Instructions Related to 837 Health Care Claim/Encounter: Dental (837D) Transactions Based on ASC X12 Implementation Guide

Companion Guide Version Number: 1.1 September 1, 2012

Preface

Companion guides 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 Implementation Guide (Transaction Instructions). Either the Communications/Connectivity component or the Transaction Instruction component must be included in every companion guide. The components may be published as separate documents or as a single document.

The Communications/Connectivity component is included in the companion guides when the publishing entity wants to convey the information needed to commence and maintain communication exchange.

The Transaction Instruction component is included in the companion guides when the publishing entity wants to clarify the implementation guide instructions for submission of specific electronic transactions. The Transaction Instruction component content is limited by ASC X12's copyrights and Fair Use statement.

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837 Health Care Claim/Encounter: Dental Transaction Instructions

1 Transaction Instructions Introduction

1.1 Background

1.1.1 Overview of HIPAA Legislation

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) includes provisions for administrative simplification. This requires the Secretary of the federal 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.

1.1.2 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).

1.1.3 Compliance According to ASC X12

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

- Defining, explanatory, or clarifying content contained in the implementation guide.
- Requirement contained in the implementation guide.

1.2 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 requirement documents. This companion guide conforms to all the requirements of any associated ASC X12 Implementation Guides and is in conformance with the ASC X12 Implementation Guides' Fair Use and Copyright statements.

1.3 Companion Guide Audience

Companion guides are intended for information technology and/or systems staff who will be coding billing systems or software for compliance with the federal HIPAA regulations.

1.4 Purpose of Companion Guides

The information contained in this companion guide applies to ForwardHealth, which includes the following programs: BadgerCare Plus, Wisconsin Medicaid, SeniorCare, Wisconsin Chronic Disease Program (WCDP), the Wisconsin Well Woman Program (WWWP), and Medicaid managed care programs. All of these programs use ForwardHealth interChange for processing.

The companion guides are to be used with HIPAA Implementation Guides and to supplement the requirements in the HIPAA ASC X12 Implementation Guides,

without contradicting those requirements. Implementation guides define the national data standards, electronic format, and values for each data element within an electronic transaction. The purpose of the companion guides is to provide trading partners with a guide to communicate ForwardHealth-specific information required to successfully exchange transactions electronically with ForwardHealth.

ForwardHealth will accept and process any HIPAA-compliant transaction; however, a compliant transaction that does not contain ForwardHealth-specific information, though processed, may be denied for payment. For example, a compliant 837 Health Care Claim/Encounter (837) created without a ForwardHealth member identification number will be processed by ForwardHealth but will be denied payment. For questions regarding appropriate billing procedures, as well as for policy and billing information, providers should refer to their policy-specific area of the ForwardHealth Online Handbook.

Companion guides highlight the data elements significant for ForwardHealth. For transactions created by ForwardHealth, companion guides explain how certain data elements are processed. Refer to the companion guide first if there is a question about how ForwardHealth processes a HIPAA transaction. For further information, contact the ForwardHealth Electronic Data Interchange (EDI) Department at (866) 416-4979.

1.5 Acceptable Characters

All alpha characters used in 837 transactions must be in an uppercase format. The 837 transaction must not contain any carriage returns nor line feeds; the data must be received in one, continuous stream.

1.6 Acknowledgements

An accepted 999 Implementation Acknowledgement, rejected 999 Implementation Acknowledgement, or rejected TA1 InterChange Acknowledgement will be generated in response to all submitted files. Trading partners are responsible for retrieving acknowledgments from the Web to determine the status of their files.

1.7 Examples

See Section 4.1 of this guide for examples.

2 Referenced ASC X12 Implementation Guides

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

Unique ID	Name
005010X224A2	**837 Health Care Claim: Dental (837D)**

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.

