

**Ohio Department of Aging**

**Companion Guide**

**and**

**Transaction Specifications**

**for HIPAA**

**837 Claims: Professional**

**Version 2.6**

**November 2005**

- 1. Introduction**
- 2. ASC X12 Control Segments**
- 3. 837 Health Care Claim – Professional**
- 4. 837 Common Errors (updated 11/21/2007)**

# 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 (004010X098)
- ASC X12N 837 (004010X098A1) (Addenda)

## 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 (004010X098).

### 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
ISA14	0 or 1	Only enter a '1' if you can 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	004010X098A1	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**

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP	REPEAT
62	005	ST	Transaction set Header	R	1		
63	010	BHT	Beginning of Hierarchical Transaction	R	1		
66	015	REF	Transmission Type Identification	R	1		
<b>LOOP ID – 1000A SUBMITTER NAME</b>							<b>1</b>
67	020	NM1	Submitter Name	R	1		
71	045	PER	Submitter EDI Contact Information	R	2		
<b>LOOP ID – 1000B RECEIVER NAME</b>							<b>1</b>
74	020	NM1	Receiver Name	R	1		

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

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP	REPEAT
<b>LOOP ID – 2000A BILLING/PAY-TO PROVIDER HIERARCHICAL LEVEL</b>							<b>&gt;1</b>
77	001	HL	Billing/Pay-to Provider Hierarchical Level	R	1		
79	003	PRV	Billing/Pay-to Provider Specialty Information	S	1		
<b>LOOP ID – 2010AA BILLING PROVIDER NAME</b>							<b>1</b>
84	015	NM1	Billing Provider Name	R	1		
88	025	N3	Billing Provider Address	R	1		
89	030	N4	Billing Provider City/State/Zip Code	R	1		
91	035	REF	Billing Provider Secondary Identification	S	8		

<b>LOOP ID – 2010AB PAY-TO PROVIDER NAME 1</b>					
99	015	NM1	Pay-to Provider Name	S	1
103	025	N3	Pay-to Provider Address	R	1
104	030	N4	Pay-to Provider City/State/Zip Code	R	1
106	035	REF	Pay-to Provider Secondary Identification	S	5

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

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP	REPEAT
<b>LOOP ID – 2000B SUBSCRIBER HIERARCHICAL LEVEL &gt;1</b>							
108	001	HL	Subscriber Hierarchical Level	R	1		
110	005	SBR	Subscriber Information	R	1		
114	007	PAT	Patient Information	S	1		
<b>LOOP ID – 2010BA SUBSCRIBER NAME 1</b>							
117	015	NM1	Subscriber Name	R	1		
121	025	N3	Subscriber Address	S	1		
122	030	N4	Subscriber City/State/Zip Code	S	1		
124	032	DMG	Subscriber Demographics Information	S	1		
126	035	REF	Subscriber Secondary Identification	S	4		
<b>LOOP ID – 2010BB PAYER NAME 1</b>							
130	015	NM1	Payer Name	R	1		
136	035	REF	Payer Secondary Identification	S	3		
<b>LOOP ID – 2300 CLAIM INFORMATION 100</b>							
170	130	CLM	Claim Information	R	1		
220	175	AMT	Patient Amount Paid	S	1		
238	180	REF	Claim ID Number for Clearinghouses and Other Transmission Intermediaries	S	1		
246	190	NTE	Claim Note	S	1		
<b>LOOP ID – 2310B RENDERING PROVIDER NAME 1</b>							
276	250	NM1	Rendering Provider Name	S	1		
279	255	PRV	Rendering Provider Specialty Information	S	1		
281	271	REF	Rendering Provider Secondary Identification	S	5		
<b>LOOP ID – 2400 SERVICE LINE 50</b>							
398	365	LX	Service Line	R	1		
400	370	SV1	Professional Service	R	1		
435	455	DTP	Date – Service Date	R	1		
472	470	REF	Line Item Control Number	S	1		
488	485	NTE	Line Note	S	1		
572	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. May 2000 version 004010X098 was the first implementation published and approved by CMS for professional claims. After initial review and feedback, an addenda, 004010X098A1, was published and approved by CMS in October 2002. To be HIPAA compliant, both documents must be followed.

