
VI. CLAIMS EDI PROCESSING PROCEDURES

A. General Information

Providers wishing to submit claims electronically to IEHP must be sent in ANSI X12 837 Ver. 4010 in a 128 bit encryption (review Section II, “Getting Started – File Transfer Procedures).

When Providers want to submit EDI claims they must ensure that their file is compliant with ANSI X12 837 Ver. 4010 companion guide. The companion guide contains all information IEHP requires in addition to what the HIPAA ANSI X12 837 Ver. 4010 implementation guide requires. For a better understanding of the format, Providers can download ANSI X12 837 Ver. 4010 implementation guide from Washington Publishing Company at <http://www.wpc-edi.com>.

Providers must test their files with IEHP prior to submitting claims in production level. Testing includes verifying all loops and segments are included as required in ANSI X12 837 Ver. 4010 implementation guide, and whether all fields are using the required formats and field separators. Providers have to successfully process at least two consecutive files in order to move into production mode. Providers are urged to use third-party testing and complete the certification process prior to submitting to IEHP to insure that the files they send meet HIPAA standards. Currently, Providers may test their files for free at <http://www.hipaadesk.com/>.

Claims in production are processed by our pre-processors and an EDI acknowledgement files (ANSI X12 997 & ANSI X12 277) are generated and placed in the providers outbound folder after each submission. ANSI X12 997 confirms the claim file was accepted by the pre-processors. The ANSI X12 277 provides detail on each claim and indicates whether a claim was received successfully or rejected by our pre-processor. Providers can pick up this response file from the outbound claims section of their FTP folder (see File Transmission section). Providers can also check the status of their claims by visiting the IEHP Provider website at <http://ww2.iehp.org/IEHP/Providers/>.

VII. CLAIMS EDI PROCESSING PROCEDURES

B. Naming Conventions

1. Hospital Claims

Naming Conventions

The naming convention for Hospital EDI Claim submissions consists of the following:

- All file names start with the two character Provider Sub-ID number.
- The 3rd character is 'I' for institutional hospital claims.
- The 4th through 9th character is the date the file was created, MMDDYY.
- The 10th character is file sequence identifier sent on the same day, A-Z.
- The extension must be **837**, *prior to encryption*, to identify all EDI Claims file submitted by the Provider. The encryption process changes the extension to **ASC** or **PGP** which is the correct format for submission.

EDI Claims File Examples

File Sent from Hospital to IEHP

An example of the file naming convention for the first submission of an EDI Claims File is **01I042503A.837**

- ◆ **01** identifies the Hospital
(*Reference the Provider Sub-ID Chart for your two-character Hospital code.*)
- ◆ **I** is for institutional hospital claim
- ◆ **04** is month the file was created
- ◆ **25** is day the file was created
- ◆ **03** is year the file was created
- ◆ **A** is first sequence sent on same day (A-Z)
- ◆ **.837** HIPAA 837 file extension

Data File Sent from IEHP to Hospital

An example of the file naming convention for 997 EDI acknowledgement after decryption is **01I042503A.997**

- ◆ **01I042503A** is file name originally sent by provider in earlier example
- ◆ **.997** is HIPAA EDI acknowledgement file extension

An example of the file naming convention for 277 claims response file after decryption is **01I042503A.277**

- ◆ **01I042503A** is file name originally sent by provider in earlier example
- ◆ **.277** is HIPAA claims response file extension

VII. CLAIMS EDI PROCESSING PROCEDURES

B. Naming Conventions

2. IPA/Medical Claims

Naming Conventions

The naming convention for Medical EDI Claim submissions consists of the following:

- All file names start with the one or two character Provider Sub-ID number.
- The 3rd character is 'P' for professional medical claims.
- The 4th through 9th character is the date the file was created, MMDDYY.
- The 10th character is file sequence identifier sent on the same day, A-Z.
- The extension must be **837**, *prior to encryption*, to identify all EDI Claims file submitted by the Provider. The encryption process changes the extension to **ASC** or **PGP** which is the correct format for submission.

EDI Claims File Examples

File Sent from IPA to IEHP

An example of the file naming convention for the first submission of an EDI Claims File is **AP042503A.837**

- ◆ **A** identifies the IPA affiliation
(*Reference the Provider Sub-ID Chart for your one or two-character IPA code.*)
- ◆ **P** is for professional medical claim
- ◆ **04** is month the file was created
- ◆ **25** is day the file was created
- ◆ **03** is year the file was created
- ◆ **A** is first sequence sent on same day (A-Z)
- ◆ **.837** HIPAA 837 file extension

Data File Sent from IEHP to IPA

An example of the file naming convention for 997 EDI acknowledgement after decryption is **AP042503A.997**

- ◆ **AP042503A** is file name originally sent by provider in earlier example
- ◆ **.997** is HIPAA EDI acknowledgement file extension

An example of the file naming convention for 277 claims response file after decryption is **AP042503A.277**

- ◆ **AP042503A** is file name originally sent by provider in earlier example
- ◆ **.277** is HIPAA claims response file extension

VII. CLAIMS EDI PROCESSING PROCEDURES

C. File Transmission

Provider File Preparation For Transmission

Using *PGP*, the Provider must compress and encrypt all files with IEHP's Public Encryption Key. The Public Key file is named **IEHPKEY1.ASC**. IEHP's Public Encryption Key (Key) is available in the **/public.key** folder on the IEHP's FTP server. When providers are in their home folder they need to go to main folder first before going into **/public.key** folder. For questions and answers about the encryption software and for better clarification please refer to Section II. D, "Getting Started – File Transfer Procedures", PGP Procedures Questions and Answers.

Method Of File Transmission

The compressed, encrypted files must be submitted to IEHP using FTP. The files must be placed in the **/claims/inbound** folder of Provider's folder,(Example:/13/claims/inbound) directory on the FTP server. If IEHP's FTP server is down please call IEHPs IT department at (909) 890-2025, who will provide alternative methods for sending files.

