837 Superior Companion Guide

Refers to the Implementation Guides based on the HIPAA Transaction ASC X12N. Standards for Electronic Data Interchange X12N/005010x222 Health Care Claim: Professional (837P) and ASC X12N/005010x223 Health Care Claim: Institutional (837I)

Overview

The Companion Guide provides Superior HealthPlan's trading partners with guidelines for submitting the ASC X12N/005010x222 Health Care Claim: Professional (837P) and the ASC X12N/005010x223 Health Care Claim: Institutional (837I). The Superior Companion Guide documents any assumptions, conventions or data issues that may be specific to Superior business processes when implementing the HIPAA ASC X12N 5010A Technical Reports Type 3 (TR3). As such, this Companion Guide is unique to Superior and its affiliates.

This document does not replace the HIPAA ASC X12N 5010A Technical Reports Type 3 (TR3) for electronic transactions, nor does it attempt to amend any of the rules therein or impose any mandates on any trading partners of Superior. This document provides information on Superior- specific code handling and situation handling that is within the parameters of the HIPAA administrative Simplification rules. Readers of this Companion Guide should be acquainted with the HIPAA Technical Reports Type 3, their structure and content. Information contained within the HIPAA TR3s has not been repeated here, although the TR3s have been referenced when necessary. The HIPAA ASC X12N 5010A Technical Reports Type 3 (TR3) can be purchased at http://*store.x12.org*.

The Companion Guide provides supplemental information to the Trading Partner Agreement (TPA) that exists between Superior and its trading partners. Refer to the TPA for guidelines pertaining to Superior legal conditions surrounding the implementations of EDI transactions and code sets. Refer to the Companion Guide for information on Superior business rules or technical requirements regarding the implementation of HIPAA compliant EDI transactions and code sets.

Nothing contained in this guide is intended to amend, revoke, contradict or otherwise alter the terms and conditions of the Trading Partner Agreement. *Please note: If there is an inconsistency with the terms of this guide and the terms of the Trading Partner Agreement, the terms of the Trading Partner Agreement shall govern*.

Express permission to use X12 copyrighted materials within this document has been granted.

Rules of Exchange

The Rules of Exchange section details the responsibilities of trading partners in submitting or receiving electronic transactions with Superior.

Transmission Confirmation

Transmission confirmation may be received through one (1) of two (2) possible transactions: the ASC X12C/005010X231 Implementation Acknowledgment for Health Care Insurance (TA1, 999). A TA1 Acknowledgement is used at the ISA level of the transmission envelope structure, to confirm a positive transmission or indicate an error at the ISA level of the transmission. The 999 Acknowledgement may be used to verify a successful transmission or to indicate various types of errors. Confirmations of transmissions, in the form of TA1 or 999 transactions, should be received within 24 hours of batch submissions, usually sooner. Senders of transmissions should check for confirmations within this time frame.

Batch Matching

Senders of batch transmissions should note that transactions are unbundled during processing, and rebundled so that the original bundle is not replicated. Trace numbers or patient account numbers should be used for batch matching or batch balancing.

TA1 Interchange Acknowledgement

The TA1 Interchange Acknowledgement provides senders a positive or negative confirmation of the transmission of the ISA/IEA Interchange Control.

999 Functional Acknowledgement
The 999 Functional Acknowledgement reports on all Implementation Guide edits from the Functional Group and transaction sets.

277CA Health Care Claim Acknowledgement
The X12N005010X214 Health Care Claim Acknowledgment (277CA) provides a more detailed explanation of the transaction set. Superior also provides the Pre-Adjudication rejection reason of the claim within the STC12 segment of the 2220D loop. *Please note: The STC03 – Action Code will only be a "U" if the claim failed on HIPAA validation errors, not Pre-Adjudication errors.*

Duplicate Batch Check
To ensure that duplicate transmissions have not been sent, Superior checks five (5) values within the ISA for redundancy:

- ISA06, ISA08, ISA09, ISA10, ISA13

Collectively, these numbers should be unique for each transmission. A duplicate ISA/IEA receives a TA1 response of "025" (Duplicate Interchange Control Number).

To ensure that Transaction Sets (ST/SE) have not been duplicated within a transmission, Superior checks the ST02 value (Transaction Set Control Number), which should be a unique ST02 within the Functional Group transmitted.

Please note: ISA08 and GS03 could also be the Single Payer ID.

