CareSource

HIPAA Transaction Standard Companion Guide

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

Refers to the Implementation Guides based on ASC X12 version 005010X222

Companion Guide Version Number: 1.0

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.

Table of Contents

Introduction

This document is intended as a companion to the Health Care Claim: Professional (837) – ASC X12N/005010X222, 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 errata and IG documents “837 Professional A1” and “837 Professional” respectively, which are published by the Washington Publishing Company www.wpc-edi.com.

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.

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

Contact Information

- EDI Technical Assistance: EDIServices@caresource.com
- Provider Services Number: 1-800-488-0134
- Applicable Website: www.caresource.com

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

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.

Transaction Specific Information – 837 Health Care Claim: Professional

Page #	Loop ID	Reference	Name	Values	Length	Notes/Comments
C.3		ISA	**Interchange Control Header**			
C.4		ISA01	Authorization Information Qualifier	00	2	No Authorization Information Present
C.4		ISA03	Security Information Qualifier	00	2	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	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**			
C.7		GS01	Functional Identifier Code	HC	2	
C.7		GS02	Application Sender's Code	311143265	15	
C.7		GS03	Application Receiver's Code		15	Trading Partner's ID
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	005010X222A1	12	
70		ST	**Transaction Set Header**			Each ST/SE should contain only one claim
70		ST01	Transaction Set Identifier Code	837	3	
70		ST02	Transaction Set Control Number		9	

70		ST03	Implementation Guide Reference	005010X222A1	35	
71		BHT	**Beginning of Hierarchical Transaction**			
71		BHT01	Hierarchical Structure Code	0019	4	Information Source, Subscriber, Dependent
71		BHT02	Transaction Set Purpose Code	00	2	Original
72		BHT03	Submitter Transaction Identifier		50	CareSource Claim ID
72		BHT04	Transaction Set Creation Date		8	CCYYMMDD
72		BHT05	Transaction Set Creation Time		8	HHMM
72		BHT06	Transaction Type Code	RP	2	Reporting
74	1000A	NM1	**Submitter Name**			
74	1000A	NM101	Entity Identifier Code	41	3	
75	1000A	NM102	Entity Type Qualifier	2	1	
75	1000A	NM103	Organization Name		60	Use value “CareSource”
75	1000A	NM108	Identification Code Qualifier	46	2	
75	1000A	NM109	Identification Code	311143265	80	
76	1000A	PER	**Submitter EDI Contact Info**			
77	1000A	PER01	Contact Function Code	IC	2	Information Contact
77	1000A	PER02	Submitter Contact Name		60	“SERVICE CENTER”
77	1000A	PER03	Communication Number Qualifier	TE	2	Telephone
77	1000A	PER04	Communication Number		256	Current CareSource Email Address

77	1000A	PER05	Communication Number Qualifier	EM	2	Email
78	1000A	PER06	Communication Number		256	Current CareSource Phone Number
78	1000A	PER07	Communication Number Qualifier	TE	2	Telephone
78	1000A	PER08	Communication Number		256	Current CareSource Phone Number
79	1000B	NM1	**Receiver Name**			
79	1000B	NM101	Entity Identifier Code	40	3	Receiver
79	1000B	NM102	Entity Type Qualifier	2	1	Non-Person Entity
80	1000B	NM103	Organization Name		60	Receiver Name
80	1000B	NM108	Identification Code Qualifier	46	2	ETIN
80	1000B	NM109	Identification Code		80	Receiver Primary Identifier
81	2000A	HL	**Billing Provider Hierarchical Level**			
81	2000A	HL01	Hierarchical ID Number		12	
81	2000A	HL03	Hierarchical Level Code	20	2	Information Source
82	2000A	HL04	Hierarchical Child Code	1	1	
87	2010AA	NM1	**Billing Provider Name**			
88	2010AA	NM101	Entity Identifier Code	85	3	Billing Provider
88	2010AA	NM102	Entity Type Qualifier		1	
88	2010AA	NM103	Organization Name		60	Billing Provider Last Name or Organization Name
88	2010AA	NM104	Billing Provider First Name		35	

