

## Health New England X12 837 Claims Companion Guide

HNE has developed the following Companion Guide as a support tool for our trading partners when submitting electronic Professional and Institutional claims. HNE accepts such claims in the format described in the *National Electronic Data Interchange Transaction Set Implementation Guide*, ASC X12 837, version 004010. (We also may refer to this as the *HIPAA Implementation Guide*, or “the Guide.”) HNE will accept Professional and Institutional claims in the format consistent with forms 004010X098A1 and 004010X096A1 respectively, both published in October 2002. Washington Publishing Company registered users may download pdf files of these Guides at <http://www.wpc-edi.com>.

Our trading partners may select from several different options for filing claims electronically:

- Providers can submit files through HNEDirect, our secure website (HNE providers only).
- All trading partners can submit files to our FTP server
- HNE can retrieve files from a trading partner’s FTP server.
  
- HNE can receive and send files through NEHEN if you are registered with NEHEN. See <http://www.nehen.com> for more information on membership benefits.
  
- Clearinghouses – See **Clearinghouse** under HIPAA for a complete list.

If you are not filing your claims electronically and you would like more information, please contact HNE’s Provider Relations Department 413-787-4000, extension 5000 or by email at [provideroperations@hne.com](mailto:provideroperations@hne.com).

EDI files are processed on business days between 8:00 AM and 1:00 PM. Files received after 1:00 PM will be processed at 8:00 AM the next business day.

All text data on the EDI file must be in Uppercase.

### **Envelope Structure**

We understand that we are only one of your many trading partners – we do not expect you to customize your content just for us. HNE uses ECTMap® and ECGateway® from Sybase to process EDI (X12) transactions. Because of the flexibility of this software, we have a limited number of filing requirements which are described below:

**Segments per line:** We do not require EDI files with one segment per line. EDI files may be submitted as one continuous string of text.

**Delimiters:** We have no standard or preference for delimiters. If you have no standard or preference, follow the *HIPAA Implementation Guides*.

Health New England  
X12 837 Claims Companion Guide

**Control Segments:** Please use the standard EDI file guidelines described in the HIPAA Implementation Guide, Appendix B, for control segments.

**ISA Segment:** The ISA Segment is the first line that HNE receives in an EDI file. Some elements within each ISA segment have a number of possible values. Please use the following values for each ISA element:

ISA01	00
ISA02	10 spaces
ISA03	00
ISA04	10 spaces
ISA05	Please do not use the value ZZ. We can accept all other codes listed in appendix B.1, however we prefer 30.
ISA06	Assign the value based on the qualifier in ISA05. If you use 30 in ISA 05, please use your U.S. Federal Tax Identification Number.
ISA07	Please do not use the value ZZ. We can accept 01, 30, or 33; however, we prefer 30.
ISA08	Based on which qualifier you use in ISA07, these values can be used:
	Qualifier      Value
	01              152427324
	30              042864973
	33              95673

For other ISA elements, please follow the implementation guide.

**GS Segment:** Please use the following values for each GS element.

GS01	HC
GS02	We can accept anything, but prefer to mimic what is in ISA06
GS03	We can accept anything, but prefer to mimic what is in ISA08

For other GS elements, please follow the implementation guide.

**Control Numbers:** At least one of the ISA, GS and ST control numbers must increment from one day to the next. Although this is left to your preference, please note below the effect that this may have on the 997 Functional Acknowledgment.

**997 Functional Acknowledgment transaction:** The 997 Functional Acknowledgment transaction does not reflect the ISA control number received on the 837 Claim. If you want to use the 997 to reconcile the 837 (or any other transaction we do in the future) then the GS and/or ST control numbers should increment from day to day.

**Multiple submissions:** There are no restrictions for multiple submissions:

## Health New England X12 837 Claims Companion Guide

- We can accept multiple ISA-IEA envelopes within a single file.
- We can accept multiple GS-GE envelopes within a single ISA-IEA.
- We can accept multiple ST-SE envelopes within a single GS-GE.
- We can accept multiple billing providers (2000 loop) within a single ST-SE envelope.

