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## **IV. ENCOUNTER DATA PROCESSING PROCEDURES**

### **A. General Information**

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Reporting encounter data is a shared obligation of IEHP and Providers. DHCS has mandated encounter data report formats and reporting timelines with which IEHP is required to comply. IEHP, in turn, contractually requires capitated Providers to provide encounter data based on IEHP's state obligations. IEHP has streamlined reporting requirements, to the extent possible, and implemented electronic methodologies for Providers to transfer encounter data as securely, economically, and efficiently as possible.

In accordance with DHCS regulations, IEHP requires Providers to submit encounter data within 90 days of each month end. Encounter data must be submitted for all covered services provided to assigned capitated Members. Covered services include PCP visits as well as subcapitated services, regardless of place of service, type of service, or method of reimbursement to the provider of services. Failure to provide adequate and valid encounter data in the required format results in penalties being imposed as described in IEHP Capitated Agreement. The attached Companion Guides describe some specific data element and format requirements for submission of encounter data to IEHP.

IEHP requires Providers to utilize the HIPAA Compliant 837 Version 4010 transaction code set when submitting encounter data. Records are identified by a unique Claim Reference Number (CRN) and the IEHP assigned Provider code. Notes describing some of the required data elements are outlined in this manual.

Upon receipt of an encounter data file, IEHP creates a 997 Functional Acknowledgment report. The report notifies Providers of any syntax errors. After IEHP processes and edits the encounter data, two files are created. The first file contains the valid encounters that have passed all data element edits. This file is uploaded into the IEHP system for submission to DHCS. The second file, formatted with an RP? extension contains a report describing the reasons the invalid data elements were not valid ("?" is used in the above example in place of "h" for Institutional (Hospital), "m" for Professional (Medical) or "p" for Pharmacy). The RP? files are returned to Providers by placing them on IEHP's FTP server for retrieval in accordance with the Encounter Data File Due Date Schedule in Section IV D.

Hospital Providers: DHCS requires IEHP to report Outpatient Medical Encounters, Inpatient Admission Encounters, Long Term Care Encounters and Pharmacy Encounters. DHCS defines an Outpatient Encounter as each physician encounter, laboratory test, X-ray, therapy procedure, DME, prosthetic, orthotic, transportation, outpatient service, home health, skilled nursing, etc.

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## IV. ENCOUNTER DATA PROCESSING PROCEDURES

### B. Naming Conventions

#### 1. Hospitals

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##### Naming Conventions

The naming convention for Hospital encounter data submissions consists of the following:

- All file names start with the two character Provider Sub-ID number (Hospital code).
- The 3<sup>rd</sup> through 6<sup>th</sup> characters represent the two-digit month and the last two digits of the year (MMYY) (e.g. 0911 represents September 2011). The month should indicate the month the encounters/claims were processed. For example, encounters processed in September 2011 are due November 1, 2011 and the file name would be nn**0911**. *Please refer to the Encounter Data File Due Date Schedule on page IV-7.*
- The 7<sup>th</sup> character identifies the type of encounter as “**h**” for *hospital* (Institutional).
- The 8<sup>th</sup>, 9<sup>th</sup> and 10<sup>th</sup> characters represent the three-digit iteration or version of the encounter data file.
- The iteration or version of the encounter data file must be unique based on the month and year the encounters/claims were processed regardless the type of encounter.
- The extension must be **enc**, *prior to encryption*, to identify encounter data files submitted by the Provider. The encryption process changes the extension to **asc**, which is the correct format for submission.
- The file name is case sensitive. Use only lower case letters in the naming convention.

##### Encounter Data File Examples

##### File Sent from Hospital to IEHP

An example of the file naming convention for the first submission of a hospital encounter file is **010911h001.enc**

- ◆ **01** identifies the Hospital  
(*Reference the Provider Sub-ID Chart for your two-character Hospital code*)
- ◆ **09** is for the month of September (represents Encounters processed in September)
- ◆ **11** is the last digit of the year (2011)
- ◆ **h** identifies a hospital (Institutional) encounter
- ◆ **001** identifies the first submission or iteration of the file
- ◆ **.enc** defines an encounter data file

##### Report File Sent from IEHP to Hospital

An example of the file naming convention for the report describing the reasons the data elements were not valid is **010911h01.rph**

- ◆ **01** identifies the Hospital  
(*Reference the Provider Sub-ID Chart for your two-character Hospital code.*)
- ◆ **09** is for the month of September (represents Encounters processed in September)
- ◆ **11** is the last digit of the year (2011)
- ◆ **h** identifies a hospital (Institutional) encounter
- ◆ **001** identifies the first submission or iteration of the file
- ◆ **.rph** defines a report file with all invalid hospital encounters (the **h** identifies a hospital encounter)

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## IV. ENCOUNTER DATA PROCESSING PROCEDURES

### B. Naming Conventions

#### 2. IPAs

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##### Naming Conventions

The naming convention for IPA encounter data submissions consists of the following:

- All file names start with the Provider Sub-ID (IPA code).
- The 2<sup>nd</sup> through 5<sup>th</sup> characters represent the two-digit month and the last two digits of the year (MMYY) (e.g. 0911 represents September 2011). The month should indicate the month the encounters/claims were processed. For example encounters processed in September 2011 are due November 01, 2011 and the file name would be **n0911**. *Please refer to the Encounter Data File Due Date Schedule in Section IV E on page IV-7.*
- The 6<sup>th</sup> character must be **m** for *medical*.
- The 7<sup>th</sup>, 8<sup>th</sup> and 9<sup>th</sup> characters represent the iteration or version of the encounter data file (e.g. a0911m001.enc for the first submission, a0911m002.enc for the second, etc.).
- **The iteration or version of the encounter data file must be unique based on the month and year the encounters/claims were processed regardless the type of encounter.**
  - This file can be transferred back and forth as many times as needed to meet IEHP requirements; **however**, if the file does not meet validity and adequacy requirements by the dates listed for final corrected errors due to IEHP in Section IV E, IEHP imposes penalties until the file meets IEHP requirements.
  - The extension must be **enc**, *prior to encryption*, to identify encounter data files submitted by the Provider. The encryption process changes the extension to **asc**, which is the correct format for submission.
  - The file name is case sensitive. Use only lower case letters in the naming convention.