89	2010AA	NM105	Billing Provider Middle Name or Initial		25	
89	2010AA	NM108	Identification Code Qualifier	XX	2	Centers for Medicare and Medicaid Services NPI
90	2010AA	NM109	Identification Code		80	Billing Provider NPI
91	2010AA	N3	**Billing Provider Address**			
91	2010AA	N301	Billing Provider Address Line 1		55	
91	2010AA	N302	Billing Provider Address Line 2		55	
92	2010AA	N4	**Billing Provider City, State, Zip**			
92	2010AA	N401	City Name		30	
93	2010AA	N402	State		2	
93	2010AA	N403	Zip Code		15	
94	2010AA	REF	**Billing Provider Tax Identification**			
94	2010AA	REF01	Reference Id Qualifier	EI	3	Employer's Identification Number
94	2010AA	REF02	Reference Identification		50	Billing Provider Tax Identification Number
101	2010AB	NM1	**Pay-To Address Name**			
101	2010AB	NM101	Entity Identifier Code	87	3	Pay-To Provider
102	2010AB	NM102	Entity Type Qualifier	2	1	1 = Person 2 = Non-Person Entity
103	2010AB	N3	**Pay-To Address (Billing Provider)**			This may be the same value as the billing provider address. There is a backlog

						item to address duplication.
103	2010AA	N301	Pay-To Provider Address Line 1		55	
103	2010AA	N302	Pay-To Provider Address Line 2		55	
104	2010AA	N4	**Pay-To City, State, Zip**			
104	2010AA	N401	City Name		30	
105	2010AA	N402	State		2	
105	2010AA	N403	Zip Code		15	
114	2000B	HL	**Subscriber Hierarchical Level**			
114	2000B	HL01	Hierarchical ID Number		12	
115	2000B	HL02	Hierarchical Parent ID		12	
115	2000B	HL03	Hierarchical Level Code	22	2	Subscriber
115	2000A	HL04	Hierarchical Child Code	0	1	No Subordinate HL Segment in This Hierarchical Structure
116	2000B	SBR	**Subscriber Information**			
116	2000B	SBR01	Payer Responsibility Seq Number Code		1	
117	2000B	SBR02	Individual Relationship Code	18	2	18 = Self
117	2000B	SBR03	Reference Identification	Group ID	50	Subscriber Group or Policy Number
117	2000B	SBR04	Name		60	Subscriber Group Name
117	2000B	SBR05	Insurance Type Code		3	

118	2000B	SBR09	Claim Filing Indicator Code		2	
121	2010BA	NM1	**Subscriber Name**			
121	2010BA	NM101	Entity Identifier Code	IL	3	Insured or Subscriber
122	2010BA	NM102	Entity Type Qualifier		1	1 = Person
122	2010BA	NM103	Last Name		60	Subscriber Last Name
122	2010BA	NM104	First Name		35	Subscriber First Name
122	2010BA	NM105	Middle Name		25	Subscriber Middle Name or Initial
122	2010BA	NM108	Identification Code Qualifier	MI	2	Member Identification Number
123	2010BA	NM109	Identification Code		80	Subscriber Primary Identifier
124	2010BA	N3	**Subscriber Address**			
124	2010BA	N301	Subscriber Address Line 1		55	
124	2010BA	N302	Subscriber Address Line 2		55	
125	2010BA	N4	**Subscriber City, State, Zip**			
125	2010BA	N401	City Name		30	
125	2010BA	N402	State		2	
126	2010BA	N403	Zip Code		15	
127	2010BA	DMG	**Subscriber Demographic Info**			
127	2010BA	DMG01	Date Time Period Qualifier	D8	3	
127	2010BA	DMG02	Date Time Period		35	Subscriber Birth Date
128	2010BA	DMG03	Gender Code		1	
133	2010BB	NM1	**Payer Name**			
133	2010BB	NM101	Entity Identifier Code	PR	3	Payer

