Instructions Related to 837 Health Care Claim/Encounter: Institutional (837I) Transactions Based on ASC X12 Implementation Guide

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Preface

Companion guides may contain two types of data, instructions for electronic communications with the publishing entity (Communications/Connectivity Instructions) and supplemental information for creating transactions for the publishing entity while ensuring compliance with the associated ASC X12 Implementation Guide (Transaction Instructions). Either the Communications/Connectivity component or the Transaction Instruction component must be included in every companion guide. The components may be published as separate guides or as a single guide.

The Communications/Connectivity component is included in the companion guides when the publishing entity wants to convey the information needed to commence and maintain communication exchange.

The Transaction Instruction component is included in the companion guides when the publishing entity wants to clarify the implementation guide instructions for submission of specific electronic transactions. The Transaction Instruction component content is limited by ASC X12's copyrights and Fair Use statement.

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837 Health Care Claim/Encounter: Institutional Transaction Instructions

1 Transaction Instructions Introduction

1.1 Background

1.1.1 Overview of HIPAA Legislation

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) includes provisions for administrative simplification. This requires the Secretary of the federal Department of Health and Human Services (HHS) to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. HIPAA directs the Secretary to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard HIPAA serves to:

- Create better access to health insurance.
- Limit fraud and abuse.
- Reduce administrative costs.

1.1.2 Compliance According to HIPAA

The HIPAA regulations at 45 CFR 162.915 require that covered entities not enter into a trading partner agreement that would do any of the following:

- Change the definition, data condition, or use of a data element or segment in a standard.
- Add any data elements or segments to the maximum defined data set.
- Use any code or data elements that are marked “not used” in the standard’s implementation specifications or are not in the standard’s implementation specification(s).
- Change the meaning or intent of the standard’s implementation specification(s).

1.1.3 Compliance According to ASC X12

The ASC X12 requirements include specific restrictions that prohibit trading partners from modifying any:

- Defining, explanatory, or clarifying content contained in the implementation guide.
- Requirement contained in the implementation guide.

1.2 Intended Use

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

1.3 Companion Guide Audience

Companion guides are intended for information technology and/or systems staff who will be coding billing systems or software for compliance with the federal HIPAA regulations.

1.4 Purpose of Companion Guides

The information contained in this companion guide applies to ForwardHealth, which includes the following programs: BadgerCare Plus, Wisconsin Medicaid, SeniorCare, Wisconsin Chronic Disease Program (WCDP), the Wisconsin Well Woman Program (WWWP), and Medicaid managed care programs. All of these programs use ForwardHealth interChange for processing.

The companion guides are to be used with HIPAA Implementation Guides and to supplement the requirements in the HIPAA ASC X12 Implementation Guides, without contradicting those requirements. Implementation guides define the national data standards, electronic format, and values for each data element within an electronic transaction. The purpose of the companion guides is to provide trading partners with a guide to communicate ForwardHealth-specific information required to successfully exchange transactions electronically with ForwardHealth.

ForwardHealth will accept and process any HIPAA-compliant transaction; however, a compliant transaction that does not contain ForwardHealth-specific information, though processed, may be denied for payment. For example, a compliant 837 Health Care Claim/Encounter (837) created without a ForwardHealth member identification number will be processed by ForwardHealth but will be denied payment. For questions regarding appropriate billing procedures, as well as for policy and billing information, providers should refer to their policy-specific area of the ForwardHealth Online Handbook.

Companion guides highlight the data elements significant for ForwardHealth. For transactions created by ForwardHealth, companion guides explain how certain data elements are processed. Refer to the companion guide first if there is a question about how ForwardHealth processes a HIPAA transaction. For further information, contact the ForwardHealth Electronic Data Interchange (EDI) Department at (866) 416-4979.

1.5 Acceptable Characters

All alpha characters used in 837 transactions must be in an uppercase format. The 837 transaction must not contain any carriage returns nor line feeds; the data must be received in one, continuous stream.

1.6 Acknowledgements

An accepted 999 Implementation Acknowledgement, rejected 999 Implementation Acknowledgement, or rejected TA1 InterChange Acknowledgement will be generated in response to all submitted files. Trading partners are responsible for retrieving acknowledgments from the Web to determine the status of their files.

1.7 Examples

See Section 4.1 of this guide for examples.

2 Referenced ASC X12 Implementation Guides

This table lists the X12N Implementation Guides for which specific transaction instructions apply and are included in Section 3 of this guide.

Unique ID	Name
005010X223A2	837 Health Care Claim: Institutional (837I)

3 Instruction Tables

These tables contain one or more rows for each segment for which a supplemental instruction is needed.

Legend
SHADED rows represent “segments” in the X12N implementation guide.
NON-SHADED rows represent “data elements” in the X12N implementation guide.

