Alameda Alliance for Health

Standard Companion Guide Transaction Information

Instructions related to Transactions based on ASC X12 Implementation Guides, version 005010X222A1

Health Care Claims (837P) Transaction for Inbound

Professional Encounters Companion Guide

Version Number: V.1.4

May 2020

Document History (Version Control)

Version	Date	Author	Brief Description of Modifications
1.0	11/01/2017	Yash Doshi	Created
1.1	07/03/2019	Sunita Maharjan	Claim id for partially paid claim
1.2	09/17/2019	Linda Yang	Add 3.3 File Contents to limit 10000 records per submission file Add 3.4 File Resubmission to use different Claim ID
1.3	10/23/2019	Linda Yang	Add 6, 7, 8 and 9 in A.4 Additional Void/Replacement rules
1.4	05/15/2020	Cindy Rogers	Updated IT Help Desk email

Preface

Companion Guides (CG) may contain two types of data, instructions for electronic communications with the publishing entity (Communications/Connectivity Instructions) and supplemental information for creating transactions for the publishing entity while ensuring compliance with the associated ASC X12 IG (Transaction Instructions). Either the Communications/Connectivity component or the Transaction Instruction component must be included in every CG. The components may be published as separate documents or as a single document.
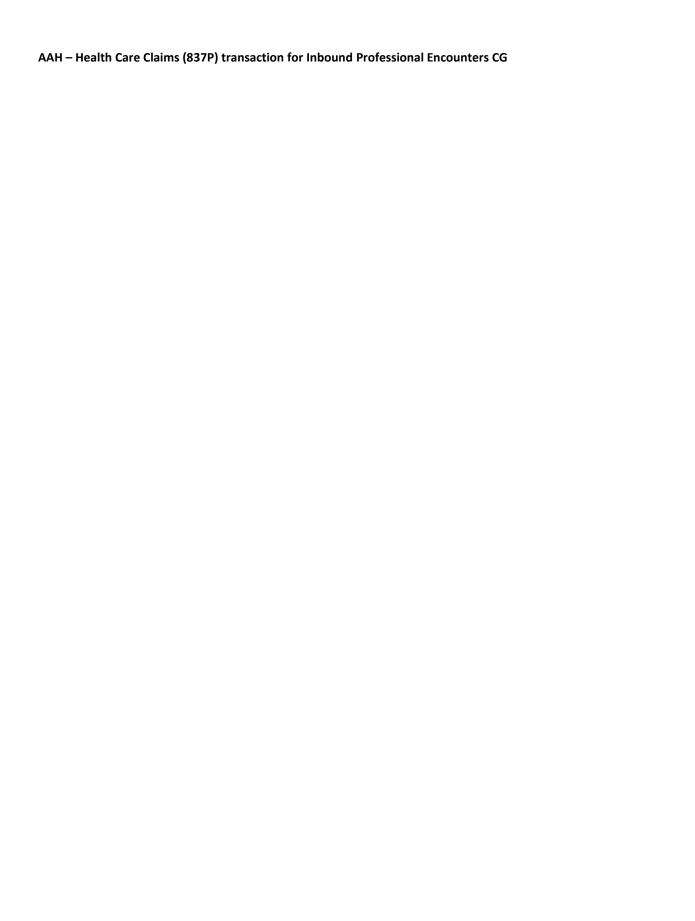
The Communications/Connectivity component is included in the CG when the publishing entity wants to convey the information needed to commence and maintain communication exchange.

The Transaction Instruction component is included in the CG when the publishing entity wants to clarify the IG instructions for submission of specific electronic transactions. The Transaction Instruction component content is limited by ASCX12's copyrights and Fair Use statement.

