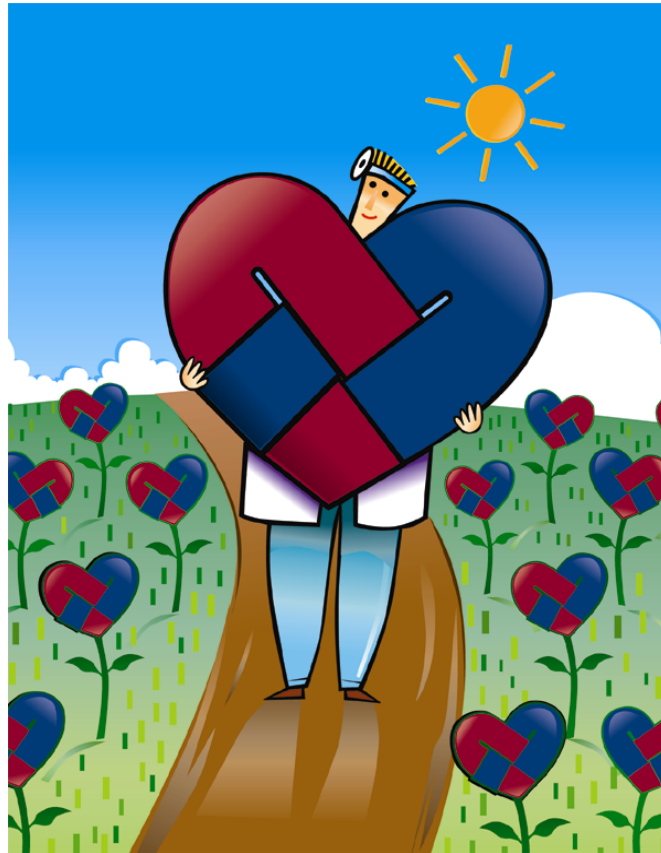


Manual for HealthLink 837 Series Claims Transactions



Companion Guide for Payors

- ANSI X12N Implementation Guide 004010X098A1: 837 – Health Care Claim – Professional (1500s)
- ANSI X12N Implementation Guide 004010X096A1: 837 – Health Care Claim – Institutional (UB92s)

Companion Guide Version Number: 5.2 – TDC.4.009

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Introduction

HealthLink Electronic Transaction Manual

HealthLink, NCPPO and AHI claims are sent to payors in ANSI 837-4010A1 (Implementation Guide With Addenda) HIPAA claims format. This manual explains the use of business-specific fields for the benefit of payors receiving electronic claims from our networks.

Compliance Tool

HealthLink uses the "HIPAA Toolkit" from Sybase as a self-certification tool for EDI transactions. Edifecs is used as a testing tool for outbound claims transactions for payors.

Applicability

This Companion Guide is designed to assist payors on implementing and understanding outbound network claims for HealthLink, NCPPO and Affiliated Healthcare Inc. (AHI) PPO. This guide supplements information in and should be read in conjunction with the ANSI X12 Implementation Guides.

Claim Submissions from Providers

HealthLink requires that providers who wish to submit electronic claims to HealthLink do so via a clearinghouse. HealthLink currently receives claims directly from WebMD, the SSI Group and Gateway EDI. Providers may utilize any clearinghouse they wish, but HealthLink ultimately receives the claims from these three designated clearinghouses. Providers may continue to submit manual claims after the HIPAA EDI compliance date of October 16, 2003. HealthLink encourages providers to submit claims electronically.

Claims Submissions to Payors from HealthLink, NCPPO and/or AHI

Payors may receive their electronic claims from HealthLink in several ways. Payors may receive claims from the WebMD, Interactive Payor Network ("IPN"), Interactive Planet, or Trizetto clearinghouses, which are our most popular connection types. HealthLink also supports a direct connection, where the payor receives repriced claims via FTP processes with encryption to protect PHI. This direct connection functionality is used primarily for largest volume trading partners.

Electronic Claims and Eligibility

HealthLink requires that payors wishing to receive electronic repriced claims submit electronic eligibility to HealthLink. The purpose of this is to ensure proper routing of claims as well as maintain a high level of automated repricing, thereby decreasing the amount of time it takes to get the claim repriced by HealthLink and forwarded to the payor of record. HealthLink uses eligibility to route claims to correct payors.

Scope of Companion Document

This Companion Document to the ASCX12N Implementation Guides adopted under HIPAA clarifies and specifies the data content when exchanging repriced claims electronically with HealthLink. Transmissions based on this companion document, used in tandem with the ANSI X12N Implementation Guides, are compliant with both the X12 syntax and those guidelines. This Companion Guide is intended to convey information that is within the framework of the ASC X12N Implementation Guides adopted for use under HIPAA. The Companion Guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the Implementation Guides.

