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

Standard Medi-Cal Companion Guide (CG) Transaction Information

Effective January1, 2019

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: 1.8

This document Copyright © 2019 by Inland Empire Health Plan (IEHP) . All rights reserved. It may be freely redistributed in its entirety provided that this copyright notice is not removed. It may not be sold for profit or used in commercial documents without the written permission of the copyright holder. This document is provided "as is" without any express or implied warranty. Note that the copyright on the underlying ASC X12 Standards is held by IEHP on behalf of ASC X12.

2019 © Companion Guide copyright by Inland Empire Health

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

Table of Contents

Introduction 4

Implementation Usage 6

Implementation 6

- Interchange Control Header 10
  - ISA Segment - Interchange Control Header 11
  - GS Segment - Functional Group Header 12
- Table 1 - Header 12
  - ST -837- Header Segment 12
  - BHT - Beginning of Hierarchical Transaction 13
  - Loop 1000A -NM1-Submitter Name 13
  - Loop 1000A -PER- Submitter EDI Contact Information 14
  - Loop 1000B -NM1- Receiver Name 14
- Table 2 - Billing Provider Detail 15
  - Loop 2000A -HL- Billing Provider Hierarchical Level 15
  - Loop 2000A -PRV- Billing Provider Specialty Information 15
  - Loop 2010AA -NM1- Billing Provider Name Information 16
- Table 2 - Subscriber Detail 18
  - Loop 2000B -SBR- Subscriber Hierarchical Level 19
  - Loop 2010BA -NM1- Subscriber Name Information 20
  - Loop 2010BB -NM1- Payer Name 21
- Table 2 - Patient Detail 21
  - Loop 2300 -CLM- Claim Information 22
  - Loop 2310A -NM1- Attending Provider Information 27
  - Loop 2320 -AMT- Coordination of Benefits (COB) Payer Paid Amount 31
  - Loop 2330B -NM1- Other Payer Name 32
  - Loop 2400 -SV2- Service line Information 33
  - Loop 2430 -SVD- Line Adjudication Information 34
- Transaction Set Trailer 36

Fuctional Group Trailer 36
Interchange Control Trailer 36
Example 1- IPA Submitting Institutional Encounter Data 38
Example 2- Capitated Hospital Institutional Encounter Data 38
Frequently Asked Questions 38
Contact Information 39

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

Introduction

The Purpose of the Companion Guide

This document will provides a definitive statement of what Submitters must be able to support in this ANSI ASC X12N 837I Health Care Claims. This document is intended to outline the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its associated rules.

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

This document is to describe and provide you with specific Loops, Segments and Data Elements that are required to exchange X12N 837I transactions with 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.

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

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.

837I 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 Washington Publishing Company http://www.wpc-edi.com.

File Size Limitations

ISA/ IEA transaction sets should not exceed 5,000 encounters. IEHP Also, it is highly recommended that Submitters when submitting larger numbers of encounters within each ST/SE transaction set, not to exceed 5,000 encounters

IEHP Reports

999 - Functional Acknowledgment

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

Three (3) possible acknowledgement values are:
"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.

277CA – Claim Acknowledgement

The 277CA is used to acknowledge the acceptance or rejection of encounters submitted using a hierarchical level (HL) structure. The first level of hierarchical editing is at the Information Source level. The next level is at the Information Receiver level. The third hierarchal level is at the Billing Provider of Service level, and the fourth and final level is done at the Patient level. Edits received at any hierarchical level will stop and no further editing will take place.

Encounter Validation Response (EVR)

The response files will provide the following level of detail 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

- Invalid
- Valid
- Total Records Validated
- Validity

Phase 1(Inbound)

- Each test file must contain Twenty (25) encounters
- Each test files must pass Strutural validation must be 100% valid (999 Report)
- Validity must be 95% or higher (EVR Report)
- 999 and EVR report will be provided to the Submitter.

- Each Submitter must three (3) rounds of test files in order to move on the to Phase (2).