3.1 05010X223A2 — 837 Health Care Claim: Institutional

Loop ID	Reference	Name	Codes	Notes/Comments
	ISA	Interchange Control Header		The ISA is a fixed-length record with fixed-length elements. *Note:* Deviating from the standard ISA element sizes will cause the interchange to be rejected.
	ISA03	Interchange Control Security Information Qualifier	00	Use “00” — No Security Information Present.
	ISA05	Interchange ID (Sender) Qualifier	ZZ	Enter the value “ZZ” — Mutually Defined.
	ISA06	Interchange Sender ID		Enter the nine-digit numeric Trading Partner ID assigned by ForwardHealth interChange.
	ISA07	Interchange ID (Receiver) Qualifier	ZZ	Enter the value “ZZ” — Mutually Defined.
	ISA08	Interchange Receiver ID	WISC_DHFS	Enter “WISC_DHFS”.
	GS	Functional Group Header		

Loop ID	Reference	Name	Codes	Notes/Comments
	GS02	Application Sender's Code		Enter the same value as ISA06, the nine-digit numeric Trading Partner ID assigned by ForwardHealth interChange.
	GS03	Application Receiver's Code	WISC_TXIX WISC_WWWP WISC_WCDP	Claim: Enter the value “WISC_TXIX” for Wisconsin Medicaid and BadgerCare Plus, “WISC_WWWP” for the WWWP or “WISC_WCDP” for the WCDP. Encounter: “WISC_TXIX” only.
	BHT	Beginning of Hierarchical Transaction		
	BHT06	Claim Identifier	CH (Claim) RP (Encounter)	Claim: Enter the value “CH” — Chargeable. Encounter: Enter the value “RP” — Reporting.
1000A	NM1	Submitter Name		
1000A	NM109	Submitter Identifier		Enter the same value as ISA06, the nine-digit numeric Trading Partner ID assigned by ForwardHealth interChange.
1000B	NM1	Receiver Name		
1000B	NM103	Receiver Name	FORWARDHEALTH	Enter “FORWARDHEALTH” to indicate the claims/encounters are being sent to ForwardHealth interChange.
1000B	NM109	Receiver Primary Identifier	WISC_TXIX WISC_WWWP WISC_WCDP	Claim: Enter the value “WISC_TXIX” to indicate Wisconsin Medicaid and BadgerCare Plus, “WISC_WWWP” to indicate WWWP, or “WISC_WCDP” to indicate WCDP. Encounter: “WISC_TXIX” only.
2000A	PRV	Billing Provider Specialty Information		
2000A	PRV02	Reference Identification Qualifier	PXC	Enter the value “PXC”, mutually defined, to indicate the next element will be the taxonomy code of the billing provider. *Note:* Taxonomy codes are only required if the National Provider Identifier (NPI) has multiple certifications and the taxonomy is necessary to determine the appropriate one.
2000A	PRV03	Provider Taxonomy Code		Enter the taxonomy that was reported to ForwardHealth for the service you are billing. *Note:* The provider is required to use the appropriate taxonomy code that is associated to

Loop ID	Reference	Name	Codes	Notes/Comments
				the provider type and specialty currently on file with ForwardHealth.
2010AA	NM1	Billing Provider Name		Include this segment to submit the Billing Provider's name and, when applicable, the provider's NPI when it is used as the identifier.
2010AA	N3	Billing Provider Address		Enter the address on file with ForwardHealth in this segment. *Note:* Do not submit a P.O. Box in this segment. If a P.O. Box needs to be reported, use the Pay-to-Address loop.
2010AA	N4	Geographic Location		Use the physical address as reported on the provider's Medicaid, WCDP, or WWWP certification.
2010AA	N403	Billing Provider Postal Zone or ZIP Code		Enter the ZIP+4 code that corresponds to the physical address on file with ForwardHealth.
2010AB	NM1	Pay-to Address Name		*Note:* The information in this segment will not be used to determine where to send the provider Remittance Advice (RA) and/or 835 Health Care Claim Payment/Advice (835). The RA and/or the 835 will be sent to the entity established during the provider certification process. Encounter submissions will not receive an 835.
2010BA	NM1	Subscriber Name		Enter information about the subscriber/member in this loop.
2010BA	NM102	Entity Type Qualifier	1	Enter the value "1" to indicate the subscriber is a person.
2010BA	NM103	Subscriber Last Name		Enter the member's last name. *Note:* Use Wisconsin's Enrollment Verification System (EVS) to obtain the correct spelling of the member's name. If the name or spelling of the name on the member's identification card and the EVS do not match, use the spelling from the EVS.
2010BA	NM104	Subscriber First Name		Enter the member's first name. *Note:* Use the EVS to obtain the correct spelling of the member's name. If the name or spelling of the name on the member's identification card and the EVS do not match, use the spelling from the EVS.
2010BA	NM108	Identification Code Qualifier	MI	Enter the value "MI" for the member ID.

Loop ID	Reference	Name	Codes	Notes/Comments
2010BA	NM109	Subscriber Primary Identifier		Enter the member's 10-digit ForwardHealth identification number. *Note:* Do not enter any other numbers or letters. Use the ForwardHealth ID card or the EVS to obtain the correct identification number.
2010BB	NM1	Payer Name		
2010BB	NM103	Payer Name	FORWARDHEALTH	Enter value "FORWARDHEALTH".
2010BB	NM109	Payer Identifier	WISC_TXIX WISC_WWWP WISC_WCDP	Claim: Enter value "WISC_TXIX" for Wisconsin Medicaid and BadgerCare Plus, "WISC_WWWP" for the WWWP or "WISC_WCDP" for the WCDP. Encounter: "WISC_TXIX" only.
2010BB	REF	Billing Provider Secondary Identification		Include this segment if the provider in Loop 2010AA is the provider certified by ForwardHealth interChange to submit claims/encounters and the provider's NPI will not be submitted in Loop 2010AA: NM109. *Note:* Non-healthcare (Atypical) providers are required to submit this segment.
2010BB	REF01	Reference Identification Qualifier	G2	Enter the value "G2" for Wisconsin Medicaid, BadgerCare Plus, WCDP, and WWWP. *Note:* Non-healthcare (Atypical) providers are required to submit this segment.
2010BB	REF02	Billing Provider Secondary Identifier		Enter the eight or nine-digit billing provider number assigned by ForwardHealth interChange. *Note:* Non-healthcare (Atypical) providers are required to submit their eight or nine-digit billing provider number.
2010CA	REF	Property and Casualty Claim Number		This segment will not be used by ForwardHealth.
2300	CLM	Claim Information		
2300	CLM01	Patient Control Number		*Note:* ForwardHealth interChange will process member control numbers up to 20 characters in length.
2300	CLM02	Total Claim Charge Amount		Enter the total billed amount for the entire claim/encounter.