1 Identifying Participating Provider Status

HealthLink provider numbers (identification numbers) are found in Loop 2010AA, in element REF02 with a “G2” qualifier (see section 9 of this guide for details). The number is a six digit number followed by four additional digits which identifies HealthLink, NCPPO or AHI’s unique provider number with the location and billing entity. Identifying the provider “par status” is important for proper administration of Open Access claims. See section 3 of this guide for details.

The provider participating status can be obtained in the “Line Pricing/Repricing Information” segment (“HCP”). If a claim has been processed as non-participating, the following elements will be populated:

ANSI Data Element	ANSI Loop	Data Element Name	Value	Notes
HCP01	2300, 2400	Pricing Methodology	“00” (Zero Priced Not Covered Under Contract)	The presence of this value indicates that this claim is from a non-participating provider. Claims for non-participating providers using UCR pricing do not use “00”.
HCP13	2300, 2400	Reject Reason Code	“T1” (Cannot identify Provider as TPO (Third Party Organization) Participant)	T1 Non-Par T2 Payor Non-Participant T3 Insured Non-Participant T4 Payor Missing T5 Certification Missing T6 Insufficient Data for Repricing
HCP15	2300, 2400	Exception Code	“3” (Services or Specialist not in Network)	

Providers on “letters of agreement” types of contracts (before fully contracted and credentialed) are identified as “par”.

1.1 Provider Taxonomy (Specialty) Codes

The Provider Taxonomy Code (Element PRV03) in Loop 2310B (Rendering Provider) or Loop 2000A (Billing/Pay-To Provider) may be used to distinguish whether or not a provider is performing a primary care or specialist service, at the claim level. This is useful to payors needing to identify whether a particular service is primary care or specialty to assign co-payment amounts.

HealthLink considers the following taxonomy codes as primary care providers:

- Family Practice **207Q00000X**
- General Practice **208D00000X**
- Pediatrics **208000000X**
- Obstetrics/Gynecology (as PCP) **207V00000X**
- Internal Medicine (as Primary Care Physician) **207R00000X**
- Geriatrics under Internal Medicine **207RG0300X**
- Geriatrics under Family Practice **207QG0300X**

The full list of Provider Taxonomy Codes may be downloaded from the Washington Publishing Company at <http://www.wpc-edi.com>, and are updated twice yearly.

2 Identifying A Network (Repricing Organization Identifiers)

In addition to repricing claims for the HealthLink network, HealthLink also reprices claims for other networks, such as NCPPO. HealthLink utilizes the HCP04 data element, Repricing Organization Identifier, at both the claim level (2400 loop) and line level (2300 loop) to indicate to the payor which network repriced the claim. This is valid on both Institutional (837I) and professional (837P) claim types.

Value	EOB Remark from Payor
900010001	HealthLink PPO/Open Access
900010002	NCPPO
900010003	NCPPO Mental Health
900010004	WC "Premier Network"
900010005	AHI/UNI
900010006	Freedom Network
900010007	Freedom Network Select
900010008	HealthLink HMO or HealthLink Open Access (used at payor discretion)
900010009	American Health (AHA)
900010010	CCN Wrap
900010011	Health Partners – Kansas (HPK)
900010012	Accountable Health Plans (Superien**)
900010013	Alliance PPO (Superien**)
900010014	American Lifecare (Superien**)
900010015	America's PPO (Superien**)
900010016	Associates For Health Care (Superien**)
900010017	Directcare America (Superien**)
900010018	Encore Health Network (Superien**)
900010019	First Choice Of The Midwest (Superien**)
900010020	Health Care Value Mgmt (Superien**)
900010021	Health Choice-AL (Superien**)
900010022	Health Management Network (Arizona Medical Network) (Health Management Network) (Rural Arizona Medical Network) (Superien**)
900010023	Idaho Physicians Network (Superien**)
900010024	Intergroup (Superien**)
900010025	Interplan (Superien**)
900010026	Interwest Health (Superien**)
900010027	Magnacare (Superien**)
900010028	Mountain Medical Affiliates (Superien**)
900010029	Northwest One (Superien**)
900010030	Preferred Community Choice Of Oklahoma (Superien**)
900010031	Not In Use
900010032	The Preferred Plan Inc. (Superien**)
900010033	Premier Health Systems (Superien**)
900010034	Providence Preferred (Superien**)