Phase 2 (Outbound)

- DHCS 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. For the purposes of error resolution. DHCS encourages plans to receive the EVR file at a minimum.
- DHCS requires that encounters to 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.

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

Detail Level

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.

- Client Identification Number (CIN) – 2010BA NM109
- Date(s) of Service – 2400 DTP*472 DTP03 (can be a range)
- Admission Date/Hour - 2300 DTP*435 DTP03 (can be a date or a date/time)
- Discharge Hour - 2300 DTP*096 DTP03

- 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.
- Revenue Code – 2400 SV201
- Procedure Code – 2400 SV201-2
- Procedure Modifier(s) – 2400 SV201-3,4,5,6
- 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.

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	No Authorization Sent “00” No	2/2
R	ISA02	Authorization Information	(Filled with spaces)	10/10
R	ISA03	Security Information Qualifier	No Security Information “00”	2/2
R	ISA04	Security Information	(Filled with Spaces)	10/10

R	ISA05	Interchange ID Qualifier	Mutually Defined “ZZ”	2/2
R	ISA06	Interchange Sender ID	Noted: IEHP Expected Value. Assigned 3 Digit Sender ID	15/15
R	ISA07	Code Identifying Receiver	Mutually Defined “ZZ”	2/2
R	ISA08	Interchange Receiver ID	Receiver ID “00303” Note: IEHP Expected Value IEHP Receiver ID	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	Version 5 Release 1 “5010”	5/5
R	ISA13	Interchange Control Number	The Interchange Control Number, ISA13, must be identical to the associated Interchange Trailer IEA02.	9/9
R	ISA14	Acknowledgment Requested	No Interchange Acknowledgment Requested “0”	1/1
R	ISA15	Usage Indicator	Production Data “P” Test “ T”	1/1
R	ISA16	Component Element Separator	Component Element Terminator Colon “ : ”	1/1
		Data Element Separator	Asterisk “ * ” Data Element Separator	
		Segment Terminator	Tilde “ ~ “ Segment Terminator	

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

GS Segment - Functional Group Header

Usage	Ref Des.	Name	Code/Definition	Length
R	GS01	Functional Identifier Code	Health Care Claim " HC"	2/2
R	GS02	Application Sender's Code	Noted: IEHP Expected Value. Assigned 3 Digit Sender ID	2/15
R	GS03	Application Receiver's Code	IEHP Receiver ID "00303" Note: IEHP Expected Value IEHP Receiver ID	2/15
R	GS04	Date	Date of Transmission "CCYYMMDD "	8/8
R	GS05	Time	Time of Transmission, 24 Hour Format "HHMM"	4/8
R	GS06	Group Control Number	GS06 must be unique within a single transmission that is, within a single ISA to IEA enveloping structure. Note: IEHP Expected Value GS06 be unique within all transmission over a period of time to be determined by the sender	1/9
R	GS07	Responsible Agency Code	Accredited Standards Committee X12 "X"	1 / 2
R	GS08	Version/Release/Industry Identifier Code	"005010X223A2"	1/12

BHT – Beginning of Hierarchical Transaction

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

Usage	Ref Des.	Name	Code/Definition	Length
R	BHT01	Beginning of Hierarchical Transaction	Information Source, Subscriber, Dependent "0019"	4/4
R	BHT02	Transaction Set Purpose Code	Original "00" Note: IEHP Expected Value	2/2
R	BHT03	Reference Identification	The BHT03 is the number assigned by the originator to identify the transaction within the originator's business application system	1/50
R	BHT04	Date	Transaction Set Creation Date	8/8
R	BHT05	Time	Transaction Set Creation Time	4/8
R	BHT06	Transaction Type Code	Reporting " RP" Note: IEHP Expected Value	2/2

Loop 1000A -PER- Submitter EDI Contact Information

Usage	Ref Des.	Name	Code/Definition	Length
R	PER01	Contact Function Code	Information Contact "IC" Note: IEHP Expected Value	2/2
S	PER02	Name	Submitter Contact Name	1/60
R	PER03	Communication Number Qualifier	Telephone "TE" Note: IEHP Expected Value	2/2
R	PER04	Communication Number		1/256

