Companion Guide

Professional Billing
837P

Release 4

X12N 837 (Version 5010A1) Healthcare Claims Submission Implementation Guide

Published October 2018

Revision History

Date	Release	Appendix name/ loop & segments	Description
April 2011	1	Initial Release	
October 2011	2	2010CA Patient Loop	5.2 General Claims Helpful Tips
December 2016	3	Phone Numbers	Update for new location
October 2018	4	Update for corporate name change	Allways Health Partners

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1. Introduction

1.1 Intended Audience

This companion guide is intended for the business and technical areas, within or on behalf of a provider organization, responsible for the testing and setup of electronic claims submissions to Allways Health Partners. In addition, this information should be communicated to, and coordinated with, the provider's billing office in order to ensure that the required billing information is provided to its billing agent/submitter. This guide supports the submission of X12N 837 addenda for Professional (837P) health care claims.

1.2 Purpose of the Companion Guide

This document has been prepared as a Allways Health Partners specific companion guide to the 837P transaction sets. It supplements but does not contradict any requirements in the 837P version 5010A1 Implementation Guide.

The primary purpose of the document is to assist the user with the submission of a valid 837P claims transaction and is not intended to be a billing guideline.

1.3 How to obtain copies of the Implementation Guides

Implementation Guides for all HIPAA transactions are available electronically at www.wpc-edi.com/HIPAA.

2. General Information

2.1 Confidentiality, Privacy and Security

Maintaining the confidentiality of personal health information has been, and continues to be, one of ALLWAYS HEALTH PARTNERS's guiding principles. ALLWAYS HEALTH PARTNERS has a strict Confidentiality Policy with regard to safeguarding patient, employee, and health plan information. All staff are required to be familiar with, and comply with ALLWAYS HEALTH PARTNERS's policy on the Confidentiality of Member Personal and Clinical Information to ensure that all member information is treated in a confidential and respectful manner. The policy permits use or disclosure of members' medical or personal information only as necessary to

conduct required business and perform care management, approved research, quality assurance and measurement activities when authorized to do so by a member or as required by law.

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

- Maintaining Confidentiality of Protected Information
- Confidentiality Safeguards
- Security Standards
- Return or Destruction of Protected Information
- Compliance with State and Federal regulatory and statutory requirements
- Required disclosure
- Use of Business Associates
- Implementing trading partner agreements prior to receiving electronic files

2.2 Security Statement

ALLWAYS HEALTH PARTNERS has implemented a best practice approach to protecting the integrity and availability of protected health information. ALLWAYS HEALTH PARTNERS is evaluating its current standards for the exchange of protected health information, electronic storage and/or transmission over telecommunications systems/networks based on the current HIPAA security regulations to determine whether updates or changes to established protocols will be needed.

3. Contacts

3.1 Privacy Contact

For privacy questions please contact:

Privacy Officer
Allways Health Partners
399 Revolution Drive
Somerville, Ma. 02145

1-800-433-5556 (Toll-free) and ask for Privacy Officer

3.2 Transaction Contact:

The ALLWAYS HEALTH PARTNERS E-commerce department is the contact for all transaction-related questions. For user set up and to establish testing, please contact:

E-commerce
Allways Health Partners
399 Revolution Drive
Somerville, MA 02145

(857) 282-3004

3.3 Provider Relations

Should you need to have additional providers set up, please contact your Provider Relations representative.

1-855-444-4647

4. Establishing Connectivity with ALLWAYS HEALTH PARTNERS

4.1 Initiating EDI Setup

ALLWAYS HEALTH PARTNERS offers a variety of options to send 837P Professional claims to ALLWAYS HEALTH PARTNERS. The preferred options are to submit through NEHEN if you are a participating provider. ALLWAYS HEALTH PARTNERS will accept transactions from clearing houses and direct submission from providers who can send and pick up transactions from our secure server utilizing either a VPN (virtual private network), PGP encryption or FTP over SSL (file transfer protocol over secured socket layer) connections.

4.2 Trading Partner Setup

Providers wishing to submit electronic claims transactions to ALLWAYS HEALTH PARTNERS should contact the ALLWAYS HEALTH PARTNERS E-Commerce Department via telephone to initiate a setup request or you can also download printable versions from www.ALLWAYSHEALTH.Org.