997 EDI acknowledgement and 277 claims response file transmission

IEHP places 997 and 277 files on the FTP server in the **/claims/outbound** folder in the Provider's folder, (Example: /13/claims/outbound). 997 & 277 EDI acknowledgement files are placed in the Provider's folder as soon as IEHP processes 837 claims files.

Decrypting The File

Providers who receive 997 and 277 files must use *PGP* to decrypt the transmitted data files. To decrypt files, Providers choose "Decrypt", select the transmitted files, and then enter their Pass Phrase. Please refer to Section II. D, "Getting Started – File Transfer Procedures" for more detailed information.

EDI File Format

1. The Claims EDI Companion Guide can be obtained by contacting Provider Services at IEHP. For your convenience a copy is included at the end of this section.
2. The ANSI X12 837 Ver. 4010 implementation guide is available from Washington Publishing Company at <http://www.wpc-edi.com>.

Claims
X12 837 4010 CLAIMS COMPANION GUIDE
Institutional (004010X096A1)

Inland Empire Health Plan
X12 837 4010 COMPANION DOCUMENT
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Claims

X12 837 4010 CLAIMS COMPANION GUIDE

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INTRODUCTION

The Federal Department of Health and Human Services has adopted regulations, under the Health Insurance Portability and Accountability Act (HIPAA), that establish minimum standards for certain electronic transactions conducted among health plans, clearinghouses and certain health care providers ("covered entities). These rules were scheduled to go into effect October 16, 2002. However, most covered entities, including Inland Empire Health Plan (IEHP), obtained a one-year extension. Inland Empire Health Plan will be compliant by October 16, 2003.

The HIPAA implementation guides provide assistance in developing and executing the electronic transfer of health care data. The implementation guides can be downloaded, free of charge, from the Washington Publishing Company Web site at www.wpc-edi.com

The 837 4010(004010X096) implementation guide should be used for claim submission if you are currently submitting claims on the UB-92 electronic format.

- Effective October 16, 2003 only the X12 837 version 4010 identified under HIPAA will be supported for electronic claim transactions.

Health care plans are required by law to have the ability to send and receive HIPAA compliant transactions. Based on the 837 4010(004010X096) implementation guide there are specific 'IEHP' business requirements that must be further clarified so entities can do business with Inland Empire Health Plan.

This document will identify IEHP specific requirements for the 837 4010(004010X096) implementation guide using available data within the implementation guide.

Major Items:

IEHP has assumed the proposed HIPAA addenda will be required for October 16, 2003.

Therefore:

- Use of the National Drug Code is mandated under the current HIPAA legislation. IEHP will not require, support or validate the NDC codes as part of our 4010 implementation. Entities should continue to submit 'J' HCPCS codes as they do today.
- Use of the Taxonomy codes is mandated under the current HIPAA legislation. IEHP will not require, support or validate Taxonomy codes as part of our 4010 implementation.
- HIPAA requires a HCPCS code on every outpatient service line. IEHP will only require HCPCS codes line.
- We will not require a corresponding HCPCS code on outpatient claim lines if the revenue code (e.g., 270) has no corresponding HCPCS equivalent.

Electronic Media Claims (EMC) bulletins will be issued at a later date. The documentation will include all edits, the use of the 997 Acknowledgement and the new EMC receipt report. This document also references other documents that have not been completed at this time.

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| Item | | IEHP Requirement |
|------|--|---|
| 1 | <p>There are many notes in the implementation guide that require data based on an inpatient or outpatient claim.</p> <p>The implementation guide does not define inpatient or outpatient.</p> <p>IEHP determines the claim type based on the type of bill.</p> | <p>IEHP definition of Institutional Claim Types:</p> <ul style="list-style-type: none"> • Inpatient Type of Bills: 11x, 12x, 17x, 18x, 21x, 22x, 27x, 28x, 81x, and 82x <p>Note: 81x and 82x will only be referenced as inpatient when revenue code 655 or 656 is present.</p> <ul style="list-style-type: none"> • Outpatient Type of Bills: 13xm 14xm 23xm 33xm 34xm 71x, 72x, 73x, 74x, 75x, 76x and 83x • Home Health Type of Bills: 33x and 34x • Home Health Type of Bills: 81x and 82x <p>Note: 81x and 82x will only be referenced as hospice when there is no presence of revenue code 655 or 656.</p> |
| 2 | Character Sets Supported by IEHP | <p>IEHP will support all values identified in the Basic and Extended Character Set documented in Appendix A of the 837 4010 implementation guides.</p> <p>The Extended Character Set includes lower case (a.z). Lower case alpha values are not allowed in fields with an 'ID' attribute. They must be submitted in upper case as specified in the implementation guide.</p> <p>For example: BHT06 must equal 'CH' and not 'ch'.</p> |
| 3 | Multiple ISA through IEA'S in a file with different Receiver ID's (ISA08) | <p>IEHP will accept multiple ISA through IEA'S in a file if the receiver type are for the same Receiver ID (ISA08).</p> <ul style="list-style-type: none"> • If your file contains multiple ISA through IEA's the receiver ID in ISA08 must all be the same. • All ISA through IEA's with a value in ISA08 equal to the ISA08 value in the first ISA segment in the file will process. • All ISA through IEA's with a value in ISA08 not equal to the ISA08 value in the first ISA segment in the file will NOT be processed. |
| 4 | Mixed Transaction Sets | <p>IEHP will only accept multiple transactions of the same type within a single transmission (ISA through IEA). For example, multiple 837 transactions.</p> <p>IEHP will not support a single transmission containing different transactions such as an 837 (claim), 270 (eligibility request) and 276 (claims status request).</p> <p>IEHP will not accept the 275 transaction until it becomes a HIPPA standard. Attachment data should be communicated through fax, mail or email.</p> |
| 5 | Combined Claim Submissions | This document only addresses claims for processing by IEHP. |
| 6 | Subscriber ID Format | Refer to the Detail Transaction Instruction section of this document for submission format. The front-end edit documentation will contain complete edit requirements on the subscriber ID. |
| 7 | Subscriber and Patient Last and First Name Formats | Must be Alpha and may contain one embedded space and/or hyphen. |
| 8 | Subscriber and patient name – middle initial format. | Must equal A-Z or null. |

