

Loop Information	Version	Loop Identifier	Loop Repeat	Loop Usage
	4010A1	2300	100	Required
	5010	2300	100	Required
4010A1 Loop Name:	CLAIM INFORMATION			
5010 Loop Name:	CLAIM INFORMATION			
<b>Implementation Difference:</b> There is No Change to this record.				

Segment Information	Version	Loop Identifier	Segment Identifier	Segment Repeat	Segment Usage
	4010A1	2300	CLM	1	Required
	5010	2300	CLM	1	Required
4010A1 Segment Name:	CLAIM INFORMATION				
5010 Segment Name:	CLAIM INFORMATION				
<b>4010A1 Note:</b> 1. Because this is a required segment, this is a required loop. See Appendix A for further details on ASC X12 syntax rules. 2. 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. There is no recommended limit to the number of ST-SE transactions within a GS-GE or ISA-IEA. Willing trading partners can agree to set limits higher. 3. For purposes of this documentation, the claim detail information is presented only in the dependent level. Specific claim detail information can be given in either the subscriber or the dependent hierarchical level. Because of this the claim information is said to "float." Claim information is positioned in the same hierarchical level that describes its owner-participant, either the subscriber or the dependent. In other words, the claim information, loop 2300, is placed following loop 2010BD in the subscriber hierarchical level when the patient is the subscriber, or it is placed at the patient/dependent hierarchical level when the patient is the dependent of the subscriber as shown here. When the patient is the subscriber, loops 2000C and 2010CA are not sent. See 2.3.2.1, HL Segment, for details.			<b>5010 Situational Rule:</b> No Situational Rule <b>5010 Note:</b> 1. 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. There is no recommended limit to the number of ST-SE transactions within a GS-GE or ISA-IEA. Willing trading partners can agree to set limits higher. 2. For purposes of this documentation, the claim detail information is presented only in the dependent level. Specific claim detail information can be given in either the subscriber or the dependent hierarchical level. Because of this, the claim information is said to "float." Claim information is positioned in the same hierarchical level that describes its owner-participant, either the subscriber or the dependent. In other words, the claim information, Loop ID-2300, is placed following Loop ID-2010BB in the Subscriber Hierarchical Level (HL) when patient information is sent in Loop ID-2010BA of the Subscriber HL. Claim information is placed in the Patient HL when the patient information is sent in Loop ID-2010CA of the Patient HL. When the patient is the subscriber or is considered to be the subscriber, Loop ID-2000C and Loop ID-2010CA are not sent. See Subscriber/Patient HL Segment explanation in section 1.4.3.2.2.1 for details.		
<b>Implementation Difference:</b> The notes were modified slightly in the name of clarity. There is no real change.					

Element Detail	Version	Loop Identifier	Element Identifier	Data Element	Min/Max Data Type	Element Usage
	4010A1	2300	CLM 01	1028	1/38 AN	Required
	5010	2300	CLM 01	1028	1/38 AN	Required
4010A1 Element Name:	Patient Account Number					
5010 Element Name:	Patient Control Number					
<b>4010A1 Note:</b> The number that the submitter transmits in this position is echoed back to the submitter in the 835 and other transactions. This permits the submitter to use the value in this field as a key in the submitter's system to match the claim to the payment information returned in the 835 transaction. The two recommended identifiers are either the Patient Account Number or the Claim Number in the billing submitter's patient management system. The developers of this implementation guide strongly recommend that submitters use completely unique numbers for this field for each individual claim.  The maximum number of characters to be supported for this field is '20'. A provider may submit fewer characters depending upon their needs. However, the HIPAA maximum requirement to be supported by any responding system is '20'. Characters beyond 20 are not required to be stored nor returned by any 837-receiving system.			<b>5010 Situational Rule:</b> No Situational Rule <b>5010 Note:</b> The number that the submitter transmits in this position is echoed back to the submitter in the 835 and other transactions. This permits the submitter to use the value in this field as a key in the submitter's system to match the claim to the payment information returned in the 835 transaction. The two recommended identifiers are either the Patient Account Number or the Claim Number in the billing submitter's patient management system. The developers of this implementation guide strongly recommend that submitters use unique numbers for this field for each individual claim.  When Loop ID-2010AC is present, CLM01 represents the subrogated Medicaid agency's claim number (ICN/DCN) from their original 835 CLP07 - Payer Claim Control Number. See Section 1.4.1.4 of the front matter for a description of post payment recovery claims for subrogated Medicaid agencies.  The maximum number of characters to be supported for this field is '20'. Characters beyond the maximum are not required to be stored nor returned by any 837-receiving system.			
<b>Implementation Difference:</b> The Industry Name was changed to be more consistent with the intent of the field.  Additional notes have been added in support of the Medicaid Subrogation business process. When claims are submitted by Medicaid Agencies or other payers, they will replace the provider's Patient Control Number with their Payer Claim Control Number.  For all other uses, there is no change to this element.						

