

837 I Health Care Claim HIPAA 5010A2 Institutional

Revision summary

Revision Number	Date	Summary of Changes
1.0	5/20/11	Original
1.1	6/20/11	Added " <i>within the timeframes required by applicable law</i> " sentence to page 32.
1.2	10/18/11	Clarification on page 14 under REF 2010BB Business Rule and <i>Element Note</i> for Billing Provider Secondary Identifier

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Disclaimer

This AmeriHealth (hereinafter referred to as "AH") Companion Guide to EDI Transactions (the "Companion Guide") provides trading partners with guidelines for submitting electronic batch transactions. Because the HIPAA ASC X12N Implementation Guides require transmitters and receivers to make certain determinations/elections (*e.g.*, whether, or to what extent, situational data elements apply), this Companion Guide documents those determinations, elections, assumptions, or data issues that are permitted to be specific to AH's business processes when implementing the HIPAA ASC X12N 5010A2 Implementation Guides.

This Companion Guide does not replace or cover all segments specified in the HIPAA ASC X12N Implementation Guides. It does not attempt to amend any of the requirements of the Implementation Guides, or impose any additional obligations on trading partners of AH that are not permitted to be imposed by the HIPAA Standards for Electronic Transactions. This Companion Guide provides information on AH specific codes relevant to AH's business processes and rules and situations that are within the parameters of HIPAA. Readers of this Companion Guide should be acquainted with the HIPAA Implementation Guides, their structure, and content.

This Companion Guide provides supplemental information to the Trading Partner Agreement that exists between AH and its trading partners. Trading partners should refer to their Trading Partner Agreement for guidelines pertaining to AH's legal conditions surrounding the implementation of the EDI transactions and code sets. However, trading partners should refer to this Companion Guide for information on AH's business rules or technical requirements regarding the implementation of HIPAA-compliant EDI transactions and code sets.

Nothing contained in this Companion Guide is intended to amend, revoke, contradict, or otherwise alter the terms and conditions of the Trading Partner Agreement. If there is an inconsistency between the terms of this Companion Guide and the terms of the Trading Partner Agreement, the terms of the Trading Partner Agreement will govern.

Overview of Document

This Companion Guide is to be used as a supplement to the 837 Institutional Health Care Claim Implementation Guide, version 5010A2, including all Erratas issued up through June 2010. As such, this Companion Guide must be referred to for transmitting the 837 Institutional Health Care Claim transaction to AH.

The purpose of this Companion Guide is to outline AH processes for handling the 837 Institutional Health Care Claim (hereinafter referred to as the "837I"), and to delineate specific data requirements for the submission of AH transactions.

The Companion Guide was developed to guide organizations through the implementation process so that the resulting transaction will meet the following business objectives:

- **Convey all business information required by AH to process transactions.**
- **Interpret information in the same way:** The definition of the transaction will be specific so that trading partners can correctly interpret, from a business perspective, the information that is received from each other.
- **Simplify the communication:** The transaction will be standard to simplify communication between trading partners and to follow the requirements of HIPAA. [TOP](#)

General Instructions

The 837I can be used to submit health care claim billing information, encounter information, or both, from providers of health care services to payers, either directly or via trading partner or clearinghouse.

Payers include, but are not limited to:

- Insurance Company
- Health Maintenance Organization (HMO)
- Government Agency (Medicare, Medicaid, CHAMPUS, etc.)

Transmission Size

5,000 Claims per ST (limit is for CLM segment). [TOP](#)

Transaction Structure & Processing -- Batch Mode

There will be a separate ISA-IEA set for each different type of transaction. For example, if an electronic transmission between two trading partners contains claims and authorizations, there will be two ISA-IEA sets; one for the claims (837I) and one for the authorizations (278).

This Companion Guide reflects conventions for batch implementation of the ANSI X12 837I. [TOP](#)

Batch Mode Process

The 837I will be implemented in batch mode. The submitting organization will send the 837I to AH through some means of telecommunications and will not remain connected while AH processes the transaction.

