Health Care Claims: Institutional (837)

Standard Companion Guide
Transaction Information

October 19, 2012
Version 1.0

Preface

Companion Guides (CGs) may contain two types of data: Instructions for electronic communications with the publishing entity (Communications/Connectivity Instructions) and supplemental information for creating transactions for the publishing entity while ensuring compliance with the associated ASC X12 IG (Transaction Instructions). Either the communications/connectivity component or the Transaction Instruction component must be included in every CG. The components may be published as separate documents or as a single document.

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Transaction Instruction (TI)

1. TI Introduction

1.1 Background

1.1.1 Overview of HIPAA Legislation

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 translations to enable health information to be exchanged electronically and to adopt specifications for implementing each standard HIPAA serves to:

- Create better access to health insurance
- Limit fraud and abuse
- Reduce administrative costs

1.1.2 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:

- Change the definition, data condition, or use of a data element or segment in a standard
- Add any data elements or segments to the maximum defined data set
- 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)
- Change the meaning or intent of the standard's implementation specification(s)

1.1.3 Compliance According to ASC X12

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

- Modifying any defining, explanatory, clarifying content (Section 1), example (Sections 2 and 3) or appendix (Section 4) information contained in the implementation guide
- Modifying any requirements, including loop, segment or element names, notes or rules, examples, appendix, or code list subsets from Section 2

1.2 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 requirements 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.

2. Included ASC X12 Implementation Guides

This table lists the X12N Implementation Guides for which specific transaction instructions apply and which are included in Section 3 of this document.

Unique ID	Name
005010X223	Health Care Claim: Institutional

3. Instruction Tables

The instruction tables contain a row for each segment where 005010X223 Health Care Claim: Institutional has something additional to convey.

In addition to the row for each segment, one or more additional rows are used to describe 005010X223 Health Care Claim: Institutional usage for composite and simple data elements and for any other information. Notes and comments should be placed at the deepest level of detail. For example, a note about a code value should be placed on a row specifically for that code value, not in a general note about the segment.

The following table specifies the columns and suggested use of the rows for the detailed description of the transaction set companion guides.

Legend
SHADED rows represent **segments** in the X12N implementation guide
NONSHADED rows represent **data elements** in the X12N implementation guide.

3.1 005010X223A2 Health Care Claim: Institutional

837 Health Care Claim: Institutional

Loop ID	Reference	Name	Codes	Notes/Comments
	ISA	Interchange Control Header		
	ISA01	Authorization Information Qualifier	00	'00' — No Authorization Information Present
	ISA03	Security Information Qualifier	00	'00' — No Security Information Present (No Meaningful Information in I04)
	ISA05	Interchange ID Qualifier	ZZ	'ZZ' — Mutually Defined
	ISA06	Interchange Sender ID		This field should include the Direct Submitter Trading partner ID assigned by Amerigroup.
	ISA07	Interchange ID Qualifier	ZZ	'ZZ' — Mutually Defined
	ISA08	Interchange Receiver ID	AMGP_<*State Abbreviation*>	'AMGP_<State Abbreviation>' The state abbreviation should represent the state in which the provider participates in the Medicaid program. Example: AMGP_TX
	GS	Functional Group Header		
	GS01	Functional ID Code	HC	'HC' Health Care Claim (837)

	GS02	Application Sender's Code		This will be equal to the value in ISA06.
	GS03	Application Receiver's Code		This will be equal to the value in ISA08.
	GS08	Version/Release/Industry ID Code		'005010X223A2'
	ST	Transaction Set Header		
	ST01	Transaction Set Identifier Code	837	'837' — Health Care Claim
	ST03	Implementation Convention Reference		'005010X223A2'
	BHT	Beginning of Hierarchical Transaction		
	BHT06	Transaction Type Code	CH	'CH' — Chargeable
1000A	NM1	Submitter Name		
1000A	NM109	Submitter Identifier		Populate with the 'DS' number provided at the time the trading partner agreement was executed.
1000B	NM1	Receiver Name		
1000B	NM103	Name Last or Organization Name		'Amerigroup'
1000B	NM108	Identification Code Qualifier	46	
1000B	NM109	Identification Number		'AMGP_<*State Abbreviation*>' The state abbreviation should represent the state in which the provider participates in the Medicaid or Medicare program.
2000A	PRV	Billing/Pay-to-Provider Information		

2000A	PRV03	Billing Provider Taxonomy Code		The taxonomy code may be mandatory based on the requirements of the state.
2010AA	NM1	Billing Provider, Individual or Organization Name		
2010AA	NM108	Billing Provider Identification Code Qualifier		Submitters in all states must provide the National Provider Identifier (NPI) of the billing Provider.
2010AA	N3	Billing Provider Address		
2010AA	N301 N302	Address Information		P.O. boxes are no longer acceptable. A claim must be submitted with a physical address. If a P.O. box is received, the claim will be rejected.
2010AA	N4	Billing Provider City/State/ZIP Code		
2010AA	N403	Billing Provider ZIP Code		Nine-digit U.S. postal ZIP code is required.
2000B	SBR	Subscriber Information		
2000B	SBR09	Claims Filing Indicator Code	CI	Value: CI
2010BA	NM1	Subscriber Name		
2010BA	NM102	Entity Type Qualifier	1	'1' — (Person)
2010BA	NM108	Identification Code Qualifier	MI	'MI' — Member Identification Number
2010BB		Payer Individual or Organizational Name		
2010BB	NM103	Payer Name		Amerigroup payer name
2010BB	NM108	Identification Code Qualifier		Payer identification code qualifier
2010BB	NM109	Payer Identifier		'AMGP_<*State Abbreviation*>'

