Standard CMC Companion Guide (CG) Transaction Information
Effective June 30, 2016

IEHP Instructions related to Implementation Guides (IG) based

837 Health Care Claim: Professional Transaction based on ASC X12 Technical Report Type 3 (TR3), Version 005010X222A1

Companion Guide Version Number: 1.0

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Revisions

Action	Date	Responsible Party
Creation date for 837 Health Care Claim: Professional Transaction based on ASC X12 Technical Report Type 3 (TR3), Version 005010X222A1	06/30/2016	Encounter Data Group

Introduction

A. The Purpose of the Companion Guide

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) required the Federal Department of Health and Human Services to establish national standards for electronic Healthcare transaction and national identifier for providers, health plans, and employers. The mandates also address the security and privacy of health data.

The Version005010X220A1of the ASCX12 Implementation Guide includes HIPAA addenda updates or format, content, and field values, The HIS Companion Document are intended to supplement rather than replace or violate the standard Implementation Guide for each transaction set. The information in these documents is NOT intended to:

1. Modify the definition, data condition, or use of any data element or segment in the standard Implementation Guides.
2. Add any additional data elements or segment to the defined data set.
3. Utilize any code or data values that are not valid in the standard implementation Guides.
4. Change the meaning or intent or any implementation specifications' in the standard Implementations Guides.

Companion Documents are available to external entities (health plans, program contractors, providers, third party processors, and billing services) to clarify the information on HIPAA-compliant electronic interfaces. The Companion Documents are intended for members of the technical staff of external entities.

This document does not describe the technical interface environment; including connectivity requirements and protocols, and electronic interchange IDs this document also provides specific information on the fields and values required for transactions exchanged with IEHP.

B. Disclaimer

This Companion Document is intended to be a technical document describing the specific technical and procedural requirements for interfaces between IEHP and its trading partners. It does not supersede either health plan contracts or the specific procedure manuals for various operational processes. If there are conflicts between this document and either the provider contracts or operational procedure manuals, the contract or procedure manual will prevail.

Substantial effort has been taken to minimize conflicts or errors. IEHP, IEHP, and their employees will not be liable or responsible for any errors or expenses resulting from the use

of information in this document. If you believe there is an error in the document, please notify IEHP immediately.

C. 837 Health Care Claim: Professional Transaction

The IEHP 837 Health Care Claim: Professional Transaction may be transmitted any day of the week to IEHP from a customer's business partner. The transaction provides data on Medicare Advantage / Part D data.

D. Technical Infrastructure and Procedures

Business partners transmitting 837 Health Care Claim: Professional Transaction to IEHP by connecting to the IEHP Network. They go from the Internet through a Virtual Private Network (VPN) tunnel to the IEHP Secure File Transfer Protocol (SFTP) Server. In standard software-to-hardware VPN connections, VPN client software is installed and configured on each machine at the client site that requires SFTP access. Business partners can contact IEHP for more information on establishing connections through the SFTP Server.

E. Transaction Standards

HIPAA standards are specified in the ASC X12 Implementation Guide for each mandated transaction and are not repeated here.

An overview of requirements specific to each transaction can be found in the ASC X12 837 Health Care Claim: Professional Transaction Implementation Guide. Each Guide contains information related to ASC X12 Implementation.

1. Format and content of interchanges and functional groups;
2. Format and content of the header, detailer and trailer segments specific to the transaction;
3. Code sets and values authorized for use in the transaction;
4. Allowed exceptions to specific transaction requirements;
5. Transmission sizes are limited based on two (2) factors; and
6. Number of Segments/Records allowed by HIPAA and ASC X12 standards.

Standards for the maximum file size of each transaction set are specified in the appropriate Implementation Guide or its authorized Addenda. 837 Transactions follow HIPAA updated ASC X12 standards. These standards involve Interchange (ISA/IEA) and Functional Group (GS/GE) Segments or "outer envelopes." All Transactions are enclosed in transmission level ISA/IEA envelopes. Within the ISA/IEA envelope are at least one functional group level GS/GE envelope(s). Within the GS/GE groups are at least one transaction set ST/SE. ST/SEs contain the detail segments and data.

This document uses the following names to refer to the data elements within the IEHP PDP data file.

Loop ID	The Implementation Guide's identifier for a data loop within a transaction; the data loop consists of specific segments as identified in the HIPAA ANSI standard.
Segment ID	The Implementation Guide's identifier for a data segment.
Element ID	The Implementation Guide's identifier for a data element within a segment.
Element Name	A data element name as shown in the Implementation Guide. When the industry name differs from the Data Element Dictionary name, the more descriptive industry name is used.
Element Definition / Length	How the data element is defined in the Implementation Guide. For ISA and IEA Segments only, fields are of fixed lengths and are present whether or not they are populated. For this reason, field lengths are provided in this column after element definitions.
Valid Values	The valid values from the Implementation Guide that are used by IEHP.
Definition/Format	Definitions of valid values used by IEHP and additional information about IEHP data element requirements.

