

837 I Health Care Claim Institutional

For Independence Administrators

Disclaimer

This Independence Administrators (hereinafter referred to as "IA") Companion Guide to EDI Transactions (the "Companion Guide") provides trading partners with guidelines for submitting electronic batch transactions. Because the HIPAA ASC X12N Implementation Guides require transmitters and receivers to make certain determinations/elections (*e.g.*, whether, or to what extent, situational data elements apply), this Companion Guide documents those determinations, elections, assumptions, or data issues that are permitted to be specific to IA's business processes when implementing the HIPAA ASC X12N 4010A1 Implementation Guides.

This Companion Guide does not replace or cover all segments specified in the HIPAA ASC X12N Implementation Guides. It does not attempt to amend any of the requirements of the Implementation Guides, or impose any additional obligations on trading partners of IA that are not permitted to be imposed by the HIPAA Standards for Electronic Transactions. This Companion Guide provides information on IA specific codes relevant to IA's business processes and rules and situations that are within the parameters of HIPAA. Readers of this Companion Guide should be acquainted with the HIPAA Implementation Guides, their structure, and content.

This Companion Guide provides supplemental information to the Trading Partner Agreement that exists between IA and its trading partners. Trading partners should refer to their Trading Partner Agreement for guidelines pertaining to IA's legal conditions surrounding the implementation of the EDI transactions and code sets. However, trading partners should refer to this Companion Guide for information on IA's business rules or technical requirements regarding the implementation of HIPAA-compliant EDI transactions and code sets.

Nothing contained in this Companion Guide is intended to amend, revoke, contradict, or otherwise alter the terms and conditions of the Trading Partner Agreement. If there is an inconsistency between the terms of this Companion Guide and the terms of the Trading Partner Agreement, the terms of the Trading Partner Agreement will govern.

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Overview of Document

This Companion Guide is to be used as a supplement to the 837 Institutional Health Care Claim Implementation Guide, version 4010A1, issued October 2002. As such, this Companion Guide must be referred to for transmitting the 837 Institutional Health Care Claim transaction to IA.

The purpose of this Companion Guide is to outline IA processes for handling the 837 Institutional Health Care Claim (hereinafter referred to as the "837I"), and to delineate specific data requirements for the submission of IA transactions.

The Companion Guide was developed to guide organizations through the implementation process so that the resulting transaction will meet the following business objectives:

- **Convey all business information required by IA to process transactions.**
- **Interpret information in the same way:** The definition of the transaction will be specific so that trading partners can correctly interpret, from a business perspective, the information that is received from each other.
- **Simplify the communication:** The transaction will be standard to simplify communication between trading partners and to follow the requirements of HIPAA. [TOP](#)

General Instructions

The 837I can be used to submit health care claim billing information, encounter information, or both, from providers of health care services to payers, either directly or via trading partner or clearinghouse.

Payers include, but are not limited to:

- Insurance Company
- Government Agency (Medicare, Medicaid, CHAMPUS, etc.)
- Health Maintenance Organization (HMO)

Transmission Size

5,000 Claims per ST (limit is for CLM segment).

Transaction Structure & Processing -- Batch Mode

There will be a separate ISA-IEA set for each different type of transaction. For example, if an electronic transmission between two trading partners contains claims and authorizations, there will be two ISA-IEA sets; one for the claims (837I) and one for the authorizations (278).

This Companion Guide reflects conventions for batch implementation of the ANSI X12 837I.

Batch Mode Process

The 837I will be implemented in batch mode. The submitting organization will send the 837I to Independence Blue Cross (hereinafter referred to as the "IBC") through some means of telecommunications and will not remain connected while IBC processes the transaction.

If a portion of or the entire ISA segment is unreadable or does not comply with the Implementation Guide and if there is sufficient routing information that can be extracted from the ISA, IBC will respond with an appropriate TA1 transaction. Otherwise, IBC will be unable to respond. In either case, the batch will not be processed.

IBC will respond with a 997 transaction as an acknowledgment to every batch file of 837I transactions that is received. This 997 acknowledgment will be sent whether or not the provider, or its intermediary, requests it. The acknowledgment 997 transaction will indicate whether or not the batch can be processed. If the GS segment of the batch does not comply with the Implementation Guide, IBC may not be able to process the transaction.

If the information associated with any of the claims in the 837I ST-SE batch is not correctly formatted from a syntactical perspective, all claims between the ST-SE will be rejected. Providers should consider this possible response when determining how many patients and claims they will submit in a single 837I.

National Provider Identifier (NPI)

AmeriHealth will require the submission of National Provider Identification Number (NPI) for all electronic claims (837) submitted May 23rd 2007 or thereafter.

