Integrated Services of Kalamazoo (ISK)

COMPANION GUIDE FOR THE 837 PROFESSIONAL CLAIM Version 5010A1

Version Date: 05/12/2022

This document is intended as a companion to the 005010X222 • 837P Health Care Claim: Professional Technical Report 3 (TR3) dated May 2006. This document also includes updates appearing in:

- Errata 005010X222E1 • 837 Health Care Claim: Professional dated January 2009
- Errata 005010X222A1 • 837 Health Care Claim: Professional dated June 2010

The TR3 documents replace the 4010A1 Implementation Guide and related Addenda. The 5010A1 TR3 and related Errata documents can be downloaded from the Washington Publishing Company web site at http://www.wpc-edi.com/content/view/817/1.

This document is expected to be used in conjunction with the TR3 and related Errata for the 837P transaction set. The content of this document follows the guidelines authorized in the version modifications to the Health Insurance Portability and Accountability Act (HIPAA) Final Rule transaction standards published in the Federal Register January 16, 2009.

This document is based, in part on the HIPAA 5010/837P MDHHS Companion Guide produced by and available from Michigan Department of Health and Human Services (MDHHS). https://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_24020-150709--,00.html.

This document specifically does not address every data element, whether required or optional, nor every scenario nor situation that the National Implementation Guides address. It is vital that you, your software vendor, or claim service provider conform to the specifications as detailed in the National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Claim: Professional. The purpose of this document is to assist you in the proper completion for submission to ISK. Information provided in this guide is subject to change.

Loop	Segment	Data Element	Comments
	ISA	ISA05	"ZZ"
	ISA	ISA06	Submitter ID (use NPI)
	ISA	ISA07	"ZZ"
	ISA	ISA08	"1710066253"
	ISA	ISA15	**"P" for production or "T" for test**
	GS	GS02	Submitter ID (same as ISA06)
	GS	GS03	"1710066253" (same as ISA08)
	GS	GS08	"005010X222A1"
	BHT – Beginning of Hierarchical Transaction	BHT06 – Transaction Type Code	Use "CH" (Chargeable)
1000A – Submitter Name	NM1*41	NM109	Vendor Identification Number (same as GS02 Application Sender's code)
1000B – Receiver Name	NM1*40	NM102 – Entity Type Qualifier	Use "2"
		NM103 – Organization Name	Use "ISK"
		NM109 - Receiver	Use "1710066253" This contains the same value as ISA08

Loop	Segment	Data Element	Comments
		Primary Identifier	
2000A Billing Provider	PRV*BI	PRV02	Use "PXC" (Taxonomy Code)
		PRV03 – Provider Taxonomy Code	Expected Values (not limited to): '101YM0800X' - Professional Services '323P00000X' - Specialized Residential MDHHS requires taxonomy code to always be submitted to identify the provider specialty.
2010AA – Billing Provider Name	NM1*85 Billing Provider Name	NM108 – Identification Code Qualifier	Use "XX" (NPI)
		NM109 – Billing Provider Identifier	Billing Provider's NPI
		REF01 – Reference ID Qualifier	Use "EI" (EIN)
		REF02 – Reference Identifier	Billing Provider's EIN
2000B Subscriber Hierarchical Level	SBR – Subscriber Information	SBR02 - Individual Relationship Code	Use "18" (self)
		SBR09 - Claim Filing Indicator Code	Use "ZZ" (for mutually defined or unknown)
2010BA Subscriber Name	NM1*IL	NM108 – Identification Code Qualifier	Use "MI" (Member ID)
		NM109 – Subscriber Primary Identifier	Use the 8-digit Consumer Case Number
2010BA Subscriber Name	REF – Subscriber Secondary Identification	REF01 – Reference Identification Qualifier	Use "SY" (SSN)
		REF02 – Reference Identification	Consumer SSN.
2010BB Payer Name	NM1*PR	NM101 – Entity Identifier Code	Use "PR".
		NM102 – Entity Type Qualifier	Use "2"

Loop	Segment	Data Element	Comments
		NM103 – Organization Name	Use "ISK"
		NM108 – Identification Code Qualifier	Use "PI" (for Payer ID)
		NM109 – Payer Identifier	Use "1710066253" (ISK's NPI)
2000C		Loop – Patient	MDHHS business rules require that the patient is always the subscriber. Do not submit 2000C loop.
2300 Claim Information	CLM Claim Submitter's Identifier	CLM01	Submitter's Unique Claim Identifier
2300		CLM05-3 – Claim Frequency Code	Use "1" on original claim submissions.
2300	REF – Prior Authorization Number	REF01 Reference Identification Qualifier	Use "G1", if your services required prior authorization. *Claim interface can be configured to allow submissions without REF*G1 segment for a particular submitter upon request. System will then lookup authorization number based on provided subscriber ID and services billed, however, it's highly recommended to explicitly submit authorization number on each claim, to ensure that correct authorization is utilized.*
		REF02 – Prior Authorization Number	Use the 12 or 13-digit authorization number assigned by ISK.
2300	HI – Health Care Diagnosis Code	HI01 – Principal Diagnosis	Required on every claim.
		HI01-1	'ABK' Principal Diagnosis ICD-10 Codes.
		HI01-2	Diagnosis Code without the decimal point
			Up to 3 Additional Diagnosis Codes may be sent. The Qualifier Code for these additional Diagnosis Codes would be 'ABF' for ICD-10.
2310B	Rendering Provider Name		Rendering provider loop is required for billing– identify location or staff (refer to billing rules) providing the service. NPI of the rendering provider must be specified either in loop 2310B or 2420A for all professional services.
2310B	NM1*82 Rendering Provider Name	NM108 – Identification Code Qualifier	Use "XX" (NPI)

