# 837P 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.

# Table of Contents

# 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 Guide 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 |
|---|---|
| 005010X222A1 | Health Care Claim: Professional (837) |

# 3 Instruction Tables

These tables contain one or more rows for each segment for which 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: Professional

The 837 Professional Transaction is used to submit health care claims and encounter data to a payer for payment. The following companion document provides data clarification for the 837 Health Care Claim: Professional (005010X222A1 transaction set. (Addenda dated June 2010)

**Special Notes – Applicable to Entire Transaction**

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

**With the implementation of 5010, files submitted with invalid NPI will reject and claims will not be processed.**

*For all providers with NPI, the provider NPI, Taxonomy Code and Zip Code+4 must be received in the appropriate loops. The loops are:*

- *2000A Billing/Pay to Provider Specialty Information(Taxonomy)*
- *2010AA Billing Provider (NPI and Zip Code+4)*
- *2310B Rendering Provider*
- *2420A Rendering Provider*

*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 and the Zip Code+4 must be sent in N403.* All zip codes must be numeric, no hyphens, length of 9. *Please note that the combination of NPI, Taxonomy Code, and Zip Code+4 is used in determining the correct Automated Voice Response System (ARVS) Provider Number under which a claim is to be processed. Claims lacking this information may deny, if a match cannot be made to a valid AVRS Provider Number.*

*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. Claims lacking this information may deny, if a match cannot be made to a valid AVRS Provider Number.*

**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 Professional 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. Professional claims should be submitted with '005010X222A1' 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 carrier code is submitted in the ISA08 Interchange Receiver ID. The Connecticut Medical Assistance Program carrier code 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. Additional Billing information is to be submitted in Loop 2100BB for atypical providers. |
| 8 | Dependent Loops of transactions will not be processed with the exception of Third Party Claims where the Connecticut Medical Assistance Program client is a dependent on other primary insurance. |
| 9 | A maximum of 50 details per claim will be processed. Details in excess of 50 on any one claim will fail HIPAA compliance. |
| 10 | 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. |
| 11 | The NDC and N4 modifier will be required in Loop 2410 when billing S, Q or J series HCPCS codes. |

## 005010X222 Health Care Claim: Professional

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| | | Beginning of Hierarchical Transaction | | |
| | BHT06 | Transaction Type Code | 31, CH, RP | Claim or Encounter Indicator<br>“CH” – Chargeable (Use with Professional Health Care Claim)<br>“RP” – Reporting (Use with Professional Health Care Encounter)<br>Claims submitted using “RP” in BHT06 will process. However, they will be denied. |
| 1000A | NM1 | Submitter Name | | |
| 1000A | NM109 | Identification Code | | Unique ID assigned by DSS/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 All Provider Identification Sections**

**For Medical Providers**

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 Non-Healthcare Providers**

The corresponding REF segment, where REF01=G2 should contain the AVRS Provider ID

**Specialty Information**

Under HIPAA guidelines, Provider Specialty Information is situational as to whether it is required for payer processing of the claim. Now that NPI has been implemented, it is recommended that the PRV (Taxonomy Code) information always be sent to further assist in processing the claim since NPI, Taxonomy Code and Zip Code+4 are used to identify a given provider. Claims lacking specialty information will deny if the correct provider cannot be identified.

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| 2010AA | NM1 | Billing Provider Name | | |
| 2010AA | NM109 | Identification Code | XX | For providers with NPI<br>Valid 10 digit NPI assigned to the provider when NM108 qualifier equals XX.<br>For atypical providers:<br>NM108 and NM109 at this loop should not be submitted.<br>Send AVRS provider number in 2010BB REF02 |
| 2010AA | N4 | Billing Provider City, State, Zip Code | | |
| 2010AA | N403 | Postal Code | | Billing Provider nine digit Zip Code |
| 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 | 0 | Always "0" (zero), for Connecticut Medical Assistance Program. No Subordinate HL Segment in this Hierarchical Structure. |

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| 2000B | SBR | Subscriber Information | | |
| 2000B | SBR04 | Name (Insured Group Name) | | Always 'Medicaid' |
| 2000B | SBR09 | Claim Filing Indicator Code | 11, 12, 13, 14, 15, 16, 17, AM, BL, CH, CI, DS, FI, HM, LM, MA, MB, MC, OF, TV, VA, WC, ZZ | Should be "MC", Medicaid |
| 2010BA | NM1 | Subscriber Name | | |
| 2010BA | NM102 | Entity Type Qualifier | 1, 2 | Always "1", Person |
| 2010BA | NM108 | Identification Code Qualifier | MI, II | Always "MI", Member Identification Number |
| 2010BA | NM109 | Subscriber Primary Identifier | | 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 |
| 2010BB | NM108 | Identification Code Qualifier | PI, XV | Always "PI", Payor Identification |
| 2010BB | NM109 | Identification Code | | Always "061274678" CT DSS MMIS CONTRACT ADMINISTRATOR Tax ID Number |
| 2010BB | REF | Payer Secondary Identification | | |
| 2010BB | REF01 | Reference Identification Qualifier | 2U, EI, FY, NF, G2 | 'G2" when the Billing Provider is a atypical |
| 2010BB | REF02 | Reference Identification | | AVRS id of an atypical provider |
| 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. |

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| 2300 | CLM05-3 | Claim Filing Indicator Code | 1, 7,8 | 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 | Original Reference Number (ICN) | | |
| 2300 | REF01 | Reference Identification Qualifier | F8 | Required when submitting a voided or replacement claim as indicated by CLM05-3 |
| 2300 | REF02 | Claim Original Reference Number | | Use the control number assigned to the last approved claim. |
| 2300 | CRC | EPSDT Referral | | EPSDT information must be entered in Loop 2300 if the EPSDT indicator in Loop 2400 SV111 equals 'Y'. |
| 2300 | HI | Health Care Diagnosis Code | | 3-5 byte ICD9 CM Diagnosis codes , no decimal points. |
| 2310B | REF | Rendering Provider Secondary Identification | | |
| 2310B | REF01 | Reference Identification Qualifier | OB, 1G, G2 | 'G2" when the Billing Provider is a atypical |
| 2310B | REF02 | Reference Identification | | AVRS id of an atypical provider |
| 2400 | SV1 | Professional Service | | |
| 2400 | SV104 | Quantity | | Service unit counts in excess of 9999 while accepted, will result in non-payment. |
| 2410 | LIN | Drug Identification | | NDC information for Professional transactions will be processed in Loop 2410. Required if billing HCPCS codes in Q, S or J series. |
| 2410 | CTP | Drug Pricing | | NDC information for Professional transactions will be processed in Loop 2410. Required if billing HCPCS codes in Q, S or J series. |
| 2420A | REF | Rendering Provider Secondary Identification | | |
| 2420A | REF01 | Reference Identification Qualifier | 0B, 1G, G2 | 'G2" when the Billing Provider is a atypical |

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| 2420A | REF02 | Reference Identification | | AVRS id of an atypical provider |
| 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