Loop ID	Reference	Name	Codes	Notes/Comments
				Note: ForwardHealth interChange will process claims/encounters submitted with a negative total billed amount as if the provider submitted a zero total billed amount.
2300	CLM05-1	Facility Type Code		Enter the first two digits of the type of bill. See the National Uniform Billing Committee (NUBC) Manual or Web site at *www.nubc.org/* for the appropriate value selections.
2300	CLM05-3	Claim Frequency Code	1 2 3 4 7 8	The third digit of the type of bill, as defined by the NUBC, is the frequency code. Use the claim frequency code to indicate whether the claim/encounter is an admit through discharge, interim, or a replacement/void of a previously adjudicated and paid claim/encounter. It is always appropriate to use the following values when submitting claims/encounters to ForwardHealth interChange: • "1" — Indicates the complete claim/encounter is being submitted to ForwardHealth interChange. • "7" — Indicates this claim/encounter is replacing a previously submitted and adjudicated claim/encounter. ForwardHealth interChange will void the previously submitted claim/encounter and completely replace it with this corrected claim/encounter. • "8" — Indicates ForwardHealth interChange should recoup the previously submitted claim/encounter in its entirety. When submitting claims with type of bill 11X, 15X, 16X, 17X, or 18X, it is also appropriate to use the following values: • "2" — Indicates that this is the first claim/encounter in an interim billing situation. ForwardHealth interChange will process the claim/encounter as if the provider submitted a "1". • "3" — Indicates that this is a continuing claim/encounter of an interim billing situation. ForwardHealth interChange will process the claim/encounter as if the provider submitted a "7". See the notes for the usage of "7" above. • "4" — Indicates that this is the last claim/encounter in an interim billing situation. ForwardHealth interChange will process the claim/encounter as if the provider submitted a "7". See the notes for the usage of "7" above. *Note:* The use of values "3", "4", "7", and "8" can result in the previously submitted claim/encounter being adjusted. Include the

Loop ID	Reference	Name	Codes	Notes/Comments
				internal control number (ICN) from the previously submitted claim/encounter in the Original Reference Number segment in Loop 2300. Any adjustment request without the previous ICN will be processed as if the provider submitted a “1” in this element. Electronic claim adjustments are subject to the same requirements as paper claim adjustments and therefore may result in a letter to the provider if the requirements are not met. Do not use adjustment values if reconsideration of the original claim payment is needed. All requests for claim reconsideration should be submitted on paper with supporting documentation. See the NUBC Manual or Web site, *www.nubc.org/* for additional information on value selections. Encounter: Provider letters and paper submissions/requests will not be supported for encounter processing.
2300	DTP	Admission Date/Hour		
2300	DTP	Date-Repricer Received Date		This segment will not be used by ForwardHealth.
2300	CL1	Institutional Claim Code		Use this segment to provide hospital claim/encounter specific information.
2300	CL101	Admission Type Code		Enter the Type of Admission Code. See the NUBC Manual or Web site, *www.nubc.org/* for additional information on value selections.
2300	CL102	Admission Source Code		Enter the Source of Admission Code. See the NUBC Manual or Web site, *www.nubc.org/* for additional information on value selections.
2300	CL103	Patient Status Code		Enter the Patient Status Code. See the NUBC Manual or Web site, *www.nubc.org/* for additional information on value selections.
2300	PWK	Claim Supplemental Information		Claim: Use this segment if it is necessary to indicate supplemental information has been submitted for the claim. Encounter: Use this segment if it is necessary to indicate an encounter chart review.

Loop ID	Reference	Name	Codes	Notes/Comments
2300	PWK01	Report Type Code	09 (Encounter)	Encounter: Enter the value “09” — Progress Report.
2300	PWK02	Attachment Transmission Code	BM (Claim) AA (Encounter)	Claim: Enter the value “BM” — By Mail. Encounter: Enter the value “AA” – Available by request at provider site.
2300	PWK05	Identification Code Qualifier	AC (Claim)	Claim: Enter the value “AC” — Attachment Control Number. This element is required when PWK02 contains the value “BM”.
2300	CN1	Contract Information		The DHS requires BadgerCare Plus/Supplemental Security Income (SSI) HMOs to report a "shadow price" on the HMO Encounter 837 transaction when the service is provided by a sub-capitated provider.
2300	CN101	Contract Type Code	05 (Capitated)	Encounter: Enter the value “05” to indicate a capitated amount to follow. This element is required on encounters when the service is provided by a sub-capitated provider.
2300	CN102	Contract Amount		Enter the "shadow price".
2300	REF	Prior Authorization		ForwardHealth interChange does not require the prior authorization (PA) number be submitted on the 837 transaction. *Note:* For PA policy guidelines refer to your service area of the Online Handbook.
2300	REF	Payer Claim Control Number		Include this segment when requesting an electronic adjustment (a value of “7” or “8” in CLM05-3 indicates that an adjustment is being requested).
2300	REF02	Payer Claim Control Number		Enter the most recent ICN assigned by ForwardHealth interChange. This is the ICN that will be adjusted.
2300	REF	Auto Accident State		This segment will not be used by ForwardHealth.
2300	CRC	EPSDT Referral		This segment will not be used by ForwardHealth.
2300	HI	Principal Diagnosis		Enter the principal diagnosis in this segment.
2300	HI01-9	Present on Admission Indicator	N U W Y	Enter the Present on Admission (POA) indicator as applicable. *Note:* Exempt providers are not required to submit a POA indicator.

