Healthcare and Family Services, Bureau of Information Services

HIPAA 5010 - Health Care Claim: Professional (837P) Standard Companion Guide

Instructions related to Transactions based on ASC X12 Implementation Guide version 005010X222 and the ERRATA 005010X222A1 dated June 2010

837 Professional Companion Guide Version Number: 1.2

May 2010

Preface

Companion Guides (CG) may contain two types of data, instructions for electronic communications with the publishing entity (Communications/Connectivity Instructions) and supplemental information for creating transactions for the publishing entity while ensuring compliance with the associated ASC X12 IG (Transaction Instructions). Either the Communications/Connectivity component or the Transaction Instruction component must be included in every CG. The components may be published as separate documents or as a single document.

The Communications/Connectivity component is included in the CG when the publishing entity wants to convey the information needed to commence and maintain communication exchange.

The Transaction Instruction component is included in the CG when the publishing entity wants to clarify the IG instructions for submission of specific electronic transactions. The Transaction Instruction component content is limited by ASCX12's copyrights and Fair Use statement.

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Transaction Instruction (TI)

1 TI Introduction

1.1 Background

1.1.1 Overview of HIPAA Legislation

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 carries provisions for administrative simplification. This requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. HIPAA directs the Secretary to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard HIPAA serves to:

- Create better access to health insurance
- Limit fraud and abuse
- Reduce administrative costs

1.1.2 Compliance according to HIPAA

The HIPAA regulations at 45 CFR 162.915 require that covered entities not enter into a trading partner agreement that would do any of the following:

- Change the definition, data condition, or use of a data element or segment in a standard.
- Add any data elements or segments to the maximum defined data set.
- Use any code or data elements that are marked “not used” in the standard’s implementation specifications or are not in the standard’s implementation specification(s).
- Change the meaning or intent of the standard’s implementation specification(s).

1.1.3 Compliance according to ASC X12

ASC X12 requirements include specific restrictions that prohibit trading partners from:

- Modifying any defining, explanatory, or clarifying content contained in the implementation guide.
- Modifying any requirement contained in the implementation guide.

1.2 Intended Use

The Transaction Instruction component of this companion guide must be used in conjunction with the ASC X12 version 005010X222 Health Care Claim Professional (837P) Implementation Guide and the Errata 005010X222A1 dated June 2010. 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 Implementation Guide and is in conformance with ASC X12's Fair Use and Copyright statements.

2 Included ASC X12 Implementation Guides

This table lists the X12N Implementation Guides for which specific transaction Instructions apply and which are included in Section 3 of this document.

Unique ID	Name
005010X222	Health Care Claim: Professional (837)

3 Instruction Tables

These tables contain one or more rows for each segment for which a supplemental instruction is needed.

Legend
SHADED rows represent “segments” in the X12N implementation guide.
NON-SHADED rows represent “data elements” in the X12N implementation guide.

HFS Unique 837P Items

005010X222A1 Health Care Claim: Professional

Loop ID	Reference	Name	Codes	Notes/Comments
1000A	NM1	Submitter Name		
1000A	NM109	Identification Code		Must be your Federal Tax ID Number
1000B	NM1	Receiver Name		
1000B	NM103	Organization Name		Must be “Illinois Medicaid”
1000B	NM109	Identification Code		Must be “37-1320188”
2000A	PRV	Billing Provider Specialty Information		
2000A	PRV03	Provider Taxonomy Code		Taxonomy is required by HFS on all claims. The provider must submit the appropriate taxonomy for the service billed. The allowable taxonomy codes can be found on the department’s Web site at the Handbook for Electronic Processing, 4010 Companion Guide page. A complete list of taxonomy codes can be found on the WPC Web site.
2010BA	NM1	Subscriber Name		

