Statewide Planning and Research Cooperative System (SPARCS)

Bureau of Health Informatics

Division of Information & Statistics

Office of Quality and Patient Safety

New York State Department of Health

Standard Companion Guide
Transaction Information

Instructions Related to Transactions
Based on ASC X12 Implementation Guides, Version 5010

Transaction Information Companion Guide

Version Number: 1.2 (October 2017)

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Preface

Companion Guides (CG) may contain two types of data: instructions for electronic communications with the publishing entity (Communications/Connectivity Instructions), and supplemental information for creating transactions for the publishing entity while at the same time ensuring compliance with the associated ASC X12 Implementation Guide (IG) (Transaction Instructions). Either the Communications/Connectivity component or the Transaction Instruction component must be included in every CG. The components may be published as separate documents or as a single document.

The Communications/Connectivity component is included in the CG when the publishing entity wants to convey the information needed to commence and maintain communication exchange.

The Transaction Instruction component is included in the CG when the publishing entity wants to clarify the IG instructions for submission of specific electronic transactions. The Transaction Instruction component content is limited by ASC X12's copyrights and Fair Use statement.

1 Transaction Instruction (TI) Introduction

1.1 Background

1.1.1 Overview of Health Care Service: Data Reporting Transactions

The Health Care Service: Data Reporting Transaction standard was developed to create a standard transaction set for exchanging pre-adjudicated health care service data. This standard was defined for providers to exchange this data with trading partners including All Payer Claims Databases administrators and other data reporting entities.

The Health Care Service: Data Reporting Transactions serve to:

- Support analysis performed by All Payer Claims Databases
- Promote consistency in pre-adjudicated health care service data reporting
- Reduce administrative costs

1.1.2 HIPAA Role in Implementation Guides

The Health Care Service: Data Reporting Implementation Guide was developed for use by the health care industry. At this time, it has not been adopted as a HIPAA standard and is not a HIPAA covered transaction.

1.2 Intended Use

The Transaction Instruction component of this Companion Guide must be used in conjunction with an associated ASC X12 Implementation Guide. The instructions in this companion guide are not intended to be stand-alone requirements documents.

1.3 Exceptions

New York State Department of Health (NYSDOH) selected this transaction to support the adoption of a single health care pre-adjudicated health care service data reporting standard for the format, data elements, and code sets to be used for reporting to All Payer Claims Databases. NYSDOH expects providers to collect, maintain, and submit information contained within the provider's systems as required by the associated X12 Implementation Guide and this Companion Guide. This information is essential for NYSDOH to perform health care analytics. This companion guide conforms to the requirements of any associated ASC X12 Implementation Guide, and is in conformance with ASC X12's Fair Use and Copyright statements.

2 Included ASC X12 Implementation Guides

Table 1: X12N Implementation Guides below lists the X12N Implementation Guides for which specific Transaction Instructions apply and which are included in Section 3 of this document.

Unique ID	Name
005010X225A2	Health Care Service: Data Reporting (837)
005010X231A1	Implementation Acknowledgment For Health Care Insurance (999)
005010X214	Health Care Claim Acknowledgment (277)

Table 1: X12N Implementation Guides

The Implementation Guides are available at http://store.x12.org/

3 Instruction Tables

These tables contain one or more rows for each segment for which a supplemental instruction is needed.

Legend
SHADED rows represent “segments” in the X12N Implementation Guide.
NON-SHADED rows represent “data elements” in the X12N Implementation Guide.

Table 2: Instruction Table Legend

3.1 ASC X12/005010X225A2 Health Care Services: Data Reporting (837R)

Loop ID	Reference	Name	Notes/Comments
	ST03	Version, Release, or Industry Identifier	Must equal "005010X225A2".
1000A	NM1	Submitter Name	
1000A	NM109	Submitter Identifier	Must equal the SPARCS Collector Code assigned by DOH.
1000B	NM1	Receiver Name	
1000B	NM103	Receiver Name	Must equal “SPARCS”.
1000B	NM109	Receiver Primary Identifier	NYSDOH expects to receive “SPARCS”.
2010AA	REF	Service Provider Secondary Identification	
2010AA	REF01	Reference Identification Qualifier	NYSDOH must receive an iteration of this segment with “1J” - Facility ID Number.
2010AA	REF02	Service Provider Secondary Identifier	In the “1J” - Facility ID Number iteration, this must equal the Permanent Facility Identifier (PFI).
2000B	SBR	Subscriber Information	
2000B	SBR01	Payer Responsibility Sequence Number Code	Must equal “P”. Source of Payment Typology I reported in the NTE segment must be the typology for this payer (see Appendix A).
2010BA	NM1	Subscriber Name	
2010BA	NM109	Subscriber Primary Identifier	For insured subscribers, NYSDOH expects to receive the Plan’s member identifier for the subscriber. For patients with no insurance, NYSDOH expects to receive “NO INSURANCE”.
2010BA	N3	Subscriber Address	