##### Encounter Data File Examples

##### File Sent from IPA to IEHP

An example of the file naming convention for the first submission of an encounter file is **a0911m001.enc**

- ◆ **a** identifies the IPA  
(*Reference the Provider Sub-ID Chart for your IPA code*)
- ◆ **09** is for the month of September (represents Encounters processed in September)
- ◆ **11** is the last digit of the year (2011)
- ◆ **m** identifies a medical (*Professional*) encounter
- ◆ **001** identifies the first submission or iteration of the file
- ◆ **.enc** defines an encounter data file

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## IV. ENCOUNTER DATA PROCESSING PROCEDURES

### B. Naming Conventions

#### 2. IPAs

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##### Report File Sent from IEHP to IPA

An example of the file naming convention for the report describing the reasons the data elements were not valid is **a0911m001.rpm**

- ◆ **a** identifies the IPA  
(*Reference the Provider Sub-Id Chart for your IPA code*)
- ◆ **09** is for the month of September (represents Encounters processed in September)
- ◆ **11** is the last digit of the year (2011)
- ◆ **m** identifies a medical file (*Professional*)
- ◆ **001** identifies the first submission or iteration of the file
- ◆ **.rpm** defines a report file with all invalid medical encounters The **m** identifies a medical (*Professional*) file

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## IV. ENCOUNTER DATA PROCESSING PROCEDURES

### C. File Transmission

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#### 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 **IEHPKEY.ASC**. IEHP's Public Encryption Key (Key) is available in the **/prov\_vol/user/Enctr/public.key** directory on the IEHP FTP server. The Key changes every six months for security reasons. For questions and answers about the encryption software and for better clarification please refer to the PGP Procedures Questions and Answers in Section II D.

#### Method Of File Transmission

The compressed, encrypted files must be submitted to IEHP using FTP. The files must be placed in the **Encounter Folder within your Provider folder** on the FTP server. If the provider experiences difficulties accessing IEHP's FTP server, the provider should contact the IEHP Healthcare Analytics and Reporting department at (909) 890-5649. If the FTP server is down, the files must be e-mailed or copied to CDs and submitted via Federal Express.

If you identify that the server is down, please contact the IEHP Help Desk at (909) 890-2025. If the server is down for 48 hours, IEHP will contact you directly to establish an alternative methodically.

#### Invalid File Transmission Schedule

IEHP places error reports on the FTP server in the invalid folder in the Provider's folder, (Example: /prov\_vol/users/01/invalid). The files are placed in the Provider's invalid folder within three working days from their receipt date, as long as the files conform to IEHP naming conventions and encryption procedures. IEHP notifies the Provider via e-mail upon receipt of a file, and/or if there are any issues during the decryption of the files. Once the files have been processed, an additional e-mail is sent to notify the Provider that reports are ready to be picked up. It is the Provider's responsibility to check the FTP server for any error reports within three working days of file submission. A report is transmitted for each file submitted. If a report is not received within three working days of file submission, the Provider should notify the Healthcare Analytics and Reporting department at (909) 890-5649.

#### Timeliness Of Data Submission

Refer to the Encounter Data Due Date Schedule on page IV-E-1 to ensure your files are submitted on time.

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## IV. ENCOUNTER DATA PROCESSING PROCEDURES

### D. Encounter Data Questions And Answers

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**Q: How is validity determined?**

**A:** Validity is determined by calculating the number of unique Claim Reference Numbers (CRNs) submitted within the file less the number of non-fatal errors. The number of valid CRNs is divided by the result. The accumulation of all encounter data records submitted with the same file name must be at least 95% valid in order to meet IEHP validity standards. Note: Cumulative validity reports are placed on the FTP server on a weekly basis.

**Q: How is adequacy determined?**

**A:** Adequacy is determined by grouping all the valid data received by month of service and then performing a count on place of service and/or procedure codes to determine if the encounter was an inpatient, physician visit, outpatient or emergency room service.

Providers must meet the following adequacy standards, on a monthly basis, for data that is due to IEHP:

IPAs	Standard	417 encounters per 1000 Members per month
Hospitals	Inpatient	14 bed days per 1000 Members per month
	ER	19 visits per 1000 Members per month

Note: Adequacy reports are placed on the FTP server on a weekly basis.

**Q: Can we use the same CRN numbers as long as the files are named differently?**

**A:** No. The CRN must be a unique number assigned to that encounter. The same CRN must be used if any corrections to the encounter are required.

**Q: How do we correct a record within a file once IEHP has received and accepted the encounter as a valid record?**

**A:** Once IEHP accepts a record as valid, you must void the record prior to sending a corrected record. To void a record you must send IEHP the original record with the following changes:

1. Place a "1" in the "Adjustment Code" field (you must also insert the original CRN in the Loop 2300 Ref segment).
2. The final field that requires modification is the Claim Reference # in Loop 2300 CLM01 segment (the CRN in this field must now be different than the original CRN. Successful submission of this record will void the original record).
3. Now you are ready to submit the corrected record (the corrected record must have another unique CRN, as if it were a first time submission).

## IV. ENCOUNTER DATA PROCESSING PROCEDURES

### E. Encounter Data File Due Date Schedule

The following schedule outlines what data (the month that services were rendered) is due to IEHP. It also provides timelines when IEHP provides any error reports and the date this corrected data is due back to IEHP.