This implementation guide is based on the February 2011 005010X222A1 standards, referred to as Version 5, Release 1, Sub-release 0 (005010).

The unique Version/Release/Industry Identifier Code for transaction sets that are defined by this implementation guide is 005010X222A1

The two-character Functional Identifier Code for the transaction set included in this implementation guide.

1. 837 Health Care Claim: Professional Transaction

The version/Release/Industry Identifier Code and the applicable Functional Identifier Code must be transmitted goal allow users to request changes to the electronic transactions formats. To request changes for consideration to the ASC X12 standards, please contact the HIPAA Designated Standards Maintenance Organizations web site at.

F. IEHP Functional Acknowledgement/Reports

TA1 – Interchange Acknowledgement

The TA1 report enables the receiver to notify the sender when there are problems with the interchange control structure. As the interchange envelope enters the EDFES, the EDI translator performs TA1 validation of the control segments/envelope. The sender will only receive a TA1 if there are syntax errors in the submitted file. Errors found in this stage will cause the entire X12 interchange to reject with no further processing

IPA will receive a TA1 interchange report acknowledging the syntactical inaccuracy of an X12 interchange header ISA and trailer IEA and the envelope's structure. Encompassed in the TA1 is the interchange control number, interchange date and time, interchange acknowledgement code and interchange note code

999- Functional Acknowledgment

The 999 Acknowledgement may produce three results:

1. Accepted (A)
2. Rejected (R)
3. Accepted with errors (E)

As a result, the 999 may acknowledge receipt of a transaction, such as a healthcare claim, but it does not necessarily mean that transaction will be processed. The 999 can also report on exactly what syntax issues caused the errors in the original transaction.

EVR- Encounter Validation Response (EVR) Extensible Markup Language (XML) files

The response files will provide details on whether a file was accepted or rejected and whether an encounter data record was accepted or denied. If errors were found in the encounter data files submitted, it will result in a rejected file and/or denied encounter data record.

CMS Acknowledgements and/or Reports

A submitted encounter file will be either accepted or rejected by CMS. The following response reports are provided by CMS:

1. *TA1 – Interchange Acknowledgement*
    a. The TA1 report enables the receiver to notify the sender when there are problems with the interchange control structure. The sender will only receive a TA1 if there are syntax errors in the submitted file.

2. *999 – Functional Group acknowledgement*
    a. The 999 acknowledgement report provides information on the validation of the GS\GE functional groups(s) and the consistency of the data.

3. *277CA – Claim Acknowledgement*

a. The 277CA is used to acknowledge the acceptance or rejection of encounters submitted using a hierarchical level (HL) structure. The first level of hierarchical editing is at the Information Source level. The next level is at the Information Receiver level. The third hierarchal level is at the Billing Provider of Service level; and the fourth and final level is done at the Patient level. Edits received at any hierarchical level will stop and no further editing will take place.

4. *MAO-001 – Encounter Data Duplicate Report*

   a. MAO-001 report will not be provided if there are no duplicate errors received on submitted encounters.

5. *MAO-002- Encounter Data Processing Status Report*

   a. The MAO-002 reflects two (2) statuses at the encounter and service line level: "accepted" and "rejected". Lines that reflect a status of "accepted" yet contain an error message in the Edit Description column are considered "informational" edits.

6. *MAO-004- Encounter Data Diagnosis Eligible for Risk Adjustment Report*

   The CMS acknowledgement and/or reports in Section 6 of the 837P Encounter Data System Companion Guide will apply with the following exceptions:

   a. Encounters designated as Medicaid will receive a 277CA report.

   b. Encounters designated as Medicaid will not receive the MAO-001 or MAO-002 reports

G. Control Segment

This section contains some information needed to create the ISA/IEA, GS/GE and ST/SE control segments for transactions to be submitted to IEHP

1. Interchange Control (ISA/IEA) and Function Group (GS/GE) envelopes must be used as described in the TR3 documents.
2. New X12 submitters may use their IEHP assigned Client id in ISA06 and GS02, and IEHP Tax id "in ISA08 and GS03, along with a value of "ZZ" in ISA05 and ISA07.
3. IEHP only supports one interchange (ISA/IEA envelope) per incoming transmission (file).
4. Multiple Functional Groups (GS/GE) may be used within an ISA/IEA as long as the GS08 Version/Release/Industry Identifier Code remains constant throughout Functional Groups.

H. Implementation Usage

This document establishes the data contents of the 837 Health Care Claim: Professional Transaction Set (837) for use within the context of an Electronic Data Interchange (EDI)

environment. The following tables describe the EDI tables, segments and loops supported by this Companion Guide. The Usage column indicates if the segment is required (R) or situational (S).

