

Claim Submission- Professional



## **Standard Companion Guide**

Version Number: 0.1

Refers to the Implementation Guides Based on

**X12 version 005010X222A1**

**Health Care Claim: Professional (837)**

**Companion Guide Version Number: 0.1**

September 2010

## Change Log

<i>Version</i>	<i>Release date</i>	<i>Changes</i>
0.1	09/21/2010	Original Draft
0.2	11/4/2011	Revised to include ICD-10 Reject information

## **Preface**

This Companion Guide to the ASC X12N Implementation Guides adopted under HIPAA clarifies and specifies the data content when exchanging electronically with United Healthcare Health Plan. Transmissions based on this companion guide, used in tandem with the X12N Implementation Guides, are compliant with both X12 syntax and those guides. This Companion Guide is intended to convey information that is within the framework of the ASC X12N Implementation Guides adopted for use under HIPAA. The Companion Guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the Implementation Guides.

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## 1. INTRODUCTION

This section describes how X12N Implementation Guides (IGs) adopted under HIPAA will be detailed with the use of the table in **Section 10**. The table contains a row for each **OHP** segment where something **additional, over, and above** the information in the IGs. That information can:

1. Limit the repeat of loops, or segments
2. Limit the length of a simple data element
3. Specify a sub-set of the IGs internal code listings
4. Clarify the use of loops, segments, composite and simple data elements
5. Any other information tied directly to a loop, segment, composite or simple data element pertinent to trading electronically with Acme Health Plan

In addition to the row for each segment, one or more additional rows are used to describe OHP's usage for composite and simple data elements and for any other information. Notes and comments should be placed at the deepest level of detail. For example, a note about a code value should be placed on a row specifically for that code value, not in a general note about the segment.

The following table specifies the columns and suggested use of the rows for the detailed description of the transaction set companion guides. The table contains a row for each segment that UnitedHealthcare has something additional, over and above, the information in the IG's. The following is just an example of the type of information that would be spelled out or elaborated on in: Section 9 – Transaction Specific Information.

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
74	1000A	NM1	Submitter Name			This type of row always exists to indicate that a new segment has begun. It is always shaded at <b>10%</b> and notes or comment about the segment itself goes in this cell.
195	2100C	NM109	Subscriber Primary Identifier		<b>15</b>	This type of row exists to limit the length of the specified data element.
195	2100C	NM108	Identification Code Qualifier	<b>MI</b>		This type of row exists when a note for a particular code value is required. For example, this note may say that value <b>MI</b> is the only valid value. Not populating the first 3 columns makes it clear that the code value belongs to the row

immediately above it.

226	2300	HI	Health Care Diagnosis Code Code List Qualifier Code	<b>BK</b>	This row illustrates how to indicate a component data element in the Reference column and also how to specify that only one code value is applicable.
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**1.1 SCOPE**

This document is to be used for the implementation of the HIPAA 5010 837 Professional Claims Transaction for the purpose of submitting provider claims electronically to UnitedHealthcare, Oxford Health Plans (OHP). This document is to be used as a Companion Guide (CG) to the **837 Health Care Claim: Professional ASC X12N (005010X222A1) Implementation Guide**, also referred to as **Technical Report Type 3 (TR3)**. This guide is not intended to replace the TR3.

**1.1 OVERVIEW**

This CG will replace, in total, the previous OHP CG for Professional Claims submission and must be used in conjunction with the TR3 instructions. The CG is intended to assist you in implementing electronic claim submission transactions that meet OHP processing standards, by identifying pertinent structural and data related requirements and recommendations.

Updates to this companion guide will occur periodically and new documents will be posted on [www.Oxfordhealth.com](http://www.Oxfordhealth.com); these updates will also be available at [http://www.uniprise.co/hipaa/companion\\_docs.html](http://www.uniprise.co/hipaa/companion_docs.html) and distributed to all registered trading partners with reasonable notice, or a minimum of 30 days, prior to implementation.

In addition, all trading partners will receive an email with a summary of the updates and a link to the new documents posted online.

**1.1 REFERENCE**

For more information regarding **837 Health Care Claim: Professional ASC X12N (005010X222A1) Implementation Guide** and to purchase copies of this and any related documents, consult the Washington Publishing Company web site at [www.wpc-edi.com](http://www.wpc-edi.com)

## 1.1 ADDITIONAL INFORMATION

The American National Standards Institute (ANSI) is the coordinator for information on national and international standards. In 1979 ANSI chartered the Accredited Standards Committee (ASC) X12 to develop uniform standards for electronic interchange of business transactions and eliminate the problem of non-standard electronic data communication. The objective of the ASC X12 committee is to develop standards to facilitate electronic interchange relating to all types of business transactions. The ANSI X12 standards is recognized by the United States as the standard for North America. Electronic Data Interchange (EDI) adoption has been proved to reduce the administrative burden on providers.

