
9. IEHP 5010 837I INSTITUTIONAL MEDI-CAL ENCOUNTER COMPANION GUIDE

Standard Medi-Cal Companion Guide (CG) Transaction Information

Effective January 1, 2024

IEHP Instructions related to Implementation Guides (IG) based on

ASC X12 Version 005010X223A2

Health Care Claim: Institutional

Companion Guide Version Number: 1.9

2024

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Introduction

The Purpose of the Companion Guide

This document will provide a definitive statement of what Submitters must be able to support in their ANSI ASC X12N 837I 00510X223A2 encounter files.

This document does not outline the technical interface environment, including connectivity requirements and protocols

This document will provide specific Loops, Segments and Data Elements that are outlined for the 837I transactions with IEHP and which are specific to IEHP.

| | |
|---------------------|---|
| Loop ID | The Implementation Guide's identifier for a data loop within a transaction; the data loop consists of specific segments as identified in the HIPAA ANSI standard. |
| Segment ID | The Implementation Guide's identifier for a data segment. |
| Element ID | The Implementation Guide's identifier for a data element within a segment. |
| Element Name | A data element name as shown in the Implementation Guide. When the industry name differs from the Data Element Dictionary name, the more descriptive industry name is used. |

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| | |
|------------------------------------|--|
| Element Definition / Length | How the data element is defined in the Implementation Guide. For ISA and IEA Segments only, fields are of fixed lengths and are present whether or not they are populated. For this reason, field lengths are provided in this column after element definitions. |
| Valid Values | The valid values from the Implementation Guide that are used by IEHP. |
| Definition/Format | Definitions of valid values used by IEHP and additional information about IEHP data element requirements. |

Intended Use

The Transaction Instruction component of this companion guide must be used in conjunction with an associated ASC X12 TR3. The instructions in this companion guide are not intended to be stand-alone requirements documents. IEHP Companion Guide conforms to all the requirements of any associated ASC X12 TR3's and is in conformance with ASC X12's Fair Use and Copyright statements.

Implementation Guides (IG) / TE# area available for purchase from Washington Publishing Company <http://www.wpc-edi.com>.

Implementation

This section describes all of the EDI headers, tables, segments, loops and trailers supported by this Companion Guide. The table does not represent all of the fields necessary for a successful transaction. The following loops and segments are elements that IEHP would like you to pay special attention to when creating this electronic transaction.

File Size Limitations

Per each ISA/ IEA transaction set, it should not exceed 5,000 encounters.

Contact Information

For further questions regarding encounters submissions, please email encounterdata@iehp.org.

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IEHP Response Reports

TA1,999,277CA, EVR.RPT and EVR.XML reports will be sent so the Trading Partner can receive conformation that IEHP has received their 837 File submission.

IEHP Encounter Validation Response (EVR.RPT)

The EVR response files will provide the following summary level and detail information outlined below.

Three (3) Stage values are:

Stage 1 - File Level

- Record Count
- Rejected
- Passed Format Validation

Stage 2 - Encounter Level

- Number of Accepted Records
- Number of Duplicate Records
- Number of Records where Members are not Eligible
- Number of Denied Records
- Total Records Processed

Stage 3 – Validity Percentage

- Denied and Rejected
- Accepted
- Total Records Validated
- Validity Percentage

Rejection Details

- IEHP Tracer ID
- Claim ID
- ICN/ENC ID
- No. (Service Line Number)
- Loop
- Element name
- Freq. (Frequency Code)
- Status
- Error Severity
- Error ID
- Message (Error Description)

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- Report Source

End to End Testing Prerequisite

Phase 1 (Inbound IEHP Validation)

- Each test file must contain Twenty-five (25) encounters
- Each test files must pass Structural validation must be 100% valid (999 Report)
- Validity must be 95% or higher (EVR Report)
- 999, 277CA, EVR.RPT and EVR.XML report will be provided to the Submitter.
- Each Submitter must submit three (3) rounds of test files prior to moving to Phase Two (2).