Table of Contents

Transaction Instruction (TI)

1 TI Introduction

1.1 Overview of HIPAA Legislation

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 carries provisions for administrative simplification. This requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. HIPAA directs the Secretary to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard HIPAA serves to:

- Create better access to health insurance

- Limit fraud and abuse

- Reduce administrative costs

- Compliance according to HIPAA

The HIPAA regulations at 45 CFR 162.915 require that covered entities not enter into a trading partner agreement that would do any of the following:

- Change the definition, data condition, or use of a data element or segment in a standard.

- Add any data elements or segments to the maximum defined data set.

- Use any code or data elements that are marked "not used" in the standard's implementation specifications or are not in the standard's implementation specification(s).

- Change the meaning or intent of the standard's implementation specification(s).

1.2 Compliance according to ASC X12

ASC X12 requirements include specific restrictions that prohibit trading partners from:

- Modifying any defining, explanatory, or clarifying content contained in the implementation guide.

- Modifying any requirement contained in the implementation guide.

1.3 Intended Use

The Transaction Instruction component of this companion guide must be used in conjunction with an associated ASC X12 Implementation Guide. The instructions in this companion guide are not intended to be stand-alone requirements documents. This companion guide conforms to all the requirements of any associated ASC X12 Implementation Guides and is in conformance with ASC X12's Fair Use and Copyright statements.

2 Included ASC X12 Implementation Guides

This table lists the X12N Implementation Guides for which specific transaction Instructions apply and which are included in Section 3 of this document.

Unique ID	Name
005010X222A1	Health Care Claim: Professional (837)

3 Instruction Tables

These tables contain one or more rows for each segment for which a supplemental instruction is needed.

Legend
SHADED rows represent "segments" in the X12N implementation guide.
NON-SHADED rows represent "data elements" in the X12N implementation guide.

Only those elements that require specific explanation are included in these tables. The underlying TR3 document for this transaction is available at http://store.x12.org.

3.1   Available Transaction Responses

Any responses to submitted encounter files will be posted to a TP's designated SFTP "response" folder.

TA1 response is available for trading partners.

TP may choose to receive <u>any</u> of the following response files for each submitted encounter data file.

- 999 –X12 standard transactions.

- 277 –X12 standard transactions.

- Custom nonstandard encounter submission Report for trading partners who cannot accept 277CA.

==For every encounter submission, trading partners will receive AAH ICN (Internal Control Number) in 277CA or proprietary report==.

3.2   Transaction Components

The Alliance **requires** the following delimiters be used:

DELIMITER FOR:	NAME	CHARACTER
Data Element Separator	Asterisk	*
Repetition Separator	Carat	^
Component Element Separator	Colon	:
Segment Terminator	Tilde	~

3.3   File Contents

Files should be comprised of only 837P (Professional) transactions. Each ST-SE can have up to 5,000 instances of the 2300 loop. Each file should have no more than 10,000 records.

3.4   File Resubmission

If the resubmitted Claim ID already exist in database, Claim ID need to be modified to eliminate duplication rejection. For example:

First submission Claim ID: 20190625921011400215

If the Claim ID already exists in database, the resubmission should use a different claim ID: 20190625921011400215R

3.5   Submitted Encounter File Naming Conventions

The Alliance will certify test claim files that pass 100% error free. Certification to move to production requires three clean test files. These three test files containing clean claims will move to Alameda's adjudication system to create a test 835-5010 ERA file. This separate process could take 7 -10 days since our 835-5010 creation process is separate from the inbound 837 claims process. The EDI department will work closely with each trading partner during this step.

For 837 Claim or Encounters submissions: CAAAYYMMDD.00# or EAAAYYMMDD.00#

Where:

C= Claim File, E = encounter file

AAA = Trading partner designation assigned by the Alliance YY= submission Year

MM = Submission Month DD = Submission Day

00# = Sequence identification number, using 001 for first file submitted in a day, incrementing for each additional file submitted that day.

