HIPAA EDI Companion Guide

For

837 Institutional and Professional Health Care Claims

Companion Guide Version: 2.0

ASCX12N National Electronic Data Interchange Transaction Set Implementation and Addenda Guides, Version 005010A1/A2

Health Partners Plans, Inc. (HPP), uses Jefferson Health Plans as the marketing name for some of its lines of business. Current lines of business are: Jefferson Health Plans Individual and Family Plans, Jefferson Health Plans Medicare Advantage, Health Partners Plans Medicaid, and Health Partners Plans CHIP. All communications will specify the impacted line of business within the content of the message.

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INTRODUCTION

This EDI Companion Guide is to be used in conjunction with the ASCX12N 837 Standards for Electronic Data Interchange Technical Report Type 3 and Business Services Companion Guides. This guide defines communication specifications, specific Jefferson Health Plans business rules and information applicable to the 837 Institutional ("I") and Professional ("P") transactions. Jefferson Health Plans will use and accept standard code sets on the 837 transactions. Please refer to the HIPAA Implementation Guide for valid code set values.

Jefferson Health Plans will receive valid HIPAA X12N 837I & P transactions from Business Services and will in turn respond to Business Services with valid X12N transactions. Contact your billing software vendor and request that your Jefferson Health Plans claims and encounters be submitted through the Jefferson Health Plans claims clearinghouse. You can also direct your current clearinghouse to forward your claims to Jefferson Health Plans clearinghouse.

The following information is intended to serve only as a companion document to the HIPAA X12N 837 Institutional and Professional Standards for electronic data Interchange Technical Report Type 3.

Document Control - Version History

The following version history is provided to easily identify updates between Companion Guide versions. Each update is numbered. All corresponding areas of the document related to this update are also numbered.

#	Version	Date	Author	Updates
(1)	1.0	10/11	Operations Technical Support	• Initial version of the 5010 Companion Guide. • This version was also posted to the external website
(2)	2.0	10/17/13	Claims Department	• Added new plan name and company logo. • This version was also posted to the external website. • Coding- when submitting J-code the NDC must be included.
3	3.0	10/9/24	Claims Department	• Updated naming and contact information

Section 1 – 837 Institutional Claims

General Requirements for the Electronic Claims Submission Process (837 Institutional Claims)

This section will address a variety of issues that will facilitate the Institutional Claims Submission Process.

- Only loops, segments, and data elements valid for the HIPAA 837 Institutional (005010X223A2) Technical Report Type 3 will be translated. Deviating from the Technical Report Type 3 Guidelines and submitting invalid data will cause files to be rejected.

- Only one transaction type per transmission.

- The delimiters which Jefferson Health Plans will accept are listed below. The following characters must not be used within the data content of the 837I:
  - Data Element = * (Asterisk)
  - Segment = ~ (Tilde)
  - Component/Element = < (Less than sign)

- No more than 5,000 claims should be submitted by any provider at one time.

- WebMD/Emdeon Business Services will perform HIPAA compliance checking for all transactions received. If the transaction fails compliance checking, a "997 Functional Acknowledgement – Reject" will be generated and transmitted to the provider. The provider will be expected to correct the data and ***immediately*** retransmit the transaction.

- Rejected claims must be resubmitted within 180 days of the original date of service.

- Negative values submitted in the following fields will not be processed and will result in claim rejections: Total Claim Charge Amount (2300 Loop, CLM02), Patient Amount Paid (2300 Loop, AMT02), Other Payer Patient Paid Amount (2320 Loop, AMT02), COB Total Allowed Amount (2320 Loop, AMT02).

- We suggest retrieval of the ANSI 997 Functional Acknowledgment files on the first business day after the claim file is submitted, but no later than five days after the file submission.

- Providers submitting claims for Institutional Services should enter their five (5) digit Jefferson Health Plans Provider Identification Number in the 2310A REF01 'G2' qualifier, as shown in the table "837 Institutional" on page 6 of this companion guide.

- Jefferson Health Plans EDI can be reached via EDI@jeffersonhealtplans.com.

