
IX. 5010 STANDARD COMPANION GUIDE

A. Transaction Introduction

Standard Companion Guide (CG) Transaction Information Effective January 1, 2012

IEHP Instructions related to Implementation Guides (IG) based

On X12 Version 005010X222A1

Health Care Claim/Encounter: Professional (837)

and on X12 Version 005010X223A2

Health Care Claim/Encounter: Institutional (837)

Companion Guide Version Number: 1.4

April 2012-Draft

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IX. 5010 STANDARD COMPANION GUIDE

A. Transaction Introduction

Preface

This transaction instruction is expected to be used in parallel with the Technical Report Type 3 (TR3) implementation guides (IG) available for purchase from Washington Publishing Company <http://www.wpc-edi.com>. It is provided because Inland Empire Health Plan wants to clarify the IG instructions for submission of specific electronic transactions. This companion guide is not meant to exceed the requirements or usages of data nor replace the guidelines expressed in the TR3s.

Contact Information

For further questions regarding claims or encounters submissions, please contact

- EDI Claims (Institutional and Professional)- edi@iehp.org or 909-890-2025
- EDI Encounters (Institutional and Professional)- edi@iehp.org or 909-890-5649

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A. Transaction Introduction

Background

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 carries provisions for administrative simplification. This requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. HIPAA directs the Secretary to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard HIPAA serves to:

- Create better access to health insurance
- Limit fraud and abuse
- Reduce administrative costs

Compliance according to HIPAA

The HIPAA regulations at 45 CFR 162.915 require that covered entities not enter into a trading partner agreement that would do any of the following:

- Change the definition, data condition, or use of a data element or segment in a standard.
- Add any data elements or segments to the maximum defined data set.
- Use any code or data elements that are marked “not used” in the standard’s implementation specifications or are not in the standard’s implementation specification(s).
- Change the meaning or intent of the standard’s implementation specification(s).

Compliance according to ASC X12

ASC X12 requirements include specific restrictions that prohibit trading partners from:

- Modifying any defining, explanatory, or clarifying content contained in the implementation guide.
- Modifying any requirement contained in the implementation guide.

Intended Use

The Transaction Instruction component of this companion guide must be used in conjunction with an associated ASC X12 Implementation Guide. The instructions in this companion guide are not intended to be stand-alone requirement documents. This companion guide conforms to all the requirements of any associated ASC X12 Implementation Guides and is in conformance with ASC X12’s Fair Use and Copyright statements.

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B. Included ASC X12 Implementation Guides

Below lists the X12N Implementation Guides for which specific transaction instructions apply and which are included in Heading 1 and 2 of section B in this document.

Unique ID	Section	Name
005010X222A1	B.1	Health Care Claim/Encounter: Professional (837)
005010X223A2	B.2	Health Care Claim/Encounter: Institutional (837)

Section B.1 and B.2 include tables that contain one or more rows for each segment for which a supplemental instruction is needed. The table does not represent all of the fields necessary for a successful transaction. The TR3 should be reviewed for that information.

Legend
SHADED rows represent “segments” in the X12N implementation guide.
NON-SHADED rows represent “data elements” in the X12N implementation guide.

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B. Included ASC X12 Implementation Guides