A Trading Partner Agreement form is required to initiate a trading partner set up. A person who is authorized to approve the trading partner set up, whether directly from the provider or through a

billing entity, must sign the authorization. The signed form will initiate a Trading Partner Agreement with ALLWAYS HEALTH PARTNERS, giving authorization for ALLWAYS HEALTH PARTNERS to accept claims on behalf of the provider. Once a valid Trading Partner Agreement is in place, testing can begin. If any of the information on the Authorization Form changes, a new form must be completed and submitted to ALLWAYS HEALTH PARTNERS's E-Commerce Department.

ALLWAYS HEALTH PARTNERS's E-Commerce Department will return an EDI authorization to the Trading Partner with all the necessary information to submit electronic transactions. The information will include:

- An assigned default user ID and password and a mailbox (folder) for file drop off and retrieval
- Submitter (ISA06) and the Submitter Application ID (GS02) – Trading Partner ID

If you have providers that will be servicing ALLWAYS HEALTH PARTNERS members (Loop 2310B Rendering Provider segment) and they are not listed on the provided documentation, please contact Provider Relations to initiate getting setup in the ALLWAYS HEALTH PARTNERS Provider file. ALLWAYS HEALTH PARTNERS will require an NPI (National Provider Identifier) in the Loop 2310B, NM109 segment.

ALLWAYS HEALTH PARTNERS will accept transmissions only from authorized Trading Partners who have signed an ALLWAYS HEALTH PARTNERS Trading Partner Agreement. Files for providers who submit without a Trading Partner Agreement in place will be rejected. The ALLWAYS HEALTH PARTNERS E-Commerce Coordinator will then contact you to establish a valid Trading Partner Agreement.

Submitters should include a script in their file pick up process that deletes the file from the server. (An archive copy of all files is stored and backed up daily by ALLWAYS HEALTH PARTNERS. Eliminating the file from the server will improve overall performance.)

4.3 Testing

ALLWAYS HEALTH PARTNERS requires submitters to test claim submissions and retrieval of 999 and claim responses prior to submitting production claims. Once in production, ALLWAYS HEALTH PARTNERS reserves the right to require re-testing if it is determined that the submitter is receiving/generating an unacceptable volume of errors or types of errors.

The following outlines the testing process:

- Prior to testing, the E-Commerce Department will provide the submitter with a test plan specific to his/her organization.

- Test cycles will be scheduled with the submitter during regular business hours – Monday through Friday, 8:30AM to 5:00PM, EST.

- The submitter will be notified when and how many test files can be sent to ALLWAYS HEALTH PARTNERS.

- The claims submitted for testing should be a general representation of the types of claims that are normally submitted and must contain a reasonable variety of services and diagnoses.

- In general, turnaround time for test files is 48 hours, but is dependent on the testing process and the quality of the data.

- Once the tests are completed, the E-Commerce Department will notify the submitter and review the results with the submitter. Submitters will be instructed to move files to production upon successful testing sign off.

- The submitter's mailbox name remains the same when moving from test to production. The file status will change from test to production when testing is complete.

4.4 Production

The E-Commerce Department will review the following schedules with the submitter:

- Claim File Drop off
- Response Retrieval
- Monitoring period

ALLWAYS HEALTH PARTNERS will monitor closely the first few production runs to ensure successful submission.

ALLWAYS HEALTH PARTNERS RESERVES THE RIGHT TO REQUIRE RE-TESTING IF IT IS DETERMINED THAT A SUBMITTER IS RECEIVING/GENERATING AN UNACCEPTABLE VOLUME OF ERRORS OR TYPES OF ERRORS.

5. ALLWAYS HEALTH PARTNERS Specific Conditional Data Requirements and Edits

5.1 Business Edits and Helpful Tips

In addition to compliance checking for required transaction data elements, ALLWAYS HEALTH PARTNERS will implement business front end reject edits as a vehicle to improve accuracy and turnaround of claims. A reject edit does not mean the claim is being denied for payment. Rather it means submitted information is either invalid or incorrect and should be corrected and re-submitted. Additionally this section includes helpful hints to setting up a successful transaction.

Member Validation

- Do not use dashes or spaces when entering the ALLWAYS HEALTH PARTNERS member ID number.

- All ALLWAYS HEALTH PARTNERS members have a unique member ID. We recommend that you bill all patient-related services in the Subscriber Loop (2000B). The ALLWAYS HEALTH PARTNERS member number should be placed in Loop 2010BA, segment NM109, given that a unique member ID identifies each Allways Health Partners member.

- ALLWAYS HEALTH PARTNERS will reject any claim that does not have a valid ALLWAYS HEALTH PARTNERS member ID.

- ALLWAYS HEALTH PARTNERS uses the member ID, date of birth, plan effective and end dates to validate ALLWAYS HEALTH PARTNERS eligibility.

