

Harvard Pilgrim Health Care Neighborhood Health Plan Tufts Health Plan

Companion Guide

837 Health Care Claim: Institutional

For use with:

ASC X12N 837 Health Care Institutional Transaction Set
Implementation Guides and Addenda.

ASC X12N 837I (004010X096A1)

Published by NEHEN Payers as a resource for *all* New England providers.



NEW ENGLAND HEALTHCARE EDI NETWORK

Date	Chapter	Section	Description
2/5/2007	Chapter 1 – How to Use the NEHEN Companion Guide	Contact Information	Updated contact information for NEHEN and HPHC
		Transaction Information / Technical Requirements / Conditional Data Requirements / Provider Numbers	Replaced references to ‘Payer Assigned Provider Numbers’ or Legacy IDs with National Provider Identifier (NPI). Modified what is expected by Payers in the NM108/NM109 as well as the REF01/REF02 segments.
	Chapter 2 – NEHEN Process	All	Replaces all references of <i>NEHENLite</i> with <i>NEHEN Express</i>
		Reporting / File Acknowledgement Report	Tufts Health Plan is now able to support the 997 Functional Acknowledgement transaction set.
	Chapter 3 – Harvard Pilgrim Health Care	All	Replaced all references to “Harvard Pilgrim Provider Number” with “National Provider Identifier (NPI)”.
		Generating a Successful Transaction / General Claim Information / More Format Rules	Added details for national products/joint offerings: Choice Plus and Options.
		Generating a Successful Transaction / Member Validation	Distinguished between validation for ‘Legacy Products’ and ‘Joint Offering Products’.
		Generating a Successful Transaction / Provider Validation	Distinguished validation rules for Rendering and Referring Providers.
		Reporting / 277 Acknowledgement	HPHC may issue more than one 277 Acknowledgment transaction for a single file of claims.
		Reporting / Harvard Pilgrim Response Report	New and Updated Response Code definition Field #6 will contain the provider’s NPI rather than the provider’s HPHC Provider ID
		Production	ISA15 must contain “P” for Production files and

Date	Chapter	Section	Description
			"T" for Test files.
	Chapter 4 – Neighborhood Health Plan	All	All references to "NHP Vendor Number" have been modified due to the implementation of the National Provider Identifier (NPI)
		NHP Claims Submission Report	The Billing Provider Number has been changed to the Billing Provider NPI
	Chapter 5 – Tufts Health Plan	All	All references to "Tufts HP Provider Identifiers" have been modified due to the implementation of the National Provider Identifier (NPI)
		Security Statement	THP has updated their Security Statement based on the modified HIPAA regulations.
		Generating a Successful Transaction / General Claim Information	Additional Loops will be supported for COB claim processing.
		Reporting	Tufts HP now supports the 997 Functional Acknowledgement transaction.
		Reporting / Response Reports / Rejection Criteria and Error Messages	New messages were added Provider ID related messages were revised 837I messages were removed
		Testing / Pre-Testing Requirements for Submitters	The process has been modified.
		Testing / Migration from Testing to Production	Dial In Numbers and APRF values no longer apply
	Chapter 6 – NEHEN 837 Professional Claim Submission Criteria		Changes made based on NPI Compliance and the new UB-04 paper claim form

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**837 HEALTH CARE CLAIM:
INSTITUTIONAL COMPANION GUIDE**

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HOW TO USE THE NEHEN COMPANION GUIDE

Introduction

Members of NEHEN benefit from the spirit of collaboration. It is in this spirit that a group of payers within NEHEN worked together to produce this combined 837 Companion Guide. Now providers who do business with payers who adopt the NEHEN Companion Guide need only one (Companion Guide) reference for helpful information regarding the implementation of the 837 with any NEHEN Payer.

The NEHEN Payers who have contributed to and who support this document are:

Harvard Pilgrim Health Care



Neighborhood Health Plan of Massachusetts



Tufts Health Plan



The information in this guide applies to the above payers (hereafter referred to as “Payer” or “Payers”) who have adopted this NEHEN Companion Guide.

- 🔍 [Chapter 6: NEHEN 837 Institutional Claim Submission Specifications](#) represents collective specifications that apply to *all* providers submitting to NEHEN Payers regardless of whether or not the provider is a NEHEN member.

Document Objective

This document is a supplement to the ASC X12N 837 (Version 4010A1) Implementation Guide and Addenda and does not contradict any requirements in the ASC guide.

The NEHEN 837 Companion Guide documents and clarifies when conditional data elements and segments must be used for processing or reporting and identifies codes and data elements that do not apply to NEHEN Payers.

A provider should use this document to ensure that their 837 claim format is correct and that all claims in their file will be accepted into Payer systems for processing. Providers should consult with specific Payer business rules documentation on pre-processing and adjudication. Generally these can be obtained on each Payer's web site.



The [Contacts](#) section in Chapter 1 provides complete Payer contact information along with their web site address.

Audience

The NEHEN 837 Companion Guides are designed to serve as reference guides for technical and business audiences of provider organizations who are responsible for the setup and testing of electronic claims submissions to Payers. This information should also be communicated to and coordinated with provider billing offices in order to ensure that all required billing information is provided to provider billing agents (submitters).

Security Statement

Confidentiality, Privacy and Security

Each NEHEN Payer has a security and confidentiality policy with regard to safeguarding patient, employee, and health plan information (see the *Security Statement* section at the beginning of each Payer chapter). The policies permit use or disclosure of member medical or personal information only as necessary to conduct required business and perform care management, approved research, quality assurance and measurement activities when authorized to do so by a member or as required by law.

Contact Information (NEHEN and Payers)

NEHEN

www.nehen.org

General Questions

NEHEN Program Management

Email: questions@nehen.org

Technical Questions

Laurance Stuntz

Phone: 781-290-1479

Email: lstuntz@csc.com

 **Note:** To download a copy of this NEHEN Companion Guide, please visit www.nehen.org.

Harvard Pilgrim Health Care

www.harvardpilgrim.org

Harvard Pilgrim EDI Team (Responsible for all phases of testing and implementation)

Harvard Pilgrim EDI Team

Phone: 800-708-4414 (Option 1 then option 3)

Fax: 617-509-1165

Email: edi_team@hphc.org

Neighborhood Health Plan

www.nhp.org

Neighborhood Health Plan E-Commerce Department (responsible for all phases of testing and implementation)

Neighborhood Health Plan E-Commerce Department

Phone: 617-772-5500

Email: Ecomm@nhp.org

Tufts Health Plan

www.tuftshealthplan.com

Tufts HP EDI Operations

Phone: 888-880-8699 x4042

Fax: 617-923-5555

Email: EDI_Operations@tufts-health.com

Provider Services

Phone: 888-884-2404

Transaction Information

Getting Started

In order to submit a valid transaction, please refer to the *National Electronic Data Interchange Transaction Set Implementation Guides & Addenda for the Health Care Claim: Institutional ASC X12N 837 (004010X096A1)*. This transaction guide can be retrieved at the Washington Publishing Company's website at www.wpc-edi.com.

Submitters must go through the appropriate set-up and authorization process in order to transmit electronic claims to NEHEN Payers. Please refer to the *Setup* and *Testing* sections in each Payer chapter before submitting electronic claims.



Institutional Claim Submission Specifications. [Chapter 6](#) contains specifications for all NEHEN Payers. Certain situational data is required in order to effectively process claims. In addition to required data (R), all NEHEN Payers require certain situational data (S) in order to process claims. Chapter 6 provides detailed information on this subject.

Technical Requirements

NEHEN Payers support batch ANSI X12N 004010X096A1 Health Care Claim: Institutional transactions. The transaction is fully HIPAA compliant in structure and content.

File Attributes

NEHEN Payers and most payers in New England recommend the following characteristics for uniform claim files:

- Each claim file should contain one, and only one, ISA and one, and only one, GS segment. A GS segment may contain multiple ST segments.
- Although the HIPAA Transaction Set Implementation Guide allows the repeating of Provider Information (2000A Loop) for each claim, the size of transmission **files can be reduced by up to 20% by using only one repeat of Provider information followed by all Subscriber and Claim information for that Provider**. Grouping the claims of each subscriber together can further reduce file transmission files.
- NEHEN recommends no more than 5,000 claims per file. This is an operational not technical recommendation. A submitter should contact the NEHEN Payer's EDI Team if more than 5,000 claims are anticipated per file.
- NEHEN Payers recommend 80 service lines per claim. If a claim has more than 80 lines, NEHEN Payers request that the submitter split the claim into multiple claims, each with less than 80 service lines.

- Do not use carriage returns or line feeds at the ends of segments. The tilde (~) serves as a segment terminator.
- If using a situational segment, all required data elements must be used correctly or the file will fail.

Conditional Data Requirements

This section highlights some conditional requirements of NEHEN Payers. All conditional requirements (situational data) for the Payers are included in [Chapter 6: 837 Institutional Claim Submission Specifications](#).

Claim Tracking Identification Number (Trading Partner Claim IDs)

Payers strongly recommend that all submitters generate a unique Claim Tracking Identification Number (as described in Loop 2300 Ref segment on page 187 of the Implementation Guide) for each claim that is submitted to them. It is recommended that these IDs be unique both within a file and across files. In other words, generate a new claim ID even if the claim was submitted previously. This will facilitate problem resolution and tying out responses to submitted claims.

Provider Numbers

The number of Provider segments related to the 837 looping structure can become confusing. Generally Payers expect to receive the provider's National Provider ID (NPI) and valid Tax ID.

How to Configure Looping Structure for Provider Identification

Set NM108 to XX (National Provider ID). Set NM109 to the provider's NPI.

Secondary Identification is a Situational segment but **required** for NEHEN Payer business processing.

- REF01 is set to EI (Provider Tax ID) or SY (Provider Social Security Number)
- REF02 contains the Provider's Tax ID or SSN

A Billing/Pay-To Provider (Loop 2000A) is required for each HL group.

- If the Billing and Pay-To Providers are the same, then the PRV segment is not used and only Billing Provider information is sent (Loop 2010AA). Unless overridden at the claim level (Loop 2310E), this will be the provider that NEHEN Payers will pay for all claims (the servicing provider).
- If Billing and Pay-To are different, then both loops (2010AA and 2010AB) are sent. The PRV segment (PRV01 = BI or PT) is used to specify which of the two providers (Billing or Pay-To) should be considered the servicing provider for all claims (unless overridden at the claim level – Loop 2310E).

Member Eligibility

Inaccurate member information is one of the most common causes of claim rejection. Use NEHEN or a Payer Provider Eligibility Verification tool to verify member information prior to claim submission.

Electronic Claims Submission: Implementation Process

Finding the Information You Want

NEHEN and each member NEHEN Payer has a chapter in this Guide dedicated to practices and procedures unique to their organization's processing of the 837. In each of these NEHEN and Payer chapters, information is organized according to the outline below.

Channels for Claim Submission

Setup

Generating a Successful Transaction

- General Claim Information
 - File Naming Conventions
 - More Format Rules
- Code Set Validation
- Member Validation
- Provider Validation

Reporting

997 Acknowledgment Reports

Response Reports

- Response File Specifications

Testing

Migration from Testing to Production

Production

NEHEN PROCESS



NEHEN and the Claims Process

NEHEN Providers are responsible for producing 837 claims as required by the NEHEN Payers. NEHEN technology supports the claims process by automating the delivery and tracking of claims files for Provider members. The following features are included in the NEHEN Claim Submission Process:

File Transmission

The NEHEN eGateway picks up claim files from the Provider's network and transfers them to the appropriate NEHEN or non-NEHEN payer according to the Payer's claim delivery and transfer location requirements and using a payer-specified naming convention.

The NEHEN Payer eGateway may send 997 and/or response files directly the Provider e-Gateway. The NEHEN e-Gateway may also "pick up" reports from Non-NEHEN Payers.

Claim File Tracking

The NEHEN eGateway tracks the status of each claim file as it moves from Provider to Payer. The *NEHEN Express* application may be used to view the status of each claim file. Statuses are changed when a file is sent, a 997 is received and a response file is received.

Response Report Viewing

NEHEN Express may also be used to view response reports from NEHEN Payers.

Channels for Claim Submission

NEHEN members may use the NEHEN Channel for claim submission to Harvard Pilgrim Health Care, Neighborhood Health Plan and Tufts Health Plan. The NEHEN channel uses your existing NEHEN connections to the NEHEN Payers and the NEHEN eGateway.

Each of the NEHEN Payers has other options for claim submission. These are detailed in the individual Payer chapters in this guide.

Security Statement

See NEHEN's [Security Statement](#) in Chapter 1.

Setup

Providers must contact each Payer (see [Contacts](#) in Chapter 1) to obtain authorization to begin testing. The Setup process specific to each NEHEN Payer can be found in the Payer-specific chapters in this Guide.

In addition to obtaining authorization to send claims to the Payers, NEHEN Members must set up the NEHEN eGateway for batch file transfer of claims to each Payer. The NEHEN Administrator for a NEHEN Provider must follow the instructions documented in the NEHEN document titled “Setting up Batch File Transmission through NEHEN.” The document can be found at the NEHEN website, www.NEHEN.org or by contacting NEHEN Technical Support.

The steps outlined in the document include:

1. Ensure the network to support claim delivery is in place. As long as a provider is already using NEHEN for other transactions (eligibility, claim status, etc.), that network connection can also be used for claims.
2. Determine whether an eGateway upgrade is needed and perform the upgrade if necessary.
3. Set up an FTP server to receive response reports, 997 functional acknowledgements, and 835 remittance advices. The provider may need to open a port in their network firewall to allow the payer to send these transactions.
4. Configure the eGateway for batch transactions. Decisions to be made include the batch delivery schedule, location on the network for inbound and outbound files, and file naming conventions.
5. Determine the “Application Sender ID” that will be used by claims coming from various Submitters within the provider organization. This is very important because the Application Sender ID is used to route claims and responses as well as give the payer an appropriate contact to call about any issues.

Generating a Successful Transaction



837 Institutional Claim Submission Specifications

As detailed in the National Electronic Data Interchange *Transaction Set Implementation Guides & Addenda for the Health Care Claim: Institutional ASC X12N 837 (004010X096A1)*, certain situational data is required in order to effectively process claims. For detailed information on this subject as it applies to NEHEN Payers please refer to [Chapter 6: 837 Institutional Claim Submission Specifications](#).

File Naming Conventions

The NEHEN provider does not have to rename claim files to the Payer-specified naming convention. The NEHEN eGateway uses a mapping file that contains the naming convention for Payers and renames the files prior to sending them to the Payer. The NEHEN Claim File tracking application lists files by both the Provider file name and the Payer file name.

For reference, delivered claim files should be named as follows for all NEHEN Payers.

[value from ISA06]_[value from GS02]_[I or P depending on claim type]_[timestamp].837

This is implemented in the Mapping file with a file name of:

[NEHENID]_[GS Sender ID]_[I or P]_\$.837 or
 \$i_\$g_[I or P]_\$.837 (needs NEHENEDI 8.1 or greater)

Reporting

NEHEN Payers may return the Functional Acknowledgment Transaction Set (997) as an acknowledgement of incoming 837 files to say that the data was received and whether the format is acceptable. Once the file has passed, the NEHEN Payer may provide a report that specifies the claims that have been accepted or rejected for further processing. Finally, the Payers may return and electronic remittance advice (835) transaction detailing the payment amount on each claim.

The NEHEN eGateway supports the delivery of 997 Functional Acknowledgement Reports, 835 Health Care Claim Payment Advice and Proprietary Response Reports directly from the NEHEN Payer to the Provider e-Gateway. In addition, the NEHEN eGateway can pick up all three types of reports from a site designated by a NEHEN or non-NEHEN Payer.

Additional details regarding the supported reports and sample formats can be found in the Payer-specific chapters in this guide.

File Acknowledgement Report

Harvard Pilgrim, Tufts Health Plan and Neighborhood Health Plan support the Functional Acknowledgment Transaction Set (997) and use it as an acknowledgement of the incoming 837 file. Payers return the 997 as they begin processing the 837 file. For this reason, there will be a

delay between receipt of the claims file and return of the 997 transaction. The submitter should review the 997 to verify that the file will be processed. NEHEN File Tracking software allows the submitter to view whether a file has passed or failed based on the 997 Acknowledgement.

Response Reports

Each of the NEHEN Payers returns a proprietary response/submitter report that may be delivered to or picked up by a Providers NEHEN eGateway.

Details regarding the proprietary formats and process for the NEHEN Payers are included in the Payer-Specific chapters in this guide.

In general, EDI Response Reports are returned within two days. Review all reports provided by your vendor and/or Payer. If you have not received a status on a claim within four days, contact the Payer's EDI team (see [Contacts](#) in Chapter 1).

If your claim is rejected, and you are not sure why or how to correct it, it is important to contact the appropriate EDI Team as soon as possible to ensure that the claim is resubmitted before the filing limit expires.

Note: Save a copy of all Response Reports for filing limit documentation.

Electronic Remittance Advice (835)

Each of the NEHEN Payers supports the 835 Health Care Claim Payment Advice. The 835 can be delivered to the Provider eGateway by the NEHEN Payer. The NEHEN eGateway can also pick up 835 files from Non-NEHEN Payers.

Contact NEHEN technical support to set up your eGateway for the 835. Contact NEHEN Payers directly regarding receiving the 835. (see [Contacts](#) in Chapter 1).

Testing

All NEHEN Payers require claim submitters to test prior to submitting production claims. Providers must follow the testing process specified by each payer in the Payer-specific chapters of this guide.

NEHEN providers must include testing of the NEHEN eGateway setup as part of claim testing to ensure that claim files are delivered and all reports are received as expected. Please refer to the document “Setting up Batch File Transmission through NEHEN” available on www.NEHEN.org or from NEHEN technical support for steps needed to test through NEHEN.

NEHEN technical support will assist you in preparing to test using the NEHEN technology and support you through the testing process and migration to production. Please contact NEHEN technical support when you are ready to test with a NEHEN Payer.

Migrating from Testing to Production

Upon successful completion of the testing process, the NEHEN Payers and Providers will determine when to begin to submit production claims. The Payer will provide the information necessary to properly configure the NEHEN eGateway for production. Again, this information is included in “Setting up Batch File Transmission through NEHEN”.

Once the eGateway is set up 837 Claim files may be sent to Payers.

Production

Once in production, Providers should utilize NEHEN Claim file tracking to monitor the delivery of claim files to NEHEN and non-NEHEN Payers. Follow NEHEN technical support procedures to determine if assistance is necessary.

NEHEN Payer information regarding production claims is included in the Payer-specific chapters of this Guide.

HARVARD PILGRIM HEALTH CARE



Security Statement

Confidentiality, Privacy and Security

Maintaining the confidentiality of personal health information continues to be one of Harvard Pilgrim's guiding principles. Harvard Pilgrim has a strict confidentiality policy for safeguarding patient, employee, and health plan information. All staff is required to be familiar with, and comply with Harvard Pilgrim's policy on the Confidentiality of Member Personal and Clinical Information to ensure that it is treated in a confidential and respectful manner. The policy permits use or disclosure of members medical or personal information only as necessary to conduct required business, care management, approved research or quality assurance or measurement activities or when authorized to do so by a member, or as required by law.

To comply with internal policies as well as provisions of the Health Insurance Portability and Accountability Act (HIPAA), Harvard Pilgrim has outlined specific requirements applicable to the electronic exchange of protected health information (PHI) including provisions for:

- Maintaining confidentiality of protected information
- Confidentiality safeguards
- Security standards
- Return or destruction of protected information
- Compliance with state and federal regulatory and statutory requirements
- Required disclosure
- Use of business associates

These requirements are detailed in the Trading Partner Agreement presented to Harvard Pilgrim's electronic trading partners during our initial discussions.

Harvard Pilgrim offers a variety of solutions to transmit PHI using a public network. In accordance with Harvard Pilgrim Policy and the HIPAA Security Rule, any PHI that is transmitted using a public network must be encrypted. Web-based applications are configured to use the Secure Socket Layer security software capabilities, and only a browser with support for 128-bit high encryption is acceptable under this policy. In addition, Harvard Pilgrim's policy requires the use of any encryption technology to be approved by the Harvard Pilgrim Information Security Officer prior to its implementation.

Harvard Pilgrim's electronic trading partners wishing to interface their legacy systems and use FTP (File Transfer Protocol) to transmit EDI transactions are supported using a secure FTP client from SSH Communications. The transmissions are secured using public key encryption and

rely upon digital certificates to authenticate the server with the client software used by the provider.

Channels for Claim Submission

Harvard Pilgrim offers several direct channels for HIPAA-compliant 837 4010A1 Professional claim submission. Besides using the NEHEN gateway, claims may be submitted via HPHConnect, dial-up modem or Secure File Transfer Protocol (SFTP). All channels are offered at no cost per transaction.

Providers and billing services that submit claims via Harvard Pilgrim EDI Direct are supported with the highest levels of customer service and reporting information.

Note: Harvard Pilgrim will continue to accept claim submissions from clearinghouses.

Harvard Pilgrim's EDI Team is responsible for all phases of testing and implementation. Please contact the EDI Team when you are ready to begin testing. For Harvard Pilgrim's contact information, see [Chapter 1: Contact Information](#).

The EDI team will make sure that you have the all necessary information for the EDI option of your choice:

- **NEHEN eGateway**

To send claims via the NEHEN eGateway, you need to be a member. For more information, call Sira Cormier at 781-290-1300 or e-mail scormier@csc.com.

- **HPHConnect**

To send claims through HPHConnect, you must have registered for HPHConnect. You also need to have the File Transfer Agent (FTA) activated. If you haven't signed up for HPHConnect you may do so through the *HPHC* website.

- **EDI-Direct**

Dial-up Modem—To submit claims via a modem, a dedicated telephone line is required. The EDI Team will provide a phone number and instructions.

Secure File Transfer Protocol (SFTP)—To submit claims via SFTP, you must use SSH.com software. Harvard Pilgrim will provide the license and software free of charge. A CD-ROM and instructions will be provided.

