| CMS Manual System | **Department of Health & Human Services (DHHS)** |
|---|---|
| Pub 100-20 One-Time Notification Transmittal Sheet | **Centers for Medicare & Medicaid Services (CMS)** |
| **Transmittal 234** | **Date: AUGUST 18, 2006** |
| | **Change Request 5229** |

**Subject: Modification of NPI Editing Requirements in CR 4023 and of an Attachment to CR 4320**

**I. SUMMARY OF CHANGES:** CR 4023, Transmittal 190, contained many edits for NPIs and provider legacy identifiers when reported on claims or other EDI transactions effective October 1, 2006 and later. Some of those business requirements were written based on an incorrect assumption that any provider for which information was furnished on a claim, including referring/ordering and other secondary providers, would be enrolled in Medicare and therefore in the Medicare Provider Identifier Crosswalk, which is not always the case. This CR corrects affected CR 4023 business requirements, and also attachment 1 of CR 4320, Transmittal 204, which listed provider information locations in X12 transactions.

**New/Revised Material**
**Effective Date: October 1, 2006**
**Implementation Date: October 2, 2006**

***Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.***

**II. CHANGES IN MANUAL INSTRUCTIONS:** (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED

| R/N/D | CHAPTER/SECTION/SUBSECTION/TITLE |
|---|---|
| N/A | |

**III. FUNDING:**
No additional funding will be provided by CMS; contractor activities are to be carried out within their FY **2006** operating budgets.

**IV. ATTACHMENTS:**

**One-Time Notification**

***Unless otherwise specified, the effective date is the date of service.***

# Attachment – One-Time Notification

| Pub. 100-20 | Transmittal: 234 | Date: August 18, 2006 | Change Request 5229 |
|---|---|---|---|

**SUBJECT: Modification of NPI Editing Requirements in CR 4023 and of an Attachment to CR 4320**

## I. GENERAL INFORMATION

**A. Background:** Change Request (CR) 4023, Transmittal 190, contained many edits for NPIs and provider legacy identifiers when reported on claims or other EDI transactions effective October 1, 2006 and later. Some of the requirements erroneously assumed that any provider for whom information is reported in a claim, including a referring/ordering or other secondary provider, would need to be enrolled in Medicare and therefore listed in the Medicare Provider Identifier Crosswalk, which is not always the case. Those business requirements are being modified in this CR. These modifications are to be implemented to eliminate incorrect claim and other EDI transaction rejections.

For provider identifier editing purposes, providers have been divided into two categories. Unless otherwise noted, the edits apply to 837, free billing software, DDE (FIs only) and paper claims.

1. Billing, pay-to and rendering providers are categorized as primary providers. They are required to be enrolled in Medicare for the claim to qualify for payment. As such, the NPI, one or more corresponding legacy identifiers (OSCAR for FI providers, NSC for DME suppliers, or a PIN for a carrier provider) and a Taxpayer Identification Number (TIN, either an employer identification number [EIN] or an SSN) would be in the Medicare Provider Identifier Crosswalk for these providers. When preparing an 837 COB claim, always report the NPI, legacy identifier, and TIN for a billing, pay-to or rendering provider.

   If either an NPI-only or an NPI-Medicare legacy number pair is submitted on a claim for a primary provider and cannot be located in the Medicare Provider Identifier Crosswalk, the claim must be denied. Dummy numbers are not considered "real" legacy identifiers for billing, pay-to or rendering providers located in the U.S. A "real" legacy identifier must be reported for every billing, pay-to and rendering provider. Dummy numbers are never included in the Medicare Provider Identifier Crosswalk.

