9. IEHP 5010 837I INSTITUTIONAL MEDI-CAL ENCOUNTER COMPANION GUIDE

Standard Medi-Cal Companion Guide (CG) Transaction Information

Effective January1, 2020

IEHP Instructions related to Implementation Guides (IG) based on

ASC X12 Version 005010X223A2
Health Care Claim: Institutional

Companion Guide Version Number: 1.8
2020

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Introduction

The Purpose of the Companion Guide

This document will provide a definitive statement of what Submitters must be able to support in their ANSI ASC X12N 837I 00510X223A2 encounter files.

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

This document will provide specific Loops, Segments and Data Elements that are outlined for the 837I transactions 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. IEHP 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) / TE# area available for purchase from Washington Publishing Company http://www.wpc-edi.com.

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).

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.

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)

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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.

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:

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- 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

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	ISA11	Repetition Separator	^	Carat Repetition Separator
R	ISA12	Interchange Control Version Number	5010	ASC X12 Standard Approved
R	ISA14	Acknowledgment Requested	0	TA1 not provided

R	ISA15	Usage Indicator	P T	P = Production T = Test

GS Segment - Functional Group Header

Usage	Ref Des.	Name	Code/Definition	Length
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 -837- Header Segment

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	1/60
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 -NM1- Billing Provider Hierarchical Level – 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 Line 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

Usage	Ref Des.	Name	Code	Note
S	SBR03	Group Number		Must Be Blank
S	SBR09	Claim Filling Indicator Code	MC	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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Table 2- Patient Detail

2300 - CN1- Contract Information.

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

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
R	SBR09	Claim Filing Indicator Code	MC	MC = Medicaid

Loop 2320 -AMT- Coordination of Benefits

Usage	Ref Des.	Name	Code	Note
R	AMT01	Amount Qualifier Code	D	D = Payor Paid Amount
R	AMT01	Payer Paid Amount		
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 Client Identification Number (CIN)

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

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: What is Encounter Data? Does it include any claims data submitted from providers to plans?
A1: Encounter Data comprises any claims data information entered in the 5010 format.

Q2: What does "adjudicated" mean?

A2: Adjudicated claims are those that are approved accepted or denied claims.

Q3: Will revenue codes be a required field for encounter submissions?
A3: Yes, revenue codes will be a required field of the 5010 837 format**.**

Q4: Are Submitters required to submit encounter data weekly or monthly?
A4: Currently, Submitters are required to submit encounter data monthly. However, IEHP strongly recommend that plans submit more frequently.

Q5: Will the National Provider Identification (NPI) number be required for claims submission?
A5: Yes, NPI is required.

Q6: Where do I find information on file naming conventions, connectivity protocol, and file transfer procedures?

A6: 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.

Q7: What is IEHP's policy on Billing Provider Address and 9-Digit Zip Codes?
A7: 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.

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Q8: **Will IEHP new member ID Card start with a four (4)?**
A8: As of April 1, 2018 with IEHP Go-Live all NEW IEHP Member's ID numbers will start with a four (4). Keep in mind that if a Member was active in the past, they will retain the ID number they had when they originally were with IEHP, this is so that IEHP can maintain Member Continuity. In addition to IEHP member ID's ending in '00', new IEHP members will receive an auto numbered ID beginning with 4XXXXXXXXXXX00.

Q9: Why is CMS removing the Social Security Numbers (SSNs) from all Medicare Cards?

A9: CMS is taking the SSN off the Medicare cards is to fight medical identity theft for people with Medicare. By replacing the SSN-based HICN on all Medicare cards to protect Members.

Q10: What will the New MBI Medicare Beneficiary ID look like?

A10: The MBI will be different from the HICN and RRB number. The MBI will have 11-characters in length. The MBI will consist of numbers and uppercase letters no special characters.

Other Resources

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

http://www.wedi.org

Workgroup for Electronic Data Interchange in Healthcare.

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

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

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