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A CELERIAN GROUP COMPANY

TRICARE

HIPAA Transaction
Standard Companion Guide

ASC X12N 837 (005010X223A2)
Health Care Claim Institutional

June 2017

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Introduction

This document is the property of PGBA, LLC and is for the use solely in your capacity as Trading Partner of health care transactions with PGBA, LLC.

This document provides information related to specific elements within the ASC X12/005010X222A1 Health care Claim (837) implementation guide. Also referred to as HIPAA Implementation Guide, 005010X222A1 or ASC X12 TR3, interchangeably, throughout this guide. It does not change the definition, data conditions, or use of the data elements or segments in a standard, nor does it add data elements or segments to the maximum defined data set. It will not 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), or change the meaning or intent of the HIPAA standards implementation specifications. (Refer to Standards for Electronic Transactions, *Federal Register, Vol. 75, No. 197, October 13, 2010*].

This document is intended solely for use as a companion to the Health Insurance Portability and Accountability Act (HIPAA) mandated ASC X12 TR3 Implementation Guides for the 837 professional transaction set. Specific payer instructions contained in this document are provided for clarification purposes only. This document should be used in conjunction with the applicable ASC X12 TR3s available at http://store.X12.org, companion documents, physician's manuals, and/or other billing guidelines published by our clearinghouse payers.

The Final Rule adopting updated versions of the standards for electronic transactions was published in the Federal Register on October 13, 2010. The URL Link to the Federal Register is: http://www.access.gpo.gov. This final rule also adopts a transaction standard for Medicaid pharmacy subrogation. In addition, this final rule adopts two standards for billing retail pharmacy supplies and professional services, and clarifies who the "senders" and "receivers" are in the descriptions of certain transactions. The updated versions are available and can be downloaded through http://store.X12.org.

This document is incorporated by reference in the Trading Partner Agreement. All instructions were written as known at the time of publication and are subject to change. Changes will be communicated on the TRICARE web site: www.myTRICARE.com.

Appropriate steps must be taken before submitting production ASC X12 transactions, such as testing, completion of an EDIG Trading Partner Agreement validation and demographic confirmation with our customer support staff. To begin the process, receive more information or ask questions, please contact the EDI Help Desk at 1-800-325-5920 (Menu Option 2).

837 Health Care Claim (005010X223A2) – Reporting Instruction Clarifications

Overview

The Health Insurance Portability and Accountability Act (HIPAA) requires that all health insurance payers in the United States comply with the EDI technology standards for health care as established by the Secretary of Health and Human Services for Administrative Simplification. The use of standard transactions and code sets will improve Federal and Private health care programs, and the effectiveness and efficiency of the health care industry. The 837 transaction set 005010X223A2 has been selected as the format to meet HIPAA requirements for the electronic submission of Institutional health care claims.

- ✓ PGBA may edit data submitted beyond the requirement defined in the HIPAA Implementation Guide.
- ✓ PGBA may reject interchanges, functional groups or segments that do not follow ASC X12 TR3 guides and PGBA Companion Document requirements
- ✓ PGBA may reject an interchange that is submitted with a submitter identification number that is not authorized for electronic submission.

Trading partners should note that if the information associated with any of the claims on the 837 ST-SE envelope is not correctly formatted from a syntactical perspective, that all claims between the ST-SE envelope would be rejected. Providers and submitters should consider this possible response when determining the size of their transactions.

Character Set Requirement

The following character set guidelines must be followed to avoid file rejections. X12 transactions sent to PGBA should not include control characters, examples such as line feed or carriage control.

****IMPORTANT BULLETINS****

NPI and Location

There may be gaps between your enumeration strategy compared to PGBA's internal legacy identifiers. To ensure correct one (NPI) to many (legacy ID) crosswalks, verify the addresses that PGBA, LLC has on file for each location and specialty (taxonomy) by becoming a member of www.myTRICARE.com, or contacting customer service. Once you have verified that the service address you will submit on a claim matches an address on PGBA's provider files, follow these guidelines: For UB04, only send post office boxes in FL2 (2010AB). FL1 should be used for physical address where services were rendered and map to the 2010AA loop in the HIPAA EMC format. Loop 2310E can be used to send a physical address only when physical address not provided in 2010AA. When loop 2310E is sent, an NPI is required in NM109.

