5. 837 DATA SUBMISSION AND TECHNICAL REQUIREMENTS

This section provides additional detail about the file submission and specific characteristics about the 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 samples below.

837I sample file: https://www.whainfocenter.com/WHAInfoCenter/media/DataSubmitters/837I_Sample-File.pdf

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

837R sample file: https://www.whainfocenter.com/WHAInfoCenter/media/DataSubmitters/837R-Sample-File.pdf

This manual references the 837 Professional Health Care Claim – ASC X12N 837 (005010X222A1)

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

5.1 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.

5.2 WHAIC 837 File Handler and De-Identification Program

Prior to uploading an 837 file, the following steps must be taken to remove and replace patients name with a 64-character Unique Case Identifier **(UCID)** in their 837 claims file. The primary purpose of the UCID is to assist facilities in identifying when a readmission occurs at a different facility from where the original admission or ambulatory surgery occurred. In addition, to preserve historical trending, the five-character encrypted case ID **(ECID)** is also required, as the two data elements are used for different purposes. Batch Files will be rejected if a patient name is detected.

5.3 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

5.4 Special Characters in the Claims Data

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: Element format is **UCID-ECID** UCID is characters 1 – 64 ECID is characters 66-70	Ex: Race:Ethnicity DMG05 value of **5:2:3** is treated as Race = 5, Ethnicity = 2, Race2 = 3

5.5 Mapping Rules and 837 File Specifications

This section addresses a variety of issues that will facilitate the 837 Claims Submission Process. Only the sections and segments that are required or situational **and apply** to the WHAIC data collection requirements, or that are different from the ANSI 837 Guide sections are written in this manual. **The file must be structurally correct** to meet the 837 standards**, meaning our parser will not work if it does not meet the ASC X12 Implementation Guide.**

Fields marked Situational **does not** mean optional. For example, Insurance Certificate Number (Insurance ID Number) and Payer Name is required on all records, but the field says situational because not all patients have insurance and for self-pay, the field may be left blank.

- Only loops, segments, and data elements valid for the HIPAA 837I (005010X223A2), 837P (005010X222A1) and 837R (005010X225A2) will be translated. Deviating from the Technical Report Guidelines and submitting invalid data will cause the file/batch to reject.
- Uploaded files are not limited in total size, but a single transaction (ST – SE envelope) can have no more than 5,000 CLM segments or 10 million characters. Files exceeding either limit will be rejected.
- WIpop's max upload size is currently 100 megabytes for facilities that do not use the black box/file handler to upload data.

When a HIPAA compliant ANSI 837 Institutional or Reporting formatted file with the additional required fields, including all mapped fields listed below, is submitted the data file should pass the WIpop Edits. Data elements listed as “Situational” or “Not Used” in the ANSI 837 Institutional Guide but REQUIRED by WHAIC are listed below.

5.6 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. For more information on mapping to a 1500 claim form see NUCC MAP.

This document notes the loops and elements relevant to WHAIC Data Collection. **This is not intended to serve as a complete 837 reference, not all requirements for a valid 837 file are specified.** Vendor support is required and can take 3-6 months to develop and test files.

http://www.nubc.org/resources/PDFs/BillTypeFrequencyCodes837.pdf

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.
N	Not used/needed	Not required, not edited, not collected. If submitted, it will be ignored.
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, if supplied.

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

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	

Loop	Element	Field Description	R, S, O	Values/Mapping Comments	WIpop Name / Notes
1000A	NM109	Identification Code of Submitter	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 ISA06 & GS02
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 associated with facility. Valid facility NPI number must be on file with WHAIC.	WIpop Field Name: NPI Billing Provider: NPI nbr 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 / ECID 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**	

Loop	Element	Field Description	R, S, O	Values/Mapping Comments	WIpop Name / Notes
2000B	SBR03	Policy Number – Insurance SBR03 is Policy or Group Number	R	Send "NULL" if Self-pay Other AKA terms: Policy #, Member ID, Insurance Card #, Group Number, certificate number.	Insurance Cert # - can only be NULL or blank for self-pay. Self-pay is required.
2000B	SBR09	Claim Filing Indicator Code	S	Code identifying type of claim See Appendix 7.3.1 (Required if on claim) Effective date for submission of new field Q12020	See Appendix 7.3.1 for list of codes associated with primary payer. Do not pre-map this field.
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. See Section 5.2 for information on creating Encrypted UCID
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 & ECID	R	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1 Element format is **UCID-ECID** UCID is characters 1 – 64 ECID is characters 66-70 837 File Handler/Black Box Instructions| DOWNLOAD	This field is to be used for encrypting the patient and/or subscriber name. Provide Patient UCID-ECID if different from subscriber. See Section 5.2
2010CA	NM109	Patient UCID & ECID	R	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1 Element format is **UCID-ECID**	This field is to be used for encrypting the patient and/or subscriber name. Provide Patient UCID-ECID