Value	EOB Remark from Payor
900010035	Southcare (Superien**)
900010036	Tennessee Healthcare Network (Superien**)
900010037	Virginia Health Network (VHN) (Superien**)
900010038	Carilion Health Plans* (Superien**)
900010039	Guthrie Health Systems* (Superien**)
900010040	Northern Alabama Managed Care, Inc.* (Superien**)
900010041	CHP (InforMed)
900010042	HPO Travel
900010043	Competitive Health Plan
900010044	Fortified Provider Network
900010045	Health Coalition Partners
900010046	Healthcare Part E Texas
900010047	Health Payors Organization
900010048	HPO Select
900010049	Integrated Health Plan
900010050	Managed Healthcare NW
900010051	Midwest Med Preferred
900010052	Integrated Health Plan
900010053	Preferred Health Partnership
900010054	Pacific Health Alliance
900010055	Preferred Health Plan
900010056	Primary Health Services
900010057	Integrated Health Plan
900010058	Devon Health Network
900010153	Payor Specific – Epoch-St. John’s Mercy
900010154	Map Alliance PPO/MAPSI (Superien)
900010155	HCD HealthCare Direct (Superien)
900010156	PPO PROplus (Superien)
900010157	PRH IHP/Prime Health (HPO)
900010180	American PPO
900010181	Payor Specific-CGN-PPO
900010182	Payor Specific-CGN-OA
900010183	Occupational Health Management (WC only) (new 3/15/06)
900010184	Tri-State Health Care Coalition (Quincy, IL) (new 3/15/06)
End of Repricing Organization Identifiers	

*Only payors or groups with specific contracts may use these network affiliations as described below.

**Superien has several different values corresponding to the various sub-leased networks. Requires special contract for access (and special EOB remark programming).

For payors utilizing **National Care Network (NCN)** as an out-of-network cost containment program, the following table of repricing organization identifiers and EOB remark codes need to be set-up and recognized by the payor.

NCN provider discounts will not be honoured unless EOB’s have proper remark descriptions. NCN access/use requires a special HealthLink contract and special rate established.

Payors not using NCN services should not program their system for these special repricing organization identifiers (range from 90001 0059 to 90001 0152) unless using NCN services.

NCN Identifier	EOB Remark from Payor
900010059	Adjustment taken through National Care Network – 800-499-9708
900010060	Adjustment taken through National Care Network – 800-499-9708
900010061	Adjustment taken through National Care Network – 800-499-9708
900010062	Allowed amount recommended by National Care Network – 800-499-9708
900010063	American Care Source (800-499-9708)
900010064	Discount taken through American PPO, (800) 499-9708
900010065	Multiplan (800-499-9708)
900010066	NPPN / PlanVista Solutions (800-499-9708)
900010067	NPPN / PlanVista Solutions – 1st Choice Midwest (FCM)(800-499-9708)
900010068	NPPN / PlanVista Solutions – ABPA/PROHEALTH (800-499-9708)
900010069	NPPN / PlanVista Solutions – Accountable Health Plans (800-499-9708)
900010070	NPPN / PlanVista Solutions – Americas PPO (800-499-9708)
900010071	NPPN / PlanVista Solutions – Arizona Medical Network (800-499-9708)
900010072	NPPN / PlanVista Solutions – Assoc Primary Care Phys (800-499-9708)
900010073	NPPN / PlanVista Solutions – Baycare (800-499-9708)
900010074	NPPN / PlanVista Solutions – Beltone (800-499-9708)
900010075	NPPN / PlanVista Solutions – Carrington International Group (800-499-9708)
900010076	NPPN / PlanVista Solutions – CHN/CT (800-499-9708)
900010077	NPPN / PlanVista Solutions – CHN/NJ (800-499-9708)
900010078	NPPN / PlanVista Solutions – Community Health Partners (800-499-9708)
900010079	NPPN / PlanVista Solutions – Dahlberg Miracle Ear (800-499-9708)
900010080	NPPN / PlanVista Solutions – Dimension (800-499-9708)
900010081	NPPN / PlanVista Solutions – Family Chiropractic America (800-499-9708)
900010082	NPPN / PlanVista Solutions – Galazy Health Network (800-499-9708)
900010083	NPPN / PlanVista Solutions – Health Management (800-499-9708)
900010084	NPPN / PlanVista Solutions – Health Point Phys Org (800-499-9708)
900010085	NPPN / PlanVista Solutions – Healthcare Network America (HNA) (800-499-9708)
900010086	NPPN / PlanVista Solutions – Healthspan (800-499-9708)
900010087	NPPN / PlanVista Solutions – Heartland (800-499-9708)
900010088	NPPN / PlanVista Solutions – Henry Ford Health Systems (800-499-9708)
900010089	NPPN / PlanVista Solutions – HFN (800-499-9708)
900010090	NPPN / PlanVista Solutions – Intergroup (800-499-9708)
900010091	NPPN / PlanVista Solutions – Interplan (800-499-9708)
900010092	NPPN / PlanVista Solutions – Interwest Health (800-499-9708)
900010093	NPPN / PlanVista Solutions – Mayan PPO (800-499-9708)
900010094	NPPN / PlanVista Solutions – Medical Resources (800-499-9708)
900010095	NPPN / PlanVista Solutions – MH Net (800-499-9708)
900010096	NPPN / PlanVista Solutions – National Hospital Network (800-499-9708)
900010097	NPPN / PlanVista Solutions – National Provider Network (800-499-9708)
900010098	NPPN / PlanVista Solutions – Novanet (800-499-9708)

