CareSource

HIPAA Transaction Standard Companion Guide

CareSource Outbound 837 Health Care Claim: Institutional Vendor 5010 Companion Guide

Refers to the Implementation Guides based on ASC X12 version 005010X223

Companion Guide Version Number: 1.0

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Preface

The information contained in this guide is meant to provide assistance to vendors regarding the health information that will be provided by CareSource. The sole purpose of this document is to provide guidance to entities who wish to become a Trading Partner. Every effort has been made to assure the information in this guide conforms to current requirements of the law. Each Medicaid provider and Trading Partner has the ultimate responsibility to follow federal and state laws. All users of this guide are advised to review these legal requirements with their legal counsel.

This Companion Guide to the ASC X12N Implementation Guides adopted under HIPAA clarifies and specifies the data content when exchanging electronically with CareSource. Transmissions based on this Companion Guide, used in tandem with the X12N Implementation Guides, are compliant with both X12 syntax and those guides. This Companion Guide is intended to convey information that is within the framework of the ASC X12N Implementation Guides adopted for use under HIPAA. The Companion Guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the Implementation Guides.

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Table of Contents

1. **INTRODUCTION**
   Scope
   Overview
   References
   Additional Information

2. **GETTING STARTED**
   Working with CareSource
   Trading Partner Registration
   Certification and Testing Overview

3. **TESTING WITH THE PAYER**

4. **CONNECTIVITY WITH THE PAYER / COMMUNICATIONS**
   Process Flows and Passwords
   Transmission Administrative Procedures
   Re-Transmission Procedures
   Communication Protocol Specifications

5. **CONTACT INFORMATION**
   EDI Customer Service
   EDI Technical Assistance
   Provider Service Number
   Applicable Website / E-mail

6. **CONTROL SEGMENTS / ENVELOPES**
   ISA-IEA
   GS-GE
   ST-SE

7. **PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS**

8. **ACKNOWLEDGEMENTS AND/OR REPORTS**
   Report Inventory

9. **TRADING PARTNER AGREEMENTS**
   Trading Partners

10. **TRANSACTION SPECIFIC INFORMATION**
    APPENDICES
    1. Implementation Checklist
    2. Business Scenarios
    3. Transmission Examples
    4. Frequently Asked Questions
    5. Change Summary

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1. INTRODUCTION

This document is intended as a companion to the Health Care Claim: Institutional (837) – ASC X12N/005010X223, published in May 2006. This Companion Guide will provide CareSource vendors with specific segments and elements that will be provided on an EDI 837 outbound file. This clarifying information will be listed in a table format consisting of a row for each segment that CareSource has something additional, over and above, the information in the Implementation Guide or what standard data will be provided. That information can:

1. Limit the repeat of loops, or segments
2. Limit the length of a simple data element
3. Specify a subset of the Implementation Guides internal code listing
4. Clarify the use of loops, segments, composite and simple data elements
5. Any other information tied directly to a loop, segment, composite or simple data element pertinent to trading electronically with CareSource

SCOPE

The Companion Guide is intended to be used as a supplement of the Implementation Guides.

OVERVIEW

This Companion Guide clarifies what CareSource provides in specific loops/segments.

REFERENCES

This Companion Guide supplements the document "Health Care Claim: Institutional (837)", which is published by the **Washington Publishing Company** **www.wpc-edi.com**.

ADDITIONAL INFORMATION

2. GETTING STARTED

WORKING WITH CARESOURCE

Please email CareSource's EDI department at EDIServices@caresource.com to initiate interaction regarding questions/comments/clarifications needed regarding this Companion Guide.

TRADING PARTNER REGISTRATION

CERTIFICATION AND TESTING OVERVIEW

3. TESTING WITH THE PAYER

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4. CONNECTIVITY WITH THE PAYER/COMMUNICATIONS

If you have not been set up for a testing account, the CareSource EDI Specialists can provide you with information on:

- PROCESS FLOWS AND PASSWORDS
- TRANSMISSION ADMINISTRATIVE PROCEDURES
- RE-TRANSMISSION PROCEDURE
- COMMUNICATION PROTOCOL SPECIFICATIONS

5. CONTACT INFORMATION

- EDI CUSTOMER SERVICE:
- EDI TECHNICAL ASSISTANCE: EDIServices@caresource.com
- PROVIDER SERVICES NUMBER: 1-800-488-0134
- APPLICABLE WEBSITE: www.caresource.com

6. CONTROL SEGMENTS / ENVELOPES

Specific requirements/expectations, based on transaction type, will be communicated by the EDI department during the life cycle requirements phase for the following:

- ISA-IEA Interchange Control
- GS-GE Functional Group
- ST-SE Transaction Set

7. PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS

8. ACKNOWLEDGEMENTS AND/OR REPORTS

REPORT INVENTORY

9. TRADING PARTNER AGREEMENTS

TRADING PARTNERS

An EDI Trading Partner is defined as any CareSource customer (provider, billing service, software vendor, employer group, financial institution, etc.) that transmits to or receives electronic data from CareSource.