1. 005010X222A1 Health Care Claim/Encounter: Professional

Loop ID	Reference	Name	Codes	Notes/Comments
		Beginning of Hierarchical Transaction		
	BHT06		“CH” = Claim “RP” = Encounter	If submitting claim, use “CH” If submitting encounter/post-adjudicated claim, use “RP”
1000A	NM1	Submitter Name		
1000A	NM109	Sender Primary Identifier		Assigned by IEHP. Same as GS02 and ISA06.
1000A	PER	Submitter EDI Contact Information		
	PER03	Communication Number Qualifier	TE	It is recommended that Submitters populate the submitter’s telephone number.
	PER05	Communication Number Qualifier	EM	It is recommended that Submitters populate the submitter’s email address.
1000B	NM1	Receiver Name		
1000B	NM102	Entity Type Qualifier	2	Non-Person Entity
1000B	NM103	Name Last Or Organization Name	IEHP	IEHP’s Name.
1000B	NM109	Receiver Primary Identifier	“00303”	Same as GS03. IEHP’s receiver ID.
2000A	PRV	Billing Provider Specialty Information		
2000A	PRV03	Provider Taxonomy Code		Taxonomy code always required for submissions.
2010AA	NM1	Billing Provider Name		
	NM108	Billing Provider ID	XX	NPI Identifier
	NM109	Billing Provider Identifier	1999999984	Must be populated with a ten digit number and must begin with the number 1 (NPI only). Atypical professional provider default NPI.
2010AA	N4	Billing Provider City, State, Zip Code		
	N403	Zip Code		The full nine (9) digits of the Zip Code are required. If the last four (4) digits of the ZIP code are not available, populate a default value of “9999”.
2010AA	REF	Billing Provider Tax		

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B. Included ASC X12 Implementation Guides

1. 005010X222A1 Health Care Claim/Encounter: Professional

Loop ID	Reference	Name	Codes	Notes/Comments
		Identification		
	REF01	Reference Identification Qualifier	EI	Employer's Identification Number
	REF02	Reference Identification		1999999998- Atypical professional provider default EIN for post-adjudicated claims/capitated encounters, if atypical provider performed service.
2010BA	NM1	Subscriber Name		
	NM108	Subscriber ID Qualifier	MI	Must be populated with a value of MI- Member Identification Number
2010BA	NM109	Subscriber Primary Identifier		Must equal the 14-digit IEHP ID number.
2010BC	NM1	Payer Name		
	NM109	Payer Identifier		For encounter data, use assigned IEHP Provider ID code. If only one character, add a trailing zero (i.e., C0)
2300	CLM	Claim Information		
	CLM02	Total Claim Charge Amount		Must balance to the sum SV2 service line in Loop 2400
	CLM05-3	Claim Frequency Type Code	1 7 8	1 = Original claim submission 7 = Replacement 8 = Deletion
2300	CN1	Contract Information		
2300	CN101	Contract Type Code	02, 05, 09	Required for post-adjudicated claims and capitated encounters when loop ID- 2400, CN101, line level contract type, is not used. 02 = "per diem" (Paid), 05 = "Capitated" (capitated) 09 = "Other" (Denied)
2300	REF	Payer Claim Control Number		
	REF01	Original Reference Number	F8	
	REF02	Payer Claim Control Number		Identifies ICN from original claim when submitting adjustment (replacement or voided claim or encounter).
2300	REF	Claim Identifier for Transmission Intermediaries		Required
	REF01	Original Reference Number	D9	

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B. Included ASC X12 Implementation Guides

1. 005010X222A1 Health Care Claim/Encounter: Professional

Loop ID	Reference	Name	Codes	Notes/Comments
	REF02	Payer Claim Control Number		Unique claim number required for all submissions.
2300	HI	Health Care Diagnosis Code		
2300	HI01-1	Code List Qualifier Code (Principal Diagnosis Code)	BK	BK is the only valid value at this time. Claims with ABK will be rejected until ICD10 implementation.
2300	HI02-1 to HI12-1	Code List Qualifier Code	BF	BF is the only valid value at this time. Claims with ABF will be rejected until ICD10 implementation.
2310B	PRV	Rendering Provider Specialty Information		
2310B	PRV03	Provider Taxonomy Code		Taxonomy code always required for submissions.
2320	CAS	Claim Adjustment		
	CAS02	Adjustment Reason Code		For post-adjudicated claims and capitated encounters, if a claim is denied, the claim denial reason code should be populated.
2330B	DTP	Claim Check or Remittance Date		Required for encounters/post-adjudicated claims when loop ID-2430, line check or remittance date is not used. DTP01 = "573"
2400	SV1	Professional Service		
2400	SV101-1	Product or Service ID Qualifier	HC	IEHP only accepts valid HCPCS. The AMA's CPT codes are also level 1 HCPCS so also reported under HC.
2400	SV103	Unit or Basis for Measurement Code	UN or MJ	When submitting an anesthesia procedure code, time must be reported in minutes (MJ.) Otherwise report in Units (UN.)
2400	CN1	Contract Information		
2400	CN101	Contract Type Code	02, 05, 09	Required for post-adjudicated claims and capitated encounters if different than what was report on claim level (loop ID-2300, CN101) 02 = "per diem" (Paid), 05 = "Capitated" (capitated) 09 = "Other" (Denied)
2420A	PRV	Rendering Provider Specialty		

