



HIPAA X 12 Transaction Standards

Companion Guide

837 Professional/ Institutional Health Care Claim

Version 5010

Trading Partner Companion Guide Information and Considerations

837P/837I

June 11, 2012

Overview

The Companion Guide provides Centene trading partners with guidelines for submitting 5010 version of 837 Professional and Institutional Claims. The Centene Companion Guide documents any assumptions, conventions, or data issues that may be specific to Centene business processes when implementing the HIPAA ASC X12N 5010A Technical Reports Type 3 (TR3). As such, this Companion Guide is unique to Centene and its affiliates.

This document does NOT replace the HIPAA ASC X12N 5010A Technical Reports Type 3 (TR3) for electronic transactions, nor does it attempt to amend any of the rules therein or impose any mandates on any trading partners of Centene. This document provides information on Centene- specific code handling and situation handling that is within the parameters of the HIPAA administrative Simplification rules. Readers of this Companion Guide should be acquainted with the HIPAA Technical Reports Type 3, their structure and content. Information contained within the HIPAA TR3s has not been repeated here although the TR3s have been referenced when necessary. The HIPAA ASC X12N 5010A Technical Reports Type 3 (TR3) can be purchased at <http://store.x12.org>.

The Companion Guide provides supplemental information to the Trading Partner Agreement (TPA) that exists between Centene and its trading partners. Refer to the TPA for guidelines pertaining to Centene legal conditions surrounding the implementations of EDI transactions and code sets. Refer to the Companion Guide for information on Centene business rules or technical requirements regarding the implementation of HIPAA compliant EDI transactions and code sets.

Nothing contained in this guide is intended to amend, revoke, contradict, or otherwise alter the terms and conditions of the Trading Partner Agreement. **If there is an inconsistency with the terms of this guide and the terms of the Trading Partner Agreement, the terms of the Trading Partner Agreement shall govern.**

Rules of Exchange

The Rules of Exchange section details the responsibilities of trading partners in submitting or receiving electronic transactions with Centene.

Transmission Confirmation

Transmission confirmation may be received through one of two possible transactions: the TA1 Interchange Acknowledgement or the 999 Functional Acknowledgement. A TA1 Acknowledgement is used at the ISA level of the transmission envelope structure, to confirm a positive transmission or indicate an error at the ISA level of the transmission. The 999 Acknowledgement may be used to verify a successful transmission or to indicate various types of errors.

Confirmations of transmissions, in the form of TA1 or 999 transactions, should be received within 24 hours of batch submissions, and usually sooner. Senders of transmissions should check for confirmations within this time frame.

Batch Matching

Senders of batch transmissions should note that transactions are unbundled during processing, and rebundled so that the original bundle is not replicated. Trace numbers or patient account numbers should be used for batch matching or batch balancing.

TA1 Interchange Acknowledgement

The TA1 Interchange Acknowledgement provides senders a positive or negative confirmation of the transmission of the ISA/IEA Interchange Control.

999 Functional Acknowledgement

The 999 Functional Acknowledgement reports on all Implementation Guide edits from the Functional Group and transaction Sets.

The IK5 segment in the Functional Acknowledgement may contain an A, E, or R. An 'A' indicates the entire transaction set was accepted. While an 'R' indicates the entire transaction set was rejected. However, an 'E' may be used if the transaction set was accepted but within the transaction set there were claims which may have rejected or have a warning message. Rejected claims will be identified with a CTX segment in between the IK3 & IK4 segments.

277CA Health Care Claim Acknowledgement

The 277CA Health Care Claim Acknowledgement provides a more detailed explanation of the transaction set. Centene also provides the Pre-Adjudication rejection reason of the claim within the STC12 segment of the 2220D loop. ***NOTE: The STC03 – Action Code will only be a “U” if the claim failed on HIPAA validation errors, NOT Pre-Adjudication errors.***

Duplicate Batch Check

To ensure that duplicate transmissions have not been sent, Centene checks five values within the ISA for redundancy:

- ISA06
- ISA08
- ISA09
- ISA10
- ISA13

Collectively, these numbers should be unique for each transmission. A duplicate ISA/IEA receives a TA1 response of “025” (Duplicate Interchange Control Number).

To ensure that Transaction Sets (ST/SE) have not been duplicated within a transmission, Centene checks the ST02 value (the Transaction Set Control Number), which should be a unique ST02 within the Functional Group transmitted. Duplicate Transaction Sets (ST/SE) return a 999 Functional Acknowledgement with an IK502 value of "23" (Transaction Set Control Number not unique within the Functional Group).

