Univera Healthcare

Companion Guide for the following transactions:

ASC X12N/005010X223 Health Care Claim Institutional (837)

ASC X12N/005010X222 Health Care Claim Professional (837)

ASC X12C/005010X231 Implementation Acknowledgement for Health Care Insurance (999)

ASC X12N/005010X214 Health Care Claim Acknowledgement (277)

* ASC X12N/005010X221 Health Care Claim Payment/Advice (835) is available through Instamed.com

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1 Introduction

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 translations to enable health information to be exchanged electronically and to adopt specifications for implementing each standard.

On January 16, 2009, HHS published a final rule that replaces the HIPAA Accredited Standards Committee (ASC) X12 Version 4010A1 with the ASC X12 Version 5010.

1.1 Purpose of the Companion Guide

The Univera Healthcare Transaction Companion Guide explains the procedures necessary for Trading Partners of Univera Healthcare to transmit Electronic Data Interchange (EDI) transactions (submission of claims and receipt of electronic remittance advices).

This companion guide to the ASC 005010 HIPAA Implementation Guides clarifies and specifies payer-specific data content being requested when data is transmitted electronically to the clearinghouse. Transmissions based on this payer-specific companion document, used in conjunction with the 005010 HIPAA Implementation Guides, are compliant with both ASC X12 syntax and those guides.

This guide is a revision to the existing Univera Healthcare companion guide that was based on the ASC X12N 4010A1 standard.

As documented in the X12 published Intellectual Property Use guidelines (http://store.x12.org/x12ip/default_ip.htm), this companion guide:

- Not intended to replace, duplicate, countermand or contradict any requirement of the associated 005010 HIPAA Implementation Guides.

- Intended to be used solely to clarify the associated 005010 HIPAA Implementation Guide instructions to provide Univera Healthcare payer-specific requirements only. It describes the specific requirements for using the Clearinghouse. You will need to refer to the specific 005010 HIPAA Implementation Guides for the guidelines and interpretation of all required/situational fields, loops, and segments.

This Univera Healthcare Companion Guide is to be used in conjunction with the following 005010 HIPAA Implementation Guides (with the associated addenda, if any, indicated):

- ASC X12N/005010X223A2 – Health Care Claim: Institutional (837)

- ASC X12N/005010X222A1 – Health Care Claim: Professional (837)

- ASC X12C/005010X231A1 – Implementation Acknowledgment for Health Care Insurance (999)

- ASC X12N/005010X214 – Health Care Claim Acknowledgement (277)

1.2 Scope

This guide is intended to communicate Univera Healthcare payer-specific requirements.

The effective date of this document is based on and reflects currently published Type 1 Errata for all of the EDI transactions covered by this manual. The nomenclature used to identify a specific transaction identifies it as having associated errata. For example:

- ASC X12N/005010X223 – Health Care Claim Institutional (837) with no associated Errata

- ASC X12N/005010X223A2 – Health Care Claim Institutional (837) with Type 1 associated Errata (specifically, A2)

Periodically, the HHS mandated changes to the existing ASC X12 standard and/or Univera Healthcare payer-specific requirements may necessitate a revision to or replacement of this guide. Revisions or replacements to this manual will be posted on the Lifetime Healthcare Companies website, (www.lifethc.com) and the Univera Healthcare website, www.univerahealthcare.com/provider) (HIPAA Resources).

1.3 References

The Health Insurance Portability and Accountability Act (HIPAA) requires that all health insurance payers in the U.S. comply with the EDI standards for health care as established by the Secretary of Health and Human Services. The ASC X12N versions have been established as the standard for claim transactions. These implementation guides are available electronically via the Washington Publishing Co. web site, www.wpc-edi.com.

2 Getting Started

2.1 Trading Partners

An EDI Trading Partner is defined as any Univera Healthcare customer (provider, billing service, clearinghouse or software vendor, etc.) that transmits to, or receives electronic data from the clearinghouse.

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 a separate agreement 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.

The Trading Partner Agreements are available at:
http://www.lifethc.com/vendors/vendor_consent_forms.shtml

Please complete the appropriate forms and mail the original documents to:
Excellus Health Plan, Inc
EDI Solutions
PO Box211256
Eagan Minnesota 55121

2.2 Trading Partner Registration

To register as a testing vendor, provider or clearinghouse, please contact EDI Solutions @ EDI.Solutions@excellus.com.

