Health Care Claim Professional

837-P

ASC X12N 837- P
Refers to the Implementation Guides
Based on X12 Version 005010
January 2012 Errata

Revision	Revision Date	Revision Notes
Initial Create	07/01/2011	Initial Create

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SECTION 1. INTRODUCTION

1.1 Purpose

The purpose of this Companion Guide is to assist Community Health Choice, Inc. ("CHC") contracted providers meet the requirements of the National Electronic Data Interchange Transaction Set Implementation Guide, issued as a technical guide to comply with the requirements Electronic Data Interchange ("EDI") requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). CHC has updated its data sets for EDI files utilizing the ASC X12 nomenclature.

This Companion Guide is designed to provide CHC contracted providers who submit health care claims and/or encounters with the specified data sets CHC and its contracted clearinghouses require per HIPAA transaction. This Companion Guide covers the 837-P, professional claims, file format. Using the data sets specified in this Companion Guide will assist CHC and its contracted clearinghouse to process provider claims more efficiently and accurately.

1.2 Contact Information

If a CHC contracted provider has technical problems with the submission of claims, CHC recommends that the provider contact the appropriate clearinghouse. The following is contact information for each clearinghouse:

Clearinghouse	Web Contacts	CHC Payer ID
AVAILITY	availity.com	48145
EMDEON	emdeon.com	48145
PRACTICE INSIGHT	practiceinsight.net	48145
RELAY HEALTH	relayhealth.com	48145
SSI	thessigroup.com	48145
TKSOFTWARE	tksoftwareinc.com	48145

If CHC contracted providers require technical assistance from CHC, providers may contact CHC Provider Relations, 713-566-6995 or 1-888-760-2600, email: providerrelations@chchealth.org.
Technical assistance is available from 8:00 a.m. to 5:00 p.m.

1.3 Privacy and Security Statement

The HIPAA Privacy Regulation became effective April 14, 2003, and the compliance date for the Security Regulation is April 21, 2005. Covered entities must implement and coordinate the Privacy and Security Rules into their standard business practices and coordinate them with the electronic transmission of protected health information. CHC has trained all staff in the proper use and protection of protected health information and developed a set of administrative policies and procedures to support that effort.

One of the requirements of the HIPAA Privacy Rule is for covered entities to issue a Privacy Notice. The Health and Human Services Commission mailed to each Medicaid recipient a HIPAA Privacy Notice in March, 2003. The Notice can be viewed or downloaded from the State's claims administrator's web site. CHC issued its own Notice of Privacy Practices in April, 2003, and the Notice can be viewed on CHC's Website at .www.chchealth.org

Section 2. 837-P Health Care Claim-Professional

This section is used to describe the required data sets for claim status processing by CHC regarding status of Texas Medicaid Claims. The 837-P format is used for submission of Electronic Claims/Encounters for health care professionals. As an assumption for these file formats, if the subscriber is the same individual as the Patient then the Patient Loop is not to be populated per HIPAA compliance.

Loop ID	Element ID	Data Value	Description
Control Segments			
Interchange Control Header			
	ISA05	ZZ	Mutually Defined is used to submit this file format to NHIC
	ISA06	Your ID	This is the Submitter ID.
	ISA07	ZZ	Mutually Defined is used to submit this file format to NHIC
	ISA08	Our ID	This is the CHC ID
	ISA15	P T	"P" should be used for testing prior to HIPAA implementation and for Production. If Testing in production after HIPAA implementation, "T" must be used
	GS08	005010X222A1	CHC will support the approved addenda for 837-P
Beginning of Hierarchical Transition			
	BHT02	00	CHC will process all 837 transactions as original
	BHT06	CH	CHC will process all 837 transactions as charges.
Detail, Subscriber Level			
Subscriber Name			
2010BA	NM109		Populate with client's 9 digit Medicaid number.
Early Periodic Screening, Diagnostics, and Treatment			
EPSDT Indicator			
2400	SV111		Populate appropriate value for EPSDT

SECTION 3. PROCEDURES FOR CLAIM SUBMISSION

3.1 CHC's Contracted Clearinghouses

CHC contracted providers must submit their claims through one of the following clearinghouses:

Clearinghouse	Web Contacts	CHC Payer ID
AVAILITY	availity.com	48145
EMDEON	emdeon.com	48145
PRACTICE INSIGHT	practiceinsight.net	48145
RELAY HEALTH	relayhealth.com	48145
SSI	thessigroup.com	48145
TKSOFTWARE	tksoftwareinc.com	48145

Each clearinghouse has unique technical requirements for the submission of claims. Providers must contact their clearinghouse to determine their specific data submission requirements. Each provider should establish a testing schedule with their clearinghouse to ensure a smooth transition to HIPAA compliant transactions. Please remember to include your valid Texas Provider Identification ("TPI") number when submitting any claims. CHC can also receive claims directly from Providers, if the claim files are in the HIPAA 837 format and the Provider has successfully tested 837 files with CHC. If a Provider chooses this route, a User ID and password will be assigned to allow the Provider to log-on and drop files to CHC's secure website. Please contact CHC's Provider Relations at 713-566-6995 or toll-free at 1-888-760-2600 or e-mail: providerrelations@chchealth.org, for further information.

3.2 Claims Query

Providers may check claims status and member eligibility on CHC Website, www.chchealth.org. Providers simply log into their account and are transferred to a secure portion of the Website. From the secure portion, providers may enter Member name and identification number and receive claims and eligibility information. Providers must complete an application to gain access to the secure portion of CHC's website. For more information, please contact CHC at Provider Relations, 713-566-6995 or 1-888-760-2600, email: providerrelations@chchealth.org.

3.3 Compliance Date

Beginning January 01, 2012, CHC contracted providers must submit their electronic claims to CHC contracted clearinghouses using HIPAA-compliant formats. Electronic claims submitted in a non-HIPAA format will be rejected. Providers should refer to the HIPAA Implementation Guides at www.wpc-edi.com/hipaa/HIPAA_40.asp.

3.4 Paper Claims

If a provider is billing CHC using paper claims, the provider must use approved procedure codes and modifiers. Paper claims for services on or after October 16, 2003, which include Medicaid local codes will be denied.

SECTION 4. CODE SETS

4.1 HIPAA Medical Code Sets

Medical code sets are the clinical codes that providers use to bill for patient encounters. The medical code sets that are approved for use by HIPAA are the following:

- **ICD-10-CM International Classification of Diseases, 10th Edition, Clinical Modification**
- **ICD-9-CM International Classification of Diseases, 9th Edition, Clinical Modification, Volume 1 and Volume 2**

  Used to encode diseases, injuries, impairments, other health related problems.

- **ICD-10-PCS International Classification of Diseases, 10th Edition, Procedure Code System**
- **ICD-9-CM International Classification of Diseases, 9th Edition, Clinical Modification, Volume 3 Procedures**

  Used to encode prevention, diagnosis, treatment and management.

- **NDC: National Drug Code**

  Used to encode drugs and biologics.

- **Code on Dental Procedures and Nomenclature**

  Used to encode dental procedures.

- **HCPCS: Health Care Financing Administration Common Procedure Coding System, and CPT-4: Current Procedural Terminology, 4th Edition**

  Used to encode physician services and other health-related services such as physical and occupational therapy, radiological services, laboratory and other diagnostic tests, prosthetic devices and durable medical equipment and other medical supplies.

4.2 Medicaid Local Procedure Codes and Modifiers

Beginning with dates of service on or after October 16, 2003, HIPAA will eliminate most local procedure codes and modifiers. Please refer to the 2003 HIPAA Special Medicaid Bulletin No. 170 and 2003 HIPAA Special Medicaid Bulletin No. 174, published by NHIC, which maps the affected local procedure codes and modifiers to the appropriate national procedure codes and modifiers. You may download 2003 HIPAA Special Medicaid Bulletins No. 170 and 174 at www.tmhp.com/Texas_Medicaid_Bulletin/Forms.

4.3 Reference Material

The following information will allow users to find and download the proper reference material from the Texas Medicaid Healthcare Partnership website.

1. In your browser go to www.tmhp.com.
2. Click on "providers" from the icons listed on the screen.
3. Click on Reference Material.