Element Detail	Version	Loop Identifier	Element Identifier	Data Element	Min/Max Data Type	Element Usage
	4010A1	2300	CLM 02	782	1/18 R	Required
	5010	2300	CLM 02	782	1/18 R	Required
4010A1 Element Name:	Total Claim Charge Amount					
5010 Element Name:	Total Claim Charge Amount					
<b>4010A1 Note:</b> For encounter transmissions, zero (0) may be a valid amount.			<b>5010 Situational Rule:</b> No Situational Rule <b>5010 Note:</b> The Total Claim Charge Amount must be greater than or equal to zero.  The total claim charge amount must balance to the sum of all service line charge amounts reported in the Professional Service (SV1) segments for this claim.			
<b>Implementation Difference:</b> A rule has been added that makes it clear the Total Claim Charge Amount cannot be less than zero. Balancing instruction has also been added.  The Practical Min/Max is established in Appendix B, Section B.1.1.3.1.2 (Decimal). The section limits the Decimal fields to 10 characters excluding periods and sign indicators. As a result, the recommendation is to set the field length maximum at 11. (for example 99999999.99)						

Element Detail	Version	Loop Identifier	Element Identifier	Data Element	Min/Max Data Type	Element Usage
	4010A1	2300	CLM 05-1	1331	1/2 AN	Required
	5010	2300	CLM 05-1	1331	1/2 AN	Required
4010A1 Element Name:	Facility Type Code					
5010 Element Name:	Place of Service Code					
<b>4010A1 Note:</b> Use this element for codes identifying a place of service from code source 237. As a courtesy, the codes are listed below, however, the code list is thought to be complete at the time of publication of this implementation guideline. Since this list is subject to change, only codes contained in the document available from code source 237 are to be supported in this transaction and take precedence over any and all codes listed here.  THE CODES WERE DELETED by eEmergence in the interest of space.			<b>5010 Situational Rule:</b> No Situational Rule <b>5010 Note:</b> No 5010 Note			
<b>Implementation Difference:</b> The Industry Name changed to more clearly represent the correct code source. Facility Type codes are for Institutional claims while Place of Service codes are used for Professional claims.  The 4010 note was deleted as it is unnecessary.						

Element Detail	Version	Loop Identifier	Element Identifier	Data Element	Min/Max Data Type	Element Usage
	4010A1	2300	CLM 05-2	1332	1/2 ID	Not Used
	5010	2300	CLM 05-2	1332	1/2 ID	Required
4010A1 Element Name:	Facility Code Qualifier					
5010 Element Name:	Facility Code Qualifier					
<b>4010A1 Note:</b> No 4010 Note			<b>5010 Situational Rule:</b> No Situational Rule <b>5010 Note:</b> No 5010 Note			
<b>Implementation Difference:</b> This component was changed from "Not Used" to "Required" in order to properly qualify CLM05-1. The code used here is the means for properly identifying the code source being used.						

Code Detail	Version	Loop Identifier	Element Identifier	Code Qualifier	Code Description
	4010A1				
	5010	2300	CLM 05-2	B	Place of Service Codes for Professional or Dental Services
<b>4010A1 Note:</b> No 4010 Note			<b>5010 Situational Rule:</b> No Situational Rule <b>5010 Note:</b> No 5010 Note		
<b>Implementation Difference:</b> This code indicates the code source for CLM05-1 is from the Place of Service code listing.					

