# 837I Health Care Claim Companion Guide

## Standard Companion Guide Transaction Information

## Instructions related to Transactions based on ASC X12 Implementation Guides, version 005010

**Companion Guide Version Number: 1.0**

**March, 2011**

# Preface

Companion Guides (CG) may contain two types of data, instructions for electronic communications with the publishing entity (Communications/Connectivity Instructions) and supplemental information for creating transactions for the publishing entity while ensuring compliance with the associated ASC X12 IG (Transaction Instructions). Either the Communications/Connectivity component or the Transaction Instruction component must be included in every CG. The components may be published as separate documents or as a single document.

The Communications/Connectivity component is included in the CG when the publishing entity wants to convey the information needed to commence and maintain communication exchange.

The Transaction Instruction component is included in the CG when the publishing entity wants to clarify the IG instructions for submission of specific electronic transactions. The Transaction Instruction component content is limited by ASCX12’s copyrights and Fair Use statement.

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# Transaction Instruction (TI)

## 1 TI Introduction

### 1.1 Background

#### 1.1.1 Overview of HIPAA Legislation

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

#### 1.1.2 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).

### 1.1.3 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.

## 1.2 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 requirements 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.

# 2 Included ASC X12 Implementation Guides

This table lists the X12N Implementation Guides for which specific transaction Instructions apply and which are included in Section 3 of this document.

| Unique ID | Name |
|---|---|
| 005010X223 | Health Care Claim: Institutional (837) |

# 3 Instruction Tables

These tables contain one or more rows for each segment for which a supplemental instruction is needed.

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

## 3.1 837 Health Care Claim: Institutional

The 837 Institutional Transaction is used to submit health care claims and encounter data to a payer for payment. This format is used to bill long term care, inpatient, outpatient, and home health claims. The following companion document provides data clarification for the 837 Health Care Claim: Institutional (005010X223A2) transaction set. (Addenda dated April 2010)

**Special Notes – Applicable to Entire Transaction**

**Subscriber, Insured, and Member = Client in the Connecticut Medical Assistance Program Environment**

The Connecticut Medical Assistance Program does not allow for dependents to be enrolled under a primary subscriber, rather all clients are primary subscribers within each program.

**Provider Identification = National Provider Identifier (NPI) or Atypical provider identifier**

*For all covered entities, the provider NPI, Taxonomy Code and Zip Code+4 must be received in the appropriate loops. All zip codes must be numeric, no hyphens, length is 9. The loops are:*

- *2000A Billing/Pay to Provider Specialty Information (Taxonomy)*
- *2010AA Billing Provider (NPI and Zip Code+4)*

*The NPI will be sent in the NM109 where NM108 equals XX. The Taxonomy Code will be sent in the PRV03 where PRV02 equals PXC.*

*For all covered entities, the provider NPI, Taxonomy and Zip Code+4 must be received in the appropriate loops as required by the 5010 standard. The loops are:*

- *2310A Attending Physician - NPI, Taxonomy*
- *2310B Operating Physician - NPI*
- *2310C Other Operating Physician - NPI*
- *2310D Rendering Physician - NPI*
- *2310E Service Facility Location – NPI, Address*
- *2310F Referring Physician - NPI*

*The NPI will be sent in the NM109 where NM108 equals XX. The Zip Code+4 will be sent in N403. All zip codes must be numeric, no hyphens, length of 9.*

*For all atypical providers where an NPI is not assigned, the claim must contain the Connecticut Medical Assistance Program Provider ID within the appropriate loops within the REF segment where REF01 equals G2.*
*Note that the Billing Provider Secondary ID segment which can contain this provider ID is in a new location, Loop 2010 BB.*

**Connecticut Medical Assistance Program Health Plan ID = Connecticut Federal Tax ID**

The Connecticut Medical Assistance Program will use the CT Federal Tax ID in all instances requiring a Health Plan ID. At such a time as the National Health Plan ID is approved and available, that ID will be used.