Date Encounter Data Due To IEHP	Claims Processed In The Month Of	File Name Due (Assessed for Validity)	Month of Service Assessed for Adequacy	Final Date Corrected Errors Due to IEHP
01/02/2012	Nov-2011	id1111txxx.enc	Sept-2011	01/31/2012
02/01/2012	Dec-2011	id1211txxx.enc	Oct-2011	02/28/2012
03/01/2012	Jan-2012	id0112txxx.enc	Nov-2011	03/31/2012
04/02/2012	Feb-2012	id0212txxx.enc	Dec-2011	04/30/2012
05/01/2012	Mar-2012	id0312txxx.enc	Jan-2012	05/31/2012
06/01/2012	Apr-2012	id0412txxx.enc	Feb-2012	06/30/2012
07/02/2012	May-2012	id0512txxx.enc	Mar-2012	07/31/2012
08/01/2012	Jun-2012	id0612txxx.enc	Apr-2012	08/31/2012
09/03/2012	Jul-2012	id0712txxx.enc	May-2012	09/30/2012
10/01/2012	Aug-2012	id0812txxx.enc	Jun-2012	10/31/2012
11/01/2012	Sept-2012	id0912txxx.enc	Jul-2012	11/30/2012
12/03/2012	Oct-2012	id1012txxx.enc	Aug-2012	12/31/2012
01/02/2013	Nov-2012	id1112txxx.enc	Sep-2012	01/31/2013
02/01/2013	Dec-2012	id1212txxx.enc	Oct-2012	02/28/2013
03/03/2013	Jan-2013	id0113txxx.enc	Nov-2012	03/31/2013
04/01/2013	Feb-2013	id0213txxx.enc	Dec-2012	04/30/2013
05/01/2013	Mar-2013	id0313txxx.enc	Jan-2013	05/31/2013
06/02/2013	Apr-2013	id0413txxx.enc	Feb-2013	06/30/2013
07/01/2013	May-2013	id0513txxx.enc	Mar-2013	07/31/2013
08/01/2013	Jun-2013	id0613txxx.enc	Apr-2013	08/31/2013
09/01/2013	Jul-2013	id0713txxx.enc	May-2013	09/30/2013
10/01/2013	Aug-2013	id0813txxx.enc	Jun-2013	10/31/2013
11/03/2013	Sep-2013	id0913txxx.enc	Jul-2013	11/30/2013
12/01/2013	Oct-2013	id1013txxx.enc	Aug-2013	12/31/2013
01/02/2014	Nov-2013	id1113txxx.enc	Sep-2013	01/31/2014

\*ID is your IEHP assigned Provider Number – one or two characters for IPAs, two for Hospitals (in lower case)  
 (xxx is the file type and encounter type and file iteration number, e.g. “t001” for medical file, first iteration)

t is the file type and encounter type nnn is the file iteration number.

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## IV. ENCOUNTER DATA PROCESSING PROCEDURES

### F. Tables

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#### ADJUDICATION STATUS

Identifies encounter as being paid, denied, or capitated.

P = Paid

D = Denied

C = Capitated

Cannot be blank; must contain one of the above codes

#### PLACE OF SERVICE

03 - School	33 - Custodial Care	65 - End Stage Renal Disease Treatment Facility
04 - Homeless Shelter	34 - Hospice	71 - State or Local Public Health Clinic
11 - Office	41 - Ambulance-Land	72 - Rural Health Clinic
12 - Patient's Home	42 - Ambulance- Air or Water	81 - Independent Lab
15 - Mobile Unit	51 - Inpatient Psych. Facility	91 - Adult Subacute
20 - Urgent Care Facility	52 - Psych. Facility Partial Hospitalization	92 - ICF-DD-N
21 - Inpatient Hospital	53 - Community Mental Health Center	93 - ICF-DD-H
22 - Outpatient Hospital	54 - Intermediate Care Facility/ Developmentally Disabled rehabilitative	94 - Non-Home
23 - Emergency Room - Hospital	55 - Residential Substance Abuse Treatment Facility	95 - Mobile Van
24 - Ambulatory Surgery Clinic	56 - Psychiatric Residential Treatment Facility	96 - Pediatric Subacute
25 - Inpatient Birthing Center	61 - Comprehensive Inpatient Rehab Facility	
26 - Military Treatment Facility	62 - Comprehensive Outpatient Rehab Facility	
31 - Skilled Nursing Facility, Level B		
32 - Nursing Facility, Level A		

#### NECESSITY CODE

Identifies the reason for admission.

1 - Emergency/Accident

3 - Elective

4 - Newborn

5 - Newborn Twins

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## IV. ENCOUNTER DATA PROCESSING PROCEDURES

### F. Tables

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#### RENDERING PROVIDER COUNTY CODE

01 - Alameda	16 - Kings	31 - Placer	46 - Sierra
02 - Alpine	17 - Lake	32 - Plumas	47 - Siskiyou
03 - Amador	18 - Lassen	33 - Riverside	48 - Solano
04 - Butte	19 - Los Angeles	34 - Sacramento	49 - Sonoma
05 - Calaveras	20 - Madera	35 - San Benito	50 - Stanislaus
06 - Colusa	21 - Marin	36 - San Bernardino	51 - Sutter
07 - Contra Costa	22 - Mariposa	37 - San Diego	52 - Tehama
08 - Del Norte	23 - Mendocino	38 - San Francisco	53 - Trinity
09 - El Dorado	24 - Merced	39 - San Joaquin	54 - Tulare
10 - Fresno	25 - Modoc	40 - San Luis Obispo	55 - Tuolumne
11 - Glenn	26 - Mono	41 - San Mateo	56 - Ventura
12 - Humboldt	27 - Monterey	42 - Santa Barbara	57 - Yolo
13 - Imperial	28 - Napa	43 - Santa Clara	58 - Yuba
14 - Inyo	29 - Nevada	44 - Santa Cruz	99 - Out of State Provider
15 - Kern	30 - Orange	45 - Shasta	

#### PATIENT STATUS CODES

##### Outpatient Services Only

AA = referred to another physician

AB = return to referring physician

AC = return if needed - PRN

AD = telephone follow-up

BB = refer to CCS

BD = refer to WIC services

#### DISCHARGE PATIENT STATUS CODES

##### Hospital

01 - discharged to home or self care

02 - discharged / transferred to another acute facility

03 - discharged / transferred to a skilled nursing facility

04 - discharged / transferred to an ICF

20 - expired

30 - still a patient or expected to return

31 - admitted first interim bill

32 - transferred to transitional care

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## **IV. ENCOUNTER DATA PROCESSING PROCEDURES**

