Indiana Health Coverage Programs

HIPAA Transaction Standard Companion Guide

Refers to the Implementation Guides
Based on ASC X12 version 005010

Health Care Claim: Institutional (837)

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Preface

This companion guide to the v5010 ASC X12N implementation guides and associated errata adopted under the Health Insurance Portability and Accountability Act (HIPAA) clarifies and specifies the data content when exchanging electronically with the Indiana Health Coverage Programs (IHCP). Transmissions based on this companion guide, used in tandem with the v5010 ASC X12N implementation guides, are compliant with both ASC X12 syntax and those guides. 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.

Table of Contents

1 INTRODUCTION 4
1.1 SCOPE 5
1.2 OVERVIEW 5
1.2.1 OVERVIEW OF HIPAA LEGISLATION 5
1.2.2 COMPLIANCE ACCORDING TO HIPAA 5
1.2.3 COMPLIANCE ACCORDING TO ASC X12 5
1.3 REFERENCES 5
1.3.1 GOVERNMENT AND OTHER ASSOCIATIONS 5
1.3.2 ASC X12 STANDARDS 5
1.4 ADDITIONAL INFORMATION 6

2 GETTING STARTED 6
2.1 WORKING WITH THE IHCP 6
2.2 TRADING PARTNER REGISTRATION 6
2.3 CERTIFICATION AND TESTING OVERVIEW 7

3 TESTING WITH THE PAYER 7

4 CONNECTIVITY WITH THE PAYER/COMMUNICATIONS 8
4.1 PROCESS FLOWS 8
4.2 TRANSMISSION ADMINISTRATIVE PROCEDURES 9
4.3 COMMUNICATION PROTOCOL SPECIFICATIONS 9
4.4 PASSWORDS 9

5 CONTACT INFORMATION 9
5.1 GAINWELL EDI TECHNICAL ASSISTANCE 9
5.2 PROVIDER SERVICE 9
5.3 APPLICABLE WEBSITES/E-MAIL 10

6 CONTROL SEGMENTS / ENVELOPES 10
6.1 ISA – IEA 10
6.2 GS – GE 10

7 PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS 10
7.1 FILE STRUCTURE 10
7.2 837 CLAIM PROCESSING GUIDELINES 10
7.2.1 NPI CROSSWALK VALIDATION 10
7.2.2 REPLACEMENT AND VOIDED CLAIMS 11
7.2.3 ENCOUNTER CLAIMS 12

8 ACKNOWLEDGEMENTS AND/OR REPORTS 12

9 TRADING PARTNER AGREEMENTS 12

10 TRANSACTION-SPECIFIC INFORMATION 12
10.1 005010X223A1 HEALTH CARE CLAIM: INSTITUTIONAL (837) 13

11 APPENDICES 19
11.1 IMPLEMENTATION CHECKLIST 19
11.3 TRANSMISSION EXAMPLE 20
11.3 CHANGE SUMMARY 20

1 INTRODUCTION

This section describes how ASC X12N implementation guides (IGs) adopted under the Health Insurance Portability and Accountability Act (HIPAA) will be detailed with the use of a table. The tables contain a row for each segment that the Indiana Health Coverage Programs (IHCP) has something additional, over and above, the information in the IGs. That information can:

- Limit the repeat of loops, or segments
- Limit the length of a simple data element
- Specify a sub-set of the IGs internal code listings
- Clarify the use of loops, segments, composite and simple data elements

Any other information tied directly to a loop, segment, composite or simple data element pertinent to trading electronically with the IHCP.

In addition to the row for each segment, one or more additional rows are used to describe the IHCP's usage for composite and simple data elements and for any other information. Notes and comments are placed at the deepest level of detail. For example, a note about a code value is placed on a row specifically for that code value, not in a general note about the segment.

The following table specifies the columns and suggested use of the rows for the detailed description of the transaction set companion guides. The table contains a Notes/Comments column to provide additional information from the IHCP for specific segments provided by the TR3 implementation guides. The following is an example of the type of information that would be elaborated on in *Section 10: Transaction-Specific Information*.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
193	2100C	NM1	Subscriber Name			This type of row always exists to indicate that a new segment has begun. It is always shaded at 10%, and notes or comments about the segment itself go in this cell.
195	2100C	NM109	Subscriber Primary Identifier		15	This type of row exists to limit the length of the specified data element.
196	2100C	REF	Subscriber Additional Identification			
197	2100C	REF01	Reference Identification Qualifier	18, 49, 6P, HJ, N6		These are the only codes transmitted by the IHCP.
			Plan Network Identification	N6		This type of row exists when a note for a particular code value is required. For example, this note may say that value N6 is the default. Not populating the first three columns makes it clear that the code value belongs to the row immediately above it.
218	2110C	EB	Subscriber Eligibility or Benefit Information			
231	2110C	EB13-1	Product/Service ID Qualifier	AD		This row illustrates how to indicate a component data element in the Reference column and also how to specify that only one code value is applicable.

1.1 SCOPE

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.

1.2 OVERVIEW

1.2.1 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 healthcare transactions primarily between healthcare providers and plans. HIPAA directs the Secretary to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard HIPAA serves to:

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

1.2.2 COMPLIANCE ACCORDING TO HIPAA

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

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

1.2.3 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.

1.3 REFERENCES

In addition to the resources available on the Indiana Medicaid for Providers website (in.gov/medicaid/providers), there are other websites that contain helpful information to assist in the implementation of the electronic data interchange process. Links to these websites are listed below, separated by category for easy reference.

