X12 Standards for Electronic Data Interchange
Technical Report Type 3

Health Care Claim: Professional (837)

Change Log : 005010 - 007030

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New Loops/Segments

For new loops, the change log will only reflect the new loop identifier and name and associated segments. For new segments added to existing loops, the change log will only reflect the segment name.

Non-substantive Changes

Changes considered by the work group to be non-substantive in nature will not appear in the change log. This includes changes to correct typographical or grammatical errors, updated examples, reformatted text, updated industry names, and modifications to rules and notes either for consistency across TR3s or for proper textual construct that did not change the note's original intent.

Location	X323 | Health Care Claim: Professional 1.3 Implementation Limitations
Action	**Modify Chapter 1** Section 1.3.2 Other Usage Limitations: Paragraph 1: Changed to: When processing in batch mode, receiving trading partners may have system limitations which control the size of the transmission they can receive. Some submitters may have the capability and the desire to transmit large 837 transactions with thousands of claims contained in them. The developers of this implementation guide recommend that trading partners limit the size of the transaction (ST-SE envelope) to a maximum of 5000 CLM segments. Willing trading partners can agree to higher limits. There is no recommended limit to the number of ST-SE transactions within a GS-GE or ISA-IEA.
CR 186	Section 1.3.2 Other Usage Limitations - Revise limitations to support real-time transactions.

Location	X323 | Health Care Claim: Professional 1.3 Implementation Limitations
Action	**Modify Chapter 1** Section 1.3.2 Other Usage Limitations Added Paragraph: When a claim is processed in real-time, only one CLM per ISA/IEA is allowed and must be responded to in a single communication session.
CR 187	Section 1.3.2 Other Usage Limitations - Revise limitations to support real-time transactions.

Location	X323 | Health Care Claim: Professional 1.4 Business Usage
Action	**Modify Chapter 1** Section 1.4 Business Usage, change Paragraph 1 Changed to: This transaction set can be used to submit health care claim billing information, encounter information, or requests for predetermination from providers of health care services to payers, either directly or via intermediary billing services and claims clearinghouses. Added Paragraph 2 NOTE: The 837 is not intended for use in exchanging referrals and certifications. Use the 278 Health Care Services Review - Request for Review and Response transaction instead.
CR 191	Section 1.4 Business Usage - revise to support predetermination.

Location	X323 | Health Care Claim: Professional 1.4 Business Usage
Action	**Modify Chapter 1** Section 1.4.2 Coordination of Benefits: Added paragraph: Note: This section does not apply to predetermination requests.
CR 192	Section 1.4.1 Coordination of Benefits - revise to support predetermination.

Location	X323 | Health Care Claim: Professional 1.4 Business Usage
Action	**Modify Chapter 1** Section 1.4.2.1 Coordination of Benefits Data Models -- Detail: Paragraph 1 Changed to: The 837 Transaction handles two different models of benefit coordination. Both models are discussed in this section. Section 3, Examples, contains detailed examples of the Provider-to-Payer-to-Provider model. Each COB related data element contains notes within this implementation guide specifying when it is used. The HIPAA final rules contain additional information on COB.
CR 1132	Reference to COB model is too general.

Location	X323 | Health Care Claim: Professional 1.4 Business Usage

Action	**Modify Chapter 1** Section 1.4.2.1 Coordination of Benefits Data Models - Detail: Paragraph 3 Changed to: Step 2. Upon receipt of the 835, the provider sends a second health care claim transaction (837) to Payer B, the secondary payer. The Subscriber loop (Loop ID-2000B) now contains information about the subscriber who holds the policy with Payer B. The Other Subscriber Information loop (Loop ID-2320) now contains information about the subscriber for Payer A. Any total amounts paid at the claim level go in the AMT segment in Loop ID-2320. Any claim level adjustment codes are retrieved from the 835 from Payer A and put in the RAS (Claim Adjustment Information) segment in Loop ID-2320. Claim Level Allowed Amounts reported in the 835 are included in an AMT with qualifier B6 in Loop ID-2320. Line Level adjustment reason codes are retrieved similarly from the 835 and go in the RAS (Service Adjustment Information) segment in the 2430 loop. Line Level Allowed Amounts reported in the 835 are included in an AMT with qualifier B6 in Loop ID-2430. Payer B adjudicates the claim and sends the provider an electronic remittance advice.
CR 1230	Provide payers the ability to report the allowed amount for informational purposes for coordination of benefits.

Location	X323 | Health Care Claim: Professional 1.4 Business Usage
Action	**Modify Chapter 1** Section 1.4 Business Usage: Paragraph 3 Changed to: The transaction defined by this implementation guide is generally intended to originate with the health care provider or health care provider's designated agent. In some instances, a health care payer may originate an 837 to report a health care encounter to another payer or sponsoring organization. In other cases, where a Factoring Agent is involved, the Factoring Agent, who has acquired the ownership of the receivable but, has not provided the medical service or product related to a claim, may originate an 837 to another payer for reimbursement. The 837 Transaction provides all necessary information to allow the destination payer to at least begin to adjudicate the claim. The 837 coordinates with a variety of other transactions including, but not limited to, the following: Health Care Status Notification (277), Health Care Claim Payment/Advice (835) and the Implementation Acknowledgement (999). See Section 1.6 - Transaction Acknowledgements, and Section 1.7 - Related Transactions, for a summary description of these interactions.
CR 948	Update the 837 and 276/277 TR3s front matter to include information about Factoring Agents and Predetermination.

Location	X323 | Health Care Claim: Professional 1.4 Business Usage
Action	**Modify Chapter 1** Section 1.4.2.1.1 Coordination of Benefits Claim Level: Paragraph 1 Changed to: The destination payer's information is located in Loop ID-2010BB. In addition, any destination payer-specific claim information (for example, referral number) is located in the 2300 loop. All provider identifiers in the 2310 REF Segments are specific to the destination payer. Loop ID-2320 occurs once for each payer responsible for the claim, except for the payer receiving the 837 transaction set (destination payer). Provider identifiers in the 2330 REF Segments are specific to the corresponding non-destination payer.
CR 1134	To clarify provider identifier references within the front matter.

Location	X323 | Health Care Claim: Professional 1.4 Business Usage
Action	**Modify Chapter 1** Section 1.4.2.2 Coordination of Benefits Claims from Paper or Proprietary Remittance Advices: Paragraph 4 Changed to: Generally, a subsequent COB payer(s) determines payment on a combination of "Group Code" and "Claim Adjustment Reason Code" provided in the RAS segment at either the claim or service line. The primary considerations of Group Code of subsequent COB payers are:
CR 21	The 1.4.4.2 Service Line (Balancing) example should clarify the difference between the $5 claim adjustment and $5 line adjustment.

Location	X323 | Health Care Claim: Professional 1.4 Business Usage
Action	**Modify Chapter 1** Section 1.4.2.2 Coordination of Benefits Claims from Paper or Proprietary Remittance Advices: Table 2 Change description for code 45 to: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. [Use group codes PR or CO depending upon liability]. Change description for code 96 to: Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

CR 913	Clarify claim adjustment reason codes 45 and 96 in front matter section 1.4.2.2 Coordination of Benefits Form Paper or Proprietary Remittance Advice.
Location	X323 | Health Care Claim: Professional 1.4 Business Usage
Action	**Modify Chapter 1** Section 1.4.2.2 Coordination of Benefits Claims from Paper or Proprietary Remittance Advices: Paragraph 7 Changed to: Note: Some Claim Adjustment Reason Codes, require at least one Remittance Advice Remark Code (RARC) to further explain the reason for adjustment. The claim submitter is responsible for determining the most appropriate Remittance Advice Remark Code to use.
CR 913	Clarify claim adjustment reason codes 45 and 96 in front matter section 1.4.2.2 Coordination of Benefits Form Paper or Proprietary Remittance Advice.
Location	X323 | Health Care Claim: Professional 1.4 Business Usage
Action	**Modify Chapter 1** Section 1.4.3 Property & Casualty Replaced entire section
CR 919	Recommend revising the current text, including minor changes and re-arrangement of the content, and adding a reference to "statutes" in paragraph 3 (statutes and regulations are different, statutes are law developed by a legislative body and regulations are typically developed by other jurisdictional entities).
Location	X323 | Health Care Claim: Professional 1.4 Business Usage
Action	**Modify Chapter 1** Added Section 1.4.3 Property & Casualty: Paragraph 7 When sending an appeal or reconsideration Property and Casualty bill, it is important to indicated that the bill is a replacement bill in CLM05-3 with a value of 7, and to include the payer's control number of the original bill in the Payer Claim Control Number REF segment in Loop ID-2300.
CR 1154	For consistency across all TR3s.
Location	X323 | Health Care Claim: Professional 1.4 Business Usage

Action	**Modify Chapter 1** Section 1.4.4.2.1.1 Transaction Set Header (ST) Segment: Paragraph 1 Changed to: The Transaction Set Header (ST) segment identifies the transaction set by using 837 as the data value for the transaction set identifier code data element, ST01. The transaction set originator assigns the unique transaction set control number that is contained in ST02.
CR 1154	For consistency across all TR3s.
Location	X323 | Health Care Claim: Professional 1.4 Business Usage
Action	**Modify Chapter 1** Section 1.4.4.2.2.4 Hierarchical Level (HL) Structural Summary: Bulleted List Bullet 4 changed to: Data element HL04 indicates whether or not subordinate hierarchical levels exist. A value of "1" indicates subordinate hierarchical levels. A value of "0" indicates no subordinate hierarchical levels exist for this HL.
CR 920	The last bullet uses two terms for child HLs, subordinate and subsequent. Suggest only using one term - subordinate. Subsequent has a different meaning. There could be subsequent HLs in a transaction that are not subordinate.
Location	X323 | Health Care Claim: Professional 1.4 Business Usage
Action	**Modify Chapter 1** Section 1.4.5.1 Claim Level, Paragraph 3 Changed to: 2) Claim Payment Amounts Note: This type of balancing does not apply to predetermination requests.
CR 193	Section 1.4.4.1 Coordination of Benefits - revise to support predetermination.
Location	X323 | Health Care Claim: Professional 1.4 Business Usage
Action	**Modify Chapter 1** Section 1.4.5.1 Claim Level: Paragraph 4 Changed to: When a previous payer's adjudication data is only at the claim level, the claim level Payer Paid Amount (Loop ID-2320 AMT02) must equal the Total Claim Charge Amount (Loop ID-2300 CLM02) less any claim level adjustment amounts for that payer (Loop ID-2320 RAS adjustments).

CR 921	The calculation doesn't identify all of the related qualifications.
Location	X323 | Health Care Claim: Professional 1.4 Business Usage
Action	**Modify Chapter 1** Section 1.4.5.1 Claim Level: Paragraph 6 Changed to: Line level payment information is reported in Loop ID-2430 SVD02. In order to perform the balancing function, the receiver must know which payer the line payment belongs to. This is accomplished using the identifier reported in Loop ID-2430 SVD01. The value reported in this field must match the corresponding Other Payer Responsibility Sequence Code reported in Loop ID-2320 SBR01.
CR 917	Revise the last sentence of 1.4.5.1 Claim Level Balancing to "This identifier must match the identifier of the corresponding payer, reported in Loop ID-2330B NM109." Also, explain the alternative of using the 2330B REF instead of the 2330B NM109.
Location	X323 | Health Care Claim: Professional 1.4 Business Usage
Action	**Modify Chapter 1** Section 1.4.5.2 Service Line: Added Paragraph: Note: This section does not apply to predetermination requests.
CR 194	Section 1.4.4.2 Coordination of Benefits - revise to support predetermination.
Location	X323 | Health Care Claim: Professional 1.4 Business Usage
Action	**Modify Chapter 1** Section 1.5 Business Terminology Added new term: Real Time Adjudication Allows providers to submit an electronic claim that is adjudicated in real time and receive a response in real time detailing payment or denial of the rendered service. This capability allows providers to accurately identify and collect member responsibility based on the finalized claim adjudication results.
CR 1037	Incorporate real-time claim processing and adjudication information in the TR3.

Location	X323 | Health Care Claim: Professional 1.4 Business Usage
Action	**Modify Chapter 1** Section 1.5 Business Terminology Added: Real Time Predetermination/Estimation - allows providers to submit an electronic claim for a proposed service and receive a response in real time detailing the anticipated payment or denial of the proposed service. The response estimates the payment and member responsibility based on the current point in time and the data submitted for the proposed service. This capability allows providers to identify potential member responsibility and set patient financial expectations prior to a service.
CR 1037	Incorporate real-time claim processing and adjudication information in the TR3.

Location	X323 | Health Care Claim: Professional 1.4 Business Usage
Action	**Modify Chapter 1** Added Section 1.4.2.5 Claim / Service Adjustment Information Segment
CR 1079	Provide additional explanation related to the correct use of the RAS segment.

Location	X323 | Health Care Claim: Professional 1.4 Business Usage
Action	**Modify Chapter 1** Section 1.4.2.4 Coordination of Benefits - Medicaid Subrogation: Added Paragraph 4: For Subrogation claims, the submitting payer's own Payer Claim Control Number is reported in Loop ID-2300 (Claim Information) data element CLM01 (Claim Submitter's Identifier), rather than the Provider's Assigned Claim Identifier. The submitting payer's Payer Claim Control Number is reported here so that the identifier can be carried through for payment re-association purposes.
CR 1545	Support subrogation claims for multiple payer types.

Location	X323 | Health Care Claim: Professional 1.4 Business Usage
Action	**Modify Chapter 1** Section 1.4.2.4 Coordination of Benefits - Medicaid Subrogation: Added Paragraph 5: Receiving payers are to direct information requests about subrogation claims

	to the submitting payer (as identified in Loop ID-2330B (Other Payer Name)) rather than to the original billing provider.
CR 1545	Support subrogation claims for multiple payer types.
Location	X323 | Health Care Claim: Professional 1.4 Business Usage
Action	**Modify Chapter 1** Section 1.5 Business Terminology Added new term: Device Device* means an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including any component, part, or accessory, which is- (1) recognized in the official National Formulary, or the United States Pharmacopeia, or any supplement to them, (2) intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease, in man or other animals, or (3) intended to affect the structure or any function of the body of man or other animals, and which does not achieve its primary intended purposes through chemical action within or on the body of man or other animals and which is not dependent upon being metabolized for the achievement of its primary intended purposes. * This term is defined in 21 USC 321(h), as of the TR3 publication date. If a regulatory definition is changed, the revised definition supersedes the definition provided here.
CR 1548	Provide the ability to report the device identifier (DI) of the Unique Device Identifier (UDI) for pharmacy services.
Location	X323 | Health Care Claim: Professional 1.4 Business Usage
Action	**Modify Chapter 1** Added Section 1.4.6 Obtaining Approval for use of K3 Segment The K3 Segment was added to ASC X12N transactions to support a temporary solution for unexpected data requirements of a regulatory/legislative authority. It cannot be used for any other purpose.
CR 1384	Establish consistent procedures for handling requests for K3 usage across TR3s.
Location	X323 | Health Care Claim: Professional 1.4 Business Usage

Action	**Modify Chapter 1** Added Section 1.4.6.1 Requester Submission Before a proposal can be considered by ASC X12N, a change request must be submitted with the relevant business documentation to the ASC X12 change request website at http://changerequest.x12.org/.
CR 1384	Establish consistent procedures for handling requests for K3 usage across TR3s.

Location	X323 | Health Care Claim: Professional 1.4 Business Usage
Action	**Modify Chapter 1** Added Section 1.4.6.2 ASC X12N Review/Approval ASC X12N will review the request to determine the business need and if there is no existing method within the implementation guide to meet the requirement. If ASC X12N determines that there is business need and there is no method to meet the requirement the requester will receive approval to use the K3 Segment on a temporary basis until a permanent location can be defined within a future transaction implementation.
CR 1384	Establish consistent procedures for handling requests for K3 usage across TR3s.

Location	X323 | Health Care Claim: Professional 1.4 Business Usage
Action	**Modify Chapter 1** Added Section 1.4.6.3 Formatting of K3 Content The format in which the requirements will be met within the K3 Segment itself must be coordinated between the requester and ASC X12N to ensure a consistent implementation of the requirements for all trading partners. ASC X12N will work with the requester to define those format requirements and will post an RFI (Request for Interpretation) to the ASC X12 Interpretation Portal at http://www.x12.org/x12org/subcommittees/x12rfi.cfm on behalf of the requester.
CR 1384	Establish consistent procedures for handling requests for K3 usage across TR3s.

Location	X323 | Health Care Claim: Professional 1.4 Business Usage
Action	**Modify Chapter 1** Section 1.4.2.3 Coordination fo Benefits - Service Line Procedure Code Bundling and Unbundling

	Section Name changed to: Coordination of Benefits - Procedure Code Data Changed By Adjudication Entire section contents were rewritten.
CR 667	Enhance front matter related to Bundling and Coordination of Benefits.
Location	X323 | Health Care Claim: Professional 1.4 Business Usage
Action	**Modify Chapter 1** Removed Section 1.4.2.3 Coordination of Benefits - Service Line Procedure Code Bundling and Unbundling - Bullet 5. - The Adjustment Group Code in RAS02 will be either CO (Contractual Obligation) or PI (Payer Initiated), depending upon the provider/payer relationship.
CR 923	The CARC-RARC TR2 allows CO, PI and PR. In order to avoid conflict between documents, should the last bullet point to the TR2 as the 835 does?
Location	X323 | Health Care Claim: Professional 1.4 Business Usage
Action	**Modify Chapter 1** Section 1.4.2.4 Coordination of Benefits - Medicaid Subrogation: Sub Head Changed to: Coordination of Benefits - Subrogation
CR 1545	Support subrogation claims for multiple payer types.
Location	X323 | Health Care Claim: Professional 1.4 Business Usage
Action	**Modify Chapter 1** Section 1.4.2.4 Coordination of Benefits - Medicaid Subrogation: Paragraph 1 Changed to: At the time of this publication subrogation is not a HIPAA mandated business usage of the ASC X12 837 Health Care Claim, however willing trading partners may use this Implementation Guide for this purpose.
CR 1545	Support subrogation claims for multiple payer types.
Location	X323 | Health Care Claim: Professional 1.4 Business Usage
Action	**Modify Chapter 1** Section 1.4.2.4 Coordination of Benefits - Medicaid Subrogation: Paragraph 2

	Changed to: This Implementation Guide provides the ability for willing trading partners to allow direct billing by one payer to another payer for the purpose of claim subrogation. These pay-to-plan claims are identified by: The BHT06 Value of 31 - Subrogation Demand and The inclusion of Loop ID-2010AC Pay-to Plan Name Loop.
CR 1545	Support subrogation claims for multiple payer types.

Location	X323 | Health Care Claim: Professional 1.4 Business Usage
Action	**Modify Chapter 1** Section 1.4.2.4 Coordination of Benefits - Medicaid Subrogation: Paragraph 3 Changed to: The payer seeking payment is also identified in Loop ID-2330B (Other Payer Name). Loop ID-2320 (Other Subscriber Information) and Loop ID-2430 (Line Adjudication Information) includes all required segments to indicate adjudication results of the original claim that was submitted to that payer by the Billing Provider.
CR 1545	Support subrogation claims for multiple payer types.

Location	X323 | Health Care Claim: Professional 1.4 Business Usage
Action	**Modify Chapter 1** Section 1.4.4.1 Loop Labeling, Sequence, and Use: Paragraph 1 Changed to: The 837 transaction uses two naming conventions for loops. Loops are labeled with a descriptive name as well as with a shorthand label. Loop ID-2000A BILLING PROVIDER contains information about the billing provider, pay-to address and pay-to plan. The descriptive name -- BILLING PROVIDER -- informs the user of the overall focus of the loop. The Loop ID is a short-hand name, for example 2000A, that gives, at a glance, the position of the loop within the overall transaction. Loop ID-2010AA BILLING PROVIDER NAME, Loop ID-2010AB PAY-TO ADDRESS, and Loop ID-2010AC PAY-TO PLAN NAME are subloops of Loop ID-2000A. When a loop is used more than once, a letter is appended to its numeric portion to allow the user to distinguish the various iterations of that loop when using the shorthand name of the loop. For example, loop 2000 has three possible iterations: Billing Provider Hierarchical Level (HL), Subscriber HL and Patient HL. These loops are labeled 2000A, 2000B and 2000C respectively.

CR 1009	Clarify the last sentence of the first paragraph related to how the 2000 loops are reported and nested.
Location	X323 | Health Care Claim: Professional 1.4 Business Usage
Action	**Modify Chapter 1** Section 1.4.4.2.2 Table 2 - Detail Information: Paragraph 2 Removed: NOTE: The hierarchical levels within this transaction MUST comply with the sequence defined by BHT01. For example, the Billing Provider information must precede the Subscriber information in the transaction.
CR 1008	Revise the note about requiring the order to match BHT01 for clarity.
Location	X323 | Health Care Claim: Professional 1.5 Business Terminology
Action	**Modify Chapter 1** Section 1.5 Business Terminology Claim Changed to: For the purposes of this implementation guide, claim is intended to be an all-inclusive term to represent reimbursable claims, encounter reporting, and predetermination requests. When there are differences, they are specifically noted.
CR 206	Section 1.5 Business Terminology - Revise the claim definition to include predeterminations.
Location	X323 | Health Care Claim: Professional 1.5 Business Terminology
Action	**Modify Chapter 1** Section 1.5 Business Terminology Encounter Changed to: Non-reimbursable claim for which the health care encounter information is gathered for reporting. Also thought of as the reporting of a face-to-face encounter between a patient and a provider for which no reimbursement will be made. Often seen in pre-paid capitated financial arrangements in which the provider of services is paid in advance for the patient's health care needs. In

	some areas called a capitated or zero pay claim. An encounter record may not be the same as a post adjudicated claim record used for health care statistical data analysis reporting.
CR 925	Clarify the differences between encounters and post adjudicated claim reporting.
Location	X323 | Health Care Claim: Professional 1.5 Business Terminology
Action	**Modify Chapter 1** Section 1.5 Business Terminology Pay-To Plan Claims Changed to: Pay-to plan claims are payment requests billed by one health plan directly to other health plans. This process is commonly referred to as subrogation. These claims were originally submitted to and paid by the first health plan. An example of a pay-to plan claim is a payment request from a Medicaid agency direct to another health plan that may have liability for the member and services on the claim originally paid by the Medicaid agency.
CR 22	1.5 Business Terminology section - "Pay-to Plan" definition should include the term "subrogation."
Location	X323 | Health Care Claim: Professional 1.5 Business Terminology
Action	**Modify Chapter 1** Section 1.5 Business Terminology Added new term: Real Time Adjudication Allows providers to submit an electronic claim that is adjudicated in real time and receive a response in real time detailing payment or denial of the rendered service. This capability allows providers to accurately identify and collect member responsibility based on the finalized claim adjudication results.
CR 1037	Incorporate real-time claim processing and adjudication information in the TR3.
Location	X323 | Health Care Claim: Professional 1.5 Business Terminology
Action	**Modify Chapter 1** Section 1.5 Business Terminology Added:

	Real Time Predetermination/Estimation - allows providers to submit an electronic claim for a proposed service and receive a response in real time detailing the anticipated payment or denial of the proposed service. The response estimates the payment and member responsibility based on the current point in time and the data submitted for the proposed service. This capability allows providers to identify potential member responsibility and set patient financial expectations prior to a service.
CR 1037	Incorporate real-time claim processing and adjudication information in the TR3.

Location	X323 | Health Care Claim: Professional 1.5 Business Terminology
Action	**Modify Chapter 1** Added Section 1.4.2.5 Claim / Service Adjustment Information Segment
CR 1079	Provide additional explanation related to the correct use of the RAS segment.

Location	X323 | Health Care Claim: Professional 1.5 Business Terminology
Action	**Modify Chapter 1** Section 1.4.2.4 Coordination of Benefits - Medicaid Subrogation: Added Paragraph 4: For Subrogation claims, the submitting payer's own Payer Claim Control Number is reported in Loop ID-2300 (Claim Information) data element CLM01 (Claim Submitter's Identifier), rather than the Provider's Assigned Claim Identifier. The submitting payer's Payer Claim Control Number is reported here so that the identifier can be carried through for payment re-association purposes.
CR 1545	Support subrogation claims for multiple payer types.

Location	X323 | Health Care Claim: Professional 1.5 Business Terminology
Action	**Modify Chapter 1** Section 1.4.2.4 Coordination of Benefits - Medicaid Subrogation: Added Paragraph 5: Receiving payers are to direct information requests about subrogation claims to the submitting payer (as identified in Loop ID-2330B (Other Payer Name)) rather than to the original billing provider.
CR 1545	Support subrogation claims for multiple payer types.

Location	X323 | Health Care Claim: Professional 1.5 Business Terminology

Action	**Modify Chapter 1** Section 1.5 Business Terminology Added new term: Device Device* means an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including any component, part, or accessory, which is- (1) recognized in the official National Formulary, or the United States Pharmacopeia, or any supplement to them, (2) intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease, in man or other animals, or (3) intended to affect the structure or any function of the body of man or other animals, and which does not achieve its primary intended purposes through chemical action within or on the body of man or other animals and which is not dependent upon being metabolized for the achievement of its primary intended purposes. * This term is defined in 21 USC 321(h), as of the TR3 publication date. If a regulatory definition is changed, the revised definition supersedes the definition provided here.
CR 1548	Provide the ability to report the device identifier (DI) of the Unique Device Identifier (UDI) for pharmacy services.

Location	X323 | Health Care Claim: Professional 1.5 Business Terminology
Action	**Modify Chapter 1** Added Section 1.4.6 Obtaining Approval for use of K3 Segment The K3 Segment was added to ASC X12N transactions to support a temporary solution for unexpected data requirements of a regulatory/legislative authority. It cannot be used for any other purpose.
CR 1384	Establish consistent procedures for handling requests for K3 usage across TR3s.

Location	X323 | Health Care Claim: Professional 1.5 Business Terminology
Action	**Modify Chapter 1** Added Section 1.4.6.1 Requester Submission Before a proposal can be considered by ASC X12N, a change request must be submitted with the relevant business documentation to the ASC X12 change request website at http://changerequest.x12.org/.
CR 1384	Establish consistent procedures for handling requests for K3 usage across TR3s.

Location	X323 | Health Care Claim: Professional 1.5 Business Terminology
Action	**Modify Chapter 1** Added Section 1.4.6.2 ASC X12N Review/Approval ASC X12N will review the request to determine the business need and if there is no existing method within the implementation guide to meet the requirement. If ASC X12N determines that there is business need and there is no method to meet the requirement the requester will receive approval to use the K3 Segment on a temporary basis until a permanent location can be defined within a future transaction implementation.
CR 1384	Establish consistent procedures for handling requests for K3 usage across TR3s.

Location	X323 | Health Care Claim: Professional 1.5 Business Terminology
Action	**Modify Chapter 1** Added Section 1.4.6.3 Formatting of K3 Content The format in which the requirements will be met within the K3 Segment itself must be coordinated between the requester and ASC X12N to ensure a consistent implementation of the requirements for all trading partners. ASC X12N will work with the requester to define those format requirements and will post an RFI (Request for Interpretation) to the ASC X12 Interpretation Portal at http://www.x12.org/x12org/subcommittees/x12rfi.cfm on behalf of the requester.
CR 1384	Establish consistent procedures for handling requests for K3 usage across TR3s.

Location	X323 | Health Care Claim: Professional 1.5 Business Terminology
Action	**Modify Chapter 1** Section 1.5 Business Terminology: Added new term: Predetermination Request A request for predetermination of benefits (or predetermination) is a pre-service request for a statement of the exact benefits that would have been paid had the predetermination request been an actual claim. The predetermination request would include all data necessary to fully adjudicate a claim except for date(s) of service.
CR 196	Section 1.5 Business Terminology - add predetermination definition.

Location	X323 | Health Care Claim: Professional 1.5 Business Terminology
Action	**Modify Chapter 1** Section 1.5 Business Terminology Secondary Payer Changed to: The term secondary payer indicates any payer who is not the primary payer. The secondary payer may be the secondary, tertiary, quaternary, etc., up to the eleventh payer.
CR 926	Revise the Secondary Payer definition to cover all potential secondary payers. The TR3 supports up to 11 payers.

Location	X323 | Health Care Claim: Professional 1.5 Business Terminology
Action	**Modify Chapter 1** Section 1.5 Business Terminology Unbundling Changed to: This definition is in the context of coordination of benefits from the perspective of the prior payer's adjudication. Unbundling occurs when one submitted procedure code was adjudicated and reported back as two or more different procedure codes.
CR 1153	To clarify intended use.

Location	X323 | Health Care Claim: Professional 1.5 Business Terminology
Action	**Modify Chapter 1** Section 1.5 Business Terminology Added new term: Estimation A request for estimation (or predetermination) is a pre-service request for a statement of the exact benefits that would have been paid had the estimation been an actual claim. The estimation request would include all data necessary to fully adjudicate a claim except for date(s) of service.
CR 214	Add the predetermination definition to Section 1.5.

