

eMedNY

**New York State Department of
Health Office of Health
Insurance Programs**

**837 Professional Health Care
Claim: Supplemental
Companion Guide**

NPI EDITION

eMedNY

HIPAA V4010X098A1 837: Health Care Claim: Professional

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COMPANION GUIDE DISCLAIMER:

The New York State Department of Health (NYSDOH) has provided this Medicaid Supplemental Companion Guide for the 837 Professional Transaction, Addendum version (ASC X12N 004010X098A1) for use by Providers, Clearinghouses and all Covered Entities who are Trading Partners of NYSDOH and the New York State Medicaid Program. NYSDOH has focused primarily on the rules and policies regulating the submission of NYS Medicaid data as specified within this Supplemental Companion Guide and the NYSDOH 837 Professional Companion Guide. NYSDOH has provided this document with related information at <http://www.nyhipaadesk.com> as a resource to assist Providers and other Trading Partners in preparing HIPAA compliant electronic transactions in accordance with the program requirements of NYS Medicaid. NYSDOH does not offer individual training in the use of the ASC X12N transactions.

The information provided herein is believed to be true and correct based on the Addendum Version of the HIPAA guidelines. HIPAA regulations are continuing to evolve, therefore NYSDOH makes no guarantee, expressed or implied, as to the accuracy of the information provided herein. Furthermore, this is a living document and the information provided herein is subject to change as NYSDOH policy changes or as HIPAA legislation is updated or revised.

CG MODIFICATION TRACKING:

>V3.1

- 12/29/2008 Minor rewording of Cost Avoidance/Zero Fill section.
- 08/11/2008 Revised National Provider Identifier section of front matter and all "Provider" sections to reflect the eMedNY system requirements after NPI implementation.

>V3.0

- 12/18/2007 Changed "CHAP" to "SCHIP" to reflect renamed State Children's Health Insurance Program.
- 09/18/2007 Removed phone system options information from NYS Medicaid Note in front matter, leaving the call center 800 number. Added note to refer to Technical Supplementary Guide.
- 08/16/2007 Added the location of the 0FILL data, in addition to the note already present, in the section on Zero Fill. Also added note on what to send when claim is not eligible for Zero Fill.
- 03/14/2007 Added information to refer to the Technical Supplementary Companion Guide in NYS Medicaid Notes in the front matter.
- 02/05/2007 Changed title to reflect new name for NYSDOH Office of Health Insurance Programs, removed "NPI Edition" from title.

>V2.2

- 01/22/2007 – Significant rewording of NPI section to state that the eMedNY system will not be ready to receive the NPI as the primary provider identifier by the Compliance Date of May 23, 2007.
- 01/18/2007 – Modified text in Claim Filing Indicator Code section, added information about Medicare HMO coverage. Also renamed the section
- 10/30/2006 Added Specialty Code 192 to table in "Service Authorization Exception Codes" section
- 10/06/2006 Corrected date in NPI section
- 06/13/2006 Minor rewording in Disclaimer.
- 05/23/2006 Modified NYS Medicaid Note in front matter to state that for batch submission of Professional claims NYSDOH requires the 837P.
- 03/23/2006 Clarified Coordination of Benefits balancing in the CAS segment section
- 03/17/2006 Added new "National Provider Identifier (NPI)" section with critical information for sending NPI and related information prior to the Compliance Date of May 23, 2007

>V2.1

- 11/16/2005 Removed "Differences between Phase I and Phase II" section from front matter
- 10/31/2005 Added references to Non-emergency Transportation CG.
- 10/28/2005 Added more detailed information about identifying a Supervising Provider by a medical license number.
- 09/23/2005 Updated support phone numbers in front matter, removed "Draft"
- 04/20/2005 Added note about 16-digit TCN number to CG Modification Tracking. Added note about using TCN in voids and adjustments; and added note about retrieving TCN using 276/277 to NYS Medicaid Note in front matter. Corrected out-of-state Institutional Unit phone number.

NYS MEDICAID NOTE:

This Supplemental Companion Guide (CG), which is provided by the New York State Department of Health (NYSDOH), outlines instructions specific to Providers who utilize the 837 Professional Healthcare Claim (837P). The document includes a listing of the various code sets that are used by to the NYS Medicaid claims processing system. As an aid to developers and programmers using this CG, technical references have been added to serve as pointers to specific areas of the 837P Companion Guide (Ex. Loop-ID 2300, CLM05). NYSDOH will provide crosswalks of MMIS to HIPAA codes in this CG Supplemental, for those fields/elements that require translation.

This Supplemental Companion Guide does not modify the standards; rather, it puts forth the subset of information from the

Implementation Guide (IG) that will be required for processing transactions. It is important that Providers use this document as a supplement to the 837P Companion Guide, which itself is a supplement of the 837P Implementation Guide (IG).

