

# 837 I Health Care Claim Institutional

## Revision summary

Revision Number	Date	Summary of Changes
6.0	5/27/04	Verbiage changes throughout the companion guide
7.0	06/29/04	Updated to include the appropriate AmeriHealth qualifier "G2" on pages 15 and 17.
8.0	10/26/06	NPI Requirements add to page 6.
9.0	11/10/06	REF segment qualifier update
10.0	11/29/06	Removal of 2310D segment
11.0	03/06/08	Value Codes A1, A2, B1, B2, C1 and C2 are to be reported in a CAS segment

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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 4010A1 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 4010A1, issued October 2002. 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 IBC\KHPE through some means of telecommunications and will not remain connected while IBC\KHPE 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, IBC\KHPE will respond with an appropriate TA1 transaction. Otherwise, IBC\KHPE will be unable to respond. In either case, the batch will not be processed.

IBC\KHPE will respond with a 997 transaction as an acknowledgment to every batch file of 837I transactions that is received. This 997 acknowledgment will be sent whether or not the provider, or its intermediary, requests it. The acknowledgment 997 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, IBC\KHPE 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 will require the submission of National Provider Identification Number (NPI) for all electronic claims (837) submitted May 23<sup>rd</sup> 2007 or thereafter.

If you have obtained your NPI(s) and submitted them to us, you may begin to report them **in addition to your current provider identification numbers.**

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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** Provider Information  
 Loop: **2000A Billing/Pay-To 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)  <b>BI for Billing</b> <b>PT for Pay-To</b>
PRV02	Reference Identification Qualifier	Enter value:  <b>ZZ for Mutual Defined</b>
PRV03	Reference Identification	Enter value:  <b>Provider Taxonomy Code</b>

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:  <b>XX</b> - Health Care Financing Administration National Provider Identifier
NM109	Identification Code	Enter the appropriate National Provider ID (NPI)

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Segment: **REF** Billing Provider Secondary Information  
 Loop: **2010AA Billing Provider Name**  
 Level: **Detail**  
 Usage: Situational by Implementation Guide  
 Business: **Based on AH's business, AH always requires this segment be included. AH requires submission with only the following data elements for this segment:**  
 Rule:

Data Element Summary

Ref Des	Element Name	Element Note
REF01	Reference Identification Qualifier	Enter code value:  <b>G2</b> for AH Products <b>1C</b> for Medicare Crossover Claims <b>1D</b> for Family Planning Claims <b>and</b> <b>BQ</b> for Family Planning Claims <b>EI</b> Provider Tax ID number for all claims <b>Note: Since the NPI is mandated, the billing provider's tax id number must be submitted in the secondary reference segment</b> <b>SY</b> Social Security Number
REF02	<b>Original Reference Number</b>	Enter the appropriate provider identification number.

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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)  <b>CI</b> for AH Products <b>MA</b> or <b>MB</b> for Medicare Crossover Claims <b>MC</b> 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
NM109	Subscriber Primary Identifier	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.

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Segment: **NM1** Payer Name  
 Loop: **2010BC 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: <b>PI</b> (Payer ID)
NM109	Payer Supplemental Id	Enter value: (choose one)
	<b>60061</b>	AH NJ PPO AH NJ CMM
	<b>95044</b>	AH DE Commercial HMO AH NJ Commercial HMO AH DE APOS AH Mercy (Family Planning Only) AH NJ APOS
	<b>93688</b>	AH DE PPO AH DE CMM

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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
NM109	Payer Primary Identifier	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.

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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	<b>BK</b> Principal Diagnosis
HI01-2	Industry Code	Enter value: Principal Diagnosis

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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: **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 Information**  
 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 " <b>S</b> " Secondary or " <b>T</b> " Tertiary is populated, the pages 19-23 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. 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: <b>BE</b> (Value Information)
HI01-2	Value Code	<b>09</b> (Coinsurance Amount in 1 <sup>st</sup> calendar year) <b>11</b> (Coinsurance Amount in 2 <sup>nd</sup> calendar year) <b>08</b> (Lifetime Reserve Amount in 1 <sup>st</sup> year) <b>10</b> (Lifetime Reserve Amount in 2 <sup>nd</sup> year) <b>06</b> (Medicare Blood Deductible) <b>NOTE:</b> Coinsurance and Deductible (previously identified by Value Codes A1, A2, B1, B2, C1 and C2) are to be reported in the CAS segments.

Segment: **CAS** Claims Adjustment  
 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) <b>CO</b> (Contractual Obligations) <b>CR</b> (Corrections and Reversals) <b>OA</b> (Other Adjustments) <b>PI</b> (Payer Initiated Reductions) <b>PR</b> (Patient Responsibility)
CAS02	Claims Adjustment Reason Code	<b>Enter Adjustment Reason Code at the claim level</b>
CAS03	Claim Adjusted Amount	Enter value: <b>Adjustment Amount</b>

**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** Payer Prior 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: <b>C4</b> (Prior Payment)
AMT02	Amount	Enter value: <b>Prior Payment Amount</b>

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Segment: **NM1** 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: <b>IL</b> (Insured or Subscriber)
NM102	Entity Type Qualifier	Enter code value: (choose one) <b>1</b> (Person) <b>2</b> (Non Person Entity)
NM103	Subscriber Last Name	Enter value: <b>Subscriber last or Organization Name</b>
NM104	Subscriber First Name	Enter value: <b>Subscriber's first name is required.</b>
NM108	Identification Code Qualifier	Enter code value: (choose one) <b>MI</b> (Member Identification Number) <b>ZZ</b> (Mutually Defined)
NM109	Identification Code	Enter value: <b>Member Identification Number</b> <b>Employee Identification Number</b>

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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	Enter code value: (choose one) <b>5</b> (Late Charge) <b>6</b> (Correction) <b>7</b> (Replacement)

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Segment: **REF** Original Reference 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: <b>F8</b> (Original Reference Number)
REF02	<b>Original Reference Number</b>	Enter value: <b>AH claim number</b>

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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: <b>EA</b> (Medical Record Number)
REF02	<b>Original Reference Number</b>	Enter value: <b>Medical record number</b>

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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: <b>ADD</b> (Additional Information)
NTE02	<b>Original Reference Number</b>	<b>Enter a detail description regarding the adjustment request.</b>

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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, IBC 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 IBC, the file is checked for compliance. Within IBC, 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.*

### 997 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 997 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 997 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.*