837 PROFESSIONAL CLAIMS AND ENCOUNTERS TRANSACTION COMPANION GUIDE

OCTOBER 19, 2012
ASCX12N 837 (005010X222A1)
VERSION 3.0
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1.0 Overview

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) legislation mandates that many of the major health care electronic data exchanges, such as electronic claims and remittance advices, be standardized into the same national format for all payers, providers, and clearinghouses. All providers who submit governed data electronically to CSC must submit in the mandated HIPAA formats. HIPAA specifically names several electronic standards that must be followed when certain health care information is exchanged. These standards are published as National Electronic Data Interchange Transaction Set Implementation Guides. They are commonly called Implementation Guides (IGs) and are referred to as IGs throughout this document. The implementation guide for a 5010 transaction is also known as a Technical Report Type 3 or TR3. The following table lists the adopted standards. The file types that CSC supports for communication to and from Provider Agencies are marked in bold.

This document is applicable to HIPAA 5010 standards and, as such, is effective January 1, 2012.

<table>
<thead>
<tr>
<th>Business Category</th>
<th>Transaction Name/Implementation Guide</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims Processing</td>
<td>ASC X12N 837P (005010X222A1)</td>
<td>Health Care Claim: Professional</td>
</tr>
<tr>
<td>Explanation of Payment/Remittance</td>
<td>ASC X12N 835 (005010X221A1)</td>
<td>Payment/Advice</td>
</tr>
<tr>
<td>Advice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Claim Status</td>
<td>ASC X12N 276/277 (005010X212)</td>
<td>Health Care Claims Status Request and Response</td>
</tr>
</tbody>
</table>

The Implementation Guides are available for download through the Washington Publishing Company Web site at [http://www.wpc-edi.com](http://www.wpc-edi.com) and other locations. Developers must have copies of the respective Implementation Guides as well as all associated Errata and Addenda prior to beginning the development process.

CSC has developed technical companion guides to assist application developers during the implementation process. In most instances, an existing data exchange format has completely changed, for instance claims. In other cases, a new method for electronic data exchange has been developed, such as prior authorization. The information contained in the CSC Companion Guide is only intended to supplement the adopted Implementation Guides and provide guidance and clarification as it applies to CSC. The CSC Companion Guide is never intended to modify, contradict, or reinterpret the rules established by the Implementation Guides.
2.0 Introduction

The ASC X12N 837P (005010X22A1) transaction is the HIPAA mandated instrument by which professional claim or encounter data must be submitted. Any claim that would be submitted on paper such as a service authorization billing form must be submitted using this transaction if the data is submitted electronically. This document is intended only as a companion guide and is not intended to contradict or replace any information in the IG or the Early Intervention Provider Billing Manual. It is highly recommended that implementers have the following resources available during the development process:

- This document, Companion Guide – 837 Professional Claims and Encounters Transactions
- ASC X12N 837 TR3 or Implementation Guide (IG) (005010X222A1)
- Early Intervention Provider Billing Manual

Additionally, there are several processing assumptions, limitations, and guidelines a developer must be aware of when implementing the 837P transaction. The following list identifies these processing stipulations:

- CSC will accept only one transaction (ST/SE) per interchange (ISA/IEA).
- CSC will accept up to 5000 CLM segments per ST – SE. The IG recommends creating this limitation to avert circumstances where file size management may become an issue.
- Patient loops, 2000C and 2010CA, are ignored because the CSC members/subscribers are always the same as the patient.
- All monetary amounts have explicit decimals. The decimal point always appears in the character stream if the decimal point is at any place other than the right end. If the value is an integer, decimal point at the right end, the decimal point should be omitted. See the IG for additional clarification.
- Negative quantities or amounts are rejected.
- Quantities and amounts have pre-adjudication edits. Refer to the appropriate segments for CSC formats.
- Other data elements with lengths greater than CSC definitions are truncated.
- Qualifier codes are case sensitive and should be presented as they are in the IGs.
- CSC is referred to as CRO-CSC in applicable Receiver segments.
- CSC treats all 837P transactions as original claims. Claim adjustments must be submitted through the paper process or via the website. See the Early Intervention Provider Billing Manual for details. Replacement or void claims are treated as original claims.
- For Version 5010, the Implementation Guide (IG) is also called the Technical Report 3 (TR3). In this document the terms are treated as synonymous.
3.0 Data Exchange Technical Specifications and Interchange Control