If a portion of or the entire ISA segment is unreadable or does not comply with the Implementation Guide and if there is sufficient routing information that can be extracted from the ISA, AH will respond with an appropriate TA1 transaction. Otherwise, AH will be unable to respond. In either case, the batch will not be processed.

AH will respond with a 999 transaction as an acknowledgment to every batch file of 837I transactions that is received. This 999 acknowledgment will be sent whether or not the provider, or its intermediary, requests it. The acknowledgment 999 transaction will indicate whether or not the batch can be processed. If the GS segment of the batch does not comply with the Implementation Guide, AH may not be able to process the transaction.

If the information associated with any of the claims in the 837I ST-SE batch is not correctly formatted from a syntactical perspective, all claims between the ST-SE will be rejected. Providers should consider this possible response when determining how many patients and claims they will submit in a single 837I. [TOP](#)

National Provider Identifier (NPI)

AmeriHealth requires the submission of National Provider Identification Number (NPI) for all electronic claims (837) submitted May 23rd 2007 or thereafter.

You may also report your current provider identification numbers **in addition to your NPI(s)**.

Present on Admission Indicators (POA)

AmeriHealth requires the submission of POA codes on electronic inpatient claims (837).

These values are to be populated in the HIXX-9 (ninth position of the diagnosis composite) segments. Please refer to the 837 Institutional Health Care Claim Implementation Guide for details.

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837 Institutional: Segment Usage Detail

The 837 Institutional Data Element Segment identifies the specific data content required by AH.

AH Business Rules referenced in the Segment Usage Detail represent the following situations;

The element is required by the Implementation Guide and required by AH.

The element is situational by the Implementation Guide and, when the situation exists, is required to be included by AH.

The element is situational by the Implementation Guide and based on AH's business, is always required by AH.

Segment: **BHT** Beginning of Hierarchical Transaction
Segment: BHT Beginning of Hierarchical Transaction
Loop: **Beginning of Hierarchical Transaction**
Level: **Detail**
Usage: Required by Implementation Guide
Business: **AH requires submission with only the following data**
Rule: **elements for this segment:**

Data Element Summary

Ref Des	Element Name	Element Note
BHT06	Transaction Type Code	Enter code value:

CH = Use when submitting claims

RP = Use when submitting encounters

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Segment: **PRV** Billing Provider Specialty Information
 Loop: **2000A Billing Provider Hierarchical Level**
 Level: **Detail**
 Usage: Situational by Implementation Guide
 Business **AH requires submission with only the following data**
 Rule: **elements for this segment:**

Data Element Summary

Ref Des	Element Name	Element Note
PRV01	Provider Code	Enter value: (choose one) BI for Billing PT for Pay-To
PRV02	Reference Identification Qualifier	Enter value: PXC for Healthcare Provider Taxonomy
PRV03	Reference Identification	Enter value: Provider Taxonomy Code

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Segment: **NM1** Billing Provider Name
 Loop: **2010AA Billing Provider Name**
 Level: **Detail**
 Usage: Required by Implementation Guide
 Business **AH requires submission with only the following data**
 Rule: **elements for this segment:**

Data Element Summary

Ref Des	Element Name	Element Note
NM108	Reference Identification Qualifier	Enter code value: XX - Centers for Medicare and Medicaid Services National Provider Identifier
NM109	Identification Code	Enter the appropriate National Provider ID (NPI)

NOTE: When the organization is not a health care provider (is an “atypical” provider) and, thus, not eligible to receive an NPI, the NM108 and NM109 fields will be omitted. The “atypical” provider must submit their TIN in the REF segment and their assigned AH Corporate ID in loop 2010BB/REF (Billing Provider Secondary Identification segment).

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Segment: **N3** Billing Provider Address
 Loop: **2010AA Billing Provider Address**
 Level: **Detail**
 Usage: Required by Implementation Guide
 Business: **AH requires submission with only the following data**
 Rule: **elements for this segment:**

Data Element Summary

Ref Des	Element Name	Element Note
N301	Address Information	The Billing Provider Address must be a street address. Post Office Box or Lock Box addresses are to be sent in the Pay-To Address Loop (Loop ID 2010AB), if necessary.

