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## **12. IEHP 5010 837I INSTITUTIONAL CLAIM COMPANION GUIDE**

### **A. Included ASC X12 Implementation Guides**

#### **1. 005010X223A2 Health Care Claim: Institutional**

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**Standard Companion Guide (CG) Transaction Information  
Effective January 1, 2018**

**IEHP Instructions related to Implementation Guides (IG) based**

**and on X12 Version 005010X223A2  
Health Care Claim: Institutional (837)**

**Companion Guide Version Number: 1.7  
2018**

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## **12. IEHP 5010 837I INSTITUTIONAL CLAIM COMPANION GUIDE**

### **A. Included ASC X12 Implementation Guides**

#### **1. 005010X223A2 Health Care Claim: Institutional**

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#### **Preface**

- A. This transaction instruction is expected to be used in parallel with the Technical Report Type 3 (TR3) implementation guides (IG) available for purchase from Washington Publishing Company <http://www.wpc-edi.com>. It is provided because Inland Empire Health Plan wants to clarify the IG instructions for submission of specific electronic transactions. This companion guide is not meant to exceed the requirements or usages of data nor replace the guidelines expressed in the TR3s.

#### **Contact Information**

- A. For further questions regarding claims submissions, please contact
1. EDI Claims (Professional)- [edispecialist@iehp.org](mailto:edispecialist@iehp.org) or 909-890-2025

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## **12. IEHP 5010 837I INSTITUTIONAL CLAIM COMPANION GUIDE**

### **A. Included ASC X12 Implementation Guides**

#### **1. 005010X223A2 Health Care Claim: Institutional**

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##### **Background**

A. The Health Insurance Portability and Accountability Act (HIPAA) of 1996 carries provisions for administrative simplification. This requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between Health Care Providers and plans. HIPAA directs the Secretary to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard HIPAA serves to:

1. Create better access to health insurance
2. Limit fraud and abuse
3. Reduce administrative costs

B. Compliance according to HIPAA

The HIPAA regulations at 45 CFR 162.915 require that covered entities not enter into a trading partner agreement that would do any of the following:

1. Change the definition, data condition, or use of a data element or segment in a standard.
2. Add any data elements or segments to the maximum defined data set.
3. Use any code or data elements that are marked “not used” in the standard’s implementation specifications or are not in the standard’s implementation specification(s).
4. Change the meaning or intent of the standard’s implementation specification(s).

C. Compliance according to ASC X12

ASC X12 requirements include specific restrictions that prohibit trading partners from:

1. Modifying any defining, explanatory, or clarifying content contained in the implementation guide.
2. Modifying any requirement contained in the implementation guide.

D. Intended Use

The Transaction Instruction component of this companion guide must be used in conjunction with an associated ASC X12 Implementation Guide. The instructions in this companion guide are not intended to be stand-alone requirement documents. This companion guide conforms to all the requirements of any associated ASC X12 Implementation Guides and is in conformance with ASC X12’s Fair Use and Copyright statements.

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## **12. IEHP 5010 837I INSTITUTIONAL CLAIM COMPANION GUIDE**

### **A. Included ASC X12 Implementation Guides**

#### **1. 005010X223A2 Health Care Claim: Institutional**

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Below lists the X12N Implementation Guides for which specific transaction instructions apply and which are included in Heading 1 and 2 of section B in this document.

<b><u>Unique ID</u></b>	<b><u>Section</u></b>	<b><u>Name</u></b>
005010X223A2	B.2	Health Care Claim Institutional (837I)

Section B.1 include tables that contain one or more rows for each segment for which a supplemental instruction is needed. The table does not represent all of the fields necessary for a successful transaction. The TR3 should be reviewed for that information.

## 12. IEHP 5010 837I INSTITUTIONAL CLAIM COMPANION GUIDE

### A. Included ASC X12 Implementation Guides

#### 2. 005010X223A2 Health Care Claim: Institutional

##### ISA Segment - Interchange Control Header

<u>Usage</u>	<u>Ref Des.</u>	<u>Name</u>	<u>Code/Definition</u>	<u>Length</u>
R	ISA01	Authorization Information Qualifier	00 = No Authorization Sent	2/2
R	ISA02	Authorization Information	Blank (Space Fill)	10/10
R	ISA03	Security Information Qualifier	00 = No Security Information	2/2
R	ISA04	Security Information	Blank (Space Fill)	10/10
R	ISA05	Interchange ID Qualifier (Sender)	ZZ = Mutually Defined	2/2
R	ISA06	Interchange Sender ID	3 digit ID assigned by IEHP	15/15
R	ISA07	Interchange ID Qualifier (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	00501 Version	5/5
R	ISA13	Interchange Control Number	Must be identical to IEA02	9/9
R	ISA14	Acknowledgment Requested	1 = Interchange acknowledgment information.	1/1
R	ISA15	Interchange Usage Indicator	T = Test, P = Production	1/1
R	ISA16	Component Element Separator	Colon : Component Element Terminator	1/1
		Note: Segment Terminator	Tilde ~ Segment Terminator	
		Note: Data Element Separator	Asterisk * Data Element	

