



**'OHANA EDI TRANSACTION SET
837I X12N HEALTH CARE
CLAIM / ENCOUNTER INSTITUTIONAL
ASC X12N (004010X096A1)
Companion Guide**

**Inbound
837 Institutional
Claims / Encounter Submission**



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REVISION HISTORY

Date	Rev #	Author	Description
12/01/2005	DRAFT	G. Webb	Initial draft
04/10/2006	Final	"	Final Review)cosmetic updates
04/18/2006		"	Added NPI statement (2010AA)
03/19/2008	DRAFT	Sean Malone	
06/16/2008	DRAFT	Craig Smitman	Review and Updates
	Final	Fred Thorpe	Business Review and Approval
09/15/2008	2.1	Craig Smitman	Clearinghouse Submitters
01/05/2009	2.2	Craig Smitman	Added Hawaii information

CONTACT ROSTER

Trading Partners and Providers ; Questions, Concerns, Testing information please email the following	
EDI Coordinator	
EDICoordinator@wellcare.com	Multi group supported email distribution
EDI Testing	
EDITesting@wellcare.com	Multi group supported email distribution



INTRODUCTION

'Ohana Health Plan ("Ohana") used the standard format for Claims Data reporting from Providers and Trading Partners (TPs). 'Ohana X12N 837 Institutional Claim 'Companion Guide" is intended for use by 'Ohana Providers and TPs in conjunction with ANSI ASC X12N National Implementation Guide. It has been written to assist those Submitters who will be implementing the X12N 837I Healthcare Claim Institutional transaction. This 'Ohana Companion Guide clarifies the HIPAA-designated standard usage and must be used in conjunction with the following document:

The 837I Healthcare Claim Institutional Implementation Guides (IG)

To purchase the IG contact the Washington Publishing company at www.wpc-edi.com/hipaa/HIPAA_40.asp.

This 'Ohana Companion Guide contains data clarifications derived from specific business rules that apply exclusively to claims processing for 'Ohana Health Plan. Field requirements are located in the ASC X12N 837I (004010X096A1) Implementation Guide.

Submitters are advised that updates will be made to the Companion Guides on a continual basis to include new revisions to the web sites below. Submitters are encouraged to check our website periodically for updates to the Companion Guides.

Reporting States

This Guide covers further clarification to Providers and TPs reporting claims to 'Ohana and providing services in the following states;

<u>Medicaid Sate Companion Guide:</u>	<u>Companion Guide Release Date</u>
• Florida – FL	Version 8.4 December 22, 2006
• Georgia – GA	Version 2.4 July 20, 2007
• Ohio – OH	Version 10 June 2007
• Illinois – IL	HFS 302 (1) April 2006
• Louisiana – LA	Version 1.5 January 20, 2005
• New York – NY	Version 3.0 May 09, 2007
• Missouri – MO	Not available in document
• Texas – TX	June 1, 2003
• Hawaii – HI	Version 1.5 March 2004



Reporting States Notes:

Missouri Home Health Care Note:

For home health claims, enter the narrative information from the "Home Health Certification and Plan of Treatment" and the "Medical Update and Patient Information" forms clarifying the data elements reported in NTE01. Patient information to be reported, based on the Note Reference

Code, may include:

- **ALG**—may report patient's allergies that are relevant to the care being given
- **DCP**—goals, rehab potential or discharge plans must be reported
- **DGN**—may report additional information concerning diagnosis
- **DME**—may report equipment and supplies that are relevant to the care being provided
- **MED**—may report patient's medications that are relevant to the care being provided
- **NTR**—may report patient's nutritional requirements that are relevant to the care being provided
- **ODT**—must report interim order by physician for applicable time frame, by discipline; first three (3) bytes of note must begin with SN-, AI-, PT-,
- **OT-, or ST-**, indicating the discipline the interim orders address
- **RHB**—reason homebound must be reported
- **RLH**—reasons patient leaves home-not applicable to MO Medicaid
- **RLH**—times and reasons patient not at home-not applicable to MO Medicaid
- **SET**—may report unusual home or social environment, or both, that are relevant to the care being provided
- **SFM**—may report safety measures taken that are relevant to the care being provided
- **SPT**—may report supplemental information in the plan of care
- **UPI**—must report information required by Home Health program policy, such as: date and time of birth and date and time of discharge if billing Y9505 or 99501; weight, height, and age of low birth weight child; documentation of deficient weight relative to the child's height for a failure-to-thrive child; patient's status on dates of service being billed; or other information home health agency deems important for adjudication decisions.

Missouri Nursing Home Service Line Claims Notes

For outpatient and hospice claims, refer to the Missouri Medicaid Policy manuals for specific requirements.

For nursing home claims, select revenue code from one of the following categories:

1. Select revenue code to indicate reserve time periods:
 - **0180** equals non-covered leave of absence
 - **0182** equals home leave for patient convenience
 - **0183** equals home leave for therapeutic leave
 - **0184** equals hospital leave to an ICF/MR
 - **0185** equals hospital leave for non-ICF/MR facility
 - **0189** equals Medicare qualifying stay days
2. Select revenue code to indicate skilled nursing services:
 - **0190** equals subacute care general classification
 - **0191** equals subacute care - level I
 - **0192** equals subacute care - level II



- **0193** equals subacute care - level III
- **0194** equals subacute care - level IV
- **0199** equals subacute care other
- **0550** equals skilled nursing general classification
- **0559** equals skilled nursing other

Indicating any of the above revenue codes does not alter the amount of your per diem payment. Use these codes when you previously would have indicated a skilled nursing indicator of 'Y'.

3. Select revenue code to indicate non-skilled nursing time periods:

- **0110** equals room-board/private
- **0119** equals other/private
- **0120** equals room-board/semi
- **0129** equals other/2-bed



GENERAL INFORMATION

Valid Provider Identifiers

All Submitters are required to use the National Provider Identification (NPI) numbers that is now required in the ANSI ASC X12N 837 as per the 837 Institutional (004010X096A1) Implementation Guide for all appropriate loops.

HIPAA Standard Electronic Claims – 837 Professional, Institutional, and Dental Claims			
Provider submits a transaction with...	Dual Receipt Period (Now through 05/22/07)	Contingency Period (05/23/07 – 05/22/08)	Full Implementation (Post 05/23/08) (A notification will be sent 60 days before requiring the use of NPI only on transactions)
Legacy ID Only (Provider License# or Medicare ID)	Accept Transaction	Accept Transaction	Reject Transaction
NPI & Legacy ID (Provider License# or Medicare ID)	Accept Transaction (Dual Receipt)	Accept Transaction (NPI must be in primary loops)	Reject Transaction
NPI Only	Reject (unless testing is completed with EDI area)	Accept Transaction (NPI must be registered with us)	Accept Transaction

'Ohana Front-End WEDI Snip Validation

The 'Ohana Front-End System, utilizing EDIFICS Validation Engine, will be performing **four** levels of WEDI Snip Validation for the State of Florida starting on July 1, 2008 and **three** levels of WEDI Snip Validation for All other States starting on August 1, 2008.

WEDI SNIP Levels

- WEDI SNIP Type 1: EDI Syntax Integrity Testing
- WEDI SNIP Type 2: HIPAA Syntactical Requirement Testing
- WEDI SNIP Type 3: Balancing
- WEDI SNIP Type 4: Situational Testing

Coordination of Benefits (COB)

All Submitters that adjudicate claims for 'Ohana or have COB information from other payers are required to send in all the Coordination of Benefits and Adjudication Loops as per the 837 Institutional (004010X096A1) Implementation Guide as per Coordination of Benefits Section 1.4.2.