3.1 005010X224A2 — 837 Health Care Claim:

Loop ID	Reference	Name	Codes	Notes/Comments
	ISA	Interchange Control Header		The ISA is a fixed-length record with fixed-length elements. *Note:* Deviating from the standard ISA element sizes will cause the interchange to be rejected.
	ISA03	Security Information Qualifier	00	Enter the value “00” — No Security Information Present (No Meaningful Information in I04).
	ISA05	Interchange ID (Sender) Qualifier	ZZ	Enter the value “ZZ” — Mutually Defined.
	ISA06	Interchange Sender ID		Enter the nine-digit numeric Trading Partner ID assigned by ForwardHealth interChange.
	ISA07	Interchange ID (Receiver) Qualifier	ZZ	Enter the value “ZZ” — Mutually Defined.
	ISA08	Interchange Receiver ID	WISC_DHFS	Enter the value “WISC_DHFS”.
	GS	Functional Group Header		
	GS02	Application Sender's Code		Enter the same value as ISA06, the nine-digit Trading Partner ID assigned

Loop ID	Reference	Name	Codes	Notes/Comments
				by ForwardHealth interChange.
	GS03	Application Receiver's Code	WISC_TXIX	"WISC_TXIX" identifies Wisconsin Medicaid or BadgerCare Plus.
	BHT	Beginning of Hierarchical Transaction		
	BHT06	Claim Identifier	CH (Claim) RP (Encounter)	Claims: Enter the value "CH" — Chargeable. Encounters: Enter the value "RP" — Reporting.
1000A	NM1	Submitter Name		
1000A	NM109	Submitter Identifier		Enter the same value as ISA06, the nine-digit Trading Partner ID assigned by ForwardHealth interChange.
1000B	NM1	Receiver Name		
1000B	NM103	Receiver Name	FORWARDHEALTH	Enter "FORWARDHEALTH" to indicate the claims/encounters are being sent to ForwardHealth interChange.
1000B	NM109	Receiver Primary Identifier	WISC_TXIX	Enter the same value as GS03, "WISC_TXIX" for Wisconsin Medicaid.
2000A	PRV	Billing Provider Specialty Information		*Note:* Taxonomy codes are only required if the National Provider Identifier (NPI) has multiple certifications and the taxonomy is necessary to determine the appropriate one.
2000A	PRV03	Reference Identification		Enter the taxonomy that was reported to ForwardHealth for the service you are billing.
2010AA	NM1	Billing Provider Name		*Note:* ForwardHealth only accepts the use of NPIs as identification for dental providers.
2010AA	NM102	Entity Type Qualifier	1	Enter the "1" value to indicate that the biller is a person.

Loop ID	Reference	Name	Codes	Notes/Comments
			2	Enter the “2” value to indicate that the biller is a non-person entity.
2010AA	N3	Billing Provider Address		Enter the address that is currently on file with ForwardHealth. *Note:* Do not enter a P.O. Box in this segment. If a P.O. Box needs to be reported, use the Pay-To Address loop.
2010AA	N4	Geographic Location		Use the physical address as reported on the provider’s Wisconsin Medicaid certification.
2010AA	N403	Billing Provider Postal Zone or ZIP Code		Enter the ZIP+4 code that will correspond to the physical address on file with ForwardHealth.
2010AB	NM1	Pay-To Address Name		*Note:* The information in this segment will not be used to determine where to send the provider Remittance Advice (RA) and/or the 835 Health Care Claim Payment/Advice (835). The RA report and/or the 835 will be sent to the entity established during the provider certification process. Encounter submissions will not receive an 835.
2010AC	NM1	Pay-to Plan Name		This loop will only be used for subrogation.
2010BA	NM1	Subscriber Name		Enter information about the subscriber/member in this loop.
2010BA	NM102	Entity Type Qualifier	1	Enter the value “1” to indicate that the member is a person.
2010BA	NM103	Subscriber Last Name		Enter the member’s last name. *Note:* Use Wisconsin’s Enrollment Verification System (EVS) to obtain the correct spelling of the member’s name. If the name or spelling of the name on the member identification card and the EVS do not match, use the spelling from the EVS.
2010BA	NM104	Subscriber		Enter the member’s first name.

Loop ID	Reference	Name	Codes	Notes/Comments
		First Name		*Note:* Use the EVS to obtain the correct spelling of the member's name. If the name or spelling of the name on the member identification card and the EVS do not match, use the spelling from the EVS.
2010BA	NM108	Identification Code Qualifier	MI	Enter the value "MI" for member identification number.
2010BA	NM109	Subscriber Primary Identifier		Enter the member's 10-digit ForwardHealth identification number. *Note:* Do not enter any other numbers or letters. Use the ForwardHealth card or the EVS to obtain the correct identification number.
2010BB	NM1	Payer Name		
2010BB	NM103	Payer Name	FORWARDHEALTH	Enter the value "FORWARDHEALTH".
2010BB	NM109	Payer Identifier	WISC_TXIX	Enter the value "WISC_TXIX" for Wisconsin Medicaid.
2010CA	REF	Property and Casualty Patient Identifier		This segment will not be used by ForwardHealth.
2300	CLM	Claim Information		
2300	CLM01	Patient Control Number		*Note:* ForwardHealth interChange will process member control numbers up to 20 characters in length.
2300	CLM02	Total Claim Charge Amount		Enter the total billed amount for the entire claim/encounter. *Note:* ForwardHealth interChange will process claims/encounters submitted with a negative billed amount as if the provider submitted a zero billed amount.
2300	CLM05-3	Claim Frequency Code	1 7 8	The third digit of the type of bill, as defined by the National Uniform Billing Committee (NUBC), is the frequency code. Use the claim frequency code to