### 3.1.1 Overall 837 Health Care Claim Institutional Formatting

| Item Number | Connecticut Medical Assistance Program Specifications |
|---|---|
| 1 | A transmission with multiple GS-GE's within one ISA-IEA will be accepted. |
| 2 | A transmission will be rejected if an invalid Version/Release/Industry Identifier Code is submitted in GS08. Institutional claims should be submitted with '005010X223A2' in GS08. |
| 3 | Dollar amounts in excess of 9,999,999.99, while accepted, will result in non-payment. |
| 4 | Negative values submitted in amount fields, while accepted, will result in non-payment. |
| 5 | A transmission may be rejected if an invalid receiver ID is submitted in the ISA08 Interchange Receiver ID. The Connecticut Medical Assistance Program Receiver ID is '061274678'. |
| 6 | Professional and Institutional transactions cannot be mixed within the same ST-SE envelope. |
| 7 | Billing information is to be entered in Loop 2010AA Billing Provider. |
| 8 | A maximum of 999 details per claim will be processed. Details in excess of 999 on any one claim will fail HIPAA compliance. |
| 9 | The NPI will be required on all incoming Medicare coinsurance and deductible claims. The trading partner should enter the NPI in Loop 2010AA NM109–Billing Provider Identifier on claims submitted to Medicare. |
| 10 | The NDC code, N4 Modifier and HCPCS code will be required on outpatient claims in Loop 2410 when certain physician administered drugs are billed. |

## 005010X223 Health Care Claim: Institutional

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| | BHT | Beginning of Hierarchical Transaction | | |
| | BHT06 | Transaction Type Code | | Claim or Encounter Indicator<br>"CH" – Chargeable (Use with Institutional Health Care Claim)<br>"RP" – Reporting (Use with Institutional Health Care Encounter)<br>Claims submitted using 'RP' in BHT06 will process. However, they will be denied unless the submitter is a Connecticut Managed Care Organization.<br>Value '31'(subrogation) is not used by CT Medicaid. |
| 1000A | NM1 | Submitter Name | | |
| 1000A | NM109 | Identification Code | | Unique ID assigned by HP; this identification will be assigned once an EMC submitter is authorized to submit claims to HP. A transmission will be rejected when sent with an unauthorized submitter identification number |
| 1000B | NM1 | Receiver Name | | |
| 1000B | NM103 | Name Last or Organization Name | | "CT DSS MMIS CONTRACT ADMINISTRATOR"<br>All caps |
| 1000B | NM109 | Identification Code | | "061274678" designates the Connecticut Medical Assistance Program receiver ID. |

**For Medical Providers – The following applies to all provider identification sections:**

NM1 segment should contain the NPI in NM109 with NM108 set to XX for health care providers. The corresponding REF segment, when NM108=XX, must contain REF01 of EI for Employer's Identification Number (EIN) or SY for Social Security Number (SSN). REF02 contains the value for the healthcare provider based on the qualifier used in REF01. The length of EIN must be equal to 10 with hyphen or 9 without. The length of SSN must be equal to 11 with hyphens or 9 without.

**For Atypical Providers – The following applies to all provider identification sections:**

NM108 and NM109 are not populated when the Provider does not have an NPI. The corresponding REF segment, where REF01=G2 should contain the Atypical Provider Identifier.

**Provider Specialty**

Provider Specialty Information is made situational as to whether it is required for payer processing of the claim. It is recommended that the PRV (Taxonomy Code) information always be sent per Implementation Guide specifications to further assist in processing the claim since NPI, Taxonomy Code, and Zip Code are used to identify a given provider.

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| 2000B | HL | Subscriber Hierarchical Level | | Implement with recommendation of maximum of 5000 CLM segments in a single transaction (ST-SE) |
| 2000B | HL04 | Hierarchical Child Code | | Always "0" (zero), for Connecticut Medical Assistance Program. No Subordinate HL Segment in this Hierarchical Structure. |
| 2000B | SBR | Subscriber Information | | |
| 2000B | SBR04 | Name | | When submitting a claim to the CT Medical Assistance Program field should be populated with 'Medicaid' CT Medical Assistance program does not have a group number. |
| 2000B | SBR09 | Claim Filing Indicator Code | | Should be "MC", Medicaid |
| 2010BA | NM1 | Subscriber Name | | |
| 2010BA | NM102 | Entity Type Qualifier | | Always "1", Person |
| 2010BA | NM108 | Identification Code Qualifier | | Always "MI", Member Identification Number |
| 2010BA | NM109 | Identification Code | | 9-character Unique Medicaid Client ID assigned by DSS; must be left justified |
| 2010BB | NM1 | Payer Name | | |
| 2010BB | NM103 | Name Last or Organization Name | | "CT DSS MMIS CONTRACT ADMINISTRATOR"<br>All caps |

