Manual for HealthLink 837 Series Claims

Companion Guide for Payors

Instructions related to Transactions based on
ASC X12 Implementation Guides

HealthLink®

Companion Guide Version Number: V 1.3 – TDC.11.001

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Preface

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

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

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

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1 Transaction Instruction (TI) Introduction

1.1 Background

Overview of HIPAA Legislation

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

- Create better access to health insurance
- Limit fraud and abuse
- Reduce administrative costs

Compliance according to HIPAA

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

- Change the definition, data condition, or use of a data element or segment in a standard.
- Add any data elements or segments to the maximum defined data set.
- Use any code or data elements that are marked “not used” in the standard’s implementation specifications or are not in the standard’s implementation specification(s).
- Change the meaning or intent of the standard’s implementation specification(s).

Compliance according to ASC X12

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

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

1.2 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 ASC X12’s Fair Use and Copyright statements.

2 Included ASC X12 Implementation Guides

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

Unique ID	Name
005010X222A1	Health Care Claim: Professional (837)
005010X223A2	Health Care Claim: Institutional (837)

3 Instruction Tables

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

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

3.1 005010X222A1 Health Care Claim: Professional

Loop	Reference	Name	Codes	Notes/Comments
2010AA	NM1	Billing Provider Name		Occasionally, we will receive electronic claims with Billing Provider information, but no Provider name and/or Provider ID for this, which is required under HIPAA.
2010AA	NM101	Entity Identifier Code	85	
2010AA	NM102	Entity Type Qualifier	2	
2010AA	NM103	Billing Provider Last or Organizational Name	XX	If this field is blank, HealthLink will populate the data element.
2010AA	NM108	Identification Code Qualifier	XX	If this field is blank, HealthLink will populate the data element.
2010AA	NM109	Billing Provider Identifier		If this field is blank, HealthLink will populate the data element with “9999999999”.

Loop	Reference	Name	Codes	Notes/Comments
2010AA	PER	Billing Provider Contact Information		Per CMS HIPAA guidance, telephone numbers should consist only of ten numeric digits. Dashes and parenthesis marks are invalid characters.
2010AA	PER04	Communication Number		If this field has invalid characters, HealthLink will populate the data in the following manner: “0000000000” (ten zeros)
2010AA	PER06	Communication Number		If this field has invalid characters, HealthLink will populate the data in the following manner: “0000000000” (ten zeros)
2010AA	PER08	Communication Number		If this field has invalid characters, HealthLink will populate the data in the following manner: “0000000000” (ten zeros)
Loop	**Reference**	**Name**	**Codes**	**Notes/Comments**
2000B	SBR	Subscriber Information		Several of the payors for which we reprice claims utilize HealthLink’s Open Access network products for some of their groups.

2000B	SBR09	Claim Filing Indicator Code	12	The payor may utilize the following method to determine the status of the provider who rendered the service.
2000B	SBR09	Claim Filing Indicator Code	HM	The payor may utilize the following method to determine the status of the provider who rendered the service.
2000B	SBR09	Claim Filing Indicator Code	ZZ	The payor may utilize the following method to determine the status of the provider who rendered the service.
2000B	SBR09	Claim Filing Indicator Code	WC	The payor may utilize the following method to determine the status of the provider who rendered the service.
2000B	SBR09	Claim Filing Indicator Code	14	The payor may utilize the following method to determine the status of the provider who rendered the service.

Loop	Reference	Name	Codes	Notes/Comments
2010BA	NM1	Subscriber Name		Occasionally, we will receive electronic claims with Subscriber information, but no Subscriber name and/or Subscriber ID for this, which is required under HIPAA.
2010BA	NM101	Entity Identifier Code	IL	
2010BA	NM102	Entity Type Qualifier	1	
2010BA	NM103	Subscriber Last Name	XX	If this field is blank, HealthLink will populate the data element.
2010BA	NM104	Subscriber First Name	XX	If this field is blank, HealthLink will populate the data element.
2010BA	NM108	Identification Code Qualifier	MI	If this field is blank, HealthLink will populate the data element.
2010BA	NM109	Subscriber Primary Identifier		If this field is blank, HealthLink will populate the data element with “9999999999”.

Loop	Reference	Name	Codes	Notes/Comments
2010BB	NM1	Payer Name		Occasionally, we will receive electronic claims with Payor information but no Payor name and/or Payor ID for this, which is required under HIPAA.
2010BB	NM101	Entity Identifier Code	PR	
2010BB	NM102	Entity Type Qualifier	2	
2010BB	NM103	Payer Last Name	XX	If this field is blank, HealthLink will populate the data element.
2010BB	NM104	Payer First Name	XX	If this field is blank, HealthLink will populate the data element.
2010BB	NM108	Identification Code Qualifier	PI	If this field is blank, HealthLink will populate the data element.
2010BB	NM109	Payer Identifier		If this field is blank, HealthLink will populate the data element with “9999999999”.

Loop	Reference	Name	Codes	Notes/Comments
2300	CLM	Claim Information		
2300	CLM05-3	Claim Frequency Code	1	If the claim is original to HealthLink, CLM05-3 in the 2300 loop will be populated with “1” (“Original claim”).
2300	CLM05-3	Claim Frequency Code	7	If this is an adjustment to a claim previously processed by HealthLink, CLM05-3 will be populated with “7” (“Replacement claim”).
2300	CLM06	Provider or Supplier Signature Indicator	Y	If this field is blank, HealthLink will populate the data element.
2300	CLM07	Medicare Assignment Code	A	If this field is blank, HealthLink will populate the data element.
2300	CLM10	Patient Signature Source Code	P	If CLM09 (Release of Information Code) does not equal “N”, this code is required. If CLM10 is blank, HealthLink will populate the data in the following manner

Loop	Reference	Name	Codes	Notes/Comments
2300	CLM11	Related Causes Information		If an Accident Date is provided on the claim the assumption is that the condition being reported is Accident or Employment related. In these cases a Related-Causes Code is required in the 837.
2300	CLM11-1	Related Causes Code	OA	If this field is blank, HealthLink will populate the data element.
Loop	**Reference**	**Name**	**Codes**	**Notes/Comments**

2300	DTP	Date - Accident		If an Accident indicator is provided on the claim the assumption is that the condition being reported is Accident or Employment related. In these cases an Accident Date is required in the 837.
2300	DTP01	Date Time Qualifier	439	
2300	DTP02	Date Time Period Format Qualifier	D8	
2300	DTP03	Accident Date		If this date is blank or invalid, HealthLink will populate the following data element with "19010101"

Loop	Reference	Name	Codes	Notes/Comments
2300	DTP	Date - Admission		If a discharge date is present on the claim, the admission date is required.
2300	DTP01	Date Time Qualifier	435	
2300	DTP02	Date Time Period Format Qualifier	D8	
2300	DTP03	Related Hospitalization Admission Date		If this date is blank or invalid, HealthLink will populate the following data element with "19010101"

Loop	Reference	Name	Codes	Notes/Comments
2300	DTP	Date - Discharge		If an admission date is present on the claim, the discharge date is required.
2300	DTP01	Date Time Qualifier	96	
2300	DTP02	Date Time Period Format Qualifier	D8	
2300	DTP03	Related Hospitalization Discharge Date		If this date is blank or invalid, HealthLink will populate the following data element with "19010101"

Loop	Reference	Name	Codes	Notes/Comments
2300	DTP	Date - Onset Of Current Illness/Symptom		If the claim indicates there was a related illness or symptoms but does not have a valid date. HealthLink will populate with a default value.
2300	DTP01	Date Time Qualifier	431	
2300	DTP02	Date Time Period Format Qualifier	D8	
2300	DTP03	Onset of Current Illness or Injury Date		If this date is blank or invalid, HealthLink will populate the following data element with "19010101"
Loop	**Reference**	**Name**	**Codes**	**Notes/Comments**

2300	REF	Repriced Claim Number		HealthLink assigns a unique Document Control Number (“DCN”) (11 digits) to each claim that it processes.
2300	REF01	Reference Identification Qualifier	9A	
2300	REF02	Repriced Claim Reference Number		The DCN assigned to the claim has a structure which uses the DCN “E1804021010” as an example: See section 4.2.3.9