Loop ID	Reference	Name	Codes	Notes/Comments
				indicate whether the claim/encounter is being submitted for the first time or if it is a replacement/void of a previously adjudicated and paid claim/encounter: • "1" — Indicates that this is the first claim/encounter submitted to ForwardHealth interChange. • "7" — Indicates that this claim/encounter is replacing a previously submitted and adjudicated claim/encounter. ForwardHealth interChange will void the previously submitted claim/encounter and completely replace it with this corrected claim/encounter. • "8" — Indicates that ForwardHealth interChange should recoup the previously submitted claim/encounter in its entirety. *Note:* The use of values "7" and "8" can result in the previously submitted claim/encounter being adjusted. Include the internal control number (ICN) from the previously submitted claim/encounter in the original reference number segment in Loop 2300. Electronic adjustments are subject to the same requirements as paper adjustments and therefore may result in a letter to the provider if the requirements are not met. Do not use adjustment values if reconsideration of the original payment is needed. All requests for reconsideration should be submitted on paper with supporting documentation. The claim frequency code was switched to an external code source during the addenda process. See the NUBC Manual or Web site, www.nubc.org/ Encounter: Provider letters and paper submissions/requests will not be

Loop ID	Reference	Name	Codes	Notes/Comments
				supported for encounter processing.
2300	CLM19	Predeter-mination of Benefits Code		*Note:* ForwardHealth interChange does not support predetermination of benefits.
2300	REF	Service Authorization Exception Code		*Note:* If all services were not the result of emergency care, submit multiple claims/encounters.
2300	REF	Payer Claim Control Number		Include this segment when requesting an electronic adjustment (a value of "7" or "8" in CLM05-3 indicates that an adjustment is being requested).
2300	REF02	Payer Claim Control Number		Enter the most recent ICN assigned by ForwardHealth interChange. This is the ICN that will be adjusted.
2300	REF	Prior Authorization		ForwardHealth interChange does not require the prior authorization (PA) be submitted on the 837 transaction. *Note:* For PA policy guidelines, refer to the applicable service area of the Online Handbook.
2310B	NM1	Rendering Provider Name		Include this segment when NPI is the identifier used for the rendering provider. *Note:* ForwardHealth only accepts the use of an NPI as identification for a dental provider.
2310B	PRV	Rendering Provider Specialty Information		*Note:* Taxonomy codes are only required if the NPI has multiple certifications and the taxonomy is necessary to determine the appropriate one.
2310B	PRV03	Provider Taxonomy Code		Enter the taxonomy code that was reported to ForwardHealth for the service you are billing.
2310D	NM1	Assistant Surgeon Name		Enter information about the assistant surgeon in this segment, if applicable. *Note:* ForwardHealth only accepts the use of an NPI as identification for a

Loop ID	Reference	Name	Codes	Notes/Comments
				dental provider.
2310D	PRV	Assistant Surgeon Specialty Information		*Note:* Taxonomy codes are only required if the NPI has multiple certifications and the taxonomy is necessary to determine the appropriate one.
2310D	PRV03	Provider Taxonomy Code		Enter the taxonomy code that was reported to ForwardHealth for the service you are billing.
2320	SBR	Other Subscriber Identification		This segment is used when other payers are known to potentially be involved in paying on this claim. Managed care organizations use this segment on an encounter to identify the MCO as a payer. This would be in addition to any other payer information that may have been on the encounter prior to the MCO's adjudication.
2320	SBR09	Claim Filing Indicator Code	HM (Encounter)	Encounter: Enter "HM" to indicate an HMO.
2320	CAS	Claim Level Adjustments		Include this segment when another payer has made payment at the claim level. If the other payer returned an 835, the CAS segment from the 835 should be copied to this CAS. *Note:* For more information on indicators and disclaimer codes, see Section 4.1 of this guide.
2320	AMT	COB Payer Paid Amount		This segment contains the amount paid on the claim by the payer within the 2320 loop. *Note:* For more information on indicators and disclaimer codes, see Section 4.1 of this guide.
2320	AMT	Remaining Patient Liability		Enter the remaining patient liability amount in this segment. *Note:* For more information on indicators and disclaimer codes, see Section 4.1 of this guide.
2320	AMT	COB Total		Use this segment when the member

