Standard Medi-Cal Companion Guide (CG) Transaction Information
Effective June 30, 2016

IEHP Instructions related to Implementation Guides (IG) based

837 Health Care Claim: Institutional Transaction based on ASC X12 Technical Report Type 3 (TR3), Version 005010X223A2

Companion Guide Version Number: 1.0

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Revisions

Action	Date	Responsible Party
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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 Version 005010X223A2 of 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: Institutional Transaction

The IEHP 837 Health Care Claim: Institutional 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: Institutional 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: Institutional 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 005010X223A2 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 005010X223A2

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

1. 837 Health Care Claim: Institutional 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 (3) 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.

IEHP - Testing Requirements

Providers 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 IEHP to confirm that the DHCS 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

DHCS Acknowledgements and/or Reports

A submitted encounter file will be either accepted or rejected by DHCS.

1. DHCS will NOT return TA1 response is available at this time.
2. DHCS will return 999- X12 Standard Transactions Acknowledgement Report.
    a. The 999 acknowledgement report provides information on the validation of the GS\GE functional groups(s) and the consistency of the data.
3. DHCS will return 277 –X 12 standard transactions.
4. A single 277 will be returned that will only reflect the two ST-SEs that were accepted.
5. DHCS will return Encounter Validation Response (EVR) – custom XML error report detailing each error including file position of each record found to be in error, error value and error message.

DHCS Duplicate Logic

Encounters will be evaluated for duplicates at the service line level. If a service line is found to be a duplicate of a previously submitted service line, the entire encounter will be denied.

For the purposes of an 837 Institutional service line, a duplicate would have the same following values as a previously submitted service line:

1. Client Identification Number (CIN) – 2010BA NM109
2. Date(s) of Service – 2400 DTP*472 DTP03 (can be a range)
3. Admission Date/Hour - 2300 DTP*435 DTP03 (can be a date or a date/time)
4. Discharge Hour - 2300 DTP*096 DTP03
5. Rendering Provider – can be sourced from a variety of places The valued stored for purposes of duplicate validation will be the value derived for rendering provider at the service line level. This derived value may have been submitted at a higher level where no other identifier was submitted at either the claim or service line. This derived value may also be either a Medi-Cal Provider ID or State License number depending upon the presence of an NPI. If no NPI is submitted because the provider is atypical, a submitted secondary identifier will be used. The order of priority for secondary identifiers is Medi-Cal Provider ID first and State License Number second.

6. Revenue Code – 2400 SV201
7. Procedure Code – 2400 SV201-2
8. Procedure Modifier(s) – 2400 SV201-3,4,5,6
9. Drug code – 2410 LIN03 – Drug code is used when it is present

Conditional usage of Drug Code - When a submitted encounter is compared to previously submitted encounters and all other key fields match but one of the encounters has a drug code and the other does not – this situation is still identified as a duplicate. If all other key fields match and the drug codes are different, the situation is not a duplicate.

In order to appropriately represent encounters for the same service that can be performed multiple times in a day, usage of modifiers: 59, 76 and 77 will over-ride the duplicate validation logic; however, the use of these modifiers will be strictly monitored.

DHCS - Testing Requirements

DHCS requires that encounters be submitted in files dedicated to a specific Healthcare Plan Code (HCP).

The specific HCP will be included in the submitted file name and the file ISA segment as described in succeeding.

Sections Encounters for beneficiaries not enrolled in this HCP but included on the submitted file will be denied.

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. Encounter Identification by DHCS

In accordance with X12 837 Professional data specification rules, unless the encounter is a void or replacement, CLM01 must be unique, a submitted encounter that has the same

value in CLM01 as a previously submitted encounter will be denied. To aid in encounter identification, plans must use the HCP number of the plan that the beneficiary was enrolled in at the time of the encounter as the first three characters of CLM01.

During DHCS processing, each encounter will be assigned a unique identification number. This number will be provided back to the submitter in both the 277 and the EVR file. When attempting to correct a previously submitted encounter, plans must use this Encounter-ID as defined below

I. Correcting a Submitted Encounter Denied by DHCS

Submitted encounters will be either accepted or denied by DHCS. When DHCS denies a submitted encounter the reasons for the denial will be reported on the available EVR file.

Submitted encounters can be subsequently corrected by either a void or a replacement action.

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

1. The submitter of the 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 277 or EVR) of 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.

