IEHP 5010 PROFESSIONAL 837P COVERED CALIFORNIA ENCOUNTER COMPANION GUIDE

Standard Companion Guide (CG) Transaction Information
IEHP Covered California

Effective January 1, 2024

IEHP Instructions related to Implementation Guides (IG) based

837P Health Care Claim: Professional Transaction based on ASC X12 Technical Report Type 3 (TR3), Version 005010X222A1

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Introduction

The Purpose of the Companion Guide:

This document provides a definitive statement of what Submitters must be able to support in their ANSI ASC X12N 837P 00510x222A1 encounter files.

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

This document provides specific Loops, Segments and Data Elements that are outlined for 837P transactions exchanged 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.
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 This 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)/TR3 available for purchase from Washington Publishing Company http://www.wpc-edi.com

File Size Limitations

ISA/IEA transaction sets should not exceed 5,000 encounters.

Contact Information

For further questions regarding encounters submission, please email EncounterData@iehp.org

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)
- 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.
- Submitters 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 to their respective Regulatory Agency (i.e., Cover California)
- Regulatory response report 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, 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.

Duplicated 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.

Currently, the following values are the minimum set of items used for matching an encounter in the IEHP STEMS

- Covered CA Member ID – 2010BA NM109
- Date(s) of Service – 2400 DTP*472 DTP03 (can be a range) Rendering Provider – Can be sourced from variety of places.
- Procedure Code(s) – 2400 SV101-2
- Procedure Modifier(s) – 2400 SV101-3,4,5,6
- Drug Code – 2410 LIN03 - Drug code is used when present.

Conditional usage of Drug Code - When a submitted encounter is compared to previously submitted encounters and all other key fields match but one of the encounters has a drug code and the other does not – this situation is still identified as a duplicate. If all other key fields match and the drug codes are different, the situation is not a duplicate.

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.

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 Covered CA Member ID 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.

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 CLM05	Inbound Status

		Inbound REF*F8		
A1 - Original	34758		1	Accepted
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

Implementation

The below instructions are expected to be used in addition to the Technical Report Type 3 (TR3) Implementatation Guide (IG). 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. ISA Segment - Interchange Control Header

Usage	Ref Des.	Name	Code	Note
R	ISA01	Authorization Information Qualifier	00	No Authorization
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	ISA08	Interchange Receiver ID	IEHPCCA	IEHP Covered California Receiver ID

R	ISA11	Repetition Separator	^	Carat Repetition Separator
R	ISA12	Interchange Control Version Number	00501	ASC X12 Standard Approved
R	ISA13	Interchange Control Number		A control number assigned by interchange sender. Must be unique within a 12 month period.
R	ISA14	Acknowledgment Requested	0	TA1 not provided
R	ISA15	Interchange Usage Indicator	P T	P = Production T = Test

GS Segment - Functional Group Header

Usage	Ref Des.	Name	Code	Note
R	GS01	Functional Identifier Code	HC	Health Care Claim
R	GS02	Application Sender's Code		Assigned by IEHP
R	GS03	Application Receiver's Code	IEHPCCA	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

BHT – Beginning of Hierarchical Transaction

Usage	Ref Des.	Name	Code	Note
R	BHT02	Transaction Set Purpose Code	00	00 = Original

Usage	Ref Des.	Name	Code	Note
R	BHT06	Transaction Type Code	RP	RP = Reporting

1000A -PER- Submitter EDI Contact Information

Usage	Ref Des.	Name	Code	Note
S	PER02	Free Form Name		Submitter Contact Name
R	PER03	Communication Number Qualifier	TE	Telephone Number
R	PER04	Communication Number		Phone number including area code
S	PER05	Communication Number Qualifier	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
R	NM109	Identification Code	IEHPCCA	Should match ISA08 and GS03

Table 2-Billing Provider Detail

Loop 2000A – PRV- 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

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

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

Usage	Ref Des.	Name	Code	Code
S	N403	Postal Code	Billing Provider Postal Zone or ZIP Code	Full (9) digit Zip Code required. If last (4) digits are not available, populate with "9998".