NCN Identifier	EOB Remark from Payor
900010099	NPPN / PlanVista Solutions – NPPN Direct (800-499-9708)
900010100	NPPN / PlanVista Solutions – Ohio Preferred Network (800-499-9708)
900010101	NPPN / PlanVista Solutions – Physicians Network (800-499-9708)
900010102	NPPN / PlanVista Solutions – PIPA (800-499-9708)
900010103	NPPN / PlanVista Solutions – PPOIN (800-499-9708)
900010104	NPPN / PlanVista Solutions – PPOIN (800-499-9708)
900010105	NPPN / PlanVista Solutions – Provider Strategies Inc (800-499-9708)
900010106	NPPN / PlanVista Solutions – Qualchoice of Arkansas (800-499-9708)
900010107	NPPN / PlanVista Solutions – Rural Arizona (800-499-9708)
900010108	NPPN / PlanVista Solutions – Select PPO (800-499-9708)
900010109	NPPN / PlanVista Solutions – Signature (Nashville) (800-499-9708)
900010110	NPPN / PlanVista Solutions – Susquehanna Health Care (800-499-9708)
900010111	NPPN / PlanVista Solutions – The Initial Group (800-499-9708)
900010112	NPPN / PlanVista Solutions – TRPN (800-499-9708)
900010113	NPPN / PlanVista Solutions – Universal/LA (800-499-9708)
900010114	NPPN / PlanVista Solutions – Universal/NV (800-499-9708)
900010115	NPPN / PlanVista Solutions – MRI/NPPN (800-499-9708)
900010116	NPPN / PlanVista Solutions – Baptist Health Services Group (800-499-9708)
900010117	NPPN / PlanVista Solutions – Physicians Care Network (800-499-9708)
900010118	NPPN / PlanVista Solutions – PPOIN/ProHealth (800-499-9708)
900010119	NPPN / PlanVista Solutions – TRPN/FPN (800-499-9708)
900010120	NPPN / PlanVista Solutions – Interplan/WA (800-499-9708)
900010121	NPPN / PlanVista Solutions – Independent Medical Systems (800-499-9708)
900010122	PPO NEXT West, Inc. (800-499-9708)
900010123	ProAmerica / BCE Emergis (800-499-9708)
900010124	Three Rivers Provider Network (800-499-9708)
900010125	Three Rivers Provider Network Dir (TRPN) (800-499-9708)
900010126	Three Rivers Provider Network (TRPN) – Araz (800-499-9708)
900010127	Three Rivers Provider Network (TRPN) – American Care Source (800-499-9708)
900010128	Three Rivers Provider Network (TRPN) – Baptist Health Services Group (800-499-9708)
900010129	Three Rivers Provider Network (TRPN) – California Medical Foundation (800-499-9708)
900010130	Three Rivers Provider Network (TRPN) – Community Care Network (800-499-9708)
900010131	Three Rivers Provider Network (TRPN) (800-499-9708)
900010132	Three Rivers Provider Network (TRPN) – Dimensions (800-499-9708)
900010133	Three Rivers Provider Network (TRPN) – Family Health America (800-499-9708)
900010134	Three Rivers Provider Network (TRPN) – First Choice Network (800-499-9708)
900010135	Three Rivers Provider Network (TRPN) – Fortified Provider Network (800-499-9708)
900010136	Three Rivers Provider Network (TRPN) – HFN (800-499-9708)
900010137	Three Rivers Provider Network (TRPN) – IHP (800-499-9708)
900010138	Three Rivers Provider Network (TRPN) – IMS (800-499-9708)
900010139	Three Rivers Provider Network (TRPN) – Initial Group (800-499-9708)
900010140	Three Rivers Provider Network (TRPN) – Interwest (800-499-9708)

NCN Identifier	EOB Remark from Payor
900010141	Three Rivers Provider Network (TRPN) – MCS (800-499-9708)
900010142	Three Rivers Provider Network (TRPN) – National Provider Network (800-499-9708)
900010143	Three Rivers Provider Network (TRPN) – Ohio Preferred Network (800-499-9708)
900010144	Three Rivers Provider Network (TRPN) – Ohio Preferred Network (800-499-9708)
900010145	Three Rivers Provider Network (TRPN) – Prime Health Services (800-499-9708)
900010146	Three Rivers Provider Network (TRPN) – Quality HealthCare Partnership (800-499-9708)
900010147	Three Rivers Provider Network (TRPN) – Universal Health Network (800-499-9708)
900010148	Adjustment taken through Health Coalition Partners
900010149	Adjustment taken through Health Coalition Partners/HPO
900010150	Claim was processed according to contracted rate with Arizona Medical Network
900010151	Claim was processed according to contracted rate with Rural Arizona Network
900010152	Claim was processed according to contracted rate with Health Management Network
End of Special NCN Identifiers	