Loop	Reference	Name	Codes	Notes/Comments
2300	REF	Adjusted Repriced Claim Number		
2300	REF01	Reference Identification Qualifier	9C	
2300	REF02	Adjusted Repriced Claim Reference Number		The DCN assigned to the claim has a structure which uses the DCN “E1804021010” as an example: See section 4.2.3.9

Loop	Reference	Name	Codes	Notes/Comments
2300	REF	Claim Identifier For Transmission Intermediaries		
2300	REF01	Reference Identification Qualifier	D9	Clearinghouse Trace Number
2300	REF02	Clearinghouse Trace Number		The DCN assigned to the claim has a structure which uses the DCN “E1804021010” as an example: See section 4.2.3.9

Loop	Reference	Name	Codes	Notes/Comments
2300	HCP	Claim Pricing/Repricing Information		The provider participating status can be obtained in the “Line Pricing/Repricing Information” segment (“HCP”). If a claim has been processed as non-participating, the following elements will be populated:
2300	HCP01	Pricing Methodology	0	The presence of this value indicates that this claim is from a non-participating provider. Claims for non-participating providers using UCR pricing do not use “00”.
2300	HCP13	Reject Reason Code	T1	Cannot identify Provider as TPO (Third Party Organization) Participant)
2300	HCP15	Exception Code	3	Services or Specialist not in Network

Loop	Reference	Name	Codes	Notes/Comments
2310A	NM1	Referring Provider Name		Occasionally, we will receive claims with Referring Physician information but no Provider name and/or Provider ID for this physician, which is required under HIPAA.
2310A	NM101	Entity Identifier Code	DN	
2310A	NM102	Entity Type Qualifier	1	
2310A	NM103	Referring Provider Last Name	XX	If this field is blank, HealthLink will populate the data element.
2310A	NM104	Referring Provider First Name	XX	If this field is blank, HealthLink will populate the data element.
2310A	NM108	Identification Code Qualifier	XX	If this field is blank, HealthLink will populate the data element.
2310A	NM109	Referring Provider Identifier		If this field is blank, HealthLink will populate the data element with “9999999999”.

Loop	Reference	Name	Codes	Notes/Comments
2310B	NM1	Rendering Provider Name		Occasionally, we will receive electronic claims with “Rendering Provider” information but no Provider ID Number for this physician, which is required under HIPAA.
2310B	NM108	Identification Code Qualifier	XX	If this field is blank, HealthLink will populate the data element.
2310B	NM109	Rendering Provider Identifier		If this field is blank, HealthLink will populate the data element with “9999999999”.

Loop	Reference	Name	Codes	Notes/Comments
2310D	NM1	Supervising Provider Name		Occasionally, we will receive electronic claims with Supervising Provider information but no Provider name and/or Provider ID for this physician, which is required under HIPAA.
2310D	NM101	Entity Identifier Code	DQ	
2310D	NM102	Entity Type Qualifier	1	
2310D	NM103	Supervising Provider Last Name	XX	If this field is blank, HealthLink will populate the data element.
2310D	NM104	Supervising Provider First Name	XX	If this field is blank, HealthLink will populate the data element.
2310D	NM109	Supervising Provider Identifier		If this field is blank, HealthLink will populate the data element with “9999999999”.

Loop	Reference	Name	Codes	Notes/Comments
2320	SBR	Other Subscriber Information		If the claim contains other insurance information or indicates there is other coverage, then additional other insurance coverage information is required.
2320	SBR01	Payer Responsibility Sequence Number Code	S	
2320	SBR02	Individual Relationship Code	21	
2320	SBR03	Insured Group or Policy Number		If this field is blank, HealthLink will populate the data element with “”UNKNOWN.
2320	SBR04	Other Insured Group Name		If this field is blank, HealthLink will populate the data element with “”UNKNOWN.
2320	SBR09	Claim Filing Indicator Code	ZZ	

Loop	Reference	Name	Codes	Notes/Comments
2320	OI	Other Insurance Coverage Information		If the claim contains other insurance information or indicates there is other coverage, then additional other insurance coverage information is required.
2320	OI03	Benefits Assignment Certification Indicator	Y	If this field is blank, HealthLink will populate the data element.

Loop	Reference	Name	Codes	Notes/Comments
2330A	NM1	Other Subscriber Name		If the claim contains other insurance information or indicates there is other coverage, then additional other insurance coverage information is required.
2330A	NM101	Entity Identifier Code	IL	
2330A	NM102	Entity Type Qualifier	1	
2330A	NM103	Other Insured Last Name	XX	If this field is blank, HealthLink will populate the data element.
2330A	NM104	Other Insured First Name	XX	If this field is blank, HealthLink will populate the data element.
2330A	NM109	Other Insured Identifier		If this field is blank, HealthLink will populate the data element with “9999999999”.

Loop	Reference	Name	Codes	Notes/Comments
2330B	NM1	Other Payer Name		If the claim contains other insurance information or indicates there is other coverage, then additional other insurance coverage information is required.
2330B	NM101	Entity Identifier Code	PR	
2330B	NM102	Entity Type Qualifier	2	
2330B	NM103	Other Payer Last or Organization Name	XX	If this field is blank, HealthLink will populate the data element.
2330B	NM108	Identification Code Qualifier	PI	If this field is blank, HealthLink will populate the data element.
2330B	NM109	Other Payer Primary Identifier		If this field is blank, HealthLink will populate the data element with “9999999999”.

Loop	Reference	Name	Codes	Notes/Comments
2400	SV1	Professional Service		Occasionally, we will receive electronic claims without the required Units of Service field, which is required under HIPAA.
2400	SV104	Service Unit Count	1	If this field is blank, HealthLink will populate the data element.

Loop	Reference	Name	Codes	Notes/Comments
2400	HCP	Line Pricing/Repricing Information		
2400	HCP01	Pricing Methodology	0	The presence of this value indicates that this claim is from a non-participating provider. Claims for non-participating providers using UCR pricing do not use “00”.
2400	HCP13	Reject Reason Code	T1	“T1” (Cannot identify Provider as TPO (Third Party Organization) Participant)
2400	HCP15	Exception Code	3	“3” (Services or Specialist not in Network)

Loop	Reference	Name	Codes	Notes/Comments
2420A	NM1	Rendering Provider Name		Occasionally, we will receive electronic claims with “Rendering Provider” information but no Provider ID Number for this physician, which is required under HIPAA.
2420A	NM108	Identification Code Qualifier	XX	If this field is blank, HealthLink will populate the data element.
2420A	NM109	Rendering Provider Identifier		If this field is blank, HealthLink will populate the data element with “9999999999”.

Loop	Reference	Name	Codes	Notes/Comments
2420B	NM1	Purchased Service Provider Name		Occasionally, we will receive claims with Purchased Service Provider information but no Provider name and/or Provider ID for this physician, which is required under HIPAA.
2420B	NM101	Entity Identifier Code	QB	
2420B	NM102	Entity Type Qualifier	1	
2420B	NM108	Identification Code Qualifier	XX	If this field is blank, HealthLink will populate the data element.
2420B	NM109	Other Payer Primary Identifier		If this field is blank, HealthLink will populate the data element with “9999999999”.

Loop	Reference	Name	Codes	Notes/Comments
2420E	NM1	Ordering Provider Name		Occasionally, we will receive claims with Ordering Physician information but no Provider name and/or Provider ID for this physician, which is required under HIPAA.
2420E	NM101	Entity Identifier Code	DK	
2420E	NM102	Entity Type Qualifier	1	
2420E	NM103	Ordering Provider Last Name	XX	If this field is blank, HealthLink will populate the data element.
2420E	NM104	Ordering Provider First Name	XX	If this field is blank, HealthLink will populate the data element.
2420E	NM108	Identification Code Qualifier	XX	If this field is blank, HealthLink will populate the data element.
2420E	NM109	Ordering Provider Identifier		If this field is blank, HealthLink will populate the data element with “9999999999”.

Loop	Reference	Name	Codes	Notes/Comments
2420F	NM1	Referring Provider Name		Occasionally, we will receive claims with Referring Physician information but no Provider name and/or Provider ID for this physician, which is required under HIPAA.
2420F	NM101	Entity Identifier Code	DN	
2420F	NM102	Entity Type Qualifier	1	
2420F	NM103	Referring Provider Last Name	XX	If this field is blank, HealthLink will populate the data element.
2420F	NM104	Referring Provider First Name	XX	If this field is blank, HealthLink will populate the data element.
2420F	NM108	Identification Code Qualifier	XX	If this field is blank, HealthLink will populate the data element.
2420F	NM109	Referring Provider Identifier		If this field is blank, HealthLink will populate the data element with “9999999999”.