134	2010BB	NM102	Entity Type Qualifier	2	1	Non-Person Entity
134	2010BB	NM103	Organization Name		60	CareSource Market Name
134	2010BB	NM108	Identification Code Qualifier	PI	2	Payor Identification
134	2010BB	NM109	Identification Code		80	CareSource payer identifier by LOB
135	2010BB	N3	**Payer Address**			
135	2010BA	N301	Payer Address Line 1		55	
135	2010BA	N302	Payer Address Line 2		55	
136	2010BA	N4	**Payer City, State, Zip**			
136	2010BA	N401	City Name		30	
136	2010BA	N402	State		2	
137	2010BA	N403	Zip Code		15	
157	2300	CLM	**Claim Information**			
158	2300	CLM01	Claim Submitter's Identifier		38	Patient Control Number
159	2300	CLM02	Monetary Amount		18	Total Claim Charge Amount
159	2300	CLM05-1	Facility Code Value		2	Place Of Service Code
159	2300	CLM05-2	Facility Code Qualifier	B	2	Place Of Service Codes
159	2300	CLM05-3	Claim Frequency Type Code	1 = Original 7 = Corrected	1	Claim Frequency Code
159	2300	CLM06	Yes/No Condition or Response Code		1	Provider or Supplier Signature Indicator
160	2300	CLM07	Provider Accept Assignment Code		1	Assignment or Plan Participation Code
160	2300	CLM08	Yes/No Condition or Response Code		1	Benefits Assignment Certification Indicator

161	2300	CLM09	Release of Information Code		1	
161	2300	CLM10	Patient Signature Source Code	P	1	
161	2300	CLM11-1	Related-Causes Code		3	Related Causes Code
162	2300	CLM11-2	Related-Causes Code		3	Related Causes Code
162	2300	CLM11-4	State		2	
162	2300	CLM12	Special Program Code		3	Special Program Indicator
163	2300	CLM20	Delay Reason Code		2	
194	2300	REF	**Prior Authorization**			
194	2300	REF01	Reference Id Qualifier	G1	3	G1 = Prior Authorization Number
195	2300	REF02	Reference Identification		50	Prior Authorization Number
196	2300	REF	**Payer Claim Control Number**			Used on corrected or adjusted claims to reflect the previous claim id.
196	2300	REF01	Reference Id Qualifier	F8	3	F8 = Original Reference Number
196	2300	REF02	Reference Identification		50	Payer Claim Control Number
202	2300	REF	**Claim Identification for Transmission Intermediaries**			
202	2300	REF01	Reference Id Qualifier	D9	3	
203	2300	REF02	Reference Identification		20	Value Added Network Trace Number
207	2300	K3	**File Information**			
208	2300	K301	Fixed Format Information		80	
226	2300	HI	**Health Care Diagnosis Code**			

226	2300	HI01-1	Code List Qualifier Code	ABK	3	ICD-10-CM Principle Diagnosis
227	2300	HI01-2	Industry Code		30	Diagnosis Code
227	2300	HI02-1	Code List Qualifier Code	ABF	3	ICD-10-CM Diagnosis
227	2300	HI02-2	Industry Code		30	Diagnosis Code
***	*2300*	*****	*HI03 through HI12 are possible situational elements but are not all shown here*	*****	***	Same structure as HI02
257	2310A	NM1	**Referring Provider Name**			
258	2310A	NM101	Entity Identifier Code	DN	3	DN = Referring Provider
258	2310A	NM102	Entity Type Qualifier	1	1	1 = Person
258	2310A	NM103	Last Name or Organization Name		60	Referring Provider Last Name
258	2310A	NM104	First Name		35	Referring Provider First Name
258	2310A	NM105	Middle Name		25	Referring Provider Middle Name or Initial
259	2310A	NM108	Identification Code Qualifier	XX	2	Only used when NM109 is valued.
259	2310A	NM109	Identification Code		80	NPI
262	2310B	NM1	**Rendering Provider Name**			
263	2310B	NM101	Entity Identifier Code	82	3	82 = Rendering Provider
263	2310B	NM102	Entity Type Qualifier		1	
263	2310B	NM103	Last Name or Organization Name		60	Rendering Provider Last Name
263	2310B	NM104	First Name		35	Rendering Provider First Name
263	2310B	NM105	Middle Name		25	Rendering Provider Middle Name or Initial