Loop ID	Reference	Name	Codes	Notes/Comments
2010BA	NM103	Subscriber Last Name		Must be the Last Name of the Recipient exactly as it appears on the MediPlan Card, All Kids Card or IL Cares RX Card.
2010BA	NM104	Subscriber First Name		Must be the First Name of the Recipient exactly as it appears on the MediPlan Card, All Kids Card or IL Cares RX Card.
2010BA	NM105	Subscriber Middle Name or Initial		Must be the Middle Name of the Recipient exactly as it appears on the MediPlan Card, All Kids Card or IL Cares RX Card.
2010BA	NM107	Name Suffix		Must be the Name Suffix of the Recipient exactly as it appears on the MediPlan Card, All Kids Card or IL Cares RX Card.
2010BA	NM109	Subscriber Primary Identifier		Must be the Recipient's 9-digit Number as it is shown on the MediPlan Card, All Kids Card or IL Cares RX Card
2010BB	NM1	Payer Name		
2010BB	NM103	Payer Name		Must be "ILLINOIS MEDICAID".
2010BB	NM109	Payer Identifier		Must be "37-1320188"
2010BB	REF	REF-Billing Provider Secondary Identification		
2010BB	REF01	Reference Identification Qualifier	G2	Atypical providers must use "G2" Provider Commercial Number
2010BB	REF02	Billing Provider Secondary Identifier		Atypical Providers must send the HFS Provider ID in this field. NM108 and NM109 should be left blank in the 2010AA segment when the Atypical provider does not have an NPI.
2300	CLM	Claim Information		
2300	CLM01	Patient Control Number		HFS will process and return up to 20 Characters only on remittances.
2300	DTP	Discharge Date		

Loop ID	Reference	Name	Codes	Notes/Comments
2300	DTP03	Related Hospital Discharge Date		For HFS this element must be reported for therapies in order to determine if care is within 60 days or beyond 60 days of the hospital discharge.
2300	AMT	Patient Amount Paid		
2300	AMT02	Patient Amount Paid		Co-payments should not be reported in this field. Co-payments will be automatically subtracted by the Department.
2300	REF	Referral Number		
2300	REF02	Referral Number		Report the referral number obtained by the Primary Care Physician for the services.
2300	REF	Prior Authorization		
2300	REF02	Prior Authorization Number		Report the HFS prior approval number in this field.
2300	REF	Payer Claim Control Number		
2300	REF02	Payer Claim Control Number		When billing for Claim Type 7 or 8, you must use this element to report the Document Control Number (DCN) of the original paid claim or service line that is to be voided or rebilled. See section on void/replacements under Payer Specific Business Rules and Limitations.
2300	NTE	Claim Note		
2300	NTE01	Note Reference Code	ADD	Must use “ADD” when the services require additional information to be reported.
2300	NTE02	Claim Note Text		For all claims that are special priced, include the appropriate required detail in this section. For emergency and non-emergency transportation claims, this element will contain the State, Vehicle License Number, Origin Time, and Destination Time. See section on Transportation claims under the Payer Specific Business Rules and Limitations section for more detail.

Loop ID	Reference	Name	Codes	Notes/Comments
2300	CR1	Ambulance Transport Information		
2300	CR106	Transport Distance		Transportation providers must report the number of "loaded" miles.
2300	CRC	EPSDT Referral		
2300	CRC02	Certification Condition Code Applies Indicator	"Y"/"N"	It is critical that providers utilize this indicator to report that an EPSDT screening service was provided.
2310A	NM1	Referring Provider Name		
2310A	NM101	Entity Identifier Code	"DN"	Must be "DN" for: Consultations, laboratory services, and therapy services.
2310A	REF	Referring Provider Secondary Identification	"0B", "1G"	If the provider is not enrolled with HFS, must use "0B" to supply your State License Number OR use "1G" to supply the UPIN. All other identifiers will be ignored.
2330B	DTP	Claim Check or Remittance Date		
2330B	DTP03	Adjudication or Payment Date		For HFS, this segment is required when loop 2320 is used.
2330B	REF	Other Payer Secondary identifier		
2330B	REF01	Reference Identification Qualifier	"2U"	Must be "2U"
2330B	REF02	Reference Identification		For HFS a secondary identification number is always required when loop 2320 is used. Must be the 3-digit TPL code followed by the 2-digit Status Code assigned by HFS to other payers. For example: REF*2U*91001~ Code 910 = Medicare Part B