Element Detail	Version	Loop Identifier	Element Identifier	Data Element	Min/Max Data Type	Element Usage
	4010A1	2300	CLM 07	1359	1/1 ID	Required
	5010	2300	CLM 07	1359	1/1 ID	Required
4010A1 Element Name:	Medicare Assignment Code					
5010 Element Name:	Assignment or Plan Participation Code					
<b>4010A1 Note:</b> CLM07 indicates whether the provider accepts Medicare assignment. The NSF mapping to FA0-59.0 occurs only in payer-to-payer COB situations.			<b>5010 Situational Rule:</b> No Situational Rule <b>5010 Note:</b> Within this element the context of the word assignment is related to the relationship between the provider and the payer. This is NOT the field for reporting whether the patient has or has not assigned benefits to the provider. The benefit assignment indicator is in CLM08.			
<b>Implementation Difference:</b> The Industry Name was changed since the usage of this field is no longer limited to Medicare.  In 4010, this field is required for all claims, yet it specifically describes the relationship the provider has with Medicare. If it is necessary for the provider to describe the relationship with the destination payer and the destination payer is other than Medicare, this is done in CLM16.  In 5010, this one field defines the relationship between the provider and the destination payer. The element is still required for all claims, but now has a direct relationship to the destination payer. This may be a significant change to providers who have this value hard-coded in their system.  The element name has been updated to coincide with the new usage.						

Code Detail	Version	Loop Identifier	Element Identifier	Code Qualifier	Code Description	
	4010A1	2300	CLM 07	A	Assigned	
	5010	2300	CLM 07	A	Assigned	
<b>4010A1 Note:</b> No 4010 Note			<b>5010 Situational Rule:</b> No Situational Rule <b>5010 Note:</b> Required when the provider accepts assignment and/or has a participation agreement with the destination payer. OR Required when the provider does not accept assignment and/or have a participation agreement, but is advising the payer to adjudicate this specific claim under participating provider benefits as allowed under certain plans.			
<b>Implementation Difference:</b> Notes have been added to clearly state when code "A" (Assigned) is to be used.  This is inclusive of the traditional Medicare usage and the Plan Participation Agreement indicator (CLM16 in 4010).						

Code Detail	Version	Loop Identifier	Element Identifier	Code Qualifier	Code Description	
	4010A1	2300	CLM 07	B	Assigned Accepted on Clinical Lab Services Only	
	5010	2300	CLM 07	B	Assigned Accepted on Clinical Lab Services Only	
<b>4010A1 Note:</b> No 4010 Note			<b>5010 Situational Rule:</b> No Situational Rule <b>5010 Note:</b> Required when the provider accepts assignment for Clinical Lab Services only.			
<b>Implementation Difference:</b> Notes have been added to clearly state when code "B" (Assigned Accepted on Clinical Lab Services Only) is to be used.						

Code Detail	Version	Loop Identifier	Element Identifier	Code Qualifier	Code Description
	4010A1	2300	CLM 07	C	Not Assigned
	5010	2300	CLM 07	C	Not Assigned
<b>4010A1 Note:</b> No 4010 Note				<b>5010 Situational Rule:</b> No Situational Rule <b>5010 Note:</b> Required when neither codes 'A' nor 'B' apply.	
<b>Implementation Difference:</b> Notes have been added to clearly state when code "C" (Not Assigned) is to be used.					

Code Detail	Version	Loop Identifier	Element Identifier	Code Qualifier	Code Description
	4010A1	2300	CLM 07	P	Patient Refuses to Assign Benefits
	5010				
<b>4010A1 Note:</b> No 4010 Note				<b>5010 Situational Rule:</b> No Situational Rule <b>5010 Note:</b> No 5010 Note	
<b>Implementation Difference:</b> In 4010, Code "P" (Patient Refuses to Assign Benefits) when the patient refuses to assign benefit payment to the provider.  In 5010, code "P" was deleted because this element is intended to define the relationship between the provider and the payer.  Code "W" (Not Applicable) has been added to CLM08 (Benefits Assignment Certification Indicator) to identify when the Patient Refuses to Assign Benefits. This enables users to answer all questions in the proper context.					