Drug Identification

All Submitters that are sending in Claims that have Drug Procedure codes are required to complete the 2410 Drug Identification Loop(s) as per the 837 Intuitonal (004010X096A1) Implementation Guide

Electronic Submission

Institutional service claims submitted using the ANSI ASC X12N 837 format should be separated from all Encounter reporting. When sending Institutional service claims 'Ohana expects the BHT06, Claims Identifier to be set to "**CH**". When reporting Encounters 'Ohana expects the BHT06 to be set to "**RP**".

Fee for Service Clearinghouse Submitters

All Fee For Service (FFS) Providers / Vendors must send there claims through a Clearinghouse. 'Ohana is currently contracted with Emdeon, ACS-Gateway, Availity and SSI. Please contact your clearinghouse for the 'Ohana Payer ID to use for Claim Routing and any other pertinent ID's

Encounter File Upload for Direct Submitters

EDI files for production should be submitted to the following Secure FTP site <http://edi.wellcare.com/human.aspx>, using secure File Transfer Protocol (SFTP); See section FTP Process.

Submission Frequency

We process files 24 by 7.

File Size Requirements

The following list outlines the file sizes by transaction type:

Transaction Type	Testing Purposes	Production Purposes
837 formats – claims/encounters	50-100 claims	< 5000 claims per ST/SE



FTP PROCESS for Production Encounters and Test files

Secure File Transfer Protocol

MOVEit® is 'Ohana's preferred file transfer method of transferring electronic transactions over the Internet. It has the FTP option or online web interface.

Secure File Transfer Protocol (SFTP) is specifically designed to handle large files and sensitive data. 'Ohana utilizes Secure Sockets Layer (SSL) technology, the standard internet security and SFTP ensures unreadable data transmissions over the Internet without a proper digital certificate.

- Registered users are assigned a secure mailbox where all reports are posted. Upon enrollment, they will receive a login and password.

In order to send files to 'Ohana submitters need to have an FTP client that supports AUTH SSL encryption.

The AUTH command allows 'Ohana to specify the authentication mechanism name to be used for securing the FTP session. Sample FTP client examples are:

- WS_FTP PRO® (The commercial version supports automation and scripting)
 - WS_FTP PRO® has instructions on how to connect to a WS_FTP Server using SSL.
- Core FTP Lite® (The free version supports manual transfers)
 - Core FTP Lite® has instructions on how to connect to a WS_FTP Server. Additionally, 'Ohana can provide setup assistance.



Encounter FILE TEST PROCESS

'Ohana will accept test files on a case-by-case basis. Notify the Testing Coordinator of your intent to test and to schedule accordingly.

IF YOU DO NOT NOTIFY 'OHANA OF YOUR INTENT TO TEST, YOUR CLAIM SUBMISSION MAY BE OVERLOOKED.

Encounter Testing

1. Create test files in the ANSI ASC X12N 837I format.
 - Files should include all types of provider claims.
 - Batch files by 837I type of claim and group by month.
 - Set Header Loops for Test:
 - Header ISA15 to "T"
 - Header BHT06 use "CH" in the Header for claims
 - Header BHT06 use "RP" in the Header for encounters
2. Name each batch file according to the File Naming Standards listed below:
 - Your company Identifier short name must be 5 characters (Example: CMPNM)
 - 837TEST
 - Date test file is submitted to 'Ohana (CCYYMMDDHHMM)
 - Last byte equaling file type I = Institutional services

Example: CMPNM_837TEST_200509011525I
3. Transmit your **TEST** files to the 'Ohana SFTP site: <https://edi.wellcare.com> or submitted through your Clearinghouse.
4. Email a copy of the file Upload Response and your file name to the EDI Coordinator (See contact roster)

Encounter Production

After the Provider or TPs are production ready 'Ohana will accept ANSI ASC X12N 837I format and process batch files daily. Files must have the appropriate PRODUCTION identifiers as listed in the 837I Mapping Documents.