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10. TRANSACTION SPECIFIC INFORMATION - 837 HEALTH CARE CLAIM: INSTITUTIONAL

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
C.3		ISA	**Interchange Control Header**			
C.4		ISA01	Authorization Information Qualifier	00	2	No Authorization Information Present
C.4		ISA02	Interchange/Authorization Information		10	No Security Information Present
C.4		ISA03	Security Information Qualifier	00,01	2	No Security Information Present
C.4		ISA04	Security Information Qualifier		10	No Security Information Present
C.4		ISA05	Interchange ID Qualifier	ZZ	2	Mutually Defined
C.4		ISA06	Interchange Sender ID	311143265	15	Use for all plans
C.5		ISA07	Interchange ID Qualifier	ZZ	2	
C.5		ISA08	Interchange Receiver ID		15	Trading Partner’s ID
C.5		ISA09	Interchange Date		6	YYMMDD
C.5		ISA10	Interchange Time		4	HHMM
C.5		ISA11	Repetition Separator	^	1	
C.5		ISA12	Interchange Control Version Number	00501	5	
C.5		ISA13	Interchange Control Number		9	
C.6		ISA14	Acknowledgement Requested	0,1	1	No Interchange Acknowledgment Requested
C.6		ISA15	Interchange Usage Indicator	P or T	1	P – Production T – Test
C.6		ISA16	Component Element Separator	|	1	
C.7		GS	**Functional Group Header**			

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C.7		GS01	Functional Identifier Code	HC	2	
C.7		GS02	Application Sender's Code	311143265	15	Interchange/Functional Group/SenderCode
C.7		GS03	Application Receiver's Code		15	Interchange/Functional Group/ReceiverCode
C.7		GS04	Functional Group Creation Date		8	CCYYMMDD
C.8		GS05	Functional Group Creation Time		8	HHMM
C.8		GS06	Group Control Number		9	
C.8		GS07	Responsible Agency Code	X	2	
C.8		GS08	Version/Release Code	005010X223A2	12	Interchange/Functional Group/Version
67		ST	**Transaction Set Header**			Each ST/SE should contain only one claim
67		ST01	Transaction Set Identifier Code	837	3	
67		ST02	Transaction Set Control Number		9	
67		ST03	Implementation Guide Reference	005010X223A2	35	
68		BHT	**Beginning of Hierarchical Transaction**			
68		BHT01	Hierarchical Structure Code	0019	4	Information Source, Subscriber, Dependent
68		BHT02	Transaction Set Purpose Code	00	2	Original
69		BHT03	Submitter Transaction Identifier		50	Originator Application Transaction Identifier - ClaimID
69		BHT04	Transaction Set Creation Date		8	CCYYMMDD
69		BHT05	Transaction Set Creation Time		8	HHMMSS or HHMMSSDD
69		BHT06	Transaction Type Code	31,CH,RP	2	Chargeable, Reporting
71	1000A	NM1	**Submitter Name**			

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71	1000A	NM101	Entity Identifier Code	41	3	
72	1000A	NM102	Entity Type Qualifier	1,2	1	
72	1000A	NM103	Organization Name		60	Use value “CareSource”
72	1000A	NM108	Identification Code Qualifier	46	2	
72	1000A	NM109	Identification Code	31114	80	
73	1000A	PER	**Submitter EDI Contact Info**			
74	1000A	PER01	Contact Function Code	IC	2	Information Contact
74	1000A	PER02	Submitter Contact Name		60	“SERVICE CENTER”
74	1000A	PER03	Communication Number Qualifier	TE	2	Email, Facsmile, Telephone
74	1000A	PER04	Communication Number		256	Current CareSource Email Address
75	1000A	PER05	Communication Number Qualifier	EM	2	Email,TelephoneExt,Facsmile,Telephone
75	1000A	PER06	Communication Number		256	Current CareSource Phone Number
75	1000A	PER07	Communication Number Qualifier	TE	2	Email,TelephoneExt,Facsmile,Telephone
75	1000A	PER08	Communication Number		256	Current CareSource Phone Number
76	1000B	NM1	**Receiver Name**			
76	1000B	NM101	Entity Identifier Code	40	3	Receiver
76	1000B	NM102	Entity Type Qualifier	2	1	Non-Person Entity
77	1000B	NM103	Organization Name		60	Receiver Name
77	1000B	NM108	Identification Code Qualifier	46	2	ETIN
77	1000B	NM109	Identification Code		80	Receiver Primary Identifier
78	2000A	HL	**Billing Provider Hierarchical Level**			

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78	2000A	HL01	Hierarchical ID Number	1	12	
78	2000A	HL03	Hierarchical Level Code	20	2	Information Source
79	2000A	HL04	Hierarchical Child Code	1	1	
84	2010AA	NM1	**Billing Provider Name**			
85	2010AA	NM101	Entity Identifier Code	85	3	Billing Provider
85	2010AA	NM102	Entity Type Qualifier	1,2	1	
85	2010AA	NM103	Organization Name		60	Billing Provider Last Name or Organization Name
86	2010AA	NM108	Identification Code Qualifier	XX	2	Centers for Medicare and Medicaid Services NPI
86	2010AA	NM109	Identification Code		80	Billing Provider NPI
87	2010AA	N3	**Billing Provider Address**			
87	2010AA	N301	Billing Provider Address Line 1		55	
87	2010AA	N302	Billing Provider Address Line 2		55	
88	2010AA	N4	**Billing Provider City, State, Zip**			
88	2010AA	N401	City Name		30	
89	2010AA	N402	State		2	
89	2010AA	N403	Zip Code		15	
89	2010AA	N404	Country Code		3	