### **F. Tables**

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#### **PATIENT STATUS CODES**

##### Long Term Care

- |                                                    |                                                    |
|----------------------------------------------------|----------------------------------------------------|
| 00 – Still under care                              | 08 – Leave of absence to acute hospital/discharged |
| 01 – Admitted (Interim bill)                       | 09 – Leave of absence to home/discharged           |
| 02 – Expired                                       | 10 – Admit/expired                                 |
| 03 – Discharged to acute hospital                  | 11 – Admitted/discharged to acute hospital         |
| 04 – Discharged to home                            | 12 – Admitted/discharged to home                   |
| 05 – Discharged to another LTC facility            | 13 – Admitted/discharged to another LTC facility   |
| 06 – Leave of absence to acute hospital (bed hold) |                                                    |
| 07 – Leave of absence to home                      |                                                    |

## IV. ENCOUNTER DATA PROCESSING PROCEDURES

### F. Tables

#### LONG TERM CARE ENCOUNTER ACCOMMODATION CODES

TYPE OF ACCOMMODATION	REGULAR SERVICE	PATIENT LEAVE DAYS DD /NON-DD	BED HOLD
<b>NURSING FACILITIES (NF)</b>			
Level A (formerly ICF):			
Regular	21	23 / 22	N/A
Rehabilitation program-Mentally disordered	31	N/A / 32	N/A
Level B (formerly SNF):			
NF Regular	01	03 / 02	N/A
NF Rural Swing Bed Program	04	N/A / 05	N/A
NF Special Treatment Program-Mentally disordered	11	N/A / 12	N/A
Acute Subacute:			
Hospital-based - Ventilator Dependent	71	N/A / 79	73
Hospital - based - Non-Ventilator Dependent	72	N/A / 80	74
Freestanding NF- Ventilator Dependent	75	N/A / 81	77
Freestanding NF- Non-Ventilator Dependent	76	N/A / 82	78
Pediatric Subacute:			
Hospital -based	85	N/A / 89	87
Freestanding NF -Ventilator Dependent	91	N/A / 95	93
Freestanding NF - Non-Ventilator Dependent	92	N/A / 96	94
<b>INTERMEDIATE CARE FACILITIES (ICF)</b>			
ICF-Developmentally Disabled (DD) Program	41	43 / N/A	N/A
ICF-DD 60 or more beds with 1-59 Distinct Part Beds	45	48 / N/A	N/A
ICF-DD 100 or more beds with 60-99 Distinct Part Beds	51	53 / N/A	N/A
ICF-DD-Habilitative 4-6 beds	61	63 / N/A	N/A
ICF-DD Habilitative 7-15 beds	65	68 / N/A	N/A
ICF-DD Nursing 4-6 beds	62	64 / N/A	N/A
ICF-DD Nursing 7-15 beds	66	69 / N/A	N/A

## **Hospital Encounter**

X12 837 4010 ENCOUNTER DATA COMPANION GUIDE  
Institutional (004010X096A1)

Inland Empire Health Plan  
X12 837 4010 ENCOUNTER DATA COMPANION  
Institutional (004010X096A1)

# **Hospital Encounter**

## **X12 837 4010 ENCOUNTER DATA COMPANION GUIDE**

### **Institutional (004010X096A1)**

#### **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 has been compliant since October 16, 2003.

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

The 837 4010(004010X096A1) implementation guide should be used for Encounter Data submissions.

- Effective October 16, 2003, the X12 837 version 4010 identified under HIPAA is supported for Encounter Data transactions.

Health care plans are required by law to have the ability to send and receive HIPAA compliant transactions. Based on the 837 4010(004010X096A1)implementation004010X096A1) implementation guide, there are specific IEHP business requirements that must be further clarified so entities can do business with IEHP.

This document will identify IEHP specific requirements for the 837 4010(004010X096A1)implementation004010X096A1) implementation guide using available data within the implementation guide.

Note: Changes made for Revision 5 have been bolded.

# Hospital Encounter

## X12 837 4010 ENCOUNTER DATA COMPANION GUIDE

### Institutional (004010X096A1)

	Item	IEHP Requirement
1	<p>There are many notes in the implementation guide that require data based on an inpatient or outpatient encounter.</p> <p>The implementation guide does not define inpatient or outpatient.</p> <p>IEHP determines the encounter type based on the type of bill.</p>	<p>IEHP definition of Institutional Claim Types:</p> <ul style="list-style-type: none"> <li>• Inpatient Type of Bills: 11X, 12X, 17X, 18X, 81X, and 82X.</li> <li>• Long Term Care Type of Bills: 21X, 22X, 27X, and 28X.</li> </ul> <p>Note: 81X and 82X will only be referenced as inpatient when revenue code 655 or 656 is present.</p> <hr/> <ul style="list-style-type: none"> <li>• Outpatient Type of Bills: 13X, 14X, 23X, 33X, 34X, 71X, 72X, 73X, 74X, 75X, 76X and 83X.</li> </ul> <hr/> <ul style="list-style-type: none"> <li>• Home Health Type of Bills: 33X and 34X</li> <li>• Hospice Type of Bills: 81X and 82X.</li> </ul> <hr/> <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. For example: BHT06 must equal 'RP' and not 'rp'.</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"> <li>• If your file contains multiple ISA through IEA's the receiver ID in ISA08 must all be the same.</li> <li>• 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.</li> <li>• 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.</li> </ul>
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>
5.	Subscriber and Patient Last and First Name Formats	<p>Must be Alpha and may contain one embedded space and/or hyphen.</p>
6.	Subscriber and patient name - middle initial format.	<p>Must equal A-Z or null.</p>
7.	Field Size Limitations	<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>
8.	X12 997 Acknowledgment Transaction	<p>An X12 997 Acknowledgment Transaction will be created for every encounter functional group, GS through GE</p>