Usage	Ref Des.	Name	Code/Definition	Length
S	PER05	Communication Number Qualifier	Email Address “EM”	2/2
S	PER06	Communication Number		1/256
S	PER07	Communication Number Qualifier	Submitter’s Fax Number “ FX”	2/2
S	PER08	Communication Number		1/256
N	PER09	Contact Inquire Reference		1/20

Loop 1000B -NM1- Receiver Name

Usage	Ref Des.	Name	Code/Definition	Length
R	NM101	Entity Identifier Code	Receiver “40”	2/3
R	NM102	Entity Type Qualifier	Non-Person Entity “2”	1/1
R	NM103	Name Last or Organization Name	Inland Empire Health Plan “IEHP” Note: IEHP Expected Value	1/60
N	NM104	Name First		1/35
N	NM105	Name Middle		1/25
N	NM106	Name Prefix		1/10
N	NM107	Name Suffix		1/2
R	NM108	Identification Code Qualifier	Electronic Transmitter Identification Number (ETIN) “46”	1/2

Usage	Ref Des.	Name	Code/Definition	Length
R	NM109	Identification Code	Receiver Primary Identifier "00303" Note: IEHP Expected Value Should match ISA06 and GS03	2/80

Table 2-Billing Provider DetailLoop 2010AA -NM1- Billing Provider Name

Usage	Ref Des.	Name	Code/Definition	Length
R	NM101	Entity Identifier Code	Billing Provider "85"	2/3
R	NM102	Entity Type Qualifier	Person "1" Non-Person Entity "2"	1/1
R	NM103	Name Last or Organization Name		1/60
N	NM104	Name First	Billing Provider First Name	1/35
N	NM105	Name Middle	Billing Provider Middle Name or Initial	1/25
N	NM106	Name Prefix		1/25
N	NM107	Name Suffix	Billing Provider Name Suffix	1/10
S	NM108	Identification Code Qualifier	Centers for Medicare and Medicaid Services National Provider Identifier "XX"	1/2
S	NM109	Identification Code	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 Note: IEHP Expected Value Physical Address	1/55
S	N302	Address Information	Billing Provider Address Line Note: IEHP Expected Value 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	Billing Provider State or Province Code "CA" NOTE: IEHP Expected Value.	2/2
S	N403	Postal Code	Billing Provider Postal Zone or Zip Note: IEHP Expected Value. Full (9) digit Zip Code required. If last (4) digits are not available, populate with "9998".	3/15
S	N404	County Code		2/3
N	N405	Location Qualifier		1/30
N	N406	Location Identifier		1/3
S	N407	Country Subdivision Code		

Table 2- Subscriber Detail

Loop 2000B -SBR- Subscriber Information

Usage	Ref Des.	Name	Code/Definition	Length
R	SBR01	Payer Responsibility Sequence Number Code	Secondary "S"	1/1
R	SBR02	Individual Relationship Code	Self "18"	2/2
S	SBR03	Reference Identification	Note: IEHP Expected Value SBR03& SBR04 Must Not Be Used Simultaneously	1/50
S	SBR04	Name	Medical "MED" Note: IEHP Expected Value SBR04 & SBR03) Must Not Be Used Simultaneously	1/60
N	SBR05	Insurance Type Code		1/3
N	SBR06	Coordination of Benefits Code		1/1
N	SBR07	Yes/ No Condition or Response Code		1/1
D	SBR08	Employment Status Code		2/2
S	SBR09	Claim Filling Indicator Code	Medical "MC" Note: IEHP Expected Value.	1/2

