WHAIC Ambulatory Surgery Center Technical Document & Tips to Create a File

WHAIC Data Submission and General Questions

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DISCLAIMER: This document supports the freestanding ASC file Development for an 837P file. The full manual along with all the detailed technical specifications and appendices can be found on the WHA Information Center website.

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Data Submission in a HIPAA Complaint 837 claims file format

Wisconsin Hospital Association Information Center (WHAIC) collects data from **Medicare Certified Wisconsin Hospitals and Freestanding Ambulatory Surgery Centers.**

Pursuant to Chapter 153, Wisconsin Statutes , the WHAIC has been authorized by the Wisconsin Department of Administration to collect and report hospital and freestanding ambulatory surgery center data. WHAIC collects data quarterly and produces public use data sets, custom data sets and four annual publications.

Chapter 153 of the Wisconsin Statutes directs what information must be submitted to WHAIC; however, although health care has evolved tremendously over the past three decades, many sections of the statute had not been updated until April of 2016, when the Wisconsin Health Care Data Modernization Act was passed. The Health Care Data Modernization Act removed outdated provisions in Chapter 153 and included an opportunity to bring Chapter 153 into greater alignment with the national ANSI 837 standard.

The WHAIC WIpop Manual and Technical Specification Guide follows the national ANSI 837 standards and provides specifications for the submission of inpatient and outpatient hospital data, and FASC data to the WHAIC. Failure to comply with the requirements outlined in the Statutes, or submission deadlines as referenced in this Companion Guide, may result in a non-compliance letter to the Wisconsin Department of Administration and may include significant penalties and forfeitures.

The Statute also states facilities that use a third-party vendor shall provide a copy of the trading partner agreement if the service of a third-party vendor is used to prepare and submit patient claims/records to WHAIC. As per *Wisconsin Administrative Code* DHS 120.12 (5) (b) 6 (a) and 120.13(2) (d) 1. *"To ensure confidentiality, hospitals and freestanding ambulatory surgery centers using qualified vendors to submit data shall provide to [WHAIC]* ***an original trading partner agreement that has been signed and notarized by the qualified vendor and the hospital or ambulatory surgery center****.*

Hospitals and ASCs are accountable for their qualified vendor's failure to submit and edit data in the formats required by WHAIC.

The WHA Information Center database is publicly available and widely released to hospitals and health systems, researchers, consultants, state and federal government agencies, universities, vendors, and web-based data organizations. WHAIC makes every effort to maintain the highest quality information, and as per state statute, each facility is required to implement a validation process whereby each facility will engage in verification and sign off of all submitted data upon timely completion of a quarter.

Freestanding Ambulatory Surgery Records (OPS)

Hospital outpatient departments, hospital-affiliated ambulatory surgery centers, and freestanding ambulatory surgery centers (FASC) are required to submit selected items—or aggregations of items—on all ambulatory surgeries. This includes procedures for self-paying patients, Workers' Compensation, and Charity Care.

A. Reporting by Procedure Date

Outpatient surgery records are reported based on the **procedure date**, i.e., the quarter in which the surgical procedure or service was performed. The procedure date—not the admit/discharge date. Some facilities may pull by statement from/to dates—to determine the reporting quarter for OPS.

- If a service spans multiple dates that cross a quarter boundary, the record should still be reported in the quarter of the **principal procedure**.
- Minor overlaps of one or two days into the next quarter are acceptable as long as the principal procedure date falls within the correct quarter and revenue line-item dates (if provided) align with the admit/discharge or statement dates.

Example: If a procedure occurs on 06/30 but the patient is discharged on 07/01, the record should be included in the Q2 submission because the procedure occurred in Q2.

B. Place of Service (POS)

WHAIC assigns the record to **Place of Service (POS) '1'** for services classified as ambulatory/day/same-day or outpatient surgery, including FASC facility IDs in the 200's and 400's or when applicable **UB Revenue Codes** are present.

C. Freestanding Ambulatory Surgery Centers (FASC)

- FASC are **not required to use revenue codes**.
- Billing is done via **837P or CMS 1500** forms with the appropriate CPT or HCPCS codes for services, supplies, or other items.
- Type of bill is **not required** for FASC claims, but WIpop requires mapping to **0999, 0831, or a variant**, per state statute.

D. Exception Rules for OPS

- Procedures occurring within the **90-day global surgical period** (e.g., cataract surgeries performed on both eyes within 90 days) are exempt from certain edits.
- Services up to **90 days after the principal procedure date** are allowed if a **Left (LT) or Right (RT) modifier** is present.

E. Special Note for 837i Files

Some FASC submit using **837i (institutional format)**. WHAIC uses revenue line-item details (Revenue Codes **036X [excluding 0361], 0481, 049X, or 0750**) and dates of service to determine principal and additional procedure codes. Mapping and programming are required for 837i submissions. For details, see the **main hospital manual**.

036X – OR Services *not 0361*	0481 – Cardiac Cath	049X – Ambulatory Surgical Care	0750 – GI Services

Discharge Data Collection Overview

This section defines the expectations and exceptions for the data submission requirements and limitations. See Section VII for information on specific data submission and technical requirements.

Facilities must use the secured web-based submission tool known as WIpop [pronounced WHY POP] to submit its quarterly discharge data to WHAIC.

WIPOP users must register for and have an active WIpop account. Hospitals and ASCs are responsible **for managing access to WIpop and all registered users. Any changes to the list of users must be corrected in WIpop or communicated to WHAIC staff.**

- External Cause of Injury (**ECI) Codes are required**, as per state statute, with a diagnosis code in S section and some T codes.

A. Format failures

Data submission files must pass basic formatting and compliance checks to be processed in the WIpop database. If a file is rejected for failing the format requirements an email notification will be sent to the submitter and primary contact detailing the reason for failed formatting. For more information on file failures contact us at whainfocenter@wha.org *Facilities are accountable for their qualified vendor's failure to submit data and/or create the 837 claims file required by WHAIC.*

Examples of format failures:

- The file contains PHI - patient name or social security number.
- More than 10% of records missing address to complete the census block group detail.
- Greater than 25% of records with a race or ethnicity of unavailable / denied *effective Q318
- Structurally insufficient or missing segments, facility ID, etc. File size is over 100Meg.
- Duplicating patient control numbers / encounters in the file.

B. Timelines for Data Submission

Data must be reported quarterly, within 45 days of the close of the quarter. Calendar quarters end on March 31, June 30, September 30, and December 31. Monthly files are encouraged. The WHAIC website Data Submitters Tab has the most current Calendar information available.

The WHAIC discharge data submission site includes both a **WIpop Test** site and a **WIpop Production** site.

