8. IEHP 5010 837I INSTITUTIONAL IEHP DUALCHOICE ENCOUNTER COMPANION GUIDE

Dual Choice Cal MediConnect Plan (Medicare-Medicaid Plan) Encounter Companion Guide (CG) Transaction Information

Effective January 1, 2020

IEHP Instructions related to Implementation Guides (IG) based on

ASC X12 Version 005010X223A2

Health Care Claim: Institutional (837)

Companion Guide Version Number: 1.8

2020

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Introduction

The Purpose of This Companion Guide:

This document provides a definitive statement of what Submitters must be able to support in their ANSI ASC X12N 837I 005010X223A2 encounter files

This document does not outline the technical interface environment; including connectivity requirements and protocols.

This document provides specific Loops, Segments and Data Elements that are outlined for the 837I transactions exchanged with IEHP and which are specific to IEHP.

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.

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Intended Use

The Transaction Instruction component of this companion guide must be used in conjunction with an associated ASC X12 TR3. The instructions in this companion guide are not intended to be stand-alone requirements documents. This companion guide conforms to all the requirements of any associated ASC X12 TR3's and is in conformance with ASC X12's Fair Use and Copyright statements.

Implementation Guides (IG) / TR3 available for purchase from Washington Publishing Company http://www.wpc-edi.com

Implementation

The below instructions are expected to be used in addition to the Technical Report Type 3 (TR3) Implementatation Guide (IG). The table does not represent all of the fields necessary for a successful transaction. The following loops and segments are elements that IEHP would like you to pay special attention to when creating this electronic transaction.

File Size Limitations

ISA/ IEA transaction sets should not exceed 5,000 encounters.

Contact Information

For further questions regarding encounters submissions, please email edispecialist@iehp.org

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IEHP Response Reports

999 - Functional Acknowledgment

The 999-transaction set is designed to report on adherence to IG level edits and IEHP standard syntax errors.

There are three (3) key acknowledgment values:
"A" – Accepted
"R" – Rejected
"E" – Partially Accepted; At Least One (1) Transaction Set Was Rejected

When viewing the 999 report, Submitters should navigate to the IK5 and AK9 segments. If an "A" is displayed in the IK5 and AK9 segments, the claim file is accepted and will continue processing. If an "R" is displayed in the IK5 and AK9 segments, an IK3 and an IK4 segment will be displayed. These segments indicate what loops and segments contain the error that requires correction so the interchange can be resubmitted. The third element in the IK3 segment identifies the loop that contains the error. The first element in the IK3 and IK4 indicates the segment and element that contain the error. The third element in the IK4 segment indicates the reason code for the error.

IEHP Encounter Validation Response (EVR)

The EVR response files will provide the following summary level and detail information outlined below.

Three (3) Stage values are:

Stage 1 - File Level
- Record Count
- Rejected
- Accepted
- In Progress

Stage 2 - Encounter Level
- Duplicate
- Member Not Eligible
- Accepted for IEHP Validation
- Total Records Processed

Stage 3 – Validity Summary
- Invalid

- Valid
- Total Records Validated
- Validity

Rejection Details

- Record (IEHP assigned tracking number)
- Claim ID
- No. (Service Line Number)
- Loop
- Element name
- Error Severity
- Message (Error Description)

End to End Testing Prerequisite

Phase 1 (Inbound IEHP Validation)

- Each test file must contain Twenty-five (25) encounters
- Each test files must pass Structural validation must be 100% valid (999 Report)
- Validity must be 95% or higher (277CA/EVR Report)
- 999 and EVR report will be provided to the Submitter.
- Each Submitter must submit three (3) rounds of test files prior to moving to Phase Two (2).

Phase 2 (Outbound Regulatory Validation)

- Outbound test files containing no more than six (6) encounters deemed valid by IEHP will be forwarded on to their respective Regulatory Agency (i.e. DHCS and CMS).
- Requlatory response reports outlining the final encounter status will be provided to the submitter via IEHP.
- Upon completion of the three (3) successfully rounds of testing, meaning 95% of the outbound test data has been accepted by the Regulatory Agency, the submitter will then be promoted to production.

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IEHP adhere to Regulatory Bodies Duplicate Logic

In order to ensure encounters submitted are not duplicates of encounters previously submitted, IEHP will perform header and detail level duplicate checking. If the header and/or detail level duplicate, checking determines that the file is a duplicate, the file will reject, and an error report will be returned to the submitters.

Duplicate Encounters

Once the encounter is processed in IEHP (EDPS) it is stored in an internal repository. If a new encounter is submitted that matches specific values on another stored encounter, the encounter will reject as a duplicate encounter. The encounter will be returned to the submitter with an error message identifying it as a duplicate encounter.