(Example: CAAA130229.001 would be the first file submitted on February 29, 2013, CAAA130229.002 would be the second file submitted that day)

3.6   Provider EDI Enrollment

For EDI claims submitters, enrollment is required to set up your system with the Alameda Alliance claims adjudication system. Please follow the instructions and print, complete, sign and fax the EDI Trading Partner Agreement form which is located on the internet located here:

https://www.alamedaalliance.org/~/media/files/modules/publications/provider/billing%20information/edi%20enrollment%20form%205010%20updated%20w_27x_11042016.pdf

3.7   Duplicate Encounters

Encounters will be evaluated for duplicates at the service line level. If a service line is found to be a duplicate of a previously submitted service line, the entire encounter will be denied.

For the purposes of an 837 Professional service line, a duplicate would have the same following values as a previously submitted service line:

- Client Identification Number (CIN) – 2010BA NM109

- Date(s) of Service – 2400 DTP*472 DTP03 (can be a range)

- Rendering Provider

- Procedure Code – 2400 SV101-2

- Procedure Modifier(s) – 2400 SV101-3,4,5,6

<mark>Encounter previously denied by AAH shall be submitted as replacement. If not, then it will dupe out.</mark>

3.8   ISA/IEA

Loop ID	Reference	Name	Codes	Notes/Comments
ISA		Interchange Control Header		
	ISA01	Authorization Information Qualifier	00	
	ISA02	Authorization Information		10 blanks
	ISA03	Security Information Qualifier	00	
	ISA04	Security Information		10 blanks
	ISA05	Interchange ID Qualifier	ZZ	
	ISA06	Interchange Sender ID		Sender's or Trading Partner's Federal Tax ID
	ISA07	Interchange ID Qualifier	ZZ	This ID qualifies the Receiver in ISA08.
	ISA08	Interchange Receiver ID	943216947	AAH Tax ID number
	ISA11	Repetition Separator	^	

Loop ID	Reference	Name	Codes	Notes/Comments
	ISA13	Interchange Control Number		The Interchange Control Number, ISA13 - must be a positive unsigned number identical to the associated Interchange Trailer IEA02.
	ISA14	Acknowledgement Requested	0	No TA1 response is available at this time.
	ISA16	Component Element Separator	:	
IEA		Interchange Control Trailer		
	IEA02	Interchange Control Number		Must match the value in ISA13

3.9 GS/GE

Loop ID	Reference	Name	Codes	Notes/Comments
GS		Functional Group Header		
	GS01	Functional Identifier Code	HC	
	GS02	Application Sender's Code		Sender's Federal Tax ID - "
	GS03	Application Receiver's Code	943216947	AAH Tax ID
	GS06	Group Control Number		This must match the value in GE02.
	GS08	Version / Release / Industry Identifier Code	005010X222A1	
GS		Functional Group Header		
	GE02	Group Control Number		This must match the value in GS06.

3.10   ST/SE

Loop ID	Reference	Name	Codes	Notes/Comments
ST		Transaction Set Header		
	ST01	Transaction Set Identifier Code	837	
	ST02	Transaction Set Control Number		This value must match the value in SE02
	ST03	Implementation Convention Reference	005010X222A1	.
SE		Transaction Set Trailer		
	SE01	Number of Included Segments		Transaction Segment Count
	SE02	Transaction Set Control Number		This value must match the value in ST02
BHT		Beginning of Hierarchical Transaction		
	BHT06	Transaction Type Code	CH, RP	For Claims - use CH – 'Chargeable' For Encounters - use RP – 'Reporting'
1000A		Submitter Name		
1000A	NM109	Identification Code	Submitter's Federal Tax ID	Submitter's Federal Tax ID
1000B		Receiver Name		
1000B	NM103	Receiver Name	Alameda Alliance for Health	'Alameda Alliance for Health'
1000B	NM109	Receiver Primary Identifier	943216947	The Alliance's Federal Tax ID
2000B		Subscriber Information		
2000B	SBR01	Payer Responsibility Sequence Number Code	P, S, T	Use 'P' for claims. Use "S" for encounters. Use "S" or "T" when true COB exists and include the appropriate COB loops per the IG.