POA Indicator

For institutional claims that are exempt from present on admission (POA) reporting, do not send HI01-9.

Duplicate Claims

The 'DUP' edit effective for claims filed after April 1, 2011. – This claim is a duplicate submission of a claim that processed within the last 120 days. If changes need to be made to the previously processed claim, please resubmit as a corrected claim. If you are attempting to obtain claim status, submit a 276 Claim Status transaction. Claim status can also be verified at www.myTRICARE.com.

Institutional 837 Interchange Envelope and Functional Group Structure

Trading partners should follow the Interchange Control Structure (ICS), Functional Group Structure (GS), Interchange and Functional Acknowledgement guidelines set forth in the EDI Gateway Technical User manual found in the HIPAA Critical Center on www.southcarolinablues.com.

Data Clarification Table Error Code Description

Code	Error Description
CN1	CN104-127 REFERENCE ID REQUIRED
OB1	CLM OR ENCOUNTER ID MUST BE CH - CHARGEABLE
OCC	TOTAL CLAIM CHARGES MUST BE < $10,000,000.00
OC1	TOT CHARG AT THE LINE MUST BE LESS THAN $100,000
OL2	LX01-554 ASSIGNED NUMBER < 1,000
ON1	ENTITY TYPE QUAL FOR SUBSC NAME MUST = 1
ON2	ID CODE QUALIFIER SUBSC NAME MUST = MI
OP2	INDIVIDUAL RELSHP MUST BE VALID
OS5	ONLY 2 REPEATS OF OTHER SUBSC INFO ALLOWED
T05	CONTRACT INFO. NEEDED | CUR SEGMENT REQUIRED
T06	CLAIM ORIGINAL REF NUMBER NOT F8
T07	2300-180-REF02-127 CLAIM NUMBER IS INVALID – MUST BE 13 CHARACTERS OF FORMAT 9999XXXXX9999
T08	MONETARY AMT NOT PRESENT
T12	PRINCIPAL QUALIFIER NOT 'BK'
T13	PRINCIPAL QUALIFIER NOT 'BR'
T15	REF-ID-QUAL NOT | ATTEND-PHYS-2ND-ID = ' '
T17	NM108 IDENTIFICATION CODE QUALIFIER NOT PI

Code	Error Description
T19	SBR03 SUBSCRIBER IS EQUAL TO SELF (18)
T20	CLAIM OR ENCOUNTER ID NOT 'CH'
T21	FOREIGN CURRENCY NOT = 'USD'
T22	NM108 IDENTIFICATION QUAL INCORRECT
T25	BILLING PROVIDER 2ND-ID IS INVALID
T26	NM109 SUBSCRIBER PRIMARY ID NOT NUMERIC
T27	SBR SEGMENT REQUIRED
T29	PRODUCT | SERVICE ID QUALIFIER NOT HC OR HP
T30	ADMITTING CODE NOT 'BJ'
T31	MORE THAN 3 OCCURRENCES OF THE OTHER SUBSRIBER COB INFO
T32	2310B REF01 MUST EQUAL G2
T33	2320/SBR09 MUST NOT EQUAL MB, 2320/AMT01 MUST EQUAL D
T34	PRODUCT|SERVICE ID QUALIFIER NOT HC
60Y	FREQUENCY CODE IS INVALID

Data Clarification Table for the Institutional 837 Health Care Claim (005010X223A2) Transaction Set

