10. IEHP 5010 837P PROFESSIONAL IEHP DUALCHOICE ENCOUNTER COMPANION GUIDE

Standard CMC Companion Guide (CG) Transaction Information

Effective January 01, 2019

IEHP Instructions related to Implementation Guides (IG) based

837 Health Care Claim: Professional Transaction based on ASC X12 Technical Report Type 3 (TR3), Version 005010X222A1

Companion Guide Version Number: 1.8

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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 837P 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 will outline and provide specific Loops, Segments and Data Elements that are outlined for transactions exchanged 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.

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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.

837 Health Care Claim: Professional 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

Functional Acknowledgement/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.

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277CA – Claim Acknowledgement

After the file accepts at the interchange and functional group levels, the third level of editing occurs at the transaction set level in order to create the Claim Acknowledgement Transaction (277CA) report. To checks the validity of the values within the data elements. For instance, data element N403 must be a valid nine (9)-digit ZIP code. If a non-existent ZIP code is populated, the IEHP will reject the claims. The 277CA is an unsolicited acknowledgement report from

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 (999 Acknowledgement Transaction Sets)
- Record Count
- Rejected
- Accepted

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

Stage 3 - Validity
- Invalid
- Valid
- Total Record Validated
- Validity

Duplicate Encounters Logic

In order to ensure claim submitted are not duplicates of claim 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 Professional service line, a duplicate would have the same following values as a previously submitted service line.

Currently, the following values are the minimum set of items used for matching an encounter in the IEHP EDPS

- Client Identification Number (CIN) – 2010BA NM109
- Date(s) of Service – 2400 DTP*472 DTP03 (can be a range)
- Rendering Provider – can be sourced from a variety of places

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.

- Procedure Code – 2400 SV101-2
- Procedure Modifier(s) – 2400 SV101-3,4,5,6
- 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.

End to End Testing Requirements

Phase 1 (Inbound)

- File containing Twenty (25) encounters
- Files Sturcture must be 100% valid (999 Report)
- Validity must be 95% or higher (EVR Report)
- Results will be provided to the Submitters
- Three (3) rounds of test files will be required to move on the to Phase Two (2) testing

Phase 2 (Outbound)

- File containing Twenty (25) encounters will be uploaded to CMS test environment
- Files Sturcture must be 100% valid (999 Report)
- 277CA Claim Acknowledgement

- MA0-001 Encounter Data Duplicate Report
- MAO-002 Encounter Data Processing Status Report
- MAO-004 Encounter Data Diagnoses Eligible for Risk Adjustment

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).

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	3 Digit ID assigned by IEHP	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	Interchange Usage Indicator	T = Test P = Production	1/1
R	ISA16	Component Element Separator	Colon : Component Element Terminator	1/1
R		Data Element Separator	Asterisk * Data Element	
R		Segment Terminator	Tilde= ~ Segment Terminator	

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	005010X222A1	1/12

Table 1-Header

ST -837- Header Segment

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Usage	Ref Des.	Name	Code/Definition	Length
R	ST01	Transaction Code of document	837 = Health Care Claim: Professional	3/3
R	ST02	Transaction 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
R	ST03	Implementation Guide Version Name	005010X222A1	1/35

BHT – Beginning of Hierarchical Transaction

Usage	Ref Des.	Name	Code/Definition	Length
R	BHT01	Hierarchical Structure Code	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	Transaction Type Code	RP- Reporting	2/2

Loop 1000A- NM1-Submitter Name

Usage	Ref Des.	Name	Code/Definition	Length
R	NM101	Entity Identifier Code	41=Submitter	2/3
R	NM102	Entity Type Qualifier	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
R	NM108	Identification Code Qualifier	46= Electronic Transmitter Identification Number (ETIN)	½
R	NM109	Identification Code	Assigned by IEHP. Same as GS02 and ISA06.	2/80

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	Compliant, (10) digit, phone number when PER03 = “TE”. Telephone extensions can be identified in PER05 and listed in PER06 if necessary.	1/256
S	PER05	Communication Number Qualifier	“EM” It is recommended that Submitters populate the submitter’s email address.	2/2
S	PER06	Communication Number	List valid email address when PER05 = “EM”.	1/256
S	PER07	Communication Number Qualifier		2/2
S	PER08	Communication Number		