Claims

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| | Item | IEHP Requirement |
|----|--|---|
| 9. | <p>Claims Processing Systems Field Size Limitations</p> <p>In order to facilitate claims processing, IEHP recommends certain field size limits in some of the implementation guide fields. If more than the recommended field sizes are submitted, manual review of the claims may result.</p> | <p>Monetary Amounts – IEHP recommends that the claim total charges not exceed 9 positions. We recommend that no more than 8 positions are entered in any other 837 monetary field. If more than these recommended positions are entered, we will accept the transaction but a minor delay in claims processing may occur.</p> <p>External Code Sources – External code sources can limit the field size from what is defined in the implementation guide.</p> <p>If the IG allows for 30 positions and the external code source defines 2 positions, the valid field size would be a maximum of two positions.</p> <p>Example: For condition Codes, the ID allows for 30 positions. Since the Condition codes are defined by NUBC as 2 positions, the field size is reduced to 2 positions.</p> |
| 10 | X12 997 Acknowledgment Transaction | <p>An X12 997 Acknowledgment Transaction will be created for every claim functional group, GS through GE (GS01 equal to HC) submitted to IEHP.</p> <p>The 997 reports accepted and rejected transactions (ST through SE) at the X12 standard level. Standard level errors are reported on rejected transactions.</p> <p>It is imperative that claim submitters retrieve and process the 997 transaction.</p> <p>Additional information on the 997 will be documented separately.</p> |
| 11 | Front End Validation | The levels of editing performed in the front-end system will be documented separately. |
| 12 | Negative Values in 'R' defined fields | Data Element types defined in the implementation guide as 'R' allow negative or positive values to be submitted. The front-end edit documentation will contain specific fields where negative values are not allowed. For these specific fields, if a leading minus (-) sign is present, the claim will be returned with an IEHP business edit. |
| 13 | Service Line Charge Amounts | IEHP requires at least one service line with a dollar amount greater than zero. A line with a revenue code of 0001 does not count as a service line. |
| 14 | Revenue Codes | <p>The National Uniform Billing committee (NUBC) defines revenue codes as a 4 position numeric field. The leading zero is a significant value and must be present.</p> <p>Examples: 0360 is a valid code submitted in 2400, SV201. 360 is an invalid code submitted in 2400, SV201.</p> |
| 15 | Service Line Charge Amounts | The data element is defined as a 'R' (Required) value and decimals are allowed per the HIPAA implementation guide. For service line units, IEHP will only accept whole units. As an example 1.0 would be allowed. If 1.5 is present, the claim will be returned with a business edit. |
| 16 | Group Number Format | Refer to the Detail Transaction Instruction section of this document for group number format. The front-end edit documentation will contain complete edit requirements on the group number. |

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| | Item | IEHP Requirement | | | | | | | | | | | | |
|-----------|--------------------------------------|--|-----------|------|-----------|---|----------|------------------------|---|-------|-----------------------|---|-------|--------------------|
| 17 . | Submission of Electronic Adjustments | <p>The 837 4010 allows for the electronic submission of adjustments to previously processed claims. IEHP will apply certain business edits to insure we can facilitate the processing of electronic adjustments.</p> <p>We will accept valid 837 adjustments on all previously adjudicated claims regardless of the claim format used to submit the original claim.</p> <p>Fields required for submission of electronic adjustments: 2300 CLM05-3 equal to '7' or '8' 2300 REF (REF01 equal to 'F8' 2300 REF (REF02 equal to Original Reference No. 2300 NTE (NTE01 = ADD)</p> <p style="padding-left: 40px;">2300 NTE required when HI value equal to D9 2300 HI (HI value equal to D0-D9 or E0)</p> | | | | | | | | | | | | |
| 18 . | Billing Provider | <p>IEHP will process all claims, which contain a valid IEHP Number supplied as the Billing Provider identified in the Loop 2010AA Ref Segment.</p> <p>The Pay-to-Provider in Loop 2010AB and the Service Facility Provider in Loop 2310E can be submitted, however, they will not be used for processing claims.</p> | | | | | | | | | | | | |
| 19 . | Subscriber and Patient Loops | <p>Refer to the implementation guide for submission of claims when the subscriber and patient are the same and when the subscriber and patient are different.</p> | | | | | | | | | | | | |
| 20 . | Delimiters | <p>IEHP recommends using the delimiters defined in section A.1.2.7</p> <table border="0" style="width: 100%;"> <thead> <tr> <th style="text-align: left;">Character</th> <th style="text-align: left;">Name</th> <th style="text-align: left;">Delimiter</th> </tr> </thead> <tbody> <tr> <td>*</td> <td>Asterisk</td> <td>Data Element Separator</td> </tr> <tr> <td>:</td> <td>Colon</td> <td>Sub-element Separator</td> </tr> <tr> <td>~</td> <td>Tilde</td> <td>Segment Terminator</td> </tr> </tbody> </table> <p>Use of other characters can be discussed during the testing period with trading partners.</p> | Character | Name | Delimiter | * | Asterisk | Data Element Separator | : | Colon | Sub-element Separator | ~ | Tilde | Segment Terminator |
| Character | Name | Delimiter | | | | | | | | | | | | |
| * | Asterisk | Data Element Separator | | | | | | | | | | | | |
| : | Colon | Sub-element Separator | | | | | | | | | | | | |
| ~ | Tilde | Segment Terminator | | | | | | | | | | | | |
| 21 . | Hierarchical Level Data Structure | <p>Please refer to section</p> | | | | | | | | | | | | |