- Claims submitted for an eligible member with the wrong member ID will be rejected back to the provider and the rejection will inform the provider of the valid ALLWAYS HEALTH PARTNERS member ID.

- ALLWAYS HEALTH PARTNERS will not correct an invalid member number, but will provide you with information so that you can correct and re-send the claim if appropriate.

- Use ALLWAYS HEALTH PARTNERSNet.org or NEHEN to verify the accuracy of member information prior to submission.

- Special characters, such as hyphens (Tellington-Jones) and apostrophes (O‘Donnell) are acceptable for last names.

Provider Validation

- ALLWAYS HEALTH PARTNERS requires the submission of a valid NPI Billing number and rendering provider NPI number on all claims transactions. Please contact your Provider Relations representative if you need to have providers added to ALLWAYS HEALTH PARTNERS.

- Use the Billing Provider NPI number (Loop 2010AA) NM109 .

- Member and provider demographics submitted on a claim do not update the member and provider information stored in ALLWAYS HEALTH PARTNERS's claims processing system. With the exception of data validation (for example, ALLWAYS HEALTH PARTNERS may compare the provider's tax ID on the claim to the one stored in ALLWAYS HEALTH PARTNERS's system), ALLWAYS HEALTH PARTNERS uses the member and provider demographics that are stored in its internal systems to validate submitted data and to adjudicate a claim.

- In addition to the billing NPI number, a valid group or valid rendering provider NPI number must be submitted on the electronic claim. Loop 2310B, Rendering Provider NM109 segment, should be used to put the Provider NPI number. (See attached ALLWAYS HEALTH PARTNERS specific transaction map for valid rendering provider values.)

- ALLWAYS HEALTH PARTNERS requires that you have a valid Trading Partner Agreement on file prior to initiating electronic submission of the 837P.

Code Set Validation

- ALLWAYS HEALTH PARTNERS will require the submission of industry standard code sets. A submitter must submit standard codes (CPT, HCPC, Diagnosis Code, Place of Service, Bill Type, etc.) on the claim unless otherwise noted.

- You may send up to twenty-four (24) diagnosis codes per claim.

5.2 General Claims Helpful tips

- ALLWAYS HEALTH PARTNERS recommends no more than five thousand (5,000) claims per file. This is an operational, not technical, recommendation. A submitter should contact the E-Commerce Department if more than five thousand (5,000) claims are anticipated per file.

- ALLWAYS HEALTH PARTNERS will not accept claims with future dates of service.

- Service unit counts (units or minutes) cannot exceed 999 (Loop 2400, SV104)

- When using counts or anesthesia minutes, Loop 2400 allows for one or the other but not both.
  - If you are billing for anesthesia services, then set SV103 to "MJ" and submit minutes in SV104.
  - For other types of claims, all service lines require a unit count for the procedure code. Set SV103 to "UN" and submit the number of units in SV104.

- If you would like to submit NDC codes, please do so using Loop 2410, LIN segment. ALLWAYS HEALTH PARTNERS requires that you submit no more than one NDC code for each service code, i.e., you can submit, at most, one LIN segment for each SV1 segment. If you have multiple NDC codes for one service, repeat the service multiple times, once for each code. For example, to bill three NDC codes to go with one procedure code (J-Code), bill the procedure code three times, with each instance of the procedure code having a different NDC code.

- All ALLWAYS HEALTH PARTNERS Members have unique identification numbers and are considered subscribers. The 2010CA Patient Loop should not be submitted on any claim to ALLWAYS HEALTH PARTNERS. Use of the Patient Loop will cause the claim to be rejected back to you.

- Data submitted in Loop 2300, CLM20 (Delay Reason Code), will not be used for processing. Any request for an override to the timely filing limits must be done directly with a claims reviewer.
- Total submitted charges (Loop 2300, CLM02) must equal the sum of the line item charge amounts (Loop 2400, SV102) for the claim.
- Any data submitted in Loop 2300, PWK (Paperwork) segment, may not be considered for processing.