Element Detail	Version	Loop Identifier	Element Identifier	Data Element	Min/Max Data Type	Element Usage
	4010A1	2300	CLM 08	1073	1/1 ID	Required
	5010	2300	CLM 08	1073	1/1 ID	Required
<b>4010A1 Element Name:</b>		Benefits Assignment Certification Indicator				
<b>5010 Element Name:</b>		Benefits Assignment Certification Indicator				
<b>4010A1 Note:</b> No 4010 Note				<b>5010 Situational Rule:</b> No Situational Rule <b>5010 Note:</b> This element answers the question whether or not the insured has authorized the plan to remit payment directly to the provider.		
<b>Implementation Difference:</b> The note was added to make it clear this element answers the question of whether or not the insured has authorized the plan to remit payment directly to the provider.  The intent is to resolve significant confusion as to the context of CLM07 and CLM08.						

Code Detail	Version	Loop Identifier	Element Identifier	Code Qualifier	Code Description
	4010A1				
	5010	2300	CLM 08	W	Not Applicable
<b>4010A1 Note:</b> No 4010 Note				<b>5010 Situational Rule:</b> No Situational Rule <b>5010 Note:</b> Use code 'W' when the patient refuses to assign benefits.	
<b>Implementation Difference:</b> This code was added to replace CLM07 - Code "P" (Patient Refuses to Assign Benefits). The placement of code "P" in CLM07 is incorrect. Moving the response to this element puts the answer in proper context with the question.					

Element Detail	Version	Loop Identifier	Element Identifier	Data Element	Min/Max Data Type	Element Usage
	4010A1	2300	CLM 09	1363	1/1 ID	Required
	5010	2300	CLM 09	1363	1/1 ID	Required
4010A1 Element Name:	Release of Information Code					
5010 Element Name:	Release of Information Code					
<b>4010A1 Note:</b> No 4010 Note			<b>5010 Situational Rule:</b> No Situational Rule <b>5010 Note:</b> The Release of Information response is limited to the information carried in this claim.			
<b>Implementation Difference:</b> There has been much discussion as to the scope of the Release of Information identified in this element. Opinions on this topic are very divergent. Some view it as data relative to the claim, while others view it as a blanket authorization.  In light of the HIPAA Privacy Rule, the workgroup determined the scope of this release must be limited to the information included within the claim. This determination was made in response to the "Minimum Necessary" component of the rule. In addition, several of the values have been deemed inappropriate for usage under this definition and, therefore, have been deleted.						

Code Detail	Version	Loop Identifier	Element Identifier	Code Qualifier	Code Description
	4010A1	2300	CLM 09	A	Appropriate Release of Information on File at Health Care Service Provider or at Utilization Review Organization
	5010				
<b>4010A1 Note:</b> No 4010 Note				<b>5010 Situational Rule:</b> No Situational Rule <b>5010 Note:</b> No 5010 Note	
<b>Implementation Difference:</b> Code "A" (Appropriate Release of Information on File at Health Care Service Provider or at Utilization Review Organization) has been deleted because a blanket release of information such as outlined here goes beyond the scope of the "Minimum Necessary" component of the Privacy Rule.					

Code Detail	Version	Loop Identifier	Element Identifier	Code Qualifier	Code Description
	4010A1	2300	CLM 09	I	Informed Consent to Release Medical Information for Conditions or Diagnoses Regulated by Federal Statutes
	5010	2300	CLM 09	I	Informed Consent to Release Medical Information for Conditions or Diagnoses Regulated by Federal Statutes
<b>4010A1 Note:</b> No 4010 Note				<b>5010 Situational Rule:</b> No Situational Rule <b>5010 Note:</b> Required when the provider has not collected a signature AND state or federal laws do not require a signature be collected.	
<b>Implementation Difference:</b> The note was added to clarify code "I" (Informed Consent to Release Medical Information for Conditions or Diagnoses Regulated by Federal Statutes) is to be used when the claim is being submitted as allowed under the payment, treatment, and healthcare operations exemption of the Privacy Rule AND a signature has not been collected.					

Code Detail	Version	Loop Identifier	Element Identifier	Code Qualifier	Code Description
	4010A1	2300	CLM 09	M	The Provider has Limited or Restricted Ability to Release Data Related to a Claim
	5010				
<b>4010A1 Note:</b> No 4010 Note				<b>5010 Situational Rule:</b> No Situational Rule <b>5010 Note:</b> No 5010 Note	
<b>Implementation Difference:</b> Code "M" (The Provider has Limited or Restricted Ability to Release Data Related to a Claim) has been deleted as there is no current applicability within the scope of the question as defined within the 5010 implementation.					