Loop ID	Reference	Name	Codes	Notes/Comments
				For other TPL codes, please reference Appendix 9 in Chapter 100 of the General Policy and Procedures Provider Handbook.
2400	SV1	Professional Service		
2400	SV101-03	Procedure Modifier		HFS will recognize and process up to four (4) modifiers per service line that impact the processing and/or pricing of the claims. See Chapter 200 of your provider handbook for more information.
2400	SV103	Unit or Basis for Measurement Code	"MJ", "UN"	Use MJ=Minutes to report anesthesia minutes and time for assistant surgeon. Use UN=Units for all other services provided.
2400	SV111	Yes/No Condition or Response Code	"Y"	If the services provided are the follow up services that resulted from an EPSDT screening, report "Y".
2400	CR1	Ambulance Transport Information		
2400	CR106	Transport Distance		Must be the number of loaded miles traveled for transport by any type of vehicle.
2400	DTP	Date – Service Date		
2400	DTP02	Date Time Period Qualifier	"D8"	HFS will only accept "D8"
2400	REF	Line Item Control Number		
2400	REF02	Line Item Control Number		If the provider completes this element, HFS will return it on the 835 when the claim is adjudicated.
2400	REF	Prior Authorization		
2400	REF02	Prior Authorization Number		Report the HFS prior approval number for the service if different than the 2300 loop.

Loop ID	Reference	Name	Codes	Notes/Comments
2400	REF	Referral Number		
2400	REF02	Referral Number		Report the referral number obtained by the Primary Care Physician for the service if different than the 2300 loop.
2400	NTE	Line Note		
2400	NTE01	Note Reference Code	"ADD"	Must use "ADD" when the services require additional information to be reported.
2400	NTE02	Line Note Text		For all special priced claims, include the appropriate required detail in this section. This will overwrite the claim level information for the service line. For emergency and non-emergency transportation claims, this element will contain the State, Vehicle License Number, Origin Time, and Destination Time. See section on Transportation claims under the Payer Specific Business Rules and Limitations section for more detail.
2420E	REF	Ordering Provider Secondary Identification		HFS requires this segment for DME, Lab, and Portable X-Ray claims.
2420E	REF01	Reference identification Qualifier		If the provider is not enrolled with HFS, must use "0B" to supply your State License Number OR use "1G" to supply the UPIN. All other identifiers will be ignored.
2430	SVD	Line Adjudication Information		
2430	SVD02	Service line Paid Amount		HFS will apply line level TPL payments. This value will be used in conjunction with the CAS02 Patient Responsibility value to create the Medicare Approved Amount.
2430	CAS	Line Adjustment		

Loop ID	Reference	Name	Codes	Notes/Comments
2430	CAS01	Claim Adjustment Group Code	"PR"	HFS requires All Medicare Cross Over Claims to contain the "PR" value. This is used to report the Patient Responsibility Amount. This value is then used to create the Medicare Approved Amount. Refer to the Business Scenarios for more information.
2430	CAS03	Adjustment Amount		The Patient Responsibility amount is required for all Medicare Cross Over Claims. Refer to the Business Scenarios for more information.

4 TI Additional Information

4.1 Business Scenarios

Medicare Approved Amount – The Medicare Approved Amount equals the amount for the service line that was approved by the payer. This amount must be reported at the service line level. The Medicare Approved Amount will be calculated by HFS utilizing two segments that are required by primary payers. The first value used will be the Medicare paid amount that is required in loop 2430 - SVD02 Service Line Paid Amount. In the 2430 loop HFS will look for the CAS03 – Monetary amount value when the CAS01 claim adjustment group code is equal to PR-Patient Responsibility and add that to the Medicare paid amount to derive the Medicare Approved Amount. Each primary payer is required to send in these segments and fields if there was a primary payment for the service.

See Example below: Multi – Line Medicare Primary Claim

LX1 - Values

Amt	Segment/field	Data Element	Loop	Loop Name
138.54	SVD-02	Paid Amount	2430	Line Adjudication Info
34.63	CAS-03 / PR	Patient Responsibility Amt	2430	Line Adjudication Info
138.54+34.63 = 173.17	Approved Amount	HFS Calculated Medicare Approved Amount		

LX2 - Values

Amt	Segment/field	Data Element	Loop	Loop Name
23.01	SVD-02	Paid Amount	2430	Line Adjudication Info
5.76	CAS-03 / PR	Patient Responsibility Amt	2430	Line Adjudication Info
23.01 + 5.76 = 28.77	Approved Amount	HFS Calculated Medicare Approved Amount		

Coordination of Benefits (COB) Information

Insurance in Addition to Illinois Medicaid

For those claims where the subscriber has insurance in addition to Illinois Medicaid, utilize Loop 2330B, REF02 to report the 3-digit HFS TPL code, followed by the 2 digit status code. These instructions are relevant to all primary payers including Medicare. The complete list of TPL codes can be found in Chapter 100, Appendix 9 of the General Policy and Procedures Provider Handbook. The list of Status Codes can be found in Appendix 1 in Chapter 200 of the Handbook for your provider type.

