



Instructions Related to 837 Health Care Claim/Encounter: Professional (837P) 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 Guides (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 documents or as a single document.

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: Professional Transaction Instructions

1 Transaction Instruction Introduction

1.1 Background

1.1.1 Overview of HIPAA Legislation

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) carries 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 C.F.R. § 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 documents. 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 ID 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 Functional Acknowledgement, rejected 999 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 which are included in Section 3 of this guide.

Unique ID	Name
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005010X222A1	837 Health Care Claim: Professional (837P)
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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 05010X222A1 — 837 Health Care Claim: Professional

Loop ID	Reference	Name	Codes	Notes/Comments
	ISA	Interchange Control Header		The ISA is a fixed-length record with fixed-length elements. <i>Note:</i> Deviating from the standard ISA element sizes will cause the interchange to be rejected.
	ISA03	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 Qualifier	ZZ	Enter the value “ZZ” — Mutually Defined.
	ISA08	Interchange Receiver ID	WISC_DHFS	Enter “WISC_DHFS”.
	GS	Functional Group Header		
	GS02	Application Sender's Code		Enter the same value as ISA06, the nine-digit numeric Trading Partner ID assigned by ForwardHealth interChange.

Loop ID	Reference	Name	Codes	Notes/Comments
	GS03	Application Receiver's Code	WISC_TXIX WISC_WWWP WISC_WCDP	Claims: Enter the value "WISC_TXIX" for Wisconsin Medicaid and BadgerCare Plus, "WISC_WWWP" for the WWWP or "WISC_WCDP" for WCDP. Encounters: "WISC_TXIX" only.
	BHT	Beginning of Hierarchical Transaction		
	BHT06	Claim Identifier	CH (Claim) RP (Encounter)	Claims: Enter the value "CH" — Chargeable. Encounters: 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 that the claims/encounters are being sent to ForwardHealth interChange.
1000B	NM109	Receiver Primary Identifier	WISC_TXIX WISC_WWWP WISC_WCDP	Enter the same value as GS03. Claim: Enter "WISC_TXIX" to indicate Wisconsin Medicaid, BadgerCare Plus and SeniorCare, "WISC_WWWP" to indicate the WWWP, or "WISC_WCDP" to indicate WCDP. Encounter: "WISC_TXIX" only.
2000A	PRV	Billing Provider Specialty Information		
2000A	PRV01	Provider Code	BI	<i>Note:</i> If a rendering provider is not indicated on the claim/encounter, ForwardHealth will assume the rendering provider and the billing provider are the same entity.

Loop ID	Reference	Name	Codes	Notes/Comments
2000A	PRV02	Reference Identification Qualifier	PXC	<p>Enter PXC “Health Care Provider Taxonomy” to indicate the next element will be the taxonomy code of the billing provider.</p> <p><i>Note:</i> Taxonomy codes are only required if the National Provider Identifier (NPI) has multiple certifications and the taxonomy is necessary to determine the appropriate one.</p>
2000A	PRV03	Provider Taxonomy Code		<p>Enter the provider’s taxonomy code.</p> <p><i>Note:</i> The provider is required to use the appropriate taxonomy code that is associated to the provider type and specialty currently on file with ForwardHealth.</p>
2010AA	NM1	Billing Provider Name		<p>Include this segment to submit the Billing Provider’s name and, when applicable, the Provider’s NPI when it is used as the identifier.</p>
2010AA	N3	Billing Provider Address		<p>Enter the address on file with ForwardHealth in this segment.</p> <p><i>Note:</i> 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.</p>
2010AA	N4	Geographic Location		<p>Use the physical address as reported on the provider’s Wisconsin Medicaid, WCDP, or WWWP certification.</p>
2010AA	N403	Postal Code		<p>Enter the ZIP+4 code that corresponds to the physical address on file with ForwardHealth.</p>
2010AB	NM1	Pay-to Address		<p><i>Note:</i> 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.</p> <p>Encounter submissions will not receive an 835.</p>

