisis, use Place of Service 15.
   - The Current Procedural Terminology (CPT) code and its associated modifiers are defined in the SMHS Billing Manual May 2024 (dhcs.ca.gov)
   - For a complete list of Procedure Codes in IBHIS, including the modifiers for duplicate overrides (27, 59, XE, XP, XU) and/or County Funded modifier (HX), refer to the Addendum Guide to Procedure Codes for IBHIS at Quality Assurance Manuals Page. The latest draft can be directly accessed via: Guide to Procedure Codes (lacounty.gov) .
   - The QA Bulletin 14-04 IBHIS Addendum Guide to Service & Procedure Codes contains further information regarding the guide and the use of duplicate override modifier which can be found at: http://file.lacounty.gov/SDSInter/dmh/218857_14-04UpdateGuidetoProcedureCodes&Duplicates.pdf.
7. Use the County Funded Procedure Code Modifier (HX) when submitting most claims using Non Medi-Cal outpatient or CalWORKs Provider Authorizations.
   - 134,183,200,231,6000 and H2014 are the only Non-Medi-Cal procedure codes that do not use the HX modifier.
   - Do not use any other modifiers except for HX when sending claims with Non Medi-Cal authorizations.
8. LACDMH 835s
   - System creates 835 segregated by Fiscal Year.
   - Providers will receive an 835 for all Denied claims at the time that the claim is adjudicated and an 835 for all approved claims when the provider receives payment.
9. Retro claim adjudication
   - DMH Approved Medi-Cal billable claims are subsequently submitted to State for adjudication. Medi-Cal claims that are subsequently denied by the state will result in a 2nd 835, known as a Retro Claim Adjudication. Retro claim adjudication 835s follow all of the standard HIPAA 835 requirements for reversals and corrections. See the HIPAA 835 v5010 Technical Report, section 1.10.2.8 – Reversals and Corrections for further information.
   - Retro claim adjudications will also be reported in all SIFT reports that provide claim level data.

10. Replacement Claims
    - Replacement claims allow providers to submit updates or corrections to previously approved or denied claims and keep the date the original claim was received. Contract providers may replace most Medi-Cal or non-Medi-Cal claims; however, claims may be replaced only under certain conditions. Refer to CBO Bulletin: NGA 24-006 for updated guidance on replacing claims in the Integrated Behavioral Health Information System (IBHIS).
11. Residential, Therapeutic Foster Care (TFC), Psychiatric Health Facility (PHF) and Life Support Claims.
    - Claims for Residential, TFC, PHF and Life Support services must be reported using the 837 Professional format.
    - Residential, TFC, PHF and Life Support claims must report claims in UNITS using 'UN' for the Unit or Basis of Measurement Code in SV103.
12. Successful claims processing is dependent on consistency between 837 claim data and the client data that is established through the Client Web Services interface. The following inconsistencies will result in claim denials:
    - The client ID, gender and date of birth on the claim must match the client ID, gender and date of birth in IBHIS.
      - Client ID – 2010BA/NM109 Subscriber Primary Identifier
      - Gender – 2010BA DMG03 Subscriber Gender Code
      - Date of Birth – 2010BA DMG02 Subscriber Birth Date
    - IBHIS validates that the client has a Legal Entity or FFS episode for the date of service on Outpatient, Inpatient (Professional) and Day Treatment claims.
    - IBHIS validates that the client has a unique episode at the program of service level for all 24-hour services and that the service/statement dates are within the episode. 24-hour services include Inpatient, Residential, TFC, PHF and Life Support.
    - Inpatient, Residential, TFC, PHF and Life Support (24-hour) claims that include the discharge date will be denied. This rule also applies when the date of service, admit and discharge dates are the same date.
    - IBHIS validates that claims with Medi-Cal Funding Source Authorizations have an established Medi-Cal Guarantor in their Financial Eligibility (Medi-Cal (10)). The Medi-Cal Guarantor must be set with Eligibility Verified set to Yes.
    - IBHIS validates that claims with Non Medi-Cal Funding Source Authorizations have the LA County Guarantor (16) in their Financial Eligibility.
13. COS Claims - COS claims will be processed the same as any other 837 claim:
    - COS claims are delivered to the same file location as any other 837 file.
    - COS claims can be included in the same 837 transaction as an 837 that contains direct service claims.
    - COS claims will be reported via the standard 999, 277CA and 835 response files.
    - Void/Replacement functionality will be available in the same way that any 837 for direct services is Replaced or Voided.
    - They will be listed on all SIFT reports that provide claim level data.
    - COS claims must be reported with the total # of minutes for all practitioners involved in providing the service using measurement code (MJ). DMH IBHIS rate tables have been modified to pay by the minute, rather than by the hour.
    - When rendering Community Outreach Services (COS) with a client for procedure code 231 Community with Client, DMH requires the Client ID, whether the ID is COS/DMH IBHIS Client ID and/or a Potential Client ID from Services Request Tracking System (SRTS), to be submitted on 837 Claim Loop 2300, NTE Claim Note segment as follows. This requirement includes COS provided to clients enrolled in Wraparound Programs. All providers should meet this claiming requirement for all services rendered 1/1/2027 or later without any exception.
      - Example1: NTE*ADD*PC1123456 for Potential Client ID from SRTS
      - Example2: NTE*ADD*2123456 for COS DMH/IBHIS Client ID
14. LACDMH allows **one service line per claim** for Pre-CalAIM billing and **multiple services per claim**, only when submitting a primary code with add-on codes for Post-CalAIM billing.
    - For example, 90791 (primary) with add-on codes 90785 (interactive complexity) and G2212 (prolong).

15. LACDMH requires each Inpatient (837I), Residential (837P), TFC (837P), PHF (837P) and Day Treatment (837P) day to be reported as a single claim per day.

- For Inpatient services, the measurement code ‘DA’ will continue to be used in revenue codes.

16. Claiming Services that are subject to Cost Based Payment Method, such as claims submitted for services rendered at an Urgent Care Center (UCC) program that follows the cost based payment model. Payment based on the cost and not based on the services submitted.
    - Provider must acquire a separate DUNS number for the Cost Based Program/Urgent Care Facility.
    - Provider must complete a separate TPA under the new DUNS number and there will be a separate integration folder available for claiming.
    - LACDMH require the claims to be submitted on 837P format using the DUNS number acquired for the UCC facility in the ISA06, GS02 and 1000A/NM109 fields.
    - The clients served under the UCC can share the same outpatient episode created under the Legal Entity. If no outpatient episode exists under the Legal Entity, one must be created.
    - LACDMH will issue separate provider authorizations for UCC based on the available funding sources allocated for UCC.
    - Unit of Measurement
        - Prior to July 1, 2023, claims must be submitted with measurement code ‘UN’ in the SV103 field and number of hours in SV104.
            - If 60 minutes of service are rendered, the claim must be submitted with ‘UN’ in SV103 and 1 in SV04.
            - If 120 minutes of service are rendered, the claim must be submitted with ‘UN’ in SV103 and 2 in SV04.
        - Effective July 1, 2023, claims must be submitted with measurement code ‘UN’ in the SV103 field and number of hours in SV104.
            - Ex: If 60 minutes of service are rendered, the claim must be submitted with ‘UN’ in SV103 and 1 in SV04.
            - If 120 minutes of service are rendered, the claim must be submitted with ‘UN’ in SV103 and 2 in SV04.
    - The minimum measurement that can be submitted on a claim is 1.
    - The maximum measurement that can be submitted on a Med-Cal claim is 20 and on a Non Medi-Cal claim is 24.
17. LACDMH requires services provided via Telehealth to be reported on a claim with proper Place of Service value, as follows:
    - When the Telehealth service is provided in the client’s home, set the Place of Service value to ‘10’ and provide the client's home address in Loop 2420C Service Facility Location. The State will deny claims with date of service of July 1, 2023 and later, when the Place of Service value is set to '10' and the client's home address is NOT provided in Loop 2420C Service Facility Location.
    - Set the Place of Service value to '02' when the Telehealth service is provided at any location other than the client’s home; ensure that the service location address is submitted in Loop 2420C Service Facility Location.
18. The primary procedure code and add-on code must be submitted on the same claim; otherwise, the State will deny a service line billed with an add-on procedure code, if the primary procedure code is not present in the same claim. Use add-on code when:
    - submitting a claim for a service that needs to be prolonged,
    - if the primary procedure code does not have dedicated add-on code,
    - or if the primary code is an evaluation and management code, which is the highest code number at the end of a series **(**ex: 99205 is associated as the longest time range in the 99202-99205 series).
19. The duration of sign language or oral interpretation (T1013) cannot exceed the total duration of the primary service and add-on services. One (1) unit of T1013 is equal to 15 minutes. If the LE submits more units of T1013 than are allowed by the sum of all the primary services provided, the service line for interpretation services will be denied by Medi-Cal. T1013 Sign Language or Oral Interpretation and 90785 Interactive Complexity cannot be submitted on the same claim as the primary service. If a clinician used an oral interpreter to provide therapy, the claim will include a service line for the therapy and a service line for the oral interpretation. Only one (1) unit of Interactive Complexity is allowed with any primary service.
20. When claiming for services provided by a Clinical Trainee (Student), the supervisor’s NPI must be reported at the claim level (loop 2310D). Claims for services provided by Clinical Trainees that do not report a supervisor’s NPI will be denied by Medi-Cal.
21. Evidence-Based Practices (EBPs) Monthly Bundled Billing Rules

- Monthly Bundled EBPs under the BH-CONNECT initiative are designated by HCPCS and an 837 professional claim must list all component services in a single claim that occurred during the calendar month.
- Monthly Bundled Claiming Logic:
  - **One Claim Per Month**: Only one monthly EBP claim is submitted per client, per calendar month.
  - Service Line 1 (the Bundle): This first service line must carry the HCPCS code and the full or partial monthly reimbursement rate.
  - **Subsequent Service Lines (Component Services)**: Every individual contact is listed on its own service line using the HCPCS code (overriding the original full or partial monthly rate) with the charge amount of $1.00.

1. **UK Modifier (Collateral)**: Any service that is collateral contact (with a support person rather than the client) must include the 'UK' modifier on that specific service line.
2. **Full/Partial Monthly Rate**: To trigger the full/partial monthly rate, the system evaluates the services lines to ensure that the required minimum number of total units and face-to-face units are met.
3. During the adjudication, DMH will approve the first line of service with full/partial rate and all remaining service lines will be denied.

6.3 Generation of Outbound 837 Medi-Cal Claims

1. The Practitioner's Taxonomy will be transmitted to the state based on the information stored in the IBHIS Practitioner/Performing Provider table.
2. The Pregnancy Indicator will be transmitted to the state based on the information stored in the IBHIS Client Condition – Pregnancy table. EDI Providers will update the pregnancy information via Client Web Services. FFS Providers will update client pregnancy information using ProviderConnect NX.
3. The Katie A. Demonstration Project Identifier will be transmitted to the state when it has been received from the Inbound 837 to LA County.
4. The Health Maintenance Organization (HMO) Medicare Risk indicator will be transmitted to the state when it has been received from the inbound 837 to LA County.
5. The Healthy Families SED indicator will be transmitted to the state based on the information received from the Inbound 837 to LA County.
6. Claims are only sent to the state when the Financial Eligibility/Eligibility Verified flag is set to Yes via Client Web Services. Providers indicate to LA County DMH which claims are to be sent to the state by using Medi-Cal Authorizations on their EDI claims.
7. Financial Eligibility for Medi-Cal and LA County is generated on behalf of the Trading Partner via Client Services when a client is admitted or updated. The client's demographic information that's sent to the state comes from the Financial Eligibility information stored in IBHIS as the subscriber information. The following data elements will be sent on outbound 837P and 837I Medi-Cal claims based on the information created for Financial Eligibility for Medi-Cal:
   - Client's Relationship To Subscriber - Self
   - Subscriber First Name
   - Subscriber Last Name
   - Subscriber Address
   - Subscriber Zip
   - Subscriber City
   - Subscriber State
   - Subscriber Policy # - CIN #
   - Subscriber Assignment of Benefits
   - Subscriber Release of Information
   - Subscriber's Gender

   Guarantor Order – will be calculated based on whether there were prior payer adjudications that were submitted on the inbound 837

   The following data elements will be sent on outbound 837P and 837I claims from the inbound claims when the claim was previously adjudicated by Medicare/OHC and included the Medicare/OHC loop:
   - Guarantor Order
   - Client's Relationship To Subscriber
   - Subscriber First Name

- Subscriber Last Name
- Subscriber Address
- Subscriber Zip
- Subscriber City
- Subscriber State
- Subscriber Policy # (CIN for Medi-Cal, HIC for Medicare, subscriber ID for OHC)
- Subscriber Assignment of Benefits
- Subscriber Release of Information
- Subscriber's Gender

Client Date of Birth will also be sent on outbound 837 Medi-Cal claims.

8. The following data elements will be sent on outbound 837I Medi-Cal claims based on the information entered via the Client Web Services Admit and Discharge Client routines:
   - Admission Date and Time
   - Discharge Date and Time
   - Type of Admission
   - Source of Admission
   - Type of Discharge
9. 837P claims transmitted to the state send the diagnosis code which was received on the inbound 837P claim.
10. 837I claims transmitted to the state send the principal diagnosis code which was received on the inbound 837I claim and send the admitting diagnosis based on the admitting diagnosis entered via the Client Web Services diagnosis calls. System expects an admitting diagnosis with a diagnosis date on or before the episode admission date.

6.4 Generation of Outbound 835 Files to Contract Providers

1. Per the national HIPAA 835 guide, IBHIS uses the Claim Status Code values 1, 2 and 3 (CLP02) when adjudicating original claims, regardless of whether the claim was approved or denied. IBHIS does not return the Claim Status Code 4 when a claim is denied.

7 ACKNOWLEDGEMENTS AND/OR REPORTS

7.1 Acknowledgement

1. LACDMH returns an Interchange Acknowledgment (TA1) segment when requested, based on the value transmitted in ISA14. LACDMH recommends that the provider request for the acknowledgement receipt (value 1) for all submissions.
2. LACDMH provides Implementation Acknowledgment transactions (999) for all inbound Functional Groups (i.e., 837s). Please refer to examples at section 10.4 for more information
3. LACDMH provides the Health Care Claim Acknowledgment transaction (277CA) for all claims. Only accepted claims will be assigned an IBHIS claim ID. Please refer to examples at section 10.5 for more information.
4. LACDMH does not request the Interchange Acknowledgments (TA1) segment on outbound interchanges.
5. LACDMH accepts, but does not require or process, Implementation Acknowledgment (999) transactions for all outbound Functional Groups.

7.2 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. In order to successfully link an 837 to the correct 277CA, the 837 must contain a unique

value in the BHT03 for every 837 file generated. LACDMH recommends you use a unique BHT03 value for all your submissions.