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90	2010AA	REF	**Billing Provider Tax Identification**			
90	2010AA	REF01	Reference Id Qualifier	EI	3	Employer's Identification Number
90	2010AA	REF02	Reference Identification		50	Billing Provider Tax Identification Number
91	2010AA	PER	**Billing Provider Contact Info**			
92	2010AA	PER01	Contact Function Code	IC	2	Information Contact
92	2010AA	PER02	Name		60	Billing Provider Contact Name
92	2010AA	PER03	Communication Number Qualifier	TE	2	Email,Facsmile,Telephone
92	2010AA	PER04	Communication Number		256	Billing Provider Email Address
94	2010AB	NM1	**Pay-To Address Name**			
94	2010AB	NM101	Entity Identifier Code	87	3	87 = Pay-To Provider
95	2010AB	NM102	Entity Type Qualifier	2	1	
96	2010AB	N3	**Pay-To Address**			
96	2010AB	N301	Address Information		55	
96	2010AB	N302	Address Information		55	
97	2010AB	N4	**Pay-To City, State, Zip**			
97	2010AB	N401	City Name		30	
98	2010AB	N402	State		2	
98	2010AB	N403	Postal/Zip Code		15	

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107		HL	**Subscriber Hierarchical Level**			
107	2000B	HL01	Hierarchical ID Number		12	
108	2000B	HL02	Hierarchical Parent ID		12	
108	2000B	HL03	Hierarchical Level Code	22	2	Subscriber
108	2000A	HL04	Hierarchical Child Code	0,1	1	No Subordinate HL Segment in This Hierarchical Structure
109	2000B	SBR	**Subscriber Information**			
109	2000B	SBR01	Payer Responsibility Seq Number Code		1	
110	2000B	SBR02	Individual Relationship Code	18	2	18 = Self
110	2000B	SBR03	Reference Identification		50	Subscriber Group or Policy Number
110	2000B	SBR04	Name		60	Subscriber Group Name
110	2000B	SBR09	Claim Filing Indicator Code		2	
112	2010BA	NM1	**Subscriber Name**			
112	2010BA	NM101	Entity Identifier Code	IL	3	Insured or Subscriber
113	2010BA	NM102	Entity Type Qualifier	1,2	1	Person, Non-Person Entity
113	2010BA	NM103	Last Name		60	Subscriber Last Name
113	2010BA	NM104	First Name		35	Subscriber First Name
113	2010BA	NM105	Middle Name		25	Subscriber Middle Name or Initial
113	2010BA	NM108	Identification Code Qualifier	MI	2	Unique Health Identifier,Member Identification Number
114	2010BA	NM109	Identification Code		80	Subscriber Primary Identifier

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115	2010BA	N3	**Subscriber Address**			
115	2010BA	N301	Subscriber Address Line 1		55	
115	2010BA	N302	Subscriber Address Line 2		55	
116	2010BA	N4	**Subscriber City, State, Zip**			
116	2010BA	N401	City Name		30	
116	2010BA	N402	State		2	
117	2010BA	N403	Zip Code		15	
118	2010BA	DMG	**Subscriber Demographic Info**			
118	2010BA	DMG01	Date Time Period Qualifier	D8	3	
118	2010BA	DMG02	Date Time Period		35	Subscriber Birth Date
119	2010BA	DMG03	Gender Code	F,M,U	1	
122	2010BB	NM1	**Payer Name**			
122	2010BB	NM101	Entity Identifier Code	PR	3	Payer
123	2010BB	NM102	Entity Type Qualifier	2	1	Non-Person Entity
123	2010BB	NM103	Organization Name	CareSource	60	
123	2010BB	NM108	Identification Code Qualifier	PI	25	Payor Identification,CMS PlanID
123	2010BB	NM109	Identification Code		80	CareSource payer identifier by LOB
124	2010BB	N3	**Payer Address**			
124	2010BA	N301	Payer Address Line 1		55	

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124	2010BA	N302	Payer Address Line 2		55	
125	2010BB	N4	**Payer City, State, Zip**			
125	2010BB	N401	City Name		30	
125	2010BB	N402	State		2	
126	2010BB	N403	Zip Code		15	
143	2300	CLM	**Health Claim**			
144	2300	CLM01	Claim Submitter's Identifier		38	Patient Control # or Claim # in billing submitter's system
145	2300	CLM02	Monetary Amount		18	Total Claim Charge Amount
145	2300	CLM05-1	Facility Code Value		2	Place Of Service Code
145	2300	CLM05-2	Facility Code Qualifier	A	2	Uniform Billing Claim Form Bill Type
145	2300	CLM05-3	Claim Frequency Type Code		1	Claim Frequency Code
146	2300	CLM07	Provider Accept Assignment Code		1	Assignment or Plan Participation Code
146	2300	CLM08	Response Code	N,W,Y	1	No,Not Applicable,Yes
147	2300	CLM09	Release of Information Code	I,Y	1	Informed Consent,Signed Statement
147	2300	CLM20	Delay Reason Code	1,2,3,4,5,6,7,8,9,10,11,15	2	
149	2300	DTP	**Date – Discharge Hour**			
149	2300	DTP01	Date/Time Qualifier	096	3	Discharge
149	2300	DTP02	Date Time Period Qualifier	TM	3	HHMM
149	2300	DTP03	Date Time Period		35	Statement From and Statement To Dates
150	2300	DTP	**Statement Dates**			
150	2300	DTP01	Date/Time Qualifier	434	3	Statement
159	2300	DTP02	Date Time Period Qualifier	RD8	3	CCYYMMDD