# Hospital Encounter

## X12 837 4010 ENCOUNTER DATA COMPANION GUIDE

### Institutional (004010X096A1)

Item	IEHP Requirement												
	<p>(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 encounter submitters retrieve and process the 997 transaction.</p> <p>Additional information on the 997 will be documented separately.</p>												
9.	<p>Revenue Codes</p> <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>												
10.	<p>Service Line Units</p> <p>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.</p>												
11.	<p>Submission of Electronic Adjustments</p> <p>The 837 4010 allows for the electronic submission of adjustments to previously processed encounters. 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 encounters regardless of the format used to submit the original encounter.</p> <p>Fields required for submission of electronic adjustments:</p> <p>2300 CLM05-3 equal to '8'            2300 REF (REF01 equal to 'F8'            2300 2300 REF (REF02 equal to Original Reference No.)            NTE (NTE01 = ADD)            2300 NTE required when HI value equal to D9            2300 HI (HI value equal to D0-D9 or E0)</p>												
12.	<p>Subscriber and Patient Loops</p> <p>Refer to the implementation guide for submission of encounters when the subscriber and patient are the same and when the subscriber and patient are different.</p>												
13.	<p>Delimiters</p> <p>IEHP recommends using the delimiters defined in section A.1.2.7</p> <table style="width: 100%; border-collapse: collapse;"> <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											
14.	<p>File Naming Convention</p> <p>Examples: 02113h01.enc (Institutional)            a113m01.enc (Professional)            bh113m01.enc (Ancillary)</p> <p>File name begins with Provider ID (2 digit for Hospitals, 1 lower case character for IPAs, and 2 lower case characters for Ancillary Providers) followed by the two digit month and the last digit of the year in which encounters/claims were processed, the file type (h=Institutional, m=Medical), the two digit iteration number of the file (01=initial submission, 02=second submission, etc) and the file extension. enc. Once encrypted, the file extension must be .asc or .pgp.</p>												
15.	<p>Limitation to Transaction Size</p> <p>IEHP requires providers to limit the size of a transaction to a maximum of 5,000 CLM segments.</p>												

# Hospital Encounter

## X12 837 4010 ENCOUNTER DATA COMPANION GUIDE

### Institutional (004010X096A1)

837I Loop	837I Segment and Element	UB92 Map	IEHP Encounter Element#	837I Element Name	IEHP Requirement
	ISA05			Interchange ID Qualifier	Must equal 'ZZ'
	ISA06			Interchange Sender ID	Must equal the IEHP assigned Provider ID Code.
	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 TAL Acknowledgment.
	ISA15			Usage Indicator	Valid values are 'P' or 'T'. A submitter must be authorized to submit encounters to IEHP. The submitter's encounters must pass the test (T) phase before the production (P) submission is allowed. Once approved for production, 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 '004010X096A1'
	BHT02			Transaction Set Purpose Code	Must equal '00' or '18' IEHP will accept both values.
	BHT06			Transaction Type Code	Must equal 'RP'
	REF02			Transmission Type Code	Must equal '004010X096A1'. This transaction is being used in a production mode. To indicate if a transmission is a test or production, use segment ISA15.
1000B	NM109			Receiver Primary Identifier	We recommend using the same value submitted in GS03.
2000A	PRV01-03		14	Billing Provider Specialty Information	Use to report taxonomy code if billing provider is same as rendering. PRV01=BI, PRV02=ZZ, PRV03=taxonomy code indicating specialty.
2010AA	NM101-05	1	10	Billing Provider Name	NM101= '85', NM102= '2'
2010AA	NM108			Identification Code Qualifier	Must equal '24'(Tax ID#) or '34' (SSN).
2010AA	NM109	5		Billing Provider Primary ID Number	Must equal the NPI#, Tax ID#, or SSN
2010AA	N301-N403		11	Billing Provider Zip CodeAddress	IEHP requires Bill/Pay-To Provider zip code if it is same as Rendering Provider.
2010AA	REF01			Reference Identification Qualifier	0B=State License#, 1D=Medi-Cal ID#
2010AA	REF02		9	Billing Provider Secondary Identification	IEHP requires Bill/Pay-To provider ID. ID can be state license#, Medi-Cal#,or Tax ID# of an

