

Harvard Pilgrim Health Care Neighborhood Health Plan Tufts Health Plan

Companion Guide

837 Health Care Claim: Professional

For use with:

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

ASC X12N 837P (004010X098A1)

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



NEW ENGLAND HEALTHCARE EDI NETWORK

Revision History

Date	Chapter	Section	Description
2/1/2007	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

Date	Chapter	Section	Description
		Production	ISA15 must contain "P" for Production files and "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 paper claim forms.

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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 Professional 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 837P (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: Professional ASC X12N 837P (004010X098A1)*. 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.



Professional 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 004010X098A1 Health Care Claim: Professional 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 Professional 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 Identifier (NPI) and valid Tax ID.

How to Configure Looping Structure for Provider Identification

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

Secondary Identification is a Situational segment but **required** for NEHEN Payer business processing when NM109 is the NPI.

- REF01 is set to EI (Employer's Identification Number) or SY (Social Security Number)
- REF02 must contain the provider's valid 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 2310B).

Using Counts or Anesthesia Minutes

In Loop 2400, the 837 format allows for use of either counts or minutes, but not both. Harvard Pilgrim requires minutes for anesthesia claims.

If you are billing for anesthesia services, submit minutes in SV104; do not submit counts/units.

- Set SV103 to MJ; SV104 contains the total anesthesia minutes.

For other types of claims, all service lines require a count for the procedure code.

- Set SV103 to UN; SV104 contains the numeric value of quantity.

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/or 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 Professional Claim Submission Specifications

As detailed in the National Electronic Data Interchange *Transaction Set Implementation Guides & Addenda for the Health Care Claim: Professional ASC X12N 837P (004010X098A1)*, 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 Professional 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 Professional 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 Professional 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_P_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>_P_<CCYYMMDD>_<HHMM>.997

997 File returned by Harvard Pilgrim

<ISA06>_<GS02>_P_<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.

Using Counts or Anesthesia Minutes

In Loop 2400, the 837 format allows for use of either counts or minutes, but not both. Harvard Pilgrim requires minutes for anesthesia claims.

If you are billing for anesthesia services, submit minutes in SV104; do not submit counts/units.

- Set SV103 to MJ; SV104 contains the total anesthesia minutes.

For other types of claims, all service lines require a count for the procedure code.

- Set SV103 to UN; SV104 contains the numeric value of quantity.

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 used 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.

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 when patient has a unique member identification number.

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

	SBR03	NM108	NM109
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.

Rendering Provider Number

The provider number at the service line level (Rendering Provider loop 2420A-REF segment) can overwrite the provider numbers in Billing Provider loop 2010AA-REF, Pay-To Provider loop 2010BA-REF, and Rendering Provider 2310B-REF segments. Regardless of the Provider being populated, 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.

Referring Provider Number

Use of the Referring Provider loops 2310A and 2420F are situational by nature. However a Referring Provider loop is required when the member's product (HMO or POS) requires a primary care physician referral for specialty services in order to adjudicate a claim correctly.

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 Acknowledgments 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 days Harvard pilgrim will contact 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 Acknowledgement 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

Field #	Field Name	Description	Format	Start Position	End Position
06	Billing Provider	This is the provider to whom <i>HPHC</i> 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 <i>HPHC</i> . 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
12	Service Start Date	First service start date from claim. For Institutional Claims this is Loop 2300 "Claim Information," segment DTP "Statement Dates" where Date-Time qualifier is 434. For Professional Claims this is Loop 2400 Service Line, segment DTP "Service Date" where the Date-Time qualifier is 472.	CCYYMMDD	195	202
13	Procedure Code	As submitted on the claim. For Institutional Claims this is Loop 2300 "Claim Information," segment HI "Principal Procedure Information" where Procedure Code List qualifier is BP/BR. For Professional Claims this is Loop 2400 Service Line, segment SV1 "Professional Service" where the product/service ID qualifier is HC.		203	208
14	Message Code	<i>HPHC</i> 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

Field #	Field Name	Description	Format	Start Position	End Position
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 837 Professional 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 enrolling the provider with NHP.

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 Professional 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 Professional 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 837 Professional 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 Professional 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.

Using Counts or Anesthesia Minutes

When using counts or anesthesia minutes, Loop 2400 allows for one or the other but not both.

- If you are billing for anesthesia services, then set SV103 to “MJ” and submit minutes in SV104.
- For other types of claims, all service lines require a unit count for the procedure code. Set SV103 to “UN” and submit the number of units in SV104.

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 number on all claims transactions. Please use the *Trading Partner Agreement* to verify that you have the

correct NPI 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 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.

Submitter Reports

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 Dollar Amount of Claims Accepted: \$761.00

Total Dollar 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 Professional 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 Professional 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 2330A) 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

- Tufts HP will capture all four Procedure Code Modifiers (Element SV101-3) if sent, but only the first modifier will be utilized during processing.
- Mapping should suppress leading or trailing zeros or spaces. Revenue codes for Professional claims are the only exception. Use three digits and a leading zero. (Example: 0424.)

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

- Tufts HP strongly recommends that Rendering Provider Information (Loop 2310B) be sent on all professional claims. If the Rendering Provider Loop is not sent, the grid below determines how Tufts HP will capture the Provider Information.

Loop	Description
Rendering Provider Information (Loop 2310B)	Tufts HP uses this information for the Rendering Provider.
Pay-to Provider Information (Loop 2010AB)	Tufts HP uses this information for the Payee. If Loop 2310B is not present, Tufts HP uses this information for the Rendering Provider as well as the Payee.
Billing Provider Information (Loop 2010AA)	Tufts HP uses this information for the Billing Provider. If Loop 2010AB is not present, Tufts HP uses this information for the Payee as well as for the Billing Provider. If neither Loop 2310B nor Loop 2010AB is present, Tufts HP uses this information for the Rendering Provider, Payee, and Billing Provider.

- 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 23rd, 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 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 # XXXXXX	Patient Account # XXXXXXXXXX	Error Message Invalid Member ID	Field Content XXXXXXXXXX
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Example Tufts EDI Claim Acceptance Detail Report

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

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

Record # XXXXXX	Account # XXXXXXXXXX	Claim # XXXXXXXXXX	Product XXX
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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 Professional 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.
PAYEE ID CANNOT EQUAL PROVIDER ID#	Payee/Pay To ID # submitted cannot be used as Provider/Rendering ID #
CLAIM TYPE NOT ACCEPTED	Provider type not authorized to submit professional claims.
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.

Message	Criteria
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 date of birth.
PAT. ACCT. SPACES	Patient account number is not submitted.
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 EMPLOYMENT FLAG	Employment flag is invalid.
INVALID AUTO ACCIDENT FLAG	Auto accident flag is invalid.
INVALID OTHER ACCIDENT FLAG	Other accident flag is invalid.
PATIENT OR AUTH SIGNATURE MUST BE OBTAINED	Patient or Authorization signature has not been obtained.
INSURED OR AUTH SIGNATURE MUST BE OBTAINED	Insured or Authorization signature has not been obtained.
INVALID TYPE OF BILL	Value is not a valid type of bill as defined by HIPAA.
RELEASE OF INFO. FLAG MUST BE OBTAINED	Value does not equal 'Y'.
DOS BEYOND RECEIPT DATE	Date of service cannot exceed the receipt date.
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.

Message	Criteria
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.
INVALID DOS	Date of service is invalid.
INVALID NOS - NOT NUMERIC	Number of service is invalid. [Must be numeric.]
AMT. BILLED NOT NUMERIC	Amount billed is invalid. [Must be numeric.]

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 setup 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 PROFESSIONAL CLAIM
SUBMISSION SPECIFICATIONS**

CH. 6 NEHEN 837 Professional Claim Submission Specification

Seg	Segment	Loop	Seg	Max	HCFA Form	NEHEN	NEHEN Notes	FAQ
ID	Description	ID	Req	use	(Box)	Recommended Values		
ISA	Interchange control header		R	1				
	ISA01 - Auth info qualifier					"00"		
	ISA02 -Auth info qualifiei						10 spaces (blank)	
	ISA03- Security info qua					"00"		
	ISA04 - security info						10 spaces (blank)	
	ISA05 - Interchange ID qual					ZZ		
	ISA06 - Interchange sender ID						Sender's identification, as per trading partner agreement.	Y
	ISA07 - Interchange ID qual					01 ZZ	DUNS Number Mutually Defined	
	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 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					00410X098A1	NEHEN Guide includes all 837 P Addenda changes published through October 2002	
ST	Transaction set header		R	1				
62	ST01 - Transaction set id code		R			837		
	ST02 - Transaction Set control number		R				HPHC and NHP: File is rejected by 997 if any ST02 does not match its SE02. Assigned by submitter	
BHT	Beginning of Hierarchical Transaction		R	1				
63	BHT01 - Hierarchical Structure Code		R			0019		
	BHT02 - Transaction Set Purpose Code		R			00	NEHEN Payers treat all submission as Original (00) even if 18 is specified.	
	BHT03 - Reference ID		R				Assigned by sender.	
	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, it is treated as though CH	
REF	Transmission Type ID		R	1				
66	REF01 - Reference ID Qualifier		R			87		
	REF02 - Reference ID		R			004010X098A1		
	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				

CH. 6 NEHEN 837 Professional Claim Submission Specification

Seg	Segment	Loop ID	Seg Req	Max use	HCFA Form (Box)	NEHEN Recommended Values	NEHEN Notes	FAQ
ID	Description	ID	Req	use				
67	NM101 - Entity ID Code		R			41		
	NM102 - Entity Type Qualifier		R			1 2		
	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	ETIN	
	NM109 - ID Code		R				THP will work with trading partners prior to implementation to determine the six-digit submitter code.	
PER	Submitter EDI Contact Information	1000A	R	2			Loop is required but not processed by NEHEN Payers	
71	PER01 - Contact Function Code		R					
	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				
74	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				
77	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				
79	PRV01 - Provider Code		R			BI/PT	Refer to Companion Guide Provider Number Description	
	PRV02 - Reference ID Qualifier		R			ZZ	Ignored by NEHEN Payers	
	PRV03 - Taxonomy Code		R				Ignored by NEHEN Payers	
CUR	Foreign Currency info	2000A	S	1			If present, must be syntactically correct but not processed by NEHEN Payers	
81	CUR01 - Entity ID Code		R					
	CUR02 - Currency Code		R					
	LOOP 2010AA BILLING PROVIDER NAME			1				
NM1	Billing Provider Name	2010AA	R	1				
84	NM101 - Entity ID Code		R			85	THP uses this information for the Billing Provider. If loop 2010AB is not present, THP uses this information for the Payee as well as for the Billing Provider. If neither Loop 2310B nor Loop 2010AB is present, THP uses this information for the Rendering Provider, Payee and Billing Provider.	
	NM102 - Entity Type Qualifier		R			1 or 2		
	NM103 - Name Last or Organization Name		R			33		
	NM104 - Name First		S			33		
	NM105 - Name Middle		S			33		
	NM107 - Name Suffix		S			33		
	NM108 - ID Code Qualifier		R			XX	NEHEN Providers require XX - NPI to be submitted after May 23, 2007	
	NM109 - ID Code		R			33a	10-digit National Provider ID (NPI)	

