

Virginia Department of Medical Assistance Services

**837 Professional Encounters
For Non-Emergency Transportation
Data Clarification
for
LogistiCare**



**ASC X12N 837
Version 004010X098A1**

**Version 2.0
December 1, 2008**

INTRODUCTION

This document is a companion to the National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Claim: Professional, ASC X12N 837 dated May 2000 (IG) and the Addenda dated October 2002 (004010X098A1). The 837 IG and Addenda are available from the Washington Publishing Company and may be downloaded from www.wpc-edi.com/hipaa/.

DMAS intends that this clarification document be used in conjunction with the IG and Addenda, which contain all of the Health Insurance Portability and Accountability Act (HIPAA) transaction and code set requirements. This document supplements the IG and Addenda with data clarifications that are authorized under HIPAA. It is provided to clarify situations where the IG is not specific and to help the contracted non-emergency transportation vendor understand how DMAS will be using the inbound 837 transactions and its data elements in the Virginia Medicaid Management Information System (VaMMIS).

PURPOSE

The purpose of this clarification is to outline DMAS's specific requirements with respect to the 837 data loops, segments, and elements for encounters. The goal is to facilitate the contracted non-emergency transportation vendor's understanding of DMAS's data needs.

Non-emergency transportation claims and encounter data submitted to DMAS using the 837 transactions should follow the Provider-to-Provider-to-Payer COB data model referenced in the IG (see page 15 of the guide for information about this model). This model contains loops, segments, and data elements that provide information necessary for DMAS's MMIS and decision support systems.

Page numbers on the following data-clarification matrix refer to the page number in the IG on which the data element appears. Page numbers that begin with "A" are Addenda page numbers. Page numbers that begin with "B" are from Appendix B of the IG, EDI Control Directory.

All data elements that are used by the VaMMIS are listed on the following matrix. The matrix does **not** include all data elements that are required by the IG and those must be coded according to instructions in the IG. The instructions here are not intended to override instructions or requirements contained in the IG; they are provided to clarify DMAS's expectations with respect to the various data elements within the 837 transaction where interpretation is possible.

Not all data elements that are indicated as used on the following matrix are required in every situation. Some of the data elements indicated as used are required only when a specific situation is present. For example, Ambulance Transport Reason Code is only required on ambulance services; it is not required on non-emergency transportation services.

If the Transportation vendor sends any claims that are not covered under its contract with DMAS, those claims must be send in a separate ISA-IEA envelope. They should not be mixed with the encounter data the vendor is reporting for services rendered under contract with DMAS.

REQUIRED ENCOUNTER DATA

All encounters processed by the Vendor should be submitted to DMAS in the prescribed format, including records that were denied for most reasons.

The exceptions, which should NOT be submitted to DMAS, are:

- Encounters that are rejected by the Vendor
- Encounters that are duplicates of records previously received and adjudicated by LogistiCare
- Encounters that contain an invalid Medicaid recipient identifier
- Encounters for Medicaid recipients who are not enrolled in Virginia Medicaid

If the encounter being submitted is one that you have denied, the encounter should be submitted to DMAS with the appropriate denial reason code from the Adjustment Reason Code set (code source 139) appearing in the first CAS segment of the encounter.

ADJUSTMENTS and VOIDS

When submitting adjustment or void records, please ensure the adjusted or void record conform to the following requirements:

1. If the record to which the adjustment applies was not previously submitted to VaMMIS, the original record must precede the adjustment record in the file containing the adjustment record. In other words, you can submit an original and adjustment record in the same file as long as the original record precedes the adjustment record.
2. Your claim number on the original record must be coded in Loop 2300, REF segment (page 180 of IG), REF02 – Original Reference Number. If this number does not match a number in the DMAS system, the adjustment or void record will be assigned a fatal error code.
3. If you are adjusting or voiding one service line on a claim that has more than one line, you must adjust or void all lines. The order in which the service lines appear on an adjusted or voided claim must be the same as on the original claim.