# Hospital Encounter

## X12 837 4010 ENCOUNTER DATA COMPANION GUIDE

### Institutional (004010X096A1)

837I Loop	837I Segment and Element	UB92 Map	IEHP Encounter Element#	837I Element Name	IEHP Requirement
				Number	individual, group or facility that has billed for, or reported a covered services.
2000B	SBR01			Payer Responsibility Sequence Code	This value should be "P" for Primary.
2000B	SBR09			Claim Filing Indicator	Must equal 'HM'
2010BA	NM102			Entity Type Qualifier	Must equal '1'
2010BA	NM108			Identification Code Qualifier	Must equal 'MI'
2010BA	NM109	60	6	Subscriber Primary Identifier	Must equal either the 14 digit subscriber identification number as shown on the IEHP ID Card, the SSN, the Medi-Cal ID# or the CIN# number.
2010BC	NM108			Identification Qualifier Code	Must equal 'PI' (Payer Identification)
2010BC	NM109		2	Payer Identifier	2 digit IEHP Assigned Provider ID Code
2010BA	DMG01-03	14	8	Demographic- Date of Birth and Gender	DMG01='D8', DMG02= DOB as CCYYMMDD DMG03= 'F'(female), 'M'(male), or 'U'(unknown)
2300	CLM01		1	Patient Account Number (Claim Reference Number)	IEHP will capture and store up to twenty (20) characters. This must be a unique encounter identifier.
2300 2400	CLM02 SV201 and SV203			Total Claim Charge Amount Product or Service ID Qualifier Line Item Charge Amount	Total charge amount reported in CLM02 must equal sum of the service line total charges. Only include decimal point if reporting cents. Examples: \$100.01 = 100.01 \$100.10 = 100.1 or 100.10 \$100.00 = 100
2300	CLM05-1	4 (1 <sup>st</sup> and 2nd char )	22	Facility Type Code	If CLM05-1 equals '33' or '34', then CL103 (patient status code) must be present. IEHP requires pt. status code for the following outpatient encounters: 33X and 34X(HomeHealth).
2300	CLM05-3	4 (3 <sup>rd</sup> char )	4	Claim Frequency Code Billing Code	Must be 1, 6, 7, or 8. If reporting 7, provider must first void record using Code 8.
2300	CLM12		3	Special Program Code	Required if services rendered under one of the following circumstances: 01-CHDP 02-CCS 03-Special Federal Funding 05-Disability 07-Induced Abortion-Danger of Life 08-Induced Abortion-Rape or Incest 09-Second Opinion or Surgery
2300	DTP03			Discharge Date	DTP01= '096'
2300	DTP03		25	Statement Date	DTP01= '434', DTP02= 'RD8' (date range)
2300	DTP03	17	24	Admission Date	DTP01= '435'
2300	CL101	19	26	Admission Necessity Code	Must be 1, 2, 3, 4, 5, or 9
2300	CL103		23	Discharge Status	Use 2 digit Discharge Status Code, see tables.
2300	REF		5	Original Reference Number	Use Claim Reference Number encounter was originally submitted with. A REF segment with a 'F8' qualifier is required when submitting encounter data adjustments (CLM05-3 equal to 8)
2300	NTE01			Note Reference Code	Enter "ADD" for Additional Information.
2300	NTE02		20	Billing Note	Enter Adjudication Status. P=Paid, C=Capitated, D=Denied
2300	CR610			Product Service ID Qualifier	For Home Health encounters. HC = HCPCS code, ID = ICD-9-CM surgical procedure code. Only required when a surgical procedure was performed.
2300	CR611		Detail 7 and 8	Surgical Procedure Code	For Home Health encounters. Only required when a surgical procedure was performed.
2300	DTP			Discharge Date	CCYYMMDD
2300	HI01-1	80		Principal Procedure	Must equal 'BR'

# Hospital Encounter

## X12 837 4010 ENCOUNTER DATA COMPANION GUIDE

### Institutional (004010X096A1)

837I Loop	837I Segment and Element	UB92 Map	IEHP Encounter Element#	837I Element Name	IEHP Requirement
				Information	Principal Procedure code Qualifier
2300	HI	81		Other Procedure Code	Qualifier must equal 'BQ' (repeats 12 times within segment) Other Procedure Information.
2300	HI	67 68 69 70 71 72	17,18,19, 27,28,29	Principal Diagnosis (BK) Admitting Diagnosis (BJ) E-Code (BN) Other Diagnosis (BF)	Decimals are not allowed. <b>H101 must equal 'BK' IEHP will not accept 'ZZ'. Use an additional HI segment to report 'Other Diagnosis' ('BF'), may report up to 6 (six) diagnosis codes in one segment.</b>
2310A	NM101-09			Attending Physician Name	NM101 equals '71' (Attending Physician ID) NM102 must equal '1' NM103-NM104 required NM108 IEHP will accept '24' Or '34' NM109 is required
2310A	PRV01-03		13 and 14	Attending Physician Specialty Information	PRV01= 'AT', PRV02= 'ZZ', PRV03= taxonomy code indicating specialty.
2310A	REF01-02		16	Attending Physician Identification.	REF01= '0B' for State License# or '1D' for Medi-Cal ID#
2310B	NM101-09			Rendering(Operating) Physician Name	NM101 equals '72', NM102= '1' (Operating Physician ID) NM108= 'XX' '24' (Tax ID) or '34' (SSN)
2310B	PRV01-03		13 and 14	Rendering (Operating) Provider Specialty	PRV01= 'OP', PRV02= 'ZZ'. PRV03= taxonomy code indicating specialty. <b>NOTE: Use only if reporting a surgical procedure. To report attending physician, use loop 2310A.</b>
2310C	NM1			Other Provider Name	NM101 equals '73' (Other Physician ID) NM108 IEHP will accept 'XX' '24' or '34'
2310E	N401N301 -N403			Service Facility Location	Required if service location is different from Bill/Pay-To Provider in Loop 2010AA. N403= must use valid zip code.
2330B	NM101			Entity Identifier Code	Must use PR
2330B	NM102			Entity Type Qualifier	Must use 2
2330B	NM103			Organization Name	Other Payer (Organization) Name
2330B	NM108			Identification Code Qualifier	Must use PI
2330B	NM109			Other Payer Primary Identifier	Use 2 digit IEHP assigned Provider ID code
2330B	DTP01-03		21	Claim Adjudication Date	<b>DTP01= '573', DTP02= 'D8' DTP03= CCYYMMDD (i.e. 20050101=Jan 01, 2005) Date processed or paid.</b>
2400	SV201	42	Detail 9	Service Line Revenue Code	Use appropriate 4 digit revenue code. If revenue code is 3 digits, use preceding zero.
2400	SV202-1	44	Detail 7,8	Product or Service ID Qualifier	Must equal 'HC'
2400	SV202-2 and -3		Detail 7,8	Product or Service ID	ICD-9-CM Surgical, CPT, or HCPCS Code, required for outpatient. Followed by modifier, if applicable. Example: 89019:ZS
2400	SV203	47	Detail 5	Service Line Billed	Amount billed. Only include decimal point if reporting cents. Examples: \$100.01 = 100.01 \$100.10 = 100.1 or 100.10 \$100.00 = 100
2400	DTP01- = 472 DTP02	45	Detail 3,4	Service Line Date	For outpatient bills (determined by type of bill), DTP01= '472' DTP02= Rmust equal D8 (date range)
2430	SVD02		Detail 6	Service Line Paid	Amount paid. Only include decimal point if reporting cents. Examples: \$100.01 = 100.01 \$100.10 = 100.1 or 100.10 \$100.00 = 100

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Professional (004010X098A1)

Inland Empire Health Plan  
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# **Medical Encounter**

## **X12 837 4010 ENCOUNTER DATA COMPANION GUIDE**

### **Professional (004010X098A1)**

#### **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 has been compliant since October 16, 2003.

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

The 837 4010(004010X098A1) implementation guide should be used for Encounter Data submissions.