2. All other providers for which data could be reported on an institutional (837-I) or professional (837-P), free billing software or DDE claim, or on a revised Form CMS-1500 or a Form CMS-1450 (UB-04), once those paper claims are accepted by Medicare, are considered secondary providers. Since the Form HCFA-1450 (UB-92) and the currently used Form CMS-1500 do not allow reporting of both NPIs and legacy identifiers, information on secondary providers in those paper claims is not included in the following requirements. Secondary providers may be enrolled, but are not required to be enrolled in Medicare (unless they plan to bill or be paid by Medicare for care rendered to Medicare beneficiaries).

   a. If both an NPI and a Medicare legacy identifier (other than a dummy UPIN or any other similar dummy identifier) are reported on a claim for the same secondary provider during

Stage 2, it signifies that the provider is enrolled in Medicare. In that case, the same edits that apply to an NPI and legacy identifier when submitted by a primary provider are to be applied to the secondary provider's NPI-legacy pair, unless the contractor processing the claim is a DMERC/DMEMAC. If an NPI and an NSC, or an NPI and a UPIN are received, a DMERC/DMEMAC is to edit as for a primary provider. If an NPI and a PIN are received as secondary provider identifiers by a DMERC/DMEMAC, the NPI is to be edited as in b, below. DMERCs/DMEMACs are not required to edit PINs as they do not generally have access to PIN files.

b. If only an NPI, or an NPI and a dummy legacy identifier (or PIN in the case of a DMERC/DMEMAC), is submitted to identify a secondary provider in a claim, that NPI is to be edited to:

    i. Determine that it has 10 digits; begins with a 1, 2, 3 or 4, and that the check digit in the $10^{th}$ position of the number is correct; and

    ii. Determine if there is a Medicare Provider Identifier Crosswalk entry for that NPI.

        1) If there is not a listing in the Medicare Provider Identifier Crosswalk for that NPI, it will not be possible to report any supplemental identifier to a COB payer. If sent a PIN, however, a DMERC/DMEMAC is to forward that to a secondary payer.

        2) Never reject a claim if the NPI for a referring/ordering provider or another secondary provider cannot be located in the Medicare Provider Identifier Crosswalk, unless both an NPI and a legacy identifier (UPIN only in the case of a DMERC/DMEMAC) were reported in a claim for that provider.

        3) If there is a listing in the Medicare Provider Identifier Crosswalk for that NPI, include the corresponding legacy identifier in any subsequently issued COB claim.

        4) If a TIN was submitted on a claim to identify a secondary provider, forward that TIN to any applicable secondary payer. Do not report a TIN if located in the Medicare Provider Identifier Crosswalk, but not submitted in a claim for a secondary provider.

When a Medicare-issued provider legacy identifier is the only identifier reported on a claim for any provider (primary or secondary), including a paper claim submitted on a Form HCFA-1450 (UB-92) or the currently used version of the Form CMS-1500, that identifier is to be edited to ascertain that it complies with the physical requirements (length, if numeric or alphanumeric as applicable) for that type of Medicare legacy provider identifier. The claim must be denied if any Medicare legacy identifier reported on a claim does not meet those physical requirements for that type of identifier. A contractor is not required to search for a legacy number in the Medicare Provider Identifier Crosswalk if not accompanied by an NPI. An 837 claim must also be denied if a TIN is not reported for a billing or pay-to (not a rendering) provider, as this is an 837 implementation guide requirement, but this TIN edit does not apply to paper, DDE (FI only), or free billing software claims that contain billing or pay-to provider data.

Attachment 1 to CR 4320, Transmittal 204, is also being revised as part of this CR to:

1. Reflect this change in editing of referring/ordering and other secondary provider NPIs;

2. Identify those secondary providers for which the 837-I or 837-P version 4010A1 implementation guides only require reporting of an NPI or other identifier "if known." Claims are not to be denied due to the absence of an identifier for those secondary providers, unless submission of an identifier is required for any of those providers under Medicare pre-NPI policies and requirements;

3. Note that the CLM segment contains type of bill (institutional claims) or place of service (professional claims) that could also be used to help identify the applicable legacy number in a one NPI to many legacy identifiers situation. In some cases, information of this nature is also reported at the service level when the information for some services may be different than the information that applies to all the other services;

4. Clarify when provider taxonomy codes may and may not be reported for certain types of providers, according to the 837 implementation guides; and

5. Clarify that certain segments in the 2330 loop of the 837-P and 837-I would be reported only for COB claims. (As result of a typo, this attachment had previously indicated it would Not be reported for COB claims.)

Summary of requirements in this CR that supersede specific business requirements or noted information in CRs 4320 and 4023:

1. Attachment 1 in this CR fully replaces attachment 1 in CR 4320.

2. Requirements 5229.1-1.5 in this CR replace business requirement 4023.8 of CR 4023, deleting the reference to application of those edits to referring providers for DMERCs. The edit is now written to apply only to billing, pay-to and rendering providers.