## 2. GETTING STARTED

### 2.1 WORKING WITH OHP

OHP is partnered with **Ingenix Connectivity Solutions (ICS)** to streamline EDI workflow processes and reduce transaction costs. Ingenix offers a secure, easy-to-use path to virtually all commercial and government payers. For more information about Ingenix solutions and services, visit [www.ingenix.com](http://www.ingenix.com) or call 888-445-8745.

**Oxford Direct-Connect** powered by **Post-N-Track (PNT)** allows you to submit HIPAA transactions directly to OHP free of charge.

OHP has a support call center for all EDI inquiries and issues triaging. Contact **OHP Provider e-solutions Customer Support** at 1-800-599-4334 or email to [EDIProviderAssistance@oxhp.com](mailto:EDIProviderAssistance@oxhp.com).

### 2.1 TRADING PARTNER REGISTRATION

For Post-n-Track visit [www.post-n-track.com](http://www.post-n-track.com) or call at 1-860-257-2030

For Ingenix visit [www.ingenix.com](http://www.ingenix.com) or call 888-445-8745.

### 2.1 CERTIFICATION AND TESTING OVERVIEW

OHP does not certify Providers or Clearinghouses.

### 2.1 TESTING WITH PAYER

OHP does not test directly with Providers. OHP does testing is based on the Workgroup for Electronic Data Interchange (WEDI) Strategic National Implementation Process (SNIP) Testing Sub-Workgroups recommendations on the types of testing that need to occur in order to remain in line with the health care industry’s testing recommendations.

HIPAA Levels of Compliance Tested:

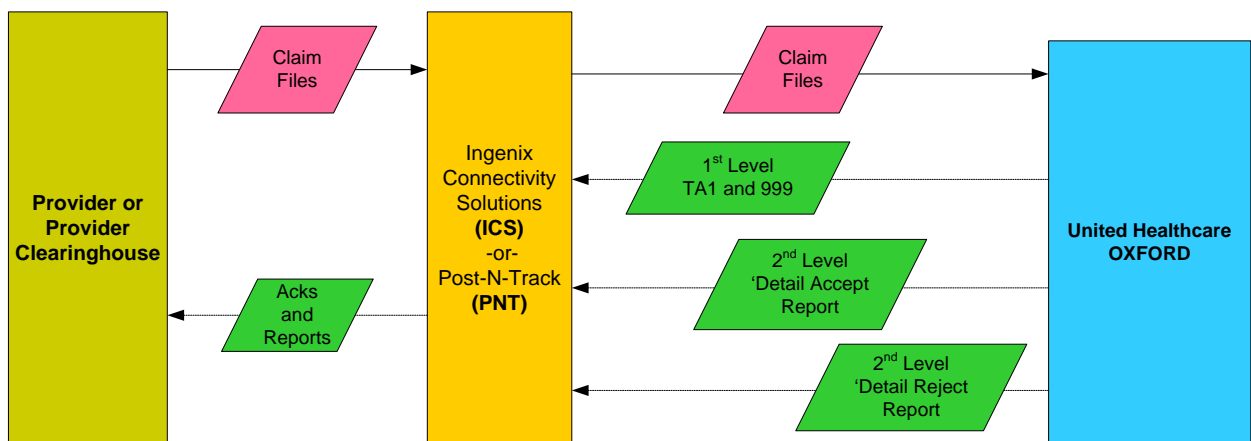
1. Integrity Testing
2. Requirement Testing
3. Balancing
4. Situation Testing
5. Code Set Testing (Partial, see section 6.2))

Other Testing Requirements:

- 1) Production data
- 2) Adequate Volume
- 3) Various Claim Types when applicable

### 3. CONNECTIVITY WITH THE PAYER / COMMUNICATIONS

#### 3.1 PROCESS FLOWS



**Claim Submission-  
Professional**

OHP receives and processes HIPAA 837 claims transactions Monday through Sunday. For each physical claim file received (ISA-IEA interchange) the following is returned:

- 1- A 1<sup>st</sup> level TA1 and 999 Acknowledgements are returned near-time.
- 2- A 2<sup>nd</sup> level proprietary "Accept" report is returned. This report identifies all claims that passed HIPAA validation and are accepted into OHP's front-end system. Both the Clearinghouse and Oxford assigned Document Control Numbers are included
- 3- A 2<sup>nd</sup> level proprietary "Reject" report is returned the following day. This report identifies all claims failing front-end validation.