Loop 2010BA –NM1 - Subscriber Name

Usage	Ref Des.	Name	Code/Definition	Length
R	NM101	Entity Identifier Code	Insured or Subscriber "IL"	2/3
R	NM102	Entity Type Qualifier	Person "1" Note: IEHP Expected Value.	1/1
R	NM103	Name Last or Organization Name	Subscriber Last Name	1/60
S	NM104	Name First	Subscriber First Name	1/35
S	NM105	Name Middle	Subscriber Middle Name or Initial	1/25
N	NM106	Name Prefix		1/10
S	NM107	Name Suffix	Subscriber Name Suffix	1/10
S	NM108	Identification Code Qualifier	Member Identification Number "MI" Note: IEHP Expected Value	1 / 2
S	NM109	Identification Code	Note: IEHP Expected Value must equal the *IEHP-14-digit IEHP ID or Client Identification Number (CIN)	2/80
N	NM110	Entity Relationship Code		2/2
N	NM111	Entity Identifier Code		2/3
N	NM112	Name Last or Organization Name		1/60

Loop 2010BB -NM1- Payer Name

Usage	Ref Des.	Name	Code/Definition	Length
R	NM101	Entity identifier Code	Payer “PR”	2/3
R	NM102	Entity Type Qualifier	Non- Person Entity “2”	1/1
R	NM103	Payer Name	“IEHP” or “Inland Empire Health Plan” Note: IEHP Expected Value	1 /60
N	NM104	Name First		1/35
N	NM105	Name Middle		1/25
N	NM106	Name Prefix		1/10
N	NM107	Name Suffix		1/10
R	NM108	Identification Code Qualifier	Payer Identification “PI” Note: IEHP Expected Value	1/2
R	NM109	Identification Code	IEHP Receiver ID“00303” Note: IEHP Expected Value.	2/8
N	NM110	Entity Relationship Code		2/2
N	NM111	Entity Identifier Code		2/3
N	NM112	Name Last or Organization Name		1/60

Loop 2010BB -REF- Billing Provider Secondary Identification

Usage	Ref Des.	Name	Code/Definition	Length
R	REF01	Reference Identification Qualifier	Provider Commercial Number “G2” Note: IEHP Expected Value.	2/3

Usage	Ref Des.	Name	Code/Definition	Length
			This is to be used by all payers including Medicare, Medicaid, and Blue Cross etc.	
R	REF02	Reference Identification	Billing Provider Secondary Identifier	1/50
N	REF03	Description		1/80
N	REF04	Reference Identifier		1/80

Table 2-Patient Detail**2300 - PWK - Claim Supplemental Info**

Usage	Ref Des.	Name	Code/Definition	Length
S	PWK01	Report Type Code	Populated for chart review submissions only “09” Populated for encounters generated as a result of paper claims “0Z” Populated for encounters generated as a result of 4010 submission only “PY” Note: IEHP Expected Values	2/2
S	PWK02	Attachment Transmission Code	Populated for chart review “AA” Note: IEHP Expected Value	1/2
N	PWK03	Report Copies Needed		1 / 2
N	PWK04	Entity Identifier Code		2/3
N	PWK05	Identification Code Qualifier	Required when PWK02 “ BM, EL, EM, FX or FT” Note: IEHP Expected Values	1 / 2

Usage	Ref Des.	Name	Code/Definition	Length
S	PWK06	Identification Code	Required when PWK02 "BM, EL, EM, FX or FT" Note: IEHP Expected Values	2/80
N	PWK07	Description		1/80
N	PWK08	Action Indicated		1/80
N	PWK09	Request Category Code		1 / 2

2300 -CL1- Institutional Claim Code

Usage	Ref Des.	Name	Code/Definition	Length
R	CL101	Admission Type Code	Emergency "1" Urgent "2" Elective "3" Newborn "4" Reserved "6" Reserved "7" Reserved "8" Unknown "9" Note: IEHP Expected Values.	1/1
R	CL102	Admission Source Code	Note: Required for all inpatient and outpatient services.	1/1
R	CL103	Patient Status Code		1 / 2
N	CL104	Nursing Home Residential Status Code		1/1

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

2300 - CN1- Contract Information

Note: Required when the submitter is contractually obligated to supply this information on post-adjudicated claims.