264	2310B	NM108	Identification Code Qualifier	XX	2	
264	2310B	NM109	Identification Code		80	NPI
265	2310B	PRV	**Rendering Provider Specialty Information**			
265	2310B	PRV01	Provider Code	PE	3	Performing
265	2310B	PRV02	Reference Id Qualifier	PXC	3	Health Care Taxonomy Code
265	2310B	PRV03	Reference Identification		50	Provider Taxonomy Code
269	2310C	NM1	**Service Facility Location Name**			
270	2310C	NM101	Entity Identifier Code	77	3	77 – Service Location
270	2310C	NM102	Entity Type Qualifier	2	1	Non-Person Entity
270	2310C	NM103	Last Name or Organization Name		60	Laboratory or Facility Name
270	2310C	NM108	Identification Code Qualifier	XX	2	Centers for Medicare and Medicaid Services NPI
271	2310C	NM109	Identification Code		80	Laboratory or Facility Primary Identifier
272	2310C	N3	**Service Facility Location Address**			
272	2310C	N301	Service Facility Address Line 1		55	
272	2310C	N302	Service Facility Address Line 2		55	
273	2310C	N4	**Service Facility Location City, State, Zip**			
273	2310C	N401	City Name		30	
274	2310C	N402	State		2	
274	2310C	N403	Zip Code		15	

292	2310F	N3	**Ambulance Drop-off Address Line**			
351	2400	SV1	**Professional Service**			
352	2400	SV101-1	Product/Service ID Qualifier		2	Product or Service ID Qualifier
353	2400	SV101-2	Product/Service ID		48	Procedure Code
353	2400	SV101-3	Procedure Modifier		2	Up to 4 optional modifers.
353	2400	SV101-4	Procedure Modifier		2	Up to 4 optional modifers.
353	2400	SV101-5	Procedure Modifier		2	Up to 4 optional modifers.
354	2400	SV101-6	Procedure Modifier		2	Up to 4 optional modifers.
354	2400	SV101-7	Description		80	
354	2400	SV102	Monetary Amount		18	Line Item Charge Amount
355	2400	SV103	Unit or Basis for Measurement Code		2	MJ = Minutes UN = Unit
355	2400	SV104	Quantity		15	Service Unit Count
355	2400	SV105	Facility Code		2	Place Of Service Code
356	2400	SV107-1	Diagnosis Code Pointer		2	Primary Diagnosis
356	2400	SV107-2	Diagnosis Code Pointer		2	Second Diagnosis
356	2400	SV107-3	Diagnosis Code Pointer		2	Third Diagnosis
356	2400	SV107-4	Diagnosis Code Pointer		2	Fourth Diagnosis
357	2400	SV109	Yes/No Condition or Response Code	Y	1	Emergency Indicator
357	2400	SV111	Yes/No Condition or Response Code	Y	1	EPSDT Indicator
357	2400	SV112	Yes/No Condition or Response Code	Y	1	Family Planning Indicator
358	2400	SV115	Copay Status Code	0	1	0 = Copay Exempt

