

**Ohio Department of Aging**

**Companion Guide  
and  
Transaction Specifications  
for HIPAA**

**837 Claims: Professional**

**Version 2.7 for 5010  
February 2012**

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# 1 Introduction

## 1.1 Document Objective

This Companion Guide provides information about the 837 Professional Claims transaction that is specific to the Ohio Department of Aging (ODA), its' administrative agencies and trading partners. It identifies segments, elements and code values needed to adjudicate claims successfully through the Passport Information Management System (PIMS).

## 1.2 Intended Users

Companion Guides are intended for the technical staff of trading partners responsible for electronic (EDI) transaction file exchanges.

## 1.3 Relationship to HIPAA Implementation Guides

Companion Guides supplement the HIPAA Implementation Guide for each of the HIPAA transactions. Rules for format, content, and field values can be found in the HIPAA Implementation Guides. This document describes the ODA environment and interchange conventions for the 837 Professional Claim. It provides specific information on the elements and values required for successful adjudication of claims through PIMS.

Companion Guides are intended to supplement rather than replace the standard HIPAA Implementation Guide for the 837 Professional Claim.

Information in this document is not intended to:

- Modify the definition, data condition, or use any data element or segment in the standard implementation guide
- Add any additional data elements or segments to the defined data set
- Utilize any code or data values that are not valid in the standard implementation guide
- Change the meaning or intent of any implementation specifications in the standard implementation guide

## 1.4 Standard Implementation Guide

The standard implementation guide for 837 Professional Claim Transaction Set is the American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12 Transaction Set Implementation Guide for the Health Care Claim Professional and all approved Addenda. Version of the 837-P Claim Implementation Guide and Addenda used in preparation of this document are:

- ASC X12N 837 (005010X222A1)

## 2.0 ASC X12 Control Segments

This section is used to identify the required data values for ASC X12 EDI Envelopes needed for claim processing. If unfamiliar with ASC X12 Control Headers, refer to ASC X12 Nomenclature (Appendix A) in HIPAA Implementation Guide (005010X222A1).

### 2.1 Interchange Control Header

Element ID	Data Value	Description
ISA01	00	No Authorization Information present
ISA02		Spaces
ISA03	00	No Security Information present
ISA04		Spaces
ISA05	ZZ	Mutually Defined
ISA06	Trading Partner Number	Set by Trading Partner Profile
ISA07	ZZ	Mutually Defined
ISA08	OHIOAGING	Value assigned by ODA
ISA13	Interchange Control Number	
ISA14	0 or 1	Only enter a '1' if you want to receive and process a Transmission Acknowledgement (TA1).
ISA15	T or P	T for a test interchange, P for a production interchange

### 2.2 Group Control Header

Element ID	Data Value	Description
GS02	Trading Partner Number	Set by Trading Partner Profile
GS03	OHIOAGING	Value assigned by ODA
GS08	005010X222A1	Indicates HIPAA 837 Health Care Claims: Professional Addenda Implementation Guide is being used.

### 3.0 837 Health Care Claim - Professional

This section is used to describe the segments required by ODA for claim processing. The 837-P format is used for submission of electronic claims for health care professionals. This is the file that is sent to ODA for processing. In this file format the subscriber is the patient so the Patient Loop is not to be populated per HIPAA compliance.

## 837 Health Care Claim: Professional

The 837 transaction is designed to transmit one or more claims for each billing provider. The hierarchy of the looping structure is billing provider, subscriber, patient, claim level, and claim service line level. Billing providers who sort claims using this hierarchy will use the 837 more efficiently because information that applies to lower levels in the hierarchy will not have to be repeated within the transaction.

**Table 1 - Header**

POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP	REPEAT
005	ST	Transaction set Header	R	1		
010	BHT	Beginning of Hierarchical Transaction	R	1		
<b>LOOP ID – 1000A SUBMITTER NAME</b>						<b>1</b>
020	NM1	Submitter Name	R	1		
045	PER	Submitter EDI Contact Information	R	2		
<b>LOOP ID – 1000B RECEIVER NAME</b>						<b>1</b>
020	NM1	Receiver Name	R	1		

**Table 2 – Detail, Billing/Pay-to Provider Hierarchical Level**

POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP	REPEAT
<b>LOOP ID – 2000A BILLING/PAY-TO PROVIDER HIERARCHICAL LEVEL</b>						<b>&gt;1</b>
001	HL	Billing/Pay-to Provider Hierarchical Level	R	1		
003	PRV	Billing/Pay-to Provider Specialty Information	S	1		
<b>LOOP ID – 2010AA BILLING PROVIDER NAME</b>						<b>1</b>
015	NM1	Billing Provider Name	R	1		
025	N3	Billing Provider Address	R	1		
030	N4	Billing Provider City/State/Zip Code	R	1		
035	REF	Billing Provider Secondary Identification	S	8		
<b>LOOP ID – 2010AB PAY-TO PROVIDER NAME</b>						<b>1</b>
015	NM1	Pay-to Provider Name	S	1		
025	N3	Pay-to Provider Address	R	1		
030	N4	Pay-to Provider City/State/Zip Code	R	1		
035	REF	Pay-to Provider Secondary Identification	S	5		