**Edits should not be worked in the test site unless the facility is verifying something specific.*

C. Race Collection

Race and/or Ethnicity

WHAIC is a contracted entity of the State of Wisconsin. The State of WI requires collection and reporting of race and/or ethnicity data. Batch files will be **rejected if more than 25% of race and ethnicity codes are missing.**

Effective Q42024 WHAIC began to implement the two (2) new OMB Race categories and codes and asks that you update your data collection efforts. This change will require facilities to update the patient registration questions and mapping to the updated list of race options. In addition, we also encourage facilities to collect and report a more detailed sub-category of race. Meaning, we are expanding the race field to allow for the collection of the main category as well as allowing patients to self-identify in reporting (more than one) sub-category in the discharge data if collected.

Improving Race and Ethnicity Data Collection to Advance Health Equity
WHA and WHAIC are partnering with the Wisconsin Department of Health Services (DHS) to strengthen how hospitals and health systems collect and report patient race and ethnicity data at registration/Admission. Accurate and complete demographic data is essential to identify disparities in care, improve access, and support better patient outcomes.

Our shared goal is to ensure that patients are able to select more than one race, allowing us to better track inequities and plan for care that meets the needs of all communities.

We are asking for your leadership and support in this effort. Please help us by:

- Sharing the importance of this initiative with your patient registration teams and others who support discharge data reporting.
- Encouraging timely updates to data collection systems.
- Ensuring revisions to verbal, written, and electronic forms, as well as EMR/EHR workflows, to incorporate the new combined race/ethnicity question.

It is important to note that many organizations remain unaware of the recent updates and requirements. In alignment with federal Office of Management and Budget (OMB) standards, two new race and ethnicity categories must now be collected:

- **Middle Eastern or North African**
- **Hispanic or Latino**

Your engagement will be critical to the success of this initiative. By prioritizing complete and accurate data collection, we can work together to reduce disparities and deliver more equitable care to the patients and communities we serve.

WHAIC Implementation of New OMB Guidelines

Implementation Timeline: Effective Date: Q4 2024 New Race Data Collection Updated and Available.

Requirement: By Q3 2026 - All facilities are required to submit data according to the new guidelines and codes.

Interim: During the transition period, WHAIC will allow for both types of submission of race and ethnicity while working with facilities to update their extracts.

Key Changes:

- Single Question Format: There is no longer a separate category for ethnicity. The new format combines race and ethnicity into a single question.
- Reasoning: The OMB's research indicates that a single question format reduces confusion and more accurately reflects how people view their identity.
- Update Data Collection Systems: Ensure all verbal, written, EMR/EHR and collection systems and processes are updated to reflect the new combined race and ethnicity categories. We encourage hospitals and ASCs to collect data at the detailed level.
- Update the 837 File Loop 2010BA/2010CA and Element DMG05-1. DMG is a composite element, which repeats up to 10 times. RET
- Resources: Addressing Health Care Disparities through Race, Ethnicity and Language (REaL) Data | IFDHE
- ifdhe_real_data_resource.pdf
- https://spd15revision.gov/ OMB Guidance

Simplified Listing of Main Categories

WHAIC Code	Main Category	Description
1	American Indian or Alaska Native	A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
2	Asian	A person having origins in any of the original peoples of East Asia, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
3	Black or African American	A person having origins in any of the Black racial groups of Africa.
4	Native Hawaiian or other Pacific Islander	A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
5	White	A person having origins in any of the peoples of North America, Europe, North Africa, or the Middle East.
6	**NEW: Middle Eastern or North African (MENA)**	MENA Americans can trace their origins to more than a dozen countries, including Egypt, Morocco, Iran, Turkey and Yemen. People from there can be white, brown or Black, as well as identify with an ethnic group, like Arab, Kurdish, Chaldean and more.
8	**NEW: Hispanic or Latino**	A person of Mexican, Puerto Rican, Cuban, Central or South American, or Spanish culture or origin, regardless of race.
7	Declined	A person who refuses to answer this question.
9	Unavailable	A person unable to answer this question, or no available family member or caregiver to respond for the patient. May also be used by patients if their race is unknown.

Ethnicity Valid Until 12/31/2026

1	Hispanic or Latino	A person of Mexican, Puerto Rican, Cuban, Central or South American, or Spanish culture or origin, regardless of race.
2	Non-Hispanic or Latino	Person not of Hispanic or Latino ethnicity.
7	Declined	A person who refuses to answer this question or cannot identify him/herself ethnicity.
9	Unavailable/Unknown	A person unable to answer the question, or ethnicity is unknown to the patient.

Detailed listing of categories with Subcategory codes

Main Code	Main Category Description	Subcategory Code	Subcategory Code	Subcategory Code	Subcategory Code	Subcategory Code	Subcategory Code
1	American Indian or Alaskan Native	101 - Aztec	102 - Cherokee	103 - Eskimo	104 - Iroquois	105 -Maya	106 -Navajo
2	Asian, Asian American, Asian Indian	201 - Chinese	202 - Filipino	203 - Hmong	204-Japanese	205 - Korean	206 - Laotian or Vietnamese
3	Black or African American	301 - African	302 - Jamaican	303 - Ethiopian	304 - Haitian	305 -Nigerian	306 - Somali
4	Native Hawaiian or Pacific Islander	401 -Chamorro	402 -Guamanian	403 - Fijian	404-Marshallese	405 - Tongan	406 - Samoan
5	White / Caucasian	501 - English	502 - German	503 - Irish	504 - Italian	505 - Polish	506 - Scottish
6	NEW: Arab, Middle Easter or North African	601 - Egyptian	602 - Iraqi	603 - Lebanese	604 - Pakistani	605 - Syrian	606- Moroccan
8	NEW: Hispanic or Latino	801 - Cuban	802 - Dominican	803 - Guatemalan	804 - Mexican	805 - Puerto Rican	806 - Salvadoran
7	Declined						
9	Unavailable						

D. Bill Types and Replacement Claims

FASC must submit Bill Types (Type of Bills) as per State Statute, although not required on the 837P: **WHAIC will accept 0831 or 0999 – programmed accordingly.**

We do not accept replacement, voided or corrected claims/encounters in any of the data. Unlike insurance companies, we have no mechanisms in place to automatically search and replace a previously submitted encounter or record. *The data is submitted and released for use by hospitals, policy makers, researchers and consumers based on calendar quarters, therefore it is impractical to replace a record/claim from a previous quarter once the data is released.*

- For example, types of bills ending in 7 (example 0837) will be assigned an edit.

E. Payers Need to be Mapped to WHAIC code list

Although there is no national payer/plan ID, most insurance cards/EDI systems/clearinghouses have payer IDs assigned for Medicare, commercial and state level benefit plans in order to pay and/or direct a claim. For more information see Expected Source of Payment Appendix and Payer ID mapping in Section 7.4 of main hospital manual.