ANSI FIELDS FOR SUBMITTER AND PROVIDER VALIDATION

These fields will be required to have the following data:

837 Institutional

Loop	Element	Field Description	Length	Mapping Comments
0000	ISA05	Interchange ID Qualifier	2/2	'ZZ'
0000	ISA06	Interchange Sender ID (*)	15/15	'133052274'
0000	ISA07	Interchange ID Qualifier	2/2	'ZZ'
0000	ISA08	Interchange Receiver ID	15/15	'801420001' (1)
0000	ISA15	Usage Indicator	1/1	MUST USE "P" FOR PRODUCTION
0000	GS02	Application Sender's Code	2/15	'133052274'
0000	GS03	Application Receiver's Code	2/15	'801420001' (1)
0000	BHT02	Transaction Set Purpose	2/2	'00'
1000A	NM102	Entity Type Qualifier	1/1	'2'
1000A	NM103	Organization Name	1/60	'EMDEON'
1000A	NM108	Identification Code Qualifier	1/2	'46'
1000A	NM109	Identification Code	2/80	'133052274'
1000A	PER02	Name	1/60	'EMDEON CUSTOMER SOLUTIONS'
1000A	PER03	Communication Number Qualifier	2/2	'TE'
1000A	PER04	Communication Number	1/256	'8008456592'
1000B	NM109	Identification Code	2/80	'801420001' (1)
2010AA	**NM108**	**Billing Entity Identification Qualifier**	**1/2**	**'XX'**
2010AA	NM109	**Billing Entity Identification Code**	2/80	USE APPROPRIATE NPI NUMBER
2010AA	**N3**	**Billing Provider Address**	**1/55**	**PROVIDER BILLING ADDRESS**
2010AA	**N4**	**Billing Provider City, State, Zip**	2/30	INCLUDE CITY, 2-CHARACTER STATE CODE AND 9-DIGIT ZIP CODE
2010AA	REF01	Billing Provider Secondary Identifier	2/3	'EI'
2010AA	REF02	Billing provider Secondary Identifier	1/50	**PROVIDER TAX IDENTIFICATION NUMBER**
2010AB	NM108	Pay-To Provider **Identification Qualifier**	1 / 2	'XX'
2010AB	NM109	Pay-To Provider Identification **Number Code**	2/80	USE APPROPRIATE NPI NUMBER
2010AB	N3	Address Information	1/55	ADDRESS INFORMATION

Loop	Element	Field Description	Length	Mapping Comments
2010AB	N4	**City, State Zip Code**	2/30	INCLUDE CITY, 2-CHARACTER STATE CODE AND 9-DIGIT ZIP CODE
2300	**NTE01**	**Billing Reference Code Text**	**3/3**	**'ADD'**
2310A	NM108	Attending Provider **Identification Qualifier**	1 / 2	'XX'
2310A	NM109	Attending Provider **Identification Code**	2/80	USE APPROPRIATE NPI NUMBER
2310A	REF01	Reference Identification Qualifier	2/3	'G2'
2310A	REF02	Reference Identification	1/50	Jefferson Health Plans PROVIDER IDENTIFICATION NUMBER (5 DIGITS)
2310B	NM108	Operating Physician **Identification Qualifier**	1 / 2	'XX'
2310B	NM109	Operating Physician **Identification Code**	2/80	USE APPROPRIATE NPI NUMBER
2310C	NM108	Other Operating Physician **Identification Qualifier**	1 / 2	'XX'
2310C	NM109	Other Operating Physician **Identification Code**	2/80	USE APPROPRIATE NPI NUMBER
2310E	NM108	Service Facility **Identification Qualifier**	1 / 2	'XX'
2310E	NM109	Service Facility **Identification Code**	2/80	USE APPROPRIATE NPI NUMBER
2310E	N3	Service Facility Address	1/55	ADDRESS INFORMATION
2310E	N4	Geographic Location	2/30	INCLUDE CITY, 2-CHARACTER STATE CODE AND 9-DIGIT ZIP CODE
2420A	NM108	Operating Physician **Identification Qualifier**	1 / 2	'XX'
2420A	NM109	Operating Physician **Identification Code**	2/80	USE APPROPRIATE NPI NUMBER
2420B	NM108	Other Operating Physician **Identification Qualifier**	1 / 2	'XX'
2420B	NM109	Other Operating Physician **Identification Code**	2/80	USE APPROPRIATE NPI NUMBER

(*) ISA06 & ISA08 have a required element min/max length of 15 characters. Trailing spaces may be required.

