



Health Insurance Portability Accountability Act (HIPAA)
Transaction and Code Sets

Companion Guide

Health Care Claim 837 Institutional (837I) X12N

January 21, 2010

Bravo Health Inc. issues this Companion Guide in an effort to provide the trading partners with the most up-to-date information related to the 997 functional acknowledgment transaction. Any and all information in this companion guide is considered the most current as of the publication date and is subject to change at any time. BRAVO HEALTH recommends that each time you test or submit a transaction that you refer to the most current Companion Guide posted to the BRAVO HEALTH website.

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1. **Introduction**

Under the Health Insurance Portability Accountability Act (HIPAA) of 1996 Administrative Simplification Provisions, the Secretary of the Department of Health and Human Services (DHHS) was directed to adopt standards to support electronic exchange of administrative and financial health care transactions. HIPAA directs the Secretary of DHHS to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard transaction.

Audience

This document is intended to provide information to our trading partners about the submission of standard transactions to BRAVO HEALTH. It contains specifications of the transaction, helpful guidance for getting started and testing your files as well as important contact information. This document includes substantial technical information related to the processing of the HIPAA ASC X12N 837I claims and should be shared with both technical and business staff.

Purpose of the Companion Guide

This Companion Guide to the ASC X12N Implementation Guide “Health Care Claim Institutional 837I”, inclusive of addenda, adopted under HIPAA clarifies and specifies the data content required when data is transmitted electronically to BRAVO HEALTH. The file transmissions should be based on this document together with the X12N Implementation Guides.

This companion guide is intended to be used in **conjunction with and not a substitute for the** X12N Implementation Guides, nor to replace them. Additionally, this Companion Guide is intended to convey information that is within the framework and structure of the X12N Implementation Guides and not to contradict or exceed them.

All instructions in this document were written using information known at the time of the publication and are subject to change. Future changes to this document will be available on the BRAVO HEALTH web site <http://www.bravohealth.com>. BRAVO HEALTH is not responsible for the performance of software you may use to complete this transaction.

Code Sets

Code sets for medical data are required for data elements in the administrative and financial health care transaction standards adopted under HIPAA for diagnoses, procedures and drugs. The following code sets have been adopted as the standard medical data code sets:

- The combination of Health Care Financing Administration Common Procedure Coding System (HCPCS), as updated and distributed by the DHHS and Current Procedural Terminology, Fourth Edition (CPT-4), as updated and distributed by the American Medical Association for physician services and other health related services.
- International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM), Volumes 1,2 and 3 procedures (including the Official ICD-9-CM Guidelines for Coding and Reporting), as updated and distributed by the DHHS.
- Drug and Biologic Codes – National Drug Codes (NDC) are the standard medical data code sets for drugs and biologics for retail pharmacy transactions. There are no identified standard medical code sets in place for non- retail pharmacy transactions.
- Dental Procedures and Nomenclature, as updated and distributed by the American Dental Association (ADA), for dental services

Implementation Guides

Implementation Guides are available from the Washington Publishing Company's web site at <http://www.wpc-edi.com/HIPAA>.

Glossary

A glossary of terms related to HIPAA and the Implementation Guides is available from the Washington Publishing Company's web site

http://www.wedi.org/snip/public/articles/HIPAA_GLOSSARY.PDF

Additional Information (Privacy)

BRAVO HEALTH entities acting as health plans are covered entities under the HIPAA regulations. Submitters are generally either covered entities themselves, or are business associates of covered entities, and therefore are required to comply with HIPAA privacy standards. As required by law, BRAVO HEALTH has implemented and operationalized the HIPAA privacy regulations. Therefore, it can be expected that test or live data is protected data when submitted to BRAVO HEALTH under HIPAA privacy requirements.

Bravo Health, Inc. Contact

All inquiries regarding set-up, connectivity, testing, and file submission for either test or live data should be directed to Bravo Health's EDI Help Desk at 215 606-6938.