Appendix B, Section B.1.1 of each X12N HIPAA Implementation Guide or TR 3 provides complete detail about the rules for ensuring integrity and maintaining the efficiency of data exchange. Data files are transmitted in an electronic envelope. The communication envelope consists of an interchange envelope and functional groups. The interchange control structure described in the Implementation Guide is used for inbound files. An inbound interchange control structure is the envelope that wraps all transaction data (ST-SE) sent to CSC for processing. The following pages detail specific information about what is required by CSC in certain segments and elements as it relates to inbound communication to CSC. Refer to the Implementation Guide for complete information about all other segments and elements.

3.1 Inbound transaction Segments

Segment Name: Interchange Control Header
Segment ID: ISA
Usage: Required
Segment Notes:
- All positions within each data element in the ISA segment must be filled.
- Delimiters are specified in the interchange header segment.
- ISA01 should be populated with “00” to indicate no security.
- ISA03 should be populated with “00” to indicate no security.
- ISA05 should be populated with “ZZ” to indicate that the value is mutually defined.
- ISA06 should be populated with the nine digit federal tax ID. This field has a required length of 15 bytes; therefore, the field must be blank filled to the right.
- ISA07 should be populated with “ZZ” to indicate that the value is mutually defined.
- ISA08 should be populated with “CRO-CSC” This field has a required length of 15 bytes; therefore, the field must be blank filled to the right.
- The character immediately following the segment ID, ISA, defines the data elements separator. The last character in the segment defines the component element separator, and the segment terminator is the byte that immediately follows the component element separator. Examples of the separators are as follows:

<table>
<thead>
<tr>
<th>Character</th>
<th>Name</th>
<th>Delimiter</th>
</tr>
</thead>
<tbody>
<tr>
<td>*</td>
<td>Asterisk</td>
<td>Data Element Separator</td>
</tr>
<tr>
<td>&gt;</td>
<td>Greater Than</td>
<td>Sub Element Separator</td>
</tr>
<tr>
<td>~</td>
<td>Tilde</td>
<td>Segment Terminator</td>
</tr>
<tr>
<td>^</td>
<td>Caret</td>
<td>Repetition Separator</td>
</tr>
</tbody>
</table>

Example:

ISA*00*  *00*  *ZZ*999999999  *Z*CRO-CSC  *930602*1253^^*00501*00000095*0*P>*~
Segment Name: Functional Group Header
Segment ID: GS
Usage: Required
Segment Notes:
- Element GS02 should be populated with the Provider’s nine digit federal tax ID.
- Element GS03 should be populated with the value “CRO-CSC”

Example:
GS*HC*912936336*CRO-CSC*20030808*145901*5*X*005010X222A1~

3.2 Sample Inbound Interchange Control

This example illustrates a file that includes 837P transactions.

ISA*00*          *00*          * ZZ* 4472691280001  * ZZ*CRO-CSC        *930602*1253*U*00501* 00000905*0*P*>~
GS*HS*4472691280001*CRO-CSC*20020606*105531*5*X*005010X222A1~
ST – 837 TRANSACTION SET HEADER
837P DETAIL SEGMENTS
SE – 837 TRANSACTION SET TRAILER
GE*1*5~
IEA*1*00000905~
4.0 Segment Usage – 837 Professional

4.1 Segment Usage Matrix

The following matrix lists segments that CSC utilizes from 837P files using the 5010 format. Additionally, it includes a CSC Usage column that identifies segments that are required or situational for use by CSC. A required segment must appear on all transactions. Failure to include a required segment results in a compliance error. A situational segment is not required for every transaction. However, it may be required under certain circumstances. Please refer to the Early Intervention Provider Manual for specific billing requirements. Any segment identified in the Usage column as required or situational is explained in the Segment and Data Element Description section of the document.