For Example: Medicare Part B TPL is 910 and the status of 01 for TPL Adjudicated
REF*2U*91001

4.2 Payer Specific Business Rules and Limitations

General Information

This section contains information on processing electronic claims based on the 005010X222 version of the ASC X12N Professional Health Care Claim (837P) Implementation Guide and the Errata (005010X222A1) dated June 2010. This document will identify information that is specific to conducting Electronic Data Interchange (EDI) with the Illinois Medical Assistance Program and other health care programs funded or administered by the Illinois Department of Healthcare and Family Services (HFS).

Questions, comments, or suggestions regarding this information should be directed to HFS Webmaster

Paper Claims: HFS will continue to accept paper claims using the state mandated billing forms. Example, physicians can continue to bill using the HFS 2360 and Durable Medical Equipment and Supply providers can continue to use the HFS 2210.

At this time HFS is not able to accept electronic claims and match them to a paper attachment. Therefore any claim that requires a specific attachment, based on service, will still be required to be sent in on a paper claim.

Providers must continue to follow the policies outlined in the HFS provider handbooks, notices, rules, and laws.

Amount Fields – The maximum number of characters to be submitted in the dollar amount field is nine (9) characters. Dollar amounts in excess of 9,999,999.99 (excluding commas and the decimal point) may be rejected.

Claim Frequency (CLM05-3) –HFS will accept the following codes:

Code	Definition
1	Admit through Discharge Claim
7	Replacement or a Prior Claim or Service Line
8	Void/Cancel of Prior Claim or Service Line

If the claim contains a frequency digit other than 1, 7, or 8, it will be defaulted to “1” and will be processed as a normal claim.

Void or Replacement of a Claim/Service Line – The Department will accept an 837 transaction to void or replace a payable or pending-payable claim. Providers can void a single service line or an entire claim.

In order to process the void the following data elements must match the original claim:

HFS Document Control Number (DCN)
Provider NPI or for Atypical providers the HFS Provider Number
HFS Recipient ID Number

If these elements match, the service section or claim will be voided and the payment credited against a future voucher. If all three do not match, the transaction will be rejected.

If the elements for the new claim do not match the ones on the original claim, you must void the original claim with a Bill Type “8” and submit a separate replacement claim with the corrected information and the appropriate bill type (not 7 or 8).

Void a Prior Claim (Bill Type “8”)

To void a single service line or an entire claim, enter Claim Frequency "8" in CLM05-3. If the DCN of the original payable or pending-payable claim plus a Service Section of "00" is entered in REF02 of the 2300 Loop, the entire claim

will be voided. If the DCN plus a Service Section number of greater than "00" from the original payable or pending-payable service line is entered, only that service line will be voided.

1. Void entire claim for DCN: 201025522123456

   REF02: 20102552212345600

2. Void Service Line 2 only for DCN: 201025515123456

   REF02: 20102551512345602

Replacement of a Prior Claim (Bill Type "7")

To replace a single service line or an entire claim, enter Claim Frequency "7". If the DCN of the original payable or pending-payable claim, plus a Service Section of "00" is entered in REF02 of the 2300 Loop, the original claim will be voided and replaced with the information contained in the resubmitted 837. If the DCN plus a Service Section number of greater than "00" from the original payable or pending-payable service line is entered, only that service line will be voided and replaced with the new information contained in the resubmitted 837.

EPSDT – It is critical that providers utilize the CRC02 value of Y/N in the 2300 Loop on claims when an EPSDT screening is provided. If the services being provided are follow up services that resulted from an EPSDT screening, then at the service line level, report "Y" in the SV111 Segment of the 2400 Loop**.**

Family Planning – It is critical that providers utilize element SV112 of Loop 2400 when Family Planning services are performed. This allows the Department to appropriately report services to CMS.