3 Identifying Products (HMO, PPO, Open Access)

Several of the payors for which we reprice claims utilize HealthLink’s Open Access network products for some of their groups. The 837 format does not have a specific data element that can be used to identify Open Access indicators. The payor may utilize the following method to determine the status of the provider who rendered the service.

ANSI Data Element	ANSI Loop	Data Element (and Use)	Defaulted Data Element Value
SBR09	2000B	Claim Indicator (for PPO par status)	“12” (PPO)
SBR09	2000B	Claim Indicator (for HMO par status)	“HM” (HMO)
SBR09	2000B	Claim Indicator (for Non-Par)	“ZZ” (Out of Network)
SBR09	2000B	Claim Indicator (for WC)	“WC” (Workers Comp)
SBR09	2000B	Claim Indicator (for EPO)	“14” (EPO)

The table below shows the HealthLink network products and the corresponding provider access allowed.

Reference on Network Products	
HL Network Product	HL Provider Access
PPO	PPO, OON
OA I	HMO, No OON
OA II	HMO, OON
OA III	HMO, PPO, OON
NCPPO Perf Net	EPO
Workers Comp	WC, OON

*OON = Out of Network.

An alternative instead of SBR09 is to use the Repricing Organization Identifiers (900010001 for PPO; and 900010008 for HMO or OA Tier I). See Section 2.

4 Repricing Messages

HealthLink communicates various repricing messages for payors. HealthLink utilizes its proprietary messages that are currently in use for manual claims.

The 837 format has a Claim Level and Claim Line Level File Information segment (“K3”) which can be used for communicating such messages. The table below shows how HealthLink communicates these messages in the K3 Segment. The K3 segment can repeat up to 10 times. The first occurrence of the K3 segment will contain the adjustment reason code and description. The error codes and descriptions will start in the 2nd occurrence of the K3 segment.

837 Data Element	Occurrence	Position	Meaning
K301	1	1-3	Adjustment Reason Code
K301	1	4-80	Adjustment Reason Description
K301	2-10	1-3	Error Code
K301	2-10	4-80	Error Description

If the claim has not been adjusted, but an error code exists, the first instance of the K3 segment will contain “NA”.

See Appendix A for the most common error codes and descriptions for claims sent to payors.

4.1 Professional Claims 837P (HCFA 1500 or CMS 1500 in future)

The Pricing Messages will be available in the File Information (“K3”) at the Claim Line Level, Loop 2400.

4.2 Institutional Claims 837I (UB92s or UB04 in future)

In the 837I, the File Information (“K3”) segment occurs only at the claim level. Therefore, the pricing messages will be available at the Claim Level, Loop 2300.

4.3 Pricing Methodologies

HealthLink utilizes several pricing methodologies. The table below shows the HIPAA codes that HealthLink uses and a description for each provider reimbursement method.

Value in HCP01	Description	Use
00	Zero Pricing (Not Covered Under Contract)	For non-participating provider claims priced as billed
01	Priced as Billed at 100%	For participating* providers at 100%; also for billed less than contract rate
02	Priced at the Standard Fee Schedule	Priced using fee schedules for participating* providers
03	Priced at a Contractual Percentage	Priced using percent discount for participating* providers
04	Code Bundling	Indicates Changes from Code Review (1500 Claim Types Only)
06	Per Diem Pricing	Per diem pricing for participating* providers
07	Flat Rate Pricing	Fixed/flat case rate pricing (cardiac DRG, ASC surgical rate pricing, etc.) for participating* providers
08	Combination Pricing	Used for claim level pricing methodology when line items priced using different methodologies, such as per diem plus an implant at percent discount

10	Other Pricing	Manual pricing for participating* providers and repricing at % of HIAA as specified by the payor for non-participating providers.**
14	Adjustment Pricing	Change from original claim or original repriced amount

* LOA =Participating providers and providers not yet credentialed, but contracted in the interim on a “letter of agreement”.

** Some Self-Funded Self-Administered groups request HealthLink to reprice non-participating provider claims at a percentage of HIAA.

HealthLink populates the HCP segment at both the claim level (Loop 2300) and the line item level (Loop 2400) for both professional claims and institutional claims.

5 Bundling (Code Editing)

Correct coding (bundling) or code review / editing will be communicated in HealthLink’s outbound priced claims for professional claims (1500s) only, and for business blocks with code review / editing enabled (most business blocks).

