



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

Companion Guide

Health Care Claim 837Professional (837P) X12N
Version 00410A1

January 21, 2010

This Companion Guide is issued in an effort to provide the trading partners of Bravo Health, with the most up-to-date information related to the 837P standard transaction. Any and all information in this 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 and 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, Inc. It contains specifications of the specific 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 837P 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 Professional 837P”, inclusive of addenda, adopted under HIPAA clarifies and specifies the data content required when data is transmitted electronically to Bravo Health, Inc. 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** X12N Implementation Guides, not 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, Inc. Web site <http://www.bravohealth.com>. Bravo Health, Inc. 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 and 2 (including the Official ICD-9-CM Guidelines for Coding and Reporting), as updated and distributed by the DHHS.
- International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM), Volume 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)

The Bravo Health, Inc. entities acting as health plans are covered entities under the HIPAA regulations. Submitters of 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 a internet connection,
- 2) Purchase and utilization of PGP software

If you are interested in establishing direct connectivity please contact the Bravo Health, Inc. staff 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, Inc. 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. Professional Claims ASC X12N 837P
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	I Unique Identifying control number for transaction set. Transaction set control numbers in ST02 and SE02 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	# 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	004010X098DA1-Test 004010X098A! - 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	Provider/Clearinghouse Name
				NM 108	Identification Code Qualifier	46
				NM 109	Submitter ID Code	Submitter Primary Identification Number
	Submitter Name	PER	Submitter EDI Contact Information	PER 01	Contact Function Code	IC

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Loop ID	Loop Name	Segment ID	Segment Name	Element ID	Element Name	Value		
1000B	Receiver Name	NM1	Receiver Name	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		
				NM 101	Entity ID Code	40		
				NM 102	Entity Type Qualifier	2		
				NM 103	Name Last/Org Name			
				NM 108	Identification Code Qualifier	46		
2010AA	Billing Provider Name	NM1	Billing Provider Name	NM101	Entity Id Code	85		
				NM 102	Entity Type Qualifier	1-Person 2-Non Person		
				NM103	Name Last/Org Name	Group Name		
				NM108	ID Code Qualifier	XX*		
				NM109	ID Code	NPI		
	Billing Provider Address	N 3	Billing Provider Address	N 301	Address Information	Billing Provider Address 1		
				N 4	Billing Provider City/State/Zip Code	N 401	City Name	Billing Provider City
						N 402	State or Provider Code	Billing Provider State
						N 403	Postal Code	Billing Provider Zip code
2000B	Subscriber Information	SBR	Subscriber Information	SBR 01	Payer Responsibility Sequence #	P-Primary		

*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	
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	
	Subscriber Address	N3	Subscriber Address	N 301	Address Information	Member Address 1	
				N4	Subscriber City/State/Zip Code	N 401	City Name
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		
2010BB	Payer Name	NM1	Payer Name	NM 101	Entity ID Code	PR	
				NM 102	Entity Type Qualifier	2	
				NM 103	Name Last/Org Name	Payer - Primary	
				NM 108	ID Code Qualifier	PI	
				NM 109	ID Code		
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	Member Address 1		
			N4	Patient City/State/Zip	Member City		

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Loop ID	Loop Name	Segment ID	Segment Name	Element ID	Element Name	Value
			Code	N 402	State Code	Member State
				N 403	Postal Code	Member Zip Code
		DMG	Patient Demographic Information	DMG 01	Date Time Period D8 Format Qualifier	
				DMG 02	Date Time Period Patients Date of Birth	
				DMG 03	Gender Code	F-Female M-Male U-Unknown
2300	Claim Information	CLM	Claim Information	CLM 01	Claim Submitter Identifier	Claim Number
				CLM 02	Monetary Amount	Total Submitted Charges
				CLM05-1	Health Care Service Location Facility Code Value	Facility Type Code as identified in Code Source 237 table
				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 Signature on File)	N-No Y-Yes
				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

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Loop ID	Loop Name	Segment ID	Segment Name	Element ID	Element Name	Value
						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 Payer or at Plan Sponsor
						Y-Yes, provider has a signed statement permitting release of Medical Data related to claim
2400	Professional Service	SV1	Service Line	SV 101-1	Service ID Qualifier	<p>HC-CMS COMMON procedure Coding System (HCPCS) CPT codes are included in HC</p> <p>IV-Home Infusion EDI Coalition (HIEC) Service Codes</p> <p>N! -N4 National Drug Codes (format dependent)</p>
		DTP	Service Date	DTP 01	Date/Time Qualifier	472
				DTP 02	Date/Time Period Qualifier	D8-Date RD8-Date Range
				DTP 03	Date/Time Period	CCYYMMDD
	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.
2. 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.
3. Modifiers must be appended to the CPT/HCPCS codes in the line items where they apply.
4. Claims requiring attachments (i.e. EOB's, invoices, etc.) cannot be submitted via EDI at this time.
5. Anesthesia claims must use ASA codes. Units must be in minutes – not in fractions of hours or days.
6. Replacement and void claim requests must be submitted on paper.
7. Claims with service dates that span a calendar year should be split into two separate claims.