The EDI team, as needed, will give out all other information such as passwords and Sender ID's.

Setup

In addition to a Trading Partner agreement, you are required to complete an Authorization Form. The purpose of this form is to allow the EDI Team to verify provider information prior to claims transmission. If any of the information on the Authorization Form changes, a new form must be completed and submitted to the EDI Team.

Generating a Successful Transaction



837 Institutional Claim Submission Specifications

Certain situational data is required in order to effectively process claims. For detailed information on this subject please refer to [Chapter 6: 837 Institutional Claim Submission Specifications](#).

Note that the most common causes for claim rejection are the inaccuracy of:

- Member Eligibility—Use HPHConnect or NEHEN to verify the accuracy of member information prior to submission.
- Provider Information—Be sure that the National Provider Identifier (NPI) and Tax ID number are valid and accurately entered.

General Claim Information

Submission format (837-Institutional or 837-Professional) is determined by your contract with Harvard Pilgrim or Harvard Pilgrim billing guidelines. Submission formats are addressed during Testing.

Note: Harvard Pilgrim does accept 837-Dental claims. Please contact the EDI Team if you would like to submit dental claims electronically.

File Naming Conventions

Claim files sent to Harvard Pilgrim should adhere to the following naming conventions:

ISA06_GS02_I_CCYYMMDD_HHMM.837

Format for claim files names sent to Harvard Pilgrim

The ISA06 and GS02 are your submitter and sender IDs given to you by the EDI team. The P or I indicate the type of file institutional or professional. This is followed by the full year month and date followed by the hour and minutes sent. The date and time allows the program to recognize if the file is one previously sent or a new file. The extension of (dot).837 indicates claim submission.

Note: For NEHEN Members, the NEHEN e-Gateway will rename your file according to the Payer-specific naming conventions.

A correct naming convention is important since the EDI program will not recognize the file for pickup otherwise. You should take care to ensure that the file is named as specified above.

Files returned back to you are also named in a specific way:

<ISA06>_<GS02>_I_<CCYYMMDD>_<HHMM>.997

997 File returned by Harvard Pilgrim

<ISA06>_<GS02>_I_<CCYYMMDD>_HHMM.CS837

Response Files returned by Harvard Pilgrim

Your system will be able to identify files by the extension and change in date and time.

More Format Rules

- With the addition of national products Choice Plus and Options (Joint Offering products are sold jointly by HPHC and United Health Care), member identification numbers will not follow the alpha-numeric 11-character format (HP followed by nine alpha-numeric characters). Choice Plus and Options member identifiers consist of a nine-character subscriber ID and six-character group number.
- When entering the Harvard Pilgrim member ID number, do not use dashes or spaces. For numbers with an “HP0” prefix, be certain to use numeric Zero, and not the alpha letter ‘O.’
- Special characters, such as hyphens (Tellington-Jones) and apostrophes (O’Donnell) are acceptable for last names.
- Per the Implementation Guide, whenever a monetary amount is used, the number should include a decimal point (unless Attribute is not set to R). For example, send 10.61, not 1061. \$10.00 would be submitted as 10 only.

Code Set Validation

Harvard Pilgrim requires that you use industry standard codes at all times. The most current versions of the following reference materials are good sources for obtaining industry standard coding:

- Current Procedural Terminology (CPT)
- Health Care Procedure Coding System (HCPCS)
- UB-92 Revenue Codes (National uniform Billing Committee)
- ICD-9-CM for Diagnosis Codes.

Harvard Pilgrim use to require that ICD-9 codes (Diagnosis and Procedure codes) contain a decimal point, for example, 7961 not 796.1. This issue is not addressed in the Implementation Guide. Harvard Pilgrim now assumes the decimal will be sent if the Diagnosis/Procedure is qualified (796.0 or 796.1). If not qualified, do not send the trailing decimal (796). A common error is to include an invalid trailing 0. For example, 796.10 or 490.0 or 490.00. Please refer to Harvard Pilgrim billing guidelines to determine the specificity of Diagnosis and Procedure codes that must be submitted on a claim.

The Implementation Guide specifies that all Revenue Codes must have a CPT or HCPC for an outpatient claim (Page 446 elements SV201 and SV202). There are revenue codes that don't have a corresponding CPT/HCPC. In this event, Harvard Pilgrim has applied the "reasonability" rule. If a revenue code does not have a corresponding billing CPT/HCPC, then one can't be submitted.

Member Validation

Legacy Products

If the patient is the subscriber, you must enter his/her date of birth. If the patient is not the subscriber, Harvard Pilgrim will accept any date that is entered into the subscriber loop. If the patient is not the subscriber, the patient's relationship to the subscriber must be submitted (Loop 2000C PAT01). If you do not have that information and it is not returned on Harvard Pilgrim's 271 (Eligibility Response) transaction, in other words the relationship is unknown, submit Code 21 (unknown).

Loop 2010BA requires that all mandatory segments be populated. NM108 (ID Qualifier) and NM109 (Member ID) must be sent. The Member ID suffix is always 00.

If your system maps all patients as subscribers, set SBR02 of the SBR segment to 18 (Patient relationship: Self). in loop 2000B. Do not send loop 2010CA.

If both the patient and subscriber loops are present, do not populate SBR02 in loop 2000B-SBR segment. In addition, 2010CA-NM108 and NM109 must be sent.

If your current process does not capture all the required subscriber and patient data:

- Use any date for Subscriber DOB
- Patient DOB must be the birth date of the recipient of services listed
- Subscriber Member ID suffix should be 00
- If the Patient Member ID suffix is unknown, use 01 as a default

Joint Offering Products

“Choice Plus Joint Offering” and “Options Joint Offering” member identifiers consist of a nine-character subscriber ID and six-character group number. Subscriber ID and group number do not solely identify a member; Harvard Pilgrim uses the nine-character Subscriber ID and six-character Group Number along with patient/dependent demographics to identify the patient.

When the subscriber is the patient and subscriber ID and group number are required for claims submission, Harvard Pilgrim recommends trading partners comply with the following:

- Subscriber information (2000B) SBR03 segment contains the six-character Group Number
- NM109 of the subscriber loop (2010BA) contains the nine-character Subscriber ID

When the patient is not the subscriber then Harvard Pilgrim requires the following:

- Subscriber information (2000B) SBR03 segment contains the six-character Group Number
- NM109 of the subscriber loop (2010BA) contains the nine-character Subscriber ID
- Patient hierarchical level (2000C) and patient name (2010CA) contains dependent information

	SBR03	NM108	NM109
<u>Subscriber is the Patient</u>			
Subscriber Information (2000B) Subscriber Name (2010BA)			
Recommended	Group Number	“MI”	Subscriber ID
Supported to accommodate trading partner system limitations	Not Required	“MI”	Concatenated Subscriber ID and Group Number (e.g. 999999999666666 where 999999999 is the Subscriber ID and 666666 is the Group Number)
<u>Subscriber is not the Patient</u>			
Subscriber Information (2000B) Subscriber Name (2010BA) Patient Hierarchical Level (2000C) Patient Name (2010CA)			
Recommended	Group Number	“MI”	Subscriber ID
Supported to accommodate trading partner system limitations	Not Required	“MI”	Concatenated Subscriber ID and Group Number (e.g. 999999999666666 where 999999999 is the Subscriber ID and 666666 is the Group Number)

Provider Validation

Although Provider Taxonomy Code is a required field in PRV segments, Harvard Pilgrim does not currently use the taxonomy code for claims adjudication. Submitters may enter any valid taxonomy code.

Provider Number

The provider number at the service line level (Service Facility loop 2310E-REF segment) can overwrite the claim level provider number (Billing Provider loop 2010AA-REF segment). If the service level provider number is used, please ensure that a valid National Provider Identifier (NPI) is populated in the NM1 segment and a valid Tax ID is populated in the REF segment.

Reporting

Harvard Pilgrim issues the following reports to indicate the acceptance/rejection of files and claims into the claims processing system:

File Acknowledgement (997)

Harvard Pilgrim supports the Functional Acknowledgment Transaction Set (997), and uses it as an acknowledgement of the incoming 837 file. Harvard Pilgrim returns the File Acknowledgement as it begins processing the 837 file. For this reason, there will be a delay between receipt of the claims file and return of the File Acknowledgement. The submitter should review the File Acknowledgement to verify that the file has been accepted. This will be the only electronic notification that Harvard Pilgrim has rejected the 837 file. If, for some reason a subsequent problem arises with the file, Harvard Pilgrim will contact the submitter.

277 Acknowledgement

Harvard Pilgrim supports the 277 Acknowledgement Transaction. The 277 Acknowledgement Report may be created before all edits are applied to an 837 claim file. In supporting the National Plans Choice Plus and Options, Harvard Pilgrim may return a subsequent (second) 277 Acknowledgement when the status of a claim changes after the original 277 Acknowledgement is delivered. Harvard Pilgrim will return updates and re-created subsequent 277 Acknowledgements within six business days. The subsequent (second) 277 Acknowledgement will contain both updated claim status(es) and unchanged claim status from the original Acknowledgement file. If a claim status changes after six business days Harvard Pilgrim will contact the submitters directly. For more information regarding the 277 Acknowledgement, please refer to the 277 Companion Guide.

Harvard Pilgrim Response Report

Harvard Pilgrim returns a proprietary (non-standard) acknowledgement status for each claim received. Each claim response will be either an acknowledgement that Harvard Pilgrim has received the claim and is forwarding it for further processing, or that Harvard Pilgrim has rejected the claim and the reason why.

Note: It is important to note that, unlike a 277 transaction, claims in a Harvard Pilgrim proprietary (non-standard) Response Report do not always tie back to an individual claim submission file. The Response Report may sometimes contain acknowledgements or rejections for claims submitted in several different submission files.

Note: A single rejected claim may generate multiple responses.

Harvard Pilgrim may only process claims with the notation, “claim accepted for further processing”. Claims with other notation should be considered “rejected” and must be corrected for resubmission electronically to Harvard Pilgrim in order to be processed.

To accommodate Joint Offering products, Harvard Pilgrim has updates current response codes and has created some new response codes. Updated and new response codes will begin with a “U”. The associated response code description will begin with “REVISED”. Claims with a changed status will be returned on the first proprietary response report created after the claim status is updated.

Note: For Joint Offering products Subscriber ID and Group Number, Harvard Pilgrim returns a 15 character linked Subscriber ID and Group Number as the Member ID.

Submitters should save Response Reports, either electronically or in print, since they serve as “receipts” and are required by Harvard Pilgrim as proof of submission. Save an unformatted copy of all Response Reports for filing limit documentation. Harvard Pilgrim suggests that each report be saved until all claims have been returned on a paper Explanation of Payment (EOP) or an 835 Electronic Remittance Advice (ERA). The minimum time to save Response Reports should be 90 days after filing limit.

EDI Response Reports are returned within four days in a daily file that is available for pickup at 8:30 a.m., Sunday through Friday. For NEHEN Members, Response Reports may be delivered directly to the provider e-Gateway. As a rule, if a claim has not been acknowledged within four (4) business days (excluding holidays), the submitter should contact the EDI Team (see [Chapter 1: Contact Information](#)).

If your claim was rejected, and you are not sure why or how to correct it, it is important to contact the EDI Team as soon as possible to ensure that the claim is resubmitted before the filing limit expires.

Response File Specifications

- The Harvard Pilgrim response file is fixed field, fixed length. There are no field delimiters.
- Any field that is not populated will be blank filled. All fields are right justified and blank filled.
- Harvard Pilgrim may cross-walk member ID numbers. An informational response is returned.

- When entering the Harvard Pilgrim member ID number, do not use dashes or spaces. For numbers with an “HP0” prefix, be certain to use numeric Zero, and not the alpha letter ‘O.’
- Response files are not appended.
- A unique file name is assigned to each Response file.

Response Files are available for pickup, Monday through Friday at 8:30AM. As part of the retrieval process, providers are required to delete response files.

Response File Specifications

Field #	Field Name	Description	Format	Start Position	End Position
01	Mailbox ID	HPHC-Assigned Mailbox or Folder	AN	01	10
02	Claim Status Date	Date HPHC generated this status line. <i>This is not the date the status was returned to the submitter.</i>	CCYYMMDD	11	18
03	Trading Partner Claim ID	Value submitted in loop 2300 “Claim Information,” segment REF “Claim ID Number for clearinghouses and Other Transmission Intermediaries” where Reference ID qualifier is D9.	AN	19	48
04	HPHC Claim ID	HPHC assigned claim number. Blank filled if claim is rejected prior to claim number assignment. If accepted for further processing, this will be the adjudication system’s claim number. <i>The HPHC internal claim number is 12 characters although the field is 20.</i>	YYMMDD<xxn nzz>	49	68
05	EDI Claim ID	EDI-assigned. Each claim submitted to HPHC via EDI is assigned a unique EDI claim number. This is <i>not</i> the same as the HPHC Internal Claim Number in field 04.	AN	69	88
06	Billing Provider	This is the provider to whom HPHC will pay the claim. For Institutional Claims, this is the provider’s Tax ID. For Professional Claims, this is the provider’s NPI.	AN	89	108
07	Filler	Blank-Filled	AN	109	112
08	Member ID	As determined by HPHC. The member ID may or may not match the submitted member ID.	AN	113	132
09	Patient First Name	As submitted on the incoming claim.	AN	133	157
10	Patient Middle Name	As submitted on the incoming claim.	AN	158	159
11	Patient Last Name	As submitted on the incoming claim.	AN	160	194

Field #	Field Name	Description	Format	Start Position	End Position
12	Service Start Date	<p>First service start date from claim.</p> <p>For Institutional Claims this is Loop 2300 "Claim Information," segment DTP "Statement Dates" where Date-Time qualifier is 434.</p> <p>For Professional Claims this is Loop 2400 Service Line, segment DTP "Service Date" where the Date-Time qualifier is 472.</p>	CCYYMMDD	195	202
13	Procedure Code	<p>As submitted on the claim.</p> <p>For Institutional Claims this is Loop 2300 "Claim Information," segment HI "Principal Procedure Information" where Procedure Code List qualifier is BP/BR.</p> <p>For Professional Claims this is Loop 2400 Service Line, segment SV1 "Professional Service" where the product/service ID qualifier is HC.</p>		203	208
14	Message Code	HPHC returned message code.	AN	209	213
15	Message Text	Message text associated with Field 14 Message Code	AN	214	273
16	Patient Control Number	Patient Control Number as submitted on the incoming claim.	AN	274	311
17	Principle Diagnosis Code	<p>The returned Principle Diagnosis Code will not include a decimal.</p> <p>For Institutional Claims this is Loop 2300 "Claim Information," segment HI "Principal, Admitting, E-Code and Patient Reason For Visit Diagnosis Information" where Code List Qualifier Code is BK.</p> <p>For Professional Claims this is in Loop 2300 "Claim Information" segment "Health Care Diagnosis Code" where Code List Qualifier Code is BK.</p>	AN	312	318
18	Patient Date of Birth	As submitted on the incoming claim.	CCYYMMDD	319	326

Testing

Harvard Pilgrim requires submitters to test claim submission and retrieval of 997 and claim responses prior to submitting claims in production. Once in production, Harvard Pilgrim reserves the right to require re-testing if it is determined that the submitter is receiving and/or generating an unacceptable volume of errors or particular type of error.

Prior to testing, the EDI Team provides the submitter with a test plan specific to his/her organization. This included when and how many test files may be sent to Harvard Pilgrim for Testing. Test cycles are scheduled with the submitter during regular business hours—Monday through Friday, 8:30 a.m. to 5:00 p.m., EST.

Claims submitted for testing should be a general representation of the types of claims that are normally submitted and must contain a reasonable variety of services and diagnoses. A minimum of 50 claims should be in the file.

Even if you have already certified and tested with a third party, Harvard Pilgrim tests with all electronic submitters in order to verify Harvard Pilgrim business rules are implemented. The goal is to eliminate errors and rejects. If a provider has already tested with a third party, testing should be relatively straightforward.

Harvard Pilgrim requires individual testing for 837 Institutional, Dental and Professional files. This is because the Institutional, Dental and Professional 837 are different enough, from a HIPAA-compliant and Harvard Pilgrim business rule and billing guideline standpoint, to warrant testing for all claim types.

In general, turnaround time for test files is 48 hours, but is dependent on the testing process and the quality of the data.

Migrating from Testing to Production

Upon successful completion of the testing process, the EDI Team gives the submitter approval to submit claims to the production environment.

- The EDI Team provides the submitter with the necessary connection information (production mailbox, user ID and password, dial-in phone numbers, FTP sites, processing schedule, etc.)
- The EDI team reviews the following schedules with the submitter:
 - claim file drop-off
 - response retrieval
 - monitoring period

Note: The EDI Team monitors the first few production runs to ensure successful submission.

- The EDI Team reserves the right to require re-testing if it is determined that a submitter is receiving and/or generating an unacceptable volume of errors or type of error.

Harvard Pilgrim retrieves claims once a day, Monday through Friday. Harvard Pilgrim forwards electronic claims to its processing system each day of the business week, with the exception of Thursday. Files are batch-processed during the night.

Production

Once approval has been given to the submitter by the EDI Team to submit claims to the production environment, it is helpful to keep the following in mind when in production phase:

- ISA15 must contain “P” for production, any other value will fail the file.
- Responses (acknowledgement or rejection) are returned at different steps in the process; there is no one-to-one correlation between an incoming claim file and an outbound claim response file.
- Although Harvard Pilgrim’s claims processing system uses some proprietary codes, a submitter must submit standard claim codes (CPT, HCPC, Place of Service, etc.).
- Existing member (subscriber/patient) validation rules (ID, first four characters of the last name, date of birth) are used for 837-4010A1 claims.
- Member and provider information submitted on a claim does not update the member and provider information stored in Harvard Pilgrim’s claims processing system.

With the exception of data validation (e.g. Comparison of the patient’s date of birth on the claim to the one stored in Harvard Pilgrim’s system), Harvard Pilgrim uses the member and provider information that is stored in its internal systems to adjudicate a claim.

NEIGHBORHOOD HEALTH PLAN



Security Statement

NHP has implemented a best practice approach to protecting the integrity and availability of protected health information. NHP is evaluating its current standards for the exchange of protected health information, electronic storage and/or transmission over telecommunications systems/networks based on the current HIPAA security regulations to determine whether updates or changes to established protocols will be needed.

Confidentiality, Privacy and Security

Maintaining the confidentiality of personal health information has been, and continues to be, one of NHP's guiding principles. NHP has a strict Confidentiality Policy with regard to safeguarding patient, employee, and health plan information. All staff are required to be familiar with, and comply with NHP's policy on the Confidentiality of Member Personal and Clinical Information to ensure that all member information is treated in a confidential and respectful manner. The policy permits use or disclosure of members' medical or personal information only as necessary to conduct required business and perform care management, approved research, quality assurance and measurement activities when authorized to do so by a member or as required by law.

In order to comply with our own internal policies and the provisions of the Health Insurance Portability and Accountability Act, 1996 (HIPAA), NHP has outlined specific requirements applicable to the electronic exchange of protected health information (PHI) including provisions for:

- Maintaining Confidentiality of Protected Information
- Confidentiality Safeguards
- Security Standards
- Return or Destruction of Protected Information
- Compliance with State and Federal regulatory and statutory requirements
- Required disclosure
- Use of Business Associates
- Implementing trading partner agreements prior to receiving electronic files

Channels for Claim Submission

NHP offers a variety of options to send 837I Institutional claims to NHP. The preferred option is to submit through NEHEN if you are a participating provider. If not, our preferred clearing house is AMPMED, a Navimedix company. NHP will accept transactions from other clearing houses and will review requests for direct submission from providers who can send and pick up transactions from our secure server utilizing either an HTTPS protocol or secured FTP protocol. NHP can also use VPN connections with providers who can support this.

Setup

Providers wishing to submit electronic claims transactions to NHP should contact the NHP E-Commerce Department via e-mail or telephone to initiate a setup request. Please refer to Neighborhood Health Plan's [Contact Information](#) in Chapter 1 for details.

The *User Agreement*, *NHP Privacy and Security Agreement*, and *Trading Partner Agreement* required by Neighborhood Health Plan may be accessed at their website, www.NHP.org. A Trading Partner Agreement indicating approval by the provider or billing service to submit claims electronically to the test environment must be on file at Neighborhood Health Plan before testing can begin.

Trading Partners

NHP will accept transmissions only from authorized Trading Partners who have signed an NHP *Trading Partner Agreement*. Files for providers who submit without a Trading Partner Agreement in place will be rejected. An NHP E-Commerce Coordinator will then contact you to establish a valid Trading Partner Agreement.

The Trading Partner Agreement form is required to initiate a Trading Partner setup. A person who is authorized to approve the Trading Partner setup, whether directly from the provider or through a billing entity, must sign the Authorization. The signed Authorization initiates a Trading Partner Agreement with NHP, giving authorization for NHP to accept claims on behalf of the provider. Once a valid Trading Partner Agreement is in place, testing can begin. If any of the information on the Authorization Form changes, a new form must be completed and submitted to NHP's E-Commerce Department.

NHP's E-Commerce Department will return an EDI authorization to the Trading Partner with all the necessary information to submit electronic transactions. The information will include:

- An assigned default user ID and password and a mailbox (folder) for file drop off and retrieval
- Submitter (ISA06) and the Submitter Application ID (GS02) – Trading Partner ID

NHP will return a list of all providers that are associated with the requested Vendor ID to facilitate Electronic processing. If you have providers that will be servicing NHP members and

they are not listed on the provided documentation, please contact provider relations to initiate getting an NHP provider number.

Once Setup is complete, an NHP E-Commerce coordinator will contact the submitter to review testing plans and test file submission. The E-Commerce coordinator will work with you through the full testing process and will be your main contact for production support.

The E-Commerce team will assign the Submitter (ISA06) and the Submitter Application ID (GS02).

Note: For NEHEN Members, NEHEN will coordinate these to be consistent with the ID used in other HIPAA Transactions.