There are many segments not noted in this matrix that are nonetheless required by the X12 standard. Refer to the Implementation Guide or TR3 for information regarding these segments. They will be required in files submitted to CSC, but the Implementation Guide must be consulted for their use and formatting.

<table>
<thead>
<tr>
<th>Segment ID</th>
<th>Loop ID</th>
<th>Segment Name</th>
<th>CSC Usage</th>
</tr>
</thead>
<tbody>
<tr>
<td>NM1</td>
<td>1000A</td>
<td>Submitter Name</td>
<td>R</td>
</tr>
<tr>
<td>NM1</td>
<td>2010BA</td>
<td>Subscriber Name</td>
<td>R</td>
</tr>
<tr>
<td>N3</td>
<td>2010BA</td>
<td>Subscriber Address</td>
<td>R</td>
</tr>
<tr>
<td>N4</td>
<td>2010BA</td>
<td>Subscriber City/State/Zip</td>
<td>R</td>
</tr>
<tr>
<td>DMG</td>
<td>2010BA</td>
<td>Subscriber Demographic Information</td>
<td>R</td>
</tr>
<tr>
<td>NM1</td>
<td>2010BB</td>
<td>Payer Name</td>
<td>R</td>
</tr>
<tr>
<td>CLM</td>
<td>2300</td>
<td>Claim Information</td>
<td>R</td>
</tr>
<tr>
<td>REF</td>
<td>2300</td>
<td>Prior Authorization or Referral Number</td>
<td>R</td>
</tr>
<tr>
<td>REF</td>
<td>2300</td>
<td>Medical Record Number</td>
<td>R</td>
</tr>
<tr>
<td>HI</td>
<td>2300</td>
<td>Health Care Diagnosis Code</td>
<td>R</td>
</tr>
<tr>
<td>NM1</td>
<td>2310B</td>
<td>Rendering Provider Name</td>
<td>R</td>
</tr>
<tr>
<td>PRV</td>
<td>2310B</td>
<td>Rendering Provider Specialty Information</td>
<td>R</td>
</tr>
<tr>
<td>REF</td>
<td>2310B</td>
<td>Rendering Provider Secondary Information</td>
<td>S</td>
</tr>
<tr>
<td>SV1</td>
<td>2400</td>
<td>Professional Service</td>
<td>R</td>
</tr>
<tr>
<td>DTP</td>
<td>2400</td>
<td>Date – Service Date</td>
<td>R</td>
</tr>
<tr>
<td>REF</td>
<td>2400</td>
<td>Prior Authorization</td>
<td>S</td>
</tr>
<tr>
<td>REF</td>
<td>2400</td>
<td>Line Item Control Number</td>
<td>S</td>
</tr>
<tr>
<td>NTE</td>
<td>2400</td>
<td>Line Note</td>
<td>R</td>
</tr>
</tbody>
</table>
4.2 Segment and Data Element Description

This section contains information pertaining to any segments that are required or situational for the CSC implementation of the HIPAA 837P. Please refer to the Implementation Guide or TR3 for complete information on the elements and specific formatting of these segments.

**Segment Name – Industry assigned segment name as identified in the IG.**
**Segment ID –** The industry assigned segment ID as identified in the IG.
**Loop ID –** The loop within which the segment should appear.
**Usage –** Identifies the segment as required or situational.
**Segment Notes –** A brief description of the purpose or use of the segment.
**Example –** An example of complete segment.

**Segment Name: Submitter Name**
Segment ID: NM1
Loop ID: 1000A
Usage: Required
Segment Notes:
- This segment identifies the submittter.
- Element NM109 must include the CSC-assigned sender ID (ETIN) which consists of the nine digit tax ID plus the four digit Provider Account sequence number for the provider.