Expected Source of Payment ID/Type:	MPC	09	Claim File Indic Code:	MB
Secondary Source of Payment ID/Type:	T19	09	Prov Based Loc:	
Insurance Certificate Number:	H45141302		Payer ID:	61101

Payer ID Data Element: 837I, 837R, 837P: Loop 2010BB / REF01 (NF (NAIC Code), REF02 = Value

- **Definition:** Support the Exchange of EDI Claims Using a Payer List and Payer ID. When using the services of a clearinghouse, it is important the proper Payer ID is used so the EDI claims are sent to the right payer.
- **Purpose:** This field is made available as an internal and external cross check if a Payer Identification is reported on the EDI claims file. Based on WHAIC research most facilities use an EDI Claims Payer List to identify or map a Payer ID to support their electronic transactions are routed to the right health plan.

  Are payer IDs universal?
  Some national payers, such as Aetna (60054), Cigna (62308), and United Healthcare (87726) have universal payer IDs that can be used across all clearinghouses. Other payers can have different payer ids based on the clearinghouse.

WHAIC Notes: Our goal is to get the PayerID off the encounter/claim. Once we have consistency with the Payer ID, we will attempt to create an internal table to validate payers more frequently for accuracy.

F. Removing Duplicates from File Submission

There are two types of batch file rejects as it relates to duplicate records that apply to this process.

1. Duplicates within same file - two records with the same patient control number:

   a. **Resubmit the batch with the phrase "exclude_duplicates" somewhere within the file name.**
      i. Example file name: Q220_WHAIC_ facilityname_exclude_duplicates.txt
   b. We will keep the original encounter/record if it has a valid bill type.
   c. The batch file email response will include the number of records submitted and number of duplicates removed.

2. Duplicate patient control number of a record/encounter that already exists in WIpop:

- If the WIpop file contains a duplicate patient control number for an encounter that was previously uploaded, rerun the batch file with the phrase "**exclude_duplicates" (see example above) to remove the duplicate record(s) in the new file.** We will not replace original file records/encounters because there are too many variables such as trying to locate a duplicate record that is in a batch marked complete, and/or edits have already been worked, or the record is from a previous quarter.

Ambulatory (day/outpatient) Surgery Records (OPS)

Freestanding ambulatory surgery centers (FASC) are required to submit encounters for ambulatory surgeries, **<u>including records of self-pay patients, workers comp, charity care, etc.</u>**

A **principal procedure code** is required on all outpatient surgery records per statutory requirements. WHAIC assigns the principal procedure field and procedure date using revenue line-item details.

- The principal procedure is determined by the **highest qualifying CPT/HCPCS code charge**.
  - If multiple items have the same highest charge, the **earliest service date** is selected.
- Assignment follows **official CPT and HCPCS coding guidelines**, supplemented by historical data and algorithms when needed.

Definition: The principal procedure is the procedure performed for definitive treatment, rather than for diagnostic or exploratory purposes, or to manage a complication.

For discharge data submissions, WHAIC generally considers CPT codes in the surgical range **15999–69979**, with limited exceptions, as eligible for principal procedure assignment

ASCs are not required to use a revenue code, but if one is provided, we ask they comply with the codes used by hospitals:

> *036X – Operating Room Services *except revenue code 0361 – which is assigned to OHO POS 6 minor outpatient treatment. 0481 – Cardiology – Cardiac Cath; 049X – Ambulatory Surgical Care; and 0750 – GI Services*

Definition: The principal procedure is the procedure performed for definitive treatment, rather than for diagnostic or exploratory purposes, or to manage a complication.

For discharge data submissions, WHAIC generally considers CPT codes in the surgical range **15999–69979**, with limited exceptions, as eligible for principal procedure assignment

The **<u>procedure date</u>** (not the statement from and through) is used to determine which quarter to use when reporting OPS.

- For example, if the procedure is performed on 06/30, but the patient had follow-up or on rare occasion discharged on 7/1, it should be included in the second quarter data submission.
- *Dates of service are not included in the discharge data. If a claim makes its way into the next quarter, we ask that you change the DOS to match the quarter the data is submitted for and not delete the record.*

- *Exception Rules OPS:* Records for claims that occur within the 90-day global surgical period (such as cataract surgeries that are often performed on both eyes within the 90-day global surgery period), are exempt from the edit.
  - A service date up to 90 days after the principal procedure date will be allowed if a Left (LT) or Right (RT) modifier is on record.

How to Register and Upload data into WIpop

New Users / Registration

1. Go to our website and use the Data Submitters tab
2. Drill down to Applications Login and choose WIpop (pronounced WHY POP)
3. Proceed to register. Choose your Role (Primary, Secondary or User)
4. User accounts will be activated within 24-48 hours.

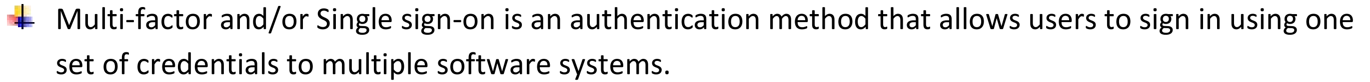
New Look and Feel

WIpop

Sign In — Existing user

Register — NEW USER

- Enter in email - WHAIC will first verify if user has an active account.
- If no email is found, the user will be required to register on the WIpop site and select a role based on primary or secondary contact (see WIpop Roles), as it relates to WHAIC Data Submissions.
- User will use their own facility email address, Username or PW



- Multi-factor and/or Single sign-on is an authentication method that allows users to sign in using one set of credentials to multiple software systems.

WIpop

Please enter your work email address to request access to WIpop. Note: *Enter your hospital or business email so that we can check our records to see if an account already exists.*

Submit

WIpop

User Information

First Name*	Last Name*
Justin	Flory
Job Title	**Email***
Healthcare Data Programmer	justin.florytest500@gmail.com
Business Phone*	**Mobile Phone**
5555555	
Organization*	
WHA Information Center	

Previous Next

WIpop

If you registered using a Microsoft account (hotmail, outlook.com, or business active directory account) you will log in with that username and password.

Sign In

Register

Welcome, Cindy C. | Sign out
Messages (0) | Administration

WIpop

Home | User Links | WIpop Manual | Data Detail | Data Deliverables

Announcements & Important Dates

9/29/2023	Rice Lake WIpop Training	Add To Calendar
9/28/2023	Milwaukee WIpop Training	Add To Calendar

WIpop Production

WIpop Test

Attention WIpop Users

Reminders:

- This is a secured website. WHAIC **DOES NOT** register new users. All users must register and create their own secured account in WIpop (pronounced WHYPOP). The WHAIC website has instructions for how to register in the online manual.
- If an existing user needs access removed or updated, email whainfocenter@wha.org.
- Effective Q42023 WHAIC will begin using multifactor authentication. Multi-factor authentication (MFA) is a multi-step account login process that requires users to enter a code sent to their email.

