837P Health Care Claim HIPAA 5010A1 Professional

Revision summary

Revision Number	Date	Summary of Changes
1.0	09/15/2011	Original
1.1	09/16/2011	Document reorganized
1.2	11/03/2011	Language changed on page 13 from “always required” to “suggests”

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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 5010A1 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 Professional Health Care Claim Implementation Guide, version 5010A1, including all Errata issued up through June 2010. As such, this Companion Guide must be referred to for transmitting the 837 Professional Health Care Claim transactions to IA.

The purpose of this Companion Guide is to outline IA requirements for handling the 837 Professional and to delineate specific data requirements for the submission of the 837P to IA.

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

- **Convey all required 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 837P can be used to submit health care claim billing information, encounter information, or both, from providers of health care services either directly or via trading partner or clearinghouse.
TOP

Payers include, but not limited to:

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

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 claims (837) and one for authorizations (278).

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

Batch Mode Process

The 837P will be implemented in batch mode. The submitting organization will send the 837P 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 837P 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 837P 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 837P.

TOP

National Provider Identifier (NPI)

Independence Administrators requires the submission of National Provider Identification Number (NPI) for all electronic claims (837).

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

TOP

837 Professional: Segment Usage Detail

The 837 Professional 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
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: 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	Identification Code Qualifier	Enter code value: **XX -** Centers for Medicare and Medicaid Services 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 IBC/KHPE Corporate ID in loop 2010BB/REF (Billing Provider Secondary Identification segment).

TOP

Segment: N3 Billing Provider Address
Loop: **2010AA Billing Provider Address**
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: **2010BB 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 Primary Identifier	Enter value: (choose one) **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 suggests 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 IA
REF02	**Original Reference Number**	Enter the appropriate provider identification number.

NOTE: Appropriate provider identification numbers are assigned IBC/KHPE Corporate ID [ten (10) digits-numeric) or IA provider number [six (6) alphanumeric digits].

TOP

Segment: NM1 Patient Name
Loop: **2010CA Patient 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	Patient's First Name	Enter 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 more that 20 characters.

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 for adjustment requests (corrections and reversals):**

Data Element Summary

Ref Des	Element Name	**Element Note**
CLM05-3	Claims Frequency Type Code	Enter code value: (choose one) **7** (Replacement) **8** (Void/Cancel)

TOP

Segment:	REF Payer Claim Control Number (Original Reference Number)
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 when submitting an adjustment request (corrections and reversals):**

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: **The IA claim number**

TOP

Segment: NTE Claim Notes
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 when submitting an adjustment request (corrections and reversals):**

Data Element Summary

Ref Des	Element Name	**Element Note**
NTE01	Notes Reference Code	Enter code value: **ADD** (To provide additional detail description for the adjustment).
NTE02	Claim Note Text	Enter a detail description regarding the adjustment request.

TOP

Segment: NM1 Rendering Provider Name
Loop: **2310B Rendering 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**
NM101	Entity Identifier Code	Enter code value: **82** (Rendering Provider)
NM102	Entity Type Qualifier	Enter code value: (choose one) **1** (Person) **2** (Non Person Entity)
NM103	Name Last or Organization Name	Enter value: **Rendering Provider last or Organization Name**
NM104	Name First	Value: **Requesting Rendering Provider's first name**
NM108	Identification Code Qualifier	Enter code value: **XX -** Centers for Medicare and Medicaid Services National Provider Identifier
NM109	Identification Code	Enter the appropriate Rendering Provider National Provider ID (NPI).

TOP

Segment:	REF Rendering Provider Secondary Identification
Loop:	**2310B Rendering Provider Name**
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**
REF01	Reference Identification Qualifier	Enter code value: **G2** for IA
REF02	Reference Identification	Enter the appropriate rendering provider identification number.

NOTE: Appropriate provider identification numbers are assigned IBC/KHPE Corporate ID [ten (10) digits-numeric) or IA provider number [six (6) alphanumeric digits].

TOP

Segment: NM1 Service Facility Location
Loop: **2310C Service Facility Location**
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**
NM101	Entity Identifier Code	Enter code value: **77** Service Location
NM102	Entity Type Qualifier	Enter code value: **2** (Non Person Entity)
NM103	Name Last or Organization Name	Enter value: **Laboratory or Organization Name**
NM108	Identification Code Qualifier	Enter code value: **XX –** Centers for Medicare and Medicaid Services National Provider Identifier
NM109	Identification Code	Enter the appropriate National Provider ID (NPI).

