Health Care Claim: Professional 837

ASC X12N/005010x222

Companion Guide Version Number: 2.8
January 2022

Document History

Revision date	Revision	Commentary
March 2011	1.0	New
06/05/12	1.1	Updated to 5010
06/09/14	1.2	Co-branded with FTC; updated table references Transaction availability.
09/15/15	2.0	Updated to ICD-10: standardized corporate entity names
09/07/16	2.1	Removed FTC; updated links and corrected loops.
06/12/2017	2.2	Updated Fallon Health EDI system Maintenance informa
04/09/2018	2.3	Updated the Clearing house information.
05/12/2018	2.4	Updated Fallon Health EDI system Maintenance informa
08/17/2018	2.5	Updated the Clearing house information; also updated to Fallon Health Provider manuals.
09/10/2019	2.6	Updated Claim Submission Limits
01/14/2022	2.7	Updated Fallon Health EDI system Maintenance informa
3/15/2022	2.8	Updated verbiage surrounding Max # of Service Lines

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Introduction

The Health Insurance Portability and Accountability Act – Administration Simplification (HIPAA-AS) requires that Fallon Health (FH), and Fallon Health Weinberg (FHW), and all other covered entities comply with the electronic data interchange standards for health care as established by the Secretary of Health and Human Services. The Department of Health and Human Services (HHS) released the Final Rule adopting the updated versions of the standards under the Health Insurance Portability and Accountability Act (HIPAA). This rule updates the mandated X12 transactions to version 005010 with a compliance date of January 1, 2012. The 5010 Technical Report Type 3s (TR3s) for each transaction can be downloaded for a fee from the WPC Web site, www.wpc-edi.com/.

Although the TR3s contain requirements for use of specific segments and data elements within the segments, the reports were for use by all health benefit payors. This document has been prepared as a Fallon Health-specific companion document to the TR3s to clarify when conditional data elements and segments must be used for Fallon Health reporting, and to identify those codes and data elements that do not apply to Fallon Health.

This companion guide document supplements, but does not contradict, any requirements in the 837 version 5010 TR3.

The intended audience for this document is the technical area that is responsible for submitting electronic claims transactions to Fallon Health. In addition, this information should be communicated and coordinated with the provider's billing office in order to ensure the required billing information is provided to their billing agent/submitter.

Confidentiality, privacy and security

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

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

- maintaining confidentiality of protected information
- confidentiality safeguards
- security standards
- return or destruction of protected information
- compliance with state and federal regulatory and statutory requirements
- required disclosure
- use of business associates

Implementing EDI transactions with Fallon Health:

Contact an EDI Coordinator at:

1-866-275-3247, option 6, or e-mail edi.coordinator@Fallon Health.org

Set-up for direct submission to Fallon Health:

Providers wishing to request a claim status directly to Fallon Health in the EDI 837 format should contact an EDI Coordinator at1-866-275-3247, Option 6, or via e-mail to edi.coordinator@fallonhealth.org. The information necessary for implementation will be provided and an enrollment packet in PDF format can be obtained from the Fallon Health website at fallonhealth.org/providers/provider-tools/provider-tools-registration.aspx

Set-up for submission to Fallon Health via a clearinghouse

Providers wishing to submit a claim to Fallon Health via a clearinghouse should contact the clearinghouse directly and provide them with our Payor ID number. A Payor ID number is required for claim submissions that go through a clearinghouse and is used to route your claims to the correct health plan for payment. Our contracted clearinghouses and associated Payor IDs are listed below:

- **Change Healthcare (formerly known as Emdeon or WebMD)**
  Call 1-800-845-6592 or visit their website at http://www.changehealthcare.com
  Fallon Health: Payor ID: 22254; FHW: Payor ID: 22254

- **NEHEN**
  Call: 1-781-907-7210
  Website: nehen.org
  Email: nehen@maehc.org

- **Athena Health** (Billing Service)
  Call: 1-617-402-1000 or
  Website: athenahealth.com

Trading partner set-up

There are many data elements in the ISA segment of the X12N 837 version 5010 TR3 specifications that are used for processing control purposes. For example, the ISA segment contains data elements
such as authorization information, security information, sender identification and receiver identification that can be used for control purposes. These data elements are agreed upon by the trading partners prior to exchange of electronic information. Fallon Health-specific requirements are defined in subsequent sections of this document.