CH. 6 NEHEN 837 Professional Claim Submission Specification

Seg	Segment	Loop	Seg	Max	HCFA Form	NEHEN		FAQ
ID	Description	ID	Req	use	(Box)	Recommended	NEHEN Notes	
						Values		
N3	Billing Provider Address	2010AA	R	1				
88	N301 - Address Information		R		33		Informational only; HPHC will use provider demographics that are stored in HPHC systems	
	N302 - Address Information		S		33		If present, must be syntactically correct but not processed by HPHC If present Tufts HP will use for processing	
N4	Billing Provider City/State/ZIP Code	2010AA	R	1				
89	N401 - City Name		R		33		Informational Only	
	N402 - State or Province Code		R		33		Informational Only	
	N403 - Postal Code		R		33		Informational Only	
	N404 - Country Code		S		33		If present, must be syntactically correct but not processed by HPHC	
REF	Billing Provider Secondary ID	2010AA	S	8				
91	REF01 - Reference ID Qualifier		R		33b, pos 1-2	EI/SY LU	Refer to provider number section of companion Guide. Either the Employee Identification Number (EI) or Social Security Number (SY) must be sent. THP: If you currently use a THP Legacy ID containing an address suffix you will need to create an additional REF segment containing the Location Code (LU).	
	REF02 - Reference ID		R		33b, pos 3+	Tax ID or SSN Location Code	This number (SSN or TIN) must be the same as it appears on the Provider's 1099 Tax Form. THP: If using a secondary address the suffix must be entered. (Location Code)	
REF	Credit/Debit Billing Information	2010AA	S	8			If present, must be syntactically correct but not processed by NEHEN Payers	
94	REF01 - Reference ID Qualifier		R					
	REF02 - Reference ID		R					
PER	Billing Provider Contact Information	2010AA	S	2				
96	PER01 - Contact Function Code		R					
	PER02 - Name		R					
	PER03 - Communication Number Qualifier		R			TE	Informational Only - NEHEN Payers treat 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	
	LOOP 2010AB PAY-TO PROVIDER NAME			1				
NM1	Pay-To Provider Name	2010AB	S	1			THP uses this as the Payee. If Loop 2310B is not present, Tufts HP uses this information for the Rendering as well as the Payee.	
99	NM101 - Entity ID Code		R			87		
	NM102 - Entity Type Qualifier		R			1	HPHC treats all as Non-Person	
	NM103 - Name Last/Org Name		R			2	Provider Last Name or Organization	
	NM104 - Name First		S				If submitted Tufts HP will use for processing	
	NM105 - Name Middle		S				If submitted Tufts HP will use for processing	
	NM107 - Name Suffix		S				If present, must be syntactically correct but not processed by HPHC If submitted Tufts HP and NHP will use for processing	
	NM108 - ID Code Qualifier		R			XX	NEHEN Payers will require XX - NPI to be submitted	
	NM109 - ID Code		R				10-digit National Provider ID (NPI)	
N3	Pay-To Provider address	2010AB	R	1				
103	N301 - Address info		R			address 1	Informational only	
	N302 - Address info		S				If present, must be syntactically correct, but not processed by NEHEN Payers	

CH. 6 NEHEN 837 Professional Claim Submission Specification

Seg	Segment	Loop ID	Seg Req	Max use	HCFA Form (Box)	NEHEN Recommended Values	NEHEN Notes	FAQ
N4	Pay-To Provider City/State/ZIP Code	2010AB	R	1				
104	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 by NEHEN Payers	
REF	Pay-To Provider Secondary ID	2010AB	S	5				
106	REF01 - Reference ID Qualifier		R			EI/SY/LU	Refer to Provider Number section of companion Guide. Either the Employee Identification Number (EI) or Social Security Number (SY) must be submitted. THP: If you currently use a THP Legacy ID containing an address suffix you will need to create an additional REF segment containing the Location Code (LU).	
	REF02 - Reference ID		R				Tax ID, SSN, or Location Code (address suffix)	
	LOOP 2000B SUBSCRIBER HIERARCHICAL LEVEL			>1				
HL	Subscriber Hierarchical Level	2000B	R	1				
108	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				
110	SBR01 - Payer Resp Seq No Code		R			P	HPHC will treat all valid values as F	
	SBR02 - Individual Relationship Code		S	6			18 Used if Subscriber is the Patient	
	SBR03 - Reference ID		S	11		Policy number Group number	Refer to HPHC Companion Guide - Member Validation section	
	SBR04 - Name		S	11C		Plan Name	Informational Only	
	SBR05 - Insurance Type Code		S				Informational Only	
	SBR09 - Claim Files Indicator Code		S	1			Informational Only - Type of claim(such as HMO)	
PAT	Patient Information	2000B	S	1				
114	PAT05 - Date Time Period Format Qualifier		S				If present, must be syntactically correct but not processed by HPHC	
	PAT06 - Date Time Period		S					
	PAT07 - Unit/Basis for Measurement code		S					
	PAT08 - Weight		S					
	PAT09 - Yes/No Condition or Response Code		S					
	LOOP 2010BA SUBSCRIBER NAME			1				
NM1	Subscriber Name	2010BA	R	1				
117	NM101 - Entity ID Code		R			IL		
	NM102 - Entity Type Qualifier		R				1 Payers assume 1 (Person)	
	NM103 - Name Last/Org Name		R	4 (& 2 if pat)			Person's Last Name	
	NM104 - Name First		S	4 (& 2 if pat)			If submitted Tufts HP will use for processing	
	NM105 - Name Middle		S	4 (& 2 if pat)			If submitted Tufts HP will use for processing	
	NM107 - Name Suffix		S				If present, must be syntactically correct, but not processed by HPHC If submitted Tufts HP will use for processing	
	NM108 - ID Code Qualifier		S			MI	NEHEN Payers assumes the Payer-assigned member id follows regardless of submitted value	
	NM109 - ID Code		S	1a		Member or Subscriber ID	Payer assigned Member ID Refer to HPHC Companion Guide - Member Validation section	
N3	Subscriber Address	2010BA	S	1				
121	N301 - Address Information		R	7 (& 5 if pat)		address 1	Informational Only	
	N302 - Address Information		S	7 (& 5 if pat)		addr2		
N4	Subscriber City/State/ZIP Code	2010BA	S	1				
122	N401 - City Name		R	7 (& 5 if pat)		city	Informational Only	
	N402 - State/Prov Code		R	7 (& 5 if pat)		state	Informational Only	
	N403 - Postal Code		R	7 (& 5 if pat)		zip	Informational Only	

CH. 6 NEHEN 837 Professional Claim Submission Specification

Seg	Segment	Loop	Seg	Max	HCFA Form	NEHEN	NEHEN Notes	FAQ
ID	Description	ID	Req	use	(Box)	Recommended Values		
	N404 - Country Code		S					
						7 (& 5 if pat)		
DMG	Subscriber Demographic Information	2010BA	S	1				
124	DMG01 - Date Time Format Qualifier		R			D8		
	DMG02 - Date Time Period		R		11A	CCYYMMDD	Date of Birth of Subscriber	
	DMG03 - Gender Code		R		11A	M/F/U		
REF	Subscriber Secondary id	2010BA	S	4			The member id should be sent in NM109. This is used only if 2010CA-NM109 is absent	
126	REF01 - Reference ID Qualifier		R					
	REF02 - Reference ID		R					
REF	Property and Casualty Claim Number	2010BA	S	1			If present, must be syntactically correct but not processed	
128	REF01 - Reference ID Qualifier		R					
	REF02 - Reference ID		R					
	LOOP 2010BB PAYER NAME			1				
NM1	Payer Name	2010BB	R	1				
130	NM101 - Entity ID Code		R			PR		
	NM102 - Entity Type Qualifier		R				2	
	NM103 - Name Last/Org Name		R			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	2010BB	S	1			If present, must be syntactically correct, but not processed	
134	N301 - Address Information		R					
	N302 - Address Information		S					
N4	Payer City/State/ZIP Code	2010BB	S	1			If present, must be syntactically correct, but not processed	
135	N401 - City Name		R					
	N402 - State/Prov Code		R					
	N403 - Postal Code		R					
	N404 - Country Code		S					
REF	Payer Secondary ID	2010BB	S	3			If present, must be syntactically correct, but not processed	
137	REF01 - Reference ID Qualifier		R					
	REF02 - Reference ID		R					
	LOOP 2010BC RESPONSIBLE PARTY NAME							
NM1	Responsible Party Name	2010BC	S	1			If present, must be syntactically correct, but not processed	
139	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	2010BC	R	1			If present, must be syntactically correct, but not processed	
143	N301 - Address Information		R					
	N302 - Address Information		S					
N4	Responsible Party City/State/ZIP Code	2010BC	R	1			If present, must be syntactically correct, but not processed	
144	N401 - City Name		R					
	N402 - State/Prov Code		R					
	N403 - Postal Code		R					