I. Implementation

This section describes all of the EDI headers, tables, segments, loops and trailers supported by this Companion Guide. If a segment or a data element is not listed it is not supported. The Usage column indicates if the segment is required (R) or situational (S).

J. IEHP - Testing Requirements

CMC's will be required to submit test files to ensure the submitter's systems are properly configured for data submission. Before exchanging production transactions, each plan must complete testing to become certified. This process allows CMC's to confirm that the CMS operational guidance has been properly programmed in their systems. A test file will need to be submitted containing 25 encounters and must pass 100% of the front end edits. In the event more than 25 encounters are submitted, the file must receive an accepted or partially accepted 999, and 277CA with a minimum of an 80% acceptance rate.

K. Void or Replacements

Submitted encounters will be either accepted or rejected by CMS. When CMS rejects a submitted encounter the reasons for the rejection will be reported on IEHP EVR, (CMS) 277CA and (CMS) MAO-002 file.

When a submitter needs to correct or void an encounter, the following data must be provided:

1. The submitter of the voided or correcting encounter must be the same as the submitter of the encounter being corrected.
2. CLM01 must equal the value of CLM01 on the encounter being replaced or voided.
3. The Encounter-ID (from either EVR, 277 or MAO-002) for the encounter to be corrected must be placed in the Payer Claim Control Number REF segment in the 2300 loop (REF*F8).
4. A value of either "7" (replacement) or "8" (void) must be placed in the Claim Frequency Code in CLM05-03.

Interchange Control Header

ISA Segment - Interchange Control Header

Usage	Ref Des.	Name	Code/Definition	Length
R	ISA01	Authorization Information	00 = No Authorization Sent	2/2

		Qualifier		
R	ISA02	Authorization Information	(Filled with spaces)	10/10
R	ISA03	Security Information Qualifier	00 = No Security Information	2/2
R	ISA04	Security Information	(Filled with spaces)	10/10
R	ISA05	Interchange ID Qualifier	ZZ = Mutually Defined	2/2
R	ISA06	Interchange Sender ID	Value based on ISA05	15/15
R	ISA07	Code Identifying Receiver	ZZ = Mutually Defined	2/2
R	ISA08	Interchange Receiver ID	00303	15/15
R	ISA09	Interchange Date	YYMMDD format	6/6
R	ISA10	Interchange Time	HHMM format	4/4
R	ISA11	Repetition Separator	Carat ^ Repetition Separator	1/1
R	ISA12	Interchange Control Version Number	5010 = Version 5 Release 1	5/5
R	ISA13	Interchange Control Number	Sequential Number (must be identical to the value in the associated Interchange Control trailer, IEA02)	9/9
R	ISA14	Acknowledgment Requested	1 = Interchange acknowledgment information.	1/1
R	ISA15	Usage Indicator	T = Test, P = Production	1/1
R	ISA16	Component Element Separator	Colon= Component Element Terminator	1/1
		Segment Terminator	Tilde= ~ Segment Terminator	
		Data Element Separator	Asterisk= * Data Element Separator	

GS Segment - Functional Group Header

Usage	Ref Des.	Name	Code/Definition	Length

R	GS01	Functional Identifier Code	HC= Health Care Claim	2/2
R	GS02	Application Sender's Code	Assigned by IEHP. Same as ISA06	2/15
R	GS03	Application Receiver's Code	00303 (IEHP ID)	2/15
R	GS04	Date	CCYYMMDD (date of transmission)	8/8
R	GS05	Time	HHMM (time of transmission, 24 hour format)	4/8
R	GS06	Group Control Number	Sequential Number (assigned by IEHP; must be identical to value in the associated functional group trailer, GE02)	1/9
R	GS07	Responsible Agency Code	X = Accredited Standards Committee X12	1 / 2
R	GS08	Version/Release/Industry Identifier Code	005010X222A1	1/12

Table 1-Header

ST -837- Header Segment

Usage	Ref Des.	Name	Code/Definition	Length
R	ST01	Transaction Code of document	837 = Health Care Claim: Professional	3/3
R	ST02	Transaction Control Number	Sequential Number (must be identical to the value in the associated Transaction Set trailer, SE02) Used to identify file level duplicates collectively with ISA13, GS06, and BHT03	4/9
R	ST03	Implementation Convention Reference	005010X222A1 Reference assigned to identify implementation convention. This field contains the same value as GS08.	1/35