Generating a Successful Transaction



837 Institutional Claim Submission Specifications

Certain situational data is required in order to effectively process claims. For detailed information on this subject please refer to [Chapter 6: 837 Institutional Claim Submission Specifications](#).

General Claim Information

All segments and fields required for the 837 in order to be format and content-compliant must be sent regardless of NHP internal processing requirements. NHP requires, per the Implementation Guide, that these fields be submitted. If they are not used to adjudicate the claim, the content will not be validated.

Transactions that are not structurally valid will be rejected and will be returned to the sender. You must submit incoming 837 claim data using the character set referenced in the 837I Institutional Implementation Guide.

Member and Provider Demographics submitted on a claim do not update the member and provider information stored in NHP's claims processing system. With the exception of data validation (for example, NHP may compare the provider's tax ID on the claim to the one stored in NHP's system), NHP uses the member and provider demographics that are stored in its internal systems to validate submitted data and to adjudicate a claim.

Claims submitted through NEHEN or directly from a provider contain only one ISA and one GS segment. A GS segment should contain only one ST segment.

Claims submitted from clearing houses. NHP will accept a file with multiple ISA and GS records from their clearing house trading partners. It is expected that these files will contain multiple ISA and GS records. However, each individual provider submissions should adhere to the recommended standard.

Dates. All dates that are submitted on an incoming 837 claim transaction should be valid calendar dates in the appropriate format based on the respective qualifier. Failure to submit a valid calendar date may result in rejections of the claim or the applicable interchange (transmission).

Claim Tracking Number. NHP strongly recommends that all submitters generate a unique Claim TRACKING Identification Number (as described in Loop 2300 Ref segment on page 187 of the Implementation Guide) for each claim that is submitted to NHP. NHP recommends that these IDs be unique both within a file and across files. In other words, generate a new claim tracking ID even if the claim was submitted previously. This facilitates problem resolution and tying out NHP's responses to submitted claims.

Only Loops, segments, and data elements valid for the HIPAA Institutional Implementation Guide will be translated. Non-implementation guide data may not be sent for processing consideration.

Compression of files is not supported for transmissions between the submitter and NHP.

Attachments. Currently there is no standard for submitting attachments electronically. If you use the transaction to indicate that you will be forwarding an attachment or paper work, choose one of the following media to send the attachment segment. Please use the following instructions to submit and make sure any attachments include the appropriate attachment number that was placed in Loop 2300, the PWK06 field.

Mail:

Neighborhood Health Plan
 Attn: Claims Department, Attachments Unit
 253 Summer St
 Boston, MA 02210-1120
Fax: 617-772-5516

File Naming Conventions

NHP determines file naming conventions. Once a Trading Partner Agreement is established, NHP provides a unique file naming convention and a folder structure on its secure server for you to drop off and pick up your claims files.

Submitters should include in their file pick up process a script that deletes the file from the server. (An archive copy of all files is stored and backed up daily by NHP. Eliminating the file from the server will improve overall performance.)

Note: For NEHEN Members, the NEHEN e-Gateway will rename your file according to the Payer-specific naming conventions.

More Format Rules

- Special characters, such as hyphens (Tellington-Jones) and apostrophes (O'Donnell) are acceptable for last names.

Code Set Validation

- NHP requires the submission of industry standard code sets. A submitter must submit standard codes (CPT, HCPC, Diagnosis Code, Place of Service, Bill Type, etc.) on the claim unless otherwise noted.
- Diagnosis codes have a maximum size of five (5).
- Up to twenty-four (24) diagnosis codes per claim may be submitted.

Member Validation

- Use NHPNet.org or NEHEN to verify the accuracy of member information prior to submission.
- NHP rejects any claim that does not have a valid NHP Member ID.
- Do not use dashes or spaces when entering the NHP member ID number.
- NHP uses the Member ID, Date of Birth, Plan Effective and End Dates to validate NHP enrollment.
- All NHP members have a unique Member ID. We recommend that you bill all patient-related services in the Subscriber Loop (2000B). The NHP member number should be placed in Loop 2010BA, segment NM109, given that a unique member ID identifies each Neighborhood Health Plan member.
- Claims submitted for an eligible member with the wrong member ID will be rejected back to the provider. NHP will not correct an invalid member number but will provide information to assist correction and a re-send of the claim if appropriate.

Provider Validation

- NHP requires the submission of a valid NPI number and a rendering provider NPI number on all claims transactions. Please use the *Trading Partner Agreement* to verify that you have the correct NPI number for the correct segment. Please contact your Provider Relations representative if you need to have providers added to NHP.
- You should use either Billing Provider (Loop 2010AA) NM109 or Pay-To Provider (Loop 2010AB) NM109 to place your NPI number. NHP recommends that you use the Billing Provider Loop as both of these segments capture the same NPI number.

- In addition to the Billing Provider NPI number a valid group or valid rendering provider NPI number must be submitted on the electronic claim. (See attached NHP specific transaction map for valid rendering provider values.)

Reporting

In addition to compliance checking for required transaction data elements, NHP has implemented business front-end reject edits as a vehicle to improve accuracy and turnaround of claims. A reject edit does not mean the claim is being denied for payment. Rather it means submitted information is either invalid or incorrect and should be corrected and re-submitted.

The following are sample NHP submitter reports:

NHP CLAIMS SUBMISSION REPORT

Submitted File Name: SEND1.nhpclm.1020

Report Run Date: October 20, 2003 10:34:57 AM EDT

Submission Date (from GS04): 20031016

Billing Provider NPI (from 20010AA NM109): 9999999999

Trading Partner Identifier (from GS02): NEHEN099

Total Number of Claims Submitted: 5

Total Number of Claims Accepted: 4

Total Number of Claims Rejected: 1

Total Dollar Amount of Claims Submitted: \$787.00

Total Dolar Amount of Claims Accepted: \$761.00

Total Dolar Amount of Claims Rejected: \$26.00

REJECTED CLAIM SUMMARY

Claim	Submitted Patient	Reject Reason	Loop/Segment
Account No.(CLMO1)		Data Value Causing Rejection	
=====			
1	509958860 19700225	Member's DOB	2010BA DMG02

ACCEPTED CLAIM SUMMARY

Claim	Submitted Patient	NHP CLAIM CONTROL NUMBER
Account No.(CLMO1)		
=====		
1	5099588600	700-001-001
2	5099589099	700-002-001
3	5099585644	700-004-001
4	5099586622	700-005-001

997 File Acknowledgement Report

First Level File Acknowledgement Report. NHP supports the Functional Acknowledgment Transaction Set (997) and uses it as an acknowledgement of the incoming 837 file. NHP sends a 997 Acknowledgement Report for all inbound files. If accepted, NHP acknowledges the number of records and total dollars received. If it does not pass compliance, the entire file will be rejected.

Acknowledgement Report Specifications

ANSI Segment	R/S	Description	Field Size	Error Code - Description
AK304	S	Segment syntax error code	3	1- Unrecognized segment id 2- Unexpected segment 3- Mandatory segment missing 4- Loop occurs over maximum times 5- Segment exceeds maximum use 6- Segment not in defined transaction set 7- Segment not in proper sequence 8- Segment has data element errors
AK502	S	Transaction set syntax error code	3	1- Transaction not supported (used if version is wrong or if submitter not authorized to submit transaction set) 2- add others
AK901	R	Functional group Ack Code	1	A- Accepted P- Partially accepted (at least one transaction set ST/SE was rejected) R- Rejected
AK905	S	Functional group syntax error code	3	1- Functional group not supported (GS01) 2- Functional group version not supported (GS08) 3- Functional group trailer missing (no GE) 4- Group control number in the functional group header and trailer do not agree (if GS06 and GE02 don't match) 5- Number of included transaction sets does not match actual count (GE compared with calculated count) 6- Group control number violates syntax (GS06)

The acknowledgement report is sent to your outbound acknowledgement folder or to your e-gateway for retrieval by you if you are a NEHEN member.

997 Acknowledgement reports are generally available within twenty-four (24) hours of the file receipt. Your retrieval file script should include a delete script in your file process. Delete the file out of your outbound mailbox after you have successfully retrieved it.

Unsolicited 277 Transaction

NHP uses a proprietary front-end processor. Files that are accepted by the NHP ANSI Translator are not necessarily submitted to the claims adjudication system for processing. NHP returns a 277 generally within twenty-four (24) to forty-eight (48) hours of the file receipt. This initial claims receipt includes an acknowledgement of claims accepted and or rejected. The unsolicited claims status can be used to validate the status of your claims on a weekly basis.

Initial Claims Receipt 277 Response - STC01 Valid Codes:

- A2 Claim has been received and forwarded to the claims adjudication system.
- A3 Claim has been rejected and has not been sent to the adjudication system.

Please refer to the table below for a list of reject reasons (STC02).

Error Code	Description
21	Missing or invalid information.
33	Subscriber and subscriber id not found.
73	Payment made to entity, assignment of benefits not on file.
88	Entity not eligible for benefits for submitted dates of service.
121	Service line number greater than maximum allowable for payer. <i>(NHP cannot accept more than 80 service lines.)</i>
135	Entity's commercial provider id.
142	Entity's license/certification number.
153	Entity's id number. <i>Identifier Code = IL (Insured/Subscriber)</i>
158	Entity's date of birth
218	NDC number.
232	Admitting diagnosis.
254	Primary diagnosis code.
255	Diagnosis code.

Error Code	Description
448	Invalid billing combination. See STC12 for details. This code should only be used to indicate an inconsistency between two or more data elements on the claim. A detailed explanation is required in STC12 when this code is used. <i>(STC12 contains the correct ID Number to submit)</i>
453	Procedure Code Modifier(s) for Service(s) Rendered
454	Procedure code for services rendered.
455	Revenue code for services rendered.
465	Principal Procedure Code for Service(s) Rendered

- The submitter should review the 277 to verify that all claims have been accepted and sent for processing or rejected

If a claim has been submitted to the claims adjudication system, the weekly Unsolicited 277 Transaction will have the following STC01 valid codes:

- F0 Finalized, claim completed adjudication cycle
- P1 Pending in process
 - P3 Pending, waiting for requested information to continue processing
 - R0 Pending, initial request for additional information sent

Note: The initial request for information will be indicated with the R0 code. All subsequent notifications will denote the P3 code until the information is received. Once the information is received the claim will go back to a P1 status until Finalized.

The 277 Unsolicited Claim Status, as described in Section 2.6.2 of the Implementation Guide, is not a HIPAA-mandated transaction but is supported by NHP. At this level, NHP passes good claims to the claims system and passes back claims that failed NHP business edits.

If your EDI file was rejected, and you are not sure why or how to correct it, it is important to contact the E-Commerce Department as soon as possible to ensure that your claim file is resubmitted before the filing limit expires.

The unsolicited report is sent to your outbound folder for retrieval by you. Your pick up file script should include a delete script in your file process. Delete the file out of your outbound mailbox after you have successfully retrieved it.

Submitters should review the 277 to verify that all batches have been accepted and sent for processing.

NHP offers the 276/277 Claims Status Request Response through NEHEN and NHPnet. NHP will work with clearing house trading partners to determine their readiness to accept a 276/277 request response.

Electronic EOP

The final report that NHP generates for the transaction is an 835 once the claim has been adjudicated and paid/posting status is completed. (The 835 Implementation Guide provides detailed payment status and reject codes.)

Testing

NHP requires submitters to test claim submissions and retrieval of 997 and claim responses prior to submitting production claims. Once in production, NHP reserves the right to require re-testing if it is determined that the submitter is receiving/generating an unacceptable volume of errors or types of errors.

The following outlines the testing process:

- Prior to testing, the E-Commerce Department provides the submitter with a test plan specific to his/her organization.
- Test cycles are scheduled with the submitter during regular business hours – Monday through Friday, 8:30 a.m. to 5:00 p.m., EST.
- The submitter is notified when and how many test files may be sent to NHP.
- The claims submitted for testing should be a general representation of the types of claims that are normally submitted and must contain a reasonable variety of services and diagnoses.
- In general, turnaround time for test files is 48 hours, but is dependent on the testing process and the quality of the data.

Migration from Testing to Production

- Once Testing is completed, the E-Commerce Department notifies the submitter and reviews the results with the submitter. Submitters are instructed to move files to production upon successful testing sign off.
- The submitter's mailbox name remains the same when moving from test to production. The file status changes from Testing to Production when testing is complete.

Production

The E-Commerce Department reviews the following schedules with the submitter:

- Claim File Drop off
- Response Retrieval
- Monitoring period

NHP monitors closely the first few production runs to ensure successful submission.

Note: NHP reserves the right to require re-testing if it is determined that a submitter is receiving/generating an unacceptable volume of errors or types of errors.

TUFTS HEALTH PLAN



Security Statement

HIPAA Security Regulations

The HIPAA Security regulations have been finalized. The final regulations outline standards for the security of individual health information used by health plans, health care clearinghouses and health care providers. The health plans, clearinghouses and providers are required to comply with these regulations on or before May 23, 2007. Tufts Health Plan has taken reasonable and appropriate steps to be compliant with the Security Rule.

Channels for Claim Submission

Tufts Health Plan offers the following channels for HIPAA standard 837 4010A1 claim submission for institutional and professional submitters:

NEHEN – through the NEHEN eGateway. There is no charge to the provider for this method of claim submission. Please contact EDI Operations for setup information.

Direct Submission – Tufts Health Plan can accept 837 Institutional and Professional claims directly from the submitter's billing system via modem. There is no charge for direct claim submission. Contact EDI Operations for setup information.

Clearinghouses – Tufts Health Plan accepts claims from all major clearinghouses. However, there is usually a charge associated with using a clearinghouse. Contact EDI Operations for information related to submitting through clearinghouses.

Tufts Health Plan is not responsible for any software used by the submitter to generate 837 claim files.

Setup

Providers interested in submitting electronic claim transactions should contact EDI Operations at Tufts Health Plan via email or telephone for a Setup Request. Please refer to Tufts Health Plan [Contact Information](#) in Chapter 1 for more detail.

Refer to www.tuftshealthplan.com or call Tufts HP EDI Operations for a Direct Submitter EDI Setup Form. EDI Operations will coordinate the appropriate process to set up an electronic data interchange. This includes completing enveloping requirements. EDI Operations will notify the submitter of the testing procedures when setup is complete. Once EDI Operations reviews testing procedures with the submitter, test claims can be sent to Tufts Health Plan.

Generating a Successful Transaction



837 Institutional Claim Submission Specifications

Certain situational data is required in order to effectively process claims. For detailed information on this subject please refer to [Chapter 6: 837 Institutional Claim Submission Specifications](#).

General Claim Information

- A maximum of 5000 CLM segments will be accepted by Tufts HP.
- Tufts HP will accept Institutional and Professional Claim transactions for all business products, however institutional claim files must be separate from professional claim files. Files should not contain both types of claims.
- For Frequency Types 6, 7, and 8, (Element CLM05-3), Tufts HP's original claim number (Original Reference Number - Element REF02) must be submitted as stated in the implementation guides. Tufts HP strongly recommends sending the Original Reference Number with Frequency Types 3, 4, and 5.
- When contacting Tufts HP with claims questions for claims with Frequency Types 3, 4, 5, 6, 7 and 8 (Element CLM05-3), please use Tufts HP's original claim number even though a new claim number for that submission will be assigned.
- The Tufts HP implementation of Coordination of Benefits (COB) Information utilizes the COB Header (Loop 2320), Other Subscriber Information (Loop 2330A), Other Payer Information (Loop 2330B) and COB Detail (Loop 2430) within the 837 transaction. Tufts HP strongly recommends closely reviewing these loops in the implementation guide before submitting COB information.
- Although the HIPAA Transaction Set Implementation Guide allows the repeating of Provider Information (2000A Loop) for each claim, the size of transmission files can be reduced by up to 20% by using only one repeat of Provider information followed by all

Subscriber and Claim information for that Provider. File transmission files can be further reduced by grouping the claims of each subscriber together.

File Naming Conventions

Note: For NEHEN Members, the NEHEN e-Gateway will rename your file according to the Payer-specific naming conventions.

Code Set Validation

- Mapping should suppress leading or trailing zeros or spaces. Revenue codes for Institutional claims are the only exception. Use three digits and a leading zero. (Example: 0424.)
- Tufts HP will capture all four Procedure Code Modifiers (Element SV201-3) if sent, but only the first modifier will be utilized during processing.

Member Validation

- Each Tufts HP member is uniquely identified. Thus Tufts HP strongly recommends treating all members as subscribers, and submitting member ID in Element NM109 of Loop 2010BA.

Provider Validation

- The Service Facility Information (Loop 2310E) should be submitted if the Provider of Services is different from the Pay-to Provider (Loop 2010AB). Tufts HP strongly recommends that Service Facility Information always match Pay-to Provider Information given that the payee should always equal the provider on Tufts HP institutional claims.
- If Pay-to Provider Information (Loop 2010AB) is not sent in the 837 transaction, Tufts HP will capture payee information from the Billing Provider Information (Loop 2010AA).
- Tufts HP Provider Identifiers will no longer be allowed in the Secondary Identification REF Segments as of May 23, 2007 now that the National Provider Identifiers (NPI) have been released. Please follow the 837 I and P implementation guides on how to utilize the National Provider ID (NPI).

Reporting

Tufts HP adheres to structural specifications for required and situational fields as stated in the Implementation Guides. If the incoming 837I or 837P structure does not comply, the file will fail in the validation process. The submitter will receive a 997 Functional Acknowledgement for notification the file has failed.

Response Reports

Submitter reports include basic file information: submission status, submission date, reasons for file rejections, and file totals. For an example of a submitter report, see the sample that follows this section.

See [Tufts Health Plan Rejection Criteria and Associated Error Messages](#), in this chapter for a list of submitter report error-related information.

When a compliant file is received, the submitter report will typically be available within one business day.

Sample Response Reports

Example Tufts EDI Claim Acceptance Summary Report

REPORT DATE: TUFTS HEALTH PLAN PAGE:
 REPORT ID: ELECTRONIC DATA INTERCHANGE (EDI)
 CLAIMS ACCEPTANCE
 EVENT ID:

 THIS REPORT LISTS THE TOTAL NUMBER OF CLAIMS ACCEPTED/ REJECTED FOR YOUR EDI SUBMISSION BY TUFTS HEALTH PLAN FOR THE DATE INDICATED. PLEASE ENSURE THAT ALL REJECTED CLAIMS ARE CORRECTED AND RESUBMITTED WITHIN ANY APPLICABLE FILING LIMIT. IF YOU HAVE ANY QUESTIONS REGARDING THIS REPORT, PLEASE CONTACT THE EDI OPERATIONS DEPT (617) 972-9400 EXTENSION 4042.

MAIL TO: SUBMISSION DATE:
 SUBMITTED BY:
 VOLUME SERIAL ID:
 PAYEE ID:

TOTAL CLAIM LINES	TOTAL CLAIMS	TOTAL AMOUNT BILLED
TOTAL RECORDS		
-----	-----	-----

TOTAL CLAIMS SUBMITTED:
 TOTAL CLAIMS ACCEPTED:
 TOTAL CLAIM REJECTED:

REJECTED CLAIMS

Record #	Patient Account #	Error Message	Field Content
XXXXXX	XXXXXXXXXX	Invalid Member ID	XXXXXXXXXX

Example Tufts EDI Claim Acceptance Detail Report

REPORT DATE:
 REPORT ID:
 EVENT ID:

TUFTS HEALTH PLAN
 ELECTRONIC DATA INTERCHANGE (EDI) CLAIMS

PAGE:

MAIL TO:

SUBMISSION DATE:
 SUBMITTED BY:
 VOLUME SERIAL ID:
 PAYEE ID:

Record #	Account #	Claim #	Product
XXXXXX	XXXXXXXXXX	XXXXXXXX	XXX

TOTAL CLAIMS:

Rejection Criteria and Error Messages on Response Reports

The grid below outlines electronic claim error messages that can be found on Tufts HP submitter reports.

Rejection Criteria for 837 Institutional Claims

Message	Criteria
CLAIM ACCEPTED	Tufts Health Plan accepted the claim submitted.
INVALID MEMBER ID	Member ID/Suffix is not in Tufts Health Plan system.
INVALID SUBSCRIBER	Subscriber is not in Tufts Health Plan system.
ADMIT/REF NPI NOT ON FILE AT PAYER	Admit/Ref NPI is not in Tufts Health Plan system.
PROVIDER NPI NOT ON FILE AT PAYER	Provider NPI is not in Tufts Health Plan system.
INVALID PRIMARY DIAG CODE	Primary diag code is not in Tufts Health Plan system, or the 1 st position of diag code is E-Code.
INVALID SECONDARY DIAG CODE	Secondary diag code is not in Tufts Health Plan system.
INVALID ADDR-SUFFIX	Payment address suffix is incorrect.
INVALID PAT. DOB	Patient's date of birth does not match Tufts Health Plan patient date of birth on file.
DOB EXCEEDS DOS FOR MEMB-ID	Member's date of birth is after date of service.
WRONG DATE OF BIRTH FOR MEM	Date of birth is not within 7 days of member's

Message	Criteria
	date of birth.
PAT. ACCT. SPACES	Patient account number is not submitted.
INVALID BEGIN DOS	Beginning date of service is invalid.
INVALID END DOS	End date of service is invalid for type of bill. [Except for frequency types 2 or 3 (Interim Bills) that do not require end date of service.]
DOB > BEGIN DOS	Date of birth is greater than the date of service.
DOB > TODAY	Date of birth is greater than today's date.
INVALID SEX	Value does not equal 'F', 'M', or 'U'.
ASSIGN BEN. MUST = Y	Value does not equal 'Y'.
INVALID TYPE OF BILL	Value is not a valid type of bill as defined by HIPAA.
INSTITUTE INPAT. NOT ACCEPTED	Type of bill is not valid for type of submission.
INSTITUTE OUTPAT. NOT ACCEPTED	Type of bill is not valid for type of submission.
BEGIN DOS > TODAY	Begin date of service is after today's date.
19970101 IS > THAN BEGIN DOS	Begin date of service is before 01/01/1997.
BEGIN DOS NOT = ADM. DATE	Begin date of service does not equal the admit date.
END DOS > TODAY	End date of service must be before today's date. [Except for frequency types 2 or 3 (Interim Bills) that do not require end date of service.]
DOB > END DATE	Date of birth cannot be after the end date. [Except for frequency types 2 or 3 (Interim Bills) that do not require end date of service.]
BEGIN DOS > END DOS	Beginning date of service cannot be after the end date. [Except for frequency types 2 or 3 (Interim Bills) that do not require end date of service.]
ADM HR REQUIRED FOR INPATIENT CLAIM	The admit hour is not submitted.
INVALID ADM. HOUR	Admit hour is invalid.
SOURCE OF ADM. REQ. FOR INPATIENT CLAIM	Source of admission is not submitted.