##### GS Segment - Functional Group Header

<u>Usage</u>	<u>Ref Des.</u>	<u>Name</u>	<u>Code/Definition</u>	<u>Length</u>
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	GS08	Version/Release/Industry Identifier Code	005010X223A2	1/12

##### ST – 837- Transaction Set Header

<u>Usage</u>	<u>Ref Des.</u>	<u>Name</u>	<u>Code/Definition</u>	<u>Length</u>
R	ST02	Transaction Control Number	Sequential Number (must be identical to the value in the associated Transaction Set trailer, SE02)	4/9

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### A. Included ASC X12 Implementation Guides

#### 2. 005010X223A2 Health Care Claim: Institutional

R	ST03	Implementation Convention Reference	005010X223A2 This field contains the same value as GS08.	1/35
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#### BHT – Beginning of Hierarchical Transaction

<u>Usage</u>	<u>Ref Des.</u>	<u>Name</u>	<u>Code/Definition</u>	<u>Length</u>
R	BHT06	Transaction Type Code	CH – Chargeable	2/2

#### Loop 1000A- NM1- Submitter Name Information

<u>Usage</u>	<u>Ref Des.</u>	<u>Name</u>	<u>Code/Definition</u>	<u>Length</u>
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
R	NM109	Sender Primary Identifier Check ID List	Assigned by IEHP. Same as GS02 and ISA06.	2/80

#### Loop 1000A -PER- Submitter EDI Contact Information

<u>Usage</u>	<u>Ref Des.</u>	<u>Name</u>	<u>Code/Definition</u>	<u>Length</u>
R	PER01	Contact Function Code	TE = Telephone It is recommended that Submitters populate the submitter's telephone number.	2/2
R	PER03	Communication Number Qualifier	TE = Telephone It is recommended that Submitters populate the submitter's telephone number.	2/2
R	PER04	Communication Number		1/256
S	PER05	Communication Number Qualifier	EM = Email Address  It is recommended that Submitters populate the submitter's email address.	2/2

## 12. IEHP 5010 837I INSTITUTIONAL CLAIM COMPANION GUIDE

### A. Included ASC X12 Implementation Guides

#### 2. 005010X223A2 Health Care Claim: Institutional

##### Loop 1000B -NM1- Receiver Name Information

<u>Usage</u>	<u>Ref Des.</u>	<u>Name</u>	<u>Code/Definition</u>	<u>Length</u>
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)	1/2
R	NM109	Identification Code	00303= Receiver Primary Identifier	2/80

##### Loop 2000A -PRV- Billing Provider Specialty Information

<u>Usage</u>	<u>Ref Des.</u>	<u>Name</u>	<u>Code/Definition</u>	<u>Length</u>
R	PRV01	Provider Code	BI = Billing	1/3
R	PRV02	Reference ID Qualifier	PXC= Health Care Provider Taxonomy Code	2/3
R	PRV03	Provider Taxonomy Code		1/50

##### Loop 2010AA -NM1- Billing Provider Name Information

<u>Usage</u>	<u>Ref Des.</u>	<u>Name</u>	<u>Code/Definition</u>	<u>Length</u>
R	NM101	Entity Identifier Code	85= Billing Provider	2/3
R	NM102	Entity Type Qualifier	1= Person 2= Non-Person Entity	1/1
R	NM103	Name Last or Organization Name		1/60
R	NM108	Identification Code Qualifier	XX = NPI Identifier	1/2
R	NM109	Billing Provider Identifier	NPI	2/80

##### Loop 2010AA-N3- Billing Provider Address

<u>Usage</u>	<u>Ref Des.</u>	<u>Name</u>	<u>Code/Definition</u>	<u>Length</u>
R	N301	Address Information	Billing Provider Address Line. Must Be A	1/55