New Trading Partners
New trading partners should access https://sites.edifecs.com/index.jsp?centene, register for access and perform the steps in the Superior trading partner program. The EDI Support Desk (EDIBA@Centene.com) will contact you with additional steps necessary upon completing your registration.

Claims Processing

Acknowledgements
Senders receive four (4) types of acknowledgement transactions:

- TA1 transaction to acknowledge the Interchange Control Envelope (ISA/IEA) of a transaction.
- 999 transaction to acknowledge the Functional Group (GS/GE) and Transaction Set (ST/SE).
- 277CA transaction to acknowledge health care claims.
- The Superior Audit Report, at the claim level of a transaction.

Please note: the only acknowledgement of receipt is the return of the Claim Audit Report and/or a 277CA.

Coordination of Benefits (COB) Processing
To ensure the proper processing of claims requiring coordination of benefits, Superior recommends that providers validate the patient's Membership Number and supplementary or primary carrier information for every claim.

Code Sets
Only standard codes, valid at the time of the date(s) of service, should be used.

Corrections and Reversals
The 837 defines what values submitters must use to signal payers that the Inbound 837 contains a reversal, or correction to a claim, that has previously been submitted for processing. For both Professional and Institutional 837 claims, 2300 CLM05-3 (Claim Frequency Code) must contain a value for the National UB Data Element Specification Type List Type of Bill Position 3.

Data Format/Content
Superior accepts all compliant data elements on the 837 Professional Claim. The following points outline consistent data format and content issues that should be followed for submission.

Dates

The following statements apply to any dates within an 837 transaction:

- All dates should be formatted according to Year 2000 compliance, CCYYMMDD, except for ISA segments where the date format is YYMMDD.
- The only values acceptable for “CC” (century) within birthdates are 18, 19 or 20.
- Dates that include hours should use the following format: CCYYMMDDHHMM.
- Use Military format, or numbers from 0 to 23, to indicate hours. For example, an admission date of 201006262115 defines the date and time of June 26, 2010 at 9:15 PM.
- No spaces or character delimiters should be used in presenting dates or times.
- Dates that are logically invalid (e.g. 20011301) are rejected.
- Dates must be valid within the context of the transaction. For example, a patient’s birth date cannot be after the patient’s service date.

Decimals

All percentages should be presented in decimal format. For example, a 12.5% value should be presented as .125.

Dollar amounts should be presented with decimals to indicate portions of a dollar; however, no more than two (2) positions should follow the decimal point. Dollar amounts containing more than two (2) positions after the decimal point are rejected.

Monetary and Unit Amount Values

Superior accepts all compliant data elements on the 837 Professional Claim; however, monetary or unit amount values that are in negative numbers are rejected.

Delimiters

Delimiters are characters used to separate data elements within a data string. Delimiters suggested for use by Superior are specified in the Interchange Header segment (the ISA level) of a transmission; these include the tilde (~) for segment separation, the asterisk (*) for element separation and the colon (:) for component separation.

Phone Numbers

Phone numbers should be presented as contiguous number strings, without dashes or parenthesis markers. For example, the phone number (336) 555-1212 should be presented as 3365551212. Area codes should always be included. Superior requires the phone number to be AAABBBCCCC where AAA is the Area code, BBB is the telephone number prefix, and CCCC is the telephone number.

Additional Items

- Superior will not accept more than 97 service lines per UB-04 claim.
- Superior will not accept more than 50 service lines per CMS 1500 claim.
- Superior will only accept single digit diagnosis pointers in the SV107 of the 837P.
- The Value Added Network Trace Number (2300-REF02) is limited to 30 characters.

Identification Codes and Numbers

General Identifiers

Federal Tax Identifiers

Any Federal Tax Identifier (Employer ID or Social Security Number) used in a transmission should omit dashes or hyphens. Superior sends and receives only numeric values for all tax identifiers.

Sender Identifier

The Sender Identifier is presented at the Interchange Control (ISA06) of a transmission. Superior expects to see the sender’s Federal Tax Identifier (ISA05, qualifier 30) for this value. In special circumstances, Superior will accept a “Mutually Defined” (ZZ) value. Senders wishing to submit a ZZ value must confirm this identifier with Superior EDI.