General Business Requirements for the 837 Institutional 5010A2 Claims Submission Process

This subsection will address a variety of issues that will facilitate the Electronic Media Claims Processing Process for the 837 Institutional (005010X223A2).

Coding

- Use most recent ICD-10, CPT, HCPC, and Revenue codes.
- Always check for 4th and 5th digit code requirements.
- An electronic claim cannot span two (2) separate calendar years. Charges must be filed for the previous year separately from the current year.
- No more than 5,000 claims will be accepted for any provider at one time.
- The maximum number of characters to be submitted in the dollar amount field is seven (7) characters.
- You may send up to sixteen (16) diagnosis codes per claim; however, the last twelve (12) diagnosis codes will not be considered in processing.

Member Identifiers

- Submitters must use the entire alphanumeric or numeric identification code for the Subscriber Identifier (Loop 2010BA, NM109), as it appears on the member's identification card.
  - Health Partners Plans Medicaid members have a nine (9) digit numeric member ID number
  - Health Partners Plans CHIP members have a ten (10) digit numeric member ID number
  - Jefferson Health Plans Individuals and Family (ACA) members have an alpha numeric member ID number starting with J
  - Jefferson Health Plans Medicare (Medicare Advantage) members have a seven (7) digit numeric member ID number

Provider Identifiers

- Jefferson Health Plans accepts the following provider identifiers:
  - **NPI Only (2010AA Loop, NM108 with the XX qualifier)**
  - **NPI Only (2310B Loop, NM108 with the XX qualifier)**

Section 2 – 837 Professional Claims

General Requirements for the Electronic Claims Submission Process (837 Professional Claims)

This section will address a variety of issues that will facilitate the Professional Claims Submission Process.

- Only loops, segments, and data elements valid for the HIPAA 837 Professional (005010X222A1) Technical Report Type 3 will be translated. Deviating from the Technical Report Type 3 and submitting invalid data will cause files to be rejected.

- Only one transaction type per transmission.

- The delimiters which Jefferson Health Plans will accept are listed below. The following characters must not be used within the data content of the 837P:
  - Data Element = * (Asterisk)
  - Segment = ~ (Tilde)
  - Component/Element = : (Colon)

- No more than 5,000 claims should be submitted by any provider at one time.

- WebMD/Emdeon Business Services will perform HIPAA compliance checking for all transactions received. If the transaction fails compliance checking, a "997 Functional Acknowledgement – Reject" will be generated and transmitted to the provider. The provider will be expected to correct the data and ***immediately*** retransmit the transaction.

- Rejected claims must be resubmitted within 180 days of the original date of service.

- Negative values submitted in the following fields will not be processed and will result in the claim being rejected: Total Claim Charge Amount (2300 Loop, CLM02), Patient Amount Paid (2300 Loop, AMT02), Patient Weight (2300 and 2400 Loop, CR102), Transport Distance (2300 and 2400 Loop, CR106), Payer Paid Amount (2320 Loop, AMT02), Allowed Amount (2320 Loop, AMT02), Line Item Charge Amount (2400 Loop, SV102), Service Unit Count (2400 Loop, SV104), Total Purchased Service Amount (2300 Loop, AMT02), and Purchased Service Charge Amount (2400 Loop, PS102).

- We suggest retrieval of the ANSI 997 Functional Acknowledgment files on the first business day after the claim file is submitted, but no later than five days after the file submission.

- Jefferson Health Plans EDI can be reached via EDI@jeffersonhealthplans.com.