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Segment:

SBR Subscriber Information

Loop:

2000B Subscriber Hierarchical Level

Level:

Detail

Usage:

Required by Implementation Guide

Business

AH requires submission with only the following data

Rule:

elements for this segment:

Data Element Summary

Ref Des	Element Name	Element Note
SBR09	Claim Filing Indicator Code	Enter value: (choose one) CI for AH Products MA or MB for Medicare Crossover Claims MC for Family Planning Claims only

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Segment: **NM1** Subscriber Name
 Loop: **2010BA Subscriber Name**
 Level: **Detail**
 Usage: Required by Implementation Guide
 Business **AH requires submission with only the following data**
 Rule: **elements for this segment:**

Data Element Summary

Ref Des	Element Name	Element Note
NM104	Subscriber First Name	Enter value: Subscriber's first name is required when NM102 = 1 and the person has a first name.
NM109	Subscriber Primary Identifier	<p>Enter the value from the subscriber's identification card (ID Card), including alpha characters. Spaces, dashes and other special characters that may appear on the ID Card are for readability and appearance only, are not part of the identification code, and therefore should not be submitted in this transaction.</p> <p>Note: When the subscriber is not the patient, the patient's ID (from the ID card) will be submitted in this 2010BA/NM109 field segment. The remainder of the patient's information (name, birth date, etc.) will continue to be submitted in the 2010CA loop.</p>

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Segment: **NM1** Payer Name
 Loop: **2010BB Payer Name**
 Level: **Detail**
 Usage: Required by Implementation Guide
 Business Rule: **AH requires submission with only the following data elements for this segment:**

Data Element Summary

Ref Des	Element Name	Element Note
NM108	Payer Identification Code	Enter code value: PI (Payer ID)
NM109	Payer Supplemental Id	Enter value: (choose one)
	60061	AH NJ PPO AH NJ CMM
	95044	AH DE Commercial HMO AH NJ Commercial HMO AH DE APOS AH Mercy (Family Planning Only) AH NJ APOS
	93688	AH DE PPO AH DE CMM

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Segment: **REF** Billing Provider Secondary Information
 Loop: **2010BB Payer Name**
 Level: **Detail**
 Usage: Situational by Implementation Guide
 Business **Although not required, based on AH's business, AH**
 Rule: **recommends this segment be included. AH requires**
submission with only the following data elements for
this segment:

Data Element Summary

Ref Des	Element Name	Element Note
REF01	Reference Identification Qualifier	Enter code value: G2 for all AH Products and Family Planning Claims
REF02	Billing Provider Secondary Identifier	Enter the AmeriHealth assigned provider identification number.

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Segment: **NM1** Patient Name
 Loop: **2010CA Patient Name**
 Level: **Detail**
 Usage: Required by Implementation Guide
 Business Rule: **When the situation exists, AH requires that this segment be included. AH requires submission with only the following data elements for this segment:**

Data Element Summary

Ref Des	Element Name	Element Note
NM104	Patient's First Name	Enter value: Patient's first name is required when NM102 = 1 and the person has a first name.

Note: The patient's ID (from the ID card) must be submitted in the 2010BA/NM109 field segment. The remainder of the patient's information (name, birth date, etc.) will continue to be submitted in the 2010CA loop.

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Segment: **CLM** Health Claim Information
Loop: **2300 Claim Information**
Level: **Detail**
Usage: Required by Implementation Guide
Business **AH requires submission with only the following data**
Rule: **elements for this segment:**

Data Element Summary

Ref Des	Element Name	Element Note
CLM01	Claim Submitter's Identifier (Patient Control Number)	Do not enter values with more than 20 characters.