2000B	SBR03	Subscriber Group or Policy Number	MCAL, ACC, IHSS, AS, ASD	Use these alpha numeric numbers to indicate line of business. MCAL – MediCal, ACC – Alliance Complete Care, IHSS – Group Care, AS – Alliance Select, ASD – Alliance Select Direct.
2010BA		**Subscriber Name**		
2010BA	NM108	Subscriber: Member Id Number	MI	Enter 'MI' to qualify the member's primary identifier; the member ID.

2010BA	NM109	Subscriber Primary Identifier	HSN
			
			DHCS CIN
				The Alliance issued 9 digit subscriber number is preferred and required for encounters. AAH will also accept:
				  - DHCS's CIN Number
				  -
				Note: Add 0's if member id is less than 9 digits in length. Member ID: 000012345

2010BB		**Payer Name**		
2010BB	NM103	Payer Name	ALAMEDA ALLIANCE FOR HEALTH	ALAMEDA ALLIANCE FOR HEALTH
2010BB	NM108	Identification Code Qualifier	PI	PI - Payer Identification
2010BB	NM109	Payer Identifier	1508910779	Use the Alliance's NPI number
2010CA		**Patient Name**		AAH does not accept this loop for encounter submission.
2300	**CLM**	**Claim Information**		
2300	CLM01	Patient Control Number		A unique number is required. If not unique then the claim will be denied.
				Split the *partially paid* encounter with *a unique claim* number before submitting to AAH. If not the claim will be denied.

2300	CLM02	Total Claim Charge Amount		Must be greater than or equal to zero and total must equal sum of all line level charges
2300	CLM05-3	Claim Frequency Type Code	1 – Original 7 – Replacement 8 – Void	For encounters, AAH will not any accept claim frequency codes other than 1, 7 and 8.
2300		Contract Information		
2300	CN1	Contract Information	02 – FFS 05 – Capitated 09 – Denied	AAH will reject encounter if CN1 is left blank or invalid code is submitted by TP.
2300	AMT	Patient Amount Paid		Required if patient has paid an amount toward this claim such as a co-payment
2300	REF	Referral Number		Required when a referral number is needed for the claim/encounter.
2300	REF	Prior Authorization		Required when a prior authorization number is needed for the
2300	REF	Payer Claim Control Number		For replacements/voids, AAH Internal control number is expected. TP's are expected to reference ICN received from AAH.
2300	REF	CLAIM IDENTIFIER FOR TRANSMISSION INTERMEDIARIES		Trading Partner's internal control number. This data element will be sent back to the TP in 277CA.

2300	REF	Clinical Laboratory Improvement Amendment (CLIA) Number		Required if facility is CLIA certified and performing CLIA covered lab services.
2300	NTE	Claim Note		Required for encounters to report the date the delegated entity received the encounter. Use CCYYMMDD format.
2300	HI	Health Care Diagnosis Code		
2300	HI01-HI01-2	Diagnosis Type Code	ABK	Valid ICD-10 codes are accepted.
2300	HI02-HI12-1	Diagnosis Type Code	ABF	Valid ICD-10 codes are accepted.
2310C	NM1	Service Facility Location Name		Service/Rendering location segment required for all claims and encounters
2320	SBR	Other subscriber information		
2320	SBR01	Payer Responsibility Sequence Number Code	P or T	Required when submitting COB information. Required for all encounters. Use P when delegated entity was primary payer or T when delegated entity had true COB with another payer.