Voids and adjustments to previous claims require the Transaction Control Number (TCN) from the remittance advice. The TCN can also be retrieved by submitting a 276 transaction and receiving a 277.

The New York State Department of Health (NYSDOH) requires batch submission of claims for Medicaid-covered professional services to be conducted in standard electronic format as per the specifications described in the 837 Professional Companion Guide and in this 837 Professional Supplemental Companion Guide.

SUPPORT

Please refer to the Technical Supplementary Companion Guide for information about transaction header structures, transaction size limits, electronic communications methods, and enrollment as a trading partner. This document is available for download at nyhipaadesk.com.

For further assistance, NYSDOH and its fiscal agent, Computer Sciences Corporation (CSC), are urging providers to visit a web community, <https://www.nyhipaadesk.com/>, which will provide Companion Guide updates and other pertinent information. In addition, questions may be sent to NYSDOH's Test Support Team at nyhipaadesk@csc.com.

Providers with questions may call the eMedNY Call Center at: 1-800-343-9000.

Please be advised that Unit representatives will only answer questions related to New York Medicaid HIPAA requirements.

The ASC X12N Implementation Guides and their associated addenda are available in electronic format at: www.wpc-edi.com/hipaa. Pharmacy Providers can acquire the NCPDP Implementation Guide from www.ncdp.org.

1. Submitter Name:

The first entity identified in the transaction is the Submitter, identified in the Submitter Name segment (Loop-ID 1000A, NM1 where NM101='41' and NM102='1' or '2'). NYSDOH will return the Remittance Advice (RA) to the Submitter identified by Electronic Transmitter Identification Number (ETIN, formerly referred to as TSN) at NM109. This ETIN may differ from the one reported in the ISA and GS segments. The Submitter is not a Provider in all cases. The Submitter may be an intermediary contracted for billing purposes, such as a service bureau or clearinghouse.

2. National Provider Identifier (NPI)

AS OF THE PUBLICATION DATE OF THIS DOCUMENT THE EMEDNY SYSTEM IS SCHEDULED FOR NPI IMPLEMENTATION ON SEPTEMBER 1, 2008. ALL NYS MEDICAID PROVIDERS WHO ARE HEALTH CARE PROVIDERS ARE REQUIRED TO VISIT EMEDNY.ORG TO REGISTER THEIR NPI(S) AS SOON AS POSSIBLE.

For information about the requirements for reporting NPI, refer to the NYS Medicaid Notes for the NM1 segments of each loop at levels 2310 and 2420 in the 837 Professional: Health Care Claim Companion Guide. Note that after the eMedNY system's NPI implementation the NPI must be used to identify all health care providers reported in the claim, with the sole exception of the Referring Provider, who may be identified by NYS Medicaid Provider ID or License Number, only if the NPI is not available. However, every effort should be made to use the NPI of the Referring Provider when applicable.

3. Provider(s) Identified in the 837 Professional Transaction:

Professional healthcare claims submitted on an 837P can include information about a variety of providers. To successfully submit Professional claims to NYSDOH, care must be taken to include all loops and segments required for processing NYS Medicaid claims.

Billing Provider Name:

NYSDOH requires the Billing Provider to be identified in the Billing Provider Name loop (Loop-ID 2010AA, starting with NM1 where NM101='85'). By default the Billing Provider is also processed as the Servicing Provider, unless the Rendering Provider Name loop is sent.

NYSDOH encourages providers to send the NPI in this location. During the period leading up to the eMedNY NPI implementation, the Billing Provider Name NM1 segment that starts loop 2010AA will be accepted with the following Identifiers and Qualifiers:

- NPI (NM108 will contain a Qualifier of 'XX' and NM109 will contain the Billing Provider's NPI), or
- Employer ID Number (NM108 will contain a Qualifier of '24' and NM109 will contain the Billing Provider's Employer ID Number), or
- Social Security Number (NM108 will contain a Qualifier of '34' and NM109 will contain the Billing Provider's Social Security Number).

AFTER NPI IMPLEMENTATION THE NATIONAL PROVIDER IDENTIFIER (NPI) IN THE BILLING PROVIDER NAME NM1 SEGMENT WILL BE REQUIRED,

A professional group's identifiers should not be reported in the Billing Provider Name loop. If payment is to be made to a group provider the group should be identified in the Pay-to Provider Name Loop (Loop-ID 2010AB, starting with NM1 where NM101='87').

The Billing Provider will be overridden in the claims processing system under certain circumstances, as discussed below under the Rendering Provider section. This will not affect payment, which will be made to the Pay-to Provider, but it will affect Claim Status Inquiry and claims inquiry by eMedNY Call Center staff.