7.3 277CA Claim Status Codes

The following scenarios will result in claim rejections that will be seen on the IBHIS 277CA:

Inbound 837P/I Claim Rejections	Claim Status Codes on IBHIS 277CA
When an 837 Professional or 837 Institutional claim is submitted with other health care coverage without the SBR segment for the secondary payer in the 'Other Subscriber Information' Loop 2320, it will be rejected with code: A3:0 – Missing Secondary Payer	A3:0
Missing Admission Diagnosis on an Inpatient/837I claim	A6:232
Evidence Based Practice (EBP) code is missing	A6:442
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
When an 837 Professional or 837 Institutional claim is submitted with other health care coverage without the SBR segment for the primary payer in the 'Other Subscriber Information' Loop 2320, it will be rejected with code: A7:0 – Missing Primary Payer	A7:0
Procedure code not defined in IBHIS MSO CPT table	A7:21 & A7:454
A replacement or void claim request will be rejected when the request is submitted prior to the receipt of payment advice (835) for the original claim.	A7:3
Client ID with the 'MSO' prefix but does not exist in IBHIS	A7:33
Client ID without the 'MSO' prefix	A7:33
Total claim charge amount does not equal the sum of line item charge amount	A7:178
A claim will be rejected if a valid ICD-9 or ICD-10 qualifier (ABJ or BJ) is sent, based on the date of service, but the diagnosis code itself (ICD-9 or ICD-10) is not valid in the Admitting Diagnosis field (837I - 2300 HI01-2)	A7:232
A claim will be rejected if a valid ICD-9 or ICD-10 qualifier (ABK or BK) is sent, based on the date of service, but the diagnosis code itself (ICD-9 or ICD-10) is not valid in the Principal Diagnosis field (837P & 837I 2300 HI01-2)	A7:254
A claim will be rejected if a claim contains mixture of services with DOS (outpatient) or discharge/thru date (inpatient) before and after the cutover date and/or both ICD-9 and ICD-10 qualifiers are submitted on the claim or invalid Diagnosis Code submitted on the claim	A7:255
Claim is out of balance – service line paid amount + all service line adjustment amounts do not equal the line item charge amount	A7:400

Inbound 837P/I Claim Rejections	Claim Status Codes on IBHIS 277CA
Diagnosis Code Not Defined in IBHIS 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
A claim will be rejected if an ICD-10 diagnosis indicator is received and the service date (outpatient) or discharge/thru date (inpatient) prior to 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
Effective 07/01/2019, a claim will be rejected if 'Claim Level Service Facility Location(2310 Loop)' address or 'Line Level Service Facility Location(2420 Loop)' address contains an invalid zip code (5 Digit) and/or Non Numeric Zip+4. System always expects 9 digits with first 5 digit zip code validated against USPS zip codes. If the last 4 digits are unknown, use the default value '9998'.	A7:481
A claim will be rejected if a valid ICD-9 or ICD-10 qualifier (ABN or BN) is sent, based on the date of service, but the diagnosis code itself (ICD-9 or ICD-10) is not valid in the External Cause of Injury field (837I - 2300 HI01-2)	A7:509
Claim adjustment reason code in the CAS segment is invalid or was not active on the Coordination of Benefits Adjudication/Payment Date (2430:DTP03)	A7:521
Medicare is the secondary payer, and the Medicare Coordination of Benefits Insurance Type Code is missing or invalid (2320:SBR05)	A7:578
When an 837 Professional and/or 837 Institutional claim is submitted with other health care coverage, the AMT segment for the Coordination of Benefit in the 'Other Subscriber Information' loop 2320 is missing and/or the SVD and CAS segments in the 'Line Adjudication Information' Loop 2430C are out of balance, it will be rejected with code: A7:672 – Other Payer's Payment Information is out of balance	A7:672
A claim will be rejected if a valid ICD-9 or ICD-10 qualifier (APR or PR) is sent, based on the date of service, but the diagnosis code itself (ICD-9 or ICD-10) is not valid in the Patient Reason for Visit field (837I - 2300 HI01-2)	A7:673
A claim will be rejected if a claim contains mixture of services with DOS (outpatient) or discharge/thru date (inpatient) before and after the cutover date and/or both ICD-9 and ICD-10 qualifiers are submitted on the claim.	A7:732
Rejection code A7:787 will be returned on a 277 file for a claim that failed off batch processing during 837 files validation process. The rejected claim cannot be replaced and must be resubmitted as a new claim.	A7:787

7.4 Possible Negative 999 Reasons

Possible -999 Reasons	Example
When system encounters an 837 file that has incomplete segments/file truncation, the file will be rejected with a -999. If Provider receives this file level rejection for a complete 837 transaction that was submitted, please report the issue with a HEAT ticket to DMH to investigate.	IK*R*5~ AK9*R*1*1*0~ (The file was truncated due to an FTP issue)
Effective 07/01/2019, zip code in Billing Provider Loop 2010 should be 9 digit . In the absence of a 9 digit zip code, the file will be rejected with -999. If the last 4 digits are unknown, use the default value 9998.	CTX*SITUATIONAL TRIGGER*N4*09~ IK5*R*5~ AK9*R*1*1*0~ (The zip code in 2010A loop only contained 5 digits)

8 OPERATIONAL INFORMATION

8.1 Hours of Operation

Unless otherwise notified, claims processing will be online 7 days a week, 24 hours a day.

9 TRANSACTION SPECIFIC INFORMATION

9.1 Health Care Claim: Professional (837P)

Loop ID	Reference	Name	Codes	Notes/Comments
Beginning of Hierarchical Transaction				
	BHT02	Transaction Set Purpose Code	00	LACDMH expects to receive this code value.
	BHT06	Transaction Type Code	CH	LACDMH expects to receive this code value.
Submitter Name				
1000A	NM109	Submitter Identifier		Enter the 9-digit DUNS number, with no trailing spaces.
Receiver Name				
1000B	NM103	Receiver Name		LACDMH expects to receive 'LAC DEPARTMENT OF MENTAL HEALTH'
1000B	NM109	Receiver Primary Identifier		LACDMH expects to receive 'LACODMH'.
Billing Provider Specialty Information				
2000A	PRV03	Billing Provider Specialty Information		LACDMH adjudication is not impacted by the provider Taxonomy Code
SBR - Subscriber Information				

Loop ID	Reference	Name	Codes	Notes/Comments
2000B	SBR01	Payer Responsibility Sequence Number		Set to the appropriate payment responsibility for the claim. The value will be the highest-level following adjudication by a previous payer. For example, a Medi-Medi claim that contains the Medicare Other Payer loop will be represented as a Secondary claim when reported to LACDMH. A straight Medi-Cal or Indigent claim will be represented as a Primary claim.
Subscriber Name				
2010BA	NM102	Entity Type Qualifier	1	A LACDMH subscriber is always a person.
2010BA	NM108	Identification Code Qualifier	MI	
2010BA	NM109	Subscriber Primary Identifier		The LACDMH subscriber identifier is an alpha numeric field comprised of 'MSO' concatenated with the ClientID. 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 'MSO12345'.
Payer Name				
2010BB	NM103	Payer name		The destination payer is always LACDMH. LACDMH expects to receive 'LAC DEPARTMENT OF MENTAL HEALTH'
2010BB	NM108	Identification Code Qualifier	PI	LACDMH expects to receive this code value.
2010BB	NM109	Payer identifier		'953893470'
Claim Information				
2300	CLM01	Patient Control Number		LACDMH requires that this be a unique identifier.
2300	CLM05-1	Place of Service Code		If the place of service was via telephone, set this value to '11'. If the place of service was via Telehealth, set this value to '02'. If the place of service was via Telehealth Provided in Patients Home, set this value to '10'.
2300	CLM05-3	Claim Frequency Code		DMH accepts Original, '1', Replacement, '7' and Void, '8' claim frequency codes.
Share of Cost (SOC)				
2300	AMT01	Amount Qualifier Code	F5	
2300	AMT02	Patient Paid Amount		Patient SOC Amount obligated
Original Reference Number ICN/DCN				
2300	REF01	Reference ID Qualifier	F8	
2300	REF02	Claim Original Reference Number		Replacement and Void claims can only be submitted after the claim has been adjudicated in IBHIS and the provider has received an 835 with the IBHIS assigned claim ID number. Report the IBHIS assigned claim identifier, for the claim to be replaced/voided in this field.

Loop ID	Reference	Name	Codes	Notes/Comments
Katie A Identifier				
2300	REF01	Reference ID Qualifier	P4	
2300	REF02	Demonstration Project Identifier	KTA	To identify all specialty mental health services provided to Katie A. subclass members, providers shall identify all claims for services provided to clients identified as Katie A. subclass members by supplying the Loop 2300 REF-Demonstration Project Identifier (DPI) segment with the value “KTA” as the Demonstration Project Identifier (data element REF02).
Claim Note(Healthy Families)				
2300	NTE01	Note Reference	ADD	Additional Information
2300	NTE02	Description	SED	Indicates Healthy Families
Health Care Diagnosis Code				
2300	HI01-01	Code List Qualifier Code		For dates of service prior to the ICD-10 compliance date must use “BK”. For dates of service on or after the ICD-10 compliance date must use “ABK”.
2300	HI01-02, HI02-02, HI03-02, … HI12-02	Diagnosis Code		Use UPPERCASE, for any letters in an ICD-9 or ICD-10 code. Use ICD-9 codes for any dates of service prior to 10/1/2015. Use ICD-10 codes for any dates of service on or after 10/1/2015.
Supervisor Provider				
2310D	NM101	Entity Identifier Code	DQ	Supervising Physician
2320 SBR - Other Subscriber Information Only submit the 2320 Other Subscriber Loop for payers that have previously adjudicated the claim and/or have financial responsibility on the claim **prior to being sent to LACDMH**.				
2320	SBR01	Payer Responsibility Sequence Number		Set to the appropriate payment responsibility for the claim.
2320	SBR09	Claim Filing Indicator Code		Use 11 when the payer in this iteration of the 2320 loop is Medi-Cal. Use MB when the payer in this iteration of the 2320 loop is Medicare. Use 16 when the payer in this iteration of the 2320 loop is a Medicare HMO plan. Use appropriate code for all other payers.
AMT - Coordination of Benefits COB Payer Paid Amount				
2320	AMT01	Amount Qualifier CodCe	D	Use **D** to report amount paid by Medicare/OHC. This amount will be used for balancing processing. Must supply even if the amount is zero.
2320	AMT02	COB Payer Paid Amount		For Local Plan Contracted and FFS providers, that have previously sent claims and received remit advices from Medicare and/or private insurance, this field must be populated with the amount paid by Medicare and/or private insurance, even if it is zero.
NM1 - Other Payer Name				
2330B	NM109	Other Payer Primary Identifier		An identification number for the other payer, such as ‘01182’ for Medicare.
LX – Service Line Number				

Loop ID	Reference	Name	Codes	Notes/Comments
2400	LX01	Line Counter		Set to 1. LACDMH allows one service line per claim.
SV1 - Professional Service				
2400	SV101-02	Procedure Code		Group claims - Refer to the explanation found in the Group Claim Bulletin located at: http://file.lacounty.gov/SDSInter/dmh/165411_11-02GroupClaimingFinal.pdf
2400	SV101-03 thru SV101-06	Procedure Code Modifier		Refer to the Addendum Guide to Procedure Codes for IBHIS located at https://dmh.lacounty.gov/qa/qama/ for a complete list of Procedure Codes in IBHIS (including the modifiers for Duplicate Overrides (59 & 76), Telephone (SC), Tele-psychiatry (GT) and/or County Funded (HX). Modifiers must be submitted in the order listed in the Addendum Guide to Procedure Codes for IBHIS. **(Outdated link)** For further billing info on Telephone and Tele-psychiatry, see DMH INFORMATION NOTICE NO.: 10-23 at: https://www.dhcs.ca.gov/formsandpubs/MHArchives/InfoNotice10-23.pdf
2400	SV103	Unit or Basis of Measurement Code	UN MJ	Claims with date of service prior to July 1, 2023 for Outpatient Services claimed by the minute: Use 'MJ' / Minutes; Crisis Stabilization claimed by the hour: Use measurement code 'MJ' / Minutes. Claims with date of service on or after July 1, 2023: • Outpatient Services: Use measurement code 'UN' in Units. • Day Treatment, Residential, PHF or Life Support: Continue to use measurement code 'UN' in Units. • .
2400	SV104	Service Unit Count		Set to the number of units or minutes or hours. Use the procedure code that matches the appropriate face to face time. Enter minutes as the total of face to face + other time. Crisis Stabilization claims must represent the number of hours claimed for. Must be 1 for Day Treatment, Residential, TFC, PHF and Life Support claims. For Local Contract Provider Group claims, refer to the explanation found in the Group Claim Bulletin located at: http://file.lacounty.gov/SDSInter/dmh/165411_11-02GroupClaimingFinal.pdf

Loop ID	Reference	Name	Codes	Notes/Comments
2400	SV109	Emergency Indicator	Y	SV109 is the Emergency Aid Code indicator. A 'Y' value indicates the client has an emergency aid code. If the client has no Emergency Aid code do not send.
DTP – Service Date				
2400	DTP01	Date Time Qualifier	472	
2400	DTP02	Date Time Period Format Qualifier	D8	Use D8 for all services, including Day Treatment, Residential, TFC, PHF and Life Support
2400	DTP03	Service Date		Submit the service date
REF - Prior Authorization				
2400	REF01	Prior Authorization Qualifier	G1	
2400	REF02	Prior Authorization Number		Report the Provider, Member or Fee-For-Service Authorization # in the Prior Authorization field.
NTE Service Note				
2400	NTE01	Note Reference Code	DCP	Use DCP for reporting the Evidence Based Practice (EBP) code.
2400	NTE02	Claim Note Text		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. Allowable EBP Codes are located at: https://dmh.lacounty.gov/pc/cp/edi/
Service Facility Location – send the 2420C Service Facility Location loop when the health care service was delivered in a location other than the billing provider office. DO NOT ENTER an NPI for the Service Facility Location Effective July 1, 2023, the State will deny claims when the Place of Service is '10 Telehealth Provided in Patients Home' and the client's home address is NOT provided in Loop 2420C Service Facility Location.				
2420C	NM101	Entity Identifier Code	77	
2420C	NM102	Entity Type Qualifier	2	
2420C	NM103	Facility Name		Enter the name or description where the service was delivered
2420C	N301	Facility Address Line		Enter the street address where the service was delivered
2420C	N401	Facility City Name		Enter the city where the service was delivered
2420C	N402	Facility State		Enter the state where the service was delivered
2420C	N403	Facility Zip		Enter the zip code where the service was delivered Note: you must enter the full nine digit zip code in this field
Loop 2430 Line Adjudication Information – IBHIS requires the 2430 loop and required 2430 segments whenever a claim was adjudicated by a prior payer and there is a 2320 Other Subscriber Loop on the claim.				
SVD – Line Adjudication Information – the SVD segment is required whenever a claim was adjudicated by a prior payer and there is a 2320 Other Subscriber Loop on the claim.				
CAS – Line Adjustment				

Loop ID	Reference	Name	Codes	Notes/Comments
2430	CAS01 – CAS04	Claim Line Adjustments		Required when the payer identified in Loop 2330B made payment adjustments which caused the amount paid to differ from the amount originally charged. Medicare/OHC adjustments must be reported at the Service Line level.