380	2400	DTP	**Service Date**			
380	2400	DTP01	Date/Time Qualifier	472	3	472 = Service Date
380	2400	DTP02	Date Time Period Format Qualifier	D8/RD8	3	
381	2400	DTP03	Date Time Period		35	Service Date or Range
401	2400	REF	**Line Item Control Number**			
401	2400	REF01	Reference Id Qualifier	6R	3	Provider Control Number
402	2400	REF02	Reference Identification		50	Line Item Control Number
416	2400	HCP	**Line Pricing/Repricing Information**			
417	2400	HCP01	Pricing Methodology		2	
417	2400	HCP02	Monetary Amount		18	Repriced Allowed Amount
496		SE	**Transaction Set Trailer**			
496		SE01	Transaction Segment Count		10	
496		SE02	Transaction Set Control Number		9	Must match ST02
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 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.

This companion guide will not further address when NDC needs to be reported. Instead, it will address how to report NDC when it is required.

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

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 NCPDP	837 Transaction Unit of Measure 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 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.

V. Reporting NDC in Professional Claims

A. Data Requirements

SV1 is where the drug procedure code is reported. Qualifier “HC” in SV101-1 indicates that the procedure code is a HCPCS or Current Procedural Terminology

(CPT®) code. The actual procedure code is reported in SV101-2. SV103 is the qualifier for the procedure units and SV104 is where the procedure units are reported. All of the SV1 data elements for reporting drug procedure code information are required.
The Drug Information (LIN) segment is situational and is required to be reported when federal or state regulations mandate that the drugs or biologics be reported with NDC. Providers or submitters may also report NDC when it 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.

B. Examples

Example 1
A patient is given an injection in the physician's office of 500 mg Ampicillin sodium, which is reconstituted from a 500 mg vial of powder.

Therefore:

- HCPCS: J0290 (Injection, Ampicillin sodium, 500 mg)
- NDC: 00781-9407-78
- HCPCS unit: 1
- NDC quantity: 1
- Unit of measure: UN

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

Loop	Segment	Data Element	Data Reported
2400	SV1	SV101-1	**HC**
		SV101-2	J0290
		SV103	UN
		SV104	1
2410	LIN	LIN02	N4
		LIN03	00781940778
2410	**CTP**	CTP04	1
		CTP05-1	UN

Example 2

A patient is given an injection in the physician's office of 250 mg Ampicillin sodium, which is reconstituted from a 500 mg vial of powder.

Therefore:
- HCPCS: J0290 (Injection, Ampicillin sodium, 500 mg)
- NDC: 00781-9407-78
- HCPCS unit: 1
- NDC quantity: 0.5
- Unit of measure: UN

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

Loop	Segment	Data Element	Data Reported
2400	SV1	SV101-1	HC
		SV101-2	J0290
		SV103	UN
		SV104	1
2410	**LIN**	LIN02	N4
		LIN03	63323031110
2410	CTP	CTP04	0.5
		CTP05-1	UN

Example 3

A patient is given an injection in the physician's office of 10 mL of calcium gluconate, which comes in a 10 mL vial of liquid.

Therefore:

- HCPCS: J0610 (Injection, calcium gluconate, per 10 mL)
- NDC: 63323-0311-10
- HCPCS unit: 1
- NDC quantity: 10
- Unit of measure: ML

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

Loop	Segment	Data Element	Data Reported
2400	SV1	SV101-1	HC
		SV101-2	J0610
		SV103	UN
		SV104	1
2410	LIN	LIN02	N4
		LIN03	63323031110
2410	CTP	CTP04	10
		CTP05-1	ML

Example 4

A patient is given an injection in the physician's office of 45 mg of Stelara, which comes in a 45 mg/0.5 mL syringe.
Therefore:

- HCPCS: J3357 (Injection, ustekinumab, 1 mg)
- NDC: 57894-0060-03
- HCPCS unit: 45
- NDC quantity: 0.5
- Unit of measure: ML

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

Loop	Segment	Data Element	Data Reported
2400	SV1	SV101-1	HC
		SV101-2	J3357
		SV103	UN
		SV104	1
2410	LIN	LIN02	N4
		LIN03	63323031110
2410	CTP	CTP04	10
		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 SV101-7 (Description). The situational rule for SV101-7 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. The description can be the NDC or a description of the drug. See ASC X12 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 SV101-7 is sufficient.