Loop ID	Reference	Name	Codes	Notes/Comments
2300	HI	Admitting Diagnosis		Enter the admitting diagnosis in this segment. *Note:* An admitting diagnosis is required for all inpatient claims/encounters.
2300	HI	Patient's Reason for Visit		Enter the patient reason(s) for visit in this segment *Note:* A patient reason for visit is required on outpatient claims/encounters.
2300	HI	Other Diagnosis Information		Enter additional diagnosis codes in this segment, if necessary. *Note:* ForwardHealth interChange will use up to 24 diagnosis codes in this segment, in addition to the principal diagnosis, to process a claim/encounter.
2300	HI01-2 HI02-2 HI03-2 HI04-2 HI05-2 HI06-2 HI07-2 HI08-2 HI09-2 HI10-2 HI11-2 HI12-2	Other Diagnosis		Enter additional diagnosis codes in order of importance.
2300	HI01-9 HI02-9 HI03-9 HI04-9 HI05-9 HI06-9 HI07-9 HI08-9 HI09-9 HI10-9 HI11-9 HI12-9	Present on Admission Indicator	N U W Y	Enter the POA indicator if applicable. *Note:* Exempt providers are not required to submit a POA indicator.
2300	HI	Principal Procedure Information		Enter principal procedure information in this segment.
2300	HI	Other Procedure Information		Enter additional procedure information in this segment.

Loop ID	Reference	Name	Codes	Notes/Comments
2300	HI	Occurrence Span Information		Enter occurrence span information in this segment. *Note:* To document a hospital leave of absence for long term care claims/encounters, enter “75” as the occurrence span code and list the dates of absence. At the detail level, enter the corresponding revenue code “185”.
2300	HI	Value Information		Enter value code information in this segment. *Note:* Use this segment to indicate covered and noncovered days for all institutional claim/encounter types.
2310A	NM1	Attending Provider Name		
2310A	NM101	Entity Identifier Code	71	When code 71 is used, the term physician covers any type of provider filling this role.
2310A	NM103	Attending Provider Last Name		The attending provider is the individual who has overall responsibility for the patient's medical care and treatment reported on the claim/encounter. This can be an individual or organizational entity. For example, personal care providers: This data element should indicate the attending personal care provider, not the attending physician. If the attending personal care provider does not have an NPI or ForwardHealth provider number, then the billing organization information should be used.
2310A	PRV	Attending Provider Specialty		*Note:* Taxonomy codes are only required if the NPI has multiple certifications and the taxonomy is necessary to determine the appropriate one.
2310A	PRV03	Provider Taxonomy Code		Enter the attending provider’s taxonomy. *Note:* The taxonomy submitted must match the taxonomy on file with ForwardHealth.
2310A	REF	Attending Provider Secondary Identification		Use this segment as an identifier if no NPI is available for the provider. If the provider has an NPI, report it in NM1 segment and do not send this REF segment.
2310A	REF01	Reference Identification Qualifier	G2	Enter “G2” to submit the provider’s ForwardHealth provider number.
2310A	REF02	Attending Provider Secondary Identifier		Enter the attending provider’s eight or nine-digit provider number.

Loop ID	Reference	Name	Codes	Notes/Comments
2310B	REF	Operating Physician Secondary Identification		Use this segment as an identifier if no NPI is available for the provider. If the provider has an NPI, report it in NM1 segment and do not send this REF segment.
2310B	REF01	Reference Identification Qualifier	G2	Enter “G2” to submit provider’s ForwardHealth ID number.
2310B	REF02	Operating Provider Secondary Identifier		Enter the operating provider’s eight or nine-digit provider number.
2310B	REF	Other Operating Physician Secondary Identification		Use this segment as an identifier if no NPI is available for the provider. If the provider has an NPI, report it in the NM1 segment and do not send this REF segment.
2310C	REF01	Reference Identification Qualifier	G2	Enter “G2” to submit the provider’s ForwardHealth provider number.
2310C	REF02	Other Operating Provider Secondary Identifier		Enter the other operating provider’s eight or nine-digit provider number.
2310D		Rendering Provider		*Note:* This loop is required if billing a professional service on an outpatient claim, otherwise do not send.
2310D	REF	Rendering Provider Secondary Identification		Use this segment as an identifier if no NPI is available for the provider. If the provider has an NPI, report it in the NM1 segment and do not send this REF segment.
2310D	REF01	Reference Identification Qualifier	G2	Enter “G2” to submit provider’s ForwardHealth provider number.
2310D	REF02	Rendering Provider Secondary Identifier		Enter the rendering provider’s eight or nine-digit ForwardHealth provider number.
2310F		Referring Provider Name		*Note:* This loop is required if billing a professional service on an outpatient claim/encounter, otherwise do not send.
2310F	NM1	Referring Provider Name		Required on an outpatient claim/encounter when the referring provider is different than the attending provider. Information in Loop ID-2310 applies to the entire claim/encounter unless overridden on a service