9.2 Health Care Claim: Professional (837P) COS

Community Outreach Services

Loop ID	Reference	Name	Codes	Notes/Comments
Beginning of Hierarchical Transaction				
	BHT02	Transaction Set Purpose Code	00	LACDMH expects to receive this code value.
	BHT06	Transaction Type Code	CH	LACDMH expects to receive this code value.
Submitter Name				
1000A	NM109	Submitter Identifier		Enter the 9-digit DUNS number, with no trailing spaces.
Receiver Name				
1000B	NM103	Receiver Name		LACDMH expects to receive ‘LAC DEPARTMENT OF MENTAL HEALTH’
1000B	NM109	Receiver Primary Identifier		LACDMH expects to receive ‘LACODMH’.
Billing Provider Specialty Information				
2000A	PRV03	Billing Provider Specialty Information		LACDMH adjudication is not impacted by the provider Taxonomy Code
SBR - Subscriber Information				
2000B	SBR01	Payer Responsibility Sequence Number	P	DMH is always primary for COS services.
Subscriber Name				
2010BA	NM102	Entity Type Qualifier	1	For COS claims, the subscriber/patient will be identified as a person, even when the COS service was related to a group of people.
2010BA	NM103	Name Last	COS	Must use “COS”
2010BA	NM104	Name First	Service	Must Use “SERVICE”
2010BA	NM108	Identification Code Qualifier	MI	
2010BA	NM109	Subscriber Primary Identifier		For COS claims, use ‘MSO8888888’ as the Subscriber ID
2010BA	N301	Address		Must use “510 S VERMONT AVE”
2010BA	N401	City Name		Must use “LOS ANGELES”
2010BA	N402	State		Must use “CA”
2010BA	N403	Zip Code		Must use “900201912”
2010BA	DMG01	Date Time Format Qualifier	D8	Date of Birth
2010BA	DMG02	Date Time		Must use “20130701”
2010BA	DMG03	Gender Code	U	Must use “U”
Payer Name				
2010BB	NM103	Payer name		The destination payer is always LACDMH. LACDMH expects to receive ‘LAC DEPARTMENT OF MENTAL HEALTH’
2010BB	NM108	Identification Code Qualifier	PI	LACDMH expects to receive this code value.
2010BB	NM109	Payer identifier		‘953893470’

Loop ID	Reference	Name	Codes	Notes/Comments
Claim Information				
2300	CLM01	Patient Control Number		LACDMH requires that this be a unique identifier.
2300	CLM05-1	Place of Service Code		Use any appropriate Place of Service code.
2300	CLM05-3	Claim Frequency Code		DMH accepts Original, '1', Replacement, '7' and Void, '8' claim frequency codes.
Original Reference Number ICN/DCN				
2300	REF01	Reference ID Qualifier	F8	
2300	REF02	Claim Original Reference Number		Replacement and Void claims can only be submitted after the claim has been adjudicated in IBHIS and the provider has received an 835 with the IBHIS assigned claim ID number. Report the IBHIS assigned claim identifier, for the claim to be replaced/voided in this field.
NTE Claim Note – **This segment is required ONLY for COS provided to Wraparound Clients.**				
2300	NTE01	Note Reference Code	ADD	Use ADD Qualifier for 'Additional Information'
2300	NTE02	Claim Note Text	PC1123456 or 2123456	Potential Client ID from SRTS or COS 231 DMH/IBHIS Client ID is required to enter here.
Health Care Diagnosis Code				
2300	HI01-01	Code List Qualifier Code		For dates of service prior to the ICD-10 compliance date must use "BK". For dates of service on or after the ICD-10 compliance date must use "ABK".
2300	HI01-02	Diagnosis Code		For dates of service prior to the ICD-10 compliance date must use "V7109". For dates of service on or after the ICD-10 compliance date must use "Z0389".
Rendering Provider				
2310	NM101	Entity Identifier Code	82	
2310	NM102	Entity Type Qualifier	1	
2310	NM103	Name Last		Last Name of the Primary COS Provider
2310	NM104	Name First		First Name of the Primary COS Provider
2310	NM108	Identification Code Qualifier	XX	
2310	NM109	Identification Code		Primary COS Provider's NPI #
LX – Service Line Number				
2400	LX01	Line Counter		Set to 1. LACDMH allows one service line per claim.
SV1 - Professional Service				

2400	SV101-02 SV101-03 thru SV101-06	Procedure Code Procedure Code Modifier		Must use one of the identified COS codes and modifier if applicable. Refer to the Addendum Guide to Procedure Codes for IBHIS located at: https://dmh.lacounty.gov/qa/qama/ for a complete list of Procedure Codes in IBHIS (including the modifiers for Duplicate Overrides (59 & 76), Telephone (SC), Tele-psychiatry (GT) and/or County Funded (HX). Modifiers must be submitted in the order listed in the Addendum Guide to Procedure Codes for IBHIS.
2400	SV103	Unit or Basis of Measurement Code	MJ	COS services must use “MJ” - minutes
2400	SV104	Service Unit Count		For COS services, Use the total # of minutes for all practitioners involved in providing the service. Documentation time should be included. Travel time is excluded.
REF - Prior Authorization				
2400	REF01	Prior Authorization Qualifier	G1	
2400	REF02	Prior Authorization Number		Use the appropriate Non Medi-Cal **P-AUTH auth**orization number
NTE Service Note				
2400	NTE01	Note Reference Code	DCP	Use DCP for reporting the Evidence Based Practice (EBP) code.
2400	NTE02	Claim Note Text	99	COS Claims must use “99” Claims will reject if this segment is not present.
LQ – Form Identification Code				
2440	LQ01	Code List Qualifier Code	AS	Must use “AS”
2440	LQ02	Industry Code	IBHISCOS	Must use “IBHISCOS”
FRM – Supporting Documentation				
2440	FRM01	Assigned Identification	D26	
2440	FRM03	Reference Identification		Required on every COS claim. Refer tab D.26 in the DMH IBHIS COS Dictionary Values spreadsheet for information on Service Type Codes. For more information, refer to the QA Manuals page at https://dmh.lacounty.gov/qa/qama/ or refer to the bulletin found in: http://file.lacounty.gov/SDSInter/dmh/1032292_COSManual12-2017.pdf
2440	FRM01	Assigned Identification	D12	

2440	FRM03	Reference Identification		Required on every COS claim. Refer tab D.12 in the DMH IBHIS COS Dictionary Values spreadsheet for information on Service Type Codes. For more information, refer to the QA Manuals page at https://dmh.lacounty.gov/qa/qama/ or refer to the bulletin found in: http://file.lacounty.gov/SDSInter/dmh/1032292_COSManual12-2017.pdf
2440	FRM01	Assigned Identification	D43	
2440	FRM03	Reference Identification		Required on every COS claim. Refer tab D.43 in the DMH IBHIS COS Dictionary Values spreadsheet for information on Service Type Codes. For more information, refer to the QA Manuals page at https://dmh.lacounty.gov/qa/qama/ or refer to the bulletin found in: http://file.lacounty.gov/SDSInter/dmh/1032292_COSManual12-2017.pdf
2440	FRM01	Assigned Identification	D01	
2440	FRM03	Reference Identification		Required on every COS claim. Refer tab D.01 in the DMH IBHIS COS Dictionary Values spreadsheet for information on Service Type Codes. For more information, refer to the QA Manuals page at https://dmh.lacounty.gov/qa/qama/ or refer to the bulletin found in: http://file.lacounty.gov/SDSInter/dmh/1032292_COSManual12-2017.pdf
2440	FRM01	Assigned Identification	D23	
2440	FRM03	Reference Identification		Required on every COS claim. Refer tab D.23 in the DMH IBHIS COS Dictionary Values spreadsheet for information on Service Type Codes. For more information, refer to the QA Manuals page at https://dmh.lacounty.gov/qa/qama/ or refer to the bulletin found in: http://file.lacounty.gov/SDSInter/dmh/1032292_COSManual12-2017.pdf
2440	FRM01	Assigned Identification	D25	
2440	FRM03	Reference Identification		Required on every COS claim. Refer tab D.25 in the DMH IBHIS COS Dictionary Values spreadsheet for information on Service Type Codes. For more information, refer to the QA Manuals page at https://dmh.lacounty.gov/qa/qama/ or refer to the bulletin found in: http://file.lacounty.gov/SDSInter/dmh/1032292_COSManual12-2017.pdf
2440	FRM01	Assigned Identification	Contacts	
2440	FRM03	Reference Identification		Number of persons contacted

9.3 Health Care Claim: Inpatient (837I)

Loop ID	Reference	Name	Codes	Notes/Comments
Beginning of Hierarchical Transaction				
	BHT02	Transaction Set Purpose Code	00	LACDMH expects to receive this code value.
	BHT06	Transaction Type Code	CH	LACDMH expects to receive this code value.
Submitter Name				
1000A	NM109	Submitter Identifier		Enter the 9-digit DUNS number, with no trailing spaces.
Receiver Name				
1000B	NM103	Receiver Name		LACDMH expects to receive 'LAC DEPARTMENT OF MENTAL HEALTH'
1000B	NM109	Receiver Primary Identifier		LACDMH expects to receive 'LACODMH'.
Billing Provider Specialty Information				
2000A	PRV03	Billing Provider Specialty Information		LACDMH adjudication is not impacted by the provider Taxonomy Code
SBR - Subscriber Information				
2000B	SBR01	Payer Responsibility Sequence Number		Set to the appropriate payment responsibility for the claim. The value will be the highest level following adjudication by a previous payer. For example, a Medi-Medi claim that contains the Medicare Other Payer loop will be represented as a Secondary claim when reported to LACDMH. A straight Medi-Cal or Indigent claim will be represented as a Primary claim.
Subscriber Name				
2010BA	NM102	Entity Type Qualifier	1	A LACDMH subscriber is always a person.
2010BA	NM108	Identification Code Qualifier	MI	
2010BA	NM109	Subscriber Primary Identifier		The LACDMH subscriber identifier is an alpha numeric field comprised of 'MSO' concatenated with the ClientID. 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 'MSO12345'.
Payer Name				
2010BB	NM103	Payer name		The destination payer is always LACDMH. LACDMH expects to receive 'LAC DEPARTMENT OF MENTAL HEALTH'
2010BB	NM108	Identification Code Qualifier	PI	LACDMH expects to receive this code value.
2010BB	NM109	Payer identifier		'953893470'
Claim Information				
2300	CLM01	Patient Control Number		LACDMH requires that this be a unique identifier.

Loop ID	Reference	Name	Codes	Notes/Comments
2300	CLM05-3	Claim Frequency Code		Enter the appropriate code: 1 - Admit & Discharge Claim –charges for an entire episode 2 - Interim 1st Claim 3 - Interim Continuing Claim 4 - Interim Last Claim 5 – Late Charge Only 7 - Replacement of Prior Claim 8 - Void/Cancel of prior Claim
DTP – Statement Dates				
2300	DTP01	Date/Time Qualifier	434	
2300	DTP02	Date Time Period Format Qualifier	RD8	
2300	DTP03	Statement From and To Date		Enter the Service Date you are claiming for. You must use the date range format, but the From and To dates must be the same date.
REF - Prior Authorization				
2300	REF01	Prior Authorization Qualifier	G1	
2300	REF02	Prior Authorization Number		Report the Provider or Member Authorization # in the Prior Authorization field.
Original Reference Number ICN/DCN				
2300	REF01	Reference ID Qualifier	F8	
2300	REF02	Claim Original Reference Number		Replacement and Void claims can only be submitted after the claim has been adjudicated in IBHIS and the provider has received an 835 with the IBHIS assigned claim ID number. Report the IBHIS assigned claim identifier, for the claim to be replaced/voided in this field.
Katie A Identifier				
2300	REF01	Reference ID Qualifier	P4	
2300	REF02	Demonstration Project Identifier	KTA	To identify all specialty mental health services provided to Katie A. subclass members, providers shall identify all claims for services provided to clients identified as Katie A. subclass members by supplying the Loop 2300 REF-Demonstration Project Identifier (DPI) segment with the value “KTA” as the Demonstration Project Identifier (data element REF02).
NTE Claim Note				
2300	NTE01	Note Reference Code	DCP	Use DCP for reporting the Evidence Based Practice (EBP) code.

Loop ID	Reference	Name	Codes	Notes/Comments
2300	NTE02	Claim Note Text		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. Allowable EBP Codes are located at: https://dmh.lacounty.gov/pc/cp/edi/
Billing Note (Healthy Families)				
2300	NTE01	Note Reference	ADD	Additional Information
2300	NTE02	Description	SED	Indicates Healthy Families
Principal Diagnosis Code				
2300	HI01-01	Diagnosis Type Code	ABK BK	Use ABK for Dates of Service of 10/1/15 and later Use BK for Dates of Service prior to 10/1/15
2300	HI01-02	Principal Diagnosis Code	 F3111 29570	Do not send decimal points. Send ICD-10 for Dates of Service of 10/1/15 and later Send ICD-9 for Dates of Service prior to 10/1/15
Admitting Diagnosis Code				
2300	HI01-01	Diagnosis Type Code	ABJ BJ	Use ABJ for Dates of Service of 10/1/15 and later Use BJ for Dates of Service prior to 10/1/15
2300	HI01-02	Admitting Diagnosis Code	 F3111 29570	Do not send decimal points. Send ICD-10 for Dates of Service of 10/1/15 and later Send ICD-9 for Dates of Service prior to 10/1/15
Share of Cost (SOC) – Value Information – To report patient paid amount				
2300	HI01-01	Code List Qualifier Code	BE	DMH expects to receive “BE” value when reporting the patient paid amount.
2300	HI01-02	Value Code	FC	DMH expects to receive “FC” value when reporting the patient paid amount.
2300	HI01-05	Value Code Amount		Enter dollar amount the patient has paid.
Attending Provider				
2310A	NM101	Entity Identifier Code	71	The Attending Provider loop is always required
2310A	NM108	Identification Code Qualifier	XX	Use XX to report the NPI in NM109
2300	NM109	Attending Provider Primary Identifier		Enter the Attending Provider’s NPI
2320 SBR - Other Subscriber Information Only submit the 2320 Other Subscriber Loop for payers that have previously adjudicated the claim and/or have financial responsibility on the claim **prior to being sent to LACDMH**.				

Loop ID	Reference	Name	Codes	Notes/Comments
2320	SBR01	Payer Responsibility Sequence Number		Set to the appropriate payment responsibility for the claim.
2320	SBR09	Claim Filing Indicator Code		Use 11 when the payer in this iteration of the 2320 loop is Medi-Cal. Use MB when the payer in this iteration of the 2320 loop is Medicare. Use 16 when the payer in this iteration of the 2320 loop is a Medicare HMO plan. Use appropriate code for all other payers.
AMT - Coordination of Benefits COB Payer Paid Amount				
2320	AMT01	Amount Qualifier Code	D	Use **D** to report amount paid by Medicare/OHC. This amount will be used for balancing processing. Must supply even if the amount is zero.
2320	AMT02	COB Payer Paid Amount		For Local Plan Contracted and FFS providers, that have previously sent claims and received remit advices from Medicare and/or private insurance, this field must be populated with the amount paid by Medicare and/or private insurance, even if it is zero.
NM1 - Other Payer Name				
2330B	NM109	Other Payer Primary Identifier		An identification number for the other payer, such as '01182' for Medicare.
LX – Service Line Number				
2400	LX01	Line Counter		Set to 1. LACDMH allows one service line per claim.
SV2 – Inpatient Service Line				
2400	SV202-01	Product or Service ID Qualifier	HC	LACDMH expects to receive this code value.
2400	SV202-02	Procedure Code		Refer to the Addendum Guide to Procedure Codes for IBHIS located at https://dmh.lacounty.gov/qa/qama/ for a complete list of Procedure Codes in IBHIS. Modifiers must be submitted in the order listed in the Addendum Guide to Procedure Codes for IBHIS.
2400	SV202-03 thru SV202-06	Procedure Code Modifier		Refer to the Addendum Guide to Procedure Codes for IBHIS located at https://dmh.lacounty.gov/qa/qama/ for a complete list of Procedure Codes in IBHIS. Modifiers must be submitted in the order listed in the Addendum Guide to Procedure Codes for IBHIS.
2400	SV204	Unit or Basis of Measurement Code	DA	Inpatient Services – use 'DA' / Days
2400	SV205	Service Unit Count		Must be 1
Loop 2430 Line Adjudication Information – IBHIS requires the 2430 loop and required 2430 segments whenever a claim was adjudicated by a prior payer and there is a 2320 Other Subscriber Loop on the claim.				
SVD – Line Adjudication Information – the SVD segment is required whenever a claim was adjudicated by a prior payer and there is a 2320 Other Subscriber Loop on the claim.				
CAS – Line Adjustment				

Loop ID	Reference	Name	Codes	Notes/Comments
2430	CAS01 – CAS04	Claim Line Adjustments		Required when the payer identified in Loop 2330B made payment adjustments which caused the amount paid to differ from the amount originally charged. Medicare/OHC adjustments must be reported at the Service Line level.