1.3.1 GOVERNMENT AND OTHER ASSOCIATIONS

Center for Medicare and Medicaid Services (CMS): http://www.cms.gov
WEDI – Workgroup for Electronic Data Interchange: http://www.wedi.org

1.3.2 ASC X12 STANDARDS

Washington Publishing Company: http://www.wpc-edi.com
Data Interchange Standards Association: http://www.disa.org
American Nation Standards Institute: http://www.ansi.org
Accredited Standards Committee: http://www.x12.org

1.4 ADDITIONAL INFORMATION

The American National Standards Institute (ANSI) is the coordinator for information on national and international standards. In 1979, ANSI chartered the Accredited Standards Committee (ASC) X12 to develop uniform standards for electronic interchange of business transactions and eliminate the problem of non- standard electronic data communication. The objective of the ASC X12 committee is to develop standards to facilitate electronic interchange relating to all types of business transactions. The ANSI X 12 standard is recognized by the United States as the standard for North America. Electronic Data Interchange (EDI) adoption has been proved to reduce the administrative burden on providers.

The intended audience for this companion guide is the technical and operational staff responsible for generating, receiving, and reviewing electronic healthcare transactions.

National Provider Identifier

As a result of HIPAA, the federal HHS adopted a standard identifier for healthcare providers. The Final Rule published by the HHS adopted the National Provider Identifier (NPI) as the standard identifier.

The NPI replaces all payer-specific identification numbers (such as the Medicaid provider number, known in Indiana as the IHCP Provider ID) on nationally recognized electronic transactions (also known as standard transactions); therefore, all healthcare providers are required to obtain an NPI to identify themselves on these transactions. The NPI is the only identification number that should be submitted on these transactions from a healthcare provider.

For all non-healthcare providers where an NPI is not assigned, the IHCP Provider ID should be submitted.

Additional information can be found on the *National Provider Identifier* page in the Provider Enrollment section of the Indiana Medicaid for Providers website at in.gov/medicaid/providers.

2 GETTING STARTED

2.1 WORKING WITH THE IHCP

Indiana Medicaid trading partners exchange electronic healthcare transactions with the IHCP via the Secure File Transfer Protocol-SFTP (File Exchange) or HTTPS/S Web Services connection.

After establishing a transmission method, each trading partner must successfully complete testing. Additional information is provided in *Section 3: Testing With the Payer*. Trading partners are permitted to enroll for Production connectivity after successful completion of testing.

2.2 TRADING PARTNER REGISTRATION

All trading partners enrolling for Production connectivity are required to complete the IHCP Trading Partner Profile and Trading Partner Agreement , accessible from the *Electronic Data Interchange (EDI) Solutions* page, in the Business Transactions section of the Indiana Medicaid for Providers website at in.gov/medicaid/providers.

Those trading partners that are using a currently enrolled billing agent, clearinghouse, or software vendor do not need to enroll separately. Only one trading partner ID is assigned per submitter location per connection type. If multiple trading partners are needed for the same address location, please attach a letter to the Trading Partner Agreement explaining the need for the additional trading partner ID. Providers must use the IHCP Provider Healthcare Portal to delegate a clearinghouse, billing agent, or software vendor access to retrieve their 835 (Electronic Remittance Advice). Information on how to delegate access is found in the *Provider Healthcare Portal* reference module.

Current trading partners that would like to request an update to their existing account must complete the IHCP Trading Partner Profile.

2.3 CERTIFICATION AND TESTING OVERVIEW

The Health Insurance Portability and Accountability Act (HIPAA) requires that all healthcare organizations that exchange HIPAA transaction data electronically with the Indiana Health Coverage Programs (IHCP) establish an electronic data interchange (EDI) relationship. All entities requesting to exchange data with the IHCP must be tested and approved by the IHCP before production transmission begins.

Vendors must review the X12N transaction HIPAA implementation guides and the IHCP companion guides to carefully assess the changes needed to their businesses and technical operations to meet the requirements of HIPAA. The national X12N transaction HIPAA implementation guides are available on the X12 website at x12.org.

3 TESTING WITH THE PAYER

The following steps describe the testing process for EDI vendors that have not yet been approved by the IHCP.

1. **Complete the Trading Partner Profile**
   The IHCP requires each testing entity exchanging data directly with the IHCP to complete and submit the IHCP Trading Partner Profile (accessible from the Indiana Medicaid for Providers website at in.gov/medicaid/providers) to initiate the testing process. When the IHCP receives the profile form, testing information is sent to the vendor. Follow the instructions received in the testing information to ensure accuracy and completeness of testing.

2. **Conduct application development**
   Trading partner testing includes HIPAA compliance testing as well as validating the use of conditional, optional and mutually defined components of the transaction. The vendor must modify its business application systems to comply with the IHCP companion guides.

3. **Test each transaction**
   Connectivity testing performed with the transmissions ensures a successful connection between the sender and receiver of data. Two levels of data testing are required:

   - **Compliance Testing**
     All transactions must pass data integrity, requirements, balancing, and situational compliance testing. Although third-party HIPAA certification is not required, the preceding levels of compliance are required and must be tested.

     Compliance is accomplished when the transaction is processed without errors. The software used by the IHCP for compliance checking and the translation of the HIPAA transaction is Edifecs.

   - **IHCP Specification Validation Testing**
     Specification validation testing ensures conformity to the IHCP companion guides. This testing ensures that the segments or records that differ based on certain healthcare services are properly created and produced in the transaction data formats. Validation testing is unique to specific relationships between entities and includes testing field lengths, output, security, load/capacity/volume, and external code sets.

4. **Become an IHCP-approved software vendor**
   The testing and approval process differs slightly for software developers, billing services, and clearinghouses. The processes are described in the following subsections.

   Software Developers

   Entities whose clients will be submitting directly to the IHCP are not required to become IHCP trading partners. When testing and approval are complete, the IHCP sends certification of approval to the software developer. On receipt of this approval, the software developer should inform its clients that its software has been approved. However, providers are required to complete the procedures outlined in *Section 2.2: Trading Partner Registration* to enroll for production connectivity.

Billing Services, Clearinghouses and Managed Care Entities

At completion of testing and approval, a certification of approval notification is sent to the vendor.

Billing services, clearinghouses, and managed care entities (MCEs) must submit a signed IHCP Trading Partner Agreement. The Trading Partner Agreement is a contract between parties that have chosen to become electronic business partners. This document stipulates the general terms and conditions under which the partners agree to exchange information electronically. The signed Trading Partner Agreement must be emailed to INXIXTradingPartner@gainwelltechnologies.com or faxed to 317-488-5185.

