
12. IEHP 5010 837I INSTITUTIONAL CLAIMS COMPANION GUIDE

Standard Companion Guide (CG) Transaction Information
DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan)

Effective January 1, 2019

IEHP Instructions related to Implementation Guides (IG) based

and on X12 Version 005010X223A2
Health Care Claim: Institutional (837)

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 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.

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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.

837I Health Care Claim: Institutional Transaction

The version/Release/Industry Identifier Code and the applicable Functional Identifier Code must be transmitted to 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 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.

277CA – Claim Acknowledgement

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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 IEHP to Trading Partners.

IEHP adhere to DHCS Duplicate 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 Institutional service line, a duplicate would have the same following values as a previously submitted service line.

- 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.

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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	No Authorization Sent "00"	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 (Sender)	Mutually Defined "ZZ"	2/2
R	ISA06	Interchange Sender ID	Noted: IEHP Expected Value. Assigned 3 Digit Sender ID	15/15
R	ISA07	Interchange ID Qualifier (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	Interchange Usage Indicator	Production Data "P" Test "T"	1/1

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R	ISA16	Component Element Separator	YYMMDD format	1/1
		Data Element Separator	Asterisk “ * “Data Element	
		Segment Terminator	Tilde “~ “ Segment Terminator	

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

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BHT – Beginning of Hierarchical Transaction

R	BHT01	Hierarchical Structure Code	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	Claim or Encounter Identifier	Chargeable “CH” Note: IEHP Expected Value	2/2

Loop 1000A -PER- Submitter EDI Contact Information

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
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		1/225

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N	PER09	Contact Inquire Reference		1/20
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Loop 1000B -NM1- Receiver Name Information

Usage	Ref Des.	Name	Code/Definition	Length
R	NM101	Entity Identifier Code	Receiver “40”	2/3
R	NM102	Entity Type Qualifer	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
R	NM109	Identification Code	Receiver Primary Identifier “00303” Note: IEHP Expected Value Should match ISA06 and GS03	2/80

Loop 2010AA -NM1- Billing Provider Name Information

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

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Usage	Ref Des.	Name	Code/Definition	Length
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
N	NM107	Name Suffix	Billing Provider Name Suffix	1/10
S	NM109	Identification Code	Billing Provider Identifier	2/80

Loop 2010AA-N3- Billing Provider Address

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

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Usage	Ref Des.	Name	Code/Definition	Length
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		

Loop 2000B –SBR- Subscriber Information

Usage	Ref Des.	Name	Code/Definition	Length
R	SBR01	Payer Responsibility Sequence Number Code	Primary "P"	1/1
R	SBR02	Individual Relationship Code	Self "18"	2/2
S	SBR03	Subscriber Group or Policy Number	(SBR03& SBR04)Must Not Be Used Simultaneously.	1/50
S	SBR04	Subscriber Group Name	Medical "MED" Note: IEHP Expected Value (DHCS) Medicare " CMC" or Medicaid " CCI" Note: IEHP Expected Value. IEHP Dual Choice Cal MediConnect (CMS) (SBR04 & SBR03)Must Not Be Used Simultaneously.	

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Usage	Ref Des.	Name	Code/Definition	Length
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" Medicare "MA" Note: IEHP Expected Values.	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	2/80

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Usage	Ref Des.	Name	Code/Definition	Length
			Client Identification Number (CIN)	
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

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Usage	Ref Des.	Name	Code/Definition	Length
N	NM112	Name Last or Organization Name		1/60

Loop 2010BA -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. This is to be used by all payers including Medicare, Medicaid, and Blue Cross etc.	2/3
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

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Usage	Ref Des.	Name	Code/Definition	Length
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
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

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Usage	Ref Des.	Name	Code/Definition	Length
R	CL103	Patient Status Code		1 / 2
N	CL104	Nursing Home Residential Status Code		1/1

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

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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
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

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Usage	Ref Des.	Name	Code/Definition	Length
R	SV202-2	Procedure Code/ Service ID	Procedure Code	1/48
S	SVD202-3	Procedure Modifier		2/2
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

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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

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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

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Frequently Asked Questions

Q: What is the role of the Clearinghouse?

A: The term “health Care Clearinghouse” is defined as a public or private entity that processes or facilitates the processing of nonstandard data elements of health information into standard data elements. Clearinghouse will provide for the collection of the information needed to successfully exchange EDI transaction between provider and the payer. Clearinghouse will establish consistent editing acknowledgment & error handling of the electronic data interchange(EDI) transaction across the network providers.

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

A: Yes, NPI will be required.

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 4XXXXXXXXXXXX00.

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

A: 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

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.

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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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