IX. 5010 STANDARD COMPANION GUIDE**B. Included ASC X12 Implementation Guides****1. 005010X222A1 Health Care Claim/Encounter: Professional**

Loop ID	Reference	Name	Codes	Notes/Comments
		Information		
2420A	PRV03	Provider Taxonomy Code		Taxonomy code always required for submissions.
2430	SVD	Line Adjudication Information		Required for post-adjudicated claims and capitated encounters.
2430	SVD02	Service Line Paid		0 is an acceptable value.
2430	CAS	Line Adjustments		
	CAS02	Adjustment Reason Code		For post-adjudicated claims and capitated encounters, if service line is denied, the claim denial reason code should be populated.

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B. Included ASC X12 Implementation Guides

2. 005010X223A2 Health Care Claim/Encounter: Institutional

Loop ID	Reference	Name	Codes	Notes/Comments
		Beginning of Hierarchical Transaction		
	BHT06		“CH” = Claim “RP”=Encounter	If submitting claim, use CH If submitting encounter/post-adjudicated claim, use RP
1000A	NM1	Submitter Name		
	NM109	Sender Primary Identifier		Assigned by IEHP. Same as GS02 and ISA06.
1000A	PER	Submitter EDI Contact Information		
	PER03	Communication Number Qualifier	TE	It is recommended that Submitters populate the submitter’s telephone number.
	PER05	Communication Number Qualifier	EM	It is recommended that Submitters populate the submitter’s email address.
1000B	NM1	Receiver Name		
	NM102	Entity Type Qualifier	2	Non-Person Entity
	NM103	Name Last Or Organization Name	IEHP	IEHP’s Name.
	NM109	Receiver Primary Identifier	“00303”	Same as GS03. IEHP’s receiver ID.
2000A	PRV	Billing Provider Specialty Information		
	PRV03	Provider Taxonomy Code		Taxonomy code always required for submissions.
2010AA	NM1	Billing Provider Name		
	NM108	Billing Provider ID	XX	NPI Identifier
	NM109	Billing Provider Identifier	1999999976	Must be populated with a ten digit number and must begin with the number 1 (NPI only). Atypical institutional provider default NPI.
2010AA	N4	Billing Provider City, State, Zip Code		
	N403	Zip Code		The full nine (9) digits of the Zip Code are required. If the last four (4) digits of the ZIP code are not available, populate a default value of “9999”.
2010AA	REF	Billing Provider Tax		

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B. Included ASC X12 Implementation Guides

2. 005010X223A2 Health Care Claim/Encounter: Institutional

		Identification		
	REF01	Reference Identification Qualifier	EI	Employer's Identification Number
	REF02	Reference Identification		1999999997- Atypical institutional provider default EIN for post-adjudicated claims/capitated encounters, if atypical provider performed service.
2010BA	NM1	Subscriber Name		
	NM108	Subscriber ID Qualifier	MI	Must be populated with a value of MI- Member Identification Number
	NM109	Subscriber Primary Identifier		Must equal the 14-digit IEHP ID number.
2010BC	NM1	Payer Name		
	NM109	Payer Identifier		For encounter data, use assigned IEHP Provider ID code. If only one character, add a trailing zero (i.e., C0)
2300	CLM	Claim Information		
	CLM02	Total Claim Charge Amount		Must balance to the sum SV2 service line in Loop 2400
	CLM05-3	Claim Frequency Type Code	1 2 3 4 7 8 9	1 = Original claim submission 2=Interim- First Claim 3=Interim- Continuing Claim 4=Interim- Last Claim 7 = Replacement 8 = Deletion 9=Final Claim for a Home Health PPS Episode
2300	DTP	Date- Admission Date/Hour		
	DTP02	Date Time Period Format Qualifier	D8	D8=CCYYMMDD DT=CCYYMMDDHHMM
	DTP03	Admission Date/Hour		Hours (HH) are expressed as "00" for midnight, "01" for 1A.M. and so on through "23" for 11P.M. Minutes (MM) are expressed as "00" through "59". If the actual minutes are not known, use a default of "00". This is only required for original or final bills.