Loop ID	Reference	Name	Codes	Notes/Comments
		Non-Covered Amount		has other insurance but the charges are known to be noncovered. When applicable based on the above statement, enter the total billed amount and no other AMT segments for the other payer. *Note:* This will generate an OI Indicator of OI-Y.
2330B	NM1	Other Payer Name		
2330B	NM109	Other Payer Primary Identifier		Enter the other payer's identifier. *Note:* ForwardHealth interChange will use this number in combination with loop 2430 to calculate other insurance payments.
2330B	REF	Other Payer Prior Authorization		This segment will not be used by ForwardHealth.
2330B	REF	Other Payer Predeter-mination		This segment will not be used by ForwardHealth.
2330B	REF	Other Payer Claim Control		This segment will not be used by ForwardHealth.
2330E		Other Payer Supervising Provider		This loop will not be used by ForwardHealth.
2330F		Other Payer Billing Provider		This loop will not be used by ForwardHealth.
2330G		Other Payer Service Facility Location		This loop will not be used by ForwardHealth.
2330H		Other Payer Assistant Surgeon		This loop will not be used by ForwardHealth.
2400	SV3	Dental Service		
2400	SV302	Line Item		Enter the billed amount for each

Loop ID	Reference	Name	Codes	Notes/Comments
		Charge Amount		service line. *Note:* ForwardHealth interChange will process claims/encounters submitted with a negative service line billed amount as if the provider submitted a zero service line billed amount.
2400	TOO	Tooth Information		*Note:* The 5010 version of the 835 does not allow for the tooth number to be returned. If the tooth number is necessary for your system's reconciliation, create separate service lines for each tooth and use a unique value in the line item control number segment for each service line. This segment can repeat 32 times per procedure billed. If multiple tooth numbers are submitted on one service line, ForwardHealth interChange will create one service line for each tooth number to adjudicate the claim.
2400	REF	Prior Authorization or Referral Number		ForwardHealth interChange does not require the PA number be submitted on the 837 transaction. *Note:* For PA policy guidelines, refer to the applicable service area of the Online Handbook.
2420A	NM1	Rendering Provider Name		Enter the rendering provider's NPI in this segment if the rendering provider is ForwardHealth interChange certified and different than the billing provider. *Note:* ForwardHealth only accepts the use of an NPI as identification for a dental provider.
2420A	PRV	Rendering Provider Specialty Information		Include this segment to include the taxonomy code for the rendering provider if detail level rendering provider has been listed. *Note:* Taxonomy codes are only required if the NPI has multiple certifications and the taxonomy is necessary to determine the appropriate certification.

Loop ID	Reference	Name	Codes	Notes/Comments
2420A	PRV03	Provider Taxonomy Code		Enter the rendering provider's taxonomy code for the service that is being billed. *Note:* The provider must use the appropriate taxonomy code that is associated to the provider type and specialty currently on file with ForwardHealth.
2430	SVD	Line Adjudication Information		This segment is used when other payers are known to potentially be involved in paying on this claim at the detail line. Managed care organizations can use this segment on an encounter to identify the detail amount paid to their provider.
2430	SVD01	Other Payer Primary Identifier		The identifier indicates the other payer by matching the appropriate Other Payer Primary Identifier in Loop 2330B, Element NM109.
2430	SVD02	Service Line Paid Amount		
2430	CAS	Service Adjustment		Include this segment when another payer has made payment at the service line. If the other payer returned an 835, the CAS segment from the 835 should be copied to this CAS. *Note:* ForwardHealth interChange will use the information in the CAS segment in place of the "other insurance indicator" submitted prior to HIPAA.

4 Transaction Instructions Additional Information

4.1 Business Scenarios

4.1.1 Terminology

The term “subscriber” will be used as a generic term throughout the companion guide. This term could refer to any one of the following programs for which the 837D transaction is being processed:

- BadgerCare Plus.
- SeniorCare.
- Wisconsin Medicaid.