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150	2300	DTP03	Date Time Period		35	Statement From and Statement To Dates
151	2300	DTP	**Admission Date/Hour**			
151	2300	DTP01	Date/Time Qualifier	435	3	Admission
151	2300	DTP02	Date Time Period Format Qualifier	D8,DT	3	CCYYMMDD,CCYYMMDDHHMM
151	2300	DTP03	Date Time Period		35	Statement From and Statement To Dates
152	2300	DTP	**Repricer Received Date**			
152	2300	DTP01	Date/Time Qualifier	050	3	Admission
152	2300	DTP02	Date Time Period Format Qualifier	D8	3	CCYYMMDD
152	2300	DTP03	Date Time Period		35	Statement From and Statement To Dates
153	2300	CL1	**Institutional Claim Code**			
153	2300	CL101	Admission Type Code		1	
153	2300	CL102	Admission Source Code		1	
153	2300	CL103	Patient Status Code		2	
158	2300	CN1	**Contract Information**			
158	2300	CN101	Contract Type Code	01,02,03,04,05,06,09	2	DRG,PerDiem,Variable PerDiem,Flat,Capitated,Percent,Other
158	2300	CN102	Monetary Amount		18	
164	2300	REF	**Prior Authorization**			
164	2300	REF01	Reference Identification Qualifier	G1	3	Prior Authorization Number
165	2300	REF02	Reference Identification		50	
166	2300	REF	**Payer Claim Control Number**			
166	2300	REF01	Reference Identification Qualifier	F8	3	Original Reference Number
166	2300	REF02	Reference Identification		50	
170	2300	REF	**Claim Identifier for Transmission Intermediaries**			

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170	2300	REF01	Reference Identification Qualifier	D9	3	Claim Number
171	2300	REF02	Reference Identification		50	Value Added Network Trace Number
173	2300	REF	**Medical Record Number**			
173	2300	REF01	Reference Identification Qualifier	EA	3	Medical Record ID Number
173	2300	REF02	Reference Identification		50	
176	2300	K3	**File Information**			
177		K301	Fixed Format Information		80	
184		HI	**Principal Diagnosis/Healthcare Diagnosis**			
184		HI101-1	Code List Qualifier Code	ABK	3	ICD-10-CM Principal Diagnosis
185		HI101-2	Industry Code		30	
187	2300	HI	**Admitting Diagnosis**			
188	2300	HI01-1	Code List Qualifier Code	ABJ	3	ICD-10-CM Admitting Diagnosis
188	2300	HI01-2	Industry Code		30	Admitting Diagnosis Code
189	2300	HI	**Patient's Reason for Visit**			
190	2300	HI01-1	Code List Qualifier Code	APR	3	ICD-10-CM Patient's Reason for Visit
190	2300	HI01-2	Industry Code		30	Patient's Reason for Visit
191	2300	HI02-1	Code List Qualifier Code	APR	3	ICD-10-CM Patient's Reason for Visit
191	2300	HI02-2	Industry Code		30	Patient's Reason for Visit
192	2300	HI03-1	Code List Qualifier Code	APR	3	ICD-10-CM Patient's Reason for Visit
192	2300	HI03-2	Industry Code		30	Patient's Reason for Visit
193	2300	HI	**External Cause of Injury**			

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194	2300	HI01-1	Code List Qualifier Code	ABN	3	ICD-10-CM Diagnosis
194	2300	HI01-2	Industry Code		30	External Cause of Injury
195	2300	HI01-9	Yes/No Condition		1	Present on Admission Indicator
196	2300	HI02-1	Code List Qualifier Code	ABN	3	ICD-10-CM Diagnosis
196	2300	HI02-2	Industry Code		30	Other Diagnosis
197	2300	HI02-9	Yes/No Condition		1	Present on Admission Indicator
198-215	*2300*	*HI03 – HI11*	*****	*****	***	*Elements HI03 through HI11 are possible but are not shown individually.*
216	2300	HI12-1	Code List Qualifier Code	ABN	3	ICD-10-CM Diagnosis
216	2300	HI12-2	Industry Code		30	Other Diagnosis
217	2300	HI12-9	Yes/No Condition		1	Present on Admission Indicator
218	2300	HI	**(DRG) Diagnosis Related Group Information**			
218	2300	HI01-1	Code List Qualifier Code	DR	3	Diagnosis Related Group (DRG)
219	2300	HI01-2	Industry Code		30	Diagnosis Related Group (DRG) Code
220	2300	HI	**Other Diagnosis Information**			
221	2300	HI01-1	Code List Qualifier Code	ABF	3	ICD-10-CM Diagnosis
221	2300	HI01-2	Industry Code		30	Other Diagnosis
221	2300	HI01-9	Yes/No Condition		1	Present on Admission Indicator
222	2300	HI02-1	Code List Qualifier Code	ABF	3	ICD-10-CM Diagnosis
222	2300	HI02-2	Industry Code		30	Other Diagnosis
223	2300	HI02-9	Yes/No Condition		1	Present on Admission Indicator
***	*2300*	*HI03 – HI11*	*****	*****	***	*Elements HI03 through HI11 are possible but are not shown individually.*