J. Implementation Usage

This document establishes the data contents of the 837 Health Care Claim: Institutional 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).

K. 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).

Interchange Control Header

ISA Segment - Interchange Control Header

Usage	Ref Des.	Name	Code/Definition	Length
R	ISA01	Authorization Information Qualifier	00 = No Authorization Sent	2/2
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	005010X223A2	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: Institutional	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	005010X223A2 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	Beginning of Hierarchical Transaction	0019= Information Source, Subscriber, Dependent	4/4
R	BHT02	Transaction Set Purpose Code	00= Original	2/2
R	BHT03	Reference Identification	Originator Application Transaction Identifier	1/50
R	BHT04	Date	Transaction Set Creation Date	8/8
R	BHT05	Time	Transaction Set Creation Time	4/8
R	BHT06	Claim or Encounter Identifier	RP- Reporting	2/2

Loop 1000A- NM1- Submitter Name Information

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

Usage	Ref Des.	Name	Code/Definition	Length
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)	1/2
FR	NM109	Identification Code	Sender Primary Identifier Check ID List	2/80

Loop 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		1/256
S	PER05	Communication Number Qualifier		2/2
S	PER06	Communication Number		1/256
S	PER07	Communication Number Qualifier		2/2
S	PER08	Communication Number		1/256

Loop 1000B -NM1- Receiver Name Information

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)	1/2
R	NM109	Identification Code	00303= Receiver Primary Identifier Note: Should match ISA06 and GS03	2/80

Table 2-Billing Provider Detail

Loop 2000A -HL- Billing Provider Hierarchical Level Information

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 Information

Usage	Ref Des.	Name	Code/Definition	Length
R	PRV01	Provider Code	BI = Billing	1/3

Usage	Ref Des.	Name	Code/Definition	Length
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

Usage	Ref Des.	Name	Code/Definition	Length
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
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	Billing Provider Identifier		2/80

Loop 2010AA-N3- Billing Provider Address Information

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

Usage	Ref Des.	Name	Code/Definition	Length
			Note: Must be a physical address	
S	N302	Address Information	Billing Provider Address Line Note: Must be a physical address	1/55

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

Usage	Ref Des.	Name	Code/Definition	Length
R	N401	City Name	Billing Provider City Name	2/30
S	N402	State or Province		2/2
S	N403	Postal Code	Billing Provider Postal Zone or Zip Code Note: Full (9) digit Zip Code required. If last (4) digits are not available populate with “9998”.	3/15

Loop 2010AA- REF- Billing Provider Tax Identification Information

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

Loop 2010AB-NM1- Billing Provider Pay-to-Address Name

Usage	Ref Des.	Name	Code/Definition	Length
S	NM101	Entity Identifier Code	87 = Pay-to-Provider	2/3
R	NM102	Entity Type Qualifier	2 = Non-Person Entity	2/2

Loop 2010AB- Billing Provider Pay-to-Address-Address

Usage	Ref Des.	Name	Code/Definition	Length
R	N301	Address information	Pay-to address	1/55
R	N401	City Name	Pay-to address City	2/30
R	N402	State or Province	Pay-to address State Code	2/2
R	N403	Postal Code	Pay-to address Postal Code	3/15

Table 2- Subscriber Detail

Loop 2000B -SBR- Subscriber Hierarchical Level

Usage	Ref Des.	Name	Code/Definition	Length
R	SBR01	Payer Responsibility Sequence Number Code	S= Secondary	1/1
R	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	SBR09	Claim Filling Indicator Code	MA- Medicare Part A MC= Medicaid	1/2

Loop 2010BA -SBR- Subscriber Name Information

Note: Each member must be identified in the Subscriber loop (2010BA), the Patient loop (2010CA) must not be sent. The Medi-Cal Client Identification Number (CIN) must be used in 2010BA NM1*IL NM109, with NM108 = "MI".

