
# Instructions Related to 837 Health Care Claim/Encounter: Professional (837P) 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 Guides (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: Professional Transaction Instructions

# 1 Transaction Instruction Introduction

## 1.1 Background

### 1.1.1 Overview of HIPAA Legislation

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) carries 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 requirements 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 Guide's 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 Functional Acknowledgement, rejected 999 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 which are included in Section 3 of this guide.

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

# 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 05010X222A1 — 837 Health Care Claim: Professional

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

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| | | | | interChange. |
| | GS03 | Application Receiver's Code | WISC_TXIX<br>WISC_WWWP<br>WISC_WCDP | Claims: Enter the value “WISC_TXIX” for Wisconsin Medicaid and BadgerCare Plus, “WISC_WWWP” for the WWWP or “WISC_WCDP” for WCDP.<br><br>Encounters: “WISC_TXIX” only. |
| | BHT | Beginning of Hierarchical Transaction | | |
| | BHT06 | Claim Identifier | CH (Claim)<br>RP (Encounter) | Claims: Enter the value “CH” — Chargeable.<br>Encounters: Enter the value “RP” — Reporting. |
| 1000A | NM1 | Submitter Name | | |
| 1000A | NM109 | Submitter Identifier | | Enter the same value as ISA06, the nine-digit numeric Trading Partner ID assigned by ForwardHealth interChange. |
| 1000B | NM1 | Receiver Name | | |
| 1000B | NM103 | Receiver Name | FORWARDHEALTH | Enter “FORWARDHEALTH” to indicate that the claims/encounters are being sent to ForwardHealth interChange. |
| 1000B | NM109 | Receiver Primary Identifier | WISC_TXIX<br>WISC_WWWP<br>WISC_WCDP | Enter the same value as GS03.<br><br>Claim: Enter “ WISC_TXIX” to indicate Wisconsin Medicaid, BadgerCare Plus and SeniorCare, “WISC_WWWP” to indicate the WWWP, or “WISC_WCDP” to indicate WCDP. |

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| | | | | Encounter: "WISC_TXIX" only. |
| 2000A | PRV | Billing Provider Specialty Information | | |
| 2000A | PRV01 | Provider Code | BI | *Note:* If a rendering provider is not indicated on the claim/encounter, ForwardHealth will assume the rendering provider and the billing provider are the same entity. |
| 2000A | PRV02 | Reference Identification Qualifier | PXC | Enter PXC "Health Care Provider Taxonomy" to indicate the next element will be the taxonomy code of the billing provider.<br><br>*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 | Provider Taxonomy Code | | Enter the provider's taxonomy code.<br><br>*Note:* The provider is required to use the appropriate taxonomy code that is associated to the provider type and specialty currently on file with ForwardHealth. |
| 2010AA | NM1 | Billing Provider Name | | Include this segment to submit the Billing Provider's name and, when applicable, the Provider's NPI when it is used as the identifier. |
| 2010AA | N3 | Billing Provider Address | | Enter the address on file with ForwardHealth in this segment.<br><br>*Note:* Do not submit 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, |

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| | | | | WCDP, or WWWP certification. |
| 2010AA | N403 | Postal Code | | Enter the ZIP+4 code that corresponds to the physical address on file with ForwardHealth. |
| 2010AB | NM1 | Pay-to Address | | *Note:* The information in this segment will not be used to determine where to send the provider Remittance Advice (RA) and/or 835 Health Care Claim Payment/Advice (835). The RA and/or the 835 will be sent to the entity established during the provider certification process.<br><br>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 the subscriber is a person. |
| 2010BA | NM103 | Subscriber Last Name | | Enter the member's last name.<br><br>*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's identification card and the EVS do not match, use the spelling from the EVS. |
| 2010BA | NM104 | Subscriber First Name | | Enter the member's first name.<br><br>*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's identification card and the EVS do not match, use the spelling from the EVS. |