TOP

Segment:	LIN Drug Identification
Loop:	**2410 — Drug Identification**
Level:	**Detail**
Usage:	Situational by Implementation Guide
Business Rule:	**IA 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 provide 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**
CPT03	Unit Price	Enter Value: Drug Unit Price
CPT04	Quantity	Enter Value: National Drug Unit Count
CPT05	Composite Unit of Measure	
CPT05-1	Unit or Basis for Measurement Code	Enter Code Value: (choose one) **F2** for International Unit **GR** for Gram **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

Segment: NM1 Rendering Provider Name
Loop: **2420A Rendering Provider Name**
Level: **Detail**
Usage: Situational by Implementation Guide
Business Rule: **IA requires submission if the Rendering Provider NM1 information is different than that carried in the 2310B (claim) loop and this particular service line has a different Rendering Provider.**

Data Element Summary

Ref Des	Element Name	**Element Note**
NM101	Entity Identifier Code	Enter code value: **82** (Rendering Provider)
NM102	Entity Type Qualifier	Enter code value: (choose one) **1** (Person) **2** (Non Person Entity)
NM103	Name Last or Organization Name	Enter value: **Rendering Provider last or Organization Name**
NM104	Name First	Value: **Rendering Provider first name**
NM108	Identification Code Qualifier	Enter code value: **XX -** Centers for Medicare and Medicaid Services National Provider Identifier
NM109	Identification Code	Enter the appropriate National Provider ID (NPI).

TOP

Segment:	REF Rendering Provider Secondary Identification
Loop:	**2420A Rendering Provider Name**
Level:	**Detail**
Usage:	Situational by Implementation Guide
Business Rule:	**IA requires submission if the Rendering Provider NM1 information is different than that carried in the 2310B (claim) loop and this particular service line has a different Rendering Provider.**

Data Element Summary

Ref Des	Element Name	**Element Note**
REF01	Reference Identification Qualifier	Enter code value: **G2** for IA
REF02	Reference Identification	Enter the appropriate rendering provider identification number.

NOTE: Appropriate provider identification numbers are assigned IBC/KHPE Corporate ID [ten (10) digits-numeric) or IA provider number [six (6) alphanumeric digits].

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 28-32 are required.

TOP

Segment:	CAS Claims Level Adjustment
Loop:	**2320 Other Subscriber Information**
Level:	**Detail**
Usage:	Required by Implementation Guide
Business Rule:	**IA requires submission with only the following data elements for this segment when submitting a Coordination of Benefits at the claim level:**

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 value: **Adjustment Reason Code**
CAS03	Claim Adjusted Amount	Enter value: **Adjustment Amount**

TOP

Segment: AMT COB Payer Paid Amount
Loop: **2320 Other Subscriber Information**
Level: **Detail**
Usage: Required by Implementation Guide
Business Rule: **IA requires submission with only the following data elements for this segment when submitting a Coordination of Benefits:**

Data Element Summary

Ref Des	Element Name	**Element Note**
AMT01	Amount Qualifier Code	Enter code value: **D** (Payer Amount Paid)
AMT02	Monetary Amount	Enter value: **Payer Paid Amount**

TOP

Segment:	AMT COB Patient Responsibility Amount
Loop:	**2320 Other Subscriber Information**
Level:	**Detail**
Usage:	Required by Implementation Guide
Business Rule:	**IA requires submission with only the following data elements for this segment when submitting a Coordination of Benefits:**

Data Element Summary

Ref Des	Element Name	**Element Note**
AMT01	Amount Qualifier Code	Enter code value: **F2** (Patient Responsibility Actual)
AMT02	Monetary Amount	Enter value: **Patient Responsibility Amount**

TOP

Segment: NM1 Other Subscriber Name
Loop: **2330A Other Subscriber Name**
Level: **Detail**
Usage: Required by Implementation Guide
Business Rule: **IA requires submission with only the following data elements for this segment IA requires submission with only the following data elements for this segment when submitting a Coordination of Benefits:**

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	Name Last or Organization Name	Enter value: **Subscriber last or Organization Name**
NM104	Name First	Enter value: **Subscriber's first name**
NM108	Identification Code Qualifier	Enter code value: **MI** (Member Identification Number)
NM109	Identification Code	Enter value: **Member Identification Number**

TOP

Segment: CAS Claims Adjustment
Loop: **2430 — Line Adjudication Information**
Level: **Detail**
Usage: Situational by Implementation Guide
Business Rule: **IA requires submission with only the following data elements for this segment when submitting a Coordination of Benefits at the line level:**

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 value: **Adjustment Reason Code at the line level**
CAS03	Claim Adjusted Amount	Enter value: **Adjustment Amount**

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, IA 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 837P is received by IA, the file is checked for HIPAA compliance. Within IA, 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 within the timeframes required by applicable law.

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

The Unsolicited 277 acknowledgment is used for the 837P. The Unsolicited 277 acknowledgment provides accepted or rejected claim status for each claim contained within the batch.

****It is important to note that:*
Only accepted claims are submitted to the claims adjudication system for processing and the outcome results will appear on the statement of remittance (SOR).
A detailed explanation of the reason for claim rejection is contained in the STC12 segment of the Unsolicited 277 transaction.

Example: A batch file is received with three 837P 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.