## 12. IEHP 5010 837I INSTITUTIONAL CLAIM COMPANION GUIDE

### A. Included ASC X12 Implementation Guides

#### 2. 005010X223A2 Health Care Claim: Institutional

<u>Usage</u>	<u>Ref Des.</u>	<u>Name</u>	<u>Code/Definition</u>	<u>Length</u>
S	N302	Second Address Line	Street Address (No PoBox Allowed). Must Be A Street Address (No PoBox Allowed).	1/55

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

<u>Usage</u>	<u>Ref Des.</u>	<u>Name</u>	<u>Code/Definition</u>	<u>Length</u>
R	N401	City Name	Billing Provider City Name	2/30
S	N402	State or Province	<b>NOTE: Please Make Sure To Include The Two Charater State ID IE. "CA"</b>	2/2
R	N403	Postal Code	Billing Provider Postal Zone or Zip Code <b>Note: Full (9) digit Zip Code required. If last (4) digits are not available populate with "9998". (Do Not Send with "0000" or "9999").</b>	3/15

#### Loop 2010AA- REF- Billing Provider Tax Identification Information

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

#### Loop 2000B –SBR- Subscriber Information

<u>Usage</u>	<u>Ref Des.</u>	<u>Name</u>	<u>Code/Definition</u>	<u>Length</u>
S	SBR09	Claim Filling Indicator Code	MediCal Members = MC MediCare Members = MA	1/2

#### Loop 2010BA –NM1- Subscriber Name Information

<u>Usage</u>	<u>Ref Des.</u>	<u>Name</u>	<u>Code/Definition</u>	<u>Length</u>
R	NM108	Subscriber ID Qualifier	MI = Member Identification Number	1/2
R	NM109	Identification Code	Subscriber Primary Identifier Must equal the **14-digit IEHP ID	2/80



## 12. IEHP 5010 837I INSTITUTIONAL CLAIM COMPANION GUIDE

### A. Included ASC X12 Implementation Guides

#### 2. 005010X223A2 Health Care Claim: Institutional

<u>Usage</u>	<u>Ref Des.</u>	<u>Name</u>	<u>Code/Definition</u>	<u>Length</u>
			number. CIN(Medi-Cal ID) or SS#.	

#### Loop 2010BB -NM1- Payer Name

<u>Usage</u>	<u>Ref Des.</u>	<u>Name</u>	<u>Code/Definition</u>	<u>Length</u>
R	NM101	Entity identifier Code	PR = Payer	2/3
R	NM102	Entity Type Qualifier	2 = Non- Person Entity	1/1
R	NM103	Payer Name	IEHP or Inland Empire Health Plan	1 /60
R	NM108	Identification Code Qualifier	PI = Payer Identification XV – Centers for Medicare and Medicaid	1/2
R	NM109	Payer Identifier	IEHP ID – Note: Provide this Value 00303	2/80

#### Loop 2300 -CLM- Claim Information

<u>Usage</u>	<u>Ref Des.</u>	<u>Name</u>	<u>Code/Definition</u>	<u>Length</u>
R	CLM01	Claim Submitter's Identifier	Patient Control Number  Must be a unique number when Claim Frequency Type Code (CLM05-3) = "1".	1/38
R	CLM02	Total Claim Charge Amount	Total Claim Charge Amount  Must balance to the sum of all SV2 Service Line Charge Amounts <b>NOTE: No Leading Zero Allowed</b>	1/18
R	CLM05-3	Claim Frequency Type Code	1 = Original claim submission 2=Interim- First Claim 3=Interim- Continuing Claim 4=Interim- Last Claim 7 = Replacement 8 = Deletion or Void 9=Final Claim for a Home Health PPS Episode	1/1
R	CLM05-3	Claim Frequency Type Code	1 = Original claim submission 2=Interim- First Claim 3=Interim- Continuing Claim 4=Interim- Last Claim 7 = Replacement	1/1

## 12. IEHP 5010 837I INSTITUTIONAL CLAIM COMPANION GUIDE

### A. Included ASC X12 Implementation Guides

#### 2. 005010X223A2 Health Care Claim: Institutional

<u>Usage</u>	<u>Ref Des.</u>	<u>Name</u>	<u>Code/Definition</u>	<u>Length</u>
			8 = Deletion or Void 9=Final Claim for a Home Health PPS Episode	

