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Best Practice Recommendation for

Submitting & Processing Claims (5010 version)

For use with ASC X12N 837 (005010X222)
Health Care Claim: Professional, Institutional & Dental
Technical Report Type 3

Version 1.8

Version	
Issue Date	**Explanation**
02-22-10	Initial release
11-26-10	Minor clarification refinements related to submitting supporting documentation (pg 8)
01-18-11	Incorporate 'Practices for Identifying a Patient' (page 6)
02-21-11	Receipt of claims will be acknowledged with a 999. Health plans are also encouraged to send 277CA. (page 6)
04-19-11	Best Practice for Completing Patient Reason for Visit field (pages 1011)
05-20-11	• Modify Background section (pg 2-3) • Add Best Practice for Provider Addresses and NPI subparts (pages 11-12)
08-20-2011	Amend; Pay To Address does not require a 9 digit zip code (page 11)
03-07-12	Add urls for other BPRs that are referenced (page 13)

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Best Practice Recommendation
Submitting & Processing Claims

Topic: Exchanging detailed information about a provider's claim for services using the 5010v of the HIPAA 837 transactions

Goals: Define an acceptable set of information that will allow a health plan to process an electronic claim from a provider and to communicate information about the processing of the claim using the 276-277 and/or 835 transactions.

Summary: This document outlines how the 5010v of the HIPAA 837 transactions should be used by the provider to send an electronic claim to a health plan.

Applicability: This BPR Document should be a useful guide for providers and other 837 transaction submitters, e.g. billing services, that are exchanging transactions **directly** with participating health plans.

This BPR Document may be less useful when a provider, or other 837 transaction submitter, IS NOT exchanging transactions directly with participating health plans. Information contained in this document **may not** apply to exchanges between:

- Providers and public programs such as Medicare and Medicaid: Information about these programs is available at: **www.cms.gov**
- Providers and Clearinghouses*:* Providers should note that clearinghouses, and other intermediaries, may implement the transaction differently than what is outlined in this BPR Document. The clearinghouse may reformat the provider's transaction before passing it along to the health plan. This reformatting may add unforeseen complexity to the process of transaction exchange.

Background

This BPR Document is intended to accompany the Technical Report Type 3 (TR3), previously referred to as Implementation Guide, for the ASC X12N 837 Health Care Claim: Professional, Institutional & Dental Transactions. A complete version of the TR3s can be purchased at http:www.wpc-edi.com.
Providers must be able to send and health plans must be able to receive a compliant 837 transaction. The HIPAA mandated 837 TR3 specifies the complete set of requirements that must be met in order to be compliant.

Objective & Scope of the 837 Best Practice Recommendation (BPR) Document

The objective of this BPR document is to recommend practices for how the 837 transactions should be used to accomplish specific business objectives related to the submission and processing of claim information.

This document assumes that:
1. The reader is familiar with the HIPAA transaction and the related X12 TR3 and has experience implementing the transaction.
2. The creation and exchange of the 837 transaction by the health plan and provider organization will comply with all requirements laid out in the TR3.

As such, the intent of this BPR document is to expand upon and NOT to repeat the requirements contained in the TR3. However, requirements from the TR3 will be included in this document when the requirement was in the 4010A1v but was typically not followed OR is new to the 5010v and, as such, may be overlooked in the implementation process, AND would significantly enhance administrative simplicity if it was followed. In these cases, the appropriate section of the TR3 will be referenced, but the details of the requirement will not be repeated.

This document may also contain business and operation practices that are not addressed in the TR3.

Within Scope of this Document:

Practices related to the use of the 837 transaction by providers and other billing organizations to convey information to health plans about claims for payment for services provided will be included in this document. This includes claims to primary payers, secondary payers, tertiary payers, etc.

Outside Scope of this Document:

Practices related to the use of the 837 transaction *between health plans* for the purpose of Coordination of Benefits (COB) will not be included in this document.

Practices Common Across HIPAA Transactions

1. *Health Plan Companion Documents*: Prior to creating, submitting and/or receiving transactions to/from a health plan, providers should contact the health plan to get their list of any unique data or business requirements. The health plan's requirements are typically discussed in a document referred to by a variety of names such as Trading Partner Agreement, Companion Document, etc.