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| 837I Loop | 837I Segment and Element | Element Name | IEHP Requirement |
|-----------|--------------------------|--|---|
| | ISA05 | Interchange ID Qualifier | Must equal 'ZZ' |
| | ISA06 | Interchange Sender ID | Must equal the IEHP assigned Submitter ID number. Your Submitter ID number is used as your Trading Partner ID for IEHP and is validated against internal control files. |
| | ISA07 | Interchange ID Qualifier | Must equal 'ZZ' |
| | ISA08 | Interchange Receiver ID | Must equal '00303' If your transmission contains multiple ISA through IEA's, the value in all ISA08 elements must be equal. |
| | ISA09 | Interchange Date | The Interchange Date must be present in ISA09 and must be in the YYMMDD format. The date must be equal to or less than the current date. Dates prior to the year 2000 and future dates are not allowed. |
| | ISA12 | Interchange Control Version Number | Must equal '00401' |
| | ISA14 | Acknowledgment Requested | IEHP will produce a TA1 Acknowledgment. |
| | ISA15 | Usage Indicator | Valid values are 'P' or 'T'. A submitter must be authorized to submit claims to IEHP. The submitter's claims must pass the test (T) phase before the production (P) claim submission is allowed. Once approved for production claims, test files can be submitted at any time. |
| | GS02 | Application Sender's Code | IEHP does not edit this element. The value submitted must meet the implementation guide attributes. |
| | GS03 | Application Receiver's Code | Must equal 00303 for IEHP. |
| | GS04 | Date | The Functional Group Creation Date must be present in GS04 and must be in CCYYMMDD format. The date must be equal to or less than the current date. Dates prior to the year 2000 are not allowed. |
| | GS05 | Time | The Recommended format is HHMM. |
| | GS06 | Group Control Number | The X12 document, X12.6 Control Structure, section 3.9.1 "states the GS06 and GE02 shall by themselves be unique within a reasonably extended time frame whose boundaries shall be defined by trading partner agreement". IEHP requires the GS and GE control number to be unique within the ISA through IEA. The GS06 and GE02 control number must be equal |
| | GS08 | Version/Release/Industry Identifier Code | Must equal '004010X096' |
| | BHT02 | Transaction Set Purpose Code | Must equal '00' or '18' IEHP will accept both values. |
| | BHT06 | Transaction Type Code | Must equal 'CH' |
| | REF02 | Transmission Type Code | Must equal '004010X096'. This transaction is being used in a production mode. To indicate if a transmission is a test or production, use ISA15. |
| 1000B | NM109 | Receiver Primary Identifier | We recommend using the same value that submitted in GS03 |
| 2010AA | NM108 | Identification Code Qualifier | 'XX' (NPI) |
| 2010AA | NM109 | Billing Provider Primary ID Number | NPI (10-digit) if NM108 = 'XX' |

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| 837I Loop | 837I Segment and Element | Element Name | IEHP Requirement |
|-----------|--------------------------|--|---|
| 2010AA | REF01 | Reference Identification Qualifier | Although this segment is situational in the implementation guide, IEHP requires at least one REF segment with a '1A' qualifier. |
| 2010AA | REF02 | Billing Provider Secondary Identification Number | This value must equal the 12 digit IEHP assigned provider number. |
| 2000B | SBR01 | Payer Responsibility Sequence Code | If SBR01 equals 'S' or 'T', then Loop 2320 is required. |
| 2000B | SBR03 | Insured Group or Policy Number | The implementation guide defines this element as an alphanumeric field with a minimum size of 1 and a maximum size of 30. System will not validate the group number (This number is usually the group number on the member's ID card. |
| 2000B | SBR09 | Claim Filing Indicator | Must equal 'CI' |
| 2010BA | NM102 | Entity Type Qualifier | Must equal '1' |
| 2010BA | NM108 | Identification Code Qualifier | Must equal 'MI' |
| 2010BA | NM109 | Subscriber Primary Identifier | Must equal the subscriber identification number as shown on the IEHP ID Card. Do not enter the suffix or the dependent number. |
| 2010BC | NM108 | Identification Code Qualifier | Must equal 'PI' |
| 2010BC | NM109 | Payer Identifier | The plan code on the subscriber's ID card. |
| 2010CA | NM108 | Identification Code Qualifier | Must equal 'MI' |
| 2010CA | NM109 | Patient Payer Identifier | The same requirements apply to the Patient Primary Identifier that apply to the Subscriber Primary Identifier. |
| 2300 | CLM01 | Patient Account Number | IEHP will only store up to 20 positions for a patient control number as noted in the implementation guide. Patient Account number is alpha-numeric and cannot contain a '*' or '<'.</td></tr> <tr> '33'="" '34',="" '7'="" '8'="" 'aa',="" 'add'="" 'bg'="" 'd9'="" (patient="" 0001="" 2300="" 33x="" 34x.<="" 5="" <="" <td><="" <td>2300<="" <tr>="" a="" accident="" adjustment:="" amount="" amount<="" and="" associated="" be="" benefits="" bills:="" causes="" charge="" charges.="" cl103="" claim="" clm02="" clm05-1="" clm05-3="" clm11-1,2,3="" clm11-4="" code="" code<="" code)="" dia,="" either="" element="" equal="" equals="" first="" following="" for="" frequency="" has="" hi="" id="" identify="" iehp="" if="" in="" indicator<="" is="" item="" line="" must="" not="" nte="" nte01="" nte02="" of="" one="" or="" oth<="" outpatient="" populated="" populated.<="" pos,unt,mdf,dep,soa,med,aut,tdf,cdr="" positions="" present,="" present.="" province<="" qualifier="" qualifier<="" reason="" reported="" require="" required.<="" requires="" revenue="" segment="" segment,="" segment.="" service="" state="" status="" sum="" sv203<="" tbody="" td><="" td><td><="" td><td>2400<="" td><td>auto="" td><td>billing="" td><td>claim="" td><td>clm02<="" td><td>clm05-1<="" td><td>clm05-3<="" td><td>clm11-1,2,3<="" td><td>clm11-4<="" td><td>clm11-5<="" td><td>clm18<="" td><td>country="" td><td>explanation="" td><td>facility="" td><td>if="" td><td>line="" td><td>product="" td><td>related="" td><td>sv201="" td><td>total="" that="" the="" then="" this="" three="" to="" total="" tr>="" type="" value="" values="" we="" with=""> </tr>> |