Testing

All trading partners are required to test the exchange of electronic transactions with Fallon Health prior to the exchange of production files with live data.

All test files will be processed at time of receipt, and feedback to the trading partner will occur within five business days. This feedback will occur via e-mail. Preliminary test files should contain no more than 25 claims. Simulation testing will occur once the preliminary testing is complete. Files for simulation testing should contain at least as many claims as a production file.

Fallon Health requires the following naming convention for all test files submitted: XXMMDDYYVT.txt (10-character maximum). The first two letters are used to identify trading partner, then two-digit month, two-digit day, two-digit year, version number and test file indicator. If multiple files are to be sent on the same day, version numbers would need to be sent as part of the file naming convention.

The test indicator is crucial to the entry of the file into the test environment.

Test files submitted through a clearinghouse will be named according to their current agreed- upon naming convention.

Production

At the completion of successful simulation testing, trading partners will be given a production username and password, as well as a date to begin the exchange of compliant production transaction files.

Fallon Health requires the following naming convention for all production files submitted: XXMMDDYYV1.837 (10-character maximum). The first two letters are used to identify trading partner, then two-digit month, two-digit day, two-digit year, version number, and production file indicator. If multiple files are to be sent on the same day, then version numbers would need to be sent as part of the file naming convention.

The production indicator is crucial to the entry of the file into the production environment.

Maintenance

Routine downtime is scheduled weekly from 6 PM to 11 PM on Thursdays and 8 AM to 12 PM on Sundays to support maintenance and enhancements for all EDI transactions. Non-routine downtime will be communicated via email at least one week in advance. Emergency unscheduled downtime will be communicated to trading partners via email within one hour following the determination that emergency downtime is needed.

Acknowledgements

TA1 interchange acknowledgement

Both lines of business will generate a TA1 acknowledgement if the trading partner requests it by submitting a 1 in the ISA14. If a trading partner does not want a TA1 acknowledgement, a 0 should be submitted in the ISA14.

999 implementation acknowledgement

Both lines of business will generate 999 acknowledgements for all trading partners. It is the trading partner's responsibility to retrieve and review the 999 to determine if Fallon Health accepted or rejected the file in its entirety.

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Claim Status is available from Fallon Health as a separate transaction. We are currently capable of accepting both batch and real-time submissions. Please contact the EDI Team directly if you are interested, as additional testing is required in order to take advantage of this transaction.

Payor-specific data requirements

General

This section is designed to assist with the specific data elements and segments that are required by Fallon Health in order to appropriately process claims for payment.

EDI-837 requires the following terminators

Segment Terminator (ASCII Value 126)	~
Data Element Separator (ASCII Value 42)	*
Sub-element Terminator (ASCII Value 62)	>

Provider manuals containing details on our billing procedures for all Fallon Health subsidiaries are available at the appropriate websites listed below.

Fallon Health: https://fchp.org/providers/provider-manual.aspx

FHW: http://fallonweinberg.org/Providers/provider-manual.aspx

Provider identifiers

The Health Insurance Portability and Accountability Act requires providers to use their National Provider Identifier (NPI) when submitting claims electronically. In order to process claims appropriately and in a
timely manner, Fallon Health requires NPIs be submitted as the provider identifiers.

Member identifiers

In order to process claims appropriately and in a timely manner, the member's Fallon Health ID number needs to be populated in the appropriate loops and segments. The subscriber's member ID is populated in loop 2010BA NM109.

Adjustment claims

Fallon Health has the ability to process electronic claims submitted with certain claim frequency codes as adjustments to existing claims when the patient account number and the billing provider of the newly
submitted claim matches an existing claim. In order for these to process correctly, a 7 (Replacement of prior claim) or 8 (Void/Cancel of prior claim) should be submitted in the 2300 CLM05-3.

Covering providers

Covering physician claims cannot be accepted electronically at this time. These claims need to be submitted on paper.

Coordination of benefits (COB)

Providers should submit any CAS segments (Claim level adjustments) in the 2320 loop on 837 files. Fallon Health will consider claims with this information for coordination of benefits review.