   The health plan's document should make their unique requirements readily and clearly visible to the provider upon a quick glance at the document. Examples of unique requirements for transactions to be sent to the health plan include, but may not be limited to:
   - Use of the ISA & IEA segments
   - Use of the GE & GS segments
   - Use of the Transaction Set Control Numbers (ST02, SE02)
   - Payer ID to be used
   - Instruction for use of zip codes (if any)
   - Instructions for Atypical Provider (if any)
   - Instructions for use of Taxonomy Codes (if they are required)

Practices for Formatting, Acknowledging Receipt and Following Up on 837 Claims

1. *Formatting the Claim*

   a. When populating transactions with claim information, no more than 5000 claims will be sent within an ST-SE segment.

   b. The organization submitting the 837 transaction to the health plan is considered the Submitting Organization. That organization should be identified in ISA06, GS02, and in the Submitter Loop 1000A 'Submitter Name'.

      Example: When a professional provider organization uses a billing service to submit their claims, the billing service is the Submitting Organization.

2. *Acknowledging Receipt and Following Up*

   a. Health plans will acknowledge receipt of a submitted claim using a 999 Acknowledgment transaction. Some health plans may also respond with a 277CA transaction. All health plans are encouraged to respond with a 277CA, which is expected to be a future BPR.

b. At any time after submitting the claim, a provider will check on the status of the claim using the HIPAA 276/277 transaction or by accessing the health plans web site. Unless instructed by the health plan, providers should avoid resubmitting claims. Resubmitting claims as a method of checking on claims status will complicate the processing cycle.

c. When a claim has been processed, health plans will communicate with the provider using the HIPAA 835 transaction.

- Line item control numbers put in the 2400REF segment of the 837 will be returned by the health plan on the corresponding 835(s).

Practices for Identifying a Patient

Every effort should be made to send the patient information as the subscriber when the patient has a unique id number for their insurance. However, there are circumstances when the provider may have difficulty identifying that a patient has a unique ID number. The following scenarios illustrate typical circumstances and how they are likely to be handled when submitting an 837 Claim.

- Scenario 1:

  The patient has a unique ID number and indicates this to the provider. Or, the provider identifies the patient's unique ID number using the 270/271 transaction set or eligibility/benefits web capability.

  The 837 will be sent out listing the patient as the subscriber in loops 2000B and 2010BA. The ID number will be listed in loop 2010BA

- Scenario 2:

  A patient presents his card to the registration staff at the hospital/clinic and is asked “Who is the subscriber?” The patient states that their spouse/domestic partner is the subscriber (as the insurance is through their spouse’s/domestic partner's health plan). The patient is registered as being a dependant. (It is not known, without seeing both insurance cards, whether the patient has a unique number.)

  The 837 will be sent out listing the spouse/domestic partner as the subscriber in loops 2000B and 2010BA, along with the patient’s ID number in loop 2010BA. The patient should be listed in the PAT segment, loops 2000C and 2010CA. 2010CA will contain no ID number.

- Scenario 3:

  A mother and child visit a clinic and the mother indicates that she is the

subscriber and the patient is registered as being a dependant. (Actually, the child has a unique ID number, but it is not identified before the claim is sent out.)

The 837 will be sent out listing the mother as the subscriber in loops 2000B and 2010BA, along with the patient's ID number in loop 2010BA. The patient should be listed in the PAT segment, loops 2000C and 2010CA. 2010CA will contain no ID number.

In all circumstances, the health plan will attempt to identify the patient as a subscriber and as a dependant to the subscriber.

Practices for Identifying the Different Providers

1. *National Provider Identifier (NPI) & Atypical Providers:* In all situations where a provider name is entered in the transaction, the appropriate NPI for that provider, at the appropriate enumeration level, should also be entered in the appropriate place within the transaction.

   Atypical Providers can submit electronically using the 837 and are encouraged to do so. Since Atypical Providers do not have an NPI, they will need to use another type of identifying number on the transaction. Providers without an NPI should contact the health plan or review the health plan's companion document for specific instructions.