Location	X323 | Health Care Claim: Professional 1.5 Business Terminology

Action	**Modify Chapter 1** Section 1.5 Business Terminology Added new term: Pay-to Factoring Agent A non-healthcare provider entity that purchases the rights to a financial obligation or receivable from a healthcare provider and thus owns full rights to the financial obligation. In many cases, the Pay-to Factoring Agent will receive the initial bill from the provider and will become the payer. The Pay-to Factoring Agent will subsequently submit the claim/bill for the medical services rendered to the responsible claim administrator and based on adjudication outcome will receive the payment for the services rendered.
CR 95	The Property & Casualty industry needs the ability to report external entities who purchase accounts receivable assets on behalf of a payer (i.e. Factoring Agent.)
Location	X323 | Health Care Claim: Professional 1.5 Business Terminology
Action	**Modify Chapter 1** Section 1.5 Business Terminology Added new term: Factoring Claims In the HealthCare industry, as well as many other industries, business models are in place where open receivables as assets are sold to external entities serving as a "Factor". This is commonly known as medical receivables financing and is intended to both improve cash flow for the provider selling the receivable as well as to enhance business connectivity between provider and payer entities.
CR 95	The Property & Casualty industry needs the ability to report external entities who purchase accounts receivable assets on behalf of a payer (i.e. Factoring Agent.)
Location	X323 | Health Care Claim: Professional 1.7 Related Transactions
Action	**Modify Chapter 1** Section 1.7.1 Health Care Claim Payment/Advice (835), Paragraph 1 Changed to: Information in the Health Care Claim Payment/Advice (835) transaction is generated by the payer's adjudication system. However, in a coordination of benefits (COB) situation where the provider is sending an 837 claim to a

	secondary payer for payment, information from the 835 may be included in the secondary 837. Data from specific segments/elements in the 835 are crosswalked directly into the subsequent 837. Added Paragraph 2: The payer's response to a predetermination request (837) will also be returned in a Health Care Claim Payment/Advice (835) transaction. Refer to the Health Care Claim Payment / Remittance Advice TR3 for informationon coding specific to a response to a predetermination request. If theservices described in the predetermination request are subsequently rendered and then submitted in an 837 claim for payment, another 835 will be returned to advise of the finalized adjudication results and payment.
CR 197	Revise Section 1.7.1 to support predeterminations.
Location	X323 | Health Care Claim: Professional 1.7 Related Transactions
Action	**Modify Chapter 1** Section 1.7.1 Health Care Claim Payment/Advice (835) Added Paragraph: The 835 response to a real-time claim for payment or a real-time predetermination request may be returned in either batch or real-time mode.
CR 188	Revise Section 1.7.1 Health Care Claim Payment/Advice (835) to support real-time transactions.
Location	X323 | Health Care Claim: Professional 1.7 Related Transactions
Action	**Modify Chapter 1** Section 1.7.1 Health Care Claim Payment/Advice (835): Paragraph 2 Changed to: The payer's response to a predetermination request (837) will also be returned in a Health Care Claim Payment/Advice (835) transaction when the predetermination request was processed successfully. Refer to the Health Care Claim Payment / Remittance Advice TR3 for information on coding specific to a response to a predetermination request. If the services described in the predetermination request are subsequently rendered and then submitted in an 837 claim for payment, another 835 will be returned to advise of the finalized adjudication results and payment.
CR 197	Revise Section 1.7.1 to support predeterminations.
Location	X323 | Health Care Claim: Professional 1.10 National Provider Identifier Usage within the HIPAA 837 Transaction

Action	**Modify Chapter 1** 1.10.2 Organization Health Care Provider Subpart Representation: Paragraph 3 Changed to: Service Location. An organization health care provider's NPI used to identify the Service Location must be external to the entity identified as the Billing Provider (for example; reference lab). It is not permissible to report an organization health care provider's NPI as the Service Location if the Service Location is a subpart of the Billing Provider.
CR 75	1.10.3 Organization Health Care Provider Subpart Representation: Revise paragraph to clarify the usage of organizational NPI subparts.

Location	X323 | Health Care Claim: Professional 1.10 National Provider Identifier Usage within the HIPAA 837 Transaction
Action	**Modify Chapter 1** Section 1.10.3 Subparts and the 2010 AA - Billing Provider Name Loop, paragraph 1 Changed to: When the Billing Provider is an organization health care provider, the NPI of the organization health care provider or its subpart is reported in NM109. When an organization health care provider has determined a need to enumerate subparts, it is required that a subpart's NPI be reported as the Billing Provider. The subpart reported as the Billing Provider MUST always represent the most detailed level of enumeration and MUST be the same identifier sent to any trading partner. For additional explanation, see Section 1.10.2 - Organization Health Care Provider Subpart Representation.
CR 1387	To clarify intended use.

Location	X323 | Health Care Claim: Professional 1.10 National Provider Identifier Usage within the HIPAA 837 Transaction
Action	**Modify Chapter 1** Section 1.10.3 Subparts and the 2010 AA - Billing Provider Name Loop, paragraph 3 Changed to: The TIN of the Billing Provider, used for IRS Form 1099 purposes, must be reported in the REF segment of Loop ID-2010AA Billing Provider.
CR 1387	To clarify intended use.

Location	X323 | Health Care Claim: Professional 1.10 National Provider Identifier Usage within the HIPAA 837 Transaction

Action	**Modify Chapter 1** 1.10.2 Organization Health Care Provider Subpart Representation - Paragraph 1.
CR 1154	For consistency across all TR3s.

Location	X323 | Health Care Claim: Professional 1.10 National Provider Identifier Usage within the HIPAA 837 Transaction
Action	**Delete Chapter 1** Section 1.10.2 Implementation Migration Strategy.
CR 1387	To clarify intended use.

Location	X323 | Health Care Claim: Professional 1.11 Coding of Drugs in the 837 Claim
Action	**Modify Chapter 1** Section 1.11 Coding of Drugs in the 837 Claim: Paragraph 1 Changed to: This section provides guidance on the coding of compound drug claims under HIPAA as accomplished in the 2400 and 2410 loops.
CR 911	This should be reworded to "guidance of compound drug claims under HIPAA" based on the removal of Single Drug Billing.

Location	X323 | Health Care Claim: Professional 1.12 Additional Instructions and Considerations
Action	**Modify Chapter 1** Section 1.12.2 Rejecting Claims Based on the Inclusion of Situational Data, Sub Heading Changed to: Situational Data specific to Payer's Adjudication
CR 946	Clarify what is in X12's purview with regard to compliance, including handling of situational rules.

Location	X323 | Health Care Claim: Professional 1.12 Additional Instructions and Considerations
Action	**Modify Chapter 1** 1.12.2 Situational Data specific to Payer's Adjudication: Paragraph 2 Changed to: The purpose is to enable proper adjudication for any potential downstream payers as well as allow affected providers to collect and report information consistently for all trading partners when desired. As a result, the submitter is not restricted from sending the information to other payers in addition to the

	specific payer that has a known adjudication impact. In a payer-to-payer COB model, each payer should pass all data received in case it is needed by a subsequent payer.
CR 29	Provide guidance that all data elements from the original claim need to be passed to subsequent payers in the payer-to-payer COB model.
Location	X323 | Health Care Claim: Professional 1.12 Additional Instructions and Considerations
Action	**Modify Chapter 1** Section 1.12.4 Provider Tax IDs: Paragraph 1 Changed to: For purposes of this implementation, the Billing Provider is the provider or provider organization to which payment is intended to be made. This payment is included in the provider's 1099 reporting. The Employer Identification Number (EIN) or Social Security Number (SSN) for the billing provider is only reported in the Billing Provider Tax Identification REF segment in Loop ID-2010AA Billing Provider. The EIN and SSN qualifiers are not valid in any provider REF segments other than the 2010AA Billing Provider loop. Other reference qualifiers must be used in the REF segments in those loops to provide identifying information, such as "A6" for Provider's Identifier.
CR 497	Remove REF Segment qualifier G2 and add A6 to better accommodate atypical providers.
Location	X323 | Health Care Claim: Professional 1.12 Additional Instructions and Considerations
Action	**Modify Chapter 1** Section 1.12.5 Inpatient and Outpatient Designation: Paragraph 1 Changed to: Not applicable for this guide.
CR 51	Remove the definitions for Inpatient and Outpatient across all the 837 TR3s.
Location	X323 | Health Care Claim: Professional 1.12 Additional Instructions and Considerations
Action	**Modify Chapter 1** Section 1.12.6 Date of Service for Predetermination Requests, Paragraph Changed to: Since the date of service associated with a predetermination request is assumed to be the date the transaction is created, validation of all medical code sets (such as procedure codes and diagnosis codes) is based upon the creation date reported in the DTP Segment (Original Claim Creation Date). The determination of reimbursement rates, patient responsibility, or any other

	situation where the service date would have significance, are to be based upon the date of payer adjudication.
CR 205	Add instructions on the use of Date of Service in Predetermination Requests.

Location	X323 | Health Care Claim: Professional 1.12 Additional Instructions and Considerations
Action	**Modify Chapter 1** Added Section 1.12.6 Date of Service for Predetermination Requests Since the date of service associated with a predetermination request is assumed to be the date the transaction is created, validation of all medical code sets (such as procedure codes and diagnosis codes) is based upon the creation date reported in the DTP Segment (Original Claim Creation Date). The determination of reimbursement rates, patient responsibility, or any other situation where the service date would have significance, are to be based upon the date of payer adjudication.
CR 205	Add instructions on the use of Date of Service in Predetermination Requests.

Location	X323 | Health Care Claim: Professional | 837 | 0050 ST - Transaction Set Header
Action	**Modify Data Element Note** Transaction Set Header / ST02 (Transaction Set Control Number) Changed to: The Transaction Set Control Numbers in ST02 and SE02 must be identical. The number is assigned by the originator and must be unique within a functional group (GS-GE). For example, start with the number 0001 and increment from there. The number also aids in error resolution research.
CR 999	Revise the ST02 notes across the TR3's to make them consistent.

Location	X323 | Health Care Claim: Professional | 837 | 0100 BHT - Beginning of Hierarchical Transaction
Action	**Add Data Element Note** Transaction Set Header / BHT01 (Hierarchical Structure Code) Used to specify the sequential order of HL segments. The HL loops in the data stream must comply with this sequential order. An HL parent loop must be followed by any subordinate child loops prior to commencing a new HL parent loop at the same hierarchical level.
CR 1000	Unambiguously state that HL segments must be in the data stream in order.

Location	X323 | Health Care Claim: Professional | 837 | 0100 BHT - Beginning of Hierarchical Transaction

Action	**Modify Data Element Code Note** Transaction Set Header / BHT06 (Transaction Type Code) 31 (Subrogation Demand) Changed to: Use when willing trading partners agree to perform post payment claim recovery through the submission of subrogation claims. NOTE: At the time of this writing, Subrogation Demand is not a HIPAA mandated use of the 837 transaction.
CR 1545	Support subrogation claims for multiple payer types.

Location	X323 | Health Care Claim: Professional | 837 | 0100 BHT - Beginning of Hierarchical Transaction
Action	**Delete Data Element Note** "This is the date that the original submitter created the claim file from their business application system."
CR 729	Support transmission of the original date the claim was created.

Location	X323 | Health Care Claim: Professional | 837 | 0100 BHT - Beginning of Hierarchical Transaction
Action	**Delete Data Element Note** "This is the time that the original submitter created the claim file from their business application system."
CR 729	Support transmission of the original date the claim was created.

Location	X323 | Health Care Claim: Professional | 837 | 0200 | 1000A NM1 - Submitter Name
Action	**Delete Data Element Code Note** Loop ID 1000A / NM108 (Identification Code Qualifier) 46 (Electronic Transmitter Identification Number (ETIN)) Removed: Established by trading partner agreement
CR 1558	Format code notes consistently.

Location	X323 | Health Care Claim: Professional | 837 | 0150 | 2010AA NM1 - Billing Provider Name
Action	**Delete Segment Note** "Beginning on the NPI compliance date: When the Billing Provider is an organization health care provider, the organization health care provider's NPI

	or its subpart's NPI is reported in NM109. When a health care provider organization has determined that it needs to enumerate its subparts, it will report the NPI of a subpart as the Billing Provider. The subpart reported as the Billing Provider MUST always represent the most detailed level of enumeration as determined by the organization health care provider and MUST be the same identifier sent to any trading partner. For additional explanation, see section 1.10.3 Organization Health Care Provider Subpart Presentation."
CR 164	Loop 2010AA - NM1 Billing Provider Name: Delete the TR3 Note 1 since the NPI is now mandated.

Location	X323 | Health Care Claim: Professional | 837 | 0150 | 2010AA NM1 - Billing Provider Name
Action	**Modify Segment Note** Changed to: When the entity is not a Health Care provider (a.k.a. an atypical provider), the Billing Provider should be the legal entity. However, willing trading partners may agree upon varying definitions. Proprietary identifiers necessary for the receiver to identify the entity are to be reported in the Loop ID-2010BB REF, Billing Provider Secondary Identification segment.
CR 873	Revise the TR3 Note referencing Tax ID.

Location	X323 | Health Care Claim: Professional | 837 | 0150 | 2010AA NM1 - Billing Provider Name
Action	**Modify Segment Note** Changed to: The Billing Provider may be an individual only when the health care provider performing services is an independent, unincorporated entity. In these cases, the Billing Provider is the individual whose tax identification number is used for 1099 purposes. That individual's NPI is reported in NM109, and the individual's Tax Identification Number must be reported in the REF segment of this loop. The individual's NPI must be reported when the individual provider is eligible for an NPI. See section 1.10.1 (Providers who are Not Eligible for Enumeration) and 1.10.3 (Subparts and the 2010AA - Billing Provider Name Loop).
CR 873	Revise the TR3 Note referencing Tax ID.

Location	X323 | Health Care Claim: Professional | 837 | 0150 | 2010AA NM1 - Billing Provider Name
Action	**Modify Data Element Situational Rule** Loop ID 2010BA / NM107 (Subscriber Name Suffix) Changed to: Required when the name suffix is needed to identify the individual. If not required by this implementation guide, do not send.

CR 1154	For consistency across all TR3s.
Location	X323 | Health Care Claim: Professional | 837 | 0150 | 2010AA NM1 - Billing Provider Name
Action	**Delete Segment Note** "Prior to the NPI compliance date, proprietary identifiers necessary for the receiver to identify the Billing Provider entity are to be reported in the REF segment of Loop ID-2010BB."
CR 164	Loop 2010AA - NM1 Billing Provider Name: Delete the TR3 Note 1 since the NPI is now mandated.
Location	X323 | Health Care Claim: Professional | 837 | 0250 | 2010AA N3 - Billing Provider Address
Action	**Add Segment Note** If billing provider address is in an area where there are no street addresses, enter a description of the location (for example, "crossroad of State Road 34 and 45" or "Exit near Mile marker 265 on Interstate 80".
CR 874	Clarify what to do if the provider does not have a physical address, e.g. rural or remote locations.
Location	X323 | Health Care Claim: Professional | 837 | 0300 | 2010AA N4 - Billing Provider City, State, ZIP Code
Action	**Modify Data Element Note** Multiple Locations / N403 (Postal Code) Changed to: When reporting the ZIP code for U.S. addresses, the full nine digit ZIP code must be provided when one exists.
CR 760	Remove the restrictive requirement for a 9 digit ZIP code in N403.
Location	X323 | Health Care Claim: Professional | 837 | 0350 | 2010AA REF - Billing Provider Tax Identification
Action	**Modify Segment Note** Changed to: This is the tax identification number (TIN) of the Billing Provider in 2010AA.
CR 873	Revise the TR3 Note referencing Tax ID.
Location	X323 | Health Care Claim: Professional | 837 | 0400 | 2010AA PER - Billing Provider Contact Information
Action	**Modify Segment Situational Rule** Changed to: Required when this information is different than that contained in the Loop ID-1000A - Submitter PER segment and no Factoring Agent or Pay-to-Plan is

	present. If not required by implementation guide, do not send.
CR 875	There is conflict between the PER in 2010AA and 2010AD. Suggest that 2010AA PER be changed to include "...and no Factoring Agent or Pay-to-Plan is present."
Location	X323 | Health Care Claim: Professional | 837 | 0150 | 2010AB NM1 - Pay-to Address
Action	**Modify Loop Name** Loop ID 2010AB / NM1 (Pay-to Provider Address) Changed to: PAY-TO ADDRESS
CR 169	Modify segment name to align with information reported for the Pay-to-Address.
Location	X323 | Health Care Claim: Professional | 837 | 0150 | 2010AB NM1 - Pay-to Address
Action	**Modify Segment Note** Changed to: Loop ID-2010AB only contains address information when different from the Billing Provider Address. There are no applicable identifiers for Pay-To Address information.
CR 1153	To clarify intended use.
Location	X323 | Health Care Claim: Professional | 837 | 0150 | 2010AC NM1 - Pay-To Plan Name
Action	**Modify Segment Situational Rule** Changed to: Required when BHT06 = 31 (Subrogation Demand). If not required by this implementation guide, do not send.
CR 1545	Support subrogation claims for multiple payer types.
Location	X323 | Health Care Claim: Professional | 837 | 0150 | 2010AC NM1 - Pay-To Plan Name
Action	**Modify Data Element Code Value** Loop ID 2010AC / NM101 (Entity Identifier Code) Changed to: PTP - Pay-to Plan Name.
CR 757	Modify code value for Pay-to Plan Name for consistency across guides.
Location	X323 | Health Care Claim: Professional | 837 | 0150 | 2010AC NM1 - Pay-To Plan Name

Action	**Modify Data Element Usage** Loop ID 2010AC / NM108 (Identification Code Qualifier) Changed to: SITUATIONAL
CR 693	Revise National Plan ID (PIDR) references in 2010AC (PID), 2010BB and 2330B NM108 to align with the Health Plan Identifier regulation.
Location	X323 | Health Care Claim: Professional | 837 | 0150 | 2010AC NM1 - Pay-To Plan Name
Action	**Delete Data Element Code Value** Loop ID 2010AC / NM108 (Identification Code Qualifier) Removed: PI (Payor Identification)
CR 693	Revise National Plan ID (PIDR) references in 2010AC (PID), 2010BB and 2330B NM108 to align with the Health Plan Identifier regulation.
Location	X323 | Health Care Claim: Professional | 837 | 0150 | 2010AC NM1 - Pay-To Plan Name
Action	**Modify Data Element Usage** Loop ID 2010AC / NM109 (Identification Code) Changed to: SITUATIONAL
CR 693	Revise National Plan ID (PIDR) references in 2010AC (PID), 2010BB and 2330B NM108 to align with the Health Plan Identifier regulation.
Location	X323 | Health Care Claim: Professional | 837 | 0150 | 2010AC NM1 - Pay-To Plan Name
Action	**Delete Segment Note** This loop may only be used when BHT06 = 31.
CR 878	6020 Public Review Comment received to remove restriction to allow the use of Loop 2010AC to Medicaid only.
Location	X323 | Health Care Claim: Professional | 837 | 0150 | 2010AC NM1 - Pay-To Plan Name
Action	**Modify Data Element Situational Rule** Multiple Loops / NM109 (Identification Code) Changed to: Required when reporting the Health Plan ID (HPID) or Other Entity Identifier (OEID). If not required by this implementation guide, do not send.
CR 693	Revise National Plan ID (PIDR) references in 2010AC (PID), 2010BB and 2330B NM108 to align with the Health Plan Identifier regulation.

Location	X323 | Health Care Claim: Professional | 837 | 0350 | 2010AC REF - Pay-to Plan Secondary Identification
Action	**Modify Segment Situational Rule** REF (Payer Secondary Identification) Changed to: Required when NM109 of this loop is not used. OR Required when an additional identification number to that provided in the NM109 of this loop is necessary to identify the entity. If not required by this implementation guide, do not send.
CR 694	Revise rules, notes and qualifiers to align with the Health Plan Identifier regulation.

Location	X323 | Health Care Claim: Professional | 837 | 0350 | 2010AC REF - Pay-to Plan Secondary Identification
Action	**Modify Segment Situational Rule** REF (Pay-to Plan Secondary Identification) Changed to: Required when NM109 of this loop is not used. OR Required when an additional identification number to that provided in the NM109 of this loop is necessary to identify the entity. If not required by this implementation guide, do not send.
CR 694	Revise rules, notes and qualifiers to align with the Health Plan Identifier regulation.

Location	X323 | Health Care Claim: Professional | 837 | 0350 | 2010AC REF - Pay-to Plan Secondary Identification
Action	**Delete Data Element Code Value** Loop 2010AC - REF01 (Reference Identification Qualifier) Removed: FY (Claim Office Number) NF (National Association of Insurance Commissioners (NAIC) Code)
CR 693	Revise National Plan ID (PIDR) references in 2010AC (PID), 2010BB and 2330B NM108 to align with the Health Plan Identifier regulation.

Location	X323 | Health Care Claim: Professional | 837 | 0350 | 2010AC REF - Pay-to Plan Secondary Identification
Action	**Delete Data Element Code Note** "This code is only allowed when the National Plan Identifier is reported in

	NM109 of this loop."
CR 696	Revise National Plan ID (PIDR) references in 2010AC (PID) and 2010BB REF01 to align with the Health Plan Identifier regulation.
Location	X323 | Health Care Claim: Professional | 837 | 0150 | 2010AD NM1 - Pay-to Factoring Agent Name
Action	**Add Loop** Loop ID 2010AD / PAY-TO FACTORING AGENT NAME
CR 346	Create a new loop to support reporting of Factoring Agent on Property and Casualty Claims.
Location	X323 | Health Care Claim: Professional | 837 | 0150 | 2010AD NM1 - Pay-to Factoring Agent Name
Action	**Modify Data Element Situational Rule** Multiple Loops / NM109 (Identification Code) Changed to: Required when reporting the Health Plan ID (HPID) or Other Entity Identifier (OEID). If not required by this implementation guide, do not send.
CR 693	Revise National Plan ID (PIDR) references in 2010AC (PID), 2010BB and 2330B NM108 to align with the Health Plan Identifier regulation.
Location	X323 | Health Care Claim: Professional | 837 | 0010 | 2000B HL - Subscriber Level
Action	**Add Data Element Code Note** Loop ID 2000B / HL04 (Hierarchical Child Code) 0 (No Subordinate HL Segment in This Hierarchical Structure.) Use when the patient can be uniquely identified to the destination payer in Loop ID-2010BB by a unique Member Identification Number.
CR 1506	Change situational Rule to include reference to 2000B HL04=1 for editing clarity.
Location	X323 | Health Care Claim: Professional | 837 | 0010 | 2000B HL - Subscriber Level
Action	**Add Data Element Code Note** Loop ID 2000B / HL04 (Hierarchical Child Code) 1 (Additional Subordinate HL Data Segment in This Hierarchical Structure.) Use when the patient is not the subscriber and cannot be identified to the destination payer by a unique Member Identification Number

CR 1506	Change situational Rule to include reference to 2000B HL04=1 for editing clarity.
Location	X323 | Health Care Claim: Professional | 837 | 0010 | 2000B HL - Subscriber Level
Action	**Modify Data Element Note** Changed to "Refer to Section 1.4.3.2.2.2 Subscriber / Patient Hierarchical Level (HL) Segments for instructions on submitting subscriber and dependent claims in the same batch."
CR 163	Loop 2000B - HL - Subscriber HL04: eliminate redundancy and conflicts between the front matter (Section 1.4.3.2.2.2) and the element notes.
Location	X323 | Health Care Claim: Professional | 837 | 0010 | 2000B HL - Subscriber Level
Action	**Delete Data Element Note** "In the first case (HL04 = 0), the subscriber is the patient and there are no dependent claims."
CR 163	Loop 2000B - HL - Subscriber HL04: eliminate redundancy and conflicts between the front matter (Section 1.4.3.2.2.2) and the element notes.
Location	X323 | Health Care Claim: Professional | 837 | 0010 | 2000B HL - Subscriber Level
Action	**Delete Data Element Note** "The second case (HL04 = 1) happens when claims for one or more dependents of the subscriber are being sent under the same billing provider HL (for example, a spouse and son are both treated by the same provider). In that case, the subscriber HL04 = 1 because there is at least one dependent to this subscriber. The dependent HL (spouse) would then be sent followed by the Loop ID-2300 for the spouse. The next HL would be the dependent HL for the son followed by the Loop ID-2300 for the son."
CR 163	Loop 2000B - HL - Subscriber HL04: eliminate redundancy and conflicts between the front matter (Section 1.4.3.2.2.2) and the element notes.
Location	X323 | Health Care Claim: Professional | 837 | 0010 | 2000B HL - Subscriber Level
Action	**Delete Data Element Note** "In order to send claims for the subscriber and one or more dependents, the Subscriber HL, with Relationship Code SBR02=18 (Self), would be followed by the Subscriber's Loop ID-2300 for the Subscriber's claims. Then the Subscriber HL would be repeated, followed by one or more Patient HL loops for the dependents, with the proper Relationship Code in PAT01, each followed by their respective Loop ID-2300 for each dependent's claims."

CR 163	Loop 2000B - HL - Subscriber HL04: eliminate redundancy and conflicts between the front matter (Section 1.4.3.2.2.2) and the element notes.
Location	X323 | Health Care Claim: Professional | 837 | 0050 | 2000B SBR - Subscriber Information
Action	**Modify Data Element Situational Rule** Multiple Loops / SBR03 (Subscriber Group or Policy Number) Changed to: Required when the subscriber's identification card shows a group number. OR Required when the subscriber's group number is otherwise gathered (e.g. eligibility inquiry). If not required by this implementation guide, do not send.
CR 30	Modify the situational rule to allow for other methods of gathering the group or policy number.
Location	X323 | Health Care Claim: Professional | 837 | 0050 | 2000B SBR - Subscriber Information
Action	**Modify Data Element Situational Rule** Loop ID 2000B and 2320 / SBR04 (Subscriber Group Name) Changed to: Required when the subscriber's identification card shows a group name. OR Required when the subscriber's group name is otherwise gathered (e.g. eligibility inquiry). If not required by this implementation guide, may be provided at the sender's discretion, but cannot be required by the receiver.
CR 1215	Remove restriction on reporting the Group Name.
Location	X323 | Health Care Claim: Professional | 837 | 0050 | 2000B SBR - Subscriber Information
Action	**Modify Data Element Usage** Loop ID 2000B / SBR05 (Insurance Type Code) Changed to: NOT USED
CR 47	2000B SBR05 - Change to Not Used as the Insurance Type Code is only needed when Medicare is the non-destination payer and Medicare is not primary.
Location	X323 | Health Care Claim: Professional | 837 | 0050 | 2000B SBR - Subscriber Information

Action	**Add Data Element Code Value** Loop ID 2300 / SBR09 (Claim Filing Indicator Code) ME (Medicare Advantage Plan)
CR 941	Support reporting of Medicare Advantage insurance type for health care claims.
Location	X323 | Health Care Claim: Professional | 837 | 0050 | 2000B SBR - Subscriber Information
Action	**Add Data Element Code Value** Loop ID 2000B / SBR09 (Claim Filing Indicator Code) UK (Unknown)
CR 942	A permanent code value should be assigned for "Unknown".
Location	X323 | Health Care Claim: Professional | 837 | 0050 | 2000B SBR - Subscriber Information
Action	**Modify Data Element Code Note** Multiple Locations / SBR09 (Claim Filing Indicator Code) ZZ (Mutually Defined) Changed to: Use when mutually agreed upon between trading partners.
CR 942	A permanent code value should be assigned for "Unknown".
Location	X323 | Health Care Claim: Professional | 837 | 0070 | 2000B PAT - Patient Information
Action	**Modify Segment Situational Rule** Changed to: Required when the patient is the subscriber or is considered to be the subscriber (Loop ID 2000B HL04 = 0) and at least one of the element requirements are met. If not required by this implementation guide, do not send.
CR 1494	Modify the situational rule to enable content editing within the transaction.
Location	X323 | Health Care Claim: Professional | 837 | 0070 | 2000B PAT - Patient Information
Action	**Modify Data Element Situational Rule** Multiple Loops / PAT07 and PAT08 (Patient Weight) Changed to: Required when patient weight is needed for Medicare Durable Medical

	Equipment claims. If not required by this implementation guide, may be provided at the sender's discretion but cannot be required by the receiver.
CR 499	Revise the 2000B/2000C PAT07/PAT08 situational rule to allow for other scenarios where a weight is needed. In addition, other qualifiers may be needed to support the type of weight being reported.
Location	X323 | Health Care Claim: Professional | 837 | 0070 | 2000B PAT - Patient Information
Action	**Modify Data Element Situational Rule** Multiple Loops / PAT09 (Pregnancy Indicator) Changed to: Required when mandated by law. The determination of pregnancy shall be completed in compliance with applicable law. If not required by this implementation guide, do not send.
CR 37	Revise the Data Elements that are Yes/No Indicators for consistency.
Location	X323 | Health Care Claim: Professional | 837 | 0070 | 2000B PAT - Patient Information
Action	**Add Data Element Code Value** Loop 2000B / PAT09 (Pregnancy Indicator) N (No)
CR 37	Revise the Data Elements that are Yes/No Indicators for consistency.
Location	X323 | Health Care Claim: Professional | 837 | 0070 | 2000B PAT - Patient Information
Action	**Add Data Element Code Value** Loop 2000B / PAT09 (Pregnancy Indicator) U (Unknown)
CR 37	Revise the Data Elements that are Yes/No Indicators for consistency.
Location	X323 | Health Care Claim: Professional | 837 | 0150 | 2010BA NM1 - Subscriber Name
Action	**Add Segment Note** If a patient can be uniquely identified to the destination payer in Loop ID-2010BB by a unique Member Identification Number, then the patient is the subscriber or is considered to be the subscriber and is identified at this level, and the patient HL in Loop ID-2000C is not used. If the patient is not the subscriber and cannot be identified to the destination payer by a unique Member Identification Number or it is not known to the

	sender if the Member Identification number is unique, both this HL and the patient HL in Loop ID-2000C are required.
CR 879	Add TR3 subscriber/patient definition notes from the HL segment to the 2010BA NM1 Segment.
Location	X323 | Health Care Claim: Professional | 837 | 0150 | 2010BA NM1 - Subscriber Name
Action	**Modify Data Element Situational Rule** Loop ID 2010BA / NM107 (Subscriber Name Suffix) Changed to: Required when the name suffix is needed to identify the individual. If not required by this implementation guide, do not send.
CR 1154	For consistency across all TR3s.
Location	X323 | Health Care Claim: Professional | 837 | 0250 | 2010BA N3 - Subscriber Address
Action	**Modify Segment Situational Rule** Changed to: Required when the patient is the subscriber or considered to be the subscriber. OR Required for Workers' Compensation when the patient`s relationship to the subscriber is an employee (Loop ID 2000C PAT01=20). If not required by this implementation guide, do not send.
CR 1445	Enable reporting of address information in the subscriber loop for professional workers' compensation eBills.
Location	X323 | Health Care Claim: Professional | 837 | 0300 | 2010BA N4 - Subscriber City, State, ZIP Code
Action	**Modify Segment Situational Rule** Changed to: Required when the patient is the subscriber or considered to be the subscriber. OR Required for Workers' Compensation when the patient`s relationship to the subscriber is an employee (Loop ID 2000C PAT01=20). If not required by this implementation guide, do not send.