National Provider Identifier (NPI)

The NPI is required on all electronic claim submittals with the exception of atypical providers who have not enumerated a NPI. The NPI that is submitted in the 837 Transaction must be a NPI that has been reported to the department, prior to billing, to ensure that a crosswalk can be made from the

NPI to their HFS legacy number. If the NPI is not reported to the department, it cannot be crosswalked and HFS will reject the claim.

Atypical providers who are not eligible for enumeration need to use the 2010BB – Billing Provider Secondary Identification segment to report the HFS assigned provider number.

COBC Claims - For a COBC claim, when the submitted NPI doesn't map to a Payee, the FEIN or SSN for the Billing Provider is used to identify the Payee. If there are multiple Payee matches based on the FEIN or SSN, then the match is based on FEIN or SSN and ZIP Code.

Patient/Subscriber- The patient is always the subscriber. Claim information should only be placed at the subscriber, (or SBR Segment) hierarchical level (even when using the mother's Recipient Identification Number to bill newborn services). Claims with information in the Patient hierarchical level will not be accepted into our processing system. Do not use the PAT segment for the patient

Taxonomy - The providers must report in *PRV03 o*f the 2000A Loop the billing provider taxonomy code. For HFS, the provider taxonomy code will be utilized to derive the Department's unique categories of service. For additional detail on Taxonomy codes, refer to Appendix 5 of Chapter 300 Provider Handbook for Electronic Processing.

Transportation – A diagnosis code is required on all 5010 transportation claims. If the diagnosis code is provided by the treating physician or other practitioner, enter the code in the HI*BK segment of the 2300 loop. If there is no diagnosis code available, transportation providers can use a default ICD-9 code of 799.9, or upon implementation, ICD-10 code of R69.

Note: Effective 10/01/2015, the new ICD-10 code set will be implemented, thus making the ICD-9 code value invalid. A valid ICD-10 code must be used on all claims with a service date of 10/01/2015 and after.

Transportation claims, emergency and non-emergency, must report specific information about the trip in the NTE 2300 Loop. The State code, Vehicle License Number, Origin Time, and Destination Time must be reported in Loop 2300 Claim Note, NTE02 element. The information contained in this field will apply to all service sections unless overridden in the 2400 Loop.

NTE01: Value "ADD"

NTE02: State or Province Code, Vehicle License Number, Origin Time, Destination Time
Example:
NTE*ADD* IL,12345678,1155,1220 and must follow this format:

- Each field must be separated with a comma.

The length for each field is listed below:

Length	Description
2	State or Province Code (Use Code source 22: States and Outlying Areas of the U.S.
8	Vehicle License Number
4	Origin Time Time expressed in 24-hour clock time as follows: HHMM, where H = hours (00-23), M = minutes (00-59)
4	Destination Time Time expressed in 24-hour clock time as follows: HHMM, where H = hours (00-23), M = minutes (00-59)

NOTE: The State or Province Code, Origin Time and Destination Time fields **must** contain the length per field as listed above. Vehicle license number may vary from 1 to a maximum of 8 characters. If the license plate number is less than 8 characters, left justify and space fill.

Transportation Modifiers – Emergency Transportation Claims

Place Codes for origin and destination will be reported using Procedure Modifiers, and they will be reported with each procedure code billed. The one-digit modifiers are combined to form a two-digit modifier that identifies the transportation provider's place of origin with the first digit, and the destination with the second digit. Values of these Modifiers are:

Modifier	Description
D	Diagnostic or therapeutic site, other than P or H when used as an origin code
E	Residential facility
H	Hospital
N	Skilled nursing facility
P	Physician's office
R	Residence
S	Scene of accident or acute event
X	Destination code only, intermediate stop at physician's office on the way to the hospital.

Transportation Modifiers – Non-Emergency Transportation Claims

Place Codes for origin and destination will be reported using Procedure Modifiers, and they will be reported with each procedure code billed. The one-digit modifiers are combined to form a two-digit modifier that identifies the transportation provider's place of origin with the first digit, and the destination with the second digit.