Claim Submission Limits

Claims Allowed per Transactions (ST/SE envelope): Per HIPAA implementation guidelines regarding the CLM (Claim Information) segment, Fallon Health requires trading partners limit the size of the transaction (ST/SE) envelope to a maximum of 5,000 CLM segments.

In addition, Fallon Health strongly recommends to limit the claim submission file size to be under 10MB for processing efficiency.

ISA segment specifications

	Description			Description	Fallon Health-	Fallon Health
	Interchange control					
				Authorization	00	
				Authorization	Blank fill	
				Security information	00	
				Security information	Blank fill	
				Interchange ID qualifier	ZZ	
				Interchange sender ID	Trading partner name	Limited to 15
				Interchange ID qualifier	ZZ	
				Interchange receiver ID	FCHP or FHW	Appropriate to the
				Interchange date	YYMMDD	
				Interchange time	24-hour time	
				Repetition separator	Any value other than the data element separator, component element	Please reference TR3 for change to the usage of
				Interchange control	005010	
				Interchange control	Unique number	
				Acknowledgement	0 or 1	
				Usage indicator	T for Test or P	
				Sub Element Terminator	>	

BOLD indicates value should be submitted as shown. All fields in the ISA are required and fixed length and should be blank filled if field value sent is not at the requested length.

GS segment specifications

Size	Description	Req	Field #	Description	Fallon Health-specific requirements	Fallon Health notes
	Functional group header	R				
2		R	1	Functional identifier code	HC	
2-15		R	2	Application sender's code	Trading partner tax ID#	
2-15		R	3	Application receiver's code	FALLON837I or FHW837I	Appropriate to line of business; must match the line of business in ISA08
8		R	4	Date	CCYYMMDD	
4-8		R	5	Time	HHMM	
1-9		R	6	Group control number	Group control number	
1-2		R	7	Responsible agency code	X	
1-12		R	8	Version/release/industry identifier code	005010X222A1	

BOLD indicates value should be submitted as shown.

ST segment specifications

Size	Description	Req'd	Field #	Description	Fallon Health-specific requirements	Fallon Health notes
	Transaction set header	R				
3		R	1	Transaction set identifier code	837	
4-9		R	2	Transaction set control number	ID# or counter	
1-35		R	3	Implementation convention reference	005010X222A1	Should be the same value as what is submitted in the GS08

BOLD indicates value should be submitted as shown.

Fallon Health-specific requirements

Loop	Seg	Description	Req	Field	Description	Fallon Health-	Fallon Health notes
2010AA	NM1	Billing provider name	R				
				NM108	Identification code qualifier	XX	
				NM109	Identification code	Billing provider NPI	
2010AB	NM1	Pay-to address name	S				Please reference TR3 for change to the usage of this loop/segment and note that Fallon Health will continue to make payments to the address in our claims processing system and not to the address submitted in this loop.
2010BA	NM1	Subscriber name	R				Please reference TR3 for change to the usage of this loop/segment
				SBR108	Identification code qualifier	MI	
				SBR109	Identification code	Member ID number	Member ID found on member ID card
2000C	HL	Patient hierarchical level	S				Please reference TR3 for change to the usage of this loop/segment
	PAT	Patient information	R				
2010CA	NM1	Patient name	R				
2300	CLM	Claim information	R				
				CLM01	Claim Submitter's Identifier	Patient Control number	Individual number used to identify specific claims. Can be a maximum of 38 alpha/numeric characters
				CLM05-3	Claim frequency type code	Valid Claim Frequency Type Code	If a 7 or 8 are received in this data element, Fallon Health will try to process claim as an adjustment to an existing claim. Reference section above on adjustment claims.
2310A	NM1	Referring provider name	S				
				NM108	Identification code qualifier	XX	
				NM109	Identification code	Referring provider NPI	
2310B	NM1	Rendering provider name	S				
				NM108	Identification code qualifier	XX	
				NM109	Identification code	Rendering provider NPI	
2400	HI	Diagnosis Code Qualifier	R	HI01	Code list qualifier code	ICD-10 Qualifier	All DX code qualifiers are now required to be the 3-character ICD10 codes. In all cases, the existing ICD9 code will be prefaced with "A"
2400	SV1	Professional service	R	SV107-2	Diagnosis code pointer	Valid diagnosis code pointer	Fallon Health requires the usage of correct diagnosis code pointers. The diagnosis pointer submitted must point to one of the diagnosis codes submitted on the claim. For example, if 4 diagnosis codes are sent, the diagnosis pointer sent should only be 1 thru 4.