Message	Criteria
INVALID SOURCE OF ADMISSION	Source of admission is invalid
SOURCE OF ADMISSION NOT NUMERIC	Source of admission must be a valid value. [Can not be numeric.]
DISCHARGE HR NOT NUMERIC	Discharge hour must be numeric. [Except for frequency types 2 or 3 (interim bills) that do not require a discharge hour.]
DISCHARGE HR REQ FOR INPATIENT CLAIM	Discharge hour is not submitted. [Except for frequency types 2 or 3 (interim bills) that do not require a discharge hour.]
INVALID DISCHARGE HOUR	Discharge hour is invalid. [Except for frequency types 2 or 3 (interim bills) that do not require a discharge hour.]
RELEASE OF INFO. FLAG MUST BE OBTAINED	Release of information code does not equal Y.
INVALID ADMIT DATE	Admit date is invalid.
DOB > ADM DATE	Date of birth is greater than the admit date.
ADM DATE > TODAY	Admit date is greater than today's date.
19970101 IS > THAN ADM DATE	Admit date is before 01/01/1997.
ADM. DATE NOT = BEG. DOS	Admit date does not equal the begin date of service.
INVALID DISCHARGE DATE	Discharge date is invalid. [Except for frequency types 2 or 3 (interim bills) that do not require a discharge date.]
BEGIN DOS > DISCHARGE DATE	Begin date of service is greater than the discharge date, [Except for frequency types 2 or 3 (interim bills) that do not require a discharge date.]
ADM. DIAG. REQUIRED FOR INPATIENT CLAIM	Admit diag is not submitted.
INVALID ADM. DIAG	Admit diag is invalid.
ADMISSION TYPE REQUIRED	Admission type is not submitted.
INVALID ADMISSION TYPE	Admission type is invalid.
ADM TYPE XREF INVALID - MUST BE 1-4,9	Admission type is invalid.
ADMISSION TYPE MUST BE 1-4, 9	Admission type does not equal 1-4 or 9.

Message	Criteria
DISCHARGE STATUS REQUIRED	Discharge status is not submitted. [Except for frequency types 2 or 3 (interim bills) that do not require a discharge status.]
INVALID DISCHARGE STATUS	Discharge status is not valid. [Except for frequency types 2 or 3 (interim bills) that do not require a discharge status.]
INVALID DISCHARGE STATUS RANGE	Discharge status range is not valid. [Except for frequency types 2 or 3 (interim bills) that do not require a discharge status range.]
ATT PHYS ID IS REQUIRED	Attending Physician ID is not submitted.
INVALID OTHER DIAG2	Not a valid diagnosis code in Tufts Health Plan's system.
INVALID OTHER DIAG3	Not a valid diagnosis code in Tufts Health Plan's system
INVALID OTHER DIAG4	Not a valid diagnosis code in Tufts Health Plan's system
INVALID OTHER DIAG5	Not a valid diagnosis code in Tufts Health Plan's system
INVALID OTHER DIAG6	Not a valid diagnosis code in Tufts Health Plan's system
INVALID OTHER DIAG7	Not a valid diagnosis code in Tufts Health Plan's system
INVALID OTHER DIAG8	Not a valid diagnosis code in Tufts Health Plan's system
INVALID OTHER DIAG9	Not a valid diagnosis code in Tufts Health Plan's system
INVALID OTHER DIAG10	Not a valid diagnosis code in Tufts Health Plan's system
INVALID OTHER DIAG 11	Not a valid diagnosis code in Tufts Health Plan's system
INVALID OTHER DIAG 12	Not a valid diagnosis code in Tufts Health Plan's system
INVALID OTHER DIAG 13	Not a valid diagnosis code in Tufts Health Plan's system
INVALID OTHER DIAG 14	Not a valid diagnosis code in Tufts Health

Message	Criteria
	Plan's system
INVALID OTHER DIAG 15	Not a valid diagnosis code in Tufts Health Plan's system
INVALID OTHER DIAG 16	Not a valid diagnosis code in Tufts Health Plan's system
INVALID OTHER DIAG 17	Not a valid diagnosis code in Tufts Health Plan's system
INVALID OTHER DIAG 18	Not a valid diagnosis code in Tufts Health Plan's system
INVALID OTHER DIAG 19	Not a valid diagnosis code in Tufts Health Plan's system
INVALID OTHER DIAG 20	Not a valid diagnosis code in Tufts Health Plan's system
INVALID OTHER DIAG 21	Not a valid diagnosis code in Tufts Health Plan's system
INVALID OTHER DIAG 22	Not a valid diagnosis code in Tufts Health Plan's system
INVALID OTHER DIAG 23	Not a valid diagnosis code in Tufts Health Plan's system
INVALID OTHER DIAG 24	Not a valid diagnosis code in Tufts Health Plan's system
INVALID OTHER PROC 1	Not a valid HCPCS/CPT code if qualifier is 'BO'. Not a valid ICD-9 procedure code if qualifier is 'BQ' from the beginning to end date of service.
INVALID OTHER PROC 2	Not a valid HCPCS/CPT code if qualifier is 'BO'. Not a valid ICD-9 procedure code if qualifier is 'BQ' from the beginning to end date of service.
INVALID OTHER PROC 3	Not a valid HCPCS/CPT code if qualifier is 'BO'. Not a valid ICD-9 procedure code if qualifier is 'BQ' from the beginning to end date of service.
INVALID OTHER PROC 4	Not a valid HCPCS/CPT code if qualifier is 'BO'. Not a valid ICD-9 procedure code if qualifier is 'BQ' from the beginning to end date of service.

Message	Criteria
INVALID OTHER PROC 5	Not a valid HCPCS/CPT code if qualifier is 'BO'. Not a valid ICD-9 procedure code if qualifier is 'BQ' from the beginning to end date of service.
INVALID OTHER PROC 6	Not a valid HCPCS/CPT code if qualifier is 'BO'. Not a valid ICD-9 procedure code if qualifier is 'BQ' from the beginning to end date of service.
INVALID OTHER PROC 7	Not a valid HCPCS/CPT code if qualifier is 'BO'. Not a valid ICD-9 procedure code if qualifier is 'BQ' from the beginning to end date of service.
INVALID OTHER PROC 8	Not a valid HCPCS/CPT code if qualifier is 'BO'. Not a valid ICD-9 procedure code if qualifier is 'BQ' from the beginning to end date of service.
INVALID OTHER PROC 9	Not a valid HCPCS/CPT code if qualifier is 'BO'. Not a valid ICD-9 procedure code if qualifier is 'BQ'.
INVALID OTHER PROC 10	Not a valid HCPCS/CPT code if qualifier is 'BO'. Not a valid ICD-9 procedure code if qualifier is 'BQ' from the beginning to end date of service.
INVALID OTHER PROC 11	Not a valid HCPCS/CPT code if qualifier is 'BO'. Not a valid ICD-9 procedure code if qualifier is 'BQ' from the beginning to end date of service.
INVALID OTHER PROC 12	Not a valid HCPCS/CPT code if qualifier is 'BO'. Not a valid ICD-9 procedure code if qualifier is 'BQ' from the beginning to end date of service.
INVALID OTHER PROC 13	Not a valid HCPCS/CPT code if qualifier is 'BO'. Not a valid ICD-9 procedure code if qualifier is 'BQ' from the beginning to end date of service.
INVALID OTHER PROC 14	Not a valid HCPCS/CPT code if qualifier is 'BO'. Not a valid ICD-9 procedure code if qualifier is 'BQ' from the beginning to end date of service.
INVALID OTHER PROC 15	Not a valid HCPCS/CPT code if qualifier is 'BO'. Not a valid ICD-9 procedure code if qualifier is 'BQ' from the beginning to end date

Message	Criteria
	of service.
INVALID OTHER PROC 16	Not a valid HCPCS/CPT code if qualifier is 'BO'. Not a valid ICD-9 procedure code if qualifier is 'BQ' from the beginning to end date of service.
INVALID OTHER PROC 17	Not a valid HCPCS/CPT code if qualifier is 'BO'. Not a valid ICD-9 procedure code if qualifier is 'BQ' from the beginning to end date of service.
INVALID OTHER PROC 18	Not a valid HCPCS/CPT code if qualifier is 'BO'. Not a valid ICD-9 procedure code if qualifier is 'BQ' from the beginning to end date of service.
INVALID OTHER PROC 19	Not a valid HCPCS/CPT code if qualifier is 'BO'. Not a valid ICD-9 procedure code if qualifier is 'BQ' from the beginning to end date of service.
INVALID OTHER PROC 20	Not a valid HCPCS/CPT code if qualifier is 'BO'. Not a valid ICD-9 procedure code if qualifier is 'BQ' from the beginning to end date of service.
INVALID OTHER PROC 21	Not a valid HCPCS/CPT code if qualifier is 'BO'. Not a valid ICD-9 procedure code if qualifier is 'BQ' from the beginning to end date of service.
INVALID OTHER PROC 22	Not a valid HCPCS/CPT code if qualifier is 'BO'. Not a valid ICD-9 procedure code if qualifier is 'BQ' from the beginning to end date of service.
INVALID OTHER PROC 23	Not a valid HCPCS/CPT code if qualifier is 'BO'. Not a valid ICD-9 procedure code if qualifier is 'BQ' from the beginning to end date of service.
INVALID OTHER PROC 24	Not a valid HCPCS/CPT code if qualifier is 'BO'. Not a valid ICD-9 procedure code if qualifier is 'BQ' from the beginning to end date of service.
PAYEE ID IS NOT EQUAL TO PROVIDER ID	Payee ID and Provider ID do not equal. [Tufts HP requires that Payee ID and Provider ID equal on institutional claims.]

Message	Criteria
PAYEE NPI NOT ON FILE AT PAYER	Payee NPI is not in the Tufts Health Plan System.
INVALID PRIM-PROC	Primary procedure code is invalid and/or not effective on the beginning date of service of claim.
INVALID PRIM-PROC MODIFIER	Modifier is invalid and/or not effective on beginning date of service of claim.
INVALID PRIM-PROC MODIFIER 2	Modifier is invalid and/or not effective on beginning date of service of claim.
INVALID PRIM-PROC MODIFIER 3	Modifier is invalid and/or not effective on beginning date of service of claim.
INVALID PRIM-PROC MODIFIER 4	Modifier is invalid and/or not effective on beginning date of service of claim.
INVALID 001414 PRIM-PROC	Procedure must have a valid admit refer ID.
DOS > RECEIPT DATE	Date of service is greater than date received
INVALID DOS	Date of service is invalid.
INVALID NOS - NOT NUMERIC	Number of service is invalid. [Must be numeric.]
DISCHARGE HOUR IS REQ. FOR THIS REV. CODE	Discharge hour not submitted for type of claim or type of bill [Specifically for revenue codes 760, 761, 762 or 769.]
AMT. BILLED NOT NUMERIC	Amount billed is invalid. [Must be numeric.]
REV. CODE REQUIRES AMT. BILLED > 0	Amount billed is invalid for service line. [Must contain amount greater than 0.]
DOS NOT IN RANGE OF BEG. AND ENDING DOS	Date of service is not in range of the beginning and ending date of service. [Except frequency type 2 or 3 (interim bills) that do not require ending date of service.]
DOS=0 AND BEG. AND ENDING DOS ARE NOT EQUAL	Date of service is not submitted on the service line.
REV. CODE REQUIRED FOR INSTITUTIONAL CLAIM	This revenue code requires a valid procedure code.
INVALID REVENUE CODE	Revenue code invalid and/or not effective for beginning date of service of claim.

Message	Criteria
INVALID PRINCIPLE PROCEDURE	Not a valid HCPCS/CPT code if qualifier is 'BP' from the beginning to end date of service. Not a valid ICD-9 procedure code if qualifier is 'BR' from the beginning to end date of service.

Testing

Testing by Tufts Health Plan is required before a submitter can submit 837 claim files, and is comprised of 3 phases:

- Communications testing (for new submitters)
- Structural testing (for 837 format)
- Operational testing (for 837 content)

Pre-testing Requirements for New Submitters

Providers interested in submitting electronic claim transactions via NEHEN should contact the vendor directly who will then facilitate set up with EDI Operations. EDI Operations will facilitate an IP address for the provider, working through the NEHEN support staff.

Upon setup completion, EDI Operations notifies the submitter and NEHEN technical support that the eGateway and telecommunications are set up. The submitter can then configure its eGateway to send the claims transactions to the Tufts HP test eGateway. Upon successful testing between Tufts HP and the new submitter, the submitter migrates to a production status.

Testing

- Submitters will be assigned a single point of contact in the EDI Operations area for testing your 837 claim file.
- Submitters are asked to have completed any required third party vendor upgrades prior to testing.
- Submitters are asked to notify the Tufts Health Plan EDI Operations Department prior to sending a test file.
- 837 test claim files should preferably contain approximately 100 claims (50 claims at a minimum) and should reflect a typical mix of claim types (e.g. services, diagnoses, THP products) from the submitter.
- Turnaround for file testing is generally less than 48 hours, but may depend on the quality of the data.

- After structural testing, Tufts Health Plan will validate the content of the claims, and review the submitter reports with the submitter.
- After successful testing, Tufts Health Plan will contact the submitter to signoff on the test results and decide on a mutually agreeable migration date. The signoff form also documents the date of the last file to be submitted in the current format as well as the first file to be submitted in the new format.

Migration from Testing to Production

- After migration, submitters can only submit in the 837 format, as the THP proprietary format will no longer be accepted.
- Submitters will need to:
 1. Change enveloping spec ISA-15 from a T (test) to a P (production)
- EDI Operations will monitor the first few production runs to ensure successful transmission.

Production

- Claim files must be received before 5am to be processed that business day. Claims are processed once a day, Monday through Friday.
- Member and provider information submitted on a claim does not update the member and provider information stored in Tufts Health Plan's claim processing system.

**NEHEN 837 INSTITUTIONAL CLAIM
SUBMISSION SPECIFICATIONS**

Seg	Segment	Loop	Seg	Max	UB-04 Ref (Box)	NEHEN Recommended Values	NEHEN Notes	FAQ
ID	Description	ID	Req	seg use				
ISA	Interchange control header		R	1				
	ISA01 - Auth info qualifier					00		
	ISA02 -Auth info qualifier						ten spaces (blank)	
	ISA03- Security info qual					00		
	ISA04 - security info						ten spaces (blank)	
	ISA05 - Interchange ID qual					ZZ		
	ISA06 - Interchange sender ID						Sender's identification, as per trading partner agreement.	Y
	ISA07 - Interchange ID qual					HPHC: ZZ NHP: ZZ THP: 01		
	ISA08 - Interchange Rx ID					THP: 170558746 HPHC: HPHC or other TPA id for HPHC NHP: NHP or other TPA id for NHP		
	ISA09 - Envelope creation date						Enter the date using the format YYMMDD	
	ISA10 - Envelope creation time						Enter the time using the format HHMM	
	ISA11 - Interchange control std					U	HIPAA version	
	ISA12 - Interchange Version					"00401"		
	ISA13 - Interchange control						Sender assigned control number	
	ISA14 - Ack requested					0		
	ISA15 - Test/production					P/T	THP/HPHC - A file should indicate "P" when going to the production mailbox and "T" when going to the test mailbox. If the flag is not set to the appropriate character, the file will be rejected. NHP will determine P or T status based on NHPs TAP database of approved submitters	
	ISA16 - Component Element Separator					:	105th byte of ISA	
	Segment terminator					~	Tilde ~ or other value as specified by sender	
GS	Functional Group header		R	1				
	GS01 - Functional ID Code					HC		
	GS02 - Application Sender's Code						Sender's id based on trading partner agreement.	Y
	GS03 - Appl. Receiver's Code					HPHC: NEHEN003 NHP: NEHEN013 THP: 170558746		
	GS04 - Data Interchange Date					CCYYMMDD	Date	
	GS05 - Data Interchange Time					HHMM	Time	
	GS06 - Data Interchange Ctl No.						Assigned by Sender	
	GS07 - Responsible Agency code					X		
	GS08 - Version					00410X096A1	NEHEN Guide includes all 837 I Addenda changes published through	
ST	Transaction set header		R	1				
56	ST01 - Transaction set id code		R			837		
	ST02 - Transaction control number		R				HPHCand NHP: File is rejected by 997 if any ST02 does not match its SE02. Assigned by submitter	
BHT	Beginning of Hierarchical Transaction		R	1				
57	BHT01 - Hierarchical Structure Code		R			0019		
	BHT02 - Transaction Set Purpose Code		R			00	NEHEN Payers treats all submission as Original (00) even if 18 is specified.	
	BHT03 - Reference ID		R				Assigned by sender.	

Seg	Segment	Loop	Seg	Max	UB-04 Ref (Box)	NEHEN Recommended Values	NEHEN Notes	FAQ
ID	Description	ID	Req	seg use				
	BHT04 - Date		R			Assigned by submitter - CCYYMMDD	Date file was generated by the submitter; not necessarily the date sent to Payer	
	BHT05 - Time		R			Assigned by submitter HHMM	Time file was created	
	BHT061 - Transaction Type Code		R			CH	NEHEN Payers treat claims & encounters the same. If RP is sent, treated as though CH	
REF	Transmission Type ID		R	1				
60	REF01 - Reference ID Qualifier		R			87		
	REF02 - Reference ID		R			004010X096A1		
	LOOP 1000A SUBMITTER NAME			1			This is the entity sending this file to Payer. It is the Trading Partner (provider or clearing house)	
NM1	Submitter Name	1000A	R	1				
61	NM101 - Entity ID Code		R			41		
	NM102 - Entity Type Qualifier		R			1 2	Payers treat both 1 & 2 as 1 (Non-Person) for institutional claims	
	NM103 - Name Last/Org Name		R				Generated by submitter	
	NM104 - Name First		S				If present, must be syntactically correct, but not processed by NEHEN Payers.	
	NM105 - Name Middle		S				If present, must be syntactically correct, but not processed by NEHEN Payers.	
	NM108 - ID Code Qualifier		R			46		
	NM109 - ID Code		R					
PER	Submitter EDI Contact Information	1000A	R	2			Required but not Processed by NEHEN Payers	
64	PER01 - Contact Function Code		R			IC		
	PER02 - Name		R					
	PER03 - Communication Number Qualifier		R					
	PER04 - Communication Number		R					
	PER05 - Communication Number Qualifier		S					
	PER06 - Communication Number		S					
	PER07 - Communication Number Qualifier		S					
	PER08 - Communication Number		S					
	LOOP 1000B RECEIVER NAME			1				
NM1	Receiver Name	1000B	R	1				
67	NM101 - Entity ID Code		R			40	NEHEN Payer is the receiver	
	NM102 - Entity Type Qualifier		R			2	Non-Person	
	NM103 - Name Last/Org Name		R				Suggest (HPHC, THP or NHP) or copy NM109 value	
	NM108 - ID Code Qualifier		R			46	ETIN	
	NM109 - ID Code		R			HPHC: NEHEN003 THP: 170558746 NHP: NEHEN013	The code that identifies Payer to the sender.	
	LOOP 2000A BILLING/PAY-TO PROVIDER			>1				
HL	Billing/Pay-To Provider Hierarchical Level	2000A	R	1				
69	HL01 - Hierarchical ID Number		R				Initial value of 1 and incremented sequentially	
	HL03 - Hierarchical Level Code		R			20		
	HL04 - Hierarchical Child Code		R			1		
PRV	Billing/Pay-To Provider Specialty Information	2000A	S	1				
71	PRV01 - Provider Code		R			BI or PT	Refer to Companion Guide Provider Number Description	
	PRV02 - Reference ID Qualifier		R			ZZ	Ignored by HPHC	

Seg	Segment	Loop	Seg	Max	UB-04 Ref (Box)	NEHEN Recommended Values	NEHEN Notes	FAQ
ID	Description	ID	Req	seg use				
	PRV03 - Reference ID		R		51		Ignored by HPHC	
CUR	Foreign Currency info	2000A	S	1			If present, must be syntactically correct but Ignored by NEHEN Payers	
73	CUR01 - Entity ID Code		R					
	CUR02 - Currency Code		R					
	LOOP 2010AA BILLING PROVIDER NAME			1			If Pay-to Provider, Loop 2010AB is not submitted, Tufts HP will capture Payee information from this Loop - 2010AA	
NM1	Billing Provider Name	2010AA	R	1				
76	NM101 - Entity ID Code		R			85		
	NM102 - Entity Type Qualifier		R			1 or 2		
	NM103 - Name Last or Organization Name		R		1, Line 1			
	NM108 - ID Code Qualifier		R			XX	As of May 23, 2007, NPI must be submitted for all Providers.	
	NM109 - ID Code		R				National Provider ID	
N3	Billing Provider Address	2010AA	R	1				
79	N301 - Address Information		R		1, Line 2			
	N302 - Address Information		S				If present, must be syntactically correct but not processed by NEHEN Payers	
N4	Billing Provider City/State/ZIP Code	2010AA	R	1				
80	N401 - City Name		R		1, Line 3	city	Informational Only	
	N402 - State or Province Code		R		1, Line 3	state	Informational Only	
	N403 - Postal Code		R		1, Line 3	zip	Informational Only	
	N404 - Country Code		S		1, Line 4		If present, must be syntactically correct but not processed.	
REF	Billing Provider Secondary ID	2010AA	S	8		NA		
							companion Guide.	
82	REF01 - Reference ID Qualifier		R			EI/SY/LU	Either Employee Identification Number (EI) or Social Security Number (SY) may be sent.	
	REF02 - Reference ID		R				Tax ID or SSN THP: Address Suffix (LU)	
REF	Credit/Debit Billing Information	2010AA	S	8			If present, must be syntactically correct but not processed by NEHEN Payers	
85	REF01 - Reference ID Qualifier		R					
	REF02 - Reference ID		R					
PER	Billing Provider Contact Information	2010AA	S	2			Not required	
87	PER01 - Contact Function Code		R			IC		
	PER02 - Name		R					
	PER03 - Communication Number Qualifier		R			TE	Informational Only - HPHC treats all codes as TE	
	PER04 - Communication Number		R				Sender's Telephone Number	
	PER05 - Communication Number Qualifier		S				If present, must be syntactically correct but not processed	
	PER06 - Communication Number		S				If present, must be syntactically correct but not processed	
	PER07 - Communication Number Qualifier		S				If present, must be syntactically correct but not processed	
	PER08 - Communication Number		S				If present, must be syntactically correct but not processed	