Usage	Ref Des.	Name	Code/Definition	Length
R	NM101	Entity Identifier Code	IL = Insured or Subscriber	2/3
R	NM102	Entity Type Qualifier	1 = Person Individual Last Name or Organizational Name	1/1
R	NM103	Name Last or Organization Name	Individual Last Name or Organization Name	1/60
S	NM104	Name First	Individual First Name Note: Required when NM102 is equal to "1" (person) and the person have a first name. If not required by this implementation guide, do not send.	1/35
S	NM105	Name Middle	Individual middle name or initial Note: Required if supplied by member. If not required by this implementation guide, do not send	1/25
S	NM106	Name Prefix	Prefix to individual name Note: Required if supplied by member. If not required by this implementation guide, do not send	1/10
S	NM107	Name Suffix	Name suffix (Sr., Jr., etc.)	1/10
S	NM108	Identification Code Qualifier	MI = Member Identification Number	1 / 2
S	NM109	Identification Code	Must equal the **14-digit IEHP ID number or SSN#.	2/80

Loop 2010BA -N3- Subscriber Residence Street Address

Usage	Ref Des.	Name	Code/Definition	Length
R	N301	Address Information	Street address of subscriber	1/55
S	N302	Address Information	Additional street address information of subscriber	1/55

Loop 2010BA -N4- Subscriber City, State, Zip Code

Usage	Ref Des.	Name	Code/Definition	Length
R	N401	City Name	City of subscriber	2/30
S	N402	State or Province Code	Two letter postal abbreviation of subscriber's state	2/2
S	N403	Postal Code	Subscriber's Zip Code	3/15

Loop 2010BA -DMG- Segment – Demographic Information

Usage	Ref Des.	Name	Code/Definition	Length
R	DMG01	Date Time Period Format Qualifier	D8 = Date expressed in format CCYYMMDD	2/3
R	DMG02	Date Time Period	Member Birth Date	1/35
R	DMG03	Gender Code	F = Female M = Male	1/1
S	DMG04	Marital Status Code	B = Registered Domestic Partner D = Divorced I = Single M = Married R = Unreported	1 / 1

Usage	Ref Des.	Name	Code/Definition	Length
			S = Separated U = Unmarried W = Widowed X = Legally Separated	

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	Payer Name	IEHP or Inland Empire Health Plan	1 /0
R	NM108	Identification Code Qualifier	PI = Payer Identification	1/2
R	NM109	Payer Identifier	IEHP assigned Submitter ID	2/8

Loop 2010BA -REF- Billing Provider Secondary Identification

Usage	Ref Des.	Name	Code/Definition	Length
R	REF01	Original Reference Number	G2= Medicaid State Assigned Identification Number	2/3
R	REF02	Medicaid Subscriber ID Number	Medicaid State Assigned Identification Number	1/35

<u>Table 2-Patient Detail</u>

Loop 2300 -CLM- Claim Information

Usage	Ref Des.	Name	Code/Definition	Length
R	CLM01	Patient Control Number	PR = Payer	2/3
R	CLM02	Total Charge Amount		1/1
R	CLM05_01	Facility Type Code		1/2
R	CLM05_03	Claim Frequency Type Code	1 = Original Claim Submission 2= Interim - First Claim 3= Interim – Continuing Claim 4= Interim – Last Claim 7 = Replacement 8 = Void 9 = Final Claim for a Home Health PPS Episode	1/1

Loop 2300 - DTP Segment – Statement Dates

Usage	Ref Des.	Name	Code/Definition	Length
R	DTP01	Date/Time Qualifier	434 = Statement	3/3
R	DTP02	Date Time Period Format Qualifier	RD8 = CCYYMMDD	2/3
R	DTP03	Date Time Period	Statement From and to Date	1/35
R	DTP01	Date/Time Qualifier	435 = Statement	3/3
R	DTP02	Date Time Period Format Qualifier	D8 = CCYYMMDD DT = CCYYMMDDHHMM Note: Required on all Inpatient claims	2/3
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”.	

Usage	Ref Des.	Name	Code/Definition	Length
			This is only required for original or final bills	
R	DTP03	Date Time Period	Statement From and to Date	1/35

2300 - PWK - Claim Supplemental Info

Usage	Ref Des.	Name	Code/Definition	Length
S	PWK01	Report Type Code	09 = Populated for chart review submissions only 0Z = Populated for encounters generated as a result of paper claims PY = Populated for encounters generated as a result of 4010 submission only	2/2
S	PWK02	Attachment Transmission Code	AA = populated for chart review	1/2

2300 -CL1- Contract Information

Usage	Ref Des.	Name	Code/Definition	Length
R	CL101	Admission Type Code	1 = Emergency 2 = Urgent 3 = Elective 4 = Newborn 6 = Reserved 7 = Reserved 8 = Reserved	1/1