4.1.2 Examples

ForwardHealth interChange derives coordination of benefit information from the 837 that providers directly submitted. This companion guide has pointed out the pieces of information ForwardHealth interChange uses to derive those values; however, the implementation guide frequently requires additional information in the segments where this information is found. Below are examples that show how the information may appear on the 837 transaction.

4.1.3 Other Insurance Indicators

In order to have an other insurance indicator assigned to a claim/encounter, at least one additional payer must be represented on the claim/encounter. The inclusion of a 2320 loop and any required subloops represent each payer. ForwardHealth can assign one of three Other Insurance codes to electronic claims/encounters based on information supplied on the claim/encounter.

There are three Other Insurance (OI) Indicators that potentially can be associated with a claim/encounter. The three codes are: “Blank,” “OI-P,” and “OI-D.”

A disclaimer code of “Blank” is present when the member does not have commercial insurance. A disclaimer code of “OI-P” is present when the member has commercial insurance coverage, the claim was submitted to the insurance carrier and a payment was made on the claim. A disclaimer code of “OI-D” is present when the member has commercial insurance coverage and the claim was submitted to the insurance carrier, but the claim was denied.

Other Insurance = OI-D

In this example, the provider billed $100.00. The other payer has paid $0.00. The reason the other payer did not pay the claim is indicated with the CAS segment copied from the 835 received from that payer.

Loop 2320

SBR*S*18***C1****CI~
CAS*PR*35*100~
AMT*D*0~
OI***Y***Y~

Loop 2330A

NM1*IL*1*LAST NAME*FIRST
NAME****MI*999999999~

Loop 2330B

NM1*PR*2*COMMERCIAL/OTHER
INS*****PI*001~
DTP*573*D8*20031016~

Other Insurance = OI-P

In this example, the provider billed $115.66. The other payer allowed $115.66 and has paid $83.56. The difference between the allowed

amount and the paid amount is $32.10 and is represented on the CAS segment copied from the 835 transaction received from that payer.

Loop 2320

SBR*S*18***C1***CI~

CAS*PR*2*32.10~

AMT*D*83.56~

OI***Y***Y~

Loop 2330A

NM1*IL*1*LAST NAME*FIRST

NAME****MI*999999999~

Loop 2330B

NM1*PR*2*OTHER INSURANCE_CARRIER*****PI*001~
DTP*573*D8*20031016~

4.2 Payer-Specific Business Rules and Limitations

4.2.1 Scheduled Maintenance

ForwardHealth recycles the real-time servers every night between 00:00 a.m. to 01:00 a.m. Central Standard Time (CST). Real-time processing is not available during this period.

ForwardHealth schedules regular maintenance every Sunday from 00:00 a.m. to 04:00 a.m. CST. Real-time processing is not available during this period.

4.3 Frequently Asked Questions

None.

4.4 Other Resources

Washington Publishing Company (WPC) at *www.wpc-edi.com/.*

ASC X12 at *www.x12.org/*.

For further information about how ForwardHealth interChange processes a HIPAA transaction, contact the ForwardHealth EDI Department at (866) 416-4979.

5 Transaction Instructions Change Summary

Version 2.0 Revision Log

Companion Document: 837D Health Care Dental Claim/Encounter
Approved: 03/2012
Modified by: DJC

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
	Document in Entirety				Replaced “claims” or “claim” with “claims/encounters” or “claim/encounter” as applicable throughout the guide.
	11	BHT	Beginning of Hierarchical Transaction		Added segment.
	11	BHT06	Claim Identifier	CH (Claim) RP (Encounter)	Added element to designate encounter. Claims will use “CH”; Encounters will use “RP”.
2010	12	2010AB	Pay-to-Address		Added clarification. Encounter submissions will not receive an 835.
2300	15	CLM05-3	Claim Frequency Code		Added clarification. Provider letters and paper submissions/ requests will not be supported for encounter processing.
2320	17	SBR	Other Subscriber Identification		Added segment. Encounter can use this segment to identify that MCO is providing amount paid to its provider.

2320	17	SBR09	Claim Filing Indicator Code	HM (Encounter)	Added element. Encounter can use “HM” to identify MCO as a payer.
2400	20	SVD	Line Adjudication Information		Added segment.
2430	21	SVD01	Other Payer Primary Identifier		Added element. Encounter can use this element to identify MCO as a payer.
2430	21	SVD02	Service Line Paid Amount		Added element. Encounter can use this element to identify MCO amount paid to provider at line level.