Loop ID	Reference	Name	Codes	Notes/Comments
2010AC	NM1	Pay-to Plan Name		This loop will only be used for subrogation.
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. <i>Note:</i> 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 ID card and the EVS do not match, use the spelling from the EVS.
2010BA	NM104	Subscriber First Name		Enter the member's first name. <i>Note:</i> 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 ID card and the EVS do not match, use the spelling from the EVS.
2010BA	NM108	Identification Code Qualifier	MI	Enter the value "MI" to indicate a member ID.
2010BA	NM109	Subscriber Primary Identifier		Enter the member's 10-digit ForwardHealth ID number. <i>Note:</i> Do not enter any other numbers or letters. Use the ForwardHealth ID card or the EVS to obtain the correct ID number.
2010BB	NM1	Payer Name		
2010BB	NM103	Payer Name	FORWARDHEALTH	Enter the 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 WCDP. Encounter: "WISC_TXIX" only.

Loop ID	Reference	Name	Codes	Notes/Comments
2010BB	REF	Billing Provider Secondary Identification		<p>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.</p> <p><i>Note:</i> Non-healthcare (Atypical) providers are required to submit this segment.</p>
2010BB	REF01	Reference Identification Qualifier	G2	<p>Enter the value "G2" for Wisconsin Medicaid, BadgerCare Plus, WCDP, and WWWP.</p>
2010BB	REF02	Payer Secondary Identifier		<p>Enter the eight or nine-digit billing provider number assigned by ForwardHealth interChange.</p> <p><i>Note:</i> Non-healthcare (Atypical) providers are required to submit their eight or nine-digit billing provider number.</p>
2010CA	REF	Property and Casualty Patient Identifier		<p>This segment will not be used by ForwardHealth.</p>
2300	CLM	Claim Information		<p>Enter relevant claim/encounter information in this segment.</p>
2300	CLM01	Patient Control Number		<p><i>Note:</i> ForwardHealth interChange will process member control numbers up to 20 characters in length.</p>
2300	CLM02	Total Claim Charge Amount		<p>Enter the total billed amount for the entire claim/encounter.</p> <p><i>Note:</i> ForwardHealth interChange will process claims/encounters submitted with a negative total billed amount as if the provider submitted a zero total billed amount.</p>
2300	CLM05-3	Claim Frequency Code	1 7 8	<p>The third digit of the type of bill, as defined by the National Uniform Billing Committee (NUBC), is the frequency code. Use one of the following claim frequency codes to indicate if the claim/encounter is being submitted for the first time or if it is a</p>

Loop ID	Reference	Name	Codes	Notes/Comments
				<p>replacement/void of a previously adjudicated claim/encounter and paid claim/encounter:</p> <ul style="list-style-type: none"> • "1" — Indicates that this is the first claim/encounter submitted to ForwardHealth interChange. • "7" — Indicates that 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 that ForwardHealth interChange should recoup the previously submitted claim/encounter in its entirety. <p><i>Note:</i> The use of values "7" and "8" can result in the previously submitted claim/encounter being adjusted. Include the internal control number (ICN) from the previously submitted claim/encounter in the original reference number segment in Loop 2300.</p> <p>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. ForwardHealth interChange will not adjust claims if all the details are denied from the previous submission.</p> <p>Do not use adjustment values if reconsideration of the original claim payment is needed. All requests for reconsideration should be submitted on paper with supporting documentation.</p> <p>The claim frequency code was switched to an external code source during the addenda process. See the NUBC manual or website, www.nubc.org/ for additional information on value selections.</p> <p>Encounter: Provider letters and paper submissions/requests will not be supported for encounter processing.</p>

Loop ID	Reference	Name	Codes	Notes/Comments
2300	DTP	Date-Property and Casualty Date of First Contact		This segment will not be used by ForwardHealth.
2300	DTP	Date-Repricer Received Date		This segment will not be used by ForwardHealth.
2300	PWK	Claim Supplemental Information		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.
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: 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 Department of Health Services 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" — 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".