2320	SBR03	Insured Group or Policy Number	MCAL, ACC, IHSS, AS, ASD	Required for all encounters; Use these alpha numeric numbers to indicate line of business. MCAL – MediCal, ACC – Alliance Complete Care, IHSS – Group Care, AS – Alliance Select, ASD – Alliance Select Direct.
2320	AMT	COB Payer Paid Amount		
2320	AMT	COB Payer Paid Amount		Required for claims where there is COB and for all encounters. CMS is requiring payers paid amount as a part their Encounter Data Processing System (EDPS).
2320	OI	Other Insurance Coverage Information		
2320	OI03	Benefits Assignment Certification Indicator		Required for claims when there is true COB and for all encounters. Must match the value in Loop 2300, CLM08
2330A	NM1	Other Subscriber Name		Required for claims when there is true COB and for all encounters. Must match the values in Loop 2010BA
2330B	NM1	Other Payer Name		Required for claims when there is true COB and for all encounters. For encounters submit the name of the delegated entity.

2330B	NM109	Other Payer Primary Identifier		Use the adjudicating payer's Tax ID number. For encounters, this number should match SVD01 of Loop 2430.
2330B	DTP	Check Or Remittance Date		Required for claims when there is true COB and for all encounters to report the date the claim was paid (if done at the claim level; or can report this at the line level but not both).
2400	CN1	Contract Information		
2400	CN101	Contract Information	02 - Per Diem, (i.e. FFS) 05 – Capitated 09 - Denied	AAH will reject encounter if CN1 is left blank or invalid code is submitted by TP.
2400	NTE	Line Note		
2400	NTE02	Line Note		Required for claims when there is true COB and for all encounters to report lines with a denied status. Service line denial code followed by a hyphen then the denial reason with a maximum of 80 characters.
2410	LIN	Drug Identification		Valid NDC codes will be accepted.
2430	SVD	Line Adjudication Information		Required for claims when there is true COB and for all encounters to report information regarding the adjudication of the claim. SVD01 should match the value in Loop 2330B, NM109 (Other Payer's Tax ID)

2430	CAS	Line Adjust ment		Required for encounters to report adjustments on previously submitted encounters.
2430	DTP	Line Check Or Remitta nce Date		Required for claims when there is true COB and for all encounters to report the date the claim line was paid.

4 Connectivity/Contact Information

4.1 Transferring Files

All electronic data is transferred to and from the Alliance electronically via the Internet to the Alliance's File Secure Transfer Protocol (SFTP) server. The secure FTP server software called "AAH Secure Transport Access" provides a straight SFTP connection or alternatively, an HTTPS connection, which behaves like a web portal. Both step-by-step guides describing these communications methods will be provided to new EDI submitters for file submission and file retrieval (277CA, TA1 and 999 files).

4.2 Requirements

All Providers are required to have the following hardware and software to send and receive data:

1. Internet access and SFTP software.
2. A PC running Windows 98, Windows XP, Vista and Windows 7

Supported SFTP Configurations:

- Secure FTP with SSL 128bit encryption.
- Strong passwords are required and enforced.
- SSL is mandatory on both data and command channels.
- Explicit SSL connection is required.

The following software has tested with AAHFTP server without problems:

- We recommend using FileZilla FTP Client.
- Download and Install the Free Client.
- (http://filezilla-project.org/download.php?type=client)

For new EDI submitters, a secure FTP mailbox will be setup and credentials (username and password) provided to the submitters.

4.3 Contact SFTP Customer Service

Assistance with secure FTP connection to the Alliance or password changes should be referred to:

The Alameda Alliance for Health
Service Desk
Call: 510-747-4520
Email: ITServiceDesk@alamedaalliance.org

4.4 Contact: EDI Technical

For questions or comments regarding this Companion Guide or other X12 related questions, please contact:

Yash Doshi
EDI Manager
Phone: 510-747-6187
Email: ydoshi@alamedaalliance.org

5 TI Additional Information

Frequently Asked Questions

Q. What is the difference between a claim file and an encounter file?

A. A claim file is typically submitted by an Alliance directly contracted provider for adjudication and payment by the Alliance. Encounter files are submitted by the Alliance's delegated entities and includes claims that have been previously adjudicated and paid by the delegated entity. Some of the differences in the files are:

- BHT06 - for claims you would report a "CH" for chargeable whereas for encounters you would report an "RP" for reportable.