Encounter Naming Standards:

'Ohana uses the file name to help track each batch file from the drop off site through the end processing into 'Ohana's data warehouse.

1. Claim Header information for Production and Encounters ID's:
 - Set Header Loops for Production:



- Header ISA15 to "P"
 - Header BHT06 use "CH" in the Header for claims
 - Header BHT06 use "RP" in the Header for encounters
2. Name each batch file according to the File Naming Standards listed below:
- Your company Identifier short name must be 5 characters (Example: CMPNM)
 - 837I ROD
 - Date production file is submitted to 'Ohana (CCYYMMDDHHMM)
 - Last byte equaling file type I = Institutional services
 - **Example:** CMPNM _837I ROD_200509011525I
3. 'Ohana recommends the use of EDIFECs or CLAREDI for SNIP Level 1 through 6 for integrity testing prior to uploading your production files.
4. Transmit your Production files to 'Ohana through the SFTP site or through your clearinghouse. For direct submitters see FTP Process section.
5. After the file has passed through 'Ohana's Enterprise Systems validation process, (includes business edits), the electronic ANSI ASC X12N 997 (Functional Acknowledgement) outlining file acceptance/rejection will be posted to the SFTP site within 24 hours. See the 837 IG for additional information about the response coding and Attachment C in this Guide for examples.
6. If the file is unreadable then trading partner will be notified by a 'Ohana third party coordinator via email.



DESIGNATOR DESCRIPTION

M - Mandatory - The designation of mandatory is absolute in the sense that there is no dependency on other data elements. This designation may apply to either simple data elements or composite data structures. If the designation applies to a composite data structure then at least one value of a component data element in that composite data structure shall be included in the data segment.

R - Required - At least one of the elements specified in the condition must be present.

S – Situational - If a Segment or Field is marked as “Situational”, it is only sent if the data condition stated applies.



FURTHER CLAIM FIELD DESCRIPTION

Refer to the IG for the initial mapping information. The grid below further clarifies additional information 'Ohana requires.

Interchange Control Header:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Notes</u>
	ISA06	Interchange Sender ID	M	1		For Direct submitters Unique ID assigned by 'Ohana. Example: 123456 followed by spaces to complete the 15-digit element
	ISA08	Interchange Receiver ID	M	1		For Clearinghouse submitters please use ID as per the clearinghouse For Direct submitters Use "OHANA" Note: Please make sure the Receiver ID is left justified with trailing spaces for a total of 15 characters. Do not use leading ZEROS. For Clearinghouse submitters please use ID as per the clearinghouse.

Functional Group Header:

	GS02	Senders Code	M	1		For Direct submitters Use your existing 'Ohana Submitter ID or the trading partner ID provided during the enrollment process. For Clearinghouse submitters please use ID as per the clearinghouse
	GS03	Receivers Code	M	1		For Direct submitters Use WC ID "OHANA" For Clearinghouse submitters please use ID as per the clearinghouse



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Header:						
Pos	Id	Segment Name	Req	Max Use	Repeat	Notes
010	BHT06	Claim/Encounter Identifier	R	1		Use value the value of "CH" or "RP"
LOOP ID - 1000A – Submitter Name					<u>1</u>	
020	NM109	Submitter Identifier	R			For Direct Submitters Submitter's "ETIN" i.e., Use the 'Ohana Submitter ID or 6-digit trading partner ID assigned during the EDI enrollment process. For Clearinghouse submitters please use ID as per the clearinghouse
LOOP ID - 1000B – Receiver Name					<u>1</u>	
020	NM103	Receiver Name	R	1		For Direct Submitters Use value "OHANA HEALTH PLAN, INC" For Clearinghouse submitters please use ID as per the clearinghouse
020	NM109	Receiver Primary ID	R	1		For Direct Use the value of Payer IID For Clearinghouse submitters please use ID as per the clearinghouse



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Detail:

Pos	Id	Segment Name	Req	Max Use	Repeat	Notes
LOOP ID - 2000A – Billing/Pay-To Provider Hierarchical Level					≥1	
003	PRV03	Billing/Pay-To Provider Specialty Information	S	1		<p>State Note: IL, NY, GA submitters are required to Use the value of “BI” = Billing or “PT” Pay-To Provider in the “PRV01” and the Taxonomy Code in the “PRV03”.</p> <p>MO Submitters are required to Use the value of “BI” = Billing or “PT” Pay-To Provider in the “PRV01” and the Taxonomy Code in the “PRV03 if submitter has multiple MO HealthNet Legacy Provider ID’s</p>
LOOP ID - 2010AA – Billing Provider Name					1	
015	NM108	Provider Primary Type	R	1		Must have value of “XX”.
015	NM109	Billing Provider ID	R	1		Must have NPI.
035	REF01	Reference Identification Qualifier	R	8		<p>All States: All submitters are required to use the value of “EI”.</p>
035	REF02	Billing Provider Additional Identifier	R	8		<p>All States: All submitters are required to send in their “TAX ID”.</p>
LOOP ID - 2010AB – Pay to Provider’s Name					1	
015	NM108	Provider Primary Type	S-R	1		Must have the value of “XX”
015	NM109	Pay to Provider’s Identifier	R	1		Must have NPI.
035	REF01	Reference Identification Qualifier	S-R	8		<p>All States All submitters are required to use the Use the value of “EI”.</p>
035	REF02	Billing Provider Additional Identifier	R	8		<p>All States: All submitters are required to send in their “TAX ID”.</p>
LOOP ID - 2000B – Subscriber Hierarchical Level					≥1	
005	SBR01	Payer Responsibility Sequence Number Code	R	1		Use the value of “P” if ‘Ohana is the primary payer.
005	SBR09	Claim Filing Indicator Code		1		Value equal to Medicaid or Medicare filing.
007	PAT09	Pregnancy Indicator	S			Use indicator of “Y” if subscriber is pregnant.
LOOP ID - 2010BA – Subscriber Name					1	
015	NM108	Subscriber Primary Identification code Qualifier	S-R			Use the value “MI”.
015	NM109	Subscriber Primary Identifier				Subscriber Medicaid/Medicare ID,
032	DMG01	Subscriber Demographic Information	S-R	1		Required when Loop ID-2000B, SBR02 = “18” (self).
LOOP ID - 2010BB – Payer Name					1	



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015 **NM108** Identification code Qualifier
015 **NM109** Identification code

Use value "PI".
Use value Payer ID

LOOP ID – 2300 – Claim Information					<u>1</u>	
	DTP03	Admission Date	S-R	1	1	<p>State Note: HI – When submitting claims the Admission Date is required with a DTP01 qualifier of "435", DTP02 of "DT" and the admission time must include minutes on the 837 Transaction, minutes are truncated for Med-QUEST claim adjudication. Enter "00" if admission minutes are unknown.</p>
	CL1	Institutional Claim Codes	S-R	1	1	<p>State Note: OH - For nursing facility room and board claims: 1. Use admission source codes: 5, transfer from an SNF, or 6, transfer from another health care facility in CL102 when a patient has transferred into the facility. 2. Use the following patient status codes in CL103: Patient Status 01 Discharged to home or self care (routine discharge) 02 Discharged to Hospital 03 Discharged to SNF 04 Discharged to ICF 06 Discharged/transferred to home under care of a home health service organization. 30 Still Patient 41 Expired in a Medical Facility 50 Hospice - Home 51 Hospice - Medical facility</p>
190	NTE01	Claim Note - ID	S-R	1	10	<p>State Note: MO - For home health claims, enter the applicable Note Reference Code identifying the functional area or purpose reported in NTE02.</p>