Phase 2 (Outbound Regulatory Validation)

- Outbound test files containing no more than six (6) encounters deemed valid by IEHP will be forwarded on to their respective Regulatory Agency (i.e. DHCS and CMS).
- Regulatory response reports outlining the final encounter status will be provided to the submitter via IEHP.
- Upon completion of the three (3) successfully rounds of testing, meaning 95% of the outbound test data has been accepted by the Regulatory Agency, the submitter will then be promoted to production.

IEHP adhere to Regulatory Bodies Duplicate Logic

In order to ensure encounters submitted are not duplicates of encounters previously submitted, IEHP will perform header and detail level duplicate checking. If the header and/or detail level duplicate, checking determines that the file is a duplicate, the file will reject, and an error report will be returned to the submitters.

Duplicate Encounters

Once the encounter is processed in IEHP (STEMS) it is stored in an internal repository. If a new encounter is submitted that matches specific values on another stored encounter, the encounter will reject as a duplicate encounter. The encounter will be returned to the submitter with an error message identifying it as a duplicate encounter.

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For the purpose of an 837I Institutional service line, a duplicate would have the same following values as a previously submitted service line:

- Member ID - HICN/MBI
- Date of Service - 2400 DTP*472 DTP03
- Admission Date/Hour – 2300 DTP*435 DTP03
- Discharge Hour – 2300 DTP*096 DTP03
- Revenue Code(s) – 2400 SV201
- Procedure Code(s) – 2400 SV202-2
- Procedure Modifier(s) – 2400 SV202-3,4,5,6
- Attending/Rendering Provider NPI – Can be sourced from a variety of places. Please refer to the (TR3) Implementation Guide.
- Drug Code – 2410 LIN03 – Drug code is used when presented

Additional Modifiers for Overriding Duplicate Logic:

Additional modifiers are available for overriding duplicate edits. Note that these modifiers are only reported with CPT® and/or HCPCS Level II codes, therefore they cannot be used on the hospital encounter for the delivery and subsequent hospital stay.

| Modifier | Definition |
|-----------------|---|
| 59 | When it is necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. (Used primarily with codes 36818 thru 36819 and 76816). |
| 76 | When the same provider must repeat a procedure or service subsequent to the original procedure/service. |
| 77 | When another provider must repeat a procedure or service subsequent to the original procedure/service. |

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Newborn Modifier Code for Overriding Duplicate Logic:

Modifier 25 (Only used for Mother and Newborn) - Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service.

Note: Childbirth encounter reporting includes inpatient and professional services provided to the mother and the newborn during admission. Newborns are covered under the mother's health plan ID or Client Index Number (CIN) for the first 60 days after birth.

Correcting Denied and Rejected Encounter Submissions

Submitted encounters can be either rejected, accepted or denied by IEHP. When IEHP rejects or denies an encounter the reasons for the rejection and/or denial will be reported on either the 999, 277CA, EVR.RPT or EVR.XML file.

Denied and rejected encounters that have been corrected by the submitter can subsequently be resubmitted to IEHP as an "Original" (Frequency Code = '1') encounter. When resubmitting corrected encounter(s) a new inbound (837I/837P) encounter file should be used.

When a submitter needs to correct and resubmit a denied encounter, the original Patient Control Number (2300_CLM01) must be used in order to bypass the IEHP duplicate check.

Denied Correction Example #1: Inbound Original Denied > Original Denied Corrected and Resubmitted

| File Name | Inbound CLM01 | Inbound REF*F8 | Inbound CLM05 | Inbound Status |
|-----------------|---------------|----------------|---------------|--------------------------|
| ABC0120m001.enc | 12345 | NA | 1 | Denied – Invalid DX Code |
| ABC0120m002.enc | 12345 | NA | 1 | Accepted – Valid DX Code |

Replacement and Void Encounters Submissions

Only encounters accepted by IEHP are eligible for Void or Replacement. The usage of both actions is dependent on the remediation needs of the Submitter. Denied or rejected encounters should be corrected and resubmitted using the "Correction Submission" method outline above.