Error Code	Loop ID	Reference	Notes/Comments	Industry/Element Name	Page #
T20	N/A	BHT06	**All Files** – Must equal **CH (Chargeable).** The claim or encounter identifier code specifies the type of transaction. It is used to indicate the type of billed service.	Claim or Encounter Identifier Transaction Type Code	59
	1000A	NM109	PGBA, LLC requires this field to be your **Trading Partner Identification Number**	Identification Code Submitter Identifier	63
	1000B	NM103	PGBA, LLC requires this field to be **TRICARE**	Receiver Name Name Last or Organization Name	68
	1000B	NM109	PGBA, LLC requires this field to be **571132733**	Identification Code Receiver Primary Identifier	68
T21	2000A	CUR02	Do not send.	Currency Code	74
T25	2010BB	REF02	**Required when NM109 in Loop 2010AA is not used.** Use 'G2' in REF01 and REF02 is the 'TRICARE provider number'.	Billing Provider Secondary Identification	129
ON1	2010BA	NM102	Code qualifying the type of entity. All payers must use: **1 Person**	Entity Type Qualifier	113
ON2	2010BA	NM108	This field is required if NM102 equals 1 (Person). Must use: **MI Member Identification Number** This is the subscriber's identification number.	Identification Code Qualifier	113-114

Error Code	Loop ID	Reference	Notes/Comments	Industry/Element Name	Page #
T26	2010BA	NM109	If NM102 equals 1 (Person) then this field is required. PGBA, LLC requires this field to be the **Subscriber's 9 digit Social Security Number (SSN) or 11 digit DOD Benefits Number (DBN).**	Subscriber Primary Identifier Identification Code	114
T17	2010BB	NM108	Must equal: **PI Payor Identification**	Identification Code Qualifier	100
	2010BB	NM109	PGBA, LLC this field should be **38520.**	Payer Identifier Identification Code	100
OCC	2300	CLM02	Must not be greater than 9,999,999.99.	Total Claim Charge Amount	145
60Y	2300	CLM05 - 3	PGBA, LLC will recognize the following Frequency Types: **Valid HIPAA codes between 0 – 9, G, I, J, and M.** *Note: Facility code and frequency must be consistent.*	Claim Frequency Type Code	145
CN1	2300	CN104	This field must be present when CN101 in Loop 2300, data element 1166 (Contract Type Code) equals 09 (Other). Reference ID = MTF ID	Contract Code Reference Identification	159
T06/ T07	2300	REF02	This field will be the Original Claim Number (13 characters) if CLM05 – 3 in Loop 2300, data element 1325 (Claim Frequency Type Code) equals 7 (Corrected).	Payer Claim Control Number	166
T13	2300	HI01 - 1	Must equal **BR (International Classification of Diseases Clinical Modification)**.	Code List Qualifier Code	240

Error Code	Loop ID	Reference	Notes/Comments	Industry/Element Name	Page #
	2320	AMT 01	Must equal **D** **Required:** This segment must be present if in Loop 2000B, SBR01 (Payer Responsibility Sequence Number Code) does not equal P (Primary). COB Primary Payer is identified in Loop 2330B.	Qualifier	364
		AMT 02	Primary Payer amount paid. **Not Present:** This segment must not be present if in Loop 2000B, SBR01 (Payer Responsibility Sequence Number Code) equals P (Primary).	COB Primary payer paid amount.	
	2330B	NM109	If another payer is the Primary Payer, PGBA, LLC requires this field to be the **Other Payer's ID.**	Other Payer Primary Identifier	385
T29	2400	SV202 - 1	All PGBA, LLC claims use the following qualifiers: **HC** Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes. AMA's CPT codes are also level 1 HCPCS and should be reported under HC. **HP** Health Insurance Prospective Payment System (HIPPS) Skilled Nursing Facility Rate Code	Product/Service ID Qualifier	425

Edit / Error Messages

A description of the edits performed on the 837 Institutional claims. It lists error codes, their associated error message, and the type of edit performed. References to loops and segments can be found in the ASC X12 TR3 837 005010X223A2 manual.