Code Detail	Version	Loop Identifier	Element Identifier	Code Qualifier	Code Description
	4010A1	2300	CLM 09	N	No, Provider is Not Allowed to Release Data
	5010				
<b>4010A1 Note:</b> No 4010 Note				<b>5010 Situational Rule:</b> No Situational Rule <b>5010 Note:</b> No 5010 Note	
<b>Implementation Difference:</b> Code "N" (No, Provider is Not Allowed to Release Data) has been deleted as there is no current applicability within the scope of the question as defined in the 5010 implementation.					

Code Detail	Version	Loop Identifier	Element Identifier	Code Qualifier	Code Description
	4010A1	2300	CLM 09	O	On file at Payor or at Plan Sponsor
	5010				
<b>4010A1 Note:</b> No 4010 Note				<b>5010 Situational Rule:</b> No Situational Rule <b>5010 Note:</b> No 5010 Note	
<b>Implementation Difference:</b> Code "O" (On file at Payor or at Plan Sponsor) has been deleted as a blanket release of information such as outlined here would go beyond the scope of the "Minimum Necessary" component of the Privacy Rule.					

Code Detail	Version	Loop Identifier	Element Identifier	Code Qualifier	Code Description
	4010A1	2300	CLM 09	Y	Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a claim
	5010	2300	CLM 09	Y	Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a claim
<b>4010A1 Note:</b> No 4010 Note				<b>5010 Situational Rule:</b> No Situational Rule <b>5010 Note:</b> Required when the provider has collected a signature. OR Required when state or federal laws require a signature be collected.	
<b>Implementation Difference:</b> The 5010 note was added to clearly state when this code is to be used.					

Element Detail	Version	Loop Identifier	Element Identifier	Data Element	Min/Max Data Type	Element Usage
	4010A1	2300	CLM 10	1351	1/1 ID	Situational
	5010	2300	CLM 10	1351	1/1 ID	Situational
4010A1 Element Name:	Patient Signature Source Code					
5010 Element Name:	Patient Signature Source Code					
<b>4010A1 Note:</b> CLM10 is required except in cases where code "N" is used in CLM09.				<b>5010 Situational Rule:</b> Required when a signature was executed on the patient's behalf under state or federal law.  If not required by this implementation guide, do not send. <b>5010 Note:</b> No 5010 Note		
<b>Implementation Difference:</b> In 4010, this element is required for the majority of claims. In 5010, the only time it may matter what document/signature source the provider received is when the patient is unable to sign for themselves and someone else is signing on their behalf. All other codes have been removed.						

Code Detail	Version	Loop Identifier	Element Identifier	Code Qualifier	Code Description	
	4010A1	2300	CLM 10	B	Signed signature authorization form or forms for both HCFA-1500 Claim Form block 12 and block 13 are on file	
	5010					
<b>4010A1 Note:</b> No 4010 Note				<b>5010 Situational Rule:</b> No Situational Rule <b>5010 Note:</b> No 5010 Note		
<b>Implementation Difference:</b> Code "B" (Signed signature authorization form or forms for both HCFA-1500 Claim Form block 12 and block 13 are on file) has been deleted because it has been deemed irrelevant.						

Code Detail	Version	Loop Identifier	Element Identifier	Code Qualifier	Code Description	
	4010A1	2300	CLM 10	C	Signed HCFA-1500 Claim Form on File	
	5010					
<b>4010A1 Note:</b> No 4010 Note				<b>5010 Situational Rule:</b> No Situational Rule <b>5010 Note:</b> No 5010 Note		
<b>Implementation Difference:</b> Code "C" (Signed HCFA-1500 Form on file) has been deleted because it has been deemed irrelevant.						