3. The edits in business requirement 4023.7 are to be applied to a referring/ordering, rendering, purchased service, service facility location, or supervising provider (applies to carriers & DMERCs/DMEMACs) or an attending, operating, other (such as a referring provider), or service facility provider (applies to FIs and RHHIs) when both an NPI and a legacy number are reported on a claim for those types of provider. See the DMERC/DMEMAC exception in A.2 above. Not all of these "secondary" providers are required to enroll in Medicare and as a result not all will be listed in the Medicare Provider Identifier Crosswalk.

4. Requirement 5229.5 in this CR replaces business requirement 4023.29. This was written to clarify that claim submitters are not able to submit Medicare provider legacy identifiers for providers that have not enrolled in Medicare (applies to secondary providers only). An exception exists for DMERCs/DMEMACs as they require that an NSC number be reported as the legacy identifier for every supplier, even if a supplier is not enrolled in Medicare.

5. Requirement 5229.3 in this CR replaces business requirement 4023.14.

6. Requirement 5229.6 in this CR replaces business requirement 4023.33.

7. Requirement 5229.7-7.2 in this CR replaces business requirement 4023.38.

**B. Policy** Medicare legislation and regulations do not permit CMS to require that "secondary" providers such as a referring/ordering physician, be enrolled in Medicare as a condition for payment of the services or supplies they order, furnish, supervise delivery of etc., for beneficiaries when those services are billed, paid-to or rendered by "primary" providers. For example, CMS could pay a hospital for services ordered for a patient by a non-Medicare physician, for hospital care when the admitting or attending physician is not enrolled in Medicare, hospital surgery costs when the surgeon is not enrolled in Medicare, or a hospital when services are purchased from another provider "under arrangements" even if that other provider is not enrolled in Medicare.

Although Medicare will accept and issue NPIs as provider identifiers in HIPAA standard transactions, paper claims and standard paper remittances (SPRs), Medicare will continue to crosswalk NPIs to the corresponding legacy identifier when payment is affected.

## II. BUSINESS REQUIREMENTS

*"Shall" denotes a mandatory requirement*
*"Should" denotes an optional requirement*

These business requirements are effective when the claim is processed, rather than the date received or the date of service.

| Requirement Number | Requirements | Responsibility ("X" indicates the columns that apply) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | FI | RHHI | Carrier | DMERC | Shared System Maintainers | | | | Other |
| | | | | | | FISS | MCS | VMS | CWF | |
| 5229.1 | When an electronic claim (837, NCPDP, free billing software, DDE claim [FIs only]), or a paper claim effective with implementation of the Form CMS-1450 (UB-04) and the revised Form CMS-1500, is submitted with an NPI for one or more providers, and no Medicare provider legacy number has been submitted for one or more of those providers, the shared system shall perform the following edits for each billing/pay-to, or rendering provider, i.e., primary provider NPI on a claim:<br><br>a. Search the Cross Walk for the NPI of the billing, pay-to or rendering provider. | | | | | X | X | X | X | |
| 5229.1.1 | b. If the NPI is not located, the shared system shall return the claim to the submitter for correction of the NPI. | | | | | X | X | X | | |
| 5229.1.2 | c. If the NPI is located, determine if an Employer Identification Number (EIN) or an SSN (qualified with EI or SY respectively in REF01 in the same 837 claim provider loop as that type of provider) was submitted in the claim and also matches the Taxpayer Identification Number (TIN) in the Medicare Provider Identifier Crosswalk entry for that NPI. (This does not apply to NCPDP, paper, free billing software or DDE claims if there is no requirement for submission of a TIN for a billing/pay-to provider that applies to those claims.) If submitted but it does not match, the shared system shall return the claim to the submitter for correction. | | | | | X | X | X | | |
| 5229.1.3 | d. If no TIN was submitted for a billing or pay-to-provider in an 837 claim, the shared system shall return the claim to the submitter for correction as the 837 implementation guides require that a TIN be reported for each billing or pay-to-provider. | | | | | X | X | X | | |