ANSI FIELDS FOR SUBMITTER AND PROVIDER VALIDATION

These fields will be required to have the following data:

837 Professional

Loop	Element	Field Description	Length	Mapping Comments
0000	ISA05	Interchange ID Qualifier	2/2	'ZZ'
0000	ISA06	Interchange Sender ID (*)	15/15	'133052274'
0000	ISA07	Interchange ID Qualifier	2/2	'ZZ'
0000	ISA08	Interchange Receiver ID	15/15	'801420001' (1)
0000	ISA15	Usage Indicator	1/1	Must use "P" for production
0000	GS02	Application Sender's Code	2/15	133052274
0000	GS03	Application Receiver's Code	2/15	'801420001' (1)
0000	BHT02	Transaction Set Purpose	2/2	'00'
1000A	NM102	Entity Type Qualifier	1/1	'2'
1000A	NM103	Organization Name	1/60	'EMDEON'
1000A	NM108	Identification Code Qualifier	1/2	'46'
1000A	NM109	Identification Code	2/80	'133052274'
1000A	PER02	Name	1/60	'EMDEON CUSTOMER SOLUTIONS'
1000A	PER03	Communication Number Qualifier	2/2	'TE'
1000A	PER04	Communication Number	1/256	'8008456592'
1000B	NM109	Identification Code	2/80	'801420001' (1)
2010AA	NM108	Billing Provider Identification Code Qualifier	1/2	'XX'
2010AA	NM109	Billing Provider Identification Code	2/80	USE APPROPRIATE NPI NUMBER
2010AA	**N3**	Address Information	1/55	ADDRESS INFORMATION
2010AA	N4	Geographic Location	2/30	INCLUDE CITY, 2-CHARACTER STATE CODE AND 9-DIGIT ZIP CODE
2010AA	REF01	Billing Provider Reference Identification Qualifier	2/3	'EI'
2010AA	REF02	Billing Provider Secondary Identifier	1/50	TAX IDENTIFICATION NUMBER
2010AB	N3	Address Information	1/55	ADDRESS INFORMATION
2010AB	N4	Geographic Location	2/30	INCLUDE CITY, 2-CHARACTER STATE CODE AND 9-DIGIT ZIP CODE
2000B	PAT09	Pregnancy Indicator	1/1	'Y'
2300	NTE01	Claim Note Reference Code	3/3	'ADD"

Loop	Element	Field Description	Length	Mapping Comments
2300	NTE02	Description (Note Text)	1/80	'VC11'
2310A	NM108	Referring Physician Identification Code Qualifier	1 / 2	'XX'
2310A	NM109	Referring Physician Identification Code	2/80	USE APPROPRIATE NPI NUMBER
2310B	NM108	Rendering Physician Identification Code Qualifier	1 / 2	'XX'
2310B	NM109	Rendering Physician Identification Code	2/80	USE APPROPRIATE NPI NUMBER
2310C	NM108	Service Facility Location Identification Code Qualifier	1 / 2	'XX'
2310C	NM109	Service Facility Location Identification Code	2/80	USE APPROPRIATE NPI NUMBER
2310D	NM108	Supervising Provider Name Identification Code Qualifier	1/ 2	'XX'
2310D	NM109	Supervising Provider Name Identification Code	2/80	USE APPROPIATE NPI NUMBER
2420A	NM108	Rendering Provider Identification Code Qualifier	1 / 2	'XX'
2420A	NM109	Rendering Provider Identification Code	2/80	USE APPROPRIATE NPI NUMBER
2420B	NM108	Purchased Service Provider Identification Code Qualifier	1 / 2	'XX'
2420B	NM109	Purchased Service Provider Identification Code Qualifier	2/80	USE APPROPRIATE NPI NUMBER

* ISA06 & ISA08 have a required element min/max length of 15 characters. Trailing spaces may be required.

General Business Requirements for the 837 Professional 4010A1 Claims Submission Process

*This section will address a variety of issues that will facilitate the Electronic Claims Processing for 837 Professional (*005010X222A1*).*

Coding

- Use most recent ICD-10, CPT, and HCPCS codes.
- Jefferson Health Plans/Health Partner Plans does not accept the use of National Drug Codes (NDC) by non-retail pharmacies. J-Code submissions are required unless otherwise specified in provider contract. Providers are required to include the National Drug Codes (NDC) when submitting a J-Code.
- Always check for 4th and 5th digit code requirements.

