X12 Standards for Electronic Data Interchange
Technical Report Type 3

Health Care Service: Data Reporting (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	X326 | Health Care Service Data Reporting 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	X326 | Health Care Service Data Reporting 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	X326 | Health Care Service Data Reporting 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	X326 | Health Care Service Data Reporting 1.4 Business Usage
Action	**Modify Chapter 1** Added Section 1.4.3 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	X326 | Health Care Service Data Reporting 1.4 Business Usage
Action	**Modify Chapter 1** Added Section 1.4.3.1 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	X326 | Health Care Service Data Reporting 1.4 Business Usage
Action	**Modify Chapter 1** Added Section 1.4.3.2 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	X326 | Health Care Service Data Reporting 1.4 Business Usage
Action	**Modify Chapter 1** Added Section 1.4.3.3 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	X326 | Health Care Service Data Reporting 1.4 Business Usage
Action	**Modify Chapter 1** Section 1.4.2.1 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	X326 | Health Care Service Data Reporting 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	X326 | Health Care Service Data Reporting 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	X326 | Health Care Service Data Reporting 1.5 Business Terminology
Action	**Modify Chapter 1** Section 1.5 Business Terminology Added:

	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	X326 | Health Care Service Data Reporting 1.10 National Provider Identifier Usage within the HIPAA 837 Transaction
Action	**Modify Chapter 1** Removed National Provider Identifier Usage within the HIPAA 837 Transaction: Bulleted List - Providers who are not eligible for enumeration - Organization health care provider subpart representation - Subparts and the service provider
CR 1154	For consistency across all TR3s.

Location	X326 | Health Care Service Data Reporting 1.10 National Provider Identifier Usage within the HIPAA 837 Transaction
Action	**Modify Chapter 1** Section 1.10.1 Providers who are Not Eligible for Enumeration: Paragraph Changed to: Atypical providers are service providers that do not meet the definition of health care provider. Examples include taxi drivers, carpenters, personal care providers, etc. Although, they are not eligible to receive an NPI, these providers perform services that are reimbursed by some health plans. This implementation guide accommodates both the NPI (to identify health care providers) and proprietary identifiers (to identify atypical/non-health care providers).
CR 1154	For consistency across all TR3s.

Location	X326 | Health Care Service Data Reporting 1.10 National Provider Identifier Usage within the HIPAA 837 Transaction
Action	**Modify Chapter 1** 1.10.3 Subparts and the 2010AA - Service Provider Name Loop: Paragraph 5 Changed to: Do not confuse the above instructions with Loops 2310A through 2310F and Loops 2420A and 2420B when the service provider is a physician (Attending Provider, Operating Physician, Rendering Provider, and Referring Provider).
CR 1153	To clarify intended use.

Location	X326 | Health Care Service Data Reporting 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	X326 | Health Care Service Data Reporting 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	X326 | Health Care Service Data Reporting 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	X326 | Health Care Service Data Reporting 1.10 National Provider Identifier Usage within the HIPAA 837 Transaction
Action	**Delete Chapter 1** 1.10.2 Implementation Migration Strategy
CR 1154	For consistency across all TR3s.

Location	X326 | Health Care Service Data Reporting 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	X326 | Health Care Service Data Reporting 1.11 Coding of Drugs in the 837 Claim
Action	**Delete Chapter 1** 1.11.1 Single Drug Billing
CR 1153	To clarify intended use.

Location	X326 | Health Care Service Data Reporting 1.12 Guidelines For Miscellaneous Recurring Situations
Action	**Modify Chapter 1** Section 1.12.4 Provider Tax IDs: Paragraph 1 Changed to: For purposes of this implementation, the health service provider is the entity that provided or participated in some aspect of the health care service described in the encounter. The Employer Identification Number (EIN) or

	Social Security Number (SSN) for the service provider is only reported in the Service Provider Tax Identification REF segment in Loop ID-2010AA Service Provider. The EIN and SSN qualifiers are not valid in any provider REF segments other than the 2010AA Service 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. Up to four segments of Loop 2010AA (repeat) is allowed.
CR 497	Remove REF Segment qualifier G2 and add A6 to better accommodate atypical providers.

Location	X326 | Health Care Service Data Reporting 1.12 Guidelines For Miscellaneous Recurring Situations
Action	**Delete Chapter 1** Section 1.12.5 Claim and Line Redundant Information
CR 912	6020 Public Review Comment received indicating Section 1.12.5 conflicts with the line level situational rules and section 2.2.1.1. Please remove section 1.12.5. The way to accomplish the intent of 1.12.5 is to use the first form of situational rules (as explained in 2.2.1 of TR3 Common Content) where applicable.

Location	X326 | Health Care Service Data Reporting | 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	X326 | Health Care Service Data Reporting | 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 1154	For consistency across all TR3s.

Location	X326 | Health Care Service Data Reporting | 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	X326 | Health Care Service Data Reporting | 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	X326 | Health Care Service Data Reporting | 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	X326 | Health Care Service Data Reporting | 837 | 0150 | 2010AA NM1 - Service Provider Name
Action	**Modify Data Element Situational Rule** Loop ID 2010AA / NM108 (Identification Code Qualifier) Changed to: Required when NM109 is used. If not required by this implementation guide, do not send.
CR 1478	Remove duplication of situational rules between the element and the code qualifier across the TR3.

Location	X326 | Health Care Service Data Reporting | 837 | 0350 | 2010AA REF - Service Provider Secondary Identification
Action	**Modify Data Element Code Value** Loop ID 2010AA / REF01 (Reference Identification Qualifier) Changed G2 (Commercial Number) to 6 (Provider Identifier)

CR 497	Remove REF Segment qualifier G2 and add A6 to better accommodate atypical providers.
Location	X326 | Health Care Service Data Reporting | 837 | 0350 | 2010AA REF - Service Provider Secondary Identification
Action	**Delete Data Element Code Value** 0B - State License Number
CR 503	Workers' compensation implementers need to use the 0B (State License Number) qualifier in 837 REF segments.
Location	X326 | Health Care Service Data Reporting | 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	X326 | Health Care Service Data Reporting | 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	X326 | Health Care Service Data Reporting | 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	X326 | Health Care Service Data Reporting | 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	X326 | Health Care Service Data Reporting | 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	X326 | Health Care Service Data Reporting | 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	X326 | Health Care Service Data Reporting | 837 | 0050 | 2000B SBR - Subscriber Information
Action	**Add Data Element Note** Loop ID 2000B / SBR01 (Payer Responsibility Sequence Code) This code value identifies, in the opinion of the submitter, the relative adjudication order of the destination payer among all of the payers identified in this claim.
CR 1153	To clarify intended use.

Location	X326 | Health Care Service Data Reporting | 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	X326 | Health Care Service Data Reporting | 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	X326 | Health Care Service Data Reporting | 837 | 0050 | 2000B SBR - Subscriber Information
Action	**Add Data Element Note** Loop ID 2000B / SBR09 (Claim Filing Indicator Code) ME (Medicare Advantage Plan)
CR 941	Support reporting of Medicare Advantage insurance type for health care claims.

Location	X326 | Health Care Service Data Reporting | 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	X326 | Health Care Service Data Reporting | 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	X326 | Health Care Service Data Reporting | 837 | 0050 | 2000B SBR - Subscriber Information
Action	**Add Data Element Situational Rule** Loop ID 2000B / SBR10 (Source of Payment Typology Code) Required when authorized by state or federal law or regulations. If not required by this implementation guide, do not send.
CR 1202	To allow for more granular reporting of the source of payment when required by state or federal regulation.

Location	X326 | Health Care Service Data Reporting | 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	X326 | Health Care Service Data Reporting | 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	X326 | Health Care Service Data Reporting | 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	X326 | Health Care Service Data Reporting | 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	X326 | Health Care Service Data Reporting | 837 | 0350 | 2010BA REF - Subscriber Secondary Identification
Action	**Modify Data Element Code Note** Loop ID 2010BA / REF01 (Reference Identification Qualifier) ABB (Personal ID Number) Changed to: Use when reporting state specific linkage variable at the encounter.

CR 1558	Format code notes consistently.
Location	X326 | Health Care Service Data Reporting | 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	X326 | Health Care Service Data Reporting | 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	X326 | Health Care Service Data Reporting | 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	X326 | Health Care Service Data Reporting | 837 | 0150 | 2010BB NM1 - Payer Name
Action	**Delete Data Element Code Value** 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	X326 | Health Care Service Data Reporting | 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	X326 | Health Care Service Data Reporting | 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	X326 | Health Care Service Data Reporting | 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	X326 | Health Care Service Data Reporting | 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	X326 | Health Care Service Data Reporting | 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	X326 | Health Care Service Data Reporting | 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	X326 | Health Care Service Data Reporting | 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	X326 | Health Care Service Data Reporting | 837 | 0070 | 2000C PAT - Patient Information
Action	**Add Data Element Note** Loop ID 2000C / PAT01 (Individual Relationship Code) Specifies the patient's relationship to the person insured.
CR 1154	For consistency across all TR3s.