Billing Provider Secondary Identification:

Prior to the eMedNY NPI implementation, NYSDOH will continue to require a valid NYS Medicaid Provider ID and Locator Code, belonging to the Billing Provider, to satisfy the business requirements for NYS Medicaid in processing a claim. Two iterations of the Billing Provider Secondary Identification REF segment must be sent with the following Identifiers and Qualifiers:

- NYS Medicaid Provider ID (REF01 will contain a Qualifier of '1D' and REF02 will contain the Billing Provider's Provider ID), and
- Locator Code (REF01 will contain a Qualifier of 'LU' and REF02 will contain the Locator Code for the service location).

AFTER NPI IMPLEMENTATION THERE MUST BE AN ITERATION OF THE BILLING PROVIDER SECONDARY IDENTIFICATION REF SEGMENT WITH:

- Employer ID Number (Qualifier 'EI' in REF01 and the EIN in REF02), or
- Social Security Number (Qualifier 'SY' in REF01 and the SSN in REF02), or
- Federal Taxpayer ID Number (Qualifier 'TJ' in REF01 and the TIN in REF02).

Note that the Qualifiers used in the REF segment are different than the ones used in NM1.

During the initial period following NPI implementation, the NYS Medicaid Provider ID and Locator Code will continue to be accepted, but will not be required, in iterations of the REF segment. This does not affect the requirement to send the EIN, SSN, or Taxpayer ID Identifier and Qualifier. Note that the value sent for these identifiers is not used for claims processing or for tax reporting purposes, since this information is maintained in the system as part of the provider enrollment and maintenance process.

Pay-to Provider Name:

NYSDOH expects to receive the Pay-to Provider loop (Loop-ID 2010AB, starting with NM1 where NM101='87') when payment is to go to a professional group rather than to the individual provider. When loop 2010AB is sent, the Pay-to Provider is processed as the Group Provider.

NYSDOH encourages providers to send the NPI in this location. During the period leading up to the eMedNY NPI implementation, the Pay-to Provider Name NM1 segment that starts loop 2010AB will be accepted with the following Identifiers and Qualifiers:

- NPI (NM108 will contain a Qualifier of 'XX' and NM109 will contain the Pay-to Provider's NPI), or
- Employer ID Number (NM108 will contain a Qualifier of '24' and NM109 will contain the Pay-to Provider's Employer ID Number).

AFTER NPI IMPLEMENTATION THE NATIONAL PROVIDER IDENTIFIER (NPI) IN THE BILLING PROVIDER NAME NM1 SEGMENT WILL BE REQUIRED,

Pay-to Provider Secondary Identification:

Prior to the eMedNY NPI implementation, NYSDOH will continue to require the NYS Medicaid Group Provider ID of the Pay-to Provider. An iteration of the Pay-to Provider Secondary Identification REF segment must be sent with:

- NYS Medicaid Provider ID (REF01 will contain a Qualifier of '1D' and REF02 will contain the Pay-to Provider's Provider ID).

AFTER NPI IMPLEMENTATION THERE MUST BE AN ITERATION OF THE PAY-TO PROVIDER SECONDARY IDENTIFICATION REF SEGMENT WITH:

- Employer ID Number (Qualifier 'EI' in REF01 and the EIN in REF02), or
- Federal Taxpayer ID Number (Qualifier 'TJ' in REF01 and the TIN in REF02).

Note that the Qualifiers used in the REF segment are different than the ones used in NM1.

During the initial period following NPI implementation, the NYS Medicaid Provider ID will continue to be accepted, but will not be required, in an iteration of the REF segment. This does not affect the requirement to send the EIN or Federal Taxpayer ID Identifier and Qualifier.

Rendering Provider Name:

By default the Rendering Provider is processed as the Servicing Provider. The Rendering Provider Name loop (Loop-ID 2310B) is indicated by use of a Qualifier in the Rendering Provider Name NM1 segment (NM101='82'). The Rendering Provider Name loop at the claim level is required by the 837 Professional Implementation Guide whenever the Pay-to Provider Name loop (Loop-ID 2010AB) is sent, in order to specify whether the Billing Provider or the Pay-to Provider rendered the services. Additionally, NYSDOH expects the Rendering Provider loop in certain cases, including claims for eye care and for physician's assistant claims.

NYSDOH encourages providers to send the NPI in this location. During the period leading up to the eMedNY NPI implementation, the Rendering Provider Name NM1 segment that starts loop 2310B will be accepted with the following Identifiers and Qualifiers:

- NPI (NM108 will contain a Qualifier of 'XX' and NM109 will contain the Rendering Provider's NPI), or
- Employer ID Number (NM108 will contain a Qualifier of '24' and NM109 will contain the Rendering Provider's Employer ID Number), or
- Social Security Number (NM108 will contain a Qualifier of '34' and NM109 will contain the Rendering Provider's Social Security Number).