- Effective October 16, 2003, the X12 837 version 4010 identified under HIPAA is supported for Encounter Data transactions.

Health care plans are required by law to have the ability to send and receive HIPAA compliant transactions. Based on the 837 4010(004010X098A1) implementation guide there are specific IEHP business requirements that must be further clarified so entities can do business with IEHP.

This document will identify IEHP specific requirements for the 837 4010(004010X098A1) implementation guide using available data within the implementation guide.

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### Professional (004010X098A1)

	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 'RP' and not 'rp'.</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"> <li>• If your file contains multiple ISA through IEA's the receiver ID in ISA08 must all be the same.</li> <li>• 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.</li> <li>• 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.</li> </ul>
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>
4.	Subscriber and Patient Last and First Name Formats	<p>Must be Alpha and may contain one embedded space and/or hyphen.</p>
5.	Subscriber and patient name - middle initial format.	<p>Must equal A-Z or null.</p>
6.	Field Size Limitations	<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>
7.	X12 997 Acknowledgment Transaction	<p>An X12 997 Acknowledgment Transaction will be created for every encounter data file, 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 submitter's retrieve and process the 997 transaction.</p> <p>Additional information on the 997 will be documented separately.</p>
8.	Submission of Electronic Adjustments	<p>The 837 4010 allows for the electronic submission of adjustments to previously processed encounters. 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 encounters, regardless of the format used to submit the original encounter.</p> <p>Fields required for submission of electronic adjustments:</p> <p>2300 CLM05-3 equal to '8'  2300 REF (REF01 equal to 'F8")  2300 REF (REF02 equal to Original Reference No.)</p>

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	Item	Empire Requirement												
9.	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 encounter will be returned with an error message.												
10.	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.												
11.	Subscriber and Patient Loops	Refer to the implementation guide for submission of encounters when the subscriber and patient are the same and when the subscriber and patient are different.												
12.	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.												
13.	Delimiters	IEHP recommends using the delimiters defined in section A.1.2.7  <table border="0" style="width: 100%;"> <tr> <td style="width: 33%;">Character</td> <td style="width: 33%;">Name</td> <td style="width: 33%;">Delimiter</td> </tr> <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> </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												
14.	File Naming Convention Examples: 02113h01.enc (Institutional) a113m01.enc (Professional) bh113m01.enc (Ancillary)	File name begins with Provider ID (2 digit for Hospitals, 1 lower case character for IPAs, and 2 lower case characters for Ancillary Providers) followed by the two digit month and the last digit of the year in which encounters/claims were processed, the file type (h=Institutional, m=Medical), the two digit iteration number of the file (01=initial submission, 02=second submission, etc) and the file extension .enc. Once encrypted, the file extension must be .asc or .pgp.												
15.	Limitation to Transaction Size	IEHP requires providers to limit the size of a transaction to a maximum of 5,000 CLM segments.												

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## X12 837 4010 ENCOUNTER DATA COMPANION GUIDE

### Professional (004010X098A1)

837P Loop	837P Segment and Element	HCFA 1500 Map	IEHP Encounter Element#	837P Element Name	IEHP Requirement
	ISA05			Interchange ID Qualifier	Must equal 'ZZ'
	ISA06			Interchange Sender ID	Must equal the IEHP assigned Provider ID. If ID is a single character, follow with a zero. Example: 'a0'
	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 encounters to IEHP. The submitter's encounters must pass the test (T) phase before the production (P) submission is allowed. Once approved for production, 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 '004010X098A1'
	BHT02			Transaction Set Purpose Code	Must equal '00' or '18' IEHP will accept both values.
	BHT06			Transaction Type Code	Must equal 'RP'
	REF02			Transmission Type Code	Must equal '004010X098A1'. This transaction is being used in a production mode. To indicate if a transmission is a test or production, use segment ISA15.
1000B	NM109			Receiver Primary Identifier	We recommend using the same value submitted in GS03.
2000A	PRV01-03		14	Billing Provider Specialty Information	Use to report taxonomy code if billing provider is same as rendering. PRV01=BI, PRV02=ZZ, PRV03=taxonomy code indicating specialty.
2010AA	NM101-05	33	10	Billing Provider Name	NM101 must equal '85'
2010AA	NM108			Identification Code Qualifier	'XX' (NPI)

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### Professional (004010X098A1)