BHT – Beginning of Hierarchical Transaction

Usage	Ref Des.	Name	Code/Definition	Length
R	BHT01	Hierarchical Structure Code	Information Source, Subscriber, Dependent	4/4
R	BHT02	Transaction Set Purpose Code	00= Original	2/2
R	BHT03	Originator Application Transaction Identifier	Should equal the values populated in the ISA13 and GS06	1/50
R	BHT04	Date	Transaction Set Creation Date	8/8
R	BHT05	Time	Transaction Set Creation Time	4/8
R	BHT06	Transaction Type Code	RP- Reporting	2/2

Loop 1000A- NM1-Submitter Name

Usage	Ref Des.	Name	Code/Definition	Length
R	NM101	Entity Identifier Code	41=Submitter	2/3
R	NM102	Entity Type Qualifier	1= Person 2= Non-Person Entity	1/1
R	NM103	Name Last or Organization Name	Submitter Last or Organization Name	1/60
S	NM104	Name First	Submitter First Name	1/35
S	NM105	Name Middle	Submitter Middle Name or Initial	1/25
R	NM108	Identification Code Qualifier	46= Electronic Transmitter Identification Number (ETIN)	½
R	NM109	Identification Code	Assigned by IEHP. Same as GS02 and ISA06.	2/80

1000A -PER- Submitter EDI Contact Information

Usage	Ref Des.	Name	Code/Definition	Length
R	PER01	Contact Function Code	IC= Information Contact	2/2
S	PER02	Name	Submitter Contact Name	1/60
R	PER03	Communication Number Qualifier	TE= Telephone	2/2
R	PER04	Communication Number	Compliant, (10) digit, phone number when PER03 = "TE". Telephone extensions can be identified in PER05 and listed in PER06 if necessary.	1/256
S	PER05	Communication Number Qualifier		2/2
S	PER06	Communication Number	List valid email address when PER05 = "EM".	1/256
S	PER07	Communication Number Qualifier		2/2
S	PER08	Communication Number		

Loop 1000B -NM1- Receiver Name

Usage	Ref Des.	Name	Code/Definition	Length
R	NM101	Entity Identifier Code	40= Receiver	2/3
R	NM102	Entity Type Qualifier	2= Non-Person Entity	1/1
R	NM103	Name Last or Organization Name	IEHP= Inland Empire Health Plan	1/60
R	NM108	Identification Code Qualifier	46= Electronic Transmitter Identification Number (ETIN)	2/80
R	NM109	Identification Code	00303= Receiver Primary Identifier Same as GS03 and ISA08. IEHP's Receiver ID.	2/80

Table 1-Billing Provider Detail

Loop 2000A –HL- Billing Provider Hierarchical Level

Usage	Ref Des.	Name	Code/Definition	Length
R	HL01	Hierarchical ID Number		1/12
R	HL03	Hierarchical Level Code	20= Information Source	1/2
R	HL04	Hierarchical Child Code	1= Additional Subordinate HL Data Segment in This Hierarchical Structure	1/1

Loop 2000A – PRV- Billing Provider Specialty

Usage	Ref Des.	Name	Code/Definition	Length
R	PROV1	Payer Responsibility Sequence Number Code	B= Billing	1/3
R	PRV02	Reference Identification Qualifier	PXC= Health Care Provider Taxonomy Code	2/3

Loop 2010AA NM1- Billing Provider Name

Usage	Ref Des.	Name	Code/Definition	Length
R	NM101	Entity Identifier Code	85= Billing Provider	2/3

Usage	Ref Des.	Name	Code/Definition	Length
R	NM102	Entity Type Qualifier	1 = Person 2 = Non-Person Entity In most instances the Rendering Provider NPI MUST have an Entity Type Qualifier = 1 (Person). If the Billing Provider NPI is an Organization (Entity Type = 2), the Rendering Provider segment will likely be required.	1/1
R	NM103	Name Last or Organization Name	Billing Provider Last or Organizational Name	1/60
S	NM104	Name First	Billing Provider First Name	1/35
S	NM105	Name Middle	Billing Provider Middle Name or Initial	1/25
S	NM107	Name Suffix	Billing Provider Name Suffix	1/10
S	NM108	Identification Code Qualifier	XX= Centers for Medicare and Medicaid Services National Provider Identifier	1/2
S	NM109	Identification Code	Must be a valid 10 digit NPI. Will be validated against the NPPES file.	2/80

Loop 2010AA N3- Billing Provider Address

Usage	Ref Des.	Name	Code/Definition	Length
R	N301	Address Information	Billing Provider Address Line	1/55
S	N302	Address Information	Billing Provider Address Line	1/55

Loop 2010AA -N4- Billing Provider City, State, Zip Code

Usage	Ref Des.	Name	Code/Definition	Length

Usage	Ref Des.	Name	Code/Definition	Length
R	N401	City Name	Billing Provider City Name Street address required. Post Office Box NOT allowed.	2/30
S	N403	Postal Code	Billing Provider Zone or Zip Code	3/15
S	N404	Country Code	Us the alpha-2 country codes from Part 1 of ISO 3166.	2/3
S	N407	Country Subdivision Code	Use the country subdivision codes from Part 2 of ISO 3166.	1/3