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| 837I Loop | 837I Segment and Element | Element Name | IEHP Requirement |
|-----------|--|--|---|
| 2300 | PWK01 | Attachment Report Type Code | The following values will be reviewed for Home Health Claims: 'AS' Admission Summary 'B3' Physician Order 'CT' Certification 'DG' Diagnostic Report 'DS' Discharge Summary 'EB' Explanation of Benefits 'NN' Nursing Notes 'OZ' Support Data for Claim 'PZ' Physical Therapy Cert. 'RT' Report of Test and Analysis |
| 2300 | PWK02 | Attachment Transmission Code | If entered, IEHP supports values 'AA', 'BM', 'FX' or 'EM' |
| 2300 | PWK07 | Attachment Description | This element allows for up to 80 bytes of data per Attachment Report Type Code (PWK01). The PWK segment can be submitted up to 10 times. A total of 800 bytes of data can be submitted using any of the values in PWK01. |
| 2300 | REF | Original Reference Number | A REF segment with a 'F8' qualifier is required when submitting electronic claim adjustments (CLM-5-3 equal to 7 or 8) |
| 2300 | NTE01 CRC03- CRC07 (CRC01=75) | Claim Note | When CRC01='75' and CRC03-CRC07='OL' then the 2300 NTE segment must be present. |
| 2300 | NTE01 CRC03- CRC07 (CRC01=77) | Claim Note | When CRC01='77' and CRC03-CRC07='MC' then the 2300 NTE segment must be present. |
| 2300 | NTE | Billing Note NTE01=ADD | |
| 2300 | CR610 CR611 | Product Service ID Qualifier (ID) Surgical Procedure Code | Decimals are not allowed. |
| 2300 | HI01-1 | Principal Procedure Information | Must equal 'BR' Principal Procedure code Qualifier |
| 2300 | HI | Other Procedure Code | Qualifier must equal 'BQ' (repeats 12 times within segment) Other Procedure Information. |
| 2300 | HI | Principal Diagnosis (BK) Admitting Diagnosis (BJ) Patient Reason for Visit (ZZ) E-Code (BN) Other Diagnosis (BF) | Decimals are not allowed. |
| 2300 | HI | Principal Procedure (BR) Other Procedure (BQ) | Decimals are not allowed. |
| 2310A | NM1 | Attending Physician Name | NM101 equals '71' (Attending Physician ID) NM102 must equal '1' NM103 is required NM104 is required NM108 IEHP will accept 'XX' NM109 NPI (10-digit) if NM108 = 'XX'. |
| 2310A | REF | Attending Physician Secondary ID | REF01 = '0B'; REF02 = State License #. |
| 2310B | NM1 | Operating Physician Name | NM101 equals '72' (Attending Physician ID) NM108 IEHP will accept 'XX' NM109 NPI (10-digit) if NM108 = 'XX'. |
| 2310B | REF | Operating Physician Secondary ID | REF01 = '0B'; REF02 = State License #. |

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| | | | |
|-----------|--------------------------|----------------------------------|--|
| 2310C | NM1 | Other Provider Name | NM101 equals '73' (Attending Physician ID) NM108 IEHP will accept 'XX' NM109 NPI (10-digit) if NM108 = 'XX'. |
| 2310B | REF | Other Provider Secondary ID | REF01 = '0B'; REF02 = State License #. |
| 2320 | SBR09 | Claim Filing Indicator Code | If value is equal to 'MA' then 2330B NM109 must equal '00308' |
| 2330B | NM109 | Other Payer Primary Identifier | If value is equal to '00308' then 2330B NM109 must equal 'MA' |
| 837I Loop | 837I Segment and Element | Element Name | IEHP Requirement |
| 2400 | SV202-1 | Product or Service ID Qualifier | Must equal 'HC' |
| 2400 | DTP01 = 472 DTP02 | Service Line Date | For outpatient bills (determined by type of bill), DTP02 must equal D8) |
| 2420A | NM1 | Attending Physician Name | NM101 equals '71' (Attending Physician ID) NM102 must equal '1' NM103 is required NM104 is required NM108 IEHP will accept 'XX' NM109 NPI (10-digit) if NM108 = 'XX'. |
| 2420A | REF | Attending Physician Secondary ID | REF01 = '0B'; REF02 = State License #. |

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INTRODUCTION

The Federal Department of Health and Human Services has adopted regulations, under the Health Insurance Portability and Accountability Act (HIPAA), that establish minimum standards for certain electronic transactions conducted among health plans, clearinghouses and certain health care providers ("covered entities). These rules were scheduled to go into effect October 16, 2002. However, most covered entities, including Inland Empire Health Plan (IEHP), obtained a one-year extension. Inland Empire Health Plan will be compliant by October 16, 2003.

The HIPAA implementation guides provide assistance in developing and executing the electronic transfer of health care data. The implementation guides can be downloaded, free of charge, from the Washington Publishing Company Web site at www.wpc-edi.com

The 837 4010(004010X098) implementation guide should be used for claim submission if you are currently submitting claims on the UB-92 electronic format.