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

- Member ID - HICN/MBI
- Date of Service - 2400 DTP*472 DTP03
- Admission Date/Hour – 2300 DTP*435 DTP03
- Discharge Hour – 2300 DTP*096 DTP03
- Revenue Code(s) – 2400 SV201
- Procedure Code(s) – 2400 SV202-2
- Procedure Modifier(s) – 2400 SV202-3,4,5,6
- Attending/Rendering Provider NPI – Can be sourced from a variety of places. Please refer to the (TR3) Implementation Guide.
- Drug Code – 2410 LIN03 – Drug code is used when presented

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ISA Segment - Interchange Control Header

Usage	Ref Des.	Name	Code	Note
R	ISA01	Authorization Information Qualifier	00	No Authorization Sent
R	ISA02	Authorization Information		Space Fill
R	ISA03	Security Information Qualifier	00	No Security Information
R	ISA04	Security Information		Space Fill
R	ISA05	Interchange ID Qualifier	ZZ	Mutually Defined
R	ISA06	Interchange Sender ID		Assigned by IEHP
R	ISA07	Code Identifying Receiver	ZZ	Mutually Defined
R	ISA08	Interchange Receiver ID	00303	IEHP Receiver ID
R	ISA11	Repetition Separator	^	Carat Repetition Separator
R	ISA12	Interchange Control Version Number	00501	ASC X12 Standard Approved
R	ISA14	Acknowledgment Requested	0	TA1 not provided
R	ISA15	Interchange Usage Indicator	P T	P = Production T = Test

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GS Segment - Functional Group Header

Usage	Ref Des.	Name	Code	Note
R	GS01	Functional Identifier Code	HC	Health Care Claim
R	GS02	Application Sender's Code		Assigned by IEHP
R	GS03	Application Receiver's Code	00303	Value must match ISA08

Table 1-Header

ST – Transaction Set Header

Usage	Ref Des.	Name	Code	Note
R	ST01	Transaction Set Identifier Code		
R	ST02	Transaction Set Control Number		Must match the value in SE02

BHT – Beginning of Hierarchical Transaction

Usage	Ref Des.	Name	Code	Note
R	BHT02	Transaction Set Purpose Code	00	00 = Original
R	BHT06	Transaction Type Code	RP	RP = Reporting

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Loop 1000A -PER- Submitter EDI Contact Information

Usage	Ref Des.	Name	Code	Note
S	PER02	Free Form Name		Submitter Contact Name
R	PER03	Communication Number Qualifier	TE	TE = Telephone
R	PER04	Communication Number		Phone number including area code
S	PER05	Communication Number Qualifier	EM	EM = Email Address

Loop 1000B -NM1- Receiver Name

Usage	Ref Des.	Name	Code	Note
R	NM103	Name Last or Organization Name	Inland Empire Health Plan	"IEHP" is also acceptable
R	NM109	Receiver ID	00303	Should match ISA08 and GS03

Table 2-Billing Provider Detail

Loop 2000A – PRV - Billing Provider Specialty Information – Required by IEHP

Usage	Ref Des.	Name	Code	Note
R	PRV03	Billing Provider Specialty Info		Provider Taxonomy Code

Loop 2010AA -N3- Billing Provider Address Information

Usage	Ref Des.	Name	Code	Note
R	N301	Address Information		Billing Provider Address Line Must be Physical Address
S	N302	Second Address Information		Billing Provider Address Must be Physical Address

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

Usage	Ref Des.	Name	Code	Note
S	N403	Zip Code		The full nine (9) digits of the ZIP Code are required. If the last four (4) digits of the ZIP code are not available, populate a default value of “9998”.

Table 2-Subscriber Detail

Loop 2000B -SBR- Subscriber Information

Usage	Ref Des.	Name	Code	Note
R	SBR01	Payer Responsibility Sequence Number Code	S	S = Secondary
R	SBR02	Individual Relationship Code	18	18 = Self
R	SBR03	Group Number		Must Be Blank
R	SBR04	Group Name	CMC CCI	CMC = Dual Medicare Part A/B CCI = Dual Medicaid

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Usage	Ref Des.	Name	Code	Note
S	SBR09	Claim Filling Indicator Code	MA MC	MA = Medicare Part A MC = Medicaid

Loop 2010BA -NM1- Subscriber Name

Usage	Ref Des.	Name	Code	Note
R	NM102	Entity Type Qualifier	1	1 = Person
S	NM108	Identification Code Qualifier	MI	MI = Member ID Number
S	NM109	Identification Code		14-digit IEHP ID or Member Beneficiary ID (MBI)

Loop 2010BB -NM1- Destination Payer Name

Usage	Ref Des.	Name	Code	Note
R	NM103	Destination Payer Name	Inland Empire Health Plan	"IEHP" is also acceptable
R	NM108	Identification Code Qualifier	PI	PI = Payer Identification
R	NM109	Payer Identifier	00303	IEHP

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Loop 2300CN1- Contract Information

Usage	Ref Des.	Name	Code	Note
R	CN101	Contract Type Code	01 02 05 09	01 = Diagnosis Related Group – DRG (Expected 2300_HI01-02 = DR and DRG code present) 02 = Per Diem 05 = Capitated 09 = Denied
R	CN102	Contract Paid Amount		Must match 2320_AMT02 when 2000B_SBR09 = MC