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When a submitter needs to replace or void an encounter, the following data must be provided:

IEHP Inbound Replacement Encounter Requirements

- 2300_CLM01 = Unique Patient Control Number
- 2300_CLM05-3 = 7
- 2300_REF*F8 = Original submitter assigned Patient Control Number (2300_CLM01)
- Usage: Replacing an encounter previously accepted or Denied by IEHP with a updated encounter.

Replacement Example #1: Accepted Inbound Original > Original Accepted Replaced

| Encounter Name | Inbound CLM01 | Inbound REF*F8 | Inbound CLM05 | Inbound Status |
|------------------|---------------|----------------|---------------|----------------|
| A1 - Original | 48294 | | 1 | Accepted |
| A7 - Replacement | 10384 | 48294 | 7 | Accepted |

Replacement Example #2: Accepted Inbound Original > Accepted Original Replacement Denied

Note: The 2300_REF*F8 segment must point to a previously accepted or denied

| Encounter Name | Inbound CLM01 | Inbound REF*F8 | Inbound CLM05 | Inbound Status |
|------------------|---------------|----------------|---------------|---------------------------------|
| A1 - Original | 12345 | | 1 | Accepted |
| A7 - Replacement | 98765 | | 7 | Denied – REF*F8 Segment Missing |

IEHP Inbound Void Encounter Requirements

- 2300_CLM01 = Unique Patient Control Number
- 2300_CLM05-3 = 8
- 2300_REF*F8 = Original submitter assigned Patient Control Number (2300_CLM01)
- Usage: Deleting an encounter previously Accepted or Denied by IEHP.

Void Example #1: Accepted Inbound Original > Accepted Inbound Void

| Encounter Name | Inbound CLM01 | Inbound REF*F8 | Inbound CLM05 | Inbound Status |
|----------------|---------------|----------------|---------------|----------------|
| A1 - Original | 34758 | | 1 | Accepted |

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| | | | | |
|-----------|-------|-------|---|----------|
| A8 - Void | 27493 | 34758 | 8 | Accepted |
|-----------|-------|-------|---|----------|

Void Example #2: Accepted Inbound Original > Original Accepted Void Denied.

Note: The 2300_REF*F8 segment must be present and point to a previously accepted record.

| Encounter Name | Inbound CLM01 | Inbound REF*F8 | Inbound CLM05 | Inbound Status |
|----------------|---------------|----------------|---------------|---------------------------------|
| A1 - Original | 12345 | | 1 | Accepted |
| A8 - Void | 98765 | 56821 | 8 | Denied – REF*F8 CLM01 Not Found |

ISA Segment - Interchange Control Header

| Usage | Ref Des. | Name | Code | Note |
|-------|----------|-------------------------------------|------|---|
| R | ISA01 | Authorization Information Qualifier | 00 | No Authorization Sent |
| R | ISA02 | Authorization Information | | Space Fill |
| R | ISA03 | Security Information Qualifier | 00 | No Security Information |
| R | ISA04 | Security Information | | Space Fill |
| R | ISA05 | Interchange ID Qualifier | ZZ | Mutually Defined |
| R | ISA06 | Interchange Sender ID | | Assigned by IEHP |
| R | ISA07 | Code Identifying Receiver | ZZ | Mutually Defined |
| R | ISA11 | Repetition Separator | ^ | Carat Repetition Separator |
| R | ISA12 | Interchange Control Version Number | 5010 | ASC X12 Standard Approved |
| R | ISA13 | Interchange Control Number | | A control number assigned by interchange sender. Must be unique within a 12 month period. |