NATIONAL PROVIDER IDENTIFIER

The final rule on National Provider Identifiers (NPI) becomes effective on May 23, 2008. The final rule specifies that a covered provider must use its assigned NPI where called for on all HIPAA-specified electronic transactions exchanged between covered entities beginning on May 23, 2008.

For providers that are not considered health care providers and cannot obtain an NPI (such as taxi drivers), DMAS is developing a plan to provide those providers with a ten-digit ID that will mimic the NPI. This ID is referred to as an API, atypical provider identification. In the event a provider is an emergency and a non-emergency vendor, their NPI number obtained for emergency transportation services can be used for both.

DMAS DOCUMENTATION

To further assist MCOs in the encounter data submission process, DMAS is providing other information that MCOs should review. These documents include:

- EDI Submission Manual at <https://virginia.fhsc.com/providers/Manuals.asp>
- Companion Guides at <https://virginia.fhsc.com/hipaa/CompanionGuides.asp>
- Encounter Data Submission Manual at <http://www.dmas.virginia.gov/mc-encounter.htm>

The Companion Guides are not specific to encounter data, but may contain helpful information not found in the Data Clarifications or this Encounter Data Submission Manual.

**Data Clarification – 837 Professional Transaction
LogistiCare Non-Emergency Transportation Services
only for use by LogistiCare in relation to the fee-for-service Contract**

Page	Loop	Segment	Data Element	Clarification
B.3		ISA	ISA01 – Authorization Information Qualifier	Use “00”
B.3		ISA	ISA02 – Authorization Information	Use ten blanks
B.4		ISA	ISA03 – Security Information Qualifier	Use “00”
B.4		ISA	ISA04 – Security Information	Use ten blanks
B.4		ISA	ISA05 – Interchange ID Qualifier	Use “ZZ”
B.4		ISA	ISA06 – Interchange Sender ID	Use “1075” for LogistiCare
B.4		ISA	ISA07 – Interchange ID Qualifier	Use “ZZ”
B.5		ISA	ISA08 – Interchange Receiver ID	Use “VMAP FHSC FA”
B.5		ISA	ISA09 – Interchange Date	YYMMDD of interchange
B.5		ISA	ISA10 – Interchange Time	HHMM of interchange
B.5		ISA	ISA11 – Interchange Control Standards Identifier	Use “U”
B.5		ISA	ISA12 – Interchange Control Version Number	Use “00401”
B.5		ISA	ISA13 – Interchange Control Number	Nine-digit control number assigned by sender. Must match the value in IEA02.
B.6		ISA	ISA14 – Acknowledgment Requested	Use “0”

Page	Loop	Segment	Data Element	Clarification
B.6		ISA	ISA15 – Usage Indicator	Use “P” for production data or “T” for test data
B.6		ISA	ISA16 – Component Element Separator	Use “>”
B.8		GS	GS01 – Functional Identifier Code	Use “HC”
B.8		GS	GS02 – Application Sender’s Code	Use “1075” for LogistiCare
B.8		GS	GS03 – Application Receiver’s Code	Use “VMAP FHSC FA”
B.8		GS	GS04 – Functional Group Creation Date	CCYYMMDD
B.8		GS	GS05 – Creation Time	HHMM
B.9		GS	GS06 – Group Control Number	Assigned by LogistiCare. Must be identical to the associated functional group trailer, GE02.
B.9		GS	GS07 – Responsible Agency Code	Use “X”
B.9		GS	GS08 – Version/Release/ Industry Identifier Code	Use “004010X098A1”
62		ST	ST01 – Transaction Set Identifier Code	Use “837”
62		ST	ST02 – Transaction Set Control Number	Use a number that is unique within the functional group and interchange (GS-GE and ISA-IEA). Must be identical to SE02.
63		BHT	BHT01 – Hierarchical Structure Code	Use “0019”
64		BHT	BHT02 – Transaction Set Purpose Code	Use “00” if original submission; use “18” if the file is being resubmitted.
64		BHT	BHT03 – Originator Application Transaction Identifier	Specific to LogistiCare – this will operate as the batch control number.