**3.1 TRANSMISSION ADMINISTRATIVE PROCEDURES**

**3.1 RE-TRANSMISSION PROCEDURE**

**3.1 COMMUNICATION PROTOCOL SPECIFICATIONS**

**3.1 PASSWORDS**

For sections 3.2 – 3.5, Physicians and Healthcare professionals should contact their current clearinghouse vendor for information on the most current process.

**3.1 SYSTEM AVAILABILITY & DOWNTIME**

OHP's normal business hours for 837 EDI processing are as follows all times are EST:

Sunday	6:00 AM	thru	10:00 PM
Monday	6:00 AM	thru	10:00 PM
Tuesday	6:00 AM	thru	10:00 PM
Wednesday	6:00 AM	thru	10:00 PM
Thursday	6:00 AM	thru	10:00 PM
Friday	6:00 AM	thru	10:00 PM
Saturday	6:00 AM	thru	2:00 PM
Sunday	6:00 AM	thru	1:00 PM

OHP systems may be down for general maintenance and upgrades.

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The following message communicating system unavailability is posted on each login page on **Oxfordhealth.com**:

**Service Notifications:**

Scheduled System Maintenance:

- Daily from 2am to 3am EDT
- Saturday 1pm to Monday 6am EDT

As a result, certain transactions will be unavailable during these hours. We apologize for any inconvenience and thank you for your patience.

**3.1 COSTS TO CONNECT**

Physicians and Healthcare professionals should contact their current clearinghouse vendor to discuss costs.

## **4. CONTACT INFORMATION**

### **4.1 EDI CUSTOMER SERVICE**

**OHP Provider e-solutions Customer Support** services are available Monday-Friday from 8:30am to 5:00pm EST to assist with a variety of questions and issues. This includes; General questions about OHP Companion Guides, transmission related difficulties, electronic setup with vendors or clearinghouse, and clearinghouse and vendor reports.

Contact us at 1-800-599-4334 or via e-mail at [EDIProviderAssistance@oxhp.com](mailto:EDIProviderAssistance@oxhp.com)

### **4.1 EDI TECHNICAL ASSISTANCE**

Physicians and Healthcare professionals should first contact their current clearinghouse vendor should technical issues arise. The clearinghouse will escalate any issue as needed to OHP.

Clearinghouses and other intermediaries please contact **OHP Provider e-solutions Customer Support**.

### **4.1 PROVIDER SERVICE NUMBER**

For general claims inquiries regarding policies, payment, or claim status information that cannot be obtained via a self-service claim status request, call the **OHP Provider Service** line at **1-800-866-1353**.

#### 4.1 APPLICABLE WEBSITES / E-MAIL

OHP has a robust website [www.Oxfordhealth.com](http://www.Oxfordhealth.com) where providers can check **Claims** and **Eligibility** status, and submit **Authorizations**, **Notification**, and **Referrals**. A suite of other EDI and provider tools are available.

Other:

**OHP Provider e-solutions Customer Support** [EDIProviderAssistance@oxhp.com](mailto:EDIProviderAssistance@oxhp.com)

**Oxford DirectConnect** visit [www.post-n-track.com](http://www.post-n-track.com).

**Ingenix Connectivity Solutions (ICS)** visit [www.ingenix.com](http://www.ingenix.com)

**Washington Publishing Company** visit at [www.wpc-edi.com](http://www.wpc-edi.com)

**Uniprise** visit [www.uniprise.co./hipaa/companion\\_docs.html](http://www.uniprise.co./hipaa/companion_docs.html)

## 5. CONTROL SEGMENTS / ENVELOPES

### 5.1 ISA-IEA

Transactions transmitted during a session or as a batch are identified by an Interchange header segment (ISA) and trailer segment (IEA) which form the envelope enclosing the transmission. The ISA marks the beginning of the transmission (batch), provides expected Sender and Receiver identification information, and also identifies delimiter use within the data contained within.

**OHP** requires only one Interchange Level (ISA-IEA) be present per physical file. Any separator identified in Appendix B (B.1 ASC X12 Nomenclature), ***with the exception of a Pipe Delimiter***, can be used as a delimiter as long as the separator is identified in the appropriate section within the ISA, and only if the separator does not occur in the data as stated in Section B.1.1.2.4.1 - Base Control Set.