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B. Included ASC X12 Implementation Guides

2. 005010X223A2 Health Care Claim/Encounter: Institutional

2300	CN1	Contract Information		
	CN101	Contract Type Code	02, 05, 09	Required for post-adjudicated claims and capitated encounters. 02 = "per diem" (Paid), 05 = "Capitated" (capitated) 09 = "Other" (Denied)
2300	REF	Payer Claim Control Number		
	REF01	Original Reference Number	F8	
	REF02	Payer Claim Control Number		Identifies ICN from original claim when submitting adjustment (replacement or void).
2300	REF	Claim Identifier for Transmission Intermediaries		Required
	REF01	Original Reference Number	D9	
	REF02	Payer Claim Control Number		Unique claim number required for all submissions.
2300	HI	Principal Diagnosis Code		
	HI01-1	Code List Qualifier Code	BK	BK is the only valid value at this time. Claims with ABK will be rejected until ICD10 implementation.
2300	HI	Admitting Diagnosis		
	HI01-1	Code List Qualifier Code	BJ	BJ is the only valid value at this time. Claims with ABJ will be rejected until ICD10 implementation.
2300	HI	Patient's Reason for Visit		
	HI01-1 to HI01-3	Code List Qualifier Code	PR	PR is the only valid value at this time. Claims with APR will be rejected until ICD10 implementation.
2300	HI	External Cause of Injury		
	HI01-1 to HI12-1	Code List Qualifier Code	BN	BN is the only valid value at this time. Claims with ABN will be rejected until ICD10 implementation.
2300	HI	Other Diagnosis Information Code		
	HI01-1 to HI12-1	Code List Qualifier Code	BF	BF is the only valid value at this time. Claims with ABF will be rejected until ICD10 implementation.
2300	HI	Principal Procedure		

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B. Included ASC X12 Implementation Guides

2. 005010X223A2 Health Care Claim/Encounter: Institutional

		Information		
	HI01-1	Code List Qualifier Code	BR	BR is the only valid value at this time. Claims with BBR will be rejected until ICD10 implementation.
2300	HI	Other Procedure Information		
	HI01-1 to HI12-1	Code List Qualifier Code	BQ	BQ is the only valid value at this time. Claims with BBQ will be rejected until ICD10 implementation.
2310A	PRV	Attending Provider Specialty Information		
	PRV03	Provider Taxonomy Code		Taxonomy code always required for submissions.
2320	CAS	Claim Adjustment		
	CAS02	Adjustment Reason Code		For post-adjudicated claims and capitated encounters, if a claim is denied, the claim denial reason code should be populated.
2330B	DTP	Claim Check or Remittance Date		Required for encounters/post-adjudicated claims when loop ID-2430, line check or remittance date is not used. DTP01 = "573"
2400	SV2	Institutional Service Line		
	SV202-1	Product or Service ID Qualifier	HC	IEHP only accepts valid HCPCS. Because the AMA's CPT codes are also level 1 HCPCS codes, they are also reported under HC.
2430	SVD	Line Adjudication Information		Required for post-adjudicated claims and capitated encounters.
	SVD02	Service Line Paid		0 is an acceptable value.
2430	CAS	Line Adjustments		
	CAS02	Adjustment Reason Code		For post-adjudicated claims and capitated encounters, if service line is denied, the claim denial reason code should be populated.

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C. Control Segment/Envelopes

ISA – Interchange Control Header Segment
 GS- Functional Group Header Segment
 ST- Transaction Set Header segment
 First 837 Transaction
 SE- Transaction Set Trailer Segment
 ST- Transaction Set Header segment
 First 837 Transaction
 SE- Transaction Set Trailer Segment
 ST- Transaction Set Header segment
 First 837 Transaction
 SE- Transaction Set Trailer Segment
 GE- Functional Group Trailer Segment
 ISE- Interchange control Segment

The below table represent only those field that IEHP requires a specific value in or has guidance as to what that value should be. The table does not represent all of the fields necessary for a successful transaction. The TR3 should be reviewed for that information.

