Special Billing Instructions: Federally Qualified Health Centers, Rural Health Clinics and Indian Health Services Memorandum of Agreement

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‹‹ASC X12N 837 v.5010 was developed by the Accredited Standards Committee (ASC) X12N and accredited by the American National Standards Institute (ANSI). The 837 claim is comparable to the *UB-04* claim form for inpatient and outpatient services. Submitters may refer to the explanation of items found in the *UB-04 Completion: Inpatient Services* and *UB-04 Completion: Outpatient Services* sections of the Part 2 manual, except when entering data for the comparable items listed in this section. This section identifies the field values specific to the 837 claims format.››

‹‹Informational Lines for 837 Claims››

An informational line is an associated line item or line items listed immediately following the HIPAA-compliant global billing code set used to bill the face-to-face encounter with the recipient. Informational lines **are not separately reimbursed**. When submitting informational lines providers should remember:

- The *Revenue Code* field (FL 42) on the informational line must be a four-digit revenue code. Reference ASC X12N 837 v.5010 Loop 2400 Segment SV201.
- Entering a service date in the *Service Date* field (FL 45) on the informational line is optional.
- The *Service Units* field (FL 46) on the informational line may contain the number of service units provided for the procedure code. For Electronic Data Interchange (EDI) transactions, reference ASC X12N 837 v.5010 Loop 2400 Segment.
- The *Total Charges* field (FL 47) for each informational line must be zeros. For EDI transactions, reference ASC X12N 837 v.5010 Loop 2400 Segment SV203.

Example of billing a HIPAA-compliant billing code set with informational lines:

Line	FL42 Rev. CD	FL43 Description	FL44 HCPCS /RATE/ HIPPS Code	FL45 Serv. Date	FL46 Serv. Units	FL47 Total Charges	FL48 Non-Covered Charges
1	0520	Clinic Visit	T1015	110117	01	32500	<- payable line
2	0520	None	80018	110117	01	000	<- informational
3	0520	None	99213	110117	01	000	<- informational
4	0520	Optometry	92004	110517	01	20000	<- payable line
5	0520	None	92002	110517	01	000	<- informational

Figure 1: 837 Data String Sample:

LX*1~SV2*0520*HC:T1015*325.00*UN*1~DTP*472*D8*20171101 (payable line)

LX*2~SV2*0520*HC:80018**UN*1~DTP*472*D8*20171101 (informational)

LX*3~SV2*0520*HC:99213**UN*1~DTP*472*D8*20171101 (informational)

LX*4~SV2*0520*HC:92004*200.00*UN*1~DTP*472*D8*20171115 (payable line)

LX*5~SV2*0520*HC:92002**UN*1~DTP*472*D8*20171115 (informational)

Note: ‹‹ An 837 claim submitted with an informational line on the first detail line of the claim will be rejected. An 837 claim detail line 01 must include only HIPAA-compliant billing code sets.››

‹‹When billing an 837 claim, if the addition of informational lines causes the claim to exceed 22 lines, the claim must be split and services billed on separate claims.›› Electronic claims that exceed 22 claim lines with informational lines will be denied in their entirety.

‹‹Legend››

‹‹Symbols used in the document above are explained in the following table.››

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.