837 Professional/Institutional Health Care Claim - MEDICAL							
CENTENE							
IS - Interchange Control Header		GS - Functional Group Header		GE - Functional Group Trailer		IEA - Interchange Control Trailer	
ISA01	00	GS01	HC	GE01	<i>refer to TR3</i>	IEA01	<i>refer to TR3</i>
ISA02	<i>refer to TR3</i>	GS02	SENDER ID	GE02	<i>refer to TR3</i>	IEA02	<i>refer to TR3</i>
ISA03	00	GS03	421406317				
ISA04	<i>refer to TR3</i>	GS04	<i>refer to TR3</i>				
ISA05	ZZ	GS05	<i>refer to TR3</i>				
ISA06	SENDER ID	GS06	<i>refer to TR3</i>				
ISA07	30	GS07	X				
ISA08	421406317	GS08	005010X223 A2				
ISA09	<i>refer to TR3</i>		For 837I				
ISA10	<i>refer to TR3</i>	GS08	005010X222 A1				
ISA11	^(5E)		For 837P				
ISA12	00501						
ISA13	<i>refer to TR3</i>						
ISA14	<i>refer to TR3</i>						
ISA15	<i>refer to TR3</i>						
ISA16	<i>refer to TR3</i>						

837 Professional/Institutional Health Care Claim – Behavioral Health

CENTENE

IS - Interchange Control Header		GS - Functional Group Header		GE - Functional Group Trailer		IEA - Interchange Control Trailer	
ISA01	00	GS01	HC	GE01	<i>refer to TR3</i>	IEA01	<i>refer to TR3</i>
ISA02	<i>refer to TR3</i>	GS02	SENDER ID	GE02	<i>refer to TR3</i>	IEA02	<i>refer to TR3</i>
ISA03	00	GS03	68068				
ISA04	<i>refer to TR3</i>	GS04	<i>refer to TR3</i>				
ISA05	ZZ	GS05	<i>refer to TR3</i>				
ISA06	SENDER ID	GS06	<i>refer to TR3</i>				
ISA07	ZZ	GS07	X				
ISA08	68068	GS08	005010X223 A2				
ISA09	<i>refer to TR3</i>		For 837I				
ISA10	<i>refer to TR3</i>	GS08	005010X222 A1				
ISA11	^ (5E)		For 837P				
ISA12	00501						
ISA13	<i>refer to TR3</i>						
ISA14	<i>refer to TR3</i>						
ISA15	<i>refer to TR3</i>						
ISA16	<i>refer to TR3</i>						

New Trading Partners

New trading partners should access <https://www.centene.com/edifecs> , register for access, and perform the steps in the Centene trading partner program. The EDI Support Desk (EDIBA@Centene.com) will contact you with additional steps necessary upon completing your registration.

Claims Processing

Acknowledgements

Senders receive four types of acknowledgement transactions: the TA1 transaction to acknowledge the Interchange Control Envelope (ISA/IEA) of a transaction, the 999 transaction to acknowledge the Functional Group (GS/GE) and Transaction Set (ST/SE), the 277CA transaction to acknowledge health care claims, and the Centene Audit Report. At the claim level of a transaction, the only

acknowledgement of receipt is the return of the Claim Audit Report and/or a 277CA. ***NOTE: Trading Partners will not be provided a 997 once they begin submitting 5010 version of transactions.***

Coordination of Benefits (COB) Processing

To ensure the proper processing of claims requiring coordination of benefits, Centene recommends that providers validate the patient's Membership Number and supplementary or primary carrier information for every claim.

All Sum of paid amount (AMT02 in loop 2320) and all line adjustment amounts (CAS in 2320 & 2340) must equal the total charge amount (CLM). Additionally, the service charge amount must equal the value of all drug charges (sum of CTP03 and CTP04 in 2410).

If the claim was adjudicated by another payer identified in the 2330B loop the AMT – Payer Paid Amount and AMT – Remaining Patient Liability must be completed.

Primary and secondary coverage for the same claim will not be processed simultaneously. Claims that contain both primary and secondary coverage must be broken down into two claims. File the primary coverage first and submit the secondary coverage after the primary coverage claim has been processed. Submitters can be assured that the primary coverage claim has been processed upon receipt of the EOP or ERA. A secondary coverage claim that is submitted prior to the processing of its preceding primary coverage claim will be denied, based on the need for primary insurance information.

Code Sets

Only standard codes, valid at the time of the date(s) of service, should be used.