Loop 2010AA -REF- Billing Provider Tax Identification

Usage	Ref Des.	Name	Code/Definition	Length
R	REF01	Reference ID Qualifier	EI = Employer's Identification Number	2/3
R	REF02	Reference Identification	Billing Provider Tax Identification Number	1/50

Table 2-Subscriber Detail

Loop 2000B -SBR- Subscriber Information

Usage	Ref Des.	Name	Code/Definition	Length
R	SBR01	Payer Responsibility Sequence Number	S= Secondary	1/1
S	SBR02	Individual Relationship Code	18= Self	2/2
S	SBR03	Reference Identification	Subscriber Group or Policy Number	1/50
S	SBR04	Name	Subscriber Group Name	1/60
S	SBR05	Insurance Type Code		1/3

Usage	Ref Des.	Name	Code/Definition	Length
S	SBR09	Claim Filing Indicator Code	MB= Medicare Part B MC= Medicaid	1/2

Loop 2010BA NM1- Subscriber Name

Usage	Ref Des.	Name	Code/Definition	Length
R	NM101	Entity Identifier Code	MI Must be populated with a value of MI- Member Identification Number	2/3
R	NM102	Entity Type Qualifier	1= Person 2= Non- Person Entity	1/60
R	NM103	Name Last or Organization Name	Subscriber Last Name	1/60
S	NM104	Name First	Subscriber First Name	1/35
S	NM105	Name Middle	Subscriber First Middle	1/25
S	NM107	Name Suffix	Subscriber Name Suffix	1/10
S	NM108	Identification Code Qualifier		1/2
S	NM109	Identification Code	Must equal the **14-digit IEHP ID number or SS#	2/80

Loop 2010BB NM1- Payer Name

Usage	Ref Des.	Name	Code/Definition	Length
R	NM101	Entity Identifier Code	PR= Payer	2/3
R	NM102	Entity Type Qualifier	2= Non- Person Entity	1/1
R	NM103	Name Last or	IEHP or Inland Empire Health Plan	1/60

Usage	Ref Des.	Name	Code/Definition	Length
		Organization Name		
R	NM108	Identification Code Qualifier	PI= Payer Identification	1/2
R	NM109	Identification Code	"00303" Must be a unique number when Claim Frequency Type Code (CLM05-3) = "1".	2/80

Table 1-Patient Detail

Loop 2300 CLM- Claim Information

Usage	Ref Des.	Name	Code/Definition	Length
R	CLM01	Patient Control Number	Patient Control Number Must be a unique number when Claim Frequency Type Code (CLM05-3) = "1".	1/38
R	CLM02	Monetary Amount	Total Claim Charge Amount Must balance to the sum of all SV1-02 (Service line in Loop 2400)	1/18
R	CLM05-3	Claim Frequency Type Code	1 = Original claim submission 7 = Adjustment 8 = Void	1/1

Loop 2300 CN1- Contract Information

Usage	Ref Des.	Name	Code/Definition	Length
R	CN101	Contract Type Code	02 = Per Diem (Paid) 05 = Capitated (Capitated) 09 = Other (Denied) If the Encounter consists of more than (1) Service Line, follow this guideline. At least (1) Service Line is paid (Loop	2/2

Usage	Ref Des.	Name	Code/Definition	Length
			2430 SVD02 > 0), the Encounter is "Paid". At least (1) Service Line is Capitated (Loop 2430 SVD02 = 0) and there are other Service Lines that are Denied, the Encounter is "Capitated". All Service Lines are Denied (Loop 2430 SVD02 = 0 and CAS02 includes a valid denial reason), the Encounter is "Denied". Must be in line with SVD02 and CAS02.	
S	CN102	Monetary Amount	Contract Amount Must match AMT02 in loop 2320 and the sum of all SVD02 segments in Loops 2430.	1/18

Loop 2300 REF- Payer Claim Control Number

Usage	Ref Des.	Name	Code/Definition	Length
R	REF01	Reference ID Qualifier	F8 = Original Reference Number	2/3
R	REF02	Reference Identification	Payer Claim Control Number This must be the PCN (Loop 2300 CLM01) of the encounter that is being replaced (Loop 2300 CLM05-3 = "7") or voided (Loop CLM05-3 = "8").	1/50

Loop 2300 REF- Claim Identifier for Transmission Intermediaries

Usage	Ref Des.	Name	Code/Definition	Length
R	REF01	Reference Identification Qualifier	D9= Claim Number	2/3

Usage	Ref Des.	Name	Code/Definition	Length
R	REF02	Reference Identification	Value Added Network Trace Number Unique number. Use the same number from Loop 2300, CLM01.	1/50