Location	X326 | Health Care Service Data Reporting | 837 | 0350 | 2010CA REF - Patient Secondary Identification
Action	**Modify Data Element Code Note** Loop ID 2010BA / REF01 (Reference Identification Qualifier) ABB (Personal ID Number) Changed to: Use when reporting state specific linkage variable at the encounter.
CR 1558	Format code notes consistently.

Location	X326 | Health Care Service Data Reporting | 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	X326 | Health Care Service Data Reporting | 837 | 1300 | 2300 CLM - Claim Information
Action	**Add Data Element Note** Loop ID 2300 / CLM02 (Total Claim Charge Amount) The total claim charge amount must balance to the sum of all service line charge amounts reported in the Institutional Service Line (SV2) segments for this claim.
CR 1154	For consistency across all TR3s.

Location	X326 | Health Care Service Data Reporting | 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	X326 | Health Care Service Data Reporting | 837 | 1300 | 2300 CLM - Claim Information
Action	**Modify Data Element Usage** Loop ID 2300 / CLM11 (Related Causes Information) Changed to: SITUATIONAL
CR 1413	For consistency across the 837 TR3s.

Location	X326 | Health Care Service Data Reporting | 837 | 1300 | 2300 CLM - Claim Information
Action	**Add Data Element Situational Rule** Loop ID 2300 / CLM11 (Related Causes Information) Required when the services provided are related to an auto accident. If not required by this implementation guide, do not send.
CR 1413	For consistency across the 837 TR3s.

Location	X326 | Health Care Service Data Reporting | 837 | 1300 | 2300 CLM - Claim Information
Action	**Add Data Element Code Note** Loop ID 2300 / CLM11-01 (Related Causes Code) AA (Auto Accident)
CR 1413	For consistency across the 837 TR3s.

Location	X326 | Health Care Service Data Reporting | 837 | 1300 | 2300 CLM - Claim Information
Action	**Add Data Element Situational Rule** Loop ID 2300 / CLM11-04 (State or Province Code) Required when CLM11-01 has a value of "AA" to identify the state, province or sub-country code in which the automobile accident occurred. If accident occurred in a country or location that does not have states, provinces or sub-country codes named in code source 22, do not use. If not required by this implementation guide, do not send.
CR 1413	For consistency across the 837 TR3s.

Location	X326 | Health Care Service Data Reporting | 837 | 1300 | 2300 CLM - Claim Information
Action	**Add Data Element Situational Rule** Loop ID 2300 / CLM11-05 (Country Code) Required when CLM11-01 has a value of "AA" and the accident occurred in a country other than US or Canada. If not required by this implementation guide, do not send.
CR 1413	For consistency across the 837 TR3s.

Location	X326 | Health Care Service Data Reporting | 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	X326 | Health Care Service Data Reporting | 837 | 1350 | 2300 DTP - Discharge Time
Action	**Modify Segment Name** DTP (DISCHARGE HOUR) Changed to: DISCHARGE TIME
CR 1509	To clarify intended use.
Location	X326 | Health Care Service Data Reporting | 837 | 1350 | 2300 DTP - Discharge Time
Action	**Modify Segment Situational Rule** Changed to: Required when use of the Discharge Time is directed by the National Uniform Billing Committee (NUBC) Official UB Data Specifications Manual and is not a predetermination request. If not required by this implementation guide, do not send.
CR 1216	Revise the TR3 to better align with the official UB Data Specifications Manual.
Location	X326 | Health Care Service Data Reporting | 837 | 1350 | 2300 DTP - Discharge Time
Action	**Modify Segment Situational Rule** Changed to: Required when use of the Discharge Time is directed by the National Uniform Billing Committee (NUBC) Official UB Data Specifications Manual. If not required by this implementation guide, do not send.
CR 1216	Revise the TR3 to better align with the official UB Data Specifications Manual.
Location	X326 | Health Care Service Data Reporting | 837 | 1350 | 2300 DTP - Discharge Time
Action	**Delete Segment Note** "This segment is required on all final inpatient claims."
CR 1213	To eliminate redundancy within the guide.
Location	X326 | Health Care Service Data Reporting | 837 | 1350 | 2300 DTP - Admission Date/Hour or Start of Care Date
Action	**Modify Segment Name** DTP (ADMISSION DATE/HOUR) Changed to: ADMISSION DATE/HOUR OR START OF CARE DATE
CR 810	The Admission date should be based solely on original inpatient admittance date/time.

Location	X326 | Health Care Service Data Reporting | 837 | 1350 | 2300 DTP - Admission Date/Hour or Start of Care Date
Action	**Modify Segment Situational Rule** Changed to: Required when directed by the National Uniform Billing Committee (NUBC) Official UB Data Specifications Manual and the claim is not a predetermination request. If not required by this implementation guide, do not send.
CR 1216	Revise the TR3 to better align with the official UB Data Specifications Manual.

Location	X326 | Health Care Service Data Reporting | 837 | 1350 | 2300 DTP - Admission Date/Hour or Start of Care Date
Action	**Add Segment Note** It is acceptable for the Admission Date to differ from the Statement From Date reported in Loop 2300 DTP Statement Dates. See Admission/Start of Care Date in the NUBC Manual (Form Locator 12).
CR 1154	For consistency across all TR3s.

Location	X326 | Health Care Service Data Reporting | 837 | 1350 | 2300 DTP - Admission Date/Hour or Start of Care Date
Action	**Add Data Element Note** Loop ID 2300 / DTP02 (Date Time Period Format Qualifier) Refer to the NUBC manual to determine whether to send date and time or date only.
CR 1154	For consistency across all TR3s.

Location	X326 | Health Care Service Data Reporting | 837 | 1350 | 2300 DTP - Admission Date/Hour or Start of Care Date
Action	**Delete Data Element Code Note** Loop ID 2300 / DTP (Admission Date/Hour Removed: Required for home health and hospice.
CR 1154	For consistency across all TR3s.

Location	X326 | Health Care Service Data Reporting | 837 | 1350 | 2300 DTP - Admission Date/Hour or Start of Care Date
Action	**Delete Data Element Code Note** Loop ID 2300 / DTP (Admission Date/Hour or Start of Care Date) Removed: Required for inpatient claim.

CR 1154	For consistency across all TR3s.
Location	X326 | Health Care Service Data Reporting | 837 | 1400 | 2300 CL1 - Institutional Claim Code
Action	**Modify Data Element Situational Rule** Loop ID 2300 / CL102 (Admission Source Code) Changed to: Required when directed by the National Uniform Billing Committee (NUBC) Official UB Data Specifications Manual. If not required by this implementation guide, do not send.
CR 1216	Revise the TR3 to better align with the official UB Data Specifications Manual.
Location	X326 | Health Care Service Data Reporting | 837 | 1400 | 2300 CL1 - Institutional Claim Code
Action	**Delete Data Element Note** Loop ID 2300 / CL102 (Admission Source Code) Refer to the NUBC Manual for clarification of what services are neither inpatient nor outpatient.
CR 1216	Revise the TR3 to better align with the official UB Data Specifications Manual.
Location	X326 | Health Care Service Data Reporting | 837 | 1400 | 2300 CL1 - Institutional Claim Code
Action	**Delete Data Element Note** Loop ID 2300 / CL102 (Admission Source Code) Required as directed by the NUBC Manual.
CR 1216	Revise the TR3 to better align with the official UB Data Specifications Manual.
Location	X326 | Health Care Service Data Reporting | 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	X326 | Health Care Service Data Reporting | 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	X326 | Health Care Service Data Reporting | 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	X326 | Health Care Service Data Reporting | 837 | 1550 | 2300 PWK - Claim 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	X326 | Health Care Service Data Reporting | 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	X326 | Health Care Service Data Reporting | 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	X326 | Health Care Service Data Reporting | 837 | 1800 | 2300 REF - Auto Accident State
Action	**Delete Segment** Loop ID 2300 / REF (AUTO ACCIDENT STATE)
CR 1413	For consistency across the 837 TR3s.
Location	X326 | Health Care Service Data Reporting | 837 | 1800 | 2300 REF - Auto Accident State
Action	**Modify Segment Repeat** Changed to: 1
CR 1205	Modify the repeat count to match the number of qualifiers available for use.
Location	X326 | Health Care Service Data Reporting | 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 1.4.3.1 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	X326 | Health Care Service Data Reporting | 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	X326 | Health Care Service Data Reporting | 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	X326 | Health Care Service Data Reporting 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	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Principal Diagnosis
Action	**Modify Data Element** Loop ID 2300 / HI01-09 (Present on Admission Indicator) Changed to: Data Element 1271 Added: Code Source 959
CR 762	Allow the use of an external code list for Present on Admission Indicator to allow for code maintenance outside of the standard.

Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Principal Diagnosis
Action	**Delete Data Element Code Note** Loop ID 2400 / HI01-01 - HI12-01 (Code List Qualifier Code)

	ABF (International Classification of Diseases Clinical Modification (ICD-10-CM) Other Diagnosis) ABJ (International Classification of Diseases Clinical Modification (ICD-10-CM) Admitting Diagnosis) ABK (International Classification of Diseases Clinical Modification (ICD-10-CM) Principal Diagnosis) ABN (International Classification of Diseases Clinical Modification (ICD-10-CM) External Cause of Injury Code) APR (International Classification of Diseases Clinical Modification (ICD-10-CM) Patient's Reason for Visit) Removed: Use on or after the mandated HIPAA ICD-10-CM implementation date.
CR 1558	Format code notes consistently.

Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Admitting Diagnosis
Action	**Modify Segment Situational Rule** Changed to: Required when directed by the National Uniform Billing Committee (NUBC) Official UB Data Specifications Manual. If not required by this implementation guide, do not send.
CR 1216	Revise the TR3 to better align with the official UB Data Specifications Manual.

Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Admitting Diagnosis
Action	**Delete Data Element Code Note** Loop ID 2400 / HI01-01 - HI12-01 (Code List Qualifier Code) ABF (International Classification of Diseases Clinical Modification (ICD-10-CM) Other Diagnosis) ABJ (International Classification of Diseases Clinical Modification (ICD-10-CM) Admitting Diagnosis) ABK (International Classification of Diseases Clinical Modification (ICD-10-CM) Principal Diagnosis) ABN (International Classification of Diseases Clinical Modification (ICD-10-CM) External Cause of Injury Code)

	APR (International Classification of Diseases Clinical Modification (ICD-10-CM) Patient's Reason for Visit) Removed: Use on or after the mandated HIPAA ICD-10-CM implementation date.
CR 1558	Format code notes consistently.
Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Patient's Reason For Visit
Action	**Modify Segment Situational Rule** Changed to: Required when directed by the National Uniform Billing Committee (NUBC) Official UB Data Specifications Manual. If not required by this implementation guide, do not send.
CR 1216	Revise the TR3 to better align with the official UB Data Specifications Manual.
Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Patient's Reason For Visit
Action	**Delete Data Element Code Note** Loop ID 2400 / HI01-01 - HI12-01 (Code List Qualifier Code) ABF (International Classification of Diseases Clinical Modification (ICD-10-CM) Other Diagnosis) ABJ (International Classification of Diseases Clinical Modification (ICD-10-CM) Admitting Diagnosis) ABK (International Classification of Diseases Clinical Modification (ICD-10-CM) Principal Diagnosis) ABN (International Classification of Diseases Clinical Modification (ICD-10-CM) External Cause of Injury Code) APR (International Classification of Diseases Clinical Modification (ICD-10-CM) Patient's Reason for Visit) Removed: Use on or after the mandated HIPAA ICD-10-CM implementation date.
CR 1558	Format code notes consistently.
Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - External Cause of Injury

Action	**Modify Data Element** Loop ID 2300 / HI01-09 - HI12-09 (Present on Admission Indicator) Changed to: Data Element 1271 Added: Code Source 959
CR 762	Allow the use of an external code list for Present on Admission Indicator to allow for code maintenance outside of the standard.
Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - External Cause of Injury
Action	**Delete Segment Note** In order to fully describe an injury using ICD-10-CM, it will be necessary to report a series of 3 external cause of injury codes.
CR 72	HI - EXTERNAL CAUSE OF INJURY - verify the situational rules and the segment note are in sync.
Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - External Cause of Injury
Action	**Delete Data Element Code Note** Loop ID 2400 / HI01-01 - HI12-01 (Code List Qualifier Code) ABF (International Classification of Diseases Clinical Modification (ICD-10-CM) Other Diagnosis) ABJ (International Classification of Diseases Clinical Modification (ICD-10-CM) Admitting Diagnosis) ABK (International Classification of Diseases Clinical Modification (ICD-10-CM) Principal Diagnosis) ABN (International Classification of Diseases Clinical Modification (ICD-10-CM) External Cause of Injury Code) APR (International Classification of Diseases Clinical Modification (ICD-10-CM) Patient's Reason for Visit) Removed: Use on or after the mandated HIPAA ICD-10-CM implementation date.
CR 1558	Format code notes consistently.
Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Diagnosis Related Group (DRG) Information

Action	**Modify Segment Situational Rule** Changed to: Required when directed by the National Uniform Billing Committee (NUBC) Official UB Data Specifications Manual. If not required by this implementation guide, do not send.
CR 1216	Revise the TR3 to better align with the official UB Data Specifications Manual.

Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Other Diagnosis Information
Action	**Modify Data Element** Loop ID 2300 / HI01-09 - HI12-09 (Present on Admission Indicator) Changed to: Data Element 1271 Added: Code Source 959
CR 762	Allow the use of an external code list for Present on Admission Indicator to allow for code maintenance outside of the standard.

Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Other Diagnosis Information
Action	**Delete Data Element Code Note** Loop ID 2400 / HI01-01 - HI12-01 (Code List Qualifier Code) ABF (International Classification of Diseases Clinical Modification (ICD-10-CM) Other Diagnosis) ABJ (International Classification of Diseases Clinical Modification (ICD-10-CM) Admitting Diagnosis) ABK (International Classification of Diseases Clinical Modification (ICD-10-CM) Principal Diagnosis) ABN (International Classification of Diseases Clinical Modification (ICD-10-CM) External Cause of Injury Code) APR (International Classification of Diseases Clinical Modification (ICD-10-CM) Patient's Reason for Visit) Removed: Use on or after the mandated HIPAA ICD-10-CM implementation date.
CR 1558	Format code notes consistently.

Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Principal Procedure Information

Action	**Modify Segment Situational Rule** Changed to: Required when directed by the National Uniform Billing Committee (NUBC) Official UB Data Specifications Manual. If not required by this implementation guide, do not send.
CR 1216	Revise the TR3 to better align with the official UB Data Specifications Manual.

Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Principal Procedure Information
Action	**Delete Data Element Code Value** Loop ID 2300 / HI01-01 (Code List Qualifier Code) CAH (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	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Principal Procedure Information
Action	**Delete Data Element Code Note** Loop ID 2400 / HI01-01 - HI12-01 (Code List Qualifier Code) BBQ (International Classification of Diseases Clinical Modification(ICD-10-PCS) Other Procedure Codes) BBR (International Classification of Diseases Clinical Modification(ICD-10-PCS) Principal Procedure Codes) Removed: Use on or after the mandated HIPAA ICD-10-PCS implementation date.
CR 1558	Format code notes consistently.

Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Principal Procedure Information
Action	**Modify Data Element Code Note** Loop ID 2300 / HI01-01 (Code List Qualifier Code) BBR (International Classification of Diseases Clinical Modification (ICD-10-PCS) Principal Procedure Codes) Changed to: Use on or after the mandated HIPAA ICD-10-PCS implementation date Refer to Section 1.12.7 for further information regarding predetermination of benefits.

CR 754	Support use of the ICD-10 code set for diagnosis code reporting.
Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Principal Procedure Information
Action	**Add Data Element Code Note** for consistency with institutional guide.
CR 822	6020 Public Review Comment received requests the we add a space between the words "transactions" and "covered" in the first paragraph of the CAH code note.
Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Principal Procedure Information
Action	**Delete Data Element Code Value** HO - Home Infusion EDI Coalition (HIEC) Product/Service Code.
CR 355	Remove code source 513 - Home Infusion EDI Coalition (HIEC)Product/Service Codes.
Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Other Procedure Information
Action	**Modify Segment Situational Rule** Changed to: Required when directed by the National Uniform Billing Committee (NUBC) Official UB Data Specifications Manual. If not required by this implementation guide, do not send.
CR 1216	Revise the TR3 to better align with the official UB Data Specifications Manual.
Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Other Procedure Information
Action	**Delete Data Element Code Value** Loop ID 2300 / HI01-01 - HI12-01 (Code List Qualifier Code) CAH (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	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Other Procedure Information
Action	**Delete Data Element Code Note** Loop ID 2400 / HI01-01 - HI12-01 (Code List Qualifier Code) BBQ (International Classification of Diseases Clinical Modification(ICD-10-PCS) Other Procedure Codes)

