837 I Health Care Claim Institutional

Revision#	Date	Summary
1.0	10/26/06	Original
1.1	10/26/08	NPI requirements
1.2	06/14/11	All associated updates from 4010 to 5010.

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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 5010A2 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.

Overview of Document

This Companion Guide is to be used as a supplement to the 837 Institutional Health Care Claim Implementation Guide, version 5010A2, including all Erratas issued up through June 2010. 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.

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).

TOP

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 IA through some means of telecommunications and will not remain connected while IA 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, IA will respond with an appropriate TA1 transaction. Otherwise, IA will be unable to respond. In either case, the batch will not be processed.

IA will respond with a 999 transaction as an acknowledgment to every batch file of 837I transactions that is received. This 999 acknowledgment will be sent whether or not the provider, or its intermediary, requests it. The acknowledgment 999 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, IA 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.

TOP

National Provider Identifier (NPI)

IA will require the submission of National Provider Identification Number (NPI) for all electronic claims.

You may also report your current provider identification numbers **in addition to your NPI(s).**

Present on Admission Indicators (POA)

IA requires the submission of POA codes on electronic inpatient claims (837).

These values are to be populated in the HIXX-9 (ninth position of the diagnosis composite) segments. Please refer to the 837 Institutional Health Care Claim Implementation Guide for details.

TOP

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

TOP

Segment:	PRV Provider Information
Loop:	**2000A Billing/Pay-To Provider Hierarchical Level**
Level:	**Detail**
Usage:	Situational 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
PRV01	Provider Code	Enter value: (choose one) **BI** for **Billing**
PRV02	Reference Identification Qualifier	Enter value: **PXC** for **Healthcare Provider Taxonomy**
PRV03	Reference Identification	Enter value: **Provider Taxonomy Code**

Segment:	NM1 Billing Provider Name
Loop:	**2010AA Billing Provider 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	Reference Identification Qualifier	Enter code value: **XX -** Health Care Financing Administration National Provider Identifier
NM109	Identification Code	Enter the appropriate National Provider ID (NPI)

NOTE: When the organization is not a health care provider (is an "atypical" provider) and, thus, not eligible to receive an NPI, the NM108 and NM109 fields will be omitted. The "atypical" provider must submit their TIN in the REF segment and their assigned Independence Blue Cross Corporate ID in loop 2010BB/REF (Billing Provider Secondary Identification segment).

TOP

Segment:	**N3** Billing Provider Address
Loop:	**2010AA Billing Provider Address Detail**
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**
N301	Address Information	The Billing Provider Address must be a street address. Post Office Box or Lock Box addresses are to be sent in the Pay-To Address Loop (Loop ID 2010AB), if necessary.

TOP

Segment:	SBR Subscriber Information
Loop:	**2000B Subscriber Hierarchical Level**
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**
SBR09	Claim Filing Indicator Code	Enter value: (choose one) **CI** for IA Products **MA** or **MB** for Medicare Crossover Claims

TOP

Segment: **NM1** Subscriber Name

Loop: **2010BA Subscriber 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**
NM104	Subscriber First Name	Enter value: **Subscriber's first name is required when NM102 = 1 and the person has a first name.**
NM109	Subscriber Primary Identifier	Enter the value from the subscriber's identification card (ID Card), including alpha characters. Spaces, dashes and other special characters that may appear on the ID Card are for readability and appearance only, are not part of the identification code, and therefore should not be submitted in this transaction. Note: When the subscriber is not the patient, the patient's ID (from the ID card) will be submitted in this 2010BA/NM109 field segment. The remainder of the patient's information (name, birth date, etc.) will continue to be submitted in the 2010CA loop.