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| 2010BA | NM108 | Identification Code Qualifier | MI | Enter the value "MI" to indicate a member ID. |
| 2010BA | NM109 | Subscriber Primary Identifier | | Enter the member's 10-digit ForwardHealth identification number.<br><br>*Note:* Do not enter any other numbers or letters. Use the ForwardHealth ID 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<br>WISC_WWWP<br>WISC_WCDP | Claim: Enter value “WISC_TXIX” for Wisconsin Medicaid and BadgerCare Plus, “WISC_WWWP” for the WWWP or “WISC_WCDP” for WCDP.<br><br>Encounter: “WISC_TXIX” only. |
| 2010BB | REF | Billing Provider Secondary Identification | | Include this segment if the provider in Loop 2010AA is the provider certified by ForwardHealth interChange to submit claims/encounters and the provider’s NPI will not be submitted in Loop 2010AA, NM109.<br><br>*Note:* Non-healthcare (Atypical) providers are required to submit this segment. |
| 2010BB | REF01 | Reference Identification Qualifier | G2 | Enter the value “G2” for Wisconsin Medicaid, BadgerCare Plus, WCDP, and WWWP. |
| 2010BB | REF02 | Payer Secondary Identifier | | Enter the eight or nine-digit billing provider number assigned by ForwardHealth interChange.<br><br>*Note:* Non-healthcare (Atypical) providers are required to submit their |

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| | | | | eight or nine-digit billing provider number. |
| 2010CA | REF | Property and Casualty Patient Identifier | | This segment will not be used by ForwardHealth. |
| 2300 | CLM | Claim Information | | Enter relevant claim/encounter information in this segment. |
| 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.<br><br>*Note:* ForwardHealth interChange will process claims/encounters submitted with a negative total billed amount as if the provider submitted a zero total billed amount. |
| 2300 | CLM05-3 | Claim Frequency Code | 1<br>7<br>8 | The third digit of the type of bill, as defined by the National Uniform Billing Committee (NUBC), is the frequency code. Use one of the following claim frequency codes to indicate if the claim/encounter is being submitted for the first time or if it is a replacement/void of a previously adjudicated claim/encounter and paid claim/encounter:<br>• "1" — Indicates that this is the first claim/encounter submitted to ForwardHealth interChange.<br>• "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.<br>• "8" — Indicates that ForwardHealth interChange should recoup the |

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| | | | | previously submitted claim/encounter in its entirety.<br><br>*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.<br><br>Electronic claim adjustments are subject to the same requirements as paper claim adjustments and therefore may result in a letter to the provider if the requirements are not met. ForwardHealth interChange will not adjust claims if all the details are denied from the previous submission.<br><br>Do not use adjustment values if reconsideration of the original claim payment is needed. All requests for reconsideration should be submitted on paper with supporting documentation.<br><br>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/* for additional information on value selections.<br><br>Encounter: Provider letters and paper submissions/requests will not be supported for encounter processing. |
| 2300 | DTP | Date-Property and Casualty Date of First Contact | | This segment will not be used by ForwardHealth. |
| 2300 | DTP | Date-Repricer Received Date | | This segment will not be used by ForwardHealth. |
| 2300 | PWK | Claim Supplemental Information | | Use this segment if it is necessary to indicate supplemental information has been submitted for the claim. |

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| | | | | Encounter: Use this segment if it is necessary to indicate an encounter chart review. |
| 2300 | PWK01 | Report Type Code | 09 (Encounter) | Encounter: Enter the value “09” — Progress Report |
| 2300 | PWK02 | Attachment Transmission Code | BM (Claim)<br><br>AA (Encounter) | Claim: Enter the value “BM” — by mail.<br><br>Encounter: Available by request at provider site. |
| 2300 | PWK05 | Identification Code Qualifier | AC (Claim) | Claim: Enter the value “AC” — Attachment Control Number. This element is required when PWK02 contains the value “BM”. |
| 2300 | REF | Prior Authorization | | ForwardHealth interChange does not require the prior authorization (PA) number be submitted on the 837 transaction.<br><br>*Note:* For PA policy guidelines refer to the applicable service area of the Online Handbook. |
| 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 | Care Plan Oversight | | This segment will not be used by ForwardHealth. |
| 2300 | HI | Health Care Diagnosis Code | | Enter information in this segment to supply information related to the delivery of health care.<br><br>*Note:* ForwardHealth interChange will use up to 12 diagnosis codes to process a claim/encounter. |

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| 2310A | REF | Referring Provider Secondary Identification | | Use this segment as an identifier if no NPI is available for the provider. If the provider has an NPI, report it in NM1 segment and do not send this REF segment. |
| 2310A | REF01 | Reference Identification Qualifier | G2 | Enter "G2" to submit provider number. |
| 2310A | REF02 | Referring Provider Secondary Identifier | | Enter the rendering provider's eight or nine-digit provider number. |
| 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 rendering provider's taxonomy code.<br><br>*Note:* The provider is required to use the appropriate taxonomy code that is associated to the provider type and specialty currently on file with ForwardHealth. |
| 2310C | PER | Service Facility Contract Information | | This segment will not be used by ForwardHealth. |
| 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. |