Loop 2320 -SBR- Other Subscriber Information

Usage	Ref Des.	Name	Code	Note
R	SBR01	Payer Responsibility Sequence Number Code	P	P = Primary
R	SBR02	Individual Relationship Code	18	18 = Self
S	SBR03	Group Number		Must Be Blank
S	SBR04	Group Name	CMC CCI	CMC = Dual Medicare Part A/B CCI = Dual Medicaid
R	SBR09	Claim Filing Indicator Code	MA MC	MA = Medicare Part A MC = Medicaid

Loop 2320 -AMT- Coordination of Benefits

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Usage	Ref Des.	Name	Code	Note
R	AMT01	Amount Qualifier Code	D	D = Payor Paid Amount
R	AMT01	Payer Paid Amount		

Loop 2330A -NM1- Other Subscribers Name

Usage	Ref Des.	Name	Code	Note
R	NM102	Entity Type Qualifier	1	1 = Person
R	NM108	Other Identification Code Qualifier	MI	MI = Member ID Number
R	NM109	Other Subscriber Primary ID		14-digit IEHP ID or Member Beneficiary ID (MBI)

Loop 2330B -NM1- Other Payer Name

Usage	Ref Des.	Name	Code	Note
R	NM103	Other Payer Last or Organization Name		Organization/Payer responsible for claim adjudication
R	NM108	Identification Code Qualifier	PI	PI = Payor Identification
R	NM109	Other Payer Primary Identifier		Must match 2430_SVD01

Loop 2430 -SVD- Service Line Adjudication Information

Usage	Ref Des.	Name	Code	Note
R	SVD01	Other Payer Primary Identifier		Must match 2330B_NM109

Trailer Segments

SE – Transaction Set Trailer

Usage	Ref Des.	Name	Code	Note
R	SE01	Number of Included Segments		Transaction Segment Count
R	SE02	Transaction Set Control Number		Must match the value in ST02

GE Segment – Functional Group Trailer

Usage	Ref Des.	Name	Code	Note
R	GE01	Number of Transaction Sets Included		
R	GE02	Group Control Number		Must match the value in GS06

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IEA Segment - Interchange Control Trailer

Usage	Ref Des.	Name	Code	Note
R	IEA01	Number of Included Functional Groups		A count of the number of functional groups included in a interchanges
R	IEA02	Interchange Control Number		A control number assigned by the interchange sender

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Frequently Asked Questions

Q1: How do you correct an Original (Freq. 1) encounter rejected by IEHP?
A1: If the initial encounter is rejected by IEHP, then send corrected encounter as Original.

Q2: How do you submit additional service lines not captured in the original (Freq. 1) encounter accepted by IEHP?
A2: Additional service line information identified as missing from the Original accepted encounter should be sent in a new encounter without the previously accepted service lines being included.

Q3: How do you submit corrections for encounters accepted by IEHP?
A3: If the Original encounter was accepted by IEHP and changes other that additional service lines (i.e. Provider NPI, DX Codes etc.) are needed, then first submit a Void (Freq.8), once the void has been accepted, submit the corrected encounter as an Original.

Q4: What is Encounter Data? Does it include any claims data submitted from providers to plans?
A4: Encounter Data comprises any claims data information showing the use of provider services by health plan enrollees that is used to develop cost profiles of a particular group of enrollees and then guide decisions about or provide justification for the adjustment of premiums.

Q5: What does adjudicated mean?

A5: Adjudicated is a term used to refer to the process of paying claims submitted or denying them after comparing claims to the benefit or coverage requirements.

Q6: Will revenue codes be a required field for encounter submissions?
A6: Yes, revenue codes will be a required field in the 5010 X12-837I format.

Q7: Are Submitters required to submit encounter data weekly or monthly?
A7: Currently, Submitters are required to submit encounter data monthly. However, IEHP strongly recommend that plans submit more frequently.

Q8: Will the National Provider Identification (NPI) number be required for claims submission?
A8: Yes, NPI will be required.

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Q9: Where do I find information on file naming conventions, connectivity protocol, and file transfer procedures?

A9: Please refer to the EDI manual published at http://ww2.iehp.org/IEHP/Providers/Information+Resources/HandbooksandManuals/EDIManual.htm for information regarding the above areas. For File Naming conventions see Section 6 Claims Processing Procedures and connectivity protocol see Section 2 Getting Started SFTP.

Q10: What is IEHP's policy on Billing Provider Address and 9-Digit Zip Codes?

A10: 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 Submitters.

Other Resources

IEHP's website where the EDI manual and other resources are located.

https://ww3.iehp.org/en/providers/provider-pnp-manual/

Washington Publishing Company Implementation guides (TR3) can be purchased from this site.

http://www.wpc-edi.com

Workgroup for Electronic Data Interchange in Healthcare.

http://www.wedi.org

CMS website that contains additional information and resources related to 5010.

http://www.cms.gov/Versions5010andD0/

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