10 APPENDICES

10.1 Health Care Claim: Professional 837P Examples

10.1.1 Straight Medi-Cal

Interchange (L_ISA)
ISA*00* *00* *14*996508079 *14*132486189
***131121*0822*!*00501*131121802*1*T*:~**

Functional Group (L_GS)
GS*HC*996508079*132486189*20131121*082252*131121802*X*005010X222A1~

Transaction 837P (837P)
ST*837*000000001*005010X222A1~
BHT*0019*00*131121802A*20131121*082252*CH~

Submitter Name (1000A)
NM1*41*2*LE88333 FAMILY MENTAL HEALTH SERVICES CLINIC
*******46*996508079~** ← **Submitter's DUNS**
PER*IC*BILLING DEPARTMENT*TE*5554443333~

Receiver Name (1000B)
NM1*40*2*LAC DEPARTMENT OF MENTAL HEALTH***46*LACODMH~**

Billing Provider Hierarchical Level (2000A)
HL*120*1~**

Billing Provider Name (2010AA)
NM1*85*2*1234Z FMHSC PGM-LOCATION-Z LE88333***XX*9926907927~** ← **Contracting Provider Program NPI**
N3*305 GRANDE AVE STE 202~
N4*LOS ANGELES*CA*900024160~
REF*EI*999916918~
PER*IC*BILLING MANAGER*TE*5554443333~

Subscriber Hierarchical Level (2000B)
HL*2*1*22*0~
SBR*P*18*****11~** ← **LACDMH is the destination payer, it is Primary**

Subscriber Name (2010BA)
NM1*IL*1*MEDICALDOE*MEDICALJOHN**MI*MSO9888331~** ← **Client's ID & 'MSO' is required**
N3*613 8TH STREET~
N4*LOS ANGELES*CA*90012~
DMG*D8*19860821*M~

Payer Name (2010BB)
NM1*PR*2*LAC DEPARTMENT OF MENTAL HEALTH***PI*953893470~** ← **LACDMH Payer ID**
N3*510 S Vermont Ave~
N4*Los Angeles*CA*90012~

Claim Information (2300)
CLM*131121802A-01*297.6*11:B:1*Y*A*Y*I~**
HI*ABK:F339~

Rendering Provider Name (2310B)

NM1*82*1*BRIGHT*FUTURO****XX*1899992078~ ← Performing Provider NPI

Service Line Number (2400)
LX*1~
SV1*HC:90887*297.6*UN*120***1~ ← UN for units
DTP*472*D8*20131118~
REF*G1*P71~ ← Provider Authorization number
NTE*DCP*01~ ← EBP (Evidence Based Practice) Code

Transaction 837P (837P)
SE*29*000000001~

Functional Group (L_GS)
GE*1*131121802~

Interchange (L_ISA)
IEA*1*131121802~

10.1.2 Indigent

Interchange (L_ISA)
ISA*00* *00* *14*996508079 *14*132486189
*131121*0822*!*00501*131121802*1*T*:~

Functional Group (L_GS)
GS*HC*996508079*132486189*20131121*082252*131121802*X*005010X222A1~

Transaction 837P (837P)
ST*837*000000001*005010X222A1~
BHT*0019*00*131121802A*20131121*082252*CH~

Submitter Name (1000A)
NM1*41*2*LE88333 FAMILY MENTAL HEALTH SERVICES CLINIC
*****46*996508079~ ← Submitter's DUNS
PER*IC*BILLING DEPARTMENT*TE*5554443333~

Receiver Name (1000B)
NM1*40*2*LAC DEPARTMENT OF MENTAL HEALTH*****46*LACODMH~

Billing Provider Hierarchical Level (2000A)
HL*1**20*1~

Billing Provider Name (2010AA)
NM1*85*2*1234Z FMHSC PGM-LOCATION-Z LE88333*****XX*9926907927~ ← Contracting Provider Program NPI
N3*305 GRANDE AVE STE 202~
N4*LOS ANGELES*CA*900024160~
REF*EI*999916918~
PER*IC*BILLING MANAGER*TE*5554443333~

Subscriber Hierarchical Level (2000B)
HL*2*1*22*0~
SBR*P*18*******11~ ← LACDMH is the destination payer, it is Primary

Subscriber Name (2010BA)
NM1*IL*1*INDIGENTDOE*INDIGENTJANE****MI*MSO9884330~ ← Client's ID & 'MSO' is required
N3*972 3RD AVE~

N4*LOS ANGELES*CA*90022~
DMG*D8*19560326*F~

Payer Name (2010BB)
NM1*PR*2*LAC DEPARTMENT OF MENTAL HEALTH*****PI*953893470~ ← LACDMH Payer ID
N3*510 S Vermont Ave~
N4*Los Angeles*CA*90012~

Claim Information (2300)
CLM*131121802A-01*297.6***11:B:1*Y*A*Y*I~
HI*ABK:F339~

Rendering Provider Name (2310B)
NM1*82*1*BRIGHT*FUTURO****XX*1899992078~ ← Performing Provider NPI

Service Line Number (2400)
LX*1~
SV1*HC:T1017:HE:HS:HX*297.6*UN*120***1~ ← UN for units, Procedure code is NOT Medi-Cal Billable
DTP*472*D8*20131118~
REF*G1*P51~ ← Provider Authorization number
NTE*DCP*01~ ← EBP (Evidence Based Practice) Code

Transaction 837P (837P)
SE*29*000000001~

Functional Group (L_GS)
GE*1*131121802~

Interchange (L_ISA)
IEA*1*131121802~

10.1.3 Medi-Medi

Interchange (L_ISA)
ISA*00* *00* *14*996508079 *14*132486189
*131121*0822*!*00501*131121802*1*T*:~

Functional Group (L_GS)
GS*HC*996508079*132486189*20131121*082252*131121802*X*005010X222A1~

Transaction 837P (837P)
ST*837*000000001*005010X222A1~
BHT*0019*00*131121802A*20131121*082252*CH~

Submitter Name (1000A)
NM1*41*2*LE88333 FAMILY MENTAL HEALTH SERVICES CLINIC
*****46*996508079~ ← Submitter's DUNS
PER*IC*BILLING DEPARTMENT*TE*5554443333~

Receiver Name (1000B)
NM1*40*2*LAC DEPARTMENT OF MENTAL HEALTH*****46*LACODMH~

Billing Provider Hierarchical Level (2000A)
HL*1**20*1~

Billing Provider Name (2010AA)
NM1*85*2*1234Z FMHSC PGM-LOCATION-Z LE88333***XX*9926907927~** ← **Contracting Provider Program NPI**
N3*305 GRANDE AVE STE 202~
N4*LOS ANGELES*CA*900024160~
REF*EI*999916918~
PER*IC*BILLING MANAGER*TE*5554443333~

Subscriber Hierarchical Level (2000B)
HL*2*1*22*0~
SBR*S*18*****11~** ← **LACDMH is the destination payer, it is Secondary because this is a Medicare, Medi-Cal claim**

Subscriber Name (2010BA)
NM1*IL*1*MEDICAREDOE*MEDICAREJOHN**MI*MSO9888400~** ← **Client's ID & 'MSO' is required**
N3*11 7TH STREET~
N4*LOS ANGELES*CA*90012~
DMG*D8*19450413*M~

Payer Name (2010BB)
NM1*PR*2*LAC DEPARTMENT OF MENTAL HEALTH***PI*953893470~** ← **LACDMH Payer ID**
N3*510 S Vermont Ave~
N4*Los Angeles*CA*90012~

Claim Information (2300)
CLM*131121802A-01*297.6*11:B:1*Y*A*Y*I~**
HI*BK:29602~

Rendering Provider Name (2310B)
NM1*82*1*BRIGHT*FUTURO**XX*1899992078~** ← **Performing Provider NPI**

Other Subscriber Information (2320)
SBR*P*18*****MB~** ← **Primary Payer is Medicare Part B**
AMT*D*96.6~ ← **Payor Amount Paid, amount zero is acceptable**
OI*Y***I~**

Other Subscriber Name (2330A)
NM1*IL*1*MEDICAREDOE*MEDICAREJOHN**MI*12345678A~** ← **Client's HIC (Medicare Beneficiary ID)**
N3*11 7TH STREET~
N4*LOS ANGELES*CA*90012~

Other Payer Name (2330B)
NM1*PR*2*MEDICARE***PI*01182~** ← **Medicare Part B Southern California Payer ID is 01182**

Service Line Number (2400)
LX*1~
SV1*HC:90887*297.6*UN*120*1~** ← **UN for units**
DTP*472*D8*20130918~
REF*G1*P11~ ← **Provider Authorization number**
NTE*DCP*01~ ← **EBP (Evidence Based Practice) Code**

Line Adjudication Information (2430)
SVD*01182*96.6*HC:90887120~** ← **Line Adjudication Information from Medicare Part B Southern California Payer ID 01182**
CAS*CO*45*201~ ← **Line Adjustment by Medicare Part B Southern California Payer ID 01182**
DTP*573*D8*20131030~ ← **Line Check or Remittance Date**

Transaction 837P (837P)
SE*39*000000001~

Functional Group (L_GS)
GE*1*131121802~

Interchange (L_ISA)
IEA*1*131121802~

10.1.4 OHC-Medi-Cal

Interchange (L_ISA)
ISA*00* *00* *14*996508079 *14*132486189
***131121*0822*!*00501*131121802*1*T*:~**

Functional Group (L_GS)
GS*HC*996508079*132486189*20131121*082252*131121802*X*005010X222A1~

Transaction 837P (837P)
ST*837*000000001*005010X222A1~
BHT*0019*00*131121802A*20131121*082252*CH~

Submitter Name (1000A)
NM1*41*2*LE88333 FAMILY MENTAL HEALTH SERVICES CLINIC
*******46*996508079~** ← **Submitter's DUNS**
PER*IC*BILLING DEPARTMENT*TE*5554443333~

Receiver Name (1000B)
NM1*40*2*LAC DEPARTMENT OF MENTAL HEALTH***46*LACODMH~**

Billing Provider Hierarchical Level (2000A)
HL*120*1~**

Billing Provider Name (2010AA)
NM1*85*2*1234Z FMHSC PGM-LOCATION-Z LE88333***XX*9926907927~** ← **Contracting Provider Program NPI**
N3*305 GRANDE AVE STE 202~
N4*LOS ANGELES*CA*900024160~
REF*EI*999916918~
PER*IC*BILLING MANAGER*TE*5554443333~

Subscriber Hierarchical Level (2000B)
HL*2*1*22*0~
SBR*S*18*****11~** ← **LACDMH is the destination payer, it is Secondary because this is an OHC, Medi-Cal claim**

Subscriber Name (2010BA)
NM1*IL*1*OHCDOE*OHCJANE**MI*MSO9888621~** ← **Client's ID & 'MSO' is required**
N3*311 9TH STREET~
N4*LOS ANGELES*CA*90012~
DMG*D8*19840721*F~

Payer Name (2010BB)
NM1*PR*2*LAC DEPARTMENT OF MENTAL HEALTH***PI*953893470~** ← **LACDMH Payer ID**
N3*510 S Vermont Ave~
N4*Los Angeles*CA*90012~

Claim Information (2300)
CLM*131121802A-01*297.6***11:B:1*Y*A*Y*I~
HI*ABK:F339~

Rendering Provider Name (2310B)
NM1*82*1*BRIGHT*FUTURO****XX*1899992078~ ← Performing Provider NPI

Other Subscriber Information (2320)
SBR*P*18*******CI~ ← Primary Payer is a Commercial Payor
AMT*D*96.6~ ← Payor Amount Paid, amount zero is acceptable
OI***Y***I~

Other Subscriber Name (2330A)
NM1*IL*1*OHCDOE*OHCJANE****MI*AET633-8~ ← Client's Aetna HMO membership ID
N3*311 9TH STREET~
N4*LOS ANGELES*CA*90012~

Other Payer Name (2330B)
NM1*PR*2*Aetna HMO*****PI*60054~ ← OHC payor is Aetna HMO with Payer ID 60054

Service Line Number (2400)
LX*1~
SV1*HC:90887*297.6*UN*120***1~ ← UN for units
DTP*472*D8*20131018~
REF*G1*P21~ ← Provider Authorization number
NTE*DCP*01~ ← EBP (Evidence Based Practice) Code

Line Adjudication Information (2430)
SVD*60054*96.6*HC:90887**120~ ← Line Adjudication Information from Aetna HMO ID 60054
CAS*CO*45*201~ ← Line Adjustment by Aetna HMO
DTP*573*D8*20131030~ ← Line Check or Remittance Date

Transaction 837P (837P)
SE*39*000000001~

Functional Group (L_GS)
GE*1*131121802~

Interchange (L_ISA)
IEA*1*131121802~

10.1.5 OHC-Medi-Medi

Interchange (L_ISA)
ISA*00* *00* *14*996508079 *14*132486189
*131121*0822*!*00501*131121802*1*T*:~

Functional Group (L_GS)
GS*HC*996508079*132486189*20131121*082252*131121802*X*005010X222A1~

Transaction 837P (837P)
ST*837*000000001*005010X222A1~
BHT*0019*00*131121802A*20131121*082252*CH~

Submitter Name (1000A)
NM1*41*2*LE88333 FAMILY MENTAL HEALTH SERVICES CLINIC
*****46*996508079~ ← Submitter's DUNS

PER*IC*BILLING DEPARTMENT*TE*5554443333~

Receiver Name (1000B)
NM1*40*2*LAC DEPARTMENT OF MENTAL HEALTH***46*LACODMH~**

Billing Provider Hierarchical Level (2000A)
HL*120*1~**

Billing Provider Name (2010AA)
NM1*85*2*1234Z FMHSC PGM-LOCATION-Z LE88333***XX*9926907927~** ← **Contracting Provider Program NPI**
N3*305 GRANDE AVE STE 202~
N4*LOS ANGELES*CA*900024160~
REF*EI*999916918~
PER*IC*BILLING MANAGER*TE*5554443333~

Subscriber Hierarchical Level (2000B)
HL*2*1*22*0~
SBR*T*18*****11~** ← **LACDMH is the destination payer, it is Tertiary because this is an OHC Medi-Medi claim**

Subscriber Name (2010BA)
NM1*IL*1*OHCMMDOE*OHCMMJANE**MI*MSO9811621~** ← **Client's ID & 'MSO' is required**
N3*311 9TH STREET~
N4*LOS ANGELES*CA*90012~
DMG*D8*19840721*F~

