

837 Health Care Claim
Companion Guide

Professional and Institutional

Revised December 2007

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Introduction

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 was passed in order to provide better access to health insurance, limit fraud and abuse, and reduce administrative costs of the health care industry. This act required the Department of Health and Human Services (HHS) to adopt standards that support the electronic data interchange (EDI) of health care transactions. In order for the industry to achieve its desired goal, all organizations involved in electronic interchange of data must comply with the standard transactions and code sets that have been developed. These guidelines are outlined in the ANSI X12N 837 Health Care Claims transaction implementation guides. By adopting these standards the efficiency and effectiveness of the health care will improve by encouraging the use of electronic data interchange throughout the industry.

Purpose

The purpose of this document is to provide submitters with the necessary information to successfully submit electronic claims to Advanced Behavioral Health, Inc (ABH). This companion guide should be used in combination with the ANSI X12N 837 implementation guides. These guides are available from Washington Publishing Company on their website at www.wpc-edi.com/hipaa/.

Types of transactions accepted by ABH are:

- 837 Professional Health Care Claim – ASC X12 837 (004010X098A1)
- 837 Institutional Health Care Claim – ASC X12 837 (004010X096A1)

For those submitters who have previously submitted State of CT General Assistance batch claims electronically, no changes have been made other than the names of the parties involved. For those submitters who have not submitted electronic claims in the past, this companion guide will describe specific requirements necessary for processing claims through Advanced Behavioral Health's system. This guide in no way replaces any requirements that are found in the ANSI X12N implementation guides.

References

Listed below are some additional websites containing information that may be helpful during the implementation process:

Accredited Standards Committee (ASC X12N) – <http://www.x12n.org/>

Centers for Medicare and Medicaid Services (CMS) – <http://www.cms.hhs.gov/hipaa/>

United States Department of Health and Human Services (DHHS) – <http://aspe.hhs.gov/admsimp/>

Washington Publishing Company – <http://wpc-edi.com/hipaa/>

Additional information

Delimiters Supported

A delimiter is a character that is used to separate data elements, or mark the end of a segment. The preferred delimiters for electronic data are an (*) asterisk for separation of data elements, a (:) colon for separation of sub-elements, and (~) tilde for indication of a segment end. Other delimiters will be accepted according to the ANSI X12N guidelines. Note that once a delimiter has been specified, it cannot be used in the data elements transferred or it will cause the file to be rejected.

Maximum Limitations

The 837 transaction is designed to submit one or more claims per billing provider. The hierarchy built into the structure is billing provider, subscriber, patient, claim, and claim service. The number of times that each of these loops may repeat is defined in the implementation guides. For example, there cannot be more than 100 claims per client, and no more than 50 service lines per professional claim/999 service lines per institutional claim. ABH will require that only one interchange be submitted per transaction. In addition, there may be only one type of claim (institutional or professional) submitted per interchange, and therefore per file.

When files are validated, after being submitted to ABH, they will be checked and accepted (pass) or rejected (fail) based on the entire file's formatting. Therefore, partial files will not be accepted. Providers will be notified of this response via a download page on the ABH website. If a file is rejected, the message will indicate to the provider what they will need to correct. If there are questions about any error messages that are unclear, please contact the ABH customer service for assistance.

Submission Specifications

Provider organizations who wish to submit electronic 837 transactions to Advanced Behavioral Health must have a valid submitter id and password. If you do not have this information you may acquire one by contacting the Customer Support at 800-606-3677 X6440 or downloading, completing and submitting the form on ABH's website at http://www.abhct.com/resources_gabhp.htm.

In addition, provider organizations wishing to submit batch claims electronically to ABH must submit one accepted, error free test file and receive verification that the file loaded successfully before submitting production files. In order to submit test files, an ID and password will be assigned by filling out the access form referenced above. The ID will allow submitters to submit only test files until the successful file has been received, at which time the ID will be activated for production files.

Provider organizations who will be submitting their claims through the single data-entry claims system on the Internet will not need to test any files and will be able to start submitting claims as soon as they receive their ID and password.