	BBR (International Classification of Diseases Clinical Modification(ICD-10-PCS) Principal Procedure Codes) Removed: Use on or after the mandated HIPAA ICD-10-PCS implementation date.
CR 1558	Format code notes consistently.
Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Other Procedure Information
Action	**Modify Data Element Code Note** Loop ID 2300 / HI01-01 (Code List Qualifier Code) BBR (International Classification of Diseases Clinical Modification (ICD-10-PCS) Principal Procedure Codes) Changed to: Use on or after the mandated HIPAA ICD-10-PCS implementation date Refer to Section 1.12.7 for further information regarding predetermination of benefits.
CR 754	Support use of the ICD-10 code set for diagnosis code reporting.
Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Other Procedure Information
Action	**Delete Data Element Code Value** HO - Home Infusion EDI Coalition (HIEC) Product/Service Code.
CR 355	Remove code source 513 - Home Infusion EDI Coalition (HIEC)Product/Service Codes.
Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Value Information
Action	**Add Segment Note** See the National Uniform Billing Committee (NUBC) Official UB Data Specifications Manual for instruction on how to report each value code.
CR 1485	The 837 Institutional Claim needs to send non-monetary data in the HI segment. DM015113
Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Value Information
Action	**Modify Data Element Usage** Loop ID 2300 / HI01-05 (Monetary Amount) Changed to: SITUATIONAL

CR 1485	The 837 Institutional Claim needs to send non-monetary data in the HI segment. DM015113
Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Value Information
Action	**Add Data Element Situational Rule** Loop ID 2300 / HI01-05 (Monetary Amount) Required when it is necessary to report a value code that specifies a monetary amount. If not required by this implementation guide, do not send.
CR 1485	The 837 Institutional Claim needs to send non-monetary data in the HI segment. DM015113
Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Value Information
Action	**Add Data Element Note** Loop ID 2300 / HI01-05 (Monetary Amount) If HI01-05 is populated, then HI01-10 must not be used.
CR 1485	The 837 Institutional Claim needs to send non-monetary data in the HI segment. DM015113
Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Value 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	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Value Information
Action	**Add Data Element** Loop ID 2300 / HI01-10 (Industry Code) Usage: SITUATIONAL Required when it is necessary to report a value code that specifies a non-monetary value. If not required by this implementation guide, do not send.

CR 1485	The 837 Institutional Claim needs to send non-monetary data in the HI segment. DM015113
Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Value Information
Action	**Add Data Element Note** Loop ID 2300 / HI01-10 (Industry Code) If HI01-10 is populated, then HI01-05 must not be used.
CR 1485	The 837 Institutional Claim needs to send non-monetary data in the HI segment. DM015113
Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Value Information
Action	**Modify Data Element Usage** Loop ID 2300 / HI02-05 (Monetary Amount) Changed to: SITUATIONAL
CR 1485	The 837 Institutional Claim needs to send non-monetary data in the HI segment. DM015113
Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Value Information
Action	**Add Data Element Situational Rule** Loop ID 2300 / HI02-05 (Monetary Amount) Required when it is necessary to report a value code that specifies a monetary amount. If not required by this implementation guide, do not send.
CR 1485	The 837 Institutional Claim needs to send non-monetary data in the HI segment. DM015113
Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Value Information
Action	**Add Data Element Note** Loop ID 2300 / HI02-05 (Monetary Amount) If HI02-05 is populated, then HI02-10 must not be used.
CR 1485	The 837 Institutional Claim needs to send non-monetary data in the HI segment. DM015113
Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Value Information

Action	**Add Data Element** Loop ID 2300 / HI02-10 (Industry Code) Usage: SITUATIONAL Required when it is necessary to report a value code that specifies a non-monetary value. If not required by this implementation guide, do not send.
CR 1485	The 837 Institutional Claim needs to send non-monetary data in the HI segment. DM015113
Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Value Information
Action	**Add Data Element Note** Loop ID 2300 / HI02-10 (Industry Code) If HI02-10 is populated, then HI02-05 must not be used.
CR 1485	The 837 Institutional Claim needs to send non-monetary data in the HI segment. DM015113
Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Value Information
Action	**Modify Data Element Usage** Loop ID 2300 / HI03-05 (Monetary Amount) Changed to: SITUATIONAL
CR 1485	The 837 Institutional Claim needs to send non-monetary data in the HI segment. DM015113
Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Value Information
Action	**Add Data Element Situational Rule** Loop ID 2300 / HI03-05 (Monetary Amount) Required when it is necessary to report a value code that specifies a monetary amount. If not required by this implementation guide, do not send.
CR 1485	The 837 Institutional Claim needs to send non-monetary data in the HI segment. DM015113
Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Value Information
Action	**Add Data Element Note** Loop ID 2300 / HI03-05 (Monetary Amount)

	If HI03-05 is populated, then HI03-10 must not be used.
CR 1485	The 837 Institutional Claim needs to send non-monetary data in the HI segment. DM015113
Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Value Information
Action	**Add Data Element** Loop ID 2300 / HI03-10 (Industry Code) Usage: SITUATIONAL Required when it is necessary to report a value code that specifies a non-monetary value. If not required by this implementation guide, do not send.
CR 1485	The 837 Institutional Claim needs to send non-monetary data in the HI segment. DM015113
Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Value Information
Action	**Add Data Element Note** Loop ID 2300 / HI03-10 (Industry Code) If HI03-10 is populated, then HI03-05 must not be used.
CR 1485	The 837 Institutional Claim needs to send non-monetary data in the HI segment. DM015113
Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Value Information
Action	**Modify Data Element Usage** Loop ID 2300 / HI04-05 (Monetary Amount) Changed to: SITUATIONAL
CR 1485	The 837 Institutional Claim needs to send non-monetary data in the HI segment. DM015113
Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Value Information
Action	**Add Data Element Situational Rule** Loop ID 2300 / HI04-05 (Monetary Amount) Required when it is necessary to report a value code that specifies a monetary amount. If not required by this implementation guide, do not send.
CR 1485	The 837 Institutional Claim needs to send non-monetary data in the HI segment. DM015113

Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Value Information
Action	**Add Data Element Note** Loop ID 2300 / HI04-05 (Monetary Amount) If HI04-05 is populated, then HI04-10 must not be used.
CR 1485	The 837 Institutional Claim needs to send non-monetary data in the HI segment. DM015113

Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Value Information
Action	**Add Data Element** Loop ID 2300 / HI04-10 (Industry Code) Usage: SITUATIONAL Required when it is necessary to report a value code that specifies a non-monetary value. If not required by this implementation guide, do not send.
CR 1485	The 837 Institutional Claim needs to send non-monetary data in the HI segment. DM015113

Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Value Information
Action	**Add Data Element Note** Loop ID 2300 / HI04-10 (Industry Code) If HI04-10 is populated, then HI04-05 must not be used.
CR 1485	The 837 Institutional Claim needs to send non-monetary data in the HI segment. DM015113

Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Value Information
Action	**Modify Data Element Usage** Loop ID 2300 / HI05-05 (Monetary Amount) Changed to: SITUATIONAL
CR 1485	The 837 Institutional Claim needs to send non-monetary data in the HI segment. DM015113

Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Value Information
Action	**Add Data Element Situational Rule** Loop ID 2300 / HI05-05 (Monetary Amount)

	Required when it is necessary to report a value code that specifies a monetary amount. If not required by this implementation guide, do not send.
CR 1485	The 837 Institutional Claim needs to send non-monetary data in the HI segment. DM015113
Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Value Information
Action	**Add Data Element Note** Loop ID 2300 / HI05-05 (Monetary Amount) If HI05-05 is populated, then HI05-10 must not be used.
CR 1485	The 837 Institutional Claim needs to send non-monetary data in the HI segment. DM015113
Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Value Information
Action	**Add Data Element** Loop ID 2300 / HI05-10 (Industry Code) Usage: SITUATIONAL Required when it is necessary to report a value code that specifies a non-monetary value. If not required by this implementation guide, do not send.
CR 1485	The 837 Institutional Claim needs to send non-monetary data in the HI segment. DM015113
Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Value Information
Action	**Add Data Element Note** Loop ID 2300 / HI05-10 (Industry Code) If HI05-10 is populated, then HI05-05 must not be used.
CR 1485	The 837 Institutional Claim needs to send non-monetary data in the HI segment. DM015113
Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Value Information
Action	**Modify Data Element Usage** Loop ID 2300 / HI06-05 (Monetary Amount) Changed to: SITUATIONAL