Seg	Segment	Loop	Seg	Max	UB-04 Ref (Box)	NEHEN Recommended Values	NEHEN Notes	FAQ
ID	Description	ID	Req	seg use				
	LOOP 2010AB PAY-TO PROVIDER NAME			1				
NM1	Pay-To Provider Name	2010AB	S	1			If this Loop - 2010AB is not submitted, Tufts HP will capture Payee information from Loop 2010AA, Billing Provider	
91	NM101 - Entity ID Code		R			87		
	NM102 - Entity Type Qualifier		R			2		
	NM103 - Name Last/Org Name		R				Provider Last Name or Organization Refer to the Companion Guide.	
	NM108 - ID Code Qualifier		R			XX	National Provider ID (NPI) is required after May 23, 2007	Y
	NM109 - ID Code		R				Pay to Provider NPI	
N3	Pay-To Provider address	2010AB	R	1				
94	N301 - Address info		R			adr1	Informational only	
	N302 - Address info		S				If present, must be syntactically correct, but not processed	
N4	Pay-To Provider City/State/ZIP Code	2010AB	R	1				
95	N401 - City Name		R			city	Informational only	
	N402 - State or Province Code		R			state	Informational only	
	N403 - Postal Code		R			zip	Informational only	
	N404 - Country Code		S				If present, must be syntactically correct, but not processed	
REF	Pay-To Provider Secondary ID	2010AB	S	5				
	REF01 - Reference ID Qualifier		R			EI/SY/LU	Refer to Provider Number section of companion Guide. Employee Identification Number (EI) or Social Security Number (SY) may be sent in addition to the NPI THP: If THP Legacy ID currently contains and address suffix, you must create an additional REF segment containing the Location Code (LU)	Y
	REF02 - Reference ID		R				Pay to Provider Tax ID or SSN THP: Address Suffix (LU) - optional	
	LOOP 2000B SUBSCRIBER HIERARCHICAL LEVEL			>1				
HL	Subscriber Hierarchical Level	2000B	R	1				
99	HL01 - Hierarchical ID Number		R				Supplied by sender	
	HL02 - Hierarchical Parent ID Number		R				Supplied by sender	
	HL03 - Hierarchical Level code		R			22	Subscriber	
	HL04 - Hierarchical Child Code		R			0 1	If Subscriber is the Patient then 0. If Subscriber is NOT the Patient, then 1	
SBR	Subscriber Information	2000B	R	1				
101	SBR01 - Payer Resp Seq No Code		R			P	HPHC will treat all valid values as P	
	SBR02 - Individual Relationship Code		S		59	18	Used if Subscriber is the Patient	
	SBR03 - Reference ID		S		62	Group Number	HPHC only; all others Informational only	
	SBR04 - Name		S		61	Plan Name	Informational Only	
	SBR09 - Claim Files Indicator Code		S				Informational Only - Type of claim(such as HMO)	
	LOOP 2010BA SUBSCRIBER NAME			1				
NM1	Subscriber Name	2010BA	R	1				
108	NM101 - Entity ID Code		R			IL		
	NM102 - Entity Type Qualifier		R			1 2	HPHC assumes 1 (Person)	

Seg	Segment	Loop	Seg	Max	UB-04 Ref (Box)	NEHEN Recommended Values	NEHEN Notes	FAQ
ID	Description	ID	Req	seg use				
	NM103 - Name Last/Org Name		R		58		Person's Last Name	
	NM104 - Name First		S		58			
	NM105 - Name Middle		S		58			
	NM107 - Name Suffix		S				If present, must be syntactically correct, but not processed	
	NM108 - ID Code Qualifier		S			MI ZZ	NEHEN Payers assumes the Payer assigned member id follows regardless of submitted value Note: include suffix Payer Assigned MemberID	
	NM109 - ID Code		S		60		See the Member Validation section of the Companion Guide for additional information.	
N3	Subscriber Address	2010BA	S	1				
112	N301 - Address Information		R			addr1	Informational Only	
	N302 - Address Information		S			addr2	If present, must be syntactically correct, but not processed	
N4	Subscriber City/State/ZIP Code	2010BA	S	1				
113	N401 - City Name		R			city		
	N402 - State/Prov Code		R			state		
	N403 - Postal Code		R			zip		
	N404 - Country Code		S				If present, must be syntactically correct, but not processed	
DMG	Subscriber Demographic Information	2010BA	S	1				
115	DMG01 - Date Time Format Qualifier		R			D8		
	DMG02 - Date Time Period		R			CCYYMMDD	Date of Birth of Subscriber - must be valid date not used for processing	
	DMG03 - Gender Code		R			M/F/U		
REF	Subscriber Secondary id	2010BA	S	4			The member id should be sent in NM109. This is used only if 2010BA-NM109 is absent	
117	REF01 - Reference ID Qualifier		R			1G		
	REF02 - Reference ID		R			Payer Member ID	Payer assigned Member ID	
REF	Property and Casualty Claim Number	2010BA	S	1			If present, must be syntactically correct but not processed	
119	REF01 - Reference ID Qualifier		R					
	REF02 - Reference ID		R					
	LOOP 2010BB CREDIT/DEBIT CARD ACCT HOLDER NAME			1				
NM1	Credit/Debit Card Account Holder Name	2010BB	S	1			If present, must be syntactically correct but not processed	
121	NM101 - Entity ID Code		R					
	NM102 - Entity Type Qualifier		R					
	NM103 - Name Last/Org Name		R					
	NM104 - Name First		S					
	NM105 - Name Middle		S					
	NM107 - Name Suffix		S					
	NM108 - ID Code Qualifier		R					
	NM109 - ID Code		R					
REF	Credit/Debit Card Information	2010BB	S	2			If present, must be syntactically correct but not processed	
124	REF01 - Reference ID Qualifier		R					

Seg	Segment	Loop	Seg	Max	UB-04 Ref (Box)	NEHEN Recommended Values	NEHEN Notes	FAQ
ID	Description	ID	Req	seg use				
	REF02 - Reference ID		R					
	LOOP 2010BC PAYER NAME			1				
NM1	Payer Name	2010BC	R	1				
126	NM101 - Entity ID Code		R			PR		
	NM102 - Entity Code Qualifier		R			2		
	NM103 - Name Last/Org Name		R		50	HPHC, THP, NHP		
	NM108 - ID Code Qualifier		R			PI		
	NM109 - ID Code		R			HPHC: NEHEN003 THP: 170558746 NHP: NEHEN013	The code that identifies Payer to the sender.	
N3	Payer Address	2010BC	S	1			If present, must be syntactically correct but not processed	
129	N301 - Address Information		R					
	N302 - Address Information		S					
N4	Payer City/State/ZIP Code	2010BC	S	1			If present, must be syntactically correct but not processed	
130	N401 - City Name		R					
	N402 - State/Prov Code		R					
	N403 - Postal Code		R					
	N404 - Country Code		S					
REF	Payer Secondary ID	2010BC	S	3			If present, must be syntactically correct but not processed	
132	REF01 - Reference ID Qualifier		R			TJ		
	REF02 - Reference ID		R			tax id		
				1				
	LOOP 2010DB RESPONSIBLE PARTY NAME							
NM1	Responsible Party Name	2010BD	S	1			If present, must be syntactically correct but not processed	
134	NM101 - Entity ID Code		R					
	NM102 - Entity Type Qualifier		R					
	NM103 - Name Last/Org Name		R					
	NM104 - Name First		S					
	NM105 - Name Middle		S					
	NM107 - Name Suffix		S					
N3	Responsible Party Address	2010BD	R	1			If present, must be syntactically correct but not processed	
136	N301 - Address Information		R					
	N302 - Address Information		S					
N4	Responsible Party City/State/ZIP Code	2010BD	R	1			If present, must be syntactically correct but not processed	
137	N401 - City Name		R					
	N402 - State/Prov Code		R					
	N403 - Postal Code		R					
	N404 - Country Code		S					
	LOOP 2000C PATIENT HIERARCHICAL LEVEL			>1			Only sent if Patient is not the Subscriber.	
HL	Patient Hierarchical Level	2000C	S	1				
139	HL01 - Hierarchical ID Number		R				Generated by sender	
	HL02 - Hierarchical Parent ID Number		R				Generated by sender	

Seg	Segment	Loop	Seg	Max	UB-04 Ref (Box)	NEHEN Recommended Values	NEHEN Notes	FAQ
ID	Description	ID	Req	seg use				
	HL03 - Hierarchical Level code		R			23		
	HL04 - Hierarchical Child Code		R			0	Patient is not the subscriber	
PAT	Patient Information	2000C	R	1				
141	PAT01 - Individual Relationship Code		R		59		If relationship is not known then specify 21. HPHC does not utilize in its claims processing.	
	LOOP 2010CA PATIENT NAME			1				
NM1	Patient Name	2010CA	R	1				
145	NM101 - Entity ID Code		R			QC		
	NM102 - Entity Type Qualifier		R			1	Person	
	NM103 - Name Last/Org Name		R		8, line 2b		Patient Last Name	
	NM104 - Name First		R		8, line 2b		Patient First Name	
	NM105 - Name Middle		S		8, line 2b			
	NM107 - Name Suffix		S				If present, must be syntactically correct but not processed	
	NM108 - ID Code Qualifier		S			MI	IF ZZ is sent, Payer will treat it as though MI	
	NM109 - ID Code		S		8, line 1a (patient) 60 (subscriber)	Payer Assigned Patient or Subscriber ID	This is the complete member id. Not just the contract (include suffix). THP, however, will continue to calculate the suffix from the contract part of the ID. Reer to the Member Validation section of the Companion Guide for additional information.	
N3	Patient Address	2010CA	R	1				
148	N301 - Address Information		R		9			
	N302 - Address Information		S		9			
N4	Patient City/State/ZIP Code	2010CA	R	1				
149	N401 - City Name		R		9	city		
	N402 - State/Prov Code		R		9	state		
	N403 - Postal Code		R		9	zip		
	N404 - Country Code		S		9		If present, must be syntactically correct but not processed	
DMG	Patient Demographic Information	2010CA	R	1				
151	DMG01 - Date Time Format Qualifier		R			D8		
	DMG02 - Date Time Period		R		10	CCYYMMDD	Patient Date of Birth	
	DMG03 - Gender Code		R		11	M/F/U		
REF	Patient Secondary ID Number	2010CA	S	5			The Payer member id should be sent in 2010CA-NM109.	
153	REF01 - Reference ID Qualifier		R			1G		
	REF02 - Reference ID		R			Payer Assigned Member ID		
REF	Property and Casualty Claim Number	2010CA	S	1			If present, must be syntactically correct but not processed	
155	REF01 - Reference ID Qualifier		R					
	REF02 - Reference ID		R					
	LOOP 2300 CLAIM INFORMATION			100				
CLM	Claim Information	2300	R	1				
157	CLM01 - Claim Submitter's Identifier		R		3A		This will be returned on the EOP (835) and Claim Status (277). Be careful not to use special characters that are also transaction delimiters.	Y
	CLM02 - Monetary Amount		R		47		Total Claim Charged Amount. Decimal point is expected Ten Dollars and 99 cents is 10.99	
	CLM05 - Health Care Service Location							

Seg	Segment	Loop	Seg	Max	UB-04 Ref (Box)	NEHEN Recommended Values	NEHEN Notes	FAQ
ID	Description	ID	Req	seg use				
	CLM05 - 1 - Facility Code Value		R		4 pos 1,2		1st two positions of Bill type	
	CLM05 - 2 - Facility Code Qualifier		R		4 pos 4	A	Must be syntactically correct but not processed by HPHC	
	CLM05 - 3 - Claim Frequency Type Code		R		4 pos 3		3rd Position of Bill type.H910 NUBC Defined	
	CLM06 - Yes/No Condition or Response Code		R					
	CLM07 - Provider Accept Assignment Code		S					
	CLM08 - Yes/No Condition or Response Code		R		53			
	CLM09 - Release of Information Code		R		52			
	CLM12 - Special Program Code		S					
	CL M18 - Yes/No Condition or Response Code		R				If present, must be syntactically correct, but not processed	
	CLM20 - Delay Reason Code		S				If present, must be syntactically correct, but not processed	
DTP	Discharge Hour	2300	S	1				
165	DTP01 - Date/Time Qualifier		R			096		
	DTP02 - Date Time Period Format Qualifier		R			TM	HHMM only per guide.	
	DTP03 - Date Time Period		R		16	HHMM		
DTP	Statement Dates	2300	R	1				
167	DTP01 - Date/Time Qualifier		R			434		
	DTP02 - Date Time Period Format Qualifier		R			D8/RD8	D8 if single date of service; RD8 if from and through	
	DTP03 - Date Time Period		R		6		If D8 then CCYYMMDD If RD8 then CCYYMMDD-CCYYMMDD	
DTP	Admission Date/Hour	2300	S	1				
169	DTP01 - Date/Time Qualifier		R			435		
	DTP02 - Date Time Period Format Qualifier		R			DT		
	DTP03 - Date Time Period		R		12/13	CCYYMMDDHHMM		
CL1	Institutional Claim Code	2300	S	1				
171	CL101 - Admission Type Code		S		14		From Code Source 231	
	CL102 - Admission Source Code		S		15		From Code Source 230	
	CL103 - Patient Status Code		S		17		From Code Source 239	
PWK	Claim Supplemental Information	2300	S	10			If present, must be syntactically correct but not processed	
173	PWK01 - Report Type Code		R					
	PWK02 - Report Transmission Code		R					
	PWK05 - ID Code Qualifier		S					
	PWK06 - ID Code		S					
	PWK07 - Description		S					
CN1	Contract Information	2300	S	1				
176	CN101 - Contract Type Code		R			01	HPHC: Specify 01 if DRG otherwise not processed by HPHC	
	CN102 - Monetary Amount		S				DRG amount. Include decimal point. Ten dollars and 1 cent is 10.01	
	CN103 - Percent		S				If present, must be syntactically correct but not processed	
	CN104 - Reference ID		S				DRG if DRG is submitted	
	CN105 - Terms Discount Percent		S				If present, must be syntactically correct but not processed	
	CN106 - Version Identifier		S				If present, must be syntactically correct but not processed	
AMT	Payer Estimated Amount Due	2300	S	1			Informational Only	
178	AMT01 - Amount Qualifier Code		R			C5		
	AMT02 - Monetary Amount		R		55		Include decimal point. Ten dollars and 1 cent is 10.01	

Seg	Segment	Loop	Seg	Max	UB-04 Ref (Box)	NEHEN Recommended Values	NEHEN Notes	FAQ
ID	Description	ID	Req	seg use				
AMT	Patient Estimated Amount Due	2300	S	1			Informational Only.	
180	AMT01 - Amount Qualifier Code		R			F3	Patient Responsibility	
	AMT02 - Monetary Amount		R				Informational Only. Include decimal point. Ten dollars is 10.00	
AMT	Patient Paid Amount	2300	S	1			Informational Only	
182	AMT01 - Amount Qualifier Code		R			F5		
	AMT02 - Monetary Amount		R				Informational Only. Include decimal point. Ten dollars and 1 cent is 10.01	
AMT	Credit/Debit Card Maximum Amount	2300	S	1			If present, must be syntactically correct but not processed	
184	AMT01 - Amount Qualifier Code		R					
	AMT02 - Monetary Amount		R					
REF	Adjusted Repriced Claim Number	2300	S	1			If present, must be syntactically correct but not processed	
185	REF01 - Reference ID Qualifier		R			9C		
	REF02 - Reference ID		R					
REF	Repriced Claim Number	2300	S	1			If present, must be syntactically correct but not processed	
186	REF01 - Reference ID Qualifier		R			9A		
	REF02 - Reference ID		R					
REF	Claim ID Number for ClearingHouses and Other Transmission Intermediaries	2300	S	2			This is not a required field but NEHEN Payers strongly recommend its use. Refer to the NEHEN Companion Guide.	Y
187	REF01 - Reference ID Qualifier		R			D9		
	REF02 - Reference ID		R			Submitter Claim ID	Trading Partner Claim ID	
REF	Document ID Code	2300	S	1			If present, must be syntactically correct but not processed	
189	REF01 - Reference ID Qualifier		R					
	REF02 - Reference ID		R					
REF	Original reference Number (ICN/DCN)	2300	S	1			THP: Not required for structural compliance, however Tufts HP is strongly recommending submitting the REF02 on any adjustments HPHC: If present, must be syntactically correct but not processed by HPHC	
191	REF01 - Reference ID Qualifier		R					
	REF02 - Reference ID		R		64			
REF	Investigational Device Exemption Number	2300	S	1		NA	If present, must be syntactically correct but not processed	
193	REF01 - Reference ID Qualifier		R					
	REF02 - Reference ID		R					
REF	Service Authorization Exception Code	2300	S	1			If present, must be syntactically correct but not processed	
195	REF01 - Reference ID Qualifier		R					
	REF02 - Reference ID		R					
REF	Peer Review Organization (Pro) Approval Number	2300	S	1			If present, must be syntactically correct but not processed	
197	REF01 - Reference ID Qualifier		R					
	REF02 - Reference ID		R					
REF	Prior Authorization or Referral Number	2300	S	2				
198	REF01 - Reference ID Qualifier		R			G1	Assume Authorization	

Seg	Segment	Loop	Seg	Max	UB-04 Ref (Box)	NEHEN Recommended Values	NEHEN Notes	FAQ
ID	Description	ID	Req	seg use				
	REF02 - Reference ID		R		63		Payer assigned Referral or Auth Number	
REF	Medical Record Number	2300	S	1				
200	REF01 - Reference ID Qualifier		R		3b	EA		
	REF02 - Reference ID		R				Provider's Medical Record number	
REF	Demonstration Project ID	2300	S	1		NA	If present, must be syntactically correct but not processed	
202	REF01 - Reference ID Qualifier		R					
	REF02 - Reference ID		R					
K3	File Information	2300	S	10			If present, must be syntactically correct but not processed	
204	K301 - Fixed Form Information		R					
NTE	Claim Note	2300	S	10			Payers do not pass Claim Note information to its Adjudication System	
205	NTE01 - Note Reference Code		R					
	NTE02 - Description		R		80			
NTE	Billing Note	2300	S	1			Payers do not pass Billing Note information to its Adjudication System	
208	NTE01 - Note Reference Code		R					
	NTE02 - Description		R		80			
CR6	Home Health Care Information	2300	S	1			If present, must be syntactically correct but not processed	
210	CR601 - Prognosis Code		R					
	CR602 - Date		R					
	CR603 - Date Time Period Format Qualifier		S					
	CR604 - Date Time Period		S					
	CR605 - Date		R					
	CR606 - Yes/No Condition or Response Code		R					
	CR607 - Yes/No Condition or Response Code		R					
	CR608 - Certification Type Code		R					
	CR609 - Date		S					
	CR610 - Product/Service ID Qualifier		S					
	CR611 - Medical Code Value		S					
	CR612 - Date		S					
	CR613 - Date		S					
	CR614 - Date		S					
	CR615 - Date Time Period Format Qualifier		S					
	CR616 - Date Time Period		S					
	CF617 - Patient Location Code		R					
	CR618 - Date		S					
	CR619 - Date		S					
	CR620 - Date		S					
	CR621 - Date		S					
CRC	Home Health Functional Limitations	2300	S	3			If present, must be syntactically correct but not processed	
218	CRC01 - Code Category		R					
	CRC02 - Yes/No Condition or Response Code		R					
	CRC03 - Condition Indicator		R					
	CRC04 - Condition Indicator		S					
	CRC05 - Condition Indicator		S					
	CRC06 - Condition Indicator		S					
	CRC07 - Condition Indicator		S					
CRC	Home Health Activities Permitted	2300	S	3			If present, must be syntactically correct but not processed	
221	CRC01 - Code Category		R					
	CRC02 - Yes/No Condition or Response Code		R					