If your provider organization utilizes a third-party health care clearinghouse or other agency to submit batch claim files, the organization must submit a copy of a signed Business Associate or Trading Partner agreement along with the access request form. The Department of Mental Health & Addiction Services reserves the right to make final decisions regarding approval of access for third-party agencies. If you have further questions about obtaining access for a third-party agency, please contact our Provider Relations Department at (800) 606-3677, Ext. 6440.

Interchange Control Header/Trailer Specifications

Seg	Data Element	Name	Usage	Comments	Expected Value
Header					
ISA		Interchange Control Header	R		
	ISA01	Authorization Information Qualifier	R		Use '03' Additional Data Identification to indicate that a login ID is present in ISA02.
	ISA02	Authorization Information	R	Information used for additional identification or authorization.	Use the ABH Submitter ID as the login ID.
	ISA03	Security Information Qualifier	R		Use '01' Password to indicate that a password is present in ISA04.
	ISA04	Security Information	R	Additional security information identifying the sender.	Use the ABH Submitter ID password.
	ISA05	Interchange ID Qualifier	R		Refer to the implementation guide for a list of valid qualifiers.
	ISA06	Interchange Sender ID	R		Refer to the implementation guide specifications.
	ISA07	Interchange ID Qualifier	R		Use 'ZZ' Mutually Defined
	ISA08	Interchange Receiver ID	R		Use 'ABH'
	ISA09	Interchange Date	R	Date format YYMMDD	
	ISA10	Interchange Time	R	Time format HHMM	
	ISA11	Interchange Control Standards Identifier	R	Code used to identify the agency responsible for the control standard used by the message. Valid values: 'U' U.S. EDI Community of ASC X12	Use 'U' U.S. EDI Community of ASC X12
	ISA12	Interchange Control Version Number	R	Valid values: '00401' Draft standards for Trial Use Approved for Publication by ASC X12 Procedures Review Board through October 1997.	Use the current standard approved for the ISA/IEA envelope.
	ISA13	Interchange Control Number	R	The interchange control number must match the interchange trailer IEA02.	This value is to be defined by the senders system. If not used, this field must be zero filled.
	ISA14	Acknowledgement Requested	R	Valid values: '0' No Acknowledgement Requested '1' Interchange Acknowledgement Requested	
	ISA15	Usage Indicator	R	Valid values: 'P' Production 'T' Test	This Usage Indicator should be set appropriately. When submitting initial tests use 'T', for all other files use 'P'.
	ISA16	Component Element Separator	R	The delimiter must be a unique character not found in any of the data included in the batch. This element will contain the delimiter that will be used to separate components within a data element. This value must be different from the element separator and segment terminator.	

Seg	Data Element	Name	Usage	Comments	Expected Value
Trailer					
IEA		Interchange Control Trailer	R		
	IEA01	Number of Included Functional Groups	R	Count of the number of functional groups in the interchange.	
	IEA02	Interchange Control Number	R	The interchange control number in IEA02 must match the interchange header value sent in ISA13.	The interchange control numbers in the IEA and ISA segments will be compared. If the numbers do not match the file will be rejected.

Functional Group Header/Trailer Specifications

Seg	Data Element	Name	Usage	Comments	Expected Value
Header					
GS		Functional Group Header	R		
	GS01	Functional Identifier Code	R	Valid values: 'HC' Health Care Claims (837)	Use 'HC' Health Care Claims (837)
	GS02	Application Sender's Code	R		The sender defines this value.
	GS03	Application Receiver's Code	R		This field identifies how the file was received by ABH. Use 'EDI' for electronic transfer of data.
	GS04	Date	R	Date format CCYYMMDD	
	GS05	Time	R	Time format HHMM.	
	GS06	Group Control Number	R	The group control number in GS06 must be the same as the associated group trailer element (GE02).	
	GS07	Responsible Agency Code	R	Valid values: 'X' Accredited Standards Committee X12	Use 'X' Accredited Standards Committee X12
	GS08	Version/Release Industry ID Code	R	Valid values: '004010X098A1' - Professional Addenda Approved for Publication by ASC X12. '004010X096A1' - Institutional Addenda Approved for Publication by ASC X12.	Use the current standard approved for publication by ASC X12.