The following is an example to demonstrate how the service lines will be communicated for code bundling.

Example

A professional claim is received by HealthLink that contains 2 service lines with procedure codes A and B, each billed with 1 unit at \$100.00. The original claim, as received by HealthLink, will contain the two service lines and will look like the illustration below in the 837 format.

(Loop 2400)
 LX*1~ (Service line 1)
 SV1*HC:A*100*UN*1~

(Loop 2400)
 LX*2~ (Service line 2)
 SV1*HC:B*100*UN*1~

After running this claim through Code Review, it is determined that these 2 claim lines should be billed as procedure code C, that has an allowable of \$120.00 based upon our provider contract.

The “modified” claim will now appear as shown in the illustration below:

(Loop 2330B)* (Secondary Payor Information see below)
 NM1*PR*2*REPRICER*****PI*REPRICER~

(Loop 2400) (Original Service Line 1; proc code A)
 LX*1~
 SV1*HC:A*100*UN*1~

(Loop 2430) (Modified Service Line; repriced at \$120.00; proc code C)
 SVD*REPRICER*120*HC:C**1*1~

(Loop 2400) (Original Service Line 2, proc code B)
 LX*2~
 SV1*HC:B*100*UN*1~

(Loop 2430) (Modified Service Line; bundled into line above)
 SVD*REPRICER*0*HC:C**1*1~
 CAS*CO*97*100~ (Original Billed amount of \$100.00 adjusted)

It is necessary for HealthLink to include an “Other Payor” loop, Loop 2330B, in order to make the claim appear as a secondary claim and satisfy the HIPAA compliant edits. If this truly were a secondary claim, HealthLink would indicate the secondary payor information in this segment and send the claim to the secondary payor. Because HealthLink is not sending the claim to the secondary payor, we use the default text “REPRICER”, in order to communicate HealthLink as the repricer.

To summarize, the code review/editing will illustrate (within the outbound electronic claim):

- HealthLink as the “repricer”.
- The original claim line items with original units and billed amounts for each service line.
- The correct code or codes with the correct allowed amount, and original billed amount.
- The net effect will be to show the original billed amounts and codes, the correct code(s) with allowed amounts corresponding with each.

6 Coordination of Benefits

HealthLink will receive Coordination of Benefits (COB) information on the claims received. We will pass on to the payors all COB information received in the appropriate COB data segments in the 837.

These are the specific 837 loops that contain Coordination of Benefits (COB) information.

- Loop 2320.
- Loop 2330.
- Loop 2430.

7 Non-Standard Claims Converted to Standard Claims

Identifying Electronic vs. Paper Claims

If the HealthLink Document Control Number (DCN) begins with an “E”, HealthLink received the claim electronically from a provider. If the HealthLink DCN starts with any other character, the claim was received on paper (or manually). Professional and institutional claims which can be scanned and via imaging made into an electronic claim, are handled in this manner, so that payors can receive the majority of claims electronically.

HealthLink scans and uses OCR for both professional and institutional claims types, by the use of a front-end scanning-EDI vendor.

Paper Claims (Manual Claims)

HealthLink will continue to receive paper (manual) claim submissions from providers. In order to submit as many HIPAA compliant electronic claim transactions as possible, HealthLink will make every effort possible to convert the paper (manual) claims into a HIPAA compliant claim for transmission to payors.

Paper (manual) claims typically don't have all of the necessary data elements present to be converted into a HIPAA compliant 837 claim. However, a number of these claims have enough “essential” data elements that, if combined with default populated “UNKNOWN” data, can be converted into a HIPAA complaint transaction. By doing this, HealthLink can provide a much higher level of HIPAA compliant transactions to payors.

Under certain circumstances, claims cannot be translated without affecting the validity of the claims. In these instances, HealthLink will not convert the claims into the 837 format. Examples include (but are not limited to) for professional claim types:

- If Box 11D (is there another health benefit plan?) = “yes” and/or if Box 9 is populated
- If Box 15 (If patient has had same or similar illness) is populated

- If Box 16 (Dates Patient Unable to Work in Current Occupation) is populated
- If Box 18 (Hospitalization Dates Related to Current Services) is populated
- If Box 20 (Outside Lab) is populated
- If Box 22 (Medicaid Resubmission Code) is populated

Non-Standard Electronic Claims

Per CMS HIPAA guidance, HealthLink continues to accept non-standard electronic claims from providers. A number of the required data elements on the 837 are not required in the proprietary formats that we receive from providers. Therefore, HIPAA required data might be missing from some claims. Again, by populating default “UNKNOWN” data, these can be converted into HIPAA compliant transactions.