**Table 2 – Detail, Subscriber Hierarchical Level**

POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
<b>LOOP ID – 2000B SUBSCRIBER HIERARCHICAL LEVEL</b>					<b>&gt;1</b>
001	HL	Subscriber Hierarchical Level	R	1	
005	SBR	Subscriber Information	R	1	
007	PAT	Patient Information	S	1	
<b>LOOP ID – 2010BA SUBSCRIBER NAME</b>					<b>1</b>
015	NM1	Subscriber Name	R	1	
025	N3	Subscriber Address	S	1	
030	N4	Subscriber City/State/Zip Code	S	1	
032	DMG	Subscriber Demographics Information	S	1	
035	REF	Subscriber Secondary Identification	S	4	
<b>LOOP ID – 2010BB PAYER NAME</b>					<b>1</b>
015	NM1	Payer Name	R	1	
035	REF	Payer Secondary Identification	S	3	
035	REF	Billing Provider Secondary Identification	S	3	
<b>LOOP ID – 2300 CLAIM INFORMATION</b>					<b>100</b>
130	CLM	Claim Information	R	1	
175	AMT	Patient Amount Paid	S	1	
180	REF	Claim ID Number for Clearinghouses and Other Transmission Intermediaries	S	1	
190	NTE	Claim Note	S	1	
<b>LOOP ID – 2310B RENDERING PROVIDER NAME</b>					<b>1</b>
250	NM1	Rendering Provider Name	S	1	
255	PRV	Rendering Provider Specialty Information	S	1	
271	REF	Rendering Provider Secondary Identification	S	5	
<b>LOOP ID – 2400 SERVICE LINE</b>					<b>50</b>
365	LX	Service Line	R	1	
370	SV1	Professional Service	R	1	
455	DTP	Date – Service Date	R	1	
470	REF	Line Item Control Number	S	1	
485	NTE	Line Note	S	1	
555	SE	Transaction Set Trailer	R	1	

## NOTES:

- 1/020 Loop 1000B contains receiver name. PASSPORT Administrative Agency is the receiver of this claim.
- 2/015 Loop 2010 contains Payer Name. The payer is the PASSPORT Administrative Agency. Payer id is PAA ID (values are: PAA 1, PAA 2, PAA 3, PAA 4, PAA 5, PAA 6, PAA 7, PAA 8, PAA 9, PAA 10A, PAA 10B, PAA 11, and CSS).

### 3.1 Segment/Elements and Codes

The ASC X12 standards are generic. Each community decides which elements to use and which code values in those elements are applicable. For health care, HIPAA is an example of the health care community determining which segments, elements and code values to use from the ASC X12 837 Claim standards.

In a similar manner, ODA will identify segments, elements and code values it needs from the HIPAA versions to adjudicate the claim. ODA cannot change any mandatory (required) segments and elements nor add any segments and elements. In the previous 837-P Health Care Claim – Professional Transaction section the segments were identified. In this section, the elements and code values are further defined to meet the adjudication process.

This section identifies only the changes needed to successfully process and adjudicate a claim through PIMS.

#### Table 1 Header

<b>1/010</b>	<b>BHT</b>	<b>Beginning of Hierarchical Transaction</b>
	• BHT06	Transaction Type Code
		➤ Enter code: “CH” (Chargeable)

#### Loop ID – 1000A Submitter Name

<b>1/020</b>	<b>NM1</b>	<b>Submitter Name</b>
	• NM109	Identification Code (Submitter Primary Identification Number)
		➤ Use value from Trading Partner Profile (TPP)

<b>1/045</b>	<b>PER</b>	<b>Submitter EDI Contact Information</b>
	• PER03	Communication Number Qualifier
		➤ Enter “TE” (Telephone)

#### Loop ID – 1000B Receiver Name

<b>1/020</b>	<b>NM1</b>	<b>Receiver Name</b>
	• NM103	Last or Organization Name
		➤ Enter “PASSPORT Administrative Agency” as the receiver
	• NM109	Identification Code (Receiver Primary Identification Number)
		➤ Enter PASSPORT Administrative Agency ID (PAA 1, PAA 2, PAA 3, PAA 4, PAA 5, PAA 6, PAA 7, PAA 8, PAA 9, PAA 10A, PAA 10B, PAA 11, AND CSS) as the receiver identification number

## Table 2 Detail

### Loop ID – 2010AA Billing Provider Name

The Billing Provider is the person or organization submitting the claim. If the Billing and Pay-To Providers are the same entity, complete loop 2010AA and do not use loop 2010AB. If the Billing Provider represents a third party billing service or a branch/field office of a provider, then complete both loops 2010AA and 2010AB where loop 2010AB identifies the party to receive the claim payment.