Loop 2300 HI- Health Care Diagnosis Code

Usage	Ref Des.	Name	Code/Definition	Length
R	HI01	Health Care Code Information	IP = Insured Party	2/2
R	HI01	Code List Qualifier Code	ABK= (ICD-10-CM) Principal Diagnosis BK= (ICD-9-CM) Principal Diagnosis	1/3
R	HI01-2	Industry Code	Diagnosis Code	1/30

Loop 2310A NM1- Referring Provider

Usage	Ref Des.	Name	Code/Definition	Length
R	NM101	Entity Identifier Code	DN= Referring Provider P3= Primary Care Provider	2/3
R	NM102	Entity Type Qualifier	1= Person	1/1
R	NM103	Name Las or Organization Name	Referring Provider Last Name	1/60
S	NM104	Name First	Referring Provider First Name	1/35
S	NM105	Name Middle	Referring Provider Middle Name or Initial	1/25
S	NM107	Name Suffix	Referring Provider Name Suffix	1/10
S	NM108	Identification Code	XX= Centers for Medicare and Medicaid Services National Provider	1 / 2

Usage	Ref Des.	Name	Code/Definition	Length
		Qualifier	Identifier	
S	NM109	Identification Code	Referring Provider Identifier	2/80

Loop 2310B NM1- Rendering Provider Name

Usage	Ref Des.	Name	Code/Definition	Length
R	NM101	Entity Identifier Code	82= Rendering Provider	2/3
R	NM102	Entity Type Qualifier	1= Person 2= Non-Person Entity	1/1
R	NM103	Name Last or Organization Name	Rendering Provider Last or Organization Name	1/60
S	NM104	Name First	Rendering Provider First Name	1/35
S	NM105	Name Middle	Rendering Provider Middle or Initial	1/25
S	NM107	Name Suffix	Rendering Provider Name Suffix	1/10
S	NM108	Identification Code Qualifier	XX= Center for Medicare and Medicaid Services National Provider Identifier	1/2
S	NM109	Identification Code	Rendering Provider Identifier	2/80

Loop 2310B PRV- Rendering Provider Specialty Information

Usage	Ref Des.	Name	Code/Definition	Length
R	PRV01	Provider Code	PE= Performing	1/3
R	PRV002	Reference Identification Qualifier	PXC= Health Care Provider Taxonomy Code	2/3
R	PRV03	Reference Identification	Provider Taxonomy Code Taxonomy Code Required when Rendering Provider differs from Billing Provider.	1/50

Usage	Ref Des.	Name	Code/Definition	Length
			Failure to include an accurate Taxonomy Code will result in inaccurate attribution of Encounters	

Loop 2310C NM1- Service Facility Location Name

Usage	Ref Des.	Name	Code/Definition	Length
R	NM101	Entity Identifier Code	77= Service Location	2/3
R	NM102	Entity Type Qualifier	2= Non-Person Entity	1/1
R	NM103	Name Las or Organization Name	Laboratory or Facility Name	1/60
S	NM108	Identification Code Qualifier	XX= Centers for Medicare and Medicaid Service National Provider Identifier	1 / 2
S	NM109	Identification Code	Laboratory or Facility Primary Identifier WHEN REQUIRED - Must be a valid 10 digit NPI. Will be validated against the NPPES file.	2/80

Loop 2310E NM1- Ambulance Pick-up Location

Usage	Ref Des.	Name	Code/Definition	Length
R	NM101	Entity Identifier Code	PW= Pickup Address	2/3
R	NM102	Entity Type Qualifier	2= Non-Person Entity	1/1

Loop 2310E N3- Ambulance Pick-up Location Address

Usage	Ref Des.	Name	Code/Definition	Length
R	N301	Address Information	Ambulance Pick-up Address Line	1/55
S	N302	Address Information	Ambulance Pick-up Address Line	1/55

Loop 2310E N4- Ambulance Pick-up Location City, State, Zip Code

Usage	Ref Des.	Name	Code/Definition	Length
R	N401	City Name	Ambulance Pick-up City Name	2/30
S	N402	State or Province Code	Ambulance Pick-up State or Province Code	2/2
S	N403	Postal Code	Ambulance Pick-up Postal Zone or Zip Code	3/15
S	N404	Country Code	Use the alpha-2 country codes from Part 1 of ISO 3166.	2/3
S	N407	Country Subdivision Code		1/3

Loop 2310F N3- Ambulance Drop-Off Location Address

Usage	Ref Des.	Name	Code/Definition	Length
R	N301	Address Information	Address Information	1/55
S	N302	Address Information	Address Information	1/55