Error Code	Edit Description
A53	**BIRTHING CENTER REV CODE-MUST BE OUTPATIENT** If the Service Line Revenue code (2400 | SV201) is '724' then the second digit of the Facility Type Code (2300 | CLM05-1) **must** not be '1'.
BH9	**ADMITTING DIAGNOSIS INVALID OR NOT ENTERED** The admitting diagnosis (2300 | **HI01-2** is invalid.
B02	**INVALID BILL CLASS - OF TYPE BILL** The second digit of the Facility Type Code (2300 | CLM05-1) must equal '1', '2', '3', '4', '5', '6', '7', or '8'.
BT4	**PROC INVALID FOR DOS**
B20	**REVENUE CODE ------- INVALID** Revenue code (2400 | SV201) not valid.
B22	**REVENUE CODE ------- TOTAL CHARGE INVALID** The Service Line Charge Amount (2400 | SV203) must be > zero on each occurrence/line item (excluding revenue codes 0001,0022 and 0023).
B37	**SURGERY PROC REQD WITH SURGERY REVENUE CODE** If the service line revenue code range is '360' thru '369', then the Principal Procedure Code (2300 | HI01-2, 2300 | HI02-2, 2300 | HI03-2, 2300 | HI04-2, 2300 | HI05-2) must be valid code. Only applies to inpatient claims with accommodations revenue code.
B59	**IMBEDDED BLANKS IN SPONSOR NAME** Spaces/blanks in Sponsor's Last Name (2010BA | NM103) or Sponsor's First Name (2010BA | NM104)
B67	**COND CODE-OCC CODE INCONSISTENT - EMP RELATED** If occurrence code (2300 | HI01-2) = '04', then condition code (2300 | HI01-2) must be '02'
B79	**1ST OCC CODE ----- DATE NOT VALID** (2300 | HI01-4)
B80	**2ND OCC CODE ----- DATE NOT VALID** (2300 | HI02-4)
B81	**3RD OCC CODE ----- DATE NOT VALID** (2300 | HI03-4)
B82	**4TH OCC CODE ----- DATE NOT VALID** (2300 | HI04-4)
B83	**5TH OCC CODE ----- DATE NOT VALID** (2300 | HI05-4)
DGQ	**NDC# MUST BE 11 DIGITS** 2410 LIN03 must be 11 digits when LIN02 = N4.

Error Code	Edit Description
DP1	Duplicate of claim submitted same day
DUP	**DUP – Duplicate of a claim paid in last 60 days**
EB6	**S AND R CODE NOT COMPATIBLE W/DIAGNOSIS CODE** Sex code (2010BA | DMG03 or 2010CA | DMG03) or relationship code (2000B | SBR02 OR 2000C | PAT01) are not compatible with gender or age specific diagnosis (2300 | HI).
E05	**INVALID DATE OF BIRTH, ENTER AS CCYYMMDD**
H16	**CHARGE MUST BE GREATER THAN ZERO**
H64	**STATE IS INVALID** A) The Subscriber's State (2010BA/N402) or Patient's state (2010CA/N402) must be a valid state. B) If the Patient or Subscriber's (2010BA/N401, 2010CA/N401) city name is (first four bytes) 'APO' or 'FPO', then state must be one of the following 'AA', 'AC','AE' or 'AP'.
H65	**INVALID SPONSOR ID** The Subscriber's Primary Identifier (2010BA/NM09) must be numeric and less than 12 bytes.
H68	**SUBS/SPON LAST/FIRST NAME MISSING OR INVALID** Subscriber Name (2010BA | NM103 | NM104) must be alphabetic.
H83	**STATE AND ZIP CODE INCONSISTENT** State (2010AA, 2010BA / N402) and Zip Code (2010AA, 2010BA / N403) must be consistent.
HP3	**INVALID HCPCS CODE** (2400 / SV202)
HTC	**INVALID TREATMENT AUTHORIZATION CODE** (2300/REF02 WITH G1 QUALIFIER) For bill types equal to 322,332,327,337,328,329 or 339 that do not have condition code 21, are not for maternity or children under age 18, and the effective From Date of Service of the episode is on or after 01/01/08, the treatment authorization code must have the following format: Positions 1, 2, 5, 6 and 9 must be numeric. Positions 3, 4, 7 and 8 must be alphabetic. Position 10 must contain 1 or 2. Positions 11-18 must be alphabetic.
NB1	**BABY DIAG ON CHILD, NEED TOA=4 & SOA= 5 OR 6** If the Diagnosis code "Industry code" (2300 |HI01-2, HI02-2) or other diagnosis code (2300 | HI01-2, HI01-2, HI02-2, HI03-2, HI04-2, HI05-2, HI06-2, HI07-2, HI08-2, HI10-2, HI11-2, HI12-2) is 'V300' thru 'V399', '7600' thru 7799' and the Admission type code (2300 |Cl101) is '4' then the Admission source code (2300 |Cl102) value must be '5' or '6'.
NP1	**INVALID BILLING PROVIDER** NPI - (2010AA/NM109). Billing NPI missing or invalid. NPI required for this loop and must pass Luhn-10. Must provide NPI if eligible; otherwise submit TRICARE provider number.
NP7	**INVALID SERVICE FACILITY LOCATION ID NPI** - (2310E/NM109). Service facility NPI missing or invalid. NPI required when this loop is sent and must pass Luhn-10.
N04	**DUT'S MUST EQUAL 1** Units must be at least 1 (2400 / SV205)
PST	**2000B/2320 SBR MUST BE P, S OR T**