Page	Loop	Segment	Data Element	Clarification
64		BHT	BHT04 – Creation Date	CCMMYYDD
65		BHT	BHT05 – Creation Time	HHMM
65		BHT	BHT06 - Transaction Type Code	Use “RP” (Reporting or encounter)
66		REF	REF01 – Reference ID Qualifier	Use “87”
66		REF	REF02 – Transmission Type Code	Use “004010X098A1”
68	1000A	NM1	NM109 – Submitter Primary Identifier	Use “1075” for LogistiCare
75	1000B	NM1	NM103 – Last Name or Organization Name	Use “Dept of Med Assist Svcs”
75	1000B	NM1	NM109 – Receiver Primary ID Code	Use “Dept of Med Assist Svcs”
86	2010AA	NM1	NM108 – Identification Code Qualifier	If submitting the NPI number, use “XX” If submitting an API number, use the following along with the REF01 segment: 24 = Employer’s Identification Number 34 = Social Security Number
86	2010AA	NM1	NM109 – Billing Provider ID	This is the ID for the provider that is billing for the service (never LogistiCare’s ID).
92	2010AA	REF	REF01 – Reference ID Qualifier	“1D” (Medicaid Provider Number)
92	2010AA	REF	REF02 – Billing Provider Secondary ID	This is the ten-digit API number of the billing provider, never LogistiCare’s ID.
109	2000B	HL	None	The number of claims within an ST/SE segment is limited to 5,000 as recommended in the IG.
110	2000B	SBR	SBR01 – Payer Responsibility Sequence Number Code	Use “S” (secondary) or “T” (tertiary)

Page	Loop	Segment	Data Element	Clarification
118	2010BA	NM1	NM103 – Subscriber’s Last Name	Report the last name of the subscriber
118	2010BA	NM1	NM104 – Subscriber’s First Name	Report the first name of the subscriber
119	2010BA	NM1	NM108 – Subscriber ID Qualifier	Use “MI” (Member Identification Number)
119	2010BA	NM1	NM109 – Subscriber Primary ID	Use the twelve-digit enrollee ID number assigned by Virginia Medicaid
171	2300	CLM		Note that the HIPAA implementation guides allow only 100 repetitions of the 2300 CLM loop within each patient/subscriber loop.
171	2300	CLM	CLM01 – Claim Submitter’s Identifier	LogistiCare’s claim ID.
172	2300	CLM	CLM02 – Total Claim Charges	The total amount charged by the provider for the services on this record.
173	2300	CLM	CLM05-1 – Place of Service	See allowed values in code source 237.
173	2300	CLM	CLM05-3 – Claim Frequency Type Code	Use one of the following codes: 1 – Original Claim 7 – Replacement Claim 8 – Void If the claim contains a value of 7 or 8, please see the ADJUSTMENTS and VOIDS section of the introduction to ensure the records conform to DMAS’s requirements.
176	2300	CLM	CLM11-1 – Related Causes Information	Required if claim was related to: AA – Auto Accident EM – Employment OA – Other Accident
208	2300	DTP	DTP03 – Related Hospitalization Admission Date	Hospital Admission Date, if applicable