SECTION 5. Comparison

5.1 Comparison of Version 4010 verses Version 5010

Click on link to see side-by-side comparison of 837-P Version 4010 versus Version 5010

GLOSSARY

ANSI X12 276/277	HIPAA standardized ANSI X12 format for claims status inquiry request and response data.
ANSI X12 278	HIPAA standardized ANSI X12 transaction format for health care service review.
ANSI X12 835	HIPAA standardized ANSI X12 transaction format for finalized electronic remittance and status reports.
ANSI X12 837-D	HIPAA standardized ANSI X12 transaction format for dental claims.
ANSI X12 837-I	HIPAA standardized ANSI X12 transaction format for institutional claims.
ANSI X12 837-P	HIPAA standardized ANSI X12 transaction format for professional claims.
Client	Person receiving the services.
CMS	Claim Management System for processing long-term care claims and data.
Compass 21	Medicaid claim processing system for Texas.
CSHCN	**C**hildren with **S**pecial **H**ealth **C**are **N**eeds.
Data Element	Corresponds to a field in data processing terminology. Assigned unique reference number. Each element has a name, description, type, minimum length and maximum length. The length of an element is the number of character positions used, except as noted for numeric, decimal and binary elements. Data element types are: Nn Numeric (with an assumed number of decimal positions) R Decimal Real Number (including decimal or negative sign) ID Identifier AN Alphanumeric string DT Date TM Time
Data Segment	Corresponds to a record in data processing terminology. Consists of logically related data elements in a defined sequence (defined by X12). Each segment begins with a segment identifier, which is not a data element and one or more related data elements, which are preceded by a data element separator. Each segment ends with a segment terminator.
DED Name	This is the name of segment.
Delimiter	A character used to separate two data elements (or sub-elements) or to end a segment. They are specified in the interchange header segment (ISA). Once specified in the ISA, they should not be used in the data elsewhere other than as a separator or terminator.
ECMS	Electronic Commerce Management System
EDI	An acronym for Electronic Data Interchange.
Electronic Data Interchange	The application-to-application transfer of key business information transacted in a standard format using a computer-to-computer communications link. There are typically 6 components used in order to do EDI. They are: an EDI file, a trading partner, an application file/form, translator (mapper), communications and value added network or value-added service provider.
Element ID	Reference number for a data element see above

Implementation Guides	Documents that provide standardized data requirements and content as the specifications for consistent implementation of a standard transaction set. The Washington Publishing Company publishes HIPAA Implementation Guides on their web site: www.wpc-edi.com.
Interface	The point at which two systems connect to pass data.
Loop ID	A number identifying a group of related segments.
NHIC	National Heritage Insurance Company, a subsidiary of Electronic Data Systems (EDS) contracted by the Texas Department of Health to administer, process, and report Texas Medicaid claims and claim/encounter data.
Procedure Code	Code indicating the service rendered to the patient.
Routing	Separation of data based on specific criteria for subsequent transfer to an internal or external system.
Submitter	Identity which uploads the file electronically or sends the file on paper.
Subscriber	Person who holds the insurance policy. For Medicaid the patient is the subscriber.
Trading Partners	Entities that exchange electronic data files. Agreements are sometimes made between the partners to define the parameters of the data exchange and simplify the implementation process.
Translation Software	Commercial computer software that with input instructions converts a standard format to an application format or an application format to a standard format. Most translation software products also compliance check standard format files and automatically create interchange/functional acknowledgements to identify receipt and translation status of a file. Some products also offer translation capability from any format to any format.
X12 Transaction Set	A transaction set is considered one business document which is composed of a transaction set header control segment, one or more data segments, and a transaction set trailer control segment.
X12N	An Accredited Standards Committee (ASC) commissioned by the American National Standards Institute (ANSI) to develop standards for Electronic Data Interchange (EDI). While X12 indicates EDI, the N identifies the Insurance.

The information in this Companion Guide may be subject to change. Community Health Choice, Inc. will communicate any significant changes to its contracted providers and update the Companion Guides placed on its Website. If you have any questions, please contact Provider Relations at 713-566-6995 or 1-888-760-2600, email providerrelations@chchealth.org.