CH. 6 NEHEN 837 Professional Claim Submission Specification

Seg	Segment	Loop ID	Seg Req	Max use	HCFA Form (Box)	NEHEN Recommended Values	NEHEN Notes	FAQ
	ID Description	ID	Req	use				
	N404 - Country Code		S					
	LOOP 2010BD CREDIT/DEBIT CARD ACCT HOLDER NAME				1			
NM1	Credit/Debit Card Account Holder Name	2010BD	S	1			If present, must be syntactically correct, but not processed	
146	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	2010BD	S	2			If present, must be syntactically correct, but not processed	
150	REF01 - Reference ID Qualifier		R					
	REF02 - Reference ID		R					
	LOOP 2000C PATIENT HIERARCHICAL LEVEL				>1			
HL	Patient Hierarchical Level	2000C	S	1			Only sent if Patient is not the Subscriber.	
152	HL01 - Hierarchical ID Number		R				Generated by sender	
	HL02 - Hierarchical Parent ID Number		R				Generated by sender	
	HL03 - Hierarchical Level code		R			23		
	HL04 - Hierarchical Child Code		R			0	Patient is not the subscriber	
PAT	Patient Information	2000C	R	1				
154	PAT01 - Individual Relationship Code		R	6			If relationship is not known then specify 21. HPHC does not utilize in its claims processing.	
	PAT07 - Unit/Basis for Measurement code		S				If present, must be syntactically correct but not processed by HPHC	
	PAT08 - Weight		S				If present, must be syntactically correct but not processed by HPHC	
	PAT09 - Yes/No Condition or Response Code		S				If present, must be syntactically correct but not processed by HPHC	
	LOOP 2010CA PATIENT NAME				1			
NM1	Patient Name	2010CA	R	1				
157	NM101 - Entity ID Code		R			QC		
	NM102 - Entity Type Qualifier		R			1	Person	
	NM103 - Name Last/Org Name		R	2			Patient Last Name	
	NM104 - Name First		R	2			Patient First Name	
	NM105 - Name Middle		S	2			If submitted Tufts HP will use for processing	
	NM107 - Name Suffix		S				If submitted Tufts HP will use for processing	
	NM108 - ID Code Qualifier		S			MI	IF ZZ is sent, Payers will treat it as though M	
	NM109 - ID Code		S	1a		Payer Assigned Member or Subscriber ID	This is the complete member id. Not just the contract (include suffix). HPHC and THP, however, will continue to calculate the suffix from the contract part of the ID. Refer to HPHC Companion Guide - Member Validation section	
N3	Patient Address	2010CA	R	1				
161	N301 - Address Information		R	5		addr1		
	N302 - Address Information		S	5		addr2		
N4	Patient City/State/ZIP Code	2010CA	R	1				
162	N401 - City Name		R	5		city		
	N402 - State/Prov Code		R	5		state		
	N403 - Postal Code		R	5		zip		
	N404 - Country Code		S	5			If present, must be syntactically correct but not processed	
DMG	Patient Demographic Information	2010CA	R	1				
164	DMG01 - Date Time Format Qualifier		R			D8		
	DMG02 - Date Time Period		R	3		CCYYMMDD	Patient Date of Birth	
	DMG03 - Gender Code		R	3		M/F/U		
REF	Patient Secondary ID Number	2010CA	S	5			The Payer member id should be sent in 2010CA-NM109.	
166	REF01 - Reference ID Qualifier		R					
	REF02 - Reference ID		R					

CH. 6 NEHEN 837 Professional Claim Submission Specification

Seg	Segment	Loop	Seg	Max	HCFA Form	NEHEN	NEHEN Notes	FAQ
ID	Description	ID	Req	use	(Box)	Recommended Values		
REF	Property and Casualty Claim Number	2010CA	S	1			If present, must be syntactically correct but not processed	
168	REF01 - Reference ID Qualifier		R					
	REF02 - Reference ID		R					
	LOOP 2300 CLAIM INFORMATION			100				
CLM	Claim Information	2300	R	1				
170	CLM01 - Claim Submitter's Identifier		R	26			Patient Control Number. 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	28			Total Claim Charged Amount. Decimal point is expected Ten Dollars and one cent is 10.01	
	CLM05 - 1 - Facility Code Value		R				Place of Service Code	
	CLM05 - 3 - Claim Frequency Type Code		R					
	CLM06 - Yes/No Condition or Response Code		R	31				
	CLM07 - Provider Accept Assignment Code		S	27				
	CLM08 - Yes/No Condition or Response Code		R					
	CLM09 - Release of Information Code		R					
	CLM10 - Patient Signature Source Code		S					
	CLM11 - Related Causes Code		S					
	CLM11 - 1 - Related-Causes Code		R	10 a-c				
	CLM11 - 2 - Related-Causes Code		S	10 a-c				
	CLM11 - 3 - Related-Causes Code		S	10 a-c				
	CLM11 - 4 - State or Province Code		S	10-Place				
	CLM11 - 5 - Country Code		S				If present, must be syntactically correct, but not processed by HPHC	
	CLM12 - Special Program Code		S					
	CLM16 - Provider Agreement Code							
	CLM20 - Delay Reason Code		S					
DTP	Date - Initial Treatment	2300	S	1				
182	DTP01 - Date/Time Qualifier		R			454		
	DTP02 - Date Time Period Format Qualifier		R			D8		
	DTP03 - Date Time Period		R					
DTP	Date - Date Last Seen	2300	S	1				
186	DTP01 - Date/Time Qualifier		R			304		
	DTP02 - Date Time Period Format Qualifier		R			D8		
	DTP03 - Date Time Period		R					
DTP	Date - Onset of Current Illness/Symptom	2300	S	1				
188	DTP01 - Date/Time Qualifier		R			431		
	DTP02 - Date Time Period Format Qualifier		R			D8		
	DTP03 - Date Time Period		R	14				
DTP	Date - Acute Manifestation	2300	S	5				
190	DTP01 - Date/Time Qualifier		R			453		
	DTP02 - Date Time Period Format Qualifier		R			D8		
	DTP03 - Date Time Period		R					
DTP	Date - Similar Illness/Symptom Onset	2300	S	10				
192	DTP01 - Date/Time Qualifier		R			438		
	DTP02 - Date Time Period Format Qualifier		R			D8		
	DTP03 - Date Time Period		R	15				
DTP	Date - Accident	2300	S	10				
194	DTP01 - Date/Time Qualifier		R			439		
	DTP02 - Date Time Period Format Qualifier		R			D8/DT		
	DTP03 - Date Time Period		R	14			If D8 the CCYYMMDD. If DT then CCYYMMDDHHMM	
DTP	Date - Last Menstrual Period	2300	R	1				
196	DTP01 - Date/Time Qualifier		R			484		
	DTP02 - Date Time Period Format Qualifier		R	14		D8		
	DTP03 - Date Time Period		R					

CH. 6 NEHEN 837 Professional Claim Submission Specification

Seg	Segment	Loop	Seg	Max	HCFA Form (Box)	NEHEN Recommended Values	NEHEN Notes	FAQ
ID	Description	ID	Req	use				
DTP	Date - Last X-Ray	2300	S	1			If present, must be syntactically correct but not processed by payers	
197	DTP01 - Date/Time Qualifier		R					
	DTP02 - Date Time Period Format Qualifier		R					
	DTP03 - Date Time Period		R					
DTP	Date - Hearing and Vision Prescription	2300	S	1			If present, must be syntactically correct but not processed by payers	
200	DTP01 - Date/Time Qualifier		R					
	DTP02 - Date Time Period Format Qualifier		R					
	DTP03 - Date Time Period		R					
DTP	Date - Disability Begin	2300	S	5				
201	DTP01 - Date/Time Qualifier		R			360		
	DTP02 - Date Time Period Format Qualifier		R			D8		
	DTP03 - Date Time Period		R					
					16			
DTP	Date - Disability End	2300	S	5				
203	DTP01 - Date/Time Qualifier		R			361		
	DTP02 - Date Time Period Format Qualifier		R			D8		
	DTP03 - Date Time Period		R		16			
DTP	Date - Last Worked	2300	S	1				
205	DTP01 - Date/Time Qualifier		R			297		
	DTP02 - Date Time Period Format Qualifier		R			D8		
	DTP03 - Date Time Period		R					
DTP	Date - Authorized Return to Work	2300	S	1				
206	DTP01 - Date/Time Qualifier		R			296		
	DTP02 - Date Time Period Format Qualifier		R			D8		
	DTP03 - Date Time Period		R					
DTP	Date - Admission	2300	S	1				
208	DTP01 - Date/Time Qualifier		R			435		
	DTP02 - Date Time Period Format Qualifier		R			D8		
	DTP03 - Date Time Period		R		18			
DTP	Date - Discharge	2300	R	1				
210	DTP01 - Date/Time Qualifier		R			096		
	DTP02 - Date Time Period Format Qualifier		R			D8		
	DTP03 - Date Time Period		R		18			
DTP	Date - Assumed and Relinquished Care Dates	2300	S	2			If present, must be syntactically correct but not processed by Payers	
212	DTP01 - Date/Time Qualifier		R					
	DTP02 - Date Time Period Format Qualifier		R					
	DTP03 - Date Time Period		R					
PWK	Claim Supplemental Information	2300	S	10			If present, must be syntactically correct but not processed by HPHC and THP. If Submitted will be used by NHP for processing	
214	PWK01 - Report Type Code		R					
	PWK02 - Report Transmission Code		R					
	PWK05 - ID Code Qualifier		S					
	PWK06 - ID Code		S					
CN1	Contract Information	2300	S	1			If present, must be syntactically correct but not processed by Payers	
217	CN101 - Contract Type Code		R					
	CN102 - Monetary Amount		S					
	CN103 - Percent		S					
	CN104 - Reference ID		S					
	CN105 - Terms Discount Percent		S					
	CN106 - Version Identifier		S					
AMT	Credit/Debit Card Maximum Amount	2300	S	1			If present, must be syntactically correct but not processed by Payers	
219	AMT01 - Amount Qualifier Code		R					
	AMT02 - Monetary Amount		R					
AMT	Patient Amount Paid	2300	S	1				
220	AMT01 - Amount Qualifier Code		R			F5		