#### Loop 2300 - DTP Segment – Statement Dates

<u>Usage</u>	<u>Ref Des.</u>	<u>Name</u>	<u>Code/Definition</u>	<u>Length</u>
R	DTP01	Date/Time Qualifier	435 = Admission	3/3
R	DTP02	Date Time Period Format Qualifier	D8=CCYYMMDD DT=CCYYMMDDHHMM	1/35
R	DTP03	Admission Date/Hour	Hours (HH) are expressed as “00” for midnight, “01” for 1A.M. and so on through “23” for 11P.M. Minutes (MM) are expressed as “00” through “59”. If the actual minutes are not known, use a default of “00”. This is only required for original or final bills.	1/35

#### 2300 -REF- Payer Claim Control Number

<u>Usage</u>	<u>Ref Des.</u>	<u>Name</u>	<u>Code/Definition</u>	<u>Length</u>
R	REF01	Reference Identification Qualifier	F8 -Original Reference Number	2/3
R	REF02	Payer Claim Control Number	Identifies ICN from original claim when submitting adjustment (replacement or (void).	1/50

#### 2300 -REF- Claim Identifier for Transmission Intermediaries

<u>Usage</u>	<u>Ref Des.</u>	<u>Name</u>	<u>Code/Definition</u>	<u>Length</u>
R	REF01	Reference Identification Qualifier	D9-Claim Number	2/3
R	REF02	Payer Claim Control Number	Unique claim number required for all submissions.	1/50

## 12. IEHP 5010 837I INSTITUTIONAL CLAIM COMPANION GUIDE

### A. Included ASC X12 Implementation Guides

#### 2. 005010X223A2 Health Care Claim: Institutional

##### 2300 -HI- Health Care Diagnosis Code

<u>Usage</u>	<u>Ref Des.</u>	<u>Name</u>	<u>Code/Definition</u>	<u>Length</u>
R	HI01	Principal Diagnosis	ABK-ICD-10 Code List Qualifier BK- is only valid for claims with dates of service prior to 10/01/15	1/3
S	HI01	Admitting Diagnosis Code	ABJ-ICD-10 Code List Qualifier BJ-is only valid for claims with dates of service prior to 10/01/15	1/3
S	HI01-1 to HI01-3	Patient Reason for Visit	APR = ICD-10 Code List Qualifier PR- is only valid for claims with dates of service prior to 10/01/15	1/3
S	HI01-1 to HI12-1	External Cause of Injury	AB- ICD-10 Code List Qualifier BN-is only valid for claims with dates of service prior to 10/01/15	1/3
S	HI01-1 to HI12-1	Other Diagnosis Code Information	AB-ICD-10 Code List Qualifier BF- is only valid for claims with dates of service prior to 10/01/15	1/3
S	HI01-1	Principal Procedure Information	AB-ICD-10 Code List Qualifier BR-is only valid for claims with dates of service prior to 10/01/15	1/3
S	HI01-1 to HI12-1	Other Procedure Information	BBQ-ICD-10 Code List Qualifier BQ- is only valid for claims with dates of service prior to 10/01/15	1/3

##### 2310A -NM1- Attending Provider Name

<u>Usage</u>	<u>Ref Des.</u>	<u>Name</u>	<u>Code/Definition</u>	<u>Length</u>
S	NM101	Entity Identifier Code	71-Attending Physician Note: Required when the claim contains any services other than non-scheduled transportation.	2/3
S	NM102	Entity Type Qualifier	1- Person	1/1
S	NM103	Name Last of Organization Name	Provider Last or Organization Name	1/60
S	NM109	Attending Provider Identifier	NPI	2/80

##### 2310A -PRV – Attending Provider Specialty Information

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### A. Included ASC X12 Implementation Guides

#### 2. 005010X223A2 Health Care Claim: Institutional

<u>Usage</u>	<u>Ref Des.</u>	<u>Name</u>	<u>Code/Definition</u>	<u>Length</u>
R	PRV01	Provider Code	AT -Attending	1/3
R	PRV02	Identification Qualifier	PXC-Taxonomy Code	2/3
R	PRV03	Provider Taxonomy Code	Taxonomy Code	1/50

#### 2310B -NM1- Operating Physicians Name

<u>Usage</u>	<u>Ref Des.</u>	<u>Name</u>	<u>Code/Definition</u>	<u>Length</u>
S	NM101	Entity Identifier Code	72- Operating Physician Note: Required when a surgical procedure code is listed.	2/3
S	NM102	Entity Type Qualifier	1 - Person	1/1
S	NM103	Name Last or Organization Name	Last Name of Operating Physician	1/60
S	NM109	Operating Physician Identifier	NPI	2/80