CR 1445	Enable reporting of address information in the subscriber loop for professional workers' compensation eBills.
Location	X323 | Health Care Claim: Professional | 837 | 0350 | 2010BA REF - Property & Casualty Claim Number
Action	**Modify Segment Situational Rule** Changed to: Required when the services included in this claim are to be considered as part of a Nonworkers' Compensation Property & Casualty claim. OR Required when the services included in this claim are considered Workers' Compensation and the claim number has been established by the payer at the time of service. If not required by this implementation guide, do not send.
CR 78	Modify situational rule to allow the P&C number "if known."
Location	X323 | Health Care Claim: Professional | 837 | 0350 | 2010BA REF - Property & Casualty Claim Number
Action	**Add Segment Note** In the case where the patient is the same person as the subscriber, the property and casualty claim number is sent in Loop ID-2010BA. In the case where the patient is a different person than the subscriber, this number is sent in Loop ID-2010CA. If Loop ID-2010CA is sent, then the property and casualty claim number must not be sent in Loop ID-2010BA.
CR 881	Add a segment note clarifying the P&C Claim Number is only sent in one loop or the other, based on whether the patient is the subscriber.
Location	X323 | Health Care Claim: Professional | 837 | 0400 | 2010BA PER - Property & Casualty Subscriber Contact Information
Action	**Add Segment Note** For property and casualty claims, the P&C Subscriber Contact may be used to report the name and telephone number of the policy holder. The policyholder for automobile accident claims is typically the individual or company listed on the proof of insurance card. The policyholder for workers' compensation claims is typically the patient's employer. When the policyholder or "subscriber" is a non-person entity, it is recommended that the health care provider use the name of a responsible individual within that organization.
CR 1153	To clarify intended use.
Location	X323 | Health Care Claim: Professional | 837 | 0150 | 2010BB NM1 - Payer Name

Action	**Modify Data Element Usage** Loop ID 2010BB / NM108 (Identification Code Qualifier) Changed to: SITUATIONAL
CR 693	Revise National Plan ID (PIDR) references in 2010AC (PID), 2010BB and 2330B NM108 to align with the Health Plan Identifier regulation.
Location	X323 | Health Care Claim: Professional | 837 | 0150 | 2010BB NM1 - Payer Name
Action	**Modify Data Element Usage** Loop ID 2010BB / NM109 (Payer Identifier) Changed to: SITUATIONAL
CR 693	Revise National Plan ID (PIDR) references in 2010AC (PID), 2010BB and 2330B NM108 to align with the Health Plan Identifier regulation.
Location	X323 | Health Care Claim: Professional | 837 | 0150 | 2010BB NM1 - Payer Name
Action	**Modify Data Element Situational Rule** Multiple Loops / NM109 (Identification Code) Changed to: Required when reporting the Health Plan ID (HPID) or Other Entity Identifier (OEID). If not required by this implementation guide, do not send.
CR 693	Revise National Plan ID (PIDR) references in 2010AC (PID), 2010BB and 2330B NM108 to align with the Health Plan Identifier regulation.
Location	X323 | Health Care Claim: Professional | 837 | 0250 | 2010BB N3 - Payer Address
Action	**Modify Segment Situational Rule** Changed to: Required when the payer address is available and the submitter intends for the claim to be printed on paper at the next EDI location (for example, a clearinghouse). If not required by this implementation guide may be provided at the sender's discretion, but cannot be required by the receiver.
CR 1214	Modify the situational rule to allow for submission of payer address even though the claim may not be printed to paper at the next EDI location.
Location	X323 | Health Care Claim: Professional | 837 | 0300 | 2010BB N4 - Payer City, State, ZIP Code
Action	**Modify Segment Situational Rule** Changed to: Required when the payer address is available and the submitter intends for

	the claim to be printed on paper at the next EDI location (for example, a clearinghouse). If not required by this implementation guide may be provided at the sender's discretion, but cannot be required by the receiver.
CR 1214	Modify the situational rule to allow for submission of payer address even though the claim may not be printed to paper at the next EDI location.

Location	X323 | Health Care Claim: Professional | 837 | 0350 | 2010BB REF - Payer Secondary Identification
Action	**Modify Segment Repeat** Changed to: 1
CR 1205	Modify the repeat count to match the number of qualifiers available for use.

Location	X323 | Health Care Claim: Professional | 837 | 0350 | 2010BB REF - Payer Secondary Identification
Action	**Modify Segment Situational Rule** REF (Payer Secondary Identification) Changed to: Required when NM109 of this loop is not used. OR Required when an additional identification number to that provided in the NM109 of this loop is necessary to identify the entity. If not required by this implementation guide, do not send.
CR 694	Revise rules, notes and qualifiers to align with the Health Plan Identifier regulation.

Location	X323 | Health Care Claim: Professional | 837 | 0350 | 2010BB REF - Payer Secondary Identification
Action	**Delete Data Element Code Value** Loop ID 2010BB / REF01 (Reference Identification Qualifier) Removed: EI (Employer's Identification Number) FY (Claim Office Number) NF (National Association of Insurance Commissioners (NAIC) Code)
CR 693	Revise National Plan ID (PIDR) references in 2010AC (PID), 2010BB and 2330B NM108 to align with the Health Plan Identifier regulation.

Location	X323 | Health Care Claim: Professional | 837 | 0350 | 2010BB REF - Payer Secondary Identification
Action	**Delete Data Element Code Note** "This code is only allowed when the National Plan Identifier is reported in NM109 of this loop."

CR 696	Revise National Plan ID (PIDR) references in 2010AC (PID) and 2010BB REF01 to align with the Health Plan Identifier regulation.
Location	X323 | Health Care Claim: Professional | 837 | 0350 | 2010BB REF - Billing Provider Secondary Identification
Action	**Modify Segment Situational Rule** Changed to: Required when NM109 in Loop 2010AA is not used and an identification number other than the NPI is necessary for the receiver to identify the provider. If not required by this implementation guide, do not send.
CR 170	Revise the Situational Rule, as the NPI mandate is now in effect.
Location	X323 | Health Care Claim: Professional | 837 | 0350 | 2010BB REF - Billing Provider Secondary Identification
Action	**Modify Data Element Code Value** Loop ID 2010BB / REF01 (Reference Identification Qualifier) Changed G2 (Commercial Number) to A6 (Provider Identifier)
CR 497	Remove REF Segment qualifier G2 and add A6 to better accommodate atypical providers.
Location	X323 | Health Care Claim: Professional | 837 | 0010 | 2000C HL - Patient Level
Action	**Modify Segment Situational Rule** Changed to: Required when 2000B HL04 = 1. If not required by this implementation guide, do not send.
CR 1506	Change situational Rule to include reference to 2000B HL04=1 for editing clarity.
Location	X323 | Health Care Claim: Professional | 837 | 0010 | 2000C HL - Patient Level
Action	**Add Data Element Note** Loop ID 2000C / HL01 (Hierarchical ID Number) The first HL01 within each ST-SE envelope must begin with "1", and be incremented by one each time an HL is used in the transaction. Only numeric values are allowed in HL01.
CR 1109	For consistency, consider restricting HL01 to numeric values and requiring that enumeration of HL01 begin with 1 and be incremented by 1 for each iteration.
Location	X323 | Health Care Claim: Professional | 837 | 0010 | 2000C HL - Patient Level

Action	**Delete Data Element Code Note** Loop ID 2000C / HL03 (Hierarchical Level Code) 23 (Dependent) Removed: This code conveys that the information in this HL applies to the patient when the subscriber and the patient are not the same person.
CR 1558	Format code notes consistently.

Location	X323 | Health Care Claim: Professional | 837 | 0070 | 2000C PAT - Patient Information
Action	**Modify Data Element Situational Rule** Multiple Loops / PAT07 and PAT08 (Patient Weight) Changed to: Required when patient weight is needed for Medicare Durable Medical Equipment claims. If not required by this implementation guide, may be provided at the sender's discretion but cannot be required by the receiver.
CR 499	Revise the 2000B/2000C PAT07/PAT08 situational rule to allow for other scenarios where a weight is needed. In addition, other qualifiers may be needed to support the type of weight being reported.

Location	X323 | Health Care Claim: Professional | 837 | 0070 | 2000C PAT - Patient Information
Action	**Modify Data Element Situational Rule** Multiple Loops / PAT09 (Pregnancy Indicator) Changed to: Required when mandated by law. The determination of pregnancy shall be completed in compliance with applicable law. If not required by this implementation guide, do not send.
CR 37	Revise the Data Elements that are Yes/No Indicators for consistency.

Location	X323 | Health Care Claim: Professional | 837 | 0070 | 2000C PAT - Patient Information
Action	**Add Data Element Code Value** Loop 2000C / PAT09 (Pregnancy Indicator) N (No) U (Unknown)
CR 37	Revise the Data Elements that are Yes/No Indicators for consistency.

Location	X323 | Health Care Claim: Professional | 837 | 0350 | 2010CA REF - Property & Casualty Claim Number
Action	**Modify Segment Situational Rule** Changed to: Required when the services included in this claim are to be considered as part of a Nonworkers' Compensation Property & Casualty claim. OR Required when the services included in this claim are considered Workers' Compensation and the claim number has been established by the payer at the time of service. If not required by this implementation guide, do not send.
CR 78	Modify situational rule to allow the P&C number "if known."

Location	X323 | Health Care Claim: Professional | 837 | 1300 | 2300 CLM - Claim Information
Action	**Modify Data Element Note** Loop ID 2300 / CLM01 (Provider's Assigned Claim Identifier) Changed to: The maximum number of characters to be supported for this field is `35'. Characters beyond the maximum are not required to be stored nor returned by any 837-receiving system.
CR 504	Tighten the requirements for use of CLM01 across the guides.

Location	X323 | Health Care Claim: Professional | 837 | 1300 | 2300 CLM - Claim Information
Action	**Modify Data Element Note** Loop ID 2300 / CLM01 (Provider's Assigned Claim Identifier) Changed to: When Loop ID-2010AC is not present, this identifier is generated by the provider for the purpose of reassociation to their claim accounts receivable, and must not be modified. This identifier, as submitted in the 837, is returned in the 835 and/or other transactions. This identifier is not to be validated beyond standard TR3 syntax and semantic rules.
CR 504	Tighten the requirements for use of CLM01 across the guides.

Location	X323 | Health Care Claim: Professional | 837 | 1300 | 2300 CLM - Claim Information
Action	**Modify Data Element Note** Loop ID 2300 / CLM01 (Provider Assigned Claim Identifier)

	Note 2 changed to: When Loop ID-2010AC is present, CLM01 represents the Pay-To Plan's claim number (ICN/DCN) assigned during their processing of the claim. See Section 1.4.2.4 Coordination of Benefits - Subrogation for information on subrogation claim reporting.
CR 1545	Support subrogation claims for multiple payer types.

Location	X323 | Health Care Claim: Professional | 837 | 1300 | 2300 CLM - Claim Information
Action	**Add Data Element Note** Multiple Loops / Multiple Data Elements Data Element 782 (Monetary Amount): The maximum length of this instance of data element 782 is 10.
CR 1013	Add a consistent element note explaining the maximum length to every monetary amount element.

Location	X323 | Health Care Claim: Professional | 837 | 1300 | 2300 CLM - Claim Information
Action	**Modify Data Element Usage** Loop ID 2300 / CLM07 (Medicare Assignment Code) Changed to: SITUATIONAL
CR 750	Allow reporting of Medicare Assignment information for Medicare Crossover Claims.

Location	X323 | Health Care Claim: Professional | 837 | 1300 | 2300 CLM - Claim Information
Action	**Add Data Element Situational Rule** Loop ID 2300 / CLM07 (Medicare Assignment Code) Required when the subscriber's health plan for the destination payer is Medicare, including Medicare Fee For Service (FFS) or a Medicare Advantage Plan (Medicare Part C). If not required by this implementation guide, do not send.
CR 750	Allow reporting of Medicare Assignment information for Medicare Crossover Claims.

Location	X323 | Health Care Claim: Professional | 837 | 1300 | 2300 CLM - Claim Information
Action	**Add Data Element Note** Loop ID 2300 / CLM07 (Medicare Assignment Code)

	Added Note 2: This element indicates the provider's assignment with the Medicare Fee For Service (FFS) program and by extension the Medicare Advantage Plan (Medicare Part C). Added Note 3: The value in this element does not supersede an agreement between the provider and payer regarding assignment or participation status unless that agreement allows claim by claim exceptions. Added note 4: On COB claims where Medicare is not the destination payer, assignment or participation designation with Medicare is not reported in this CLM07 element; rather, it is reported in the Loop 2320 Other Insurance Coverage Information (OI Segment) corresponding to Medicare as the other payer.
CR 750	Allow reporting of Medicare Assignment information for Medicare Crossover Claims.
Location	X323 | Health Care Claim: Professional | 837 | 1300 | 2300 CLM - Claim Information
Action	**Modify Data Element Note** Loop ID 2300 / CLM07 (Medicare Assignment Code) Changed to: This element is NOT for reporting whether the patient has or has not assigned benefits to the provider. The benefit assignment indicator is in CLM08.
CR 750	Allow reporting of Medicare Assignment information for Medicare Crossover Claims.
Location	X323 | Health Care Claim: Professional | 837 | 1300 | 2300 CLM - Claim Information
Action	**Modify Data Element Code Note** Loop ID 2300 / CLM07 (Medicare Assignment Code) A (Assigned) Changed to: Modify shared note 1560 across guides x259, x260 and x261 as follows: Use when the provider has a participation agreement with Medicare.

	OR Use when the provider does not have a participation agreement with Medicare but has elected to accept assignment for this claim.
CR 750	Allow reporting of Medicare Assignment information for Medicare Crossover Claims.
Location	X323 | Health Care Claim: Professional | 837 | 1300 | 2300 CLM - Claim Information
Action	**Modify Data Element Code Note** Loop ID 2300 / CLM07 (Medicare Assignment Code) C (Not Assigned) Changed to: Use when the provider does not have a participation agreement with Medicare and has elected not to accept assignment for this claim.
CR 750	Allow reporting of Medicare Assignment information for Medicare Crossover Claims.
Location	X323 | Health Care Claim: Professional | 837 | 1300 | 2300 CLM - Claim Information
Action	**Add Data Element Code Value** Loop ID 2300 / CLM11-02 (Related Causes Code) EM (Employment)
CR 1528	Modify situational rule to enable content editing within the transaction.
Location	X323 | Health Care Claim: Professional | 837 | 1300 | 2300 CLM - Claim Information
Action	**Modify Data Element Situational Rule** Loop ID 2300 / CLM11-02 (Related Causes Code) Changed to: Required when the services are related to an employment related accident and the CLM11-01 value is "AA" or "OA". If not required by this implementation guide, do not send.
CR 1528	Modify situational rule to enable content editing within the transaction.
Location	X323 | Health Care Claim: Professional | 837 | 1300 | 2300 CLM - Claim Information

Action	**Modify Data Element Situational Rule** Loop ID 2300 / CLM11-04 (State or Province Code) Changed to: Required when CLM11-01 has a value of "AA" and the automobile accident occurred in the US, including its territories, or Canada. If not required by this implementation guide, do not send.
CR 1528	Modify situational rule to enable content editing within the transaction.

Location	X323 | Health Care Claim: Professional | 837 | 1300 | 2300 CLM - Claim Information
Action	**Modify Data Element Situational Rule** Loop ID 2300 / CLM11-05 (Country Code) Changed to: Required when CLM11-01 has a value of "AA" and the accident occurred in a country other than US, including its territories, or Canada. If not required by this implementation guide, do not send.
CR 1528	Modify situational rule to enable content editing within the transaction.

Location	X323 | Health Care Claim: Professional | 837 | 1300 | 2300 CLM - Claim Information
Action	**Modify Data Element Situational Rule** Loop ID 2300 / CLM12 (Special Program Code) Changed to: Required when the services were rendered under one of the following circumstances, programs, or projects for Medicaid. If not required by this implementation guide, do not send.
CR 1558	Format code notes consistently.

Location	X323 | Health Care Claim: Professional | 837 | 1300 | 2300 CLM - Claim Information
Action	**Delete Data Element Code Note** Loop ID 2300 / CLM12 (Special Program Code) 02 (Physically Handicapped Children's Program) 03 (Special Federal Funding) 05 (Disability) 09 (Second Opinion or Surgery) Removed: This code is used for Medicaid claims only.

CR 1558	Format code notes consistently.
Location	X323 | Health Care Claim: Professional | 837 | 1300 | 2300 CLM - Claim Information
Action	**Modify Data Element Usage** Loop ID 2300 / CLM16 (Provider Agreement Code) Changed to: SITUATIONAL
CR 750	Allow reporting of Medicare Assignment information for Medicare Crossover Claims.
Location	X323 | Health Care Claim: Professional | 837 | 1300 | 2300 CLM - Claim Information
Action	**Add Data Element Situational Rule** Loop ID 2300 / CLM16 (Provider Agreement Code) Required when a non-participating (non-par) provider is submitting a participating (par) claim and the destination payer is not Medicare, including Medicare Fee For Service (FFS) or a Medicare Advantage Plan (Medicare Part C). If not required by this implementation guide, may be provided at the sender's discretion, but cannot be required by the receiver.
CR 750	Allow reporting of Medicare Assignment information for Medicare Crossover Claims.
Location	X323 | Health Care Claim: Professional | 837 | 1300 | 2300 CLM - Claim Information
Action	**Modify Data Element Usage** Loop ID 2300 / CLM19 (Claim Submission Reason Code) Changed to: SITUATIONAL Required when the entire claim is being submitted as a predetermination request. If not required by this implementation guide, do not send.
CR 200	Revise Loop 2300 CLM19 to support predeterminations.
Location	X323 | Health Care Claim: Professional | 837 | 1300 | 2300 CLM - Claim Information
Action	**Add Data Element Note** Loop ID 2300 / CLM19 (Predetermination of Benefits Code) The Predetermination of Benefits Code, when sent, indicates that the entire claim is being sent for predetermination. When the code is not sent, the entire claim is being submitted for payment. See front matter for more information on the use of predeterminations.

CR 1199	There is a great deal of confusion regarding this element and cost to build coding for predetermination in an 837 transaction is prohibitive as well. Business areas have concern over this element and the possible interpretations as well.
Location	X323 | Health Care Claim: Professional | 837 | 1300 | 2300 CLM - Claim Information
Action	**Add Data Element Situational Rule** Loop ID 2300 / CLM21 (Claim Authorization Exception Code) Required when mandated by government law or regulation to obtain authorization for specific services(s) but, for the reasons listed, the service was performed without obtaining an authorization. If not required by this implementation guide, do not send.
CR 940	Define a permanent location for Service Authorization Exception Code in the claim.
Location	X323 | Health Care Claim: Professional | 837 | 1300 | 2300 CLM - Claim Information
Action	**Add Data Element Code Value** Loop ID 2300 / CLM21 (Claim Authorization Exception Code) 1 - Immediate/Urgent Care 2 - Services Rendered in a Retroactive Period 3 - Emergency Care 4 - Client Has Temporary Medicaid 5 - Request from County for Second Opinion to Determine if Recipient Can Work 6 - Request for Override Pending 7 - Special Handling Z - Mutually Defined
CR 940	Define a permanent location for Service Authorization Exception Code in the claim.
Location	X323 | Health Care Claim: Professional | 837 | 1300 | 2300 CLM - Claim Information
Action	**Add Data Element Code Note** Loop ID 2300 / CLM11-01 (Related Causes Code) EM (Employment) Use when reporting an employment related illness.
CR 1528	Modify situational rule to enable content editing within the transaction.

Location	X323 | Health Care Claim: Professional | 837 | 1300 | 2300 CLM - Claim Information
Action	**Delete Data Element Note** Loop ID 2300 / CLM11-02 (Related Causes Code) See CLM11-01 for valid values.
CR 1528	Modify situational rule to enable content editing within the transaction.

Location	X323 | Health Care Claim: Professional | 837 | 1300 | 2300 CLM - Claim Information
Action	**Modify Data Element Code Note** changed from "Required when the provider accepts assignment for Clinical Lab Services only." to "Use for Medicare and Medicare Advantage claims when the provider does not have a participation agreement but accepts Medicare Assignment for Clinical Lab Services only."
CR 1218	Establish one unique location for Medicare Assignment and Plan Participation reporting.

Location	X323 | Health Care Claim: Professional | 837 | 1350 | 2300 DTP - Original Claim Creation Date
Action	**Add Segment** DTP (ORIGINAL CLAIM CREATION DATE)
CR 729	Support transmission of the original date the claim was created.

Location	X323 | Health Care Claim: Professional | 837 | 1350 | 2300 DTP - Onset of Current Symptoms or Illness Date
Action	**Modify Segment Situational Rule** Changed to: Required for the initial medical service or visit performed in response to a medical emergency when the date is available and is different than the date of service. OR Required when Loop ID-2300 CLM11-01 or CLM11-02 is "EM" and the accident date is not used. If not required by this implementation guide, do not send.
CR 808	Revise the Situational Rule. If EM is entered and the bill is for 'Accident Related Work injury,' the AA or OA would also be used so the second requirement is not needed.

Location	X323 | Health Care Claim: Professional | 837 | 1350 | 2300 DTP - Acute Manifestation Date

Action	**Delete Segment** Loop ID 2300 / DTP (ACUTE MANIFESTATION DATE)
CR 1496	There is industry consensus that this segment is no longer needed.

Location	X323 | Health Care Claim: Professional | 837 | 1350 | 2300 DTP - Accident Date
Action	**Modify Segment Situational Rule** Changed to: Required when the services provided are the result of an accident (Loop 2300 CLM11-01 has a value of "AA" or "OA"). If not required by this implementation guide, do not send.
CR 1528	Modify situational rule to enable content editing within the transaction.

Location	X323 | Health Care Claim: Professional | 837 | 1350 | 2300 DTP - Prescription Date
Action	**Modify Segment Name** DTP (HEARING AND VISION PRESCRIPTION DATE) Changed to: PRESCRIPTION DATE
CR 1129	To promote consistency across all guides.

Location	X323 | Health Care Claim: Professional | 837 | 1350 | 2300 DTP - Prescription Date
Action	**Modify Segment Situational Rule** Changed to: Required on claims where a prescription has been written for hearing devices or vision frames and lenses and it is being reported on this claim. If not required by this implementation guide, do not send.
CR 828	Review/Revise the wording of the situational rule.

Location	X323 | Health Care Claim: Professional | 837 | 1350 | 2300 DTP - Authorized Return to Work Date
Action	**Add Segment Note** Required when reporting the date the provider has authorized the patient to return to work.
CR 1558	Format code notes consistently.

Location	X323 | Health Care Claim: Professional | 837 | 1350 | 2300 DTP - Authorized Return to Work Date
Action	**Delete Data Element Code Note** Loop ID 2300 / DTP01 (Date Time Qualifier) 296 (Initial Disability Period Return To Work)

	Removed: This is the date the provider has authorized the patient to return to work.
CR 1558	Format code notes consistently.
Location	X323 | Health Care Claim: Professional | 837 | 1350 | 2300 DTP - Admission Date
Action	**Modify Segment Situational Rule** Changed to: Required on all ambulance claims (Loop 2300 CR1 is present (Ambulance transport information)) that are not predetermination requests (2300 CLM19 (Predetermination of Benefits Code) is not used) when the patient was known to be admitted to a facility. OR Required when the service(s) are related to a concurrent admission to a facility and are not predetermination requests (2300 CLM19 (Predetermination of Benefits Code) is not used). If not required by this implementation guide, may be provided at the sender's discretion but cannot be required by the receiver.
CR 1521	Modify the situational rule to enable content editing within the transaction.
Location	X323 | Health Care Claim: Professional | 837 | 1350 | 2300 DTP - Discharge Date
Action	**Modify Segment Situational Rule** Changed to: Required when the service(s) are related to a concurrent facility admission the patient was discharged from the facility, the discharge date is known and the claim is not a predetermination request (2300 CLM19 (Predetermination of Benefits Code) is not used). If not required by this implementation guide, may be provided at the sender's discretion but cannot be required by the receiver.
CR 1522	Modify the situational rule to enable content editing within the transaction.
Location	X323 | Health Care Claim: Professional | 837 | 1350 | 2300 DTP - Assumed Care Date
Action	**Modify Segment Name** DTP (ASSUMED AND RELINQUISHED CARE DATES) Changed to: ASSUMED CARE DATE

CR 1507	Currently the 837P TR3 2300 DTP Assumed and Relinquished Care Date has a segment repeat of 2 to allow for the DTP01 = 90 Assumed Care Date and 91- Relinquished Care Date. A provider would never relinquish care and assume care on the same claim so consider having two distinct DTP segments with exclusionary situational rules.
Location	X323 | Health Care Claim: Professional | 837 | 1350 | 2300 DTP - Assumed Care Date
Action	**Modify Segment Repeat** Changed to: 1
CR 1507	Currently the 837P TR3 2300 DTP Assumed and Relinquished Care Date has a segment repeat of 2 to allow for the DTP01 = 90 Assumed Care Date and 91- Relinquished Care Date. A provider would never relinquish care and assume care on the same claim so consider having two distinct DTP segments with exclusionary situational rules.
Location	X323 | Health Care Claim: Professional | 837 | 1350 | 2300 DTP - Assumed Care Date
Action	**Modify Segment Situational Rule** Changed to: Required when the provider has assumed post-operative care (global surgery claims). If not required by this implementation guide, do not send.
CR 1507	Currently the 837P TR3 2300 DTP Assumed and Relinquished Care Date has a segment repeat of 2 to allow for the DTP01 = 90 Assumed Care Date and 91- Relinquished Care Date. A provider would never relinquish care and assume care on the same claim so consider having two distinct DTP segments with exclusionary situational rules.
Location	X323 | Health Care Claim: Professional | 837 | 1350 | 2300 DTP - Assumed Care Date
Action	**Modify Segment Note** Changed to: Assumed Care Date is the date care was assumed by another provider during post-operative care. Example: Physician "B" assumed post-operative care from Surgeon "A" five days after surgery. When Physician "B" submits a claim, "B" will use code "090 Report Start" to indicate the date they assumed care of this patient from Surgeon "A".
CR 1507	Currently the 837P TR3 2300 DTP Assumed and Relinquished Care Date has a segment repeat of 2 to allow for the DTP01 = 90 Assumed Care Date and 91- Relinquished Care Date. A provider would never relinquish care and assume care on the same claim so consider having two distinct DTP

segments with exclusionary situational rules.

Location	X323 | Health Care Claim: Professional | 837 | 1350 | 2300 DTP - Assumed Care Date
Action	**Delete Data Element Code Value** Loop ID 2300 / DTP Segment (ASSUMED AND RELINQUISHED CARE DATES) 091 (Report End)
CR 1507	Currently the 837P TR3 2300 DTP Assumed and Relinquished Care Date has a segment repeat of 2 to allow for the DTP01 = 90 Assumed Care Date and 91- Relinquished Care Date. A provider would never relinquish care and assume care on the same claim so consider having two distinct DTP segments with exclusionary situational rules.

Location	X323 | Health Care Claim: Professional DTP - Relinquished Care Date
Action	**Add Segment** Loop ID 2300 / DTP (RELINQUISH CARE DATE)
CR 1507	Currently the 837P TR3 2300 DTP Assumed and Relinquished Care Date has a segment repeat of 2 to allow for the DTP01 = 90 Assumed Care Date and 91- Relinquished Care Date. A provider would never relinquish care and assume care on the same claim so consider having two distinct DTP segments with exclusionary situational rules.

Location	X323 | Health Care Claim: Professional | 837 | 1350 | 2300 DTP - Repricer Received Date
Action	**Modify Segment Situational Rule** Changed to: Required when a repricer is passing the claim on to the payer. If not required by this implementation guide, do not send.
CR 1154	For consistency across all TR3s.

Location	X323 | Health Care Claim: Professional | 837 | 1350 | 2300 DTP - Repricer Received Date
Action	**Add Segment Note** This segment is not completed by providers. The information is completed by repricers only.
CR 171	Move the informational text in the situational rule to a segment note.