Error Code	Edit Description
PTD	**DATE OF SERVICE REQUIRED ON ALL LINES** For outpatient claims, the Service line date (2400 |DTP03) must be valid.
QSE	**PRINCIPAL DIAGNOSIS IS NOT VALID** (2300 |HI01-2) BK qualifier.
QSF	**PRINCIPAL DIAGNOSIS CANNOT CONTAIN AN E-CODE** (2300 |HI01-2) BK qualifier
Q69	**1ST DIAGNOSIS IS NOT VALID** (2300 |HI01-2), first occurrence of BF qualifier.
Q70	**2ND DIAGNOSIS IS NOT VALID** (2300 | HI02-2), BF qualifier.
Q71	**3RD DIAGNOSIS IS NOT VALID** (2300 | HI03-2), BF qualifier.
Q72	**4TH DIAGNOSIS IS NOT VALID** (2300 | HI04-2), BF qualifier.
Q73	**5TH DIAGNOSIS IS NOT VALID** (2300 | HI05-2). BF qualifier.
Q74	**6TH DIAGNOSIS IS NOT VALID** (2300 | HI06-2), BF qualifier.
Q75	**7TH DIAGNOSIS IS NOT VALID** (2300 | HI07-2), BF qualifier.
Q76	**8TH DIAGNOSIS IS NOT VALID** (2300 | HI08-2), BF qualifier.
QD9	**9TH DIAGNOSIS IS NOT VALID** (2300 | HI09-2), BF qualifier.
QDA	**10TH DIAGNOSIS IS NOT VALID** (2300 | HI10-2, BF qualifier.
QDB	**11TH DIAGNOSIS IS NOT VALID** (2300 | HI11-2), BF qualifier.
QDC	**12TH DIAGNOSIS IS NOT VALID** (2300 | HI12-2), BF qualifier.
QDD	**13TH DIAGNOSIS IS NOT VALID** (2300 | HI13-2), BF qualifier.
QDE	**14TH DIAGNOSIS IS NOT VALID** (2300 | HI14-2), BF qualifier.
QDF	**15TH DIAGNOSIS IS NOT VALID** (2300 | HI15-2), BF qualifier.
QDG	**16TH DIAGNOSIS IS NOT VALID** (2300 | HI16-2), BF qualifier.
QDH	**17TH DIAGNOSIS IS NOT VALID** (2300 | HI17-2), BF qualifier.
QDI	**18TH DIAGNOSIS IS NOT VALID** (2300 | HI18-2), BF qualifier.
QDJ	**19TH DIAGNOSIS IS NOT VALID** (2300 | HI19-2), BF qualifier.
QDK	**20TH DIAGNOSIS IS NOT VALID** (2300 | HI20-2), BF qualifier.
QDL	**21ST DIAGNOSIS IS NOT VALID** (2300 | HI21-2), BF qualifier.
QDM	**22ND DIAGNOSIS IS NOT VALID** (2300 | HI22-2), BF qualifier.
QDN	**23RD DIAGNOSIS IS NOT VALID** (2300 | HI23-2), BF qualifier.
QDO	**24TH DIAGNOSIS IS NOT VALID** (2300 | HI24-2), BF qualifier.
QSD	**PRINCIPAL SURGICAL CODE INVALID** (2300 | HI01-1), BR qualifier.
Q78	**1ST PROCEDURE CODE IS INVALID** (2300 | HI01-2), first occurrence of BQ qualifier.
Q79	**2ND PROCEDURE CODE IS INVALID** (2300 | HI02-2), BQ qualifier.