Loop ID	Reference	Name	Codes	Notes/Comments
2300	REF	Prior Authorization		ForwardHealth interChange does not require the prior authorization (PA) number be submitted on the 837 transaction. <i>Note:</i> For PA policy guidelines refer to the applicable 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	Care Plan Oversight		This segment will not be used by ForwardHealth.
2300	HI	Health Care Diagnosis Code		Enter information in this segment to supply information related to the delivery of health care. <i>Note:</i> ForwardHealth interChange will use up to 12 diagnosis codes to process a claim/encounter.
2310A	REF	Referring 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 provider number.
2310A	REF02	Referring Provider Secondary Identifier		Enter the rendering provider's eight or nine-digit provider number.
2310B	PRV	Rendering Provider Specialty Information		<i>Note:</i> Taxonomy codes are only required if the NPI has multiple certifications and the taxonomy is necessary to determine the appropriate one.

Loop ID	Reference	Name	Codes	Notes/Comments
2310B	PRV03	Provider Taxonomy Code		Enter the rendering provider's taxonomy code. <i>Note:</i> The provider is required to use the appropriate taxonomy code that is associated to the provider type and specialty currently on file with ForwardHealth.
2310C	NM1	Service Facility Location Name		Enter the name of the rendering facility that is currently on file with ForwardHealth.
2310C	N3	Service Facility Location Address		Enter the address of the rendering facility that is currently on file with ForwardHealth.
2310C	N4	Service Facility Location City, State, ZIP+4		Enter the city, state, and ZIP+4 code that will correspond to the rendering facility address that is currently on file with ForwardHealth.
2310C	PER	Service Facility Contract Information		This segment will not be used by ForwardHealth.
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 indicate an HMO.
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, the CAS segment from the 835 should be copied to this CAS. <i>Note:</i> 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 Payer Paid Amount		<p>This segment contains the amount paid on the claim by the payer within the 2320 loop.</p> <p><i>Note:</i> For more information on indicators and disclaimer codes, see Section 4.1 of this guide.</p>
2320	AMT	COB Total Non-Covered Amount		<p>Use this segment when the member has other insurance or Medicare but the charges are known to be noncovered.</p> <p>When applicable based on the above statement, enter the total billed amount and no other AMT segments for the other payer.</p> <p><i>Note:</i> 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.</p>
2320	AMT	Remaining Patient Liability		<p>Enter the remaining patient liability amount in this segment.</p> <p><i>Note:</i> For more information on indicators and disclaimer codes, see Section 4.1 of this guide.</p>
2330B	NM1	Other Payer Name		
2330B	NM109	Other Payer Primary Identifier		<p>Enter the other payer's identifier.</p> <p><i>Note:</i> ForwardHealth interChange will use this number in combination with Loop 2430 to calculate other insurance and Medicare payments.</p>
2330B	DTP	Claim Check or Remittance Date		<p>Required when the payer identified in this loop has previously adjudicated the claim.</p> <p><i>Note:</i> This information is either included here or in Loop 2430.</p>
2330B	REF	Other Payer Claim Control Number		<p>This segment will not be used by ForwardHealth.</p>

Loop ID	Reference	Name	Codes	Notes/Comments
2330G		Other Payer Billing Provider		This loop will not be used by ForwardHealth.
2400	SV1	Professional Service Line		
2400	SV102	Line Item Charge Amount		Enter the billed amount for each service line. <i>Note:</i> 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	SV103	Unit or Basis for Measurement Code	MJ UN	Enter the value "MJ" to indicate minutes or "UN" to indicate units. <i>Note:</i> Use "MJ" to report anesthesia services. All other services should be reported using "UN".
2400	SV112	Family Planning Indicator	Y	Enter the value "Y" if the services are related to family planning. <i>Note:</i> This element is required by ForwardHealth when it is necessary to indicate a family planning service.
2400	DTP	Date — Service Date		This segment specifies any or all of a date, a time, or a time period.
2400	DTP02	Date Time Period Format Qualifier	D8	Enter value "D8" to indicate a single date of service or "RD8" to indicate a range of service dates. <i>Note:</i> When "RD8" is used, ForwardHealth interChange will assume that the exact same service, including the number of units, was performed on each day within the range.
2400	DTP	Date — Prescription Date		<i>Note:</i> Required when a drug is billed for this line and a prescription was written (or otherwise communicated by the prescriber if not written).