2. *Billing Provider and Pay-To Address Name*: As discussed in the BPR - 835 document, the organization that originated the claims is considered to be the Billing Provider. The organization to be paid by the health plan for the services is considered to be located at the Pay-To-Address. In many cases, the Billing Provider and the Pay-To-Address are the same. For each Billing Provider, the Pay-to-Address is typically identified during the contracting process and is stored in the health plan's provider file.

   The Pay To Address Name loop in the transaction IS NOT intended to override the payment processes of the payer and any contractual relationships that may exist between the payer and the provider. When processing a claim, it is the responsibility of the payer to determine the appropriate payee. Providers should contact the health plan if they have any questions about who the health plan has on file as the appropriate payee and/or the payee address. However, in the absence of any other agreement with the provider, the usage of the Pay To Address Name loop does provide the information on how a provider wishes to be reimbursed.

3. *Reporting Provider Information*: Information about each relevant provider should be put in the appropriate place on the 837 claims. A definition for each type of provider can be found in the Appendices. The following table indicates where the

information for each provider should be put within the claim. The Comment field identifies some of the requirements for when this provider must be included on the claim. Refer to the Implementation Guide for the complete set of requirements.

Provider	837P Loop/ Segment	837I Loop/ Segment	Comment
Billing Provider Name	2010AA NM1	2010AA NM1	
Billing Provider Address	2010AA N3	2010AA N3	Can't be a PO Box
Billing Provider City, State and Zip Code	2010AA N4	2010AA N4	
Billing Provider Tax Identification	2010AA REF	2010AA REF	
Pay To Address – Address	2010AB N3	2010AB N3	Only required if different than the Billing Provider's physical location. However, health plans will use what they have in their files based upon contracting (see #2 above).
Pay To Address City, State Zip Code	2010AB N4	2010AB N4	
Attending Provider Name		2310A NM1	
Operating Physician Name (Claim & Line levels for 837I)		2310B NM1 & 2420A NM1	
Referring Provider Name Claim & Line levels for 837I)	2310A NM1	2310F NM1 & 2420D NM1	837P: Situationally required when there is referred care or services. For 837I: Only required if claim is for outpatient services and the Rendering Provider is different than the Attending Physician. (Note: on a UB04, Referring Provider would be put into 'Other')
Rendering Provider (Claim & Line levels for 837I & D)	2310B NM1	2310D NM1 & 2420C NM1	For 837P: Required if different than Billing Provider For 837I:

Provider	837P Loop/ Segment	837I Loop/ Segment	Comment
			Only required if claim is for outpatient services and the Rendering Provider is different than the Attending Physician. (Note: on a UB04, Rendering Provider would be put into 'Other')
Service Facility Location Name	2310C NM1	2310E NM1	Physical address of where the service was provided. Required if different than Billing Provider's physical address.
Service Facility Location Address		2310E N3	
Service Facility Location City, State, Zip Code		2310E N4	
Purchased Service Provider Name	2420B NM1	2420B NM1	
Supervising Provider Name Claim & Line levels for 837D)	2420D NM1		Required when the rendering provider is supervised by a physician and the supervising physician is different than that listed at the claim level for this service line
Ordering Provider Name	2420E NM1		Required when the service or supply was ordered by a provider who is different than the Rendering Provider for this service line.
Assistant Surgeon Claim & Line levels for 837D)			

Practices for Submitting and Using Diagnoses

1. Providers should submit on the 837 as many diagnoses as a) are appropriate to the patient condition and care delivered and, b) they are able to include in the 837 transaction.

2. Health plans should receive and accept all diagnoses that are included in the 837 transaction. Health plans will store the diagnoses on one or more systems and/or in a manually reviewable form.

3. When performing a business process, the health plan should use the number of diagnoses appropriate to that particular business process.

4. If the provider believes that the appropriate number of diagnoses was not used, the provider should follow the appropriate appeal process established by the health plan for the particular business process in question.