- Effective October 16, 2003 only the X12 837 version 4010 identified under HIPAA will be supported for electronic claim transactions.

Health care plans are required by law to have the ability to send and receive HIPAA compliant transactions. Based on the 837 4010(004010X098) implementation guide there are specific 'IEHP' business requirements that must be further clarified so entities can do business with Empire.

This document will identify IEHP specific requirements for the 837 4010(004010X098) implementation guide using available data within the implementation guide.

Major Items:

IEHP has assumed the proposed HIPAA addenda will be required for October 16, 2003.

Therefore:

- Use of the National Drug Code is mandated under the current HIPAA legislation. IEHP will not require, support or validate the NDC codes as part of our 4010 implementation. Entities should continue to submit 'J' HCPCS codes as they do today.
- Use of the Taxonomy codes is mandated under the current HIPAA legislation. IEHP will not require, support or validate Taxonomy codes as part of our 4010 implementation.

| | Item | Empire Requirement |
|----|---|---|
| 1. | Character Sets Supported by IEHP | <p>IEHP will support all values identified in the Basic and Extended Character Set documented in Appendix A of the 837 4010 implementation guide.</p> <p>The Extended Character Set includes lower case (a.z). Lower case alpha values are not allowed in fields with an 'ID' attribute. They must be submitted in upper case as specified in the implementation guide. For example: BHT06 must equal 'CH' and not 'ch'.</p> |
| 2. | Multiple ISA through IEA'S in a file with different Receiver ID's (ISA08) | <p>IEHP will accept multiple ISA through IEA'S in a file if the receiver types are for the same Receiver ID (ISA08).</p> <ul style="list-style-type: none"> • If your file contains multiple ISA through IEA's the receiver ID in ISA08 must all be the same. • All ISA through IEA's with a value in ISA08 equal to the ISA08 value in the first ISA segment in the file will process. • All ISA through IEA's with a value in ISA08 not equal to the ISA08 value in the first ISA segment in the file will NOT be processed. |
| 3. | Mixed Transaction Sets | <p>IEHP will only accept multiple transactions of the same type within a single transmission (ISA through IEA). For example, multiple 837 transactions.</p> <p>IEHP will not support a single transmission containing different transactions such as an 837 (claim), 270 (eligibility request) and 276 (claims status request).</p> <p>IEHP will not accept the 275 transactions until it becomes a HIPPA standard. Attachment data should be communicated through fax, mail or email.</p> |
| 4. | Combined Claim Submissions | This document only addresses claims for processing by IEHP. |

Claims

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| | Item | Empire Requirement |
|----|--|---|
| 5. | Subscriber ID Format | Refer to the Detail Transaction Instruction section of this document for submission format. The front-end edit documentation will contain complete edit requirements on the subscriber ID. |
| 6. | Subscriber and Patient Last and First Name Formats | Must be Alpha and may contain one embedded space and/or hyphen. |
| 7. | Subscriber and patient name – middle initial format. | Must equal A-Z or null. |
| 8. | <p>Claims Processing Systems Field Size Limitations</p> <p>In order to facilitate claims processing, IEHP recommends certain field size limits in some of the implementation guide fields. If more than the recommended field sizes are submitted, manual review of the claims may result.</p> | <p>Monetary Amounts – IEHP recommends that the claim total charges not exceed 9 positions. We recommend that no more than 8 positions are entered in any other 837 monetary field. If more than these recommended positions are entered, we will accept the transaction but a minor delay in claims processing may occur.</p> <p>External Code Sources – External code sources can limit the field size from what is defined in the implementation guide.</p> <p>If the IG allows for 30 positions and the external code source defines 2 positions, the valid field size would be a maximum of two positions.</p> <p>Example: For condition Codes, the ID allows for 30 positions. Since the Condition codes are defined by NUBC as 2 positions, the field size is reduced to 2 positions.</p> |
| 9. | X12 997 Acknowledgment Transaction | <p>An X12 997 Acknowledgment Transaction will be created for every claim functional group, GS through GE (GS01 equal to HC) submitted to IEHP.</p> <p>The 997 reports accepted and rejected transactions (ST through SE) at the X12 standard level. Standard level errors are reported on rejected transactions.</p> <p>It is imperative that claims submitter's retrieve and process the 997 transaction.</p> <p>Additional information on the 997 will be documented separately.</p> |
| 10 | Submission of Electronic Adjustments | <p>The 837 4010 allows for the electronic submission of adjustments to previously processed claims. IEHP will apply certain business edits to insure we can facilitate the processing of electronic adjustments.</p> <p>We will accept valid 837 adjustments on all previously adjudicated claims regardless of the claim format used to submit the original claim.</p> <p>Fields required for submission of electronic adjustments: 2301 CLM05-3 equal to '7' or '8' 2301 REF (REF01 equal to 'F8' 2301 REF (REF02 equal to Original Reference No. 2301 NTE (NTE01 = ADD)</p> <p style="padding-left: 40px;">2300 NTE required when HI value equal to D9 2300 HI (HI value equal to D0-D9 or E0)</p> |
| 11 | Front End Validation | The levels of editing performed in the front-end system will be documented separately. |
| 12 | Group Number Format | Refer to the Detail Transaction Instruction section of this document for group number format. The front-end edit documentation will contain complete edit requirements on the group number. |
| 13 | Service Line Charge Amounts | IEHP requires at least one service line with a dollar amount greater than zero. |