Reference	Name	Codes	Notes/Comments
	Interchange Control Header		
ISA01	Authorization Information Qualifier	“00”	
ISA02	Authorization Information	Space Fill	
ISA03	Security Information Qualifier	“00”	
ISA04	Security Information	Space Fill	
ISA05	Interchange ID Qualifier (Sender)	“ZZ”	
ISA06	Interchange Sender ID		Assigned by IEHP
ISA07	Interchange ID Qualifier (Receiver)	“ZZ”	
ISA08	Interchange Receiver ID	“00303”	IEHP’s Receiver ID
ISA11	Repetition Separator	“^”	Preferred
ISA14	Acknowledgment Requested	“1”	IEHP will always produce a TA1 (997).
ISA15	Interchange Usage Indicator	“P”	“T” is used during testing phase. All other transactions use “P”
ISA16	Component Element Separator	“.”	Preferred
	GS- Functional Group Header Segment		
GS01	Functional Identifier Code	“HC”	Health Care Claim
GS02	Application Sender’s Code		Assigned by IEHP. Same as ISA06.
GS03	Application Receiver’s Code	“00303”	IEHP ID.
GS08	Version/Release/Industry Identifier Code	“005010X222A1” “005010X223A2”	“005010X222A1” = professional “005010X223A2” = Institutional
ST	Transaction Set Header		
ST03	Implementation Convention Reference	“005010X222A1” or “005010X223A2”	“005010X222A1” = professional “005010X223A2” = Institutional

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D. Business Scenarios

Example 1- IPA Submitting Professional/Institutional Encounter Data

Encounter data must be submitted by IPAs 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. IPAs will indicate adjudication status and adjudication date in loop 2300, segment CN1 and loop 2330B DTP. If capitated service, indicate appropriately in loop 2300, segment CN1. In accordance with DHCS regulations, IEHP requires Providers to submit encounter data within 90 days of each month end.

Example 2- Capitated Hospital Submitting Encounter Data

Capitated Hospitals are required to submit encounter data through the encounter data system within 90 days of each month end. 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.

Example 3- Clearinghouse/IEHP Direct Providers Submitting Claim Data

Clearinghouses are largely used as an intermediary for fee-for-service providers, hospitals, and other providers submitting claims to IEHP electronically. Capitated IEHP Direct Providers may also elect to submit data through the claim system directly or through a clearinghouse. The clearinghouses must follow the instructions outlined in this guide and will pass it on to their providers as appropriate to ensure compliance. The same situations and requirements laid out in the Implementation Guides published by Washington Publishing Company will be expected to be followed by Clearinghouse and IEHP Direct submitters alike.

Example 4- Fee-for-Service Hospital Submitting Claim Data

Fee-for-Service Hospitals may elect to submit 837 Institutional files without using a clearinghouse. All the same guidelines and requirements apply. The same situations and requirements laid out in the Implementation Guides published by Washington Publishing Company will be expected to be followed by Hospital submitters.

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E. Frequently Asked Questions

Q. What is the difference between a claim file and an encounter file?

A. For the purposes of IEHP and as used in this guide, claim files are generally submitted by IEHP's directly contracted fee-for-service providers which can include hospitals, urgent cares, and IEHP Direct providers. Encounter files are submitted by IEHP's capitated IPAs and capitated hospitals. Claim files will be adjudicated by IEHP while encounter files have already been adjudicated by the IPA or hospital and are primarily for data capture and regulatory reporting. Therefore, while the file format is identical, claims and encounters have different protocols for submission and likewise different internal contacts. Instructions for Claim Processing Procedures can be located in Section VI of the EDI manual while directions for Encounter Processing Procedures can be found in Section IV of the EDI manual.