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| | | | | |
|---|-------|--------------------------|--------|----------------------------|
| R | ISA14 | Acknowledgment Requested | 0 | TA1 not provided |
| R | ISA15 | Usage Indicator | P T | P = Production T = Test |

GS Segment - Functional Group Header

| Usage | Ref Des. | Name | Code/Definition | Length |
|-------|----------|-----------------------------|-----------------|--|
| R | GS01 | Functional Identifier Code | HC | Health Care Claim |
| R | GS02 | Application Sender's Code | | Assigned by IEHP |
| R | GS03 | Application Receiver's Code | 00303 | Value must match ISA08 |
| R | GS06 | Group Control Number | | Assigned and maintained by the sender. This number must be unique within a single transmission and unique within all transmissions over a 12 month period. |

Table 1 - Header

ST -837- Header Segment

| Usage | Ref Des. | Name | Code | Note |
|-------|----------|---------------------------------|------|------------------------------|
| R | ST01 | Transaction Set Identifier Code | | |
| R | ST02 | Transaction Set Control Number | | Must match the value in SE02 |

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BHT – Beginning of Hierarchical Transaction

| Usage | Ref Des. | Name | Code | Note |
|-------|----------|------------------------------|------|----------------|
| R | BHT02 | Transaction Set Purpose Code | 00 | 00 = Original |
| R | BHT06 | Transaction Type Code | RP | RP = Reporting |

Loop 1000A -PER- Submitter EDI Contact Information

| Usage | Ref Des. | Name | Code/ | Note |
|-------|----------|--------------------------------|------------------------|----------------------------------|
| S | PER02 | Free Form Name | Submitter Contact Name | 1/60 |
| R | PER03 | Communication Number Qualifier | TE | TE = Telephone |
| R | PER04 | Communication Number | | Phone number including area code |
| S | PER05 | Communication Number Qualifier | EM | EM = Email Address |

Loop 1000B -NM1- Receiver Name

| Usage | Ref Des. | Name | Code | Note |
|-------|----------|--------------------------------|---------------------------|---------------------------|
| R | NM103 | Name Last or Organization Name | Inland Empire Health Plan | “IEHP” is also acceptable |

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| Usage | Ref Des. | Name | Code | Note |
|-------|----------|-------------|-------|-----------------------------|
| R | NM109 | Receiver ID | 00303 | Should match ISA08 and GS03 |

Table 2-Billing Provider Detail

Loop 2000A -NM1- Billing Provider Hierarchical Level – Required by IEHP

| Usage | Ref Des. | Name | Code | Note |
|-------|----------|---------------------------------|------|------------------------|
| R | PRV03 | Billing Provider Specialty Info | | Provider Taxonomy Code |

Loop 2010AA N3- Billing Provider Address Information

| Usage | Ref Des. | Name | Code | Note |
|-------|----------|----------------------------|------|---|
| R | N301 | Address Information | | Billing Provider Address Line Must be Physical Address |
| S | N302 | Second Address Information | | Billing Provider Address Line Must be Physical Address |

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Loop 2010AA-N4- Billing Provider City, State, Zip Code Information

| Usage | Ref Des. | Name | Code | Note |
|-------|----------|----------|------|---|
| S | N403 | Zip Code | | The full nine (9) digits of the ZIP Code are required. If the last four (4) digits of the ZIP code are not available, populate a default value of "9998". |

Table 2- Subscriber Detail

Loop 2000B -SBR- Subscriber Information

| Usage | Ref Des. | Name | Code | Note |
|-------|----------|---|------|----------------|
| R | SBR01 | Payer Responsibility Sequence Number Code | S | S= Secondary |
| R | SBR02 | Individual Relationship Code | 18 | 18 = Self |
| S | SBR03 | Group Number | | Must Be Blank |
| R | SBR04 | Plan Name | MED | MED = Medi-Cal |
| S | SBR09 | Claim Filling Indicator Code | MC | MC = Medicaid |