2. Getting Started

Bravo Health, Inc. will accept ASC X12N standard transactions from all covered entities and business associates. If you are not currently doing business with BRAVO HEALTH under a provider, business associate, broker or other agreement, please contact BRAVO HEALTH support staff (**section 1.5**) for instructions on how to submit files.

Many healthcare providers choose to work with an EDI clearinghouse for their electronic claim submissions. Bravo Health, Inc. has an established relationship with Emdeon/WebMD/Envoy as our clearinghouse vendor. BRAVO HEALTH will also allow connectivity and transmission of electronic claims directly to the Plan via a secure File Transfer Protocol (FTP) site.

2.1 Working with Bravo Health, Inc.

For all data transmissions, BRAVO HEALTH uses PGP encryption software to ensure the security and integrity of transmitted data. We will establish a secured individual FTP directory to transfer claim files and to retrieve acknowledgements and claim status reports.

To establish connectivity and to be able to transmit electronic transactions to BRAVO HEALTH we require the following:

- 1) Established an internet connection,
- 2) Purchase and utilization of PGP software

If you are interested in establishing direct connectivity please contact the BRAVO HEALTH technical staff listed in section 1.5 of this document. Our provider relation's staff will obtain some basic information and forward your request and information to the appropriate technical staff. Our technical staff will contact you and provide you with additional information needed to submit test and live data.

2.2 Testing

BRAVO HEALTH requires that all testing must be successfully completed prior to implementing direct 837P claims submissions. For testing purposes, create a **zipped** ANSI X12N test file of at least 15 live transactions. Be sure that your zipped file includes only 1 test file.

Do not include any dummy data in the test file. This file should contain transaction samples of all types of claims you will be submitting electronically.

BRAVO HEALTH will provide a Claims Transmission Acknowledgement report that will indicate whether were successfully completed. We require an acceptance percentage of at least 95% for testing acceptance before data can be submitted electronically. In addition, we will provide an Initial Claims Status report. This report indicates for each submitted claim whether it was accepted or rejected for processing.

BRAVO HEALTH technical staff will be working with you closely during this entire process to help you with any data problems that might occur.

NOTE:

At this time, BRAVO HEALTH cannot process Replacement and Void claim requests electronically. Void and Replacement requests must be sent to BRAVO HEALTH on paper to the following address;

**Bravo Health, Inc.
Claims Department
P.O. Box 4433
Baltimore, Maryland 21223**

The Void and Replacement hardcopy claims should be clearly stamped and identified as “CORRECTED”.

Bravo Health, Inc. Institutional Claims ASC X12N 837I
Informational Data

3. Informational Data

Loop ID	Loop Name	Segment ID	Segment Name	Element ID	Element Name	Value
		ST	Transaction Set Header	ST 01	Transaction Set Identifier Code	837
				ST 02	Transaction Set Control Number	A unique Identifying control number for transaction set. Transaction set control numbers in ST 02 and SE 02 must be identical.
		BHT	Beginning of Hierarchical Transaction	BHT 01	Hierarchical Structure Code	0019
				BHT 02	Transaction Set Purpose Code	00-Original 18-Reissue
				BHT 03	Originator Application Transaction Identifier	Number assigned by transaction originator to identify data transaction
				BHT 04	Date-transaction creation date	CCYYMMDD
				BHT 05	Time	
				BHT 06	Transaction Type Code	CH
		REF	Transaction Type Identification	REF 01	Reference ID Qualifier	87
				REF 02	Transmission Type Code	004010X096DA1-Test 004010X096A1 - Production
1000A	Submitter Name	NM1	Submitter Name	NM 101	Entity ID Code	41
				NM 102	Entity Type Qualifier	1-Person 2-Non Person
				NM 103	Name Last/Org Name	Data Submitter Name
				NM 108	Identification Code Qualifier	46
				NM 109	Submitter ID	Data Submitter Primary