### Compliance Test

All files must pass a stringent *HIPAA Implementation Guide* compliance test in order for the 837 transaction to be accepted. This test interprets the “gray box” information in the *HIPAA Implementation Guides*. A single error will result in the rejection of the entire transaction (ST-SE envelope).

Following the compliance test, the 837 transaction will trigger a 997 Functional Acknowledgment, either accepting the transaction or rejecting it with an explanation. See Appendix B in the *HIPAA Implementation Guide* for a description of the 997 Functional Acknowledgment.

At this time HNE can not generate a TA1 Interchange Acknowledgment.

### Claims Content

**PRV segment:** We can accept provider taxonomy code, but they are not required.

**Zero charges:** Charges may be zero at the claim level (CLM02) or service level (SV102 or SV203).

### HNE Requirements:

- **WHAT:** The 11-digit member number assigned by HNE  
**WHERE:** On an NM1 segment with a MI qualifier in NM108.  
This can be sent in the subscriber loop or the patient loop; the patient loop will override the subscriber loop.
- **WHAT:** Patient related to subscriber.  
**WHERE:** On a NM1 segment in the patient loop in NM109.  
The first nine digits of the patient member # must match the first nine digits of the subscriber member #.
- **WHAT:** The patient's valid date of birth  
**WHERE:** On a DMG segment with a “D8” qualifier in DMG01 and the birth date in DMG02.  
This can be sent in the subscriber loop or the patient loop; the patient loop will override the subscriber loop.

Health New England  
X12 837 Claims Companion Guide

- WHAT: A 2-digit Health Care Service Location Code
- WHERE: In CLM05.
  
- WHAT: A 3-, 4- or 5-digit value (first position could be a letter) with an appropriate qualifier preceding each Diagnosis Code.  
WHERE: On an HI segment.  
Send Diagnosis Codes at the Claim level for both institutional and professional claims.
  
- WHAT: For Professional claims, each service line must contain at least 1 diagnosis pointer  
WHERE: In the SV segment, element SV107-1 thru SV107-8.  
Acceptable values are 1 through 8. The value of the pointer must correspond to the appropriate diagnosis code entered in the HI segment.
  
- WHAT: For Institutional claims, Procedure codes  
WHERE: On an HI segment .  
For the principal procedure code, the qualifier must be “BR” in HI01-1. The principal procedure code must be in HI01-2. For other procedure codes the qualifier must be “BQ”.
  
- WHAT: The service date.  
WHERE: On a DTP segment on the individual service lines for institutional and professional claims.  
The date qualifier, DTP01, must be “472”, the date format qualifier, DTP02, can be “D8” for a date expression or “RD8” for a range of dates expression and the date in DTP03 must be a valid date.
  
- WHAT: The claim charges in the following segments based on claim type:  
WHERE:
  - Professional Claims - On a SV1 segment in the SV102 element.
  - Institutional Claims - On a SV2 segment in the SV202 element.
  
- We require minutes in the SV104 element if an anesthesia modifier is in the SV101 element on professional claims.
  
- All dates must be valid dates.
  
- **For Institutional claims**, the SV205 (Quantity alias Service Unit Count) element must be a positive integer. Zero is not allowed.
  
- **For Professional claims**, the SV104 (Quantity alias Service Unit Count) element must be a positive integer. Zero is not allowed.
  
- Claims from Institutions that are not part of HNE's provider network with dates of service prior to 1/1/2004 must be sent on paper.

Health New England  
X12 837 Claims Companion Guide

Claims that fail any of the above requirements will be rejected using a Rejected Claim Letter. This rejection is at the claim level. We address this letter to the Provider from the billing provider loop. Claims that meet the above requirements are subject to HNE membership eligibility and coverage criteria.

At this time, HNE cannot process secondary COB claims. When another payer has primary responsibility and has made payment, please submit the claim on paper (CMS-1500 or UB-04) with a copy of the primary payer's Explanation of Payment.

For each trading partner and each transaction, we keep track of primary and secondary contacts, including name, address, phone, and e-mail. Please provide this in an e-mail to [provideroperations@hne.com](mailto:provideroperations@hne.com).