Loop 2010BA –NM1 - Subscriber Name

| Usage | Ref Des. | Name | Code | Note |
|-------|----------|-------------------------------|------|-----------------------|
| R | NM102 | Entity Type Qualifier | 1 | 1= Person |
| R | NM108 | Identification Code Qualifier | MI | MI = Member ID Number |
| R | NM109 | Identification Code | | 14-digit IEHP ID or |

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| Usage | Ref Des. | Name | Code | Note |
|-------|----------|------|------|---|
| | | | | Medi-Cal Client Identification Number (CIN) |

Loop 2010BB -NM1- Destination Payer Name

| Usage | Ref Des. | Name | Code | Note |
|-------|----------|-------------------------------|---------------------------|---------------------------|
| R | NM103 | Destination Payer Name | Inland Empire Health Plan | “IEHP” is also acceptable |
| R | NM108 | Identification Code Qualifier | PI | PI = Payer Identification |
| R | NM109 | Payer Identifier | 00303 | IEHP |

Table 2- Patient Detail

2300 - CN1- Contract Information.

| Usage | Ref Des. | Name | Code | Note |
|-------|----------|------------------------|----------------------|---|
| R | CN101 | Contract Type Code | 01 02 05 09 | 01 = Diagnosis Related Group – DRG (expected to have 2300_HI01-02 = DR) 02 = Per Diem 05 = Capitated 09 = Denied |
| R | CN102 | Contracted Paid Amount | | Must match 2320_AMT02 when 2000B_SBR09 = MC |

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2320 - SBR- Other Subscriber Information

| Usage | Ref Des. | Name | Code | Note |
|-------|----------|---|------|---------------|
| R | SBR01 | Payer Responsibility Sequence Number Code | P | P = Primary |
| R | SBR02 | Individual Relationship Code | 18 | 18 = Self |
| S | SBR03 | Group Number | | Must Be Blank |
| R | SBR09 | Claim Filing Indicator Code | MC | MC = Medicaid |

Loop 2320 -AMT- Coordination of Benefits

| Usage | Ref Des. | Name | Code | Note |
|-------|----------|-----------------------|------|-----------------------|
| R | AMT01 | Amount Qualifier Code | D | D = Payer Paid Amount |
| R | AMT01 | Payer Paid Amount | | |

Loop 2330A -NM1- Other Subscriber Name

| Usage | Ref Des. | Name | Code | Note |
|-------|----------|------------------------|------|----------------------------|
| R | NM101 | Entity Identifier Code | IL | IL = Insured or Subscriber |
| R | NM102 | Entity Type Qualifier | 1 | 1 = Person |

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| Usage | Ref Des. | Name | Code | Note |
|-------|----------|-------------------------------------|------|---|
| R | NM108 | Other Identification Code Qualifier | MI | MI = Member ID Number |
| R | NM109 | Other Subscriber Primary ID | | 14-digit IEHP ID or Medi-Cal Client Identification Number (CIN) |

Loop 2330B -NM1- Other Payer Name

| Usage | Ref Des. | Name | Code | Note |
|-------|----------|---------------------------------------|------|---|
| R | NM103 | Other Payer Last or Organization Name | | Organization/Payer responsible for claim adjudication |
| R | NM108 | Identification Code Qualifier | PI | PI = Payor Identification |
| R | NM109 | Other Payer Primary Identifier | | Must match 2430_SVD01 |

Loop 2430 -SVD- Service Line Adjudication Information

| Usage | Ref Des. | Name | Code | Note |
|-------|----------|--------------------------------|------|------------------------|
| R | SVD01 | Other Payer Primary Identifier | | Must match 2330B_NM109 |

Trailer Segments

SE – Transaction Set Trailer

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| Usage | Ref Des. | Name | Code | Note |
|-------|----------|--------------------------------|------|------------------------------|
| R | SE01 | Number of Included Segments | | Transaction Segment Count |
| R | SE02 | Transaction Set Control Number | | Must match the value in ST02 |