Page	Loop	Segment	Data Element	Clarification																																				
A30	2300	AMT	AMT02 – Patient Paid Amount	Sum of all amounts paid by patient on this claim.																																				
230	2300	REF	REF01 – Reference Identification Qualifier	Use “F8” (Original Reference Number) when submitting an adjustment (replacement or void) record; do not use this segment if this is an original submission.																																				
230	2300	REF	REF02 – Original Reference Number	If this record is an adjustment to a previously submitted claim (i.e., CLM05-3 = 7 or 8), send the number of the claim being adjusted.																																				
247	2300	NTE	NTE01 – Note Reference Code	Use “ADD” (Additional Information)																																				
247	2300	NTE	NTE02 – Claim Note Text	<p>This segment has been reformatted to capture required data elements for transportation services as follows:</p> <table border="0"> <thead> <tr> <th><u>Position</u></th> <th><u>Description</u></th> <th><u>Instructions</u></th> </tr> </thead> <tbody> <tr> <td>1 to 4</td> <td>Number of Passengers</td> <td>right justify, zero fill</td> </tr> <tr> <td>5 to 6</td> <td>Enrollee Region</td> <td>left justify, space fill</td> </tr> <tr> <td>7</td> <td>Trip Type</td> <td></td> </tr> <tr> <td>8 to 9</td> <td>Trip Reason</td> <td></td> </tr> <tr> <td>10 to 13</td> <td>Pickup Time</td> <td>HHMM</td> </tr> <tr> <td>14 to 17</td> <td>Drop-off Time</td> <td>HHMM</td> </tr> <tr> <td>18 to 35</td> <td>Destination Address 1</td> <td>left justify, space fill</td> </tr> <tr> <td>36 to 53</td> <td>Destination Address 2</td> <td>left justify, space fill</td> </tr> <tr> <td>54 to 70</td> <td>Destination City</td> <td>left justify, space fill</td> </tr> <tr> <td>71 to 72</td> <td>Destination State</td> <td></td> </tr> <tr> <td>73 to 77</td> <td>Destination ZIP Code</td> <td></td> </tr> </tbody> </table> <p>See Appendix A for valid Trip Type and Trip Reason codes.</p>	<u>Position</u>	<u>Description</u>	<u>Instructions</u>	1 to 4	Number of Passengers	right justify, zero fill	5 to 6	Enrollee Region	left justify, space fill	7	Trip Type		8 to 9	Trip Reason		10 to 13	Pickup Time	HHMM	14 to 17	Drop-off Time	HHMM	18 to 35	Destination Address 1	left justify, space fill	36 to 53	Destination Address 2	left justify, space fill	54 to 70	Destination City	left justify, space fill	71 to 72	Destination State		73 to 77	Destination ZIP Code	
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71 to 72	Destination State																																							
73 to 77	Destination ZIP Code																																							
249	2300	CR1	CR103 – Ambulance Transport Code	<p>Required for services involving an ambulance. Valid values are:</p> <p>I – Initial Trip R – Return Trip T – Transfer Trip X – Round Trip</p>																																				

Page	Loop	Segment	Data Element	Clarification
249	2300	CR1	CR104 – Ambulance Transport Reason Code	Required for services involving an ambulance. Valid values are: A – Patient transported to nearest facility B – Patient transported for benefit of preferred physician C – Patient transported for nearness of family members D – Patient transported for care of specialist or specialized equipment E – Patient transferred to rehabilitation facility
250	2300	CR1	CR106 – Transport Distance	Report the transport distance in miles. Portions of miles are acceptable. This is a decimal field and the decimal should be coded.
266	2300	HI	HI01-2 – Diagnosis Code	The ICD-9-CM diagnosis for which the patient is being treated.
283	2310A	NM1	NM101 – Entity Identifier Code	Use “DN” (Referring Provider)
284	2310A	NM1	NM109 – Referring Provider Identifiers	24- Employer’s Identification Number 34- Social Security Number XX- NPI If XX-NPI is used, then either the Employer’s Identification Number or the SSN of the provider must be carried in the REF segment in this loop.
296	2310B	REF	REF01 – Reference Identification Qualifier	1D- Medicaid Provider Number EI- Employer’s Identification Number SY- Social Security Number EI or SY must be used when the 10-digit NPI is sent in the Billing Provider Name segment of this loop. When the API is sent, use the 1D qualifier.
297	2310B	REF	REF02 – Rendering Provider Secondary ID	This should be the API assigned by DMAS to the provider rendering the service.
307	2310D	N3	N301 – Address Information 1	Pickup address – the first 18 positions will be captured