When you begin working with an EDI analyst, you will be assigned a submitter identification (ID), log in ID and a password which will allow you to begin testing with the clearinghouse. Once 95 percent of your claims are passing through the edits, contact Univera Healthcare for final approval. Once final approval is received, a production ID will be assigned and you will be a certified vendor.

2.3 Working with Univera Healthcare

Transactions may be sent, 24 hours a day, seven days a week.

Report transmission problems to eCommerce: (585) 238-4618 or toll-free 1 (877) 843-8520

You are responsible for the timely retrieval of all reports delivered to your mailbox.

Important: Reports are only retained for a limited time.

Clearinghouse and payer systems verification must take place prior to approval for production.

For errors received on your TA1 report, please refer to the 005010 HIPAA Implementation Guides:

- ASC X12C/005010X231A1 – Implementation Acknowledgment for Health Care Insurance (999)

- ASC X12N/005010X214 – Health Care Claim Acknowledgement (277)

3 Testing with the Payer

3.1 Test Criteria – Claims

- **Health Care Claim Institutional (837)**
- **Health Care Claim Professional (837)**

Health Care Claim Professional (837)	10 primary 5 secondary claims (if applicable)
Health Care Claim Institutional (837)	10 primary Inpatient 5 secondary claims(if applicable) 10 primary Outpatient 5 secondary claims(if applicable)

Please refer to the appropriate Health Care Claim Institutional (837) TPA outlined in this document to determine if any specific submission requirements are needed.

Secondary Claims: For submission of secondary claims, please refer to the Health Care Claim Institutional (837) TPA for specific coding requirements.

Please Note   **It is imperative to continue to submit your production claims in the current format while testing. Please do not hold production claims while testing.**

4 Connectivity with the Payer / Communications

4.1 Transmission and Retransmission Administrative Procedures

Once your test and submitter IDs are assigned, please follow the procedures outlined in your email from Security containing your Global Scape login instructions. If you have a

question or experience an issue with Global Scape, please email
EDI.SFTP.Request@excellus.com.

4.2 Communication Protocol Specifications

The clearinghouse supports web portal and SFTP protocols. For further information, please
contact EDI.SFTP.Request@excellus.com.

5 Acknowledgements and Reports – Claim Transactions

- **ASC X12N/005010X223A2 Health Care Claim Institutional (837)**
- **ASC X12N/005010X222A1 Health Care Claim Professional (837)**

A TA1 report will be generated for **rejected files only.** The naming convention for this
report is: **SUBMITTER ID_TA1_INBOUND FILE NAME_CCYYMMDDxxxxxx
(x=sequential number)**.

The Implementation Acknowledgment for Health Care Insurance (999) will report
transaction set errors and will be created for all positive and negative cases. If the
batch passed through the 005010 HIPAA Implementation Guide edits, it will be an
accepted report (IK5 = A). If there were errors, it will be a rejected report (IK5 = R). You
must refer to the specific 005010 HIPAA Implementation Guide for any rejected
batches and correct the format errors and resubmit the batch. The naming convention
for this report is: **SUBMITTER ID_999_INBOUND FILE NAME_CCYYMMDDxxxxxx
(x=sequential number)**.

The Health Care Claim Acknowledgement (277) report will be generated for each
logical file. The naming convention for this report is: **SUBMITTER
ID_277CA_INBOUND FILE NAME_CCYYMMDDxxxxxx (x=sequential number)**.
When testing, any claims with edits must be corrected and resubmitted until you have
reached a 95 percent acceptance rate.

Within 24 to 48 hours after the original submission, you will need to reconnect to
receive your Payer Response report file. You may receive multiple payer reports.
These reports will be in the 80 byte printable format. Each rejected claim will have
specific edit codes assigned. These claims must be corrected and resubmitted. The
naming convention for this report is **SUBMITTER ID_NYS_CCYYMMDDxxxxxxxxx
(x=sequential number).**

If you need assistance on correcting any edits that appear on the following reports,
please contact the eCommerce Help Desk @ 585-238-4618 or 1-877-843-8520:

- Implementation Acknowledgment for Health Care Insurance (999)
- Health Care Claim Acknowledgement (277)
- Payer reports