The sections below describe the various data elements that are required in the 837 but may not appear on either the paper (manual) claims or non-standard electronic claims received by HealthLink. Each section has a table indicating the ANSI data element, description, and what values HealthLink will default, if no value was received.

7.1 Institutional Claims

Subscriber Group Number and Group Name

In the 2000B loop, SBR04 (Group Name) is used only if SBR03 (Group Number) is blank. HealthLink will send the payor’s group number in SBR03 when available and leave SBR04 blank.

Billing Provider (2010 AA)

Occasionally, we will receive electronic claims with Billing Provider information, but no Provider name and/or Provider ID for this, which is required under HIPAA. If these fields are blank, HealthLink will populate the following data in the data elements listed below:

NOTE: In NM109 below, HealthLink will populate the tax ID of the provider if the Billing Provider Primary Identifier is not provided. If the tax ID is not provided, then the element will be populated with “999999999”.

ANSI Data Element	ANSI Loop	Data Element Name	Defaulted Data Element Value
NM101	2010AA	Entity Identifier Code	“85” (Billing Provider)
NM102	2010AA	Entity Type Qualifier	“2” (Non-Person)
NM103	2010AA	Provider Last Name	“XX”
NM108	2010AA	ID Code Qualifier	“24”
NM109	2010AA	Billing Provider Primary Identifier	“999999999”

Pay-To Provider Name (2010 AB)

Occasionally, we will receive electronic claims with Pay-To Provider information, but no Provider name and/or Provider ID for this, which is required under HIPAA. If these fields are blank, HealthLink will populate the following data in the data elements listed below:

ANSI Data Element	ANSI Loop	Data Element Name	Defaulted Data Element Value
NM101	2010AB	Entity Identifier Code	“87” (Pay-To)
NM103	2010AB	Provider Last Name	“XX”
NM108	2010AB	ID Code Qualifier	“24”
NM109	2010AB	Pay-To Primary Identifier	“999999999”

Subscriber Name (2010 BA)

Occasionally, we will receive electronic claims with Subscriber information, but no Subscriber name and/or Subscriber ID for this, which is required under HIPAA. If these fields are blank, HealthLink will populate the following data in the data elements listed below.

NOTE: See Section 12 Subscriber Identifiers in this guide for additional details.

ANSI Data Element	ANSI Loop	Data Element Name	Defaulted Data Element Value
NM101	2010BA	Entity Identifier Code	"IL" (Subscriber)
NM102	2010BA	Entity Type Qualifier	"1" (Person)
NM103	2010BA	Last Name	"XX"
NM104	2010BA	First Name	"XX"
NM108	2010BA	ID Code Qualifier	"M"
NM109	2010BA	Primary Identifier	"999999999"

Payor Name (2010 BC)

Occasionally, we will receive electronic claims with Payor information, but no Payor name and/or Payor ID for this, which is required under HIPAA. If these fields are blank, HealthLink will populate the following data in the data elements listed below:

ANSI Data Element	ANSI Loop	Data Element Name	Defaulted Data Element Value
NM101	2010BC	Entity Identifier Code	"PR" (Payor)
NM102	2010BC	Entity Type Qualifier	"2" (Non-Person)
NM103	2010BC	Payor Last Name	"XX"
NM109	2010BC	Payor Primary Identifier	"999999999"

Provider Signature on File and Assignments of Benefits

If these fields are blank, HealthLink will populate the following data in the data elements listed below:

ANSI Data Element	ANSI Loop	Data Element Name	Defaulted Data Element Value
CLM06	2300	Provider Signature on File	"Y"
CLM07	2300	Medicare Assignment Code	"A" (Assigned)

Related Causes Code

If an Accident Date is provided on the claim the assumption is that the condition being reported is Accident or Employment related. In these cases a Related-Causes Code is required in the 837. If this field is blank, HealthLink will populate the following data in the data elements listed below:

ANSI Data Element	ANSI Loop	Data Element Name	Defaulted Data Element Value
CLM11-1	2300	Related Causes Code	"OA" (Other Accident)

Attending Physician Name (2310 A)

Occasionally, we will receive electronic claims with Attending Physician information, but no Provider name and/or Provider ID for this physician, which is required under HIPAA. If these fields are blank, HealthLink will populate the following data in the data elements listed below:

ANSI Data Element	ANSI Loop	Data Element Name	Defaulted Data Element Value
NM101	2310A	Entity Identifier Code	"71" (Attending Physician)
NM102	2310A	Entity Type Qualifier	"1" (Person)
NM103	2310A	Provider Last Name	"XX"
NM104	2310A	Provider First Name	"XX"
PRV01	2310A	Provider Code	"AT"
PRV03	2310A	Provider Taxonomy Code	Billing Provider's Taxonomy Code

Operating Physician Name (2310 B)