4 CONNECTIVITY WITH THE PAYER/COMMUNICATIONS

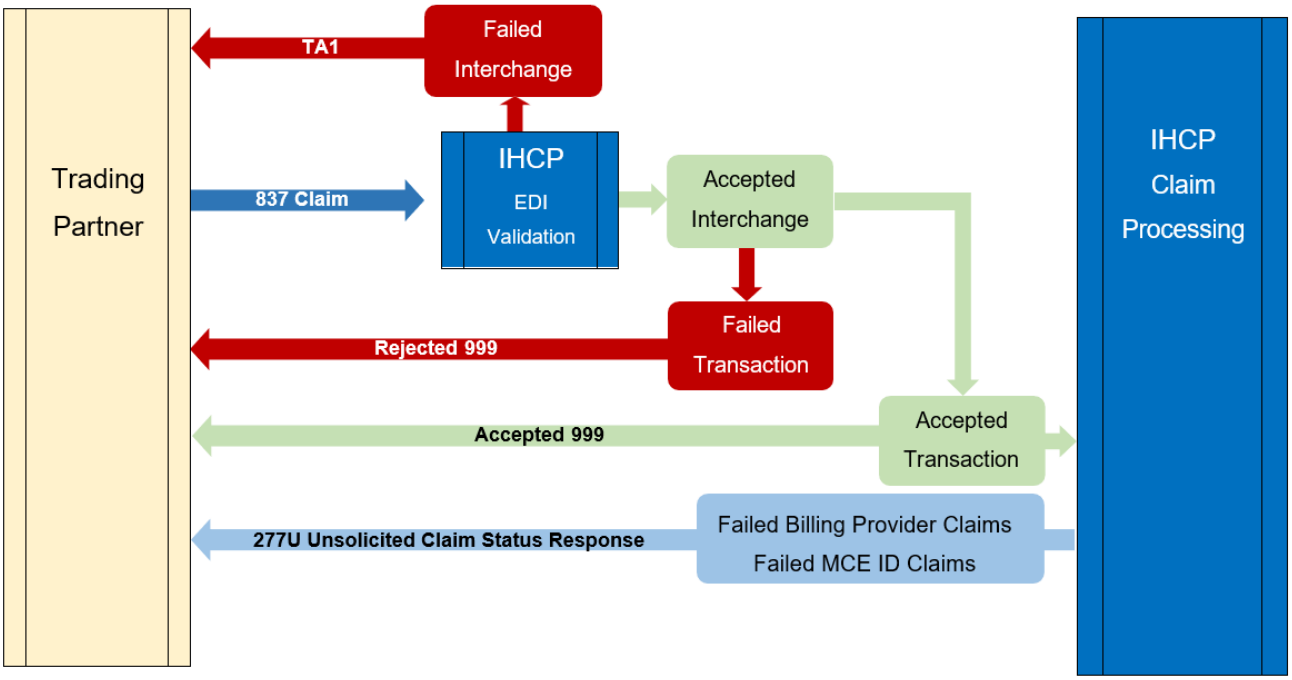
4.1 PROCESS FLOWS

The response to a batch 837I Health Care Claim will consist of the following:

1. First-level response: A TA1 will be returned when errors occur in the envelope (ISA-IEA) segments. A 999 will not be returned. All claims submitted in the batch file will not continue to claim processing.
2. Second-level response: A 999 acknowledgment will be returned reporting acceptance or rejection errors for all claims within each transaction set. Rejected claims will not continue to claim processing.
   - Please see the *IHCP TA1-999 Companion Guide* at in.gov/medicaid/providers for more information.
3. Possible third-level response: Accepted transactions are translated and processed.
   - Claims that contain invalid Billing Provider information or fail the billing provider crosswalk validation will deny and will not be finalized in the weekly financial run. They will be returned on a 277U Unsolicited Claim Status Response and not posted to the weekly Remittance Advice or 835 transaction. Please see the *277U IHCP Companion Guide* at in.gov/medicaid/providers for more information.

Each transaction is validated to ensure compliance with the ASC X12N/005010X223A2 TR3 implementation guide.

Transactions that fail this compliance will return a rejection status on the 999 acknowledgement with the error information indicating the compliance error. Transactions that pass this compliance will return an accepted status on the 999 acknowledgement and continue to next level processing.



4.2 TRANSMISSION ADMINISTRATIVE PROCEDURES

The IHCP is available only to authorized users. Submitters must be IHCP trading partners. A submitter is authenticated using a username and password assigned to the trading partner.

System Availability

The system is typically available 24 hours a day, seven days a week with the exception of scheduled maintenance windows. Scheduled maintenance information will be posted to the IHCP MOVEit (File Exchange) server at: https://mft.gainwelltechnologies.com/indiana-sftp in the announcements section.

Transmission File Size

The IHCP recommends that trading partners limit claim transmissions to no more than 5,000 claims per file.

File Naming Convention

Inbound File naming Convention Policy:

- All inbound filenames must have an extension. For example: <filename>.txt or <filename>.X12
- All inbound filenames must not contain invalid characters from the list below:

  / " ' < > | : ? * , { } [ ] ~ $ @ ( ) # & ^ ! % = + ; `
- All inbound filenames must not contain any spaces.
- All inbound filenames should be limited to 40 characters or less.

4.3 COMMUNICATION PROTOCOL SPECIFICATIONS

FTPS and SFTP using:

- MOVEit / File Exchange

More information can be found in the *IHCP Connectivity Guide* at in.gov/medicaid/providers.