Loop ID	Reference	Name	Codes	Notes/Comments
				line by the presence of Loop ID-2420 with the same value in NM101.
2310F	NM101	Entity Identifier Code	DN	Enter “DN” to submit the referring provider’s name and NPI.
2310F	NM102	Entity Type Qualifier	1	The referring provider must be a person.
2310F	NM103	Referring Provider Last Name		Enter the referring provider’s last name.
2310F	NM104	Referring Provider First Name		Enter the referring provider’s first name.
2310F	NM108	Identification Code Qualifier	XX	Enter “XX” to indicate that the next field will contain the referring provider’s NPI.
2310F	NM109	Referring Provider Identifier		Enter the referring provider’s NPI.
2320	SBR	Other Subscriber Identification		This segment is used when other payers are known to potentially be involved in paying on this claim. Managed care organizations use this segment on an encounter to identify the MCO as a payer. This would be in addition to any other payer information that may have been on the encounter prior to the MCO’s adjudication.
2320	SBR09	Claim Filing Indicator Code	HM (Encounter)	Encounter: Enter “HM” to identify MCO is providing amount paid to its provider.
2320	CAS	Claim Level Adjustments		Include this segment when another payer has made payment at the claim level. If the other payer returned an 835 transaction, the CAS segment from the 835 should be copied to this CAS. *Note:* For more information on indicators and disclaimer codes, see Section 4.1 of this guide.
2320	AMT	COB Payer Paid Amount		This segment contains the amount paid on the claim by the payer within the 2320 loop. *Note:* For more information on indicators and disclaimer codes, see Section 4.1 of this guide.
2320	AMT	Remaining Patient Liability		Enter the remaining patient liability amount in this segment. *Note:* For more information on indicators and disclaimer codes, see Section 4.1 of this guide.

Loop ID	Reference	Name	Codes	Notes/Comments
2320	AMT	COB Total Non-Covered Amount		Use this segment when the member has other insurance or Medicare but the charges are known to be noncovered. When applicable based on the above statement, enter the total billed amount and no other AMT segments for the other payer. *Note:* When reporting for commercial insurance, this will generate an OI Indicator of OI-Y. When reporting for Medicare, this will generate a Medicare Disclaimer of "8".
2320	MIA	Inpatient Adjudication Information		Include this segment when it is returned in the 835 transaction from a previous payer or if this iteration of 2320 is being used to indicate that an inpatient hospital or nursing home claim was not submitted to another payer based on the notes in the SBR segment of Loop 2320 of this guide.
2320	MOA	Outpatient Adjudication Information		Include this segment when it is returned in the 835 transaction from a previous payer or if this iteration of 2320 is being used to indicate an outpatient claim was not submitted to another payer based on the notes in the SBR segment of Loop 2320 of this guide.
2330B	NM1	Other Payer Name		
2330B	NM109	Other Payer Primary Identifier		Enter the other payer's identifier. *Note:* ForwardHealth interChange will use this number in combination with Loop 2430 to calculate other insurance and Medicare payments.
2330B	DTP	Claim Check or Remittance Date		Required when the payer identified in this loop has previously adjudicated the claim. *Note:* This information is either included here or in Loop 2430.
2330B	REF	Other Payer Prior Authorization Number		This segment will not be used by ForwardHealth.
2330B	REF	Other Payer Claim Control Number		This segment will not be used by ForwardHealth.
2330B	REF	Other Payer Prior Authorization Number		This segment will not be used by ForwardHealth.

Loop ID	Reference	Name	Codes	Notes/Comments
2330B	REF	Other Payer Claim Control Number		This segment will not be used by ForwardHealth.
2300C		Other Payer Attending Provider		This loop will not be used by ForwardHealth.
2300D		Other Payer Operating Physician		This loop will not be used by ForwardHealth.
2330E		Other Payer Other Operating Physician		This loop will not be used by ForwardHealth.
2330G		Other Payer Rendering Provider		This loop will not be used by ForwardHealth.
2330H		Other Payer Referring Provider		This loop will not be used by ForwardHealth.
2330I		Other Payer Billing Provider		This loop will not be used by ForwardHealth.
2400	SV2	Institutional Service Line		
2400	SV201	Service Line Revenue Code		Enter the revenue code specific to the service information being reported. *Note:* To document a hospital leave of absence on a long-term care claim/encounter, use 185 for the revenue code. This will correspond to the occurrence span dates and occurrence span code of 75 reported in the claim/encounter header.
2400	SV203	Line Item Charge Amount		Enter the billed amount for each service line. *Note:* ForwardHealth interChange will process claims/encounters submitted with a negative service line billed amount as if the provider submitted a zero service line billed amount.
2400	DTP	Date-Service Date		Enter the service date information in this segment.
2400	DTP02	Date Time Period Format Qualifier	D8 RD8	Enter the value “D8” to indicate a single date of service or “RD8” to indicate a range of service dates for the service line. *Note:* When “RD8” is used on outpatient claims/encounters, ForwardHealth interChange will assume the exact same service, including