| Requirement Number | Requirements | Responsibility ("X" indicates the columns that apply) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | FI | RHHI | Carrier | DMERC | Shared System Maintainers | | | | Other |
| | | | | | | FISS | MCS | VMS | CWF | |
| 5229.1.4 | e. If a TIN was submitted and matches that in the Medicare Provider Identifier Crosswalk, the shared system shall continue processing the claim. | | | | | X | X | X | | |
| 5229.1.5 | f. If an NPI was reported on a claim and located in the Medicare Provider Identifier Crosswalk, but a TIN was not reported for a rendering provider, the shared system shall continue processing the claim. | | | | | X | X | X | | |
| 5229.2 | If both an NPI and a Medicare provider legacy identifier is reported on any type of claim (other than the current version of the Form CMS-1500 or a UB-92) to identify a secondary provider, including a referring/ordering, purchased service, service facility location, or supervising provider (applies to carriers but not DMERCs/DMEMACs) or an attending, operating, other, or service facility provider (applies to FIs and RHHIs), the shared system shall verify any NPI-UPIN pair (excluding pairs that include valid surrogate UPINs) against the Medicare crosswalk. If the NPI-UPIN pair is not found on the crosswalk, the shared system shall return the claim to the submitter for correction. | | | | | X | X | X | | |
| 5229.2.1 | If only an NPI is submitted for an ordering physician/practitioner but that NPI is not located in the crosswalk, VMS shall continue processing the claim and populate spaces in the UPIN field on the VMS claim record. | | | | | | | X | | |
| 5229.2.2 | If only an NPI is submitted for an ordering physician/practitioner, and a single UPIN is located in the Medicare crosswalk, VMS shall populate the UPIN value found in the crosswalk into the VMS claim record and continue processing the claim. | | | | | | | X | | |
| 5229.2.3 | If only an NPI is submitted for an ordering physician/practitioner, and there are multiple UPINs in the Medicare crosswalk for this | | | | X | | | X | | DMEMACs |

| Requirement Number | Requirements | Responsibility ("X" indicates the columns that apply) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | FI | RHHI | Carrier | DMERC | Shared System Maintainers | | | | Other |
| | | | | | | FISS | MCS | VMS | CWF | |
| | provider, VMS shall populate spaces in the UPIN field on the VMS claim record and suspend the claim for manual determination of the applicable UPIN by the DMERC/DME MAC. | | | | | | | | | |
| 5229.2.4 | If an NPI and a valid UPIN is submitted for an ordering physician/practitioner, VMS shall validate the NPI-UPIN pair against the Medicare crosswalk and reject the claim if the pair is not located. If the NPI-UPIN pair is found on the crosswalk, VMS shall post both values on the VMS claim record. | | | | | | | X | | |
| 5229.3 | If an NPI is reported on a claim (other than a Form HCFA-1450 (UB-92) or current version of the Form CMS-1500) with or without a legacy identifier for a secondary referring/ordering, purchased service, service facility location, or supervising provider (applies to carriers & DMERCs/DMEMACs) or an attending, operating, other, or service facility provider (applies to FIs and RHHIs), and the NPI was located in the Medicare Provider Identifier Crosswalk with the corresponding legacy identifier and a TIN, but the TIN was not reported on the claim, do <u>not</u> report that TIN in any COB flat file produced. Report only the NPI and the corresponding legacy identifier, if the NPI was located in the Medicare Provider Identifier Crosswalk when no Medicare legacy identifier was reported on the inbound claim, in any COB file produced. | | | | | X | X | X | | |
| 5229.4 | Carriers, DMERCs/DMEMACs, FIs and the COBC shall notify their Medigap and COB trading partners respectively that: TINs will not be reported for secondary providers if not submitted on the claim sent to Medicare; and Since not all "secondary" providers are required to enroll in Medicare and would not then have legacy identifiers on file with Medicare, no | X | X | X | X | | | | | COBC DMEMACs |