Quarterly Data Update:

Refer to the online calendar for more information. Please be sure to review your online reports in WIpop, correct edits and maintain the timelines below.

2023 Q3 Data Submission	
Standard Data Submission Deadline – Data Due	**11/14**
Standard Deadline fix Edits & Mark QTR Complete	11/28
Extended Deadline - Due Date for Data Submission	**12/1**
Ext. Deadline fix Edits & Mark QTR Complete	*12/13*
❖ **Validation Reports in Portal – review data!**	**12/15**
Deadline to Validate and Return Affirmation	12/29
Data Released	**1/9/24**

Thank you for all you do to make sure the data is timely, accurate and complete.

Upload the data!

File Upload

Back to Production

448 - Fresenius Access Care Physicians of Madison ASC LLC

To submit your inpatient/outpatient file please choose a quarter and your preferred upload method below and click upload. Do not close the browser window while the file is being uploaded to our server. Once your file has been accepted, a notice will appear and submitter as well as facility Primary contact(s) will receive an email notification.

Step 1. --Select Quarter--

Step 2. Upload Method: Create Encrypted Patient Identifier and Upload File (AKA Black Box)

Upload 837 Claim file (file contains encrypted patient identifier)

Most ASCs will choose the first method to upload data.

Choose this method if your 837 claim contains patient names.

Step 3. Choose File No file chosen

Upload Batch Review

Submitter will upload a file from their facility directory. Depending on size, it could take anywhere from 5-10 minutes to fully load.

All data submitted will receive a response email. If you get an email that says your batch was invalid, read the message to determine what the issue is. The email will never contain PHI, if the batch is invalid due to patient name or any other PHI in the file, the **user will receive a portal login message** with additional information. If you cannot figure out how to correct the issue using the error message, contact the whainfocenter@wha.org to direct your question.

*Important: Files must be less than 3 days (72 hours) old in order for us to assist you because files are deleted after 72 hours.

Fixing Edits and Marking Batch Files Complete

Once the data is uploaded it populates into our database. Should questions arise, feel free to reach out to us for any reason. Use **your 3-digit facility ID and facility name when communicating with us** either in the subject line or in the body of the email.

- Once all edits are done, **mark** the batch complete.
- To fix edits in a closed batch, you need to click the “reopen” option.
- Once the Batch is marked complete, you will be in Read ONLY mode.

Quarter 1, 2023 (Standard Data Due Date: 5/15/2023 12:00:00 AM) Data Enter New Batch

Batch	Patient Type	Total Records	Valid Records	Invalid Records	Available Options	Alert Records
Batch Num #223011	Patient Type	Total Records	Valid Records	Invalid Records	Available Options	Alert Records
(Uploaded 4/7/2023 10:44:01 AM)	Inpatient	701	701	0	Complete	219
Delete Batch	Outpatient Surgery	827	827	0	Complete	55
Mark Batch Complete	Emergency Room	4658	4658	0	Complete	223
	Observation	278	278	0	Complete	22
	Therapies	4539	4539	0	Complete	245
	Outpatient Lab/Rad	9752	9752	0	Complete	780
	Other Outpatient	10403	10403	0	Complete	757

Batch	Patient Type	Total Records	Valid Records	Invalid Records	Available Options	Alert Records
Batch Num #222847	Patient Type	Total Records	Valid Records	Invalid Records	Available Options	Alert Records
(Uploaded 3/6/2023 6:57:20 AM)	Inpatient (Completed)	764	764	0		256
Reopen Batch	Outpatient Surgery (Completed)	907	907	0		48
Delete Batch	Emergency Room (Completed)	4867	4867	0		317
	Observation (Completed)	295	295	0		18
	Therapies (Completed)	4826	4826	0		257
	Outpatient Lab/Rad (Completed)	10829	10829	0		851
	Other Outpatient (Completed)	11601	11601	0		845

A. Running Reports:

WIpop Production

Home | User Links | WIpop Manual | Data Detail | Data Deliverables

Find Patient Record
Direct Data Entry
Create Report
Report Descriptions

Behavioral Health

Reports are available in real time or at the end of the quarter.

WIpop Production

WIpop Manual | Data Detail | Data Deliverables

Validation Reports
Data Affirmations

At the end of the quarter, reports will be produced along with an Affirmation statement that must be reviewed and approved.

Vendor Create the 837P Data Submission File

This section provides additional detail about the file submission and specific characteristics about creating a file and file expectations. Review of this section will help the technical advisor, vendor or developer create the custom 837 claim file and

format it according to WHAIC specifications. If you follow these guidelines, the file will process accurately, efficiently and with minimal edits.

Although this manual is intended to serve ASCs, some ASCs prefer to program the file using the 837I or 837R format, see the full hospital manual for those details. This document references the 837 Professional Health Care Claim – ASC X12N 837 (005010X222A1)

837P sample file: https://www.whainfocenter.com/WHAInfoCenter/media/DataSubmitters/837P_SampleFile.pdf

The 837 WIpop claims file **does NOT have** file extension requirements.

A. Interchange Control Header (ISA06)

WHAIC manages two data submission environments - one for test and one for production, therefore the data submitter is choosing the environment; the use of the ISA15 segment is not necessary or required.

An uploaded 837 file must contain data for only one facility. The facility number in ISA06, GS02, and NM109 in loop 1000A must all match the facility number specified when the file is uploaded. In other words, if the user specifies that the uploaded file is for facility 043 (Aurora - Hartford) but the file contains data and field identifiers for facility 124 (Aurora - Sheboygan), the file will be rejected.

B. Delimiters in the Segment of the file

A delimiter is a character used to separate two data elements or component elements or to terminate a segment. The delimiters are an integral part of the data. Delimiters are specified in the interchange header segment, ISA. The ISA segment can be considered implementation compliant with this guide to be a 105-byte fixed length record, followed by a segment terminator.

- the data element separator is byte number 4;
- the repetition separator is byte number 83;
- the component element separator is byte number 105; and,
- the segment terminator is the byte that immediately follows the component element separator.

Once specified in the interchange header, the delimiters are not to be used in a data element value elsewhere in the interchange. For consistency, this implementation guide uses the delimiters shown below in Delimiters Table, in all examples of the EDI transmissions.

File Delimiters

Character	Name	Delimiter
*	Asterisk	Data Element Separator
^	Carat	Repetition Separator
:	Colon	Component Element Separator
~	Tilde	Segment Terminator

The use of the following special characters should be used within the claim data as defined below.