Loop 2310F N4- Ambulance Drop-Off Location City, State, Zip Code

Usage	Ref Des.	Name	Code/Definition	Length
R	N401	City Name	Ambulance Drop-Off City Name	2/30
S	N402	State or Province Code	Ambulance Drop-Off State of Province Code	2/2

Usage	Ref Des.	Name	Code/Definition	Length
S	N403	Postal Code	Ambulance Drop-Off Postal Zone or Zip Code	3/15
S	N404	County Code	Us the alpha-2 county codes from Part 1 of ISO 3166.	2/3
S	N407	Country Subdivision Code	Use the country subdivision codes from Part 2 of ISO 3166.	1/3

Loop 2320 SBR- Other Subscriber Information

Usage	Ref Des.	Name	Code/Definition	Length
R	SBR01	Payer Responsibility Sequence Number Code	P= Primary	1/1
R	SBR02	Individual Relationship Code	18= Self	2/2
S	SBR03	Reference Identification	Insured Group or Policy Number	1/50
S	SBR04	Name	Other Insured Group Name	1/60
S	SBR05	Insurance Group Name		1/3
S	SBR09	Claim Filing Indicator Code	MB= Medicare Part B MC= Medicaid	1/2

Loop 2320 AMT- Payer Paid Amount

Usage	Ref Des.	Name	Code/Definition	Length
R	AMT01	Amount Qualifier Code	D= Payer Amount Paid Must be populated with a value of D – Payer Amount Paid	1/3
R	AMT02	Monetary Amount	Payer Paid Amount Medicare-Medicaid Plan paid amount	1/18

Usage	Ref Des.	Name	Code/Definition	Length
			Must match CN102 in loop 2300 and sum of all SVD02 segments in loops 2430.	

Loop 2330B NM1 Other Payer Name

Usage	Ref Des.	Name	Code/Definition	Length
R	NM101	Entity Identifier Code	PR= Payer	2/3
R	NM102	Entity Type Qualifier	2 Non-Person Entity	1/1
R	NM103	Name Last or Organization Name	Other Payer Organization Name The organization responsible for the adjudication information provided in the SVD02 segment of loop 2430. Not IEHP	1/60
R	NM109	Identification Code	Other Payer Primary Identifier This should be the Submitter ID assigned by IEHP and must match the value populated in the SVD01 segment of loop 2430.	2/80

The Palmetto GBA assigned ICN will be populated in the 2330B Loop REF02 segment with an FY qualifier. This ICN will be passed to the State Agency in an 837 delimited file. If the MMP populates data in the 2330B Loop REF02 segment when the REF01 = FY, Palmetto GBA will overlay the data populated in the REF02 segment with the Palmetto GBA assigned ICN.

Loop 2330B -REF01- AMT- Payer Paid Amount

Usage	Ref Des.	Name	Code/Definition	Length
R	REF01	Reference identification Qualifier	FY= Claim Office Number	1/3

Loop 2400 -SV1- Professional Service

Usage	Ref Des.	Name	Code/Definition	Length
R	SV101	Composite Medical Procedure Identifier	PR= Payer	2/3
R	SV101-1	Product/Service ID Qualifier	HC= IEHP only accepts valid HCPCS	2/2
R	SV102	Monetary Amount	Line Item Charge Amount	1/18
R	SV103	Unit or Basis for Measurement Code	MJ= Minutes UN= Unit	2/2

Loop 2400 -CN1- Contract Information

Usage	Ref Des.	Name	Code/Definition	Length
R	CN101	Contract Type Code	02 = Per Diem (Paid) 05 = Capitated (Capitated) 09 = Other (Denied) Must be in line with SVD02 and CAS01, CAS02 and CAS03.	2/2

Loop 2420A -NM1- Rendering Provider Name

Usage	Ref Des.	Name	Code/Definition	Length
R	NM101	Entity Identifier Code	82= Rendering Provider	2/3
R	NM102	Entity Type Qualifier	1= Person 2= Non-Person Entity	1/1
R	NM103	Name Last or Organization Name	Rendering Provider Last or Organization Name	1/60
S	NM104	Name First	Rendering Provider First Name	1/35
S	NM105	Name Middle	Rendering Provider Middle Name or Initial	1/25
S	NM107	Name Suffix	Rendering Provider Name Suffix	1/10

Usage	Ref Des.	Name	Code/Definition	Length
S	NM108	Identification Code Qualifier	XX= Centers for Medicare and Medicaid Services National Provider Identifier	1/ 2
S	NM109	Identification Code	Must be a valid 10 digit NPI.	2/80

Loop 2430 -SVD- Line Adjudications Information

Usage	Ref Des.	Name	Code/Definition	Length
R	CAS01	Identification Code	Other Payer Primary Identifier	2/80
R	SVD02	Monetary Amount	Service Line Paid Amount	1/18