Error Code	Edit Description
Q80	**3RD PROCEDURE CODE IS INVALID** (2300 | HI03-2), BQ qualifier.
Q81	**4TH PROCEDURE CODE IS INVALID** (2300 | HI04-2), BQ qualifier.
Q82	**5TH PROCEDURE CODE IS INVALID** (2300 | HI05-2), BQ qualifier.
Q83	**6TH PROCEDURE CODE IS INVALID** (2300 | HI06-2), BQ qualifier.
RPO	**NEED PROVIDER PHYSICAL ADDRESS IN 2010AA OR 2310E.**
008	**INVALID BLOOD PINTS REPLACED** If the Value code (2300 |HI01-2, HI02-2, HI03-2, HI04-2, HI05-2, HI06-2, HI07-2, HI08-2, HI09-2, HI10-2, HI11-2, HI12-2) is '39', the Value code associated amount (2300 |HI01-5, HI02-5, HI03-5, HI04-5, HI05-5, HI06-5, HI07-5, HI08-5, HI09-5, HI10-5, HI11-5, HI12-5) must be numeric.
365	**MORE SPECIFIC DIAGNOSIS REQUIRED** (2300 / HI)

Glossary of Terms

ASC X12 837 005010X223A2
HIPAA standardized ASC X12 transaction format approved on January 2009. The 837 transactions are for the claims submission data. All lines of business will use this transaction with the exception of retail pharmacy.

CMS
An acronym for the Centers for Medicare & Medicaid Services.

CMS 1450
The current industry standard format for institutional claims submission and is not HIPAA compliant. This format is only used for paper claims.

EDI
An acronym for Electronic Data Interchange.

EDIG
An acronym for Electronic Data Interchange Gateway.

Electronic Data Interchange
The application-to-application transfer of key business information transacted in a standard format using a computer-to-computer communications link. There are typically 6 components used in order to do EDI. They are: an EDI file, a trading partner agreement, an application file/form, translator (mapper), communications and value-added service provider.

HCFA
An acronym for Health Care Finance Administration, renamed to CMS (Centers for Medicare & Medicaid Services) in 2001.

Implementation Guides
Documents that provide standardized data requirements and content permitting the specification of consistent implementation of a standard transaction set. HIPAA implementation guides known as ASC X12 TR3s are available at http://store.X12.org.

Interface
The connection point where two systems pass data.

Routing
Separation of data based on specific criteria for subsequent transfer to an internal or external system.

Trading Partners
Entities that exchange electronic data files. Agreements are sometimes made between the partners to define the parameters of the data exchange and simplify the implementation process.

Translation Software
Commercial computer software that with input instructions converts a standard format to an application format and vise-versa. Most translation software products also compliance check standard format files and automatically create interchange/functional acknowledgements to identify receipt of translation status of a file. Some products also offer translation capability from any format to any format.

X12 Transaction Set
A transaction set is considered one business document which is composed of a transaction set header, control segment, one or more data segments, and a transaction set trailer control segment. For example, one 837 transaction set is equivalent to one claim file.

X12
An Accredited Standards Committee (ASC) commissioned by the American National Standards Institute (ANSI) to develop standard for Electronic Data Interchange (EDI). While X12 indicates EDI, the N identifies the Insurance Subcommittee that is responsible for developing EDIO standards for the insurance industry. There is a special health care task group within this subcommittee responsible for the development of health care insurance transactions.

ACS X12
In 1979, the American National Standards Institute (ANSI) chartered the Accredited Standards Committee (ASC) X12 to develop uniform standards for interindustry electronic exchange of business transactions-electronic data interchange (EDI).