5. The health plan will respond to the appeal in a manner defined by their process.

6. If the provider routinely makes appeals for the same type of situation where the diagnosis codes are incorrectly applied, the provider should notify their provider representative and request that the standard business process be changed

7. The provider representative will research the issue within the health plan and report the decision to the provider.

Practices for Coding Claims Information

1. *Pharmaceuticals:* All compound pharmaceuticals will be represented in the transaction with a 2400 loop for each single ingredient.
   - SV1(837P) or SV2(837I) = HCPC Code of the ingredient
   - CTP = Quantity of the ingredient

2. *Taxonomy Codes:* Providers should refer to the Health Plan's Companion Document for instructions and processing information about the use of taxonomy codes.

Practices for Completing Data Fields

1. Patient Reason for Visit:

Supporting References:
- 837-I TR3 Front Matter reference Section 1.12.6 Inpatient and Outpatient Designation
- Usage Note in 005010 837: Required when claim involves outpatient visits.
- UB04 Manual references to FL04 (Page 5 of 9) Exceptions to Inpatient/Outpatient General Designation by Data Element/Form Locator, referencing (Exc. #5) FL70a-c Patient Reason for Visit, and
- UB04 Manual reference FL70a-c Patient's Reason for Visit, indicates:

Completion of this field is only required on claims with Type of Bill 012X, 013X and 085X when Priority (Type) of Admission/Visit Codes are 1, 2 or 5 AND Revenue Codes 045X, 0516, 0526 or 0762 are reported.

May be reported on all other claims with Type of Bill of 012X, 013X and 085X, at submitter's discretion when this information provides additional information to support medical necessity.

Legend: Type of Bill 012X = Hospital Inpatient (Medicare Part B Only), General Designation is Outpatient, Type of Bill 013X = Hospital Outpatient, Type of Bill 085X = Specialty Facility – Critical Access Hospital, General Designation is Outpatient

2. *Billing Provider & Service Facility Location - Physical Address*

The Billing Provider Address and the Service Facility Location Address (if the location of the service is different than the Billing Provider Address) must be a physical address and not a PO Box. If 'POS type' is '12-Patient Home', the patient's actual address including 9 digit zip code must be sent in the Service facility Location. The Pay To Address can still be a PO Box.

In previous versions of the HIPAA 837-Claim transaction, providers could send a PO Box as the Billing Provider Address. Many health plans store this PO Box in their provider file. The 5010 version of the 837-Claim transaction (Institutional, Professional and Dental) requires providers to send a physical address (and not a PO Box) for the billing provider. Some health plans, as part of their claims adjudication process, compare the address submitted on the claim with address that they have in their provider file for that provider. If the addresses do not match, the whole file may be rejected or the claim(s) associated with that provider may be pended.

To prevent this from happening, providers should check with each of their health plans and, if necessary, give the health plans the physical address that they will be submitting on the claim.

3. *Billing Provider Address and Service Facility Location Address - 9 digit zip code*

A 9 digit zip code is required for the billing provider (physical address) and for any service facility location with an address that is different than the provider's billing address, e.g. patient home. If the US Post Office has not assigned a 9 digit zip code to the address, then 4 0's (zeros) should be used as the last four digits in the 9 digit zip code. (In the 4010 version of the HIPAA 837-Claim transaction, providers could send a 5 digit zip code for the billing provider and service facility location.)

4. *NPI subparts - DME, Laboratories, etc.*

   In the past, in response to a CMS requirement, Medicare providers who have separate physical locations for specified service types, e.g. DME and laboratories, created a NPI subpart for each of those entities. These NPI subparts would be used only when billing Medicare for those specified service types. Many providers would not use these NPI subparts when billing all other health plans for those service types.

   The 5010 version of the 837-Claim transaction requires providers to bill the same NPIs to all health plans for all service types. However, non-Medicare health plans are not likely to have these NPI subparts in their provider file. If health plans receive these NPI subparts on a claim, that claim will pend.

   To prevent this from happening, in those cases where providers are currently NOT sending the NPI subparts to all health plans for specified service types, e.g. DME, laboratory, etc., they should contact those health plans BEFORE submitting claims to them that contain these NPI subparts, to find out what needs to be done so that the claims will process.