Period	Dash	Colon
.	-	:
Ex: Charges 111.11	**Ex:** source of payment, ex. AAA-01	Ex: Race:Ethnicity DMG05 value of **5:2:3** is treated as Race = 5, Ethnicity = 2, Race2 = 3

C. 837P (ASC) Professional Claim Submissions - ASCs

This section applies to freestanding ambulatory surgery centers (FASC/ASCs), with a three-digit ID in the range of 200 or 400 Appendix 7.1. FASCs are required to submit selected items or aggregation of items on all ambulatory surgeries, **including records of self-pay patients.** Most of these items are located on the National Uniform Claims Committee (NUCC) or CMS-1500 claim form.

This document notes the loops and elements relevant to WHAIC Data Collection. It is not intended to serve as a complete 837 reference, not all requirements for a valid 837 file are specified. *See the main 837 Companion Guide and Tech Specifications Manual (Hospital Manual) for the 837I and 837R specs.*

Fields defined, created, or added by WHAIC from the 837 claims file

Patient Type (outpatient surgery)	Type of Encounter (Outpatient = 2)	Place of Service = 1
Principal Procedure on OP Records	Principal Procedure Date	Additional Procedures on OPS records
Principal Procedure Modifier(s)	Additional Procedure Modifier(s)	

Legend

Name	Field	Description
R	Required	Data Element Must be Submitted for the data type and must not be blank.
S	Situational	Required based upon values in the claim/EMR or other elements.
O	Optional	This element is not required and may be left blank, however, if submitted, it will be edited.
Gray shade	Blank	data is not stored, but may be sent, and may or may not be used to route data in WIpop

837P Crosswalk and WIpop Map - Summary Table of required elements

Additional Elements supplied and not mentioned in this document will be discarded by WHAIC prior to processing.

- 837 Professional Health Care Claim – ASC X12N 837 (005010X222A1) | Download Sample 837 P File

Loop	Element	Field Description	R, S, O	Values/Mapping Comments	WIpop Name / Notes
0000	ISA06	Interchange Sender ID (3 digit)	R	Use 3-digit Facility ID assigned by WHAIC. Example: Osceola Medical Center is '102' WHAIC Permanent Facility ID - Appendix 7.1 Facility List	All claims must be from the same facility. Must match GS02 & 1000A/NM109
	ISA08	Receiver ID	O	Submitter choice: leave blank or use WHAIC837	
	GS02	Application Sender's Code	O	Use 3-digit Facility ID assigned by WHAIC. Example: Osceola Medical Center is '102' WHAIC Permanent Facility ID - Appendix 7.1 Facility List	All claims must be from the same facility. Must match ISA06 & 1000A/NM109
	GS03	Application Receiver's Code	O	Submitter choice: leave blank or use WHAIC837	
0000	ST03	Implementation Guide Version	R	005010X222A1	Req but not stored.
LOOP ID 1000A/B and 2010AA Submitter and Billing (HOSPITAL / ASC) Detail LOOP 2010AA: BILLING PROVIDER NAME NM1*85*2*SAMPLE HOSPITAL PROVID*11****XX*9876543210~ N3*236 N MAIN ST~ N4*MADISON*WI*53717~ REF*EI*11-12345678~					
1000A	NM101	Entity ID code	O	41 = Submitter	
1000A	NM102	Entity Type Qualifier	R	"2" – non-person entity	
1000A	NM103	Organization Name	O	ASC name	
1000A	NM108	Identification Code Qualifier	R	46	
1000A	NM109	Identification Code of Submitter	R	Use 3-digit Facility ID assigned by WHAIC.	All claims must be from the same facility. Must match ISA06 & GS02

Loop	Element	Field Description	R, S, O	Values/Mapping Comments	WIpop Name / Notes
				Example: Osceola Medical Center is '102' WHAIC Permanent Facility ID - Appendix 7.1 Facility List	
1000B	NM101	Entity ID code	O	40 = Receiver	
1000B	NM103	Receiver Name – WHAIC	O	Use WHAIC – identifies WHAIC as receiver	
1000B	NM109	Receiver (WHAIC) Primary Identifier	O	WHAIC 837	
2010AA	NM101	Billing/Service Provider Identifier code	R	85 = Billing Provider	
2010AA	NM108	Billing Entity ID Qualifier	R	"XX"	
2010AA	NM109	Billing Entity ID Code	R	Use Facility Billing NPI Number	Facility NPI number used to bill claims.
Patient/Subscriber Detail: Patient Detail Required when the patient is different from the Subscriber. ***If not required by this Implementation Guide, do not send.***					
Patient / Subscriber details cannot be determined until processing of UCID occurs – prior to submission					
LOOP 2000B: SUBSCRIBER HIERARCHICAL LEVEL HL*2*1*22*1~ SBR*P**CERTNUM2222SJ~ LOOP 2010BA: SUBSCRIBER NAME NM1*IL*1*NULL*****MI*3CFD1B33ACBD5475CE36D8C439FEC42475B9ADBEC7B91A6926DACF0F45BE269F-S530J~ N3*123 OAK ST~ N4*MADISON*WI*53719~ DMG*D8*19830501*F*M*5:2~				**DO NOT SEND 2010CA IF PATIENT IS SUBSCRIBER**	
2000B	SBR03	Policy Number – Insurance SBR03 is Policy or Group Number	R	Send "NULL" if Self-pay Other terms: Policy #, Member ID, Insurance Card #, Group Number, certificate number.	Insurance Cert # - can only be NULL or blank for self-pay
2000B	SBR09	Claim Filing Indicator Code	S	Code identifying type of claim.	See Appendix 7.4.1 for a list of codes associated with primary payer.
2010BA	NM103	Subscriber Last Name	R	Subscriber names are not accepted. Send "NULL." NM104 – NM107 must be blank.	Patient Detail Required when the patient *__is different__* from the Subscriber
2010CA	NM103	Patient Last Name	R	Patient names are not accepted.	Send "NULL." NM104 – NM107 must be blank.

				Send "NULL." NM104 – NM107 must be blank.	
2010BA	NM109	Subscriber UCID	R	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1 Element format is **UCID** UCID is characters 1 – 64	This field is used for encrypting the patient and/or subscriber name. Provide Patient UCID if different from subscriber.
2010CA	NM109	Patient UCID	R	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1 Element format is **UCID** UCID is characters 1 – 64	This field is used for encrypting the patient and/or subscriber name. Provide Patient UCID if different from subscriber.
2010BA	N301	Subscriber Address 1	R/S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1 Address, City, State and Zip will be used to find the patient's census block group. **The block group**, but **not the address, will be saved** in WIpop. *File rejected if more than 10% of records missing address	Census Block Group -Typically, the block group number populates in WIpop during overnight processing. Files rejected if >10% missing address.
2010CA	N301	Patient Address 1	R/S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1 *File rejected if more than 10% of records missing address	Census Block Group -Typically, the block group number populates in WIpop during overnight processing. Files rejected if >10% missing address.
2010BA	N302	Subscriber Address Line 2	R/S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1	Value not stored
2010CA	N302	Patient Address Line 2	R/S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1	Value not stored
2010BA	N401	Subscriber City	R/S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1	***File rejected if > 10% of records missing address**
2010CA	N401	Patient City	R/S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1	***File rejected if > 10% of records missing address**
2010BA	N402	Subscriber State	R/S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1	Value not stored
2010CA	N402	Patient State	R/S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1	Value not stored
2010BA	N403	Subscriber Zip code	R/S	Loop 2010BA, NM101 = IL	Zip Code Stored in WIpop