6 Contact information

6.1 eCommerce Help Desk

Hours of operation: Monday through Thursday 8 a.m. – 4:30 p.m. Friday 9 a.m. – 4 p.m.
- Phone: (585) 238-4618 or toll-free 1 (877) 843-8520
- E-mail: edi.solutions@excellus.com

6.2 Applicable Websites

There are many national and regional organizations which are undertaking various activities in effort to support the success and implementation of HIPAA 5010 including:

Data and Transactions Standards
- National Uniform Billing Committee (NUBC): http://www.nubc.org
- National Uniform Claim Committee (NUCC): http://www.nucc.org
- Washington Publishing Company site with implementation guides for the X12N transaction standards: http://www.wpc-edi.com/
- ASC X12 The Accredited Standards Committee: (http://www.x12.org)

Electronic Data Interchange
- National-Workgroup for Electronic Data Interchange Strategic National Implementation Process: http://www.wedi.org/SNIP

Professional and Trade Associations/Workgroups
- The American Hospital Association (AHA): http://www.aha.org
- American Health Information Management Association Compliance: http://www.ahima.org/
- National Plan and Provider Enumeration System (NPPES): https://nppes.cms.hhs.gov/NPPES/Welcome.do

7 Common Transaction Properties

7.1 Professional & Institutional Claims

- **ASC X12N/005010X223A2 Health Care Claim Institutional (837)**
- **ASC X12N/005010X222A1 Health Care Claim Professional (837)**

7.1.1 General Rules

1. Only one ISA/IEA will be accepted per transmission. Multiple transmissions may be sent at any time.

2. There should be a maximum of 5,000 claims per transmission.

3. An Implementation Acknowledgement for Health Care Insurance (999) data interchange (the 999 Transaction with the applicable ISA, TA1, GS, GE and IEA segments) will be generated for each ISA through IEA segment set (an ASC X12 data interchange) received from a Trading Partner. The 999 transaction(s) will be routed to the Trading Partner's Global Scape account.

4. Each ASC X12 data interchange received from a Trading Partner must meet the ASC X12 syntax rules presented in the 005010 HIPAA Implementation Guide. Note: If an X12 syntax rule is violated, the Implementation Acknowledgement for Health Care Insurance (999) data interchange must indicate that the ASC X12 interchange is being rejected. The Trading Partner must correct and resubmit.

5. The syntactical requirements presented in the ASC X12N/005010X223 Health Care Claim Institutional (837) Implementation Guide will be used to determine whether the Trading Partner submitted a 5010 transaction in accordance with the aforementioned implementation guideline. Note: If a listing of code values is shown in the implementation guide for a Data Element and a code value, not in the listing, is submitted, an error will be issued on the Health Care Claim Acknowledgement (277) indicating that an invalid code value was detected.

6. The ISA, GS, GE and IEA segments are presented in Appendix B of the ASC X12N/005010X223A2 Health Care Claim Institutional (837). These segments must be submitted to meet the ASC X12 enveloping syntax requirements for the interchange of an ASC X12 transaction and the data presented in the Data Elements will be edited.

    Values for the edits are as follows:

A) For Syntax and Symantec Errors, violations will always result in the rejection of the ISA – IEA, ST-SE, data interchange via the 999 data interchange. If there is a data interchange (ISA or GS) error, all of the ST - SE transactions in the data interchange will be rejected, with a net result of the data interchange being rejected.

B) A Business Validation edit will result in either an Implementation Acknowledgment for Health Care Insurance (999) or a Health Care Claim Acknowledgement (277) error.

Therefore, rejection may occur at the ISA (Interchange), the ST (File), the BATCH (Billing Provider HL), the SUB (Subscriber HL), the PAT (Patient HL) or the CLM (Claim) level.

7.2 Health Care Claim Professional (837) TPA

This section delineates Univera payer-specific instructions for the ASC X12 transactions. The segment name, loop and element name used are those in the 005010 HIPAA Implementation Guide.

SEGMENT NAME	LOOP	ELEMENT NAME	VALID VALUE	REQUIREMENTS
File size			Max 5000 CLM segments within a ISA-IEA	
Recommended File Delimiters			* = Data Element Separator : = Sub Element Separator ~ = (Tilde) Segment Terminator { = Repetition Separator	
			All ALPHA characters should be in upper case.	
Interchange Control Header				
Interchange ID Qualifier		ISA05	ZZ	Mutually Defined.
Interchange Sender ID		ISA.06	Issued to you by EDI Solutions	Referred to as 'Submitter ID' in this Companion Guide
Interchange ID Qualifier		ISA07	ZZ	Mutually Defined.