4.4 PASSWORDS

By connecting to the IHCP File Exchange server, trading partners agree to adhere to the password policy including changing passwords every 90 days. Trading partners are responsible for managing their own data. Each trading partner is responsible for managing access to their organization's data through the IHCP security function. The contact on file for the login/user ID will receive a notification five days before the password expires and is required to manually log in and change the password. Accounts will be locked during the five-day period until the password is changed. Accounts will be disabled if the password is not changed within the five-day period. Locked and disabled accounts will cause automated connection scripts to receive an error and fail to connect. When the password is manually changed in File Exchange, the same change must be applied to all automated scripts to ensure uninterrupted service.

5 CONTACT INFORMATION

5.1 GAINWELL EDI TECHNICAL ASSISTANCE

PHONE: 800-457-4584
FAX: 317-488-5185
EMAIL: INXIXTradingPartner@gainwelltechnolgies.com

5.2 PROVIDER SERVICES

PHONE: 800-457-4584, please listen to the entire message before making your selection.

5.3 APPLICABLE WEBSITES/E-MAIL

Indiana Medicaid for Providers website: in.gov/medicaid/providers

Trading partner information can be found in the Business Transactions section of the Indiana Medicaid for Providers website, on the *Electronic Data Interchange (EDI) Solutions* page and its subpages.

For email addresses and other contact information, see the *Contact Us* page and the *IHCP Quick Reference Guide*, available under the Contact Information section of the website.

6 CONTROL SEGMENTS / ENVELOPES

6.1 ISA – IEA

837I Health Care Claim Interchange Control Header

- ISA06 (Interchange Sender ID): This is the four-byte sender ID assigned by the IHCP.
- ISA08 (Interchange Receiver ID): Required value is IHCP.
- ISA13 (Interchange Control Number): Must be unique per file.

6.2 GS – GE

837I Health Care Claim Functional Group Header

- GS02 (Application Sender Code): This is the four-byte sender ID assigned by the IHCP.
- GS03 (Application Receiver's Code): Required value is IHCP.

7 PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS

All references to "IHCP" in this companion guide refer to the Indiana Health Coverage Programs. All references to "IHCP Provider ID" in this companion guide refer to the Medicaid provider number assigned by the IHCP to a particular provider service location.

Before submitting electronic claims to the IHCP, please review the appropriate HIPAA Technical Report Type 3 (TR3) implementation guides and IHCP companion guides. . In addition, the IHCP recommends that trading partners review the IHCP provider reference modules and other resources available from the *Provider References* section of the Indiana Medicaid for Providers website at in.gov/medicaid/providers.

7.1 FILE STRUCTURE

- One interchange per file (ISA/IEA)
- One functional group per file (GS/GE)
- Multiple Transaction Sets per file are accepted (ST/SE)

7.2 837 CLAIM PROCESSING GUIDELINES

7.2.1 NPI CROSSWALK VALIDATION

With the implementation of NPI, transactions must be submitted with the NPI for healthcare providers.

BILLING PROVIDER CLASSIFICATION

The IHCP uses a crosswalk to establish a unique match between a billing provider's NPI and IHCP Provider ID. The crosswalk must successfully identify a unique IHCP provider service location. Three data elements are used in the crosswalk to identify a unique location if the NPI is associated with multiple service locations:

- NPI – Loop 2010AA NM109
- Taxonomy Code (if sent) – Loop 2000A PRV03
- Billing Provider Service Location Zip Code – Loop 2010AA N403

If the crosswalk does not establish a unique one-to-one match for the billing provider, the claim will deny in claim processing. A 277U response will be sent back to the trading partner who submitted the claim file reporting an error with the billing provider. See the *IHCP 277U Companion Guide* at in.gov/medicaid/providers for more information.

OTHER PROVIDER CLASSIFICATIONS

For all other provider classifications, the IHCP uses a crosswalk to establish a unique match between a provider's NPI and IHCP Provider ID. The crosswalk must successfully identify a unique IHCP provider service location. Two data elements are used in the crosswalk to identify a unique location if the NPI is associated with multiple service locations:

- NPI – Loop appropriate for applicable other provider classification NM109
- Taxonomy Code (if sent) – Loop appropriate for applicable other provider classification PRV03

If the crosswalk does not establish a unique one-to-one match for the other provider, the claim will deny in claims processing.

7.2.2 REPLACEMENT AND VOIDED CLAIMS

FEE-FOR-SERVICE CLAIMS

- Replacement requests submitted before 3 p.m. Eastern Time during a normal business day may take up to one business day to process. The primary reason this may occur is that the original claim has already been through a financial cycle.
- The IHCP Provider ID and service location information must be identical on a replacement as it appeared on the claim being replaced.
- The provider NPI must crosswalk to the same IHCP provider service location on a replacement as the claim being replaced.
- A replacement cannot be older than one year from the last activity that occurred on the claim being replaced.
- A replacement request cannot be performed against a denied claim due to a previous void request.
- The IHCP Provider ID, service location and member information must be identical on a void as appeared on the claim being voided.
- The provider NPI must crosswalk to the same IHCP provider service location on a void as the claim being voided.
- A void cannot be processed against a claim that was previously denied.
- The type of claim on a replacement or void must be the same type on the claim being replaced or voided.
- A replacement or void must be made against the most recent occurrence of the claim.
- A replacement or void must be made against an IHCP claim that is found in the Indiana *Core*MMIS database.

ENCOUNTER CLAIMS

- The MCE ID, Provider ID, and member information must be identical on a replacement or void as it appeared on the claim being replaced or voided.
- The type of claim on a replacement or void must be the same type on the claim being replaced or voided.
- A replacement or void cannot be older than two years from the dates of service on the claim being replaced or voided.
- A replacement or void must be made against the most recent occurrence of the claim.
- A replacement or void must be made against an IHCP claim that is found in the Indiana *Core*MMIS database.
- A void cannot be processed against a claim that was previously denied.
- A replacement request cannot be performed against a denied claim due to a previous void request.