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| 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.<br><br>*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.<br><br>*Note:* For more information on indicators and disclaimer codes, see Section 4.1 of this guide. |
| 2320 | AMT | COB Total Non-Covered Amount | | Use this segment when the member has other insurance or Medicare but the charges are known to be noncovered.<br><br>When applicable based on the above statement, enter the total billed amount and no other AMT segments for the other payer.<br><br>*Note:* When reporting for commercial insurance, this will generate an OI Indicator of OI-Y. When reporting for Medicare, this will generate a Medicare Disclaimer of 8. |
| 2320 | AMT | Remaining Patient Liability | | Enter the remaining patient liability amount in this segment.<br><br>*Note:* For more information on indicators and disclaimer codes, see Section 4.1 of this guide. |
| 2330B | NM1 | Other Payer Name | | |
| 2330B | NM109 | Other Payer Primary Identifier | | Enter the other payer's identifier.<br><br>*Note:* ForwardHealth interChange will use this number in combination with Loop 2430 to calculate other insurance |

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| | | | | and Medicare payments. |
| 2330B | DTP | Claim Check or Remittance Date | | Required when the payer identified in this loop has previously adjudicated the claim.<br><br>*Note:* This information is either included here or in Loop 2430. |
| 2330B | REF | Other Payer Claim Control Number | | This segment will not be used by ForwardHealth. |
| 2330G | | Other Payer Billing Provider | | This loop will not be used by ForwardHealth. |
| 2400 | SV1 | Professional Service Line | | |
| 2400 | SV102 | Line Item Charge Amount | | Enter the billed amount for each service line.<br><br>*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 | SV103 | Unit or Basis for Measurement Code | MJ<br>UN | Enter the value "MJ" to indicate minutes or "UN" to indicate units.<br><br>*Note:* Use “MJ” to report anesthesia services. All other services should be reported using “UN”. |
| 2400 | SV112 | Family Planning Indicator | Y | Enter the value "Y" if the services are related to family planning.<br><br>*Note:* This element is required by ForwardHealth when it is necessary to indicate a family planning service. |
| 2400 | DTP | Date — Service Date | | This segment specifies any or all of a date, a time, or a time period. |

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| 2400 | DTP02 | Date Time Period Format Qualifier | D8 | Enter value "D8" to indicate a single date of service or "RD8" to indicate a range of service dates.<br><br>*Note:* When “RD8” is used, ForwardHealth interChange will assume that the exact same service, including the number of units, was performed on each day within the range. |
| 2400 | DTP | Date — Prescription Date | | *Note:* Required when a drug is billed for this line and a prescription was written (or otherwise communicated by the prescriber if not written). |
| 2400 | REF | Prior Authorization | | ForwardHealth interChange does not require that the PA number be submitted on the 837 transaction.<br><br>*Note:* For PA policy guidelines, refer to the applicable service area of the ForwardHealth Online Handbook. |
| 2410 | | Drug Identification | | *Note:* This loop is required when submitting a drug related Healthcare Common Procedure Coding System procedure code. |
| 2410 | LIN | Drug Identification | | This segment specifies basic item/drug identification data. |
| 2410 | LIN03 | National Drug Code | | Enter the National Drug Code. |
| 2410 | CTP | Drug Quantity | | Enter pharmacy information in this segment when applicable. |
| 2410 | CTP04 | National Drug Unit Count | | Enter the numeric quantity in this field. |
| 2410 | CTP05-1 | Code Qualifier | F2<br>GR<br>ME<br>ML<br>UN | Select the unit of measurement that corresponds to the value entered in the CTP04 field. |