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237	2300	HI12-1	Code List Qualifier Code	ABF	3	ICD-10-CM Diagnosis
237	2300	HI12-2	Industry Code		30	Other Diagnosis
238	2300	HI12-9	Yes/No Condition		1	Present on Admission Indicator
239	2300	HI	**Principal Procedure Information**			
240	2300	HI01-1	Code List Qualifier Code	BBR	3	
240	2300	HI01-2	Industry Code		30	Principal Procedure Code
240	2300	HI01-3	Date Time Period Format Qualifier	D8	3	Format CCYYMMDD
240	2300	HI01-4	Date Time Period		35	Principal Procedure Date
242	2300	HI	**Other Procedure Information**			
243	2300	HI01-1	Code List Qualifier Code	BBQ	3	ICD-10-PCS
243	2300	HI01-2	Industry Code		30	Procedure Code
243	2300	HI01-3	Date Time Period Format Qualifier	D8	3	Format CCYYMMDD
243	2300	HI01-4	Date Time Period		35	Procedure Date
244	2300	HI02-1	Code List Qualifier Code	BBQ	3	ICD-10-PCS
244	2300	HI02-2	Industry Code		30	Procedure Code
244	2300	HI01-3	Date Time Period Format Qualifier	D8	3	Format CCYYMMDD
245	2300	HI02-9	Yes/No Condition		1	Procedure Date
***	*2300*	*HI03 – HI11*	*****	*****	***	*Elements HI03 through HI11 are possible but are not shown individually.*
256	2300	HI12-1	Code List Qualifier Code	BBQ	3	ICD-10-PCS
257	2300	HI12-2	Industry Code		30	Procedure Code
257	2300	HI12-3	Date Time Period Format Qualifier	D8	3	Format CCYYMMDD
257	2300	HI12-9	Yes/No Condition		1	Procedure Date
271	2300	HI	**Occurrence Information**			

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271	2300	HI01-1	Code List Qualifier Code	BH	3	Occurrence
271	2300	HI01-2	Industry Code		30	Occurrence Code
272	2300	HI01-3	Date Time Period Format Qualifier	D8	3	Format CCYYMMDD
272	2300	HI01-4	Date Time Period		35	Occurrence Code Date
272	2300	HI02-1	Code List Qualifier Code	BH	3	Occurrence
272	2300	HI02-2	Industry Code		30	Occurrence Code
273	2300	HI02-3	Date Time Period Format Qualifier	D8	3	Format CCYYMMDD
273	2300	HI02-4	Date Time Period		35	Occurrence Code Date
***	*2300*	*HI03 – HI11*	*****	*****	***	*Elements HI03 through HI11 are possible but are not shown individually.*
282	2300	HI12-1	Code List Qualifier Code	BH	3	Occurrence
282	2300	HI12-2	Industry Code		30	Occurrence Code
283	2300	HI12-3	Date Time Period Format Qualifier	D8	3	Format CCYYMMDD
283	2300	HI12-4	Date Time Period		35	Occurrence Code Date
284	2300	HI	**Value Information**			
284	2300	HI01-1	Code List Qualifier Code	BE	3	BE = Value
284	2300	HI01-2	Industry Code		30	Value Code
285	2300	HI01-5	Monetary Amount		18	Value Code Amount
285	2300	HI02-1	Code List Qualifier Code	BE	3	BE = Value
285	2300	HI02-2	Industry Code		30	Value Code
285	2300	HI02-5	Monetary Amount		18	Value Code Amount
***	*2300*	*HI03 – HI11*	*****	*****	***	*Elements HI03 through HI11 are possible but are not shown individually.*
293	2300	HI12-1	Code List Qualifier Code	BE	3	BE = Value
293	2300	HI12-2	Industry Code		30	Value Code
293	2300	HI12-5	Monetary Amount		18	Value Code Amount

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313	2300	HCP	**Claim Pricing/Repricing Information**			
314	2300	HCP01	Pricing Methodology		2	
314	2300	HCP02	Monetary Amount		18	Repriced Allowed Amount
314	2300	HCP03	Monetary Amount		18	Repriced Saving Amount
315	2300	HCP04	Reference Identification		50	Repricing Organization Identifier
315	2300	HCP05	Rate		9	Repricing Per Diem or Flat Rate Amount
315	2300	HCP06	Reference Identification		50	Repriced Approved DRG Code
315	2300	HCP07	Monetary Amount		18	Repriced Approved Amount
316	2300	HCP08	Product/Service ID		48	Repriced Approved Revenue Code
316	2300	HCP11	Unit or Basis for Measurement Code		2	DA = Days UN = Unit
316	2300	HCP12	Quantity		15	Repriced Approved Service Unit Count
317	2300	HCP13	Reject Reason Code		2	
317	2300	HCP14	Policy Compliance Code		2	
318	2300	HCP15	Exception Code		2	
319	2310A	NM1	**Attending Provider Name**			
319	2310A	NM101	Entity Identifier Code	71	3	71 = Attending Provider
320	2310A	NM102	Entity Type Qualifier	1	1	
320	2310A	NM103	Last Name or Organization Name		60	Attending Provider Last Name
320	2310A	NM104	First Name		35	Attending Provider First Name
320	2310A	NM105	Middle Name		25	Attending Provider Middle Name or Initial
321	2310A	NM108	Identification Code Qualifier	XX	2	Centers for Medicare and Medicaid Services NPI