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Loop ID	Loop Name	Segment ID	Segment Name	Element ID	Element Name	Value
					Code	Identification Number
	Submitter Name	PER	Submitter EDI Contact Information	PER 01	Contact Function Code	IC
				PER 02	Submitter Contact Name	Data Submitter Contact Name
				PER 03	Communication Number Qualifier	ED- EDI Access Number EM- Electronic Mail FX- Fax TE-Telephone
				PER 04	Communication Number	Complete Communication Number
1000B	Receiver Name	NM1	Receiver Name	NM 101	Entity ID Code	40
				NM 102	Entity Type Qualifier	2
				NM 103	Name Last/Org Name	
				NM 108	Identification Code Qualifier	46
				NM 109	Identification Code # of Receiver	
2010AA	Billing Provider Name	NM1	Billing Provider Name	NM 101	Entity ID Code	85
				NM 102	Entity Type Qualifier	2-Non Person
				NM 103	Name Last/Org Name	Billing Provider or Organization Name of data Submitter
				NM 108	ID Code Qualifier	XX*
				NM 109	ID Code	NPI
	Billing Provider Address	N 3	Billing Provider Address	N 301	Address Information	Billing Provider Address line 1
	Billing Provider City/State	N 4	Billing Provider City/State/Zip Code	N 401	City Name	Billing Provider City

*When XX qualifier (NPI) is used, then the employer ID or SSN must be carried in a REF segment in this loop.

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Loop ID	Loop Name	Segment ID	Segment Name	Element ID	Element Name	Value
				N 402	State or Provider Code	Billing Provider State Code
				N 403	Postal Code	Billing Provider Zip Code
2000B	Subscriber Information	SBR	Subscriber Information	SBR 01	Payer Responsibility Sequence #	P-Primary
2010BA	Subscriber Name	NM1	Subscriber Name	NM 101	Entity ID Code	IL
				NM 102	Entity Type Qualifier	1 Person 2 Non Person Entity
				NM103	Name Last/Org Name	Member Last Name
				NM 104	Name First	Member First Name
				NM 105	Name Middle	Member Middle Name
				NM 107	Name Suffix	
				NM 108	ID Code Qualifier MI	
				NM 109	ID Code	Member ID Number
	Subscriber Address	N3	Subscriber Address	N 301	Address Information	Member Address 1
	Subscriber City/State/Zip	N4	Subscriber City/State/Zip	N 401	City Name	Member City
				N 402	State Code	Member State
				N 403	Postal Code	Member Zip Code
		DMG	Subscriber Demographic Information	DMG 01	Date Time Period Format Qualifier	D8
				DMG 02	Date Time Period	Member Date of Birth
				DMG 03	Gender Code	F-Female M-Male U-Unknown
2010BC	Payer Name	NM1	Payer Name	NM 101	Entity ID Code	PR
				NM 102	Entity Type Qualifier	2
				NM 103	Name Last/Org Name	
				NM 108	ID Code Qualifier PI	
				NM 109	ID Code	
2000C	Patient Information	PAT	Patient Information	PAT 01	Individual Relationship Code	Code used to Specify the patients relationship to the

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Loop ID	Loop Name	Segment ID	Segment Name	Element ID	Element Name	Value
						insured person
2010CA	Patient Name	NM1	Patient Name	NM 101	Entity ID Code	QC
				NM 102	Entity Type Qualifier	1
				NM 103	Name Last	Patient Last Name
				NM 104	Patient First	Patient First Name
		N3	Patient Address	N 301	Address Information	Patient Address 1
		N4	Patient City/State/Zip Code	N 401	City Name	Patient City Name
				N 402	State Code	Patient State
				N 403	Postal Code	Patient Zip Code
		DMG	Patient Demographic Information	DMG 01	Date Time Period Format Qualifier	D8
				DMG 02	Date Time Period	Patients Date of Birth CCYYMMDD
				DMG 03	Gender Code	F-Female M-Male U-Unknown
2300	Claim Information	CLM	Claim Information	CLM 01	Claim Submitter Identifier	Patient Account Number
				CLM 02	Monetary Amount	Total Submitted Claim Charges
			Health Care Service Location Information	CLM 05		
				CLM05-1	Health Care Service Location Facility Code Value	Code specifying the type of facility where services were performed (UB-92)
				CLM05-2	Facility Code Qualifier	A
				CLM05-3	Claim Frequency Type Code	Code specifying frequency of the claim-UBC Form Bill Type (3 rd position)
				CLM 06	Yes/No Condition or Response Code (Provider	N-No Y-Yes