Example:
NM1*41*2*Clearinghouse Inc.*****46*956741230001~

**Segment Name: Subscriber Name**
Segment ID: NM1
Loop ID: 2010BA
Usage: Required
Segment Notes:
- This segment contains the CSC member name and ID number.
- Element NM109 contains the Child’s Spoe ID which is generated by the Spoe software.

Example:
NM1*IL*1*DOE*JOHN*T***MI*990002134~

**Segment Name: Subscriber Address**
Segment ID: N3
Loop ID: 2010BA
Usage: Required
Segment Notes:
- Required because the patient is the same person as the subscriber, however, CSC will not capture this data
**Segment Name: Subscriber City/State/ZIP**
Segment ID: N4
Loop ID: 2010BA
Usage: Required
Segment Notes:
- Required because the patient is the same person as the subscriber, however, CSC will not capture this data.

**Segment Name: Subscriber Demographic Information**
Segment ID: DMG
Loop ID: 2010BA
Usage: Required
Segment Notes:
- Required because the patient is the same person as the subscriber.
- Date of Birth is required
- Gender is required.

Example:

DMG*D8*20011123*M~

**Segment Name: Payer Name**
Segment ID: NM1
Loop ID: 2010BB
Usage: Required
Segment Notes:
- This segment contains the destination Payer
- Element NM103 should contain “FSSA”
- Element NM109 should contain “336814161”

Example:

NM1*PR*2* FSSA *****PI*336814161~

**Segment Name: Claim Information**
Segment ID: CLM
Loop ID: 2300
Usage: Required
Segment Notes:
- This segment contains basic data about the claim.
- Element CLM05-1 is the Facility Type Code. See IG for two character code for place of service. If there is no appropriate value list in the IG, use 99, Other Unlisted Facility and enter the POS in the NTE segment of the 2400 loop
- Element CLM05-3 is the Claim Frequency Code. It is required by the standard, but it is not used by CSC All corrections, voids and replacement claims should be sent on paper.

Example:

CLM*1234567ABC*100***11>B>1*Y*A*Y*Y*P~
Segment Name: Prior Authorization
Segment ID: REF
Loop ID: 2300
Usage: Required
Segment Notes:
  • This segment contains prior authorization or referral number.
  • Element REF02 contains the Authorization number generated by the Spoe software.

Example:
REF*G1*A99000629513~

Segment Name: Medical Record Number
Segment ID: REF
Loop ID: 2300
Usage: Required
Segment Notes:
  • This segment contains the medical record number for the patient. This is the Child ID number created by the Spoe software.
  • Element REF02 contains the Child State ID generated by the Spoe software.

Example:
REF*EA*A990006295~

Segment Name: Health Care Diagnosis Code
Segment ID: HI
Loop ID: 2300
Usage: Required
Segment Notes:
  • This segment identifies all diagnosis codes related to the claim.
  • This segment is required for all claims submitted to CSC. Only the Principal diagnosis code is recognized by CSC.
  • ICD9 Codes with Alpha characters must have those characters capitalized (i.e., V79.3).

Example:
HI*BK>V793
Segment Name: Rendering Provider Name
Segment ID: NM1
Loop ID: 2310B
Usage: Required
Segment Notes:
- This segment conveys the name of the Rendering Provider and primary number at the claim level. The Rendering Provider’s NPI number is required if it is on file with CSC.
- If the NPI number is not on file with CSC, omit elements NM108 and NM109 as shown in the example below and enter the Federal Tax ID + four character Provider Account sequence number for the Rendering Provider in the Loop 2310B REF segment.
- Since CSC does not collect NPI numbers for all agencies and providers, the second example should be used.