CR 1485	The 837 Institutional Claim needs to send non-monetary data in the HI segment. DM015113
Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Value Information
Action	**Add Data Element Situational Rule** Loop ID 2300 / HI06-05 (Monetary Amount) Required when it is necessary to report a value code that specifies a monetary amount. If not required by this implementation guide, do not send.
CR 1485	The 837 Institutional Claim needs to send non-monetary data in the HI segment. DM015113
Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Value Information
Action	**Add Data Element Note** Loop ID 2300 / HI06-05 (Monetary Amount) If HI06-05 is populated, then HI06-10 must not be used.
CR 1485	The 837 Institutional Claim needs to send non-monetary data in the HI segment. DM015113
Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Value Information
Action	**Add Data Element** Loop ID 2300 / HI06-10 (Industry Code) Usage: SITUATIONAL Required when it is necessary to report a value code that specifies a non-monetary value. If not required by this implementation guide, do not send.
CR 1485	The 837 Institutional Claim needs to send non-monetary data in the HI segment. DM015113
Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Value Information
Action	**Add Data Element Note** Loop ID 2300 / HI06-10 (Industry Code) If HI06-10 is populated, then HI06-05 must not be used.
CR 1485	The 837 Institutional Claim needs to send non-monetary data in the HI segment. DM015113

Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Value Information
Action	**Modify Data Element Usage** Loop ID 2300 / HI07-05 (Monetary Amount) Changed to: SITUATIONAL
CR 1485	The 837 Institutional Claim needs to send non-monetary data in the HI segment. DM015113

Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Value Information
Action	**Add Data Element Situational Rule** Loop ID 2300 / HI07-05 (Monetary Amount) Required when it is necessary to report a value code that specifies a monetary amount. If not required by this implementation guide, do not send.
CR 1485	The 837 Institutional Claim needs to send non-monetary data in the HI segment. DM015113

Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Value Information
Action	**Add Data Element Note** Loop ID 2300 / HI07-05 (Monetary Amount) If HI07-05 is populated, then HI07-10 must not be used.
CR 1485	The 837 Institutional Claim needs to send non-monetary data in the HI segment. DM015113

Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Value Information
Action	**Add Data Element** Loop ID 2300 / HI07-10 (Industry Code) Usage: SITUATIONAL Required when it is necessary to report a value code that specifies a non-monetary value. If not required by this implementation guide, do not send.
CR 1485	The 837 Institutional Claim needs to send non-monetary data in the HI segment. DM015113

Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Value Information

Action	**Add Data Element Note** Loop ID 2300 / HI07-10 (Industry Code) If HI07-10 is populated, then HI07-05 must not be used.
CR 1485	The 837 Institutional Claim needs to send non-monetary data in the HI segment. DM015113
Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Value Information
Action	**Modify Data Element Usage** Loop ID 2300 / HI08-05 (Monetary Amount) Changed to: SITUATIONAL
CR 1485	The 837 Institutional Claim needs to send non-monetary data in the HI segment. DM015113
Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Value Information
Action	**Add Data Element Situational Rule** Loop ID 2300 / HI08-05 (Monetary Amount) Required when it is necessary to report a value code that specifies a monetary amount. If not required by this implementation guide, do not send.
CR 1485	The 837 Institutional Claim needs to send non-monetary data in the HI segment. DM015113
Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Value Information
Action	**Add Data Element Note** Loop ID 2300 / HI08-05 (Monetary Amount) If HI08-05 is populated, then HI08-10 must not be used.
CR 1485	The 837 Institutional Claim needs to send non-monetary data in the HI segment. DM015113
Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Value Information
Action	**Add Data Element** Loop ID 2300 / HI08-10 (Industry Code) Usage: SITUATIONAL Required when it is necessary to report a value code that specifies a

	non-monetary value. If not required by this implementation guide, do not send.
CR 1485	The 837 Institutional Claim needs to send non-monetary data in the HI segment. DM015113
Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Value Information
Action	**Add Data Element Note** Loop ID 2300 / HI08-10 (Industry Code) If HI08-10 is populated, then HI08-05 must not be used.
CR 1485	The 837 Institutional Claim needs to send non-monetary data in the HI segment. DM015113
Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Value Information
Action	**Modify Data Element Usage** Loop ID 2300 / HI09-05 (Monetary Amount) Changed to: SITUATIONAL
CR 1485	The 837 Institutional Claim needs to send non-monetary data in the HI segment. DM015113
Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Value Information
Action	**Add Data Element Situational Rule** Loop ID 2300 / HI09-05 (Monetary Amount) Required when it is necessary to report a value code that specifies a monetary amount. If not required by this implementation guide, do not send.
CR 1485	The 837 Institutional Claim needs to send non-monetary data in the HI segment. DM015113
Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Value Information
Action	**Add Data Element Note** Loop ID 2300 / HI09-05 (Monetary Amount) If HI09-05 is populated, then HI09-10 must not be used.
CR 1485	The 837 Institutional Claim needs to send non-monetary data in the HI segment. DM015113
Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Value Information

Action	**Add Data Element** Loop ID 2300 / HI09-10 (Industry Code) Usage: SITUATIONAL Required when it is necessary to report a value code that specifies a non-monetary value. If not required by this implementation guide, do not send.
CR 1485	The 837 Institutional Claim needs to send non-monetary data in the HI segment. DM015113
Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Value Information
Action	**Add Data Element Note** Loop ID 2300 / HI09-10 (Industry Code) If HI09-10 is populated, then HI09-05 must not be used.
CR 1485	The 837 Institutional Claim needs to send non-monetary data in the HI segment. DM015113
Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Value Information
Action	**Modify Data Element Usage** Loop ID 2300 / HI10-05 (Monetary Amount) Changed to: SITUATIONAL
CR 1485	The 837 Institutional Claim needs to send non-monetary data in the HI segment. DM015113
Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Value Information
Action	**Add Data Element Situational Rule** Loop ID 2300 / HI10-05 (Monetary Amount) Required when it is necessary to report a value code that specifies a monetary amount. If not required by this implementation guide, do not send.
CR 1485	The 837 Institutional Claim needs to send non-monetary data in the HI segment. DM015113
Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Value Information
Action	**Add Data Element Note** Loop ID 2300 / HI10-05 (Monetary Amount)

	If HI10-05 is populated, then HI10-10 must not be used.
CR 1485	The 837 Institutional Claim needs to send non-monetary data in the HI segment. DM015113
Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Value Information
Action	**Add Data Element Situational Rule** Loop ID 2300 / HI10-10 (Industry Code) Usage: SITUATIONAL Required when it is necessary to report a value code that specifies a non-monetary value. If not required by this implementation guide, do not send.
CR 1485	The 837 Institutional Claim needs to send non-monetary data in the HI segment. DM015113
Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Value Information
Action	**Add Data Element Note** Loop ID 2300 / HI10-10 (Industry Code) If HI10-10 is populated, then HI10-05 must not be used.
CR 1485	The 837 Institutional Claim needs to send non-monetary data in the HI segment. DM015113
Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Value Information
Action	**Modify Data Element Usage** Loop ID 2300 / HI11-05 (Monetary Amount) Changed to: SITUATIONAL
CR 1485	The 837 Institutional Claim needs to send non-monetary data in the HI segment. DM015113
Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Value Information
Action	**Add Data Element Situational Rule** Loop ID 2300 / HI11-05 (Monetary Amount) Required when it is necessary to report a value code that specifies a monetary amount. If not required by this implementation guide, do not send.
CR 1485	The 837 Institutional Claim needs to send non-monetary data in the HI segment. DM015113

Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Value Information
Action	**Add Data Element Note** Loop ID 2300 / HI11-05 (Monetary Amount) If HI11-05 is populated, then HI11-10 must not be used.
CR 1485	The 837 Institutional Claim needs to send non-monetary data in the HI segment. DM015113

Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Value Information
Action	**Add Data Element** Loop ID 2300 / HI11-10 (Industry Code) Usage: SITUATIONAL Required when it is necessary to report a value code that specifies a non-monetary value. If not required by this implementation guide, do not send.
CR 1485	The 837 Institutional Claim needs to send non-monetary data in the HI segment. DM015113

Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Value Information
Action	**Add Data Element Note** Loop ID 2300 / HI11-10 (Industry Code) If HI11-10 is populated, then HI11-05 must not be used.
CR 1485	The 837 Institutional Claim needs to send non-monetary data in the HI segment. DM015113

Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Value Information
Action	**Modify Data Element Usage** Loop ID 2300 / HI12-05 (Monetary Amount) Changed to: SITUATIONAL
CR 1485	The 837 Institutional Claim needs to send non-monetary data in the HI segment. DM015113

Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Value Information
Action	**Add Data Element Situational Rule** Loop ID 2300 / HI12-05 (Monetary Amount)