3.2 005010X223A2 Health Care Claim: Institutional

Loop	Reference	Name	Codes	Notes/Comments
2010AA	NM1	Billing Provider Name		Occasionally, we will receive electronic claims with Billing Provider information, but no Provider name and/or Provider ID for this, which is required under HIPAA.
2010AA	NM101	Entity Identifier Code	85	
2010AA	NM102	Entity Type Qualifier	2	
2010AA	NM103	Billing Provider Last or Organizational Name	XX	If this field is blank, HealthLink will populate the data element.
2010AA	NM108	Identification Code Qualifier	XX	If this field is blank, HealthLink will populate the data element.
2010AA	NM109	Billing Provider Identifier		If this field is blank, HealthLink will populate the data element with “9999999999”.

Loop	Reference	Name	Codes	Notes/Comments
2000B	SBR	Subscriber Information		Several of the payors for which we reprice claims utilize HealthLink’s Open Access network products for some of their groups. The 837 format does not have a specific data element that can be used to identify Open Access indicators.
2000B	SBR09	Claim Filing Indicator Code	12	The payor may utilize the following method to determine the status of the provider who rendered the service.
2000B	SBR09	Claim Filing Indicator Code	HM	The payor may utilize the following method to determine the status of the provider who rendered the service.
2000B	SBR09	Claim Filing Indicator Code	ZZ	The payor may utilize the following method to determine the status of the provider who rendered the service.
2000B	SBR09	Claim Filing Indicator Code	WC	The payor may utilize the following method to determine the status of the provider who rendered the service.
2000B	SBR09	Claim Filing Indicator Code	14	The payor may utilize the following method to determine the status of the provider who rendered the service.
Loop	**Reference**	**Name**	**Codes**	**Notes/Comments**
2010BA	NM1	Subscriber Name		Occasionally, we will receive electronic claims with Subscriber information, but no Subscriber name and/or Subscriber ID for this, which is required under HIPAA.
2010BA	NM101	Entity Identifier Code	IL	
2010BA	NM102	Entity Type Qualifier	1	
2010BA	NM103	Subscriber Last Name	XX	If this field is blank, HealthLink will populate the data element.
2010BA	NM104	Subscriber First Name	XX	If this field is blank, HealthLink will populate the data element.

2010BA	NM108	Identification Code Qualifier	MI	If this field is blank, HealthLink will populate the data element.
2010BA	NM109	Subscriber Primary Identifier		If this field is blank, HealthLink will populate the data element with “9999999999”.

Loop	**Reference**	**Name**	**Codes**	**Notes/Comments**
2300	CLM	Claim Information		
2300	CLM06	Provider or Supplier Signature Indicator	Y	If this field is blank, HealthLink will populate the data element.
2300	CLM07	Medicare Assignment Code	A	If this field is blank, HealthLink will populate the data element.

Loop	Reference	Name	Codes	Notes/Comments
2300	CLM11	Related Causes Information		If an Accident Date is provided on the claim the assumption is that the condition being reported is Accident or Employment related. In these cases a Related-Causes Code is required in the 837.
2300	CLM11-1	Related Causes Code	OA	If this field is blank, HealthLink will populate the data element.

Loop	Reference	Name	Codes	Notes/Comments
2300	HCP	Claim Pricing/Repricing Information		The provider participating status can be obtained in the Line Pricing/Reprising Information segment (HCP). If a claim has been processed as non-participating, the following elements will be populated:
2300	HCP01	Pricing Methodology	0	The presence of this value indicates that this claim is from a non-participating provider.
				Claims for non-participating providers using UCR pricing do not use 00.
2300	HCP13	Reject Reason Code	T1	Cannot identify Provider as TPO (Third Party Organization) Participant)
2300	HCP15	Exception Code	3	Services or Specialist not in Network

Loop	Reference	Name	Codes	Notes/Comments
2310A	NM1	Attending Provider Name		Occasionally, we will receive electronic claims with Attending Physician information, but no Provider name and/or Provider ID for this physician, which is required under HIPAA
2310A	NM101	Entity Identifier Code	71	
2310A	NM102	Entity Type Qualifier	1	
2310A	NM103	Attending Provider Name Last	XX	If this field is blank, HealthLink will populate the data element.
2310A	NM104	Attending Provider Name First	XX	If this field is blank, HealthLink will populate the data element.

Loop	Reference	Name	Codes	Notes/Comments
2310B	NM1	Operating Physician Name		Occasionally, we will receive electronic claims with Operating Physician information, but no Provider name and/or Provider ID for this physician, which is required under HIPAA.
2310B	NM101	Entity Identifier Code	72	
2310B	NM102	Entity Type Qualifier	1	
2310B	NM103	Operating Physician Last Name	XX	If this field is blank, HealthLink will populate the data element.
2310B	NM104	Operating Physician Name First	XX	If this field is blank, HealthLink will populate the data element.
2310B	NM108	Identification Code Qualifier	XX	If this field is blank, HealthLink will populate the data element.
2310B	NM109	Operating Physician Primary Identifier		If this field is blank, HealthLink will populate the data element with “9999999999”.

Loop	Reference	Name	Codes	Notes/Comments
2310C	NM1	Other Operating Physician Name		Occasionally, we will receive electronic claims with Operating Physician information, but no Provider name and/or Provider ID for this physician, which is required under HIPAA.
2310C	NM101	Entity Identifier Code	ZZ	
2310C	NM102	Entity Type Qualifier	1	
2310C	NM103	Last or Organization Name	XX	If this field is blank, HealthLink will populate the data element.
2310C	NM104	First Name	XX	If this field is blank, HealthLink will populate the data element.
2310C	NM108	Identification Code Qualifier	XX	If this field is blank, HealthLink will populate the data element.
2310C	NM109	Identifier		If this field is blank, HealthLink will populate the data element with “9999999999”.

Loop	Reference	Name	Codes	Notes/Comments
2320	SBR	Other Subscriber Information		If the claim contains other insurance information or indicates there is other coverage, then additional other insurance coverage information is required by HealthLink.
2320	SBR01	Payer Responsibility Sequence Number Code	S	
2320	SBR02	Individual Relationship Code	21	
2320	SBR03	Insured Group or Policy Number		If this field is blank, HealthLink will populate the data element with “UNKNOWN”.
2320	SBR09	Claim Filing Indicator Code	ZZ	If this field is blank, HealthLink will populate the data element.

Loop	Reference	Name	Codes	Notes/Comments
2320	OI	Other Insurance Coverage Information		If the claim contains other insurance information or indicates there is other coverage, then additional other insurance coverage information which is required under HIPAA.
2320	OI03	Benefits Assignment Certification Indicator	Y	If this field is blank, HealthLink will populate the data element.

Loop	Reference	Name	Codes	Notes/Comments
2330A	NM1	Other Subscriber Name		Occasionally, we will receive electronic claims with “Other Subscriber Name” information but no Other Subscriber Name, which is required under HIPAA.
2330A	NM101	Entity Identifier Code	IL	
2330A	NM102	Entity Type Qualifier	1	
2330A	NM103	Other Insured Last Name	XX	If this field is blank, HealthLink will populate the data element.
2330A	NM104	Other Insured First Name	XX	If this field is blank, HealthLink will populate the data element.
2330A	NM109	Other Insured Identifier		If this field is blank, HealthLink will populate the data element with “9999999999”.

Loop	Reference	Name	Codes	Notes/Comments
2330B	NM1	Other Payer Name		Occasionally, we will receive electronic claims with “Other Payer Name” information but no Other Payer Name, which is required under HIPAA.
2330B	NM101	Entity Identifier Code	PR	
2330B	NM102	Entity Type Qualifier	2	
2330B	NM103	Other Payer Last or Organization Name	XX	If this field is blank, HealthLink will populate the data element.
2330B	NM108	Identification Code Qualifier	PI	If this field is blank, HealthLink will populate the data element.
2330B	NM109	Other Payer Primary Identifier		If this field is blank, HealthLink will populate the data element with “9999999999”.