Example:
NM1*82*1*LASTNAME*FIRSTNAME****XX*1234567890001~ (With NPI Number)
NM1*82*1*LASTNAME*FIRSTNAME~ (Without NPI Number)

Segment Name: Rendering Provider Specialty Information
Segment ID: PRV
Loop ID: 2310B
Usage: Required
Segment Notes:
- None

Example
PRV*PE*PXC*235Z00000X~

Segment Name: Rendering Provider Secondary Information
Segment ID: REF
Loop ID: 2310B
Usage: Situational
Segment Notes:
- This segment contains the Rendering Provider Identification Code. This consists of the nine digit Tax ID plus the four digit Provider Account Sequence Number for the rendering provider.
- This segment must be included if the NPI number is not entered in the Loop 2310B NM109 element
- Element REF02 contains the Rendering Provider’s Federal Tax ID + four character provider account sequence number for the Rendering Provider.

Example:
REF*G2*1234567890001~
**Segment Name: Professional Service**
Segment ID: SV1  
Loop ID: 2400  
Usage: Required  
Segment Notes:  
- This segment is used to specify the claim service detail for a Health Care professional.  
- Element SV101-3 should contain "GG" to submit a Same Day/Same Service claim.  
- Element SV105 should be populated with the Place of Service if provided by the IG. Otherwise, the Place of Service should be entered in the Loop 2400 NTE segment.

Example:

SV1*HC>99211>GG*25*UN*1*11**1~

**Segment Name: Durable Medical Equipment Services**
Segment ID: SV5  
Loop ID: 2400  
Usage: Situational  
Segment Notes:  
- This segment is used to report rental or purchase price information.  
- Element SV502 is required by the IG, but ignored by CSC.

Example:

SV5*HC:A4631*DA*30*50*5000*4~

**Segment Name: Date – Service Date**
Segment ID: DTP  
Loop ID: 2400  
Usage: Situational  
Segment Notes:  
- This segment is used to specify the claim service date.

Example:

DTP*472*D8*20030615~

**Segment Name: Prior Authorization**
Segment ID: REF  
Loop ID: 2400  
Usage: Situational  
Segment Notes:  
- Use this segment if the authorization number is different than the number reported at the claim level.  
- REF02 Contains the authorization number which is generated by the Spoe software.

Example:

REF*G1* A99000629513~
Segment Name: Line Item Control Number
Segment ID: REF
Loop ID: 2400
Usage: Situational
Segment Notes:
- Use this segment to submit a provider-defined identifier for the claim line. It is strongly recommended that this segment be used. Values entered in this segment will be returned in the remittance advice if received.

Example:

REF*6R*7865~

Segment Name: Line Note
Segment ID: NTE
Loop ID: 2400
Usage: Required
Segment Notes:
- This segment is used to convey the EI procedure code received in the authorization and the place of service, if necessary.
- Place of Service need not be entered if a valid value exists in the SV105-1 element.

Example:

NTE*ADD*EI=X1011~ (Without Place of Service)
NTE*ADD*EI=X1011,POS=15~ (With Place of Service)
CSC utilizes EDIFECS for testing HIPAA X12 837P files. This site can be accessed by providers once a Trading Partner Agreement has been signed. The website will allow the providers to submit test files. These test files will be processed against the CSC companion guide. Once both parties are confident in the consistency of the test files submitted, the provider will be able to upload 837P claim files, and check the status of files submitted. 278 files and 835 files are available on the Service Matrix website as soon as the Trading Partner Agreement has been received and entered. Testing does not need to be completed to make these available.

Normal processing of 837P files will occur as they are uploaded. It may take up to an hour to process a file, but files are processed in the order they are received from all agencies. The status of the files will be visible as soon as the files are processed. Please be sure that you check the status of your files after they have been processed so that you can fix any data problems that occur in a timely manner.
### 6.0 Change Log

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Version 1.0</td>
<td>01/15/2009</td>
<td>Updated Title Page and Text. Updated web page reference on page 3 Modified the document version and font style</td>
</tr>
<tr>
<td>Version 2.0</td>
<td>05/23/2011</td>
<td>Updated for 5010</td>
</tr>
<tr>
<td>Version 3.0</td>
<td>10/19/2012</td>
<td>Formatting and information changes.</td>
</tr>
</tbody>
</table>