Loop ID	Reference	Name	Codes	Notes/Comments
				the number of units, was performed on each day within the range.
2400	DTP03	Service Date		Enter the date(s) the procedure was performed. *Note*: ForwardHealth interChange requires service line dates on all outpatient claims/encounters and claims/encounters with prescription drugs billed.
2410		Drug Identification		*Note:* This loop is required when submitting a drug related HCPCS procedure code.
2410	LIN	Drug Identification		
2410	LIN03	National Drug Code		Enter the National Drug Code in this field when applicable.
2410	CTP	Drug Quantity		
2410	CTP04	National Drug Unit Count		Enter the numeric quantity in this field.
2410	CTP05-1	Code Qualifier	F2 GR ME ML UN	Select the unit of measurement that corresponds to the value entered in the CTP04 field.
2410	REF	Prescription or Compound Drug Association Number		Enter prescription or link sequence number in this segment.
2410	REF01	Reference Identification Qualifier	XZ VY	Enter the value “XZ” to indicate the pharmacy prescription number or “VY” to indicate a link sequence number.
2420B		Other Operating Physician		This loop will not be used by ForwardHealth.
2420C		Rendering Provider Name		This loop is required when billing professional services on an outpatient claim/encounter and the service level rendering provider is different than the claim/encounter level rendering provider.
2420C	REF	Rendering Provider Secondary Identification		Use this segment as an identifier if no NPI is available for the provider. If the provider has an NPI, report it in NM1 segment and do not send this REF segment.
2420C	REF01	Reference Identification Qualifier	G2	Enter the value “G2” for the ForwardHealth provider number.

Loop ID	Reference	Name	Codes	Notes/Comments
2420C	REF02	Rendering Provider Secondary Identifier		Enter the rendering provider's ForwardHealth provider number.
2420D	NM1	Referring Provider Name		Required on an outpatient claim/encounter when the referring provider is different than the attending provider and the service level referring provider is different than the claim/encounter level referring provider.
2420D	NM101	Entity Identifier Code	DN	Enter "DN" to submit the referring provider's name and NPI.
2420D	NM102	Entity Type Qualifier	1	The referring provider must be a person.
2420D	NM103	Referring Provider Last Name		Enter the referring provider's last name.
2420D	NM104	Referring Provider First Name		Enter the referring provider's first name.
2420D	NM108	Identification Code Qualifier	XX	Enter "XX" to indicate that the next field will contain the referring provider's NPI.
2420D	NM109	Referring Provider Identifier		Enter the referring provider's NPI.
2430	SVD	Line Adjudication Information		This segment is used when other payers are known to potentially be involved in paying on this claim at the detail line. Managed care organizations can use this segment on an encounter to identify the detail amount paid to their provider.
2430	SVD01	Other Payer Primary Identifier		The identifier indicates the other payer by matching the appropriate Other Payer Primary Identifier in Loop 2330B, Element NM109.
2430	SVD02	Service Line Paid Amount		Encounter: Enter the MCO amount paid to provider.
2430	CAS	Line Adjustment		Include this segment when another payer has made payment at the service line. If the other payer returned an 835 with a service line CAS, the CAS segment from the 835 should be copied to this CAS. ForwardHealth interChange will use the information in the CAS segment in place of the "other insurance indicator" and "Medicare disclaimer code" submitted on paper claims.

Loop ID	Reference	Name	Codes	Notes/Comments
				837P and "Medicare disclaimer code" submitted prior to HIPAA. Encounter: Paper claims are not supported. To generate another insurance indicator of “D”, a CAS segment for a non-Medicare payer must be used in either Loop 2320 or 2430. The value(s) of the claim adjustment reason code(s) is used to determine if the other insurance indicator is “D” or blank. If this iteration of Loop 2430 contains information from a Medicare payer, ForwardHealth interChange will also look for Medicare’s coinsurance, copayment, and deductible.

4 Transaction Instructions Additional Information

4.1 Business Scenarios

4.1.1 Terminology

The term subscriber will be used as a generic term throughout the companion guide. This term could refer to any one of the following depending upon the health program for which the 837I transaction is being processed:

- BadgerCare Plus.
- SeniorCare.
- Wisconsin Chronic Disease Program.
- Wisconsin Medicaid.
- Wisconsin Well Woman Program.

4.1.2 Examples

ForwardHealth interChange derives coordination of benefit information from the 837 that providers directly submitted. This companion guide has pointed out the pieces of information ForwardHealth interChange uses to derive those values; however, the implementation guide frequently requires additional information in the segments where this information is found. Below are examples that show how the information may appear on the 837.

4.1.3 Other Insurance Indicators

In order to have another insurance indicator assigned to a claim/encounter, at least one additional payer must be represented on the claim/encounter. The inclusion of a 2320 loop and any required subloops represent each payer. ForwardHealth can assign one of three Other Insurance codes to electronic claims/encounters based on information supplied on the claim/encounter.

There are four Other Insurance (OI) Indicators that potentially can be associated with a claim/encounter. The four codes are: “Blank”, “OI-P”, “OI-D”, and “OI-Y”.

A disclaimer code of “Blank” is present when the member does not have commercial insurance. A disclaimer code of “OI-P” is present when the member has commercial insurance coverage, the claim was submitted to the insurance carrier, and a payment was made on the claim. A disclaimer code of “OI-D” is present when the member has

commercial insurance coverage and the claim was submitted to the insurance carrier, but the claim was denied.