- COB/Other Payer Segments – for claims the segments associated with COB and the other payer are used only when there is true COB between the Alliance and another payer to whom the provider has submitted a claim. The Alliance is using the payer-to-payer COB model for the submission of encounters. In this model the Alliance is considered both the receiver and the payer in Loop 2010BB and the delegated entity is the other payer in Loop 2330B. In addition COB and Other Payer segments are used to report how the delegated entity adjudicated the claim. See the Technical Report Type 3 (TR3) implementation guides (IG) available for purchase from Washington Publishing Company http://www.wpc-edi.com for further information on

the payer-to-payer COB model.

Appendix B – Void and Replacement Scenarios

A.1   Submission of Replacement encounter correctly.

- **Original Encounter submission to AAH.**

Date	CLM01	CLM05-3	REF F8	AAH Encounter ID	Internal AAH Status	Note
03/01	A1234	1	n/a	0091234	Accepted	AAH encounter ID will be shared with TP's in 277CA or proprietary report.

- **Replacement file**

Date	CLM01	CLM05-3	REFF8	AAH Encounter ID	Internal AAH Status	Note
03/26	A1235	7	0091234	0091245 (Shared in 277CA)	Record Replaced	AAH encounter ID will be shared with TP's in 277CA or proprietary report.

A.2 Submission of Void encounter correctly.

- **Original Encounter submission to AAH.**

Date	CLM01	CLM05-3	REF F8	AAH Encounter ID	Internal AAH Status	Note
03/01	A1234	1	n/a	0091234	Accepted	AAH encounter ID will be shared with TP's in 277CA or proprietary report.

- **Void file**

Date	CLM01	CLM05-3	REF*F8	AAH Encounter ID	Internal AAH Status	Note
03/26	A1235	8	0091234	0091245 (Shared in 277CA)	Record Voided	AAH encounter ID will be shared with TP's in 277CA or proprietary report.

A.3   Submission of multiple replacements

- **Original file**

Date	CLM01	CLM05-3	REF F8	AAH Encounter ID	Internal AAH Status	Note
03/01	A1234	1	n/a	0091234	Accepted	AAH encounter ID will be shared with TP's in 277CA or proprietary report.

- **Replacement file**

Date	CLM01	CLM05-3	REFF8	AAH Encounter ID	Internal AAH Status	Note
03/26	A1235	7	0091234	0091245 (Shared in 277CA)	Record Replaced	AAH encounter ID will be shared with TP's in 277CA or proprietary report.
03/26	A1236	7	0091235	0091246 (Shared in 277CA)	Record Replaced	AAH encounter ID will be shared with TP's in 277CA or proprietary report.

A.4   Additional Void/Replacement rules

1. For replacements/voids, trading partners are expected to reference last submissions AAH Internal Control number (ICN) in (2300, REF, F8) segment.
2. Replacements/voids encounters cannot reference same AAH ICN more than one time. If so, they will be rejected.
3. Resubmission of encounters denied by AAH shall be submitted as replacements/voids. If submitted as original then AAH will deny these duplicate records.
4. For replacement/voids, Patient control number (CLM01) shall always be unique.
5. Replacements for any voided encounter record will not be accepted.
6. For 277 rejection resubmission with an ICN, use frequency code 7 in CLM01-5 segment with a new ClaimID number.
7. For 277 rejection resubmission without an ICN, use frequency code 1 in CLM-5 segment with new ClaimID number.
8. If the entire file is rejected on 999, you can resubmit the encounters by using the same ClaimID numbers.
9. Partially rejected encounters on 999, use frequency code 1 in CLM-5 segment with new ClaimID number.