Usage	Ref Des.	Name	Code/Definition	Length
			9 = unknown	
R	CL102	Admission Source Code	Code Source 231: Point of origin for admission visit	1/18
R	CL103	Contract Amount	Note: Must match AMT02 in loop 2320 and all SVD02 segments in loops 2430	1/18

2300 - CN1- Contract Information

Note: The type of arrangement used to pay the encounter must be described in the CN1 segment in the 2300 loop – CN101 Contract Type Code. When the encounter has been paid on a fee-for-service basis, CN102 should be populated with the amount paid. DHCS requires that 2300 CN1 be provided, and requests the 2400 CN1 segment to be included.

Any payments made to other health insurance carriers must be included in the relevant coordination of benefits segments

Usage	Ref Des.	Name	Code/Definition	Length
R	CN101	Contract Type Code	01 = Diagnosis Related Group (DRG) 02 = Paid 05 = Capitated 09 = Denied	2/2
R	CN102	Contract Amount	Note: Must match AMT02 in loop 2320 and all SVD02 segments in loops 2430	1/18

2300 -REF- Payer Claim Control Number

Usage	Ref Des.	Name	Code/Definition	Length
S	REF01	Reference Identification Qualifier	F8 = Original Reference Number Note: Required when CLM05_03 (Claim Frequency Code) indicates that the claim is a replacement or void.	2/3

Usage	Ref Des.	Name	Code/Definition	Length
S	REF02	Payer Claim Control Number	Note: Identifies ICN from original encounter when submitting adjustments	1/50

2300 -REF- Claim Identifier for Transmission Intermediaries

Usage	Ref Des.	Name	Code/Definition	Length
R	REF01	Claim Identifier for Transmission Intermediaries	D9 = Claim Number	2/3
R	REF02	Payer Claim Control Number	Note: Must match the PCN value present in 2300_CLM01	1/50

2300 -HI- Diagnosis Code

Usage	Ref Des.	Name	Code/Definition	Length
R	HI01	Principal Diagnosis	BK = ICD-9 Code List Qualifier ABK = ICD-10 Code List Qualifier	1/3
S	HI01	Admitting Diagnosis Code	BJ = ICD-9 Code List Qualifier ABJ = ICD-10 Code List Qualifier Note: Required when claim involves an Impatient admission	1/3
S	HI01	Patient Reason for Visit	PR = ICD-9 Code List Qualifier APR = ICD-10 Code List Qualifier Note: Required when claim involves an Outpatient visit.	1/3
S	HI01	External Cause of Injury	BN = ICD-9 Code List Qualifier ABN = ICD-10 Code List Qualifier Note: Required when an external cause	1/3

Usage	Ref Des.	Name	Code/Definition	Length
			of injury is needed to describe an injury or poisoning.	
S	HI01	Diagnosis Related Group (DRG)	DR = Diagnosis Related Group (DRG) Note: Required when an inpatient hospital is under DRG contract with payer and the contract requires the provider to provide the DRG	1/3
S	HI01	Other Diagnosis Code Information	BF = ICD-9 Code List Qualifier ABF=ICD-10 Code List Qualifier Note: Required when other conditions coexist or develop during the patients treatment	1/3
S	HI01	Principal Procedure Code	BR = ICD-9 Code List Qualifier BBR= ICD-10 Code List Qualifier Note: Required on Inpatient claims when a procedure was performed.	1/3
S	HI01	Other Procedure Information	BQ = ICD-9 Code List Qualifier BBQ = ICD-10 Code List Qualifier Note: Required on inpatient claims when additional procedures must be reported.	1/3
S	HI01	Occurrence Span Information	BI = Occurrence Span Note: Required when there is an occurrence span codes that applies to this claim.	1/3
S	HI01	Occurrence Information	BH = Occurrence Note: Required when there is an occurrence code that applies to this	1/3

Usage	Ref Des.	Name	Code/Definition	Length
			claim	
S	HI01	Value Information	BE = Value Note: Required when there is a value code that applies to this claim. HI01-2 must = A0 on all ambulance encounters. Ambulance pick up location zip must be (9) digits. If (9) are not available use '9998' as final (4) digits	1/3
S	HI01	Condition Information	BG = Condition Note: Required when there is a condition code that applies to this claim.	1/3
S	HI01	Treatment Code Information	TC = Note: Required when Home Health Agencies need to report Plan of Treatment information	1/3

2310A -NM1- Attending Provider Name

Note: Medi-Cal Managed Care requires the submission of the National Provider Identifier (NPI) on all submitted encounters, with the sole exception being for atypical Providers.