837P Loop	837P Segment and Element	HCFA 1500 Map	IEHP Encounter Element#	837P Element Name	IEHP Requirement
2010AA	NM109			Billing Provider Primary ID Number	<b>NPI (10-digit) if 'XX' is used for NM108.</b>
2010AA	N403	33	11	Billing Provider Zip Code	IEHP requires Bill/Pay-To Provider zip code if it is same as Rendering Provider.
2010AA	REF01			Reference Identification Qualifier	0B=State License#, 1D=Medi-Cal ID#
2010AA	REF02		9	Billing Provider Secondary Identification Number	IEHP requires Bill/Pay-To Provider ID. ID can be state license#, or Medi-Cal# of an individual, group or facility that has billed for, or reported a covered services.
2000B	SBR01			Payer Responsibility Sequence Code	P for Primary.
2000B	SBR09			Claim Filing Indicator	Must equal 'HM'
2010BA	NM102			Entity Type Qualifier	Must equal '1'
2010BA	NM108			Identification Code Qualifier	Must equal 'MI'
2010BA	NM109	1A	6	Subscriber Primary Identifier	Must equal either the 14 digit subscriber identification number as shown on the IEHP ID Card, the SSN, the Medi-Cal ID# or the CIN# number.
2010BB	NM108			Identification Code Qualifier	Must equal 'PI' (Payer Identification)
2010BB	NM109		2	Identification Code	IEHP assigned Provider ID Code (if Provider ID is only one character, please add a zero. This segment requires two characters.)
2010CA2 010BA	DMG01-03	3	8	Demographic- Date of Birth and Gender	DMG01='D8', DMG02= DOB as CCYYMMDD DMG03= 'F'(female), 'M'(male), or 'U'(unknown)
2010BC	NM108			Identification Code Qualifier	Not Used
2010BC	NM109			Payer Identifier	Not Used
2300	CLM01		1	Patient Account Number (Claim Reference Number)	IEHP will capture and store up to twenty (20) characters. This must be a unique encounter identifier.
2300 2400	CLM02 SV102	28		Total Claim Charge Amount Line Item Charge Amount	Total charge amount reported in CLM02 must equal the sum of all values reported in SV102.service line total charges. Only include decimal point if reporting cents. Examples: \$100.01 = 100.01 \$100.10 = 100.1 or 100.10 \$100.00 = 100
2300	CLM05		22	Place of Service	Identifies where services were rendered.
2300	CLM05-3		4	Claim Frequency Code	Must equal 1, 6, 7, or 8. If reporting 7, provider must first void record using Code 8.
2300	CLM12		3	Special Program Code	Required if services rendered under one of the following circumstances: 01-CHDP 02-CCS 03-Special Federal Funding. 05-Disability. 07-Induced Abortion-Danger of Life. 08-Induced Abortion-Rape or Incest. 09-Second Opinion or Surgery.
2300	REF		5	Original Reference Number	Use Claim Reference Number the encounter was originally submitted with. A REF segment with a 'F8' qualifier is required when submitting encounter data adjustments (CLM-5-3 equal to 8)
2300	NTE01			Note Reference Code	Enter "ADD" for Additional Information
2300	NTE02		20	Claim Note	Enter Adjudication Status. P=Paid, C=Capitated, D=Denied.
2300	CR1			Ambulance Transport Information	The implementation guide requires this

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## X12 837 4010 ENCOUNTER DATA COMPANION GUIDE

### Professional (004010X098A1)

837P Loop	837P Segment and Element	HCFA 1500 Map	IEHP Encounter Element#	837P Element Name	IEHP Requirement
					segment for encounters involving ambulance services.
2300	CRC			Ambulance Certification	The implementation guide requires this segment for encounters involving ambulance services.
2300	CRC			Patient condition Information: Vision	The implementation guide requires this segment for encounters involving replacement lenses or frames.
2300	HI	21	17,18,19,25,26,27	Principal Diagnosis (BK) Other Diagnosis (BF)	Decimals are not allowed. HI01-1= 'BK' HI01-2= Principal Diagnosis code. HI02-1= 'BF' HI02-2= Other Diagnosis (repeat up to 7 times)
2310A	NM101-03			Referring Physician Name	'XX' (NPI) NPI (10-digit)
2310A	REF01-02	17A	16	Referring Physician#	REF01= 0B for State License# or N5 for IEHP ID#
2310B	NM101-03 NM108-09	31		Rendering Provider Name	'XX' (NPI) NPI (10-digit)
2310B	REF01-02		24	Rendering Provider#	REF01= 0B for State License# or N5 for IEHP ID# (This element required if rendering provider is different from billing provider.)
2310B	PRV01-03		14	Rendering Provider Spec.	PRV01=PE, PRV02=ZZ, PRV03=taxonomy code indicating specialty.
2310D	NM1FA	32		Name of Facility Where Services were rendered	NM103 = Facility Name If NPI is present: NM108 = 'XX' NM109 = NPI (10-digit)
2310D	N401-N403			Service Facility Location	Required if service location is different from Bill/Pay-To Provider in Loop 2010AA.
2310E	NM101-04			Supervising Provider Name	NM101= DQ (Supervising Physician)
2330B	NM101-03			Entity Identifier Code	NM101= 'PR', NM102= '2',
2330B	NM108-09			Identification Code Qualifier Other Payer Primary Identifier	NM108= 'PI', NM109= IEHP assigned Provider ID Code (if Provider ID is only one character, please add a zero. This segment requires two characters.
2330B	DTP01-03		21	Claim Adjudication Date	DTP01= '573', DTP02= 'D8' DTP03= CCYYMMDD (i.e. 20050101=Jan 01, 2005) Date processed or paid.
2400	SV101-1			Product or Service ID Qualifier	Must equal 'HC'
2400	SV101-2 and -3	24D	Detail 7	HCPC or CPT-4 Codes	Procedure Code Billed, required. Followed by modifier, if applicable. Example: 89019:ZS
2400	SV102	24F	Detail 5	Service Line Billed	Amount billed. Only include decimal point if reporting cents. Examples: \$100.01 = 100.01 \$100.10 = 100.1 or 100.10 \$100.00 = 100
2400	SV104	24G	Detail 9	Units or Minutes	The value must be greater than zero
2400	DTP01-03	24A	Detail 3,4	Service dates	DTP01= '472' DTP02= 'D8' or 'RD8' DTP03= Service Date or Date range (CCYYMMDD) or (CCYYMMDD-CCYYMMDD)
2420A	NM1 82	31.1		Rendering Provider Name (Provider ID)	NM101 = '82' NM108 = '24'(TaxID), '34'(SSN), or 'XX'(NPI) NM109 = Tax ID, SSN, or NPI (10-digit)
2420A	REF01-02			Rendering Provider Secondary Name (Provider ID)	REF01 = 0B REF02 = State License #
2430	SVD02		Detail 6	Service Line Paid	Amount paid. Only include decimal point if reporting cents. Examples: \$100.01 = 100.01

**Medical Encounter**  
**X12 837 4010 ENCOUNTER DATA COMPANION GUIDE**  
**Professional (004010X098A1)**

837P Loop	837P Segment and Element	HCFA 1500 Map	IEHP Encounter Element#	837P Element Name	IEHP Requirement
					\$100.10 = 100.1 or 100.10 \$100.00 = 100