Page	Loop	Segment	Data Element	Clarification
307	2310D	N3	N302 – Address Information 2	Pickup address – the first 18 positions will be captured
308	2310D	N4	N401 – City Name	Pickup city
309	2310D	N4	N402 – State	Pickup state – use the two-digit abbreviation
309	2310D	N4	N403 – Postal Code	Pickup ZIP code – only the first five positions will be captured
318	2320	SBR		This loop will be used once by the transportation administrator and once for each additional payer.
319	2320	SBR	SBR01 – Payer Responsibility Sequence Code	Use “S” (Secondary) or “T” (Tertiary)
319	2320	SBR	SBR02 – Individual Relationship Code	Use “18” (Self)
320	2320	SBR	SBR03 – Group or Policy Number	Use “1075” for LogistiCare
320	2320	SBR	SBR04 – Group or Plan Name	Use “LogistiCare”
323	2320	CAS		If you denied this claim or made any adjustment at the claim level, use the following 2320 segments. If denials or adjustments were made at the service level, use the corresponding 2430 segments.
326	2320	CAS	CAS02, 05, 08, 11, 14, 17 – Adjustment Reason Codes	Use any denial codes in the first segments; if the claim is not denied, use the segments needed to balance the transaction.
327	2320	CAS	CAS03, 06, 09, 12, 16, 18 – Adjustment Amount	If the claim was denied, show the entire charge amount as denied; otherwise use segments as needed to balance the transaction.
332	2320	AMT	AMT02 – Payer Paid Amount	Enter the amount you paid for this claim.
334	2320	AMT	AMT02 – Allowed Amount	Enter the amount you allowed for this claim.
335	2320	AMT	AMT02 – Patient Responsibility Amount	Enter any amount paid by the patient for this claim.
343	2320	DMG	DMG02 – Other Insured Birth Date	CCYYMMDD

Page	Loop	Segment	Data Element	Clarification
343	2320	DMG	DMG03 – Other Insured Gender	Valid values are: F – Female M – Male U – Unknown
360	2330B	NM1	NM103 – Other Payer Name	“LogistiCare”
361	2330B	NM1	NM109 – Other Payer Primary Identifier	Use “1075” for LogistiCare
366	2330B	DTP	DTP03 – Date Claim Paid	The date on which your system paid this claim.
A56	2400	SV1	SV101-1 – Service ID Qualifier	Use “HC” (HCPCS Procedure)
A56	2400	SV1	SV101-2 – Procedure Code	Valid HCPCS procedure code (Part II for transportation claims). See Appendix B for list of codes DMAS will accept.
A56	2400	SV1	SV101-3 – Procedure Code Modifier	The only modifier applicable to transportation services is “GM” multiple patients on one ambulance trip.
402	2400	SV1	SV102 – Line Charge Amount	Line item charge amount.
403	2400	SV1	SV103 – Unit or Basis for Measurement	Use “UN” (Units)
403	2400	SV1	SV104 – Service Count (Quantity)	Number of Trips
404	2400	SV1	SV105 – Place of Service	Use a valid code from code source 237.
405	2400	SV1	SV107-1 – Diagnosis Code Pointer	The value used here should point to the primary diagnosis code for this service line.
414	2400	CR1	CR105 – Unit or Basis for Measurement	Use “DH” (Miles)
414	2400	CR1	CR106 – Transport Distance	Miles transported
436	2400	DTP	DTP03 – Service Date	CCYYMMDD – trip date or date on which bus pass was issued
466	2400	CN1	CN101 – Contract Information	See page 466 for valid values
470	2400	REF	REF02 – Prior Authorization or Referral Number	LogistiCare trip authorization number