Code Detail	Version	Loop Identifier	Element Identifier	Code Qualifier	Code Description	
	4010A1	2300	CLM 10	M	Signed signature authorization form for HCFA-1500 Claim Form block 13 on file	
	5010					
<b>4010A1 Note:</b> No 4010 Note				<b>5010 Situational Rule:</b> No Situational Rule <b>5010 Note:</b> No 5010 Note		
<b>Implementation Difference:</b> Code "M" (Signed signature authorization form for HCFA-1500 Claim Form block 13 on file) has been deleted because it has been deemed irrelevant.						

Code Detail	Version	Loop Identifier	Element Identifier	Code Qualifier	Code Description
	4010A1	2300	CLM 10	P	Signature generated by provider because the patient was not physically present for service
	5010	2300	CLM 10	P	Signature generated by provider because the patient was not physically present for service
<b>4010A1 Note:</b> No 4010 Note				<b>5010 Situational Rule:</b> No Situational Rule <b>5010 Note:</b> Signature generated by an entity other than the patient according to State or Federal law.	
<b>Implementation Difference:</b> The 5010 note was added to broaden the scope of who can sign on the patient's behalf if they are not present or capable. The primary requirement is the signature must be performed in accordance with applicable state laws.					

Code Detail	Version	Loop Identifier	Element Identifier	Code Qualifier	Code Description
	4010A1	2300	CLM 10	S	Signed signature authorization form for HCFA-1500 Claim Form block 12 on file
	5010				
<b>4010A1 Note:</b> No 4010 Note				<b>5010 Situational Rule:</b> No Situational Rule <b>5010 Note:</b> No 5010 Note	
<b>Implementation Difference:</b> Code "S" (Signed signature authorization form for HCFA-1500 Claim Form block 12 on file) has been deleted because it has been deemed irrelevant.					

Element Detail	Version	Loop Identifier	Element Identifier	Data Element	Min/Max Data Type	Element Usage
	4010A1	2300	CLM 11	C024		Situational
	5010	2300	CLM 11	C024		Situational
<b>4010A1 Element Name:</b>		Related Causes Information				
<b>5010 Element Name:</b>		Related Causes Information				
<b>4010A1 Note:</b> CLM11-1, CLM11-2, or CLM11-3 are required when the condition being reported is accident or employment related. If CLM11-1, CLM11-2, or CLM11-3 equals AP, then map Yes to EA0-09.0. If DTP - Date of Accident (DTP01=439) is used, then CLM11 is required.				<b>5010 Situational Rule:</b> Required when the services provided are employment related or the result of an accident.  If not required by this implementation guide, do not send. <b>5010 Note:</b> If DTP - Date of Accident (DTP01=439) is used, then CLM11 is required.		
<b>Implementation Difference:</b> The notes were revised to provide clarity. There is no implementation change.						

Code Detail	Version	Loop Identifier	Element Identifier	Code Qualifier	Code Description
	4010A1	2300	CLM 11-1	AP	Another Party Responsible
	5010				
<b>4010A1 Note:</b> No 4010 Note				<b>5010 Situational Rule:</b> No Situational Rule <b>5010 Note:</b> No 5010 Note	
<b>Implementation Difference:</b> Code "AP" (Another Party Responsible) was deleted as it provides no additional value. Usage of the other codes already indicate another party is responsible and provide the reason why.					

Element Detail	Version	Loop Identifier	Element Identifier	Data Element	Min/Max Data Type	Element Usage
	4010A1	2300	CLM 11-2	1362	2/3 ID	Situational
	5010	2300	CLM 11-2	1362	2/3 ID	Situational
4010A1 Element Name:	Related Causes Code					
5010 Element Name:	Related Causes Code					
<b>4010A1 Note:</b> Used if more than one code applies.			<b>5010 Situational Rule:</b> Required when more than one related cause code applies. See CLM11-1 for valid values.  If not required by this implementation guide, do not send. <b>5010 Note:</b> No 5010 Note			
<b>Implementation Difference:</b> The Situational Rule adds additional clarity when more then one related cause code applies.						