Q: What are Fallon's ICD-10 requirements?

A: Fallon is complying with the CMS mandated changeover date of 10/01/15. Claims submitted with ICD-9 information for dates of service after 10/01/15 may not be processed.

Q: I did not test with Fallon Health, will I be able to submit claims?

A: Yes. As long as you submit a version 5010 claim file with correct ICD-10 information, this should pass validation and be accepted for further processing.

Q: What are the specific changes for ICD-10?

A: All the diagnosis code qualifiers have changed with the addition of an "A" prefix. For example, Primary Diagnosis was "BK" for ICD-9 and will be "ABK" for ICD-10. This is universal for all code qualifiers; "A" must be added to indicate ICD-10 codes.

Q: When will Fallon begin accepting ICD-10 Codes?

A: Fallon will comply with the posted CMS regulations and will begin accepting ICD-10 codes for dates of service beginning 10/01/15.

Q: How do I bill an inpatient claim that goes across the ICD-10 transition date?

A: Inpatient claims are billed based on discharge date. If an admission is before 10/01, with a discharge date up to and including 09/30, the entire claim is to be submitted with ICD-9 codes. If admitted prior to 10/01, and a discharge date on 10/01 or after, the entire claim should be submitted with ICD-10 codes.

Q: How do I bill an outpatient claim that goes across the ICD-10 transition date?

A: Outpatient claims must be split: bill all services up to and including 09/30 on a separate bill with ICD-9 codes. Services starting 10/01 and after should be billed separately with ICD-10 codes.

Q: What is claim payment turnaround time for EDI claims?

A: In most cases, payment will be received within 30-45 business days from date of submission.

Q: What is a Fallon Health's payor ID number and when would I use one?

A: A Payor ID number is required for claim submissions that go through a clearinghouse. The number is assigned by the clearinghouse and is used to route your claims to the correct health plan for payment. If you plan on using a contracted clearinghouse to submit your claims to Fallon Health or FHW, you can obtain our Payor ID from the clearinghouse directly or by calling the EDI Team.

Q: How do I know if my claims are being submitted directly to Fallon Health or if they are submitted through a clearinghouse?

A: Your software vendor or information technology department should be able to provide you with this information. If you are having trouble determining how your claims are submitted to Fallon Health, please call 1-866-275-3241, ext. 69968, and we can help you obtain this information.

Q: If I am submitting my claims to Fallon Health through a contracted clearinghouse and I am having submission problems, who should I call?

A: You should always contact the clearinghouse helpdesk first and open up a case before calling the EDI Team. This is a required step to resolve claim submission problems.

Q: How do I begin direct EDI claims submission to Fallon Health?

A: For direct submission of ANSI X12 837 version 5010 claims files, contact an EDI coordinator at the following locations:

1-866-275-3247, option 6, or e-mail edi.coordinator@fchp.org

You will need to complete the required enrollment forms, which can either be emailed by an EDI coordinator or downloaded in PDF format from the appropriate website listed below.
Fallon Health: https://fchp.org/providers/provider-tools/provider-tools-registration.aspx
FHW: http://www.fallonweinberg.org/Providers/provider-tools/electronic-data-submission.aspx

Q: How many claim lines can I submit per claim?

A: If you submit via clearinghouse, you will need to verify with the clearinghouse what they will pass through as a single claim. Fallon Health is able to accept up to 50 claim lines per Professional claim.

Q: Does Fallon Health offer electronic notification of claims received and claims denied for each file received electronically?

A: Fallon Health will send the standard ANSI X12 999 acknowledgement to all trading partners.

Q: Does Fallon Health offer real-time eligibility and claim status?

A: Fallon Health offers a Web-based eligibility tool that allows providers to verify eligibility and Claims metric reports for a rolling 12-week period. We also offer the 276/277 Health Care Claim Status Request and Response and the 270/271 Health Care Eligibility Benefit Request and Response as separate transactions requiring additional setup and testing. Please contact the EDI Team for more information.