Loop ID	Reference	Name	Notes/Comments
2010BA	N301	Subscriber Address Line	For homeless patients, use the address reported by the patient (e.g., shelter address). If no address is reported, use the facility address.
2010BA	N4	Subscriber City, State, and Zip Code	
2010BA	N401	Subscriber City Name	For homeless patients, use the city name reported by the patient (e.g., shelter address). If no city name is reported, use the facility city name.
2010BA	N402	Subscriber State or Province Code	For homeless patients, use the state code reported by the patient (e.g., shelter address). If no state code is reported, use the facility state code.
2010BA	N403	Subscriber Postal Zone or Zip Code	For homeless patients, use the zip code reported by the patient (e.g., shelter address). If no zip code is reported, use the facility zip code.
2010BA	N406	Location Identifier (County Code)	For homeless patients, use the county code for the address reported by the patient (e.g., shelter address). If no county code is reported, use the facility county code. The county code must be the full 5 digit FIPS code (see Appendix B).
2000BA	DMG	Subscriber Demographic Information	
2010BA	DMG05	Composite Race or Ethnicity Information	NYSDOH expects to receive a minimum of 2 iterations. One with the race code and a second with the ethnicity code.
2010BA	REF	Subscriber Secondary Identification	NYSDOH expects to receive the Social Security Number when the facility has collected all or a portion of the patient's Social Security Number.
2010BA	REF02	Subscriber Secondary Identifier	If only a partial Social Security Number is available, right justify and left fill the Social Security Number with zeros (i.e., 000001234). If no Social Security Number is available, do not send the segment.
2010BB	NM1	Payer Name	
2010BB	NM103	Payer Name	For insured subscribers, NYSDOH expects to receive the Plan Name. If no insurance, NYSDOH expects to receive "SELF".
2010BB	NM109	Payer Identifier	For insured subscribers, NYSDOH expects to receive the Plan Identifier. If payer identifier is unknown or unavailable, NYSDOH expects to receive "UNKNOWN".
2010CA	N3	Patient Address	
2010CA	N301	Patient Address Line	For homeless patients, use the address reported by the patient (e.g., shelter address). If no address is reported, use the facility address.
2010CA	N4	Patient City, State, and Zip Code	

Loop ID	Reference	Name	Notes/Comments
2010CA	N401	Patient City Name	For homeless patients, use the city name reported by the patient (e.g., shelter address). If no city name is reported, use the facility city name.
2010CA	N402	Patient State or Province Code	For homeless patients, use the state code reported by the patient (e.g., shelter address). If no state code is reported, use the facility state code.
2010CA	N403	Patient Postal Zone or Zip Code	For homeless patients, use the zip code reported by the patient (e.g., shelter address). If no zip code is reported, use the facility zip code.
2010CA	N406	Location Identifier (County Code)	For homeless patients, use the county code for the address reported by the patient (e.g., shelter address). If no county code is reported, use the facility county code. The county code must be the full 5 digit FIPS code (see Appendix B).
2000CA	DMG	Patient Demographic Information	
2010CA	DMG05	Composite Race or Ethnicity Information	NYSDOH expects to receive a minimum of 2 iterations. One with the race code and a second with the ethnicity code.
2010CA	REF	Patient Secondary Identification	NYSDOH expects to receive the Social Security Number when the facility has collected all or a portion of the patient's Social Security Number.
2010BA	REF02	Patient Secondary Identifier	If only a partial Social Security Number is available, right justify and left fill the Social Security Number with zeros (i.e., 000001234). If no Social Security Number is available, do not send the segment.
2300	NTE	Claim Note	
2300	NTE01	Note Reference Code	NYSDOH must receive an iteration of this segment with "UPI".
2300	NTE02	Billing Note Text	In the "UPI", NYSDOH must receive data as specified in Appendix A.
2300	HI	External Cause of Injury	NYSDOH expects to receive External Cause of Injury codes for diagnosis codes requiring an external cause of injury as specified in Appendix C.
2300	HI	Value Information	All relevant Value Codes are expected to be submitted. There will no longer be a limited subset. Specific Value Codes will continue to be required as before. One example is Value Code of "54"- Newborn Birth Weight in Grams.