Example

A patient is given an injection in the physician's office of 500 mg of Aloprim, which is reconstituted from a 500 mg vial of powder.
Therefore:

- HCPCS: J3490 (Unclassified drugs)
- NDC: 67457-0187-50
- HCPCS unit: 1
- NDC quantity: 1

- Unit of measure: UN

The description reported in SV101-7 can be the NDC, name of the drug, or another description that provides adequate information to the receiver about the drug being 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 837P:

Loop	Segment	Data Element	Data Reported
2400	SV1	SV101-1	HC
		SV101-2	J3490
		SV101-7	67457018750
		SV103	UN
		SV104	1
2410	LIN	LIN02	N4
		LIN03	67457018750
2410	CTP	CTP04	1
		CTP05-1	UN

Or:

Loop	Segment	Data Element	Data Reported
2400	SV1	SV101-1	HC
		SV101-2	J3490
		SV101-7	**Aloprim**
		SV103	UN
		SV104	1
2410	LIN	LIN02	N4
		LIN03	67457018750
2410	CTP	CTP04	1
		CTP05-1	UN

B. 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 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 in the physician’s office for reprogramming and refill of an implantable pain pump. The compound drug includes 200 mg Hydromorphone USP (drug A), 500 mg Bupivacaine USP (drug B), and 33.3 mg Baclofen USP (drug C), which are all measured by weight.

Therefore:

- HCPCS: J3490 (Unclassified drugs)
- HCPCS unit: 1
- Drug A NDC: 38779-0524-05
- NDC quantity: 0.5
- Unit of measure: GR
- Drug B NDC: 38779-0731-04
- NDC quantity: 0.2
- Unit of measure : GR
- Drug C NDC: 38779-0388-04
- NDC quantity: 0.033
- Unit of measure : GR

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

Loop	Segment	Data Element	Data Reported
2400	SV1	SV101-1	HC
		SV101-2	J3490
		SV101-7	Hydromorphone NDC 38779052405
		SV103	UN
		SV104	1
2410	LIN	LIN02	N4
		LIN03	38779052405
2410	CTP	CTP04	0.5
		CTP05-1	GR
	REF	REF01	VY
		REF02	123456789
2400	SV1	SV101-1	HC
		SV101-2	J3490
		SV101-7	Bupivacaine

			NDC 38779073104
		SV103	UN
		SV104	1
2410	LIN	LIN02	N4
		LIN03	38779073104
2410	CTP	CTP04	0.2
		CTP05-1	GR
	REF	REF01	VY
		REF02	123456789
2400	SV1	SV101-1	HC
		SV101-2	J3490
		SV101-7	Baclofen NDC 38779038804
		SV103	UN
		SV104	1
2410	LIN	LIN02	N4
		LIN03	38779073104
2410	CTP	CTP04	0.033
		CTP05-1	GR
	REF	REF01	VY
		REF02	123456789

E. 837P 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 quantity was not included.

Loop	Segment	Data Element	Data Reported
2400	SV1	SV101-1	HC
		SV101-2	J3490
		SV103	UN
		SV104	1
2410	LIN	LIN02	N4
		LIN03	00004035239
2410	CTP	CTP04	
		CTP05-1	UN

Example 2

The following was denied because the unit of measure was not indicated in the CTP segment.

Loop	Segment	Data Element	Data Reported
2400	SV1	SV101-1	HC
		SV101-2	J3490
		SV103	UN
		SV104	1
2410	LIN	LIN02	N4
		LIN03	00517888005
2410	CTP	CTP04	1
		CTP05-1	