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190	NTE02 Claim Note - Note	R	1	10	State Note: MO - See Reporting States Notes for Home Health Care
231	HI01-1 Condition Identification Code Qualifier	S-R	1	24	State Note: NY, OH – See below if need
231	HI01-2 Condition Identification Value Code	R	1	24	<p>State Note: NY - '61' for Cost Outlier claims (the Outlier Amount will be calculated based on the Revenue Codes reported in the SV2 segments of Loop 2400).</p> <ul style="list-style-type: none"> - 'A1' for CHAPS and EPSDT claims - 'A4' for Family Planning - 'AJ' for Copay Exempt claims - 'AA' for Abortion performed due to rape - 'AB' for Abortion performed due to incest - 'AC' for Abortion performed due to serious fetal genetic defect, deformity, or abnormality - 'AD' for Abortion performed due to a life endangering physical condition caused by, arising from or exacerbated by the pregnancy itself - 'AE' for Abortion performed due to physical health of mother that is not life endangering - 'AF' for Abortion performed due to emotional/psychological health of the mother - 'AG' for Abortion performed due to social or economic reasons - 'AH' for Elective abortion - 'AI' for Sterilization Refer <p>also to the 837 Institutional Supplemental Companion Guide, Sections 12 and 22 for more information.</p> <p>OH - For nursing facility room and board claims</p>



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adjustments, use the Condition Codes (Claim Change Reasons)

- **D0** changes to Service Dates
- **D1** changes to charges
- **D2** changes to revenue codes
- **D6** cancel only to repay a duplicate or OIG overpayment
- **D7** change to make Medicare the secondary payer
- **D8** change to make Medicare the primary payer
- **D9** any other change
- **E0** change in patient status

231	HI01-1	Value Information Identification Code Qualifier	S-R	1	24
231	HI01-2	Value Information Identification Value Code	R	1	24
231	HI01-3	Value Information Identification Monetary Amount	S	1	24
	QTY	Claim Quantity			

Sate Note:
GA -"BE" Newborn Birth Weight Required when admission Type Code CL101 = "4" Newborn

Sate Note:
GA -"54"+Newborn Wight in Grams Required when admission Type Code CL0101 = "4" Newborn

Sate Note:
FL – Monetary Amount

Sate Note:
OH - QTY01- Quantity Qualifier "CD" and "LA" used in adjudication of Part C claims.

For nursing facility room and board claims , use

231			S	1	4
-----	--	--	---	---	---

- **QTY01**, Quantity Qualifier 'CA' to report covered days, including covered leave days ;
- **QTY01**, Quantity Qualifier 'NA' to report non-covered Days,
- **QTY01**, Quantity Qualifier 'CD' to



report co-insurance

LOOP ID – 2400 – Service Line				<u>1</u>		
231	SV201	Service Line Revenue Code	R	1	1	Sate Note: MO – See Reporting States Notes for Home Health Care.

ATTACHMENT A Glossary

Term	Definition
HIPAA	In 1996, Congress passed into federal law the Health Insurance Portability and Accountability Act (HIPAA) in order to improve the efficiency and effectiveness of the entire health care system. The provisions of HIPAA, which apply to health plans, healthcare providers, and healthcare clearinghouses, cover many areas of concern including, preventing fraud and abuse, preventing pre-existing condition exclusions in health care coverage, protecting patients' rights through privacy and security guidelines and mandating the use of a national standard for EDI transactions and codesets.
SSL (Secure Sockets Layer)	SSL is a commonly used protocol for managing the security of a message transmission through the Internet. SSL uses a program layer located between the HTTP and TCP layers. The "sockets" part of the term refers to the sockets method of passing data back and forth between a client and a server program in a network or between program layers in the same computer. SSL uses the public-and-private key encryption system from RSA, which also includes the use of a digital certificate.
Secure FTP (SFTP)	Secure FTP, as the name suggests, involves a number of optional security enhancements such as encrypting the payload or including message digests to validate the integrity of the transported files to name two examples. Secure FTP uses Port 21 and other Ports, including SSL.
AUTH SSL	AUTH SSL is the explicit means of implementing secure communications as defined in RFC 2228. AUTH SSL provides a secure means of transmitting files when used in conjunction with an