Loop 2430 -CAS-Line Adjustments

Usage	Ref Des.	Name	Code/Definition	Length
R	CAS01	Claim Adjustment Group Code	CO= Contractual Obligations CR= Correction and Reversals OA= Other Adjustments PI= Payor Initiated Reductions Pr= Patient Responsibility	1/2
R	CAS02	Claim Adjustment Reason Code	Adjustment Reason Code If a claim is denied in the MAOs' adjudication system, the denial reason must be populated	1/5

Loop 2430 -DTP- Claim Check/ Remittance Date

Usage	Ref Des.	Name	Code/Definition	Length
R	DTP01	Date/Time Qualifier	573= Date Claim Paid	3/3

Usage	Ref Des.	Name	Code/Definition	Length
R	DTP02	Date Time Period Format Qualifier	D8= Date Expressed in Format CCYYMMDD	2/3
R	DTP03	Date Time Period	Adjudication or Payment Date	1/35

Trailer Segments

SE – Transaction Set Trailer

Usage	Ref Des.	Name	Code/Definition	Length
R	SE01	Number of Included Segments	Transaction Segment Count	1/10
R	SE02	Transaction Set Control Number	Sequential Number (must be identical to value in element ST02)	4/9

GE Segment – Functional Group Trailer

Usage	Ref Des.	Name	Code/Definition	Length
R	GE01	Number of Transaction Sets Included	Number of ST Segments	1/6
R	GE02	Group Control Number	Sequential Number (must be identical to the value in the associated functional group header, GS06)	1/9

IEA Segment - Interchange Control Trailer

Usage	Ref Des.	Name	Code/Definition	Length
R	IEA01	Number of Included Functional Groups	Number of GS Segments	1/5
R	IEA02	Interchange Control Number	Sequential Number (same as ISA13)	9/9

L. Business Scenarios

Example 1- IPA Submitting Professional Encounter Data

Encounter data must be submitted by IPAs for all covered services provided to assigned Capitated members. Covered services include PCP visits as well as subcapitated services, regardless of place of service, type of service, or method of reimbursement to the provider of services. Failure to provide adequate and valid encounter data in the required format results in penalties being imposed as described in IEHP Capitated Agreement. IPAs will indicate adjudication status in loop 2300 and adjudication date in loop 2430. In accordance with CMS regulations, IEHP requires Providers to submit encounter data within ninety (90) days of each month end.

Example 2 - Capitated Hospital Submitting Encounter Data

Capitated Hospitals are required to submit encounter data through the encounter data system within ninety (90) days of each month end. CMS requires IEHP to report Outpatient Medical Encounters, Inpatient Admission Encounters, Long Term Care Encounters and Pharmacy Encounters. CMS defines an Outpatient Encounter as each physician encounter, laboratory test, X-ray, therapy procedure, DME, prosthetic, orthotic, transportation, outpatient service, home health, skilled nursing, etc.

M. Frequently Asked Questions

Q. What is the difference between a claim file and an encounter file?

A. For the purposes of IEHP and as used in this guide, claim files are generally submitted by IEHP's directly contracted fee-for-service providers which can include hospitals, urgent cares, and IEHP Direct providers. Encounter files are submitted by IEHP's Capitated IPAs and Capitated Facilities. Claim files will be adjudicated by IEHP while encounter files have already been adjudicated by the IPA or facility and are primarily for data capture and regulatory reporting. Therefore, while the file format is identical, claims and encounters have different protocols for submission and likewise different internal contacts. Instructions for Claim Processing Procedures can be located in Section VI of the EDI manual while directions for Encounter Processing Procedures can be found in Section IV of the EDI manual.

Q. Where do I find information on file naming conventions, connectivity protocol, and file transfer procedures?

A. Please refer to the EDI manual published at https://ww3.iehp.org/en/providers/edi-manual/ for information regarding the above areas. The information published in this companion guide is meant to be used in conjunction with the implementation guides from Washington Publishing Company for detailed instructions on the line level and IEHP's EDI Manual for connectivity and processing procedures.

Q. What is IEHP's policy on Billing Provider Address and 9-Digit Zip Codes?

A. IEHP supports the instructions in the Technical Report Type 3 (TR3) implementation guides (IG) available for purchase from Washington Publishing Company http://www.wpc-edi.com regarding Billing Provider Address and 9-digit zip codes. Therefore, the Billing Provider Address (2010AA, N3) is required and must be a physical address. PO Box and lock box addresses cannot be reported as a Billing Provider Address, but can continue to be reported in the pay-to address (2010AB, N3). The 5010 requires that all used N403 segments must contain a full 9-digit zip code. The best way to determine the 4-digit extension to your standard zip code is by contacting the US postal Service. https://tools.usps.com/go/ZipLookupAction!input.action. These instructions apply to all encounters for all healthcare Providers.

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