ODA requires Billing Provider to be a Health Care Provider. Third party billing services and clearinghouses use Loop ID 1000A Submitter.

### Loop ID – 2010AA Billing Provider Name

- |   |                              |
|---|------------------------------|
| <b>2/015 NM1</b>  | <b>Billing Provider Name</b> |
| <ul style="list-style-type: none"> <li>• NM108 Identification Code Qualifier                             <ul style="list-style-type: none"> <li>➤ “XX” National Provider Identifier</li> </ul> </li> <li>• NM109 Identification Code (Billing Provider Primary ID Number)                             <ul style="list-style-type: none"> <li>➤ the National Provider ID number</li> </ul> </li> </ul> |                              |

<b>2/035 REF</b>	<b>Billing Provider Secondary Identification</b>
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ODA requires the Billing Provider Location ID number as assigned by the PAA. See LOOP 2010BB.REF01 and LOOP 2010BB.REF01

### Loop ID – 2010AB Pay-To Provider Name

The Pay-To Provider is the person or organization receiving the claim payment or a plan. If the Pay-To and Billing Providers are the same entity, complete loop 2010AA only.

Pay-To Provider must be defined within PASSPORT prior to its use. Only one Pay-To Provider is permitted per Provider Corporate Entity (i.e., Provider Number).

Enter Pay-To Provider Location ID number in LOOP 2010.REF01 see Implementation guide page # 78.

### Loop ID – 2000B Subscriber Hierarchical Level

- |  |                               |
|--|-------------------------------|
| <b>2/005 SBR</b>   | <b>Subscriber Information</b> |
| <ul style="list-style-type: none"> <li>• SBR01 Payer Responsibility Sequence Number Code                             <ul style="list-style-type: none"> <li>➤ Enter “P” (Primary) -PAA is always primary</li> </ul> </li> <li>• SBR03 Reference Identification                             <ul style="list-style-type: none"> <li>➤ Not Used</li> </ul> </li> <li>• SBR04 Name                             <ul style="list-style-type: none"> <li>➤ Not Used</li> </ul> </li> <li>• SBR05 Insurance Type Code</li> </ul> |                               |

- Not Used
- SBR09 Claim Filing Indicator Code
  - Enter code: "MC" Medicaid

**Loop ID – 2010BA Subscriber Name****2/015 NM1 Subscriber Name**

For ODA, subscriber is the Consumer. There are no patients.

- NM108 Identification Code Qualifier
  - Enter "MI" (Member Identification Number)
- NM109 Identification Code
  - Use Client Number as assigned by PAA

**Loop ID – 2010BB Payer Name****2/015 NM1 Payer Name**

- NM108 Identification Code Qualifier
  - Enter "PI" for Payer identification or "XV" for National Plan Identification
- NM109 Identification code
  - Use ODA Agency ID (for example PAA 3) for payer id until National Plan ID is mandated.

**2/035 REF Payer Secondary Identification**

ODA requires this segment when loop id 2010BB is used and NM108 equals "XV".

- REF01 Reference Identification Qualifier
  - Enter "2U" Payer Identification Number. This REF segment is required by ODA when Payer Identification Code Qualifier (NM108) equals "XV".
- REF02 Reference Identification
  - Use ODA Agency ID (for example PAA 3) for Payer Secondary ID.

**2/035 REF Payer Provider Secondary Identification**

- REF01 Reference Identification Qualifier
  - Enter "LU" Payer Identification Number.
- REF02 Reference Identification
  - Billing Provider Secondary ID (Provider Location ID).

**Loop ID – 2300 Claim Information**

To get claim totals by funding source, submit separate claims for each funding source. If service details within a claim have mixed funding sources, the X12N 835 Health Care Claim Payment/Advice returned will also have mixed funding sources within a claim.

**2/130 CLM Claim Information**

- CLM01 Claim Submitter's Identifier
  - Maximum number of characters to be supported for this element is '20'.
- CLM06 Provider Signature on File
  - Enter 'Y' – ODA Agency has signature on file.

**Loop ID – 2310B Rendering Provider**

The Rendering Provider is required when the individual or organization rendering the care is not the same as the Billing Provider (Loop 2010AA) or Pay-To Provider (Loop 2010AB).