Loop	Reference	Name	Codes	Notes/Comments
2400	SV2	Institutional Service Line		Occasionally, HealthLink will receive claims with a 3-digit revenue code.
2400	SV201	Revenue Code		In these cases, HealthLink will convert these to the required 4-digit revenue code in SV201 in the 2400 loop.

Loop	Reference	Name	Codes	Notes/Comments
2400	HCP	Line Pricing/Repricing Information		
2400	HCP01	Pricing Methodology	0	The presence of this value indicates that this claim is from a non-participating provider.
				Claims for non-participating providers using UCR pricing do not use 00.
2400	HCP13	Reject Reason Code	T1	T1 (Cannot identify Provider as TPO (Third Party Organization) Participant)
2400	HCP15	Exception Code	3	3 (Services or Specialist not in Network)

4 TI Additional Information

4.1 Business Scenarios

Bundling (Code Editing)

Correct coding (bundling) or code review / editing will be communicated in HealthLink's outbound priced claims for professional claims (1500s) only, and for business blocks with code review / editing enabled (most business blocks). The following is an example to demonstrate how the service lines will be communicated for code bundling.

Example

Claim received as:

DOS From	Thru	POS	TOS	CPT	Mod	Diag	Chg	Unit
09-08-2006	09-08-2006	11		99213		12	83.00	1
09-08-2006	09-08-2006	11		73100	RT	12	83.00	1
09-08-2006	09-08-2006	11		76000	RT	12	142.00	1
09-08-2006	09-08-2006	11		L3800	RT	12	46.00	1
				Total Charge:				354.00

After code review – on line 3, CPT code excluded by code review and billed amount was combined into line 2 ($83 + $142)

Line	POS	Date/ BCT	Proc/ Modifier	Unit	Billed/ /DP	Allowance
1.	11	09/08/06	99213	1	83.00	
		/FE	, ,	12	53.76	
2.	11	09/08/06	RT73100	1	225.00	
		/FE	RT, ,	12	31.79	
3.	11	09/08/06	RT76000	1	0.00	
		/	RT, ,	12		
4.	11	09/08/06	RTL3800	1	46.00	
		/FE	RT, ,	12	46.00	

The main elements of 837 are created (Sensitive information is replaced with xxxxx's)

CLM*xxxxxx*354*11::1*Y*A*Y*Y~**

total billed amount for claim loop 2320 – other subscriber information

added loop for compliance

SBR*S*18*XX*XX***CI~** **-**

This amount is calculated as follows:

total billed (clm02) - (total allowed (AMT02) + sum of line item CAS (CAS03) segments)

$354 – ($131.55 + $142)

AMT*D*131.55~ total allowed for claim

DMG*D8*19000101*U~

OI***Y*B**Y~

2330A and 2330B

Added these loops for compliance

NM1*IL*1*REPRICER*REPRICER****MI*REPRICER~
N3*1303 W MAIN ST~
N4*COLLINSVILLE*IL*622340000~
NM1*PR*2*REPRICER*****PI*REPRICER~
DTP*573*D8*20060920~

LX*1~ **no change**
SV1*HC:99213*83*UN*1*11**1:2~
DTP*472*D8*20060908~
REF*6R*06091930966301~
NTE*ADD*P~
HCP*02*53.76*29.24*900010001~

LX*2~
SV1*HC:73100:RT***83***UN*1*11**1:2~
DTP*472*D8*20060908~
REF*6R*06091930966302~
NTE*TPO*P~
HCP***04*31.79***51.21*900010001~
hcp02, value of 04 indicates bundled pricing
LX*3~
SV1*HC:76000:RT***142***UN*1*11**1:2~
DTP*472*D8*20060908~
REF*6R*06091930966303~
NTE*TPO*P~
HCP*10***0***142*900010001~
zero allowed amount

Loop 2430 line adjudication information - added loop for compliance
SVD*REPRICER*0*HC:73100:RT**1***2**~
CAS*CO*97***142**~ - **amount adjusted**
DTP*573*D8*20060920~

LX*4~ **- no change**
SV1*HC:L3800:RT*46*UN*1*11**1:2~
DTP*472*D8*20060908~
REF*6R*06091930966304~
NTE*TPO*P~
HCP*02*46*0*900010001~

It is necessary for HealthLink to include an “Other Payor” loop, Loop 2330B, in order to make the claim appear as a secondary claim and satisfy the HIPAA compliant edits. If this truly were a secondary claim, HealthLink would indicate the secondary payor information in this segment and send the claim to the secondary payor. Because HealthLink is not sending the claim to the secondary payor, we use the default text “REPRICER”, in order to communicate HealthLink as the repricer.

To summarize, the code review/editing will illustrate (within the outbound electronic claim):

HealthLink as the "Repricer".
The original claim line items with original units and billed amounts for each service line. The correct code or codes with the correct allowed amount, and original billed amount. The net effect will be to show the original billed amounts and codes, the correct code(s) with allowed amounts corresponding with each

4.2 Payer Specific Business Rules and Limitations

HealthLink Electronic Transaction Manual

HealthLink claims are sent to payors in ANSI 837-5010A1 (Implementation Guide with Addenda) HIPAA claims format. This manual explains the use of business-specific fields for the benefit of payors receiving electronic claims from our networks.

Applicability

This Companion Guide is designed to assist payors on implementing and understanding outbound network claims for HealthLink. This guide supplements information in and should be read in conjunction with the ANSI X12 Implementation Guides.

Scope of Companion Document

This Companion Document to the ASCX12N Implementation Guides adopted under HIPAA clarifies and specifies the data content when exchanging repriced claims electronically with HealthLink. Transmissions based on this companion document, used in tandem with the ANSI X12N Implementation Guides, are compliant with both the X12 syntax and those guidelines. 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.

File Naming Conventions

HealthLink has established standard naming conventions for inbound and outbound ANSI transactions for automated transaction processing.

Outbound 837 Files

Outbound 837 files use the following naming convention:

PGP Encrypted Files:

HealthLink assigns a unique outbound file name to each encrypted outbound 837, such as 837i_20050601_1.pgp. The name assigned to the file has a structure described below.

Character Position	Description
1-4	The ANSI transaction type. Professional transaction will be named as "837p" and institutional as "837i".
6-13	The date the file was created by the HealthLink batch process for outbound submission. The data does not reflect the date the file was created or posted for pickup, but the date of the nightly batch process in which the file was generated.
15	The transaction type file count. This position will increment by 1 for each additional file submission for the same date. Generally, only one file of each transaction type is submitted each day. Additional files will be submitted when previous days files failed and have been corrected.

Decrypted files:

HealthLink assigns a unique outbound file name to each decrypted outbound 837, such as 34719201-XXXX_837i_20050202_1.txt. The name assigned to the file has a structure described below.

Identifying Products (HMO, PPO, Open Access)

Several of the payors for which we reprice claims utilize HealthLink's Open Access network products for some of their groups. The 837 format does not have a specific data element that can be used to identify Open Access indicators. The payor may utilize the following method to determine the status of the provider who rendered the service.

ANSI Data Element	ANSI Loop	Data Element (and Use)	Defaulted Data Element Value
SBR09	2000B	Claim Indicator (for PPO par status)	"12" (PPO)
SBR09	2000B	Claim Indicator (for HMO par status)	"HM" (HMO)
SBR09	2000B	Claim Indicator (for Non-Par)	"ZZ" (Out of Network)
SBR09	2000B	Claim Indicator (for WC)	"WC" (Workers Comp)
SBR09	2000B	Claim Indicator (for EPO)	"14" (EPO)

The table below shows the HealthLink network products and the corresponding provider access allowed.

Reference on Network Products	
HL Network Product	**HL Provider Access**
PPO	PPO, OON
OA I	HMO, No OON
OA II	HMO, OON
OA III	HMO, PPO, OON
Workers Comp	WC, OON

*OON = Out of Network

An alternative instead of SBR09 is to use the Repricing Organization Identifiers (900010001 for PPO; and 900010008 for HMO or OA Tier I).

Identifying Participating Providers Status

Identifying the provider "par status" is important for proper administration of Open Access claims.

The provider participating status can be obtained in the "Line Pricing/Repricing Information" segment ("HCP"). If a claim has been processed as non-participating, the following elements will be populated:

ANSI Data Element	ANSI Loop	Data Element Name	Value	Notes
HCP01	2300, 2400	Pricing Methodology	"00" (Zero Priced Not Covered Under Contract)	The presence of this value indicates that this claim is from a non-participating provider. Claims for non-participating providers using UCR pricing do not use "00".