				Loop 2010BA, NM102 = 1	
2010CA	N403	Patient Zip Code	R/S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1	Zip Code stored in WIpop
2010BA	DMG02	Subscriber Birth Date	R/S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1	Birth Date
2010CA	DMG02	Patient Birth Date	R/S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1	Birth Date
2010BA	DMG03	Subscriber Gender Code	R/S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1 F, M, U or O	F, M, U, O (U or O requires Cond Code 45)
2010CA	DMG03	Patient Gender Code	R/S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1 F, M, U or O	F, M, U, O (U or O requires Cond Code 45)
2010BA	DMG04	Subscriber Marital Status Code	O	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1 See Appendix 7.14 for Mapping	Marital Status optional field, supply if collected.
2010CA	DMG04	Patient Marital Status Code	O	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1 See Appendix 7.14 for Mapping	Marital Status optional field, supply if collected.
2010BA	DMG05 -1	Subscriber Race Code1 See Appendix 7.2	R/S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1 DMG05 value of **5:2:3** is treated as Race = 5, Ethnicity = 2, Race2 = 3 DMG*D8*19830501*F*M*5:2	DMG05 is a composite element, which repeats up to ten (10) times. The first two entries for the race will be used for WIpop fields RACE and RACE2. File rejected if > 25% of records = declined or unavailable.
2010CA	DMG05 -1	Patient Race Code1 See Appendix 7.2	R/S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1 DMG05 value of **5:2:3** is treated as Race = 5, Ethnicity = 2, Race2 = 3 DMG*D8*19830501*F*M*5:2	DMG05 is a composite element, which repeats up to ten (10) times. The first two entries for the race will be used for WIpop fields RACE and RACE2. File rejected if > 25% of records coded as declined or unavailable.
2010BA	DMG05 -2	Subscriber Ethnicity Code See Appendix 7.2	R/S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1 File rejected if > 25% of records = declined or unavailable.	The first entry for ethnicity will be used for field ETHN.
2010CA	DMG05 -2	Patient Ethnicity Code	R/S	Loop 2010CA, NM101 = QC	The first entry for ethnicity will be used for field ETHN.

		See Appendix 2		Loop 2010CA, NM102 = 1	
2010BA	DMG05 -3	Subscriber Race 2	S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1	Do not repeat race codes.
2010CA	DMG05 -3	Patient Race 2	S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1	Do not repeat race codes.
2010BA	DMG10	Subscriber Language Qualifier	S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1 ZZ – Mutually Defined	DMG10 = ZZ
2010CA	DMG10	Patient Language Qualifier	S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1 ZZ = Mutually Defined	DMG10 = ZZ
2010BA	DMG11	Subscriber Language Code	S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1	New Field Q319 See Appendix 7.3.1 for Code List Mapping
2010CA	DMG11	Patient Language Code	S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1	New Field Q319 See Appendix 7.3.1 for Code List
LOOP ID - 2010BB Payer Detail LOOP 2010BB: PAYER NAME NM1*PR*2*PRIMARY PAYER*****PI*A21-09~					
2010BB	NM101	Payer Entity ID Code	R	PR = Payer	
2010BB	NM102	Entity Type Qualifier	O	1 = Non-Person Entity *NM102 qualifies NM103	Discarded
2010BB	NM103	Payer Name	S	Name of Payer Organization	New Q32019: Stored on the database and used in the Unknown Payer Report to help data submitters correct data.
2010BB	NM108	(Payer) Identification Code	O	PI=Payer Identification	Discarded
2010BB	NM109	Primary Payer Identifier Code	R	Map Payer's to WHAIC Values in Appendix 7.3. Element format is **AAA-99** Example A21-09 AKA: Primary Source of Payment ID Pay ID characters 1-3 – Pay TYPE is characters 5-6 The dash is preferred, but not required.	Expected Source of Payment ID/ Type: characters 1-3 – Pay Type is characters 5-6 The dash is preferred, but not required *Self-pay requires OTH-61

2010BB	REF01	REF ID Qualifier for Payer ID Number	S	NF = Payer ID	New Field Q32019: Payer Identifier in the EDI Claims file – routes claim to correct payer.
2010BB	REF02	Payer ID Number	S	Enter the Value of the Payer ID	
LOOP ID – 2300 CLAIM INFORMATION (If Loop and Element are not included, do not send) LOOP 2300: CLAIM INFORMATION CLM*PCTRL535*2740.00***11:B:1*Y*A*Y*Y~ REF*EA*MRN123~ HI*ABK:Z85030*ABF:Z86010~					
2300	CLM01	Patient Control Number	R	ASCs often refer to this as Patient's Account No. or HAR. Do not use special characters <> *File rejected for Duplicate Patient control numbers.	Use Patient Control Number (PCONTROL or PCTRL) **IF duplicates are found, resubmit file with this phrase anywhere in the file name: exclude_duplicates Ex: 400_ASCname_exclude_duplicates
2300	CLM02	Total Claim Charge	R	Total Charges in SV1 must match this number. The total amount of all submitted charges of service for this claim.	Total Charges must match the services rendered. Do not submit PROFEE
2300	CLM05-1	Type of Bill – Facility Type Code	R	83:B:1 (alternative 99:B:9)	ASCs can use 0831, 0999 – leading zero optional to use.
2300	CLM05 – 2	Facility Code Qualifier	O	B – Place of Service Codes for Professional or Dental	Ignored if supplied – WHAIC populates
2300	CLM05-3	Type of Bill – Claim Frequency Code	R	Titled Claim Frequency Code in the 837P.	Type of Bill - ASCs may refer to this as resubmission and/or orig. ref number
2300	REF01	Ref ID qualifier for MRN	O	EA	
2300	REF02	Medical Record Number	R	MRN Number	Medical Record Number
2300	HI01-1	Principal Diagnosis Qualifier	R	ABK	
2300	HI01-2	Principal ICD-10 Diagnosis Code	R	ICD-10 Code – do not include decimal point. Claim Field may be repeated up to twelve times. HI01-2, HI02-2, HI03-2, HI04-2, etc.	Principal/Primary diagnosis code or nature of illness or injury. WHAIC can take as many diagnosis codes as collected.
2300	HI0X-1	Other Diagnosis Code Qualifier	S	ABF	
2300	HI0X-2	Other Diagnosis Codes – ICD-10	S	ICD-10 CM Codes	Diagnosis Codes only and no decimals.