CH. 6 NEHEN 837 Professional Claim Submission Specification

Seg	Segment	Loop	Seg	Max	HCFA Form	NEHEN	NEHEN Notes	FAQ
ID	Description	ID	Req	use	(Box)	Recommended Values		
	AMT02 - Monetary Amount		R		29		Include decimal point. Ten dollars an one cent is 10.01	
AMT	Total Purchased Service Amount	2300	S	1			If present, must be syntactically correct but not processed by Payers	
221	AMT01 - Amount Qualifier Code		R					
	AMT02 - Monetary Amount		R					
REF	Service Authorization Exception Code	2300	S	1			If present, must be syntactically correct but not processed by Payers	
222	REF01 - Reference ID Qualifier		R					
	REF02 - Reference ID		R					
REF	Mandatory Medicare(Section 4081) Crossover Indicator	2300	S	1			If present, must be syntactically correct but not processed by Payers	
224	REF01 - Reference ID Qualifier		R					
	REF02 - Reference ID		R					
REF	Mammography Certification Number	2300	S	1			If present, must be syntactically correct but not processed by Payers	
226	REF01 - Reference ID Qualifier		R					
	REF02 - Reference ID		R					
REF	Prior Authorization or Referral Number	2300	S	2			Used if applies to entire claim.	
227	REF01 - Reference ID Qualifier		R			9F or G1	9F if Referral/G1 if Auth	
	REF02 - Reference ID		R		23		Payer assigned Referral or Auth Number	
REF	Original reference Number (ICN/DCN)	2300	S	1			If present, must be syntactically correct but not processed by HPHC. THP will use for processing if submitted	
229	REF01 - Reference ID Qualifier		R			F8		
	REF02 - Reference ID		R					
REF	Clinical Laboratory Improvement Amendment(CLIA) Number	2300	S	3			If present, must be syntactically correct but not processed by Payers	
231	REF01 - Reference ID Qualifier		R					
	REF02 - Reference ID		R					
REF	Repriced Claim Number	2300	S	1			If present, must be syntactically correct but not processed by Payers	
233	REF01 - Reference ID Qualifier		R					
	REF02 - Reference ID		R					
REF	Adjusted Repriced Claim Number	2300	S	1			If present, must be syntactically correct but not processed by Payers	
235	REF01 - Reference ID Qualifier		R					
	REF02 - Reference ID		R					
REF	Investigation Device Exemption Number	2300	S	1			If present, must be syntactically correct but not processed by Payers	
236	REF01 - Reference ID Qualifier		R					
	REF02 - Reference ID		R					
REF	Claim Identification Number for Clearing Houses and Other Transmission Intermediaries	2300	S	1			This is not a required field but NEHEN Payers strongly recommends its use. Refer to the Companion Guide.	Y
238	REF01 - Reference ID Qualifier		R			D9		
	REF02 - Reference ID		R			Submitter claim id	Trading Partner Claim ID	
REF	Amubaltory Patient Group (AGP)	2300	S	1			If present, must be syntactically correct but not processed by Payers	
240	REF01 - Reference ID Qualifier		R			1S		
	REF02 - Reference ID		R					
REF	Medical Record Number	2300	S	1				
241	REF01 - Reference ID Qualifier		R			EA		
	REF02 - Reference ID		R				Generated by Submitter	
REF	Demonstration Project Identifier	2300	S	1			If present, must be syntactically correct but not processed by Payers	
242	REF01 - Reference ID Qualifier		R					
	REF02 - Reference ID		R					

CH. 6 NEHEN 837 Professional Claim Submission Specification

Seg	Segment	Loop	Seg	Max	HCFA Form	NEHEN		
ID	Description	ID	Req	use	(Box)	Recommended	NEHEN Notes	FAQ
						Values		
K3	File Information	2300	S	10			If present, must be syntactically correct but not processed by Payers	
244	K301 - Fixed Format Information		R					
NTE	Claim Note	2300	S	1			NEHEN Payers do not does not pass Claim Note information to its Adjudication System	
246	NTE01 - Note Reference Code		R					
	NTE02 - Description		R			Note		
CR1	Ambulance Transport Information	2300	S	1			If present, must be syntactically correct but not processed by Payers	
248	CR101 - Unit/Basis for Measurement Code		S					
	CR102 - Weight		S					
	CR103 - Ambulance Transport Code		R					
	CR104 - Ambulance Transport Code		R					
	CR105 - Unit/Basis for Measurement Code		R					
	CR106 - Quantity		R					
	CR109 - Description		S					
	CR110 - Description		S					
CR2	Spinal Manipulation Service Information	2300	S	1			If present, must be syntactically correct but not processed by Payers	
251	CR208 - Nature of Condition Code		R					
	CR210 - Description		S					
	CR211 - Description		S					
	CR212 - Yes/No Condition or Response Code		S					
CRC	Ambulance Certification	2300	S	3			If present, must be syntactically correct but not processed by Payers	
257	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	Patient Condition Information: Vision	2300	S	3			If present, must be syntactically correct but not processed by Payers	
260	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	Homebound Indicator	2300	S	1			If present, must be syntactically correct but not processed by Payers	
263	CRC01 - Code Category		R					
	CRC02 - Yes/No Condition or Response Code		R					
	CRC03 - Condition Indicator		R					
CRC	Patient Condition Information: EPSTD Referral	2300	S	3			If present, must be syntactically correct but not processed by Payers	
260	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		N					
	CRC07 - Condition Indicator		N					
HI	Health Care Diagnosis Code	2300	S	1				
265	HI01 - Health Care Code Information		R					
	HI01 - 1 - Code List Qualifier Code		R			BK	Principal Diagnosis	
	HI01 - 2 - Industry Code		R		21-1		ICD-9 Code	

CH. 6 NEHEN 837 Professional Claim Submission Specification

Seg	Segment	Loop	Seg	Max	HCFA Form (Box)	NEHEN Recommended Values	NEHEN Notes	FAQ
ID	Description	ID	Req	use				
	HI02 - Health Care Code Information		S					
	HI02 - 1 - Code List Qualifier Code		R			BF	Additional Diagnosis	
	HI02 - 2 - Industry Code		R		21-2		ICD-9 Code	
	HI03 - Health Care Code Information		S					
	HI03 - 1 - Code List Qualifier Code		R			BF	Additional Diagnosis	
	HI03 - 2 - Industry Code		R		21-3		ICD-9 Code	
	HI04 - Health Care Code Information		S					
	HI04 - 1 - Code List Qualifier Code		R			BF	Additional Diagnosis	
	HI04 - 2 - Industry Code		R		21-4		ICD-9 Code	
	HI05 - Health Care Code Information		S					
	HI05 - 1 - Code List Qualifier Code		R			BF	Additional Diagnosis	
	HI05 - 2 - Industry Code		R				ICD-9 Code	
	HI06 - Health Care Code Information		S					
	HI06 - 1 - Code List Qualifier Code		R			BF	Additional Diagnosis	
	HI06 - 2 - Industry Code		R				ICD-9 Code	
	HI07 - Health Care Code Information		S					
	HI07 - 1 - Code List Qualifier Code		R			BF	Additional Diagnosis	
	HI07 - 2 - Industry Code		R				ICD-9 Code	
	HI08 - Health Care Code Information		S					
	HI08 - 1 - Code List Qualifier Code		R			BF	Additional Diagnosis	
	HI08 - 2 - Industry Code		R				ICD-9 Code	
	HCP Claim Pricing/Repricing Information		S	1			If present, must be syntactically correct but not processed	
271								
	LOOP 2305 HOME HEALTH CARE PLAN INFORMATION		S	1			Per Implementation Guide, required for Home Health Claims and Encounters, but not processed by Payers	
	CR7 Home Health Care Plan Information	2305	S	1			If present, must be syntactically correct but not processed by Payers	
276	CR701 - Discipline Type code		R					
	CR702 - Number		R					
	CR703 - Number		R					
	HSD Health Care Services Delivery	2305	S	3			If present, must be syntactically correct but not processed by Payers	
278	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 REFERRING PROVIDER NAME			2				
	NM1 Referring Provider Name	2310A	S	2			Refer to Companion Guide.	
282	NM101 - Entity Identifier Code		R			DN		
	NM102 - Entity Type Qualifier		R			1 / 2		
	NM103 - Name Last or Qualifier Name		R		17		Provider Last Name or Organization	
	NM104 - Name First		S		17		Provider First Name	
	NM105 - Name Middle		S		17		Provider Middle Name	
	NM107 - Name Suffix		S					
	NM108 - Identification Code Qualifier		S			XX	HPhC will assume XX - National Provider IC	
	NM109 - Identification Code		S		17b		National Provider ID - NPI	
	PRV Referring Provider Specialty Information	2310A	S	1			If present, must be syntactically correct, but not processed by NEHEN Payers	
285	PRV01 - Provider Code		R					
	PRV02 - Reference Identification Qualifier		R					
	PRV03 - Reference Identifier		R				Provider Taxonomy Code	
	REF Referring Provider Secondary Identification	2310A	S	5				
288	REF01 - Reference Identification Qualifier		R			EI	Refer to Provider Number section of companion Guide. Payers expect to receive EI to indicate Provider's Tax ID	