7.2.3 ENCOUNTER CLAIMS

- The billing provider patient account number must be sent in Loop 2300 CLM01.
- The MCE internal control number (ICN), also known as Claim ID, must be sent in Loop 2330B REF02 – Other Payer Claim Control Number.
- The MCE ID and region code must be sent in Loop 2010BB REF02 with the LU qualifier.
  - Region codes of 1-9 must be submitted for dates of service previous to **6/1/2018**
  - Encounters submitted for dates of service on or after **6/1/2018** must be submitted with a region code of 'A'.
  - Encounters submitted with a missing or invalid MCE ID and region code will deny in claim processing. A 277U response will be sent back to the MCE reporting an error with the MCE ID. See the *IHCP 277U Companion Guide* at in.gov/medicaid/providers for more information.

8 ACKNOWLEDGEMENTS AND/OR REPORTS

TA1 Interchange Acknowledgment Outbound

The TA1 Interchange Acknowledgment is a means of replying to an interchange or transmission that has been sent. The TA1 verifies the envelope only. A TA1 Interchange acknowledgment is returned only in the event there are envelope errors. Encompassed in the TA1 are the interchange control number, interchange date and time, interchange acknowledgment code, and the interchange note code.

999 Functional Acknowledgement

The 999 Functional Acknowledgement is returned to confirm that a file was received and indicate if the submitted transactions passed standard level syntax and structure editing. The 999 includes information about whether the transaction had errors. Trading partners are responsible for retrieving the 999 response files to determine the accepted or rejection status of the transactions.

9 TRADING PARTNER AGREEMENTS

The IHCP Trading Partner Agreement is a contract between parties that have chosen to become electronic business partners. The Trading Partner Agreement stipulates the general terms and conditions under which the partners agree to exchange information electronically. If billing providers send multiple transaction types electronically, only one signed Trading Partner Agreement is required. Billing providers must print and complete a copy of the Trading Partner Agreement. The signed copy must be submitted to the IHCP EDI Solutions Unit.

More information can be found in the *Electronic Data Interchange (EDI) Solutions* webpage, in the Business Transactions section of the Indiana Medicaid for Providers website at in.gov/medicaid/providers.

10 TRANSACTION-SPECIFIC INFORMATION

This section describes how ASC X12N implementation guides (IGs) adopted under HIPAA will be detailed with the use of a table. The tables contain a row for each segment that the IHCP has something additional, over and above the information in the IGs. That information can:

1. Limit the repeat of loops, or segments
2. Limit the length of a simple data element
3. Specify a sub-set of the IGs internal code listings
4. Clarify the use of loops, segments, composite and simple data elements
5. Any other information tied directly to a loop, segment, composite or simple data element pertinent to trading electronically with the IHCP.

In addition to the row for each segment, one or more additional rows are used to describe the IHCP's usage for composite and simple data elements and for any other information. Notes and comments are placed at the deepest level of detail. For example, a note about a code value is placed on a row specifically for that code value, not in a general note about the segment.

The following table specifies the columns and suggested use of the rows for the detailed description of the transaction set companion guides.

10.1 005010X223A1 HEALTH CARE CLAIM: INSTITUTIONAL (837)

PAGE #	LOOP ID	REFERENCE	NAME	CODES	LENGTH	NOTES/COMMENTS
68		BHT	Beginning of Hierarchical Transaction			
69		BHT06	Transaction Type Code	CH RP		Indiana Health Coverage Programs (IHCP) uses CH for fee-for-service (FFS) claims and RP for encounter claims.
71	1000A	NM1	Submitter Name			
72	1000A	NM109	Identification Code			IHCP assigned sender ID; the first character is alphabetic followed by three numeric characters.
80	2000A	PRV	Billing Provider Specialty Information			
80	2000A	PRV03	Reference Identification			IHCP may need the taxonomy code for a successful NPI to IHCP Provider ID. The crosswalk must successfully identify a unique billing provider. Refer to *Section 7.2.1: NPI Crosswalk Validation*.
88	2010AA	N4	Billing Provider, City, State, ZIP Code			
89	2010AA	N403	Postal Code			Refer to *Section 7.2.1: NPI Crosswalk Validation*.
109	2000B	SBR	Subscriber Information			
110	2000B	SBR09	Claim Filing Indicator Code	MC		IHCP uses MC – Medicaid
112	2010BA	NM1	Subscriber Name			
113	2010BA	NM108	Identification Code Qualifier	MI II		IHCP Medicaid claims are coded with MI. IHCP Medical Review Team (MRT) / Preadmission Screening Resident Review (PASRR) claims are coded with II.
114	2010BA	NM109	Identification Code		12	IHCP Member ID for Medicaid claims is 12 digits. The Member ID for MRT/PASRR claims is 12 digits.
122	2010BB	NM1	Payer Name			
123	2010BB	NM103	Name Last or Organization Name	IHCP		IHCP uses IHCP

PAGE #	LOOP ID	REFERENCE	NAME	CODES	LENGTH	NOTES/COMMENTS
123	2010BB	NM109	Identification Code	IHCP		IHCP uses IHCP
129	2010BB	REF	Billing Provider Secondary Identification			IHCP atypical billing providers use this segment to send their IHCP Provider ID. Managed care entities (MCEs) submitting encounter claims must include their MCE ID and appropriate region code in a repeat of this segment. Refer to *Section 7.2.3: Encounter Claims*.
129	2010BB	REF01	Reference Identification Qualifier	G2 LU		IHCP expects G2 to be used by atypical providers and LU to be used only by MCEs.
130	2010BB	REF02	Reference Identification			Atypical billing providers send their IHCP Provider ID.
143	2300	CLM	Claim Information			The IHCP processes a maximum of 5000 CLM segments per ST-SE transaction set.
144	2300	CLM01	Claim Submitter's Identifier			Encounter claims must send the billing provider's patient account number in this element.
145	2300	CLM05-01	Facility Code Value			For valid codes, see the *Place of Service Code Set* page on the CMS website at cms.gov.
145	2300	CLM05-03	Claim Frequency Type Code	1 7 8		IHCP uses: 1 – Original 7 – Replacement 8 – Void
153	2300	CL1	Institutional Claim Code			
153	2300	CL101	Admission Type Code	1 2 3 4 5 9		IHCP uses Admission Type Codes 1 – Emergency 2 – Urgent 3 – Elective 4 – Newborn 5 – Trauma 9 – Unspecified
154	2300	PWK	Claim Supplemental Information			IHCP ignores this segment if BHT06=RP or if the claim is a Medicare submitted crossover claim.
156	2300	PWK02	Report Transmission Code	BM		IHCP only accepts required attachments by mail.
157	2300	PWK06	Identification Code			IHCP supports attachment control numbers of up to 30 characters.
170	2300	REF	Claim Identifier for Transmission Intermediaries			