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Segment:

HI Health Care Information Codes

Loop:

2300 Claim Information

Level:

Detail

Usage:

Situational by Implementation Guide

Business

Based on AH's business, AH always requires this

Rule:

segment be included. AH requires submission with only the following data elements for this segment:

Data Element Summary

Ref Des	Element Name	Element Note
HI01-1	Code List Qualifier Code	BK Principal Diagnosis
HI01-2	Industry Code	Enter value: Principal Diagnosis
HI01-9	Yes/No Condition Or Response Code	Enter value: Present on Admission Indicator (choose one): N No U Unknown W Not Applicable Y Yes

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Segment: **DTP** Discharge Hour
 Loop: **2300 Claim Information**
 Level: **Detail**
 Usage: Situational by Implementation Guide
 Business: **When the situation exists, AH requires that this**
 Rule: **segment be included. AH requires submission with**
only the following data elements for this segment:

Data Element Summary

Ref Des	Element Name	Element Note
DTP03	Discharge Hour	This element requires a four-digit time in the format of HHMM. Hours (HH) should be expressed as "00" for 12-midnight, "01" for 1 a.m., and so on through "23" for 11 p.m. If the hour of the discharge is not known, use a default of "00". Minutes (MM) should be expressed as "00" through "59". If the actual minutes are not known, use a default of "00".

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Segment:

DTP Admission Date / Hour

Loop:

2300 Claim Information

Level:

Detail

Usage:

Situational by Implementation Guide

Business Rule:

When the situation exists, AH requires that this segment be included. AH requires submission with only the following data elements for this segment:

Data Element Summary

Ref Des	Element Name	Element Note
DTP03	Admission Date and Hour	This element requires a twelve-digit date and time in the format of CCYYMMDDHHMM. Hours (HH) should be expressed as "00" for 12-midnight, "01" for 1 a.m., and so on through "23" for 11 p.m. If the hour of the discharge is not known, use a default of "00". Minutes (MM) should be expressed as "00" through "59". If the actual minutes are not known, use a default of "00".

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Segment: **SBR** Subscriber Information
 Loop: **2000B Subscriber Hierarchical Level**
 Level: **Detail**
 Usage: Required by the HIPAA Implementation Guide
 Business **AH requires submission with only the following data**
 Rules: **elements for this segment:**

Data Element Summary

Ref Des	Element Name	Element Note
SBR01	Payer Responsibility Sequence Number Code	If value other than "P" (Primary) is populated, the pages 21-24 are required.

Segment:

HI Value Information

Loop:

2300 Claim Information

Level:

Detail

Usage:

Situational by Implementation Guide

Business

Based on AH's business, AH always requires this

Rule:

segment be included when submitting secondary to Medicare claims. AH requires submission with only the following data elements for this segment:

Data Element Summary

Ref Des	Element Name	Element Note
HI01-1	Value Code Qualifier	Enter code value: BE (Value Information)
HI01-2	Value Code	09 (Coinsurance Amount in 1 st calendar year) 11 (Coinsurance Amount in 2 nd calendar year) 08 (Lifetime Reserve Amount in 1 st year) 10 (Lifetime Reserve Amount in 2 nd year) 06 (Medicare Blood Deductible) 80 (Covered Days) 81 (Non-covered Days) 82 (Co-insurance Days) 83 (Lifetime Reserve Days)

NOTE: Coinsurance and Deductible (previously identified by Value Codes A1, A2, B1, B2, C1 and C2) are to be reported in the CAS segments.

For Medicare Part A - **deductible** (previously identified by Value Codes A1, B1, C1) are to be reported in the CAS (Claim Adjustment Group Code "PR"=Patient Responsibility) segment.