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Seg	Segment	Loop	Seg	Max	HCFA Form	NEHEN	NEHEN Notes	FAQ
ID	Description	ID	Req	use	(Box)	Recommended Values		
	REF02 - Reference Identification		R				Provider's Tax ID	
	LOOP 2310B RENDERING PROVIDER NAME			1				
NM1	Rendering Provider Name	2310B	S	1			Refer to Provider Number Section of Companion Guide	
290	NM101 - Entity Identifier Code		R			82	Rendering Provider	
	NM102 - Entity Type Qualifier		R			1 or 2		
	NM103 - Name Last or Organization Name		R				Provider Last Name or Organization Name	
	NM104 - Name First		S					
	NM105 - Name Middle		S					
	NM107 - Name Suffix		S				If present, must be syntactically correct, but not processed	
	NM108 - Identification Code Qualifier		R		24I	XX	NEHEN Payers will assume value XX - National Provider ID (NPI)	
	NM109 - Identification Code		R		24J		National Provider ID (NPI)	
PRV	Rendering Provider Specially Information	2310B	S	1			If present, must be syntactically correct, but not processed	
293	PRV01 - Provider Code		R			PE	Performing	
	PRV02 - Reference Identification Qualifier		R			ZZ		
	PRV03 - Reference identifier		R				Taxonomy Code	
REF	Rendering Provider Secondary Identification	2310B	S	5				
							Refer to Provider Number section of companion Guide. THP: Either the Employee Identification Number (EI) or Social Security Number (SY) is required. HPHC: expects to receive the Employee Identification Number (EI)	
296	REF01 - Reference Identification Qualifier		R		24I	EI/SY		
	REF02 - Reference Identification		R		24J		EIN/Tax ID or SSN	
	LOOP 2310C PURCHASED SERVICE PROVIDER			1				
NM1	Purchased Service Provider Name	2310C	S	1			If present, must be syntactically correct, but not processed by Payers	
298	NM101 - Entity Identifier Code		R					
	NM102 - Entity Type Qualifier		R					
	NM108 - Identification Code Qualifier		S					
	NM109 - Identification Code		S					
REF	Purchased Service Provider Secondary Identification	2310C	S	5			If present, must be syntactically correct, but not processed by Payers	
301	REF01 - Reference Identification Qualifier		R					
	REF02 - Reference Identification		R					
	NM103 - Name Last or Organization Name		R		32			
	NM104 - Name First		S					
	NM105 - Name Middle		S					
	LOOP 2310D SERVICE FACILITY LOCATION			1				
NM1	Service Facility Location	2310D	S	1				
303	NM101 - Entity Identifier Code		R			77/FA/LI/TL		
	NM102 - Entity Type Qualifier		R			2	Non-Person	
	NM103 - Name Last or Organization Name		S		32		Lab/Facility Name	
	NM108 - Identification Code Qualifier		S				If present, must be XX - National Provider Identifier, but not processed by Payers.	
	NM109 - Identification Code		S		32a		National Provider Identifier (NPI)	
N3	Service Facility Location Address	2310D	R	1				
307	N301 - Address Information		R		32			
	N302 - Address Information		S				If present, must be syntactically correct, but not processed.	
N4	Service Facility Location City/State/ZIP	2310D	R	1				
308	N401 - City Name		R		32			
	N402 - State or Province Code		R		32			
	N403 - Postal Code		R		32			

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Seg	Segment	Loop	Seg	Max	HCFA Form (Box)	NEHEN Recommended Values	NEHEN Notes	FAQ
ID	Description	ID	Req	use				
	N404 - Country Code		S					
	Service Facility Location Secondary Identification	2310D	S	5			If present, must be syntactically correct, but not processed by NEHEN Payers.	
310	REF01 - Reference Identification Qualifier		R		32b	TJ	If present, must be syntactically correct, but not processed by NEHEN Payers. TJ - Provider's Tax ID	
	REF02 - Reference Identification		R		32b		Provider's Tax ID	
	LOOP 2310E SUPERVISING PROVIDER NAME			5				
NM1	Supervising Provider Name	2310E	S	1			If present, must be syntactically correct, but not processed by NEHEN Payers.	
312	NM101 - Entity Identifier Code		R				Supervising	
	NM102 - Entity Type Qualifier		R					
	NM103 - Name Last or Organization Name		R				Last Name/Organization	
	NM104 - Name First		R					
	NM105 - Name Middle		R					
	NM107 - Name Suffix		S					
	NM108 - Identification Code Qualifier		S				If present, must be syntactically correct, but not processed by NEHEN Payer.	
	NM109 - Identification Code		S				Supervising Provider NPI	
	Supervising Provider Secondary Identification	2310E	S	5			If present, must be syntactically correct, but not processed by NEHEN Payers.	
316	REF01 - Reference Identification Qualifier		R				If present, must be syntactically correct, but not processed by NEHEN Payers.	
	REF02 - Reference Identifier		R				Tax ID or SSN	
	LOOP 2320 OTHER SUBSCRIBER INFORMATION			10			Only First loop is processed if it is NOT primary Subscriber	
SBR	Other Subscriber Information	2320	S	1				
318	SBR01 - Payer Responsibility Sequence Number Code		R			S/T	If P (primary) then ignored.	
	SBR02 - Individual Relationship Code		R				If unknown, use 21	
	SBR03 - Reference Identifier		S		9a		Policy Number	
	SBR04 - Name		S		9d		Group Name	
	SBR05 - Insurance Type Code		R					
	SBR09 - Claim Filing Indicator Code		S					
	CAS Claim Level Adjustment	2320	S	5			If present, must be syntactically correct, but not processed by HPHC If submitted Tufts HP and NHP will use for processing	
323	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					
	Coordination of Benefits(COB) Payer Paid Amount	2320	S	1			If present, must be syntactically correct, but not processed by HPHC If submitted Tufts HP will use for processing	
332	AMT01 - Amount Qualifier Code		R			D		
	AMT02 - Monetary Amount		R					
	Coordination of Benefits(COB) Approved Amount	2320	S	1			If present, must be syntactically correct, but not processed by HPHC If submitted Tufts HP will use for processing	
333	AMT01 - Amount Qualifier Code		R			AAE		

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Seg	Segment	Loop	Seg	Max	HCFA Form (Box)	NEHEN Recommended Values	NEHEN Notes	FAQ
ID	Description	ID	Req	use				
	AMT02 - Monetary Amount		R					
AMT	Coordination of Benefits(COB) Allowed Amount	2320	S	1			If present, must be syntactically correct, but not processed by HPHC If submitted Tufts HP will use for processing	
334	AMT01 - Amount Qualifier Code		R			B6		
	AMT02 - Monetary Amount		R					
AMT	Coordination of Benefits(COB) Patient Responsibility Amount	2320	S	1			If present, must be syntactically correct, but not processed by HPHC If submitted Tufts HP will use for processing	
335	AMT01 - Amount Qualifier Code		R			F2		
	AMT02 - Monetary Amount		R					
AMT	Coordination of Benefits(COB) Covered Amount	2320	S	1			If present, must be syntactically correct, but not processed by HPHC If submitted Tufts HP will use for processing	
336	AMT01 - Amount Qualifier Code		R			AU		
	AMT02 - Monetary Amount		R					
AMT	Coordination of Benefits(COB) Discount Amount	2320	S	1			If present, must be syntactically correct, but not processed by HPHC If submitted Tufts HP will use for processing	
337	AMT01 - Amount Qualifier Code		R			D8		
	AMT02 - Monetary Amount		R					
AMT	Coordination of Benefits(COB) Per Day Limit Amount	2320	S	1			If present, must be syntactically correct, but not processed by HPHC If submitted Tufts HP will use for processing	
338	AMT01 - Amount Qualifier Code		R			DY		
	AMT02 - Monetary Amount		R					
AMT	Coordination of Benefits(COB) Patient Paid Amount	2320	S	1			If present, must be syntactically correct, but not processed by HPHC If submitted Tufts HP will use for processing	
339	AMT01 - Amount Qualifier Code		R			F5		
	AMT02 - Monetary Amount		R					
AMT	Coordination of Benefits(COB) Tax Amount	2320	S	1			If present, must be syntactically correct, but not processed by HPHC If submitted Tufts HP will use for processing	
340	AMT01 - Amount Qualifier Code		R			T		
	AMT02 - Monetary Amount		R					
AMT	Coordination of Benefits(COB) Total Claim Before Taxes Amount	2320	S	1			If present, must be syntactically correct, but not processed by HPHC If submitted Tufts HP will use for processing	
341	AMT01 - Amount Qualifier Code		R			T2		
	AMT02 - Monetary Amount		R					
DMG	Subscriber Demographic Information	2320	S	1			Informational Only	
342	DMG01 - Date Time Period Format Qualifier		R			D8		
	DMG02 - Date Time Period		R				Date of Birth - Informational If submitted Tufts HP will use for processing	
	DMG03 - Gender Code		R			F/M/U	Gender - Informational only	
OI	Other Insurance Coverage Information	2320	R	1			Informational Only	
344	OI03 - Yes/No Condition or Response Code		R		11d	Y/N		
	OI04 - Patient Signature source Code		R			B/C/M/P/S		
	OI06 - Release Information Code		R			A/I/M/N/O/P		
MOA	Medicare Outpatient Adjunction Information	2320	S	1			If present, must be syntactically correct, but not processed by HPHC If submitted Tufts HP will use for processing	
347	MOA01 - Percent		S					
	MOA02 - Monetary Amount		S					
	MOA03 - Reference Identification		S					
	MOA04 - Reference Identification		S					
	MOA05 - Reference Identification		S					
	MOA06 - Reference Identification		S					
	MOA07 - Reference Identification		S					
	MOA08 - Monetary Amount		S					
	MOA09 - Monetary Amount		S					

CH. 6 NEHEN 837 Professional Claim Submission Specification

Seg	Segment	Loop ID	Seg Req	Max use	HCFA Form (Box)	NEHEN Recommended Values	NEHEN Notes	FAQ
	LOOP 2330A OTHER SUBSCRIBER NAME			1			Informational	
NM1	Other Subscriber Name	2330A	R	1				
350	NM101 - Entity Identifier Code		R			IL		
	NM102 - Entity Type Qualifier		R			1 or 2		
	NM103 - Name Last or Organization Name		R		9		Last Name	
	NM104 - Name First		R		9		First Name	
	NM105 - Name Middle		R		9		Middle Name	
	NM107 - Name Suffix		S				If present,must be syntactically correct, but not processed by HPHC If submitted Tufts HP will use for processing	
	NM108 - Identification Code Qualifier		R			MI/ZZ		
	NM109 - Identification Code		r		1A		Other Insurance Subscriber Identifier	
N3	Other Subscriber Address	2330A	S	1			Informational Only	
354	N301 - Address Information		S				Address 1	
	N302 - Address Information		R				If present,must be syntactically correct, but not processed by HPHC If submitted Tufts HP will use for processing	
N4	Other Subscriber City/State/ZIP	2330A	S	1			Informational Only	
355	N401 - City Name		R					
	N402 - State or Province Code		S					
	N403 - Postal Code		S					
	N404 - Country Code		S				If present,must be syntactically correct, but not processed by HPHC If submitted Tufts HP will use for processing	
REF	Other Subscriber Secondary Identification	2330A	S	3			If present,must be syntactically correct, but not processed by NEHEN Payers	
357	REF01 - Reference Identification Qualifier		R					
	REF02 - Reference Identification		R					
	LOOP 2330B OTHER PAYER NAME			1			Informational Only	
NM1	Other Payer Name	2330B	R	1				
359	NM101 - Entity Identifier Code		R			PR	Payer	
	NM102 - Entity Type Qualifier		R			2	Non-Person	
	NM103 - Name Last or Organization Name		R					
	NM108 - Identification Code Identifier		R			PI/XV	If present,must be syntactically correct, but not processed	
	NM109 - Identification Code		R					
PER	Other Payer Contact Information	2330B	S	2			If present,must be syntactically correct, but not processed	
363	PER01 - Contact function Code		R					
	PER02 - Name		R					
	PER03 - Communication Number Qualifier		R					
	PER04 - Communication Number		R					
	PER05 - Communication=action Number Qualifier		S					
	PER06 - Communication Number		S					
	PER07 - Communication Number Qualifier		S					
	PER08 - Communication Number		S					
DTP	Claim Adjudication Date	2330B	S	1			If present, must be syntactically correct, but not processed by HPHC If submitted Tufts HP will use for processing	
366	DTP01 - Date/Time Qualifier		R					
	DTP02 - Date Time Period Format Qualifier		R					
	DTP03 - Date Time Period		R					
REF	Other Payer Secondary Identifier	2330B	S	2			Informational Only	
368	REF01 - Reference Identification Qualifier		R			2U/F8/FY/NF		
	REF02 - Reference Identification		R				Other Payer Identifier	
REF	Other Payer Prior Authorization or Referral Number	2330B	S	2			If present, must be syntactically correct, but not processed by HPHC If submitted Tufts HP will use for processing	
370	REF01 - Reference Identification Number		R					
	REF02 - Reference Identification		R					