AN ALLWAYS HEALTH PARTNERS-SPECIFIC 837P MAP CAN BE FOUND IN APPENDIX F. IT CONTAINS BOTH ALLWAYS HEALTH PARTNERS REQUIREMENTS AS WELL AS THOSE REQUIRED BY THE IMPLEMENTATION GUIDE. NOTE: ALL SEGMENTS AND FIELDS REQUIRED FOR THE 837 TO BE FORMAT AND CONTENT COMPLIANT MUST BE SENT REGARDLESS OF ALLWAYS HEALTH PARTNERS INTERNAL PROCESSING REQUIREMENTS. ALLWAYS HEALTH PARTNERS WILL REQUIRE, PER THE IMPLEMENTATION GUIDE, THAT THESE FIELDS BE SUBMITTED. IF THEY ARE NOT USED TO ADJUDICATE THE CLAIM, THE CONTENT WILL NOT BE VALIDATED. ALLWAYS HEALTH PARTNERS HAS INTENTIONALLY LEFT OUT OF ITS MAP THOSE IMPLEMENTATION GUIDE SEGMENTS/LOOPS NOT USED IN ORDER TO DECREASE THE SIZE OF THE MAP.

6. Technical Requirements for Electronic Claims Submission

6.1 File Naming Standards

On files sent to ALLWAYS HEALTH PARTNERS, the submitter can name the file as long as the name is unique. A previously submitted file name will be assumed to be a duplicate file.
In order to maintain uniqueness, ALLWAYS HEALTH PARTNERS recommends that the file contain a date time stamp within the name. Ex. CLAIM FILE.01012012.1201.TXT

6.2 File Submission Standards

- Claims submitted through NEHEN or directly from a provider:
  - Contain only one ISA and one GS segment.
- Claims submitted from clearing houses:
  - ALLWAYS HEALTH PARTNERS will accept a file with multiple ISA and GS records from our clearing house trading partners. We expect that these files will contain multiple ISA and GS records. However, each individual provider submissions should adhere to the recommended standard.

Although the HIPAA Transaction Set Implementation Guide allows the repeating of Provider Information (2000A Loop) for each claim, the size of transmission files can be reduced by up to twenty percent (20%) by using only one repeat of Provider information followed by all Subscriber and Claim information for that Provider. Grouping the claims of each subscriber together can further reduce file transmission files. ALLWAYS HEALTH PARTNERS is adhering to the structural specifications for required and situational fields as stated in the Implementation Guide.

ALLWAYS HEALTH PARTNERS STRONGLY RECOMMENDS THAT ALL SUBMITTERS GENERATE A UNIQUE CLAIM TRACKING IDENTIFICATION NUMBER (AS DESCRIBED IN LOOP 2300 REF SEGMENT OF THE IMPLEMENTATION GUIDE) FOR EACH CLAIM THAT IS SUBMITTED TO ALLWAYS HEALTH PARTNERS. ALLWAYS HEALTH PARTNERS RECOMMENDS THAT THESE IDS BE UNIQUE BOTH WITHIN A FILE AND ACROSS FILES (IN OTHER WORDS, GENERATE A NEW CLAIM TRACKING ID EVEN IF THE CLAIM WAS SUBMITTED PREVIOUSLY). THIS WILL FACILITATE PROBLEM RESOLUTION AND TYING OUT ALLWAYS HEALTH PARTNERS'S RESPONSES TO SUBMITTED CLAIMS.

- Compression of files is not supported for transmissions between the submitter and ALLWAYS HEALTH PARTNERS.
- Only Loops, segments, and data elements valid for the HIPAA Professional Implementation Guide will be translated. Non-implementation guide data may not be sent for processing consideration.

TRANSACTIONS THAT ARE NOT STRUCTURALLY VALID WILL BE REJECTED AND WILL BE RETURNED TO THE SENDER.

- You must submit incoming 837 claim data using the character set referenced in the 837P Professional Implementation Guide.
- All dates that are submitted on an incoming 837 claim transaction should be valid calendar dates in the appropriate format based on the respective qualifier. Failure to submit a valid calendar date may result in rejections of the claim or the applicable interchange (transmission).

6.3 Attachments

Currently there is no standard for submitting attachments electronically. If you use the transaction to indicate that you will be forwarding an attachment or paper work, choose one of the following media to send the attachment segment. Please use the following instructions to submit and make sure any attachments include the appropriate attachment number that was placed in Loop 2300, the PWK06 field.

Mail:
Allways Health Partners
ATTN: Claims Department, Attachments Unit
399 Revolution Drive
Somerville, MA. 02145

Fax: 617-526-1902

6.4 File Acknowledgements/Remittance Reports

ALLWAYS HEALTH PARTNERS issues the following reports to indicate the acceptance/rejection of files and
claims into the claims processing system:

999 File Acknowledgement Report

999 ACKNOWLEDGEMENT REPORTS ARE GENERALLY AVAILABLE WITHIN TWENTY-FOUR (24) HOURS OF THE FILE RECEIPT.

- The acknowledgement report will be sent to your outbound acknowledgement folder for retrieval by you.
- Your retrieval file script should include a delete script in your file process. Delete the file out of your outbound mailbox after you have successfully retrieved it.