Seg	Data Element	Name	Usage	Comments	Expected Value
Trailer					
GE		Functional Group Trailer	R		
	GE01	Number of Transaction Sets Included	R	Count of the number of transaction sets in the functional group.	Only similar transaction sets may be included in the functional group.
	GE02	Group Control Number	R	The group control number in GE02 must match that sent in the group header (GS06).	The group control numbers in the GE and GS segments will be compared. If the numbers do not match the file will be rejected.

837 Professional Claim Transaction Specifications

Seg	Data Element	Name	Usage	Comments	Expected Value
Header					
BHT		Beginning of Hierarchical Transaction	R		
	BHT02	Transaction Set Purpose Code	R	Valid values: '00' Original '18' Reissue Case	Use '00' Original.
	BHT06	Transaction Type Code	R		Use 'CH' for claims
REF		Transmission Type Identification	R		
	REF02	Transmission Type Code	R	This element contains the version number being sent.	Use '004010X098A1' for Production transaction sets. Use '004010X098DA1' for Test transaction sets.

Loop 1000A - Submitter Name					
NM1		Submitter Name	R		
	NM109	Submitter Primary Identifier	R	This element contains the ETIN (Electronic Transaction Identifier Number).	Use the ABH Submitter ID.

Loop 1000B - Receiver Name					
NM1		Receiver Name	R		
	NM103	Receiver Name	R		Use 'Advanced Behavioral Health, Inc.'
	NM109	Receiver Primary Identifier	R	This element contains the ETIN (Electronic Transaction Identifier Number).	Use 'ABH'.

Loop 2000A - Billing / Pay-To Provider Specialty Information					
PRV		Billing / Pay-To Provider Specialty Information	R		
	PRV02	Provider Specialty Code Qualifier	R		Use 'ZZ'
	PRV03	Provider Taxonomy Code	R		Send the providers taxonomy code.

Loop 2010AA - Billing Provider Name					
NM1		Billing Provider Name	R		
	NM108	Billing Provider Identification Code Qualifier	R		Use 'XX'
	NM109	Billing Provider Identifier	R		Send the Provider's National Provider ID (NPI)
N4		Billing Provider City/State/Zip Code	R		
	N403	Billing Provider Zip Code	R		Send the Provider's 9-digit zip code.
REF		Billing Provider Secondary Identification	S		When NPI is submitted in NM108/109, the provider must send either their EIN or SSN in the REF loop. Use:
	REF01	Reference Identification Qualifier	R		'E' Tax ID (to indicate the provider's EIN) 'SY' SSN (to indicate the provider's SSN)
	REF02	Billing Provider Additional Identifier	R		Send the Provider's EIN/SSN

Loop 2010AB - Pay-To Provider					
NM1		Pay-To Provider Name	R		
	NM108	Pay-To Provider Identification Code Qualifier	R		Use 'XX'
	NM109	Pay-To Provider Identifier	R		Send the Provider's National Provider ID (NPI)
N4		Pay-To Provider City/State/Zip Code	R		
	N403	Billing Provider Zip Code	R		Send the Provider's 9-digit zip code.
REF		Pay-To Provider Secondary Identification	S		When NPI is submitted in NM108/109, the provider must send either their EIN or SSN in the REF loop. Use:
	REF01	Reference Identification Qualifier	R		'E' Tax ID (to indicate the provider's EIN) 'SY' SSN (to indicate the provider's SSN)
	REF02	Pay-To Provider Additional Identifier	R		Send the Provider's EIN/SSN

Loop 2010BA - Subscriber Name					
NM1		Subscriber Name	R		
	NM108	Identification Code Qualifier	S	Required if the subscriber is a person (NM102 = 1). Also required if the subscriber is the patient.	Use 'MI' Member Identification Number.
	NM109	Subscriber Primary Identifier	S		Use the client's EMS ID.

Loop 2010BB - Payer Name					
NM1		Payer Name	R		
	NM103	Payer Name	R	Destination Payer Name	Use 'Advanced Behavioral Health, Inc.'
	NM108	Identification Code Qualifier	R		Use 'PI' Payer Identifier
	NM109	Payer Identifier	R	Destination Payer Identifier	Use 'ABH'.