General Business Requirements for the 837 Professional 4010A1 Claims Submission Process – Cont'd

- An electronic claim cannot span two (2) separate calendar years. Charges must be filed for the previous year separately from the current year.

- It is possible to bill $0.00 charge lines on professional claims.

- You may send up to four modifiers; however, the last two modifiers will not be considered for claims processing.

Member Identifiers

- Submitters must use the entire alphanumeric or numeric identification code for the Subscriber Identifier (Loop 2010BA, NM109), as it appears on the member's identification card.
  - Health Partners Plans Medicaid members have a nine (9) digit numeric member ID number
  - Health Partners Plans CHIP members have a ten (10) digit numeric member ID number
  - Jefferson Health Plans Individuals and Family (ACA) members have an alpha numeric member ID number starting with J
  - Jefferson Health Plans Medicare (Medicare Advantage) members have a seven (7) digit numeric member ID number

Provider Identifiers

- Jefferson Health Plans accepts the following provider identifiers:

  - **NPI Only (2310B Loop, NM108 with the XX qualifier)**

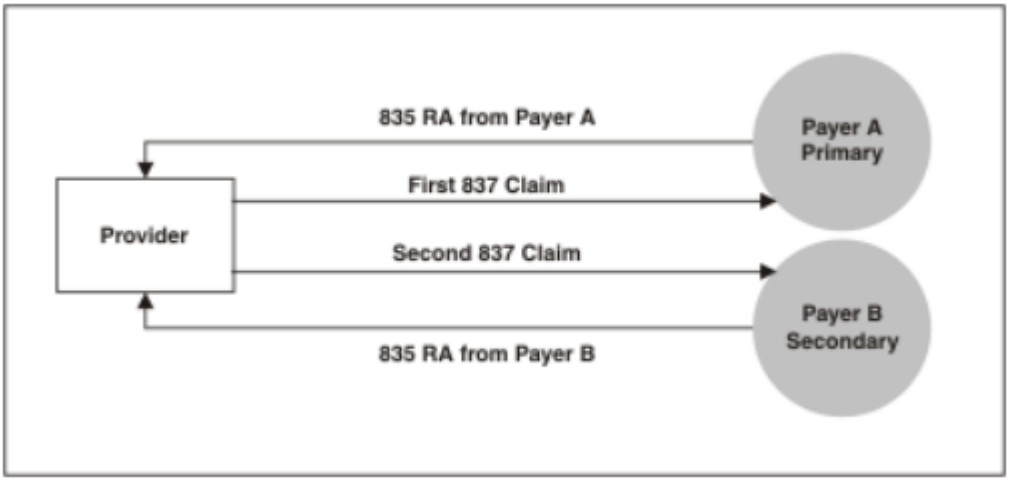
  - **NPI Only (2310B Loop, NM108 with the XX qualifier)**

General Business Requirements for COB Claim Submissions

Coordination of Benefits Data Models -- Detail The 837 Transaction handles two different models of benefit coordination. Both models are discussed in this section. Section 3, Examples, contains detailed examples of these models. Each COB related data element contains notes within this implementation guide specifying when it is used. The HIPAA final rules contain additional information on COB.

Model 1 -- Provider-to-Payer-to-Provider Step 1. In model 1, the provider originates the transaction and sends the claim information to Payer A, the primary payer. See Figure 1.1 - Provider-to-Payer-to-Provider COB Model. The Subscriber loop (Loop ID-2000B) contains information about the person who holds the policy with Payer A. Loop ID-2320 contains information about Payer B and the subscriber who holds the policy with Payer B. In this model, the primary payer adjudicates the claim and sends an electronic remittance advice (RA) transaction (835) back to the provider. The 835 contains any claim adjustment reason codes that apply to that specific claim. The claim adjustment reason codes detail what was adjusted and why.