Payer Name (2010BB)
NM1*PR*2*LAC DEPARTMENT OF MENTAL HEALTH***PI*953893470~** ← **LACDMH Payer ID**
N3*510 S Vermont Ave~
N4*Los Angeles*CA*90012~

Claim Information (2300)
CLM*131121802A-01*297.6*11:B:1*Y*A*Y*I~**
HI*ABK:F3131~

Rendering Provider Name (2310B)
NM1*82*1*BRIGHT*FUTURO**XX*1899992078~** ← **Performing Provider NPI**

Other Subscriber Information (2320)
SBR*P*18*****CI~** ← **Primary Payer is Commercial Insurance**
AMT*D*96.6~ ← **Payor Amount Paid, amount zero is acceptable**
OI*Y***I~**

Other Subscriber Name (2330A)
NM1*IL*1*OHCMMDOE*OHCMMJANE**MI*AET630-2~** ← **Client's HMO ID**
N3*311 9TH STREET~
N4*LOS ANGELES*CA*90012~

Other Payer Name (2330B)
NM1*PR*2*Aetna HMO***PI*60054~** ← **Aetna HMO Payer ID is 60054**

Other Subscriber Information (2320)
SBR*S*18*47****MB~** ← **Secondary Payer is Medicare Part B**
AMT*D*20~ ← **Payor Amount Paid, amount zero is acceptable**
OI*Y***I~**

Other Subscriber Name (2330A)

NM1*IL*1*OHCMMDOE*OHCMMJANE****MI*12345677G~ ← Client's HIC (Medicare Beneficiary ID)
N3*311 9TH STREET~
N4*LOS ANGELES*CA*90012~

Other Payer Name (2330B)
NM1*PR*2*MEDICARE*****PI*01182~ ← Medicare Part B Southern California Payer ID is 01182

Service Line Number (2400)
LX*1~
SV1*HC:90887*297.6*UN*120***1~ ← UN for units
DTP*472*D8*20131018~
REF*G1*P21~ ← Provider Authorization number
NTE*DCP*01~ ← EBP (Evidence Based Practice) Code

Line Adjudication Information (2430)
SVD*60054*96.6*HC:90887**120~ ← Line Adjudication Information from Aetna HMO Payer ID 60054
CAS*CO*45*201~ ← Line Adjustment by Aetna HMO Payer ID 60054
DTP*573*D8*20131030~ ← Line Check or Remittance Date

Line Adjudication Information (2430)
SVD*01182*20*HC:90887**120~ ← Line Adjudication Information from Medicare Part B Southern California Payer ID 01182
CAS*CO*45*181~ ← Line Adjustment by Medicare Part B Southern California Payer ID 01182
CAS*CO*23*96.6~ ← Line Adjustment by Medicare Payer ID 01182 showing OHC payment
DTP*573*D8*20131101~ ← Line Check or Remittance Date

Transaction 837P (837P)
SE*50*000000001~

Functional Group (L_GS)
GE*1*131121802~

Interchange (L_ISA)
IEA*1*131121802~

10.1.6 Day Treatment/Member Authorization

Interchange (L_ISA)
ISA*00* *00* *14*996508079 *14*132486189
*131121*0822*!*00501*131121802*1*T*:~

Functional Group (L_GS)
GS*HC*996508079*132486189*20131121*082252*131121802*X*005010X222A1~

Transaction 837P (837P)
ST*837*000000001*005010X222A1~
BHT*0019*00*131121802A*20131121*082252*CH~

Submitter Name (1000A)
NM1*41*2*LE88333 FAMILY MENTAL HEALTH SERVICES CLINIC
*****46*996508079~ ← Submitter's DUNS
PER*IC*BILLING DEPARTMENT*TE*5554443333~

Receiver Name (1000B)
NM1*40*2*LAC DEPARTMENT OF MENTAL HEALTH*****46*LACODMH~

Billing Provider Hierarchical Level (2000A)
HL*120*1~**

Billing Provider Name (2010AA)
NM1*85*2*1234Z FMHSC PGM-LOCATION-Z LE88333***XX*9926907927~** ← **Contracting Provider Program NPI**
N3*305 GRANDE AVE STE 202~
N4*LOS ANGELES*CA*900024160~
REF*EI*999916918~
PER*IC*BILLING MANAGER*TE*5554443333~

Subscriber Hierarchical Level (2000B)
HL*2*1*22*0~
SBR*P*18*****11~** ← **LACDMH is the destination payer, it is Primary**

Subscriber Name (2010BA)
NM1*IL*1*DAYTREATDOE*DAYTREATJANE**MI*MSO9778332~** ← **Client's ID & 'MSO' is required**
N3*656 5TH STREET~
N4*LOS ANGELES*CA*90012~
DMG*D8*19760721*F~

Payer Name (2010BB)
NM1*PR*2*LAC DEPARTMENT OF MENTAL HEALTH***PI*953893470~** ← **LACDMH Payer ID**
N3*510 S Vermont Ave~
N4*Los Angeles*CA*90012~

Claim Information (2300)
CLM*131121802A-01*189.33*11:B:1*Y*A*Y*I~**
HI*ABK:F3131~

Rendering Provider Name (2310B)
NM1*82*1*BRIGHT*FUTURO**XX*1899992078~** ← **Performing Provider NPI**

Service Line Number (2400)
LX*1~
SV1*HC:H2012:HE:TG*189.33*UN*1*1~** ← **Must use UN for Day Treatment, must be 1 Unit**
DTP*472*D8*20131101~ ← **Must represent 1 Day**
REF*G1*44~ ← **Member Authorization number for Day Treatment**
NTE*DCP*01~ ← **EBP (Evidence Based Practice) Code**

Transaction 837P (837P)
SE*29*000000001~

Functional Group (L_GS)
GE*1*131121802~

Interchange (L_ISA)
IEA*1*131121802~

10.1.7 Fee-For-Service

Interchange (L_ISA)
ISA*00* *00* *14*122869839 *14*132486189
***131015*0822*!*00501*131028431*1*T*:~**

Functional Group (L_GS)
GS*HC*122869839*132486189*20131015*082252*131028431*X*005010X222A1~

Transaction 837P (837P)
ST*837*000000001*005010X222A1~
BHT*0019*00*131028431A*20131015*082252*CH~

Submitter Name (1000A)
NM1*41*2*JANET SMITH MFT*****46*122869839~ ← Submitter's DUNS
PER*IC*BILLING DEPARTMENT*TE*5551231234~

Receiver Name (1000B)
NM1*40*2*LAC DEPARTMENT OF MENTAL HEALTH*****46*LACODMH~

Billing Provider Hierarchical Level (2000A)
HL*1**20*1~

Billing Provider Name (2010AA)
NM1*85*2*JANET SMITH OFFICE*****XX*9998825769~ ← FFS Billing Provider NPI
N3*42 ATHER STREET~
N4*Long Beach*CA*908159998~
REF*EI*951234569~
PER*IC*BILLING MANAGER*TE*5551231234~

Subscriber Hierarchical Level (2000B)
HL*2*1*22*0~
SBR*P*18*******11~ ← LACDMH is the destination payer, it is Primary

Subscriber Name (2010BA)
NM1*IL*1*FFSDOE*FFSJOHN****MI*MSO9999159~ ← Client's ID & 'MSO' is required
N3*1 FIRST STREET~
N4*LOS ANGELES*CA*90012~
DMG*D8*19300101*M~

Payer Name (2010BB)
NM1*PR*2*LAC DEPARTMENT OF MENTAL HEALTH*****PI*953893470~ ← LACDMH Payer ID
N3*510 S Vermont Ave~
N4*Los Angeles*CA*90012~

Claim Information (2300)
CLM*131028431A-01*71***11:B:1*Y*A*Y*Y~
HI*ABK:F3131~

Rendering Provider Name (2310B)
NM1*82*1*SMITH*JANET****XX*9908825766~ ← FFS Performing Provider NPI

Service Line Number (2400)
LX*1~
SV1*HC:90847*71*UN*60***1~ ← UN for units
DTP*472*D8*20130718~
REF*G1*F13~ ← Funding Source Authorization number for FFS clients
NTE*DCP*01~ ← EBP (Evidence Based Practice) Code

Transaction 837P (837P)
SE*29*000000001~

Functional Group (L_GS)
GE*1*131028431~

Interchange (L_ISA)
IEA*1*131028431~

10.1.8 Residential Claims

Interchange (L_ISA)
ISA*00* *00* *14*996508079 *14*132486189
***140423*0822*!*00501*131121802*1*T*:~**

Functional Group (L_GS)
GS*HC*996508079*132486189*20140423*082252*131121802*X*005010X222A1~

Transaction 837P (837P)
ST*837*000000001*005010X222A1~
BHT*0019*00*131121802A*20140423*082252*CH~

Submitter Name (1000A)
NM1*41*2*LE88333 FAMILY MENTAL HEALTH SERVICES CLINIC
*******46*996508079~** ← **Submitter's DUNS**
PER*IC*BILLING DEPARTMENT*TE*5554443333~

Receiver Name (1000B)
NM1*40*2*LAC DEPARTMENT OF MENTAL HEALTH***46*LACODMH~**

Billing Provider Hierarchical Level (2000A)
HL*120*1~**

Billing Provider Name (2010AA)
NM1*85*2*1234Z FMHSC PGM-LOCATION-Z LE88333***XX*1926907927~** ← **Contracting Provider Program NPI**
N3*305 GRANDE AVE STE 202~
N4*LOS ANGELES*CA*900024160~
REF*EI*999916918~
PER*IC*BILLING MANAGER*TE*5554443333~

Subscriber Hierarchical Level (2000B)
HL*2*1*22*0~
SBR*P*18*****11~** ← **LACDMH is the destination payer, it is Primary**

Subscriber Name (2010BA)
NM1*IL*1*RESIDENTDOE*RESIDENTJOHN**MI*MSO9899333~** ← **Client's ID & 'MSO' is required**
N3*777 ANY STREET~
N4*LOS ANGELES*CA*90005~
DMG*D8*19900101*M~

Payer Name (2010BB)
NM1*PR*2*LAC DEPARTMENT OF MENTAL HEALTH***PI*953893470~** ← **LACDMH Payer ID**
N3*510 S Vermont Ave~
N4*Los Angeles*CA*90005~

Claim Information (2300)
CLM*131121802A-01*416.04*56:B:1*Y*A*Y*I~** ← **Service Location Code 56 is for Psychiatric Residential Treatment Center**
HI*ABK:F339~

Rendering Provider Name (2310B)

NM1*82*1*BRIGHT*FUTURO****XX*1899992078~ ← Performing Provider NPI

Service Line Number (2400)
LX*1~
SV1*HC:H0018*416.04*UN*1***1~ ← H0018 is Procedure Code for Crisis Residential, UN for day(s). The number of units must be 1.

DTP*472*D8*20140101~ ← Use D8 for a single date of service. DO NOT claim for the Discharge Date.
REF*G1*P322~ ← Provider Authorization number
NTE*DCP*01~ ← EBP (Evidence Based Practice) Code

Transaction 837P (837P)
SE*29*000000001~

Functional Group (L_GS)
GE*1*131121802~

Interchange (L_ISA)
IEA*1*131121802~

10.1.9 Community Outreach Services

Interchange (L_ISA)
ISA*00* *00* *14*996508079 *14*132486189
*131121*0822*!*00501*131121802*1*T*:~

Functional Group (L_GS)
GS*HC*996508079*132486189*20131121*082252*131121802*X*005010X222A1~

Transaction 837P (837P)
ST*837*000000001*005010X222A1~
BHT*0019*00*131121802A*20131121*082252*CH~

Submitter Name (1000A)
NM1*41*2*LE88333 FAMILY MENTAL HEALTH SERVICES CLINIC
*****46*996508079~ ← Submitter's DUNS
PER*IC*BILLING DEPARTMENT*TE*5554443333~

Receiver Name (1000B)
NM1*40*2*LAC DEPARTMENT OF MENTAL HEALTH*****46*LACODMH~

Billing Provider Hierarchical Level (2000A)
HL*1**20*1~

Billing Provider Name (2010AA)
NM1*85*2*1234Z FMHSC PGM-LOCATION-Z LE88333*****XX*9926907927~ ← Contracting Provider Program NPI
N3*305 GRANDE AVE STE 202~
N4*LOS ANGELES*CA*900024160~
REF*EI*999916918~
PER*IC*BILLING MANAGER*TE*5554443333~

Subscriber Hierarchical Level (2000B)
HL*2*1*22*0~
SBR*P*18*******11~ ← LACDMH is the destination payer, it is Primary

Subscriber Name (2010BA)

NM1*IL*1*COS*SERVICE****MI*MSO8888888~ ← Client's ID/'MSO8888888' is required
N3*510 S VERMONT AVE~
N4*LOS ANGELES*CA* 900201912~
DMG*D8*20130701*U~ ← Use 20130701 as the Date of Birth and U as the Gender

Payer Name (2010BB)
NM1*PR*2*LAC DEPARTMENT OF MENTAL HEALTH*****PI*953893470~ ← LACDMH Payer ID
N3*510 S Vermont Ave~
N4*Los Angeles*CA*90012~

Claim Information (2300)
CLM*131121802A-01*297.6***99:B:1*Y*A*Y*I~
NTE*ADD*PC1123456~ ← PC = Potential Client ID from SRTS
HI*ABK:Z0389~ ← COS Diagnosis Code
– OR –
CLM*131121802A-01*297.6***99:B:1*Y*A*Y*I~
NTE*ADD*2123456~ ← COS DMH/IBHIS Client ID (refer to Section 6.2 COS Business Rule 13)
HI*ABK:Z0389~ ← COS Diagnosis Code

Rendering Provider Name (2310B)
NM1*82*1*BRIGHT*FUTURO****XX*1899992078~ ← Primary COS Performing Provider NPI

Service Line Number (2400)
LX*1~
SV1*HC:200*297.6*MJ*120***1~ ← MJ for minutes
DTP*472*D8*20131118~
REF*G1*P51~ ← Provider non Medi-Cal Authorization number
NTE*DCP*99~ ← EBP (Evidence Based Practice) Code

Form Identification (2440)
LQ*AS*IBHISCOS~ ← COS (Community Outreach Services)

Supporting Documentation (2440)
FRM*D26**7~ ← Service Type Code (Dictionary D.26)
FRM*D12**1~ ← Ethnicity Code (Dictionary D.12)
FRM*D43**001~ ← Primary Language Code (Dictionary D.43)
FRM*D01**1~ ← Age Category Code (Dictionary D.1)
FRM*D23**2~ ← Program Area Code (Dictionary D.23)
FRM*D25**7~ ← Service Recipient Type Code (Dictionary D.25)
FRM*CONTACTS**10~ ← Number of Persons Contacted

Transaction 837P (837P)
SE*48*000000001~

Functional Group (L_GS)
GE*1*131121802~

Interchange (L_ISA)
IEA*1*131121802~

10.1.10 CalAIM 837P Example with Primary and Add-on service

CLM*230301100A-03*130.05***11:B:1*Y*A*Y*I~
HI*ABK:F912~
NM1*82*1*TEST*PRACTITIONER****XX*1578682123~
LX*1~
SV1*HC:90791*43.35*UN*1***1****Y~ ← Primary Code
DTP*472*D8*20210918~
REF*G1*P16740~

