837I Health Care Claim Institutional

For AmeriHealth Administrators

Disclaimer

This AmeriHealth Administrators and Inter-County Health Plan (hereinafter referred to as AHA/ICHP) 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 AHA/ICHP'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 AHA/ICHP that are not permitted to be imposed by the HIPAA Standards for Electronic Transactions. This Companion Guide provides information on AHA/ICHP specific codes relevant to AHA/ICHP'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 AHA/ICHP and its trading partners. Trading partners should refer to their Trading Partner Agreement for guidelines pertaining to AHA/ICHP'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 AHA/ICHP's business rules or technical requirements regarding the implementation of HIPAA-complaint 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. If there is an inconsistency between the terms of this Companion Guide and any terms of one of the Implementation Guides, the relevant Implementation Guide will governs with respect to HIPAA edits, and this Companion Guide will control with respect to business edits.

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1.0 Overview of Document

This guide is to be used as a supplement to the 837 Institutional Health Care Claim Implementation Guide, version 4010A, issued May 2000. It should be used to process payments for AmeriHealth Administrators and Inter-County Health Plan, Inc. (hereinafter referred to as AHA/ICHP).

The purpose of this Companion document is to outline AHA/ICHP processes for handling the 837 Health Care Claim: Institutional Implementation Guide (hereinafter referred to as the 837 I), and to delineate specific data requirements where that option is available within the 4010A Implementation Guide.

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

1. *Convey all required business information:* The transaction will convey the comprehensive set of information that is required for health plans to conduct their business.

2. *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.

3. *Simplify the communication*: The transaction will be standard to simplify communication between trading partners and to comply with HIPAA regulation.

2.0 General Instructions

- The 837I transaction set 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.
- For purposes of this standard, providers of health care products or services may include entities such as physicians, hospitals and other medical facilities or suppliers, dentists, and pharmacies, and entities providing medical information to meet regulatory requirements. The payer refers to a third party entity that pays claims or administers the insurance product or benefit or both.

3.0 Transmission Size

5,000 Claims per ST (limit is for CLM segment)

4.0 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 referrals, there will be two ISA-IEA sets; one for the claims (837) and one for the referrals (278).
If the trading partner submits more than one type of 837 format, there will need to be separate ISA/IEA sets; one for each type 837 format.

This Companion document reflects conventions for batch implementation of the ANSI X12 837 Health Care Claim: Institutional Transaction.

5.0 Batch Mode Process

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

- On behalf of AHA/ICHP, Independence Blue Cross will respond with a 997 Transaction as an acknowledgment, to every batch of 837 transactions that is received. This acknowledgment will be sent whether or not the provider, or their intermediary, requests it. The acknowledgment will indicate that the 837 transaction was received. There may be occasions when the acknowledgment is a TA1 transaction

    - If some or all of the 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, the health plan will respond with an appropriate TA1 transaction. Otherwise, the health plan will be unable to respond. In either case, the batch will not be processed.

    - In all other cases, the health plan will respond with an appropriate 997 transaction to acknowledge receipt of the Batch. The 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, the health plan may not be able to process the transaction.

    - If the information associated with any of the claims in the 837 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 837.

837 Institutional: Segment Usage Detail

The 837 Institutional Data Element Segment identifies the specific data content required by AHA/ICHP.

AHA/ICHP Business Rules referenced in the Segment Usage Detail represent the following situations:

1) The element is required by the Implementation Guide and required by AHA/ICHP.
2) The element is situational by the Implementation Guide and, when the situation exists, is required to be included by AHA/ICHP.
3) The element is situational by the Implementation Guide and, based on AHA/ICHP's business is always required by AHA/ICHP.

Segment: REF BILLING PROVIDER SECONDARY IDENTIFICATION

Loop: 2010AA Billing Provider Name

Level: Detail

Usage: **Situational by Implementation Guide**

Notes: **Due to AHA/ICHP business practices, when this information is included, AHA/ICHP will integrate the value in the REF02 (Reference ID) data element only when the REF01 (Reference ID Qualifier) data element contains a G2 (Provider Commercial Number) value. All other values in the REF01 data element will cause the REF02 value to be ignored by AHA/ICHP.**

If other values are sent, they must adhere to the HIPAA IG for the 837 Institutional and the proper HIPAA defined syntax must be implemented.

Data Element Summary

Ref Des	Element Name	Element Note
REF01	Reference Identification Qualifier	Enter code value: **G2** (Provider Commercial Number) for AHA/ICHP products. All other values must be compliant, but will be ignored by AHA/ICHP.
REF02	Original Reference Number	Enter the appropriate provider identification number. Any other values must be compliant, but will be ignored by AHA/ICHP.