AFTER NPI IMPLEMENTATION THE NATIONAL PROVIDER IDENTIFIER (NPI) IN THE RENDERING PROVIDER NAME NM1 SEGMENT WILL BE REQUIRED WHEN THE RENDERING PROVIDER IS SENT,

Rendering Provider Secondary Identification:

Prior to the eMedNY NPI implementation, if the Rendering Provider Name loop is sent, NYSDOH will continue to require in most cases (when the Rendering Provider is not the Billing Provider) a valid NYS Medicaid Provider ID or formatted License Number, belonging to the Rendering Provider, to satisfy the business requirements for NYS Medicaid in processing a professional claim. An iteration of the Rendering Provider Secondary Identification REF segment must be sent with the following Identifiers and Qualifiers:

- NYS Medicaid Provider ID (REF01 will contain a Qualifier of '1D' and REF02 will contain the Rendering Provider's Provider ID), or
- Formatted License Number (REF01 will contain a Qualifier of '0B' and REF02 will contain the license number, formatted as specified in the FAQ entitled "License Number - How to send a License Number as a Provider Identifier", available at the nyhipaadesk.com website under FAQs).

An additional iteration of the Rendering Provider Secondary Identification REF segment should be sent to transmit the three-digit Location Number (Locator Code), if different from the Location Number sent in the Billing Provider Name loop (loop 2010AA). A Qualifier (REF01='LU') indicates that the Location Number is being sent in REF02.

During the initial period following NPI implementation, the NYS Medicaid Provider ID and formatted License Number will continue to be accepted, but will not be required, in iterations of the REF segment.

Rendering Provider Override of the Billing Provider:

Use of the Rendering Provider loop can potentially override the Billing Provider in the receiving system. When Rendering Provider information is sent only to specify that the Billing Provider, and not the Pay-to Provider, rendered the services the Rendering Provider Secondary Identification REF segment is not necessary and should not be sent so as to avoid unintended override of the Billing Provider.

Prior to the eMedNY NPI implementation the Rendering Provider in loop 2310B overrides the Billing Provider only if all three of the following conditions are met:

- the Rendering Provider Secondary Identification REF segment is sent with a NYS Medicaid Provider ID in REF02, and
- the Pay-to Provider loop 2010AB is present with a NYS Medicaid Group Provider ID in REF02, and
- the Supervising Physician loop is not present.

If any of the conditions for Billing Provider override described above are not met, the Rendering Provider information is used as the Servicing Provider only and the Billing Provider is not overridden.

After the eMedNY NPI implementation both the Rendering Provider and the Billing Provider are identified by their NPI. The three conditions for the Rendering Provider to override the Billing are essentially the same:

- the Rendering Provider Name NM1 segment is sent with an NPI that crosswalks to a NYS Medicaid Provider ID that is valid for billing NYS Medicaid, and
- the Pay-to Provider loop 2010AB is present with an NPI that crosswalks to a NYS Medicaid Group Provider ID, and
- the Supervising Physician loop is not present.

Rendering Provider information can also be sent at the line level in Loop-ID 2420A. When the conditions for override of the Billing Provider information are met the override will occur at line level only.

Supervising Provider:

NYSDOH requires the Supervising Provider to be enrolled in the NYS Medicaid program. The Supervising Provider is indicated by the use of a qualifier (NM101='DQ'). When the Supervising Provider loops is sent in a claim that has the Pay-to Provider Name loop the Supervising Provider overrides the Billing Provider.

NYSDOH requires the Supervising Provider loop (Loop-ID 2310E, or 2420D at line level) when the services were rendered by a nurse, a lab technician, an optometrist, a physician’s assistant; or in any other case in which the Rendering Provider Name loop does not identify a provider who is eligible for billing Medicaid

Prior to the eMedNY NPI implementation, when Supervising Provider information is sent, NYSDOH requires at least one iteration of the Supervising Provider Secondary Identification REF segment. A second iteration of the REF segment is conditionally required to satisfy the business requirements for processing NYS Medicaid claims:

- an iteration of the Supervising Provider Secondary Identification REF segment must be sent that contains the NYS Medicaid Provider ID, as indicated by a qualifier in REF01 of ‘1D’. If the Pay-to Provider loop 2310AB is present the Supervising Provider's Medicaid ID takes precedence over the Rendering Provider and overrides the Billing Provider. The Rendering Provider is moved to Servicing Provider.
- an iteration of the REF segment is used to send the Location Code associated with the Supervising Provider. This is only required when the Location Code is different from the one sent in Loop-ID 2010AA. The Location Code is sent in REF02, as indicated by a qualifier (REF01=’LU’).

After the eMedNY NPI implementation the Supervising Provider must be identified by their NPI (NM108=’XX’ and NM109=the Supervising Provider’s NPI).

4. Replacement/Void codes:

NYSDOH will process all values as original claims with the exception of codes '7' (Replacement) and '8' (Void). Replacement and/or Void can only be sent for previously PAID claims (Loop-ID 2300, CLM05-3).