The ISA-IEA will be validated for both compliant structure, and OHP required values contained within. Any edit failure will result in the entire Interchange (ISA-IEA) being rejected.

The below table identifies OHP ISA/IEA requirements:

Page#	LOOP ID	Reference	NAME	Codes	Length	Notes/Comments
<b>C3 –C6</b>	<b>None</b>	<b>ISA</b>	<b>ISA Interchange Control Header</b>			
		ISA01	Authorization Information Qualifier	<b>00</b>		No Authorization Information Present Qualifier.
		ISA03	Security Information Qualifier	<b>00</b>		No Security Information Present Qualifier.
		ISA05	Interchange ID Qualifier	<b>30</b>		U.S. Federal Tax Identification Number Qualifier
		ISA07	Interchange ID Qualifier	<b>30</b>		US Federal Tax Identification Number Qualifier
		ISA08	Interchange Receiver ID	<b>061118515</b>		OHP Payer ID -Right pad as needed with spaces to 15 characters.
		ISA12	Interchange Control Version Number	<b>00501</b>		Standards Approved by ACS X12 Review Board Code
		ISA13	Interchange Control Number			<b>Duplicate checking</b> against other Interchange control numbers previously received will be applied.  Must be identical to the control number in <b>ISA13</b> . -If necessary pad with spaces to 9 characters.
		ISA14	Acknowledgment Requested	<b>1</b>		Interchange Acknowledgment
		ISA15	Usage Identifier	<b>P</b>		Code indicating whether data enclosed is production or test. Test data must never be sent over Production line. P= Production T= Test
<b>C10</b>	<b>None</b>	<b>IEA</b>	<b>IEA Interchange Control Trailer</b>			<b>Required Trailer</b>
		IEA01	Number of Included Functional Groups	<b>1</b>		Number of Functional Groups (GS-GE Loops) included in the Interchange.
		IEA02	Interchange Control Number			Must be identical to the control number in <b>ISA13</b> .

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**5.1 GS-GE**

EDI transactions of a similar nature (ex 837 professional) and destined for one trading partner may be gathered into a functional group, identified by a functional group header segment (GS) and a functional group trailer segment (GE).

The GS segment marks the beginning of the functional group. OHP requires only one Functional Group (GS-GE) be present per physical file.

The GS-GE will be validated for both compliant structure, and OHP required values contained within.

Any edit failure at the Functional Group level will result in the entire Functional Group (GS-GE) being rejected.

The below table identifies OHP GS/GE requirements

Page#	LOOP ID	Reference	NAME	Codes	Length	Notes/Comments
<b>C7 –C8</b>	<b>None</b>	<b>GS</b>	<b>Functional Group Header</b>			<b>Required Header</b>
		GS01	Functional Identifier Code	<b>HC</b>		Healthcare Claim Code
		GS03	Application Receiver's Code	<b>061118515</b>		Oxford Payer ID Code
		GS06	Group Control Number			Unique control number. Must be identical to the control number in IEA02.  Must be identical to the control number in <b>GE02</b> .
		GS07	Responsible Agency Code	<b>X</b>		Accredited Standards Committee X12 Code
		GS08	Version/Release/Industry Identifier Code	<b>005010X222 A1</b>		Standards Approved by ACS X12 Review Board Code. 004010X098DA1 can be used to pilot the transaction if so indicated by Oxford

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Page#	LOOP ID	Reference	NAME	Codes	Length	Notes/Comments
						Health Plans.
<b>C9</b>	<b>None</b>	<b>GE</b>	<b>Functional Group Trailer</b>			<b>Required Header</b>
		GE01	Number of Transaction Sets Included	<b>1</b>		Number of Transaction Sets (ST-SE Loops) included in the Functional Group.
		GE02	Group Control Number			Must be identical to the control number in <b>GS06</b> .

**5.1 ST-SE**

The beginning of each individual transaction is identified using a transaction set header segment (ST). The end of every transaction is marked by a transaction set trailer segment (SE).

The ST-SE will be validated for both compliant structure, and OHP required values contained within.

Any edit failure at the Transaction Set level will result in the entire Transaction Set (GS-GE) being rejected.

Page #	LOOP ID	Reference	NAME	Codes	Length	Notes/Comments
<b>70</b>	<b>None</b>	<b>ST</b>	<b>Transaction Set Header</b>			<b>Required Header</b>
		ST01	Transaction Set Identifier Code	<b>837</b>		Healthcare Claim Code
		ST02	Transaction Set Control Number			Unique control number Must be identical to the control number in <b>SE02</b> .
		ST03	Implementation Convention Reference	<b>005010X222 A1</b>		
<b>496</b>	<b>None</b>	<b>SE</b>	<b>Transaction Set Trailer</b>			<b>Required Header</b>
		SE02	Transaction Set Control Number			Must be identical to the control number in <b>ST02</b> .