NTE*DCP*00~
LX*2~
SV1*HC:90785*43.35*UN*1*1****Y~ ← Interactive Complexity Code**
DTP*472*D8*20210918~
REF*G1*P16740~
NTE*DCP*00~
LX*3~
SV1*HC:G2212*43.35*UN*1*1****Y~ ← Prolong Code**
DTP*472*D8*20210918~
REF*G1*P16740~
NTE*DCP*00~

10.1.11 CalAIM 837P Example for Clinical Trainee (Student)

CLM*230301100A-03*99.9*11:B:1*Y*A*Y*I~**
HI*ABK:F912~
NM1*82*1* TEST*STUDENT**XX*1578682123~ ←Student NPI in Loop 2310B**
NM1*DQ*1* TEST*SUPERVISOR**XX*1624459889~ ←Supervisor NPI in loop 2310D**
LX*1~
SV1*HC:90791:AJ*86.04*UN*1*1****Y~←Primary code w Student's modifier for MFT, PCC, SW**
DTP*472*D8*20230702~
REF*G1*P17018~
NTE*DCP*00~
LX*2~
SV1*HC:90785:AJ*13.86*UN*1*1****Y~←Add-on code w Student's modifier for MFT, PCC, SW**
DTP*472*D8*20230702~
REF*G1*P17018~
NTE*DCP*00~

10.1.12 837 Professional Claim Snippet (H2033 Example Full Rate)

Subscriber Name (2010BA)
NM1*IL*1*DOE*JOHN**MI*MSO9999999~** ←Client's ID & 'MSO' is required
N3*888 TEST STREET~
N4*LOS ANGELES*CA*90012~
DMG*D8*20150821*M~

Claim Information (2300)
CLM*CXEBP001*5712.68*11:B:1*Y*A*Y*Y~** ←The total claim charge (full rate) + $1 for each additional service line
HI*ABK:F339~

Rendering Provider Name (2310B)
NM1*82*1*BRIGHT*FUTURO**XX*1899992078~**

Service Line Number (2400)
LX*1~ ← First service line: A Roll-Up bundle
SV1*HC:H2033*5707.68*UN*1*1~** ← Monthly EBP Procedure Code – Face to face (full rate charge amount)
DTP*472*D8*20260701~ ← Date of the first service
REF*G1*P9999~ ← Provider Authorization number
NTE*DCP*01~ ←EBP (Evidence Based Practice) Code

LX*2~ ← Second service line: A collateral encounter
SV1*HC:H2033:UK*1*UN*1*1~** ← Monthly EBP Procedure Code - Collateral modifier ($1 charge amount)
DTP*472*D8*20260702~ ← Date of the second service

REF*G1*P9999~ ← Provider Authorization number
NTE*DCP*01~ ←EBP (Evidence Based Practice) Code

LX*3~ ← Third service line: A face-to-face encounter
SV1*HC:H2033*1* UN*1*1~** ← Monthly EBP Procedure Code – Face to face ($1 charge amount)
DTP*472*D8*20260703~ ← Date of the third service
REF*G1*P9999~ ← Provider Authorization number
NTE*DCP*01~ ←EBP (Evidence Based Practice) Code

LX*4~ ←Fourth service line: A face-to-face encounter
SV1*HC:H2033*1* UN*1*1~**← Monthly EBP Procedure Code – Face to face ($1 charge amount)
DTP*472*D8*20260710~ ← Date of the fourth service
REF*G1*P9999~ ← Provider Authorization number
NTE*DCP*01~ ←EBP (Evidence Based Practice) Code

LX*5~ ←Fifth service line: A face-to-face encounter
SV1*HC:H2033*1* UN*1*1~** ← Monthly EBP Procedure Code – Face to face ($1 charge amount)
DTP*472*D8*20260715~ ← Date of the fifth service
REF*G1*P9999~ ← Provider Authorization number
NTE*DCP*01~ ←EBP (Evidence Based Practice) Code

LX*6~ ←Sixth service line: A face-to-face encounter
SV1*HC:H2033*1* UN*1*1~** ← Monthly EBP Procedure Code – Face to face ($1 charge amount)
DTP*472*D8*20260720~ ← Date of the sixth service
REF*G1*P9999~ ← Provider Authorization number
NTE*DCP*01~ ←EBP (Evidence Based Practice) Code

Note regarding CO45 Adjustments:
For service lines 2, 3, 4, 5 and 6, the 1.00 charge will be returned with Claim Adjustment Reason Code CO45 (Charge exceeds fee schedule / maximum allowable) on MSO 835

This occurs because the full contracted rate ($5,707.68) is adjudicated and paid on the primary roll-up line (LX*1); consequently, any additional charges on the additional individual service lines are considered to exceed the contracted rate and are adjusted accordingly.

10.1.13 837 Professional Claim Snippet (H2033 Example Partial Rate)

Subscriber Name (2010BA)
NM1*IL*1*DOE*DAVID**MI*MSO9999998~** ←Client's ID & 'MSO' is required
N3*999 ANY STREET~
N4*LOS ANGELES*CA*90012~
DMG*D8*20170615*M~

Claim Information (2300)
CLM*CXEBP002*3808.12*11:B:1*Y*A*Y*Y~** ←The total claim charge (partial rate) + $1 for each additional service line
HI*ABK:F339~

Rendering Provider Name (2310B)
NM1*82*1*BRIGHT*FUTURO**XX*1899992078~**

Service Line Number (2400)
LX*1~ ← First service line: A Roll-Up bundle
SV1*HC:H2033*3805.12*UN*1*1~** ← Monthly EBP Procedure Code – Face to face (partial rate charge amount)
DTP*472*D8*20260801~ ← Date of the first service
REF*G1*P9999~ ← Provider Authorization number
NTE*DCP*01~ ←EBP (Evidence Based Practice) Code

LX*2~ ← Second service line: A collateral encounter
SV1*HC:H2033:UK*1*UN*1*1~** ← Monthly EBP Procedure Code - Collateral modifier ($1 charge amount)
DTP*472*D8*20260805~ ← Date of the second service
REF*G1*P9999~ ← Provider Authorization number
NTE*DCP*01~ ←EBP (Evidence Based Practice) Code

LX*3~ ← Third service line: A face-to-face encounter
SV1*HC:H2033*1* UN*1*1~** ← Monthly EBP Procedure Code – Face to face ($1 charge amount)
DTP*472*D8*20260815~ ← Date of the third service
REF*G1*P9999~ ← Provider Authorization number
NTE*DCP*01~ ←EBP (Evidence Based Practice) Code

LX*4~ ←Fourth service line: A face-to-face encounter
SV1*HC:H2033*1* UN*1*1~**← Monthly EBP Procedure Code – Face to face ($1 charge amount)
DTP*472*D8*20260820~ ← Date of the fourth service
REF*G1*P9999~ ← Provider Authorization number
NTE*DCP*01~ ←EBP (Evidence Based Practice) Code

10.2 Health Care Claim: Inpatient 837I Examples

10.2.1 Straight Medi-Cal

Interchange (L_ISA)
ISA*00* *00* *14*081234983 *14*132486189
***140313*0822*!*00501*140313604*1*T*:~**

Functional Group (L_GS)
GS*HC*081234983*132486189*20140313*082252*140313604*X*005010X223A2~

Transaction 837I (837I)
ST*837*0001*005010X223A2~
BHT*0019*00*140313604A*20140313*1418*CH~

Submitter Name (1000A)
NM1*41*2*SUNSHINE MENTAL HEALTH HOSPITAL***46*081234983~** ← **Submitter's DUNS**
PER*IC*Billing Office*TE*8005552000~

Receiver Name (1000B)
NM1*40*2*LAC DEPARTMENT OF MENTAL HEALTH***46*LACODMH~**

Billing Provider Hierarchical Level (2000A)
HL*120*1~**

Billing Provider Name (2010AA)
NM1*85*2*LONG SHORE CITY WARD***XX*1005552001~** ← **Contracting Provider Program NPI**
N3*4321 FIRST STREET~
N4*LONG SHORE CITY*CA*900319998~
REF*EI*951691234~

Subscriber Hierarchical Level (2000B)
HL*2*1*22*0~
SBR*P*18*****11~** ← **LACDMH is the destination payer, it is Primary for a Medi-Cal claim**

Subscriber Name (2010BA)
NM1*IL*1*MCDOE*MCJOHN**MI*MSO923991~** ← **Client's ID & 'MSO' is required**

N3*402736 ANY STREET~
N4*LOS ANGELES*CA*90005~
DMG*D8*19470721*M~

Payer Name (2010BB)
NM1*PR*2*LAC DEPARTMENT OF MENTAL HEALTH*****PI*953893470~ ← LACDMH Payer ID
N3*510 S Vermont Ave~
N4*Los Angeles*CA*90005~

Claim Information (2300)
CLM*140313604A-01*1360***11:A:2**A*Y*Y~ ← Ex: Claim Frequency Code is "2" – Interim 1st Claim
DTP*434*RD8*20140109-20140109~ ← 1st claim of the inpatient episode. Should be the date of admission
DTP*435*DT*201401090000~ ← Admission date, there is no discharge date/inpatient episode remains open
CL1*1*1*30~
REF*G1*P320~ ← Provider Medi-Cal Authorization number
NTE*DCP*01~ ← EBP (Evidence Based Practice) Code
HI*ABK:F319~
HI*ABJ:F3131~

Attending Provider Name (2310A)
NM1*71*1*SMITH*JUAN****XX*1942312345~ ← Attending Provider NPI

Service Line Number (2400)
LX*1~
SV2*0100*HC:0100:HA*1360*DA*1~ ← Procedure Code and Modifiers. Days must be 1

Transaction 837I (837I)
SE*32*0001~

Functional Group (L_GS)
GE*1*140313604~

Interchange (L_ISA)
IEA*1*140313604~

10.2.2 Indigent

Interchange (L_ISA)
ISA*00* *00* *14*081234983 *14*132486189
*140313*0822*!*00501*140313604*1*T*:~

Functional Group (L_GS)
GS*HC*081234983*132486189*20140313*082252*140313604*X*005010X223A2~

Transaction 837I (837I)
ST*837*0001*005010X223A2~
BHT*0019*00*140313604A*20140313*1418*CH~

Submitter Name (1000A)
NM1*41*2*SUNSHINE MENTAL HEALTH HOSPITAL*****46*081234983~ <===Submitter's DUNS
PER*IC*Billing Office*TE*8005552000~

Receiver Name (1000B)
NM1*40*2*LAC DEPARTMENT OF MENTAL HEALTH*****46*LACODMH~

Billing Provider Hierarchical Level (2000A)

HL*1**20*1~

Billing Provider Name (2010AA)
NM1*85*2*LONG SHORE CITY WARD*****XX*1005552001~ <===Contracting Provider Program NPI
N3*4321 FIRST STREET~
N4*LONG SHORE CITY*CA*900319998~
REF*EI*951691234~

Subscriber Hierarchical Level (2000B)
HL*2*1*22*0~
SBR*P*18*******11~ <===LACDMH is the destination payer, it is Primary

Subscriber Name (2010BA)
NM1*IL*1*IDGDOE*IDGJOHN****MI*MSO926001~ <===Client's ID & 'MSO' is required
N3*992736 ANY STREET~
N4*LOS ANGELES*CA*90005~
DMG*D8*19670721*M~

Payer Name (2010BB)
NM1*PR*2*LAC DEPARTMENT OF MENTAL HEALTH*****PI*953893470~ <===LACDMH Payer ID
N3*510 S Vermont Ave~
N4*Los Angeles*CA*90005~

Claim Information (2300)
CLM*140313604A-01*1360***11:A:3**A*Y*Y~ ← Ex: Claim Frequency Code is "3" – Interim Continuing Claim
DTP*096*TM*0000~
DTP*434*RD8*20140110-20140110~ ← Statement must be for one day, Statement from and to Date is after the Admission date as this is a Continuing Claim
DTP*435*DT*201401090000~ ← Admission date
CL1*1*1*01~
REF*G1*P011~ <===Provider Authorization number MUST NOT be from Medi-Cal Funding Source
NTE*DCP*01~ <===EBP (Evidence Based Practice) Code
HI*ABK:F3131~
HI*ABJ:F319~

Attending Provider Name (2310A)
NM1*71*1*SMITH*JUAN****XX*1942312345~ <===Attending Provider NPI

Service Line Number (2400)
LX*1~
SV2*0100*HC:0100:HA*1360*DA*1~ ← Procedure Code and Modifiers, Days must be 1

Transaction 837I (837I)
SE*32*0001~

Functional Group (L_GS)
GE*1*140313604~

Interchange (L_ISA)
IEA*1*140313604~

10.2.3 Medi-Medi

Interchange (L_ISA)
ISA*00* *00* *14*081234983 *14*132486189
*140313*0822*!*00501*140313604*1*T*:~

Functional Group (L_GS)

GS*HC*081234983*132486189*20140313*082252*140313604*X*005010X223A2~

Transaction 837I (837I)
ST*837*0001*005010X223A2~
BHT*0019*00*140313604A*20140313*1418*CH~

Submitter Name (1000A)
NM1*41*2*SUNSHINE MENTAL HEALTH HOSPITAL*****46*081234983~ ← Submitter's DUNS
PER*IC*Billing Office*TE*8005552000~

Receiver Name (1000B)
NM1*40*2*LAC DEPARTMENT OF MENTAL HEALTH*****46*LACODMH~

Billing Provider Hierarchical Level (2000A)
HL*1**20*1~

Billing Provider Name (2010AA)
NM1*85*2*LONG SHORE CITY WARD*****XX*1005552001~ ← Contracting Provider Program NPI
N3*4321 FIRST STREET~
N4*LONG SHORE CITY*CA*900319998~
REF*EI*951691234~

Subscriber Hierarchical Level (2000B)
HL*2*1*22*0~
SBR*S*18*******11~ ← LACDMH is the destination payer, it is Secondary for a Medi/Medi claim

Subscriber Name (2010BA)
NM1*IL*1*MMDOE*MMJANE****MI*MSO9900011~ ← Client's ID & 'MSO' is required
N3*883974 ANY STREET~
N4*LOS ANGELES*CA*90005~
DMG*D8*19691025*F~

Payer Name (2010BB)
NM1*PR*2*LAC DEPARTMENT OF MENTAL HEALTH*****PI*953893470~ ← LACDMH Payer ID
N3*510 S Vermont Ave~
N4*Los Angeles*CA*90005~

Claim Information (2300)
CLM*140313604A-01*1360***11:A:3**A*Y*Y~ ←Ex: Claim Frequency Code is "3" – Interim Continuing Claim
DTP*434*RD8*20140116-20140116~ ←Statement must be for one day (20140116-20140116), Statement Dates 20140111-20140115 had been claimed previously, so this is an Interim Continuing Claim
DTP*435*DT*201401110000~←Admission Date, there is no discharge date/inpatient episode remains open
CL1*1*1*30~
REF*G1*P320~ ← Provider Medi-Cal Authorization number
NTE*DCP*01~ ← EBP (Evidence Based Practice) Code
HI*ABK:F3131~
HI*ABJ:F319~

Attending Provider Name (2310A)
NM1*71*1*SMITH*JUAN****XX*1942312345~ ← Attending Provider NPI

Other Subscriber Name (2330A)
SBR*P*18*******MA~ ← Primary Payer is Medicare Part A
AMT*D*360~ ← Payor Amount Paid, amount zero is acceptable