Loop ID	Reference	Name	Codes	Notes/Comments
2400	CN1	Contract Information		The Department of Health Services 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.
2400	CN101	Contract Type Code	05 (Capitated)	Encounter: Enter the value "05" — Capitated amount to follow. This element is required on encounters when the service is provided by a sub-capitated provider.
2400	CN102	Contract Amount		Enter the "shadow price".
2400	REF	Prior Authorization		ForwardHealth interChange does not require that the PA number be submitted on the 837 transaction. <i>Note:</i> For PA policy guidelines, refer to the applicable service area of the ForwardHealth Online Handbook.
2410		Drug Identification		<i>Note:</i> This loop is required when submitting a drug related Healthcare Common Procedure Coding System procedure code.
2410	LIN	Drug Identification		This segment specifies basic item/drug identification data.
2410	LIN03	National Drug Code		Enter the National Drug Code.
2410	CTP	Drug Quantity		Enter pharmacy information in this segment when applicable.
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.

Loop ID	Reference	Name	Codes	Notes/Comments
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 the line sequence number.
2410	REF02	Prescription Number		Enter the prescription number.
2420A	NM1	Rendering Provider Name		Enter the rendering provider's NPI in this segment if the rendering provider is ForwardHealth certified and different than the billing provider and different than the rendering provider listed in Loop 2310B.
2420A	PRV	Rendering Provider Specialty Information		<p>Include this segment to include the taxonomy code for the rendering provider if detail level rendering provider has been listed.</p> <p><i>Note:</i> Taxonomy codes are only required if the NPI has multiple certifications and the taxonomy is necessary to determine the appropriate one.</p>
2420A	PRV03	Provider Taxonomy Code		<p>Enter the rendering provider's taxonomy code for the service that is being billed.</p> <p><i>Note:</i> The provider is required to use the appropriate taxonomy code that is associated to the provider type and specialty currently on file with ForwardHealth.</p>
2420A	REF	Rendering Provider Secondary Identification		
2420D	NM1	Service Facility Location Name		Enter the name of the rendering facility that is currently on file with ForwardHealth.

Loop ID	Reference	Name	Codes	Notes/Comments
2420D	N3	Service Facility Location Address		Enter the address of the rendering facility that is currently on file with ForwardHealth.
2420D	N4	Service Facility Location City, State, ZIP+4		Enter the city, state, and ZIP+4 code that will correspond to the rendering facility address that is currently on file with ForwardHealth.
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		
2430	CAS	Line Adjudication		<p>Include this segment when another payer has made payment at the service line. If the other payer returned an 835 remittance, the CAS segment from the 835 should be copied to this CAS.</p> <p><i>Note:</i> ForwardHealth interChange will use the information in the CAS segment in place of the "other insurance indicator" and "Medicare disclaimer code" submitted prior to HIPAA.</p> <p>To generate a Medicare disclaimer code of "7", a CAS segment for a Medicare payer must be used in Loop 2430. The value(s) of the claim adjustment reason code(s) is used to determine which value is applied.</p> <p>To generate an other 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.</p> <p>If this iteration of Loop 2430 contains information from a Medicare payer, ForwardHealth interChange will also look for Medicare's coinsurance, copayment, and deductible.</p>

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 837P transaction is being processed:

- BadgerCare Plus.
- Wisconsin 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 an other 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 can potentially be associated with a claim/encounter. The four code options 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, the claim was submitted to the insurance carrier but the claim was denied.