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## 6. PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS

### 6.1 Electronic Claim Submission Guidelines

Following these guidelines will help you submit all or most of your claims electronically, without paper forms or attachments.

#### Electronic Claim Submission Guidelines

Following these guidelines will help you submit all or most of your claims electronically, without paper forms or attachments.

**A note about claim attachments:** insurance payers prefer to receive your claims electronically. In fact, many insurance companies have eliminated or significantly reduced the need for paper attachments for referrals/notifications, progress notes, ER visits, and more. Payers will request additional information when it is needed.

Services	Guidelines
<b>Laboratory</b> services	When performed in the office on an urgent basis, use modifier "ST" in the modifier field.
<b>Medicare</b> primary claims	Check your Medicare EOB to see if the claim has been forwarded to the secondary carrier for you. If it hasn't been forwarded or has been sent to the wrong carrier, then submit the claim and EOB information on paper.
Claims <b>rejected</b> on your clearinghouse reports	These claims have not been accepted for processing and adjudication by Oxford and should be corrected and resubmitted electronically.
<b>"Tracers" / re-bills</b>	It isn't necessary to send a paper claim backup for a claim sent electronically. <ul style="list-style-type: none"> <li>▪ Please allow 20-30 business days for your claim(s) to be processed.</li> <li>▪ To avoid duplicate claim denials, please check the status of your claim on <a href="http://www.oxfordhealth.com">www.oxfordhealth.com</a> instead of submitting a tracer.</li> </ul>

**The following claims and services should continue to be submitted to Oxford on paper with supporting documentation.**

Services	Guidelines
<b>Commercial primary claims</b>	When Oxford is secondary to a commercial insurance plan, we will need a copy of the primary carrier's explanation of benefits/remittance advice in order to process the claim.
<b>Corrected Medical/Physician claims</b>	Please complete the <a href="#">Participating Provider Claim Review Request Form</a> and mail it and the corrected claim to the address listed on the form.

<b>Unspecified CPT &amp; HCPCS codes</b>	Oxford needs to review medical notes in order to process claims billed with unspecified CPT and HCPCS codes. <i>Please indicate a specific CPT or HCPCS code whenever possible to avoid sending medical notes</i>
<b>Allergy Procedure Codes?</b>	<b>EDI Remarks Field*</b> Use this field to indicate number of doses, vials, or injections and as well as the dose schedule. * See specifications on next page
<b>Physician covering for Primary Care Physician (PCP)</b>	Write or type on the claim "Covering for Dr. X."

**\*\*EOB/COB Electronic Details**

For secondary claims to be paid electronically, the EOB/COB information must be submitted per IG requirements in the applicable Loops and Segments. Loops include:

- LOOP ID - 2320 OTHER SUBSCRIBER INFORMATION
- LOOP ID - 2330A OTHER SUBSCRIBER NAME
- LOOP ID - 2330B OTHER PAYER NAME
- LOOP ID - 2330C OTHER PAYER REFERRING PROVIDER
- LOOP ID - 2330D OTHER PAYER RENDERING PROVIDER
- LOOP ID - 2330E OTHER PAYER SERVICE FACILITYLOCATION
- LOOP ID - 2330F OTHER PAYER SUPERVISING PROVIDER
- LOOP ID - 2430 LINE ADJUDICATION INFORMATION

**6.2 Validation of Claims at OHP:**

OHP applies 2-levels of editing to inbound HIPAA 837 **files** and **claims**:

**1. Level-1 HIPAA Compliance:**

- Full levels 1-4.
- Claims passing are assigned an Oxford Payer **Document Control Number (DCN)** and our "accepted" for **front-end** processing.

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**2. Level-2 Front-End Validation:**

- a. Member match
  - b. Provider match
  - c. 8-Code Sets validated
    - HCPCS/CPT
    - NUBC Revenue, Condition, Occurrence, Occurrence Span, Value
    - ICD-9 Diagnosis, Procedure
    - Place of Service
3. Claims passing **front-end** validation are accepted into the **Adjudication** system for processing.
4. Claims that are received before the service date (prior to 10/1/2013) with ICD-10 qualifiers will be rejected.