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Seg	Segment	Loop	Seg	Max	HCFA Form (Box)	NEHEN Recommended Values	NEHEN Notes	FAQ
ID	Description	ID	Req	use				
REF	Other Payer Claim Adjustment Indicator	2330B	S	2			If present, must be syntactically correct, but not processed by HPHC If submitted Tufts HP will use for processing	
372	REF01 - Reference Identification Qualifier		R					
	REF02 - Reference Identification		R					
	LOOP 2330C OTHER PAYER PATIENT INFORMATION							
NM1	Other Payer Patient Information	2330C	S	1			If present, must be syntactically correct, but not processed by HPHC If submitted Tufts HP will use for processing	
374	NM101 - Entity Identifier Code		R			QC	Patient	
	NM102 - Entity Type Qualifier		R			1		
	NM108 - Identification Code Qualifier		R			MI		
	NM109 - Identification Code		R					
REF	Other Payer Patient Identification	2330C	S	3			If present, must be syntactically correct, but not processed by HPHC If submitted Tufts HP will use for processing	
376	REF01 - Reference Identification Qualifier		R					
	REF02 - Reference Identification		R					
	LOOP 2330D OTHER PAYER REFERRING							
NM1	Other Payer Referring Provider	2330D	S	2			If present, must be syntactically correct, but not processed by HPHC If submitted Tufts HP will use for processing	
378	NM101 - Entity Identifier Code		R			DN/P3		
	NM102 - Entity Type Qualifier		R					
REF	Other Payer Referring Provider Secondary Information	2330D	S	3			If present, must be syntactically correct, but not processed by HPHC If submitted Tufts HP will use for processing	
380	REF01 - Reference Identification Qualifier		R					
	REF02 - Reference Identification		R					
	LOOP 2330E OTHER RENDERING PROVIDER							
NM1	Other Payer Rendering Provider	2330E	S	1			If present, must be syntactically correct, but not processed by HPHC If submitted Tufts HP will use for processing	
382	NM101 - Entity Identifier Code		R			82	Rendering Provider	
	NM102 - Entity Type Qualifier		R					
REF	Other Payer Rendering Provider Secondary Information	2330E	R	3			If present, must be syntactically correct, but not processed by HPHC If submitted Tufts HP will use for processing	
384	REF01 - Reference Identification Qualifier		R					
	REF02 - Reference Identification		R					
	LOOP 2330F OTHER PAYER PURCHASED SERVICE PROVIDER							
NM1	Other Payer Purchased Service Provider	2330F	S	1			If present, must be syntactically correct, but not processed by HPHC If submitted Tufts HP will use for processing	
386	NM101 - Entity Identifier Code		R			QB	Purchase Service Provider	
	NM102 - Entity Type Qualifier		R					
REF	Other Payer Purchased Service Provider Identification	2330F	R	3			If present, must be syntactically correct, but not processed by HPHC If submitted Tufts HP will use for processing	
388	REF01 - Reference Identification Qualifier		R					
	REF02 - Reference Identification		R					
	LOOP 2330G OTHER PAYER SERVICE FACILITY LOCATION							
NM1	Other Payer Service Facility Location	2330G	S	1			If present, must be syntactically correct, but not processed by HPHC If submitted Tufts HP will use for processing	
390	NM101 - Entity Identifier Code		R			77/FA/LI/TL		
	NM102 - Entity Type Qualifier		R					
REF	Other Payer Service Facility Location Identification	2330G	R	3			If present, must be syntactically correct, but not processed by HPHC If submitted Tufts HP will use for processing	

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Seg	Segment	Loop	Seg	Max	HCFA Form (Box)	NEHEN Recommended Values	NEHEN Notes	FAQ
ID	Description	ID	Req	use				
392	REF01 - Reference Identification Qualifier		R					
	REF02 - Reference Identification		R					
	LOOP 2330H OTHER PAYER SUPERVISING PROVIDER							
NM1	Other Payer Supervising Provider	2330H	S	1			If present, must be syntactically correct, but not processed by HPHC If submitted Tufts HP will use for processing	
394	NM101 - Entity Identifier Code		R			DQ	Supervising Provider	
	NM102 - Entity Type Qualifier		R					
	Other Payer Supervising Provider Identification	2330H	R	3			If present, must be syntactically correct, but not processed by HPHC If submitted Tufts HP will use for processing	
396	REF01 - Reference Identification Qualifier		R					
	REF02 - Reference Identification		R					
	LOOP 2400 SERVICE LINE							
LX	Service Line	2400	R	1			NEHEN Payers supports 50 lines. Refer to the NEHEN Payers Companion Guide	
398	LX01 - Assigned number		R				Line Counter	
SV1	Professional Service	2400	R	1				
400	SV101 - 1 - Product/Service ID Qualifier		R				Procedure Code Type - Refer to HPHC Companion Guide. HPHC does not accept NDC codes.	
	SV101 - 2 - Product/Service ID		R		24D			
	SV101 - 3 - Procedure Modifier		S		24D		Modifier 1 If submitted Tufts HP will use for processing	
	SV101 - 4 - Procedure Modifier		S		24D		Modifier 2 If submitted Tufts HP will not use for processing	
	SV101 - 5 - Procedure Modifier		S		24D		Modifier 3 If submitted Tufts HP will not use for processing	
	SV101 - 6 - Procedure Modifier		S		24D		Modifier 4 If submitted Tufts HP will not use for processing	
	SV102 - Monetary Amount		R		24F		Service Line Charges	
	SV103 - Unit or Basis Measurement Code		R			F2/MJ/UN		
	SV104 - Quantity		R		24G		Service Units	
	SV105 - Facility Code Value		S		24B		Place of Service If submitted Tufts HP will use for processing	
	SV107 - 1 - Diagnosis Code Pointer		S		24E			
	SV107 - 2 - Diagnosis Code Pointer		S		24E			
	SV107 - 3 - Diagnosis Code Pointer		S		24E			
	SV107 - 4 - Diagnosis Code Pointer		S		24E			
	SV109 - Yes/No Condition or Response Code		S		24C		Emergency Indicator	
	SV111 - Yes/No Condition or Response Code		S		24H		EPSDT Indicator	
	SV112 - Yes/No Condition or Response Code		S		24H		Family Planning Indicator	
	SV115 - Copay Status Code		S				0 - CoPay Exempt	
SV5	Durable Medical Equipment Service	2400	S	1			If Present, must be syntactically correct, but not processed by NEHEN Payers.	
400	SV501 - 1 - Product/Service ID Qualifier		R					
	SV501 - 2 - Product/Service ID		R					
	SV502 - Unit or Basis Measurement Code		R					
	SV503 - Quantity		R					
	SV504 - Monetary Amount		S					
	SV505 - Monetary Amount		S					
	SV506 - Frequency Code		S					
PWK	DMREC CMN Indicator	2400	S	1			If Present, must be syntactically correct, but not processed by NEHEN Payers	
410	PWK01 - Report Type Code		R					
	PWK02 - Report Transmission Code							
CR1	Ambulance Transport Information	2400	S	1			If Present, must be syntactically correct, but not processed by NEHEN Payers	
412	CR101 - Unit/Basis for Measurement Code		S					
	CR102 - Weight		S					
	CR103 - Ambulance Transport Code		R					

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Seg	Segment	Loop	Seg	Max	HCFA Form	NEHEN		
ID	Description	ID	Req	use	(Box)	Recommended	NEHEN Notes	FAQ
						Values		
	CR104 - Ambulance Transport Reason Code		R					
	CR105 - Unit/Basis for Measurement Code		R					
	CR106 - Quantity		R					
	CR109 - Description		S					
	CR110 - Description		S					
CR2	Spinal Manipulation Service Information	2400	S	5			If Present, must be syntactically correct, but not processed by NEHEN Payers	
415	CR201 - Count		N					
	CR202 - Quantity		N					
	CR203 - Subluxation Level Code		N					
	CR204 - Subluxation Level Code		N					
	CR205 - Unit/Basis for Measurement Code		N					
	CR206 - Quantity		N					
	CR207 - Quantity		N					
	CR208 - Nature of Condition Code		R					
	CR209 - Yes/No Condition or Response Code		N					
	CR210 - Description		S					
	CR211 - Description		S					
	CR212 - Yes/No Condition or Response Code		S					
CR3	Durable Medical Equipment Certification	2400	S	1			If Present, must be syntactically correct, but not processed by NEHEN Payers	
421	CR301 - Certification Type Code		R					
	CR302 - Unit/Basis for Measurement Code		R					
	CR303 - Quantity		R					
CR5	Home Oxygen Therapy Information	2400	S	1			If Present, must be syntactically correct, but not processed by NEHEN Payers	
423	CR501 - Certification Type Code		R					
	CR502 - Quantity		R					
	CR510 - Quantity		S					
	CR511 - Quantity		S					
	CR512 - Oxygen Test Condition Code		R					
	CR513 - Oxygen Test Findings Code		S					
	CR514 - Oxygen Test Findings Code		S					
	CR515 - Oxygen Test Findings code		S					
CRC	Ambulance Certification	2400	S	3			If Present, must be syntactically correct, but not processed by NEHEN Payers	
427	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	Hospice Employee Indicator	2400	S	1			If Present, must be syntactically correct, but not processed by NEHEN Payers	
430	CRC01 - Code Category		R					
	CRC02 - Yes/No Condition or Response Code		R					
	CRC03 - Condition Indicator		R					
CRC	DMREC Condition Indicator	2400	S	2			If Present, must be syntactically correct, but not processed by NEHEN Payers	
432	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					
DTP	Date - Service Date	2400	R	1			Service Line Start/End	
435	DTP01 - Date/Time Qualifier		R			472		
	DTP02 - Date Time Period Format Qualifier		R		24A	D8/RD8	Date or Date Range	