Term	Definition
	FTP server and client that both support AUTH SSL.
Required Segment	A required segment is a segment mandated by HIPAA as mandatory for exchange between trading partners.
Situational Segment	A situational segment is a segment mandated by HIPAA as optional for exchange between trading partners.
Required Data Element	A mandatory data element is one that must be transmitted between trading partners with valid data.
Situational Data Element	A situational data element may be transmitted if data is available. If another data element in the same segment exists and follows the current element the character used for missing data should be entered.
N/U (Not Used)	An N/U (Not Used) data element included in the shaded areas if the Implementation Guide is NOT USED according to the standard and no attempt should be made to include these in transmissions.
ATTENDING PROVIDER	The primary individual provider who attended to the client/member during an in-patient hospital stay. Must be identified in 837I, Loop 2310A, REF02 Segment, by their assigned Medicaid/Medicare ID number assigned by State to the individual provider while the client was in-patient.
BILLING PROVIDER	The Billing Provider entity may be a health care provider, a billing service, or some other representative of the provider.
IMPLEMENTATION GUIDE (IG)	Instructions for developing the standard ANSI ASC X12N Health Care Claim 837 transaction sets. The Implementation Guides are available from the Washington Publishing Company.
PAY-TO-PROVIDER	This entity may be a medical group, clinic, hospital, other institution, or the individual provider who rendered the service.
REFERRING PROVIDER	Identifies the individual provider who referred the client or prescribed Ancillary services/items such as Lab, Radiology and Durable Medical Equipment (DME).
RENDERING PROVIDER	The primary individual provider who attended to the client/member. They must be identified in 837I.
TRADING PARTNERS (TPs)	Includes all of the following; payers, switch vendors, software vendors, providers, billing agents, clearinghouses
DATE FORMAT	All dates are eight (8) character dates in the format CCYYMMDD. The only date data element that varies from the above standard is the Interchange Date data element located in the ISA segment. The Interchange Date data element is a six (6) character date in the YYMMDD format.
DELIMITERS	A delimiter is a character used to separate two (2) data elements or sub-elements, or to terminate a segment. Delimiters are specified in the interchange header segment, ISA The ISA segment is a 105 byte fixed length record. The data element separator is byte number 4; the component element separator is byte number 105; and the segment terminator is the byte that immediately follows the component element



Term	Definition								
	<p>separator. Once specified in the interchange header, delimiters are not to be used in a data element value elsewhere in the transaction. The following characters are used as data delimiters for all transaction segments:</p> <table border="1" data-bbox="586 506 1365 634"> <thead> <tr> <th data-bbox="586 506 976 541">CHARACTER</th> <th data-bbox="976 506 1365 541">PURPOSE</th> </tr> </thead> <tbody> <tr> <td data-bbox="586 541 976 573">* Asterisk</td> <td data-bbox="976 541 1365 573">Data Element Separator</td> </tr> <tr> <td data-bbox="586 573 976 604">: COLON</td> <td data-bbox="976 573 1365 604">Sub-Element Separator</td> </tr> <tr> <td data-bbox="586 604 976 634">~ Tilde</td> <td data-bbox="976 604 1365 634">Segment Terminator</td> </tr> </tbody> </table>	CHARACTER	PURPOSE	* Asterisk	Data Element Separator	: COLON	Sub-Element Separator	~ Tilde	Segment Terminator
CHARACTER	PURPOSE								
* Asterisk	Data Element Separator								
: COLON	Sub-Element Separator								
~ Tilde	Segment Terminator								