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Loop ID	Loop Name	Segment ID	Segment Name	Element ID	Element Name	Value
					Signature on File)	
				CLM 07	Provider Accept Code	A = Assigned; C = Not Assigned
				CLM 08	Yes/No Condition or Response Code (Assignment of Benefits Indicator)	N-No Y-Yes
				CLM 09	Release of Info Code	A-Appropriate Release of Information on file at CMS Service Provider or at Utilization Review Organization I-Informed Consent to Release Medical Information for Conditions or Diagnoses Regulated by Federal Statutes M-The provider has limited or restricted ability to release data related to the claim N-No, provider is not allowed to release data O- On file at Pay /Plan Sponsor Y- Provider has a signed statement permitting release of Medical Data related to claim
		DTP	Statement Dates	DTP 01	Date/Time Qualifier	434
				DTP 02	Date/Time Period Format Qualifier	D8-Date RD8-Range of Dates (Used if it is necessary to indicate begin/end for from/to statement dates
				DTP 03	Date Time Period	CCYYMMDD
2400	Service Line Number	LX	Service Line Number	LX 01	Assigned Number	The service line LX segment begins with 1

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Loop ID	Loop Name	Segment ID	Segment Name	Element ID	Element Name	Value
	Institutional Service Line	SV2	Service Line Number	SV 201	Product/Service ID	and is incremented by one each additional service line of the claim (serves as line counter) NUBC Codes (Source code 132)
			Composite Medical Procedure Code	SV 202	Service Line Procedure Code	
				SV 202-1	Product/Service ID Qualifier	HC-CMS COMMON procedure Coding System (HCPCS) CPT codes are included in HC
						IV-Home Infusion EDI Coalition (HIEC) Service Codes
						N! -N4 National Drug Codes (format dependent)
				SV 202-2	Product/Service ID	HCPCS Procedure Code
				SV 203	Monetary Amount	Service Line Charge Amount
				SV 204	Unit or Basis for measurement Code	DA-Days F2-International Unit (dosage amt is only used in drug claims when the dosage of the drug is variable within a single NDC number)
				SV 205	Quantity	UB-92 Reference
2420A	Attending Physician Specialty Information	PRV	Attending Physician Name	PRV 01	Provider Code	AT
				PRV 02	Reference Identification Qualifier	ZZ-Mutually defined code
				PRV 03	Reference Identification	Provider Taxonomy (Specialty) Code

Loop ID	Loop Name	Segment ID	Segment Name	Element ID	Element Name	Value
	Transaction Set Trailer	SE	Transaction Set Trailer	SE 01	Number of Included Segments	Transaction Segment Count
				SE 02	Transaction Set Control Number	Unique Identifying control number for transaction set. Transaction set control numbers in ST02 and SE02 Must be identical.

4.Important Reminders

1. A valid Bravo Health plan assigned provider ID number must be provided in the correct place on the claim or the claim will be rejected. A valid member ID number must be provided. If the member ID number is not provided or it is in the wrong place the claim will be rejected.
2. Modifiers must be appended to the CPT/HCPCS codes in the line items where they apply.
3. Claims requiring attachments (i.e. EOB's, invoices, etc.) cannot be submitted via EDI at this time.
4. Anesthesia claims must use ASA codes. Units must be in minutes – not in fractions of hours or days.
5. Replacement and void claim requests must be submitted on paper.
6. Claims with service dates that span a calendar year should be split into two separate claims.