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Seg	Segment	Loop	Seg	Max	HCFA Form	NEHEN	NEHEN Notes	FAQ
ID	Description	ID	Req	use	(Box)	Recommended Values		
	DTP03 - Date Time Period		R			CCYYMMDD or if RD8 then CCYYMMDD-CCYYMMDD		
DTP 437	Date - Certification Revision Date DTP01 - Date/Time Qualifier DTP02 - Date Time Period Format Qualifier DTP03 - Date Time Period	2400	S R R R	1			If Present, must be syntactically correct, but not processed by NEHEN Payers	
DTP 440	Date - Begin Therapy Date DTP01 - Date/Time Qualifier DTP02 - Date Time Period Format Qualifier DTP03 - Date Time Period	2400	S R R R	1			If Present, must be syntactically correct, but not processed by NEHEN Payers	
DTP 442	Date - Last Certification Date DTP01 - Date/Time Qualifier DTP02 - Date Time Period Format Qualifier DTP03 - Date Time Period	2400	S R R R	1			If Present, must be syntactically correct, but not processed by NEHEN Payers	
DTP 445	Date - Date Last Seen DTP01 - Date/Time Qualifier DTP02 - Date Time Period Format Qualifier DTP03 - Date Time Period	2400	S R R R	1			If Present, must be syntactically correct, but not processed by NEHEN Payers	
DTP 447	Date - Test DTP01 - Date/Time Qualifier DTP02 - Date Time Period Format Qualifier DTP03 - Date Time Period	2400	S R R R	2			If Present, must be syntactically correct, but not processed by NEHEN Payers	
DTP 449	Date - Oxygen Saturation/Arterial Blood Gas Test DTP01 - Date/Time Qualifier DTP02 - Date Time Period Format Qualifier DTP03 - Date Time Period	2400	S R R R	3			If Present, must be syntactically correct, but not processed by NEHEN Payers	
DTP 451	Date - Shipped DTP01 - Date/Time Qualifier DTP02 - Date Time Period Format Qualifier DTP03 - Date Time Period	2400	S R R R	1			011	
DTP 452	Date - Onset of Current Symptom/Illness DTP01 - Date/Time Qualifier DTP02 - Date Time Period Format Qualifier DTP03 - Date Time Period	2400	S R R R	1			If Present, must be syntactically correct, but not processed by NEHEN Payers	
DTP 454	Date - Last X-RAY DTP01 - Date/Time Qualifier DTP02 - Date Time Period Format Qualifier DTP03 - Date Time Period	2400	S R R R	1			If Present, must be syntactically correct, but not processed by NEHEN Payers	
DTP 456	Date Acute Manifestation DTP01 - Date/Time Qualifier DTP02 - Date Time Period Format Qualifier DTP03 - Date Time Period	2400	S R R R	1			If Present, must be syntactically correct, but not processed by NEHEN Payers	
DTP 458	Date Initial Treatment DTP01 - Date/Time Qualifier DTP02 - Date Time Period Format Qualifier DTP03 - Date Time Period	2400	S R R R	1			If Present, must be syntactically correct, but not processed by NEHEN Payers	
DTP 460	Date - Similar Illness/Symptom Onset DTP01 - Date/Time Qualifier DTP02 - Date Time Period Format Qualifier	2400	S R R	1			If Present, must be syntactically correct, but not processed by NEHEN Payers	

CH. 6 NEHEN 837 Professional Claim Submission Specification

Seg	Segment	Loop ID	Seg Req	Max use	HCFA Form (Box)	NEHEN Recommended Values	NEHEN Notes	FAQ
	ID Description	ID	Req	use				
	DTP03 - Date Time Period		R					
MEA	Test Result	2400	S	20			If Present, must be syntactically correct, but not processed by NEHEN Payers	
464	MEA01 - Measurement Reference ID Code		R					
	MEA02 - Measurement Qualifier		R					
	MEA03 - Measurement Value		R					
CN1	Contract Information	2400	S	1			If Present, must be syntactically correct, but not processed by NEHEN Payers	
466	CN101 - Contract Type Code		R					
	CN102 - Monetary Amount		R					
	CN103 - Percent		S					
	CN104 - Reference Identification		S					
	CN106 - Version Identifier		S					
REF	Repriced Line Item Reference Number	2400	S	1			If Present, must be syntactically correct, but not processed by NEHEN Payers	
468	REF01 - Reference Identification Qualifier		R					
	REF02 - Reference Identification		R					
REF	Adjusted Repriced Line Item Reference Number	2400	S	1			If Present, must be syntactically correct, but not processed by NEHEN Payers	
469	REF01 - Reference Identification Qualifier		R					
	REF02 - Reference Identification		R					
REF	Prior Authorization or Referral Number	2400	S	2			HPC supports one Referral/Authorization number per claim. If Service Line level Ref/Auth is present, it will be used as Claim Level Ref/Auth NHP requires if the services being billed require an authorization - not used to process	
470	REF01 - Reference Identification Qualifier		R					
	REF02 - Reference Identification		R					
REF	Line Item Control Number	2400	S	1			NEHEN Payers strongly recommend using control number	
472	REF01 - Reference Identification Qualifier		R			6R	Provider Control Number	
	REF02 - Reference Identification		R					
REF	Mammography Certification Number	2400	S	1			If Present, must be syntactically correct, but not processed by NEHEN Payers	
474	REF01 - Reference Identification Qualifier		R					
	REF02 - Reference Identification		R					
REF	Clinical Laboratory Improvement Amendment(CLIA) Identification	2400	S	1			If Present, must be syntactically correct, but not processed by NEHEN Payers	
475	REF01 - Reference Identification Qualifier		R					
	REF02 - Reference Identification		R					
REF	Referring Clinical Laboratory Improvement Amendment(CLIA) Facility Identification	2400	S	1			If Present, must be syntactically correct, but not processed by NEHEN Payers	
477	REF01 - Reference Identification Qualifier		R					
	REF02 - Reference Identification		R					
REF	Immunization Batch Number	2400	S	1			If Present, must be syntactically correct, but not processed by NEHEN Payers	
478	REF01 - Reference Identification Qualifier		R					
	REF02 - Reference Identification		R					
REF	Ambulatory Patient Group (APG)	2400	S	4			If Present, must be syntactically correct, but not processed by NEHEN Payers	
479	REF01 - Reference Identification Qualifier		R					
	REF02 - Reference Identification		R					
REF	Oxygen Flow Rate	2400	S	1			If Present, must be syntactically correct, but not processed by NEHEN Payers	
480	REF01 - Reference Identification Qualifier		R					
	REF02 - Reference Identification		R					
REF	Universal Product Number (UPN)	2400	S	1			If Present, must be syntactically correct, but not processed by NEHEN Payers	

CH. 6 NEHEN 837 Professional Claim Submission Specification

Seg	Segment	Loop	Seg	Max	HCFA Form (Box)	NEHEN Recommended Values	NEHEN Notes	FAQ
ID	Description	ID	Req	use				
482	REF01 - Reference Identification Qualifier		R					
	REF02 - Reference Identification		R					
AMT	Sales Tax amount	2400	S	1			If Present, must be syntactically correct, but not processed by NEHEN Payers	
484	AMT01 - Amount Qualifier Code		R					
	AMT02 - Momentary Amount		R					
AMT	Approved Amount	2400	S	1			If Present, must be syntactically correct, but not processed by NEHEN Payers	
485	AMT01 - Amount Qualifier Code		R					
	AMT02 - Monetary Amount		R					
AMT	Postage Claimed Amount	2400	S	1			If Present, must be syntactically correct, but not processed by NEHEN Payers	
486	AMT01 - Amount Qualifier Code		R					
	AMT02 - Monetary Amount		R					
K3	File Information	2400	S	10			If Present, must be syntactically correct, but not processed by NEHEN Payers	
487	K301 - Fixed Format Information							
NTE	Line Note	2400	S	1			If Present, must be syntactically correct, but not processed by NEHEN Payers	
488	NTE01 - Note Reference Code		R					
	NTE02 - Description		R					
PS1	Purchased Service Information	2400	S	1			If Present, must be syntactically correct, but not processed by NEHEN Payers	
489	PS101 - Reference Identification		R					
	PS102 - Monetary Amount		R					
HSD	Health Care Services Delivery	2400	S	1			If Present, must be syntactically correct, but not processed by NEHEN Payers	
491	HSD01 - Quantity Qualifier		S					
	HSD02 - Quantity		S					
	HSD03 - Unit/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					
HCP	Line Pricing/Repricing Information	2400	S	1			If Present, must be syntactically correct, but not processed by NEHEN Payers	
495	HCP01 - Pricing Methodology		R					
	HCP02 - Monetary Amount		R					
	HCP03 - Monetary Amount		S					
	HCP04 - Reference Identifier		S					
	HCP05 - Rate		S					
	HCP06 - Reference Identifier		S					
	HCP07 - Monetary Amount		S					
	HCP09 - Product/Service ID Qualifier		S					
	HCP10 - Product/Service ID		S					
	HCP11 - Unit/Basis for Measurement Code		S					
	HCP12 - Quantity		S					
	HCP13 - Reject Reason Code		S					
	HCP14 - Policy Compliance Code		S					
	HCP15 - Exception Code		S					
	LOOP 2410 Drug Identification			25			If Present, must be syntactically correct, but not processed by NEHEN Payers	
LIN	Item Identification		S	>1				
	LIN02 - Product/Service ID Qualifier		R					
	LIN03 - Product/Service ID		R					
CTP	Pricing Information		S	1				
	CTP03 - Unit Price		R					
	CTP04 - Quantity		R					
	CTP05 - Composit Unit of Measure		R					
	CTP05-1 - Unit or Basis for Measurement Code		R					