#### 2310D -NM1- Rendering Provider Name

<u>Usage</u>	<u>Ref Des.</u>	<u>Name</u>	<u>Code/Definition</u>	<u>Length</u>
S	NM101	Entity Identifier Code	82- Rendering Provider Required if the rendering provider is different than the attending provider	2/3
S	NM102	Entity Type Qualifier	1- Person	1/1
S	NM103	Name Last or Organization Name	Last Name of Rendering Provider Required if the rendering provider is different than the attending provider	1/60
S	NM109	Rendering Provider Identifier	NPI	2/80

#### 2310E -NM1- Service Facility Location

<u>Usage</u>	<u>Ref Des.</u>	<u>Name</u>	<u>Code/Definition</u>	<u>Length</u>
S	NM101	Entity Identifier Code	77 = Service Location Required when the location is different than the billing provider	2/3
S	NM102	Entity Type Qualifier	2 = Non-Person Entity	1/1
S	NM103	Name Last of Organization Name	Name Last or Organization Name	1/60
S	NM109	Service Facility Primary Identifier	NPI	2/80

## 12. IEHP 5010 837I INSTITUTIONAL CLAIM COMPANION GUIDE

### A. Included ASC X12 Implementation Guides

#### 2. 005010X223A2 Health Care Claim: Institutional

##### Loop 2330B -NM1- Other Payer Name

<u>Usage</u>	<u>Ref Des.</u>	<u>Name</u>	<u>Code/Definition</u>	<u>Length</u>
R	NM101	Entity Identifier Code	PR = Payer	2/3
R	NM102	Entity Type Qualifier	2 = Non-Person Entity	1/1
R	NM103	Other Payer Organization Name	Other Payer Organization Name	1/60
S	NM109	Identification Code	Other Payer Primary Identifier	2/3

##### Loop 2400 -SV2- Service Line Information

<u>Usage</u>	<u>Ref Des.</u>	<u>Name</u>	<u>Code/Definition</u>	<u>Length</u>
R	SV201	Service Line Revenue Code	<b>NOTE: Please be sure to NOT send DUPLICATE Service Lines. Please Make Sure The Revenue Code is 4 Charaters In Length (Add Leading Zero).</b>	2/3
R	SV202-1	Product or Service ID Qualifier	HC = IEHP only accepts valid HCPCS. The AMA's CPT codes are level 1 HCPCS codes. They are also reported under HC.	2/3
R	SV202-2	Procedure Code		1/1
R	SV203	Line Item Charge Amount	<b>NOTE: No Leading Zero Allowed</b>	1/18

##### Loop 2420C – NM1 – Rendering Provider Name

<u>Usage</u>	<u>Ref Des.</u>	<u>Name</u>	<u>Code/Definition</u>	<u>Length</u>
S	NM101	Entity Identifier Code	82 – Rendering Provider	2/3
S	NM102	Entity Type Qualifier	1 – Person	1/1
S	NM103	Name Last or Organization Name	Rendering Providers Last Name	1/60
S	NM109	Identification Code	NPI - Rendering Provider Identifier	2/80

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## **12. IEHP 5010 837I INSTITUTIONAL CLAIM COMPANION GUIDE**

### **A. Included ASC X12 Implementation Guides**

#### **2. 005010X223A2 Health Care Claim: Institutional**

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##### Example 3- Clearinghouse/IEHP Direct Providers Submitting Claim Data

Clearinghouses are largely used as an intermediary for fee-for-service Providers, hospitals, and other Providers submitting claims to IEHP electronically. Capitated IEHP Direct Providers may also elect to submit data through the claim system directly or through a clearinghouse. The clearinghouses must follow the instructions outlined in this guide and will pass it on to their Providers as appropriate to ensure compliance. The same situations and requirements laid out in the Implementation Guides published by Washington Publishing Company will be expected to be followed by Clearinghouse and IEHP Direct submitters alike.

##### Example 4- Fee-for-Service Hospital Submitting Claim Data

Fee-for-Service Hospitals may elect to submit 837 Institutional files without using a clearinghouse. All the same guidelines and requirements apply. The same situations and requirements laid out in the Implementation Guides published by Washington Publishing Company will be expected to be followed by Hospital submitters.

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## **12. IEHP 5010 837I INSTITUTIONAL CLAIM COMPANION GUIDE**

### **B. Frequently Asked Questions**

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**Q. How do I decrypt the 999 or 277CA or log file?**

A. Providers must use software compatible with the Open PGP standard to encrypt and decrypt data files exchanged with IEHP. To decrypt the files, Providers choose “Decrypt”, select the transmitted files, and then enter their Pass Phrase. Please refer to EDI Manual Section II- D, “Getting Started File transfer Procedures” for more detailed information.