Payer Identifier

Single Payer IDs are used for all health plans. Please verify directly with Superior and/or Clearinghouse the Payer ID that should be used or contact the EDI Support Desk at 1-800-225-2573 X6075525 or EDIBA@centene.com.

Plan	Receiver ID	Payer ID
All	• ISA08/GS03 • 837P/837I	NMN109 when NM101 = PR
Medical	68069	68069
Behavioral Health/CBH	68068	68068
Centurion	42140	42140

Provider Identifiers

National Provider Identifiers (NPI)

HIPAA regulation mandates that providers use their NPI for electronic claims submission. The NPI is used at the record level of HIPAA transactions; for 837 claims, it is placed in the 2010AA loop. See the 837 Professional Data Element table for specific instructions about where to place the NPI within the 837 Professional file. The table also clarifies what other elements must be submitted when the NPI is used.

Billing Provider

The billing provider primary identifier should be the group/organization ID of the billing entity, filed only at 2010AA. This will be a Type 2 (Group) NPI unless the billing provider is a sole proprietor and processes all claims and remittances with a Type 1 (Individual) NPI.

Rendering Provider

When providers perform services for a subscriber/patient, the service will need to be reported in the Rendering Provider Loop (2310B or 2420A) You should only use 2420A when it is different than Loop 2310B/NM1*82.

Referring Provider

Superior has no specific requirements for referring provider information.

Atypical Provider

Atypical providers are not always assigned an NPI number; however, if an atypical provider has been assigned an NPI, then they need to follow the same requirements as a medical provider. An atypical provider which provides non-medical services is not required to have an NPI number (i.e. carpenters, transportation, etc.). Existing atypical providers need only send the Provider Tax ID in the REF segment of the billing provider loop. *Please note: If an NPI is billed in any part of the claim, it will not follow the Atypical Provider Logic.*

Subscriber Identifiers

Submitters must use the entire identification code as it appears on the subscriber's card in the 2010BA element.

Claim Identifiers

Superior issues a claim identification number upon receipt of any submitted claim. The ASC X12 Technical Reports (Type 3) may refer to this number as the Internal Control Number (ICN), Document Control Number (DCN), or the Claim Control Number (CCN). It is provided to senders in the Claim Audit Report and in the CLP segment of an 835 transaction. Superior returns the submitter's Patient Account Number (2300, CLM01) on the Claims Audit Report and the 835 Claim Payment/Advice (CLP01).

Connectivity Media for Batch Transactions

Secure File Transfer

Superior encourages trading partners to consider a secure File Transfer Protocol (FTP) transmission option. Superior offers two (2) options for connectivity via FTP.

- Method A – the trading partner will push transactions to the Superior FTP server, and Superior will push outbound transactions to the Superior FTP server.

- Method B – The trading partner will push transactions to the Superior FTP server, and Superior will push outbound transactions to the trading partner's FTP server.

Encryption
Superior offers the following methods of encryption SSH/SFTP, FTPS (Auth TLS), FTP w/PGP, HTTPS (*Please note: This method only applies with connecting to Superior's Secure FTP. Superior does not support retrieve files automatically via HTTPS from an external source at this time*.) If PGP or SSH keys are used they will be shared with the trading partner. These are not required for those connecting via SFTP or HTTPS.

Direct Submission
Superior also offers posting an 837 batch file directly on the Secure Provider Portal for processing.

Edits and Reports

Incoming claims are reviewed first for HIPAA compliance and then for Superior business rules requirements. The business rules that define these requirements are identified in the 837 Professional Data Element Table below, and are also available as a comprehensive list in the 837 Professional Claims – Superior Business Edits Table. HIPAA TR3 implementation guide errors may be returned on either the TA1 or 999 while Superior business edit errors are returned on the Superior Claims Audit Report.

Reporting
The following table indicates which transaction or report to review for problem data found within the 837 Professional Claim Transaction.

