

837 Health Care Claim Companion Guide Professional and Institutional



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COMMUNITY HEALTH PLAN

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Community Health Plan reserves the right to make changes to this *Companion Guide* at any time without notice.

INTRODUCTION

In an effort to reduce the administrative costs of health care across the nation, the Health Insurance Portability and Accountability Act (HIPAA) was passed in 1996. This legislation requires that health insurance payers in the United States comply with the electronic data interchange (EDI) standards for health care, established by the Secretary of Health and Human Services (HHS). For the health care industry to achieve the potential administrative cost savings with EDI, standard transactions and code sets have been developed and need to be implemented consistently by all organizations involved in the electronic exchange of data. The ANSI X12N 837 Health Care Claims transaction implementation guide provides the standardized data requirements to be implemented for electronic claims submissions.

PURPOSE

The purpose of this document is to provide the information necessary to submit claims information electronically to Community Health Plan. This companion guide is to be used in conjunction with the ANSI X12N implementation guides. The information describes specific requirements for processing data within the payer's system. The companion guide supplements, but does not contradict or replace any requirements in the implementation guide. The implementation guides can be obtained from the Washington Publishing Company by calling 1-800-972-4334 or are available for download on their web site at www.wpc-di.com/hipaa/.

Other important websites:

Workgroup for Electronic Data Interchange (WEDI) – <http://www.wedi.org>
United States Department of Health and Human Services (HHS) -<http://aspe.hhs.gov/admsimp/>
Centers for Medicare and Medicaid Services (CMS) – <http://www.cms.gov/hipaa/hipaa2/>
Accredited Standards Committee (ASC X12) – <http://www.x12.org/>

SPECIAL CONSIDERATIONS

Inbound Transactions Supported

This section is intended to identify the type and version of the ASC X12 837 Health Care Claim transaction that the health plan will accept.

Separate files will need to be submitted for each transaction type.

837 Professional Health Care Claim - ASC X12N 837 (004010X098A1)	X
837 Institutional Health Care Claim - ASC X12N 837 (004010X096A1)	X
837 Dental Health Care Claim - ASC X12N 837 (004010X097A1)	NO

Response Transactions Supported

This section is intended to identify the response transactions supported by the health plan.

997 Functional Acknowledgement	X
835 Health Care Claim Payment Advice - ASC X12N 835 (004010X091A1)	X
Level 3 Business Edits <ul style="list-style-type: none"> ➤ Clearinghouse Submission - Web MD Reports ➤ Direct Submission – 864 Text Message Transaction 	X

Important Notice: For Implementation Guide violations, Community Health Plan returns a 997 Transaction ONLY. Trading partners who are unable to accept a 997 are not provided with alternative error reporting mechanisms.

Delimiters Supported

A delimiter is a character used to separate two data elements or sub-elements, or to terminate a segment. Delimiters are specified in the interchange header segment, ISA. The ISA segment is a 105 byte fixed length record. The data element separator is byte number 4; the component element separator is byte number 105; and the segment terminator is the byte that immediately follows the component element separator. Once specified in the interchange header, delimiters are not to be used in a data element value elsewhere in the transaction. Community Health Plan will support the delimiters defined by the ANSI standards.

Direct Submission

Providers wishing to submit electronic Health Care Claims (837 transactions) direct to Community Health Plan should contact our Client Service Department at one of the numbers listed below:

Local: 816-271-1247

Toll Free: 800-990-9247

Provider Billing Requirements

The 837 Health Care Claim transaction provides a large amount of provider data at both the claim level and the service line level. The Billing/Pay-To loop (2000A) is a required loop. At a minimum the transaction must have a billing provider. The pay-to, rendering (professional claim) or service facility loops are dependent upon what is entered in the billing loop.

Billing Provider Name loop (2010AA) - is a required loop used to identify the original entity that submitted the electronic claim/encounter. The billing provider entity may be a health care provider, a billing service or some other representative of the provider.

Pay-To Provider Name loop (2010AB) - is a situational loop, required if the pay-to provider is a different entity from the billing provider.

Rendering Provider Name loop (2310B) – PROFESSIONAL ONLY - is a situational loop, required if the rendering provider information is different than that carried in either the billing provider or pay-to provider (2010AA/AB) loops.

Rendering Provider Name loop (2420A) – PROFESSIONAL ONLY - submission of more than one provider at the service line level will not be accepted for processing. Please submit separate claims, one for each rendering provider.

Depending on the scenario one or more of the previously mentioned loops might be present in the 837 Health Care Claim transaction.

837P: Community Health Plan's adjudication system will look for the appropriate provider number identifier using the rendering provider loop 2310 and 2420 and if one is not found, will default back to the 2000/2010 loops.

837I: Community Health Plan's adjudication system will look for the appropriate provider number identifier using the billing or pay-to-provider in the 2000A, 2010AA, or 2010AB loops respectively.