				External Cause Code Required per State Statute on records with ICD-10 diagnosis Codes in S injury range.	
2300	HI0X-1	Condition Code Qualifier	S	BG	
2300	HI0X – 2	Condition Code	S	Condition Code 45 is required when the Sex/Gender of the patients is either Unknown "U" or Other "O".	Condition Code 45 required with Unknown sex/gender.
LOOP ID 2310 (A – B) PROVIDER INFORMATION LOOP 2310A: REFERRING PROVIDER NAME NM1*DN*1*REFERRING*****XX*9876543214~ LOOP 2310B: RENDERING PROVIDER NAME NM1*82*1*RENDERING*****XX*9876543213~					
2310A	NM101	Referring Provider Qualifier	S	DN = Referring Provider	
2310A	NM108	Referring Provider ID Code Qualifier	S	XX = NPI	
2310A	NM109	Referring Provider NPI	S	Use Referring Provider NPI if available	Referring NPI – e.g., PCP NPI or "Other" specialist.
2310B	NM101	Rendering/Operating ID	R	82 = Rendering Provider	
2310B	NM108	Rendering/Operating Qualifier	R	XX = NPI	837P References Rendering not Operating
2310B	NM109	Rendering/Operating Provider NPI	R	Rendering means the same thing as Operating Provider NPI number.	Rendering NPI will equate to Operating NPI in WIpop and map accordingly.
LOOP ID – 2320 / 2330B OTHER SUBSCRIBER INFORMATION FOR SECONDARY PAYER Required if on claim LOOP 2330B: OTHER PAYER NAME NM1*PR*2*SECONDARY PAYER*****PI*A21-09~					
2320	SBR01	Payer Responsibility Sequence Code	S	S = Secondary	Include only if secondary payer applies.
2330B	NM101	Entity ID code	R/S	PR = Payer	
2330B	NM108	Payer Identifier Qualifier	R/S	PI = Payer ID	This field is for mapping of Secondary Source of payment codes. See segment Loop 2010BB / REF01 (NF (PayerID Code), REF02 = Value
2330B	NM109	Payer Identifier Code	R/S	Secondary Source of Payment ID Element format is **AAA-99** PayID is characters 1-3 – Pay TYPE is characters 5-6	Expected Source of Payment ID and Type. Two fields in WIpop. Appendix 7.3
LOOP ID – 2400 SERVICE LINE DETAIL (*REVENUE LINE-ITEM DETAIL)					

LOOP 2400: SERVICE LINE NUMBER LX*1~ SV1*HC:45380*2700.00*UN*1***1~ DTP*472*D8*20170202~					837P does not have a field for Revenue Code and ASCs typically do not report them. If ASC wants to report one, many revenue codes are accepted.
2400	SV101-1	CPT / HCPCS Qualifier	R	HC (HCPCS)	
2400	SV101-2	CPT/HCPCS Codes	R	Procedures, Services or Supplies	*CPT or HCPCS codes required on 837P
2400	SV101-3	Procedure Modifier 1	S	Modifier 1 CPT/HCPCS	Do not duplicate modifiers
2400	SV101-4	Procedure Modifier 2	S	Modifier 2 CPT/HCPCS	
2400	SV101-5	Procedure Modifier 3	S	Modifier 3 CPT/HCPCS	
2400	SV101-6	Procedure Modifier 4	S	Modifier 4 CPT/HCPCS	
2400	SV102	Line-Item Charge Amount	R	Line-Item Charge Amount – Zero is a valid amount.	Facility charge amount in this field. Charge for service, supply, or drug.
2400	SV103	Unit	R	UN = Units	
2400	SV104	Service Unit Count	R	Quantity = positive numbers only	Field required. Value must be 1 or >
2400	SV105	Place of Service Code	R	*WHAIC maps to POS 1 for OPS**	Place of Service “1” assigned by WHAIC
2400	DTP01	Service Date Qualifier	R	472	
2400	DTP02	Service Date Qualifier	R	D8	
2400	DTP03	Service Date on Revenue Line Item	R	CCYYMMDD (example: 20180103)	Service Date

D. Sample file:

837P Sample file with WHAIC-defined fields notated (Professional – FASC Only)
Q4 2024

```
ISA*00*        *00*        *ZZ*222         *ZZ*WHAIC       *040117*1253*^*00501*000000905*0*P*:~

FUNCTION GROUP
GS*HC*222*WHAIC*20170401*0802*1*X*005010X222A1~

TRANSACTION
ST*837*0021*005010X222A1~
BHT*0019*00*244579*20170205*1023*CH~

LOOP 1000A: SUBMITTER NAME
NM1*41*2*SAMPLE HOSPITAL*****46*222~
PER*IC*SUBMITTER NAME*TE*6142222222~

LOOP 1000B: RECEIVER NAME
NM1*40*2*WHAIC*****46*WHAIC 837~

LOOP 2000A: BILLING PROVIDER HIERARCHICAL LEVEL
HL*1**20*1~

LOOP 2010AA: BILLING PROVIDER NAME
NM1*85*2*SAMPLE HOSPITAL PROVID*11****XX*9876543210~
N3*236 N MAIN ST~
N4*MADISON*WI*53717~
REF*EI*11-12345678~

LOOP 2000B: SUBSCRIBER HIERARCHICAL LEVEL
HL*2*1*22*1~
SBR*P**CERTNUM2222SJ******12~

LOOP 2010BA: SUBSCRIBER NAME
NM1*IL*1*NULL*****MI*3CFD1B33ACBD5475CE36D8C439FEC42475B9ADBEC7B91A6926DACF0F45BE269F~
N3*123 OAK ST~
N4*MADISON*WI*53719~
DMG*D8*19830501*F*M*5:2*****ZZ*ENG~

LOOP 2010BB: PAYER NAME
NM1*PR*2*PRIMARY PAYER*****PI*A21-09~
REF*NF*621111~

LOOP 2000C: PATIENT HIERARCHICAL LOOP
```