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| 2410 | REF | Prescription or Compound Drug Association Number | | Enter prescription or link sequence number in this segment. |
| 2410 | REF01 | Reference Identification Qualifier | XZ<br>VY | Enter the value “XZ” to indicate the pharmacy prescription number or "VY" to indicate the line sequence number. |
| 2410 | REF02 | Prescription Number | | Enter the prescription number. |
| 2420A | NM1 | Rendering Provider Name | | Enter the rendering provider’s NPI in this segment if the rendering provider is ForwardHealth certified and different than the billing provider and different than the rendering provider listed in Loop 2310B. |
| 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.<br><br>*Note:* Taxonomy codes are only required if the NPI has multiple certifications and the taxonomy is necessary to determine the appropriate one. |
| 2420A | PRV03 | Provider Taxonomy Code | | Enter the rendering provider’s taxonomy code for the service that is being billed.<br><br>*Note:* The provider is required to use the appropriate taxonomy code that is associated to the provider type and specialty currently on file with ForwardHealth. |
| 2420A | REF | Rendering Provider Secondary Identification | | |
| 2420F | NM1 | Referring Provider Name | | Enter the referring provider’s NPI in this segment if the referring provider is |

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| | | | | ForwardHealth certified and different than the billing provider and different than the referring provider listed in Loop 2310B. |
| 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 | Line Adjudication | | Include this segment when another payer has made payment at the service line. If the other payer returned an 835 remittance, the CAS segment from the 835 should be copied to this CAS.<br><br>*Note:* ForwardHealth interChange will use the information in the CAS segment in place of the "other insurance indicator" and "Medicare disclaimer code" submitted prior to HIPAA.<br><br>To generate a Medicare disclaimer code of “7”, a CAS segment for a Medicare payer must be used in Loop 2430. The value(s) of the claim adjustment reason code(s) is used to determine which value is applied.<br><br>To generate an other insurance indicator of “D”, a CAS segment for a non-Medicare payer must be used in either Loop 2320 or 2430. The value(s) of the claim adjustment reason code(s) is used to determine if the other insurance indicator is “D” or blank.<br><br>If this iteration of Loop 2430 contains |

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| | | | | information from a Medicare payer, ForwardHealth interChange will also look for Medicare's coinsurance, copayment, and deductible. |

# 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 depending upon the health program for which the 837P transaction is being processed:

- BadgerCare Plus.
- Wisconsin SeniorCare.
- Wisconsin Chronic Disease Program.
- Wisconsin Medicaid.
- Wisconsin Well Woman Program.

### 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.

### 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 four Other Insurance (OI) Indicators that can potentially be associated with a claim/encounter. The four code options are: “Blank”, “OI-P”, “OI-D”, and “OI-Y”.

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, the claim was submitted to the insurance carrier but the claim was denied.

In this example, the provider billed $146.00. The other insurance carrier allowed zero and paid zero. The reason the other insurance carrier did not pay the claim is indicated with the CAS segment copied from the 835 received from the other insurance carrier.

Loop 2320

SBR*A*18*******CI~
CAS*PR*45*146.00~
AMT*D*0~
OI***Y***Y~

Loop 2330A

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

Loop 2330B

NM1*PR*2*ABC INSURANCE*****PI*004~
DTP*573*D8*20100819~

In this example, the provider billed $100.00 and applied $50 to deductible and $50 was beyond the maximum allowable fee.

Loop 2320

SBR*A*18*******CI~
CAS*PR*1*50.00~
CAS*CO*45*50.00~
AMT*D*0~
OI***Y***Y~

Loop 2330A
NM1*IL*1*LAST NAME*FIRST NAME****MI*9999999999~

Loop 2330B
NM1*PR*2*ABC INSURANCE*****PI*004~
DTP*573*D8*20100819~

In this example, the provider billed $40.00. The member has Other Insurance coverage, but the claim was not submitted to their insurance carrier. Refer to the ForwardHealth Online Handbook to determine when it is appropriate to submit claims/encounters to ForwardHealth without first receiving payment from the other insurance carrier.

Loop 2320
SBR*A*18*******CI~
AMT*A8*40.00~
OI***Y***Y~

Loop 2330A
NM1*IL*1*LAST NAME*FIRST NAME****MI*99999999~

Loop 2330B
NM1*IL*2*ABC INSURANCE*****PI*004~

### 4.1.4 Medicare Status Disclaimer Code

There are three Medicare Disclaimers that can potentially be associated with a claim/encounter. The three codes are: “Blank”, “7”, and “8”. A disclaimer code of “Blank” is present when the member is not enrolled in Medicare or when they are enrolled in Medicare, and Medicare has made a payment on the claim. A disclaimer code of “7” is present when the member is enrolled in Medicare, the claim was submitted to Medicare, and Medicare denied payment. A disclaimer code of “8” is present when Medicare was billed for the claim but deemed the services noncovered or when the services are known to be noncovered by Medicare and therefore not submitted for payment.