If you have obtained your NPI(s) and submitted them to us, you may begin to report them **in addition to your current provider identification numbers.**

837 Institutional: Segment Usage Detail

The 837 Institutional Data Element Segment identifies the specific data content required by IA.

IA Business Rules referenced in the Segment Usage Detail represent the following situations;

The element is required by the Implementation Guide and required by IA.

The element is situational by the Implementation Guide and, when the situation exists, is required to be included by IA.

The element is situational by the Implementation Guide and based on IA's business, is always required by IA.

Segment:	BHT Beginning of Hierarchical Transaction
Segment:	BHT Beginning of Hierarchical Transaction
Loop:	Beginning of Hierarchical Transaction
Level:	Detail
Usage:	Required by Implementation Guide
Business Rule:	IA requires submission with only the following data elements for this segment:

Data Element Summary

Ref Des	Element Name	Element Note
BHT06	Transaction Type Code	Enter code value: CH = Use when submitting claims

Segment: **PRV Billing/Pay to Provider Specialty Info.**
 Loop: **2000A Billing/Pay-To Provider Hierarchical Level**
 Level: **Detail**
 Usage: Situational by Implementation Guide
 Business **IA requires submission with only the following data**
 Rule: **elements for this segment:**

Data Element Summary

Ref Des	Element Name	Element Note
PRV01	Provider Code	Enter value: (choose one) BI for Billing PT for Pay-To
PRV02	Reference Identification Qualifier	Enter value: ZZ Mutual Defined /Taxonomy
PRV03	Provider Taxonomy	Enter value: Provider Taxonomy/Specialty Code

Segment: **SBR** **Subscriber Information**
Loop: **2000B Subscriber Hierarchical Level**
Level: **Detail**
Usage: Required by the Implementation Guide
Business **IA requires submission with only the following data**
Rules: **elements for this segment:**

Data Element Summary

Ref Des	Element Name	Element Note
SBR01	Payer Responsibility Sequence Number Code	If " S " Secondary or " T " Tertiary is populated, the pages are 19-23 as required.
SBR09	Claim Filing Indicator Code	Enter Value: BL for IA Products

Segment: **NM1 Billing Provider Name**
 Loop: **2010AA Billing Provider Name**
 Level: **Detail**
 Usage: Required by Implementation Guide > 5/23/07
 Business **IA requires submission with only the following data**
 Rule: **elements for this segment:**

Data Element Summary

Ref Des	Element Name	Element Note
NM108	Reference Identification Qualifier	Enter code value: XX - Health Care Financing Administration National Provider Identifier
NM109	Billing Provider Identifier	Enter the appropriate National Provider ID (NPI)

Segment: **REF Billing Provider Secondary Information**
 Loop: **2010AA Billing Provider Name**
 Level: **Detail**
 Usage: Situational by Implementation Guide
 Business **Based on IA's business, IA always requires this**
 Rule: **segment be included. IA requires submission with only**
the following data elements for this segment:

Data Element Summary

Ref Des	Element Name	Element Note
REF01	Reference Identification Qualifier	Enter code value: 1A for IA Products
REF02	Billing Provider Additional Identifier	Enter the appropriate provider identification number Tax Identification

Segment: **NM1 Subscriber Name**
 Loop: **2010BA Subscriber Name**
 Level: **Detail**
 Usage: Required by Implementation Guide
 Business **IA requires submission with only the following data**
 Rule: **elements for this segment:**

Data Element Summary

Ref Des	Element Name	Element Note
NM108	Identification Code Qualifier	MI: Member Identification Use for IA products.
NM109	Subscriber Primary Identifier	Enter the value from the subscriber's identification card (ID card) including alpha characters. i.e. YX_123456789 IA agreement member ID – YX_123456789

Segment: **NM1** Payer Name
Loop: **2010BC Payer Name**
Level: **Detail**
Usage: Required by Implementation Guide
Business Rule: **IA requires submission with only the following data elements for this segment:**

Data Element Summary

Ref Des	Element Name	Element Note
NM108	Identification Code Qualifier	Enter code value: PI Payer Identification
NM109	Payer Identification Code	Enter value: TA720 or 54763 IA Products You need to verify with your clearinghouse or vendor on which payer ID to use.

Segment: **NM1 Patient Name**
 Loop: **2010CA Patient Name**
 Level: **Detail**
 Usage: Required by Implementation Guide
 Business Rule: **When the situation exists, IA requires that this segment be included. IA requires submission with only the following data elements for this segment:**

Data Element Summary

Ref Des	Element Name	Element Note
NM108	Identification Code Qualifier	MI: Use for IA products.
NM109	Subscriber Primary Identifier	Enter the value from the subscriber's identification card (ID card) including alpha characters. i.e. YX_123456789 IA agreement member ID – YX_123456789

Segment: **CLM Health Claim Information**
Loop: **2300 Claim Information**
Level: **Detail**
Usage: Required by Implementation Guide
Business **IA requires submission with only the following data**
Rule: **elements for this segment:**

Data Element Summary

Ref Des	Element Name	Element Note
CLM01	Claim Submitter's Identifier (Patient Control Number)	Do not enter values with more than 20 characters.