Annotations:
- Facility 3 digit Code (points to ISA "222" and NM1*41 "222")
- Facility NPI (points to 9876543210)
- Claim Filing Indicator Code (points to SBR "12")
- Subscriber UCID (points to NM1*IL MI value)
- Subscriber Race, Ethnicity (points to DMG "5:2")
- Subscriber Language (points to "ZZ*ENG")
- Primary Payer Code (points to "A21-09")
- Primary Payer Name (points to "PRIMARY PAYER")
- Payer ID (points to "NF*621111")

```
HL*3*2*23*0~
PAT*19~

LOOP 2010CA: PATIENT NAME
NM1*QC*1*NULL*****MI*D56714B4386CC7EAB69C6D648ABF86FD0894199521D27CDD902C92E878B49459~
N3*236 N MAIN ST~
N4*MADISON*WI*53717~
DMG*D8*20030501*M*I*5:2:3*****ZZ*ENG~

LOOP 2300: CLAIM INFORMATION
CLM*PCTRL535*2740.00***11:B:1*Y*A*Y*Y~
REF*EA*MRN123~
HI*ABK:Z85030*ABF:Z86010~

LOOP 2310A: REFERRING PROVIDER NAME
NM1*DN*1*REFERRING*****XX*9876543214~

LOOP 2310B: RENDERING PROVIDER NAME
NM1*82*1*RENDERING*****XX*9876543213~

LOOP 2320: OTHER SUBSCRIBER INFORMATION
SBR*S*18~
OI***Y***Y~

LOOP 2330A OTHER SUBSCRIBER NAME
NM1*IL*1*NULL*****MI*IGNORED~

LOOP 2330B: OTHER PAYER NAME
NM1*PR*2*SECONDARY PAYER*****PI*A22-09~

LOOP 2400: SERVICE LINE NUMBER
LX*1~
SV1*HC:45380*2700.00*UN*1***1~
DTP*472*D8*20170202~

LOOP 2400: SERVICE LINE NUMBER
LX*2~
SV1*HC:H0004:HE:HR*40.00*UN*2***2~
DTP*472*D8*20170203~

SE*39*0021~
GE*1*1~
IEA*1*000000905~
```

Patient Race, Ethnicity, Race2

Patient Language

Patient UCID

Secondary Payer

Ansi Terminology and Definitions

Certain terms have been defined to have a specific meaning within this section. The following terms are particularly key to understanding and using the 837-claim file.

Control Segment	A control segment has the same structure as a data segment but is used for transferring control information rather than application information.
Control Segment, Interchange	The Interchange Control Header (ISA) is used to denote the start and end of Functional Groups (GS). Each element on the line is in a fixed position. It defines what characters are used for segments, elements, and other control characters. The ISA has an associate Interchange Control Trailer (IEA) to end the interchange group.

Control Segments	
Control Segment, Functional Group Segments	The functional group is delineated by the functional group header (GS segment) and the functional group trailer (GE segment). The functional group header starts and identifies one or more related transaction sets. It also provides control number and application identification information. The functional group trailer defines the end of the functional group of related transaction sets and provides a count of contained transaction sets.
Control Segment, Transaction Set Segments	The transaction set is delineated by the transaction set header (ST segment) and the transaction set trailer (SE segment). The transaction set header identifies the start and identifier of the transaction set. The transaction set trailer defines the end of the transaction set and provides a count of the data segments, which includes the ST and SE segments.
Control Segment, Hierarchical Level Segments	Hierarchical Level segments denote the start of a group of information. The information may be about a provider of date, about the insured person, or about a patient claim. It ends when another Hierarchical Loop occurs, or when a transaction trailer (SE) is received.
Control Segment, Relations among Control Segments	The control segments of this standard must have a nested relationship, as shown and annotated in this subsection. The letters preceding the control segment name are the segment identifier for that control segment. The indentation of segment identifiers shown below indicates the subordination among control segments. ISA Interchange Control Header GS Functional Group Header, starts a group of related transaction sets. ST Transaction Set Header starts a transaction set. HL Hierarchical Level starts a bounded loop of data segments. SE Transaction Set Trailer ends a transaction set. GE Functional Group Trailer ends a group of related transaction sets. IEA Interchange Control Trailer More than one ST/SE pair, each representing a transaction set, may be used within one functional group. More than one GS/GE pair, each representing a Functional Group, may be used within one ISA/IEA pair.
Data Element	The data element is the smallest unit of information in the X12 standard. Data elements are identified as either simple or component. A data element that occurs as an ordinal positioned member of a composite data structure is identified as a component data element. A data element that occurs in a segment outside the defined boundaries of a composite data structure is identified as a simple data element. The distinction between simple and component data elements is strictly a matter of context since a data element can be used in either capacity.
Data Element, Numeric	A numeric data element is represented by one or more digits with an optional leading sign representing a value in the normal base of ten. The value of a numeric data element includes an implied decimal point. It is used when the position of the decimal point within the data is permanently fixed and is not to be transmitted with the data. The data element dictionary defines the number of implied decimal positions. The representation for this data element type is N where N indicates that it is numeric, and n indicates the number of decimal positions to the right of the implied decimal point. If n is 0, it need not appear in the specification; N is equivalent to N0. For negative values, the leading minus sign (-) is used. Absence of a sign indicates a positive value. The plus sign (+) should not be transmitted. Leading zeros should be suppressed unless necessary to satisfy a minimum length requirement. The length of numeric type data elements does not include the optional sign. FOR EXAMPLE: Value is "-123.4". Numeric type is “N2” where the "2" indicates an implied decimal placement two positions from the right. The data stream value is "- 12340". The length is 5 (note padded zero).
Data Element, Decimal Number	A decimal data element contains an explicit decimal point and is used for numeric values that have a varying number of decimal positions. The representation for this data element type is "R." The decimal point always appears in the character stream if the decimal point is at any place other than the right end. If the value is an integer (decimal point at the right end) the decimal point should be omitted. For negative values, the leading

	minus sign (-) is used. Absence of a sign indicates a positive value. The plus sign (+) should not be transmitted. Leading zeros should be suppressed unless necessary to satisfy a minimum length requirement. Trailing zeros following the decimal point should be suppressed unless necessary to indicate precision. The use of triad separators (for example, the commas in 1,000,000) is expressly prohibited. The length of a decimal type data element does not include the optional leading sign or decimal point.
Data Element, Identifier	An identifier data element always contains a value from a predefined list of values. Trailing spaces should be suppressed unless necessary to satisfy minimum length. The representation for this data element type is "ID."
Data Element, String	A string data element is a sequence of any characters from the basic or extended character sets. The significant characters shall be left justified and shall be space filled. Leading spaces, when they occur, are presumed to be significant characters. Trailing spaces should be suppressed unless they are necessary to satisfy minimum length. The representation for this data element type is "AN."
Data Element, Date	A date data element is used to express the standard date in either YYMMDD or CCYYMMDD format in which CC is the century or first two digits of the calendar year, YY is the last two digits of the calendar year, MM is the month (01 to 12), and DD is the day in the month (01 to 31). The representation for this data element type is “DT.” Users of this guide should note that all dates within transactions are 8-character dates (millennium compliant) in the format CCYYMMDD. The only date data element that is in format YYMMDD is the Interchange Date data element in the ISA segment, and also used in the TA1 Interchange Acknowledgment, where the century can be readily interpolated because of the nature of an interchange header.

This concludes the summary of the ASC files. For the full manual click here.