ANSI Data Element	ANSI Loop	Data Element Name	Value	Notes
HCP13	2300, 2400	Reject Reason Code	"T1" (Cannot identify Provider as TPO (Third Party Organization) Participant)	T1 Non-Par T2 Payor Non-Participant T3 Insured Non-Participant T4 Payor Missing T5 Certification Missing T6 Insufficient Data for Repricing
HCP15	2300, 2400	Exception Code	"3" (Services or Specialist not in Network)	

Provider Taxonomy (Specialty) Codes

The Provider Taxonomy Code (Element PRV03) in Loop 2310B (Rendering Provider) or Loop 2000A (Billing/Pay-To Provider) may be used to distinguish whether or not a provider is performing a primary care or specialist service, at the claim level. This is useful to payors needing to identify whether a particular service is primary care or specialty to assign co-payment amounts.

HealthLink considers the following taxonomy codes as primary care providers:

Family Practice	**207Q00000X**
General Practice	**208D00000X**
Pediatrics	**208000000X**
Obstetrics/Gynecology (as PCP)	**207V00000X**
Internal Medicine (as Primary Care Physician)	**207R00000X**
Geriatrics under Internal Medicine	**207RG0300X**
Geriatrics under Family Practice	**207QG0300X**

See Section 4.42 Latest Code Sets for full list of Provider Taxonomy Codes.

Identifying A Network (Repricing Organization Identifiers)

In addition to repricing claims for the HealthLink network; HealthLink utilizes the HCP04 data element, Repricing Organization Identifier, at both the claim level (2400 loop) and line level (2300 loop) to indicate to the payor which network repriced the claim. This is valid on both Institutional (837I) and professional (837P) claim types. See Appendix A for list.

For payors utilizing National Care Network (NCN) as an out-of-network cost containment program, the following table of repricing organization identifiers and EOB remark codes need to be set-up and recognized by the payor.

NCN provider discounts will not be honored unless EOB's have proper remark descriptions. NCN access/use requires a special HealthLink contract and special rate established.

Payors not using NCN services should not program their system for these special repricing organization identifiers (range from 900010059 to 900010062, 900010064, 900010065, 900010124, 900010125, 900010141, 900010148 to 900010152, 900010300 to 900010324 and 900010326) unless using NCN services.

Repricing Messages

HealthLink communicates various repricing messages for payors. HealthLink utilizes its proprietary messages that are currently in use for manual claims.

The 837 format has a Claim Level and Claim Line Level File Information segment (“K3”) which can be used for communicating such messages. The table below shows how HealthLink communicates these messages in the K3 Segment. The K3 segment can repeat up to 10 times. The first occurrence of the K3 segment will contain the adjustment reason code and description. The error codes and descriptions will start in the 2nd occurrence of the K3 segment.

837 Data Element	Occurrence	Position	Meaning
K301	1	1-3	Adjustment Reason Code
K301	1	4-80	Adjustment Reason Description
K301	2-10	1-3	Error Code
K301	2-10	4-80	Error Description

If the claim has not been adjusted, but an error code exists, the first instance of the K3 segment will contain “NA”.
See Appendix C for the most common error codes and descriptions for claims sent to payors.

Professional: Claims 837P (CMS1500) Messages

The Pricing Messages will be available in the File Information (“K3”) at the Claim Line Level, Loop 2400.

Professional: Billing Provider (2010AA)

Occasionally, we will receive electronic claims with Billing Provider information but no Provider name and/or Provider ID for this, which is required under HIPAA. If these fields are blank, HealthLink will populate the data as listed in section 3.1 Loop 2010AA

> **NOTE:** In NM109, HealthLink will populate the tax ID of the provider if the Billing Provider Primary Identifier is not provided. If the tax ID is not provided, then the element will be populated with“999999999””.

Professional: Pay-To-Provider (2010AB)

Occasionally, we will receive electronic claims with Pay-To Provider information but no Provider name and/or Provider ID for this, which is required under HIPAA. If these fields are blank, HealthLink will populate the data as listed in section 3.1 Loop 2010AB

Professional: Subscriber Name (2010BA)

Occasionally, we will receive electronic claims with Subscriber information but no Subscriber name and/or Subscriber ID for this, which is required under HIPAA (see Section **Error! Reference source not found. Error! Reference source not found.** in this guide for more information). If these fields are blank, HealthLink will populate the data as listed in section 3.1 Loop 2010BA

Professional: Payor Name (2010 BB)

Occasionally, we will receive electronic claims with Payor information but no Payor name and/or Payor ID for this, which is required under HIPAA. If these fields are blank, HealthLink will populate the data as listed in section 3.1 Loop 2010 BB

Professional: Supervising Provider (2310 E)

Occasionally, we will receive electronic claims with Supervising Provider information but no Provider name and/or Provider ID for this physician, which is required under HIPAA. If these fields are blank, HealthLink will populate the data as listed in section 3.1 Loop 2310 E

Professional: Billing Provider Communication Number)2010 AA)

Per CMS HIPAA guidance, telephone numbers should consist only of ten numeric digits. Dashes and parenthesis marks are invalid characters. If this field has invalid characters, HealthLink will populate the data as listed in section 3.1 Loop 2010 AA

Professional: Provider Signature on file and Assignments

If these fields are blank, HealthLink will populate the following data in the data elements listed. See section 3.1 Loop 2300

Professional: Claim Frequency Code (Original and Adjustments)

If the claim is original to HealthLink, CLM05-3 in the 2300 loop will be populated with “1” (“Original claim”). If this is an adjustment to a claim previously processed by HealthLink, CLM05-3 will be populated with “7” (“Replacement claim”). See section 3.1 Loop 2300

Professional: Patient Signature Source Code

If CLM09 (Release of Information Code) does not equal “N”, this code is required. If CLM10 is blank, HealthLink will populate the data as listed in section 3.1 Loop 2300

Professional: Related Causes Code

If an Accident Date is provided on the claim the assumption is that the condition being reported is Accident or Employment related. In these cases a Related-Causes Code is required in the 837. If this field is blank, HealthLink will populate the data as listed in section 3.1 Loop 2300

Professional: Accident Date

If an Accident indicator is provided on the claim the assumption is that the condition being reported is Accident or Employment related. In these cases an Accident Date is required in the 837. If this field is blank, HealthLink will populate the data as listed in section 3.1 Loop 2300

Professional: Admission/Discharge Date

If an admission date is present on the claim, the discharge date is required. If the discharge date is present on the claim, the admission date is required in the 837. If one of these dates is blank or invalid, HealthLink will populate the data as listed in section 3.1 Loop 2300

Professional: Onset of Current Symptom, Illness

If the claim indicates there was a related illness or symptoms but does not have a valid date, HealthLink will populate the data as listed in section 3.1 Loop 2300

Professional: Referring/Ordering Physician Information

Occasionally, we will receive claims with Referring/Ordering Physician information but no Provider name and/or Provider ID for this physician, which is required under HIPAA. If these fields are blank, HealthLink will populate the data as listed in section 3.1 2310A/2420E/ 2420F

NOTE: In NM109, HealthLink will populate the tax ID of the provider if the Provider Number is not provided. If the tax ID is not provided, then the element will be populated with “999999999”.

Professional: Purchased Service Provider Name

Occasionally, we will receive electronic claims with Purchased Service Provider information but no Provider name and/or Provider ID for this physician, which is required under HIPAA. If these fields are blank, HealthLink will populate the data as listed in section 3.1 Loop 2420B

Professional: Other Insurance Information

If the claim contains other insurance information or indicates there is other coverage, then additional other insurance coverage information is required. Additionally, Other Subscriber Demographic information that is required may not be present. If the other insurance coverage information fields are blank, HealthLink will populate the data as listed in section 3.1 Loop 2320/2330A/2330B.

* “A” means the appropriate release of Information on File at Health Care Service Provider or a Utilization Review Organization.

Professional: Rendering Provider Code Qualifier and ID

Occasionally, we will receive electronic claims with “Rendering Provider” information but no Provider ID Number for this physician, which is required under HIPAA. If no Rendering Provider information is supplied, HealthLink will not populate this loop. If the provider number or qualifier is blank, HealthLink will populate the data as listed in section 3.1 Loop 2310B/ 2420A

Institutional: Claims 837I (UB04s) Messages

In the 837I, the File Information (“K3”) segment occurs only at the claim level. Therefore, the pricing messages will be available at the Claim Level, Loop 2300.