Location	X323 | Health Care Claim: Professional | 837 | 1350 | 2300 DTP - Repricer Received Date

Action	**Add Segment Note** The segment is not completed by providers. The information is completed by repricers only.
CR 31	LOOP 2300 DTP - Repricer Received Date: Include guidance that this is sent only by a repricer, never by a provider.
Location	X323 | Health Care Claim: Professional | 837 | 1550 | 2300 PWK - Claim Supplemental Information
Action	**Modify Segment Situational Rule** Changed to: Required when there is an attachment available for this claim. If not required by this implementation guide, do not send
CR 1471	Simplify the PWK segment situational rules across all 837 guides and modify the PWK02 Code notes to allow codes, AA, EL, & FT for paper attachments.
Location	X323 | Health Care Claim: Professional | 837 | 1550 | 2300 PWK - Claim Supplemental Information
Action	**Modify Data Element Code Note** Loop ID 2300 and 2400 / PWK02 (Attachment Transmission Code) FT (File Transfer) Changed to: Use when attachments are sent by File Transfer to payer or maintained by an attachment warehouse or similar vendor.
CR 1471	Simplify the PWK segment situational rules across all 837 guides and modify the PWK02 Code notes to allow codes, AA, EL, & FT for paper attachments.
Location	X323 | Health Care Claim: Professional | 837 | 1550 | 2300 PWK - Claim Supplemental Information
Action	**Modify Data Element Code Note** Multiple Loops / PWK06 (Attachment Control Number Changed to: PWK06 is a unique identifier assigned by the provider to be used to identify the attached electronic documentation. The number in PWK06 is carried in the TRN of the electronic attachment.
CR 1153	To clarify intended use.
Location	X323 | Health Care Claim: Professional | 837 | 1550 | 2300 PWK - Claim Supplemental Information
Action	**Add Data Element Code Note** Loop ID 2300 / PWK02 (Attachment Transmission Code)

	BM (By Mail) Use when paper attachments are sent by mail.
CR 1471	Simplify the PWK segment situational rules across all 837 guides and modify the PWK02 Code notes to allow codes, AA, EL, & FT for paper attachments.
Location	X323 | Health Care Claim: Professional | 837 | 1550 | 2300 PWK - Claim Supplemental Information
Action	**Add Data Element Code Note** Loop ID 2300 / PWK02 (Attachment Transmission Code) EM (E-Mail) Use when paper attachments are sent by e-mail.
CR 1471	Simplify the PWK segment situational rules across all 837 guides and modify the PWK02 Code notes to allow codes, AA, EL, & FT for paper attachments.
Location	X323 | Health Care Claim: Professional | 837 | 1550 | 2300 PWK - Claim Supplemental Information
Action	**Add Data Element Code Note** Loop ID 2300 / PWK02 (Attachment Transmission Code) FX (By Fax) Use when paper attachments are sent by fax.
CR 1471	Simplify the PWK segment situational rules across all 837 guides and modify the PWK02 Code notes to allow codes, AA, EL, & FT for paper attachments.
Location	X323 | Health Care Claim: Professional | 837 | 1600 | 2300 CN1 - Contract Information
Action	**Modify Segment Situational Rule** Changed to: Required when the submitter is contractually obligated to supply this information on post-adjudicated claims. If not required by this implementation guide, do not send.
CR 995	Revise the CN1 situational rule for clarification. The current wording implies the CN1 segment is created by providers.
Location	X323 | Health Care Claim: Professional | 837 | 1600 | 2300 CN1 - Contract Information
Action	**Add Segment Note** This segment is not completed by providers.

CR 1153	To clarify intended use.

Location	X323 | Health Care Claim: Professional | 837 | 1600 | 2300 CN1 - Contract Information
Action	**Add Data Element Code Value** Loop ID 2300 / CN101 (Contract Type Code) LM (Legislative Mandated Rate Structure)
CR 1250	Add the ability to identify special rate structures related to a Federal/State mandate.

Location	X323 | Health Care Claim: Professional | 837 | 1600 | 2300 CN1 - Contract Information
Action	**Add Data Element Code Note** Loop ID 2300 / CN101 (Contract Type Code) LM (Legislative Mandated Rate Structure) Use when contract rate is result of federal or state regulation.
CR 1250	Add the ability to identify special rate structures related to a Federal/State mandate.

Location	X323 | Health Care Claim: Professional | 837 | 1600 | 2300 CN1 - Contract Information
Action	**Modify Data Element Situational Rule** Loop ID 2300 / CN102 - CN106 Changed to: Required when this information is necessary to satisfy contract requirements. If not required by this implementation guide, do not send.
CR 995	Revise the CN1 situational rule for clarification. The current wording implies the CN1 segment is created by providers.

Location	X323 | Health Care Claim: Professional | 837 | 1600 | 2300 CN1 - Contract Information
Action	**Add Data Element Note** Multiple Loops / Multiple Data Elements Data Element 782 (Monetary Amount): The maximum length of this instance of data element 782 is 10.
CR 1013	Add a consistent element note explaining the maximum length to every monetary amount element.

Location	X323 | Health Care Claim: Professional | 837 | 1750 | 2300 AMT - Patient Amount Paid
Action	**Add Data Element Note** Multiple Loops / Multiple Data Elements Data Element 782 (Monetary Amount): The maximum length of this instance of data element 782 is 10.
CR 1013	Add a consistent element note explaining the maximum length to every monetary amount element.

Location	X323 | Health Care Claim: Professional | 837 | 1800 | 2300 REF - Service Authorization Exception Code
Action	**Delete Segment** Loop ID 2300 / REF (SERVICE AUTHORIZATION EXCEPTION CODE)
CR 940	Define a permanent location for Service Authorization Exception Code in the claim.

Location	X323 | Health Care Claim: Professional | 837 | 1800 | 2300 REF - Referral Number
Action	**Add Segment Note** Information in this Loop ID-2300 applies to the entire claim unless overridden on a service line by the presence of Loop ID-2400 with the same value in REF01.
CR 1349	The rules for referral number and referring provider at the claim and line level assume that there is always a referral tied to the entire claim; however it is possible for a referral to be applicable to select service lines but not all the service lines.

Location	X323 | Health Care Claim: Professional | 837 | 1800 | 2300 REF - Referral Number
Action	**Modify Segment Situational Rule** Changed to: Required when a referral number is assigned by the payer or Utilization Management Organization (UMO) and the referral applies to the entire claim. If not required by this implementation guide, do not send.
CR 1349	The rules for referral number and referring provider at the claim and line level assume that there is always a referral tied to the entire claim; however it is possible for a referral to be applicable to select service lines but not all the service lines.

Location	X323 | Health Care Claim: Professional | 837 | 1800 | 2300 REF - Referral Number

Action	**Modify Segment Situational Rule** Changed to: Required when a referral number is assigned by the payer or Utilization Management Organization (UMO). If not required by this implementation guide, do not send.
CR 836	Eliminate redundancy in the situational rule.

Location	X323 | Health Care Claim: Professional | 837 | 1800 | 2300 REF - Prior Authorization
Action	**Modify Segment Situational Rule** Changed to: Required when a prior authorization number is assigned by the payer or Utilization Management Organization (UMO) and the prior authorization applies to the entire claim. If not required by this implementation guide, do not send.
CR 1392	The rules for prior authorization number assume that there is always a prior authorization tied to the entire claim; however it is possible for an authorization to be applicable to select service lines but not all the service lines.

Location	X323 | Health Care Claim: Professional | 837 | 1800 | 2300 REF - Prior Authorization
Action	**Add Segment Note** This segment must not be used to report the Predetermination of Benefits Identification Number.
CR 1153	To clarify intended use.

Location	X323 | Health Care Claim: Professional | 837 | 1800 | 2300 REF - Prior Authorization
Action	**Add Segment Note** When prior authorization is submitted at the claim level (Loop ID-2300) it applies to all the service lines that do not have an overriding REF - Prior Authorization (Loop ID-2400).
CR 1392	The rules for prior authorization number assume that there is always a prior authorization tied to the entire claim; however it is possible for an authorization to be applicable to select service lines but not all the service lines.

Location	X323 | Health Care Claim: Professional | 837 | 1800 | 2300 REF - Repriced Claim Number
Action	**Modify Segment Situational Rule** Changed to: Required when this information is deemed necessary by the repricer. If not required by this implementation guide, do not send.
CR 171	Move the informational text in the situational rule to a segment note.

Location	X323 | Health Care Claim: Professional | 837 | 1800 | 2300 REF - Repriced Claim Number
Action	**Add Segment Note** This segment is not completed by providers. The information is completed by repricers only.
CR 171	Move the informational text in the situational rule to a segment note.

Location	X323 | Health Care Claim: Professional | 837 | 1800 | 2300 REF - Adjusted Repriced Claim Number
Action	**Modify Segment Situational Rule** Changed to: Required when this information is deemed necessary by the repricer. If not required by this implementation guide, do not send.
CR 171	Move the informational text in the situational rule to a segment note.

Location	X323 | Health Care Claim: Professional | 837 | 1800 | 2300 REF - Adjusted Repriced Claim Number
Action	**Add Segment Note** This segment is not completed by providers. The information is completed by repricers only.
CR 171	Move the informational text in the situational rule to a segment note.

Location	X323 | Health Care Claim: Professional | 837 | 1800 | 2300 REF - Investigational Device Exemption Number
Action	**Modify Segment Situational Rule** Changed to: Required when claim involves a Food and Drug Administration (FDA) assigned investigational device exemption (IDE) number. If not required by this implementation guide, do not send.
CR 173	Clarify the reporting of multiple IDE numbers when they apply to a claim.

Location	X323 | Health Care Claim: Professional | 837 | 1800 | 2300 REF - Investigational Device Exemption Number
Action	**Add Segment Note** When more than one IDE applies, they must be split into separate claims.
CR 173	Clarify the reporting of multiple IDE numbers when they apply to a claim.

Location	X323 | Health Care Claim: Professional | 837 | 1800 | 2300 REF - Claim Identifier For Transmission Intermediaries
Action	**Modify Segment Situational Rule** Changed to: Required when this information is deemed necessary by transmission intermediaries (clearinghouses and others) who need to attach their own

	unique claim number. If not required by this implementation guide, do not send.
CR 1153	To clarify intended use.

Location	X323 | Health Care Claim: Professional | 837 | 1800 | 2300 REF - Claim Identifier For Transmission Intermediaries
Action	**Modify Segment Note** Changed to: This segment is not used in Payer-to-Payer Coordination of Benefits (COB).
CR 311	Change the Clearinghouse/Vendor Identification Number usage to required so transactions flow properly between trading partners.

Location	X323 | Health Care Claim: Professional | 837 | 1800 | 2300 REF - Claim Identifier For Transmission Intermediaries
Action	**Delete Data Element Note** Loop ID 2300 / REF (Claim Identifier for Transaction Intermediaries) Removed: The value carried in this element is limited to a maximum of 20 positions.
CR 832	6020 Public Review Comment received to remove the 20 character limit on the REF02

Location	X323 | Health Care Claim: Professional REF - Property & Casualty State of Claim Jurisdiction
Action	**Add Segment** Loop ID 2300 / REF (PROPERTY & CASUALTY STATE OF CLAIM JURISDICTION)
CR 1343	Add a new 2300 REF segment to all 837 guides to support reporting the State of Claim Jurisdiction.

Location	X323 | Health Care Claim: Professional | 837 | 1850 | 2300 K3 - File Information
Action	**Modify Segment Situational Rule** Changed to: Required when ASC X12N has reviewed and approved the data requirements of a regulatory/legislative authority for use of the K3 Segment and has concluded that there is no current method to meet the requirement. (See Section 1.4.6.1 for obtaining ASC X12N approval). If not required by this implementation guide, do not send.
CR 1384	Establish consistent procedures for handling requests for K3 usage across TR3s.

Location	X323 | Health Care Claim: Professional | 837 | 1850 | 2300 K3 - File Information
Action	**Modify Segment Note** Changed to: The K3 segment is used only when necessary to meet the unexpected data requirement of a regulatory/legislative authority. Before this segment can be used: - ASC X12N must conclude there is no other available option in the implementation guide to meet the emergency regulatory/legislative requirement. - The requester must submit a change request accompanied by the relevant business documentation and receive approval for the request. Upon review of the request, ASC X12N will issue an approval or denial decision to the requesting entity. Approved usage(s) of the K3 Segment will be reviewed by the applicable ASC X12N work group to develop a permanent change to include the business case in future transaction implementations.
CR 1384	Establish consistent procedures for handling requests for K3 usage across TR3s.

Location	X323 | Health Care Claim: Professional | 837 | 1850 | 2300 K3 - File Information
Action	**Delete Segment Note** X12N will submit the necessary data maintenance and refer the request to the appropriate data content committee(s).
CR 1384	Establish consistent procedures for handling requests for K3 usage across TR3s.

Location	X323 | Health Care Claim: Professional | 837 | 1950 | 2300 CR1 - Ambulance Transport Information
Action	**Modify Segment Note** Changed to: The CR1 segment at the claim level (Loop ID-2300) applies to the entire claim unless overridden by a CR1 segment at the service line (Loop ID-2400).
CR 1448	Clarify use of the CR1 segment for Ambulance Transport Service at the claim and service line. Related to RFI 1951.

Location	X323 | Health Care Claim: Professional | 837 | 1950 | 2300 CR1 - Ambulance Transport Information
Action	**Modify Data Element Code Note** Loop ID 2300 / CR104 (Ambulance Transport Reason Code)

	A (Patient was transported to nearest facility for care of symptoms, complaints or both) Changed to: Use when reporting the patient was transferred to the nearest facility for care or treatment or when transporting to a residential facility.
CR 1558	Format code notes consistently.
Location	X323 | Health Care Claim: Professional | 837 | 1950 | 2300 CR1 - Ambulance Transport Information
Action	**Add Data Element Note** Loop ID 2300 / CR106 (Transport Distance) When a decimal is used, the maximum number of digits allowed to the right of the decimal is three. Note: When a decimal is needed to report units, include it in this element, for example, "15.6".
CR 804	For consistency, add a note regarding the use of decimals in CR106 (Transport Distance).
Location	X323 | Health Care Claim: Professional | 837 | 2200 | 2300 CRC - Ambulance Certification
Action	**Modify Segment Situational Rule** Changed to: Required when the claim involves ambulance transport services AND any of the condition codes listed in CRC03 apply. If not required by this implementation guide, do not send.
CR 805	Revise the situational rule to reflect a clear condition.
Location	X323 | Health Care Claim: Professional | 837 | 2200 | 2300 CRC - Homebound Indicator
Action	**Add Data Element Code Value** Loop ID 2300 / CRC02 (Certification Condition Indicator) N (No)
CR 806	Revise the DE 1073 Y/N indicator for consistency.
Location	X323 | Health Care Claim: Professional | 837 | 2200 | 2300 CRC - EPSDT Screening Service and Referral Information

Action	**Modify Segment Name** CRC (EPSDT REFERRAL) Changed to: EPSDT SCREENING SERVICE AND REFERRAL INFORMATION
CR 1058	Revise the EPSDT Referral segment name based on the situational rule wording.
Location	X323 | Health Care Claim: Professional | 837 | 2200 | 2300 CRC - EPSDT Screening Service and Referral Information
Action	**Modify Data Element Code Value** Loop ID 2300 / CRC01 (Code Qualifier) Changed to: EP (Early & Periodic Screening, Diagnosis and Treatment (EPSDT) Claim)
CR 951	Create an explicit code value to replace the ZZ (mutually defined) being used as a workaround for EPSDT Referral.
Location	X323 | Health Care Claim: Professional | 837 | 2200 | 2300 CRC - EPSDT Screening Service and Referral Information
Action	**Delete Data Element Code Note** Loop ID 2300 / CRC02 (Yes/No Condition or Response Code) N (No) Removed: If no, then choose "NU" in CRC03 indicating no referral given.
CR 1558	Format code notes consistently.
Location	X323 | Health Care Claim: Professional | 837 | 2310 | 2300 HI - Health Care Diagnosis Code
Action	**Modify Segment Repeat** Changed to: 2
CR 997	Increase the number of diagnosis codes allowed on professional claims based on payer requirements.
Location	X323 | Health Care Claim: Professional | 837 | 2310 | 2300 HI - Health Care Diagnosis Code
Action	**Add Segment Note** There are 2 repetitions of the HI segment to allow for 24 possible occurrences of ICD Diagnosis code information. The first iteration would contain diagnosis code 1-12. When used, the second iteration would contain diagnosis codes 13-24.

CR 997	Increase the number of diagnosis codes allowed on professional claims based on payer requirements.
Location	X323 | Health Care Claim: Professional | 837 | 2310 | 2300 HI - Health Care Diagnosis Code
Action	**Delete Data Element Note** "The diagnosis listed in this element is assumed to be the principal diagnosis."
CR 495	Remove the principal diagnosis qualifier as the dx pointer at the line level dictates which claim dx is principal for that specific line.
Location	X323 | Health Care Claim: Professional | 837 | 2310 | 2300 HI - Health Care Diagnosis Code
Action	**Delete Data Element Note** Removed HI01 element note to be consistent across guides.
CR 1379	For consistency across all guides.
Location	X323 | Health Care Claim: Professional | 837 | 2310 | 2300 HI - Health Care Diagnosis Code
Action	**Modify Data Element Code Value** Loop ID 2300 / HI01-01 (Code List Qualifier Code) Changed to: ABF (International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis) BF (International Classification of Diseases Clinical Modification (ICD-9-CM) Diagnosis)
CR 495	Remove the principal diagnosis qualifier as the dx pointer at the line level dictates which claim dx is principal for that specific line.
Location	X323 | Health Care Claim: Professional | 837 | 2310 | 2300 HI - Anesthesia Related Procedure
Action	**Modify Segment Situational Rule** Changed to: Required when anesthesia services are being reported on the claim, AND provider knows the surgical code, AND the provider knows the adjudication of the claim will depend on provision of the surgical code.

	If not required by this implementation guide, do not send.
CR 220	2300 HI - Change the situational rule to support predeterminations.
Location	X323 | Health Care Claim: Professional | 837 | 2310 | 2300 HI - Condition Information
Action	**Modify Segment Repeat** Changed to: 1
CR 1205	Modify the repeat count to match the number of qualifiers available for use.
Location	X323 | Health Care Claim: Professional | 837 | 2410 | 2300 HCP - Claim Pricing/Repricing Information
Action	**Modify Segment Situational Rule** Changed to: Required when this information is deemed necessary by the repricer. If not required by this implementation guide, do not send.
CR 171	Move the informational text in the situational rule to a segment note.
Location	X323 | Health Care Claim: Professional | 837 | 2410 | 2300 HCP - Claim Pricing/Repricing Information
Action	**Add Segment Note** This segment is not completed by providers. The information is completed by repricers only.
CR 171	Move the informational text in the situational rule to a segment note.
Location	X323 | Health Care Claim: Professional | 837 | 2410 | 2300 HCP - Claim Pricing/Repricing Information
Action	**Add Data Element Note** Multiple Loops / Multiple Data Elements Data Element 782 (Monetary Amount): The maximum length of this instance of data element 782 is 10.
CR 1013	Add a consistent element note explaining the maximum length to every monetary amount element.
Location	X323 | Health Care Claim: Professional | 837 | 2410 | 2300 HCP - Claim Pricing/Repricing Information
Action	**Modify Data Element Usage** Loop ID 2300 / HCP06 (Repriced Approved Ambulatory Patient Group Code) Changed to: NOT USED

CR 816	APG codes are identified at the line level. This element usage should be Not Used at the claim level.
Location	X323 | Health Care Claim: Professional | 837 | 2410 | 2300 HCP - Claim Pricing/Repricing Information
Action	**Modify Data Element Usage** Loop ID 2300 / HCP07 (Repriced Approved Ambulatory Patient Group Amount) Changed to: NOT USED
CR 816	APG codes are identified at the line level. This element usage should be Not Used at the claim level.
Location	X323 | Health Care Claim: Professional | 837 | 2410 | 2300 HCP - Claim Pricing/Repricing Information
Action	**Delete Data Element Code Value** Loop ID 2300 / HCP13 (Reject Reason Code) Removed: T2 - Cannot Identify Payer as TPO (Third Party Organization) Participant T3 - Cannot Identify Insured as TPO (Third Party Organization) Participant T4 - Payer Name or Identifier Missing T5 - Certification Information Missing
CR 313	Remove the T2-T5 values, which are no longer used in the industry.
Location	X323 | Health Care Claim: Professional | 837 | 2500 | 2310A NM1 - Referring Provider Name
Action	**Modify Data Element Situational Rule** Multiple Loops / NM109 (Identification Code) Changed to: Required when the provider has received an NPI and the NPI is available to the submitter. If not required by this implementation guide, do not send.
CR 177	Change the situational rule in all locations to reflect that the NPI is now in effect.
Location	X323 | Health Care Claim: Professional | 837 | 2500 | 2310A NM1 - Referring Provider Name
Action	**Delete Data Element Code Note** Loop ID 2310A / NM101 Entity Identifier Code) DN (Referring Provider) Use if loop is used only once.

CR 884	Current note causes conflict of code value usage.
Location	X323 | Health Care Claim: Professional | 837 | 2500 | 2310A NM1 - Referring Provider Name
Action	**Delete Data Element Code Note** Loop ID 2310A / NM101 (Entity Identifier Code) P3 (Primary Care Provider) Use only if loop is used twice.
CR 884	Current note causes conflict of code value usage.
Location	X323 | Health Care Claim: Professional | 837 | 2710 | 2310A REF - Referring Provider Secondary Identification
Action	**Modify Segment Repeat** Changed to: 1
CR 1205	Modify the repeat count to match the number of qualifiers available for use.
Location	X323 | Health Care Claim: Professional | 837 | 2710 | 2310A REF - Referring Provider Secondary Identification
Action	**Modify Segment Situational Rule** Changed to: Required when NM109 of this loop is not used and an identifier is necessary for the receiver to identify the provider. If not required by this implementation guide, do not send.
CR 175	Change the shared situational rule in all locations to reflect that the NPI is now in effect.
Location	X323 | Health Care Claim: Professional | 837 | 2710 | 2310A REF - Referring Provider Secondary Identification
Action	**Modify Data Element Code Value** Loop ID 2310A / REF01 (Reference Identification Qualifier) Changed G2 (Commercial Number) to A6 (Provider Identifier)
CR 497	Remove REF Segment qualifier G2 and add A6 to better accommodate atypical providers.
Location	X323 | Health Care Claim: Professional | 837 | 2710 | 2310A REF - Referring Provider Secondary Identification
Action	**Delete Data Element Code Value** 1G Provider UPIN Number
CR 326	Delete the UPIN qualifer on Provider segments across the TR3s.

Location	X323 | Health Care Claim: Professional | 837 | 2500 | 2310B NM1 - Rendering Provider Name
Action	**Modify Data Element Situational Rule** Loop ID 2310B / NM104 (Rendering Provider First Name) Changed to: Required when the person has a first name. If not required by this implementation guide, do not send.
CR 1135	Ensure consistency between the NUCC rendering provider definition & TR3 instructions.

Location	X323 | Health Care Claim: Professional | 837 | 2500 | 2310B NM1 - Rendering Provider Name
Action	**Modify Data Element Situational Rule** Loop ID 2310B / (Rendering Provider Middle Name or Initial) Changed to: Required when the middle name or initial of the person is needed to identify the individual. If not required by this implementation guide, do not send.
CR 1135	Ensure consistency between the NUCC rendering provider definition & TR3 instructions.

Location	X323 | Health Care Claim: Professional | 837 | 2500 | 2310B NM1 - Rendering Provider Name
Action	**Delete Data Element Code Value** Loop ID 2310B / NM102 (Entity Type Qualifier) 2 (Non-Person Entity)
CR 1135	Ensure consistency between the NUCC rendering provider definition & TR3 instructions.

Location	X323 | Health Care Claim: Professional | 837 | 2500 | 2310B NM1 - Rendering Provider Name
Action	**Modify Data Element Situational Rule** Loop ID 2010BA / NM107 (Subscriber Name Suffix) Changed to: Required when the name suffix is needed to identify the individual. If not required by this implementation guide, do not send.
CR 1154	For consistency across all TR3s.

Location	X323 | Health Care Claim: Professional | 837 | 2710 | 2310B REF - Rendering Provider Secondary Identification

Action	**Modify Segment Repeat** Changed to: 2
CR 1205	Modify the repeat count to match the number of qualifiers available for use.

Location	X323 | Health Care Claim: Professional | 837 | 2710 | 2310B REF - Rendering Provider Secondary Identification
Action	**Modify Segment Situational Rule** Changed to: Required when NM109 of this loop is not used and an identifier is necessary for the receiver to identify the provider. If not required by this implementation guide, do not send.
CR 175	Change the shared situational rule in all locations to reflect that the NPI is now in effect.

Location	X323 | Health Care Claim: Professional | 837 | 2710 | 2310B REF - Rendering Provider Secondary Identification
Action	**Modify Data Element Code Value** Loop ID 2310B / REF01 (Reference Identification Qualifier) Changed G2 (Commercial Number) to A6 (Provider Identifier)
CR 497	Remove REF Segment qualifier G2 and add A6 to better accommodate atypical providers.

Location	X323 | Health Care Claim: Professional | 837 | 2710 | 2310B REF - Rendering Provider Secondary Identification
Action	**Delete Data Element Code Value** 1G Provider UPIN Number
CR 326	Delete the UPIN qualifer on Provider segments across the TR3s.

Location	X323 | Health Care Claim: Professional | 837 | 2500 | 2310C NM1 - Service Location Name
Action	**Modify Segment Name** NM1 (SERVICE FACILITY LOCATION NAME) Changed to: SERVICE LOCATION NAME
CR 889	The data in this loop is related to the "Service Location" (which could be a service facility, patient's home, provider secondary office location). Request the name of this loop be changed to 'Service Location' across the TR3s so that the name matches the data content and is consistent.

Location	X323 | Health Care Claim: Professional | 837 | 2500 | 2310C NM1 - Service Location Name

Action	**Modify Segment Situational Rule** Changed to: Required when the name and/or the address of Service Location is different than that carried in Loop ID-2010AA (Billing Provider) AND the Service Location is not a subpart of the Billing Provider with its own NPI that is different than the NPI reported in Loop ID-2010AA NM109. If not required by this implementation guide, do not send.
CR 889	The data in this loop is related to the "Service Location" (which could be a service facility, patient's home, provider secondary office location). Request the name of this loop be changed to 'Service Location' across the TR3s so that the name matches the data content and is consistent.
Location	X323 | Health Care Claim: Professional | 837 | 2500 | 2310C NM1 - Service Location Name
Action	**Modify Segment Note** Changed to: The purpose of this loop is to identify specifically where the service is rendered. Examples include, but are not limited to, remote clinics, patient's residence, a residence (when patient doesn't live there but visiting for example), external facilities, etc. When reporting ambulance services, do not use this loop. Use Loop ID-2310E - Ambulance Pick-up Location and Loop ID-2310F - Ambulance Drop-off Location.
CR 1153	To clarify intended use.
Location	X323 | Health Care Claim: Professional | 837 | 2500 | 2310C NM1 - Service Location Name
Action	**Modify Data Element Usage** Loop ID 2310C / NM103 (Service Location Name) Changed to: SITUATIONAL
CR 888	Consider changing the NM103 element requirement from "required" to "situational". The name is not needed for all situations, e.g. when the services are performed in the patient's home.
Location	X323 | Health Care Claim: Professional | 837 | 2500 | 2310C NM1 - Service Location Name
Action	**Add Data Element Situational Rule** Loop ID 2310C / NM103 (Service Location Name) Required when the Service Location is a organization health care provider who is external to the entity identified as the Billing Provider in Loop

	ID-2010AA. If not required by this implementation guide, do not send.
CR 888	Consider changing the NM103 element requirement from "required" to "situational". The name is not needed for all situations, e.g. when the services are performed in the patient's home.
Location	X323 | Health Care Claim: Professional | 837 | 2650 | 2310C N3 - Service Location Address
Action	**Modify Segment Name** N3 (SERVICE FACILITY LOCATION ADDRESS) Changed to: SERVICE LOCATION ADDRESS
CR 889	The data in this loop is related to the "Service Location" (which could be a service facility, patient's home, provider secondary office location). Request the name of this loop be changed to 'Service Location' across the TR3s so that the name matches the data content and is consistent.
Location	X323 | Health Care Claim: Professional | 837 | 2650 | 2310C N3 - Service Location Address
Action	**Modify Segment Note** Changed to: If service location is in an area where there are no street addresses, enter a description of the location (for example, "crossroad of State Road 34 and 45" or "Exit near Mile marker 265 on Interstate 80").
CR 210	Revise the note to include predeterminations.
Location	X323 | Health Care Claim: Professional | 837 | 2700 | 2310C N4 - Service Location City, State, ZIP Code
Action	**Modify Segment Name** N4 (SERVICE FACILITY LOCATION CITY, STATE, ZIP CODE) Changed to: SERVICE LOCATION CITY, STATE, ZIP CODE
CR 889	The data in this loop is related to the "Service Location" (which could be a service facility, patient's home, provider secondary office location). Request the name of this loop be changed to 'Service Location' across the TR3s so that the name matches the data content and is consistent.
Location	X323 | Health Care Claim: Professional | 837 | 2700 | 2310C N4 - Service Location City, State, ZIP Code
Action	**Modify Data Element Note** Multiple Locations / N403 (Postal Code) Changed to: When reporting the ZIP code for U.S. addresses, the full nine digit ZIP code

	must be provided when one exists.
CR 760	Remove the restrictive requirement for a 9 digit ZIP code in N403.

Location	X323 | Health Care Claim: Professional | 837 | 2710 | 2310C REF - Service Location Secondary Identification
Action	**Modify Segment Name** REF (SERVICE FACILITY LOCATION SECONDARY IDENTIFICATION) Changed to: SERVICE LOCATION SECONDARY IDENTIFICATION
CR 889	The data in this loop is related to the "Service Location" (which could be a service facility, patient's home, provider secondary office location). Request the name of this loop be changed to 'Service Location' across the TR3s so that the name matches the data content and is consistent.

Location	X323 | Health Care Claim: Professional | 837 | 2710 | 2310C REF - Service Location Secondary Identification
Action	**Modify Segment Repeat** Changed to: 2
CR 1205	Modify the repeat count to match the number of qualifiers available for use.