5. Over Ninety Day Indicator:

HIPAA mandates that any claim that has passed the payers timely filing requirements must include a Delay Reason Code. The NYSDOH filing requirement is 90 days. Therefore, all claims for which more than 90 days has lapsed since the Date of Service must include one of the following HIPAA Codes in order to be considered for payment. Please note that Delay Reason Code 6 is not listed in the table because NYS Medicaid policy does not consider this a valid delay reason, and NYS Medicaid will deny any claim submitted using this code. If the delay reason is for interrupted maternity care or an IPRO denial/reversal, you may use code 11 – Other (Loop-ID 2300, CLM20).

HIPAA Delay Reason Code	Definition
1	Proof of Eligibility Unknown or Unavailable
2	Litigation
3	Authorization Delays
4	Delay in Certifying Provider
5	Delay in Supplying Billing Forms
7	Third Party Processing Delay
8	Delay in Eligibility Determination
9	Original Claim Rejected or Denied Due to a Reason Unrelated to the Billing Limitation Rules
10	Administration Delay in the Prior Approval Process
11	Other

6. Service Authorization Exception Codes:

The following table lists all of the Service Authorization Exception Codes used by NYS Medicaid today and all Service Authorization Exception Codes available under HIPAA.

HIPAA Service Authorization Exception Code	Definition
1	Immediate/Urgent Care
2	Services Rendered in Retroactive Period
3	Emergency Care
4	Client Has Temporary Medicaid
5	Request from County for 2nd Opinion to Determine if Recipient Can Work
6	Request for Override Pending
7	Special Handling

As a result of eliminating Specialty Codes, NYS Medicaid will implement the use of the “Special Handling” HIPAA Service Authorization Exception Code for the handling of Utilization Threshold exempt claims. Code 7 – “Special Handling” – must be reported when you would have reported one of the following Specialty Codes. (Loop-ID 2300, REF02)

MMIS Specialty Code	MMIS Specialty Code Description
020	PSC ANESTH PSC: ANESTHESIOLOGY
130	CLIA-WV-RG PSC: CLIA WAIVER/REGISTRATION (OBSOLETE 10/12/99)
150	PEDIATRIC PSC PEDIATRICS
151	PEDIA-CARD PSC PEDIATRICS: CARDIOLOGY
152	PEDIA-HEMO PSC PEDIATRICS: HEMATOLOGY – ONCOLOGY
153	PEDIA-SURG PSC PEDIATRICS: SURGERY
154	PEDIA-NEPH PSC PEDIATRICS: NEPHROLOGY
155	NEO-PERIN PSC PEDIATRICS: NEONATAL - PERINATAL MEDICINE
156	PEDIA-ENDO PSC PEDIATRICS: ENDOCRINOLOGY
157	PEDIA-PULM PSC PEDIATRICS: PULMONOLOGY
158	PREF-PHY PSC PPAC: PREFERRED PHYSICIANS AND CHILDREN PROG
159	OB-MAT-SVC PSC MOMS: MEDICAID OBSTETRICAL & MATERNAL SVC PROG
161	PEDIA-CRIT PCP PEDIATRICS: PEDIATRIC CRITICAL CARE
169	MOMS HHS PSC MOMS: HEALTH SUPPORTIVE SERVICES
186	DO-Therapy T.B. DIRECTLY OBSERVED THERAPY/PHYSICIAN
191	CHILD-PSY PSC PSY & NEURO: CHILD PSYCHIATRY
192	PSC PSY & NEURO: PSYCHIATRY (NOT CHILD)
193	CHILD-NEUR PSC PSY & NEURO: CHILD NEUROLOGY
196	PSY-NEUR-C PSC PSY & NEURO: CLOZAPINE CASE MANAGER
205	THER-RAD PSC RAD: THERAPEUTIC RADIOLOGY
247	PHSCN-FEE MANAGED CARE – PHYSICIAN ENHANCED FEE
249	HIV PCS PSC: HIV PRIMARY CARE SERVICES (CONFIDENTIAL)
270	SCHIP PSC SCHIP: STATE CHILDREN'S HEALTH INSURANCE PROGRAM
300	THER-LTM PSC: PHYSICAL THERAPY - LONG TERM MAINTENANCE
301	OCC-LTM PSC: OCCUPATIONAL THERAPY - LONG TERM MAINTENANCE
302	Speech-LTM PSC: SPEECH THERAPY – LONG TERM MAINTENANCE
303	AIDHIV-SRV PSC: AIDS/HIV SERVICES
304	MEDICAL REHABILITATION – LONG TERM MAINTENANCE
305	CLN/PEDIA PSC: PEDIATRIC SPECIALTY - ALL EXCEPT PRIMARY CARE
306	SSHS-PROG PSC: SCHOOL SUPPORTIVE HEALTH SERVICES PROGRAM
307	DME PSC: DURABLE MEDICAL EQUIPMENT (EMEVS USE ONLY)