	Required when it is necessary to report a value code that specifies a monetary amount. If not required by this implementation guide, do not send.
CR 1485	The 837 Institutional Claim needs to send non-monetary data in the HI segment. DM015113
Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Value Information
Action	**Add Data Element Note** Loop ID 2300 / HI12-05 (Monetary Amount) If HI12-05 is populated, then HI12-10 must not be used.
CR 1485	The 837 Institutional Claim needs to send non-monetary data in the HI segment. DM015113
Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Value Information
Action	**Add Data Element** Loop ID 2300 / HI12-10 (Industry Code) Usage: SITUATIONAL Required when it is necessary to report a value code that specifies a non-monetary value. If not required by this implementation guide, do not send.
CR 1485	The 837 Institutional Claim needs to send non-monetary data in the HI segment. DM015113
Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Value Information
Action	**Add Data Element Note** Loop ID 2300 / HI12-10 (Industry Code) If HI12-10 is populated, then HI12-05 must not be used.
CR 1485	The 837 Institutional Claim needs to send non-monetary data in the HI segment. DM015113
Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Standard Occupational Classification System (SOC)
Action	**Modify Data Element Code Value** Loop ID 2300 / HI01-01 (Code List Qualifier) Changed to: BUR (Bureau of Labor Statistics Standardized Occupational Codes)

CR 1559	In reviewing code notes for CR1578 found that the BUR qualifier (DE1270) was never added to the 837R. Once the ZZ is removed and replaced with the BUR qualifier, code note 350688 will be removed. DM 013211 added the BUR to DE1270
Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Standard Occupational Classification System (SOC)
Action	**Modify Data Element Code Value** Loop ID 2300 / HI02-01 (Code List Qualifier) Changed to: BUR (Bureau of Labor Statistics Standardized Occupational Codes)
CR 1559	In reviewing code notes for CR1578 found that the BUR qualifier (DE1270) was never added to the 837R. Once the ZZ is removed and replaced with the BUR qualifier, code note 350688 will be removed. DM 013211 added the BUR to DE1270
Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Standard Occupational Classification System (SOC)
Action	**Modify Data Element Code Value** Loop ID 2300 / HI03-01 (Code List Qualifier) Changed to: BUR (Bureau of Labor Statistics Standardized Occupational Codes)
CR 1559	In reviewing code notes for CR1578 found that the BUR qualifier (DE1270) was never added to the 837R. Once the ZZ is removed and replaced with the BUR qualifier, code note 350688 will be removed. DM 013211 added the BUR to DE1270
Location	X326 | Health Care Service Data Reporting | 837 | 2310 | 2300 HI - Standard Occupational Classification System (SOC)
Action	**Modify Data Element Code Value** Loop ID 2300 / HI04-01 (Code List Qualifier) Changed to: BUR (Bureau of Labor Statistics Standardized Occupational Codes)
CR 1559	In reviewing code notes for CR1578 found that the BUR qualifier (DE1270) was never added to the 837R. Once the ZZ is removed and replaced with the BUR qualifier, code note 350688 will be removed. DM 013211 added the BUR to DE1270
Location	X326 | Health Care Service Data Reporting | 837 | 2500 | 2310A NM1 - Attending Provider Name

Action	**Modify Data Element Situational Rule** Loop ID 2310A / NM108 (Identification Code Qualifier) Changed to: Required when NM109 is used. If not required by this implementation guide, do not send.
CR 1478	Remove duplication of situational rules between the element and the code qualifier across the TR3.
Location	X326 | Health Care Service Data Reporting | 837 | 2500 | 2310A NM1 - Attending Provider Name
Action	**Modify Segment Note** Changed to: See NUBC Manual for definition of institutional providers.
CR 1154	For consistency across all TR3s.
Location	X326 | Health Care Service Data Reporting | 837 | 2500 | 2310A NM1 - Attending Provider Name
Action	**Delete Data Element Code Note** Loop ID 2310A / NM101 (Entity Identifier Code) 71 (Attending Physician) "When used, the term physician is any type of provider filling this role."
CR 1558	Format code notes consistently.
Location	X326 | Health Care Service Data Reporting | 837 | 2710 | 2310A REF - Attending 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	X326 | Health Care Service Data Reporting | 837 | 2710 | 2310A REF - Attending 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	X326 | Health Care Service Data Reporting | 837 | 2710 | 2310A REF - Attending 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	X326 | Health Care Service Data Reporting | 837 | 2710 | 2310A REF - Attending Provider Secondary Identification
Action	**Delete Data Element Code Value** 0B - State License Number.
CR 1231	To better align with industry use.

Location	X326 | Health Care Service Data Reporting | 837 | 2710 | 2310A REF - Attending 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	X326 | Health Care Service Data Reporting | 837 | 2500 | 2310B NM1 - Operating Physician Name
Action	**Modify Data Element Situational Rule** Loop ID 2310B / NM108 (Identification Code Qualifier) Changed to: Required when NM109 is used. If not required by this implementation guide, do not send.
CR 1478	Remove duplication of situational rules between the element and the code qualifier across the TR3.

Location	X326 | Health Care Service Data Reporting | 837 | 2500 | 2310B NM1 - Operating Physician Name
Action	**Modify Segment Note** changed to: See NUCC Manual for definition of professional providers.
CR 1154	For consistency across all TR3s.

Location	X326 | Health Care Service Data Reporting | 837 | 2500 | 2310B NM1 - Operating Physician Name

Action	**Modify Segment Note** Changed to: See NUBC Manual for definition of institutional providers.
CR 1154	For consistency across all TR3s.

Location	X326 | Health Care Service Data Reporting | 837 | 2710 | 2310B REF - Operating Physician 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	X326 | Health Care Service Data Reporting | 837 | 2710 | 2310B REF - Operating Physician 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	X326 | Health Care Service Data Reporting | 837 | 2710 | 2310B REF - Operating Physician 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	X326 | Health Care Service Data Reporting | 837 | 2710 | 2310B REF - Operating Physician Secondary Identification
Action	**Delete Data Element Code Value** 0B - State License Number.
CR 1231	To better align with industry use.

Location	X326 | Health Care Service Data Reporting | 837 | 2710 | 2310B REF - Operating Physician 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	X326 | Health Care Service Data Reporting | 837 | 2500 | 2310C NM1 - Other Operating Physician Name
Action	**Modify Data Element Situational Rule** Loop ID 2310C / NM108 (Identification Code Qualifier) Changed to: Required when NM109 is used. If not required by this implementation guide, do not send.
CR 1478	Remove duplication of situational rules between the element and the code qualifier across the TR3.

Location	X326 | Health Care Service Data Reporting | 837 | 2500 | 2310C NM1 - Other Operating Physician Name
Action	**Modify Segment Note** changed to: See NUCC Manual for definition of professional providers.
CR 1154	For consistency across all TR3s.

Location	X326 | Health Care Service Data Reporting | 837 | 2500 | 2310C NM1 - Other Operating Physician Name
Action	**Modify Segment Note** Changed to: See NUBC Manual for definition of institutional providers.
CR 1154	For consistency across all TR3s.

Location	X326 | Health Care Service Data Reporting | 837 | 2710 | 2310C REF - Other Operating Physician 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	X326 | Health Care Service Data Reporting | 837 | 2710 | 2310C REF - Other Operating Physician 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	X326 | Health Care Service Data Reporting | 837 | 2710 | 2310C REF - Other Operating Physician 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	X326 | Health Care Service Data Reporting | 837 | 2710 | 2310C REF - Other Operating Physician Secondary Identification
Action	**Delete Data Element Code Value** 0B - State License Number.
CR 1231	To better align with industry use.

Location	X326 | Health Care Service Data Reporting | 837 | 2710 | 2310C REF - Other Operating Physician 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	X326 | Health Care Service Data Reporting | 837 | 2500 | 2310D NM1 - Rendering Provider Name
Action	**Modify Data Element Situational Rule** Loop ID 2310D / NM108 (Identification Code Qualifier) Changed to: Required when NM109 is used. If not required by this implementation guide, do not send.
CR 1478	Remove duplication of situational rules between the element and the code qualifier across the TR3.

Location	X326 | Health Care Service Data Reporting | 837 | 2500 | 2310D NM1 - Rendering Provider Name
Action	**Modify Segment Situational Rule** Changed to: Required when the Rendering Provider is different than the Attending Provider reported in Loop ID-2310A of this claim AND state or federal regulatory requirements call for a "combined claim", that is, a claim that includes both facility and professional components (for example, a Medicaid clinic bill or Critical Access Hospital Claim.) OR Required when the Rendering Provider is different than the Attending Provider reported in Loop ID-2310A of this claim AND the claim includes only a professional component.