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)
<b>1/015</b>	<b>REF</b>	<b>Transmission Type Identification</b>
	• REF02	Reference Identification
		➤ Enter "004010X098A1" for production transmissions and "004010X098DA1" for pilot transmissions

#### 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 Agreement (TPA)
<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</b> | <b>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>➤ Enter “24” (Employer’s Identification Number) or “34” (Social security Number) for now and “XX” once National Provider Identifier is mandated</li> </ul> </li> <li>• NM109 Identification Code (Billing Provider Primary ID Number)                             <ul style="list-style-type: none"> <li>➤ Use your Federal Tax ID (if NM108 = 24) or Social Security Number (if NM108 = 34) until the National Provider ID is mandated</li> </ul> </li> </ul> |                              |

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

ODA requires this segment even after NPI becomes mandated

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

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

The Pay-To Provider is the person or organization receiving the claim payment. If the Pay-To and Billing Providers are the same entity, complete loop 2010AA and do not use this loop (loop 2010AB).

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).

- |              |   |                             |
|--------------|---|-----------------------------|
| <b>2/015</b> | <b>NM1</b>  | <b>Pay-To Provider Name</b> |
|              | <ul style="list-style-type: none"> <li>• NM108 Identification Code Qualifier</li> </ul> |                             |

- Enter “24” (Employer’s Identification Number) or “34” (Social security Number) for now and “XX” once National Provider Identifier is mandated

- NM109 Identification Code
  - Use your Federal Tax ID (if NM108 = 24) or Social Security Number (if NM108 = 34) until the National Provider ID is mandatory

**2/035 REF Pay-to Provider Secondary Identification**

ODA requires this segment when loop id 2010AB is used

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

**Loop ID – 2000B Subscriber Hierarchical Level**

**2/005 SBR Subscriber Information**

- SBR01 Payer Responsibility Sequence Number Code
  - Enter “P” (Primary) -PAA is always primary
- SBR03 Reference Identification
  - Not Used
- SBR04 Name
  - Not Used
- SBR05 Insurance Type Code
  - 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) for now and “ZZ” once a HIPAA Individual Identifier is mandated
- NM109 Identification Code

- Use Client Number as assigned by PAA

**2/035 REF Pay-to Provider Secondary Identification**

ODA requires this segment when loop id 2010BA is used and NM108 equals 'ZZ'

- REF01 Reference Identification Qualifier
  - Enter "1W" Member Identification Number. This REF segment is required by ODA when Subscriber ID Code Qualifier (NM108) equals 'ZZ'.
- REF02 Reference Identification
  - Use Client Number as assigned by PAA

**Loop ID – 2010BB Payer Name**

**2/015 NM1 Payer Name**

- NM108 Identification Code Qualifier
  - Enter "PI" (Payer identification) for now and "XV" once a National Plan ID is mandated
- 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.

**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 “24” (Employer’s Identification Number) or “34” (Social security Number) for now and “XX” once National Provider Identifier is mandated
- NM109    Identification Code (Rendering Provider Primary Identifier)
  - Enter your Federal Tax ID (if NM108 = 24) or Social Security Number (if NM108 = 34) until the National Provider ID is mandated

**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 11/21/2007)

- 1) Loop 1000A.NM109 should be Submitter ID from TPP
- 2) Loop 1000B.NM109 should be PAA #
- 3) Loop 2010AA.REF01 should be "LU"
- 4) Loop 2010AA.REF02 should be Provider Location ID
- 5) Loop 2010BB.NM109 should be PAA #
- 6) Loop 2300.CLM05-3 the value should be '1'
- 7) Loop 2300.CLM09. The suggested value is 'O' means release of information at the Payer (PAA) or at Plan Sponsor.
- 8) Loop 2400.DTP02 should be Service Date Qualifier
- 9) Loop 2400.DTP03 should be Service Date
- 10) The test indicator should be 'T' so that the test file goes to Test server.  
For Production it should be 'P'
- 11) Loop 2010AA.NM109. If you are submitting TAXID please take out '-'