Loop 1000B -NM1- Receiver Name

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)	2/80
R	NM109	Identification Code	00303= Receiver Primary Identifier Same as GS03 and ISA08. IEHP's Receiver ID.	2/80

Table 1-Billing Provider Detail

Loop 2000A –HL- Billing Provider Hierarchical Level

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	Payer Responsibility Sequence Number Code	BI= Billing	1/3

Usage	Ref Des.	Name	Code/Definition	Length
R	PRV02	Reference Identification Qualifier	PXC= Health Care Provider Taxonomy Code	2/3

Loop 2010AA NM1- Billing Provider Name

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 In most instances the Rendering Provider NPI MUST have an Entity Type Qualifier = 1 (Person). If the Billing Provider NPI is an Organization (Entity Type = 2), the Rendering Provider segment will likely be required.	1/1
R	NM103	Name Last or Organization Name	Billing Provider Last or Organizational 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	NM108	Identification Code Qualifier	XX= Centers for Medicare and Medicaid Services National Provider Identifier	1/2
S	NM109	Identification Code	Must be a valid 10 digit NPI. Will be validated against the NPPES file.	2/80

Loop 2010AA N3- Billing Provider Address

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

Usage	Ref Des.	Name	Code/Definition	Length
S	N302	Address Information	Billing Provider Address Line	1/55

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

Usage	Ref Des.	Name	Code/Definition	Length
R	N401	City Name	Billing Provider City Name Street address required. Post Office Box NOT allowed.	2/30
S	N403	Postal Code	Billing Provider Zone or Zip Code	3/15
S	N404	Country Code	US the alpha-2 country codes	2/3
S	N407	Country Subdivision 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"	1/3

Loop 2010AA -REF- Billing Provider Tax Identification

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

Table 2-Subscriber Detail

Loop 2000B -SBR- Subscriber Information

Usage	Ref Des.	Name	Code/Definition	Length
R	SBR01	Payer Responsibility Sequence Number	S= Secondary	1/1
S	SBR02	Individual Relationship Code	18= Self	2/2
S	SBR03	Reference Identification	Must be blank	1/50
S	SBR04	Name	CMC= Medicare Part B CCI= Medicaid	1/60
S	SBR05	Insurance Type Code	Must be blank	1/3
S	SBR09	Claim Filing Indicator Code	MB= Medicare Part B MC= Medicaid	1/2

Loop 2010BA NM1- Subscriber Name

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 2= Non- Person Entity	1/60
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 First Middle	1/25
S	NM108	Identification Code Qualifier	MI = Member Identification Number	1/2
S	NM109	Identification Code	Must equal the **14-digit IEHP ID number, CIN (Medi-Cal ID), MBI will be used for Medicare members.	2/80

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	Name Last or Organization Name	IEHP or Inland Empire Health Plan	1/60
R	NM108	Identification Code Qualifier	PI= Payer Identification	1/2
R	NM109	Identification Code	"00303" Must be a unique number when Claim Frequency Type Code (CLM05-3) = "1".	2/80

Table 1-Patient Detail

Loop 2300 CLM- Claim Information

Usage	Ref Des.	Name	Code/Definition	Length
R	CLM01	Patient Control Number	Patient Control Number Must be a unique number when Claim Frequency Type Code (CLM05-3) = "1".	1/38
R	CLM02	Monetary Amount	Total Claim Charge Amount Must balance to the sum of all SV1-02 (Service line in Loop 2400) NOTE: No Leading Zero Allowed	1/18
R	CLM05-3	Claim Frequency Type Code	1 = Original claim submission 7 = Adjustment 8 = Void	1/1

Loop 2300 CN1- Contract Information

Usage	Ref Des.	Name	Code/Definition	Length
R	CN101	Contract Type Code	02 = Per Diem (Paid) 05 = Capitated (Capitated) 09 = Other (Denied) If the Encounter consists of more than (1) Service Line, follow this guideline. At least (1) Service Line is paid (Loop 2430 SVD02 > 0), the Encounter is "Paid". At least (1) Service Line is Capitated (Loop 2430 SVD02 = 0) and there are other Service Lines that are Denied, the Encounter is "Capitated". All Service Lines are Denied (Loop 2430 SVD02 = 0 and CAS02 includes a valid denial reason), the Encounter is "Denied". Must be in line with SVD02 and CAS02.	2/2
S	CN102	Monetary Amount	Contract Amount Must match AMT02 in loop 2320 and the sum of all SVD02 segments in Loops 2430.	1/18