	If not required by this implementation guide, do not send.
CR 892	Rural Health Clinics and Federally Qualified Health Centers bill professional services only to Medicare using the 837I. The situation rule should be updated to indicate "any provider that bills professional services only" in addition to the language that is currently there. In addition, Medicare needs to identify the line level rendering provider for various payment incentive programs. This note limits the usage to only "combined claims" but must include claims that contain only professional components.
Location	X326 | Health Care Service Data Reporting | 837 | 2500 | 2310D NM1 - Rendering Provider Name
Action	**Delete Segment Note** Removed: Information in this Loop ID-2310 applies to the entire claim unless overridden on a service line by the presence of Loop ID-2420 with the same value in NM101.
CR 1390	Revise the TR3 note references to the referring and rendering provider names.
Location	X326 | Health Care Service Data Reporting | 837 | 2500 | 2310D NM1 - Rendering Provider Name
Action	**Modify Segment Note** Changed to: See NUBC Manual for definition of institutional providers.
CR 1154	For consistency across all TR3s.
Location	X326 | Health Care Service Data Reporting | 837 | 2500 | 2310D NM1 - Rendering Provider Name
Action	**Modify Segment Note** Loop ID 2310D / NM1 (Rendering Provider Name) Changed to: See NUBC Manual for definition of institutional 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	X326 | Health Care Service Data Reporting | 837 | 2710 | 2310D 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	X326 | Health Care Service Data Reporting | 837 | 2710 | 2310D 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	X326 | Health Care Service Data Reporting | 837 | 2710 | 2310D REF - Rendering Provider Secondary Identification
Action	**Modify Data Element Code Value** Loop ID 2310D / 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	X326 | Health Care Service Data Reporting | 837 | 2710 | 2310D REF - Rendering Provider Secondary Identification
Action	**Delete Data Element Code Value** 0B - State License Number.
CR 1231	To better align with industry use.

Location	X326 | Health Care Service Data Reporting | 837 | 2710 | 2310D 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	X326 | Health Care Service Data Reporting | 837 | 2500 | 2310F NM1 - Referring Provider Name
Action	**Modify Segment Situational Rule** Changed to: Required when directed by the National Uniform Billing Committee (NUBC) Official UB Data Specifications Manual. If not required by this implementation guide, do not send.
CR 1216	Revise the TR3 to better align with the official UB Data Specifications Manual.

Location	X326 | Health Care Service Data Reporting | 837 | 2500 | 2310F NM1 - Referring Provider Name

Action	**Delete Segment Note** Removed: Information in this Loop ID-2310 applies to the entire claim unless overridden on a service line by the presence of Loop ID-2420 with the same value in NM101.
CR 1390	Revise the TR3 note references to the referring and rendering provider names.
Location	X326 | Health Care Service Data Reporting | 837 | 2500 | 2310F NM1 - Referring Provider Name
Action	**Modify Segment Note** Changed to: See NUBC Manual for definition of institutional providers.
CR 1154	For consistency across all TR3s.
Location	X326 | Health Care Service Data Reporting | 837 | 2500 | 2310F 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	X326 | Health Care Service Data Reporting | 837 | 2500 | 2310F NM1 - Referring Provider Name
Action	**Modify Segment Note** Changed to: See NUBC Manual for definition of institutional 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	X326 | Health Care Service Data Reporting | 837 | 2710 | 2310F 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	X326 | Health Care Service Data Reporting | 837 | 2710 | 2310F 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	X326 | Health Care Service Data Reporting | 837 | 2710 | 2310F REF - Referring Provider Secondary Identification
Action	**Modify Data Element Code Value** Loop ID 2310F / 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	X326 | Health Care Service Data Reporting | 837 | 2710 | 2310F REF - Referring Provider Secondary Identification
Action	**Delete Data Element Code Value** 0B - State License Number.
CR 1231	To better align with industry use.

Location	X326 | Health Care Service Data Reporting | 837 | 2710 | 2310F 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	X326 | Health Care Service Data Reporting | 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	X326 | Health Care Service Data Reporting | 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	X326 | Health Care Service Data Reporting | 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	X326 | Health Care Service Data Reporting | 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	X326 | Health Care Service Data Reporting | 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	X326 | Health Care Service Data Reporting | 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	X326 | Health Care Service Data Reporting | 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	X326 | Health Care Service Data Reporting | 837 | 2900 | 2320 SBR - Other Subscriber Information
Action	**Add Data Element Situational Rule** Loop ID 2320 / SBR10 (Source of Payment Typology Code) Required when authorized by state or federal law or regulations. If not required by this implementation guide, do not send.
CR 1202	To allow for more granular reporting of the source of payment when required by state or federal regulation.
Location	X326 | Health Care Service Data Reporting | 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	X326 | Health Care Service Data Reporting | 837 | 3000 | 2320 AMT - 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	X326 | Health Care Service Data Reporting | 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	X326 | Health Care Service Data Reporting | 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	X326 | Health Care Service Data Reporting | 837 | 3550 | 2330A REF - Other Subscriber Social Security Number
Action	**Modify Segment Repeat** Changed to: 1
CR 1205	Modify the repeat count to match the number of qualifiers available for use.
Location	X326 | Health Care Service Data Reporting | 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	X326 | Health Care Service Data Reporting | 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	X326 | Health Care Service Data Reporting | 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	X326 | Health Care Service Data Reporting | 837 | 3250 | 2330B NM1 - Other Payer Name
Action	**Delete Data Element Code Value** 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	X326 | Health Care Service Data Reporting | 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	X326 | Health Care Service Data Reporting | 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	X326 | Health Care Service Data Reporting | 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	X326 | Health Care Service Data Reporting | 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	X326 | Health Care Service Data Reporting | 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	X326 | Health Care Service Data Reporting | 837 | 3750 | 2400 SV2 - Institutional Service Line

Action	**Modify Data Element Situational Rule** Loop ID 2400 / SV202-01 (Composite Medical Procedure Identifier) Changed to: Required for outpatient claims when an appropriate procedure code or HIPPS code exists for this service line item. OR Required for inpatient claims when an appropriate HCPCS (drugs and/or biologics and/or medical or surgical supplies only) or a HIPPS code exists for this service line item. 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	X326 | Health Care Service Data Reporting | 837 | 3750 | 2400 SV2 - Institutional Service Line
Action	**Delete Data Element Code Value** Loop ID 2400 / SV202-01 (Product/Service ID Qualifier) Removed: IV (Home Infusion EDI Coalition (HIEC) Product/Service Code)
CR 355	Remove code source 513 - Home Infusion EDI Coalition (HIEC)Product/Service Codes.
Location	X326 | Health Care Service Data Reporting | 837 | 3750 | 2400 SV2 - Institutional Service Line
Action	**Add Data Element Code Value** Loop ID 2400 / SV202-01 (Produce/Service ID Qualifier) ER - Jurisdiction Specific Procedure and Supply Codes This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: If a new rule names the Jurisdiction Specific Procedure and Supply Codes as an allowable code set under HIPAA, OR The Secretary grants an exception to use the code set as a pilot project as allowed under the law, OR For claims which are not covered under HIPAA.
CR 1154	For consistency across all TR3s.

Location	X326 | Health Care Service Data Reporting | 837 | 3750 | 2400 SV2 - Institutional Service Line
Action	**Delete Data Element Code Value** Loop ID 2400 / SV202-01 (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	X326 | Health Care Service Data Reporting | 837 | 3750 | 2400 SV2 - Institutional Service Line
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	X326 | Health Care Service Data Reporting | 837 | 3750 | 2400 SV2 - Institutional Service Line
Action	**Add Data Element Situational Rule** Loop ID 2400 / SV202-09 (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	X326 | Health Care Service Data Reporting | 837 | 3750 | 2400 SV2 - Institutional Service Line
Action	**Add Data Element Situational Rule** Loop ID 2400 / SV202-10 (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	X326 | Health Care Service Data Reporting | 837 | 3750 | 2400 SV2 - Institutional Service Line

Action	**Add Data Element Situational Rule** Loop ID 2400 / SV202-11 (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	X326 | Health Care Service Data Reporting | 837 | 3750 | 2400 SV2 - Institutional Service Line
Action	**Add Data Element Situational Rule** Loop ID 2400 / SV202-12 (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	X326 | Health Care Service Data Reporting | 837 | 3750 | 2400 SV2 - Institutional Service Line
Action	**Add Data Element Note** Loop ID 2400 / SV203 (Line Item Charge Amount) Zero "0" is an acceptable value for this element.
CR 1153	To clarify intended use.
Location	X326 | Health Care Service Data Reporting | 837 | 3750 | 2400 SV2 - Institutional Service Line
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	X326 | Health Care Service Data Reporting | 837 | 3750 | 2400 SV2 - Institutional Service Line
Action	**Delete Data Element Code Value** Loop ID 2400 / SV204 (Unit or Basis for Measurement Code) DA (Days)

CR 1505	Since Units (UN) can substitute for Days (DA), having both options is redundant, UN is sufficient. The specific type of unit reported is indicated by revenue codes or HCPCS codes.
Location	X326 | Health Care Service Data Reporting | 837 | 3750 | 2400 SV2 - Institutional Service Line
Action	**Add Data Element Code Note** Loop ID 2400 / SV204 (Unit or Basis for Measurement Code) UN (Units) Use when reporting both accommodation and ancillary revenue codes.
CR 1505	Since Units (UN) can substitute for Days (DA), having both options is redundant, UN is sufficient. The specific type of unit reported is indicated by revenue codes or HCPCS codes.
Location	X326 | Health Care Service Data Reporting | 837 | 3750 | 2400 SV2 - Institutional Service Line
Action	**Modify Data Element Situational Rule** Loop ID 2400 / SV202-07 (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 861	6020 Public Review Comment received indicating the Description of non-specific procedure codes is too vague.
Location	X326 | Health Care Service Data Reporting | 837 | 3750 | 2400 SV2 - Institutional Service Line
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	X326 | Health Care Service Data Reporting | 837 | 4550 | 2400 DTP - Service/Assessment Date
Action	**Modify Data Element Code Note** Loop ID 2400 / DTP01 (Date Time Period Format Qualifier) RD8 (Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD) Changed to: Use when DTP01 = 472 (Service Date), a drug is billed and the "Begin and

	End" dates are different. At the discretion of the submitter, RD8 can also be used when the "Begin and End" dates are the same. RD8 cannot be required by the receiver for non-drug services. RD8 is not used for Assessment Date (DTP01 = 866).
CR 1503	Clarify the usage requirements for service date and assessment date at the line level on institutional claims.