277 CA Transaction

ALLWAYS HEALTH PARTNERS uses a proprietary front-end processor. Files that are accepted by the ALLWAYS HEALTH PARTNERS ANSI Translator are not necessarily submitted to the claims adjudication system for processing. ALLWAYS HEALTH PARTNERS will return a 277CA generally within twenty-four (24) of the file receipt. This initial claims receipt will include an acknowledgement of claims accepted and or rejected.

- Initial Claims Receipt 277CA - STC01 valid codes are:
    - A2 Claim has been **received and forwarded** to the claims adjudication system.
    - A3 Claim has been **rejected and has not been sent** to the adjudication system. Please refer to Appendix E for a list of reject reasons.

The submitter should review the 277 to verify that all claims have been accepted and sent for processing or rejected.

The 277CA as described in the Implementation Guide, is not a HIPAA-mandated transaction but is supported by ALLWAYS HEALTH PARTNERS. At this level, ALLWAYS HEALTH PARTNERS will pass good claims to the claims system and pass back claims that failed ALLWAYS HEALTH PARTNERS business edits.

If your EDI file was rejected, and you are not sure why or how to correct it, it is important to contact the E-Commerce Department as soon as possible to ensure that your claim file is resubmitted before the filing limit expires.

THE ERROR/ACCEPTANCE REPORT, A READABLE VERSION OF THE 277CA WILL BE SENT TO YOUR OUTBOUND FOLDER FOR RETRIEVAL BY YOU.

This is an example of the report:

```
ISA*00*          *00*          *ZZ*NHP            *ZZ*SUBMITTER       *110425*0836*U*00401*000031004*0*P*:~
GS*HC*NHP*SUBMITTER*20110425*0836*31004*X*004010XRPT~
ST*RPT*12345~
MIT*Claims Submission Report

NHP CLAIMS SUBMISSION REPORT

Submitted File Name:                              SUBMITTED FILE NAME.TXT
Report Run Date:                                  SUBMISSION DATE
Submission Date (from GS04):                      20110425
Billing Provider Number (from 2010AA REF02):      Null
Trading Partner Identifier (from GS02):           SUBMITTER NAME

Number of Claims Submitted:                       9
Number of Claims Accepted:                        9
Number of Claims Rejected:                        0

Total Dollar Amount of Claims Submitted:          $43,022.39
Total Dollar Amount of Claims Accepted:           $43,022.39
Total Dollar Amount of Claims Rejected:           $0.00


ACCEPTED CLAIM SUMMARY

Claim   Submitted Patient       VendorID        NHP Claim ID
Count   Account Number(CLM01)
==============================================================================================================
1          PATACT#1           BILLING NPI      11115E07329
2          PATACT#2           BILLING NPI      11115E07328
3          PATACT#3           BILLING NPI      11115E07332
4          PATACT#4           BILLING NPI      11115E07331
5          PATACT#5           BILLING NPI      11115E07330
6          PATACT#6           BILLING NPI      11115E07335
7          PATACT#7           BILLING NPI      11115E07334
8          PATACT#8           BILLING NPI      11115E07333
9          PATACT#9           BILLING NPI      11115E07336

~
SE*3*12345~
GE*1*000031004~
IEA*1*000031004~
```

Your pick up file script should include a delete script in your file process. Delete the file out of your outbound mailbox after you have successfully retrieved it.

THE SUBMITTER SHOULD REVIEW THE 277 TO VERIFY THAT ALL BATCHES HAVE BEEN ACCEPTED AND SENT FOR PROCESSING.

ALLWAYS HEALTH PARTNERS will offer the 276/277 claims status request response through NEHEN and ALLWAYSHEALTH.net. ALLWAYS HEALTH PARTNERS will work with clearing house trading partners to determine their readiness to accept a 276/277 request response.

Refer to ALLWAYS HEALTH PARTNERS's Companion Guide for the 276/277 request response transaction.

Electronic EOP

The final report that ALLWAYS HEALTH PARTNERS will generate for the transaction will be an 835 once the claim has been adjudicated and paid/posting status is completed. (The 835 Implementation Guide provides detailed payment status and reject codes.)

Appendix F – ALLWAYS HEALTH PARTNERS-Specific 837 Professional Map

Provided as a separate file: **Companion Guide – Appendix F**