| Requirement Number | Requirements | Responsibility ("X" indicates the columns that apply) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | FI | RHHI | Carrier | DMERC | Shared System Maintainers | | | | Other |
| | | | | | | FISS | MCS | VMS | CWF | |
| | Medicare legacy numbers can be forwarded to electronic trading partners in those cases. If a secondary provider is not enrolled in Medicare, no legacy numbers will be reported for the provider unless non-Medicare legacy identifiers are submitted on the claim. It is not possible for Medicare to edit the accuracy of non-Medicare legacy identifiers, however. | | | | | | | | | |
| 5229.5 | Carriers, DMERCs/DMEMACs and FIs shall notify submitters of claims (X12 837, free billing software, and DDE (FIs only), and of the Form CMS-1450 (UB-04) and revised Form CMS-1500 once implemented, but does not apply to NCPDP claims) that they should continue to submit the Medicare provider legacy identifier of each provider that is enrolled in Medicare and was issued a legacy identifier, in addition to the provider's NPI (once available) during Stage 2. | X | X | X | X | | | | | DMEMACs |
| 5229.6 | Contractors shall notify users of DDE/PPTN/PINQ screens that the screens are being expanded for Stage 2 to permit reporting of both an NPI for each provider (once obtained by a provider) in addition to the provider's Medicare legacy identifier. A Medicare legacy identifier should be reported for each billing/pay-to or rendering provider whenever an NPI is reported for that provider. Other types of providers should have a Medicare legacy number reported if those providers are enrolled in Medicare and/or received a legacy identifier from Medicare. | X | X | X | X | | | | | DMEMACs |
| 5229.6.1 | Contractors shall also notify users that failure to report a Medicare legacy number for a provider that had previously enrolled in Medicare could result in a delay in processing of their transaction. | X | X | X | X | | | | | DMEMACs |
| 5229.7 | Contractors shall continue to use legacy identifiers as their EDI submitter/access | X | X | X | X | | | | | DMEMACs |

| Requirement Number | Requirements | Responsibility ("X" indicates the columns that apply) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | FI | RHHI | Carrier | DMERC | Shared System Maintainers | | | | Other |
| | | | | | | FISS | MCS | VMS | CWF | |
| | numbers, where currently used for that purpose, after May 22, 2007, but shall not report legacy identifiers within the body of any HIPAA transaction (other than a COB transaction forwarded to a small trading partner) after that date. | | | | | | | | | |
| 5229.7.1 | Contractors shall not convert their EDI identifiers to incorporate NPIs, unless they prefer to do so for those providers that enroll in the future and may not be issued a legacy identifier. | X | X | X | X | | | | | DMEMACs |
| 5229.7.2 | Contractors shall not convert any other data bases or reports to use of the NPI in lieu or in addition to legacy identifiers unless that is necessary to produce and route an outbound response to the submitter of an electronic transaction, to interface with the shared system, or for recording of data for those providers that enroll with Medicare in the future and may not be assigned a legacy identifier. | X | X | X | X | | | | | DMEMACs |

## III. PROVIDER EDUCATION

| Requirement Number | Requirements | Responsibility ("X" indicates the columns that apply) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | FI | RHHI | Carrier | DMERC | Shared System Maintainers | | | | Other |
| | | | | | | FISS | MCS | VMS | CWF | |
| 5229.8 | A provider education article related to this instruction will be available at www.cms.hhs.gov/MLNMattersArticles shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listerv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly. | X | X | X | X | | | | | DMEMACs |

## V. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

### A. Other Instructions: CRs 4023 and 4320, Pub. 100-20 Transmittals 190 and 204 respectively

| X-Ref Requirement # | Instructions |
|---|---|
| 4023.7 | Not all "secondary" types of providers are required to enroll in Medicare and non-enrollees would not possess Medicare legacy identifiers. |
| 4023.8 | Replaced by 5229.1-1.5. Do not reject claims if a referring/ordering provider's NPI is submitted without a legacy identifier and that NPI is not located in the Medicare Provider Identifier Crosswalk. |
| 4023.14 | Replaced by 5229.3. Reporting of referring/ordering provider NPI and legacy ID information in a COB claim. |
| 4023.29 | Replaced by 5229.5. Not all "secondary" types of providers are required to enroll in Medicare. |
| 4023.33 | Replaced by 5229.6. Reporting of legacy identifiers and TINs |

| | |
|---|---|
| | in COB claims for secondary providers. |
| 4023.38 | Replaced by 5229.7-7.2. Continued use of legacy identifiers as EDI submitter numbers. |
| Attachment 1, 4320 | Replaced by attachment 1 of CR 5229. Revision to indicate where provider identifiers not always required in HIPAA transactions. |