Q. How do I decrypt the 997 or 277 or log file?

A. Providers must use software compatible with the Open PGP standard to encrypt and decrypt data files exchanged with IEHP. To decrypt the files, Providers choose "Decrypt", select the transmitted files, and then enter their Pass Phrase. Please refer to EDI Manual Section II- D, "Getting Started File transfer Procedures" for more detailed information.

Q. Where do I find information on file naming conventions, connectivity protocol, and file transfer procedures?

A. Please refer to the EDI manual published at <http://ww2.iehp.org/IEHP/Providers/Information+Resources/HandbooksandManuals/EDIManual.htm> for information regarding the above areas. The information published in this companion guide is meant to be used in conjunction with the implementation guides from Washington Publishing Company for detailed instructions on the line level and IEHP's EDI Manual for connectivity and processing procedures.

Q. What is IEHP's policy on Billing Provider Address and 9-Digit Zip Codes?

A. IEHP supports the instructions in the Technical Report Type 3 (TR3) implementation guides (IG) available for purchase from Washington Publishing Company <http://www.wpc-edi.com> regarding Billing Provider Address and 9-digit zip codes. Therefore, the Billing Provider Address (2010AA, N3) is required and must be a physical address. PO Box and lock box addresses cannot be reported as a Billing Provider Address, but can continue to be reported in the pay-to address (2010AB, N3). The 5010 requires that all used N403 segments must contain a full 9-digit zip code. The best way to determine the 4-digit extension to your standard zip code is by contacting the US postal Service. <https://tools.usps.com/go/ZipLookupAction!input.action>. These instructions apply to all claims and encounters for all healthcare providers.

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E. Frequently Asked Questions

Q. How was the reporting of Anesthesia revised from 4010 to 5010?

In 4010, IEHP allowed anesthesia time to be reported as the total number of minutes or as units regardless of the procedure code. In 5010, anesthesia services must be reported in minutes rather than units if the procedure code does not define a specific time period. If the procedure code has minutes in its description, the service can be reported in units. When reporting the time period, hours must be converted to minutes. For example, a total anesthesia time of 2 hours would be 120 minutes and should be reported as 120.

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F. Other Resources

- <http://ww2.iehp.org/IEHP/Providers/Information+Resources/HandbooksandManuals/EDIManual.htm>

IEHP's website where the EDI manual and other resources are located.

- <http://www.wpc-edi.com>.

Washington Publishing Company Implementation guides (TR3) can be purchased from this site.

- <http://www.wedi.org/>.

Workgroup for Electronic Data Interchange in Healthcare.

- <http://www.cms.gov/Versions5010andD0/>.

CMS website that contains additional information and resources related to 5010.

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G. Change Log

Version	Date of Release	Changes
1.0	6/1/2011	Initial Draft
1.1	10/7/2011	<ul style="list-style-type: none"> • ISA 11 preferred Repetition Separator changed from “*” to “^” • ISA 16 preferred Component Element Separator changed from “~” to “:” • Professional: BHT06: Clarified from if submitting encounter, use “RP” to if submitting encounter/post-adjudicated claim, use “RP” • Institutional: BHT06: Clarified from if submitting encounter, use “RP” to if submitting encounter/post-adjudicated claim, use “RP” • Professional: 2300, CN1- <i>entire segment is no longer required</i> for post-adjudicated claims and capitated encounters. <i>CN101 and CN102 is required</i> for post-adjudicated claims and capitated encounters. • Institutional: 2300, CN1- <i>entire segment is no longer required</i> for post-adjudicated claims and capitated encounters. <i>CN101 and CN102 is required</i> for post-adjudicated claims and capitated encounters. • Professional: Clarified 2300 HI01-1 as principal diagnosis. Updated secondary diagnosis from HI01-1 - HI12-1 to HI02-1-HI12-1. • Institutional: Expanded 2300 HI01-1 for patient reason for visit to HI01-1 to HI03-1. • Professional: Added loop 2330B, DTP as requirement for encounters/post-adjudicated claims date. • Institutional: Added loop 2330B, DTP as requirement for encounters/post-adjudicated claims date. • Professional: Added loop 2400, SV103 as further instruction for Anesthesia Claims. • Added Q&A regarding billing provider address and 9-digit zip code requirements in Section E. FAQ. • Added Q&A regarding Anesthesia Time Reporting Changes
1.2	11/09/2011	<ul style="list-style-type: none"> • Professional: Updated 2420A, PRV (Name =Provider Taxonomy Code) reference to PRV03 • Professional: 2000A, PRV03 / 2310B, PRV03 / 2420A, PRV03: Clarified that Taxonomy codes are required for all submitters. Notes changed from “If submitting encounter, Taxonomy code always required for submissions as IEHP’s Regulators require it. If submitting claim, follow IG” to “Taxonomy code always required for submissions.” • Institutional: 2000A, PRV03 / 2310A, PRV03: Clarified that Taxonomy codes are required for all submitters.