Seg	Segment	Loop	Seg	Max	UB-04 Ref (Box)	NEHEN Recommended Values	NEHEN Notes	FAQ
ID	Description	ID	Req	seg use				
	CRC03 - Condition Indicator		R					
	CRC04 - Condition Indicator		S					
	CRC05- Condition Indicator		S					
	CRC06 - Condition Indicator		S					
	CRC07 - Condition Indicator		S					
CRC	Home Health Mental Status	2300	S	2			If present, must be syntactically correct but not processed	
224	CRC01 - Code Category		R					
	CRC02 - Yes/No Condition or Response Code		R					
	CRC03 - Condition Indicator		R					
	CRC04 - Condition Indicator		S					
	CRC05- Condition Indicator		S					
	CRC06 - Condition Indicator		S					
	CRC07 - Condition Indicator		S					
HI	Principal, Admitting, E-Code and Patient Reason For Visit Diagnosis Information	2300	S	1				
227	HI01 Health Care Code Information		F				Principal Diagnosis	
	HI01 - 1 - Code List Qualifier Code		R			BK	If ZZ is sent it will be ignored.	
	HI01 - 2 - Industry Code		R		67		ICD-9-CM Code	
	HI02 Health Care Code Information		S				Admitting Diagnosis	
	HI02 - 1 - Code List Qualifier Code		R			BJ	If ZZ is sent it will be ignored.	
	HI02 - 2 - Industry Code		R		69		ICD-9-CM Code	
	HI03 Health Care Code Information		S				E-Code	
	HI03 - 1 - Code List Qualifier Code		R			BN		
	HI03 - 2 - Industry Code		R		77		ICD-9-CM Code	
HI	Diagnosis Related Group (DRG) Information	2300	S	1			DRG Contracted Hospitals must send to Payer	
230	HI01 - 1 - Code List Qualifier Code		R			DR		
	HI01 - 2 - Industry Code		R				Diagnosis Related Group	
HI	Other Diagnosis Information	2300	S	2			Diagnosis Codes	
232	HI01 - 1 - Code List Qualifier Code		R			BF		
	HI01 - 2 - Industry Code		R		67A		ICD-9-CM Code	
	HI02 - 1 - Code List Qualifier Code		R			BF		
	HI02 - 2 - Industry Code		R		67B		ICD-9-CM Code	
	HI03 - 1 - Code List Qualifier Code		R			BF		
	HI03 - 2 - Industry Code		R		67C		ICD-9-CM Code	
	HI04 - 1 - Code List Qualifier Code		R			BF		
	HI04 - 2 - Industry Code		R		67D		ICD-9-CM Code	
	HI05 - 1 - Code List Qualifier Code		R			BF		
	HI05 - 2 - Industry Code		R		67E		ICD-9-CM Code	
	HI06 - 1 - Code List Qualifier Code		R			BF		
	HI06 - 2 - Industry Code		R		67F		ICD-9-CM Code	
	HI07 - 1 - Code List Qualifier Code		R			BF		
	HI07 - 2 - Industry Code		R		67G		ICD-9-CM Code	
	HI08 - 1 - Code List Qualifier Code		R			BF		
	HI08 - 2 - Industry Code		R		67H		ICD-9-CM Code	
	HI09 - 1 - Code List Qualifier Code		R			BF		
	HI09 - 2 - Industry Code		R		67I		ICD-9-CM Code	
	HI10 - 1 - Code List Qualifier Code		R			BF		
	HI10 - 2 - Industry Code		R		67J		ICD-9-CM Code	
	HI11 - 1 - Code List Qualifier Code		R			BF		
	HI11 - 2 - Industry Code		R		67K		ICD-9-CM Code	
	HI12 - 1 - Code List Qualifier Code		R			BF		
	HI12 - 2 - Industry Code		R		67L		ICD-9-CM Code	
HI	Principal Procedure Information	2300	S	1				
242	HI01 - Health Care Code Information							
	HI01 - 1 - Code List Qualifier Code		R			BP/BR	BR is ICD-9	
	HI01 - 2 - Industry Code		R					
	HI01 - 3 - Date Time Period Format Qualifier		S			D8	Use if HI01 is Principal Procedure Code	
	HI01 - 4 - Date Time Period		S		74	CCYYMMDD		

Seg	Segment	Loop	Seg	Max	UB-04 Ref (Box)	NEHEN Recommended Values	NEHEN Notes	FAQ
ID	Description	ID	Req	seg use				
HI	Other Procedure Information	2300	S	2				
244	HI01 Health Care Code Information		R					
	HI01 - 1 - Code List Qualifier Code		R			BO/BQ	BO is from Code Source 130 BQ is ICD-9 (Code Source 131)	
	HI01 - 2 - Industry Code		R		74A		Standard Procedure Code	
	HI01 - 3 - Date Time Period Format Qualifier		S			D8		
	HI01 - 4 - Date Time Period		S		74A	CCYMMDD		
	HI02 - Health Care Code Information		S					
	HI02 - 1 - Code List Qualifier Code		R			BO/BQ		
	HI02 - 2 - Industry Code		R		74B		Standard Procedure Code	
	HI02 - 3 - Date Time Period Format Qualifier		S			D8		
	HI02 - 4 - Date Time Period		S		74B	CCYMMDD		
	HI03 - Health Care Code Information		S					
	HI03 - 1 - Code List Qualifier Code		R			BO/BQ		
	HI03 - 2 - Industry Code		R		74C		Standard Procedure Code	
	HI03 - 3 - Date Time Period Format Qualifier		S			D8		
	HI03 - 4 - Date Time Period		S		74C	CCYMMDD		
	HI04 - Health Care Code Information		S					
	HI04 - 1 - Code List Qualifier Code		R			BO/BQ		
	HI04 - 2 - Industry Code		R		74D		Standard Procedure Code	
	HI04 - 3 - Date Time Period Format Qualifier		S			D8		
	HI04 - 4 - Date Time Period		S		74D	CCYMMDD		
	HI05 - Health Care Code Information		S					
	HI05 - 1 - Code List Qualifier Code		R			BO/BQ		
	HI05 - 2 - Industry Code		R		74E		Standard Procedure Code	
	HI05 - 3 - Date Time Period Format Qualifier		S			D8		
	HI05 - 4 - Date Time Period		S		74E	CCYMMDD		
	HI06 - Health Care Code Information		S					
	HI06 - 1 - Code List Qualifier Code		R			BO/BQ		
	HI06 - 2 - Industry Code		R				Standard Procedure Code	
	HI06 - 3 - Date Time Period Format Qualifier		S			D8		
	HI06 - 4 - Date Time Period		S			CCYMMDD		
	HI07 - Health Care Code Information		S					
	HI07 - 1 - Code List Qualifier Code		R			BO/BQ		
	HI07 - 2 - Industry Code		R				Standard Procedure Code	
	HI07 - 3 - Date Time Period Format Qualifier		S			D8		
	HI07 - 4 - Date Time Period		S			CCYMMDD		
	HI08 - Health Care Code Information		S					
	HI08 - 1 - Code List Qualifier Code		R			BO/BQ		
	HI08 - 2 - Industry Code		R				Standard Procedure Code	
	HI08 - 3 - Date Time Period Format Qualifier		S			D8		
	HI08 - 4 - Date Time Period		S			CCYMMDD		
	HI09 - Health Care Code Information		S					
	HI09 - 1 - Code List Qualifier Code		R			BO/BQ		
	HI09 - 2 - Industry Code		R				Standard Procedure Code	
	HI09 - 3 - Date Time Period Format Qualifier		S			D8		
	HI09 - 4 - Date Time Period		S			CCYMMDD		
	HI10 - Health Care Code Information		S					
	HI10 - 1 - Code List Qualifier Code		R			BO/BQ		
	HI10 - 2 - Industry Code		R				Standard Procedure Code	
	HI10 - 3 - Date Time Period Format Qualifier		S			D8		
	HI10 - 4 - Date Time Period		S			CCYMMDD		
	HI11 - Health Care Code Information		S					
	HI11 - 1 - Code List Qualifier Code		R			BO/BQ		
	HI11 - 2 - Industry Code		R				Standard Procedure Code	
	HI11 - 3 - Date Time Period Format Qualifier		S			D8		

Seg	Segment	Loop	Seg	Max	UB-04 Ref (Box)	NEHEN Recommended Values	NEHEN Notes	FAQ
ID	Description	ID	Req	seg use				
	HI11 - 4 - Date Time Period		S			CCYYMMDD		
	HI12 - Health Care Code Information		S					
	HI12 - 1 - Code List Qualifier Code		R			BO/BQ		
	HI12 - 2 - Industry Code		R				Standard Procedure Code	
	HI12 - 3 - Date Time Period Format Qualifier		S			D8		
	HI12 - 4 - Date Time Period		S			CCYYMMDD		
HI	Occurrence Span Information	2300	S	2				
256	HI01 Health Care Code Information		R				HPHC currently requires at least 1 occurrence code .	
	HI01 - 1 - Code List Qualifier Code		R			BI	Occurrence Span	
	HI01 - 2 - Industry Code		R		35 or 36		Occurrence Code from Source 132	
	HI01 - 3 - Date Time Period Format Qualifier		R			RD8	Date Range	
	HI01 - 4 - Date Time Period		R		35 or 36	Date Range	CCYYMMDD-CCYYMMDD	
	HI02 Health Care Code Information		S					
	HI02 - 1 - Code List Qualifier Code		R			BI	Occurrence Span	
	HI02 - 2 - Industry Code		R		35 or 36		Occurrence Code from Source 132	
	HI02 - 3 - Date Time Period Format Qualifier		R			RD8	Date Range	
	HI02 - 4 - Date Time Period		R		35 or 36	Date Range	CCYYMMDD-CCYYMMDD	
	HI03 Health Care Code Information		S					
	HI03 - 1 - Code List Qualifier Code		R			BI	Occurrence Span	
	HI03 - 2 - Industry Code		R		35 or 36		Occurrence Code from Source 132	
	HI03 - 3 - Date Time Period Format Qualifier		R			RD8	Date Range	
	HI03 - 4 - Date Time Period		R		35 or 36	Date Range	CCYYMMDD-CCYYMMDD	
	HI04 Health Care Code Information		S					
	HI04 - 1 - Code List Qualifier Code		R			BI	Occurrence Span	
	HI04 - 2 - Industry Code		R		35 or 36		Occurrence Code from Source 132	
	HI04 - 3 - Date Time Period Format Qualifier		R			RD8	Date Range	
	HI04 - 4 - Date Time Period		R		35 or 36	Date Range	CCYYMMDD-CCYYMMDD	
	HI05 Health Care Code Information		S					
	HI05 - 1 - Code List Qualifier Code		R			BI	Occurrence Span	
	HI05 - 2 - Industry Code		R		35 or 36		Occurrence Code from Source 132	
	HI05 - 3 - Date Time Period Format Qualifier		R			RD8	Date Range	
	HI05 - 4 - Date Time Period		R		35 or 36	Date Range	CCYYMMDD-CCYYMMDD	
	HI06 Health Care Code Information		S					
	HI06 - 1 - Code List Qualifier Code		R			BI	Occurrence Span	
	HI06 - 2 - Industry Code		R		35 or 36		Occurrence Code from Source 132	
	HI06 - 3 - Date Time Period Format Qualifier		R			RD8	Date Range	
	HI06 - 4 - Date Time Period		R		35 or 36	Date Range	CCYYMMDD-CCYYMMDD	
	HI07 Health Care Code Information		S					
	HI07 - 1 - Code List Qualifier Code		R			BI	Occurrence Span	
	HI07 - 2 - Industry Code		R		35 or 36		Occurrence Code from Source 132	
	HI07 - 3 - Date Time Period Format Qualifier		R			RD8	Date Range	
	HI07 - 4 - Date Time Period		R		35 or 36	Date Range	CCYYMMDD-CCYYMMDD	
	HI08 Health Care Code Information		S					
	HI08 - 1 - Code List Qualifier Code		R			BI	Occurrence Span	
	HI08 - 2 - Industry Code		R		35 or 36		Occurrence Code from Source 132	
	HI08 - 3 - Date Time Period Format Qualifier		R			RD8	Date Range	
	HI08 - 4 - Date Time Period		R		35 or 36	Date Range	CCYYMMDD-CCYYMMDD	
	HI09 Health Care Code Information		S					
	HI09 - 1 - Code List Qualifier Code		R			BI	Occurrence Span	
	HI09 - 2 - Industry Code		R		35 or 36		Occurrence Code from Source 132	
	HI09 - 3 - Date Time Period Format Qualifier		R			RD8	Date Range	
	HI09 - 4 - Date Time Period		R		35 or 36	Date Range	CCYYMMDD-CCYYMMDD	
	HI10 Health Care Code Information		S					
	HI10 - 1 - Code List Qualifier Code		R			BI	Occurrence Span	
	HI10 - 2 - Industry Code		R		35 or 36		Occurrence Code from Source 132	

Seg	Segment	Loop	Seg	Max	UB-04 Ref (Box)	NEHEN Recommended Values	NEHEN Notes	FAQ
ID	Description	ID	Req	seg use				
	HI10 - 3 - Date Time Period Format Qualifier		R			RD8	Date Range	
	HI10 - 4 - Date Time Period		R		35 or 36	Date Range	CCYYMMDD-CCYYMMDD	
	HI11 Health Care Code Information		S					
	HI11 - 1 - Code List Qualifier Code		R			BI	Occurrence Span	
	HI11 - 2 - Industry Code		R		35 or 36		Occurrence Code from Source 132	
	HI11 - 3 - Date Time Period Format Qualifier		R			RD8	Date Range	
	HI11 - 4 - Date Time Period		R		35 or 36	Date Range	CCYYMMDD-CCYYMMDD	
	HI12 Health Care Code Information		S					
	HI12 - 1 - Code List Qualifier Code		R			BI	Occurrence Span	
	HI12 - 2 - Industry Code		R		35 or 36		Occurrence Code from Source 132	
	HI12 - 3 - Date Time Period Format Qualifier		R			RD8	Date Range	
	HI12 - 4 - Date Time Period		R		35 or 36	Date Range	CCYYMMDD-CCYYMMDD	
HI	Occurrence Information	2300	S	2				
							Occurrence Codes & Dates	
							THP: If Accident or Employment related, appropriate occurrence code is required. THP will only process one Occurrence code per claim	
267	HI01 Health Care Code Information		R			BH		
	HI01 - 1 - Code List Qualifier Code		R				Occurrence	
	HI01 - 2 - Industry Code		R		31 - 34		Occurrence Code from Source 132	
	HI01 - 3 - Date Time Period Format Qualifier		R			D8	Single Date	
	HI01 - 4 - Date Time Period		R		31 - 34	Date	CCYYMMDD	
	HI02 Health Care Code Information		S					
	HI02 - 1 - Code List Qualifier Code		R			BH	Occurrence	
	HI02 - 2 - Industry Code		R		31 - 34		Occurrence Code from Source 132	
	HI02 - 3 - Date Time Period Format Qualifier		R			D8	Single Date	
	HI02 - 4 - Date Time Period		R		31 - 34	Date	CCYYMMDD	
	HI03 Health Care Code Information		S					
	HI03 - 1 - Code List Qualifier Code		R			BH	Occurrence	
	HI03 - 2 - Industry Code		R		31 - 34		Occurrence Code from Source 132	
	HI03 - 3 - Date Time Period Format Qualifier		R			D8	Single Date	
	HI03 - 4 - Date Time Period		R		31 - 34	Date	CCYYMMDD	
	HI04 Health Care Code Information		S					
	HI04 - 1 - Code List Qualifier Code		R			BH	Occurrence	
	HI04 - 2 - Industry Code		R		31 - 34		Occurrence Code from Source 132	
	HI04 - 3 - Date Time Period Format Qualifier		R			D8	Single Date	
	HI04 - 4 - Date Time Period		R		31 - 34	Date	CCYYMMDD	
	HI05 Health Care Code Information		S					
	HI05 - 1 - Code List Qualifier Code		R			BH	Occurrence	
	HI05 - 2 - Industry Code		R		31 - 34		Occurrence Code from Source 132	
	HI05 - 3 - Date Time Period Format Qualifier		R			D8	Single Date	
	HI05 - 4 - Date Time Period		R		31 - 34	Date	CCYYMMDD	
	HI06 Health Care Code Information		S					
	HI06 - 1 - Code List Qualifier Code		R			BH	Occurrence	
	HI06 - 2 - Industry Code		R		31 - 34		Occurrence Code from Source 132	
	HI06 - 3 - Date Time Period Format Qualifier		R			D8	Single Date	
	HI06 - 4 - Date Time Period		R		31 - 34	Date	CCYYMMDD	
	HI07 Health Care Code Information		S					
	HI07 - 1 - Code List Qualifier Code		R			BH	Occurrence	
	HI07 - 2 - Industry Code		R		31 - 34		Occurrence Code from Source 132	
	HI07 - 3 - Date Time Period Format Qualifier		R			D8	Single Date	
	HI07 - 4 - Date Time Period		R		31 - 34	Date	CCYYMMDD	
	HI08 Health Care Code Information		S					
	HI08 - 1 - Code List Qualifier Code		R			BH	Occurrence	
	HI08 - 2 - Industry Code		R		31 - 34		Occurrence Code from Source 132	

Seg	Segment	Loop	Seg	Max	UB-04 Ref (Box)	NEHEN Recommended Values	NEHEN Notes	FAQ
ID	Description	ID	Req	seg use				
	HI08 - 3 - Date Time Period Format Qualifier		R			D8	Single Date	
	HI08 - 4 - Date Time Period		R		31 - 34	Date	CCYYMMDD	
	HI09 Health Care Code Information		S					
	HI09 - 1 - Code List Qualifier Code		R			BH	Occurrence	
	HI09 - 2 - Industry Code		R		31 - 34		Occurrence Code from Source 132	
	HI09 - 3 - Date Time Period Format Qualifier		R			D8	Single Date	
	HI09 - 4 - Date Time Period		R		31 - 34	Date	CCYYMMDD	
	HI10 Health Care Code Information		S					
	HI10 - 1 - Code List Qualifier Code		R			BH	Occurrence	
	HI10 - 2 - Industry Code		R		31 - 34		Occurrence Code from Source 132	
	HI10 - 3 - Date Time Period Format Qualifier		R			D8	Single Date	
	HI10 - 4 - Date Time Period		R		31 - 34	Date	CCYYMMDD	
	HI11 Health Care Code Information		S					
	HI11 - 1 - Code List Qualifier Code		R			BH	Occurrence	
	HI11 - 2 - Industry Code		R		31 - 34		Occurrence Code from Source 132	
	HI11 - 3 - Date Time Period Format Qualifier		R			D8	Single Date	
	HI11 - 4 - Date Time Period		R		31 - 34	Date	CCYYMMDD	
	HI12 Health Care Code Information		S					
	HI12 - 1 - Code List Qualifier Code		R			BH	Occurrence	
	HI12 - 2 - Industry Code		R		31 - 34		Occurrence Code from Source 132	
	HI12 - 3 - Date Time Period Format Qualifier		R			D8	Single Date	
	HI12 - 4 - Date Time Period		R		31 - 34	Date	CCYYMMDD	
HI	Value Information	2300	S	2				
280	HI01 - Health Care Code Information		R					
	HI01 - 1 - Code List Qualifier Code		R			BE	Specify Value Code	
	HI01 - 2 - Industry Code		R		39 - 41		Value Code	
	HI01 - 5 - Monetary Amount		R				Value Code Associated Amount Decimal Value Ten Dollars and 1 cent is 10.01	
	HI02 - Health Care Code Information		S					
	HI02 - 1 - Code List Qualifier Code		R			BE	Specify Value Code	
	HI02 - 2 - Industry Code		R		39 - 41		Value Code	
	HI02 - 5 - Monetary Amount		R				Value Code Associated Amount Decimal Value Ten Dollars and 1 cent is 10.01	
	HI03 - Health Care Code Information		S					
	HI03 - 1 - Code List Qualifier Code		R			BE	Specify Value Code	
	HI03 - 2 - Industry Code		R		39 - 41		Value Code	
	HI03 - 5 - Monetary Amount		R				Value Code Associated Amount Decimal Value Ten Dollars and 1 cent is 10.01	
	HI04 - Health Care Code Information		S					
	HI04 - 1 - Code List Qualifier Code		R			BE	Specify Value Code	
	HI04 - 2 - Industry Code		R		39 - 41		Value Code	
	HI04 - 5 - Monetary Amount		R				Value Code Associated Amount Decimal Value Ten Dollars and 1 cent is 10.01	
	HI05 - Health Care Code Information		S					
	HI05 - 1 - Code List Qualifier Code		R			BE	Specify Value Code	
	HI05 - 2 - Industry Code		R		39 - 41		Value Code	
	HI05 - 5 - Monetary Amount		R				Value Code Associated Amount Decimal Value Ten Dollars and 1 cent is 10.01	
	HI06 - Health Care Code Information		S					
	HI06 - 1 - Code List Qualifier Code		R			BE	Specify Value Code	
	HI06 - 2 - Industry Code		R		39 - 41		Value Code	
	HI06 - 5 - Monetary Amount		R				Value Code Associated Amount Decimal Value Ten Dollars and 1 cent is 10.01	
	HI07 - Health Care Code Information		S					
	HI07 - 1 - Code List Qualifier Code		R			BE	Specify Value Code	
	HI07 - 2 - Industry Code		R		39 - 41		Value Code	