				The state abbreviation should represent the state in which the provider participates in the Medicaid or Medicare program.
2010BB	REF	Payer Secondary Identification		
2010BB	REF01	Reference Identification Qualifier	G2	'G2' — Provider commercial number The Amerigroup provider ID can be submitted in this field if it is necessary in order to further define the provider rendering the service.
2300	CLM	Claim Information		
2300	CL101	Admission Type Code		Required when reporting hospital-based admissions. In the case of an Ohio newborn claim: When the claim admission type code is equal to 4, the value code must contain 54 in field 2300-HI01-2, and the admission source code must equal 5 — Born In Hospital or 6 — Born Outside Hospital in field 2300-CL102. Newborn birth weight must be present in field 2300-HI01-5.
2300	CL102	Admission Source Code		Required on all inpatient institutional claims. In the case of a newborn (admission type code=4), the process will validate the admission source code and must contain one of the following values: 1 — Born In Hospital 2 — Born Outside Hospital

2300	HI01-01	Code List Qualifier Code	BE	'BE' — value information
2300	HI01-02	Industry Code (Value Code)	54	In the case of an Ohio newborn claim: When the claim admission type code is equal to 4, the value code must contain 54 in field 2300-HI01-2, and the newborn birth weight must be present in field 2300-HI01-5. Value: 54
2300	HI01-05	Monetary Amount (Value Code Associated Amount)		In the case of an Ohio newborn claim: When the claim admission type code is equal to 4, then the value code must contain 54 in field 2300-HI01-2. The newborn birth weight must be present in field 2300-HI01-5. Value: Newborn birth weight
2300	HI01-09	Present on Admission Indicator	N, U, W, Y	N — No, U — Unknown, W — Not Applicable, Y — Yes Present on Admission Indicator required on all inpatient claims.
2310A		Attending Physician Individual or Organization		
2310A	NM109	Attending Provider Identifier		For all inpatient and home health claims, an attending physician and NPI are required on the claim.
2310B	NM1	Operating Physician Name		
2310B	NM109	Operating Physician Identification Number		Value; NPI
2310F		Referring Provider Name		
2310F	NM109	Referring Provider Identifier		Required on all Medicare-Related Home Health Agency (HHA) claims.

				Use the individual NPI of the physician who orders/refers services, not the NPI of the physician's group practice. A Group NPI is not allowed for the Referring Physician.
2400	SV202-1	Procedure/Service ID Qualifier	HC	Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes
2410		Drug Information		
2410	LIN	Drug Identification		
2410	CTP	Drug Identification Pricing Information		Required when it is necessary to provide a price specific to the NDC provided in LIN03 that is different from the price reported in SV203.

4. TI Additional Information

4.1 Payer-Specific Business Rules and Limitations

This section specifies the scenarios in which hard edits will be applied to all inbound Amerigroup claims. A claim failing one of these scenarios will result in a rejected claim, depending on the market requirements. If a claim is rejected due to compliance, the rejection is reported back to the submitter of the transaction within 24 hours or one business day after Amerigroup receives a claim. Providers are expected to provide the required information as per this guide and comply with the ASC X12N 837 5010 TR3's and its required data elements as mandated under HIPAA.

1. **HIPAA Transaction Compliance:** Incoming claims will be validated against Strategic National Implementation Process (SNIP) levels 1 through 6 of HIPAA compliance developed by SNIP. Claims rejected for HIPAA compliance are returned on a 999 and a 277CA to the appropriate clearinghouse. The clearinghouse in turn will communicate the rejection reason to the original submitter. Providers utilizing the direct submission portal will receive a submission detail report that will provide the number of claims rejected, along with the reason for rejection in addition to a 999 and 277CA.

2. **NPI requirements:** The billing NPI is required for professional and institutional claim submissions with the exception of atypical providers. The rendering provider's NPI is required if the billing and rendering are not the same. Claims rejected for these reasons will be reported back with a message stating **Missing or Invalid Provider NPI**.

3. **Taxonomy Requirement**: Taxonomy codes are required fields for claims billed for Texas and Kansas Medicaid claims. Claims submitted for Texas members must be submitted with the NPI and taxonomy code combination used in the attestation with the state. If the NPI and the taxonomy on the claim do not match the values registered with the state, the claim will be rejected.

4. **National Drug Code (NDC):** All Medicaid physician-administered and outpatient drug claims require the submission of the NDC, along with the Unit of Measure and the Quantity. Inpatient claims, and in some states 340B-qualified providers and Tribal Urban programs/Indian Health Services (ITU/IHS) services, are exempt from this requirement.

5. **Member ID:** Submitters can send either the **Amerigroup Member ID** (as given on the ID card) or the **State Medicaid Recipient ID** assigned to the member by their enrollment.

   A. **Amerigroup Member ID** will be either a nine-digit (including two trailing zeros) **or** an 11-digit numeric ID.

   B. **State Medicaid Recipient ID** will be in the following format:

   - FL — 10-digit numeric
   - GA — 12-digit numeric
   - KS — 11-digit numeric
   - LA — 13-digit numeric
   - MD — 11-digit alpha-numeric
   - NJ — 12-digit alpha-numeric
   - NM — 10-digit numeric
   - NV — 11-digit numeric
   - NY — 8-digit alpha-numeric
   - OH — 12-digit alpha-numeric
   - TX — 9-digit numeric
   - TN — 11-digit numeric
   - VA — 2-digit numeric
   - WA — 11-digit alpha-numeric

6. **Uppercase Versus Lowercase:** All alphabetic characters must be submitted in uppercase, including both alpha-numeric and ID data element types.

5. TI Change Summary

Date	Document Version	Author	Descriptions
10/2012	1.0		Updated as per WEDI/ASC X12 Standard Companion Guide Principles