Page	Loop	Segment	Data Element	Clarification
473	2400	REF	REF02 – Line Item Control Number	Line Item Control Number
485	2400	AMT	AMT02 – Approved Amount	Amount approved by LogistiCare
488	2400	NTE	NTE01	Use “ADD” (Additional Information)
488	2400	NTE	NTE02	Use only if different than the values reported at the claim level (Loop 2300). See note in the NTE02 segment at page 247.
492	2400	HSD	HSD02 – Number of Visits	If the patient has a recurring need for a specific number of trips per week, code that number here. If this record is for a bus pass, code the number of rides for which the pass was issued. Right justify and zero fill.
492	2400	HSD	HSD03 – Frequency Period	Use “WK” (Week)
554	2430	SVD	SVD02 – Service Line Paid Amount	The amount paid for this service line.
560	2430	CAS	CAS02, 05, 08, 11, 14, 17 – Adjustment Reason Codes	Use any denial codes in the first segments; if the claim is not denied, use the segments needed to balance the transaction. Same note as before
560	2430	CAS	CAS03, 06, 09, 12, 16, 18 – Adjustment Amount	If the claim was denied, show the entire charge amount as denied; otherwise use segments as needed to balance the transaction.
566	2430	DTP	DTP03 – Line Adjudication Date	Date on which this service line was paid, if different from the date shown at the claim level.
B.30		SE	SE01 – Number of Included Segments	Total number of segments included in a transaction set, including the ST and SE segments.
B.30		SE	SE02 – Transaction Set Control Number	Must match the control number in ST02.
B.10		GE	GE01 – Number of Transaction Sets Included	Total number of transaction sets included.
B.10		GE	GE02 – Group Control Number	Must be the same number contained in GS06.

Page	Loop	Segment	Data Element	Clarification
B.7		IEA	IEA01- Number of Included Functional Groups	A count of the number of functional groups included in the interchange.
B.7		IEA	IEA02 – Interchange Control Number	Must match the control number in ISA13.

Non-Emergency Transportation Data Clarification

Appendix A

Trip Type Code	Description
I	Initial Trip
R	Return Trip
T	Transfer Trip
X	Round Trip

Trip Reason Code	Description (Transportation to)
AD	Adult Day Care
AL	Intensive Assisted Living
CL	Clinic
DI	Dialysis
DN	Dental
HO	Hospital
MD	Doctor's Office
MH	Mental Health
MR	Mental Retardation
NH	Nursing Home
RE	Residence
RH	Rehabilitation
RX	Pharmacy
SC	School
SP	Specialist
UN	Unknown

Non-Emergency Transportation Data Clarification

Appendix B

DMAS Accepted HCPCS Codes

Code	Description
A0090	Non-emergency transportation, per mile – vehicle provided by individual
A0100	Non-emergency transportation; taxi – metered taxi
A0110	Non-emergency transportation and bus, intra- or inter-state carrier
A0120	Non-emergency transportation: mini-bus or other transportation systems
A0130	Non-emergency transportation: wheel-chair van
A0140	Non-emergency transportation and air travel (private or commercial) intra- or inter-state
A0160	Non-emergency transportation: per mile – case work or social worker
A0170	Transportation ancillary: parking fees, tolls, other
A0180	Non-emergency transportation – ancillary: lodging for recipient
A0190	Non-emergency transportation – ancillary: meals for recipient
A0200	Non-emergency transportation – ancillary: lodging for escort
A0210	Non-emergency transportation – ancillary: meals for escort
A0380	BLS mileage (per mile)
A0428	Ambulance service, basic life support, non-emergency transport (BLS)
T2001	Non-emergency transportation; patient attendant/escort
T2002	Non-emergency transportation; per diem
T2003	Non-emergency transportation; encounter/trip (not for use by metered taxis)
T2004	Non-emergency transportation; commercial carrier, multi-pass (multi trip bus pass)
T2005	Non-emergency transportation; stretcher van
T2006	Ambulance response and treatment, no transport
T2007	Transportation waiting time, air ambulance, and non-emergency vehicle; ½ hour increments.