Seg	Segment	Loop	Seg	Max	UB-04 Ref (Box)	NEHEN Recommended Values	NEHEN Notes	FAQ
ID	Description	ID	Req	seg use				
	HI07 - 5 - Monetary Amount		R				Value Code Associated Amount Decimal Value Ten Dollars and 1 cent is 10.01	
	HI08 - Health Care Code Information		S					
	HI08 - 1 - Code List Qualifier Code		R			BE	Specify Value Code	
	HI08 - 2 - Industry Code		R		39 - 41		Value Code	
	HI08 - 5 - Monetary Amount		R				Value Code Associated Amount Decimal Value Ten Dollars and 1 cent is 10.01	
	HI09 - Health Care Code Information		S					
	HI09 - 1 - Code List Qualifier Code		R			BE	Specify Value Code	
	HI09 - 2 - Industry Code		R		39 - 41		Value Code	
	HI09 - 5 - Monetary Amount		R				Value Code Associated Amount Decimal Value Ten Dollars and 1 cent is 10.01	
	HI10 - Health Care Code Information		S					
	HI10 - 1 - Code List Qualifier Code		R			BE	Specify Value Code	
	HI10 - 2 - Industry Code		R		39 - 41		Value Code	
	HI10 - 5 - Monetary Amount		R				Value Code Associated Amount Decimal Value Ten Dollars and 1 cent is 10.01	
	HI11 - Health Care Code Information		S					
	HI11 - 1 - Code List Qualifier Code		R			BE	Specify Value Code	
	HI11 - 2 - Industry Code		R		39 - 41		Value Code	
	HI11 - 5 - Monetary Amount		R				Value Code Associated Amount Decimal Value Ten Dollars and 1 cent is 10.01	
	HI12 - Health Care Code Information		S					
	HI12 - 1 - Code List Qualifier Code		R			BE	Specify Value Code	
	HI12 - 2 - Industry Code		R		39 - 41		Value Code	
	HI12 - 5 - Monetary Amount		R				Value Code Associated Amount Decimal Value Ten Dollars and 1 cent is 10.01	
HI	Condition Information	2300	S	2				
290	HI01 Health Care Code Information		R					
	HI01 - 1 - Code List Qualifier Code		R			BG	Specify Condition	
	HI01 - 2 - Industry Code		R		18 - 28		Condition Code	
	HI02 Health Care Code Information		S					
	HI02 - 1 - Code List Qualifier Code		R			BG	Specify Condition	
	HI02 - 2 - Industry Code		R		18 - 28		Condition Code	
	HI03 Health Care Code Information		S					
	HI03 - 1 - Code List Qualifier Code		R			BG	Specify Condition	
	HI03 - 2 - Industry Code		R		18 - 28		Condition Code	
	HI04 Health Care Code Information		S					
	HI04 - 1 - Code List Qualifier Code		R			BG	Specify Condition	
	HI04 - 2 - Industry Code		R		18 - 28		Condition Code	
	HI05 Health Care Code Information		S					
	HI05 - 1 - Code List Qualifier Code		R			BG	Specify Condition	
	HI05 - 2 - Industry Code		R		18 - 28		Condition Code	
	HI06 Health Care Code Information		S					
	HI06 - 1 - Code List Qualifier Code		R			BG	Specify Condition	
	HI06 - 2 - Industry Code		R		18 - 28		Condition Code	
	HI07 Health Care Code Information		S					
	HI07 - 1 - Code List Qualifier Code		R			BG	Specify Condition	
	HI07 - 2 - Industry Code		R		18 - 28		Condition Code	
	HI08 Health Care Code Information		S					
	HI08 - 1 - Code List Qualifier Code		R			BG	Specify Condition	
	HI08 - 2 - Industry Code		R		18 - 28		Condition Code	
	HI09 Health Care Code Information		S					
	HI09 - 1 - Code List Qualifier Code		R			BG	Specify Condition	
	HI09 - 2 - Industry Code		R		18 - 28		Condition Code	
	HI10 Health Care Code Information		S					
	HI10 - 1 - Code List Qualifier Code		R			BG	Specify Condition	
	HI10 - 2 - Industry Code		R		18 - 28		Condition Code	
	HI11 Health Care Code Information		S					
	HI11 - 1 - Code List Qualifier Code		R			BG	Specify Condition	
	HI11 - 2 - Industry Code		R		18 - 28		Condition Code	

Seg	Segment	Loop	Seg	Max	UB-04 Ref (Box)	NEHEN Recommended Values	NEHEN Notes	FAQ
ID	Description	ID	Req	seg use				
	HI12 Health Care Code Information		S					
	HI12 - 1 - Code List Qualifier Code		R			BG	Specify Condition	
	HI12 - 2 - Industry Code		R		18 - 28		Condition Code	
HI	Treatment Code Information	2300	S	2				
299	HI01 - Health Care Code Information		R					
	HI01 - 1 - Code List Qualifier Code		R			TC	Specify Treatment Code	
	HI01 - 2 - Industry Code		R				Treatment Code	
	HI02 Health Care Code Information		S					
	HI02 - 1 - Code List Qualifier Code		R			TC	Specify Treatment Code	
	HI02 - 2 - Industry Code		R				Treatment Code	
	HI03 Health Care Code Information		S					
	HI03 - 1 - Code List Qualifier Code		R			TC	Specify Treatment Code	
	HI03 - 2 - Industry Code		R				Treatment Code	
	HI04 Health Care Code Information		S					
	HI04 - 1 - Code List Qualifier Code		R			TC	Specify Treatment Code	
	HI04 - 2 - Industry Code		R				Treatment Code	
	HI05 Health Care Code Information		S					
	HI05 - 1 - Code List Qualifier Code		R			TC	Specify Treatment Code	
	HI05 - 2 - Industry Code		R				Treatment Code	
	HI06 Health Care Code Information		S					
	HI06 - 1 - Code List Qualifier Code		R			TC	Specify Treatment Code	
	HI06 - 2 - Industry Code		R				Treatment Code	
	HI07 Health Care Code Information		S					
	HI07 - 1 - Code List Qualifier Code		R			TC	Specify Treatment Code	
	HI07 - 2 - Industry Code		R				Treatment Code	
	HI08 Health Care Code Information		S					
	HI08 - 1 - Code List Qualifier Code		R			TC	Specify Treatment Code	
	HI08 - 2 - Industry Code		R				Treatment Code	
	HI09 Health Care Code Information		S					
	HI09 - 1 - Code List Qualifier Code		R			TC	Specify Treatment Code	
	HI09 - 2 - Industry Code		R				Treatment Code	
	HI10 Health Care Code Information		S					
	HI10 - 1 - Code List Qualifier Code		R			TC	Specify Treatment Code	
	HI10 - 2 - Industry Code		R				Treatment Code	
	HI11 Health Care Code Information		S					
	HI11 - 1 - Code List Qualifier Code		R			TC	Specify Treatment Code	
	HI11 - 2 - Industry Code		R				Treatment Code	
	HI12 Health Care Code Information		S					
	HI12 - 1 - Code List Qualifier Code		R			TC	Specify Treatment Code	
	HI12 - 2 - Industry Code		R				Treatment Code	
QTY	Claim Quantity	2300	S	4				
306	QTY01 - Quantity Qualifier		R			CA/CD/LA/NA		
	QTY02 - Quantity		R				Days - Decimal 1 Day is 1.00	
	QTY03 - 1 - Unit or Basis for Measurement Code		R			DA		
HCP	Claim Pricing /Repricing Information	2300	S	1			If present, must be syntactically correct, but not processed	
308	HCP01 - Pricing Methodology		R					
	HCP02 - Monetary Amount		R					
	HCP03 - Monetary Amount		S					
	HCP04 - Reference ID		S					
	HCP05 - Rate		S					
	HCP06 - Reference ID		S					
	HCP07 - Monetary Amount		S					
	HCP08 - Product/Service ID		S					
	HCP09 - Product/Service ID Qualifier		S					
	HCP10 - Product/Service ID		S					
	HCP11 - Unit or Basis for Measurement Code		S					
	HCP12 - Quantity		S					
	HCP13 - Reject Reason Code		S					

Seg	Segment	Loop	Seg	Max	UB-04 Ref (Box)	NEHEN Recommended Values	NEHEN Notes	FAQ
ID	Description	ID	Req	seg use				
	HCP14 - Policy Compliance Code		S					
	HCP15 - Exception Code		S					
	LOOP 2305 HOME HEALTH CARE PLAN INFORMATION			6			If present, must be syntactically correct, but not processed	
CR7	Home Health Care Plan Information	2305	S	1				
314	CR701 - Discipline Type Code		R					
	CR702 - Number		R					
	CR703 - Number		R					
HSD	Health Care Services Delivery	2305	S	12			If present, must be syntactically correct, but not processed	
316	HSD01 - Quantity Qualifier		S					
	HSD02 - Quantity		S					
	HSD03 - Unit or Basis for Measurement Code		S					
	HSD04 - Sample Selection Modulus		S					
	HSD05 - Time Period Qualifier		S					
	HSD06 - Number of Periods		S					
	HSD07 - Ship/Delivery or Calendar Pattern Code		S					
	HSD08 - Ship/Delivery Pattern Time Code		S					
	LOOP 2310A ATTENDING PHYSICIAN NAME			1			Refer to Provider Number section of Companion Guide	
NM1	Attending Physician Name	2310A	S	1				
321	NM101 - Entity Identifier Code		R			71		
	NM102 - Entity Type Qualifier		R			1 or 2	HPHC assumes 1	
	NM103 - Name Last or Organization Name		R		76, line 2		Provider Last Name or Organization Name If submitted Tufts HP will use for processing	
	NM104 - Name First		S		76, line 2			
	NM105 - Name Middle		S					
	NM107 - Name Suffix		S					
	NM108 - ID Code Qualifier		R			XX	National Provider ID (NPI) must be submitted after May 23, 2007. If submitted Tufts HP will use for processing	
	NM109 - ID Code		R		76, line 1		Attending Physician NPI	
PRV	Attending Physician Specialty Information	2310A	S	1			Addenda change: This loop is required by HPHC until addenda is adopted by HPHC. Not processed by HPHC. NHP: Required if Surgical Procedure Code Used	
324	PRV01 - Provider Code		R			AT/SU		
	PRV02 - Reference ID Qualifier		R			ZZ		
	PRV03 - Reference ID		R				Taxonomy Code	
REF	Attending Physician Secondary ID	2310A	S	5				
326	REF01 - Reference ID Qualifier		R		76, line 1	EI/SY	If sent, must contain Employee Identification Number (EI) or Social Security Number (SSN)	
	REF02 - Reference ID		R		76, line 1		Attending Physician Tax ID or SSN	
	LOOP 2310B OPERATING PHYSICIAN NAME			1				
NM1	Operating Physician Name	2310B	S	1			Informational only	
328	NM101 - Entity Identifier Code		R			72		
	NM102 - Entity Type Qualifier		R			1		
	NM103 - Name Last or Organization Name		R		77, line 2			
	NM104 - Name First		R		77, line 2			

Seg	Segment	Loop	Seg	Max	UB-04 Ref (Box)	NEHEN Recommended Values	NEHEN Notes	FAQ
ID	Description	ID	Req	seg use				
	NM105 - Name Middle		S					
	NM107 - Name Suffix		S				If present, must be syntactically correct, but not processed.	
	NM108 - ID Code Qualifier		R			XX	If present, must be syntactically correct, but not processed.	
	NM109 - ID Code		R		77, line 1		If present, must be syntactically correct, but not processed.	
REF	Operating Physician Secondary ID	2310B	S	5			Informational Only	
333	REF01 - Reference ID Qualifier		R		77, line 1	EI/SY	If sent, must contain Employee Identification Number (EI) or Social Security Number (SSN)	
	REF02 - Reference ID		R		77, line 1		Operating Physician Tax ID or SSN	
	LOOP 2310C OTHER PROVIDER NAME			1				
NM1	Other Provider Name	2310C	S	1				
335	NM101 - Entity Identifier Code		R			73		
	NM102 - Entity Type Qualifier		R			1 or 2		
	NM103 - Name Last or Organization Name		R		78, line 2			
	NM104 - Name First		S		78, line 2			
	NM105 - Name Middle		S					
	NM107 - Name Suffix		S				If present, must be syntactically correct but not processed.	
	NM108 - ID Code Qualifier		R			XX	Not processed by payer	
	NM109 - ID Code		R		78, line 1		National Provider ID	
REF	Other Provider Secondary ID	2310C	S	5				
340	REF01 - Reference ID Qualifier		R		78, line 1	EI/SY	If sent, must contain Employee Identification Number (EI) or Social Security Number (SSN)	
	REF02 - Reference ID		R		78, line 1		Other Provider Tax ID or SSN	
	LOOP 2310E SERVICE FACILITY NAME			1				
NM1	Service Facility Name	2310E	S	1				
349	NM101 - Entity Identifier Code		R			FA		
	NM102 - Entity Type Qualifier		R			2		
	NM103 - Name Last or Organization Name		R				If submitted Tufts HP and HPHC will use for processing	
	NM108 - ID Code Qualifier		S			XX	If submitted Tufts HP and HPHC will use for processing	
	NM109 - ID Code		S			Primary Facility NPI	If submitted Tufts HP and HPHC will use for processing	
PRV	Service Facility Specialty Information	2310E	S	1			If present, must be syntactically correct, but not processed.	
352	PRV01 - Provider Code		R			RP		
	PRV02 - Reference ID Qualifier		R			ZZ		
	PRV03 - Reference ID		R			Prv spec code		
N3	Service Facility Address	2310E	R	1				
354	N301 - Address Information		R			addr1		
	N302 - Address Information		S			addr2		
N4	Service Facility City/State/ZIP Code	2310E	R	1				
355	N401 - City Name		R			City		
	N402 - State/Prov Code		R			State		
	N403 - Postal Code		R			zip		
	N404 - Country Code		S				If present, must be syntactically correct, but not processed.	
REF	Service Facility Secondary ID	2310E	S	5				

Seg	Segment	Loop	Seg	Max	UB-04 Ref (Box)	NEHEN Recommended Values	NEHEN Notes	FAQ
ID	Description	ID	Req	seg use				
357	REF01 - Reference ID Qualifier		R			EI	If NPI is sent in NM109, Facility Tax ID should be included here.	
	REF02 - Reference ID		R				Service Facility Tax ID	
	LOOP 2320 OTHER SUBSCRIBER INFORMATION			10			HPHC will not use for processing. If submitted Tufts HP will use for processing	
SBR	Other Subscriber Information	2320	S	1				
359	SBR01 - Payer Resp Seq No Code		R		50	P	If submitted Tufts HP will use for processing	
	SBR02 - Individual Relationship Code		R		59		If submitted Tufts HP will use for processing	
	SBR03 - Reference ID		S		62		If submitted Tufts HP will use for processing	
	SBR04 - Name		S		61		processing	
	SBR09 - Claim Filing Indicator Code		S				If present, must be syntactically correct, but not processed by HPHC.	
							HPHC: If present, must be syntactically correct, but not processed by HPHC. THP: If submitted Tufts HP will use for processing NHP: Required if COB Claim - will use for processing	
CAS	Claim Level Adjustment	2320	S	5				
365	CAS01 - Claim Adjustment Group Code		R				If submitted Tufts HP will use for processing	
	CAS02 - Claim Adjustment Reason Code		R				If submitted Tufts HP will use for processing	
	CAS03 - Monetary Amount		R				If submitted Tufts HP will use for processing	
	CAS04 - Quantity		S				If submitted Tufts HP will use for processing	
	CAS05 - Claim Adjustment Reason Code		S				If submitted Tufts HP will use for processing	
	CAS06 - Monetary Amount		S				If submitted Tufts HP will use for processing	
	CAS07 - Quantity		S				If submitted Tufts HP will use for processing	
	CAS08 - Claim Adjustment Reason Code		S				If submitted Tufts HP will use for processing	
	CAS09 - Monetary Amount		S				If submitted Tufts HP will use for processing	
	CAS10 - Quantity		S				If submitted Tufts HP will use for processing	
	CAS11 - Claim Adjustment Reason Code		S				If submitted Tufts HP will use for processing	
	CAS12 - Monetary Amount		S				If submitted Tufts HP will use for processing	
	CAS13 - Quantity		S				If submitted Tufts HP will use for processing	
	CAS14 - Claim Adjustment Reason Code		S				If submitted Tufts HP will use for processing	
	CAS15 - Monetary Amount		S				If submitted Tufts HP will use for processing	
	CAS16 - Quantity		S				If submitted Tufts HP will use for processing	
	CAS17 - Claim Adjustment Reason Code		S				If submitted Tufts HP will use for processing	
	CAS18 - Monetary Amount		S				If submitted Tufts HP will use for processing	
	CAS19 - Quantity		S				If submitted Tufts HP will use for processing	
AMT	Payer Prior Amount	2320	S	1			If submitted Tufts HP will use for processing HPHC: Informational only	
371	AMT01 - Amount Qualifier Code		R			C4		
	AMT02 - Monetary Amount		R		54			

Seg	Segment	Loop	Seg	Max	UB-04 Ref (Box)	NEHEN Recommended Values	NEHEN Notes	FAQ
ID	Description	ID	Req	seg use				
AMT	Coordination of Benefits (COB) Total Allowed Amount	2320	S	1			HPHC: If present, must be syntactically correct, but not processed by HPHC. THP: If submitted, Tufts HP will use for processing	
372	AMT01 - Amount Qualifier Code		R			B6		
	AMT02 - Monetary Amount		R					
AMT	Coordination of Benefits (COB) Total Submitted Charges	2320	S	1			HPHC: If present, must be syntactically correct, but not processed by HPHC. THP: If submitted, Tufts HP will use for processing	
373	AMT01 - Amount Qualifier Code		R			T3		
	AMT02 - Monetary Amount		R					
AMT	Diagnostic Related Group (DRG) Outlier Amount	2320	S	1			HPHC: If present, must be syntactically correct, but not processed by HPHC. THP: If submitted, Tufts HP will use for processing	
374	AMT01 - Amount Qualifier Code		R			ZZ		
	AMT02 - Monetary Amount		R					
AMT	Coordination of Benefits (COB) Total Medicare Paid Amount	2320	S	1			HPHC: If present, must be syntactically correct, but not processed by HPHC. THP: If submitted, Tufts HP will use for processing	
376	AMT01 - Amount Qualifier Code		R			N1		
	AMT02 - Monetary Amount		R					
AMT	Medicare Paid Amount - 100%	2320	S	1			HPHC: If present, must be syntactically correct, but not processed by HPHC. THP: If submitted, Tufts HP will use for processing	
378	AMT01 - Amount Qualifier Code		R			KF		
	AMT02 - Monetary Amount		R					
AMT	Medicare Paid Amount - 80%	2320	S	1			HPHC: If present, must be syntactically correct, but not processed by HPHC. THP: If submitted, Tufts HP will use for processing	
380	AMT01 - Amount Qualifier Code		R			PG		
	AMT02 - Monetary Amount		R					
AMT	Coordination of Benefits (COB) Medicare A Trust Fund Paid Amount	2320	S	1			HPHC: If present, must be syntactically correct, but not processed by HPHC. THP: If submitted, Tufts HP will use for processing	
382	AMT01 - Amount Qualifier Code		R			AA		
	AMT02 - Monetary Amount		R					

Seg	Segment	Loop	Seg	Max	UB-04 Ref (Box)	NEHEN Recommended Values	NEHEN Notes	FAQ
ID	Description	ID	Req	seg use				
AMT	Coordination of Benefits (COB) Medicare B Trust Fund Paid Amount	2320	S	1			HPHC: If present, must be syntactically correct, but not processed by HPHC. THP: If submitted, Tufts HP will use for processing	
384	AMT01 - Amount Qualifier Code		R			BI		
	AMT02 - Monetary Amount		R					
AMT	Coordination of Benefits (COB) Total Non-covered Amount	2320	S	1			HPHC: If present, must be syntactically correct, but not processed by HPHC. THP: If submitted, Tufts HP will use for processing	
386	AMT01 - Amount Qualifier Code		R			AB		
	AMT02 - Monetary Amount		R					
AMT	Coordination of Benefits (COB) Total Denied Amount	2320	S	1			HPHC: If present, must be syntactically correct, but not processed by HPHC. THP: If submitted, Tufts HP will use for processing	
387	AMT01 - Amount Qualifier Code		R			YT		
	AMT02 - Monetary Amount		R					
DMG	Other Subscriber Demographic Information	2320	S	1				
388	DMG01 - Date Time Period Format Qualifier		R			D8		
	DMG02 - Date Time Period		R				DOB	
	DMG03 - Gender Code		R				Sex	
OI	Other Insurance Coverage Information	2320	R	1				
390	OI03 - Yes/No Condition or Response Code		R			Y/N	Y/N	
	OI06 - Release of Information Code		R				Release Information	
MIA	Medicare Inpatient Adjudication Information	2320	S	1			HPHC: If present, must be syntactically correct, but not processed by HPHC. THP: If submitted, Tufts HP will use for processing	
392	MIA01 - Quantity		R					
	MIA02 - Quantity		S					
	MIA03 - Quantity		S					
	MIA04 - Monetary Amount		S					
	MIA05 - Reference ID		S					
	MIA06 - Monetary Amount		S					
	MIA07 - Monetary Amount		S					
	MIA07 - Monetary Amount		S					
	MIA08 - Monetary Amount		S					
	MIA09 - Monetary Amount		S					
	MIA10 - Monetary Amount		S					
	MIA11 - Monetary Amount		S					
	MIA12 - Monetary Amount		S					
	MIA13 - Monetary Amount		S					
	MIA14 - Monetary Amount		S					
	MIA15 - Quantity		S					
	MIA16 - Monetary Amount		S					
	MIA17 - Monetary Amount		S					
	MIA18 - Monetary Amount		S					
	MIA19 - Monetary Amount		S					
	MIA20 - Reference ID		S					
	MIA21 - Reference ID		S					
	MIA22 - Reference ID		S					
	MIA23 - Reference ID		S					
	MIA24 - Monetary Amount		S					

Seg	Segment	Loop	Seg	Max	UB-04 Ref (Box)	NEHEN Recommended Values	NEHEN Notes	FAQ
ID	Description	ID	Req	seg use				
MOA	Medicare Outpatient Adjudication Information	2320	S	1			HPHC: If present, must be syntactically correct, but not processed by HPHC. THP: If submitted, Tufts HP will use for processing	
397	MOA01 - Percent		S					
	MOA02 - Monetary Amount		S					
	MOA03 - Reference ID		S					
	MOA04 - Reference ID		S					
	MOA05 - Reference ID		S					
	MOA06 - Reference ID		S					
	MOA07 - Reference ID		S					
	MOA08 - Monetary Amount		S					
	MOA09 - Monetary Amount		S					
	LOOP 2330A OTHER SUBSCRIBER NAME			1				
NM1	Other Subscriber Name	2330A	R	1				
400	NM101 - Entity Identifier Code		R			IL		
	NM102 - Entity Type Qualifier		R			1 or 2		
	NM103 - Name Last or Organization Name		R		58			
	NM104 - Name First		S		58			
	NM105 - Name Middle		S		58			
	NM107 - Name Suffix		S				If present, must be syntactically correct, but not processed.	
	NM108 - ID Code Qualifier		R			MI/ZZ		
	NM109 - ID Code		R		60		Member Id	
N3	Other Subscriber Address	2330A	S	1				
404	N301 - Address Information		R		80		Address	
	N302 - Address Information		S				If present, must be syntactically correct, but not processed.	
N4	Other Subscriber City/State/ZIP Code	2330A	S	1				
406	N401 - City Name		R		80		city	
	N402 - State/Prov Code		R		80		state	
	N403 - Postal Code		R		80		zip	
	N404 - Country Code		S				If present, must be syntactically correct, but not processed.	
REF	Other Subscriber Secondary Information	2330A	S	1			If present, must be syntactically correct, but not processed.	
408	REF01 - Reference ID Qualifier		R			IN/G/SY		
	REF02 - Reference ID		R		60			
	LOOP 2330B OTHER PAYER NAME			1				
NM1	Other Payer Name	2330B	R	1				
410	NM101 - Entity Identifier Code		R			PR		
	NM102 - Entity Type Qualifier		R			2		
	NM103 - Name Last or Organization Name		R		50			
	NM108 - ID Code Qualifier		R			PI/XV		
	NM109 - ID Code		R					
N3	Other Payer Address	2330B	S	1			HPHC: If present, must be syntactically correct, but not processed by HPHC. THP: If submitted, Tufts HP will use for processing	
412	N301 - Address Information		R					
	N302 - Address Information		S					