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G. Change Log

		<p>Notes changed from “If submitting encounter, Taxonomy code always required for submissions as IEHP’s Regulators require it. If submitting claim, follow IG” to “Taxonomy code always required for submissions.”</p> <ul style="list-style-type: none"> • Professional: Clarified 2300, CN101 by adding to notes/comments “when loop ID- 2400, CN101, line level contract type, is not used.” • Professional: Deleted 2300, CN102. • Professional: Added 2430, SVD segment as required field for post-adjudicated claims and capitated encounters. • Professional: Added 2400, CN101 as required field for post-adjudicated claims and capitated encounters if the line level information is different than the claim level. • Institutional: Deleted 2300, CN102. • Institutional: Deleted 2400, SV1 Professional Service Line • Institutional: Added 2430, SVD segment as required field for post-adjudicated claims and capitated encounters. • Professional: Added 2300, NTE segment to provide instructions for post-adjudicated claims and capitated encounters on providing denied reasons on the claim level. Required for Medicare Members Only. • Institutional: Added 2300, NTE segment to provide instructions for post-adjudicated claims and capitated encounters on providing denied reasons on the claim level. Required for Medicare Members Only. • Professional: Added 2400, NTE segment to provide instructions for post-adjudicated claims and capitated encounters on providing denied reasons on the service line level. Required for Medicare Members Only. • Institutional: Added 2400, NTE segment to provide instructions for post-adjudicated claims and capitated encounters on providing denied reasons on the service line level. Required for Medicare Members Only. • Professional: Clarified 2330B.DTP segment, Claim Check or Remittance Date, by adding “DTP01 = 573” to notes/comment section. • Professional: Clarified 2330B.DTP segment, Claim Check or Remittance Date, by adding “DTP01 = 573” to notes/comment section.
1.3	12/1/2011	<ul style="list-style-type: none"> • Professional: Removed 2300, NTE segment to provide instructions for post-adjudicated claims and capitated encounters on providing denied reasons on the claim level. Required for Medicare Members Only. • Institutional: Removed 2300, NTE segment to provide instructions for post-adjudicated claims and capitated encounters on providing denied reasons on the claim level. Required for Medicare Members Only.

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G. Change Log

		<ul style="list-style-type: none"> Professional: Removed 2400, NTE segment to provide instructions for post-adjudicated claims and capitated encounters on providing denied reasons on the service line level. Required for Medicare Members Only. Institutional: Removed 2400, NTE segment to provide instructions for post-adjudicated claims and capitated encounters on providing denied reasons on the service line level. Required for Medicare Members Only. Professional: Added 2320, CAS Segment to provide instructions for post-adjudicated claims and capitated encounters on providing the denial reason code if a claim is denied. Required for Medicare Members Only. Institutional: Added 2320, CAS Segment to provide instructions for post-adjudicated claims and capitated encounters on providing the denial reason code if a claim is denied. Required for Medicare Members Only. Professional: Added 2430, CAS Segment to provide instructions for post-adjudicated claims and capitated encounters on providing the denial reason code if a claim is denied on the service line. Required for Medicare Members Only. Institutional: Added 2430, CAS Segment to provide instructions for post-adjudicated claims and capitated encounters on providing the denial reason code if a claim is denied on the service line. Required for Medicare Members Only.
1.4	04/24/2012	<ul style="list-style-type: none"> Professional: Added 1000A, PER segment to recommend submitter's to provide telephone and email address for better future communication. Professional: Added 1000B, NM102 to clarify qualifier to be used as "2" for non-person entity. Professional: Removed 2000B SBR segment reference following CMS updated companion guide. Professional: Added 2010AA Billing Provider Name Segment to clarify that Billing Provider must be populated and be a ten digit number, beginning with 1. Also provided default NPI for atypical providers (i.e. non-emergency transportation). Professional: Added 2010AA N4 Billing Provider City, State, Zip Code to provide instructions if nine (9) digit zip code is unavailable. Professional: Added 2010AA REF segment for specific instructions regarding Atypical providers (i.e. non-emergency transportation) that are coming through as an encounter. Professional: Added 2010BA NM108 to clarify qualifier for Member ID (MI).