Location	X323 | Health Care Claim: Professional | 837 | 2710 | 2310C REF - Service Location Secondary Identification
Action	**Modify Segment Situational Rule** Changed to: Required when NM109 of this loop is not used and an identifier is necessary for the receiver to identify the provider. If not required by this implementation guide, do not send.
CR 175	Change the shared situational rule in all locations to reflect that the NPI is now in effect.

Location	X323 | Health Care Claim: Professional | 837 | 2710 | 2310C REF - Service Location Secondary Identification
Action	**Modify Segment Situational Rule** Changed to: Required when NM109 of this loop is not used, AND the Billing Provider Loop ID-2010AA NM109 is not used, AND an identifier is necessary for the receiver to identify the provider.

	If not required by this implementation guide, do not send.
CR 891	Request the situational rule be revised since proprietary identifiers are only allowed for atypical providers.
Location	X323 | Health Care Claim: Professional | 837 | 2710 | 2310C REF - Service Location Secondary Identification
Action	**Modify Data Element Code Value** Loop ID 2310C / REF01 (Reference Identification Qualifier) Changed G2 (Commercial Number) to A6 (Provider Identifier)
CR 497	Remove REF Segment qualifier G2 and add A6 to better accommodate atypical providers.
Location	X323 | Health Care Claim: Professional | 837 | 2500 | 2310D NM1 - Supervising Provider Name
Action	**Modify Segment Note** changed to: See NUCC Manual for definition of professional providers.
CR 90	Provider definitions should be removed from the TR3s and replaced with references to the NUBC/NUCC information. This insures alignment and prevents future TR3 modifications if NUBC/NUCC change the definitions.
Location	X323 | Health Care Claim: Professional | 837 | 2500 | 2310D NM1 - Supervising Provider Name
Action	**Modify Data Element Usage** Loop ID 2310D / NM108 (Identification Code Qualifier) Changed to: REQUIRED
CR 330	Remove the NPI dual use language and change the supervising provider primary identifier requirement, since the supervising provider would have an NPI.
Location	X323 | Health Care Claim: Professional | 837 | 2500 | 2310D NM1 - Supervising Provider Name
Action	**Modify Data Element Usage** Loop ID 2310D / NM109 (Supervising Provider Identifier) Changed to: REQUIRED
CR 330	Remove the NPI dual use language and change the supervising provider primary identifier requirement, since the supervising provider would have an NPI.

Location	X323 | Health Care Claim: Professional | 837 | 2500 | 2310E NM1 - Ambulance Pick-up Location
Action	**Modify Segment Situational Rule** Changed to: Required when submitting a claim for ambulance or non-emergency transportation services and the CR1 segment is present at the claim level (Loop ID-2300). If not required by this implementation guide, do not send.
CR 1523	Modify the situational rule to enable content editing within the transaction.

Location	X323 | Health Care Claim: Professional | 837 | 2500 | 2310F NM1 - Ambulance Drop-off Location
Action	**Modify Segment Situational Rule** Changed to: Required when submitting a claim for ambulance or non-emergency transportation services and the CR1 segment is present at the claim level (Loop ID-2300). If not required by this implementation guide, do not send.
CR 1523	Modify the situational rule to enable content editing within the transaction.

Location	X323 | Health Care Claim: Professional | 837 | 2900 | 2320 SBR - Other Subscriber Information
Action	**Add Segment Note** See Section 1.4.2 for more information on Coordination of Benefits.
CR 1154	For consistency across all TR3s.

Location	X323 | Health Care Claim: Professional | 837 | 2900 | 2320 SBR - Other Subscriber Information
Action	**Delete Segment Note** See Crosswalking COB Data Elements section for more information on handling COB in the 837.
CR 1154	For consistency across all TR3s.

Location	X323 | Health Care Claim: Professional | 837 | 2900 | 2320 SBR - Other Subscriber Information
Action	**Add Data Element Note** Loop ID 2320 / SBR01 (Other Payer Responsibility Sequence Code) When sending Line Adjudication Information for this payer, the identifier sent in SVD01 (Payer Identifier) of Loop ID-2430 (Line Adjudication Information) must match this value when used.
CR 1212	Ensure proper linkage between the Payer Responsibility Sequence Code (SBR01) in Loop ID 2320 and the service line payment information in Loop ID 2430 Payer Responsibility Sequence Code (SVD01).

Location	X323 | Health Care Claim: Professional | 837 | 2900 | 2320 SBR - Other Subscriber Information
Action	**Add Data Element Note** Loop ID 2320 / SBR01 (Other Payer Responsibility Sequence Code) This code value identifies, in the opinion of the submitter, the relative adjudication order of the non-destination payer in this iteration of Loop ID-2320 among all of the payers identified in this claim.
CR 1212	Ensure proper linkage between the Payer Responsibility Sequence Code (SBR01) in Loop ID 2320 and the service line payment information in Loop ID 2430 Payer Responsibility Sequence Code (SVD01).

Location	X323 | Health Care Claim: Professional | 837 | 2900 | 2320 SBR - Other Subscriber Information
Action	**Modify Data Element Situational Rule** Multiple Loops / SBR03 (Subscriber Group or Policy Number) Changed to: Required when the subscriber's identification card shows a group number. OR Required when the subscriber's group number is otherwise gathered (e.g. eligibility inquiry). If not required by this implementation guide, do not send.
CR 30	Modify the situational rule to allow for other methods of gathering the group or policy number.

Location	X323 | Health Care Claim: Professional | 837 | 2900 | 2320 SBR - Other Subscriber Information
Action	**Modify Data Element Situational Rule** Loop ID 2000B and 2320 / SBR04 (Subscriber Group Name) Changed to: Required when the subscriber's identification card shows a group name. OR Required when the subscriber's group name is otherwise gathered (e.g. eligibility inquiry). If not required by this implementation guide, may be provided at the sender's discretion, but cannot be required by the receiver.
CR 1215	Remove restriction on reporting the Group Name.

Location	X323 | Health Care Claim: Professional | 837 | 2900 | 2320 SBR - Other Subscriber Information
Action	**Modify Data Element Situational Rule** Loop ID 2320 / SBR05 (Insurance Type Code)

	Change to: Required when the payer identified in Loop ID-2010BB is Medicare, Medicare is not the primary payer (Loop ID-2000B SBR01 is not P), and the payer identified in this loop is identified as a higher priority payer than Medicare.
CR 47	2000B SBR05 - Change to Not Used as the Insurance Type Code is only needed when Medicare is the non-destination payer and Medicare is not primary.
Location	X323 | Health Care Claim: Professional | 837 | 2900 | 2320 SBR - Other Subscriber Information
Action	**Add Data Element Code Value** Loop ID 2320 / SBR09 (Claim Filing Indicator Code) ME (Medicare Advantage Plan)
CR 941	Support reporting of Medicare Advantage insurance type for health care claims.
Location	X323 | Health Care Claim: Professional | 837 | 2900 | 2320 SBR - Other Subscriber Information
Action	**Add Data Element Code Value** Loop ID 2320 / SBR09 (Claim Filing Indicator Code) UK (Unknown)
CR 942	A permanent code value should be assigned for "Unknown".
Location	X323 | Health Care Claim: Professional | 837 | 2900 | 2320 SBR - Other Subscriber Information
Action	**Modify Data Element Code Note** Multiple Locations / SBR09 (Claim Filing Indicator Code) ZZ (Mutually Defined) Changed to: Use when mutually agreed upon between trading partners.
CR 942	A permanent code value should be assigned for "Unknown".
Location	X323 | Health Care Claim: Professional | 837 | 2900 | 2320 SBR - Other Subscriber Information
Action	**Modify Data Element Situational Rule** Loop ID 2320 / SBR03 (Subscrier Group or Policy Number) Changed to:

	Required when the subscriber's identification card shows a group number. OR Required when the subscriber's group number is otherwise gathered (e.g. eligibility inquiry). If not required by this implementation guide, do not send.
CR 30	Modify the situational rule to allow for other methods of gathering the group or policy number.

Location	X323 | Health Care Claim: Professional | 837 | 2980 | 2320 RAS - Claim Adjustment Information
Action	**Add Segment** Loop ID 2300 / RAS (CLAIM ADJUSTMENT INFORMATION) Replaced: CAS (CLAIM LEVEL ADJUSTMENTS)
CR 105	Inclusion of the RAS segment supports multiple CARCs for a single dollar amount and allows association of remark codes to a specific CARC.

Location	X323 | Health Care Claim: Professional | 837 | 2980 | 2320 RAS - Claim Adjustment Information
Action	**Add Data Element Note** Multiple Loops / Multiple Data Elements Data Element 782 (Monetary Amount): The maximum length of this instance of data element 782 is 10.
CR 1013	Add a consistent element note explaining the maximum length to every monetary amount element.

Location	X323 | Health Care Claim: Professional | 837 | 2980 | 2320 RAS - Claim Adjustment Information
Action	**Delete Data Element Code Value** Loop ID 2320, Data Element RAS02 (Claim Adjustment Group Code) All Code Values were moved to External Code Source 974: Claim Adjustment Group Codes.
CR 678	835 - Make Claim Adjustment Group Code an external list to support flexibility when new codes or revisions are needed to meet changing business or regulatory requirements.

Location	X323 | Health Care Claim: Professional | 837 | 2980 | 2320 RAS - Claim Adjustment Information
Action	**Add Data Element Code Value** Loop ID 2320 / RAS03-02 (Code List Qualifier Code)

	RM (Insurance Industry Specific Remark Codes)
CR 1234	Create new external code list for industry specific remark codes that do not meet the criteria for CARCs or RARCs but are needed by their respective industries.

Location	X323 | Health Care Claim: Professional | 837 | 2980 | 2320 RAS - Claim Adjustment Information
Action	**Delete Data Element Code Value** Loop ID 2320 / RAS03-02 (Code List Qualifier Code) RX (National Council for Prescription Drug Programs Reject/Payment Codes)
CR 1234	Create new external code list for industry specific remark codes that do not meet the criteria for CARCs or RARCs but are needed by their respective industries.

Location	X323 | Health Care Claim: Professional | 837 | 3000 | 2320 AMT - Coordination of Benefits (COB) Payer Paid Amount
Action	**Add Segment Note** When Loop 2010AC is a Medicaid Agency, this amount represents the maximum amount of liability the Medicaid agency is requesting to recover by submitting the subrogation claim.
CR 1545	Support subrogation claims for multiple payer types.

Location	X323 | Health Care Claim: Professional | 837 | 3000 | 2320 AMT - Coordination of Benefits (COB) Payer Paid Amount
Action	**Modify Segment Situational Rule** Changed to: Required when the claim has been adjudicated by the payer identified in Loop ID-2330B of this loop. OR Required when Loop ID-2010AC is present. If not required by this implementation guide, do not send.
CR 1545	Support subrogation claims for multiple payer types.

Location	X323 | Health Care Claim: Professional | 837 | 3000 | 2320 AMT - Coordination of Benefits (COB) Payer Paid Amount
Action	**Add Data Element Note** Multiple Loops / Multiple Data Elements Data Element 782 (Monetary Amount):

	The maximum length of this instance of data element 782 is 10.
CR 1013	Add a consistent element note explaining the maximum length to every monetary amount element.
Location	X323 | Health Care Claim: Professional | 837 | 3000 | 2320 AMT - Coordination of Benefits (COB) Payer Paid Amount
Action	**Delete Data Element Note** Loop ID 2320 / AMT02 (Payer Paid Amount) Removed: When Loop ID-2010AC is present, this is the amount the Medicaid agency actually paid.
CR 1545	Support subrogation claims for multiple payer types.
Location	X323 | Health Care Claim: Professional AMT - Coordination of Benefits (COB) Claim Allowed Amount
Action	**Add Segment** Loop ID 2320 / AMT (COORDINATION OF BENEFITS (COB) ALLOWED AMOUNT)
CR 1230	Provide payers the ability to report the allowed amount for informational purposes for coordination of benefits.
Location	X323 | Health Care Claim: Professional | 837 | 3000 | 2320 AMT - Coordination of Benefits (COB) Total Non-Covered Amount
Action	**Modify Segment Note** Changed to: When this segment is used, the amount reported in AMT02 must equal the total claim charge amount reported in CLM02. Neither the prior payer paid AMT, nor any RAS segments are used as this claim has not been adjudicated by this payer.
CR 105	Inclusion of the RAS segment supports multiple CARCs for a single dollar amount and allows association of remark codes to a specific CARC.
Location	X323 | Health Care Claim: Professional | 837 | 3000 | 2320 AMT - Coordination of Benefits (COB) Total Non-Covered Amount
Action	**Add Data Element Note** Multiple Loops / Multiple Data Elements Data Element 782 (Monetary Amount): The maximum length of this instance of data element 782 is 10.
CR 1013	Add a consistent element note explaining the maximum length to every monetary amount element.

Location	X323 | Health Care Claim: Professional | 837 | 3000 | 2320 AMT - Remaining Patient Liability Amount
Action	**Modify Segment Situational Rule** Changed to: Required on Provider submitted claims, when the Other Payer identified in the Loop ID-2330B (of this iteration of Loop ID-2320) has adjudicated this claim, and provided claim information only, AND in the provider's opinion of the amount billable to the patient is different than the total of the amounts associated with Patient Responsibility (PR) Claim Adjustment Reason Codes in this 2320 loop. If not required by this implementation guide, may be provided at the sender's discretion, but cannot be required by the receiver.
CR 1321	Modify the situational rule to clarify the intended use of the Remaining Patient Liability AMT Segment.

Location	X323 | Health Care Claim: Professional | 837 | 3000 | 2320 AMT - Remaining Patient Liability Amount
Action	**Modify Segment Note** Changed to: In the judgment of the provider, this is the remaining amount to be paid after adjudication by the Other Payer identified in Loop ID-2330B "of this iteration of Loop ID-2320". The amount reported here may, or may not, equal the sum of the amounts reported as Patient Responsible (PR) in the RAS segments.
CR 837	Add a new TR3 note to make it clear this amount is not directly related to the PR amounts in the CAS segments.

Location	X323 | Health Care Claim: Professional | 837 | 3000 | 2320 AMT - Remaining Patient Liability Amount
Action	**Add Data Element Note** Multiple Loops / Multiple Data Elements Data Element 782 (Monetary Amount): The maximum length of this instance of data element 782 is 10.
CR 1013	Add a consistent element note explaining the maximum length to every monetary amount element.

Location	X323 | Health Care Claim: Professional | 837 | 3100 | 2320 OI - Other Insurance Coverage Information
Action	**Modify Data Element Usage** Loop ID 2320 / OI04 (Patient Signature Source Code)

	Changed to: NOT USED
CR 840	OI04 is not a payer specific indicator. The CLM10 indicator covers the entire claim. The same is true for OI06.
Location	X323 | Health Care Claim: Professional | 837 | 3100 | 2320 OI - Other Insurance Coverage Information
Action	**Modify Data Element Usage** Loop ID 2320 / OI06 (Release of Information Code) Changed to: NOT USED
CR 840	OI04 is not a payer specific indicator. The CLM10 indicator covers the entire claim. The same is true for OI06.
Location	X323 | Health Care Claim: Professional | 837 | 3100 | 2320 OI - Other Insurance Coverage Information
Action	**Add Data Element** Loop ID 2320 / OI07 (Provider Accepts Assignment Code) Usage = SITUATIONAL Required when the other payer reported in this 2320 loop is Medicare, including Medicare Fee For Service (FFS) or a Medicare Advantage Plan (Medicare Part C). If not required by this implementation guide, do not send.
CR 753	Support the ability for COB claims to forward a different value than what was originally submitted by the Provider.
Location	X323 | Health Care Claim: Professional | 837 | 3100 | 2320 OI - Other Insurance Coverage Information
Action	**Add Data Element Code Value** Loop ID 2320 / OI07 (Provider Accept Assignment Code) A - Assigned B - Assignment Accepted on Clinical Lab Services Only C - Not Assigned
CR 753	Support the ability for COB claims to forward a different value than what was originally submitted by the Provider.
Location	X323 | Health Care Claim: Professional | 837 | 3100 | 2320 OI - Other Insurance Coverage Information
Action	**Add Data Element Code Note** Loop ID 2320 / OI01 (Provider Accept Assignment Code) A (Assigned)

	B (Assignment Accepted on Clinical Lab Services Only) Use when the claim was processed as assigned.
CR 753	Support the ability for COB claims to forward a different value than what was originally submitted by the Provider.
Location	X323 | Health Care Claim: Professional | 837 | 3100 | 2320 OI - Other Insurance Coverage Information
Action	**Add Data Element Code Note** Loop ID 2320 / OI01 (Provider Accept Assignment Code) C (Not Assigned) Use when the claim was processed as non-assigned.
CR 753	Support the ability for COB claims to forward a different value than what was originally submitted by the Provider.
Location	X323 | Health Care Claim: Professional | 837 | 3100 | 2320 OI - Other Insurance Coverage Information
Action	**Add Data Element Code Note** Loop ID 2320 / OI07 (Provider Accept Assignment Code) A (Assigned) B (Assignment Accepted on Clinical Lab Services Only) Use when the claim was processed as assigned.
CR 753	Support the ability for COB claims to forward a different value than what was originally submitted by the Provider.
Location	X323 | Health Care Claim: Professional | 837 | 3100 | 2320 OI - Other Insurance Coverage Information
Action	**Add Data Element Note** Loop ID 2320 / OI07 (Provider Accept Assignment Code) For payer to payer COB claims, this code indicates how the claim was adjudicated by the previous payer, which may be different than the assignment/participation indicator submitted on the original claim.
CR 753	Support the ability for COB claims to forward a different value than what was originally submitted by the Provider.
Location	X323 | Health Care Claim: Professional | 837 | 3100 | 2320 OI - Other Insurance Coverage Information

Action	**Add Data Element** Loop ID 2320 / OI08 (Other Payer Claim Adjustment Indicator) Usage = REQUIRED
CR 994	Move the Other Payer Claim Adjustment Indicator to another segment within the transaction set.
Location	X323 | Health Care Claim: Professional | 837 | 3100 | 2320 OI - Other Insurance Coverage Information
Action	**Add Data Element** Loop ID 2320 / OI10 (Other Payer Voided Claim Indicator) Usage = REQUIRED
CR 994	Move the Other Payer Claim Adjustment Indicator to another segment within the transaction set.
Location	X323 | Health Care Claim: Professional | 837 | 3100 | 2320 OI - Other Insurance Coverage Information
Action	**Add Data Element Code Value** Loop ID 2320 / OI10 (Other Payer Voided Claim Indicator) Y (Yes) N (No)
CR 994	Move the Other Payer Claim Adjustment Indicator to another segment within the transaction set.
Location	X323 | Health Care Claim: Professional | 837 | 3200 | 2320 MOA - Outpatient Adjudication Information
Action	**Delete Segment Note** Removed: Remark codes from a paper remittance advice are reported in this Segment.
CR 1234	Create new external code list for industry specific remark codes that do not meet the criteria for CARCs or RARCs but are needed by their respective industries.
Location	X323 | Health Care Claim: Professional | 837 | 3200 | 2320 MOA - Outpatient Adjudication Information
Action	**Modify Segment Situational Rule** Changed to: Required when outpatient adjudication information is reported in the remittance advice. If not required by this implementation guide, do not send.

CR 839	The segment situation rule has an OR component that is not reflected in the element's situational rules. This could result in a requirement for a segment with no elements.
Location	X323 | Health Care Claim: Professional | 837 | 3200 | 2320 MOA - Outpatient Adjudication Information
Action	**Add Data Element Note** Multiple Loops / Multiple Data Elements Data Element 782 (Monetary Amount): The maximum length of this instance of data element 782 is 10.
CR 1013	Add a consistent element note explaining the maximum length to every monetary amount element.
Location	X323 | Health Care Claim: Professional | 837 | 3200 | 2320 MOA - Outpatient Adjudication Information
Action	**Modify Data Element Usage** Loop ID 2320 / MOA03 (Claim Payment Remark Code) Changed to: NOT USED
CR 1234	Create new external code list for industry specific remark codes that do not meet the criteria for CARCs or RARCs but are needed by their respective industries.
Location	X323 | Health Care Claim: Professional | 837 | 3200 | 2320 MOA - Outpatient Adjudication Information
Action	**Modify Data Element Usage** Loop ID 2320 / MOA04 (Claim Payment Remark Code) Changed to: NOT USED
CR 1234	Create new external code list for industry specific remark codes that do not meet the criteria for CARCs or RARCs but are needed by their respective industries.
Location	X323 | Health Care Claim: Professional | 837 | 3200 | 2320 MOA - Outpatient Adjudication Information
Action	**Modify Data Element Usage** Loop ID 2320 / MOA05 (Claim Payment Remark Code) Changed to: NOT USED
CR 1234	Create new external code list for industry specific remark codes that do not meet the criteria for CARCs or RARCs but are needed by their respective

industries.

Location	X323 | Health Care Claim: Professional | 837 | 3200 | 2320 MOA - Outpatient Adjudication Information
Action	**Modify Data Element Usage** Loop ID 2320 / MOA06 (Claim Payment Remark Code) Changed to: NOT USED
CR 1234	Create new external code list for industry specific remark codes that do not meet the criteria for CARCs or RARCs but are needed by their respective industries.

Location	X323 | Health Care Claim: Professional | 837 | 3200 | 2320 MOA - Outpatient Adjudication Information
Action	**Modify Data Element Usage** Loop ID 2320 / MOA07 (Claim Payment Remark Code) Changed to: NOT USED
CR 1234	Create new external code list for industry specific remark codes that do not meet the criteria for CARCs or RARCs but are needed by their respective industries.

Location	X323 | Health Care Claim: Professional | 837 | 3225 | 2320 HI - Health Care Information Codes
Action	**Add Data Element Note** Multiple Loops / Multiple Data Elements Data Element 782 (Monetary Amount): The maximum length of this instance of data element 782 is 10.
CR 1013	Add a consistent element note explaining the maximum length to every monetary amount element.

Location	X323 | Health Care Claim: Professional | 837 | 3230 | 2320 LQ - Health Care Remark Codes
Action	**Add Segment** Loop ID 2320 / LQ (HEALTH CARE REMARK CODES)
CR 1234	Create new external code list for industry specific remark codes that do not meet the criteria for CARCs or RARCs but are needed by their respective industries.

Location	X323 | Health Care Claim: Professional | 837 | 3250 | 2330A NM1 - Other Subscriber Name

Action	**Add Segment Note** See Section 1.4.2 for more information on Coordination of Benefits.
CR 1154	For consistency across all TR3s.

Location	X323 | Health Care Claim: Professional | 837 | 3250 | 2330A NM1 - Other Subscriber Name
Action	**Delete Segment Note** See Crosswalking COB Data Elements section for more information on handling COB in the 837.
CR 1154	For consistency across all TR3s.

Location	X323 | Health Care Claim: Professional | 837 | 3250 | 2330A NM1 - Other Subscriber Name
Action	**Modify Data Element Situational Rule** Loop ID 2010BA / NM107 (Subscriber Name Suffix) Changed to: Required when the name suffix is needed to identify the individual. If not required by this implementation guide, do not send.
CR 1154	For consistency across all TR3s.

Location	X323 | Health Care Claim: Professional | 837 | 3400 | 2330A N4 - Other Subscriber City, State, ZIP Code
Action	**Modify Segment Situational Rule** Changed to: Required when the information is available and Loop ID-2330A N3 Segment is sent in this iteration of Loop ID-2320. If not required by this implementation guide, do not send.
CR 993	Ensure a complete address in transmitted in the Other Subscriber loop.

Location	X323 | Health Care Claim: Professional | 837 | 3550 | 2330A REF - Other Subscriber Social Security Number
Action	**Modify Segment Name** REF (OTHER SUBSCRIBER SECONDARY IDENTIFICATION) Changed to: OTHER SUBSCRIBER SOCIAL SECURITY NUMBER
CR 1155	For consistency across all guides.

Location	X323 | Health Care Claim: Professional | 837 | 3250 | 2330B NM1 - Other Payer Name
Action	**Add Segment Note** See Section 1.4.2 for more information on Coordination of Benefits.

CR 1154	For consistency across all TR3s.

Location	X323 | Health Care Claim: Professional | 837 | 3250 | 2330B NM1 - Other Payer Name
Action	**Delete Segment Note** See Crosswalking COB Data Elements section for more information on handling COB in the 837.
CR 1154	For consistency across all TR3s.

Location	X323 | Health Care Claim: Professional | 837 | 3250 | 2330B NM1 - Other Payer Name
Action	**Modify Data Element Usage** Loop ID 2330B / NM108 (Identification Code Qualifier) Changed to: SITUATIONAL
CR 693	Revise National Plan ID (PIDR) references in 2010AC (PID), 2010BB and 2330B NM108 to align with the Health Plan Identifier regulation.

Location	X323 | Health Care Claim: Professional | 837 | 3250 | 2330B NM1 - Other Payer Name
Action	**Modify Data Element Usage** Loop ID 2330B / NM109 (Other Payer Primary Identifier) Changed to: SITUATIONAL
CR 693	Revise National Plan ID (PIDR) references in 2010AC (PID), 2010BB and 2330B NM108 to align with the Health Plan Identifier regulation.

Location	X323 | Health Care Claim: Professional | 837 | 3250 | 2330B NM1 - Other Payer Name
Action	**Modify Data Element Situational Rule** Multiple Loops / NM109 (Identification Code) Changed to: Required when reporting the Health Plan ID (HPID) or Other Entity Identifier (OEID). If not required by this implementation guide, do not send.
CR 693	Revise National Plan ID (PIDR) references in 2010AC (PID), 2010BB and 2330B NM108 to align with the Health Plan Identifier regulation.

Location	X323 | Health Care Claim: Professional | 837 | 3250 | 2330B NM1 - Other Payer Name
Action	**Delete Data Element Note** Loop ID 2330B / NM109 (Other Payer Primary Identifier)

	Removed: When sending Line Adjudication Information for this payer, the identifier sent in SVD01 (Payer Identifier) of Loop ID-2430 (Line Adjudication Information) must match this value.
CR 899	6020 Public Review Comment received requesting the removal of the REF02 note due to linkage changes for COB in 6020.

Location	X323 | Health Care Claim: Professional | 837 | 3320 | 2330B N3 - Other Payer Address
Action	**Modify Segment Situational Rule** Changed to: Required when the payer address is available and the submitter intends for the claim to be printed on paper at the next EDI location (for example, a clearinghouse). If not required by this implementation guide may be provided at the sender's discretion, but cannot be required by the receiver.
CR 1214	Modify the situational rule to allow for submission of payer address even though the claim may not be printed to paper at the next EDI location.

Location	X323 | Health Care Claim: Professional | 837 | 3400 | 2330B N4 - Other Payer City, State, ZIP Code
Action	**Modify Segment Situational Rule** Changed to: Required when the payer address is available and the submitter intends for the claim to be printed on paper at the next EDI location (for example, a clearinghouse). If not required by this implementation guide may be provided at the sender's discretion, but cannot be required by the receiver.
CR 1214	Modify the situational rule to allow for submission of payer address even though the claim may not be printed to paper at the next EDI location.

Location	X323 | Health Care Claim: Professional | 837 | 3550 | 2330B REF - Other Payer Secondary Identifier
Action	**Modify Segment Repeat** Changed to: 1
CR 1205	Modify the repeat count to match the number of qualifiers available for use.

Location	X323 | Health Care Claim: Professional | 837 | 3550 | 2330B REF - Other Payer Secondary Identifier
Action	**Modify Segment Situational Rule** REF (Payer Secondary Identification) Changed to: Required when NM109 of this loop is not used. OR

	Required when an additional identification number to that provided in the NM109 of this loop is necessary to identify the entity. If not required by this implementation guide, do not send.
CR 694	Revise rules, notes and qualifiers to align with the Health Plan Identifier regulation.

Location	X323 | Health Care Claim: Professional | 837 | 3550 | 2330B REF - Other Payer Secondary Identifier
Action	**Modify Segment Situational Rule** REF (Other Payer Secondary Identifier) Changed to: Required when NM109 of this loop is not used. OR Required when an additional identification number to that provided in the NM109 of this loop is necessary to identify the entity. If not required by this implementation guide, do not send.
CR 694	Revise rules, notes and qualifiers to align with the Health Plan Identifier regulation.

Location	X323 | Health Care Claim: Professional | 837 | 3550 | 2330B REF - Other Payer Secondary Identifier
Action	**Delete Data Element Code Value** Loop ID 2330B / REF01 (Reference Identification Qualifier) Removed: EI (Employer's Identification Number) FY (Claim Office Number) NF (National Association of Insurance Commissioners (NAIC) Code)
CR 693	Revise National Plan ID (PIDR) references in 2010AC (PID), 2010BB and 2330B NM108 to align with the Health Plan Identifier regulation.

Location	X323 | Health Care Claim: Professional | 837 | 3550 | 2330B REF - Other Payer Prior Authorization Number
Action	**Add Segment Note** This segment must not be used to report the Predetermination of Benefits Identification Number.
CR 1154	For consistency across all TR3s.