Claims

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| | Item | Empire Requirement | | | | | | | | | | | | |
|-----------|--|--|-----------|------|-----------|---|----------|------------------------|---|-------|-----------------------|---|-------|--------------------|
| 14 | Service Line Units | This data element is defined as an R (Required) value and decimals are allowed per the HIPAA implementation guide. For service line units, IEHP will only accept whole units. For example 1.0 would be allowed. If 1.5 is present, the claim will be returned with a business edit. | | | | | | | | | | | | |
| 15 | Type of Service Code in the National Standard Format (NSF) | The type of service code is not supported in the X12 837 version 4010 transactions. The modifiers are submitted in Loop 2400, SV1 segment. | | | | | | | | | | | | |
| 16 | Subscriber and Patient Loops | Refer to the implementation guide for submission of claims when the subscriber and patient are the same and when the subscriber and patient are different. | | | | | | | | | | | | |
| 17 | Provider Number | The Billing Provider ID is required in Loop 2010AA. The Rendering Provider ID in Loop 2310B is only required if different than the Billing Provider in Loop 2010AA or the Pay-To-Provider in Loop 2010AB. | | | | | | | | | | | | |
| 18 | Delimiters | IEHP recommends using the delimiters defined in section A.1.2.7 <table border="0" style="width: 100%;"> <thead> <tr> <th style="text-align: left;">Character</th> <th style="text-align: left;">Name</th> <th style="text-align: left;">Delimiter</th> </tr> </thead> <tbody> <tr> <td>*</td> <td>Asterisk</td> <td>Data Element Separator</td> </tr> <tr> <td>:</td> <td>Colon</td> <td>Sub-element Separator</td> </tr> <tr> <td>~</td> <td>Tilde</td> <td>Segment Terminator</td> </tr> </tbody> </table> Use of other characters can be discussed during the testing period with trading partners. | Character | Name | Delimiter | * | Asterisk | Data Element Separator | : | Colon | Sub-element Separator | ~ | Tilde | Segment Terminator |
| Character | Name | Delimiter | | | | | | | | | | | | |
| * | Asterisk | Data Element Separator | | | | | | | | | | | | |
| : | Colon | Sub-element Separator | | | | | | | | | | | | |
| ~ | Tilde | Segment Terminator | | | | | | | | | | | | |
| 19 | Negative Values in 'R' defined fields | Data Element types defined in the implementation guide as 'R' allow negative or positive values to be submitted. The front-end edit documentation will contain specific fields where negative values are not allowed. For these specific fields, if a leading minus (-) sign is present, the claim will be returned with an IEHP business edit. | | | | | | | | | | | | |

Claims

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| 837P Loop | 837P Segment and Element | Element Name | IEHP Requirement |
|-----------|--------------------------|--|---|
| | ISA05 | Interchange ID Qualifier | Must equal 'ZZ' |
| | ISA06 | Interchange Sender ID | Must equal the IEHP assigned Submitter ID number. Your Submitter ID number is used as your Trading Partner ID for IEHP and is validated against internal control files. |
| | ISA07 | Interchange ID Qualifier | Must equal 'ZZ' |
| | ISA08 | Interchange Receiver ID | Must equal '00303' If your transmission contains multiple ISA through IEA's, the value in all ISA08 elements must be equal. |
| | ISA09 | Interchange Date | The Interchange Date must be present in ISA09 and must be in the YYMMDD format. The date must be equal to or less than the current date. Dates prior to the year 2000 and future dates are not allowed. |
| | ISA12 | Interchange Control Version Number | Must equal '00401' |
| | ISA14 | Acknowledgment Requested | IEHP will produce a TA1 Acknowledgment. |
| | ISA15 | Usage Indicator | Valid values are 'P' or 'T'. A submitter must be authorized to submit claims to IEHP. The submitter's claims must pass the test (T) phase before the production (P) claim submission is allowed. Once approved for production claims, test files can be submitted at any time. |
| | GS02 | Application Sender's Code | IEHP does not edit this element. The value submitted must meet the implementation guide attributes. |
| | GS03 | Application Receiver's Code | Must equal 00303 for IEHP. |
| | GS04 | Date | The Functional Group Creation Date must be present in GS04 and must be in CCYYMMDD format. The date must be equal to or less than the current date. Dates prior to the year 2000 are not allowed. |
| | GS05 | Time | The Recommended format is HHMM. |
| | GS06 | Group Control Number | The X12 document, X12.6 Control Structure, section 3.9.1 "states the GS06 and GE02 shall by themselves be unique within a reasonably extended time frame whose boundaries shall be defined by trading partner agreement". IEHP requires the GS and GE control number to be unique within the ISA through IEA. The GS06 and GE02 control number must be equal |
| | GS08 | Version/Release/Industry Identifier Code | Must equal '004010X098' |
| | BHT02 | Transaction Set Purpose Code | Must equal '00' or '18' IEHP will accept both values. |
| | BHT06 | Transaction Type Code | Must equal 'CH' |
| | REF02 | Transmission Type Code | Must equal '004010X098'. This transaction is being used in a production mode. To indicate if a transmission is a test or production, use ISA15. |