				UCID is characters 1 – 64 ECID is characters 66-70 837 File Handler/Black Box Instructions| DOWNLOAD	if different from subscriber. See Section 5.2
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 - the block group number processes on the edge server over a period of 12-24 hours before available in WIpop. 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 - the block group number processes on the edge server over a period of 12-24 hours before available in WIpop. 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 Loop 2010BA, NM102 = 1	Zip Code Stored in WIpop
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 (U/O requires Condition Code 45)	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 (U/O requires Condition Code 45)	F, M, U, O (U or O requires Cond Code 45)
2010BA	DMG04	Marital Status Code	O	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1 See Appendix 7.14 for Mapping	Marital Status provide if collected & stored in EMR.
2010CA	DMG04	Marital Status Code	O	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1 See Appendix 7.14 for Mapping	Marital Status provide if collected & stored in EMR.
2010BA	DMG05-1	Subscriber Race Code1 See Appendix 7.2	R/S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1	DMG05 is a composite element, which repeats up to 10 times. The first two

				DMG05 value of **5:2:3** is treated as Race = 5, Ethnicity = 2, Race2 = 3 DMG*D8*19830501*F*M*5:2 File rejected if > 25% of records = declined or unavailable.	entries for race will be used for WIpop fields RACE and RACE2. File rejected if > 25% 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 **File rejected if > 25% of records coded as declined or unavailable**.	DMG05 is a composite element, which repeats up to 10 times. The first two entries for race will be used for WIpop fields RACE and RACE2.
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 See Appendix 2	R/S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1	The first entry for ethnicity will be used for field ETHN.
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	DMG10 = ZZ

				ZZ – Mutually Defined	
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	See Appendix 7.2.1 for Code List Mapping
2010CA	DMG11	Patient Language Code	S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1	See Appendix 7.2.1 for Code List Mapping
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 The actual name of the payer going out on the claim	In WIpop: Click on the Expected Source of Payment to see or validate payer name
2010BB	NM108	(Payer) Identification Code	O	PI=Payer Identification	Discarded
2010BB	NM109	Primary Payer Identifier Code *Self-pay requires OTH-61	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	Expected Source of Payment ID/ Type: characters 1-3 – Pay Type is characters 5-6 The dash is preferred, but not required

				The dash is preferred, but not required.	
2010BB	REF01	REF ID Qualifier for Payer/NAIC#	S	NF = NAIC Code	New Field Q32019: Payer Identifier in the EDI Claims file – routes claim to correct payer.
2010BB	REF02	Payer/ NAIC #	S	Enter the Value of the Payer / NAIC#	Refer to Appendix 7.3.2 for additional info.
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. *File rejected for Duplicate Patient control numbers. **IF duplicates are found, resubmit file with this phrase **anywhere in the file name**: Exclude_duplicates Example: Q318 ASCname exclude_duplicates 1118	Use Patient Control Number (PCONTROL or PCTRL) Do not use special characters <> in file
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	WHAIC Values in Appendix 7.4 TOB 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. WHAIC Values in Appendix 7.4 TOB	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 Field may be repeated up to 12 times. HI01-2, HI02-2, HI03-2, HI04-2, etc.	Principal/Primary diagnosis code or nature of illness or injury
2300	HI0X-1	Other Diagnosis Code Qualifier	S	ABF	
2300	HI0X-2	Other Diagnosis Codes – ICD-10	S	ICD-10 CM Codes ***External Cause Code Required on records with ICD-10 diagnosis Codes in S range*** and some T range.	Diagnosis Codes only and no decimals. See Appendix 4.6 for more info
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 – eg. 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	Use Rendering to mean the same thing as Operating Provider NPI number	If Rendering NPI is the only field populated, WHAIC will auto populate Operating NPI in WIpop.
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	
2330B	NM109	Payer Identifier Code	R/S	WHAIC Values in Appendix 7.3 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, 0490 may be used.	

2400	SV101-1	CPT / HCPCS Qualifier	R	HC (HCPCS)	
2400	SV101-2	CPT / HCPCS Procedure Codes	R	Procedures, Services or Supplies CPT Codes – AMA HCPCS – CMS	*CPT or HCPCS required WHAIC follows correct coding guidelines and will populate the Principal procedure based on procedure codes in revenue line item detail.
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 Charge for service, supply, or drug	Facility charge amount in this field.
2400	SV103	Unit or Basis for Measurement Code	R	UN = Units	
2400	SV104	Service Unit Count	R	Quantity = positive whole numbers only	Unit field is required. Value must be 1 or >
2400	SV105	Place of Service Code	R	For ASC's *WHAIC maps to POS 1 for OPS**	Place of Service 1 is assigned by WHAIC for all ASC claims.
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