TOP

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	Payer Identification Code	Enter code value: **PI** (Payer ID)
NM109	Payer Supplemental Id	Enter value: 54763 - AmeriHealth Administrators TA720 – Independence Administrators

TOP

Segment:	REF Billing Provider Secondary Information
Loop:	**2010BB Billing Provider Name**
Level:	**Detail**
Usage:	Situational by Implementation Guide
Business Rule:	**Based on IA's business, IA always requires 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**
REF01	Reference Identification Qualifier	Enter code value: **G2** for all IA Products
REF02	**Original Reference Number**	Enter the appropriate IBC Corporate ID number

TOP

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
NM104	Patient's First Name	Enter the value: **Patient's first name is required when NM102 = 1 and the person has a first name.** Note: The patient's ID (from the ID card) must be submitted in the 2010BA/NM109 Field segment. The remainder of the patient's information (name, birth date, etc.) will continue to be submitted in the 2010CA loop.

TOP

Segment:	CLM Health Claim Information
Loop:	**2300 Claim Information**
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**
CLM01	Claim Submitter's Identifier (Patient Control Number)	Do not enter values with more than 20 characters.

TOP

Segment:	HI Health Care Information Codes
Loop:	**2300 Claim Information**
Level:	**Detail**
Usage:	Situational by Implementation Guide
Business Rule:	**Based on IA's business, IA always requires 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**
HI01-1	Code List Qualifier Code	**BK** Principal Diagnosis
HI01-2	Industry Code	Enter value: Principal Diagnosis
HI01-9	Yes/No Condition Or Response Code	Enter value: Present on Admission Indicator (Choose one): **N** No **U** Unknown **W** Not Applicable **Y** Yes

TOP

Segment: **DTP** Discharge 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	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".

TOP

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 CCYYMMDDHHMM. 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".

TOP

Segment: **SBR** Subscriber Information

Loop: **2000B Subscriber Information**

Level: **Detail**

Usage: Required by the HIPAA Implementation Guide

Business Rules: **IA requires submission with only the following data elements for this segment:**

Data Element Summary

Ref Des	Element Name	**Element Note**
SBR01	Payer Responsibility Sequence Number Code	If value other than "P" (Primary is populated, then pages 21-24 are required.

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

Data Element Summary

Ref Des	Element Name	**Element Note**
HI01-1	Value Code Qualifier	Enter code value: **BE** (Value Information)
HI01-2	Value Code	**09** (Coinsurance Amount in 1st calendar year) **11** (Coinsurance Amount in 2nd calendar year) **08** (Lifetime Reserve Amount in 1st year) **10** (Lifetime Reserve Amount in 2nd year) **06** (Medicare Blood Deductible) **80** (Covered Days) **81** (Non-covered Days) **82** (Co-insurance Days) **83** (Lifetime Reserve Days) **Note**: For Medicare Part A – **coinsurance** amounts use Value Codes 9-11 For Medicare Part A – deductible (previously identified by Value Code A1, B1, C1) are to be reported in the CAS (Claim Adjustment Group Code "PR"=Patient Responsibility) segment.

Segment:	CAS Claim Level Adjustment
Loop:	**2320 Other Subscriber Information**
Level:	**Detail**
Usage:	Situational by Implementation Guide
Business Rule:	**Based on IA's business, IA always requires 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**
CAS01	Claims 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)
CASO2	Claims Adjustment Reason Code	**Enter Adjustment Reason Code at the claim level**
CAS03	Claim Adjusted Amount	Enter value: **Adjustment Amount**

Note:

- For **Medicare Part A Deductible** (previously identified by Value Code A1, B1, and C1) should be reported as follows in the **2320** loop.

  CAS Segment (Claim Adjustment Group Code "PR" = Patient Responsibility)

  1 = Deductible

- For **Medicare Part A – Coinsurance** amounts (previously identified by Value Codes A2, B2, and C2) use Value codes 09 – 11 (CAS Segment is not required)

- For **Medicare Part B** – Coinsurance amounts should be submitted at the **2430** loop.

  CAS segment (Claim Adjustment Group Code "PR"=Patient Responsibility)

  2 = Co-insurance

TOP

Segment: AMT Coordination of Benefits (COB) Payer Paid Amount

Loop: **2320 Other Subscriber Information**

Level: **Detail**

Usage: Situational by Implementation Guide

Business Rule: **Based on IA's business, IA always requires 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**
AMT01	Amount Qualifier	Enter code value: **D** (Payer Paid Amount)
AMT02	Amount	Enter value: **Payer Paid Amount** (amount paid by prior payer).