CONTACTS

For any questions regarding your electronic claim submission please contact our Client Service Department at one of the numbers listed below:

Local: 816-271-1247

Toll Free: 800-990-9247

SYSTEM OPERATING HOURS

Trading partners can submit ANSI 837 files to Community Health Plan 24 hours a day/ 7 days a week. Processing of these files will be a batch process that takes place after 5:00 pm each business day. All files sent after 5:00 pm will not process until the next business day. All acknowledgement reports will be available after 8:00 am the following business day. Provider remits and checks will be available on Tuesdays after 8:00am.

Interchange Control Header Specifications

Item	Loop ID Segment Descriptions and Element Names	Reference (REF) Designator	Comments
1		ISA05	ZZ
2		ISA06	Assigned number given by Community Health Plan for direct submission or an assigned number by clearinghouse, Web MD.
3		ISA07	ZZ
4		ISA08	Community Health Plans Receiver number 900100001

Functional Group Header

Item	Loop ID Segment Descriptions and Element Names	Reference (REF) Designator	Comments
1		GS02	Same as ISA06
2		GS03	Same as ISA08

Claim Transaction Specifics

Item	Loop ID Segment Descriptions and Element Names	Reference (REF) Designator	Comments
1	1000A— SUBMITTER NAME Submitter Identifier	NM109	Must match the sender ID in the GS02.
2	1000B— RECEIVER NAME Receiver Identifier	NM109	This is the same value in the GS03.
3	2010AA — BILLING PROVIDER (Primary Identifier)	NM108 NM109	NM108 = XX NM109 = NPI
4	2010AA — BILLING PROVIDER (Required Additional Identifier)	REF01 REF02	REF01 = EI REF02 = Tax ID #

Claim Transaction Specifics (cont)

Item	Loop ID Segment Descriptions and Element Names	Reference (REF) Designator	Comments
5	2010AB — PAY-TO PROVIDER (Primary Identifier)	NM108 NM109	NM108 = XX NM109 = NPI
6	2010AB — PAY-TO PROVIDER (Required Additional Identifier)	REF01 REF02	REF01 = EI REF02 = Tax ID #
7	2000B — SUBSCRIBER INFORMATION	SBR02 SBR03	SBR02 should be = to 18 when subscriber is patient. <u>Business edits</u> will be performed using SBR03, group number. This group number found on the Community Health Plan member card.
	2010BA – SUBSCRIBER NAME	DMG02 DMG03	<u>Business edits</u> will be performed using DMG02 and DMG03. Gender code should be M or F.
8	2000C — PATIENT INFORMATION	PAT01	<u>Business edits</u> will be performed using PAT01. Patient loop <u>must</u> be used if not same as subscriber. Required values are: 01, 09, 10, 17, 19, 43
9	2010CA – PATIENT NAME	DMG02 DMG03	<u>Business edits</u> will be performed using DMG02 and DMG03. Gender code should be M or F.
10	2300 — CLAIM INFORMATION Total Charges	CLM02	Total submitted charges must equal the sum of the line item charge amounts (SV102).
11	2300 — CLAIM INFORMATION Attachment Transmission Code	PWK02	To expedite claims processing mail or fax the attachment the same day the claim is submitted. Fax Number: 816-271-1266 Address: Community Health Plan Attn: Claims EDI Attachments 137 North Belt Hwy. St. Joseph, MO 64506 Please include the following information with your submission: <ul style="list-style-type: none"> ➤ Date Claim Transmitted ➤ Provider Number ➤ Patient Name ➤ Date of Service ➤ Community Health Plan Member Number All documentation must be received within 14 calendar days of electronic submission. If documentation is not received, Community Health Plan will deny the claim.

Claim Transaction Specifics (cont)

Item	Loop ID Segment Descriptions and Element Names	Reference (REF) Designator	Comments
12	2300 — CLAIM INFORMATION Diagnosis Codes	HI01	Must submit definitive diagnosis codes otherwise claim will be returned. Maximum 5 characters. Do not send decimals—they are assumed.
13	2310B — RENDERING PROVIDER NAME*	N/A	Report the individual rendering provider information if not the same as the billing provider. If information is submitted for rendering physician, the is the provider that reimbursement will be made to.
14	2310B — RENDERING PROVIDER NAME (Primary Identifier)	NM108 NM109	NM108 = XX NM109 = NPI
15	2310B — RENDERING PROVIDER NAME (Required Additional Identifier) If still submitting legacy #	REF01 REF02	REF01 = EI REF02 = Tax ID # REF01 = G2 REF02= _____
16	2400 – SERVICE LINE	NTE	Community Health Plan's claim adjudication system does not receive information transmitted in this field. If you need to transmit note information to be used in claims processing, please submit at the claim level loop 2300.
17	2420A — RENDERING PROVIDER NAME* (Primary Identifier)	NM108 NM109	NM108 = XX NM109 = NPI
18	2420A — RENDERING PROVIDER NAME (Required Additional Identifier)	REF01 REF02	REF01 = EI REF02 = Tax ID #

* When submitting loop 2310B and/or loop 2420A, both NPI and Tax ID must be present.