Vaya Health

Data Clarifications for the 837 Professional Claim, V. 5010

This document is intended as a **companion** to the **National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Claim: Professional, ASC X12N 837 (005010X222A1)**. It contains data clarifications authorized by Vaya Health. Clarifications include:

- Identifiers to use when a national standard has not been adopted
- Parameters in the implementation guide that provide options

Implementation guides may be found at the Washington Publishing Company's website at www.wpc-edi.com, for current HIPAA transaction standards for the 837, Health Care Claim: Professional (ASC X12N, version **005010X222A1**).

Critical additional notes

You are responsible for keeping track of your file names and contents.

This document specifically does not address every data element, whether required or optional, nor every scenario nor situation that the National Implementation Guides address. It is vital that you, your software vendor, or claim service provider conform to the specifications as detailed in the National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Claim: Professional. The purpose of this document is to assist you in the proper completion for submission to Vaya Health. Information provided in this guide is subject to change.

Acknowledgements

A 999 Acknowledgement report will be sent to the trading partner's DOWNLOAD area for retrieval. This report serves as the acknowledgement of the submission of a file. Typically, 999 Acknowledgement reports are available within moments of submission.

Effective April 1st, 2013, if the information associated with any of the claims in the 837P ST-SE batch is not correctly formatted from a syntactical perspective; all claims between the ST-SE will be rejected.

If you have questions or need additional assistance, contact EDI@vayahealth.com.

Page	Loop	Segment	Data Element	Comments
	Header	ISA	ISA03	Use “00” – no security information present.
			ISA05	Use “ZZ” – mutually defined.
			ISA06	Use the provider number assigned to you by Vaya Health.
			ISA07	Use “ZZ” – mutually defined.
			ISA08	Use “13010.”
	Header	GS	GS02	Use submitter ID/mailbox number issued by Vaya Health. This is the same valueprovided in the ISA06.
			GS03	Use “13010.”
	1000A		NM108	Use “46” – Electronic Transmitter Identification Number (ETIN) established by a trading partner agreement.
			NM109	Use provider number assigned to you by Vaya Health. This is the same value as provided in the ISA06.
	1000B	NM1	NM103	Use “Vaya Health”
			NM109	Use “13010”
	2000A	PRV	PRV01	Use “BI” to indicate billing provider.
			PRV02	Use qualifier “PXC” – Health Care Provider Taxonomy Code. Note: Not required for atypical providers.
			PRV03	Provider Taxonomy Codes, as maintained by the National Uniform Claim Committee, are available at http://www.wpc-edi.com/reference/codelists/healthcare/health-care-provider-taxonomy-code-set/. Submit the provider taxonomy that best fits provider type and specialty for the billing provider.
	2000B	SBR	SBR09	Use "11" for state claims, or use “MC” for Medicaid.
	2010BA	NM1	NM102	Use “1” to indicate the subscriber is a person.
			NM108	Use “MI” – Member Identification Number Qualifier.
			NM109	Enter the member’s six-digit identification number assigned by Vaya Health or the Medicaid ID for Medicaid clients.
	2010BB	NM1	NM108	Use "PI."
			NM109	Use “13010.”
		REF	REF01	Use “G2” to report atypical provider data.
			REF02	Used by atypical providers to report Medicaid provider number
	2300	DTP		This segment is used to report date of first treatment/date first seen: DTP*454*D8*20120101~
		PWK	PWK01	Submit OZ – Support Data for Claim – only to be used in combination with PWK02 to indicate Medicare does not cover the service submitted; follow rules of implementation guide for other claim paperwork.
			PWK02	Submit “AA” – Available on Request at Provider Site – only to be used to indicate Medicare does not cover the service. N.C. DMA billing instructions for Medicare overrides, or Medicare voucher indicating the service was not covered by Medicare. must be kept on file at the provider’s site. Follow rules of implementation guide for other claim paperwork.
		CRC	CRC03	Use to report EPSDT, Health Check, referral status.
			CRC04	Use to report EPSDT, Health Check, referral status.
			CRC05	Use to report EPSDT, Health Check, referral status.
	2310A	NM		Use to report Carolina Access primary care provider, local management entity or a psychiatrist authorization information, as required by DMA policy.
	2310A	NM	NM103	When referring provider is a group or office, please provide name of organization as the provider last name or UNKNOWN.
			NM109	For N.C. Medicaid, this element is used to report the NPI of the Carolina ACCESS primary care provider, local management entity or psychiatrist.
		REF		For N.C. Medicaid, used to report Carolina Access Override information when required
			REF01	For N.C. Medicaid, use a value of “G2” to report Carolina Access Override number.
			REF02	For N.C. Medicaid, use Carolina Access issued override number.
	2310B	REF	REF01	Use “G2” to report atypical provider data.
			REF02	Use the N.C. Medicaid issued provider number.
	2320	AMT	AMT01	Uses “D” – Payer Amount qualifier code in this AMT segment; no other qualifiers used in claims processing.
			AMT02	Enter the amount collected from private insurance.
	2400	SV1	SV101-01	Use “HC” – HCFA HCPC Codes.
	2410	LIN		This loop is required when submitting a drug-related HCPCS procedure code.
			LIN03	Enter the national drug code in this field, when applicable.
		CTP	CTP04	Enter the numeric quantity in this field
			CTP05-1	Enter the unit of measurement that corresponds to the value entered in the CTP04.
		REF	REF01	Use “VY” for a link sequence number of the compound drug.
			REF02	Only the first ten bytes of the reference number will be used.
	2420A		REF01	Use “G2” when billing for atypical providers.
			REF02	Used by atypical providers to report Medicaid-issued provider number