Seg	Segment	Loop	Seg	Max	UB-04 Ref (Box)	NEHEN Recommended Values	NEHEN Notes	FAQ
ID	Description	ID	Req	seg use				
N4	Other Payer City/State/ZIP Code	2330B	S	1			HPHC: If present, must be syntactically correct, but not processed by HPHC. THP: If submitted, Tufts HP will use for processing	
413	N401 - City Name		R					
	N402 - State/Prov Code		R					
	N403 - Postal Code		R					
	N404 - Country Code		S					
DTP	Claim Adjudication Date	2330B	S	1			If present, must be syntactically correct, but not processed.	
415	DTP01 - Date/Time Qualifier		R					
	DTP02 - Date Time Period Format Qualifier		R					
	DTP03 - Date Time Period		R					
REF	Other Payer Secondary ID and Reference	2330B	S	2			If present, must be syntactically correct, but not processed.	
416	REF01 - Reference ID Qualifier		R			2U/FY		
	REF02 - Reference ID		R					
REF	Other Payer Prior Authorization or Referral Number	2330B	S	1			If present, must be syntactically correct, but not processed.	
418	REF01 - Reference ID Qualifier		R					
	REF02 - Reference ID		R					
NM1	LOOP 2330C OTHER PAYER PATIENT INFORMATION			1			HPHC: If present, must be syntactically correct, but not processed by HPHC. THP: If submitted, Tufts HP will use for processing	
420	Other Payer Patient Information	2330C	S	1				
	NM101 - Entity Identifier Code		R			QC		
	NM102 - Entity Type Qualifier		R			1		
	NM108 - ID Code Qualifier		R					
	NM109 - ID Code		R					
REF	Other Payer Patient ID Number	2330C	S	3			If present, must be syntactically correct, but not processed.	
422	REF01 - Reference ID Qualifier		R					
	REF02 - Reference ID		R					
NM1	LOOP 2330D OTHER PAYER ATTENDING PROVIDER			1			If present, must be syntactically correct, but not processed.	
424	Other Payer Attending Provider	2330D	S	1				
	NM101 - Entity Identifier Code		R			71		
	NM102 - Entity Type Qualifier		R					
REF	Other Payer Attending Provider ID	2330D	R	3			If present, must be syntactically correct, but not processed.	
426	REF01 - Reference ID Qualifier		R					
	REF02 - Reference ID		R					
NM1	LOOP 2330E OTHER PAYER OPERATING PROVIDER			1			If present, must be syntactically correct, but not processed.	
428	Other Payer Operating Provider	2330E	S	1				
	NM101 - Entity Identifier Code		R			72		
	NM102 - Entity Type Qualifier		R					
REF	Other Payer Operating Provider ID	2330E	R	3			If present, must be syntactically correct, but not processed.	
430	REF01 - Reference ID Qualifier		R					
	REF02 - Reference ID		R					
NM1	LOOP 2330F OTHER PAYER OTHER PROVIDER			1			If present, must be syntactically correct, but not processed.	

Seg	Segment	Loop	Seg	Max	UB-04 Ref (Box)	NEHEN Recommended Values	NEHEN Notes	FAQ
ID	Description	ID	Req	seg use				
NM1	Other Payer Other Provider	2330F	S	1				
432	NM101 - Entity Identifier Code		R			73		
	NM102 - Entity Type Qualifier		R					
REF	Other Payer Other Provider ID	2330F	R	3			If present, must be syntactically correct, but not processed.	
434	REF01 - Reference ID Qualifier		R					
	REF02 - Reference ID		R					
	LOOP 2330H OTHER PAYER SERVICE FACILITY PROVIDER			1			If present, must be syntactically correct, but not processed.	
NM1	Other Payer Service Facility Provider	2330H	S	1				
440	NM101 - Entity Identifier Code		R			FA		
	NM102 - Entity Type Qualifier		R					
REF	Other Payer Service Facility Provider	2330H	R	3			If present, must be syntactically correct, but not processed.	
442	REF01 - Reference ID Qualifier		R					
	REF02 - Reference ID		R					
	LOOP 2400 SERVICE LINE NUMBER			999				
LX	Service Line Number	2400	R	1				
444	LX01 - Assigned Number		R				Recommended Maximum of 80 lines per claims	Y
SV2	Institutional Service Line	2400	R	1				
445	SV201 - Product/Service ID		R		42	Rev code	UB92 Rev Code	Y
	SVC202 Composite Medical Procedure Identifier		S					
	SV202 - 1 - Product/Service ID Qualifier		R			HC	Indicate type of code. Payers do not accept NDC codes (N1 - N4) NOTE: NHP would like to begin using NDC codes for Home Infusion- N4	
	SV202 - 2 - Product/Service ID		R		44		HCPC or CPT Code	
	SV202 - 3 - Procedure Modifier		S		44		Modifier 1 If submitted, Tufts HP will use for processing	
	SV202 - 4 - Procedure Modifier		S		44		Modifier 2 If submitted, Tufts HP will not use for processing	
	SV202 - 5 - Procedure Modifier		S		44		Modifier 3 If submitted, Tufts HP will not use for processing	
	SV202 - 6 - Procedure Modifier		S		44		Modifier 4 If submitted, Tufts HP will not use for processing	
	SV203 - Monetary Amount		R		47		Total charge for this svc line. Must include decimal point. 15.55 or 15.00	
	SV204 - Unit of Basis for Measurement Code		R			Unit DA/UN	Assume days or units based on type of claim. F2 will be treated as days/units	
	SV205 - Quantity		R		46	quantity	Integer	
	SV206 - Unit Rate		S		44		Inpatient claim only - Service line Accommodation rate amount Ten Dollars is 10.00	
	SV207 - Monetary Amount		S		48		Non Covered Charge Amount	
HCP	Line pricing/repricing information	2400	S	1		Added Addenda	Not required for structural compliance	
454			S	1				
	HCP01- Pricing Methodology		R				Required if submitting HCP segment	
	HCP02- Monetary Amount		R				Required if submitting HCP segment	
	HCP03- Monetary Amount		S				Not required for structural compliance	

Seg	Segment	Loop	Seg	Max	UB-04 Ref (Box)	NEHEN Recommended Values	NEHEN Notes	FAQ
ID	Description	ID	Req	seg use				
	HCP04- Reference Identification		S				Not required for structural compliance	
	HCP05- Rate		S				Not required for structural compliance	
	HCP06- Reference Identification		S				Not required for structural compliance	
	HCP07- Monetary Amount		S				Not required for structural compliance	
	HCP08- Product/Service ID		S				Not required for structural compliance	
	HCP09- Product/Service ID Qualifier		S				Not required for structural compliance	
	HCP10- Product/Service Id		S				Not required for structural compliance	
	HCP11- Unit or Basis for Measurement Code		S				Not required for structural compliance	
	HCP12- Quantity		S				Not required for structural compliance	
	HCP13- Reject Reason Code		S				Not required for structural compliance	
	HCP14- Policy Compliance Code		S				Not required for structural compliance	
	HCP15- Exception Code		S				Not required for structural compliance	
PWK	Line Supplemental Information	2400	S	5			If present, must be syntactically correct, but not processed.	
452	PWK01 - Report Type Code		R					
	PWK02 - Report Transmission Code		R					
	PWK05 - ID Code Qualifier		S					
	PWK06 - ID Code		S					
DTP	Service Line Date	2400	S	1			Outpatient Claims Only	
456	DTP01 - Date/Time Qualifier		R			472	Service Date	
	DTP02 - Date Time Period Format Qualifier		R			D8/RD8		
	DTP03 - Date Time Period		R		45	Date or Date Range	CCYYMMDD or CCYYMMDD-CCYYMMDD	
DTP	Assessment Date	2400	S	1			If present, must be syntactically correct, but not processed.	
458	DTP01 - Date/Time Qualifier		R					
	DTP02 - Date Time Period Format Qualifier		R					
	DTP03 - Date Time Period		R		45			
AMT	Service Tax Amount	2400	S	1			If present, must be syntactically correct, but not processed.	
460	AMT01 - Amount Qualifier Code		R					
	AMT02 - Monetary Amount		R					
AMT	Facility Tax Amount	2400	S	1			If present, must be syntactically correct, but not processed.	
461	AMT01 - Amount Qualifier Code		R					
	AMT02 - Monetary Amount		R					
	LOOP 2410 -Drug Identification	2410		1			If present, must be syntactically correct, but not processed.	
LIN	Drug Identification		S				Not required for structural compliance	
459	LIN02- Product/Service ID Qualifier		R				Required if submitting LIN segment	
	LIN03- Product/Service ID		R				Required if submitting LIN segment	
CTP	Drug Pricing		S				Not required for structural compliance	
462	CTP03- Unit Price		R				Required if submitting CTP segment	
	CTP04- Quantity		R				Required if submitting CTP segment	
	CTP05- Composite Unit of Measure		R				Required if submitting CTP segment	
	CTP05-1- Unit or Basis for Measurement Code		R				Required if submitting CTP segment	
REF	Prescription Number		S				Not required for structural compliance	
465	REF01- Reference Identification Qualifier		R			XZ	Required if submitting REF segment	
	REF02- Reference Identification		R				Required if submitting REF segment	

Seg	Segment	Loop	Seg	Max	UB-04 Ref (Box)	NEHEN Recommended Values	NEHEN Notes	FAQ
ID	Description	ID	Req	seg use				
	LOOP 2420A ATTENDING PHYSICIAN NAME			1			If present, must be syntactically correct, but not processed.	
NM1	Attending Physician Name	2420A	S	1				
462	NM101 - Entity Identifier Code		R			71		
	NM102 - Entity Type Qualifier		R			1 or 2		
	NM103 - Name Last or Organization Name		R			lname		
	NM104 - Name First		S			fname		
	NM105 - Name Middle		S					
	NM107 - Name Suffix		S					
	NM108 - ID Code Qualifier		R			XX	National Provider ID mandated for use after May 23, 2007	
	NM109 - ID Code		R				Attending Physician NPI	
PRV	Attending Physician Specialty Information	2420A	S	1			If present, must be syntactically correct, but not processed.	
465	PRV01 - Provider Code		R			AT		
	PRV02 - Reference ID Qualifier		R			ZZ		
	PRV03 - Reference ID		R			provider spec code		
REF	Attending Physician Secondary ID	2420A	S	1			If present, must be syntactically correct, but not processed.	
467	REF01 - Reference ID Qualifier		R			EI/SY		
	REF02 - Reference ID		R				Tax ID or SSN	
	LOOP 2420B OPERATING PHYSICIAN NAME			1			If present, must be syntactically correct, but not processed.	
NM1	Operating Physician Name	2420B	S	1			If present, must be syntactically correct, but not processed.	
469	NM101 - Entity Identifier Code		R			72		
	NM102 - Entity Type Qualifier		R			1		
	NM103 - Name Last or Organization Name		R			lname		
	NM104 - Name First		R			fname		
	NM105 - Name Middle		S					
	NM107 - Name Suffix		S					
	NM108 - ID Code Qualifier		R			XX	National Provider ID mandated for use after May 23., 2007	
	NM109 - ID Code		R				Operating Physician NPI	
PRV	Operating Physician Specialty Information	2420B	S	1			If present, must be syntactically correct, but not processed.	
472	PRV01 - Provider Code		R			OP		
	PRV02 - Reference ID Qualifier		R			ZZ		
	PRV03 - Reference ID		R				Taxonomy Code	
REF	Operating Physician Secondary ID	2420B	S	1			If present, must be syntactically correct, but not processed.	
474	REF01 - Reference ID Qualifier		R			EI/SY	Tax ID or SSN may be sent in addition to the NPI included in NM109	
	REF02 - Reference ID		R				Tax ID or SSN	
	LOOP 2420C OTHER PROVIDER NAME			1				
NM1	Other Provider Name	2420C	S	1			If present, must be syntactically correct, but not processed.	
476	NM101 - Entity Identifier Code		R			73		
	NM102 - Entity Type Qualifier		R			1 or 2		
	NM103 - Name Last or Organization Name		R					
	NM104 - Name First		S					
	NM105 - Name Middle		S					
	NM107 - Name Suffix		S					
	NM108 - ID Code Qualifier		R			XX	National Provider ID (NPI) is mandated for use after May 23, 2007	
	NM109 - ID Code		R				Other Provider NPI	
PRV	Other Provider Specialty Information	2420C	S	1			If present, must be syntactically correct, but not processed.	
479	PRV01 - Provider Code		R			OT/PE		
	PRV02 - Reference ID Qualifier		R			ZZ		

Seg	Segment	Loop	Seg	Max	UB-04 Ref (Box)	NEHEN Recommended Values	NEHEN Notes	FAQ
ID	Description	ID	Req	seg use				
	PRV03 - Reference ID		R				Taxonomy Code	
REF	Other Provider Secondary ID	2420C	S	1			If present, must be syntactically correct, but not processed.	
481	REF01 - Reference ID Qualifier		R			EI/SY	Tax ID or SSN may be sent in addition to the NPI in NM109	
	REF02 - Reference ID		R				Tax ID or SSN	
	LOOP 2430 SERVICE LINE ADJUDICATION			25				
SVD	Service Line Adjudication Information	2430	S	1			If present, must be syntactically correct, but not processed.	
490	SVD01 - ID Code		R					
	SVD02 - Monetary Amount		R					
	SVD03 - Composite Medical Procedure ID		S					
	SVD03 - 1 - Product/Service ID Qualifier		R					
	SVD03 - 2 - Product/Service ID		R					
	SVD03 - 3 - Procedure Modifier		S					
	SVD03 - 4 - Procedure Modifier		S					
	SVD03 - 5 - Procedure Modifier		S					
	SVD03 - 6 - Procedure Modifier		S					
	SVD03 - 7 - Description		S					
	SVD04 - Product/Service ID		R					
	SVD05 - Quantity		R					
	SVD06 - Assigned Number		S					
CAS	Service Line Adjustment	2430	S	99			If present, must be syntactically correct, but not processed.	
494	CAS01 - Claim Adjustment Group Code		R					
	CAS02 - Claim Adjustment Reason Code		R					
	CAS03 - Monetary Amount		R					
	CAS04 - Quantity		S					
	CAS05 - Claim Adjustment Reason Code		S					
	CAS06 - Monetary Amount		S					
	CAS07 - Quantity		S					
	CAS08 - Claim Adjustment Reason Code		S					
	CAS09 - Monetary Amount		S					
	CAS10 - Quantity		S					
	CAS11 - Claim Adjustment Reason Code		S					
	CAS12 - Monetary Amount		S					
	CAS13 - Quantity		S					
	CAS14 - Claim Adjustment Reason Code		S					
	CAS15 - Monetary Amount		S					
	CAS16 - Quantity		S					
	CAS17 - Claim Adjustment Reason Code		S					
	CAS18 - Monetary Amount		S					
	CAS19 - Quantity		S					
DTP	Service Adjudication Date	2430	S	1			If present, must be syntactically correct, but not processed.	
502	DTP01 - Date/Time Qualifier		R					
	DTP02 - Date Time Period Format Qualifier		R					
	DTP03 - Date Time Period		R					
SE	Transaction Set Transfer	2430	R	1				
503	SE01 - Number of Included Segments		R				Number of Segments including ST and SE segments	
	SE02 - Transaction Set Control Number		R				Must Match SE02	
GE	Functional Group Trailer		R	1				
	GE01 - Number of Transaction Sets Included		R				Number of Transaction Sets Included	
	GE02 - Group Control Number		R				Must equal GS06	
IEA	Interchange Control Trailer		R	1				
	IEA01 - Number of Included Functional Groups		R				Count of Function groups	

Seg	Segment	Loop	Seg	Max	UB-04 Ref (Box)	NEHEN Recommended Values	NEHEN Notes	FAQ
ID	Description	ID	Req	seg use				
	IEA02 - Interchange Control Number		R				Assigned by submitter	

FAQ

FREQUENTLY ASKED QUESTIONS & BEST PRACTICES

Introduction

The frequently asked questions in this section are a result of issues arising from claim testing. In addition to questions, NEHEN Payers and Providers provide some suggested best practices. Questions are grouped by category.

Additional questions may be submitted to NEHEN by sending e-mail to aerrico@csc.com.

Many data elements required by the 837 are not used in decisions on whether a health plan pays a claim. On the other hand, data described as situational in the 837 transaction guides will be required for payment. This section addresses questions regarding adjudication of a claim and data in the 837.

Frequently Asked Questions

Provider Validation

How do Payers use Taxonomy Code?

Taxonomy code is not used by NEHEN Payers during claim adjudication. In the December Addendum to the 837 Transaction Guides, Taxonomy Code has been change to a situational data element.

How is a Provider identified?

Completing the NM1 Segment with National Provider ID (NPI) and (optionally) the REF segment with the Tax ID identifies a provider. Refer to the NEHEN 837 Companion Guide.

Member Validation

Is “Authorization on File” required?

Tufts Health Plan will reject a claim if “Authorization on File” is “N”.

Where should Member ID be stored?

Send Member ID in the NM109 of Loop ID 2010CA or 2010BA not in the REF segment

How is Relationship Code used?

Relationship Code is not verified by the NEHEN Payers during Adjudication.

What should I do if I don’t know the patient’s relationship to the subscriber?

If the patient is not the subscriber, the patient’s relationship to the subscriber must be submitted (Loop 2000C PAT01). If the relationship is unknown, submit Code 21 (unknown).

Code Set Validation

Do Revenue Codes need to be 4 digits?

ClarEDI currently fails Revenue Codes that are 3 digits. This is ClarEDI's interpretation of the 837 Guide. The NEHEN Payers do not agree with this interpretation and will accept either 3 or 4 digit Revenue Codes.

General Claim Information

What is the required naming convention for claim files?

Payers will define the naming convention required for claim files delivered to them. See the Payer-specific chapters in this Guide. For NEHEN Providers, the eGateway will rename Provider named files into the Payer defined standard.

How and when will the 997 be used?

Harvard Pilgrim, Tufts Health Plan, and NHP will send a 997 to acknowledge that a claim file has been accepted or rejected for further processing. For NEHEN Providers, the 997 will be sent and received via the NEHEN eGateway.

How is the “submitter” defined on the 837?

For EDI purposes, the submitter is defined as the combination of the ISA06 and GS02 in the 837- this needs to be unique across NEHEN membership. NEHEN Providers, Payers, and Program Management will work together to develop a comprehensive table of contact information for each provider “submitter”.

Do not include carriage return or line feed characters after segment terminator.

Ensure that there is no embedded carriage return or line feed after a valid segment terminator in the EDI file.

What if a required element within a situational segment is missing or invalid?

If a situational segment is sent to the Payer and a required element within the situational segment is misused, the entire file will be sent back.

Do not embed EDI delimiters in Provider data.

EDI delimiters embedded in provider data will cause the claim file to be rejected. For example, make sure Patient Account Number does not have an “*” embedded if your system uses an “*” as an EDI delimiter.

Testing

I have already certified/tested with Claredi (or other third party). Why do I need to test again with the Payer?

NEHEN Payers test with all electronic submitters in order to verify that Payer business rules are implemented. The goal is to eliminate errors and rejects. If a provider has already tested with a third party, testing should be relatively straightforward.

If I have already tested 837-Professional with a NEHEN Payer, am I required to test 837-Institutional as well?

Yes. The institutional and professional 837 are different enough, both for HIPAA compliance and NEHEN Payer business rules and billing guidelines, to warrant testing for both claim types.

Should I submit on 837-Institutional or 837-Professional?

The submission format will be determined by your contract with the Payer or the Payer billing guidelines. The formats will also be addressed during testing.

NEHEN Best Practices

General Claim Information

This section documents helpful hints and best practices for submitting electronic claims.

Include a provider generated trace # in the “Claim ID for Clearinghouses...”

NEHEN Payers strongly suggest including a unique identifier in the “Claim ID for Clearinghouses and other Transmission Intermediaries” Loop 2300A REF Segment. This identifier should be unique across all claim files. A unique identifier will help providers in tracking claims.

Send One ISA-ISE per file

NEHEN Payers only expect 1 ISA-ISE per file.

Code to December Addendum to 837 Guide

NEHEN Providers and Payers should code to specifications included in the December 02/January '03 Addendum to the 837 Transaction Guides.

Institutional Claim maximum of 80 lines per claim suggested

Although the NEHEN Payers can accept the maximum allowable lines associated with a claim, Payers will break claims with more than 80 lines into separate claims for processing. Therefore, for tracking purposes, it is recommended that providers submit claims with a maximum of 80 lines.

Maximum of 5000 Claims per file suggested

NEHEN Payers can recommend a maximum of 5000 claims per file.

Submit claim lines in revenue code order

As is true today, the NEHEN Payers recommend that claim lines be submitted in ascending revenue code order.

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