Institutional: Subscriber Group Number and Group Name

In the 2000B loop, SBR04 (Group Name) is used only if SBR03 (Group Number) is blank. HealthLink will send the payor’s group number in SBR03 when available and leave SBR04 blank. See section 3.2 Loop 2000B

Institutional: Billing Provider (2010 AA)

Occasionally, we will receive electronic claims with Billing Provider information, but no Provider name and/or Provider ID for this, which is required under HIPAA. If these fields are blank, HealthLink will populate the data as listed in section 3.2 Loop 2010AA

Institutional: Pay-to-Provider

Occasionally, we will receive electronic claims with Pay-To Provider information, but no Provider name and/or Provider ID for this, which is required under HIPAA. If these fields are blank, HealthLink will populate the data as listed in section 3.2 Loop 2010AB

Institutional: Subscriber Name

Occasionally, we will receive electronic claims with Subscriber information, but no Subscriber name and/or Subscriber ID for this, which is required under HIPAA. If these fields are blank, HealthLink will populate the data as listed in section 3.2 Loop 2010BA

Institutional: Related Causes Code

If an Accident Date is provided on the claim the assumption is that the condition being reported is Accident or Employment related. In these cases a Related-Causes Code is required in the 837. If this field is blank, HealthLink will populate the data as listed in section 3.2 Loop 2300

Institutional: Attending Physician Name (2310 A)

Occasionally, we will receive electronic claims with Attending Physician information, but no Provider name and/or Provider ID for this physician, which is required under HIPAA. If these fields are blank, HealthLink will populate the data as listed in section 3.2 Loop 2310 A

Institutional: Operating Physician Name (2310 B)

Occasionally, we will receive electronic claims with Operating Physician information, but no Provider name and/or Provider ID for this physician, which is required under HIPAA. If these fields are blank, HealthLink will populate the data as listed in section 3.2 Loop 2310 B

Institutional: Other Operating Physician Name (2310C)

Occasionally, we will receive electronic claims with Other Physician information, but no Provider name, Provider Type, ID, and/or taxonomy code for this physician, which is required under HIPAA. If these fields are blank, HealthLink will populate the data as listed in section 3.2 Loop 2310C

Institutional: Other Insurance Coverage Information

If the claim contains other insurance information or indicates there is other coverage, then additional other insurance coverage information is required. Additionally, Other Subscriber Demographic information that is required may not be present. If the other insurance coverage information fields are blank, HealthLink will populate the data as listed in section 3.2 Loop 2320/2330A

Institutional: Revenue Codes

Occasionally, HealthLink will receive claims with a 3-digit revenue code. In these cases, HealthLink will convert these to the required 4-digit revenue code in SV201. See section 3.2 Loop 2400

Healthlink's Document Control Number

HealthLink assigns a unique Document Control Number ("DCN") (11 digits) to each claim that it processes. The DCN assigned to the claim has a structure described below, which uses the DCN "E1804021010" as an example:

Character Position	Value	Description
1	'E'	The claim batchers assigned designator. If this value is equal to 'E' then the claim was received electronically; any other letter indicates that the claim was received on paper and scanned into the HealthLink system.
2-3	'18'	The number of batches that claim batcher has batched for that day; this is the 18th batch created for 'E'. This is an alpha/numeric field.
4-5	'04'	The year the claim was received; this was batched in 2004
6-8	'021'	The Julian date that the claim was received; this was batched on January 21.
9-10	'01'	The exact number of the claim within the batch; this is the first claim in the batch.

Character Position	Value	Description
11	'0'	The last position designates if the claim has been adjusted and if so, which iteration it is. '0' designates the claim as the original claim, '1' would mean that it is the first adjustment, etc. The values for this position are '0-9' and 'A-Z'

Pricing Methodologies

HealthLink utilizes several pricing methodologies. The table below shows the HIPAA codes that HealthLink uses and a description for each provider reimbursement method.

Value in HCP01	Description	Use
00	Zero Pricing (Not Covered Under Contract)	For non-participating provider claims priced as billed
01	Priced as Billed at 100%	For participating* providers at 100%; also for billed less than contract rate
02	Priced at the Standard Fee Schedule	Priced using fee schedules for participating* providers
03	Priced at a Contractual Percentage	Priced using percent discount for participating* providers
04	Code Bundling	Indicates Changes from Code Review (1500 Claim Types Only)
06	Per Diem Pricing	Per diem pricing for participating* providers
07	Flat Rate Pricing	Fixed/flat Case rate pricing (cardiac DRG, ASC surgical rate pricing, etc.) for participating* providers
08	Combination Pricing	Used for claim level pricing methodology when line items priced using different methodologies, such as per diem plus an implant at percent discount
10	Other Pricing	Manual pricing for participating* providers and repricing at % of HIAA as specified by the payor for non-participating providers. **
14	Adjustment Pricing	Change from original claim or original repriced amount

* LOA =Participating providers and providers not yet credentialed, but contracted in the interim on a "letter of agreement".
** Some Self-Funded Self-Administered groups request HealthLink to reprice non-participating provider claims at a percentage of HIAA.

HealthLink populates the HCP segment at both the claim level (Loop 2300) and the line item level (Loop 2400) for both professional claims and institutional claims.

Coordination of Benefits

HealthLink will receive Coordination of Benefits (COB) information on the claims received. We will pass on to the payors all COB information received in the appropriate COB data segments in the 837.

These are the specific 837 loops that contain Coordination of Benefits (COB) information.

Loop 2320.
Loop 2330.
Loop 2430

Non-Standard Claims Converted to Standard Claims

Identifying Electronic vs. Paper Claims
If the HealthLink Document Control Number (DCN) begins with an “E”, HealthLink received the claim electronically from a provider. If the HealthLink DCN starts with any other character, the claim was received on paper (or manually). Professional and institutional claims which can be scanned and via imaging made into an electronic claim are handled in this manner, so that payors can receive the majority of claims electronically.

HealthLink scans and uses OCR for both professional and institutional claims types, by the use of a front-end scanning-EDI vendor.

Paper Claims (Manual Claims)
HealthLink will continue to receive paper (manual) claim submissions from providers. In order to submit as many HIPAA compliant electronic claim transactions as possible, HealthLink will make every effort possible to convert the paper (manual) claims into a HIPAA compliant claim for transmission to payors.

Paper (manual) claims typically don’t have all of the necessary data elements present to be converted into a HIPAA compliant 837 claim. However, a number of these claims have enough “essential” data elements that, if combined with default populated “UNKNOWN” data, can be converted into a HIPAA complaint transaction. By doing this, HealthLink can provide a much higher level of HIPAA compliant transactions to payors.

Under certain circumstances, claims cannot be translated without affecting the validity of the claims. In these instances, HealthLink will not convert the claims into the 837 format. Examples include (but are not limited to) for professional claim types:

If Box 11D (is there another health benefit plan?) = “yes” and/or if Box 9 is populated
If Box 15 (If patient has had same or similar illness) is populated
If Box 16 (Dates Patient Unable to Work in Current Occupation) is populated
If Box 18 (Hospitalization Dates Related to Current Services) is populated
If Box 20 (Outside Lab) is populated
If Box 22 (Medicaid Resubmission Code) is populated

Non-Standard Electronic Claims
Per CMS HIPAA guidance, HealthLink continues to accept non-standard electronic claims from providers. A number of the required data elements on the 837 are not required in the proprietary formats that we receive from providers. Therefore, HIPAA required data might be missing from some claims. Again, by populating default “UNKNOWN” data, these can be converted into HIPAA compliant transactions.

The sections 3.1 and 3.2 describe the various data elements that are required in the 837 but may not appear on either the paper (manual) claims or non-standard electronic claims received by HealthLink. Each section has a table indicating the ANSI data element, description, and what values HealthLink will default, if no value was received.

4.3 Frequently Asked Questions

What is HealthLink's policy regarding 997s?

Acknowledgement Files (997s)
HealthLink strongly encourages Trading Partners to send HealthLink fully populated 997s for all received 837 transactions. The only naming convention requirement is the file should contain the text "997" within the file name. Acknowledgements will help ensure that the receiving party has accepted the claim files sent by HealthLink.