Element Detail	Version	Loop Identifier	Element Identifier	Data Element	Min/Max Data Type	Element Usage
	4010A1	2300	CLM 11-3	1362	2/3 ID	Situational
	5010	2300	CLM 11-3	1362	2/3 ID	Not Used
4010A1 Element Name:	Related Causes Code					
5010 Element Name:	Related-Causes Code					
<b>4010A1 Note:</b> Used if more than one code applies.			<b>5010 Situational Rule:</b> No Situational Rule <b>5010 Note:</b> No 5010 Note			
<b>Implementation Difference:</b> In 5010, the third iteration of the Related Causes Code is changed to "Not Used" since all three of the available codes cannot logically be used at the same time. In other words, you can have an Auto Accident (AA) that is Employment (EM) related, you can have an Employment (EM) related Other Accident (OA), however, it would be inappropriate to have an Auto Accident (AA) that is Employment (EM) related and is also an Other Accident (OA).						

Element Detail	Version	Loop Identifier	Element Identifier	Data Element	Min/Max Data Type	Element Usage
	4010A1	2300	CLM 11-4	156	2/2 ID	Situational
	5010	2300	CLM 11-4	156	2/2 ID	Situational
4010A1 Element Name:	Auto Accident State or Province Code					
5010 Element Name:	Auto Accident State or Province Code					
<b>4010A1 Note:</b> Required if CLM11-1, -2, or -3 = AA to identify the state in which the automobile accident occurred. Use state postal code (CA = California, UT = Utah, etc).			<b>5010 Situational Rule:</b> Required when CLM11-1 or CLM11-2 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. <b>5010 Note:</b> No 5010 Note			
<b>Implementation Difference:</b> The note was modified to recognize the Auto Accident State or Province Code cannot be provided when the accident occurred in a country that does not have states, provinces or sub-country codes which are named in Code Source 22.						

Element Detail	Version	Loop Identifier	Element Identifier	Data Element	Min/Max Data Type	Element Usage
	4010A1	2300	CLM 11-5	26	2/3 ID	Situational
	5010	2300	CLM 11-5	26	2/3 ID	Situational
4010A1 Element Name:	Country Code					
5010 Element Name:	Country Code					
<b>4010A1 Note:</b> Required if the automobile accident occurred out of the United States to identify the country in which the accident occurred.			<b>5010 Situational Rule:</b> Required when CLM11-1 or CLM11-2 = AA and the accident occurred in a country other than US or Canada.  If not required by this implementation guide, do not send. <b>5010 Note:</b> No 5010 Note			
<b>Implementation Difference:</b> The 4010 note was expanded to provide additional clarification and guidance.						

Element Detail	Version	Loop Identifier	Element Identifier	Data Element	Min/Max Data Type	Element Usage
	4010A1	2300	CLM 12	1366	2/3 ID	Situational
	5010	2300	CLM 12	1366	2/3 ID	Situational
4010A1 Element Name:	Special Program Indicator					
5010 Element Name:	Special Program Indicator					
<b>4010A1 Note:</b> Required if the services were rendered under one of the following circumstances/programs/projects.			<b>5010 Situational Rule:</b> Required when the services were rendered under one of the following circumstances, programs, or projects.  If not required by this implementation guide, do not send. <b>5010 Note:</b> No 5010 Note			
<b>Implementation Difference:</b> There is No Change to this record.						

Code Detail	Version	Loop Identifier	Element Identifier	Code Qualifier	Code Description
	4010A1	2300	CLM 12	01	Early & Periodic Screening, Diagnosis, and Treatment (EPSDT) or Child Health Assessment Program (CHAP)
	5010				
<b>4010A1 Note:</b> No 4010 Note			<b>5010 Situational Rule:</b> No Situational Rule <b>5010 Note:</b> No 5010 Note		
<b>Implementation Difference:</b> Code "01" (Early & Periodic Screening, Diagnosis, and Treatment (EPSDT) or Child Health Assessment Program (CHAP)) has been deleted because it is redundant to other information within the transaction.  Receivers can tell a claim: - contains the EPSDT screening services because the Loop 2300 - EPSDT CRC segment is present. - service has been performed as the result of a screening referral when the Loop 2400 - SV111 element is valued.					

Code Detail	Version	Loop Identifier	Element Identifier	Code Qualifier	Code Description
	4010A1	2300	CLM 12	02	Physically Handicapped Children's Program
	5010	2300	CLM 12	02	Physically Handicapped Children's Program
<b>4010A1 Note:</b> No 4010 Note			<b>5010 Situational Rule:</b> No Situational Rule <b>5010 Note:</b> This code is used for Medicaid claims only.		
<b>Implementation Difference:</b> The 5010 note was added to clarify this code is to be used only for Medicaid claims.					