Segment:

CAS Claim Level Adjustments

Loop:

2320 Other Subscriber Information

Level:

Detail

Usage:

Situational by Implementation Guide

Business

Based on AH's business, AH always requires this

Rule:

segment be included. AH requires submission with only the following data elements for this segment:

Data Element Summary

Ref Des	Element Name	Element Note
CAS01	Claims Adjustment Group Code	Enter code value: (choose one) CO (Contractual Obligations) CR (Corrections and Reversals) OA (Other Adjustments) PI (Payer Initiated Reductions) PR (Patient Responsibility)
CAS02	Claims Adjustment Reason Code	Enter Adjustment Reason Code at the claim level
CAS03	Claim Adjusted Amount	Enter value: Adjustment Amount

NOTE: Deductible and Coinsurance (previously identified by Value Codes A1, A2, B1, B2, C1 and C2) are to be reported in the CAS segments.

PR=Patient Responsibility

1 = Deductible

2 = Co-insurance

Deductible and Co-insurance for inpatient claims should be submitted at the **2320** loop. For outpatient claims, the co-insurance and/or deductible (if applicable) should be submitted at the **2430** loop.

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Segment: **AMT** Coordination of Benefits (COB) Payer Paid Amount
 Loop: **2320 Other Subscriber Information**
 Level: **Detail**
 Usage: Situational by Implementation Guide
 Business: **Based on AH's business, AH always requires this**
 Rule: **segment be included. AH requires submission with only**
the following data elements for this segment:

Data Element Summary

Ref Des	Element Name	Element Note
AMT01	Amount Qualifier	Enter code value: D (Payer Paid Amount)
AMT02	Amount	Enter value: Payer Paid Amount (amount paid by prior payer).

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Segment: **NM1** Other Subscriber Name
 Loop: **2330A Other Subscriber Name**
 Level: **Detail**
 Usage: Situational by Implementation Guide
 Business: **Based on AH's business, AH always requires this**
 Rule: **segment be included. AH requires submission with only**
the following data elements for this segment:

Data Element Summary

Ref Des	Element Name	Element Note
NM101	Entity Identifier Code	Enter code value: IL (Insured or Subscriber)
NM102	Entity Type Qualifier	Enter code value: (choose one) 1 (Person) 2 (Non Person Entity)
NM103	Subscriber Last Name	Enter value: Subscriber last or Organization Name
NM104	Subscriber First Name	Enter value: Subscriber's first name is required when NM102 = 1 and the person has a first name.
NM108	Identification Code Qualifier	Enter code value: (choose one) MI (Member Identification Number)
NM109	Identification Code	Enter value: Member Identification Number Employee Identification Number

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Segment: **CLM** Health Claim Information
 Loop: **2300 Claim Information**
 Level: **Detail**
 Usage: Situational by Implementation Guide
 Business: **Based on AH's business, AH always requires this**
 Rule: **segment be included. AH requires submission with only**
the following data elements for this segment:

Data Element Summary

Ref Des	Element Name	Element Note
CLM05-3	Claims Frequency Type Code	Claim Frequency Type Code If one of the following values is populated, then pages 26 - 28 are required: 5 (Late Charge) 7 (Replacement) 8 (Void/Cancel)

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Segment: **REF** Payer Claim Control Number
 Loop: **2300 Claim Information**
 Level: **Detail**
 Usage: Situational by Implementation Guide
 Business **Based on AH's business, AH always requires this**
 Rule: **segment be included. AH requires submission with**
only the following data elements for this segment:

Data Element Summary

Ref Des	Element Name	Element Note
REF01	Reference Identification Qualifier	Enter code value: F8 (Original Reference Number)
REF02	Original Reference Number	Enter value: AH claim number

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Segment: **REF** Medical Record Number
 Loop: **2300 Claim Information**
 Level: **Detail**
 Usage: Situational by Implementation Guide
 Business **Based on AH's business, AH always requires this**
 Rule: **segment be included. AH requires submission with**
only the following data elements for this segment:

Data Element Summary

Ref Des	Element Name	Element Note
REF01	Reference Identification Qualifier	Enter code value: EA (Medical Record Number)
REF02	Original Reference Number	Enter value: Medical record number

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Segment: **NTE** Billing Note
 Loop: **2300 Claim Information**
 Level: **Detail**
 Usage: Situational by Implementation Guide
 Business **Based on AH's business, AH always requires this**
 Rule: **segment be included. AH requires submission with**
only the following data elements for this segment:

Data Element Summary

Ref Des	Element Name	Element Note
NTE01	Reference Identification Qualifier	Enter code value: ADD (Additional Information)
NTE02	Original Reference Number	Enter a detail description regarding the adjustment request.