For any non-standard acknowledgement files, HealthLink requests the trading partner to email these files to the Help Desk
(edi-ops@HealthLink.com).

HealthLink has developed a routine, daily file status process whereby payors are notified by phone in the event their claims files are not "picked up" timely. HealthLink will work with payors on problem files or rejected files as needed.

What is HealthLink NPI strategy?

HealthLink EDI Strategy for NPI

NPI Background

In January 2004, HIPAA Administrative Simplification provisions established the rule requiring creation of a unique national provider identifier (NPI). This rule also establishes a National Provider System (NPS) to assign, maintain and disseminate NPIs.

HealthLink has adopted the use of NPI to identify providers as of 01/26/2008.

What is HealthLink 5010 implementation strategy?

HealthLink 4010/5010 Implementation Strategy

Beginning January 1, 2011, HealthLink will be able to support version 5010 transactions.

From January 1, 2011 through December 31, 2011, HealthLink will continue to support both versions 4010A1 and 5010.
Effective January 1, 2012, HealthLink will only support version 5010 transactions.

In order to implement 5010 transactions, a trading partner testing cycle will be defined and executed for each transaction to be sent and received.

Does HealthLink use a compliance Tool?

Compliance Tool

HealthLink uses the "HIPAA Toolkit" from Sybase as a self-certification tool for EDI transactions. Edifecs is used as a testing tool for outbound claims transactions for payors.

What does HealthLink require from Providers for submitting electronic claims?

Claim Submissions from Providers

HealthLink requires that providers who wish to submit electronic claims to HealthLink do so via a clearinghouse. HealthLink currently receives claims directly from Emdeon, the SSI Group, Relay Health and Gateway EDI. Providers may utilize any clearinghouse they wish, but HealthLink ultimately receives the claims from these three designated clearinghouses.

How may Payors receive their electronic claims from HealthLink?

Claims Submissions to Payors from HealthLink

Payors may receive their electronic claims from HealthLink in several ways. Payors may receive claims from the Emdeon, Interactive Payor Network (“IPN”), Interactive Planet, or Trizetto clearinghouses, which are our most popular connection types. HealthLink also supports a direct connection, where the payor receives repriced claims via FTP processes with encryption to protect PHI. This direct connection functionality is used primarily for largest volume trading partners.

How does HealthLink prefer to receive their eligibility from Payor’s?

Electronic Claims and Eligibility

HealthLink requires that payors wishing to receive electronic repriced claims submit electronic eligibility to HealthLink. The purpose of this is to ensure proper routing of claims as well as maintain a high level of automated repricing, thereby decreasing the amount of time it takes to get the claim repriced by HealthLink and forwarded to the payor of record. HealthLink uses eligibility to route claims to correct payors.

Will HealthLink accept PO or Lock Box addresses for a Billing Provider?

The HIPAA 5010 Implementation Guides prohibit a PO Box or Lock Box address for a Billing Provider. However, they may be used in the Pay-to address segments.

Will HealthLink continue to accept diagnosis Present on Admission (POA) indicators in REF segments that the industry used with HIPAA 4010 claims?

The HIPAA 5010 Implementation Guide provides for diagnosis POA indicators in relevant Heath Insurance (HI) segments. Please refer to the Institutional 837 HIPAA 5010 IG for additional information and usage under ‘HI-Principal Diagnosis’, ’HI-External Cause of Injury’ and ‘HI-Other Diagnosis Information’.

Which type of claim should Providers use for Anesthesia claims?

The Professional 837 HIPAA 5010 Implementation Guide provides for surgical services to be billed using a Health Insurance (HI) segment. Please refer to the HIPAA 5010 IG for additional information and usage under ‘HI-Anesthesia Related Procedure’.

4.4 Other Resources

5010 Technical Reports Type 3

A copy of the 5010 Technical reports Type 3 (Formerly known as Implementation guides) can be purchased at Washington Publishing website given below. The “5010 Technical Reports” can be found under “EDI Publications”.

http://www.wpc-edi.com/

http://www.wpc-edi.com/content/view/817/1

Latest Code Lists

The lists are maintained by the Centers for Medicare and Medicaid Services (CMS), The National Uniform Claim Committee (NUCC), and committees that meet during trimester X12 meetings. A listing of the latest codes can also be found on Washington Publishing website given below.

http://www.wpc-edi.com/

http://www.wpc-edi.com/content/view/711/401/

5010 and ICD-10 Final Rule

On January 16, 2009, HHS published two final rules to adopt updated HIPAA standards; these rules are available at the Federal Register. In one rule, HHS is adopting X12 Version 5010 and NCPDP Version D.0 for HIPAA transactions. In the second final rule, HHS modifies the standard medical data code sets for coding diagnoses and inpatient hospital procedures by concurrently adopting the ICD-10-CM for diagnosis coding and the ICD-10-PCS) for inpatient hospital procedure coding.

The Final rules can be found on the CMS website www.cms.gov under “Regulations and Guidance” and navigating to “Transaction and Code Sets Standards or by going directly to the Federal Register.

https://www.cms.gov/TransactionCodeSetsStands/02_TransactionsandCodeSetsRegulations.asp

Federal Register Links:
http://edocket.access.gpo.gov/2009/pdf/E9-740.pdf
http://edocket.access.gpo.gov/2009/pdf/E9-743.pdf

Appendix A Repricing Organization Identifiers and Descriptions

Value	EOB Remark from Payor
900010001	Healthlink PPO/Open Access
900010003	Not Used
900010004	WC “Premier Network”
900010005	Not Used
900010006	Freedom Network
900010007	Freedom Network Select
900010008	Healthlink HMO Or Healthlink Open Access (Used At Payor Discretion)
900010009	Not Used
900010010	First Health Wrap
900010011	Health Partners – Kansas (HPK)
900010012	Accountable Health Plans (Superien**)
900010013	Alliance PPO (Superien**)
900010014	American Lifecare (Superien**)
900010016	Associates For Health Care (Superien**)
900010017	Directcare America (Superien**)
900010018	Encore Health Network (Superien**)
900010019	First Choice Of The Midwest (Superien**)
900010020	Health Care Value Mgmt (Superien**)
900010021	Health Choice-AL (Superien**)
900010022	Health Management Network (Arizona Medical Network) (Health Management Network) (Rural Arizona Medical Network) (Superien**)
900010023	Idaho Physicians Network (Superien**)
900010024	Intergroup (Superien**)
900010025	Interplan (Superien**)
900010026	Interwest Health (Superien**)
900010027	Magnacare (Superien**)
900010028	Mountain Medical Affiliates (Superien**)
900010029	Northwest One (Superien**)
900010030	Preferred Community Choice Of Oklahoma (Superien**)
900010031	Not Used
900010032	The Preferred Plan Inc. (Superien**)
900010033	Premier Health Systems (Superien**)
900010034	Providence Preferred (Superien**)
900010035	Southcare (Superien**)
900010036	Tennessee Healthcare Network (Superien**)
900010037	Virginia Health Network (VHN) (Superien**)
900010038	Carilion Health Plans* (Superien**)
900010039	Guthrie Health Systems*(Superien**)
900010040	Northern Alabama Managed Care, Inc.* (Superien**)
900010041	CHP (Informed)
900010042	Not Used
900010043	Competitive Health Plan
900010044	Fortified Provider Network
900010045	Health Coalition Partners

Value	EOB Remark from Payor
900010046	Healthcare Part E Texas
900010047	Health Payors Organization
900010048	HPO Select
900010049	Integrated Health Plan
900010050	Managed Healthcare NW
900010051	Midwest Med Preferred
900010052	Not Used
900010053	Preferred Health Partnership
900010054	Pacific Health Alliance
900010055	Preferred Health Plan
900010056	Primary Health Services
900010057	Not Used
900010058	Devon Health Network
900010153	Payor Specific – Epoch-St. John's Mercy
900010154	Map Alliance PPO/Mapsi (Superien)
900010155	HCD Healthcare Direct (Superien)
900010156	PPO Proplus (Superien)
900010157	PRH IHP/Prime Health (HPO)
900010158	PPOnext
900010159	Coalition America
900010160	Galaxy Health Network
900010161	HFN Platinum
900010162	Plan Care America
900010163	Alabama Managed Care
900010164	Multiplan
900010165	PHCS
900010166	Ancillary Care Services
900010181	Payor Specific-CGN-PPO
900010182	Payor Specific-CGN-OA
900010183	Occupational Health Management (WC Only) (New 3/15/06)
900010184	Tri-State Health Care Coalition (Quincy, Il) (New 3/15/06)
900010185	Preferred Health Professionals
900010186	Healthchoice Provider (WC Only)
900010187	Dentemax
900010188	Fortified Preferred
900010189	Work Comp Indiana Anthem
900010190	Unicare Network
900010191	Health Alliance (Hamp)
900010193	HFN20
900010194	LRHS
900010195	First Health
900010197	Workers Comp Multi Plan
900010198	Work Comp His
900010199	HFN For Comp Mgmt
900010201	Stratose
900010328	Healthlink Choice Network
900010329	Springfield Clinic Domestic
900010330	Connected Care