Loop ID	Reference	Name	Notes/Comments
2300	HI	Condition Information	All relevant Condition Codes are expected to be submitted. There will no longer be a limited subset. Specific Condition Codes will continue to be required as before. One example is NYSDOH expects to receive Homeless status in this segment with a Condition Code "17" – Patient Is Homeless. This is the sole indicator of Homelessness used by SPARCS.
2300	HI	Principal Procedure Information	NYSDOH will recognize ICD codes only.
2300	HI	Other Procedure Information	NYSDOH will recognize ICD codes only.
2320	SBR	Other Subscriber Information	
2320	SBR01	Payer Responsibility Sequence Number Code	Must not be "P". Source of Payment Typology II reported in the NTE segment must be the typology for the secondary payer "S". Source of Payment Typology III reported in the NTE segment must be the typology for the tertiary payer "T". (see Appendix A)
2400	SV2	Institutional Service Line	
2400	SV202	Composite Medical Procedure Identifier	NYSDOH will recognize HCPCS codes only.

3.2 ASC X12/005010X231A1 Implementation Acknowledgment for Health Care Insurance (999)

There are no special clarifications necessary for this implementation.

3.3 ASC X12/005010X214 Health Care Claim Acknowledgment (277)

There are no special clarifications necessary for this implementation.

4 Additional Information

4.1 Business Scenarios

None.

4.2 Submitter Specific Business Rules and Limitations

Each submission file may contain data for only one Facility ID (PFI).

4.3 Frequently Asked Questions

The SPARCS Website Data Submission page can be found on the "New Process" page at https://www.health.ny.gov/statistics/sparcs/submission/. On this page, you can find documentation to support implementation.

4.4 Other Resources

As the instructions in this Companion Guide are not intended to be stand-alone requirements documents, the instructions herein must be used along with:

- The Implementation Guides or Technical Reports Type 3s (TR3s): http://store.x12.org/
- Trading Partner Information Companion Guide (contains detailed information about trading partner registration and testing.)
- SPARCS website (https://www.health.ny.gov/statistics/sparcs/submission/)

For SPARCS Companion Guide questions, please contact the SPARCS submission services through the following e-mail: sparcs.submissions@health.ny.gov

5 X12 Transaction Information Change Summary

Version	Date	Section(s) Changed	Change Summary
1.1	9/27/2017	Appendix A	Changing the separator from '[' to ']'.
1.1	9/27/2017	4.2	Each submission file can only represent one facility ID (PFI).
1.2	10/12/2017	Appendix D added	Adjustment/Voids

Table 6: Change Summary

6 Appendix A – Note Segment Format (NTE)

The NTE segment will use a delimited format. The delimiter between the data elements must be "]". The "]" delimiter must not be used as the Component Element Separator.

Element	Required/ Situational	Format	Max Length	Situational Rule
Source of Payment Typology I	Required	AN	5	
Source of Payment Typology II	Situational	AN	5	Required when there is a secondary payer.
Source of Payment Typology III	Situational	AN	5	Required when there is a tertiary payer.
Heart Rate	Situational	AN	3	Required when the principle diagnosis is myocardial infarction.
Blood Pressure Systolic	Situational	AN	3	Required when the principle diagnosis is myocardial infarction.
Blood Pressure Diastolic	Situational	AN	3	Required when the principle diagnosis is myocardial infarction.
Previous Patient Control Number (CLM01)	Situational	AN	38	Required when processing an adjustment/void and the Patient Control Number in CLM01 does not match the Patient Control Number on the claim to be adjusted/voided.

Example:

511]612]54]90]149]95]ABC123~

511]]]]]]ABC123~

511~

7 Appendix B – Federal Information Processing Series (FIPS) County Code Reference

The Federal Information Processing Series (FIPS) County Codes can be downloaded from the following website:

https://www.census.gov/geo/reference/codes/cou.html

8 Appendix C – External Cause of Injury Reporting

The reporting of external cause codes is required for SPARCS data. Section 400.18(b)(2) of the NYS Rules and Regulations provide the authority for their collection as data elements required by the NYSDOH Commissioner. This follows Chapter 20 of the *ICD-10-CM Official Guidelines for Coding and Reporting*; which states that though there is not a national requirement, the requirement is subject to a state-based mandate, which the above-mentioned section does.