OI*Y***Y~**

Other Subscriber Name (2330A)
NM1*IL*1*MMDOE*MMJANE**MI*99000111D~** ← **Medicare Subscriber's HIC**
N3*883974 ANY STREET~
N4*LOS ANGELES*CA*90005~

Other Payer Name (2330B)
NM1*PR*2*MEDICARE***PI*01182~** ← **Medicare Payer ID is 01182**

Service Line Number (2400)
LX*1~
SV2*0100*HC:0100:HA*1360*DA*1~ ← **Procedure Code and Modifiers, Days must be 1**

Line Adjudication Information (2430)
SVD*01182*360*HC:0100:HA*0100*2~ ← **Line Adjudication Information from Medicare PI 01182**
CAS*CO*45*1000~ ← **Line Adjustment by Medicare PI 01182**
DTP*573*D8*20140131~ ← **Line Check or Remittance Date**

Transaction 837I (837I)
SE*42*0001~

Functional Group (L_GS)
GE*1*140313604~

Interchange (L_ISA)
IEA*1*140313604~

10.3 Health Care Claim: 835 Examples

10.3.1 Approved Original Claim/No Provider Adjustment

Interchange (L_ISA)
ISA*00* *00* *14*132486189 *14*605705605 *150409*1321*!*00501*000000062*0*P*:
~

Functional Group (L_GS)
GS*HP*132486189*605705605*20150409*132125*1*X*005010X221A1~

Transaction 835 (835)
ST*835*1458~
BPR*I*242*C*CHK**********20150409~ ← **Total Actual Provider Payment Amount of $242.00**
TRN*1*FOR BATCH 2614*1953893470~
REF*F2*AVATAR MSO 2015~
DTM*405*20150409~

Payer Identification (1000A)
N1*PR*LAC - DEPARTMENT OF MENTAL HEALTH~
N3*510 S. VERMONT AVE~
N4*LOS ANGELES*CA*90020~
PER*CX*KIMBERLY NALL*TE*2139476347*EM*KNALL@DMH.LACOUNTY.GOV~
PER*BL*LACDMH EDI HELP DESK*TE*2133511335~

Payee Identification (1000B)
N1*PE*MH CLINIC*XX*6054051605~
REF*TJ*951647605~

Header Number (2000)
LX*1~

Claim Payment Information (2100)
CLP*150409822A-01*1*242*242**HM*4479*11*1~ ← **Claim Payment Amount of $242.00 for Avatar Claim ID 4479**
NM1*QC*1*LNTESTAE*FNTESTAE****MI*3012944~
REF*F8*4479~ ← **Avatar Claim ID 4479**
DTM*232*20140615~
DTM*233*20140615~

Service Payment Information (2110)
SVC*HC:90791*242*242**100~ ← **Line Item Provider Payment Amount of $242.00 for Avatar Claim ID 4479**
DTM*472*20140615~
REF*BB*P46~
AMT*B6*242~

Transaction 835 (835)
SE*24*1458~

Functional Group (L_GS)
GE*1*1~

Interchange (L_ISA)
IEA*1*000000062~

10.3.2 Void & Approved Claims Resulting in NO Provider Payment & Provider Adjustment

The claim payment amount is less than the voided claim amount. PLB segment is included to 'zero' out the payment.

Interchange (L_ISA)
ISA*00* *00* *14*132486189 *14*605705605 *150409*1450*!*00501*000000064*0*P*:
~

Functional Group (L_GS)
GS*HP*132486189*605705605*20150409*145002*1*X*005010X221A1~

Transaction 835 (835)
ST*835*1460~
BPR*I*0*C*NON**********20150409~ ← **Total Actual Provider Payment Amount of $0.00 (no payment)**
TRN*1*FOR BATCH 2625*1953893470~
REF*F2*AVATAR MSO 2015~
DTM*405*20150409~

Payer Identification (1000A)
N1*PR*LAC - DEPARTMENT OF MENTAL HEALTH~
N3*510 S. VERMONT AVE~
N4*LOS ANGELES*CA*90020~
PER*CX*KIMBERLY NALL*TE*2139476347*EM*KNALL@DMH.LACOUNTY.GOV~
PER*BL*LACDMH EDI HELP DESK*TE*2133511335~

Payee Identification (1000B)
N1*PE*MH CLINIC*XX*6054051605~
REF*TJ*605647605~

Header Number (2000)
LX*1~

Claim Payment Information (2100)
CLP*150409822A-01*22*-242*-242**HM*4479*11*1~ ← **Claim Payment Amount of -$242.00. It is the payment reversal of the voided Avatar Claim ID 4479**
NM1*QC*1*LNTESTAE*FNTESTAE****MI*3012944~
REF*F8*4479~
DTM*232*20140615~
DTM*233*20140615~
AMT*AU*-242~

Service Payment Information (2110)
SVC*HC:90791*-242*-242**100~ ← **Line Item Provider Payment Amount of -$242.00. It is the payment reversal of the voided Avatar Claim ID 4479**
DTM*472*20140615~
REF*BB*P46~
AMT*B6*-242~

Claim Payment Information (2100)
CLP*150409822A-01*1*242*0**HM*4479*11*1~ ← **Claim Payment Amount of $0.00. It is the non-payment for the voided Avatar Claim ID 4479**
NM1*QC*1*LNTESTAE*FNTESTAE****MI*3012944~
REF*F8*4479~
DTM*232*20140615~
DTM*233*20140615~

Service Payment Information (2110)
SVC*HC:90791*242***0****0**100~ ← **Line Item Provider Payment Amount of $0.00. It is the non-payment for the voided Avatar Claim ID 4479**
DTM*472*20140615~
CAS*OA*115*242*100~
REF*BB*P46~

Claim Payment Information (2100)
CLP*150409823A-01*1*121***121****HM*4480*11*1~ ← **Claim Payment Amount of $121.00 for Avatar Claim ID 4480**
NM1*QC*1*LNTESTAE*FNTESTAE****MI*3012944~
REF*F8***4480**~
DTM*232*20140616~
DTM*233*20140616~
AMT*AU*121~

Service Payment Information (2110)
SVC*HC:90791*121***121****50~ ← **Line Item Provider Payment Amount of $121.00 for Avatar Claim ID 4480**
DTM*472*20140616~
REF*BB*P46~
AMT*B6*121~

Transaction 835 (835)
PLB*6054051240*20150630***FB**:FOR BATCH 2625***-121**~ ← **Provider Adjustment – Forwarding Balance amount of -$121 = (-$242.00 Claim ID 4479 payment reversal due to void + $121.00 Claim ID 4480)**

SE*44*1460~

Functional Group (L_GS)
GE*1*1~

Interchange (L_ISA)
IEA*1*000000064~

10.3.3 Approved Original Claim with Previous Provider Adjustment

Interchange (L_ISA)
ISA*00* *00* *14*132486189 *14*605705605 *150409*1642*!*00501*000000065*0*P*:
~

Functional Group (L_GS)
GS*HP*132486189*605705605*20150409*164206*1*X*005010X221A1~

Transaction 835 (835)
ST*835*1461~
BPR*I*121*C*CHK**********20150409~ ← **Total Actual Provider Payment Amount of $121.00**
TRN*1*FOR BATCH 2626*1953893470~
REF*F2*AVATAR MSO 2015~
DTM*405*20150409~

Payer Identification (1000A)
N1*PR*LAC - DEPARTMENT OF MENTAL HEALTH~
N3*510 S. VERMONT AVE~
N4*LOS ANGELES*CA*90020~
PER*CX*KIMBERLY NALL*TE*2139476347*EM*KNALL@DMH.LACOUNTY.GOV~
PER*BL*LACDMH EDI HELP DESK*TE*2133511335~

Payee Identification (1000B)
N1*PE*MH CLINIC*XX*6054051605~
REF*TJ*605647605~

Header Number (2000)
LX*1~

Claim Payment Information (2100)
CLP*150409826A-01*1*242*242**HM*4481*11*1~ ← **Claim Payment Amount of $242.00 for Avatar Claim ID 4481**
NM1*QC*1*LNTESTAE*FNTESTAE****MI*3012944~
REF*F8*4481~
DTM*232*20140617~
DTM*233*20140617~
AMT*AU*242~

Service Payment Information (2110)
SVC*HC:90791*242*242**100~ ← **Line Item Provider Payment Amount of $242.00 for Avatar Claim ID 4481**
DTM*472*20140617~
REF*BB*P46~
AMT*B6*242~

Transaction 835 (835)
PLB*6054051605*20150630*FB:FOR BATCH 2626*121~ ← **Provider Adjustment (outstanding) – Forwarding Balance amount of $121**
SE*25*1461~

Functional Group (L_GS)
GE*1*1~

Interchange (L_ISA)
IEA*1*000000065~

10.3.4 Approved Original Claim Followed by a Contractor Void

835 for Original Claim

Interchange (L_ISA)
ISA*00* *00* *14*132486189 *14*992499189 *150806*1219*!*00501*000000134*0*P*:~

Functional Group (L_GS)
GS*HP*132486189*992499189*20150806*121922*1*X*005010X221A1~

Transaction 835 (835)
ST*835*1722~
BPR*I*242*C*CHK**********20150806~
TRN*1*FOR BATCH 3051*1953893470~
REF*F2*AVATAR MSO 2015~
DTM*405*20150806~

Payer Identification (1000A)
N1*PR*LAC - DEPARTMENT OF MENTAL HEALTH~
N3*510 S. VERMONT AVE~
N4*LOS ANGELES*CA*90020~
PER*CX*KIMBERLY NALL*TE*2139476347*EM*KNALL@DMH.LACOUNTY.GOV~
PER*BL*LACDMH EDI HELP DESK*TE*2133511335~

Payee Identification (1000B)
N1*PE*GET WELL MH CLINIC*XX*9994099940~
REF*TJ*999947899~

Header Number (2000)
LX*1~

Claim Payment Information (2100)
CLP*150806838A-01*1*242*242**HM*10374*11*1~ ← **Approved claim; value in CLP01 is from Contractor's inbound 837 CLM01**

NM1*QC*1*LNTESTAE*FNTESTAE****MI*3012944~
REF*F8*10374~ ← **PCCN (Payer Claim Control Number) assigned by IBHIS**
DTM*232*20150417~
DTM*233*20150417~
AMT*AU*242~

Service Payment Information (2110)
SVC*HC:90791*242*242**100~
DTM*472*20150417~
REF*BB*P300~
AMT*B6*242~

Transaction 835 (835)
SE*24*1722~

Functional Group (L_GS)
GE*1*1~

Interchange (L_ISA)
IEA*1*000000134~

835 for Contractor Void

Interchange (L_ISA)

ISA*00* *00* *14*132486189 *14*992499189 *150806*1359*!*00501*000000135 *0*P*:~

Functional Group (L_GS)

GS*HP*132486189*992499189*20150806*135959*1*X*005010X221A1~

Transaction 835 (835)

ST*835*1725~

BPR*I***242***C*CHK**********20150806~ ← **There is a positive payment amount in this BPR. Other claims, not shown in this example, are being paid on this 835.**

TRN*1*FOR BATCH 3054*1953893470~

REF*F2*AVATAR MSO 2015~

DTM*405*20150806~

Payer Identification (1000A)

N1*PR*LAC - DEPARTMENT OF MENTAL HEALTH~

N3*510 S. VERMONT AVE~

N4*LOS ANGELES*CA*90020~

PER*CX*KIMBERLY NALL*TE*2139476347*EM*KNALL@DMH.LACOUNTY.GOV~

PER*BL*LACDMH EDI HELP DESK*TE*2133511335~

Payee Identification (1000B)

N1*PE*GET WELL MH CLINIC*XX*9994099940~

REF*TJ*999947899~

Header Number (2000)

LX*1~

Claim Payment Information (2100)

CLP***150806838A-01***22***-242***-242****HM*10374*11*1~ ← **Payment reversal of a void claim; value in CLP01 is from Contractor's inbound 837 CLM01**

NM1*QC*1*LNTESTAE*FNTESTAE****MI*3012944~

REF*F8***10374**~ ← **PCCN (Payer Claim Control Number) assigned by IBHIS for the original claim**

DTM*232*20150417~

DTM*233*20150417~

AMT*AU*-242~

Service Payment Information (2110)

SVC*HC:90791***-242***-242****100~ ← **Payment reversal of a void claim;**

DTM*472*20150417~

REF*BB*P300~

AMT*B6*-242~

Claim Payment Information (2100)

CLP*150806838A-01*1*242*0**HM*10374*11*1~ ← This CLP loop shows the reason for non-payment

NM1*QC*1*LNTESTAE*FNTESTAE****MI*3012944~

REF*F8*10374~

DTM*232*20150417~

DTM*233*20150417~

Service Payment Information (2110)

SVC*HC:90791*242*0**0**100~

DTM*472*20150417~

CAS*OA*115*242*100~ ← Contractor void

REF*BB*P300~

Transaction 835 (835)

SE*43*1725~

Functional Group (L_GS)

GE*1*1~

Interchange (L_ISA)

IEA*1*000000135~

10.3.5 Approved Original; State Denial Followed by a Contractor Replacement Claim

835 for Original Claim

Interchange (L_ISA)

ISA*00* *00* *14*132486189 *14*992499189 *150805*1745*!*00501*000000131*0*P*:~

Functional Group (L_GS)

GS*HP*132486189*992499189*20150805*174510*1*X*005010X221A1~

Transaction 835 (835)

ST*835*1719~

BPR*I*242*C*CHK**********20150805~

TRN*1*FOR BATCH 3047*1953893470~

REF*F2*AVATAR MSO 2015~

DTM*405*20150805~

Payer Identification (1000A)

N1*PR*LAC - DEPARTMENT OF MENTAL HEALTH~

N3*510 S. VERMONT AVE~

N4*LOS ANGELES*CA*90020~

PER*CX*KIMBERLY NALL*TE*2139476347*EM*KNALL@DMH.LACOUNTY.GOV~

PER*BL*LACDMH EDI HELP DESK*TE*2133511335~

Payee Identification (1000B)

N1*PE*GET WELL MH CLINIC*XX*9994099940~

REF*TJ*999947899~

Header Number (2000)

LX*1~

Claim Payment Information (2100)

CLP*150805833A-01*1*242*242**HM*10365*11*1~ ← **Approved claim; value in CLP01 is from Contractor's inbound 837 CLM01**

NM1*QC*1*LNTESTAE*FNTESTAE****MI*3012944~
REF*F8*10365~ ← **PCCN (Payer Claim Control Number) assigned by IBHIS**
DTM*232*20150413~
DTM*233*20150413~
AMT*AU*242~
Service Payment Information (2110)
SVC*HC:90791*242*242**100~
DTM*472*20150413~
REF*BB*P300~
AMT*B6*242~
Transaction 835 (835)
SE*24*1719~
Functional Group (L_GS)
GE*1*1~
Interchange (L_ISA)
IEA*1*000000131~

835 for State Denial of Original Claim

Interchange (L_ISA)
ISA*00* *00* *14*132486189 *14*992499189 *150805*1923*!*00501*000000132*0*P*:~
Functional Group (L_GS)
GS*HP*132486189*992499189*20150805*192350*1*X*005010X221A1~
Transaction 835 (835)
ST*835*1720~
BPR*I*242*C*CHK**********20150805~ ← **There is a positive payment amount in this BPR. Other claims, not shown in this example, are being paid on this 835.**