**B. Design Considerations: N/A**

| X-Ref Requirement # | Recommendation for Medicare System Requirements |
|---|---|

**C. Interfaces: N/A**

**D. Contractor Financial Reporting /Workload Impact: N/A**

**E. Dependencies: N/A**

**F. Testing Considerations: N/A**

## VI. SCHEDULE, CONTACTS, AND FUNDING

| | |
|---|---|
| **Effective Date*:** October 1, 2006<br><br>**Implementation Date:** October 2, 2006<br><br>**Pre-Implementation Contact(s):**<br>Kathleen.Simmons@cms.hhs.gov<br>**Post-Implementation Contact(s):**<br>Kathleen.Simmons@cms.hhs.gov | **No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.** |

***Unless otherwise specified, the effective date is the date of service.**

**Attachment**

**Attachment 1**

**Locations of Provider Information in EDI Transactions**

**837 Institutional version 4010A1 Implementation Guide (IG)**

2000A Billing/Pay-to-Provider PRV: *Taxonomy code r*equired *here* if the Service Facility Provider is the same entity as the billing provider and/or the pay-to-provider. *Do not report if the billing/pay-to-provider did not render the services.* When used, ZZ must be reported in PRV02 and the taxonomy code in PRV03.

2010AA Billing Provider Name NM1: Required segment & loop

NM108=Entry of either the EIN, SSN or NPI qualifier *always required*

NM109=The applicable number; *always required*

REF-Situational but required if necessary to report a secondary ID, such as a legacy identifier and a taxpayer identification number. *(TIN always required in REF if NPI is in NM108 and the billing provider is also the pay-to-provider; between October 1, 2006 and May 22, 2007, if the NPI is in NM109, providers are strongly encouraged to submit the corresponding legacy ID.)* Contains qualifiers for the legacy IDs (state license #, BC#, BS#, Medicare Provider #, Provider UPIN, Medicaid Provider #, Tricare #, Facility ID #, PPO #, HMO #, Clinic #, Provider Commercial #, Provider Site #, Location #, State Industrial Accident Provider #, EIN, SSN). Two REF segments needed in the same loop if necessary to report both a legacy identifier and a tax ID.

2010AB Pay-to-Provider Name NM1: Required if the pay-to-provider is different than the billing provider.

NM108, NM109--same as in 2010AA; *always required when this loop is reported*

REF—same as in 2010AA

2300 CLM—Segment and loop *is always required*

CLM05=Health Care Service Location Information *is always required*

CLM05-1=Facility Code Value *is always required*

CLM05-2=Facility Code Qualifier (codes maintained by the NUBC; see the *Type of Bill information* in Chapter 25 of the Medicare Claims Processing manual) *is always required*

CR6 Situational but required for home health claims

CR617=Patient Location Code for the place where the services were supplied to the patient. *Required. Contains codes such as A-acute care facility, C-hospice, E-long term or extended care facility, M-rehabilitation facility, O-outpatient facility, S-SNF, and L-other location.*

2310A Attending Physician Name—Required for each inpatient claim or when a home health plan of treatment is needed

NM108, NM109=Same as in 2010AA; *always required when this loop is reported*

REF—Same as in 2010AA but there would not be a second REF segment for reporting of the EIN or an SSN.

2310B Operating Physician Name—Required when *the surgeon is other than the attending physician.*

NM108, NM109—Same as in 2010AA; *always required when this loop is reported*

REF—Same as in 2010AA but there would not be a second REF segment for reporting of the EIN or an SSN

2310C Other Provider Name—Required for outpatient and home health claims to identify who rendered the care if rendered by a party other than the billing or pay-to-provider*, such as in a locum tenens situation*. Would apply if another provider temporarily furnished care while the primary provider was unavailable for a short period, such as during vacation. Required for non-outpatient claims if the physician who rendered the service for the principal procedure on the claim is other than the operating physician.