**2/250 NM1 Rendering Provider Name**

- NM108 Identification Code Qualifier
  - Enter "XX" National Provider Identifier
- NM109 Identification Code (Rendering Provider Primary Identifier)
  - National Provider ID number

**2/271 REF Rendering Provider Secondary Identification**

ODA requires this segment when loop id 2310B is used

- REF01 Reference Identification Qualifier
  - Enter "LU" Location Number
- REF02 Reference Identification
  - Use Provider Location ID as assigned by the PAA

**Loop ID – 2400 Service Line**

Report one date and service per iteration of the 2400 loop. If more than 50 occurrences per claim are necessary, create another iteration of the 2300 loop in order to continue with more 2400 loop service lines

**2/370 SV1 Professional service**

- SV101-1 Product/Service ID Qualifier
  - Enter code "HC" - Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes
- SV101-2 Product/Service ID
  - Refer to ODA HCPCS Code Table to obtain proper HCPCS code.

- SV101-3 Procedure Modifier
    - Refer to ODA HCPCS Code Table to obtain proper modifier.
  - SV101-4 Procedure Modifier
    - Refer to ODA HCPCS Code Table to obtain proper modifier.
  - SV101-5 Procedure Modifier
    - Not Used by ODA
  - SV101-6 Procedure Modifier
    - Not Used by ODA
  - SV103 Unit or Basis for Measurement Code
    - Enter “UN” – Unit for Current Billing Unit
- 2/455 DTP Date – Service Date**
- DTP03 Date Time Period
    - Refer to ODA Service Dates Bulletin to obtain instructions for completing this area.

#### 4.0 837 Common Errors (updated 02/15/2012)

- 1) Loop 1000A.NM109 submitter identification code; should be the submitter ID from the submitted EDI Trading Partner Profile form
  - 2) Loop 1000B.NM109 receiver identification code; should be PAA #
  - 3) Loop 2010BB.NM109 payer Identification code; must be PAA #
  - 4) Loop 2300.CLM05-3 claim Frequency Type code; the value must be '1' for original claim
  - 5) Loop 2300.CLM09 release of Information code; the values are "I" or "Y"  
    "I" = Informed consent by federal statutes  
    "Y" = Yes, provider has a signed statement
  - 6) Loop 2010BB.REF01 must be 'LU'
  - 7) Loop 2010BB.REF02-Fixed Format Information: ODA requires the Billing Provider Location ID to process the claims. The number(s) is/are left justified, i.e. {999999 555555 } each ID number is up to 9-digits with spaces for filler. Where {999999 } is the Billing Provider Location ID number, it must be provided. Where {555555 } is the Pay to Provider Location ID number, it is optional, it must be provided if there is a pay to provider. For additional information refer to Page # 78 in the 837 Health Care Claim document available on ODA's website:  
<http://www.aging.ohio.gov/services/passport/billingformats.aspx>.
  - 8) Loop 2400.DTP02 Date Time Period Format Qualifier: must be Service Date Qualifier.
  - 9) Loop 2400.DTP03 Date Time Period: must be Service Date.
  - 10) The value in ISA 15 Usage Indicator; must be "T" for testing or "P" for production.
  - 11) If needed, use a generic diagnosis code 7999 for those individuals.
  - 12) ISA14 Acknowledgment Requested (TA1): "1" Interchange Acknowledgment or "0" No Acknowledgment; if "1" is used the Interchange Date (ISA09), Interchange Time (ISA10) and Interchange Control Number (ISA13) will be reported either with the 999 or as a separate document.
  - 13) 837 File Syntax must be: ODAEDI.providerID.TXT.
  - 14) ISA13-Interchange Control Number (ICN): Must be unique
  - 15) 999 (Functional Acknowledgment) Will Not be generated if any of the following occurs:  
    File Name Syntax (not following the standard file name conventions - ODAEDI.TradingPartnerId.TXT);  
    Enveloping Error (ISA/IEA, GS/GE, ST/SE );  
    Duplicate ICN (ISA\_13)
- Note: if "1" is used in the ISA\_14 (Acknowledgment Requested) then a TA1 will be generated - reporting a duplicate ICN

**5.0 835 Common Errors (updated 05/08/2012)**

27	Consumer Dis-enrolled
31	Invalid Client Number
46	Invalid Service Code
62	Service Not Delivered
141	Client Institutionalized At Time Of Service
142	Claim adjusted by the monthly Medicaid patient liability amount
A1	Claim Denied
B11	Unauthorized Service
B18	Date of Service Invalid
B7	Additional Services Not Authorized
WD	Withdrawn

**6.0 277 Common Errors (updated 05/08/2012)**

24	Entity not approved as an electronic submitter
84	Invalid Service Code
128	Tax ID error
136	NPI
153	Invalid Client Number
400	Claim is out of balance