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| 2010BB | NM108 | Identification Code Qualifier | PI | Always “PI”, Payer Identification |
| 2010BB | NM109 | Identification Code | | Always “061274678” CT DSS MMIS CONTRACT ADMINISTRATOR Tax ID Number |
| 2010BB | REF | Billing Provider Secondary Identification | | |
| 2010BB | REF01 | Reference Identification Qualifier | | New segment Billing Provider Secondary ID, use qualifier ‘G2” when the Billing Provider is a Non-Covered Entity. |
| 2010BB | REF02 | Reference Identification | | New segment Billing Provider Secondary ID, enter 9 digit Provider AVRS ID when the Billing Provider is a Non-Covered Entity. |
| 2300 | CLM | Claim Information | | |
| 2300 | CLM01 | Claim Submitter’s Identifier | | Patient Account Number will accept up to 38 characters. The value received will be returned in the 835 transaction. |
| 2300 | CLM05-3 | Claim Frequency Type Code | | The claim frequency type code will indicate Connecticut Medical Assistance Program processing as follows: ‘7’ (Replacement claim), ‘8’ (Void claim). Any other values submitted in this field will cause a claim to process as an original. |
| 2300 | REF | Payer Claim Control Number | | |
| 2300 | REF01 | Reference Identification Qualifier | | “F8” – Original Reference Number<br>Required when submitting a voided or replacement claim as indicated by CLM05-3. |
| 2300 | REF02 | Reference Identification | | Use the control number assigned to the last approved claim. |
| 2300 | HI | Principal, Admitting, Patient Reason For Visit, E-Code and Other Diagnosis Information | | Diagnosis codes have a maximum size of five, and decimal points must not be entered. |
| 2300 | HI | Principal Procedure Information | | Surgical procedures will be accepted in ICD-9 formats, and ICD-10 when implemented by CMS.<br>Not CTXIX specific. |

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| 2300 | HI | Value Information | | Value codes beyond 12 occurrences will be ignored. Value Codes are now used to report Covered Days ( HI0x-2 = 80) or Non-Covered Days (HI0x-2 = 81), HI0x-7 = number of days |
| 2310A | REF | Attending Provider Secondary Identification | | |
| 2310A | REF01 | Reference Identification Qualifier | | For atypical providers: "G2" – Provider Commercial Number |
| 2310A | REF02 | Reference Identification | | Please enter the 9 digit AVRS Provider ID with a qualifier of G2 in the REF01. |
| 2330B | NM1 | Other Payer Name | | |
| 2330B | NM109 | Identification Code | | Enter the Connecticut Medical Assistance Program Carrier Code. These code values can be found at http://www.ctdssmap.com |
| 2400 | SV2 | Institutional Service Line | | |
| 2400 | SV202-1 | Product/Service ID Qualifier | | "HC" Required if outpatient billing and revenue codes 250-253, 258-259, or 634-637 are billed. |
| 2400 | SV202-2 | Product/Service ID | | HCPCS code required if outpatient billing and revenue codes 250-253, 258-259, or 634-637 are billed. |
| 2400 | SV105 | Quantity | | Service unit counts in excess of 9999, while accepted, will result in non-payment. |
| 2410 | LIN | Drug Identification | | NDC information for Outpatient transactions will be processed in Loop 2410. Required if billing HCPCS codes in Q, S or J series. |
| 2410 | LIN02 | Product/Service ID Qualifier | | "N4" Outpatient claims must include the NDC data for all physician administered drugs. |
| 2410 | LIN03 | Product/Service ID | | Enter the NDC code for the physician administered drug. Limit one per service line/detail. |
| 2410 | CTP | Drug Quantity | | |
| 2410 | CTP04 | Quantity | | Drug unit count Outpatient claims must include the NDC data for all physician administered drugs. |
| 2410 | CTP05-1 | Unit or Basis for | | F2 = International Unit |

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| | | Measurement Code | | GR = Gram<br>ME = Milligram<br>ML = Milliliter<br>UN = Unit |
| 2430 | SVD | Line Adjudication Information | | |
| 2430 | SVD06 | Assigned Number | | If services are bundled, recommend using the corresponding LX1 value of the bundled service line, with up to 3 characters allowed |

# 4 TI Change Summary

Not applicable; V1.0