MMIS Specialty Code	MMIS Specialty Code Description
308	CLNHIV-SRV CLN SP CD: HIV PRIMARY CARE SERVICES
309	SUB-ABUSE CLN SP CD: MEDICALLY SUPERVISED SUBSTANCE ABUSE
312	OMH-CDT-S CLN SP CD: OMH CONTINUING DAY TRTMT (STATE OPR)
313	OMH-HOSPS CLN SP CD: OMH PARTIAL HOSPITALIZATION (STATE OPR)
314	OMH-INTENS CLN SP CD: OMH INTEN PSYCH REHAB TRTMT (STATE OPR)
317	OMH-CDT CLN SP CD: OMH CONTINUING DAY TREATMENT
318	OMH-P-HOSP CLN SP CD: OMH PARTIAL HOSPITALIZATION
319	OMH-INTEN CLN SP CD: OMH INTENSIVE PSYCH REHAB TREATMENT
320	Cloza-Case CLN SP CD: CLOZAPINE CASE MANAGER
323	OMH-OUTCDT OMH COMP OUTPAT PROG (COPS) CONTINUING DAY TRTMT
325	Early-INTE CLN SP CD: EARLY INTERVENTION
750	ME MNT PHY MISC SP CD: METHADONE MAINTENANCE (PHYSICIAN)
798	MISC SP CD LONG TERM HOME HEALTH
900	HMO CLN SP CD: HMO CO-PAYMENT
904	OBSTETRICS CLN SP CD: OBSTETRICS
906	FMLY PLAN CLN SP CD: FAMILY PLANNING
907	ABORTION CLN SP CD: ABORTION
908	CLN SCHIP CLN SP CD: STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)
913	HEMOD CLN SP CD: HEMODIALYSIS
918	PODIATRY CLN SP CD: PODIATRY
922	ME MA TRT CLN SP CD: METHADONE MAINTENANCE TREATMENT PROGRAM
934	ONCO CHEMO CLN SP CD: ONCOLOGY - THERAPY (RADIATION OR CHEMO)
936	PED GEN ME CLN SP CD: PEDIATRIC GENERAL MEDICINE
937	PED ALLERG CLN SP CD: PEDIATRIC ALLERGY
938	PED NEUR CLN SP CD: PEDIATRIC NEUROLOGY
939	CLN PED HE CLN SP CD: PEDIATRIC HEMATOLOGY
940	PED CARDIA CLN SP CD: PEDIATRIC CARDIAC
941	PED RENAL CLN SP CD: PEDIATRIC RENAL
942	PED PULMO CLN SP CD: PEDIATRIC PULMONARY
943	PED ORTH CLN SP CD: PEDIATRIC ORTHOPEDIC
944	PED ENDOC CLN SP CD: PEDIATRIC ENDOCRINE
949	ALCO TREAT CLN SP CD: ALCOHOLISM TREATMENT PROGRAM
959	OUT CHEM CLN SP CD: OUTPAT CHEM DEPENDENCY PROG FOR YOUTH
960	CLN PD DER CLN SP CD: PEDIATRIC DERMATOLOGY
961	CLN PD DIA CLN SP CD: PEDIATRIC DIABETES
962	CLN PD SUR CLN SP CD: PEDIATRIC SURGERY
967	CLN SPCH CLN SP CD: PHC SPEECH & HEARING
968	CLN AMPUT CLN SP CD: PHC APPROVED AMPUTEE CENTER
969	APPLI VEND CLN SP CD: HOSP DME/ORTHOTIC/PROSTH APPLNC VENDOR
972	MH DAY-ST CLN SP CD: MH DAY TREATMENT (STATE OPERATED)
973	MH CNT-ST CLN SP CD: MH CONTINUING TREATMENT (STATE OPR)
975	MH DAY CLN SP CD: MENTAL HEALTH DAY TREATMENT
976	MH CNT CLN SP CD: MENTAL HEALTH CONTINUING TREATMENT
977	MRDD-ST CLN SP CD: MR/DD CLINIC TREATMENT (STATE OPERATED)
978	PRE PRIM C CLN SP CD: PREFERRED PRIMARY CARE CLINIC
979	CLN MRDD CLN SP CD: MR/DD CLINIC TREATMENT
980	TB DIR OBS T.B. DIRECTLY OBSERVED THERAPY/CLINIC
981	CLN M RETA CLN SP CD: DIAG AND RESEARCH CLINIC MR (STATE OPR)
983	CLN MNTL R CLN SP CD: SPECIALTY CLINIC - MENTAL RETARDATION
984	CLN AL-ST CLN SP CD: ALCOHOLISM CLINIC TREATMENT (STATE OPR)
985	CLN AL DY- CLN SP CD: ALCOHOLISM DAY REHAB (STATE OPERATED)
986	CLN AL CLN CLN SP CD: ALCOHOLISM CLINIC TREATMENT
987	CLN AL REH CLN SP CD: ALCOHOLISM DAY REHABILITATION
988	CLN CMP AL CLN SP CD: COMPREHENSIVE ALCOHOLISM CARE
989	CLN AL DET CLN SP CD: ALCOHOLISM DETOXIFICATION (DEMO PROJ)
990	COMP PHYS CLN SP CD: COMP PHYSICAL EXAM (SCHOOL HEALTH PROJ)