Location	X323 | Health Care Claim: Professional | 837 | 3550 | 2330B REF - Other Payer Claim Adjustment Indicator
Action	**Delete Segment** Loop ID 2330B / REF (OTHER PAYER CLAIM ADJUSTMENT INDICATOR)

CR 994	Move the Other Payer Claim Adjustment Indicator to another segment within the transaction set.
Location	X323 | Health Care Claim: Professional | 837 | 3550 | 2330B REF - Other Payer Claim Control Number
Action	**Modify Segment Situational Rule** Changed to: Required when this is a payer-to-payer COB claim. OR Required when the Other Payers Claim Control Number is available. If not required by this implementation guide, do not send.
CR 900	The TR3 Note identifies an additional aspect of the usage requirement, revise the note and the situational rule.
Location	X323 | Health Care Claim: Professional | 837 | 3250 | 2330C NM1 - Other Payer Referring Provider
Action	**Modify Segment Situational Rule** Changed to: Required when the corresponding Loop ID-2310 NM109 is not used and one or more additional payer-specific provider identifiers are required by this non-destination payer (Loop ID-2330B). If not required by this implementation guide, do not send.
CR 330	Remove the NPI dual use language and change the supervising provider primary identifier requirement, since the supervising provider would have an NPI.
Location	X323 | Health Care Claim: Professional | 837 | 3250 | 2330C NM1 - Other Payer Referring Provider
Action	**Add Segment Note** When there is only one referral on the claim, use code "DN - Referring Provider". When more than one referral exists and there is a requirement to report the additional referral, use code DN to indicate the referral received by the rendering provider on this claim. Use code "P3 - Primary Care Provider" to indicate the initial referral from the primary care provider, or whatever provider wrote the initial referral for this patient's episode of care being submitted in this transaction.
CR 1154	For consistency across all TR3s.
Location	X323 | Health Care Claim: Professional | 837 | 3250 | 2330C NM1 - Other Payer Referring Provider
Action	**Add Segment Note** See NUCC Manual for definition of professional providers.

CR 90	Provider definitions should be removed from the TR3s and replaced with references to the NUBC/NUCC information. This insures alignment and prevents future TR3 modifications if NUBC/NUCC change the definitions.
Location	X323 | Health Care Claim: Professional | 837 | 3250 | 2330C NM1 - Other Payer Referring Provider
Action	**Delete Segment Note** See Crosswalking COB Data Elements section for more information on handling COB in the 837.
CR 1154	For consistency across all TR3s.
Location	X323 | Health Care Claim: Professional | 837 | 3250 | 2330C NM1 - Other Payer Referring Provider
Action	**Delete Data Element Code Note** Loop ID 2310A / NM101 Entity Identifier Code) DN (Referring Provider) Use if loop is used only once.
CR 884	Current note causes conflict of code value usage.
Location	X323 | Health Care Claim: Professional | 837 | 3250 | 2330C NM1 - Other Payer Referring Provider
Action	**Delete Data Element Code Note** Loop ID 2310A / NM101 (Entity Identifier Code) P3 (Primary Care Provider) Use only if loop is used twice.
CR 884	Current note causes conflict of code value usage.
Location	X323 | Health Care Claim: Professional | 837 | 3550 | 2330C REF - Other Payer Referring Provider Secondary Identification
Action	**Modify Segment Repeat** Changed to: 1
CR 1205	Modify the repeat count to match the number of qualifiers available for use.
Location	X323 | Health Care Claim: Professional | 837 | 3550 | 2330C REF - Other Payer Referring Provider Secondary Identification
Action	**Modify Data Element Code Value** Loop ID 2330C / REF01 (Reference Identification Qualifier) Changed G2 (Commercial Number) to A6 (Provider Identifier)

CR 497	Remove REF Segment qualifier G2 and add A6 to better accommodate atypical providers.
Location	X323 | Health Care Claim: Professional | 837 | 3550 | 2330C REF - Other Payer Referring Provider Secondary Identification
Action	**Delete Segment Note** See Crosswalking COB Data Elements section for more information on handling COB in the 837.
CR 1154	For consistency across all TR3s.
Location	X323 | Health Care Claim: Professional | 837 | 3550 | 2330C REF - Other Payer Referring Provider Secondary Identification
Action	**Delete Segment Note** Non-destination (COB) payer's provider identification number(s).
CR 902	6020 Public Review Comment received to remove TR3 note for consistency across other payer provider loops.
Location	X323 | Health Care Claim: Professional | 837 | 3550 | 2330C REF - Other Payer Referring Provider Secondary Identification
Action	**Delete Data Element Code Value** 1G Provider UPIN Number
CR 326	Delete the UPIN qualifer on Provider segments across the TR3s.
Location	X323 | Health Care Claim: Professional | 837 | 3250 | 2330D NM1 - Other Payer Rendering Provider
Action	**Modify Segment Situational Rule** Changed to: Required when the corresponding Loop ID-2310 NM109 is not used and one or more additional payer-specific provider identifiers are required by this non-destination payer (Loop ID-2330B). If not required by this implementation guide, do not send.
CR 330	Remove the NPI dual use language and change the supervising provider primary identifier requirement, since the supervising provider would have an NPI.
Location	X323 | Health Care Claim: Professional | 837 | 3250 | 2330D NM1 - Other Payer Rendering Provider
Action	**Modify Segment Note** Changed to: See NUCC Manual for definition of professional providers.
CR 1154	For consistency across all TR3s.

Location	X323 | Health Care Claim: Professional | 837 | 3250 | 2330D NM1 - Other Payer Rendering Provider
Action	**Delete Segment Note** See Crosswalking COB Data Elements section for more information on handling COB in the 837.
CR 1154	For consistency across all TR3s.

Location	X323 | Health Care Claim: Professional | 837 | 3250 | 2330D NM1 - Other Payer Rendering Provider
Action	**Delete Data Element Code Value** Loop ID 2330D / NM102 (Entity Type Qualifier) 2 (Non-Person Entity)
CR 1135	Ensure consistency between the NUCC rendering provider definition & TR3 instructions.

Location	X323 | Health Care Claim: Professional | 837 | 3550 | 2330D REF - Other Payer Rendering Provider Secondary Identification
Action	**Modify Segment Repeat** Changed to: 2
CR 1205	Modify the repeat count to match the number of qualifiers available for use.

Location	X323 | Health Care Claim: Professional | 837 | 3550 | 2330D REF - Other Payer Rendering Provider Secondary Identification
Action	**Modify Data Element Code Value** Loop ID 2330D / REF01 (Reference Identification Qualifier) Changed G2 (Commercial Number) to A6 (Provider Identifier)
CR 497	Remove REF Segment qualifier G2 and add A6 to better accommodate atypical providers.

Location	X323 | Health Care Claim: Professional | 837 | 3550 | 2330D REF - Other Payer Rendering Provider Secondary Identification
Action	**Delete Segment Note** See Crosswalking COB Data Elements section for more information on handling COB in the 837.
CR 1154	For consistency across all TR3s.

Location	X323 | Health Care Claim: Professional | 837 | 3550 | 2330D REF - Other Payer Rendering Provider Secondary Identification
Action	**Delete Segment Note** Non-destination (COB) payer's provider identification number(s).

CR 902	6020 Public Review Comment received to remove TR3 note for consistency across other payer provider loops.
Location	X323 | Health Care Claim: Professional | 837 | 3550 | 2330D REF - Other Payer Rendering Provider Secondary Identification
Action	**Delete Data Element Code Value** 1G Provider UPIN Number
CR 326	Delete the UPIN qualifer on Provider segments across the TR3s.
Location	X323 | Health Care Claim: Professional | 837 | 3250 | 2330E NM1 - Other Payer Service Location
Action	**Modify Segment Name** NM1 (OTHER PAYER SERVICE FACILITY LOCATION) Changed to: OTHER PAYER SERVICE LOCATION
CR 889	The data in this loop is related to the "Service Location" (which could be a service facility, patient's home, provider secondary office location). Request the name of this loop be changed to 'Service Location' across the TR3s so that the name matches the data content and is consistent.
Location	X323 | Health Care Claim: Professional | 837 | 3250 | 2330E NM1 - Other Payer Service Location
Action	**Modify Segment Situational Rule** Changed to: Required when the corresponding Loop ID-2310 NM109 is not used and one or more additional payer-specific provider identifiers are required by this non-destination payer (Loop ID-2330B). If not required by this implementation guide, do not send.
CR 330	Remove the NPI dual use language and change the supervising provider primary identifier requirement, since the supervising provider would have an NPI.
Location	X323 | Health Care Claim: Professional | 837 | 3250 | 2330E NM1 - Other Payer Service Location
Action	**Delete Segment Note** See Crosswalking COB Data Elements section for more information on handling COB in the 837.
CR 1154	For consistency across all TR3s.
Location	X323 | Health Care Claim: Professional | 837 | 3550 | 2330E REF - Other Payer Service Location Secondary Identification
Action	**Modify Segment Name** REF (OTHER PAYER SERVICE FACILITY LOCATION SECONDARY

	IDENTIFICATION) Changed to: OTHER PAYER SERVICE LOCATION SECONDARY IDENTIFICATION
CR 889	The data in this loop is related to the "Service Location" (which could be a service facility, patient's home, provider secondary office location). Request the name of this loop be changed to 'Service Location' across the TR3s so that the name matches the data content and is consistent.
Location	X323 | Health Care Claim: Professional | 837 | 3550 | 2330E REF - Other Payer Service Location Secondary Identification
Action	**Modify Segment Repeat** Changed to: 2
CR 1205	Modify the repeat count to match the number of qualifiers available for use.
Location	X323 | Health Care Claim: Professional | 837 | 3550 | 2330E REF - Other Payer Service Location Secondary Identification
Action	**Modify Data Element Code Value** Loop ID 2330E / REF01 (Reference Identification Qualifier) Changed G2 (Commercial Number) to A6 (Provider Identifier)
CR 497	Remove REF Segment qualifier G2 and add A6 to better accommodate atypical providers.
Location	X323 | Health Care Claim: Professional | 837 | 3550 | 2330E REF - Other Payer Service Location Secondary Identification
Action	**Delete Segment Note** Non-destination (COB) payer's provider identification number(s).
CR 902	6020 Public Review Comment received to remove TR3 note for consistency across other payer provider loops.
Location	X323 | Health Care Claim: Professional | 837 | 3250 | 2330G NM1 - Other Payer Billing Provider
Action	**Modify Segment Situational Rule** Changed to: Required when the corresponding Loop ID-2310 NM109 is not used and one or more additional payer-specific provider identifiers are required by this non-destination payer (Loop ID-2330B). If not required by this implementation guide, do not send.
CR 330	Remove the NPI dual use language and change the supervising provider primary identifier requirement, since the supervising provider would have an NPI.

Location	X323 | Health Care Claim: Professional | 837 | 3250 | 2330G NM1 - Other Payer Billing Provider
Action	**Modify Segment Situational Rule** Changed to: Required for providers who are not Health Care Providers when the provider is sent in the corresponding Loop ID-2010AA and one or more additional payer-specific provider identification numbers are required by this non-destination payer (Loop ID-2330B) to identify the provider. If not required by this implementation guide, do not send.
CR 327	Modify notes to remove the NPI dual use language.

Location	X323 | Health Care Claim: Professional | 837 | 3250 | 2330G NM1 - Other Payer Billing Provider
Action	**Delete Segment Note** See Crosswalking COB Data Elements section for more information on handling COB in the 837.
CR 1154	For consistency across all TR3s.

Location	X323 | Health Care Claim: Professional | 837 | 3550 | 2330G REF - Other Payer Billing Provider Secondary Identification
Action	**Modify Data Element Code Value** Loop ID 2330G / REF01 (Reference Identification Qualifier) Changed G2 (Commercial Number) to A6 (Provider Identifier)
CR 497	Remove REF Segment qualifier G2 and add A6 to better accommodate atypical providers.

Location	X323 | Health Care Claim: Professional | 837 | 3550 | 2330G REF - Other Payer Billing Provider Secondary Identification
Action	**Delete Segment Note** See Crosswalking COB Data Elements section for more information on handling COB in the 837.
CR 1154	For consistency across all TR3s.

Location	X323 | Health Care Claim: Professional | 837 | 3650 | 2400 LX - Service Line Number
Action	**Modify Segment Note** Changed to: The Service Line LX segment must begin with one and is incremented by one for each additional service line of a claim.

CR 1569	Removed Front Matter reference from segment note so it can be used by all 837 guides.
Location	X323 | Health Care Claim: Professional | 837 | 3700 | 2400 SV1 - Professional Service
Action	**Delete Data Element Code Value** Loop ID 2400 / SV101-01 (Product/Service ID Qualifier) WK (Advanced Billing Concepts (ABC) Codes)
CR 749	Remove support for Advanced Billing Concept Codes (ABC) across the TR3s as HHS has discontinued the associated pilot project.
Location	X323 | Health Care Claim: Professional | 837 | 3700 | 2400 SV1 - Professional Service
Action	**Modify Data Element Situational Rule** Loop ID 2400 / SV101-07 (Description) Changed to: Required when, in the judgment of the provider, the Procedure Code does not definitively describe the service/product/supply and Loop ID-2410 is not used. If not required by this implementation guide can be provided at the sender's discretion, but cannot be required by the receiver.
CR 859	Revise the situational rule for SV101-07 to clarify the intended use.
Location	X323 | Health Care Claim: Professional | 837 | 3700 | 2400 SV1 - Professional Service
Action	**Add Data Element Situational Rule** Loop ID 2400 / SV101-09 (Procedure Modifier) Required when a fifth modifier clarifies or improves the reporting accuracy of the associated procedure code. If not required by this implementation guide, do not send.
CR 384	Revise the SVC01 to accommodate more than 4 modifiers.
Location	X323 | Health Care Claim: Professional | 837 | 3700 | 2400 SV1 - Professional Service
Action	**Add Data Element Situational Rule** Loop ID 2400 / SV101-10 (Procedure Modifier) Required when a sixth modifier clarifies or improves the reporting accuracy of the associated procedure code. If not required by this implementation guide, do not send.
CR 384	Revise the SVC01 to accommodate more than 4 modifiers.

Location	X323 | Health Care Claim: Professional | 837 | 3700 | 2400 SV1 - Professional Service
Action	**Add Data Element Situational Rule** Loop ID 2400 / SV101-11 (Procedure Modifier) Required when a seventh modifier clarifies or improves the reporting accuracy of the associated procedure code. If not required by this implementation guide, do not send.
CR 384	Revise the SVC01 to accommodate more than 4 modifiers.

Location	X323 | Health Care Claim: Professional | 837 | 3700 | 2400 SV1 - Professional Service
Action	**Add Data Element Situational Rule** Loop ID 2400 / SV101-12 (Procedure Modifier) Required when a eighth modifier clarifies or improves the reporting accuracy of the associated procedure code. If not required by this implementation guide, do not send.
CR 384	Revise the SVC01 to accommodate more than 4 modifiers.

Location	X323 | Health Care Claim: Professional | 837 | 3700 | 2400 SV1 - Professional Service
Action	**Modify Data Element Note** Loop ID 2400 / SV102 (Line Item Charge Amount) Changed to: This is the total charge amount for this service line. The amount is inclusive of the provider's base charge and/or postage claimed amounts reported within this line's AMT segments.
CR 77	For professional claims, sales tax should be reported as a line level charge using appropriate procedure codes.

Location	X323 | Health Care Claim: Professional | 837 | 3700 | 2400 SV1 - Professional Service
Action	**Add Data Element Note** Multiple Loops / Multiple Data Elements Data Element 782 (Monetary Amount): The maximum length of this instance of data element 782 is 10.
CR 1013	Add a consistent element note explaining the maximum length to every monetary amount element.

Location	X323 | Health Care Claim: Professional | 837 | 3700 | 2400 SV1 - Professional Service
Action	**Add Data Element Note** Loop ID 2400 / SV103 (Unit or Basis for Measurement Code) The qualifier MJ, Minutes, is required for time-based anesthesia procedure codes without a time period in the code description. Anesthesia procedure codes with specified time periods including, but not limited to "daily" or "15 minutes" must be reported using the qualifier UN, Units. Anesthesia procedure codes that are not time-based must use the qualifier UN, Units.
CR 1558	Format code notes consistently.

Location	X323 | Health Care Claim: Professional | 837 | 3700 | 2400 SV1 - Professional Service
Action	**Add Data Element Note** Loop ID 2400 / SV107 (Diagnosis Code Pointer) SV107 is a repeating data element that may be repeated up to 12 times. The first pointer designates the primary diagnosis for this service line. Remaining diagnosis pointers indicate declining level of importance to service line. Only the first instance of the diagnosis code pointer is required. Acceptable values are 1 through 24, and must correspond to Composite Data Elements 01 through 12 (repeat loop 1) and 13 through 24 (repeat loop 2) in the Health Care Diagnosis Code HI segment in the Claim Loop ID-2300.
CR 38	2400 SV107 DX Code Pointers: Increase the DX pointers to coincide with the number of DX codes allowed in the 2300 HI segment.

Location	X323 | Health Care Claim: Professional | 837 | 3700 | 2400 SV1 - Professional Service
Action	**Modify Data Element Usage** Loop ID 2400 / SV109 (Emergency Indicator) Changed to: REQUIRED
CR 36	Revise the 2400 SV109 Yes/No Indicator default for consistency.

Location	X323 | Health Care Claim: Professional | 837 | 3700 | 2400 SV1 - Professional Service

Action	**Modify Data Element Note** Loop ID 2400 / SV109 (Emergency Indicator) Changed to: Emergency definition: The patient requires immediate medical intervention as a result of severe, life threatening, or potentially disabling conditions.
CR 36	Revise the 2400 SV109 Yes/No Indicator default for consistency.

Location	X323 | Health Care Claim: Professional | 837 | 3700 | 2400 SV1 - Professional Service
Action	**Add Data Element Code Value** Loop ID 2400 / SV109 (Emergency Indicator) N (No)
CR 36	Revise the 2400 SV109 Yes/No Indicator default for consistency.

Location	X323 | Health Care Claim: Professional | 837 | 3700 | 2400 SV1 - Professional Service
Action	**Modify Data Element Usage** Loop ID 2400 / SV111 (EPSDT Indicator) Changed to: REQUIRED
CR 101	Revise the 2400 SV111 EPSDT Yes/No default for consistency.

Location	X323 | Health Care Claim: Professional | 837 | 3700 | 2400 SV1 - Professional Service
Action	**Add Data Element Code Value** Loop ID 2400 / SV111 (EPSDT Indicator) N (No)
CR 36	Revise the 2400 SV109 Yes/No Indicator default for consistency.

Location	X323 | Health Care Claim: Professional | 837 | 3700 | 2400 SV1 - Professional Service
Action	**Add Data Element Code Note** Loop ID 2400 / SV111 (EPSDT Indicator) Y (Yes) Use when the service is provided as a result of an EPSDT screening referral and payment is expected from Medicaid funding.
CR 1558	Format code notes consistently.

Location	X323 | Health Care Claim: Professional | 837 | 3700 | 2400 SV1 - Professional Service
Action	**Modify Data Element Usage** Loop ID 2400 / SV112 (Family Planning Indicator) Changed to: REQUIRED
CR 102	Revise the SV112 Family Planning Yes/No Indicator default for consistency.

Location	X323 | Health Care Claim: Professional | 837 | 3700 | 2400 SV1 - Professional Service
Action	**Add Data Element Code Note** Loop ID 2400 / SV112 (Family Planning Indicator) Y (Yes) A value of Y is used for Medicaid services when family planning is involved. N (No) A value of N is used when Y is not applicable.
CR 102	Revise the SV112 Family Planning Yes/No Indicator default for consistency.

Location	X323 | Health Care Claim: Professional | 837 | 3700 | 2400 SV1 - Professional Service
Action	**Add Data Element Code Value** Loop ID 2400 / SV112 (Family Planning Indicator) N (No)
CR 36	Revise the 2400 SV109 Yes/No Indicator default for consistency.

Location	X323 | Health Care Claim: Professional | 837 | 3700 | 2400 SV1 - Professional Service
Action	**Add Data Element Code Note** Loop ID 2400 / SV112 (Family Planning Indicator) Y (Yes) Use when the service is provided as a family planning service and payment is expected from Medicaid funding.
CR 1558	Format code notes consistently.

Location	X323 | Health Care Claim: Professional | 837 | 3700 | 2400 SV1 - Professional Service
Action	**Modify Data Element Code Note** Loop ID 2400 / SV112 (Family Planning Indicator)

	N (No) Use when Y is not applicable.
CR 1558	Format code notes consistently.
Location	X323 | Health Care Claim: Professional | 837 | 3700 | 2400 SV1 - Professional Service
Action	**Delete Data Element Code Value** IV - HIEC Codes
CR 612	Remove references to HIEC and ABC code lists as they are no longer valid.
Location	X323 | Health Care Claim: Professional | 837 | 3820 | 2400 TOO - Tooth Information
Action	**Modify Segment Note** Changed to: Multiple iterations of the TOO segment are allowed if and only if the procedure count sent in SV306 is greater than one.
CR 1153	To clarify intended use.
Location	X323 | Health Care Claim: Professional | 837 | 4000 | 2400 SV5 - Durable Medical Equipment Service
Action	**Add Data Element Note** Multiple Loops / Multiple Data Elements Data Element 782 (Monetary Amount): The maximum length of this instance of data element 782 is 10.
CR 1013	Add a consistent element note explaining the maximum length to every monetary amount element.
Location	X323 | Health Care Claim: Professional | 837 | 4200 | 2400 PWK - Line Supplemental Information
Action	**Modify Segment Situational Rule** Changed to: Required when there is an attachment available for this claim. If not required by this implementation guide, do not send
CR 1471	Simplify the PWK segment situational rules across all 837 guides and modify the PWK02 Code notes to allow codes, AA, EL, & FT for paper attachments.
Location	X323 | Health Care Claim: Professional | 837 | 4200 | 2400 PWK - Line Supplemental Information

Action	**Modify Data Element Code Note** Loop ID 2300 and 2400 / PWK02 (Attachment Transmission Code) FT (File Transfer) Changed to: Use when attachments are sent by File Transfer to payer or maintained by an attachment warehouse or similar vendor.
CR 1471	Simplify the PWK segment situational rules across all 837 guides and modify the PWK02 Code notes to allow codes, AA, EL, & FT for paper attachments.

Location	X323 | Health Care Claim: Professional | 837 | 4200 | 2400 PWK - Line Supplemental Information
Action	**Modify Data Element Note** Multiple Loops / PWK06 (Attachment Control Number Changed to: PWK06 is a unique identifier assigned by the provider to be used to identify the attached electronic documentation. The number in PWK06 is carried in the TRN of the electronic attachment.
CR 1153	To clarify intended use.

Location	X323 | Health Care Claim: Professional | 837 | 4200 | 2400 PWK - Line Supplemental Information
Action	**Add Data Element Code Note** Loop ID 2400 / PWK02 (Attachment Transmission Code) BM (By Mail) Use when paper attachments are sent by mail.
CR 1471	Simplify the PWK segment situational rules across all 837 guides and modify the PWK02 Code notes to allow codes, AA, EL, & FT for paper attachments.

Location	X323 | Health Care Claim: Professional | 837 | 4200 | 2400 PWK - Line Supplemental Information
Action	**Add Data Element Code Note** Loop ID 2400 / PWK02 (Attachment Transmission Code) EM (E-Mail) Use when paper attachments are sent by e-mail.
CR 1471	Simplify the PWK segment situational rules across all 837 guides and modify the PWK02 Code notes to allow codes, AA, EL, & FT for paper attachments.

Location	X323 | Health Care Claim: Professional | 837 | 4200 | 2400 PWK - Line Supplemental Information
Action	**Add Data Element Code Note** Loop ID 2400 / PWK02 (Attachment Transmission Code) FX (By Fax) Use when paper attachments are sent by fax.
CR 1471	Simplify the PWK segment situational rules across all 837 guides and modify the PWK02 Code notes to allow codes, AA, EL, & FT for paper attachments.

Location	X323 | Health Care Claim: Professional | 837 | 4200 | 2400 PWK - Durable Medical Equipment Certificate of Medical Necessity Indicator
Action	**Modify Segment Situational Rule** Changed to: Required on claims that include a Certificate of Medical Necessity (CMN). If not required by this implementation guide, do not send.
CR 853	Remove the reference to DMERC from the situational rule.

Location	X323 | Health Care Claim: Professional | 837 | 4200 | 2400 PWK - Durable Medical Equipment Certificate of Medical Necessity Indicator
Action	**Modify Data Element Code Note** Loop ID 2300 and 2400 / PWK02 (Attachment Transmission Code) FT (File Transfer) Changed to: Use when attachments are sent by File Transfer to payer or maintained by an attachment warehouse or similar vendor.
CR 1471	Simplify the PWK segment situational rules across all 837 guides and modify the PWK02 Code notes to allow codes, AA, EL, & FT for paper attachments.

Location	X323 | Health Care Claim: Professional | 837 | 4250 | 2400 CR1 - Ambulance Transport Information
Action	**Add Data Element Note** Loop ID 2400 / CR106 (Transport Distance) When a decimal is used, the maximum number of digits allowed to the right of the decimal is three. Note: When a decimal is needed to report units, include it in this element, for example, "15.6".

CR 804	For consistency, add a note regarding the use of decimals in CR106 (Transport Distance).
Location	X323 | Health Care Claim: Professional | 837 | 4350 | 2400 CR3 - Durable Medical Equipment Certification
Action	**Modify Segment Situational Rule** Changed to: Required when a Certificate of Medical Necessity (CMN) or a DME Information Form (DIF) or Oxygen Therapy Certification is included on this service line. If not required by this implementation guide, do not send.
CR 843	The term "DMERC" is no longer used. Revise the situational rule.
Location	X323 | Health Care Claim: Professional | 837 | 4500 | 2400 CRC - Hospice Employee Indicator
Action	**Delete Segment** Loop ID 2400 / CRC (HOSPICE EMPLOYEE INDICATOR)
CR 992	Currently the situational rule requires the 2400 CRC Hospice Employee Indicator on all Medicare claims involving physician services to hospice patients. Medicare uses modifiers on Hospice HCPCs to indicate a hospice employee and does not need this loop in the claim.
Location	X323 | Health Care Claim: Professional | 837 | 4500 | 2400 CRC - Condition Indicator/Durable Medical Equipment
Action	**Modify Segment Situational Rule** Changed to: Required when a Certificate of Medical Necessity (CMN) or a DME Information Form (DIF), or Oxygen Therapy Certification is included on this service line AND the information is necessary for adjudication. If not required by this implementation guide, do not send.
CR 844	The term "DMERC" is no longer used. Revise the situational rule.
Location	X323 | Health Care Claim: Professional | 837 | 4550 | 2400 DTP - Service Date
Action	**Modify Segment Usage** Changed to: SITUATIONAL
CR 225	Loop 2400 DTP - Service Date (837P) - change usage from required to situational to support predeterminations.
Location	X323 | Health Care Claim: Professional | 837 | 4550 | 2400 DTP - Service Date
Action	**Add Segment Situational Rule** Required when the claim is not submitted as a predetermination request.

	OR Required on service lines where a predetermination is requested for a drug and the payer's predetermination is known to be impacted by the drug duration. If not required by this implementation guide, do not send.
CR 225	Loop 2400 DTP - Service Date (837P) - change usage from required to situational to support predeterminations.
Location	X323 | Health Care Claim: Professional | 837 | 4550 | 2400 DTP - Service Date
Action	**Modify Segment Situational Rule** Changed to: Required when the claim is not submitted as a predetermination request. OR Required on service lines where a predetermination is requested for a drug and the payer's predetermination is known to be impacted by the drug duration. If not required by this implementation guide, do not send.
CR 225	Loop 2400 DTP - Service Date (837P) - change usage from required to situational to support predeterminations.
Location	X323 | Health Care Claim: Professional | 837 | 4550 | 2400 DTP - Service Date
Action	**Modify Segment Note** Changed to: In cases where a drug is being submitted on a service line, a date range may be used to indicate drug duration for which the drug supply will be used by the patient. The difference in dates, including both the beginning and end dates, are the days supply of the drug. Example: 20110101 - 20110107 (1/1/2011 to 1/7/2011) is used for a 7 day supply where the first day of the drug used by the patient is 1/1/2011. In the event a drug is administered on less than a daily basis (for example, every other day) the date range would include the entire period during which the drug is supplied, including the last day of use. Example: 20110101 - 20110108 (1/1/2011 to 1/8/2011) is used for an 8 day supply where the prescription is written for Q48 (every 48 hours), four doses of the drug are dispensed and the first dose is used on 1/1/2011.

CR 211	Loop 2400 DTP - Service Date segment - TR3 Note 1 - Revise the note to include predeterminations.
Location	X323 | Health Care Claim: Professional | 837 | 4550 | 2400 DTP - Service Date
Action	**Modify Data Element Code Note** Multiple Locations / DTP02 (Date Time Period Format Qualifier) RD8 (Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD) Changed to: Use when the "From and To" dates are different. However, at the discretion of the submitter, RD8 can also be used when the "From and To" dates are the same.
CR 1558	Format code notes consistently.
Location	X323 | Health Care Claim: Professional | 837 | 4550 | 2400 DTP - Prescription Date
Action	**Add Segment Note** For prescription drugs, the requirements for this segment are based on the current NCPDP Telecommunication Standard Implementation Guide.
CR 310	Allow the reporting of drug rebate information in the claim transaction.
Location	X323 | Health Care Claim: Professional | 837 | 4550 | 2400 DTP - Prescription Date
Action	**Modify Segment Situational Rule** Changed to: Required on claims where a prescription has been written for hearing devices or vision frames and lenses and it is being reported on this claim. If not required by this implementation guide, do not send.
CR 828	Review/Revise the wording of the situational rule.
Location	X323 | Health Care Claim: Professional | 837 | 4550 | 2400 DTP - Begin Therapy Date
Action	**Modify Segment Situational Rule** Changed to: Required when a Certificate of Medical Necessity (CMN) or DME Information Form (DIF), or Oxygen Therapy Certification is included on this service line. If not required by this implementation guide, do not send.
CR 845	The term "DMERC" is no longer used. Revise the situational rule.
Location	X323 | Health Care Claim: Professional | 837 | 4550 | 2400 DTP - Last Certification Date

Action	**Modify Segment Situational Rule** Changed to: Required when a Certificate of Medical Necessity (CMN), DME Information Form (DIF), or Oxygen Therapy Certification is included on this service line. If not required by this implementation guide, do not send.
CR 846	The term "DMERC" is no longer used. Revise the situational rule.
Location	X323 | Health Care Claim: Professional | 837 | 4550 | 2400 DTP - Test Date
Action	**Modify Segment Situational Rule** Changed to: Required on initial epoetin alfa claims for dialysis patients when test results are being reported. If not required by this implementation guide, do not send.
CR 227	Loop 2400 DTP - Test Date - Change the situational rule to support predeterminations.
Location	X323 | Health Care Claim: Professional | 837 | 4550 | 2400 DTP - Shipped Date
Action	**Modify Segment Situational Rule** Changed to: Required when service relates to shipped products. If not required by this implementation guide, do not send.
CR 228	Loop 2400 DTP - Shipped Date - Change the situational rule to support predeterminations.
Location	X323 | Health Care Claim: Professional | 837 | 4550 | 2400 DTP - Initial Treatment Date
Action	**Modify Segment Situational Rule** Changed to: Required when the Initial Treatment Date is known to impact adjudication for this service line involving spinal manipulation, physical therapy, occupational therapy, speech language pathology, dialysis, optical refractions, or pregnancy and is different than the date reported at the claim level (Loop ID-2300). If not required by this implementation guide, do not send.
CR 1004	Allow service level dates to override claim level dates, as appropriate.
Location	X323 | Health Care Claim: Professional | 837 | 4620 | 2400 MEA - Test Result
Action	**Modify Segment Situational Rule** Changed to: Required on dialysis-related service lines for ESRD. Use R1, R2, R3, or R4 to qualify the Hemoglobin, Hematocrit, Epoetin Starting Dosage, and Creatinine test results.