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321	2310A	NM109	Identification Code		80	Attending Provider Identifier
322	2310A	PRV	**Attending Provider Specialty Information**			
322	2310A	PRV01	Provider Code	AT	3	Attending
322	2310A	PRV02	Reference Id Qualifier	PXC	3	Health Care Taxonomy Code
322	2310A	PRV03	Reference Identification		50	Provider Taxonomy Code
326	2310B	NM1	**Operating Physician Name**			
327	2310B	NM101	Entity Identifier Code	72	3	72 = Operating Provider
327	2310B	NM102	Entity Type Qualifier		1	Person
327	2310B	NM103	Last Name or Organization Name		60	Operating Physician Last Name
327	2310B	NM104	First Name		35	Operating Physician First Name
327	2310B	NM105	Middle Name		25	Operating Physician Middle Name or Initial
328	2310B	NM108	Identification Code Qualifier	XX	2	Centers for Medicare and Medicaid Services NPI
328	2310B	NM109	Identification Code		80	Operating Physician Identifier
424	2400	SV2	**Institutional Service**			
424	2400	SV201	Product/Service ID		48	Service Line Revenue Code
425	2400	SV202-1	Product/Service ID Qualifier	ER,HC,HP,IV,WK	2	Product or Service ID Qualifier
426	2400	SV202-2	Product/Service ID		48	Procedure Code
426	2400	SV202-3	Procedure Modifier		2	Up to 4 optional modifers.
426	2400	SV202-4	Procedure Modifier		2	Up to 4 optional modifers.
427	2400	SV202-5	Procedure Modifier		2	Up to 4 optional modifers.
427	2400	SV202-6	Procedure Modifier		2	Up to 4 optional modifers.
427	2400	SV202-7	Description		80	

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427	2400	SV203	Monetary Amount		18	Line Item Charge Amount
428	2400	SV204	Unit or Basis for Measurement Code	DA,UN	2	DA = Days UN = Unit
428	2400	SV205	Quantity		15	Service Unit Count
428	2400	SV207	Monetary Amount		18	Line Item Denied Charge or Non-Covered Charge Amount
429	2400	PWK	**Line Supplemental Information**			
430	2400	PWK01	Report Type Code		2	Attachment Report Type Code
431	2400	PWK02	Report Transmission Code	AA,BM,EL,EM,FT,FX	2	Attachment Transmission Code
432	2400	PWK05	Identification Code Qualifier		2	AC = Attachment Control Number
432	2400	PWK06	Attachment Control Number		80	Attachment Control Number
433	2400	DTP	**Service Date**			
434	2400	DTP01	Date/Time Qualifier	472	3	Service
434	2400	DTP02	Date Time Period Format Qualifier	D8/RD8	3	CCYYMMDD
434	2400	DTP03	Date Time Period		35	Service Date or Range
435	2400	REF	**Line Item Control Number**			
435	2400	REF01	Reference Identification Qualifier	6R	3	Provider Control Number
436	2400	REF02	Reference Identification		50	Line Item Control Number
442	2400	HCP	**Line Pricing/Repricing Information**			
443	2400	HCP01	Pricing Methodology	00, 01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12, 13, 14	2	
443	2400	HCP02	Monetary Amount		18	
443	2400	HCP03	Monetary Amount		18	
444	2400	HCP04	Reference Identification		50	
444	2400	HCP05	Rate		9	

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444	2400	HCP06	Reference Identification		50	
444	2400	HCP07	Monetary Amount		18	
445	2400	HCP08	Product/Service ID		48	Product or Service ID
445	2400	HCP09	Product/Service ID Qualifier	ER,HC,HP,IV,WK	2	
446	2400	HCP10	Product/Service ID		48	Product or Service ID
447	2400	HCP11	Unit	DA,UN	2	DA = Days UN = Unit
447	2400	HCP12	Quantity		15	
447	2400	HCP13	Rejection Reason Code	T1,T2,T3,T4,T5,T6	2	
448	2400	HCP14	Policy Compliance Code	1,2,3,4,5	2	
448	2400	HCP15	Exception Code	1,2,3,4,5,6	2	
488		SE	**Transaction Set Trailer**			
488		SE01	Number of Included Segments		10	
488		SE02	Transaction Set Control Number		9	ST02 and SE02 Must be Identical
C.9		GE	**Functional Group Trailer**			
C.9		GE01	Number of Transaction Sets		6	
C.9		GE02	Group Control Number		9	Must match GS06
C.10		IEA	**Interchange Control Trailer**			
C.10		IEA01	Number of Functional Groups		5	
C.10		IEA02	Interchange Control Number		9	Must match ISA13

NDC Reporting Requirements in Health Care Claims

I. Purpose
The purpose of this section is to provide additional information on how to report National Drug Codes (NDC) and its related information in health care claims when it is

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known to impact adjudication.

II. Scope

This section is focused on the requirements of how to report NDC and its related information in the Accredited Standards Committee X12 (ASC X12) Health Care Claim: Professional (837P), 005010X222A1 and Health Care Claim: Institutional (837I), 005010X223A2 transactions, hereinafter referred to as "5010".

This companion guide will not address any pharmacy standard transactions, as developed by the National Council for Prescription Drug Programs (NCPDP).

III. Introduction

Reporting of NDC and its related information in claims has changed under ASC X12 Version 005010 (5010). Since the transition to 5010, many in the industry have had questions about the reporting requirements and are seeking clarification. This section will provide an overview of the reporting requirements for NDC, as defined by the ASC X12 Technical Report Type 3 (TR3) for professional and institutional claims.
In addition to questions about how to report NDC information, many have had questions about when to report it. Per the TR3, NDC information is reported when required by federal or state regulation or when the submitter determines it will support the claim and adjudication process. In general, NDC is reported for Healthcare Common Procedure Coding System (HCPCS) codes for physician-administered drugs and biologics. For example, NDC is required to be reported on Medicaid claims, and Medicare claims when Medicaid is the secondary payer.