Loop 2300 REF- Payer Claim Control Number

Usage	Ref Des.	Name	Code/Definition	Length
R	REF01	Reference ID Qualifier	F8 = Original Reference Number	2/3
R	REF02	Reference Identification	Payer Claim Control Number This must be the PCN (Loop 2300 CLM01) of the encounter that is being replaced (Loop 2300 CLM05-3 = "7") or voided (Loop CLM05-3 = "8").	1/50

Loop 2300 REF- Claim Identifier for Transmission Intermediaries

Usage	Ref Des.	Name	Code/Definition	Length
R	REF01	Reference Identification Qualifier	D9= Claim Number	2/3
R	REF02	Reference Identification	Value Added Network Trace Number Unique number. Use the same number from Loop 2300, CLM01.	1/50

Loop 2300 HI- Health Care Diagnosis Code

Usage	Ref Des.	Name	Code/Definition	Length
R	HI01	Health Care Code Information	Value Added Network Trace Number Unique number. Use the same number from Loop 2300, CLM01.	2/2
R	HI01-1	Code List Qualifier Code	ABK= (ICD-10-CM) Principal Diagnosis BK= (ICD-9-CM) Principal Diagnosis	1/3
R	HI01-2	Industry Code	Diagnosis Code	1/30

Loop 2310A NM1- Referring Provider

Usage	Ref Des.	Name	Code/Definition	Length
R	NM101	Entity Identifier Code	DN= Referring Provider P3= Primary Care Provider	2/3
R	NM102	Entity Type Qualifier	1= Person	1/1
R	NM103	Name Las or Organization Name	Referring Provider Last Name	1/60
S	NM104	Name First	Referring Provider First Name	1/35

Usage	Ref Des.	Name	Code/Definition	Length
S	NM105	Name Middle	Referring Provider Middle Name or Initial	1/25
S	NM107	Name Suffix	Referring Provider Name Suffix	1/10
S	NM108	Identification Code Qualifier	XX= Centers for Medicare and Medicaid Services National Provider Identifier	1 / 2
S	NM109	Identification Code	Referring Provider Identifier	2/80

Loop 2310B NM1- Rendering Provider Name

Usage	Ref Des.	Name	Code/Definition	Length
R	NM101	Entity Identifier Code	82= Rendering Provider	2/3
R	NM102	Entity Type Qualifier	1= Person 2= Non-Person Entity	1/1
R	NM103	Name Last or Organization Name	Rendering Provider Last or Organization Name	1/60
S	NM108	Identification Code Qualifier	XX= Center for Medicare and Medicaid Services National Provider Identifier	1/2
S	NM109	Identification Code	Must be a valid 10 digit NPI.	2/80

Loop 2310B PRV- Rendering Provider Specialty Information

Usage	Ref Des.	Name	Code/Definition	Length
R	PRV01	Provider Code	PE= Performing	1/3
R	PRV02	Reference Identification Qualifier	PXC= Health Care Provider Taxonomy Code	2/3

Usage	Ref Des.	Name	Code/Definition	Length
R	PRV03	Reference Identification	Provider Taxonomy Code Taxonomy Code Required when Rendering Provider differs from Billing Provider. Failure to include an accurate Taxonomy Code will result in inaccurate attribution of Encounters Note: This is requested in order to possibly qualify for the P4P Program	1/50

Loop 2310C NM1- Service Facility Location Name

Usage	Ref Des.	Name	Code/Definition	Length
R	NM101	Entity Identifier Code	77= Service Location Required when the location is different than the billing provider	2/3
R	NM102	Entity Type Qualifier	2 = Non-Person Entity	1/1
R	NM103	Name Las or Organization Name	Laboratory or Facility Primary Identifier Must be a valid 10 digit NPI.	1/60
S	NM108	Identification Code Qualifier	XX= Centers for Medicare and Medicaid Service National Provider Identifier	1 / 2
S	NM109	Identification Code	Laboratory or Facility Primary Identifier WHEN REQUIRED - Must be a valid 10 digit NPI. Will be validated against the NPPES file.	2/80

Loop 2310E NM1- Ambulance Pick-up Location

NOTE: This loop is Only Required When the POS is Either 41 or 42.