	OR Required on DME service lines to report the Patient's Height from the Certificate of Medical Necessity (CMN). Use HT qualifier. If not required by this implementation guide, do not send.
CR 852	Remove the DMERC reference in the situational rule.
Location	X323 | Health Care Claim: Professional | 837 | 4620 | 2400 MEA - Test Result
Action	**Add Data Element Code Note** Loop ID 2400 / MEA02 (Measurement Qualifier) HT (Height) Use when reporting height (in inches).
CR 1558	Format code notes consistently.
Location	X323 | Health Care Claim: Professional | 837 | 4650 | 2400 CN1 - Contract Information
Action	**Modify Segment Situational Rule** Changed to: Required when the submitter is contractually obligated to supply this information on post-adjudicated claims. If not required by this implementation guide, do not send.
CR 995	Revise the CN1 situational rule for clarification. The current wording implies the CN1 segment is created by providers.
Location	X323 | Health Care Claim: Professional | 837 | 4650 | 2400 CN1 - Contract Information
Action	**Add Data Element Note** Multiple Loops / Multiple Data Elements Data Element 782 (Monetary Amount): The maximum length of this instance of data element 782 is 10.
CR 1013	Add a consistent element note explaining the maximum length to every monetary amount element.
Location	X323 | Health Care Claim: Professional | 837 | 4700 | 2400 REF - Service Predetermination Identification
Action	**Add Segment** Loop ID 2400 / REF (SERVICE PREDETERMINATION IDENTIFICATION)
CR 48	Add Predetermination of Benefits to the 837P.

Location	X323 | Health Care Claim: Professional | 837 | 4700 | 2400 REF - Service Predetermination Identification
Action	**Modify Segment Situational Rule** Changed to: Required when sending the Predetermination of Benefits Identification Number for the line item that has been previously predetermined that is now being submitted for payment and is different than the number reported at the claim level (Loop ID-2300). If not required by this implementation guide, do not send.
CR 1004	Allow service level dates to override claim level dates, as appropriate.

Location	X323 | Health Care Claim: Professional | 837 | 4700 | 2400 REF - Service Predetermination Identification
Action	**Modify Data Element Situational Rule** Loop ID 2400 / REF04 (Reference Identifier) Changed to: Required when the identifier reported in REF02 of this segment is for a non-destination payer.
CR 1129	To promote consistency across all guides.

Location	X323 | Health Care Claim: Professional | 837 | 4700 | 2400 REF - Repriced Line Item Reference Number
Action	**Modify Segment Situational Rule** Changed to: Required when this information is deemed necessary by the repricer. If not required by this implementation guide, do not send.
CR 171	Move the informational text in the situational rule to a segment note.

Location	X323 | Health Care Claim: Professional | 837 | 4700 | 2400 REF - Repriced Line Item Reference Number
Action	**Add Segment Note** This segment is not completed by providers. The information is completed by repricers only.
CR 171	Move the informational text in the situational rule to a segment note.

Location	X323 | Health Care Claim: Professional | 837 | 4700 | 2400 REF - Repriced Line Item Reference Number
Action	**Add Segment Note** This segment is not completed by providers. The information is completed by repricers only.
CR 1154	For consistency across all TR3s.

Location	X323 | Health Care Claim: Professional | 837 | 4700 | 2400 REF - Adjusted Repriced Line Item Reference Number
Action	**Modify Segment Situational Rule** Changed to: Required when this information is deemed necessary by the repricer. If not required by this implementation guide, do not send.
CR 855	6020 Public Review Comment received recommending that the situational rule be changed to the same rule as the Repriced Line Item Reference Number since this is really sent at the repricer's discretion. The other situational rule is: Required when this information is deemed necessary by the repricer. If not required by this implementation guide, do not send.

Location	X323 | Health Care Claim: Professional | 837 | 4700 | 2400 REF - Adjusted Repriced Line Item Reference Number
Action	**Modify Segment Situational Rule** Changed to: Required when this information is deemed necessary by the repricer. If not required by this implementation guide, do not send.
CR 171	Move the informational text in the situational rule to a segment note.

Location	X323 | Health Care Claim: Professional | 837 | 4700 | 2400 REF - Adjusted Repriced Line Item Reference Number
Action	**Add Segment Note** This segment is not completed by providers. The information is completed by repricers only.
CR 171	Move the informational text in the situational rule to a segment note.

Location	X323 | Health Care Claim: Professional | 837 | 4700 | 2400 REF - Adjusted Repriced Line Item Reference Number
Action	**Add Segment Note** This segment is not completed by providers. The information is completed by repricers only.
CR 1154	For consistency across all TR3s.

Location	X323 | Health Care Claim: Professional | 837 | 4700 | 2400 REF - Prior Authorization
Action	**Modify Segment Repeat** Changed to: 11
CR 856	Increase the repeat count to 11 to coincide with the number of available payers.

Location	X323 | Health Care Claim: Professional | 837 | 4700 | 2400 REF - Prior Authorization
Action	**Modify Segment Situational Rule** Changed to: Required when the service line involved a prior authorization number that is different than the number reported at the claim level (Loop ID-2300) OR Required when a prior authorization only applies to this service line (Loop ID-2400) and no claim level (Loop ID-2300) prior authorization was reported. If not required by this implementation guide, do not send.
CR 1392	The rules for prior authorization number assume that there is always a prior authorization tied to the entire claim; however it is possible for an authorization to be applicable to select service lines but not all the service lines.

Location	X323 | Health Care Claim: Professional | 837 | 4700 | 2400 REF - Prior Authorization
Action	**Add Segment Note** This segment must not be used to report the Predetermination of Benefits Identification Number.
CR 1154	For consistency across all TR3s.

Location	X323 | Health Care Claim: Professional | 837 | 4700 | 2400 REF - Line Item Control Number
Action	**Modify Segment Usage** Changed to: REQUIRED
CR 212	Loop 2400 - REF - Line Item Control Number - There should always be a line item control number even for predetermination requests.

Location	X323 | Health Care Claim: Professional | 837 | 4700 | 2400 REF - Line Item Control Number
Action	**Add Segment Note** If this claim is a payer to payer COB claim and the originating claim did not have a line item control number (i.e. paper) then use the LX01 value.
CR 212	Loop 2400 - REF - Line Item Control Number - There should always be a line item control number even for predetermination requests.

Location	X323 | Health Care Claim: Professional | 837 | 4700 | 2400 REF - Line Item Control Number
Action	**Delete Segment Note** "The line item control number must be unique within a patient control number (CLM01). Payers are required to return this number in the remittance advice transaction (835) if the provider sends it to them in the 837 and adjudication is based upon line item detail regardless of whether bundling or unbundling has

	occurred."
CR 212	Loop 2400 - REF - Line Item Control Number - There should always be a line item control number even for predetermination requests.

Location	X323 | Health Care Claim: Professional | 837 | 4700 | 2400 REF - Line Item Control Number
Action	**Delete Segment Note** "Submitters are STRONGLY encouraged to routinely send a unique line item control number on all service lines, particularly if the submitter automatically posts their remittance advice. Submitting a unique line item control number allows the capability to automatically post by service line."
CR 212	Loop 2400 - REF - Line Item Control Number - There should always be a line item control number even for predetermination requests.

Location	X323 | Health Care Claim: Professional | 837 | 4700 | 2400 REF - Referral Number
Action	**Modify Segment Repeat** Changed to: 11
CR 856	Increase the repeat count to 11 to coincide with the number of available payers.

Location	X323 | Health Care Claim: Professional | 837 | 4700 | 2400 REF - Referral Number
Action	**Modify Segment Situational Rule** Changed to: Required when this service line involved a referral number AND it is different than the number reported at the claim level (Loop-ID 2300). OR Required when this service line involved a referral number AND a claim level referral (Loop ID 2300) was not reported. If not required by this implementation guide, do not send.
CR 1349	The rules for referral number and referring provider at the claim and line level assume that there is always a referral tied to the entire claim; however it is possible for a referral to be applicable to select service lines but not all the service lines.

Location	X323 | Health Care Claim: Professional | 837 | 4700 | 2400 REF - Referral Number
Action	**Modify Segment Note** Changed to: When it is necessary to assign the identifier in REF01 of this segment to one or more non-destination payers, the composite data element in REF04 is used to identify the payer that assigned this identifier.

CR 1129	To promote consistency across all guides.
Location	X323 | Health Care Claim: Professional | 837 | 4700 | 2400 REF - Referral Number
Action	**Modify Data Element Note** Loop ID 2400 / REF04 (Reference Identifier) Changed to: Required when the identifier reported in REF02 of this segment is for a non-destination payer.
CR 1129	To promote consistency across all guides.
Location	X323 | Health Care Claim: Professional | 837 | 4750 | 2400 AMT - Purchased Service Amount
Action	**Add Data Element Note** Multiple Loops / Multiple Data Elements Data Element 782 (Monetary Amount): The maximum length of this instance of data element 782 is 10.
CR 1013	Add a consistent element note explaining the maximum length to every monetary amount element.
Location	X323 | Health Care Claim: Professional | 837 | 4750 | 2400 AMT - Postage Claimed Amount
Action	**Add Data Element Note** Multiple Loops / Multiple Data Elements Data Element 782 (Monetary Amount): The maximum length of this instance of data element 782 is 10.
CR 1013	Add a consistent element note explaining the maximum length to every monetary amount element.
Location	X323 | Health Care Claim: Professional | 837 | 4750 | 2400 AMT - Usual and Customary Charge
Action	**Add Data Element Note** Multiple Loops / Multiple Data Elements Data Element 782 (Monetary Amount): The maximum length of this instance of data element 782 is 10.

CR 1013	Add a consistent element note explaining the maximum length to every monetary amount element.
Location	X323 | Health Care Claim: Professional AMT - State Care Tax
Action	**Add Segment** Loop ID 2400 / AMT (STATE CARE TAX)
CR 1359	Support state mandated care tax, when applicable.
Location	X323 | Health Care Claim: Professional | 837 | 4800 | 2400 K3 - File Information
Action	**Modify Segment Situational Rule** Changed to: Required when ASC X12N has reviewed and approved the data requirements of a regulatory/legislative authority for use of the K3 Segment and has concluded that there is no current method to meet the requirement. (See Section 1.4.6.1 for obtaining ASC X12N approval). If not required by this implementation guide, do not send.
CR 1384	Establish consistent procedures for handling requests for K3 usage across TR3s.
Location	X323 | Health Care Claim: Professional | 837 | 4800 | 2400 K3 - File Information
Action	**Modify Segment Note** Changed to: The K3 segment is used only when necessary to meet the unexpected data requirement of a regulatory/legislative authority. Before this segment can be used: - ASC X12N must conclude there is no other available option in the implementation guide to meet the emergency regulatory/legislative requirement. - The requester must submit a change request accompanied by the relevant business documentation and receive approval for the request. Upon review of the request, ASC X12N will issue an approval or denial decision to the requesting entity. Approved usage(s) of the K3 Segment will be reviewed by the applicable ASC X12N work group to develop a permanent change to include the business case in future transaction implementations.
CR 1384	Establish consistent procedures for handling requests for K3 usage across TR3s.

Location	X323 | Health Care Claim: Professional | 837 | 4800 | 2400 K3 - File Information
Action	**Delete Segment Note** X12N will submit the necessary data maintenance and refer the request to the appropriate data content committee(s).
CR 1384	Establish consistent procedures for handling requests for K3 usage across TR3s.

Location	X323 | Health Care Claim: Professional | 837 | 4850 | 2400 NTE - Third Party Organization Notes
Action	**Modify Segment Situational Rule** Changed to: Required when the TPO/repricer needs to forward additional information to the payer. If not required by this implementation guide, do not send.
CR 178	Remove the informational text from the situational rule and instead include it in a segment note.

Location	X323 | Health Care Claim: Professional | 837 | 4850 | 2400 NTE - Third Party Organization Notes
Action	**Add Segment Note** This segment is not completed by providers. The information is completed by repricers only.
CR 171	Move the informational text in the situational rule to a segment note.

Location	X323 | Health Care Claim: Professional | 837 | 4920 | 2400 HCP - Line Pricing/Repricing Information
Action	**Modify Segment Situational Rule** Changed to: Required when this information is deemed necessary by the repricer. If not required by this implementation guide, do not send.
CR 171	Move the informational text in the situational rule to a segment note.

Location	X323 | Health Care Claim: Professional | 837 | 4920 | 2400 HCP - Line Pricing/Repricing Information
Action	**Add Segment Note** This segment is not completed by providers. The information is completed by repricers only.
CR 171	Move the informational text in the situational rule to a segment note.

Location	X323 | Health Care Claim: Professional | 837 | 4920 | 2400 HCP - Line Pricing/Repricing Information

Action	**Add Data Element Note** Multiple Loops / Multiple Data Elements Data Element 782 (Monetary Amount): The maximum length of this instance of data element 782 is 10.
CR 1013	Add a consistent element note explaining the maximum length to every monetary amount element.
Location	X323 | Health Care Claim: Professional | 837 | 4920 | 2400 HCP - Line Pricing/Repricing Information
Action	**Delete Data Element Code Value** Loop ID 2400 / HCP09 (Product/Service ID Qualifier) WK (Advanced Billing Concepts (ABC) Codes)
CR 749	Remove support for Advanced Billing Concept Codes (ABC) across the TR3s as HHS has discontinued the associated pilot project.
Location	X323 | Health Care Claim: Professional | 837 | 4920 | 2400 HCP - Line Pricing/Repricing Information
Action	**Delete Data Element Code Value** Loop ID 2400 / HCP13 (Reject Reason Code) Removed: T2 - Cannot Identify Payer as TPO (Third Party Organization) Participant T3 - Cannot Identify Insured as TPO (Third Party Organization) Participant T4 - Payer Name or Identifier Missing T5 - Certification Information Missing
CR 313	Remove the T2-T5 values, which are no longer used in the industry.
Location	X323 | Health Care Claim: Professional | 837 | 4920 | 2400 HCP - Line Pricing/Repricing Information
Action	**Delete Data Element Code Value** IV - HIEC Codes
CR 612	Remove references to HIEC and ABC code lists as they are no longer valid.
Location	X323 | Health Care Claim: Professional | 837 | 4925 | 2400 CR8 - High Risk Implanted or Explanted Device
Action	**Add Segment** CR8 (HIGH RISK IMPLANTED OR EXPLANTED DEVICE)
CR 1652	Include the DI portion of the UDI for implantable devices in the claim transactions.

Location	X323 | Health Care Claim: Professional | 837 | 4930 | 2410 LIN - Drug/Supply Identification
Action	**Modify Segment Name** LIN (DRUG IDENTIFICATION) Changed to: DRUG/SUPPLY IDENTIFICATION
CR 1548	Provide the ability to report the device identifier (DI) of the Unique Device Identifier (UDI) for pharmacy services.

Location	X323 | Health Care Claim: Professional | 837 | 4930 | 2410 LIN - Drug/Supply Identification
Action	**Modify Segment Situational Rule** Changed to: Required when government regulation mandates that prescribed drugs, biologics and medical or surgical supplies are reported with NDC numbers or the Device Identifier of the Unique Device Identifier. OR Required when the provider or submitter chooses to report NDC numbers or the Device Identifier of the Unique Device Identifier to enhance the claim reporting or adjudication processes. If not required by this implementation guide, do not send.
CR 1548	Provide the ability to report the device identifier (DI) of the Unique Device Identifier (UDI) for pharmacy services.

Location	X323 | Health Care Claim: Professional | 837 | 4930 | 2410 LIN - Drug/Supply Identification
Action	**Modify Segment Situational Rule** Changed to: Required when government regulation mandates that drugs, biologics and supplies are reported with NDC numbers or the Device Identifier of the Unique Device Identifier. OR Required when the provider or submitter chooses to report NDC numbers or Device Identifier of the Unique Device Identifier to enhance the claim reporting or adjudication processes. OR

	Required when an HHS approved pilot project specifies reporting of Universal Product Number (UPN) by parties registered in the pilot and their trading partners. OR Required when government regulation mandates that medical and surgical supplies are reported with UPN's. If not required by this implementation guide, do not send.
CR 1548	Provide the ability to report the device identifier (DI) of the Unique Device Identifier (UDI) for pharmacy services.
Location	X323 | Health Care Claim: Professional | 837 | 4930 | 2410 LIN - Drug/Supply Identification
Action	**Modify Segment Note** Changed to: Drugs, biologics and medical or surgical supplies reported in this segment are a further specification of service(s) described in the SV1 segment of this Service Line Loop ID-2400. Discontinuation of Legacy Identification Numbers Assigned to Devices (National Drug Code (NDC) and National Health-Related Item Code Numbers (NHRIC)) has been replaced by the Device Identifier of the Unique Device Identifier (see section 1.5 Terminology for definition of device). See section 21 CFR Parts 16, 801, 803, et al. Unique Device Identification System; Final Rule section 801.57
CR 1548	Provide the ability to report the device identifier (DI) of the Unique Device Identifier (UDI) for pharmacy services.
Location	X323 | Health Care Claim: Professional | 837 | 4930 | 2410 LIN - Drug/Supply Identification
Action	**Add Data Element Code Value** Loop ID 2410 / LIN02 (Product/Service ID Qualifier) ZZ (Mutually Defined)
CR 1548	Provide the ability to report the device identifier (DI) of the Unique Device Identifier (UDI) for pharmacy services.
Location	X323 | Health Care Claim: Professional | 837 | 4930 | 2410 LIN - Drug/Supply Identification

Action	**Add Data Element Code Note** Loop ID 2410 / LIN02 (Product/Service ID Qualifier ZZ (Mutually Defined) Use when reporting the Device Identifier of Unique Device Identifier. Prior to the mandated implementation date for the Unique Device Identifier, willing trading partners may agree to follow an early implementation approach.
CR 1548	Provide the ability to report the device identifier (DI) of the Unique Device Identifier (UDI) for pharmacy services.
Location	X323 | Health Care Claim: Professional | 837 | 4940 | 2410 CTP - Drug Quantity
Action	**Add Data Element Note** Loop ID 2410 / CTP05-02 (Code Qualifier) When an NDC is reported in LIN03, refer to the Billing Unit Standard Fact Sheet in the public section of the NCPDP web site to determine the appropriate code value to use for this data element. Use the qualifier equivalent in meaning to the NCPDP code value. When a UPN is reported in LIN03, use code UN.
CR 1203	To clarify code value used for UPN
Location	X323 | Health Care Claim: Professional | 837 | 4960 | 2410 SV4 - Drug Service
Action	**Add Segment** Loop ID 2410 / SV4 (DRUG SERVICE)
CR 310	Allow the reporting of drug rebate information in the claim transaction.
Location	X323 | Health Care Claim: Professional | 837 | 4960 | 2410 SV4 - Drug Service
Action	**Add Data Element Note** Multiple Loops / Multiple Data Elements Data Element 782 (Monetary Amount): The maximum length of this instance of data element 782 is 10.
CR 1013	Add a consistent element note explaining the maximum length to every monetary amount element.
Location	X323 | Health Care Claim: Professional | 837 | 4970 | 2410 SV7 - Drug Adjudication

Action	**Add Segment** Loop ID 2410 / SV7 (DRUG ADJUDICATION)
CR 310	Allow the reporting of drug rebate information in the claim transaction.
Location	X323 | Health Care Claim: Professional | 837 | 5000 | 2420A NM1 - Rendering Provider Name
Action	**Modify Data Element Situational Rule** Loop ID 2420A / NM104 (Rendering Provider First Name) Changed to: Required when the person has a first name. If not required by this implementation guide, do not send.
CR 1135	Ensure consistency between the NUCC rendering provider definition & TR3 instructions.
Location	X323 | Health Care Claim: Professional | 837 | 5000 | 2420A NM1 - Rendering Provider Name
Action	**Modify Data Element Situational Rule** Loop ID 2420A / (Rendering Provider Middle Name or Initial) Changed to: Required when the middle name or initial of the person is needed to identify the individual. If not required by this implementation guide, do not send.
CR 1135	Ensure consistency between the NUCC rendering provider definition & TR3 instructions.
Location	X323 | Health Care Claim: Professional | 837 | 5000 | 2420A NM1 - Rendering Provider Name
Action	**Delete Data Element Code Value** Loop ID 2420A / NM102 (Entity Type Qualifier) 2 (Non-Person Entity)
CR 1135	Ensure consistency between the NUCC rendering provider definition & TR3 instructions.
Location	X323 | Health Care Claim: Professional | 837 | 5000 | 2420A NM1 - Rendering Provider Name
Action	**Modify Data Element Situational Rule** Loop ID 2010BA / NM107 (Subscriber Name Suffix) Changed to: Required when the name suffix is needed to identify the individual. If not required by this implementation guide, do not send.

CR 1154	For consistency across all TR3s.
Location	X323 | Health Care Claim: Professional | 837 | 5250 | 2420A REF - Rendering Provider Secondary Identification
Action	**Modify Segment Situational Rule** Changed to: Required when NM109 of this loop is not used and an identifier is necessary for the receiver to identify the provider. If not required by this implementation guide, do not send.
CR 175	Change the shared situational rule in all locations to reflect that the NPI is now in effect.
Location	X323 | Health Care Claim: Professional | 837 | 5250 | 2420A REF - Rendering Provider Secondary Identification
Action	**Modify Segment Note** Changed to: When it is necessary to assign the identifier in REF01 of this segment to one or more non-destination payers, the composite data element in REF04 is used to identify the payer that assigned this identifier.
CR 1129	To promote consistency across all guides.
Location	X323 | Health Care Claim: Professional | 837 | 5250 | 2420A REF - Rendering Provider Secondary Identification
Action	**Add Data Element Note** Loop ID 2420 / REF01 (Reference Identification Qualifier) If REF04 is not used and code A6 or LU is used, REF02 is a proprietary provider number for the destination payer identified in the Payer Name loop, Loop ID-2010BB, associated with this claim. If REF04 is used, REF02 is a proprietary provider number for the non-destination payer identified in the Other Payer Name loop, Loop ID-2330B, associated with this claim.
CR 1204	Add element note to clarify use of REF04 composite.
Location	X323 | Health Care Claim: Professional | 837 | 5250 | 2420A REF - Rendering Provider Secondary Identification
Action	**Modify Data Element Code Value** Loop ID 2420A / REF01 (Reference Identification Qualifier) Changed G2 (Commercial Number) to A6 (Provider Identifier)
CR 497	Remove REF Segment qualifier G2 and add A6 to better accommodate atypical providers.

Location	X323 | Health Care Claim: Professional | 837 | 5250 | 2420A REF - Rendering Provider Secondary Identification
Action	**Delete Data Element Code Value** Loop ID 2420A / REF (Rendering Provider Secondary Identification) Removed: 0B (State License Number)
CR 1231	To better align with industry use.

Location	X323 | Health Care Claim: Professional | 837 | 5250 | 2420A REF - Rendering Provider Secondary Identification
Action	**Modify Data Element Situational Rule** Loop ID 2420A / REF04 (Reference Identifier) Changed to: Required when the identifier reported in REF02 of this segment is for a non-destination payer.
CR 1129	To promote consistency across all guides.

Location	X323 | Health Care Claim: Professional | 837 | 5250 | 2420A REF - Rendering Provider Secondary Identification
Action	**Delete Data Element Note** Loop 2420 / REF04 (Reference Identifier) Do not use this composite when the value reported in REF01 is 0B.
CR 100	Remove 0B Qualfiier from all Provider REF segments, the NPI should be required for those providers.

Location	X323 | Health Care Claim: Professional | 837 | 5250 | 2420A REF - Rendering Provider Secondary Identification
Action	**Delete Data Element Code Value** 1G Provider UPIN Number
CR 326	Delete the UPIN qualifer on Provider segments across the TR3s.

Location	X323 | Health Care Claim: Professional | 837 | 5000 | 2420B NM1 - Purchased Service Provider Name
Action	**Modify Data Element Situational Rule** Multiple Loops / NM109 (Identification Code) Changed to: Required when the provider has received an NPI and the NPI is available to the submitter. If not required by this implementation guide, do not send.

CR 177	Change the situational rule in all locations to reflect that the NPI is now in effect.
Location	X323 | Health Care Claim: Professional | 837 | 5250 | 2420B REF - Purchased Service Provider Secondary Identification
Action	**Modify Segment Repeat** Changed to: 11
CR 1205	Modify the repeat count to match the number of qualifiers available for use.
Location	X323 | Health Care Claim: Professional | 837 | 5250 | 2420B REF - Purchased Service Provider Secondary Identification
Action	**Modify Segment Situational Rule** Changed to: Required when NM109 of this loop is not used and an identifier is necessary for the receiver to identify the provider. If not required by this implementation guide, do not send.
CR 175	Change the shared situational rule in all locations to reflect that the NPI is now in effect.
Location	X323 | Health Care Claim: Professional | 837 | 5250 | 2420B REF - Purchased Service Provider Secondary Identification
Action	**Modify Segment Situational Rule** Changed to: Required when NM109 of this loop is not used. If not required by this implementation guide, do not send.
CR 330	Remove the NPI dual use language and change the supervising provider primary identifier requirement, since the supervising provider would have an NPI.
Location	X323 | Health Care Claim: Professional | 837 | 5250 | 2420B REF - Purchased Service Provider Secondary Identification
Action	**Add Data Element Note** Loop ID 2420 / REF01 (Reference Identification Qualifier) If REF04 is not used and code A6 or LU is used, REF02 is a proprietary provider number for the destination payer identified in the Payer Name loop, Loop ID-2010BB, associated with this claim. If REF04 is used, REF02 is a proprietary provider number for the non-destination payer identified in the Other Payer Name loop, Loop ID-2330B, associated with this claim.
CR 1204	Add element note to clarify use of REF04 composite.

Location	X323 | Health Care Claim: Professional | 837 | 5250 | 2420B REF - Purchased Service Provider Secondary Identification
Action	**Modify Data Element Code Value** Loop ID 2420B / REF01 (Reference Identification Qualifier) Changed G2 (Commercial Number) to A6 (Provider Identifier)
CR 497	Remove REF Segment qualifier G2 and add A6 to better accommodate atypical providers.

Location	X323 | Health Care Claim: Professional | 837 | 5250 | 2420B REF - Purchased Service Provider Secondary Identification
Action	**Delete Data Element Code Value** Loop IU D 2420B / REF (Purchased Service Provider Secondary Identification) Removed: 0B (State License Number)
CR 1231	To better align with industry use.

Location	X323 | Health Care Claim: Professional | 837 | 5250 | 2420B REF - Purchased Service Provider Secondary Identification
Action	**Modify Segment Note** Changed to: When it is necessary to assign the identifier in REF01 of this segment to one or more non-destination payers, the composite data element in REF04 is used to identify the payer that assigned this identifier.
CR 1129	To promote consistency across all guides.

Location	X323 | Health Care Claim: Professional | 837 | 5250 | 2420B REF - Purchased Service Provider Secondary Identification
Action	**Modify Data Element Situational Rule** Loop ID 2420A / REF04 (Reference Identifier) Changed to: Required when the identifier reported in REF02 of this segment is for a non-destination payer.
CR 1129	To promote consistency across all guides.

Location	X323 | Health Care Claim: Professional | 837 | 5250 | 2420B REF - Purchased Service Provider Secondary Identification
Action	**Delete Data Element Note** Loop 2420 / REF04 (Reference Identifier) Do not use this composite when the value reported in REF01 is 0B.