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G. Change Log

		<ul style="list-style-type: none">• Professional: Added 2300, CLM Segment to clarify instructions for this segment (i.e. options for claim frequency code provided.)• Professional: Added 2300 REF*F8 as a place to hold ICN from original claim when submitting adjustment.• Professional: Added 2300 REF*D9 as requirement for unique claim number.• Professional: Removed date (10/1/2013) reference for ICD10 in all Diagnosis Segments (HI)• Professional: Updated 2320, CAS segment from being required for Medicare Members only to being required for all LOBS for post-adjudicated claims and capitated encounters if a claim is denied.• Professional: Updated 2430, CAS segment from being required for Medicare Members only to being required for all LOBS for post-adjudicated claims and capitated encounters if a claim is denied on the service line.• Institutional: Added 1000A, PER segment to recommend submitter's to provide telephone and email address for better future communication.• Institutional: Added 1000B, NM102 to clarify qualifier to be used as "2" for non-person entity• Institutional: Removed 2000B SBR segment reference following CMS updated companion guide.• Institutional: Added 2010AA Billing Provider Name Segment to clarify that Billing Provider must be populated and be a ten digit number, beginning with 1. Also provided default NPI for atypical providers (i.e. non-emergency transportation).• Institutional: Added 2010AA N4 Billing Provider City, State, Zip Code to provide instructions if nine (9) digit zip code is unavailable.• Institutional: Added 2010AA REF segment for specific instructions regarding Atypical providers (i.e. non-emergency transportation) that are coming through as an encounter.• Institutional: Added 2010BA NM108 to clarify qualifier for Member ID (MI).• Institutional: Added 2300, CLM Segment to clarify instructions for this segment. (i.e. options for claim frequency code provided.)• Institutional: Added 2300, DTP Date- Admission Date/Hour as clarifying instructions.• Institutional: Removed date (10/1/2013) reference for ICD10 in all Diagnosis Segments (HI)
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IX. 5010 STANDARD COMPANION GUIDE

G. Change Log

		<ul style="list-style-type: none">• Institutional: Added 2300 REF*F8 as a place to hold ICN from original claim when submitting adjustment.• Institutional: Added 2300 REF*D9 as requirement for unique claim number.• Institutional: Updated 2320, CAS segment from being required for Medicare Members only to being required for all LOBS for post-adjudicated claims and capitated encounters if a claim is denied.• Institutional: Updated 2430, CAS segment from being required for Medicare Members only to being required for all LOBS for post-adjudicated claims and capitated encounters if a claim is denied on the service line.• Updated Testing Procedures in Section H for Claims Submitters from claims\editest\5010\inbound' to 'claims\5010\editest' and for Encounter Submitters from 'editest\5010' to '5010\editest'
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H. Testing Procedures

Submission of Test Files for Initial 5010 Validation Only

For purposes of the initial 5010 validation of your 5010 837 formatting only, post test claims files to the 'claims\5010\editest' subfolder or encounters to the '5010\editest' subfolder in your current assigned folder. When submitting 837I test files, make sure to include both inpatient and outpatient sample data. Submit no more than fifty claims or encounters per test file. Send a notification to EDI@iehp.org once your files are posted noting the file names and submission counts per file. Test files will be evaluated to ensure adherence to the 5010 standards and companion guide requirements.

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