PAGE #	LOOP ID	REFERENCE	NAME	CODES	LENGTH	NOTES/COMMENTS
170	2300	REF02	Reference Identification			This transmission intermediary claim identifier is returned on the 999 as the CLM01 value when a claim level rejection is encountered.
173	2300	REF	Medical Record Number			
173	2300	REF02	Reference Identification			IHCP recognizes the first 30 characters.
180	2300	NTE	Billing Note			IHCP uses this segment for MCE T-MSIS data element reporting.
180	2300	NTE01	Note Reference Code	ADD		ADD – Additional Information T-MSIS – valid code for 837I is ADD (Additional Information)
181	2300	NTE02	Description		80	Remittance Number, Check Number, Allowed Charge SRC and Check Effective Date are required for MCE T-MSIS data element reporting: • Concatenated information should be separated by a Pipe Delimiter character, '|' (Pipe). • Enter 'TMSIS' followed by Remittance Number, Check Number, Allowed Charge SRC and Check Effective Date • The NTE02 Field allows up to 80 characters, only the first 30 characters of a Remittance Number and first 15 characters of a Check Number will be retained. i.e. TMSIS|123456789|123456789|MAXFEE|20180401|
						Allowed-Charge SRC ANESTH Anesthesia ASC Outpatient Surgical BILLED Percentage of Billed DRG Inpatient Acute Care FLTFEE Revenue Flat Fee HSP Hospice HSPLOC Hospice LOC INLOC IP Psy Rehab Mental Hlth LTCLOC Long Term Care MAXFEE Max Fee SYSMAN Manual pricing RBRVS RBRVS UCC Provider Specific MANUAL Used in claims coding

PAGE #	LOOP ID	REFERENCE	NAME	CODES	LENGTH	NOTES/COMMENTS
218	2300	HI	Diagnosis Related Group (DRG) Information			
219	2300	HI01-02	Industry Code			IHCP recognizes the first five characters
258	2300	HI	Occurrence Span Information			IHCP recognizes the first two characters of the occurrence code IHCP requires MCEs to submit the Occurrence Code End Dates for T-MSIS reporting purposes
258 – 269	2300	HI01-02 – HI11-02	Industry Code			IHCP recognizes the first two characters of the occurrence code. IHCP valid values are located in the IHCP provider reference modules.
259	2300	HI01-04	Date Time Period			Occurrence Span Code Date – MCEs can submit up to twelve occurrence code end dates. MCE can populate the Effective Date and End Date with the same date when an occurrence span is not applicable.
271	2300	HI	Occurrence Information			
271 – 278	2300	HI01-02 – HI08-02	Industry Code			IHCP recognizes the first eight occurrence codes. IHCP valid values are located in the IHCP provider reference modules.
284	2300	HI	Value Information			
284 – 293	2300	HI01-02 – HI12-02 HI01-02	Industry Code			IHCP valid values are located in the IHCP provider reference modules HI01-02 = 81-Non-Covered Days: MCEs are required to submit for T-MSIS data element reporting.
294	2300	HI	Condition Information			
294 – 299	2300	HI01-02 – HI07-02	Industry Code			IHCP maximum number of condition codes used for processing is seven. IHCP valid values are located in the IHCP provider reference modules.
313	2300	HCP	Claim Pricing/Repricing Information			IHCP uses this segment for MCE reporting of header level allowed amount.
314	2300	HCP02	Monetary Amount			MCE Allowed Amount is reported here.
354	2320	SBR	Other Subscriber Information			

PAGE #	LOOP ID	REFERENCE	NAME	CODES	LENGTH	NOTES/COMMENTS
356	2320	SBR09	Claim Filing Indicator Code			IHCP uses the Claim Filing Indicator Code to identify Medicare crossover claims. If the claim is a crossover, the Claim Filing Indicator must be set to one of the following: MA – Medicare Part A MB – Medicare Part B 16 – Health Maintenance Organization (HMO) Medicare Risk Encounters: Use code MC – Medicaid in SBR09 when reporting MCE coordination of benefit information.
358	2320	CAS	Claim Level Adjustments			Medicare Part A deductible, coinsurance/copayment and blood deductible amounts must be submitted at the claim level.
360 – 363	2320	CAS02, CAS05, CAS08, CAS11, CAS14, CAS17	Claim Adjustment Reason Code			Only Medicare deductible, coinsurance/copayment, and blood deductible adjustments are used by IHCP for crossover claim processing. 1 – Deductible 2 – Coinsurance 3 – Co-payment 66 – Blood Deductible
360 – 363	2320	CAS04, CAS07, CAS10, CAS13, CAS16, CAS19	Quantity			IHCP maximum quantity processed is 9999999.999
370	2320	MIA	Inpatient Adjudication Information			IHCP uses the Inpatient Adjudication Information for MCE T-MSIS data element reporting.
370	2320	MIA05, MIA20, MIA21, MIA22, MIA23	Reference Identification			MIA05, MIA20, MIA21, MIA22, MIA23 – MCEs can submit up to five unique Claim Payment Remark Codes to be used for T-MSIS data element reporting.
		MIA15	Quantity			MIA15 – MCEs should submit the Outlier Days, this field will specify the number of days paid as outliers under Prospective Payment System (PPS) and the days over the threshold for the DRG.
		MIA17	Monetary Amount			MIA17 – MCEs should submit the DRG Outlier Amount, the additional payment on a claim that is associated with either a cost outlier or length of stay outlier.