Loop	ICD-10 Qualifier
2310 HI Principal Diagnosis R 1	ABK
2310 HI Other Diagnosis Information S 2	ABF

Note: Mandate date for accepting the ICD -10 is set as 10/1/2013

5. Claims received with the value 'II' (Standard Unique Health Identifier) in Subscriber Name, field NM108 will be rejected by UnitedHealthcare.

Note: Mandate date is still not decided for using the Standard Unique Health Identifier

**7. ACKNOWLEDGEMENTS AND OR REPORTS**

1. **Level-1 HIPAA Compliance produces:**
- A **TA1** acknowledgement for the Interchange received (ISA-IEA envelope), pass or fail.
  - A **999** acknowledgement for the Functional Group (GS-GE envelope) included and each included Transaction Set (ST-SE) indicating pass, partial pass, fail.
2. **Level-2 Front-End Validation produces:**
- A proprietary **Detail Accept** Report identifying each claim passing Level-1 HIPAA compliance and accepted for processing into the front-end system. This report provides the Clearinghouse assigned Trace Number and the corresponding OHP assigned Payer Claim DCN with accept code "21".

- A proprietary **Detail Reject** Report identifying each claim failing PULSE validation. This report provides the Clearinghouse assigned Trace Number and the corresponding OHP assigned Payer Claim DCN with the applicable Unprocessed/Reject Reason code.

This section contains information and examples on any applicable payer acknowledgements

**7.2 REPORT INVENTORY**

Report
Detail Accept Report
999
TA1
Detail Reject Report

This section contains a listing/inventory of all applicable acknowledgement reports

**8. TRADING PARTNER AGREEMENTS**

**8.1 TRADING PARTNERS**

An EDI Trading Partner is defined as any UnitedHealthcare customer (provider, billing service, software vendor, employer group, financial institution, etc.) that transmits to, or receives electronic data from UnitedHealth Group.

Payers have EDI Trading Partner Agreements that accompany the standard implementation guide to ensure the integrity of the electronic transaction process. The Trading Partner Agreement is related to the electronic exchange of information, whether the agreement is an entity or a part of a larger agreement, between each party to the agreement.

For example, a Trading Partner Agreement may specify among other things, the roles and responsibilities of each party to the agreement in conducting standard transactions.

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## 9. TRANSACTION SPECIFIC INFORMATION

The below table provides any OHP specific requirements for claim construct and data values.

Page #	LOOP ID	Reference	NAME	Codes	Length	Notes/Comments
71	None	BHT	<b>Beginning of Hierarchical Transaction</b>			
		BHT02	Transaction Set Purpose Code	<b>00</b>	<b>2</b>	Code identifying the purpose of the Transaction. <b>00 = Original</b> 18 = Reissue
		BHT06	Transaction Type Code	<b>CH</b>	<b>2</b>	Claim or Encounter Indicator Code. RP should only be used at Oxford's request. RP = Encounter <b>CH = Claim</b>
74	1000A	NM1	<b>Submitter Name</b>			<b>Required Segment</b>
	1000A	NM109	Identification Code	<b>PNT =</b> 061545775 <b>ICS =</b> 841162764		Fed Tax ID of the Submitter. This number should be identical to the ISA06 and GS02 Federal Tax ID.
79	1000B	NM1	<b>Receiver Name</b>			<b>Required Segment</b>
	1000B	NM103	Name Last or Organization Name	<b>OXFORD HEALTH PLANS</b>		Receiver Name (Organization)
	1000B	NM108	Identification Code Qualifier	<b>46</b>		ETIN Code
	1000B	NM109	Identification Code	<b>061118515</b>		Oxford Payer ID
114	2000B	HL	<b>Subscriber Hierarchical Level</b>			<b>OHP patients can be uniquely identified to the OXFORD in Loop ID-2010BB by a <i>unique Member Identification Number</i>. Therefore the <b>patient</b> is considered to be the <b>subscriber</b> and is identified at this level.</b>

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Page #	LOOP ID	Reference	NAME	Codes	Length	Notes/Comments
						The Patient HL in Loop ID-2000C is not used.
121	2010BA	NM1	Subscriber Name			
		NM108	Identification Code Qualifier	MI		MI is the only valid value at this time. Claims received with value II will be rejected.
133	2010BB	NM1	Payer Name			
		NM103	Name Last or Organization Name	OXFORD HEALTH PLANS		
		NM108	Identification Code Qualifier	PI		
		NM109	Identification Code	06118515		
140	2010AA	REF	Billing Provider Secondary Identifier			Required Segment
		REF02	Reference Identification		16	
226	2300	HI	Health Care Diagnosis Code			
		HI101-2	Code List Qualifier Code	BK		BK is the only valid value at this time. Claims received with value ABK will be rejected.