Usage	Ref Des.	Name	Code/Definition	Length
R	CN101	Contract Type Code	Diagnosis Related Group (DRG) “01 “ Paid “02” Capitated “05” Denied “09” Note: IEHP Expected Values	2/2
R	CN102	Monetary Amount	Required when the provider is required by contract to supply this information on the claim Note: IEHP Expected Values	1/18
S	CN103	Percent, Decimal Format	Contract Percentage	1/6
S	CN104	Reference Identification	Contract Code	1/50
S	CN105	Terms Discount Percent	Terms Discount Percentage	1/6
S	CN106	Version Identifier	Contract Version Identifier	1/30

2300 -REF- Payer Claim Control Number

Usage	Ref Des.	Name	Code/Definition	Length
R	REF01	Reference Identification Qualifier	Original Reference Number “F8”	2/3
R	REF02	Reference Identification	Payer Claim Control Number Note: IEHP Expected Value.	1/50

Usage	Ref Des.	Name	Code/Definition	Length
N	REF03	Description		1/80
N	REF04	Reference Identifier		1/80

2300 -REF- Claim Identifier for Transmission Intermediaries

Usage	Ref Des.	Name	Code/Definition	Length
R	REF01	Reference Identification Qualifier	Claim Number "D9"	2/3
R	REF02	Reference Identification	Value Added Network Trace Number	1/50
N	REF03	Description		1/80
N	REF04	Reference Identifier		1/80

Loop 2400 -SV2- - Institutional Service Line

Usage	Ref Des.	Name	Code/Definition	Length
R	SV201	Service Line Revenue Code	Note: IEHP Expected Value. Revenue must be a valid four (4-digit) Revenue Code	1/48
R	SV202-1	Product/Service ID Qualifier	HCPCS Code "HC"	2/3
R	SV202-2	Procedure Code/ Service ID	Procedure Code	1/48
S	SVD202-3	Procedure Modifier		2/2

Usage	Ref Des.	Name	Code/Definition	Length
S	SVD202-4	Procedure Modifier		2/2
S	SVD202-5	Procedure Modifier		2/2
S	SV202-6	Procedure Modifier		2/2
S	SV202-7	Description		1/80
N	SV202-8	Product/Service ID		1/48
R	SV203	Monetary Amount	Line Item Charge Amount	1/18
R	SV204	Unit or Basis Measurement Code	Days “DA” Unit “UN”	2/2
R	SV205	Quantity	Service Unit Count	1/15
N	SV206	Unit Rate		1/10
S	SV207	Monetary Amount	Line Item Denied Charge or Non-Covered Charge Amount	1/18
N	SV208	Yes/No Condition or Response Code		1/1
N	SV209	Nursing Home Residential Status Code		1/1
N	SV210	Level of Care Code		1/1

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	The Transaction Set Control Number in ST02 and SE02 must be identical. The number must be unique within a specific Interchange (ISA-IEA), but can repeat in other interchanges	4/9

GE Segment – Functional Group Trailer

Usage	Ref Des.	Name	Code/Definition	Length
R	GE01	Number of Transaction Sets Included	Total number of transaction sets included in the functional group or interchange transmission group terminated by the trailer containing this data element	1/6
R	GE02	Group Control Number	The data interchange control number GE02 in this trailer must be identical to the same element in the associated functional group header, GS06.	1/9

IEA- Interchange Control Trailer

Usage	Ref Des.	Name	Code/Definition	Length
R	IEA01	Number of Included Functional Groups	A count of the number of functional groups included in a interchanges	1/5
R	IEA02	Interchange Control Number	A control number assigned by the interchange sender	9/9

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

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 will be 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.

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.

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

Contact Information

Encounter Data Group Address:

EncounterData@iehp.org

Veronica Aleman

IT- Specialist Encounter Data Lead
(909) 890-2091
Aleman-V@iehp.org

Kevin Johnson

IT- Specialist Encounter Data III
(909)-727-5249
Johnson-K@iehp.org

Neftali Rivera
Database Specialist I
(909)-727-5110
rivera-n@iehp.org

Audrey Kelley
Encounter Data Manager
(951) 374-3376
kelley-A@iehp.org