Location	X326 | Health Care Service Data Reporting | 837 | 4550 | 2400 DTP - Service/Assessment 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	X326 | Health Care Service Data Reporting | 837 | 4550 | 2400 DTP - Service/Assessment Date
Action	**Modify Segment Situational Rule** Changed to: Required when directed by the National Uniform Billing Committee (NUBC) Official UB Data Specifications Manual. OR Required when a drug is being submitted and the payer's adjudication is known to be impacted by the drug duration or the date the prescription was written. If not required by this implementation guide, do not send.
CR 1503	Clarify the usage requirements for service date and assessment date at the line level on institutional claims.

Location	X326 | Health Care Service Data Reporting | 837 | 4550 | 2400 DTP - Service/Assessment Date
Action	**Add Data Element Code Value** Loop ID 2400 / DTP01 (Date/Time Qualifier) 866 (Examination)
CR 851	Add assessment date to the institutional TR3. Assessment dates may fall outside the claim statement dates and in that scenario, they cannot currently be billed. This information is needed for prospective payment system billing enforcement.

Location	X326 | Health Care Service Data Reporting | 837 | 4550 | 2400 DTP - Service/Assessment 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 1503	Clarify the usage requirements for service date and assessment date at the line level on institutional claims.

Location	X326 | Health Care Service Data Reporting | 837 | 4550 | 2400 DTP - Service/Assessment Date
Action	**Delete Segment Note** Removed: In cases where a drug is being billed on a service line, a single date may be used to indicate the date the prescription was written (or otherwise communicated by the prescriber if not written).
CR 1503	Clarify the usage requirements for service date and assessment date at the line level on institutional claims.

Location	X326 | Health Care Service Data Reporting | 837 | 4550 | 2400 DTP - Service/Assessment Date

Action	**Add Data Element Code Note** Loop ID 2400 / DTP01 (Date Time Qualifier) 866 (Examination) Use when reporting the Assessment Date.
CR 1503	Clarify the usage requirements for service date and assessment date at the line level on institutional claims.
Location	X326 | Health Care Service Data Reporting | 837 | 4550 | 2400 DTP - Service/Assessment Date
Action	**Add Data Element Code Note** Loop ID 2400 / DTP02 (Date Time Period Format Qualifier) D8 (Date Expressed in Format CCYYMMDD) Use when DTP01 = 472 (Service Date), a drug is not being billed, and Loop ID 2300 Statement Dates (DTP01=434) is greater than one day.
CR 1503	Clarify the usage requirements for service date and assessment date at the line level on institutional claims.
Location	X326 | Health Care Service Data Reporting | 837 | 4550 | 2400 DTP - Service/Assessment 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	X326 | Health Care Service Data Reporting | 837 | 4550 | 2400 DTP - Service/Assessment Date
Action	**Modify Segment Situational Rule** Changed to: Required when directed by the National Uniform Billing Committee (NUBC) Official UB Data Specifications Manual and the claim is not a predetermination request. OR

	Required when a drug is being submitted and the payer's adjudication or predetermination is known to be impacted by the drug duration or the date the prescription was written. If not required by this implementation guide, do not send.
CR 1503	Clarify the usage requirements for service date and assessment date at the line level on institutional claims.
Location	X326 | Health Care Service Data Reporting | 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	X326 | Health Care Service Data Reporting | 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	X326 | Health Care Service Data Reporting | 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 SV2 segment of this Service Line Loop ID-2400.

CR 1548	Provide the ability to report the device identifier (DI) of the Unique Device Identifier (UDI) for pharmacy services.
Location	X326 | Health Care Service Data Reporting | 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	X326 | Health Care Service Data Reporting | 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	X326 | Health Care Service Data Reporting | 837 | 5000 | 2420A NM1 - Operating Physician Name
Action	**Modify Data Element Situational Rule** Loop ID 2420A / NM108 (Identification Code Qualifier) Changed to: Required when NM109 is used. If not required by this implementation guide, do not send.
CR 1478	Remove duplication of situational rules between the element and the code qualifier across the TR3.
Location	X326 | Health Care Service Data Reporting | 837 | 5000 | 2420A NM1 - Operating Physician Name
Action	**Modify Segment Note** changed to: See NUCC Manual for definition of professional providers.
CR 1154	For consistency across all TR3s.

Location	X326 | Health Care Service Data Reporting | 837 | 5000 | 2420A NM1 - Operating Physician Name
Action	**Modify Segment Note** Changed to: See NUBC Manual for definition of institutional providers.
CR 1154	For consistency across all TR3s.

Location	X326 | Health Care Service Data Reporting | 837 | 5250 | 2420A REF - Operating Physician 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	X326 | Health Care Service Data Reporting | 837 | 5250 | 2420A REF - Operating Physician 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	X326 | Health Care Service Data Reporting | 837 | 5250 | 2420A REF - Operating Physician Secondary Identification
Action	**Add Data Element Note** Loop ID 2420A / REF (Operating Physician Secondary Identification) 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 1154	For consistency across all TR3s.

Location	X326 | Health Care Service Data Reporting | 837 | 5250 | 2420A REF - Operating Physician 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	X326 | Health Care Service Data Reporting | 837 | 5250 | 2420A REF - Operating Physician 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	X326 | Health Care Service Data Reporting | 837 | 5250 | 2420A REF - Operating Physician Secondary Identification
Action	**Delete Data Element Code Value** Loop ID 2420A / REF (Operating Physician Secondary Identification) Removed: 0B (State License Number)
CR 1231	To better align with industry use.

Location	X326 | Health Care Service Data Reporting | 837 | 5250 | 2420A REF - Operating Physician 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	X326 | Health Care Service Data Reporting | 837 | 5250 | 2420A REF - Operating Physician 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	X326 | Health Care Service Data Reporting | 837 | 5250 | 2420A REF - Operating Physician 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	X326 | Health Care Service Data Reporting | 837 | 5000 | 2420B NM1 - Other Operating Physician 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	X326 | Health Care Service Data Reporting | 837 | 5000 | 2420B NM1 - Other Operating Physician Name
Action	**Modify Data Element Situational Rule** Loop ID 2420B / NM108 (Identification Code Qualifier) Changed to: Required when NM109 is used. If not required by this implementation guide, do not send.
CR 1478	Remove duplication of situational rules between the element and the code qualifier across the TR3.
Location	X326 | Health Care Service Data Reporting | 837 | 5000 | 2420B NM1 - Other Operating Physician Name
Action	**Modify Segment Note** Changed to: See NUBC Manual for definition of institutional providers.
CR 1154	For consistency across all TR3s.
Location	X326 | Health Care Service Data Reporting | 837 | 5250 | 2420B REF - Other Operating Physician 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	X326 | Health Care Service Data Reporting | 837 | 5250 | 2420B REF - Other Operating Physician 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	X326 | Health Care Service Data Reporting | 837 | 5250 | 2420B REF - Other Operating Physician 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	X326 | Health Care Service Data Reporting | 837 | 5250 | 2420B REF - Other Operating Physician 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	X326 | Health Care Service Data Reporting | 837 | 5250 | 2420B REF - Other Operating Physician Secondary Identification
Action	**Delete Data Element Code Value** Loop ID 2420B / REF (Other Operating Physician Secondary Identification)

	Removed: 0B (State License Number)
CR 1231	To better align with industry use.

Location	X326 | Health Care Service Data Reporting | 837 | 5250 | 2420B REF - Other Operating Physician 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	X326 | Health Care Service Data Reporting | 837 | 5250 | 2420B REF - Other Operating Physician 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	X326 | Health Care Service Data Reporting | 837 | 5250 | 2420B REF - Other Operating Physician 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	X326 | Health Care Service Data Reporting | 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.