Non-emergency transportation claims must contain HIPAA compliant modifiers. This will require the provider to **map the HFS proprietary codes to the HIPAA codes accepted by HFS** as shown below. The allowable values of these Modifiers for Illinois Medicaid are:

HFS Proprietary Code	HIPAA Modifier Accepted by HFS	Description
E F G	D	Diagnostic or therapeutic site, other than P or H
B C	H	Hospital
A	P	Physician's office
H I K	R	Residence

For example, if the patient is transported from his home ("K") to a physician's office ("A"), the "K" will be changed to an "R" and the "A" changed to a "P", so the modifier reported on the 837P will be "RP".

NOTE: Continue to report HFS's proprietary codes ("KA" in this example) on **paper** claims.

Other Governmental Payers Information

NIPS claims submitted to the Department of Healthcare & Family Services (HFS), by the Other Government Payers (OGP), must contain the OGPs (3) digit alphabetic identifier code, the date that the OGP paid for the service, and the OGPs payment amount.

Loop 2330B – Other Payer Name

Element ID: NM101
Element Name: Entity Identifier Code
Qualifier: PR

Element ID: NM102
Element Name: Entity Type Qualifier
Qualifier: 2 (Non-Person Entity)

Element ID: NM103
Element Name: Organization Name
This field must contain the name of the Government Entity

Element ID: NM108
Element Name: Identification Code Qualifier
Qualifier: PI (Payer Identification)

Element ID: NM109
Element Name: Identification Code
This field must contain the three (3) digit alphabetic code.

Loop 2330B – Other Payer Secondary Identifier
Element ID: REF01
Element Name: Reference Identification Qualifier
Qualifier: 2U

Element ID: REF02
Element Name: Reference Identification
This field must contain the three (3) digit alphabetic identifier code. This three (3) digit code will be reported in the first occurrence of the TPL code field for each service section.

Loop 2430 – Line Adjudication Information
Based on the 837P Implementation Guide, if this loop is used, then this segment is a “Required” segment. This requires you to report the following Element ID’s: SVD01, SVD02, SVD03, SVD05, & SVD06.

Element ID: SVD01
Element Name: Identification Code
Based on the 837P Implementation Guide, this number must match Element ID, NM109, in Loop 2330B (Other Payer Name).

Element ID: SVD02
Element Name: Monetary Amount
This field must contain the amount paid by the Other Government Payer (OGP). This amount will be reported in the first occurrence of the TPL amount field for each service section.

Element ID's: SVD03 & SVD05 are required elements within this loop.

Loop 2430 – Line Adjudication Information
Element ID: DTP01
Element Name: Date/Time Qualifier
Qualifier: 573 (Date Claim Paid)

Element ID: DTP02
Element Name: Date Time Period Format Qualifier
Qualifier: D8 (Date Expressed In Format CCYYMMDD)

Element ID: DTP03
Element Name: Date Time Period
This field must contain the date that the OGP paid for the service. This date will be reported in the first occurrence of the TPL date field for each service section.

Transmission Information:

HFS will continue to support the Medicaid Electronic Data Interchange (MEDI) system whereby authorized Providers and their agents can submit and receive electronic transactions via the Internet. Providers will have the ability to submit single claims as well as batch files utilizing the MEDI system. Additionally the

MEDI system supports claim status inquiries, eligibility inquiries, and supports an option to obtain an electronic remittance advice. Access the MEDI system and click the login option.

The Department will also continue to support its Recipient Eligibility Verification (REV) system. The REV system allows authorized Vendors a means to submit and receive electronic transactions, on behalf of Providers, for processing eligibility inquiries, claim submission and claim status. For more information on REV vendors go to the REV page on our Web site.

5 TI Change Summary

Revision Date: **05/03/2011**	**Revision Description: Revised the HFS Unique 837P Items and removed the notation that all claims require diagnosis code except for transportation and laboratory claims. Diagnosis is required for all claims as the implementation guide reflects.**
Revision Date: **10/04/2011**	**Revision Description: Updated transportation section to include diagnosis requirement and default code information.**
Revision Date:	**Revision Description:**
Revision Date:	**Revision Description:**
Revision Date:	**Revision Description:**
Revision Date:	**Revision Description:**