Interchange Receiver ID		ISA08	00802	Receiver Plan ID.
Acknowledgment Requested		ISA14	1	This will insure that a TA1 report will be generated if the file rejects.
Functional Group Header				
Application Sender's Code		GS02	Issued to you by EDI Solutions	Referred to as 'Submitter ID' in this Companion Guide
Application Receiver's Code		GS03	00802	Receiver Plan ID

SEGMENT NAME	LOOP	ELEMENT NAME	VALID VALUE	REQUIREMENTS
Beginning of Hierarchical Transaction				
Transaction Type Code		BHT06	CH	Used for claims.
Submitter Name				
Identification Code	1000A	NM109	Issued to you by EDI Solutions	Referred to as 'Submitter ID' in this Companion Guide
Receiver Name				
Identification Code	1000B	NM109	00802	Receiver Plan ID
Billing Provider Specialty Information	2000A	PRV		Required if the rendering provider is the same entity as the billing provider.
Billing Provider Tax Identification				
Reference Identification Qualifier	2010AA	REF01	EI = Employer's ID	This is the Tax ID # of the entity to be paid for the submitted services. REF segment in this loop is required with Employee ID. The employer's identification number must be a string of

				exactly nine numbers with no separators.
Subscriber Information				
Claim Filing Indicator Code	2000B	SBR09	CI = Univera	
Payer Information				
Identification Code	2010BB	NM109	UNINW	

SEGMENT NAME	**LOOP**	**ELEMENT NAME**	**VALID VALUE**	**REQUIREMENTS**
Delay Reason Code	2300	CLM20		Will be accepted, however you must follow current procedures for late filing.
Rendering Provider Specialty	2310B	PRV		Required if the billing provider is a group and rendering provider is in 2310B.
Supervising Provider Name	2310D	NM1		Required for NP/PA claims.

7.21 Health Care Claim Professional (837) COB Requirements

In order to bill any secondary claims electronically, the following segments/elements will be required. If these are not submitted, the claim will either error from the payer system, or will be returned for the missing information, requesting an EOB from the primary carrier.

SEGMENT NAME	LOOP	ELEMENT NAME	VALID VALUE	REQUIREMENTS
COB Requirements				
Claim Level				

SEGMENT NAME	LOOP	ELEMENT NAME	VALID VALUE	REQUIREMENTS
Subscriber Information	2000B	SBR		Segment information with all required elements from the IG.
Patient Amount Paid				
Amount Qualifier Code	2300	AMT01	F5	Amount Qualifier Code.
Monetary Amount	2300	AMT02	Monetary amount	Patient Amount Paid.
Other Subscriber Information	2320	SBR		Segment information with all required elements from the IG.
Claim Level Adjustments	2320	CAS		Segment with the appropriate reason codes and associated amounts. These should include deductible, copayment/ coinsurance amounts, denied and allowed charges.
Coordination of Benefits (COB) Payer Paid Amount				
Amount Qualifier Code	2320	AMT01	D	Amount Qualifier Code.
Monetary Amount		AMT02	Monetary amount	Payer paid amount.
Remaining Patient Liability				
Amount Qualifier Code	2320	AMT01	EAF	Amount Qualifier Code.
Monetary Amount		AMT02	Monetary amount	Remaining patient liability
Other Insurance Coverage Information	2320	OI		All pertinent elements are needed.

SEGMENT NAME	LOOP	ELEMENT NAME	VALID VALUE	REQUIREMENTS
Other Subscriber Name	2330A	NM1, N3, N4		All pertinent elements are needed.
Other Payer Name	2330B	NM1		All pertinent elements are needed.
Line Level				
Line Adjudication Information	2430	SVD		All pertinent elements are needed.

SEGMENT NAME	LOOP	ELEMENT NAME	VALID VALUE	REQUIREMENTS
Line Adjustment	2430	CAS		Segment with the appropriate reason codes and associated amounts. These should include deductible, copayment/ coinsurance amounts, denied and allowed charges.
Line Check or Remittance Date	2430	DTP		All pertinent elements are needed.