Segment: **CLM Health Claim Information**
Loop: **2300 Claim Information**
Level: **Detail**
Usage: Situational by Implementation Guide
Business **Based on IA's business, IA always requires this**
Rule: **segment be included. IA requires submission with only**
the following data elements for this segment:

Data Element Summary

Ref Des	Element Name	Element Note
CLM05-3	Claims Frequency Type Code	Enter code value: (choose one) 5 (Late Charge) 6 (Correction) 7 (Replacement)

Segment: **DTP Admission Date / Hour**
 Loop: **2300 Claim Information**
 Level: **Detail**
 Usage: Situational by Implementation Guide
 Business Rule: **When the situation exists, IA requires that this segment be included. IA requires submission with only the following data elements for this segment:**

Data Element Summary

Ref Des	Element Name	Element Note
DTP03	Admission Date and Hour	This element requires a twelve-digit date and time in the format of CCYMMDDHHMM. Hours (HH) should be expressed as "00" for 12-midnight, "01" for 1 a.m., and so on through "23" for 11 p.m. If the hour of the discharge is not known, use a default of "00". Minutes (MM) should be expressed as "00" through "59". If the actual minutes are not known, use a default of "00".

Segment: **DTP Discharge Hour**
 Loop: **2300 Claim Information**
 Level: **Detail**
 Usage: Situational by Implementation Guide
 Business **When the situation exists, IA requires that this**
 Rule: **segment be included. IA requires submission with only**
the following data elements for this segment:

Data Element Summary

Ref Des	Element Name	Element Note
DTP03	Discharge Hour	This element requires a four-digit time in the format of HHMM. Hours (HH) should be expressed as "00" for 12-midnight, "01" for 1 a.m., and so on through "23" for 11 p.m. If the hour of the discharge is not known, use a default of "00". Minutes (MM) should be expressed as "00" through "59". If the actual minutes are not known, use a default of "00".

Segment: **HI** **Principal, Admitting, E-Code and Patient reason
for visit diagnosis information
2300 Claim Information**
Loop: **Detail**
Level: **Situational by Implementation Guide**
Usage: **Based on IA's business, IA always requires this
segment be included. IA requires submission with only
the following data elements for this segment:**
Business
Rule:

Data Element Summary

Ref Des	Element Name	Element Note
HI01-1	Code List Qualifier Code	BK Principal Diagnosis
HI01-2	Principal Diagnosis Code	Enter value: Principal Diagnosis Code

Segment: **HI Value Information**
 Loop: **2300 Claim Information**
 Level: **Detail**
 Usage: Situational by Implementation Guide
 Business: **Based on IA's business, IA always requires this**
 Rule: **segment be included. IA requires submission with only**
the following data elements for this segment:

Data Element Summary

Ref Des	Element Name	Element Note
HI01-1	Code Qualifier	Enter code value: BE (Value Information)
HI01-2	Value Code	A1 (Coinsurance or Deductible) A2 (Coinsurance or Deductible) B1 (Coinsurance or Deductible) B2 (Coinsurance or Deductible) C1 (Coinsurance or Deductible) C2 (Coinsurance or Deductible) 09 (Coinsurance Amount in 1 st calendar year) 11 (Coinsurance Amount in 2 nd calendar year) 08 (Lifetime Reserve Amount in 1 st year) 10 (Lifetime Reserve Amount in 2 nd year) 06 (Medicare Blood Deductible)

Segment: **REF Medical Record Number**
Loop: **2300 Claim Information**
Level: **Detail**
Usage: Situational by Implementation Guide
Business: **Based on IA's business, IA always requires this**
Rule: **segment be included. IA requires submission with only**
the following data elements for this segment:

Data Element Summary

Ref Des	Element Name	Element Note
REF01	Reference Identification Qualifier	Enter code value: EA (Medical Record Identification Number)
REF02	Medical Record Number	Enter the Medical record number

Segment: **REF** **Original Reference Number (ICN/DCN)**
Loop: **2300 Claim Information**
Level: **Detail**
Usage: Situational by Implementation Guide
Business **Based on IA's business, IA always requires this**
Rule: **segment be included. IA requires submission with only**
the following data elements for this segment:

Data Element Summary

Ref Des	Element Name	Element Note
REF01	Reference Identification Qualifier	Enter code value: F8 (Original Reference Number)
REF02	Claim Original Reference Number	Enter value: IA 11 digit claim number