Medicare Disclaimers (ForwardHealth Examples)

In order to have a Medicare disclaimer code assigned to a claim/encounter, at least one Medicare payer must be represented on the claim/encounter. The inclusion of a 2320 loop and any required subloops represent each payer. ForwardHealth interChange can assign one of two Medicare disclaimer codes to electronic claims based on information supplied on the claim.

*Medicare Disclaimer = Blank (Medicare Allowed/Paid)*

In this example, the provider billed $100.00 and applied $50 to the deductible and $50 was beyond the maximum allowable fee.

Loop 2320
SBR*A*18*******MB~
AMT*D*0~
OI***Y***Y~

Loop 2330A
NM1-IL*1*LAST NAME*FIRST NAME****MI*9999999999~

Loop 2330B
NM1*PR*2*MEDICARE*****PI*004~

Loop 2430
SVD*001*0*HC:E0431**1.00~
CAS*PR*1*50.00~
CAS*CO*45*50.00~
DTP*573*D8*20100819~

*Medicare Disclaimer = 7 Denied*

In this example, the provider billed $146.00. Medicare allowed zero and paid zero. The reason Medicare did not pay the claim is indicated with the CAS segment copied from the 835 received from Medicare.

Loop 2320
SBR*A*18*******MB~
AMT*D*0~
OI***Y***Y~

Loop 2330A
NM1*IL*1*LAST NAME*FIRST NAME****MI*999999999~

Loop 2330B
NM1*PR*2*MEDICARE*****PI*004~

Loop 2430
SVD*001*0*HC:E0431**1.00~
CAS*CO*96*146.00~
DTP*573*D8*20100819~

*Medicare Disclaimer = 8*

In this example, the provider billed $40.00. The member is a Medicare beneficiary, but the claim was not submitted to Medicare. Refer to the ForwardHealth Online Handbook to determine when it is appropriate to submit claims/encounters to ForwardHealth without first receiving payment from Medicare.

Loop 2320
SBR*A*18*******MB~
AMT*A8*40.00~
OI***Y***Y~

Loop 2330A
NM1*IL*1*LAST NAME*FIRST NAME****MI*99999999~

Loop 2330B
NM1*IL*2*MEDICARE*****PI*004~

## 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 Electronic Data interchange (EDI) Department at (866) 416-4979.

# 5 Transaction Instructions Change Summary

Version 2.0 Revision Log

Companion Document: 837 Health Care Claim/Encounter: Professional (837P)

Approved: 04/2012

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. |
| | 10 | GS03 | Application Receiver’s Code | WISC_ TXIX WISC_ WWWP WISC_ WCDP | Added clarification. Encounter: “WISC_TXIX” only. |
| | 10 | BHT | Beginning of Hierarchical Transaction | | Added segment. |
| | 10 | BHT06 | Claim Identifier | CH (Claim) RP (Encounter) | Added element. Element is used to designate encounter. Claims will use “CH”; encounter will use “RP”. |

| | | | | | |
|---|---|---|---|---|---|
| 1000B | 10 | NM109 | Receiver Primary Identifier | WISC_ TXIX WISC_ WWWP WISC_ WCDP | Added clarification. Encounter: “WISC_TXIX” only. |
| 2010 | 11 | 2010AB | Pay-to-Address | | Added clarification. Encounter submissions will not receive an 835. |
| 2010BB | 12 | NM109 | Payer Identifier | WISC_ TXIX WISC_ WWWP WISC_ WCDP | Added clarification. Encounter: “WISC_TXIX” only. |
| 2300 | 14 | CLM05-3 | Claim Frequency Code | | Added clarification. Provider letters and paper submissions/ requests will not be supported for encounter processing. |
| 2300 | 15 | PWK | Claim Supple-mental Information | | Added clarification. Segment is used to designate a chart review encounter. |
| 2300 | 15 | PWK01 | Report Type Code | 09 (Encounter) | Added Element. Element will designate a chart review encounter. |
| 2300 | 15 | PWK02 | Attachment Transmission Code | BM (Claim) AA (Encounter) | Indicated “BM” is for claim. Replaced “BM” with IG language “By Mail.” Added code “AA” for encounter. |
| 2300 | 15 | PWK05 | Identification Code Qualifier | AC (C) | Indicated “AC” for claim. |
| 2320 | 17 | SBR | Other Subscriber Identification | | Added segment. Encounter can use this element to identify 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 | 21 | 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 to identify MCO amount paid to the provider at line level. |