Loop	Segment	Data Element	Comments
		NM109 Rendering Provider Identifier	Rendering provider NPI
2310B	REF – Rendering Provider Secondary ID	REF01 – Reference Identification Identifier	Use "LU" (location)
		REF02 – Rendering Provider Secondary Identifier	This ID identifies the provider / location providing the service. Use the 3 - 9 digit Provider ID assigned by ISK. This ID is available on the authorization. *If sending prior authorization number (loop 2300 REF*G1), REF*LU can be omitted. If prior authorization number is NOT sent, REF*LU must be sent, either with the rendering provider loop (2310B) or with the facility loop (2310D).*
2320 Other Subscriber Information	SBR – Subscriber Information		If the consumer has Medicare or Commercial insurance, repeat this loop for each payer.
		SBR05 – Insurance Type Code	Do not use choice "MC" in this element.
		SBR09 – Claim Filing Indicator Code	Do not use choices "MC" or "TV" in this element.
2400 Service Line	SV1 Professional Service	SV101-1 Product/Service Identifier	Use "HC" (HCPCS). Max. 50 service lines per claim
		SV101-2 - Procedure Code	HCPCS code
		SV101-3 – Procedure Modifier	Use the Modifier Code(s) as defined in your service contract.
		SV103 – Unit or Basis for Measurement Code	Use "UN" (Units)
		SV104 – Quantity	Use only whole numbers.
2400	NTE – Line Note	NTE01 – Note Reference Code	Use "ADD" (Additional Information)
		NTE02 – Description	For codes that require item description (for example T1999) list specific items, i.e. band aids, crutches" For codes that require service times, include

Loop	Segment	Data Element	Comments
			time in the following format: SVCTIME 0000-1111 000000000111111111 123456789012345678 Where "0000" represents the service start time and "1111" represents the service stop time in 24 hour (military) HHMM format. "SVCTIME" must be in position 1 of NTE02 element. "Service start time" must start in position 10 of NTE02 element.
2420A	Rendering Provider Name		Loop 2420A contains information about the rendering provider on a service line level. Required when the Rendering Provider information for this service is different than that carried in the Loop ID-2310B Rendering Provider. This loop can be used to specify professional providing the service. NPI of the rendering provider must be specified either in loop 2310B or 2420A for all professional services.
2420A	NM1*82 Rendering Provider Name	NM108 – Identification Code Qualifier	Use "XX" (NPI)
		NM109 Rendering Provider Identifier	Rendering provider NPI
2430	SVD – line level COB	SVD01 – Payer ID	Identifies the payer which adjudicated the corresponding service in COB payment arrangement
		SVD02 – Prior Paid Amount (line level)	Specify amount paid for this service by another payer. Required if claim has been previously adjudicated by payer identified in Loop 2330B. Sum of all SVD segments for a particular line is used to populate "COB Prior Paid Amount" on each service line in HCFA form.
2430	CAS – line level adjustments	CAS01	Claim Adjustment Group Code (CO, CR, OA, PI, PR) Refer to p.36 of x222 HIPAA guide: The prior payer payment + the sum total of all patient responsible adjustment amounts = the Allowed amount. *This is used to populate "COB Allowed Amount" on each service line in*

Loop	Segment	Data Element	Comments
			the claim HCFA form. The Patient Responsible adjustments are identified by use of the Category Code **PR** in CAS01. CAS*PR segment must be send if claim has been adjudicated and paid by another payer. Not sending CAS*PR will result in implied $0 "Patient Responsibility" amount, which in turn will result in "Allowed Amount" being equal to "Prior Payer Payment". In this situation, COB rules dictate a $0 expected payment.
		CAS02 CAS05 CAS08	Claim Adjustment Reason Code(s) (HIPAA code list)
		CAS03 CAS06 CAS09	Adjustment Amount(s)

General Information

- Record delimiter should be a tilde (~) followed by a carriage return and line feed.
- Field delimiter is an asterisk (*).
- Sub-element separator is a colon (:).
- **Example:** SV1*HC:99213*167*UN*1***1**N~<CR><LF>
- Send all records in the format where the patient is the subscriber.
- All data will be converted to upper case before importing it to the system.

Testing Instructions

1. Create test file and **check integrity** (i.e., BCBSM Validator or Claredi). **Be sure to put "T" in data element ISA15.**

2. Contact ISK and request login information (User ID & Password).

3. Login to ISK's EMR system.

4. Select the "Claim Submission" menu on the left.

5. Select the "Upload EDI 837 Claims File" option.

6. Follow the instructions on the screen to upload the claims file.

7. After you upload the file, email Dan Vidershain (dvidershain@pcesystems.com) to notify of your test submission.

8. The very first submission will automatically reject, regardless of any errors. You will receive an email assessment of your file within the next few days explaining all errors, if any.

Error Report Information

The Error Report is an Excel file that details errors that were found during processing of the 837. The following describes the different data elements found on the error report:

- Record ID - internal error record ID
- Batch ID - internal batch record ID
- Error Message Number - error code number
- Error Message - text description of error
- Error Type - Severity of error. Possible values: RB - reject batch, entire batch is rejected RE - reject encounter/reject claim
  RL - reject line (if a line is rejected on a claim, then the whole claim will be rejected. There will be an error of type RE listed to denote that)
  IO - warning, claim is still accepted
- Mail ID Number - internal number
- Claim Number - claim number as provided by submitter
- Line Number - service line number
- Error Value - value which is in error
- Service Date - service date of the service line in error
- Consumer ID - consumer ID of subscriber listed on the claim
- SSN - SSN of subscriber on claim
- Last Name/First Name - name of subscriber on claim