MMIS Specialty Code	MMIS Specialty Code Description
991	ROUT VST CLN SP CD: ROUTINE VISIT (SCHOOL HEALTH PROJECT)
992	OMH CMP PS OMH COMPREHENSIVE PSYCHIATRIC EMERGENCY PROG
993	HSP-BS AMB CLN SP CD: HOSPBASED/ FREESTANDING AMBULAT SURGERY
994	BLD PRODUC CLN SP CD: BLOOD PRODUCTS (ORDERED AMBULATORY)
995	GEN COUNSE CLN SP CD: GENETIC COUNSELING (ORDERED AMBULATORY)
996	HEAR SVCS CLN SP CD: HEARING SERVICES (ORDERED AMBULATORY)
997	OPER RM CLN SP CD: OPERATING ROOM (ORDERED AMBULATORY)
998	RADIOLOGY CLN SP CD: RADIOLOGY (ORDERED AMBULATORY)

7. SBR Segment – the Claim Filing Indicator Code:

It is important to populate the correct data elements when reporting Medicare Part B (Claim Filing Indicator Code MB) and/or other TPL payers in Coordination of Benefits (COB) claims. Incorrect usage of these codes may create pricing and/or payer coordination errors. The SBR09 field is required to report other payers (Loop-ID 2320, SBR09). If the client has Medicare HMO coverage (Claim Filing Indicator Code 16), there can be no Medicare Part B coverage for the same coverage period. Please note that if a client has Medicare HMO coverage on one date and Medicare Part B on another date the services must be billed as two separate claims.

8. CAS Segment: Claim Level and Line Level Balancing:

Claim level adjustments are reported in a CAS segment in Loop-ID 2320. An iteration of this loop should be sent for each payer whose potential involvement with the claim is being reported except where the provider has submitted under the "OFILL" Plan Name. The CAS segment is used in this loop to report prior payers' claim level adjustments that cause the amount paid to differ from the amount originally charged. Up to five CAS segments can occur in an iteration of the loop, each reporting the adjustment associated with a single Claim Adjustment Group Code at CAS01. Only one Group Code can occur in a CAS segment. The adjustment itself is reported with a group of three values, which can occur up to six times within a single CAS segment; Adjustment Reason Code (CAS02, CAS05, CAS08, CAS11, CAS14, CAS17); Adjustment Amount (CAS03, CAS06, CAS09, CAS12, CAS15, CAS18); and Adjustment Quantity (CAS04, CAS07, CAS10, CAS13, CAS16, CAS19). These values should come from 835 transactions received for the claim. If there were no prior payer adjustments the segment is not sent.

Line level adjustments are reported in a CAS segment in Loop-ID 2430. The segment is required when the payer identified in Loop-ID 2330B made line level adjustments that cause the amount paid to differ from the amount originally charged. The data elements do not differ from a CAS at the claim level. The values reported should come from 835 transactions received for the line item. If there were no line-level prior payer adjustments for the line item the segment is not sent.

Any adjustment amount from one adjustment should be reported only once. Do not repeat a claim-level adjustment at the line level. Also do not report the total of the line-level adjustments in a claim-level CAS segment.

When amounts from distinct claim level and line level adjustments are reported balancing should be done at both the line level (line charge minus total CAS amounts equals paid) and claim level (claim total charge minus total CAS amounts from both claim and line level equals claim level paid).

9. Coinsurance and Deductibles:

The Coinsurance and Deductible amounts will now be reported as adjustment amounts in the CAS segment, in the Patient Responsibility group (claim level Loop-ID 2320, CAS01='PR'; or line level 2430, CAS01='PR').

The Coordination of Benefits Other Payer Paid Amount (i.e. Medicare Paid Amount) is reported in the AMT segment at AMT02 (claim level Loop 2320, AMT01='D').

10. Medicare Approved Amount Calculation:

When submitting claims secondary to Medicare, Providers were required to provide the Medicare Approved Amount. The HIPAA Implementation Guides do not allow this information to be required. As a result, the approved amount will be derived as a calculation of the payment and adjustment information provided in the COB sections of the claim. The sum of the Medicare Paid Amount and the amounts assigned to the Medicare Deductible and Coinsurance Claim Adjustment Reason Codes (Codes 1 & 2) will be considered the Approved Amount.