CH. 6 NEHEN 837 Professional Claim Submission Specification

Seg	Segment	Loop	Seg	Max	HCFA Form (Box)	NEHEN Recommended Values	NEHEN Notes	FAQ
ID	Description	ID	Req	use				
REF	Prescription Number		S	1				
	REF01 - Reference Identification Qualifier		R					
	REF02 - Reference Identification		R					
	LOOP 2420A RENDERING PROVIDER			1				
NM1	Rendering Provider Name	2420	S	1			Refer to Companion Guide	
501	NM101 - Entity Identifier Code		R			82		
	NM102 - Entity Type Qualifier		R					
	NM103 - Name Last or Organization Name		R					
	NM104 - Name First		S					
	NM105 - Name Middle		S					
	NM107 - Name Suffix		S					
	NM108 - Identification Code Qualifier		R		24I	XX	NEHEN Payers will assume value XX - National Provider Identifier (NPI)	
	NM109 - Identification Code		R		24J		National Provider Identifier (NPI)	
PRV	Rendering Provider Specialty Information	2420	S	1			If Present, must be syntactically correct, but not processed by NEHEN Payers	
504	PRV01 - Provider Code		R					
	PRV02 - Reference Identification Qualifier		R					
	PRV03 - Reference Identifier		R				Provider Taxonomy Code	
REF	Rendering Provider Secondary Identification	2420	S	5				
507	REF01 - Reference Identification Qualifier		R		24I	EI	Refer to Provider Number section of Companion Guide.	
	REF02 - Reference Identification		R		24J		Provider Tax ID	
	LOOP 2420B PURCHASED SERVICE PROVIDER NAME			1				
NM1	Purchased Service Provider Name	2420B	S	1			If Present, must be syntactically correct, but not processed by NEHEN Payers	
509	NM101 - Entity Identifier Code		R					
	NM102 - Entity Type Qualifier		R					
	NM108 - Identification Code Qualifier		S					
	NM109 - Identification Code		S					
REF	Purchased Service Provider Secondary Information	2420B	S	5			If Present, must be syntactically correct, but not processed by NEHEN Payers	
512	REF01 - Reference Identification Qualifier		R					
	REF02 - Reference Identification		R					
	LOOP 2420C SERVICE FACILITY LOCATION			1				
NM1	Service Facility Location	2420C	S	1			If Present, must be syntactically correct, but not processed by NEHEN Payers	
514	NM101 - Entity Identifier Code		R					
	NM102 - Entity Type Qualifier		R					
	NM103 - Name Last or Organization Name		S					
	NM108 - Identification Code Qualifier		S					
	NM109 - Identification Code		S					
N3	Service Facility Location Address	2420C	R	1			If Present, must be syntactically correct, but not processed by NEHEN Payers	
518	N301 - Address Information		R					
	N302 - Address Information		S					
N4	Service Facility Location City/State/ZIP	2420C	R	1			If Present, must be syntactically correct, but not processed by NEHEN Payers	
519	N401 - City Name		R					
	N402 - State or Province Code		R					
	N403 - Postal Code		R					
	N404 - Country Code		S					
REF	Service Facility Location Secondary Identification	2420C	S	5			If Present, must be syntactically correct, but not processed by NEHEN Payers	
521	REF01 - Reference Identification Qualifier		R					
	REF02 - Reference Identification		R					
	LOOP 2420D SUPERVISING PROVIDER NAME			1				
NM1	Supervising Provider Name	2420C	S	1			If Present, must be syntactically correct, but not processed by NEHEN Payers	
523	NM101 - Entity Identifier Code		R					

CH. 6 NEHEN 837 Professional Claim Submission Specification

Seg	Segment	Loop	Seg	Max	HCFA Form (Box)	NEHEN Recommended Values	NEHEN Notes	FAQ
ID	Description	ID	Req	use				
	NM102 - Entity Type Qualifier		R					
	NM103 - Name Last or Organization Name		R					
	NM104 - Name First		R					
	NM105 - Name Middle		S					
	NM107 - Name Suffix		S					
	NM108 - Identification Code Qualifier		S					
	NM109 - Identification Code		S					
REF	Supervising Provider Secondary Identification	2420C	S	5			If Present, must be syntactically correct, but not processed by NEHEN Payers	
527	REF01 - Reference Identification		R					
	REF02 - Reference Identification		R					
	LOOP 2420E ORDERING PROVIDER NAME			1				
NM1	Ordering Provider Name	2420E	S	1			If Present, must be syntactically correct, but not processed by NEHEN Payers	
529	NM101 - Entity Identifier Code		R					
	NM102 - Entity Type Qualifier		R					
	NM103 - Name Last or Organization Name		R					
	NM104 - Name First		R					
	NM105 - Name Middle		S					
	NM107 - Name Suffix		S					
	NM108 - Identification Code Qualifier		S					
	NM109 - Identification Code		S					
N3	Ordering Provider Address	2420E	S	1			If Present, must be syntactically correct, but not processed by NEHEN Payers	
533	N301 - Address Information		R					
	N302 - Address Information		S					
N4	Ordering Provider City/State/ZIP Code	2420E	S	1			If Present, must be syntactically correct, but not processed by NEHEN Payers	
534	N401 - City Name		R					
	N402 - State or Province Code		R					
	N403 - Postal Code		R					
	N404 - Country Code		S					
REF	Ordering Provider Secondary Identification	2420E	S	5			If Present, must be syntactically correct, but not processed by NEHEN Payers	
536	REF01 - Reference Identification		R					
	REF02 - Reference Identification		R					
PER	Ordering Provider Contact Information	2420E	S	1			If Present, must be syntactically correct, but not processed by NEHEN Payers	
538	PER01 - Contact Function Code		R					
	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 2420F REFERRING PROVIDER NAME			2			If Present, must be syntactically correct, but not processed by NEHEN Payers	
NM1	Referring Provider Name	2420F	S	1				
541	NM101 - Entity Identifier Code		R					
	NM102 - Entity Type Qualifier		R					
	NM103 - Name Last or Organization Name		R					
	NM104 - Name First		R					
	NM105 - Name Middle		S					
	NM107 - Name Suffix		S					
	NM108 - Identification Code Qualifier		S					
	NM109 - Identification Code		S					
PRV	Referring Provider Specialty Information	2420F	S	1			If Present, must be syntactically correct, but not processed by NEHEN Payers	
544	PRV01 - Provider Code		R					
	PRV02 - Reference Identification Qualifier		R					
	PRV03 - Reference Identifier		R				Taxonomy Code	
REF	Referring Provider Secondary Identification	2420F	S	5				
547	REF01 - Reference Identification		R			EI/SY		

CH. 6 NEHEN 837 Professional Claim Submission Specification

Seg	Segment	Loop ID	Seg Req	Max use	HCFA Form (Box)	NEHEN Recommended Values	NEHEN Notes	FAQ
	ID Description	ID	Req	use				
	REF02 - Reference Identification		R				Tax ID/SSN	
	LOOP 2420G OTHER PAYER PRIOR AUTHORIZATION OR REFERRAL NUMBER			4				
NM1	Other Payer Prior Authorization or Referral Number	2420G	S	1			If Present, must be syntactically correct, but not processed by NEHEN Payers	
549	NM101 - Entity Identifier Code		R					
	NM102 - Entity Type Qualifier		R					
	NM103 - Name Last or Organization Name		R					
	NM109 - Identification Code		R					
	Other Payer Prior Authorization or Referral Number	2420G	R	2			If Present, must be syntactically correct, but not processed by NEHEN Payers	
552	REF01 - Reference Identification Qualifier		R					
	REF02 - Reference Identification		R					
	LOOP 2430 LINE ADJUDICATION INFORMATION			25				
SVD	Line Adjudication Information	2430G	S	1			If Present, must be syntactically correct, but not processed by HPHC If submitted Tufts HP will use for processing	
554	SVD01 - Identification Code		R					
	SVD02 - Monetary Amount		R					
	SVD03 - Composite Medical Procedure Identifier		R					
	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					
	SVD05 - Product/Service ID		R					
	SVD06 - Assigned Number		S					
CAS	Line Adjustment	2430G	S	99			If Present, must be syntactically correct, but not processed by HPHC If submitted Tufts HP will use for processing	
558	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	Line Adjudication Date	2430G	R	1			If Present, must be syntactically correct, but not processed by HPHC If submitted Tufts HP and NHP will use for processing	
566	DTP01 - Date/Time Qualifier		R					
	DTP02 - Date Time Period Format Qualifier		R					
	DTP03 - Date Time Period		R					
	LOOP 2440 FORM IDENTIFICATION CODE			5				
LQ	Form Identification Code	2440	S	1			If Present, must be syntactically correct, but not processed by HPHC If submitted Tufts HP and NHP will use for processing	
567	LQ01 - Code List Qualifier Code		R					
	LQ02 - Industry Code		R					

CH. 6 NEHEN 837 Professional Claim Submission Specification

Seg	Segment	Loop	Seg	Max	HCFA Form	NEHEN		
ID	Description	ID	Req	use	(Box)	Recommended	NEHEN Notes	FAQ
						Values		
FRM	Supporting Documentation	2440	R	99			If Present, must be syntactically correct, but not processed by HPHC If submitted Tufts HP and NHP will use for processing	
569	FRM01 - Assigned Identification		R					
	FRM02 - Yes/No Condition or Response Code		S					
	FRM03 - Reference Identification		S					
	FRM04 - Date		S					
	FRM05 - Percent		S					
SE	Transaction Set Trailer	2440	R	1				
	SE01 - Number of Included Segments		R				Number of Segments including ST and SE segments	
	SE02 - Transaction Set control Number		R				Must equal ST02	
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	
	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 questions@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).

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-Institutional with a NEHEN Payer, am I required to test 837-Professional 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 to 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.

Professional 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.

Professional Claim maximum of 50 lines per claim

NEHEN Payers expect no more than 50 lines per professional claim.

Maximum of 5000 Claims per file suggested

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

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