Segment: NM1 Subscriber Name

Loop: 2010BA Subscriber Name

Level: Detail

Usage: **Required by Implementation Guide**

Notes: **Due to AHA/ICHP business practices, this information is needed.**

Data Element Summary

Ref Des	Element Name	Element Note
NM108	Identification Code Qualifier	**MI:** Use for AHA/ICHP products.
NM109	Payer Primary Identifier	Enter the value from the subs identification card (ID card) including alpha characters, if present. i.e. 12345678, 12345678 TPA, 123456789 ICHP agreement member ID - 12345678 AHA agreement - 12345678TPA AHA SS# - 123456789 AHA member ID or passport ID # - number of digits can vary.

Segment: NM1 Payer Name

Loop: 2010BC Payer Name

Level: Detail

Usage: **Required by Implementation Guide**

Notes: **Due to AHA/ICHP business practices, this information is needed.**

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: **54763**: AHA/ICHP products

Segment: CLM Health Claim Information

Loop: 2300 Claim Information

Level: Detail

Usage: **Required by Implementation Guide**

Notes: **Due to AHA/ICHP business practices, this information is needed.**

This segment is required when submitting an adjustment request for previously submitted adjudicated claims.

Data Element Summary

Ref Des	Element Name	Element Note
CLM05-3	Claims Frequency Type Code	If 6, 7 or 8 must submit original claim number in Loop: 2300 Segment: REF ORIGINAL REFERENCE NUMBER (ICN/DCN) **REF01 = F8**

Segment: REF Original Reference Number

Loop: 2300 Claim Information

Level: Detail

Usage: **Situational by Implementation Guide**

Notes: **Due to AHA/ICHP business practices, this information is needed.**
This segment is required when submitting an adjustment request for previously submitted adjudicated claims.

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: Send AHA/ICHP claim number.

Segment: HI Healthcare Information Codes

Loop: 2300 Claim Information

Level: Detail

Usage: **Situational by Implementation Guide**

Business Rule: **AHA/ICHP 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	Enter value: **DR**
HI01-2	Industry Code	Diagnosis Related Group (DRG) code

Segment: HCP Claim Pricing/Repricing Information

Loop: 2300 Claim Information

Level: Detail

Usage: **Situational by Implementation Guide**

Notes: **Due to AHA/ICHP business practices, this information is needed when repricing organizations are submitting claims.**

Data Element Summary

Ref Des	Element Name	Element Note
HCP03	Monetary Amount Repriced Saving Amount	Required if HCP01 & HCP02 exist.
HCP04	Reference Identification Repricing Organization Identifier	Required if HCP01 & HCP02 exist. Mutually defined value.

Segment: CAS Claims Adjustment

Loop: 2320 Other Subscriber Information

Level: Detail

Usage: **Situational by Implementation Guide**

Notes: **Due to AHA/ICHP business practices, this information is needed. Only required for Coordination of Benefits.**

Data Element Summary

Ref Des	Element Name	Element Note
CAS01	Claims Adjustment Group Code	Enter code value: **PR** (Patient Responsibility)
CASO2	Claim Adjustment Reason Code	Enter Value **"1"** for deductible
	AND/OR	
CAS02	Claim Adjustment Reason Code	Enter Value **"2"** for coinsurance

Segment: AMT Payer Prior Payment

Loop: 2320 - Other Subscriber Information

Level: Detail

Usage: **Situational by Implementation Guide**

Notes: **Due to AHA/ICHP business practices, this information is required for Medicare COB**

Data Element Summary

Ref Des	Element Name	Element Note
AMT02	Monetary Amount	If service(s) is not approved, **0 (zero)** is deemed a valid value.

Segment: AMT Coordination of Benefits (COB) Total Allowed Amount

Loop: 2320 - Other Subscriber Information

Level: Detail

Usage: **Situational by Implementation Guide**

Notes: **Due to AHA/ICHP business practices, this information is required for Medicare COB**

Data Element Summary

Ref Des	Element Name	Element Note
AMT02	Monetary Amount	**"0"** (zero) is deemed a valid value.

Segment: HCP Claim Pricing/Repricing Information

Loop: 2400 Service Line Number

Level: Detail

Usage: **Situational by Implementation Guide**

Notes: **Due to AHA/ICHP business practices, this segment should not be used. Use the 2300 Claim Level HCP**

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, on behalf of AHA/ICHP, 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, on behalf of AHA/ICHP, 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, 837P and 837D transactions only. The Unsolicited 277 provides accepted or rejected claim status for each claim contained in the batch.

***** It's important to note,**

1. **Only accepted claims are submitted to the claims adjudication system for processing and the outcome results will appear on the explanation of benefits. (EOB)**

2. **A detailed explanation of the reason for claim rejection is contained in the STC12 segment of the transaction.**

Example: A batch 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.