TRN*1*FOR BATCH 3048*1953893470~
REF*F2*AVATAR MSO 2015~
DTM*405*20150805~
Payer Identification (1000A)
N1*PR*LAC - DEPARTMENT OF MENTAL HEALTH~
N3*510 S. VERMONT AVE~
N4*LOS ANGELES*CA*90020~
PER*CX*KIMBERLY NALL*TE*2139476347*EM*KNALL@DMH.LACOUNTY.GOV~
PER*BL*LACDMH EDI HELP DESK*TE*2133511335~
Payee Identification (1000B)
N1*PE*GET WELL MH CLINIC*XX*9994099940~
REF*TJ*999947899~
Header Number (2000)
LX*1~
Claim Payment Information (2100)
CLP*150805833A-01*22*-242*-242**HM*10365*11*1~ ← **Payment reversal due to the State denial, IBHIS PCCN 10365**

NM1*QC*1*LNTESTAE*FNTESTAE****MI*3012944~
REF*F8*10365~
DTM*232*20150413~
DTM*233*20150413~
AMT*AU*-242~
Service Payment Information (2110)
SVC*HC:90791*-242*-242**100~
DTM*472*20150413~

REF*BB*P300~
AMT*B6*-242~
Claim Payment Information (2100)
CLP*150805833A-01*1*242*0**HM***10365***11*1~ ← **IBHIS PCCN 10365; 2nd CLP gives the state's reason for denial**

NM1*QC*1*LNTESTAE*FNTESTAE****MI*3012944~
REF*F8*10365~
DTM*232*20150413~
DTM*233*20150413~
Service Payment Information (2110)
SVC*HC:90791*242*0**0**100~
DTM*472*20150413~
CAS***CO*97***242*100~ ← **State denied Claim Adjustment Reason Group and Code**
REF*BB*P300~
LQ*HE***M86**~ ← **State denied Remark Code**
Transaction 835 (835)
SE*44*1720~
Functional Group (L_GS)
GE*1*1~
Interchange (L_ISA)
IEA*1*000000132~

835 for Replacement of Original Claim – Denied by the State

Interchange (L_ISA)
ISA*00* *00* *14*132486189 *14*992499189 *150805*1959*!*00501*000000133*0*P*:
~
Functional Group (L_GS)
GS*HP*132486189*992499189*20150805*195952*1*X*005010X221A1~
Transaction 835 (835)
ST*835*1721~
BPR*I***242***C*CHK**********20150805~ ← **There is a positive payment amount in this BPR, for the approved replacement claim**

TRN*1*FOR BATCH 3049*1953893470~
REF*F2*AVATAR MSO 2015~
DTM*405*20150805~

Payer Identification (1000A)
N1*PR*LAC - DEPARTMENT OF MENTAL HEALTH~
N3*510 S. VERMONT AVE~
N4*LOS ANGELES*CA*90020~
PER*CX*KIMBERLY NALL*TE*2139476347*EM*KNALL@DMH.LACOUNTY.GOV~
PER*BL*LACDMH EDI HELP DESK*TE*2133511335~

Payee Identification (1000B)
N1*PE*GET WELL MH CLINIC*XX*9994099940~
REF*TJ*999947899~

Header Number (2000)
LX*1~

Claim Payment Information (2100)
CLP***150805839A-01***1***242***242****HM*10367*11***7***~ ← **Approved replacement claim ("7"); value in CLP01 is from Contractor's inbound 837 CLM01 value**

NM1*QC*1*LNTESTAE*FNTESTAE****MI*3012944~
REF*F8***10367***~ ← **PCCN (Payer Claim Control Number) assigned by IBHIS**
DTM*232*20150413~

DTM*233*20150413~
AMT*AU*242~

Service Payment Information (2110)
SVC*HC:90791:76*242*242**100~
DTM*472*20150413~
REF*BB*P300~
AMT*B6*242~

Transaction 835 (835)
SE*24*1721~

Functional Group (L_GS)
GE*1*1~

Interchange (L_ISA)
IEA*1*000000133~

10.3.6 Health Care Claim: CalAIM 835 Example

835 Example: Approved for primary and add-on codes

CLP*230301100A-03*1*130.05*125.55**HM*739661*11*1~ ← **Total Approved Disbursed Amount of 3 Services**
NM1*QC*1*TEST*LIABILITY****MI*2717114~
REF*F8*739661~ ← **One DMH Claim Number (PCCN) for 3 Services**
DTM*232*20210918~
DTM*233*20210918~
AMT*AU*125.55~
SVC*HC:90791*43.35*41.85**1~ ← **Primary Code Service**
DTM*472*20210918~
CAS*CO*45*1.5~
REF*BB*P16740~
AMT*B6*41.85~
SVC*HC:90785*43.35*41.85**1~ ← **Interactive Complexity Code** Service
DTM*472*20210918~
CAS*CO*45*1.5~
REF*BB*P16740~
AMT*B6*41.85~
SVC*HC:G2212*43.35*41.85**1~ ← **Prolong Code Service**
DTM*472*20210918~
CAS*CO*45*1.5~
REF*BB*P16740~
AMT*B6*41.85~

10.3.7 835 Professional Claim Snippet (H2033 Example Full Rate)

Header Number (2000)
LX*1~

Claim Payment Information (2100)
CLP* CXEBP001*1*5712.68*5707.68HM*99260515*11*1~**←Claim payment amount of $5,707.68 for claim number CXEBP001
NM1*QC*1* DOE*JOHN**MI*9999999~**
REF*F8*99260515~ ← IBHIS (MSO) claim number (PCCN)
DTM*232*20260701~
DTM*233*20260720~
AMT*AU*7005~

Service Payment Information (2110)

SVC*HC:H2033*5707.68*5707.681~** ← Full payment amount of $5,707.68 for the first service line
DTM*472*20260701~ ← Date of the first service
REF*BB*P9999~ ← Provider Authorization number
AMT*B6*7000~

SVC*HC:H2033:UK*1*00**1~** ← $0 payment for the second service line
DTM*472*20260702~ ← Date of the second service
CAS*CO*45*1*1~ ← $1 adjustment – Over contract rate
REF*BB*P9999~ ← Provider Authorization number

SVC*HC:H2033*1*00**1~** ← $0 payment for the third service line
DTM*472*20260705~ ← Date of the third service
CAS*CO*45*1*1~ ← $1 adjustment – Over contract rate
REF*BB*P9999~ ← Provider Authorization number

SVC*HC:H2033*1*00**1~** ← $0 payment for the fourth service line
DTM*472*20260710~ ← Date of fourth service
CAS*CO*45*1*1~ ← $1 adjustment – Over contract rate
REF*BB*P9999~ ← Provider Authorization number

SVC*HC:H2033*1*00**1~** ← $0 payment for the fifth service line
DTM*472*20260715~ ← Date of fifth service
CAS*CO*45*1*1~ ← $1 adjustment – Over contract rate
REF*BB*P9999~ ← Provider Authorization number

SVC*HC:H2033*1*00**1~** ← $0 payment for the sixth service line
DTM*472*20260720~ ← Date of sixth service
CAS*CO*45*1*1~ ← $1 adjustment – Over contract rate
REF*BB*P9999~ ← Provider Authorization number

10.3.8 835 Professional Claim Snippet (H2033 Example Partial Rate)

Header Number (2000)
LX*1~

Claim Payment Information (2100)
CLP* CXEBP002*1*3808.12*3805.12HM*99260516*11*1~**←Claim payment amount of $3,805.12 for claim number CXEBP002
NM1*QC*1* DOE*DAVID**MI*9999998~**
REF*F8*99260516~ ← IBHIS (MSO) Avatar claim number (PCCN)
DTM*232*20260801~
DTM*233*20260820~
AMT*AU*4003~

Service Payment Information (2110)
SVC*HC:H2033*3805.12*3805.121~** ← Full payment amount of $3,805.12 for the first service line
DTM*472*20260801~ ← Date of the first service
REF*BB*P9999~ ← Provider Authorization number
AMT*B6*4000~

SVC*HC:H2033:UK*1*00**1~** ← $0 payment for the second service line
DTM*472*20260805~ ← Date of the second service
CAS*CO*45*1*1~ ← $1 adjustment – Over contract rate
REF*BB*P9999~ ← Provider Authorization number

SVC*HC:H2033*1*00**1~** ← $0 payment for the third service line
DTM*472*20260815~ ← Date of the third service
CAS*CO*45*1*1~ ← $1 adjustment – Over contract rate

REF*BB*P9999~ ← Provider Authorization number

SVC*HC:H2033*1*00**1~** ← $0 payment for the fourth service line
DTM*472*20260820~ ← Date of fourth service
CAS*CO*45*1*1~ ← $1 adjustment – Over contract rate
REF*BB*P9999~ ← Provider Authorization number

10.4 Health Care Claim: 999 Examples

10.4.1 REJECTED 999 FILE

Interchange (L_ISA)

ISA*00* *00* *14*132486189 *14*992499189 *170613*1013*!*00501*995074028*1*P*:
~

Functional Group (L_GS)

GS*FA*132486189*992499189*20170613*1013*995074028*X*005010X231A1~

ST*999*0001*005010X231A1~

Functional Group Response :

AK1*HC*995074028*005010X222A1~ ← **AK102 is the GS06 from 837**

Transaction Set Response Header

AK2*837*995074028*005010X222A1~ ← **AK202 is the ST02 from 837**

Error Identification

IK3*CLM*20*2300*8~ ← **IK301- This element indicates the segment where the error occurred. (Error in CLM segment)**
IK302 – This element contains the location of the segment in error from the ST segment in the 837 file. (Ex : 20 means 19 segments after ST)
IK303 – This element contains the loop number of the segment in error (Loop 2300)
IK304 – This element contains the error noted in segment.

IK4*1*1028*1~ ← **This Segment indicates the offending data that triggered the error and required only when a data element error.**

(IK3 and IK4 exist only when the status of the transaction is a rejection)

Transaction Set Response Trailer

IK5*R*5~ ← **The IK5 reports that the file failed due to HIPAA error/Transaction set errors**
IK501 – Status of transaction set – A- Accepted, R-Rejected

Functional Group Response Trailer

AK9*R*1*1*1~ ← **The AK9 report the errors between the ST and SE segments in the 837**
AK901 – Functional Group Acknowledge Codes

(A- Accepted, R- Rejected)

SE*8*0001~
GE*1*995074028~
IEA*1*995074028~

10.4.2 ACCEPTED 999 FILE

Interchange (L_ISA)

ISA*00* *00* *14*132486189 *14*992499189 *170613*1013*!*00501*995074028*1*P*:
~

Functional Group (L_GS)

GS*FA*132486189*992499189*20170613*1013*995074028*X*005010X231A1~

ST*999*0001*005010X231A1~

Functional Group Response :

AK1*HC*32497*005010X222A1~ ← **AK102 is the GS06 from 837**

Transaction Set Response Header

AK2*837*1235*005010X222A1~ ← **AK202 is the ST02 from 837**

Transaction Set Response Trailer

IK5*A~ ← **IK501 – 'A' - Accepted**

Functional Group Response Trailer

AK9*A*1*1*1~ ← **AK902 - 'A' - Accepted**

SE*6*0001~
GE*1*32497~
IEA*1*000032497~

10.5 Health Care Claim: 277CA Examples

Look for the STC segment in the file.

You will be able to see the Claim Status code and/or Claim Status Category Codes in the STC segments on the report.

STC01 - Health care claim status - Verify the rejections codes against the published codes in Page 17.
STC03 – U – Reject
STC03 – WQ – Accept
STC04 – Total Claim Charge Amount

Locate the QTY01 segment to determine the Total Rejected Claims or Total Rejected Quantity.

90=Acknowledged Quantity
AA=Unacknowledged Quantity
QA=Quantity Approved
QC=Quantity Disapproved

10.5.1 277 File with Accepted and Rejected Claims

Interchange (L_ISA)

ISA*00* *00* *14*132486189 *14*992499189 *170613*1013*I*00501*995074028*1*P*:
~

Functional Group (L_GS)

GS*HN*132486189*992499189*20170613*1013*995074028*X*005010X231A1~

Transaction Header

ST*277*0001*005010X231A1~

BHT*0085*08*3*20180321*105846*TH~

Loop 2000 A – Information Source Detail

HL*1**20*1~
NM1*PR*2*LAC Department of Mental Health*****PI*00000001~
TRN*1*20180321105846~
DTP*050*D8*20180321~
DTP*009*D8*20180321~

Loop 2000B- Information Receiver Detail

HL*2*1*21*1~
NM1*41*2*LE00XXX XXXXXXX *****46*138857268~

TRN*2*170203808A~ ← **This is from the BHT03 in the 837 claim file From the 837 claim file (BHT*0019*00*170203808A*20170215*082252*CH~)**

Loop 2000B – Receiver Level Summary

STC*A1:19:40*20180222***WQ***7625~ ← **The transaction has been accepted**

QTY***90*32**~ ← **Number of Claims Accepted**
QTY***AA*1**~ ← **Number of Claims Rejected**
AMT***YU*7400**~ ← **Total Amount of Claims Accepted**
AMT***YY*225**~ ← **Total Amount of Claims Accepted**

Loop 2000C - Billing Provider Level Summary

NM1*85*1*xxxxx*xxxxxx****XX*1952418212~
TRN*1*0~
STC*A1:19:40**WQ*7625~ ← **The transaction has been accepted**
QTY*QA*32~ ← **Number of Claims Accepted**
QTY*QC*1~ ← **Number of Claims Rejected**
AMT*YU*7400~ ← **Total Amount of Claims Accepted**
AMT*YY*225~ - ← **Total Amount of Claims Rejected**

2000D - Patient Level Detail.

NM1*QC*1*LNTESTAE*FNTESTAE****MI***MSO123456**~ ← **Client ID**

TRN*2*277203818B-01~ ← **CLM02 from 837.**

STC*A2:20*20180321***WQ*186.7**~ ← **STC01: A2:20 indicates that the claim is accepted.**
STC03 : WQ Indicates that the claim was accepted.
STC04 : The claim amount for the 837 in the CLM and SV1 or SV2.

REF*1K**625725**~ ← **Payor Assigned Claim Number (DMH PCCN)**
DTP*472*D8*20161117~
HL*5*3*PT~

NM1*QC*1*LNTESTAE*FNTESTAE****MI***MSO123456**~ ← **Client ID**

TRN*2*277524828Au25z~ ← **CLM02 from 837.**

STC***A7:33***20180321***U***173.4~ ← **STC01: A7:33 indicates the error message code. For an explanation of the error message code please see the LACDMH Companion Guide.**
STC03: U Indicates that the claim was rejected.
STC04: The claim amount for the 837 in the CLM and SV1 or SV2.
REF*1K**277524828Au25z**~ ← **Since the claim is rejected, DMH return the same CLM02 from 837.**
DTP*472*D8*20180110~
HL*6*3*PT~

NM1*QC*1*LNTESTAE*FNTESTAE****MI***MSO12345**~

TRN*2***277621819B-01**~ ← **CLM02 from 837.**

STC***A7:33***20180321***U***176.4~ ← **STC01: A7:33 indicates the error message code. For an explanation of the error message code please see the LACDMH Companion Guide.**
STC03 : U Indicates that the claim was rejected.
STC04 : The claim amount for the 837 in the CLM and SV1 or SV2.

REF*1K**277621819B-01**~ ← **Since the claim is rejected, DMH return the same CLM02 from 837.**

DTP*472*D8*20170105~

SE*42*0003~
GE*1*3~
IEA*1*000000003~