Code Detail	Version	Loop Identifier	Element Identifier	Code Qualifier	Code Description
	4010A1	2300	CLM 12	07	Induced Abortion - Danger To Life
	5010				

**4010A1 Note:**  
This code is used for Medicaid claims only.

**5010 Situational Rule:**  
No Situational Rule  
**5010 Note:**  
No 5010 Note

**Implementation Difference:**

Code "07" (Induced Abortion - Danger to Life) has been deleted because abortion/sterilization information will now be submitted using condition codes in the Loop 2300 Condition Code segment. The condition codes to be used are listed at [www.nucc.org](http://www.nucc.org).

Code Detail	Version	Loop Identifier	Element Identifier	Code Qualifier	Code Description
	4010A1	2300	CLM 12	08	Induced Abortion - Rape or Incest
	5010				

**4010A1 Note:**  
This code is used for Medicaid claims only.

**5010 Situational Rule:**  
No Situational Rule  
**5010 Note:**  
No 5010 Note

**Implementation Difference:**

Code "08" (Induced Abortion - Rape or Incest) has been deleted because abortion/sterilization information will now be submitted using condition codes in the Loop 2300 Condition Code segment. The condition codes to be used are listed at [www.nucc.org](http://www.nucc.org).

Element Detail	Version	Loop Identifier	Element Identifier	Data Element	Min/Max Data Type	Element Usage
	4010A1	2300	CLM 16	1360	1/1 ID	Situational
	5010	2300	CLM 16	1360	1/1 ID	Not Used

**4010A1 Element Name:** Participation Agreement

**5010 Element Name:** Provider Agreement Code

**4010A1 Note:**  
Required if a non-participating (non-par) provider is submitting a participating (par) claim/encounter. Sending the "P" code indicates that a non-par provider is sending a par claim as allowed under certain plans.

**5010 Situational Rule:**  
No Situational Rule  
**5010 Note:**  
No 5010 Note

**Implementation Difference:**

The usage of this field changed from "Situational" to "Not Used" as the business case met by this element has been moved to CLM07. All explanatory information is provided there.

As a result of the element being changed to "Not Used", the element name changed to the generic X12 standard name.

Code Detail	Version	Loop Identifier	Element Identifier	Code Qualifier	Code Description
	4010A1	2300	CLM 16	P	Participation Agreement
	5010				

**4010A1 Note:**  
No 4010 Note

**5010 Situational Rule:**  
No Situational Rule  
**5010 Note:**  
No 5010 Note

**Implementation Difference:**

The business case met by this element has been moved to CLM07. All explanatory information is provided there.

Element Detail	Version	Loop Identifier	Element Identifier	Data Element	Min/Max Data Type	Element Usage
	4010A1	2300	CLM 20	1514	1/2 ID	Situational
	5010	2300	CLM 20	1514	1/2 ID	Situational
4010A1 Element Name:	Delay Reason Code					
5010 Element Name:	Delay Reason Code					
<b>4010A1 Note:</b> This element may be used if a particular claim is being transmitted in response to a request for information (e.g., a 277), and the response has been delayed.  Required when claim is submitted late (past contracted date of filing limitations) and any of the codes below apply.				<b>5010 Situational Rule:</b> Required when the claim is submitted late (past contracted date of filing limitations).  If not required by this implementation guide, do not send. <b>5010 Note:</b> No 5010 Note		
<b>Implementation Difference:</b> The notes were modified to provide clarity. The 4010 business example provided is one of many. Its inclusion caused some to interpret the usage as limiting. Therefore, it was deleted.						

Code Detail	Version	Loop Identifier	Element Identifier	Code Qualifier	Code Description	
	4010A1					
	5010	2300	CLM 20	15	Natural Disaster	
<b>4010A1 Note:</b> No 4010 Note				<b>5010 Situational Rule:</b> No Situational Rule <b>5010 Note:</b> No 5010 Note		
<b>Implementation Difference:</b> This code was added to the standard to enable providers to indicate a natural disaster (i.e. Hurricane Katrina) prevented timely submission of the claim.						