## 10. APPENDICES

This section contains one or more appendices.

### 10.1 IMPLEMENTATION CHECKLIST

The implementation check list will vary depending on your choice of connection; a basic check list will include, but is not limited to:

1. Register with Trading Partner
2. Create and sign contract with trading partner

3. Establish connectivity
4. Send test transactions
5. If testing succeeds, proceed to send production transactions

**10.2 BUSINESS SCENARIOS**

Please refer to Section 4.4 above, which points to the appropriate website for Washington Publishing where the reader can view the Implementation Guide, which contains various business scenario examples.

**10.3. TRANSMISSION EXAMPLES**

Please refer to Section 4.4 above, which points to the appropriate website for Washington Publishing where the reader can view the Implementation Guide, which contains various transmission examples.

**10.4 FREQUENTLY ASKED QUESTIONS**

This appendix contains a compilation of questions and answers relative to Acme Health Plan and its providers. Typical question would involve a discussion about code sets and their effective dates.

**10.7 FILE NAMING CONVENTIONS**

File	Naming Convention
Ingenix 837 Inbound Claim File	<b>Prof</b> - ediclm_841162764_medical5.yyyymmdd <b>xxxxxx</b> Where <b>xxxxxx</b> = a unique sequence number <b>Insti</b> - ediclm_841162764_hospital5.yyyymmdd <b>xxxxxx</b> Where <b>xxxxxx</b> = a unique sequence number
PNT 837 Inbound Claim File	002_006111.yyyymmdd <b>xxxxxxxxxxxx</b> .837 Where <b>xxxxxxxxxxxx</b> = a unique sequence number
OHP 999	999_ <b>Run ID</b> .edi Where <b>Run ID</b> = a unique sequence number
OHP TA1	TA1_ <b>run ID</b> .edi Where <b>Run ID</b> = a unique sequence number
OHP Detail Accept Report	Details_submitter ID.yyyymmddMMMMMM
OHP Detail Reject Report	Reject_submitter name.yyyymmdd.TXT

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**10.6 CHANGE SUMMARY**

This section describes the differences between the current Companion Guide and previous guide(s).

<b>Version</b>	<b>Release date</b>	<b>Section</b>	<b>Summary of Changes</b>
1.0	009/15/2010	First Draft	

**10.7 Definitions**

<b>Term</b>	<b>Qualifier</b>	<b>Definition</b>
<b>835</b>		<b>835</b> – Inbound file claims submission
<b>999</b>		<b>999</b> – or Functional Acknowledgement for HIPAA 837 file. B2B sends the 999 to TSO when an 837 file is received.
<b>4010</b>		<b>4010</b> – The October 1997 ASC X12 standard format, Version 4, Release 1, Sub-release 0 (00[4010])
<b>4010A1</b>		<b>4010A1</b> – The version of the transactions named in HIPAA is Version 004010 (4010) and its subsequent addenda, 004010A1 (4010A1), are collectively referred to as “4010A1.” These electronic transactions were developed by the standards development organization Accredited Standards Committee X12 (ASC X12). Standards development organizations are bodies that develop standards used in various industries, such as banking standards that enable you to use your ATM card in any ATM.
<b>5010</b>		<b>5010</b> – The August 2006 ASC X12 standard format, Version 5, Release 1, Sub-release 0 (00[5010]).
<b>Acknowledgement</b>		<b>Acknowledgement</b> – The Acknowledgement is the electronic response, or 999, or Functional Acknowledgement for HIPAA 834 file.
<b>ANSI ASC X12 ASC X12 X12</b>		<b>ANSI ASC X12</b> – is the official designation of the U.S. national standards body for the development and maintenance of Electronic Data Interchange (EDI) standards. EDI X12 (Electronic Data Interchange) is a data format based on ASC X12 standards. It is used to exchange specific data between two or more trading partners.
<b>CAQH</b>		<b>CAQH</b> – is an unprecedented nonprofit alliance of health plans and trade associations, and is a catalyst for industry collaboration on initiatives that simplify healthcare administration. CAQH solutions promote quality interactions between plans, providers, and