There are various situations that could render a disclaimer code of “OI-Y”. These include, but are not limited to, the member denied coverage or will not cooperate, the provider knows the service in question is not covered by the carrier, the member’s commercial health insurance failed to respond to initial and follow-up claims, benefits are not assignable or cannot get assignment, or benefits are exhausted.

Other Insurance = OI-D

In this example, the provider billed $146.00. The other insurance carrier allowed $0.00 and paid $0.00. The reason the other insurance carrier did not pay the claim is indicated with the CAS segment copied from the 835 received from the other insurance carrier.

Loop 2320
SBR*A*18*******CI~
CAS*CO*45*146.00~
AMT*D*0~
OI***Y***Y~

Loop 2330A
NM1*IL*1*LAST NAME*FIRST NAME****MI*999999999~

Loop 2330B
NM1*PR*2*ABC INSURANCE*****PI*001~
DTP*573*D8*20100819~

Other Insurance = OI-P

In this example, the provider billed $100.00 and applied $50.00 to deductible and $50.00 was beyond max fee.

Loop 2320
SBR*A*18*******CI~
CAS*PR*1*50.00~
CAS*CO*45*50.00~
AMT*D*0~
OI***Y***Y~

Loop 2330A
NM1-IL*1*LAST NAME*FIRST NAME****MI*9999999999~

Loop 2330B
NM1*PR*2*ABC INSURANCE*****PI*001~
DTP*573*DE*20100819~

Other Insurance = OI-Y

In this example, the provider billed $40.00. The member has other insurance coverage, but the claim was not submitted to his or her insurance carrier. Refer to the ForwardHealth Online Handbook to determine when it is appropriate to submit claims/encounters to ForwardHealth without first receiving payment from the other insurance carrier.

Loop 2320
SBR*A*18*******CI~
AMT*A8*40.00~
OI***Y***Y~

Loop 2330A
NM1*IL*1*LAST NAME*FIRST NAME****MI*99999999~

Loop 2330B
NM1*IL*2*ABC INSURANCE*****PI*001~

4.1.4 Medicare Status Disclaimer Code

There are three Medicare Disclaimers that can potentially be associated with a claim/encounter. The three codes are: “Blank”, “7”, and “8”. A disclaimer code of “Blank” is present when the member is not enrolled in Medicare or he or she is enrolled in Medicare and Medicare has made a payment on the claim. A disclaimer code of “7” is present when the member is enrolled in Medicare, the claim was submitted to Medicare, and Medicare denied payment. A disclaimer code of “8” is present when Medicare was billed for the claim but deemed the services “noncovered” or when the services are known to be “noncovered” by Medicare and therefore not submitted for payment.

Medicare Disclaimers (ForwardHealth Examples)

In order to have a Medicare disclaimer code assigned to a claim/encounter, at least one Medicare payer must be represented on the claim/encounter. The inclusion of a 2320 loop and any required subloops represent each payer. ForwardHealth

interChange can assign one of two Medicare disclaimer codes to electronic claims based on information supplied on the claim.

Medicare Disclaimer = 7 Denied

In this example, the provider billed $146.00. Medicare allowed zero and paid zero. The reason Medicare did not pay the claim is indicated with the CAS segment copied from the 835 received from Medicare.

Loop 2320
SBR* A*18*******MB~
CAS*CO*45*145.00~
AMT*D*0~
OI***Y***Y~

Loop 2330A
NM1*IL*1*LAST NAME*FIRST NAME****MI*999999999~

Loop 2330B
NM1*PR*2*MEDICARE*****PI*004~
DTP*573*D8*20100819~

Medicare Disclaimer = 8

In this example, the provider billed $40.00. The member is a Medicare beneficiary, but the claim was not submitted to Medicare. Refer to the ForwardHealth Online Handbook to determine when it is appropriate to submit claims/encounters to ForwardHealth without first receiving payment from Medicare.

Loop 2320
SBR*A*18*******MB~
AMT*A8*40.00~
OI***Y***Y~

Loop 2330A
NM1*IL*1*LAST NAME*FIRST NAME****MI*99999999~

Loop 2330B
NM1*IL*2*MEDICARE*****PI*004~

4.2 Payer-Specific Business Rules and Limitations

4.2.1 Scheduled Maintenance

ForwardHealth recycles the real-time servers every night between 00:00 a.m. to 01:00 a.m. Central Standard Time. Real-time processing is not available during this period.

ForwardHealth schedules regular maintenance every Sunday from 00:00 a.m. to 04:00 a.m. CST. Real-time processing is not available during this period.

4.3 Frequently Asked Questions

None.

4.4 Other Resources

Washington Publishing Company (WPC) at *www.wpc-edi.com/.*
ASC X12 at *www.x12.org/.*

For further information about how ForwardHealth interChange processes a HIPAA transaction, contact the ForwardHealth EDI Department at (866) 416-4979.

5 Change Summary

Version 1.1 Revision Log

Companion Document: Health Care Claim: Institutional (837I)
Approved: 07/2012
Modified by: WJ2

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2300	15	DTP	Admission Date/Hour		Removed WCDP APC note.
2300	16	HI	Admitting Diagnosis		Removed WCDP note.