**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.htm> 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 claims for all Health Care Providers.

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## 12. IEHP 5010 837I INSTITUTIONAL CLAIM COMPANION GUIDE

### C. Other Resources

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- A. <https://ww3.iehp.org/en/providers/provider-pnp-manual/>  
The Inland Empire Health Plan (IEHP) Provider Policy and Procedure Manual.
- B. <http://www.wpc-edi.com>.  
WPC Washington Publishing Company your source for EDI publication and tools.
- C. <http://www.wedi.org/>.  
The Workgroup for Electronic Data Interchange (WEDI) is the leading authority on the use of Healthcare IT to improve healthcare information exchange.
- D. <https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/Versions5010andD0/>  
CMS.gov Centers for Medicare & Medicaid Services.



## 12. IEHP 5010 837I INSTITUTIONAL CLAIM COMPANION GUIDE

### D. Change Log

Version	Date of Release	Changes
1.0	06/01/2011	Initial Draft
1.1	10/07/2011	<p>E. ISA 11 preferred Repetition Separator changed from “*” to “^”</p> <p>F. ISA 16 preferred Component Element Separator changed from “~” to “:”</p> <p>G. Professional: BHT06: Clarified from if submitting encounter, use “RP” to if submitting encounter/post-adjudicated claim, use “RP”</p> <p>H. Institutional: BHT06: Clarified from if submitting encounter, use “RP” to if submitting encounter/post-adjudicated claim, use “RP”</p> <p>I. Professional: 2300, CN1- <i>entire segment is no longer required</i> for post-adjudicated claims and capitated encounters. <i>CN101 and CN102 is required</i> for post-adjudicated claims and capitated encounters.</p> <p>J. Institutional: 2300, CN1- <i>entire segment is no longer required</i> for post-adjudicated claims and capitated encounters. <i>CN101 and CN102 is required</i> for post-adjudicated claims and capitated encounters.</p> <p>K. Professional: Clarified 2300 HI01-1 as principal diagnosis. Updated secondary diagnosis from HI01-1 - HI12-1 to HI02-1-HI12-1.</p> <p>L. Institutional: Expanded 2300 HI01-1 for patient reason for visit to HI01-1 to HI03-1.</p> <p>M. Professional: Added loop 2330B, DTP as requirement for encounters/post-adjudicated claims date.</p> <p>N. Institutional: Added loop 2330B, DTP as requirement for encounters/post-adjudicated claims date.</p> <p>O. Professional: Added loop 2400, SV103 as further instruction for Anesthesia Claims.</p> <p>P. Added Q&amp;A regarding billing provider address and 9-digit zip code requirements in Section E. FAQ.</p> <p>Q. Added Q&amp;A regarding Anesthesia Time Reporting Changes.</p>
1.2	11/09/2011	<p>R. Professional: Updated 2420A, PRV (Name =Provider Taxonomy Code) reference to PRV03</p> <p>S. Professional: 2000A, PRV03 / 2310B, PRV03 / 2420A, PRV03: Clarified that Taxonomy codes are required for all submitters. Notes changed from “If submitting encounter, Taxonomy code always required for submissions as IEHP’s Regulators require it. If submitting claim, follow IG” to “Taxonomy code</p>