Transaction Structure Level	Type of Error or Problem	Transaction or Report Returned
ISA/IEA Interchange Control		TA1
GS/GE Functional Group ST/SE Segment Detail Segments	HIPAA Implementation Guide violations	999 Superior Claims Audit Report (A proprietary confirmation and error report)
Detail Segments	Superior Business Edits (See audit report rejection reason codes and explanation.)	Superior Claims Audit Report (A proprietary confirmation and error report)
Detail Segments	HIPAA Implementation Guide violations and Superior Business Edits.	277CA

277CA/Audit Report Rejection Codes

Error Code	Rejection Reason
01	Invalid Mbr DOB
02	Invalid Mbr
06	Invalid Provider
07	Invalid Mbr DOB & Provider
08	Invalid Mbr & Provider
09	Mbr not valid at DOS
10	Invalid Mbr DOB; Mbr not valid at DOS
12	Provider not valid at DOS
13	Invalid Mbr DOB; Prv not valid at DOS
14	Invalid Mbr; Prv not valid at DOS
15	Mbr not valid at DOS; Invalid Prv
16	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Prv
17	Invalid Diag Code
18	Invalid Mbr DOB; Invalid Diag
19	Invalid Mbr; Invalid Diag
21	Mbr not valid at DOS; Prv not valid at DOS
22	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS
23	Invalid Prv; Invalid Diagnosis Code
24	Invalid Mbr DOB; Invalid Prv; Invalid Diag Code
25	Invalid Mbr; Invalid Prv; Invalid Diag Code
26	Mbr not valid at DOS; Invalid Diag Code
27	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Diag Code

Error Code	Rejection Reason
29	Provider not valid at DOS; Invalid Diag Code
30	Invalid Mbr DOB; Prv not valid at DOS; Invalid Diag
31	Invalid Mbr; Prv not valid at DOS; Invalid Diag
32	Mbr not valid at DOS; Prv not valid; Invalid Diag
33	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Prv; Invalid Diag
34	Invalid Proc
35	Invalid Mbr DOB; Invalid Proc
36	Invalid Mbr; Invalid Proc
37	Invalid Future Service Date
38	Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag
39	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag
40	Invalid Prv; Invalid Proc
41	Invalid Mbr DOB, Invalid Prv; Invalid Proc
42	Invalid Mbr; Invalid Prv; Invalid Proc
43	Mbr not valid at DOS; Invalid Proc
44	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Proc
46	Prv not valid at DOS; Invalid Proc
48	Invalid Mbr; Prv not valid at DOS; Invalid Proc
49	Mbr not valid at DOS; Invalid Prv; Invalid Proc
51	Invalid Diag; Invalid Proc
52	Invalid Mbr DOB; Invalid Diag; Invalid Proc
53	Invalid Mbr; Invalid Diag; Invalid Proc
55	Mbr not valid at DOS; Prv not valid at DOS; Invalid Proc
57	Invalid Prv; Invalid Diag; Invalid Proc

Error Code	Rejection Reason
58	Invalid Mbr DOB; Invalid Prv; Invalid Diag; Invalid Proc
59	Invalid Mbr; Invalid Prv; Invalid Diag; Invalid Proc
60	Mbr not valid at DOS;Invalid Diag;Invalid Proc
61	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Diag; Invalid Proc
63	Prv not valid at DOS; Invalid Diag; Invalid Proc
64	Invalid Mbr DOB; Prv not valid at DOS; Invalid Diag; Invalid Proc
65	Invalid Mbr; Prv not valid at DOS; Invalid Diag; Invalid Proc
66	Mbr not valid at DOS; Invalid Prv; Invalid Diag; Invalid Proc
67	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Prv; Invalid Diag; Invalid Proc
72	Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag; Invalid Proc
73	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag; Invalid Proc
74	Services performed prior to Contract Effective Date
75	Invalid units of service
76	Original Claim Number Required
77	Invalid Claim Type
78	Diagnosis Pointer- Not in sequence or incorrect length
81	Invalid units of service, Invalid Prv
83	Invalid units of service, Invalid Prv, Invalid Mbr
89	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag
91	Invalid Missing Taxonomy or NPI/Invalid Prov
92	Invalid Referring/Ordering NPI
93	Mbr not valid at DOS; Invalid Proc
96	GA OPR NPI Registration-State

Error Code	Rejection Reason
A2	Diagnosis Pointer Invalid
A3	Service Lines- Greater than 97 Service lines submitted- Invalid
B1	Rendering and Billing NPI are not tied on State File- IN rejection
B2	Not enrolled with MHS IN and/or State with rendering NPI/TIN on DOS. Enroll with MHS and Resubmit claim
B5	Invalid CLIA
C7	NPI Registration- State GA OPR
C9	Invalid/Missing Attending NPI
HP/H1/H2	ICD9 after end date/ICD10 sent before Eff Date/Mixed ICD versions