ATTACHMENT B

File Example

ISA*00* *00*
*ZZ*123456789012345*ZZ*123456789012346*020502*1758*U*00401*001000019*0*T*:
GS*HC*1234567890*1234567890*20020502*1758*20019*X*004010X096A1~
ST*837*872501~
BHT*0019*00*0125*19970411*1524*CH~
REF*87*004010X098~
NM1*41*2*FERMANN HAND & FOOT CLINIC*****46*591PD123~
PER*IC*JAN FOOT*TE*8156667777~
NM1*40*2*HEISMAN INSURANCE COMPANY*****46*555667777~
HL*1**20*1~NM1*85*2*FERMANN HAND & FOOT CLINIC*****XX*591PD123~
N3*10 1/2 SHOEMAKER STREET~
N4*COBBLER*CA*99997~
REF*EI*579999999~HL*2*1*22*1~
SBR*P*****AM~
NM1*IL*1*HOWLING*HAL***MI*B99977791G~
NM1*PR*2*HEISMAN INSURANCE COMPANY*****XV*999888777~
N3*1 TROPHY LANE~
N4*NYAC*NY*10032~HL*3*2*23*0~
PAT*41~
NM1*QC*1*DIMPSON*DJ****34*567324788~
N3*32 BUFFALO RUN~
N4*ROCKING HORSE*CA*99666~
DMG*D8*19480601*M~
REF*Y4*32323232~
CLM*900000032*185***11::1*Y*A*Y*Y*B*AA~
DTP*439*D8*19940617~
HI*BK:8842~
NM1*82*1*MOGLIE*BRUNO****XX*687AB861~
PRV*PE*ZZ*203BE004Y~
NM1*77*2*FERMANN HAND & FOOT CLINIC*****XX*591PD123~
N3*10 1/2 SHOEMAKER STREET~
N4*COBBLER*CA*99997~
LX*1~SV1*HC:99201*150*UN*1****1**Y~
DTP*472*D8*19940620~
LX*2~SV1*HC:26010*35*UN*1****1**Y~
DTP*472*D8*19940620~
SE*39*872501~
GE*1*20019
IEA*1*001000019



ATTACHMENT C

997 Interpretation

The examples below show an accepted and a rejected X12 N 997. On the 'Ohana sftp site in the respective Provider directory the X12N 997 files, when opened, will display as one complete string without carriage returns or line feeds.

Accepted 997

```
ISA*00* 00*5265 *ZZ*100000 *ZZ*100008  
*050923*1126*U*00401*000000166*1*T*~  
GS*FA*77046*100008*20031023*112600*1660001  
*X*004010X096A1~  
ST*997*0001~  
AK1*HC*19990000~  
AK2*837*TEST~  
AK5*A~  
AK9*A*1*1*1~  
SE*6*0001~  
GE*1*1660001~  
IEA*1*000000166~
```

Rejected 997

```
ISA*00* 00*5264 *ZZ*100000 *ZZ*100008  
*050923*1124*U*00401*000000165*1*T*~  
GS*FA*77046*100008*20031023*112400*1650001  
*X*004010X096A1~  
ST*997*0001~  
AK1*HC*19990000~  
AK2*837*TEST~  
AK5*R*7~  
AK9*R*1*1*~  
0~  
SE*6*0001~  
GE*1*1650001~  
IEA*1*000000165~
```

Partial 997

```
ISA*00* 00* *ZZ*'OHANA *ZZ*391933153 *080121*1329*U*00401*000000007*0*P*::~~  
GS*FA*'OHANA*391933153001*20080121*1329*7*X*004010X097A1~  
ST*997*0005~  
AK1*HC*1~  
AK2*837*0001~  
AK3*NM1*164396**8~  
AK4*9**1~  
AK5*R*5~  
AK2*837*0002~
```



**'Ohana Health Plan
837I Claims Data
Transaction Guide**

AK5*A~
AK9*E*2*2*1~
SE*10*0005~
GE*1*7~
IEA*1*000000007~