# 837 Health Care Claim
# Companion Guide

# Professional and Institutional

Revised December 2011

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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. This latest version of the Companion Guide contains the changes necessary to ensure compliance with 45 CFR Part 162, CMS-009-F.

## 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
- 837 Institutional Health Care Claim – ASC X12 837

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/admnsimp/
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.asp.

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 Repitition Separator | R | | |
| | ISA12 | Interchange Control Version Number | R | Valid values:<br>'00501' Standards Approved for Publication by ASC X12 Procedures Review Board through October 2003 | 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:<br>'0' No Acknowledgement Requested<br>'1' Interchange Acknowledgement Requested | |
| | ISA15 | Usage Indicator | R | Valid values:<br>'P' Production<br>'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.<br><br>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:<br>'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:<br>'X' Accredited Standards Committee X12 | Use 'X' Accredited Standards Committee X12 |
| | GS08 | Version/Release Industry ID Code | R | Valid values:<br>'005010X222A1' - Standards Approved for Publication by ASC X12 Procedures Review Board through October 2003.<br>'005010X223A2' - Standards Approved for Publication by ASC X12 Procedures Review Board through October 2003. | 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 Include | 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:<br>'00' Original<br>'18' Reissue Case | Use '00' Original. |
| | BHT06 | Transaction Type Code | R | | Use 'CH' for claims |
| **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 'PXC' |
| | 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.** |
| | REF01 | Reference Identification Qualifier | R | | Use:<br>'EI' Tax ID (to indicate the provider's EIN)<br>'SY' SSN (to indicate the provider's SSN) |
| | REF02 | Billing 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'. |
| **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. |
| **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 'G2' |
| | REF02 | Referring Provider Secondary Identification | R | | |

| Seg | Data Element | Name | Usage | Comments | Expected Value |
|---|---|---|---|---|---|
| **Loop 2310B - Rendering Provider Name** | | | | | |
| **NM1** | | **Rendering Provider Secondary Identification** | **S** | | |
| | NM108 | Identification Qualifier | R | | Use 'XX'. |
| | NM109 | Rendering Provider 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<br>SV101-4<br>SV101-5<br>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:<br>'D8' Single Date (CCYYMMDD)<br>'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. |

| Seg | Data Element | Name | Usage | Comments | Expected Value |
|---|---|---|---|---|---|
| **Header** | | | | | |
| **BHT** | | **Beginning of Hierarchical Transaction** | **R** | | |
| | BHT02 | Transaction Set Purpose Code | R | Valid values:<br>'00' Original<br>'18' Reissue Case | Use '00' Original. |
| | BHT06 | Transaction Type Code | R | | Use 'CH' for claims |
| | | | | | |
| **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 'PXC' |
| | 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 their EIN in the REF loop.** |
| | REF01 | Reference Identification Qualifier | R | | Use:<br>'EI' Tax ID (to indicate the provider's EIN) |
| | REF02 | Billing Provider Additional Identifier | R | | Send the Provider's EIN |
| | | | | | |
| **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'. |
| | | | | | |
| **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.<br><br>Valid values:<br>'1' - Admit through Discharge Claim<br>'2' - Interim - First Claim<br>'3' - Interim - Continuing Claim<br>'4' - Interim - Last Claim<br>'5' - Late Charge Only | Use '1', '2', '3', '4', or '5' |
| **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 'BR' 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 'BQ' Health Care Financing Administration Common Procedural Coding System. |
| | | | | | |

| Seg | Data Element | Name | Usage | Comments | Expected Value |
|---|---|---|---|---|---|
| **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<br>SV202-4<br>SV202-5<br>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:<br>'D8' Single Date (CCYYMMDD)<br>'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. |