In this example, the provider billed \$146.00. The other insurance carrier allowed zero and paid zero. 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*PR*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*004~  
DTP*573*D8*20100819~
```

In this example, the provider billed \$100.00 and applied \$50 to deductible and \$50 was beyond the maximum allowable 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*999999999~

Loop 2330B

NM1*PR*2*ABC INSURANCE****PI*004~

DTP*573*D8*20100819~

In this example, the provider billed \$40.00. The member has Other Insurance coverage, but the claim was not submitted to their 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*999999999~

Loop 2330B

NM1*IL*2*ABC INSURANCE****PI*004~

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 when they are 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 = Blank (Medicare Allowed/Paid)

In this example, the provider billed \$100.00 and applied \$50 to the deductible and \$50 was beyond the maximum allowable fee.

Loop 2320

```
SBR*A*18*****MB~  
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~
```

Loop 2430

```
SVD*001*0*HC:E0431**1.00~  
CAS*PR*1*50.00~  
CAS*CO*45*50.00~  
DTP*573*D8*20100819~
```

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~  
AMT*D*0~  
OI***Y***Y~
```

Loop 2330A

NM1*IL*1*LAST NAME*FIRST NAME****MI*99999999~

Loop 2330B

NM1*PR*2*MEDICARE*****PI*004~

Loop 2430

SVD*001*0*HC:E0431**1.00~

CAS*CO*96*146.00~

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 (CST). 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 Electronic Data interchange (EDI) Department at 866-416-4979.

5 Transaction Instructions Change Summary

Version 1.1 Revision Log

Companion Document: 837 Health Care Claim/Encounter: Professional (837P)

Approved: 04/2012

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.
2010	11	2010AB	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.
2300	14	CLM05-3	Claim Frequency Code		Added clarification. Provider letters and paper submissions/ requests will not be supported for encounter processing.
2300	15	PWK	Claim Supplemental 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 Transmission Code	BM (Claim) AA (Encounter)	Indicated "BM" is for claim. Replaced "BM" with IG language "By Mail." Added code "AA" for encounter.

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2300	15	PWK05	Identification Code Qualifier	AC (C)	Indicated "AC" for claim.
2320	17	SBR	Other Subscriber Identification		Added segment. Encounter can use this element to identify MCO is providing amount paid to its provider.
2320	17	SBR09	Claim Filing Indicator Code	HM (Encounter)	Added element. Encounter can use "HM" to identify MCO as a payer.
2400	21	SVD	Line Adjudication Information		Added segment.
2430	21	SVD01	Other Payer Primary Identifier		Added element. Encounter can use this element to identify MCO as a payer.
2430	21	SVD02	Service Line Paid Amount		Added element. Encounter can use to identify MCO amount paid to the provider at line level.

Version 1.2 Revision Log

Companion Document: 837 Health Care Claim/Encounter: Professional (837P)

Approved: 04/2015

Modified by: WJ2

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2300	16	CN1	Contract Information		The Department of Health Services 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	16	CN101	Contract Type Code	05 (Capitated)	Encounter: Enter the value "5" — Capitated amount to follow. This element is required on encounters when the service is provided by a sub-capitated provider.
2300	16	CN102	Contract Amount		Enter the "shadow price".

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2400	20	CN1	Contract Information		The Department of Health Services 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.
2400	20	CN101	Contract Type Code	05 (Capitated)	Encounter: Enter the value "5" — Capitated amount to follow. This element is required on encounters when the service is provided by a sub-capitated provider.
2400	21	CN102	Contract Amount		Enter the "shadow price".

Version 1.3 Revision Log

Companion Document: 837 Health Care Claim/Encounter: Professional (837P)

Approved: 01/2017

Modified by: JTG

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2310C	17	NM1	Service Facility Location Name		Enter the name of the rendering facility that is currently on file with ForwardHealth.
2310C	17	N3	Service Facility Location Address		Enter the address of the rendering facility that is currently on file with ForwardHealth.
2310C	17	N4	Service Facility Location City, State, ZIP+4		Enter the city, state, and ZIP+4 code that will correspond to the rendering facility address that is currently on file with ForwardHealth.
2420D	21	NM1	Service Facility Location Name		Enter the name of the rendering facility that is currently on file with ForwardHealth.
2420D	22	N3	Service Facility Location Address		Enter the address of the rendering facility that is currently on file with ForwardHealth.
2420D	22	N4	Service Facility Location City, State, ZIP+4		Enter the city, state, and ZIP+4 code that will correspond to the rendering facility address that is currently on file with ForwardHealth.