Usage	Ref Des.	Name	Code/Definition	Length
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	Provider Last or Organization Name	1/60

Usage	Ref Des.	Name	Code/Definition	Length
		Organization Name		
S	NM104	Name First	Provider First Name	1/35
S	NM105	Name Middle	Provider Middle Name	1/25
S	NM106	Name Prefix	Provider Name Prefix	1/10
S	NM107	Name Suffix	Provider Name Suffix	1/10
S	NM108	Identification Code Qualifier	XX = National Provider Identifier	1 / 2
S	NM109	Identification Code	National Provider Number (NPI)	2/80

2310B -NM1- Operating Physicians Name

Note: Required when a surgical procedure is listed on the claim.

Usage	Ref Des.	Name	Code/Definition	Length
S	NM101	Entity Identifier Code	72 = Operating Physician Note: Required when a surgical procedure code is listed on this claim.	2/3
S	NM102	Entity Type Qualifier	1 = Person	1/1
S	NM103	Operating Physicians Last Name		1/60
S	NM104	Operating Physicians First Name		1/35
S	NM108	Identification Code Qualifier	XX	1/2
S	NM109	Identification Code		2/80

2310C -NM1- Other Operating Physicians Name

Note: Required when another operating physician is involved.

Usage	Ref Des.	Name	Code/Definition	Length
S	NM101	Entity Identifier Code	ZZ = Operating Physician Note: Required when another Operating Physicians is involved.	2/3
S	NM102	Entity Type Qualifier	1 = Person	1/1
S	NM103	Other Operating Physicians Last Name		1/60
S	NM104	Other Operating Physicians First Name		1/35
S	NM108	Identification Code Qualifier	XX	1/2
S	NM109	Identification Code		2/80

2310D -NM1- Rendering Provider Name

Usage	Ref Des.	Name	Code/Definition	Length
S	NM101	Entity Identifier Code	82 = Rendering Provider Note: Required when Rendering Provider is different than the Attending Provider in 2010A	2/3
S	NM102	Entity Type Qualifier	1 = Person	1/1
S	NM103	Rendering Provider Last Name		1/60
S	NM104	Rendering Provider First Name		1/35
S	NM108	Identification Code Qualifier	XX	1/2
S	NM109	Identification Code		2/80

2310E -NM1- Service Facility Location

Note: Required if different than the Billing Provider

Usage	Ref Des.	Name	Code/Definition	Length
S	NM101	Entity Identifier Code	77 = Service Location Note: Required when the location of health care service is different than that carried in Loop 2010AA (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	NM108	Identification Code Qualifier	XX	1/2
S	NM109	Identification Code		2/80

2310F -NM1- Referring Provider Name

Note: Required on an outpatient claim when the referring provider is different from the attending provider

Usage	Ref Des.	Name	Code/Definition	Length
S	NM101	Entity Identifier Code	DN = Referring Provider Note: Required on outpatient claim when the Referring Provider is different than the Attending Provider	2/3
S	NM102	Entity Type Qualifier	1 = Person	1/1
S	NM103	Name Last of Organization Name	Referring Provider Last Name	1/60
S	NM104	First Name	Referring Provider First Name	1/35
S	NM108	Identification Code	XX	1/2

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

Loop 2320 – Coordination of Benefits

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	1/1
R	SBR09	Claim Filing Indicator Code	16 = Health Maintenance Organization (HMO) Medicare Risk	1/2
R	AMT01	Amount Qualifier Code	D = Payer Amount Paid	1/3
R	AMT02	Payer Paid Amount	Note: This value should match the value found in the CN102 segment in loop 2300	1/18
R	OI03	Yes/No Condition or Response Code	N = No W = Not Applicable Y = Yes Note: This is a cross walk from 2300_CLM08	1/1
R	OI06	Release of Information Code	I = Informed consent to release medical information for conditions or diagnoses regulated by federal statutes. Y = Yes, provider has signed statement permitting release of medical billing data related to claim Note: This a cross walk from	1/1