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| 837P Loop | 837P Segment and Element | Element Name | IEHP Requirement |
|--------------|--|--|--|
| 1000B | NM109 | Receiver Primary Identifier | We recommend using the same value that submitted in GS03 |
| 2010AA | NM108 | Identification Code Qualifier | Must equal 'XX' (NPI) |
| 2010AA | NM109 | Billing Provider Primary ID Number | Must equal NPI (10-digit) if NM108 = 'XX' |
| 2010AA | REF01 | Reference Identification Qualifier | Although this segment is situational in the implementation guide, IEHP requires at least one REF segment with a '1A' qualifier. |
| 2010AA | REF02 | Billing Provider Secondary Identification Number | This value must equal the 12 digit IEHP assigned provider number. |
| 2000B | SBR01 | Payer Responsibility Sequence Code | If SBR01 equals 'S' or 'T', then Loop 2320 is required. |
| 2000B | SBR03 | Insured Group or Policy Number | The implementation guide defines this element as an alphanumeric field with a minimum size of 1 and a maximum size of 30. (This number is usually the group number on the member's ID card.) |
| 2000B | SBR09 | Claim Filing Indicator | Must equal 'CI' |
| 2010BA | NM102 | Entity Type Qualifier | Must equal '1' |
| 2010BA | NM108 | Identification Code Qualifier | Must equal 'MI' |
| 2010BA | NM109 | Subscriber Primary Identifier | Must equal the subscriber identification number as shown on the IEHP ID Card. Do not enter the suffix or the dependent number. |
| 2010BC | NM108 | Identification Code Qualifier | Must equal 'PI' |
| 2010BC | NM109 | Payer Identifier | The plan code on the subscriber's ID card. |
| 2010CA | NM108 | Identification Code Qualifier | Must equal 'MI' |
| 2010CA | NM109 | Patient Payer Identifier | The same requirements apply to the Patient Primary Identifier that apply to the Subscriber Primary Identifier. |
| 2300 | CLM01 | Patient Account Number | IEHP will only store up to 20 positions for a patient control number as noted in the implementation guide. |
| 2300 2400 | CLM02 SV102 | Total Claim Charge Amount Line Item Charge Amount | Total claim charge amount reported in CLM02 must equal the sum of all values reported in SV102.service line total charges. |
| 2300 | CLM05-3 | Claim Frequency Code | Must equal '1', '7', or '8'. |
| 2300 | CLM05-3 NTE01=ADD NTE02 HI Qualifier equals BG | Claim Frequency Code Billing Code | If CLM05-3 is equal to '7' or '8' then the first three positions in the 2300 or 2400 NTE02 must be populated with one of the following values to identify the reason for the claim adjustment: CHG, DOS, PVN, DIA, PRC, POS, UNT, MDF, OCA, IDC, DEP, SOA, MED, AUT, TFD, CDR, OTH. |
| 2300 | CLM11-1,2,3 CLM11-4 CLM11-5 | Related Causes Code Auto Accident State of Province Country Code | If CLM11-1,2,3 is equal to 'AA', then either CLM11-4 or 5 must be populated. |
| 2300 | PWK02 | Attachment Transmission Code | If entered, IEHP supports values 'AA', 'BM', 'FX' or 'EM' |
| 2300 | REF | Original Reference Number | A REF segment with a 'F8' qualifier is required when submitting electronic claim adjustments (CLM-5-3 equal to 7 or 8) |

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| 837P Loop | 837P Segment and Element | Element Name | IEHP Requirement |
|-----------|--------------------------|--|--|
| 2300 | REF01 | Tracking Number Qualifier (Urgent Care Facilities ONLY) | REF01 = 'LU' (Urgent Care use ONLY) |
| 2300 | REF02 | Tracking Number Qualifier (Urgent Care Facilities ONLY) | REF02 = Tracking Number Provided by Urgent Care Facilities |
| 2300 | CR1 | Ambulance Transport Information | The implementation guide requires this segment for claims involving ambulance svc. |
| 2300 | CRC | Ambulance Certification | The implementation guide requires this segment for claims involving ambulance services. |
| 2300 | CRC | Patient condition Information: Vision | The implementation guide requires this segment for claims involving replacement lenses or frames. |
| 2300 | CR610 CR611 | Product Service ID Qualifier (ID) Surgical Procedure Code | |
| 2300 | HI | Principal Diagnosis (BK) Other Diagnosis (BF) | Decimals are not allowed. HI01 must equal 'BK' HI02 must equal the Principal Diagnosis codes |
| 2310A | NM1 | Referring Physician Name | NM101 equals 'DN' NM108 = 'XX' (NPI) NM109= NPI (10-digit) |
| 2310A | REF | Referring Provider Secondary # | REF01= 0B REF02 = State License# or N5 for IEHP ID# |
| 2310B | NM1 | Rendering Provider Name | NM101 equals '82' NM108= 'XX' (NPI) NM109= NPI (10-digit) |
| 2310B | REF | Rendering Provider Secondary ID | REF01= 0B REF02 = State License# |
| 2310D | NM | Name of Facility where Services were Rendered | NM101 equals 'FA' NM108= 'XX' (NPI) NM109= NPI (10-digit) |
| 2310D | REF | Rendering Facility Secondary ID | REF01 = '0B' REF02 = State License # |
| 2310E | NM1 | Supervising Provider Name | NM101 equals DQ (Supervising Physician) |
| 2320 | SBR09 | Claim Filing Indicator Code | If value is equal to 'MA' then 2330B NM109 must equal '00308' |
| 2330B | NM109 | Other Payer Primary Identifier | If value is equal to '00308' then 2330B NM109 must equal 'MA' |
| 2400 | SV101-1 | Product or Service ID Qualifier | Must equal 'HC' |
| 2400 | SV104 | Units or Minutes | The value must be greater than zero |
| 2420A | NM1 | Rendering Provider Name | NM101 equals '82' (Rendering Physician ID) NM108= 'XX' (NPI) NM109= NPI (10-digit) |
| 2420A | REF01 | Rendering Provider Secondary Identification | REF01 = '0B' REF02 = State License # |
| 2420B | NM1 | Purchased Service Provider Name | NM101 equals 'QB' (Purchases Service Provider) |
| 2420C | NM108 | Service Facility Location | IEHP will accept either qualifier of '24' or '34' |

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| | | | |
|-------|-------|--|--|
| 2420C | NM108 | Service Facility Location | The Supervising Provider ID number is not validated. |
| 2420E | NM1 | Ordering Provider Name | NM101 equals 'DK' (Ordering Physician Name) |
| 2420F | NM1 | Referring Provider Name | NM101 equals 'DN' or 'P3' |
| 2420G | NM1 | Other Payer Prior Authorization or Referral Number | NM101 equals PR (Payer) |