Practices for Submitting Supporting Documentation

Electronic Submission of Supporting Document holds promise of significant time and cost savings for health plans and providers, as well as expediting the claims payment process. Though there is a statutory requirement in HIPAA for electronic claims attachment, HHS has not published a final rule. Given the investment required of software vendors, health plans, providers and clearinghouses to develop an electronic option, it is premature to recommend a "best practice" electronic solution until a final rule is published which will mandate the solution. (Note: a very few health plans do offer a secure, electronic method for submitting documentation as a "bridge solution" until a final rule is published.)

For the majority of health plans that do not have a "bridge solution", supporting documentation will need to be submitted on paper. Note - providers should only submit supporting documentation if/as required by the health plan. Sending unnecessary paper will delay the processing of claims.

- Medicare: Medicare has recently announced how providers can use the PWK segment to send identifying information about the paper documentation that they will submit.
- Washington State health plans: The approach recommended by Washington State health plans is outlined in the Admin Simplification Guideline for Submitting Supporting Documentation that can be found on the WorkSMART web site.

At this time, use of the PWK segment within the 837 transaction is not recommended as a best practice by the WorkSMART Institute. The PWK segment does not offer an effective solution for integrating and streamlining the paper-based workflows of provider and health plan. In most cases, its use will increase the work demands on either the provider or the health plan. Providers should check with each of their health plans before using this segment."

Practices for Submitting Explanation of Payment Information

Refer to Best Practice Recommendations document titled 'Exchanging EOP Information between Providers and Health Plans' **which can be found on the OHP web site at** https://www.onehealthport.com/sites/default/files/content-uploads/bpr/Exchanging_Payment_Information.pdf

Note this document contains practices related to the 837 and the 835.

Specific Practices for Submitting & Processing Corrections to Claims

Refer to Best Practice Recommendations documents titled '**Electronic Processing of Corrections to Professional Claims**' which can be found on the OHP web site at https://www.onehealthport.com/sites/default/files/content-uploads/bpr/Electronic_Processing_Corrections_Professional_Claims.pdf and '**Electronic Processing of Corrections to Institutional Claims**' which can be found on the OHP web site at https://www.onehealthport.com/sites/default/files/content-uploads/bpr/Electronic_Processing_Corrections_Institutional_Claims.pdf

Note these documents contain practices related to the 837 and the 835.

Appendices

Provider Definitions

Source: Uniform Billing Editor by Ingenix

Provider Type	Definition
Attending Provider	The Attending Provider is the individual who has overall responsibility for the patient's medical care and treatment.
Billing Provider	The Billing Provider is the name of the provider submitting the bill. Note: The Billing Provider is, almost always, the name of the organization submitting the bill. Exceptions include, but are not limited to sole proprietors, unincorporated providers, etc.
Operating Physician	The Operating Physician is the individual with the primary responsibility for performing the surgical procedure(s).
Ordering Provider	The Ordering Provider is the individual who requested the services or items being reported on this service line. Examples include, but are not limited to, provider ordering diagnostic tests and medical equipment or supplies.
Purchased Service Provider	A Purchased Service Provider is an individual or entity that performs a service on a contractual or reassignment basis for a separate provider who is billing for the service. Examples of services include, but are not limited to: (a) processing a laboratory specimen; (b) grinding eyeglass lenses to the specifications of the Rendering Provider; or (c) performing diagnostic testing services (excluding clinical laboratory testing) subject to Medicare's anti-markup rule. In the case where a substitute provider (a locum tenens physician) is used, that individual is not considered a Purchased Service Provider.
Referring Provider	The Referring Provider is the individual who directed the patient for care to the provider rendering the services being reported. Examples include, but are not limited to, primary care provider referring to a specialist; orthodontist referring to an oral and maxillofacial surgeon; physician referring to a physical therapist; provider referring to a home health agency
Rendering Provider	The Rendering Provider is the individual who provided the care. In the case where a substitute provider (locum tenens) was used, that individual is considered the Rendering Provider. The Rendering Provider does not include individuals performing services in support roles, such as lab technicians or radiology technicians.
Supervising Provider	The Supervising Provider is the individual who provided oversight of the Rendering Provider and the care being reported. An example includes, but is not limited to, supervision of a resident physician.