7.3 Health Care Claim Institutional (837) TPA

SEGMENT NAME	LOOP	ELEMENT NAME	VALID VALUE	REQUIREMENTS
File size			Max 5000 CLM segments within a ISA-IEA	
Recommended File Delimiters			* = Data Element Separator : = Sub element Separator ~ = (Tilde) Segment Terminator { = Repetition Separator	

			All ALPHA characters should be in upper case.	
Interchange Control Header				
Interchange ID Qualifier		ISA05	ZZ	Mutually defined.
Interchange Sender ID		ISA.06	Issued to you by EDI Solutions	
Interchange ID Qualifier		ISA07	ZZ	Mutually defined.
Interchange Receiver ID		ISA08	00302	Receiver Plan ID.
Acknowledgment Requested		ISA14	1	This will insure that a TA1 report will be generated if the file rejects
Functional Group Header				
Application Sender's Code		GS02	Issued to you by EDI Solutions	
Application Receiver's Code		GS03	00302	Receiver Plan ID.
Beginning of Hierarchical Transaction				
Transaction Type Code		BHT06	CH	Used for claims.
Submitter Name				
Identification Code	1000A	NM109	Issued to you by EDI Solutions	
Receiver Name				
Identification Code	1000B	NM109	00302	Receiver Plan ID.
SEGMENT NAME	**LOOP**	**ELEMENT NAME**	**VALID VALUE**	**REQUIREMENTS**
Billing Provider Specialty Information	2000A	PRV		Required if the service facility provider is the same entity as the billing provider.
Subscriber Information				

Claim Filing Indicator Code		SBR09	CI = Univera	
Payer Information				
Identification Code	2010BB	NM109	UNINW	Payer identifier
Claim Information				
Delay Reason Code	2300	CLM20		Will be accepted, however you must follow current procedures for late filing.
Value Information				
Code List Qualifier Code	2300	HI01-1	BE	Value Information (for submitting newborn weight). This HI is required to report newborn birth weight. This is mandatory for all newborn claims. Submit birth weight in grams with associated amount.
Industry Code		HI01-2	54	Value code to report newborn birth weight.
Monetary Amount		HI01-5	NNNN	Birth weight in grams. It would look like HI*BE:54:::1234~
Attending Provider Name	2310A	NM1		Required on all inpatient claims.

7.31 Health Care Claim Institutional (837) COB Requirements

In order to bill any secondary claims electronically, the following segments/elements will be required. If these are not submitted, the claim will either error from the payer system, or will be returned for the missing information, requesting an EOB from the primary carrier.

SEGMENT NAME	LOOP	ELEMENT NAME	VALID VALUE	REQUIREMENTS
COB REQUIREMENTS				
Claim Level				
Subscriber Information	2000B	SBR		Segment information with all required elements from the IG.
Other Subscriber Information	2320	SBR		Segment information with all required elements from the IG.
Claim Level Adjustments	2320	CAS		Segment with the appropriate reason codes and associated amounts. These should include deductible, copayment/coinsurance amounts, denied and allowed charges.
Coordination of Benefits (COB) Payer Paid Amount				
Amount Qualifier Code	2320	AMT01	D	
Monetary Amount		AMT02	Monetary amount	Payer paid amount.
Remaining Patient Liability				

SEGMENT NAME	LOOP	ELEMENT NAME	VALID VALUE	REQUIREMENTS
Amount Qualifier Code	2320	AMT01	EAF	
Monetary Amount		AMT02	Monetary amount	Remaining patient liability.
Coordination of Benefits (COB) Total Non-covered Amount				
Amount Qualifier Code	2320	AMT01	A8	
Monetary Amount		AMT02	Monetary amount	Non-covered charges actual.
Other Insurance Coverage Information	2320	OI		All pertinent elements are needed.

Other Subscriber Information	2330A	NM1, N3, N4		All pertinent elements are needed.
Other Payer Name	2330B	NM1		All pertinent elements are needed.
Line Level				
Line Adjudication Information	2430	SVD		All pertinent elements are needed.
Line Adjustment	2430	CAS		Segment with the appropriate reason codes and associated amounts. These should include deductible, copayment/coinsurance amounts, denied and allowed charges
Line Check or Remittance Date	2430	DTP		All pertinent elements are needed.