Usage	Ref Des.	Name	Code/Definition	Length
			2300_CLM09	

Loop 2330A -NM1- Other Subscribers Name

Usage	Ref Des.	Name	Code/Definition	Length
R	NM101	Entity Identifier Code	IL = Insurer	2/3
R	NM102	Entity Type Qualifier	1 = Person 2 = Non-Person Entity	1/1
R	NM103	Name Last or Organization		1/60
R	NM104	Name First		1/35
R	NM105	Name Middle		1/25
R	NM108	Identification Code Qualifier	MI	1/2
R	NM109	Subscriber Primary ID	Must match the value in 2010BA_NM109	1/60

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	Organization Name	The organization responsible for the adjudication information provided in the SVD02 segment of loop 2430. Not IEHP	1/60
R	NM108	Identification Code	PI = Payer Identification	1/2

Usage	Ref Des.	Name	Code/Definition	Length
		Qualifier		
R	NM109	Subscriber Primary ID	This should be the Submitter ID assigned by IEHP and must match the value populated in the SVD01 segment of loop 2430.	1/60

Loop 2330B -REF- Other Payer Secondary Identifier

Usage	Ref Des.	Name	Code/Definition	Length
R	REF01	Reference Identifications Qualifier	FY Note: 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.	2/3

Loop 2400 -SV2- Service Line Information

Usage	Ref Des.	Name	Code/Definition	Length
R	SV201	Service Line Revenue Code		2/3
R	SV202-1	Product/Service ID Qualifier	HC = HCPCS	
R	SV202-2	Procedure Code		1/1
S	SV202-3	Procedure Modifier		1/60
S	SV202-	Description	PI = Payer Identification	1/2

Usage	Ref Des.	Name	Code/Definition	Length
	7			
R	SV203	Line Item Charge Amount		1/18

Loop 2400 -DTP- Service Date

Usage	Ref Des.	Name	Code/Definition	Length
S	DTP01	Date/Time Qualifier	472 = Service Note: Required on outpatient service lines where a drug is not being billed and statement date is greater than one day.	2/3
S	DTP02	Date Time Period Format Qualifier	D8 = Date Expressed in CCYYMMDD RD8 = Date Ranges expressed in CCYYMMDD-CCYYMMD	2/3
S	DTP03	Service Date		1/1

Loop 2430 -SVD- Line Adjudication Information-

Usage	Ref Des.	Name	Code/Definition	Length
R	SVD01	Other Payer Primary Identifier	Must match the value in 2330B_NM109	2/3
R	SVD02	Service Line Paid Amount	"0" is acceptable	1/18
S	SVD03-1	Product/Service ID Qualifier	HC = HCPS	2/2
S	SVD03-2	Procedure Code		1/48

Usage	Ref Des.	Name	Code/Definition	Length
S	SVD03-3	Modifier Code		1/18
R	SVD04	Service Line Revenue Code		1/48
R	SVD05	Paid Service Unit Count		1/15

Loop 2430 -CAS- Line Adjustment

Usage	Ref Des.	Name	Code/Definition	Length
R	CAS	Claims Adjustment Group Code	CO = Contractual Obligations CR = Correction Reversals OA = Other Adjustments PI = Payer Initiated Reductions PR = Patient Responsibility	1/2
R	CAS02	Claims Adjustment Reason Codes		1/5
R	CAS03	Adjustment Amounts		1/18

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
R	DTP02	Date Time Period Format Qualifier	D8 = Date expressed in format CCYYMMDD	1/35
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

Interchange Control Trailer

IEA Segment - Interchange Control TrailerUsage	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

1. Example 1- IPA Submitting Institutional 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 DHCS regulations, IEHP requires Providers to submit encounter data within ninety (90) days of each month end.

2. 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. DHCS requires IEHP to report Outpatient Medical Encounters, Inpatient Admission Encounters, Long Term Care Encounters and Pharmacy Encounters. DHCS 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.

N. Other Resources

1. https://ww3.iehp.org/en/providers/edi-manual/
   IEHP's website where the EDI manual and other resources are located
   http://www.wpc-edi.com.
   Washington Publishing Company Implementation guides (TR3) can be purchased from this site.

2. http://www.wedi.org/.
   Workgroup for Electronic Data Interchange in Healthcare
   https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/Versions5010andD0/index.html.
   CMS website that contains additional information and resources related to 5010

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