Version 1.2 Revision Log

Companion Document: Health Care Claim: Institutional (837I)
Approved: 09/2012
Modified by: DJC

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
	Document in Entirety				Replaced “claims” or “claim” with “claims/encounters” or “claim/encounter” as applicable throughout the guide.
	10	GS03	Application Receiver’s Code	WISC_ TXIX WISC_ WWWP WISC_ WCDP	Added clarification. Encounter: “WISC_TXIX” only.
	10	BHT	Beginning of Hierarchical Transaction		Added segment.
	10	BHT06	Claim Identifier	CH (Claim) RP (Encounter)	Added element. Element is used to designate encounter. Claims will use “CH”; encounter will use “RP”.
1000B	10	NM109	Receiver Primary Identifier	WISC_ TXIX WISC_ WWWP WISC_ WCDP	Added clarification. Encounter: “WISC_TXIX” only.
2010AB	11	NM1	Pay-to-Address		Added clarification. Encounter submissions will not receive an 835.
2010BB	12	NM109	Payer Identifier	WISC_ TXIX WISC_ WWWP WISC_ WCDP	Added clarification. Encounter: “WISC_TXIX” only.

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2300	15	CLM05-3	Claim Frequency Code		Added clarification. Provider letters and paper submissions/ requests will not be supported for encounter processing.
2300	15	PWK	Claim Supple-mental Information		Added clarification. Segment is used to designate a chart review encounter.
2300	15	PWK01	Report Type Code	09 (Encounter)	Added Element. Element will designate a chart review encounter.
2300	15	PWK02	Attachment Transmissio n Code	BM (Claim) AA (Encounter)	Indicated “BM” is for claim. Replaced “BM” with IG language “By Mail.” Added code “AA” for encounter.
2300	16	PWK05	Identification Code Qualifier	AC (Claim)	Indicated “AC” is for claim.
2320	19	SBR	Other Subscriber Identification		Added segment. Encounter can use this element to identify MCO is providing amount paid to its provider.
2320	19	SBR09	Claim Filing Indicator Code	HM (Encounter)	Added segment. Encounter can use “HM” to identify MCO is providing amount paid to its provider.
2430	23	SVD	Line Adjudication Information		Added segment.
2430	23	SVD01	Other Payer Primary Identifier		Added element. Encounter can use this element to identify MCO as a payer.
2430	24	SVD02	Service Line Paid Amount		Added element. Encounter: Enter the MCO amount paid to provider.
2430	24	CAS	Line Adjustment		Added clarification. Encounter paper claims are not supported.
	28				Added Medicare Disclaimer = Blank (Medicare Allowed/Paid) example.

Version 1.3 Revision Log

Companion Document: Health Care Claim: Institutional (837I)
Approved: 10/2013
Modified by: WJ2

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2310A	17	NM1	Attending Provider Name		
2310A	18	NM101	Entity Identifier Code	71	When code 71 is used, the term physician covers any type of provider filling this role.
2310A	18	NM103	Attending Provider Last Name		The attending provider is the individual who has overall responsibility for the patient's medical care and treatment reported on the claim/encounter. This can be an individual or organizational entity. For example, personal care providers: This data element should indicate the attending personal care provider, not the attending physician. If the attending personal care provider does not have an NPI or ForwardHealth provider number, then the billing organization information should be used.
2310F	19		Referring Provider Name		*Note:* This loop is required if billing a professional service on an outpatient claim/encounter, otherwise do not send.
2310F	19	NM1	Referring Provider Name		Required on an outpatient claim/encounter when the referring provider is different than the attending provider. Information in Loop ID-2310 applies to the entire claim/encounter unless overridden on a service line by the presence of Loop ID-2420 with the same value in NM101.
2310F	19	NM101	Entity Identifier Code	DN	Enter “DN” to submit the referring provider’s name and NPI.
2310F	19	NM102	Entity Type Qualifier	1	The referring provider must be a person.
2310F	20	NM103	Referring Provider Last Name		Enter the referring provider’s last name.

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2310F	20	NM104	Referring Provider First Name		Enter the referring provider's first name.
2310F	20	NM108	Identification Code Qualifier	XX	Enter "XX" to indicate that the next field will contain the referring provider's NPI.
2310F	20	NM109	Referring Provider Identifier		Enter the referring provider's NPI.
2420D	24	NM1	Referring Provider Name		Required on an outpatient claim/encounter when the referring provider is different than the attending provider and the service level referring provider is different than the claim/encounter level referring provider.
2420D	24	NM101	Entity Identifier Code	DN	Enter "DN" to submit the referring provider's name and NPI.
2420D	24	NM102	Entity Type Qualifier	1	The referring provider must be a person.
2420D	24	NM103	Referring Provider Last Name		Enter the referring provider's last name.
2420D	24	NM104	Referring Provider First Name		Enter the referring provider's first name.
2420D	24	NM108	Identification Code Qualifier	XX	Enter "XX" to indicate that the next field will contain the referring provider's NPI.
2420D	24	NM109	Referring Provider Identifier		Enter the referring provider's NPI.

Version 1.4 Revision Log

Companion Document: 837 Health Care Claim/Encounter: Institutional (837I)
Approved: 04/2015
Modified by: WJ2

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2300	14	CN1	Contract Information		The DHS requires BadgerCare Plus/SSI HMOs to report a "shadow price" on the HMO Encounter 837 transaction when the service is provided by a sub-capitated provider.
2300	14	CN101	Contract Type Code	05 (Capitated)	Encounter: Enter the value "5" to indicate a capitated amount to follow. This element is required on encounters when the service is provided by a sub-capitated provider.
2300	14	CN102	Contract Amount		Enter the "shadow price".