Corrections and Reversals

The 837 TR3 defines what values submitters must use to signal to payers that the inbound 837 contains a reversal or correction to a claim that has previously been submitted for processing. For both Professional and Institutional 837 claims, 2300 CLM05-3 (Claim Frequency Code) must contain a value for the National UB Data Element Specification Type List Type of Bill Position 3. Values supported for corrections and reversals are:

- 5 = "Late Charges Only" Claim
- 7 = Replacement of Prior Claim
- 8 = Void/Cancel of Prior Claim

Data Format/Content

Centene accepts all compliant data elements on the 837 Professional Claim. The following points outline consistent data format and content issues that should be followed for submission.

Dates

The following statements apply to any dates within an 837 transaction:

- All dates should be formatted according to Year 2000 compliance, CCYYMMDD, except for ISA segments where the date format is YYMMDD.

- The only values acceptable for “CC” (century) within birthdates are 18, 19, or 20.
- Dates that include hours should use the following format: CCYYMMDDHHMM.
- Use Military format, or numbers from 0 to 23, to indicate hours. For example, an admission date of 201006262115 defines the date and time of June 26, 2010 at 9:15 PM.
- No spaces or character delimiters should be used in presenting dates or times.
- Dates that are logically invalid (e.g. 20011301) are rejected.
- Dates must be valid within the context of the transaction. For example, a patient’s birth date cannot be after the patient’s service date.

Decimals

All percentages should be presented in decimal format. For example, a 12.5% value should be presented as .125.

Dollar amounts should be presented with decimals to indicate portions of a dollar; however, no more than two positions should follow the decimal point. Dollar amounts containing more than two positions after the decimal point are rejected.

Monetary and Unit Amount Values

Centene accepts all compliant data elements on the 837 Professional Claim; however, monetary or unit amount values that are in negative numbers are rejected.

Delimiters

Delimiters are characters used to separate data elements within a data string. Delimiters used by Centene are specified in the Interchange Header segment (the ISA level) of a transmission; these include the tilde (~) for segment separation, the asterisk (*) for element separation, and the colon (:) for component separation. *Please note that the pipe symbol (|) and or line feed cannot be used as delimiters.*

Phone Numbers

Phone numbers should be presented as contiguous number strings, without dashes or parenthesis markers. For example, the phone number (336) 555-1212 should be presented as 3365551212. Area codes should always be included. Centene requires the phone number to be AAABBBCCCC where AAA is the Area code, BBB is the telephone number prefix, and CCCC is the telephone number.

Additional Items

- Centene will not accept more than 97 service lines per claim.
- Centene will not accept negative values in AMT fields.
- The Value Added Network Trace Number (2300-REF02) is limited to 20 characters.

Identification Codes and Numbers

General Identifiers

Federal Tax Identifiers

Any Federal Tax Identifier (Employer ID or Social Security Number) used in a transmission should omit dashes or hyphens. Centene sends and receives only numeric values for all tax identifiers.

Sender Identifier

The Sender Identifier is presented at the Interchange Control (ISA06) of a transmission. Centene expects to see the sender's Federal Tax Identifier (ISA05, qualifier 30) for this value. In special circumstances, Centene will accept a "Mutually Defined" (ZZ) value. Senders wishing to submit a ZZ value must confirm this identifier with Centene EDI.

Provider Identifiers

National Provider Identifiers (NPI)

HIPAA regulation mandates that providers use their NPI for electronic claims submission. The NPI is used at the record level of HIPAA transactions; for 837 claims, it is placed in the 2010AA loop. See the 837 Professional Data Element table for specific instructions about where to place the NPI within the 837 Professional file. The table also clarifies what other elements must be submitted when the NPI is used.

Billing provider

The Billing Provider Primary Identifier should be the group/organization ID of the billing entity, filed only at 2010AA. This will be a Type 2 (Group) NPI unless the Billing provider is a sole proprietor and processes all claims and remittances with a Type 1 (Individual) NPI.

Rendering Provider

When providers perform services for a subscriber/patient, the service will need to be reported in the Rendering Provider Loop (2310B or 2420A) You should only use 2420A when it is different than 2310B.

Referring Provider

Centene has no requirement for Referring Provider information beyond that prescribed by the X12 implementation guide (TR3).

Atypical Provider

A typical providers are not always assigned an NPI number, however, if an Atypical provider has been assigned an NPI, then they need to follow the same requirements as a medical provider. An Atypical provider which provides non-medical services is not required to have an NPI number (i.e. carpenters, transportation, etc). Existing Atypical providers need only send the Provider Tax ID in the REF segment of the billing provider loop.

Subscriber Identifiers

Submitters must use the entire identification code as it appears on the subscriber's card in the 2010BA element.