837 Professional Claim Transaction Specifications

Seg	Data Element	Name	Usage	Comments	Expected Value
Loop 2010CA - Patient Name					
NM1		Patient Name	R		
	NM108	Identification Code Qualifier	S		Use 'MI' Member Identification Number.
	NM109	Patient Primary Identifier	S		Use the client's EMS ID.
Loop 2300 - Claim Information					
CLM		Claim Information	R		
	CLM01	Claims Submitter's Identifier	R		Patient's Account Number entered here will be returned on the EOB.
REF		Original Reference Number (ICN/DCN)	S		
	REF02	Original Reference Number (ICN/DCN)	R		When submitting an Original Reference Number use the number with the prefix of 'RC'.
Loop 2310A - Referring Provider Name					
NM1		Referring Provider Name	S		
	NM108	Identification Code Qualifier	S		Use 'XX'.
	NM109	Identification Code	S		Use the National Provider ID (NPI) of the referring provider.
REF		Referring Provider Secondary Identification	S		
	REF01	Reference Identification Qualifier	R	Required if a secondary number is necessary to identify the provider. The primary identifier should be sent in NM108/109 in this loop.	Use '24' EIN or '34' SSN
	REF02	Referring Provider Secondary Identification	R		
Loop 2310B - Rendering Provider Name					
REF		Rendering Provider Secondary Identification	S		
	REF01	Reference Identification Qualifier	R	Required if a secondary number is necessary to identify the provider. The primary identifier should be sent in NM108/109 in this loop.	Use 'XX'.
	REF02	Rendering Provider Secondary Identification	R		Use the National Provider ID (NPI) of the rendering provider.
Loop 2400 - Service Line					
SV1		Professional Service	R		
	SV101	Composite Medical Procedure Identifier	R		
	SV101-1	Product/Service ID Qualifier	R		Use 'HC' Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes.
	SV101-3 SV101-4 SV101-5 SV101-6	Procedure Modifier	S		
	SV104	Quantity	S		Use whole number unit values.
DTP		Date - Service Date	R		
	DTP02	Date/Time Period Qualifier	R	Valid values: 'D8' Single Date (CCYYMMDD) 'RD8' Range of Dates	Use 'RD8' to specify a range of dates. The from and thru service dates should be sent for each service line.

837 Institutional Claim Transaction Specifications

Seg	Data Element	Name	Usage	Comments	Expected Value
Header					
BHT		Beginning of Hierarchical Transaction	R		
	BHT02	Transaction Set Purpose Code	R	Valid values: '00' Original '18' Reissue Case	Use '00' Original.
	BHT06	Transaction Type Code	R		Use 'CH' for claims
REF		Transmission Type Identification	R		
	REF02	Transmission Type Code	R	This element contains the version number being sent.	Use '004010X096A1' for Production transaction sets. Use '004010X096DA1' for Test transaction sets.
Loop 1000A - Submitter Name					
NM1		Submitter Name	R		
	NM109	Submitter Primary Identifier	R	This element contains the ETIN (Electronic Transaction Identifier Number).	Use the ABH Submitter ID.
Loop 1000B - Receiver Name					
NM1		Receiver Name	R		
	NM103	Receiver Name	R		Use 'Advanced Behavioral Health, Inc.'
	NM109	Receiver Primary Identifier	R	This element contains the ETIN (Electronic Transaction Identifier Number).	Use 'ABH'.
Loop 2000A - Billing / Pay-To Provider Specialty Information					
PRV		Billing / Pay-To Provider Specialty Information	R		
	PRV02	Provider Specialty Code Qualifier	R		Use 'ZZ'
	PRV03	Provider Taxonomy Code	R		Send the providers taxonomy code.
Loop 2010AA - Billing Provider Name					
NM1		Billing Provider Name	R		
	NM108	Billing Provider Identification Code Qualifier	R		Use 'XX'
	NM109	Billing Provider Identifier	R		Send the Provider's National Provider ID (NPI)
N4		Billing Provider City/State/Zip Code	R		
	N403	Billing Provider Zip Code	R		Send the Provider's 9-digit zip code.
REF		Billing Provider Secondary Identification	S		When NPI is submitted in NM108/109, the provider must send either their EIN or SSN in the REF loop. Use:
	REF01	Reference Identification Qualifier	R		'EI' Tax ID (to indicate the provider's EIN) 'SY' SSN (to indicate the provider's SSN)
	REF02	Billing Provider Additional Identifier	R		Send the Provider's EIN/SSN
Loop 2010AB - Pay-To Provider					
NM1		Pay-To Provider Name	R		
	NM108	Pay-To Provider Identification Code Qualifier	R		Use 'XX'
	NM109	Pay-To Provider Identifier	R		Send the Provider's National Provider ID (NPI)
N4		Pay-To Provider City/State/Zip Code	R		
	N403	Billing Provider Zip Code	R		Send the Provider's 9-digit zip code.
REF		Pay-To Provider Secondary Identification	S		When NPI is submitted in NM108/109, the provider must send either their EIN or SSN in the REF loop. Use:
	REF01	Reference Identification Qualifier	R		'EI' Tax ID (to indicate the provider's EIN) 'SY' SSN (to indicate the provider's SSN)
	REF02	Pay-To Provider Additional Identifier	R		Send the Provider's EIN/SSN