IV. Common Content

While there are some differences between the 837P and 837I for reporting NDC, there are common formats with structure, qualifiers, and quantities reported. This section will provide an overview of this common information.

A. NDC Format

NDCs must be reported using the 5-4-2 format. If a drug's NDC does not follow this format, then a zero must be inserted at the beginning of the appropriate section of the number, as shown in the table below, in order to create the 5-4-2 format. The following table shows where to insert the zeros.

NDC	11 Digits	Examples
4-4-2 XXXX-XXXX-XX	**0**XXXX-XXXX-XX	1234-5678-91 = **0**1234-5678-91
5-3-2 XXXXX-XXX-XX	XXXXX-**0**XXX-XX	12345-678-91 = 12345-**0**678-91
5-4-1 XXXXX-XXXX-X	XXXXX-XXXX-**0**X	12345-6789-1 = 12345-6789-**0**1

Note: NDCs are reported in the 837 transaction without the hyphens.

B. Unit of Measure Qualifiers

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The 5010 valid qualifiers for the unit of measure data element in the Drug Quantity (CTP) segment, CTP05, are:

- F2 International unit
- GR Gram
- ME Milligram
- ML Milliliter
- UN Unit

In many cases, a direct conversion of units of measure from the NCPDP standard to the 837 transactions is possible, as shown below.

Conversions of NCPDP Unit of Measure to 837 Transaction Unit of Measure	
NCPDP	**837 Transaction**
mL	ML
GM	**GR**
EA	UN

The 837 transaction units of measure may not convert to the NCPDP standard units of measure. The following table shows which 837 transaction units of measure would not be appropriate for NCPDP units of measure.

If the NCPDP unit of measure is…	Then these 837 transaction units of measure are not appropriate
mL	UN, GR
GM	ML, UN
EA	ML, GR

C. Quantities Reported in SV1/SV2 and CTP

There continues to be confusion with the quantities reported for the Professional Service (SV1 in 837P)/Institutional Service Line (SV2 in 837I) segment and the CTP segment. Understanding and reporting the correct quantity is necessary for accurate and timely claim adjudication.

The HCPCS unit reported in SV1/SV2 is based on the description in the HCPCS code. Using the long version of the description of the HCPCS code, translate the dosage in the description and the quantity given into the HCPCS unit of service. (Note: Not all short version descriptions of HCPCS codes define units for the HCPCS code.) For example, if the HCPCS description states a quantity of “500 mg” and “500 mg” is administered, then the HCPCS quantity is “1.” If the HCPCS description states a quantity of “5” and “10” are administered, then the HCPCS

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quantity is “2.” When reporting HCPCS that are unspecified, refer to your payer’s specific billing instructions for how to report these quantities.
Reporting the NDC quantity in CTP04 is based on the NDC quantity dispensed. For example if the NDC unit of measure is milliliters (mL), then the NDC quantity reported will equal the quantity of mL given to the patient. It is important to report the exact NDC quantity dispensed, including decimals when appropriate. The NCPDP Billing Unit Standard should be followed to determine the correct billing unit (unit of measure) for specific NDCs.

The examples in sections V. B. and VI. B. further demonstrate how to bill service and NDC quantities. In addition, there are multiple resources available for NDC reporting. Consult with your payers for additional instructions for billing NDC. Also, check with your payers for instructions for how to bill for wasted/unused medication. Note: NCPDP has a Billing Unit Standard Implementation Guide, which may serve as an additional resource for billing NDC quantity and units.

D. Reject Codes

When reporting NDC and its related information, it is important to review the remittance advice (835) and claim status (277CA) responses to identify any missing or incorrect data that is required to adjudicate the claim. Claim Adjustment Reason Codes, Remittance Advice Remark Codes, and Claim Status Codes are possible codes that would indicate an issue with the NDC information reported in the claim.

VI. Reporting NDC in Institutional Claims

A. Data Requirements

SV2 is where the drug procedure code is reported. Qualifier “HC” in SV202-1 indicates that the procedure code is a HCPCS or CPT code. The actual procedure code is reported in SV202-2. SV204 is the qualifier for the procedure units and SV205 is where the procedure quantity is reported.
The LIN segment is situational and is required to be reported when federal or state regulations mandate that drugs or biologics be reported with NDC numbers. Providers or submitters may also report NDC numbers when this information is known to support the claim and facilitate the adjudication. LIN02 is the qualifier for reporting the NDC number, which is code value N4. LIN03 is where the NDC number is reported. Both of these data elements are required when reporting the segment.
The CTP segment is required to be reported when reporting the NDC in the LIN segment. Both CTP04 (NDC unit count) and CTP05 (unit of measure) are required.

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B. Examples

Example 1:

A patient in the hospital is given a 1000 mg dose of Ceftriaxone where two 500 mg vials of powder are reconstituted.

Therefore:

- HCPCS: J0696 (Injection, ceftriaxone sodium, 250 mg)
- NDC: 00409-7338-01
- HCPCS unit: 4
- NDC quantity: 2
- Unit of measure: UN

The following information for NDC is reported in the 837I:

Loop	Segment	Data Element	Data Reported
2400	SV2	SV202-1	HC
		SV202-2	J3490
		SV204	UN
		SV205	4
2410	LIN	LIN02	N4
		LIN03	00409733801
2410	CTP	CTP04	**2**
		CTP05-1	UN

Example 2:

A patient in the hospital is given 2 mg of Zofran where a 2 mL vial of liquid containing 2 mg/mL is used.