TOP

Segment: **NM1** Subscriber Name

Loop: **2330A Other Subscriber Name**

Level: **Detail**

Usage: Situational by Implementation Guide

Business Rule: **Based on IA's business, IA always requires 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
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	Subscriber Last Name	Enter value: **Subscriber last or Organization Name**
NM104	Subscriber First Name	Enter value: **Subscriber's first name is required when NM102 = 1 and the person has a first name.**
NM108	Identification Code Qualifier	Enter code value: (choose one) **MI** (Member Identification Number)
NM109	Identification Code	Enter value: **Member Identification Number** **Employee Identification Number**

TOP

Segment:	CLM Health Claim Information
Loop:	**2300 Claim Information**
Level:	**Detail**
Usage:	Situational by Implementation Guide
Business Rule:	**Based on IA's business, IA always requires 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**
CLM05-3	Claims Frequency Type Code	Enter code value: (choose one) If one of the following values is populated, then page 26 – 28 are required: **5** (Late Charge) **7** (Replacement) **8** (Void/Cancel)

TOP

Segment:	REF Original Reference Number
Loop:	**2300 Claim Information**
Level:	**Detail**
Usage:	Situational by Implementation Guide
Business Rule:	**Based on IA's business, IA always requires 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**
REF01	Reference Identification Qualifier	Enter code value: **F8** (Original Reference Number)
REF02	**Original Reference Number**	Enter value: **IA claim number**

TOP

Segment:	REF Medical Record Number
Loop:	**2300 Claim Information**
Level:	**Detail**
Usage:	Situational by Implementation Guide
Business Rule:	**Based on IA's business, IA always requires 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**
REF01	Reference Identification Qualifier	Enter code value: **EA** (Medical Record Number)
REF02	Original Reference Number	Enter value: **Medical record number**

TOP

Segment: NTE Billing Note
Loop: **2300 Claim Information**
Level: **Detail**
Usage: Situational by Implementation Guide
Business Rule: **Based on IA's business, IA always requires 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**
NTE01	Reference Identification Qualifier	Enter code value: **ADD** (Additional Information)
NTE02	**Original Reference Number**	**Enter a detail description regarding the adjustment request.**

TOP

Segment:	LIN Drug Identification
Loop:	**2410 – Drug Identification**
Level:	**Detail**
Usage:	Situational by Implementation Guide
Business Rule:	**IA's requires submission of Loop ID 2410 to specify billing/reporting for drugs provided that may be part of the service(s) described in SV1.**

Data Element Summary

Ref Des	Element Name	**Element Note**
LIN02	Product/Service ID Qualifier	Enter Code Value: N4 (National Drug Code in 5-4-2 format)
LIN03	Product/Service ID	Enter Value: National Drug code

TOP

Segment:	CPT Pricing Information
Loop:	**2410 – Drug Identification**
Level:	**Detail**
Usage:	Situational by Implementation Guide
Business Rule:	**IA requires the submission of Loop ID 2410 and the provision of a price specific to the NDC provided in LIN03 that is different from the price reported in SV102.**

Data Element Summary

Ref Des	Element Name	Element Note
CPT04	Quantity	Enter Value: National Drug Unit Count
CPT05	Composite Unit of Measure	
CPT05-1	Unit or Basis for Measurement Code	Enter Code Value: **F2** for International Unit **GR** for Gram **ME** for Milligram **ML** for Milliliter **UN** for Unit

TOP

Segment:	REF Reference Identification
Loop:	**2410 – Drug Identification**
Level:	**Detail**
Usage:	Situational by Implementation Guide
Business Rule:	**IA requires the submission of Loop ID 2410 if dispensing of the drug has been done with an assigned Rx number**

Data Element Summary

Ref Des	Element Name	**Element Note**
REF01	Reference Identification Qualifier	Enter Code Value: XZ (Pharmacy Prescription Number)
REF02	Reference Identification	Enter Value: Prescription Number

TOP

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.

999 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 999 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 999 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.