Value	EOB Remark from Payor
900010331	HFN CHC ELITE
900010332	Advocate For SEIU
900010333	Midlands Choice Network
900010334	Multiplan IHP Work Comp
900010335	Multiplan Healtheos Work Comp
900010338	Work Comp Kentucky Anthem
900010339	Chiropractors Access for SSM
900010340	Mercy EPO
900010341	MEM Belleville Tier 1
900010342	Unicare Network
900010343	Union Health Service
900010344	Union Medical Center
900010345	Swedish American
900010346	Dignity
900010347	Stanford
900010348	Dignity Cigna
900010349	Stanford Cigna
900010350	HSHS
900010351	MMH
900010352	MMH2
900010353	MMH3
900010354	SMH2
900010355	NueHealth Missouri
900010356	Provider's Care Network
900010357	True Blue PPO
900010358	Unity Pointe Plus
900010359	HFN CHC
900010360	Southern Il Healthcare Fndn
900010361	Southeast Health Domestic
900010362	Missouri Custom Network
900010363	SNW
900010366	COX
900010368	Community Counseling Mercy
900010369	Community Counseling Southeast
End of Repricing Organization Identifiers	

Appendix B National Care Networks (NCN) Identifiers and Descriptions

NCN Identifier	EOB Remark from Payor
900010059	Adjustment taken through National Care Network – 800-499-9708
900010060	Adjustment taken through National Care Network – 800-499-9708
900010061	Adjustment taken through National Care Network – 800-499-9708
900010062	Recommendation made by NCN Data iSight. www.dataisight.com or 1-800-499-9708
900010064	Discount taken through American PPO, (800) 499-9708
900010065	Multiplan (800-499-9708)
900010124	Three Rivers Provider Network (800-499-9708)
900010125	Three Rivers Provider Network Dir. (TRPN) (800-499-9708)
900010141	Three Rivers Provider Network (TRPN) – MCS (800-499-9708)
900010148	Adjustment taken through Health Coalition Partners
900010149	Adjustment taken through Health Coalition Partners/HPO
900010150	Claim was processed according to contracted rate with Arizona Medical Network
900010151	Claim was processed according to contracted rate with Rural Arizona Network
900010152	Claim was processed according to contracted rate with Health Management Network
900010300	Integrated Health Plan, Inc (IHP) (800-499-9708)
900010301	Integrated Health Plan, Inc (HPO) (800-499-9708)
900010302	Integrated Health Plan, Inc (Formost) (800-499-9708)
900010303	Integrated Health Plan Inc. (CHP) (800-499-9708)
900010304	Integrated Health Plan, Inc (PHS) (800-499-9708)
900010305	Integrated Health Plan, Inc (NHP) (800-499-9708)
900010306	Integrated Health Plan, Inc (PHP) (800-499-9708)
900010307	Integrated Health Plan, Inc (PHA) (800-499-9708)
900010308	Integrated Health Plan, Inc (MHN) (800-499-9708)
900010309	Integrated Health Plan, Inc (MMPP) (800-499-9708)
900010310	Integrated Health Plan, Inc (NPN) (800-499-9708)
900010311	Integrated Health Plan, Inc (PSI) (800-499-9708)
900010312	Integrated Health Plan, Inc (OCN) (800-499-9708)
900010313	Integrated Health Plan, Inc (Envisioncare) (800-499-9708)
900010314	Integrated Health Plan, Inc (SHDC) (800-499-9708)
900010315	Integrated Health Plan, Inc (PAC) (800-499-9708)
900010316	Integrated Health Plan, Inc (PHN) (800-499-9708)
900010317	Integrated Health Plan, Inc (PTN) (800-499-9708)
900010318	NCN CCH Core Choice
900010319	NCN Novanet INC
900010320	NCN PMCS Preferred Med
900010321	NCN HDA Hospital Anal

NCN Identifier	EOB Remark from Payor
900010322	NCN Network
900010323	NCN Negotiation
900010324	NCN IHP/EHS
900010325	Beechstreet (Superien**)
900010327	IHP/HFN Adjustment Taken
End of Special NCN Identifiers	

Note: NCN Identifiers no longer used: 900010063, 900010066 - 900010123, 900010126 - 900010140 and 900010142 – 900010147.

Appendix C Repricing Messages and Descriptions

Error code	Description
029	Member inactive on svc date.
031	Group not active on svc date.
036	Allowance for these charges is included in the hospital's per diem rate.
037	Duplicate claim submission!!! Please advise provider of payment or denial status asap.
113	Services not authorized; notified by claim.
114	Not subject to ambulatory review.
116	Services authorized; unable to print cert number.
137	Duplicate claim submission!!! Please advise provider of payment or denial status asap.
197	Professional fee associated with non-reviewed or non-certified services.
288	Maternity length of stay within HealthLink guidelines
337	Charges previously considered under workers compensation.
513	Services included in global.
521	Maximum allowable met or exceeded.
615	CPT code incidental to primary procedure
623	Asst surgeon must bill asst surgeon fee.
624	No allowance for asst surgeon on this procedure.
630	CPT code has been excluded in accordance with CPT guidelines.
632	CPT code has been replaced in accordance with CPT guidelines.
633	CPT has been added by code review.
638	Member cannot be identified as participating with HealthLink.
654	Multiple surgical reductions have been applied.
709	Charges not covered due to contract provisions.
749	Pre/post natal care s/b billed with delivery chrgs.
856	Newborn reimbursement included in obstetric per diem
880	Catastrophic case limit pricing
884	The allowed amount is the lesser of billed charges or the negotiated rate.
886	Automated lab; professional component included in global allowance.
930	CPT code excluded by code review.
932	CPT code replaced by code review.
933	CPT code added by code review.
955	Charges reduced to established ucr on out of network.
992	Packaged surgical procedures include operation and uncomplicated post-op care.
995	Procedure code has been terminated.

5 TI Change Summary

List of Current Changes

Change Number	Change Date	SR/Project Number	Originator	Description
Change 1 (V1.0)	01/01/2011		HealthLink EDI	The 5010 837 guide has been changed to conform to the WEDI Standard Companion Guide template.
Change 2 (V1.1)	03/18/2022		HealthLink EDI	900010368 MULTIPLAN NEW NPAR PRODUCT QBP was added to appendix of repricing organizations.
Change 3 (V1.2)	07/07/2022		HealthLink EDI	900010366 added to appendix of repricing organizations.
Change 4 (V1.3)	02/10/2023		HealthLink EDI	• 900010194 Remark changed to LRHS. • 900010368 Remark changed to Community Counseling Mercy • 900010369 Remark changed to Community Counseling Southeast.

6 Communication / Connectivity Instructions

HealthLink 5010 Support

HealthLink's 5010 support line may be reached via email or phone at (314)-925-6004 or HL_5010@HealthLink.com.

EDI Support

Please contact:

- HealthLink's Information Technology Help Desk at (314) 925-6123 (all clients), or edi-ops@HealthLink.com.
- Payor Relations at (877) 284-0101, ext 6132 (for payors), or PayorRelations@HealthLink.com, or the specific account manager's email address.
- Client Services at (314) 925-6123 (for self-funded, self-administered clients).

Transmission Methods

HealthLink supports the FTP data communication method for exchanging Electronic Claims with its Trading Partners. Trading Partners can use FTP to connect to HealthLink's FTP server over the Internet to pull their claim transactions from their mailbox.

Alternatively, HealthLink can "push" transactions to trading partners via FTP. HealthLink requires the use of PGP encryption software.