8.1 International Classification of Diseases Clinical Modification (ICD-9-CM) External Cause of Injury Code (E Codes) Reporting for Inpatient, Ambulatory Surgery, and Emergency Department

ICD-9 diagnosis codes reported in the range of 800.00-999.99 require the reporting of a valid External Cause of Injury Code unless listed below as an exception.

When an External Cause of Injury Code in the range of E850.0-E869.9 or E880.0-E928.9 is reported, then a Place of Injury Code must also be reported.

ICD-9 External Cause of Injury Exceptions

1. When the following diagnosis codes are reported as either an Other or Principal/Primary Diagnosis Code, an External Cause of Injury Code is not required.

   909.0, 909.1, 909.3, 909.4, 909.5, 909.9, 990, 995.0, 995.1, 995.2, 995.20, 995.21, 995.22, 995.23, 995.27, 995.29, 995.3, 995.4, 995.60-995.69, 995.7, 995.86, 995.89, 995.90-995.94, 999.80, 999.81, 999.82, 999.83, 999.84, 999.85, 999.88, 999.89

2. When the following diagnosis codes are reported an appropriate E-code must be reported in the External Cause of Injury Code. If the E-code was as a result of a correct medicinal substance properly administered, the E-code should be reported in an Other Diagnosis Code. If the E-code was a result of an incorrect medicinal substance and/or substance incorrectly administered, the E-code should be reported in the External Cause of Injury Code.

   999.0-999.7, 999.9, 999.31, 999.39

8.2 International Classification of Diseases Clinical Modification (ICD-10-CM) External Cause of Injury Code Reporting for Inpatient, Ambulatory Surgery, and Emergency Department

ICD-10 Diagnosis codes requiring the reporting of valid External Cause of Injury Code or Place of Injury change periodically. NYSDOH will publish documents on the SPARCS submission website containing the valid list of ICD-10 Codes with an indication of the requirement for reporting External Cause of Injury or Place of Injury Code.

9 Appendix D – Adjustment-Void Processing

The ETL process must edit adjustment and void transactions to ensure that there is a corresponding active transaction in SPARCS history. SPARCS must maintain the history of the original transaction which was adjusted or voided with a clear indication that the transaction was modified by the processing of the adjustment or void transaction. A SPARCS adjustment or void transaction will fail the Adjustment-Void edit when no corresponding transaction is found in the SPARCS history.

If the intent of the transaction is to alter the Permanent Facility Identifier, Patient Control Number or Statement To and From Date, the original/previous transaction must be voided and a new original transaction must be submitted.

Facility Patient Control Number (PCN): Facility Processing

Facilities are strongly encouraged to maintain the link to the previously processed Patient Control Number (PCN) when processing adjustments or void requests. When the previously processed PCN is included in the NTE segment, it will be used as part of the matching routine to help ensure the correct original or previous is being replaced. If it is not included, it will be assumed that the PCN in CLM01 is the same PCN that was used in the original/previous transaction.

Identifying Transaction to be Adjusted/Voided

If the "Previous Patient Control Number" is submitted in the NTE segment:

- Facility PFI (Loop 2010AA REF02 when REF01=1J – Facility ID Number)
- Statement To and From Date (Loop 2300 DTP when DTP01=434)
- Previous Patient Control Number (NTE)

If the "Previous Patient Control Number" is not submitted in the NTE segment:

- Facility PFI (Loop 2010AA REF02 when REF01=1J – Facility ID Number)
- Statement To and From Date (Loop 2300 DTP when DTP01=434)
- Patient Control Number (Loop 2300 – CLM01)

Transaction Processing

The ETL process will manage the method for processing adjustments and voids. It will identify the active transaction, update the transaction in SPARCS history to identify whether a transaction has been adjusted or voided, and store the current transaction. Based on the method for identifying the transaction to be adjusted/voided, the appropriate data will be used to retrieve active transactions from SPARCS history (previously voided transactions should be ignored).

- If no matching transactions are found, the transaction will be rejected.
- Adjustments:
  - If one matching active transaction is found, the transaction in history will be flagged as inactive and the adjustment transaction being processed will be added as active.
  - If multiple matching active transactions are found, the first active transaction found in history will be flagged as inactive and the adjustment transaction being processed will be added as active.
- Voids:
  - If one matching active transaction is found, the transaction in history will be flagged as inactive and the void transaction being processed will be added as inactive.
  - If multiple matching active transactions are found, the first transaction found in history will be flagged as inactive and the void transaction being processed will be added as inactive.