PAGE #	LOOP ID	REFERENCE	NAME	CODES	LENGTH	NOTES/COMMENTS
374	2320	MOA	Outpatient Adjudication Information			IHCP uses the Outpatient Adjudication Information for MCE T-MSIS data element reporting.
375	2320	MOA03, MOA04, MOA05, MOA06, MOA07	Reference Identification			MCEs can submit up to five unique Claim Payment Remark Codes to be used for T-MSIS data element reporting.
384	2330B	NM1	Other Payer Name			Claims submitted to Medicare that are expected to crossover to the IHCP, must include this segment and contain the payer ID assigned to the IHCP by Medicare.
385	2330B	NM109	Identification Code			Claims submitted to Medicare, that are expected to crossover to the IHCP, must use the payer ID assigned to the IHCP by Medicare – 70035 For Hoosier Healthwise (HHW) encounter claims, the payer identifier should be from this list: 300119960 – Managed Health Services (MHS) 500307680 – MDwise 400752220 – Anthem 700410350 – CareSource For Healthy Indiana Plan (HIP) encounter claims, the payer identifier should be from this list: 555763410 – MDwise 455701400 – Anthem 355787430 – MHS 755726440 – CareSource For Hoosier Care Connect (HCC) encounter claims, the payer identifier should be from this list: 399243310 – MHS 499254630 – Anthem 699842000 – UnitedHealthcare For Indiana PathWays for Aging Program (PATH) Encounter Claims, the payer identifier should be from this list: 600049000 – United Healthcare 600024500 – Humana 600012250 – Anthem Any other payers are identified as third-party liability (TPL).
395	2330B	REF	Other Payer Claim Control Number			

PAGE #	LOOP ID	REFERENCE	NAME	CODES	LENGTH	NOTES/COMMENTS
423	2400	LX	Service Line Number			
424	2400	SV2	Institutional Service Line			
428	2400	SV205	Quantity			IHCP maximum quantity processed is 9999999.999
429	2400	PWK	Line Supplemental Information			
431	2400	PWK02	Report Transmission Code	BM		IHCP only accepts required attachments by mail
432	2400	PWK06	Identification Code			IHCP supports attachment control numbers of up to 30 characters
442	2400	HCP	Claim Pricing/Repricing Information			IHCP uses this segment for MCE reporting of header level allowed amount.
443	2400	HCP02	Monetary Amount			MCE Allowed Amount is reported here.
452	2410	CTP	Drug Quantity			IHCP uses this segment for MCE T-MSIS reporting purposes.
452	2410	CPT04	Quantity			IHCP maximum quantity processed is 9999999.999
480	2430	CAS	Line Adjustment			
482 – 485	2430	CAS02, CAS05, CAS08, CAS11, CAS14, CAS17	Claim Adjustment Reason Code			Only Medicare deductible, coinsurance/copayment, and blood deductible adjustments are used by IHCP for crossover claim processing. 1 – Deductible 2 – Coinsurance 3 – Co-payment 66 – Blood Deductible
482 – 485	2430	CAS04, CAS07, CAS10, CAS13, CAS16, CAS19	Quantity			IHCP maximum quantity processed is 9999999.999

11 APPENDICES

11.1 IMPLEMENTATION CHECKLIST

See trading partner information linked from the *Electronic Data Interchange (EDI) Solutions* webpage, on the Indiana Medicaid for Providers website at in.gov/medicaid/providers.

11.3 TRANSMISSION EXAMPLE

```
ISA*00*          *00*          *ZZ*TPID        *ZZ*IHCP        *200404*0457*^*00501*714787803*1*P*>~
GS*HC*TPID*IHCP*20140404*0457*714787803*X*005010X223A2~
ST*837*714787803*005010X223A2~
BHT*0019*00*714787803*20140404*0457*CH~
NM1*41*2*TPNAME*****46*TPID~
PER*IC*TPCONTACT*TE*0000000000~
NM1*40*2*IHCP*****46*IHCP~
HL*1**20*1~
PRV*BI*PXC*208D00000X~
NM1*85*2*PROVIDERNAME*****XX*0000000000~
N3*PROVIDERADDRESS~
N4*CITY*ST*000000000~
REF*EI*000000000~
HL*2*1*22*0~
SBR*P*18*******MC~
NM1*IL*1*LASTNAME*FIRSTNAME****MI*000000000000~
N3*MEMBERADDRESS~
N4*CITY*ST*000000000~
DMG*D8*00000000*F~
NM1*PR*2*IHCP*****PI*IHCP~
CLM*10000*1188***13>A>1**A*Y*Y~
DTP*434*RD8*2020327-2020327~
CL1*3*1*01~
HI*ABK>V000~
HI*APR>V000~
NM1*71*1*XXXXX*XXXXXX****XX*000000000~
PRV*AT*PXC*208D00000X~
NM1**72*2*XXXXX*XXX****XX*000000000~
LX*1~
SV2*0300*HC>36415*18.8*UN*1~
DTP*472*D8*20200327~
REF*6R*12345~
SE*97*714787803~
GE*1*714787803~
IEA*1*714787803~
```

11.3 CHANGE SUMMARY

This section describes the differences between the current companion guide and previous guide(s).