REMEMBER: It is required that all adjustments are passed into the claim exactly as received in the Remittance Advice from the Primary Payer.

11. Spend-down – Patient Participation:

The patient participation (also known as spend-down) amount will now be reported as the Patient Amount Paid for all claims. (Loop-ID 2300, AMT02 where AMT01='F5').

12. Cost Avoidance Override/Zero Fill:

"Zero Fill" is a time and cost-saving process implemented by NYSDOH to facilitate claim payment when it is known that the primary payer or any other payer prior to Medicaid, does not cover the services and so will not pay any amount towards the claim. NYSDOH permits providers to bypass submitting the claim to the prior payer(s) who would otherwise deny the claim. Providers may populate the Plan Name field of the Subscriber Information SBR segment with the value "0FILL". By doing so providers certify that they can provide documentation that the services that were billed are not covered by the prior payer(s) (Loop-ID 2000B, SBR, SBR04=0FILL). Such documentation should be kept on-file and current by billing to the prior payer(s) for the non-covered services at least once a year.

"0FILL" should also be used on claims which have been denied (the services were not covered) or were paid zero (the entire charge was adjusted, for example, applied to deductible) by any prior payer. Note however that the complete adjudication information from any prior payer who adjudicated the claim must still be included (loop 2320 and sub-loops; and/or loop 2430 and sub-loops).

When the claim is not eligible for processing under the "0FILL" plan, NYSDOH recommends submitters enter "MEDICAID" as the Plan Name (Loop-ID 2000B, SBR04=MEDICAID).

13. EPSDT:

If services were rendered in connection with an Early Prevention Screening Diagnosis and Treatment (EPSDT) referral this must be indicated as follows (note that the 837P Addendum modified the original V4010 Implementation Guide):

- at the claim level if the claim includes charges for EPSDT screening (Loop-ID 2300, CLM, CLM12='01'; and CRC, CRC01='ZZ' and CRC02='Y')
- at the line level for each service rendered in connection with a referral that resulted from an EPSDT screening (Loop-ID 2400, SV1, SV111='Y').

It is unusual for EPSDT to be indicated at both claim and line levels, although this can occur in a group practice when a group-member provider performed the screening and as a result of the screening referred the patient to a specialist in the same group.

14. Family Planning:

If family planning services are being reported this must be indicated at the service line level in the Professional Service segment. (Loop-ID 2400, SV1, SV112='Y').

15. Related Causes Information:

If the services rendered are due to a condition that resulted from employment or an accident then at least the first sub-element of the Related Causes Information data element is required (Loop-ID 2300, CLM, CLM11-1, CLM11-2, CLM11-3). The values for this location are:

Code	Definition
AA	Auto Accident
AB	Abuse
AP	Another Party Responsible
EM	Employment
OA	Other Accident

16. Special Program Code:

If the services being reported were rendered under a Special Program this must be indicated as follows (Loop-ID 2300, CLM, CLM12):

Code	Definition
01	Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) or Children's Health Insurance Program (SCHIP)
02	Physically Handicapped Children's Program
03	Special Federal Funding
05	Disability
07	Induced Abortion - Danger to Life
08	Induced Abortion - Rape or Incest
09	Second Opinion or Surgery

17. Abortion Condition Code:

NYSDOH requires abortion condition codes to be reported for all abortion related services as follows (Loop-ID 2300, NTE, NTE02; NTE01='ADD'):

Code	Definition
AA	Abortion performed due to rape
AB	Abortion performed due to incest
AC	Abortion due to serious fetal defect or serious deformity or abnormality
AD	Abortion due to life endangering physical condition caused by or arising from pregnancy
AE	Abortion due to life endangering
AF	Abortion due to emotional/physiological health of mother
AG	Abortion due to social or economic reasons
AH	Elective Abortion
AI	Sterilization

18. Non-emergency Transportation:

The New York State Department of Health (NYSDOH) requires batch submission of claims for Medicaid-covered Non-emergency medical transportation services to be conducted in standard electronic format as per the specifications described in the 837 Professional Companion Guide for Non-emergency Transportation. These

12/29/2008

837 Professional Supplemental claims are not regulated by HIPAA, however the HIPAA-mandated transaction has been selected by NYSDOH for use. Data items requirements specific to these services are described in the 837 Health Care Claim: Professional Companion Guide for Non-Emergency Transportation at the following locations:

Loop	Segment	Data Element and/or Sub-element
2300	CLM	CLM05-1
2310A (NM1='P3')	REF	REF01, REF02
2310B	REF	REF01, REF02
2420A	REF	REF01, REF02
2420F	REF	REF01, REF02