Figure 1.1 - Provider-to-Payer-to-Provider COB Model



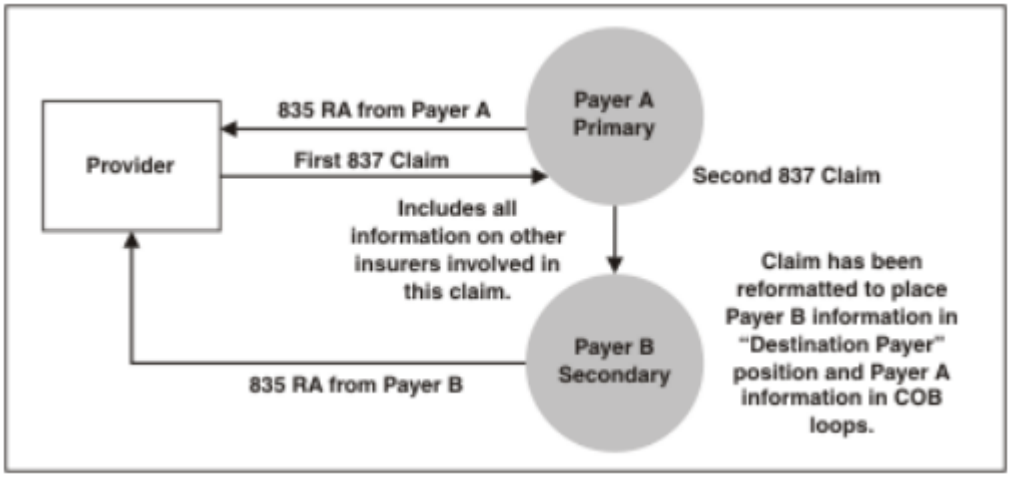
Step 2. Upon receipt of the 835, the provider sends a second health care claim transaction (837) to Payer B, the secondary payer. The Subscriber loop (Loop ID-2000B) now contains information about the subscriber who holds the policy with Payer B. The Other Subscriber Information loop (Loop ID-2320) now contains information about the subscriber for Payer A. Any total amounts paid at the claim level go in the AMT segment in Loop ID-2320. Any claim level adjustment codes are retrieved from the 835 from Payer A and put in the CAS (Claims Adjustment) segment in Loop ID-2320. Line Level adjustment reason codes are retrieved similarly from the 835 and go in the CAS segment in the 2430 loop. Payer B adjudicates the claim and sends the provider an electronic remittance advice.

Step 3. If there are additional payers (not shown in Figure 1.1 - Provider-to-Payer-to-Provider COB Model), step 2 is repeated with the 4 MAY 2006 ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3 005010X223 • 837 HEALTH CARE CLAIM: INSTITUTIONAL Subscriber loop (Loop ID-2000B) having information about the subscriber who holds the policy with Payer C, the tertiary payer. COB information specific to Payer A continues to be included as written in step 2 with an occurrence of Loop ID-2320 and specifying the payer as primary. If necessary, Loop ID-2430 is included for any line level adjudications. COB information specific to Payer

B is included by repeating the Loop ID-2320 again and specifying the payer as secondary. If necessary, Loop ID-2430 is included for Payer B line level adjudications.

Model 2 -- Provider-to-Payer-to-Payer Step 1. In model 2, the provider originates the transaction and sends claim information to Payer A, the primary payer. See Figure 1.2 - Provider-to-Payer-to-Payer COB Model. The Subscriber loop (Loop ID-2000B) contains information about the person who holds the policy with Payer A. Subscriber/payer information about secondary coverage is included in Loop ID-2320 or is on file at Payer A as a result of an eligibility file sent by Payer B (as in Medicare crossover arrangements). In this model, the primary payer adjudicates the claim and sends an 835 back to the provider.

Figure 1.2 - Provider-to-Payer-to-Payer COB Model



Step 2. Payer A reformats the 837 and sends it to the secondary payer. In reformatting the claim, Payer A takes the information about their subscriber and places it in Loop ID-2320. Payer A also takes the information about Payer B, the secondary payer/subscriber, and places it in the appropriate fields in the Subscriber Loop ID-2000B. Then Payer A sends the claim to Payer B. All COB information from Payer A is placed in the appropriate Loop ID-2320 and/or Loop ID-2430.

Step 3. Payer B receives the claim from Payer A and adjudicates the claim. Payer B sends an 835 to the provider. If there is a tertiary payer, Payer B performs step 2 in either Model 1 or Model 2.