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Segment: **LIN** Drug Identification
 Loop: **2410 – Drug Identification**
 Level: **Detail**
 Usage: Situational by Implementation Guide
 Business **AH requires submission the use of Loop ID 2410 to**
 Rule: **specify billing/reporting for drugs provided that may**
be part of the service(s) described in SV1.

Data Element Summary

Ref Des	Element Name	Element Note
LIN02	Product/Service ID Qualifier	Enter Code Value: N4 (National Drug Code in 5-4-2 Format)
LIN03	Product/Service ID	Enter Value: National Drug Code

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Segment: **CPT** Pricing Information
 Loop: **2410 – Drug Identification**
 Level: **Detail**
 Usage: Situational by Implementation Guide
 Business **AH requires the submission of Loop ID 2410 provide a**
 Rule: **price specific to the NDC provided in LIN03 that is**
different from the price reported in SV102.

Data Element Summary

Ref Des	Element Name	Element Note
CPT04	Quantity	Enter Value: National Drug Unit Count
CPT05	Composite Unit of Measure	
CPT05-1	Unit or Basis for Measurement Code	Enter Code Value: F2 for International Unit GR for Gram ME for Milligram ML for Milliliter UN for Unit

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Segment: **REF** Reference Identification
 Loop: **2410 – Drug Identification**
 Level: **Detail**
 Usage: Situational by Implementation Guide
 Business **AH requires the submission of Loop ID 2410 if**
 Rule: **dispensing of the drug has been done with an assigned Rx number.**

Data Element Summary

Ref Des	Element Name	Element Note
REF01	Reference Identification Qualifier	Enter Code Value: XZ (Pharmacy Prescription Number)
REF02	Reference Identification	Enter Value: Prescription Number

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Transaction Acknowledgements

TA1 Interchange Acknowledgement Transaction

All X12 file submissions are pre-screened upon receipt to determine if the ISA or IEA segments are unreadable or do not comply with the HIPAA Implementation Guide. If errors are found, AH will send a TA1 response transaction to notify the trading partner that the file cannot be processed. No TA1 response transaction will be sent for error-free files.

Example: Once the 837I transaction is received by AH, the file is checked for compliance. Within AH, a validation is performed on the ISA loop and the IEA loop information. If these segments are missing required elements or have a non-standard structure, the file will receive a full file reject and the TA1 response transaction will be sent to the trading partner within the timeframes required by applicable law.

999 Functional Acknowledgement

If the file submission passes the ISA/IEA pre-screening above, it is then checked for HIPAA compliance syntactical and content errors. When the compliance check is complete, a 999 will be sent to the trading partner informing them which claims in the file were accepted for processing or rejected.

Example: An X12 file has passed pre-screening, and is then checked against the HIPAA standard. Once the file has been processed against the HIPAA standard, a 999 is generated indicating which claims within the file have passed or failed syntactical/content errors. No further processing of the failed X12 transaction will occur.

Unsolicited 277

This acknowledgment is used for the 837I to provide accepted or rejected claim status for each claim contained in the batch.

***It is important to note that:

1. Only accepted claims are submitted to the claims adjudication system for processing and the outcome results will appear on the statement of remittance (SOR).
2. A detailed explanation of the reason for claim rejection is contained within the STC12 segment of the Unsolicited transaction.

Example: A batch file is received with three 837I claims that pass compliance. During processing, the first claim rejects due to invalid member information, the second claim rejects due to an invalid procedure code, and the third claim is accepted with no errors. The Unsolicited 277 is generated and returns a status of one accepted claim and two rejected claims along with an explanation of the reasons the claims were rejected. In addition, the one accepted claim is submitted to the claims adjudication system for processing.