Claim Identifiers

Centene issues a claim identification number upon receipt of any submitted claim. The ASC X12 Technical Reports (Type 3) may refer to this number as the Internal Control Number (ICN), Document Control Number (DCN), or the Claim Control Number (CCN). It is provided to senders in the Claim Audit Report and in the CLP segment of an 835 transaction. *When submitting a claim adjustment, this number must be submitted in the Original Reference Number (ICN/DCN) segment, 2300, REF02.*

Centene returns the submitter's Patient Account Number (2300, CLM01) on the Claims Audit Report and the 835 Claim Payment/Advice (CLP01).

Connectivity Media for Batch Transactions

Secure File Transfer

Centene encourages trading partners to consider a secure File Transfer Protocol (FTP) transmission option. Centene offers two options for connectivity via FTP.

- Method A – the trading partner will push transactions to the Centene FTP server and Centene will push outbound transactions to the Centene FTP server.
- Method B – The Trading partner will push transactions to the Centene FTP server and Centene will push outbound transactions to the trading partner's FTP server.

Encryption

Centene offers the following methods of encryption SSH/SFTP, FTPS (Auth TLS), FTP w/PGP, HTTPS (Note this method only applies with connecting to Centene's Secure FTP. Centene does not support retrieve files automatically via HTTPS from an external source at this time.) If PGP or SSH keys are used they will be shared with the trading partner. These are not required for those connecting via SFTP or HTTPS.

Direct Submission

Centene also offers posting an 837 batch file directly on the Provider Portal website for processing.

Edits and Reports

Incoming claims are reviewed first for HIPAA compliance and then for Centene business rules requirements. The business rules that define these requirements are identified in the 837 Professional/Institutional Data Element Table below, and are also available as a comprehensive list in the 837 Professional Claims – Centene Business Edits Table. HIPAA TR3 implementation guide errors may be returned on either the TA1 or 999 while Centene business edit errors are returned on the Centene Claims Audit Report.

Reporting

The following table indicates which transaction or report to review for problem data found within the 837 Professional Claim Transaction.

Transaction Structure Level	Type of Error or Problem	Transaction or Report Returned
ISA/IEA Interchange Control		TA1
GS/GE Functional Group ST/SE Segment Detail Segments	HIPAA Implementation Guide violations	999 Centene Claims Audit Report (a proprietary confirmation and error report)
Detail Segments	Centene Business Edits (see audit report rejection reason codes and explanation.)	Centene Claims Audit Report (a proprietary confirmation and error report)
Detail Segments	HIPAA Implementation Guide violations and Centene Business Edits.	277CA

837: Data Element Table

The 837 Data Element Table identifies only those elements within the X12 5010 Technical Report implementation guide that requirement comment within the context of Centene business processes. The 837 Data Element Table references the guide by loop name, segment name and identifier, element name and identifier. The Data Element Table also references the Centene Business Edit Code Number if there is an edit applicable to the data element in question. The Centene Business Edit Code numbers appear on the Claims Audit Report, along with a narrative explanation of the edit. For a list of the error messages and their respective code numbers, see 'Audit Report - Rejection Reason Codes and Explanation' above.

The Centene business rule comments provided in this table do not identify if elements are required or situational according to the 837 Implementation guides. It is assumed that the user knows the designated usage for the element in question. Not all elements listed in the table below are required, but if they are, the table reflects the values Centene expects to see.

837 Health Care Claim					Centene Business Rules
Loop ID	Segment Type	Segment Designator	Element ID	Data Element	
2010AA	NM1			Billing Provider Name	
			NM103- NM105	Name Last	Centene processes all alpha characters, dashes, spaces, apostrophes, or periods. No other special characters are allowed.
			NM104	Name First	If NM102 = '2' then this element should

					be blank.
2010BA	NM1	Subscriber Name			
			NM103- NM105	Name (Last, First, Middle)	Centene processes all alpha characters, dashes, spaces, apostrophes, or periods. No other special characters are allowed.
			NM109	ID Code	The member ID number should appear as it does on the membership card.
	DMG	Demographic Information			
			DMG03	Gender Code	Centene will only accept 'M', 'F', and 'O' values.
2010BB	NM1	Payer Name			
			NM103- NM105	Name Last	Centene processes all alpha characters, dashes, spaces, apostrophes, or periods. No other special characters are allowed.
			NM103	Last Name or Organization Name	Use the health plan listed under the Payer ID section of this document.
2300	REF	Payer Claim Control Number			
			REF02	Reference Identification Qualifier	If CLM05-3 = '7' or '8' REF02 must contain the original claim number.