Usage	Ref Des.	Name	Code/Definition	Length
R	NM101	Entity Identifier Code	PW = Pickup Address	2/3
R	NM102	Entity Type Qualifier	2 = Non-Person Entity	1/1

Loop 2310E N3- Ambulance Pick-up Location Address

Usage	Ref Des.	Name	Code/Definition	Length
R	N301	Address Information	Ambulance Pick-up Address Line	1/55
S	N302	Address Information	Ambulance Pick-up Address Line	1/55

Loop 2310E N4- Ambulance Pick-up Location City, State, Zip Code

Usage	Ref Des.	Name	Code/Definition	Length
R	N401	City Name	Ambulance Pick-up City Name	2/30
S	N402	State or Province Code	Ambulance Pick-up State or Province Code	2/2
S	N403	Postal Code	Ambulance Pick-up Postal Zone or Zip Code	3/15
S	N404	Country Code	Ambulance Pick Up Postal Code	2/3

Loop 2310F N3- Ambulance Drop-Off Location Address

Usage	Ref Des.	Name	Code/Definition	Length
R	N301	Address Information	Address Information	1/55
S	N302	Address Information	Address Information	1/55

Loop 2310F -NM1- Ambulance Drop-Off Location

NOTE: This loop is Only Required When the POS is Either 41 or 42.

Usage	Ref Des.	Name	Code/Definition	Length
S	NM101	Entity Identifier Code	45 = Drop Off Location	2/3
S	NM102	Entity Type Qualifier	2 = Non-Person Entity	1/1
S	NM103	Name Last or Organization Name	Required when drop-off location name is known	1/60

Loop 2310F –N3- Ambulance Drop-Off Location Address

Usage	Ref Des.	Name	Code/Definition	Length
S	N301	Address Information	Ambulance Drop-Off Address Line	1/55
S	N302	Address Information	Second Address Line	1/55

Loop 2310F N4- Ambulance Drop-Off Location City, State, Zip Code

Usage	Ref Des.	Name	Code/Definition	Length
R	N401	City Name	Ambulance Drop-Off City Name	2/30
S	N402	State or Province Code	Ambulance Drop-Off State of Province Code	2/2
S	N403	Postal Code	Ambulance Drop-Off Postal Zone or Zip Code	3/15
S	N404	County Code	Us the alpha-2 county codes from Part 1 of ISO 3166.	2/3
S	N407	Country Subdivision Code	Use the country subdivision codes from Part 2 of ISO 3166.	1/3

Loop 2320 SBR- Other Subscriber Information

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	2/2
S	SBR03	Reference Identification	Insured Group or Policy Number	1/50
S	SBR04	Name	Other Insured Group Name	1/60

Usage	Ref Des.	Name	Code/Definition	Length
S	SBR05	Insurance Group Name		1/3
S	SBR09	Claim Filing Indicator Code	MB= Medicare Part B	1/2

Loop 2320 AMT- Payer Paid Amount

Usage	Ref Des.	Name	Code/Definition	Length
R	AMT01	Amount Qualifier Code	D= Payer Amount Paid Must be populated with a value of D – Payer Amount Paid	1/3
R	AMT02	Monetary Amount	Payer Paid Amount Medicare-Medicaid Plan paid amount Must match CN102 in loop 2300 and sum of all SVD02 segments in loops 2430.	1/18

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	Name Last or Organization Name	Other Payer 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 Qualifier	PI= Payer Identification	1/2
R	NM109	Identification Code	Other Payer Primary Identifier	2/80

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

Loop 2330B -REF01- AMT- Payer Paid Amount

Usage	Ref Des.	Name	Code/Definition	Length
R	REF01	Reference identification Qualifier	FY= Claim Office Number	1/3

Loop 2400 -SV1- Professional Service

Usage	Ref Des.	Name	Code/Definition	Length
R	SV101-1	Product/Service ID Qualifier	HC= HCPCS Codes	2/2
R	SV101-2	Product/Service ID	Identity number for a product or service.	1/48
R	SV102	Monetary Amount	Line item charge amount. NOTE: No Leading Zero Allowed	1/18
R	SV103	Unit or Basis for Measurement Code	MJ = Minutes UN = Unit	2/2
R	SV107	Composite Diagnosis Code Pointer	To identify one or more deiagnosis code pointers	1
R	SV107-7	Diagnosis Code Pointer	Pointer to the diagnosis code in the order of importance to this service	1/2

Loop 2400 -CN1- Contract Information

Usage	Ref Des.	Name	Code/Definition	Length
R	CN101	Contract Type Code	02 = Per Diem (Paid) 05 = Capitated (Capitated) 09 = Other (Denied)	2/2

Usage	Ref Des.	Name	Code/Definition	Length
			Must be in line with SVD02 and CAS01, CAS02 and CAS03.	