Therefore:

- HCPCS: J2405 (Injection, ondansetron hydrochloride, per 1 mg)
- NDC: 00173-0442-02
- HCPCS unit: 2
- NDC quantity: 1
- Unit of measure: ML

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The following information for NDC is reported in the 837I:

Loop	Segment	Data Element	Data Reported
2400	SV2	SV202-1	HC
		SV202-2	J2405
		SV204	UN
		SV205	4
2410	LIN	LIN02	N4
		LIN03	00173044202
2410	CTP	CTP04	**1**
		CTP05-1	ML

C. Unspecified Codes

When reporting a procedure code that is an unspecified drug code, a description of the procedure is required to be reported in SV202-7 (Description). The situational rule for SV202-7 states that a description is required to be reported when a nonspecific procedure code is reported. The submitter is also allowed to report a description when, in their judgment, the procedure code does not definitively

describe the procedure or service. The fact that an NDC is reported in LIN03 does not negate the need to report a description. See ASC X12 Request for Interpretation (RFI) #1563 for additional information (www.x12.org/subcommittees/x12rfi.cfm).
The TR3 does not define what is considered to be an appropriate description to be reported. Providers will need to work with their payers to determine what the payers' requirements are for a description. In many cases, reporting the NDC code in SV202-7 is sufficient.

Example

A patient is given an injection in the emergency room of 5 mL of Lidocaine, which comes in a 5 mL vial of liquid.

Therefore:

- HCPCS: J3490 (Unclassified drugs)
- NDC: 00409-4270-01
- HCPCS unit: 1
- NDC quantity: 5
- Unit of measure: ML

The description reported in SV202-7 can be the NDC, name of the drug, or another description that provides adequate information to the receiver about the drug being

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reported. The bold and underline in the following examples highlight the options of reporting the NDC or the drug name as the description.

The following information for NDC is reported in the 837I:

Loop	Segment	Data Element	Data Reported
2400	SV2	SV202-1	HC
		SV202-2	J3490
		SV202-7	**00409427001**
		SV204	UN
		SV205	1
2410	LIN	LIN02	N4
		LIN03	00409427001
2410	CTP	CTP04	**5**
		CTP05-1	ML

OR:

Loop	Segment	Data Element	Data Reported
2400	SV2	SV202-1	HC
		SV202-2	J3490
		SV202-7	**Lidocaine 5 ml**
		SV204	UN
		SV205	1
2410	LIN	LIN02	N4
		LIN03	00409427001
2410	CTP	CTP04	**5**
		CTP05-1	ML

D. Compound Drugs

When reporting the administration of a compound drug, each drug component is reported on a separate service line. LIN02, LIN03, CTP04, and CTP05 data elements are reported for each component of the drug.

With a compound drug, the segment REF – Prescription or Compound Drug Association Number must also be reported. The situational rule requires this segment be reported when the dispensing of the drug was done with a prescription number or when the dispensed drug involves the compounding of two or more drugs and there is no prescription number. Additional TR3 notes explain that when a compound drug is reported, each component will have the same prescription number in order for the payer to match all components to the prescription. If there is

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no prescription number, a "link sequence number" is reported, which is a provider assigned number that is unique for the claim. The link sequence number matches the components, similar to the prescription number.

Example

A patient is given an injection of a compound drug that includes 10 mL of Drug A, which comes in a 10 mL vial of liquid, and 100 mg of Drug B, which is reconstituted from a 100 mg vial of powder.

Therefore:

- HCPCS: J3490 (Unclassified drugs)
- HCPCS unit: 1
- Drug A NDC: 11111-1111-11
- NDC quantity: 10
- Unit of measure: ML
- Drug B NDC: 22222-2222-22
- NDC quantity: 1
- Unit of measure : UN

The following information for NDC is reported in the 837I:

Loop	Segment	Data Element	Data Reported
2400	SV2	SV202-1	HC
		SV202-2	J3490
		SV202-7	**Compound drug**
		SV204	UN
		SV205	1
2410	LIN	LIN02	N4
		LIN03	11111111111
2410	CTP	CTP04	**10**
		CTP05-1	ML
	REF	REF01	VY
		REF02	123456
2400	SV2	SV202-1	HC
		SV202-2	J3490
		SV202-7	Compound drug
		SV204	UN
		SV205	1
2410	LIN	LIN02	N4
		LIN03	22222222222
2410	CTP	CTP04	**1**

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		CTP05-1	UN
	REF	REF01	VY
		REF02	123456

E. Examples of Denied Claims

The following examples show the transaction view of claims that have been denied for issues with NDC reporting.

Example 1

The following was denied because the NDC quantity and unit of measure were not included.

Loop	Segment	Data Element	Data Reported
2400	SV2	SV202-1	HC
		SV202-2	J2405
		SV204	UN
		SV205	1
2410	LIN	LIN02	N4
		LIN03	00173044202
2410	CTP	CTP04	
		CTP05-1	

Example 2

The following was denied because the NDC number format is incorrect.

Loop	Segment	Data Element	Data Reported
2400	SV2	SV202-1	HC
		SV202-2	J2405
		SV204	UN
		SV205	**2**
2410	LIN	LIN02	N4
		LIN03	00173044202
2410	CTP	CTP04	**1**
		CTP05-1	ML

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