NM108, NM109—same as in 2010AA; always required when this loop is reported
REF—Same as in 2010AA but there would not be a second REF segment for reporting of the EIN or an SSN

2310E Service Facility Name—Required if the location of the service is other than the billing or pay-to-provider's location
NM108, NM109—same as in 2010AA; *required "if known"*
REF— Same as in 2010AA but there would not be a second REF segment for reporting of the EIN or an SSN.

The following would only be included in an 837-I if there is a need to report additional payer specific provider IDs for a *COB* payer. NM108 and NM109 for NPI cannot be reported in these loops. The same REF information in 2330D applies to each of these segments.

2330D Other Payer Attending Provider—
REF—Same as in 2010AA.
2330E Other Payer Operating Provider
2330F Other Payer Other Provider
2330H Other Payer Service Facility Provider

The following would only be included if needed to identify where the provider for a specific service differed from the provider information for the rest of the claim.

2420A Attending Physician Name
NM108, NM109—same as in 2010AA; *always required when this loop is reported*
REF—Same as in 2010AA but there would not be a second REF segment for reporting of the EIN or an SSN

2420B Operating Physician Name
NM108, NM109—same as in 2010AA*; always required when this loop is reported*
REF-- Same as in 2010AA but there would not be a second REF segment for reporting of the EIN or an SSN

2420C Other Provider Name—*Required when this service involved another provider, such as a referring, ordering or assisting physician.*
*NM108,* NM109-- Same as in 2010AA; *always required when this loop is reported*
REF-- Same as in 2010AA but there would not be a second REF segment for reporting of the EIN or an SSN

**837 Professional version 4010A1 IG**

2000A Billing/Pay-to-Provider Specialty Information –Required if the rendering provider is the same as the billing or pay-to-provider.
PRV— *Taxonomy code* required when adjudication is known to be impacted by the provider's *specialty* and the rendering provider is the same as the Billing and/or Pay-to-Provider.

2010AA Billing Provider Name—*Required. If the billing (or pay-to) provider is a non-person, such as a group practice or home office of a chain, the individual who provided the service must be reported in the rendering provider loop.*
NM108, NM109=Either an EIN, SSN, or NPI qualifier *must always be reported in NM108 and the corresponding number in NM109*
*(no PRV in this loop)*

REF—Full list of secondary qualifiers; *situational but required if necessary to report another identifier, such as a taxpayer identification number when NPI is reported in NM109*

2010AB Pay-to-Provider Name—Required if different than the billing provider

NM108, NM109-- Same as in 2010AA; always required

REF—Full list of secondary qualifiers; situational but required if necessary to report another identifier, such as a taxpayer identification number when NPI is reported in NM109

2300 Claim Information (CLM)—Always required

*CLM05—Place of service code (maintained by CMS); always required Codes include: 11-office, 21 inpatient hospital, 22-outpatine t hospital, 23-ER hospital, 24 ASC, 26-Militray Treatment Facility, 31-SNF, 34-hospice, 41-land ambulance, 42-air or water ambulance, 49-independent clinic, 50-FQHC, 51-inpatient psychiatric facility, 52-outpatient psychiatric facility (partial hospitalization), 53-community mental health center*

2310A Referring Provider Name—Required *if the claim involved a referral and the specialty of that provider is needed for adjudication (not previously the case)*

NM108, NM109- Same as in 2010AA; situational; the EIN, SSN or NPI would be reported here "if known"

*PRV— Taxonomy code may not be reported unless required as part of a provider-payer contract (not the case for Medicare)*

REF-- Same as in 2010AA but there would not be a second REF segment for reporting of the EIN or an SSN

2310B Rendering Provider Name—Required if different than the billing or pay-to-provider name

NM108, NM109-- Same as in 2010AA; *always required*

PRV—Required *if taxonomy code is needed for adjudication (not previously the case for Medicare)*

REF-- Same as in 2010AA but there would not be a second REF segment for reporting of the EIN or an SSN

2310C Purchased Service Provider Name—Required if the claim involves purchased services such as a diagnostic examination obtained from a third party

NM108, NM109—Situational; *either an EIN, SSN or NPI would be reported here "if known" (no PRV in this loop)*

REF-- Same as in 2010AA but there would not be a second REF segment for reporting of the EIN or an SSN