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Term	Qualifier	Definition
		other stakeholders; reduce costs and frustrations associated with healthcare administration; facilitate administrative healthcare information exchange and encourage administrative and clinical data integration.
<b>Companion Guide</b>		<b>Companion Guide</b> – A handbook that assists with giving information and instructions on the EDI 837 transactions.
<b>EDI</b>		<b>EDI</b> – Electronic Data Interchange is the computer-to-computer exchange of business or other information between two organizations (trading partners). The data may be either in a standardized or proprietary format. Also known as electronic commerce.
<b>EDI X12 Standards and Releases</b>		<p><b>EDI X12 Standards and Releases</b> – EDI X12 is governed by standards released by ASC X12 (The Accredited Standards Committee). Each release contains set of message types like invoice, purchase order, healthcare claim, etc. Each message type has specific number assigned to it instead of name. For example: an invoice is 810, purchase order is 850 and healthcare claim is 837, Eligibility is 834 Every new release contains new version number. Version number examples: 4010, 4020, 4030, 5010, 5030, etc. Major releases start with new first number. For example: 4010 is one of the major releases, so is 5010. However 4020 is minor release. Minor releases contain minor changes or improvements over major releases. Understanding the difference between major and minor releases is important. Let say you have working translation for some messages for release 4010, and if you want to upgrade to 4020 you will notice only a few changes between the two, and if you want to upgrade to release 5010 you might need to make a lot of modifications to current translation. At the time of this writing 4010 is most widely used release. It is the first release that is Y2K compliant.</p> <p>Most of HIPAA based systems know and use 4010.</p> <p>Conclusion: to translate or validate EDI X12 data you need to know transaction number (message numeric name) and release version number. Both of those numbers are inside the file.</p>

Term	Qualifier	Definition
HIPAA		<p><b>HIPAA</b> – Health Insurance Portability and Accountability Act of 1996 is a federal law intended to improve the availability and continuity of health insurance coverage that, among other things, places limits on exclusions for pre-existing medical conditions; permits certain individuals to enroll for available group health care coverage when they lose other health coverage or have a new dependent; prohibits discrimination in group enrollment based on health status; provides privacy standards relating to individuals' personally identifiable claim-related information; guarantees the availability of health coverage to small employers and the renewability of health insurance coverage in the small and large group markets; requires availability of non-group coverage for certain individuals whose group coverage is terminated; and establishes standards for electronic transmissions.</p>
ICD-9		<p><b>ICD-9</b> – ICD-9 is an acronym used in the medical field that stands for <i>International Classification of Diseases, ninth revision</i>. In the United States, the ICD-9 covered the years 1979 to 1998. Currently, ICD-10, which is the tenth revision, is in effect as the most current database of disease classifications. ICD-9 was used in the US until the 10th revision became fully implemented in 1998, though the actual revision was concluded some years earlier.</p>
ICD-10		<p><b>ICD-10</b> – The <b>International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10)</b> is a coding of diseases and signs, symptoms, abnormal findings, complaints, social circumstances and external causes of injury or diseases, as classified by the World Health Organization (WHO). The code set allows more than 155,000 different codes and permits tracking of many new diagnoses and procedures, a significant expansion on the 17,000 codes available in ICD-9.</p>
Protocols		<p><b>Protocols</b> – Protocols are codes of correct conduct for a given situation.</p>
Qualifier		<p><b>Qualifier</b> – A qualifier is a word, number, or characters that modifies or limits the meaning of another word or group of words or dates.</p>
Segment		<p><b>Segment</b> – a string of data elements that contain specific values based on the loop and data element on file which is separated into specific sections.</p>

Term	Qualifier	Definition
<b>Third Party Administrator (TPA)</b>		<b>Third party administrator</b> – TPA’s are prominent players in the managed care industry and have the expertise and capability to administer all or a portion of the claims process. They are normally contracted by a health insurer or self-insuring companies to administer services, including claims administration, premium collection, no enrollment and other administrative activities. A hospital or provider organization desiring to set up its own health plan will often outsource certain responsibilities to a TPA.
<b>Trading Partner</b>		<b>Trading Partner</b> – A Trading Partner may represent an organization, group of organizations or some other entity. In most cases it is just an organization or company.
<b>Trading Partner Requirements</b>		<b>Trading Partner Requirements</b> – EDI X12 standard covers number of requirements for data structure, separators, control numbers, etc. However many big trading partners impose they own even more strict rules and requirements. It can be everything: specific data format requirements for some elements, requirement to contain specific segments (segments that are <u>not</u> mandatory in EDI X12 standard being made mandatory), etc. In HIPAA those specific trading partner requirements are usually listed in separate document called Companion Guide. It is essential to follow these documents to the letter when implementing EDI systems.
<b>COB</b>		Coordination of Benefits
<b>EOB</b>		Explanation of Benefits

## 10.7 Overview of Changes