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		<p>always required for submissions.”</p> <p>T. Institutional: 2000A, PRV03 / 2310A, PRV03: Clarified that Taxonomy codes are required for all submitters. Notes changed from “If submitting encounter, Taxonomy code always required for submissions as IEHP’s Regulators require it. If submitting claim, follow IG” to “Taxonomy code always required for submissions.”</p> <p>U. Professional: Clarified 2300, CN101 by adding to notes/comments “when loop ID- 2400, CN101, line level contract type, is not used.”</p> <p>V. Professional: Deleted 2300, CN102.</p> <p>W. Professional: Added 2430, SVD segment as required field for post-adjudicated claims and capitated encounters.</p> <p>X. Professional: Added 2400, CN101 as required field for post-adjudicated claims and capitated encounters if the line level information is different than the claim level.</p> <p>Y. Institutional: Deleted 2300, CN102.</p> <p>Z. Institutional: Deleted 2400, SV1 Professional Service Line</p> <p>AA. Institutional: Added 2430, SVD segment as required field for post-adjudicated claims and capitated encounters.</p> <p>BB. Professional: Added 2300, NTE segment to provide instructions for post-adjudicated claims and capitated encounters on providing denied reasons on the claim level. Required for Medicare Members Only.</p> <p>CC. Institutional: Added 2300, NTE segment to provide instructions for post-adjudicated claims and capitated encounters on providing denied reasons on the claim level. Required for Medicare Members Only.</p> <p>DD. Professional: Added 2400, NTE segment to provide instructions for post-adjudicated claims and capitated encounters on providing denied reasons on the service line level. Required for Medicare Members Only.</p> <p>EE. Institutional: Added 2400, NTE segment to provide instructions for post-adjudicated claims and capitated encounters on providing denied reasons on the service line level. Required for Medicare Members Only.</p> <p>FF. Professional: Clarified 2330B.DTP segment, Claim Check or Remittance Date, by adding “DTP01 = 573” to notes/comment section.</p> <p>GG. Professional: Clarified 2330B.DTP segment, Claim Check or Remittance Date, by adding “DTP01 = 573”</p>
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		to notes/comment section.
1.3	12/01/2011	<p>HH. Professional: Removed 2300, NTE segment to provide instructions for post-adjudicated claims and capitated encounters on providing denied reasons on the claim level. Required for Medicare Members Only.</p> <p>II. Institutional: Removed 2300, NTE segment to provide instructions for post-adjudicated claims and capitated encounters on providing denied reasons on the claim level. Required for Medicare Members Only.</p> <p>JJ. Professional: Removed 2400, NTE segment to provide instructions for post-adjudicated claims and capitated encounters on providing denied reasons on the service line level. Required for Medicare Members Only.</p> <p>KK. Institutional: Removed 2400, NTE segment to provide instructions for post-adjudicated claims and capitated encounters on providing denied reasons on the service line level. Required for Medicare Members Only.</p> <p>LL. Professional: Added 2320, CAS Segment to provide instructions for post-adjudicated claims and capitated encounters on providing the denial reason code if a claim is denied. Required for Medicare Members Only.</p> <p>MM. Institutional: Added 2320, CAS Segment to provide instructions for post-adjudicated claims and capitated encounters on providing the denial reason code if a claim is denied. Required for Medicare Members Only.</p> <p>NN. Professional: Added 2430, CAS Segment to provide instructions for post-adjudicated claims and capitated encounters on providing the denial reason code if a claim is denied on the service line. Required for Medicare Members Only.</p> <p>OO. Institutional: Added 2430, CAS Segment to provide instructions for post-adjudicated claims and capitated encounters on providing the denial reason code if a claim is denied on the service line. Required for Medicare Members Only.</p>
1.4	04/24/2012	<p>PP. Professional: Added 1000A, PER segment to recommend submitter's to provide telephone and email address for better future communication.</p> <p>QQ. Professional: Added 1000B, NM102 to clarify qualifier to be used as "2" for non-person entity.</p> <p>RR. Professional: Removed 2000B SBR segment reference following CMS updated companion guide.</p> <p>SS. Professional: Added 2010AA Billing Provider</p>