2310D Service Facility Location—Required if the place where the health care was rendered is different than the location of the billing or pay-to-provider, or if the service qualifies for a HPSA bonus *and the place of service is other than the HPSA billing address*

NM108, NM109—*Situational; either EIN, SSN or NPI would be reported here "if known" (no PRV in this loop)*

REF-- Same as in 2010AA but there would not be a second REF segment for reporting of the EIN or an SSN

2310E Supervising Provider Name—Required if the rendering provider was supervised by a physician

NM108, NM109—Situational; either the EIN, SSN or NPI would be reported here "if known" (no PRV in this loop)

REF-- Same as in 2010AA but there would not be a second REF segment for reporting of the EIN or an SSN

The following would only be included in an 837-P if there is a need to report additional payer specific provider IDs for a *COB* payer. NM108 *and NM109* are never reported in these loops and there is no PRV segment in these loops.

2330D Other Payer Referring Provider
REF-- Same as in 2010AA but there would not be a second REF segment for reporting of the EIN or an SSN (not possible to report NPI in this segment)
2330E Other Payer Rendering Provider
2330F Other Payer Purchased Service Provider
2330G Other Payer Service Facility Location
2330H Other Payer Supervision Provider

The following would only be reported if needed to identify where the provider of a specific service is different than the provider that furnished the other services/supplies in the claim.

2400 CLIA Identification—Required if claim includes lab services and some of those services were referred to an external lab for processing, that lab is also CLIA certified, and the cost of the services provided by that lab are included in this claim.
REF02=CLIA number.
*2400 Purchased Service Identifier (PSI)—Situational, but required for Medicare when a physician's claim includes purchased services. There is no qualifier for this identifier data element; any payer that requires this segment was to specify the identifier to be reported in the segment. Although this is intended to be an identifier for the entity that sold the service to the physician, due to current limitation on carrier access to PINs issued by other carriers, physicians were directed to insert their own identifier in this data element when the purchased service provider is out-of-state. This segment is required by Medicare as it is the only location where the price charged by the purchased service provider can be reported. The NPI of the purchased service provider, even if out-of-state, must be reported as the identifier by May 23, 2007. Once the NPI is required, a physician identifier may no longer be reported in this segment.*
2420A Rendering Provider Name—Required if other than the provider that rendered the other services on the claim
NM108, NM109-- Same as in 2010AA
PRV— *Taxonomy code required when this loop is reported if specialty is needed for adjudication*
REF-- Same as in 2010AA but there would not be a second REF segment for reporting of the EIN or an SSN
2420B Purchased Service Provider
NM108, NM109—*Situational; EIN, SSN or NPI would be reported here "if known"*
*(no PRV segment in this loop)*
REF-- same as in 2010AA but there would not be a second REF segment for reporting of the EIN or an SSN
2420C Service Facility Location—same as 2420B
2420D Supervising Provider Name—same as 2420B
2420E Ordering Provider Name—same as 2420B
2420F Referring Provider Name—same as 2420A (includes a PRV segment)

**835 version 4010A1 IG**
1000B Payee ID—Required
N103—TIN and NPI qualifiers
REF—Full list as in the 837 IGs for secondary qualifiers

2100 Service Provider Name—Required if the rendering provider *is* other than the payee. Information on other providers reported in a claim is not included in an 835 since those other providers are not parties to the payment issued with *the* 835.

2110 Rendering Provider Information—Required if the rendering provider for the service in this loop is different that the payee or the service provider.
REF01=NPI as well as the full list of secondary qualifiers permitted in the 837 provider REF segments.

**276/277 version 4010A1**

2100C Provider Name—Required (used the same in both the 276 and 277)
NM 108, NM109=TIN, legacy number, NPI qualifiers

**NCPDP**

Transaction Header Segment

201-B1 Service Provider ID—Required. Allows an NSC # or an NPI to be reported, but only one or the other may be reported.

Prescriber Segment

468-EZ Prescriber ID Qualifier—Required. Contains qualifiers for UPIN or NPI, but only one may be reported.

411-DB Prescriber ID—Required. Contains the UPIN at present and will be used to report the NPI, but only one may be reported.