Table 3 – Subscriber Detail

Loop 2000B -SBR- Subscriber Information

Usage	Ref Des.	Name	Code	Note
R	SBR01	Payer Responsibility Sequence Number Code	S	Secondary
S	SBR02	Individual Relationship Code		Refer to TR3

Loop 2010BA -NM1- Subscriber Name

Usage	Ref Des.	Name	Code	Note
R	NM102	Entity Type Qualifier	1	Person
S	NM108	Identification Code Qualifier	MI	Member ID Number

Usage	Ref Des.	Name	Code	Note
S	NM109	Identification Code		~~12-digit IEHP ID or~~ Covered CA Member ID

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	Payer Identification
R	NM109	Identification Code	IEHPCCA	IEHP Covered California

Table 4 – Patient Detail

Loop 2000C -HL- Patient Hierarchical Level

Usage	Ref Des.	Name	Code	Note
S	HL	Patient Hierarchical		Refer to TR3

Loop 2000C -PAT- Patient Information

Usage	Ref Des.	Name	Code	Note
R	PAT01	Individual Relationship Code		Refer to TR3

Loop 2010CA -NM1- Patient Name

Usage	Ref Des.	Name	Code	Note
R	NM101	Entity Identifier Code	QC	QC = Patient
R	NM102	Entity Type Qualifier	1	1 = Person
R	NM103	Last Name or Organization		

Usage	Ref Des.	Name	Code	Note
S	NM104	First Name		
S	NM105	Middle Name		

Loop 2300 -CN1- Contract Information

Usage	Ref Des.	Name	Code	Note
R	CN101	Contract Type Code	01 02 05 09	01 = Diagnosis Related Group 02 = Per Diem 05 = Capitated 09 = Denied

Loop 2300 -AMT- Patient Estimated Amount Due

Usage	Ref Des.	Name	Code	Note
S	AMT	Patient Estimated Amount Due		Refer to TR3
R	AMT01	Amount Qualifier	F3	F3 = Patient Responsibility
R	AMT02	Monetary Amount		

Loop 2300 -NTE- Claim Note -Network Paid Indicator

Usage	Ref Des.	Name	Code	Note
S	NTE	Claim Note		Refer to TR3
R	NTE01	Note Reference Code	ADD	ADD = Additional Information
R	NTE02	Claim Note Text	In-Network Out-of-Network	An indicator of whether the claim was paid at in-network or out-of-network level. On facility records, this field must be at the service/detail

Usage	Ref Des.	Name	Code	Note
				level as opposed to the header/claim level.

Loop 2300 -NTE- Claim Note-Network Provider Indicator

Usage	Ref Des.	Name	Code	Note
S	NTE	Claim Note		Refer to TR3
R	NTE01	Note Reference Code	ADD	ADD = Additional Information
R	NTE02	Claim Note Text	Servicing Provider Participates In-Network Servicing Provider Participates Out-of-Network	Indicates if the servicing provider participates in the network to which the patient belongs

Loop 2310B - Rendering Provider

NOTE #1: Required if the rendering provider is different than the billing provider.

NOTE #2: The rendering provider taxonomy code should also be included.

Loop 2320 -SBR- Other Subscriber Information

Usage	Ref Des.	Name	Code	Note
R	SBR01	Payer Responsibility Sequence Number Code	P	Primary
R	SBR02	Individual Relationship Code		Refer to TR3
S	SBR09	Claim Filing Indicator Code		Refer to TR3

Loop 2320 -AMT- Coordination of Benefits (COB) Payer Paid Amount

Usage	Ref Des.	Name	Code	Note
R	AMT01	Amount Qualifier	D	Refer to TR3
R	AMT02	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
R	NM108	Other Identification Code Qualifier	MI	MI = Member ID Number
R	NM109	Other Subscriber Primary ID		Covered CA Member ID

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 2400 -CN1- Contract Information

Usage	Ref Des.	Name	Code	Note
R	CN101	Contract Type Code	02 05 09	02 = Per Diem 05 = Capitated 09 = Denied

NOTE #1: The 2400 CN1 segment is expected when the service line adjudication status is different than at the header level (Loop 2300_CN1).

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

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 an interchange
R	IEA02	Interchange Control Number		A control number assigned by the interchange sender

Frequently Asked Questions

Q1: What is Encounter Data? Does it include any claims data submitted from providers to plans?
A1: Encounter Data comprises of any claims data information entered in the 5010 format.

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 File Secure 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. These instructions apply to all encounters for all healthcare Submitters.

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., Covered California) via the outbound Regulatory EVR?

A9: Encounters flagged as Denied by the regulatory agencies (i.e., Covered California) 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

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

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

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

http://www.wpc-edi.com

Workgroup for Electronic Data Interchange in Healthcare.

http://www.wedi.org

IEHP Contact Information

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