Segment: **PRV Reforming Provider Specialty Information**
Loop: **2310D Referring Provider Name**
Level: **Detail**
Usage: Situational by Implementation Guide
Business **IA requires submission with only the following data**
Rule: **elements for this segment:**

Data Element Summary

Ref Des	Element Name	Element Note
PRV01	Provider Code	RF for Referring
PRV02	Reference Identification Qualifier	ZZ Healthcare Provider Taxonomy Code Indicator
PRV03	Provider Taxonomy	Provider Taxonomy Specialty Code

Segment: **CAS Claim Level Adjustment**
 Loop: **2320 Other Subscriber Information**
 Level: **Detail**
 Usage: Situational by Implementation Guide
 Business: **Based on IA's business, IA always requires this**
 Rule: **segment be included. IA requires submission with only**
the following data elements for this segment:

Data Element Summary

Ref Des	Element Name	Element Note
CAS01	Claim Adjustment Group Code	Enter code value: (choose one) CO (Contractual Obligations) CR (Corrections and Reversals) OA (Other Adjustments) PI (Payer Initiated Reductions) PR (Patient Responsibility)
CAS02	Claims Adjustment Reason Code	Enter Adjustment Reason Code at the claim level
CAS03	Claim Adjustment Amount	Enter value: Adjustment Amount

Segment: **AMT Payer Prior Amount**
Loop: **2320 Other Subscriber Information**
Level: **Detail**
Usage: Situational by Implementation Guide
Business **Based on IA's business, IA always requires this**
Rule: **segment be included. IA requires submission with only**
the following data elements for this segment:

Data Element Summary

Ref Des	Element Name	Element Note
AMT01	Amount Qualifier	Enter code value: C4 Prior Payment - Actual
AMT02	Amount Other Payer Patient Paid Amount	Enter Monetary Amount: Prior Payment Amount

Segment: **NM1 Other Subscriber Name**
 Loop: **2330A** Other Subscriber Name
 Level: Detail
 Usage: Situational by Implementation Guide
 Business: **Based on IA's business, IA always requires this**
 Rule: **segment be included. IA requires submission with only**
the following data elements for this segment:

Data Element Summary

Ref Des	Element Name	Element Note
NM101	Entity Identifier Code	Enter code value: IL (Insured or Subscriber)
NM102	Entity Type Qualifier	Enter code value: (choose one) 1 (Person) 2 (Non Person Entity)
NM103	Other Insured Last Name	Enter value: Other Subscriber last or Organization Name
NM104	Other Insured First Name	Enter value: Other Subscriber's first name is required if a person.
NM108	Identification Code Qualifier	Enter code value: (choose one) MI (Member Identification Number) ZZ (Mutually Defined)
NM109	Other Insured Identifier	Enter Member Identification Number or Employee Identification Number

Transaction Acknowledgements

TA1 Interchange Acknowledgement Transaction

All X12 file submissions are pre-screened upon receipt to determine if the ISA or IEA segments are unreadable or do not comply with the HIPAA Implementation Guide. If errors are found, IBC will send a TA1 response transaction to notify the trading partner that the file cannot be processed. No TA1 response transaction will be sent for error-free files.

Example: Once the 837I transaction is received by IBC, the file is checked for compliance. Within IBC, a validation is performed on the ISA loop and the IEA loop information. If these segments are missing required elements or have a non-standard structure, the file will receive a full file reject and the TA1 response transaction will be sent to the trading partner.

997 Functional Acknowledgement

If the file submission passes the ISA/IEA pre-screening above, it is then checked for HIPAA compliance syntactical and content errors. When the compliance check is complete, a 997 will be sent to the trading partner informing them which claims in the file were accepted for processing or rejected.

Example: An X12 file has passed pre-screening, and is then checked against the HIPAA standard. Once the file has been processed against the HIPAA standard, a 997 is generated indicating which claims within the file have passed or failed syntactical/content errors. No further processing of the failed X12 transaction will occur.

Unsolicited 277

This acknowledgment is used for the 837I to provide accepted or rejected claim status for each claim contained in the batch.

***It is important to note that:

1. Only accepted claims are submitted to the claims adjudication system for processing and the outcome results will appear on the statement of remittance (SOR).
2. A detailed explanation of the reason for claim rejection is contained within the STC12 segment of the unsolicited transaction.

Example: A batch file is received with three 837I claims that pass compliance. During processing, the first claim rejects due to invalid member information, the second claim rejects due to an invalid procedure code, and the third claim is accepted with no errors. The Unsolicited 277 is generated and returns a status of one accepted claim and two rejected claims along with an explanation of the reasons the claims were rejected. In addition, the one accepted claim is submitted to the claims adjudication system for processing.