Loop 2420A -NM1- Rendering Provider Name

Usage	Ref Des.	Name	Code/Definition	Length
R	NM101	Entity Identifier Code	82= Rendering Provider	2/3
R	NM102	Entity Type Qualifier	1= Person 2= Non-Person Entity	1/1
R	NM103	Name Last or Organization Name	Rendering Provider Last or Organization Name	1/60
S	NM104	Name First	Rendering Provider First Name	1/35
S	NM105	Name Middle	Rendering Provider Middle Name or Initial	1/25
S	NM107	Name Suffix	Rendering Provider Name Suffix	1/10
S	NM108	Identification Code Qualifier	XX= Centers for Medicare and Medicaid Services National Provider Identifier	1/ 2
S	NM109	Identification Code	Must be a valid 10 digit NPI.	2/80

Loop 2420A -PRV-Rendering Provider Specialty Information

Usage	Ref Des.	Name	Code/Definition	Length
R	PRV01	Provider Code	PE-Performing	1/3
R	PRV02	Reference Identification Qualifier	PXC- Health Care Provider Taxonomy Code	2/3
R	PRV03	Reference Identification	Provider Taxonomy Code	1/50

Loop 2430 -SVD- Line Adjudications Information

Usage	Ref Des.	Name	Code/Definition	Length
R	CAS01	Identification Code	Other Payer Primary Identifier	2/80
R	SVD02	Monetary Amount	Service Line Paid Amount	1/18

Loop 2430 -CAS-Line Adjustments

Usage	Ref Des.	Name	Code/Definition	Length
R	CAS01	Claim Adjustment Group Code	CO= Contractual Obligations CR= Correction and Reversals OA= Other Adjustments PI= Payor Initiated Reductions Pr= Patient Responsibility	1/2
R	CAS02	Claim Adjustment Reason Code	Adjustment Reason Code If a claim is denied in the MAOs' adjudication system, the denial reason must be populated	1/5

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	2/3
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

IEA Segment - Interchange Control Trailer

Usage	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

Business Scenarios

Example 1- IPA Submitting Professional Encounter Data

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Encounter data must be submitted by IPAs for all covered services provided to assigned Capitated members. Covered services include PCP visits as well as sub capitated 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 CMS regulations, IEHP requires Providers to submit encounter data within ninety (90) days of each month end.

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

Frequently Asked Questions

Q: What is encounter file? Does it include any claims data submitted from provider to plans?

A: Encounter Data comprises any claims data information entered in the 5010 format with only adjudicated claims.

Q: Are Submitters required to submit all data with the exception of claim routed incorrectly and denied for a member not being on file?

A: All Submitters must submit all data that has been paid or denied from all types of service to IEHP for the collection of Encounter Data.

Q: Will the National Provider Identification (NPI) number be required for claims submission?

A: Yes, NPI will be required.

Q: What does adjudicated mean?

A**:** Adjudicated claims are those that are approved accepted or denied claims.

Q: Are Submitters required to submit encounter data weekly or monthly?

A: Currently, Submitters are required to submit encounter data monthly. However, IEHP strongly recommend that plans submit more frequently.

Q: For adjustment submissions, how will Submitters reference the original encounter?

A: The original claim will be referenced by using (CLM01), which is the patient control number, CAS "CR" for correction CLM05-3 frequency "7" replace prior claim.

Q: If the CAS segment balances charges and paid amounts, do plans use the 'CAS 01' for the correction reason.

A: Yes, along with CLM05-3. CAS "CR" for correction or CAS "OA" for deletion and CLM05-3 frequency "1" original claim, "7" replace prior claim, "8" void/cancel/delete prior claim indicators.

Q: **Will IEHP new member ID card start with a four (4)?**

A: 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.

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

A: 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.

Reference

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

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