GE Segment – Functional Group Trailer

| Usage | Ref Des. | Name | Code | Note |
|-------|----------|-------------------------------------|------|------------------------------|
| R | GE01 | Number of Transaction Sets Included | | |
| R | GE02 | Group Control Number | | Must match the value in GS06 |

IEA Segment - Interchange Control Trailer

| Usage | Ref Des. | Name | Code | Note |
|-------|----------|--------------------------------------|------|---|
| R | IEA01 | Number of Included Functional Groups | | A count of the number of functional groups included in a interchanges |
| R | IEA02 | Interchange Control Number | | A control number assigned by the interchange sender |

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Frequently Asked Questions

Q1: What is Encounter Data? Does it include any claims data submitted from providers to plans?

A1: Encounter Data comprises any claims data information entered in the 5010 format.

Q2: What does “adjudicated” mean?

A2: Adjudicated claims are those that are approved accepted or denied claims.

Q3: Will revenue codes be a required field for encounter submissions?

A3: Yes, revenue codes will be a required field of the 5010 837 format.

Q4: Are Submitters required to submit encounter data weekly or monthly?

A4: Currently, Submitters are required to submit encounter data monthly. However, IEHP strongly recommend that plans submit more frequently.

Q5: Will the National Provider Identification (NPI) number be required for claims submission?

A5: Yes, NPI is required.

Q6: Where do I find information on file naming conventions, connectivity protocol, and file transfer procedures?

A6: Please refer to the EDI manual published at <https://ww3.iehp.org/en/providers/provider-manuals> for information regarding the above areas. For File Naming conventions see Section 6 Claims Processing Procedures and connectivity protocol see Section 2 Getting Started Secure File Transfer Protocol (SFTP).

Q7: What is IEHP’s policy on Billing Provider Address and 9-Digit Zip Codes?

A7: IEHP supports the instructions in the Technical Report Type 3 (TR3) implementation guides (IG) available for purchase from Washington Publishing Company <http://www.wpc-edi.com> regarding Billing Provider Address and 9-digit zip codes. Therefore, the Billing Provider Address (2010AA, N3) is required and must be a physical address. PO Box and lock box addresses cannot be reported as a Billing Provider Address but can continue to be reported in the pay-to address (2010AB, N3). The 5010 requires that all used N403 segments must contain a full 9-digit zip code. The best way to determine the 4-digit extension to your standard zip code is by contacting the US postal Service. <https://tools.usps.com/go/ZipLookupAction!input.action>. These instructions apply to all encounters for all healthcare Submitters.

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Q8: How should providers submit additional service lines not captured in the Original (Freq.1) encounter accepted by IEHP?

A8: Additional service line information identified as missing from Original (2300_CLM05-3 = '1') accepted encounters should be submitted separately in a new encounter, or a Replacement (2300_CLM05-3 = '7') for the original encounter should be submitted with the addition of the new service lines.

Q9: How should providers address encounters flagged as Denied by the regulatory agencies (i.e. DHCS and/or CMS) via the outbound Regulatory EVR?

A9: Encounters flagged as Denied by the regulatory agencies (i.e. DHCS and/or CMS) via the outbound Regulatory EVR should be corrected by way of an inbound Replacement (2300_CLM05-3 = '7') and/or inbound void (2300_CLM05-3 = '8') for the original encounter accepted by IEHP.

Other Resources

<https://ww3.iehp.org/en/providers/provider-manuals>

IEHP's website where the EDI manual and other resources are located.

<http://www.wpc-edi.com>

Washington Publishing Company Implementation guides (TR3) can be purchased from this site.

<http://www.wedi.org>

Workgroup for Electronic Data Interchange in Healthcare.

<https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/Versions5010andD0>

CMS website that contains additional information and resources related to 5010.

Encounter Team Contact Information

Encounter Data Production Support:

EncounterData@iehp.org