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		<p>Name Segment to clarify that Billing Provider must be populated and be a ten digit number, beginning with 1. Also provided default NPI for atypical providers (i.e. non-emergency transportation).</p> <p>TT. Professional: Added 2010AA N4 Billing Provider City, State, Zip Code to provide instructions if nine (9) digit zip code is unavailable.</p> <p>UU. Professional: Added 2010AA REF segment for specific instructions regarding Atypical providers (i.e. non-emergency transportation) that are coming through as an encounter.</p> <p>VV. Professional: Added 2010BA NM108 to clarify qualifier for Member ID (MI).</p> <p>WW. Professional: Added 2300, CLM Segment to clarify instructions for this segment (i.e. options for claim frequency code provided.)</p> <p>XX. Professional: Added 2300 REF*F8 as a place to hold ICN from original claim when submitting adjustment.</p> <p>YY. Professional: Added 2300 REF*D9 as requirement for unique claim number.</p> <p>ZZ. Professional: Removed date (10/1/2013) reference for ICD10 in all Diagnosis Segments (HI)</p> <p>AAA. Professional: Updated 2320, CAS segment from being required for Medicare Members only to being required for all LOBS for post-adjudicated claims and capitated encounters if a claim is denied.</p> <p>BBB. Professional: Updated 2430, CAS segment from being required for Medicare Members only to being required for all LOBS for post-adjudicated claims and capitated encounters if a claim is denied on the service line.</p> <p>CCC. Institutional: Added 1000A, PER segment to recommend submitter's to provide telephone and email address for better future communication.</p> <p>DDD. Institutional: Added 1000B, NM102 to clarify qualifier to be used as "2" for non-person entity</p> <p>EEE. Institutional: Removed 2000B SBR segment reference following CMS updated companion guide.</p> <p>FFF. Institutional: Added 2010AA Billing Provider Name Segment to clarify that Billing Provider</p>
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		<p>must be populated and be a ten digit number, beginning with 1. Also provided default NPI for atypical providers (i.e. non-emergency transportation).</p> <p>GGG. Institutional: Added 2010AA N4 Billing Provider City, State, Zip Code to provide instructions if nine (9) digit zip code is unavailable.</p> <p>HHH. Institutional: Added 2010AA REF segment for specific instructions regarding Atypical providers (i.e. non-emergency transportation) that are coming through as an encounter.</p> <p>III. Institutional: Added 2010BA NM108 to clarify qualifier for Member ID (MI).</p> <p>JJJ. Institutional: Added 2300, CLM Segment to clarify instructions for this segment. (i.e. options for claim frequency code provided.)</p> <p>KKK. Institutional: Added 2300, DTP Date- Admission Date/Hour as clarifying instructions.</p> <p>LLL. Institutional: Removed date (10/1/2013) reference for ICD10 in all Diagnosis Segments (HI)</p> <p>MMM. Institutional: Added 2300 REF*F8 as a place to hold ICN from original claim when submitting adjustment.</p> <p>NNN. Institutional: Added 2300 REF*D9 as requirement for unique claim number.</p> <p>OOO. Institutional: Updated 2320, CAS segment from being required for Medicare Members only to being required for all LOBS for post-adjudicated claims and capitated encounters if a claim is denied.</p> <p>PPP. Institutional: Updated 2430, CAS segment from being required for Medicare Members only to being required for all LOBS for post-adjudicated claims and capitated encounters if a claim is denied on the service line.</p> <p>QQQ. Updated Testing Procedures in Section H for Claims Submitters from 'claims\editest\5010\inbound' to 'claims\5010\editest' and for Encounter Submitters from 'editest\5010' to '5010\editest'</p>
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1.5	06/18/2012	<p>RRR. Corrected the Loop designation for Professional &amp; Institutional Payer Name Identifier NM109 to 2010BB from 2010BC.</p> <p>SSS. DTP segment corrected to loop 2430 from 2330B.</p>
1.6	01/22/2013	<p>TTT. Updated IEHP's EDI Manual web links throughout to reference <a href="http://www.iehp.org/edi">http://www.iehp.org/edi</a></p> <p>UUU. FAQ modifications to include removal of reference to encryption no longer relevant and clarifying details added to claims/encounter differences.</p> <p>VVV. Updated Testing Procedures in Section H to reference EDI Manual testing guidance.</p>
1.7	09/14/2015	<p>WWW. Professional: Added 2000A PRV03 Billing Provider Taxonomy Code as requested.</p> <p>XXX. Professional: 2310B NM11 Rendering Provider Name.</p> <p>YYY. Professional: 2310B NM101 Entity Identifier Code 82.</p> <p>ZZZ. Professional: 2310B NM109 NPI.</p> <p>AAAA. Professional: 2310B PRV03 Provider Taxonomy Code requested.</p> <p>BBBB. Professional: 2310C NM1 Service Facility Name (Required when the location is different than the billing provider).</p> <p>CCCC. Professional: 2310C NM101 Identifier Code 77.</p> <p>DDDD. Professional: NM109 NPI.</p> <p>EEEE. Institutional: 2000A PRV03 Taxonomy Code requested.</p> <p>FFFF. Institutional: 2310B Operating Physician Name. (Required when a surgical procedure code is listed)</p> <p>GGGG. Institutional: 2310B NM101 Entity Identifier Code 72.</p> <p>HHHH. Institutional: 2310B NM109 NPI.</p> <p>IIII. Institutional: 2310D NM1 Rendering Provider Name. (Required if rendering provider is different than the attending provider).</p> <p>JJJJ. Institutional: 2310D NM101 Entity Identifier Code 82.</p>

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		<p>KKKK. Institutional: 2310D NM109 NPI.</p> <p>LLLL. Institutional: 2310E NM1 Service Facility Name. (Required when the location is different than the billing provider).</p> <p>MMMM. Institutional: 2310E NM110 Identifier Code 77.</p> <p>NNNN. Institutional: 2310E NPI.</p>
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