CR 100	Remove 0B Qualfiier from all Provider REF segments, the NPI should be required for those providers.
Location	X323 | Health Care Claim: Professional | 837 | 5250 | 2420B REF - Purchased Service Provider Secondary Identification
Action	**Delete Data Element Code Value** 1G Provider UPIN Number
CR 326	Delete the UPIN qualifer on Provider segments across the TR3s.
Location	X323 | Health Care Claim: Professional | 837 | 5000 | 2420C NM1 - Service Location Name
Action	**Modify Segment Name** NM1 (SERVICE FACILITY LOCATION NAME) Changed to: SERVICE LOCATION NAME
CR 889	The data in this loop is related to the "Service Location" (which could be a service facility, patient's home, provider secondary office location). Request the name of this loop be changed to 'Service Location' across the TR3s so that the name matches the data content and is consistent.
Location	X323 | Health Care Claim: Professional | 837 | 5000 | 2420C NM1 - Service Location Name
Action	**Modify Segment Situational Rule** Changed to: Required when the location of health care service for this service line is different than that carried in Loop ID-2310C Service Location. OR Required when Loop ID-2310C is not used and the location of health care service for this service line is different than that carried in Loop ID-2010AA Billing Provider. If not required by this implementation guide, do not send.
CR 889	The data in this loop is related to the "Service Location" (which could be a service facility, patient's home, provider secondary office location). Request the name of this loop be changed to 'Service Location' across the TR3s so that the name matches the data content and is consistent.
Location	X323 | Health Care Claim: Professional | 837 | 5000 | 2420C NM1 - Service Location Name
Action	**Modify Segment Note** Changed to: The purpose of this loop is to identify specifically where the service is rendered. Examples include, but are not limited to, remote clinics, patient's residence, a residence (when patient doesn't live there but visiting for example), external facilities, etc.

	When reporting ambulance services, do not use this loop. Use Loop ID-2420G Ambulance Pick-up Location and Loop ID-2420H Ambulance Drop-off Location.
CR 230	Loop 2420C - NM1 Service Facility Location Name - Change the TR3 Note to support predeterminations and service in a patient's home.
Location	X323 | Health Care Claim: Professional | 837 | 5000 | 2420C NM1 - Service Location Name
Action	**Modify Data Element Usage** Loop ID 2420C / NM103 (Service Location Name) Changed to: SITUATIONAL
CR 888	Consider changing the NM103 element requirement from "required" to "situational". The name is not needed for all situations, e.g. when the services are performed in the patient's home.
Location	X323 | Health Care Claim: Professional | 837 | 5000 | 2420C NM1 - Service Location Name
Action	**Add Data Element Situational Rule** Loop ID 2420C / NM103 (Service Location Name) Required when the Service Location is a organization health care provider who is external to the entity identified as the Billing Provider in Loop ID-2010AA. If not required by this implementation guide, do not send.
CR 888	Consider changing the NM103 element requirement from "required" to "situational". The name is not needed for all situations, e.g. when the services are performed in the patient's home.
Location	X323 | Health Care Claim: Professional | 837 | 5140 | 2420C N3 - Service Location Address
Action	**Modify Segment Name** N3 (SERVICE FACILITY LOCATION ADDRESS) Changed to: SERVICE LOCATION ADDRESS
CR 889	The data in this loop is related to the "Service Location" (which could be a service facility, patient's home, provider secondary office location). Request the name of this loop be changed to 'Service Location' across the TR3s so that the name matches the data content and is consistent.
Location	X323 | Health Care Claim: Professional | 837 | 5140 | 2420C N3 - Service Location Address
Action	**Modify Segment Note** Changed to:

	If service location is in an area where there are no street addresses, enter a description of the location (for example, "crossroad of State Road 34 and 45" or "Exit near Mile marker 265 on Interstate 80").
CR 210	Revise the note to include predeterminations.

Location	X323 | Health Care Claim: Professional | 837 | 5200 | 2420C N4 - Service Location City, State, ZIP Code
Action	**Modify Segment Name** N4 (SERVICE FACILITY LOCATION CITY, STATE, ZIP CODE) Changed to: SERVICE LOCATION CITY, STATE, ZIP CODE
CR 889	The data in this loop is related to the "Service Location" (which could be a service facility, patient's home, provider secondary office location). Request the name of this loop be changed to 'Service Location' across the TR3s so that the name matches the data content and is consistent.

Location	X323 | Health Care Claim: Professional | 837 | 5200 | 2420C N4 - Service Location City, State, ZIP Code
Action	**Modify Data Element Note** Multiple Locations / N403 (Postal Code) Changed to: When reporting the ZIP code for U.S. addresses, the full nine digit ZIP code must be provided when one exists.
CR 760	Remove the restrictive requirement for a 9 digit ZIP code in N403.

Location	X323 | Health Care Claim: Professional | 837 | 5250 | 2420C REF - Service Location Secondary Identification
Action	**Modify Segment Name** REF (SERVICE FACILITY LOCATION SECONDARY IDENTIFICATION) Changed to: SERVICE LOCATION SECONDARY IDENTIFICATION
CR 889	The data in this loop is related to the "Service Location" (which could be a service facility, patient's home, provider secondary office location). Request the name of this loop be changed to 'Service Location' across the TR3s so that the name matches the data content and is consistent.

Location	X323 | Health Care Claim: Professional | 837 | 5250 | 2420C REF - Service Location Secondary Identification
Action	**Modify Segment Repeat** Changed to: 20
CR 82	Modify the repeat to match the number of available qualifiers.

Location	X323 | Health Care Claim: Professional | 837 | 5250 | 2420C REF - Service Location Secondary Identification
Action	**Modify Segment Note** Changed to: When it is necessary to assign the identifier in REF01 of this segment to one or more non-destination payers, the composite data element in REF04 is used to identify the payer that assigned this identifier.
CR 1129	To promote consistency across all guides.

Location	X323 | Health Care Claim: Professional | 837 | 5250 | 2420C REF - Service Location Secondary Identification
Action	**Add Data Element Note** Loop ID 2420 / REF01 (Reference Identification Qualifier) If REF04 is not used and code A6 or LU is used, REF02 is a proprietary provider number for the destination payer identified in the Payer Name loop, Loop ID-2010BB, associated with this claim. If REF04 is used, REF02 is a proprietary provider number for the non-destination payer identified in the Other Payer Name loop, Loop ID-2330B, associated with this claim.
CR 1204	Add element note to clarify use of REF04 composite.

Location	X323 | Health Care Claim: Professional | 837 | 5250 | 2420C REF - Service Location Secondary Identification
Action	**Modify Data Element Code Value** Loop ID 2420C / REF01 (Reference Identification Qualifier) Changed G2 (Commercial Number) to A6 (Provider Identifier)
CR 497	Remove REF Segment qualifier G2 and add A6 to better accommodate atypical providers.

Location	X323 | Health Care Claim: Professional | 837 | 5250 | 2420C REF - Service Location Secondary Identification
Action	**Delete Data Element Code Value** Loop ID 2420C / REF (Service Location Provider Secondary Identification) Removed: 0B (State License Number)
CR 1231	To better align with industry use.

Location	X323 | Health Care Claim: Professional | 837 | 5250 | 2420C REF - Service Location Secondary Identification

Action	**Modify Data Element Situational Rule** Loop ID 2420A / REF04 (Reference Identifier) Changed to: Required when the identifier reported in REF02 of this segment is for a non-destination payer.
CR 1129	To promote consistency across all guides.

Location	X323 | Health Care Claim: Professional | 837 | 5000 | 2420D NM1 - Supervising Provider Name
Action	**Modify Segment Situational Rule** Changed to: Required when the rendering provider is supervised by a physician and the supervising physician for this service line is different than that listed at the claim level. If not required by this implementation guide, do not send.
CR 732	The rendering provider may be supervised for only one service line of a multi-line claim. The instructions should be revised to support this scenario.

Location	X323 | Health Care Claim: Professional | 837 | 5000 | 2420D NM1 - Supervising Provider Name
Action	**Modify Data Element Usage** Loop ID 2420D / NM108 (Identification Code Qualifier) Changed to: REQUIRED
CR 330	Remove the NPI dual use language and change the supervising provider primary identifier requirement, since the supervising provider would have an NPI.

Location	X323 | Health Care Claim: Professional | 837 | 5000 | 2420D NM1 - Supervising Provider Name
Action	**Modify Data Element Usage** Loop ID 2420D / NM109 (Supervising Provider Identifier) Changed to: REQUIRED
CR 330	Remove the NPI dual use language and change the supervising provider primary identifier requirement, since the supervising provider would have an NPI.

Location	X323 | Health Care Claim: Professional | 837 | 5000 | 2420E NM1 - Ordering Provider Name
Action	**Modify Data Element Situational Rule** Multiple Loops / NM109 (Identification Code)

	Changed to: Required when the provider has received an NPI and the NPI is available to the submitter. If not required by this implementation guide, do not send.
CR 177	Change the situational rule in all locations to reflect that the NPI is now in effect.

Location	X323 | Health Care Claim: Professional | 837 | 5140 | 2420E N3 - Ordering Provider Address
Action	**Modify Segment Situational Rule** Changed to: Required when a Certificate of Medical Necessity (CMN) or DME Information Form (DIF), or Oxygen Therapy Certification is included on this service line. If not required by this implementation guide, do not send.
CR 845	The term "DMERC" is no longer used. Revise the situational rule.

Location	X323 | Health Care Claim: Professional | 837 | 5200 | 2420E N4 - Ordering Provider City, State, ZIP Code
Action	**Modify Segment Situational Rule** Changed to: Required when a Certificate of Medical Necessity (CMN) or DME Information Form (DIF), or Oxygen Therapy Certification is included on this service line. If not required by this implementation guide, do not send.
CR 845	The term "DMERC" is no longer used. Revise the situational rule.

Location	X323 | Health Care Claim: Professional | 837 | 5250 | 2420E REF - Ordering Provider Secondary Identification
Action	**Modify Segment Repeat** Changed to: 11
CR 1205	Modify the repeat count to match the number of qualifiers available for use.

Location	X323 | Health Care Claim: Professional | 837 | 5250 | 2420E REF - Ordering Provider Secondary Identification
Action	**Modify Segment Situational Rule** Changed to: Required when NM109 of this loop is not used and an identifier is necessary for the receiver to identify the provider. If not required by this implementation guide, do not send.
CR 175	Change the shared situational rule in all locations to reflect that the NPI is now in effect.

Location	X323 | Health Care Claim: Professional | 837 | 5250 | 2420E REF - Ordering Provider Secondary Identification

Action	**Modify Segment Note** Changed to: When it is necessary to assign the identifier in REF01 of this segment to one or more non-destination payers, the composite data element in REF04 is used to identify the payer that assigned this identifier.
CR 1129	To promote consistency across all guides.

Location	X323 | Health Care Claim: Professional | 837 | 5250 | 2420E REF - Ordering Provider Secondary Identification
Action	**Add Data Element Note** Loop ID 2420 / REF01 (Reference Identification Qualifier) If REF04 is not used and code A6 or LU is used, REF02 is a proprietary provider number for the destination payer identified in the Payer Name loop, Loop ID-2010BB, associated with this claim. If REF04 is used, REF02 is a proprietary provider number for the non-destination payer identified in the Other Payer Name loop, Loop ID-2330B, associated with this claim.
CR 1204	Add element note to clarify use of REF04 composite.

Location	X323 | Health Care Claim: Professional | 837 | 5250 | 2420E REF - Ordering Provider Secondary Identification
Action	**Modify Data Element Code Value** Loop ID 2420E / REF01 (Reference Identification Qualifier) Changed G2 (Commercial Number) to A6 (Provider Identifier)
CR 497	Remove REF Segment qualifier G2 and add A6 to better accommodate atypical providers.

Location	X323 | Health Care Claim: Professional | 837 | 5250 | 2420E REF - Ordering Provider Secondary Identification
Action	**Delete Data Element Code Value** Loop ID 2420E / REF (Ordering Provider Secondary Identification) Removed: 0B (State License Number)
CR 1231	To better align with industry use.

Location	X323 | Health Care Claim: Professional | 837 | 5250 | 2420E REF - Ordering Provider Secondary Identification
Action	**Modify Data Element Situational Rule** Loop ID 2420A / REF04 (Reference Identifier)

	Changed to: Required when the identifier reported in REF02 of this segment is for a non-destination payer.
CR 1129	To promote consistency across all guides.
Location	X323 | Health Care Claim: Professional | 837 | 5250 | 2420E REF - Ordering Provider Secondary Identification
Action	**Delete Data Element Note** Loop 2420 / REF04 (Reference Identifier) Do not use this composite when the value reported in REF01 is 0B.
CR 100	Remove 0B Qualfiier from all Provider REF segments, the NPI should be required for those providers.
Location	X323 | Health Care Claim: Professional | 837 | 5250 | 2420E REF - Ordering Provider Secondary Identification
Action	**Delete Data Element Code Value** 1G Provider UPIN Number
CR 326	Delete the UPIN qualifer on Provider segments across the TR3s.
Location	X323 | Health Care Claim: Professional | 837 | 5300 | 2420E PER - Ordering Provider Contact Information
Action	**Modify Segment Repeat** Changed to: 2
CR 1205	Modify the repeat count to match the number of qualifiers available for use.
Location	X323 | Health Care Claim: Professional | 837 | 5300 | 2420E PER - Ordering Provider Contact Information
Action	**Modify Segment Situational Rule** Changed to: Required when a Certificate of Medical Necessity (CMN) or DME Information Form (DIF), or Oxygen Therapy Certification is included on this service line. If not required by this implementation guide, do not send.
CR 845	The term "DMERC" is no longer used. Revise the situational rule.
Location	X323 | Health Care Claim: Professional | 837 | 5000 | 2420F NM1 - Referring Provider Name
Action	**Modify Segment Situational Rule** Changed to: Required when this service line involves a referral AND the referring provider differs from that reported at the claim level (loop 2310A). OR

	Required when this service line involves a referral AND the claim level referring provider (Loop ID 2310A) was not reported. If not required by this implementation guide, may be provided at the sender's discretion, but cannot be required by the receiver.
CR 1349	The rules for referral number and referring provider at the claim and line level assume that there is always a referral tied to the entire claim; however it is possible for a referral to be applicable to select service lines but not all the service lines.

Location	X323 | Health Care Claim: Professional | 837 | 5000 | 2420F NM1 - Referring Provider Name
Action	**Add Segment Note** See NUCC Manual for definition of professional providers.
CR 90	Provider definitions should be removed from the TR3s and replaced with references to the NUBC/NUCC information. This insures alignment and prevents future TR3 modifications if NUBC/NUCC change the definitions.

Location	X323 | Health Care Claim: Professional | 837 | 5000 | 2420F NM1 - Referring Provider Name
Action	**Delete Data Element Code Note** Loop ID 2310A / NM101 Entity Identifier Code) DN (Referring Provider) Use if loop is used only once.
CR 884	Current note causes conflict of code value usage.

Location	X323 | Health Care Claim: Professional | 837 | 5000 | 2420F NM1 - Referring Provider Name
Action	**Modify Data Element Situational Rule** Multiple Loops / NM109 (Identification Code) Changed to: Required when the provider has received an NPI and the NPI is available to the submitter. If not required by this implementation guide, do not send.
CR 177	Change the situational rule in all locations to reflect that the NPI is now in effect.

Location	X323 | Health Care Claim: Professional | 837 | 5000 | 2420F NM1 - Referring Provider Name
Action	**Delete Data Element Code Note** Loop ID 2310A / NM101 (Entity Identifier Code)

	P3 (Primary Care Provider) Use only if loop is used twice.
CR 884	Current note causes conflict of code value usage.
Location	X323 | Health Care Claim: Professional | 837 | 5250 | 2420F REF - Referring Provider Secondary Identification
Action	**Modify Segment Repeat** Changed to: 11
CR 1205	Modify the repeat count to match the number of qualifiers available for use.
Location	X323 | Health Care Claim: Professional | 837 | 5250 | 2420F REF - Referring Provider Secondary Identification
Action	**Modify Segment Situational Rule** Changed to: Required when NM109 of this loop is not used and an identifier is necessary for the receiver to identify the provider. If not required by this implementation guide, do not send.
CR 175	Change the shared situational rule in all locations to reflect that the NPI is now in effect.
Location	X323 | Health Care Claim: Professional | 837 | 5250 | 2420F REF - Referring Provider Secondary Identification
Action	**Modify Segment Note** Changed to: When it is necessary to assign the identifier in REF01 of this segment to one or more non-destination payers, the composite data element in REF04 is used to identify the payer that assigned this identifier.
CR 1129	To promote consistency across all guides.
Location	X323 | Health Care Claim: Professional | 837 | 5250 | 2420F REF - Referring Provider Secondary Identification
Action	**Add Data Element Note** Loop ID 2420 / REF01 (Reference Identification Qualifier) If REF04 is not used and code A6 or LU is used, REF02 is a proprietary provider number for the destination payer identified in the Payer Name loop, Loop ID-2010BB, associated with this claim. If REF04 is used, REF02 is a proprietary provider number for the non-destination payer identified in the Other Payer Name loop, Loop ID-2330B, associated with this claim.
CR 1204	Add element note to clarify use of REF04 composite.

Location	X323 | Health Care Claim: Professional | 837 | 5250 | 2420F REF - Referring Provider Secondary Identification
Action	**Modify Data Element Code Value** Loop ID 2420F / REF01 (Reference Identification Qualifier) Changed G2 (Commercial Number) to A6 (Provider Identifier)
CR 497	Remove REF Segment qualifier G2 and add A6 to better accommodate atypical providers.

Location	X323 | Health Care Claim: Professional | 837 | 5250 | 2420F REF - Referring Provider Secondary Identification
Action	**Delete Data Element Code Value** Loop ID 2420F / REF (Referring Provider Secondary Identification) Removed: 0B (State License Number)
CR 1231	To better align with industry use.

Location	X323 | Health Care Claim: Professional | 837 | 5250 | 2420F REF - Referring Provider Secondary Identification
Action	**Modify Data Element Situational Rule** Loop ID 2420A / REF04 (Reference Identifier) Changed to: Required when the identifier reported in REF02 of this segment is for a non-destination payer.
CR 1129	To promote consistency across all guides.

Location	X323 | Health Care Claim: Professional | 837 | 5250 | 2420F REF - Referring Provider Secondary Identification
Action	**Delete Data Element Note** Loop 2420 / REF04 (Reference Identifier) Do not use this composite when the value reported in REF01 is 0B.
CR 100	Remove 0B Qualfiier from all Provider REF segments, the NPI should be required for those providers.

Location	X323 | Health Care Claim: Professional | 837 | 5250 | 2420F REF - Referring Provider Secondary Identification
Action	**Delete Data Element Code Value** 1G Provider UPIN Number
CR 326	Delete the UPIN qualifer on Provider segments across the TR3s.

Location	X323 | Health Care Claim: Professional | 837 | 5000 | 2420G NM1 - Ambulance Pick-up Location
Action	**Modify Segment Situational Rule** Changed to: Required when submitting a claim for ambulance or non-emergency transportation services and the CR1 segment is present at the service line (Loop ID-2400) and the ambulance pick-up location for this service line is different than the ambulance pick-up location provided in Loop ID-2310E. If not required by this implementation guide, do not send.
CR 1523	Modify the situational rule to enable content editing within the transaction.

Location	X323 | Health Care Claim: Professional | 837 | 5000 | 2420H NM1 - Ambulance Drop-off Location
Action	**Modify Segment Situational Rule** Changed to: Required when submitting a claim for ambulance or non-emergency transportation services and the CR1 segment is present at the service line (Loop ID-2400) and the ambulance drop-off location for this service line is different than the ambulance drop-off location provided in Loop ID-2310F. If not required by this implementation guide, do not send.
CR 1523	Modify the situational rule to enable content editing within the transaction.

Location	X323 | Health Care Claim: Professional | 837 | 5400 | 2430 SVD - Line Adjudication Information
Action	**Add Segment Note** Refer to Section 1.4.2.3 Coordination of Benefits - Service Line Procedure Code Bundling and Unbundling.
CR 868	Request that the unbundling example be added back in a TR3 note.

Location	X323 | Health Care Claim: Professional | 837 | 5400 | 2430 SVD - Line Adjudication Information
Action	**Modify Data Element Note** Loop ID 2430 / SVD01 (Payer Responsibility Sequece Number Code) Changed to: The value reported in this field must match the corresponding Other Payer Responsibility Sequence Code reported in Loop ID-2320 SBR01.
CR 1123	Ensure proper linkage between the Payer Responsibility Sequence Code (SBR01) in Loop ID 2320 and the service line payment information in Loop ID 2430 Payer Responsibility Sequence Code (SVD01).

Location	X323 | Health Care Claim: Professional | 837 | 5400 | 2430 SVD - Line Adjudication Information

Action	**Add Data Element Note** Multiple Loops / Multiple Data Elements Data Element 782 (Monetary Amount): The maximum length of this instance of data element 782 is 10.
CR 1013	Add a consistent element note explaining the maximum length to every monetary amount element.
Location	X323 | Health Care Claim: Professional | 837 | 5400 | 2430 SVD - Line Adjudication Information
Action	**Delete Data Element Code Value** Loop ID 2430 / SVD03-01 (Product/Service ID Qualifier) WK (Advanced Billing Concepts (ABC) Codes)
CR 749	Remove support for Advanced Billing Concept Codes (ABC) across the TR3s as HHS has discontinued the associated pilot project.
Location	X323 | Health Care Claim: Professional | 837 | 5400 | 2430 SVD - Line Adjudication Information
Action	**Modify Data Element Situational Rule** Loop ID 2430 / Multiple SVD03 Data Elements (Procedure Code Modifier) Changed to: Required when the adjudicated procedure code includes a procedure code modifier reported by the payer. If not required by this implementation guide, do not send.
CR 867	The situational rules for the modifiers should read "...reporting accuracy". In this location, these are the modifiers used in the adjudication of the service. Shouldn't these read more like "Required when the adjudicated procedure code reported by the payer includes a first (second, third, fourth) modifier..."?
Location	X323 | Health Care Claim: Professional | 837 | 5400 | 2430 SVD - Line Adjudication Information
Action	**Modify Data Element Usage** Loop ID 2430 / SVD03-07 (Procedure Code Description) Changed to: NOT USED
CR 1262	Procedure Code Description is not necessary when reporting COB claims.
Location	X323 | Health Care Claim: Professional | 837 | 5400 | 2430 SVD - Line Adjudication Information

Action	**Add Data Element Situational Rule** Loop ID 2430 / SVD03-09 (Procedure Modifier) Required when a fifth modifier clarifies or improves the reporting accuracy of the associated procedure code. If not required by this implementation guide, do not send.
CR 384	Revise the SVC01 to accommodate more than 4 modifiers.
Location	X323 | Health Care Claim: Professional | 837 | 5400 | 2430 SVD - Line Adjudication Information
Action	**Add Data Element Situational Rule** Loop ID 2430 / SVD03-10 (Procedure Modifier) Required when a sixth modifier clarifies or improves the reporting accuracy of the associated procedure code. If not required by this implementation guide, do not send.
CR 384	Revise the SVC01 to accommodate more than 4 modifiers.
Location	X323 | Health Care Claim: Professional | 837 | 5400 | 2430 SVD - Line Adjudication Information
Action	**Add Data Element Situational Rule** Loop ID 2430 / SVD03-11 (Procedure Modifier) Required when a seventh modifier clarifies or improves the reporting accuracy of the associated procedure code. If not required by this implementation guide, do not send.
CR 384	Revise the SVC01 to accommodate more than 4 modifiers.
Location	X323 | Health Care Claim: Professional | 837 | 5400 | 2430 SVD - Line Adjudication Information
Action	**Add Data Element Situational Rule** Loop ID 2430 / SVD03-12 (Procedure Modifier) Required when a eighth modifier clarifies or improves the reporting accuracy of the associated procedure code. If not required by this implementation guide, do not send.
CR 384	Revise the SVC01 to accommodate more than 4 modifiers.
Location	X323 | Health Care Claim: Professional | 837 | 5400 | 2430 SVD - Line Adjudication Information
Action	**Modify Data Element Note** Loop ID 2430 / SVD05 (Paid Service Unit Count)

	Changed to: This is the number of paid units from the remittance advice. When paid units are not present on the paper remittance advice, the value must be one.
CR 1092	Ensure consistency with the 837 COB information regarding paid units of service.

Location	X323 | Health Care Claim: Professional | 837 | 5400 | 2430 SVD - Line Adjudication Information
Action	**Delete Data Element Code Value** IV - HIEC Codes
CR 612	Remove references to HIEC and ABC code lists as they are no longer valid.

Location	X323 | Health Care Claim: Professional | 837 | 5480 | 2430 RAS - Service Adjustment Information
Action	**Add Segment** Loop ID 2430 / RAS (SERVICE ADJUSTMENT INFORMATION) Replaced: CAS (LINE ADJUSTMENT)
CR 105	Inclusion of the RAS segment supports multiple CARCs for a single dollar amount and allows association of remark codes to a specific CARC.

Location	X323 | Health Care Claim: Professional | 837 | 5480 | 2430 RAS - Service Adjustment Information
Action	**Add Data Element Note** Multiple Loops / Multiple Data Elements Data Element 782 (Monetary Amount): The maximum length of this instance of data element 782 is 10.
CR 1013	Add a consistent element note explaining the maximum length to every monetary amount element.

Location	X323 | Health Care Claim: Professional | 837 | 5480 | 2430 RAS - Service Adjustment Information
Action	**Delete Data Element Code Value** Loop ID 2430, Data Element RAS02 (Claim Adjustment Group Code) All Code Values were moved to External Code Source 974: Claim Adjustment Group Codes.
CR 678	835 - Make Claim Adjustment Group Code an external list to support flexibility when new codes or revisions are needed to meet changing business or regulatory requirements.

Location	X323 | Health Care Claim: Professional | 837 | 5480 | 2430 RAS - Service Adjustment Information
Action	**Add Data Element Code Value** Loop ID 2430 / RAS03-02 (Code List Qualifier Code) RM (Insurance Industry Specific Remark Codes)
CR 1234	Create new external code list for industry specific remark codes that do not meet the criteria for CARCs or RARCs but are needed by their respective industries.

Location	X323 | Health Care Claim: Professional AMT - Coordination of Benefits (COB) Service Allowed Amount
Action	**Add Segment** Loop ID 2430 / AMT (COORDINATION OF BENEFITS (COB) SERVICE ALLOWED AMOUNT)
CR 1230	Provide payers the ability to report the allowed amount for informational purposes for coordination of benefits.

Location	X323 | Health Care Claim: Professional | 837 | 5505 | 2430 AMT - Remaining Patient Liability Amount
Action	**Modify Segment Situational Rule** Changed to: Required when the Other Payer Identified in SVD01 of this iteration of Loop ID-2430 has adjudicated this claim and the provider's opinion of the Patient Remaining Liability amount does not equal the sum of Patient Responsible CAS amounts, and the provider has the ability to report line item information. If not required by this implementation guide, may be provided at the sender's discretion, but cannot be required by the receiver.
CR 1321	Modify the situational rule to clarify the intended use of the Remaining Patient Liability AMT Segment.

Location	X323 | Health Care Claim: Professional | 837 | 5505 | 2430 AMT - Remaining Patient Liability Amount
Action	**Add Data Element Note** Multiple Loops / Multiple Data Elements Data Element 782 (Monetary Amount): The maximum length of this instance of data element 782 is 10.
CR 1013	Add a consistent element note explaining the maximum length to every monetary amount element.

Location	X323 | Health Care Claim: Professional | 837 | 5507 | 2430 LQ - Health Care Remark Codes
Action	**Add Segment** Loop ID 2430 / LQ (HEALTH CARE REMARK CODES)
CR 1234	Create new external code list for industry specific remark codes that do not meet the criteria for CARCs or RARCs but are needed by their respective industries.

Location	X323 | Health Care Claim: Professional | 837 | 5509 | 2400 LS - Supporting Documentation Header
Action	**Add Loop Header** LS (SUPPORTING DOCUMENTATION HEADER)
CR 1234	Create new external code list for industry specific remark codes that do not meet the criteria for CARCs or RARCs but are needed by their respective industries.

Location	X323 | Health Care Claim: Professional | 837 | 5510 | 2440 LQ - Form Identification Code
Action	**Modify Segment Note** Changed to: Loop ID-2440 is designed to allow providers to attach standardized supplemental information to the claim when required to do so by the payer. The LQ segment contains information to identify the form (LQ01) and the specific form number (LQ02). In the example given below, LQ01=UT which identifies the form as a Medicare CMN form. LQ02=484.03 identifies which CMN form is being used.
CR 422	Remove references to DMERC, because it is no longer used by Medicare in reference to their DME CMN forms.

Location	X323 | Health Care Claim: Professional | 837 | 5510 | 2440 LQ - Form Identification Code
Action	**Modify Segment Note** Changed to: An example application of this Form Identification Code Loop is for Medicare DME claims for which the DME provider is required to obtain a Certificate of Medical Necessity (CMN) or DME Information Form (DIF) from the referring physician. Another example is payer documentation requirements for Home Health services.
CR 422	Remove references to DMERC, because it is no longer used by Medicare in reference to their DME CMN forms.

Location	X323 | Health Care Claim: Professional | 837 | 5510 | 2440 LQ - Form Identification Code

Action	**Modify Data Element Code Note** Loop ID 2440 / LQ01 (Code List Qualifier Code) AS (Form Type Code) Changed to: Use when reporting a Home Health form.
CR 1558	Format code notes consistently.

Location	X323 | Health Care Claim: Professional | 837 | 5525 | 2400 LE - Supporting Documentation Trailer
Action	**Add Loop Trailer** LE (SUPPORTING DOCUMENTATION TRAILER)
CR 1234	Create new external code list for industry specific remark codes that do not meet the criteria for CARCs or RARCs but are needed by their respective industries.

Location	X323 | Health Care Claim: Professional | 837 | 5550 SE - Transaction Set Trailer
Action	**Modify Data Element Note** Transaction Set Header / ST02 (Transaction Set Control Number) Changed to: The Transaction Set Control Numbers in ST02 and SE02 must be identical. The number is assigned by the originator and must be unique within a functional group (GS-GE). For example, start with the number 0001 and increment from there. The number also aids in error resolution research.
CR 999	Revise the ST02 notes across the TR3's to make them consistent.