837 Institutional Claim Transaction Specifications

Seg	Data Element	Name	Usage	Comments	Expected Value
Loop 2010BA - Subscriber Name					
NM1		Subscriber Name	R		
	NM108	Identification Code Qualifier	S	Required if the subscriber is a person (NM102 = 1). Also required if the subscriber is the patient.	Use 'MI' Member Identification Number.
	NM109	Subscriber Primary Identifier	S		Use the client's EMS ID.
Loop 2010BC - Payer Name					
NM1		Payer Name	R		
	NM103	Payer Name	R	Destination Payer Name	Use 'Advanced Behavioral Health, Inc.'
	NM108	Identification Code Qualifier	R		Use 'PI' Payer Identifier
	NM109	Payer Identifier	R	Destination Payer Identifier	Use 'ABH'.
Loop 2010CA - Patient Name					
NM1		Patient Name	R		
	NM108	Identification Code Qualifier	S		Use 'MI' Member Identification Number.
	NM109	Patient Primary Identifier	S		Use the client's EMS ID.
Loop 2300 - Claim Information					
CLM		Claim Information	R		
	CLM01	Claims Submitter's Identifier	R		Patient's Account Number entered here will be returned on the EOB.
	CLM05	Health Care Service Location Information	R		
	CLM05-3	Claim Frequency Type Code	R	UB-92 Type of Bill. Valid values: '1' - Admit through Discharge Claim '2' - Interim - First Claim '3' - Interim - Continuing Claim '4' - Interim - Last Claim '5' - Late Charge Only	Use '1', '2', '3', '4', or '5'
	CLM18	Yes/No Condition or Response Code	R	This indicator identifies if a paper EOB (Explanation of Benefits) is requested. Valid values: 'N' No 'Y' Yes	Use 'Y' Yes.
REF		Original Reference Number (ICN/DCN)	S		
	REF02	Original Reference Number (ICN/DCN)	R		When submitting an Original Reference Number use the number with the prefix of 'RC'.
HI		Principal Procedure Information	S		
	HI01	Health Care Code Information	R		
	HI01-1	Code List Qualifier	R		Use 'BP' Health Care Financing Administration Common Procedural Coding System Principal Procedure.
HI		Other Procedure Information	S		
	HI01	Health Care Code Information	R		
	HI01-1	Code List Qualifier	R		Use 'BO' Health Care Financing Administration Common Procedural Coding System.
Loop 2310A - Attending Physician Name					
REF		Attending Physician Secondary Identification	S		
	REF01	Reference Identification Qualifier	R	Required if a secondary number is necessary to identify the provider. The primary identifier should be sent in NM108/109 in this loop.	Use "XX".
	REF02	Attending Physician Secondary Identification	R		Send the Attending Physician's National Provider ID (NPI)
Loop 2400 - Service Line Number					
SV2		Institutional Service Line	R		
	SV202	Composite Medical Procedure Identifier	S		
	SV202-1	Product/Service ID Qualifier	R		Use 'HC' Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes.
	SV202-3 SV202-4 SV202-5 SV202-6	Procedure Modifier	S		
	SV205	Quantity	S		Use whole number unit values.
DTP		Date - Service Date	R		
	DTP02	Date/Time Period Qualifier	R	Valid values: 'D8' Single Date (CCYYMMDD) 'RD8' Range of Dates	Use 'RD8' to specify a range of dates. The from and thru service dates should be sent for each service line.