AIM System Change Summary

Version	DDI CO	CO Name	Revision Date	Revision Status	Revision Page Numbers / Change / Update Details	Completed By
2.0			Jan 2013	Implemented	CAQH CORE format	Systems
2.1	2145		Jan 2014	Implemented	CO 2145 Update	Systems
2.2	2405		Sep 2014	Implemented	CO 2405 Update	Systems
2.3	2445		Feb 2015	Implemented	Add MCE IDs for Hoosier Care Connect (HCC)	Systems
2.4	2451	HIP LINK R2	Aug 2015	Implemented	Pg. 10: Loop 2010BA NM109 – Added information for HIP Link Claims: For HIP Link Claims, the member ID must be prefixed with an ‘L’ Pg. 12: Loop 2300 NTE01 – Added HIP Link Claims Other Payer Allowed Amount uses UPI – Updated Information PG 12: Loop 2300 NTE02 – Added HIP Link Claims Code Other Payer Allowed Amount reported in this data element	Systems

*Core*MMIS Change Summary

Version	DDI CO	CO Name	Revision Date	Revision Status	Revision Page Numbers / Change / Update Details	Completed By
--	9538	45796 – HPE Rebranding – EDI Forms	Mar 2016	Implemented	Throughout document - Changed Hewlett Packard (HP) to Hewlett Packard Enterprise (HPE).	Systems
		Correction	Apr 2016	Implemented	Pg. 21 – Added bullet 4.2.5.3 – IHCP expects only one iteration of the functional group control segment	Systems
	CR 50755	CareSource MCE Onboarding	Oct 2016	Implemented	Pg. 16-17: Loop 2330B NM109 – Added the CareSource encounter claims payer identifier for HHW and for HIP. Pg. 18 – Revised bullet 4.2.1.1, claim will deny in claims processing if a one-to-one match for billing provider is not established, this will no longer be reported on a Submission Summary Report. Pg. 19 – Removed bullet "4.2.2 Submission Summary Report (SSR)"	Systems
3.0			Dec 2016	Implemented	Indiana *Core*MMIS Implementation	Systems
3.1			Jan 2017	Implemented	Pg. 15: Loop2330B NM109 – Removed reference to Medicare Payer ID validation. This will no longer be validated. Pg.9: Loop2300 CLM01 – Removed 'IHCP supports patient account numbers of up to 20-characters.' IHCP now supports implementation guide standard maximum length.	Systems
3.2		Rebranding	Apr 2017	Implemented	Updated throughout document Hewlett Packard Enterprise (HPE) to DXC Technology	Systems
3.3	CR52057		Jan 2018	Implemented	Updated to CAQH CORE Formatting. Pg. 15: Loop 2010BB REF – Updated MCE region code requirement of 'A'. Pg. 15: Loop 2300 CN1 segment – Removed. The *Core*MMIS system does not validate this data.	Systems
	CR56691		Mar 2018		Pg. 15: Loop 2300 NTE – Added MCE T-MSIS claim information requirements. Pg. 16: Loop 2300 HI-Value Information – Added MCE T-MSIS information for HI01-02. Pg. 17: Loop 2320 MIA: Inpatient Adjudication Information – Added information for MCE T-MSIS reporting.	
	CR56692		Mar 2018		Pg. 16: Loop 2320 MIA: Inpatient Adjudication Information – Added information for MCE T-MSIS reporting Pg. 16: Loop 2300 HI – Added information for MCE T-MSIS reporting	
	CR57000		Mar 2018		Pg. 18: Loop 2410 CTP05-1 – Added information for MCE T-MSIS reporting	
	CR52057		Mar 2018		Pg. 12, Section 7.2.2: Voids and Replacement – Updated Encounter information for MCE region code requirement for Voids and Replacements Pg. 13, Section 7.2.4: Encounter Claims – Added region code information based on dates of service and implementation effective date	
	CR52057		May 2018		Pg. 12 – Section 7.2.4: Encounter Claims – Updated Region Code effective date from 5/1/2018 to 6/1/2018	

Version	DDI CO	CO Name	Revision Date	Revision Status	Revision Page Numbers / Change / Update Details	Completed By
3.4	14804	Correction Correction	Jan 2019	Implemented	Pgs. 6–14 and Pg. 20 – Updates to IHCP Provider website links Pg. 12 – Section 7.2.1 NPI Crosswalk Validation – Correction to Loop identifiers Pg. 13 – Removed Coordination of Benefits (COB) Assumptions section Pg. 17 – Loop 2300 – REF02 segment – Added Transmission Intermediary claim identifier information for reporting on 999	Systems
3.5	58053	File Exchange Domain Name Change Correction	Jul 2019 Jul 2019		Pg. 11 – Changed link to File Exchange server to https://sftp.indianamedicaid.com Pg. 21 – Removed row for 2400 SV202-1 Product/Service ID Qualifier HC – IHCP processes claims with HC in this element – this statement was invalid	Systems
3.6			Aug 2019		Pg. 19 – Added Encounters: Use code MC – Medicaid in SBR09 when reporting MCE coordination of benefit information. Loop 2320, SBR09	Systems
3.7	CR61126	Add UnitedHealthcare for HCC	Mar 2021		Pg. 18: Loop 2320 – SBR09 values added Pg. 20: Loop 2330B, NM109, Other Payer Identifier – Added UnitedHealthcare Updated DXC to Gainwell	Systems
3.8			Mar 2022	Implemented	Pg. 10 – Added statement to limit filename to 40 bytes or less Pg. 20-21 – Removed payer IDs for obsolete HIP and HCC MCEs. Removed references to HIP Link. Updated trading partner email address and phone extension.	Systems
3.9	 CO 12414 GT-14002	Update Correction Update Update	Aug 2024 Jul 2024 Jul 2024		Pg. 7 – Updated link for implementation guides Pg. 9 – Changed link to File Exchange server to https://mft.gainwelltechnologies.com/indiana-sftp Pg. 9, Section 4.2 – Corrected inbound filename limit from “40 bytes” to “40 characters” Pg. 9, Section 5.2 – Corrected Provider Services phone number Pg. 18: Loop 2330B, NM109, Other Payer Identifier – Added Indiana PathWays for Aging (PATH) Pg. 16: Loop 2300, Claim Pricing/Repricing Information – Added IHCP uses this segment for MCE reporting of header level allowed amount. Pg. 16: Loop 2300, HCP02, Monetary Amount – Added MCE Allowed Amount is reported here. Pg. 19: Loop 2400, HCP, Claim Pricing/Repricing Information – Added IHCP uses this segment for MCE reporting of header level allowed amount. Pg. 19: Loop 2400, HCP02, Monetary Amount – Added MCE Allowed Amount is reported here.	 Systems Systems