Occasionally, we will receive electronic claims with Operating Physician information, but no Provider name and/or Provider ID for this physician, which is required under HIPAA. If these fields are blank, HealthLink will populate the following data in the data elements listed below:

ANSI Data Element	ANSI Loop	Data Element Name	Defaulted Data Element Value
NM101	2310B	Entity Identifier Code	"72" (Operating Physician)
NM102	2310B	Entity Type Qualifier	"1" (Person)
NM103	2310B	Provider Last Name	"XX"
NM104	2310B	Provider First Name	"XX"
NM108	2310B	ID Code Qualifier	"24"
NM109	2310B	Operating Physician Primary Identifier	"999999999"

Other Physician Name (2310 C)

Occasionally, we will receive electronic claims with Other Physician information, but no Provider name, Provider Type, ID, and/or taxonomy code for this physician, which is required under HIPAA. If these fields are blank, HealthLink will populate the following data in the data elements listed below:

ANSI Data Element	ANSI Loop	Data Element Name	Defaulted Data Element Value
NM101	2310C	Entity Identifier Code	"73" (Other Physician)
NM102	2310C	Entity Type Qualifier	"1" (Person)
NM103	2310C	Provider Last Name	"XX"
NM104	2310C	Provider First Name	"XX"
NM108	2310C	ID Code Qualifier	"24"
NM109	2310C	Other Physician Primary Identifier	"999999999"
PRV01	2310C	Provider Type	"OT" (Inpatient Claims) "PE" (Outpatient Claims)
PRV03	2310C	Provider Taxonomy Code	Billing Provider's Taxonomy Code

Other Insurance Coverage Information

If the claim contains other insurance information or indicates there is other coverage, then additional other insurance coverage information is required. Additionally, Other Subscriber Demographic information that is required may not be present. If the other insurance coverage information fields are blank, HealthLink will populate the following data in the data elements listed below:

ANSI Data Element	ANSI Loop	Data Element Name	Defaulted Data Element Value
SBR01	2320	Payor Responsibility Sequence Number Code	"S" (Secondary)
SBR02	2320	Individual Relationship Code	"21" (Unknown)
SBR03	2320	Reference Identification	"UNKNOWN"
SBR05	2320	Insurance Type Code	"OT" (Other)
SBR09	2320	Claim Filing Indicator Code	"ZZ" (Unknown)
DMG01	2320	Date Time Period Qualifier	"D8" (CCYYMMDD format)
DMG02	2320	Date Time Period	"19000101"
DMG03	2320	Gender Code	"U" (Unknown)
OI03	2320	Benefits Assignment Certification Indicator	"Y" (Yes)
OI04	2320	Patient Signature Source Code	"C"
OI06	2320	Release of Information Code	"A" *
NM101	2330A	Entity Qualifier Code	"IL" (Insured or Subscriber)
NM102	2330A	Entity Type Qualifier	"1" (Person)
NM103	2330A	Last Name	"XX"
NM104	2330A	First Name	"XX"
NM108	2330A	Identification Code Qualifier	"ZZ" (Unknown)
NM109	2330A	Identification Code	"999999999"
NM101	2330B	Entity Identifier Code	"PR" (Payer)
NM102	2330B	Entity Type Qualifier	"2" (Non-person)
NM103	2330B	Organization Name	"XX"
NM108	2330B	Identification Code Qualifier	"PI" (Payer)
NM109	2330B	Identification Code	"999999999"

* "A" means the appropriate release of Information on File at Health Care Service Provider or a Utilization Review Organization.

Revenue Codes

Occasionally, HealthLink will receive claims with a 3-digit revenue code. In these cases, HealthLink will convert these to the required 4-digit revenue code in SV201 in the 2400 loop.

7.2 Professional Claims

Billing Provider (2010 AA)

Occasionally, we will receive electronic claims with Billing Provider information but no Provider name and/or Provider ID for this, which is required under HIPAA. If these fields are blank, HealthLink will populate the following data in the data elements listed below:

NOTE: In NM109 below, HealthLink will populate the tax ID of the provider if the Billing Provider Primary Identifier is not provided. If the tax ID is not provided, then the element will be populated with "999999999".

ANSI Data Element	ANSI Loop	Data Element Name	Defaulted Data Element Value
NM101	2010AA	Entity Identifier Code	"85" (Billing Provider)
NM102	2010AA	Entity Type Qualifier	If First Name is populated, then "1", else then "2"
NM103	2010AA	Provider Last Name	"XX"
NM104	2010AA	Provider First Name	"XX"
NM108	2010AA	ID Code Qualifier	"24"
NM109	2010AA	Billing Provider Primary Identifier	"999999999"

Pay-To Provider Name (2010 AB)

Occasionally, we will receive electronic claims with Pay-To Provider information but no Provider name and/or Provider ID for this, which is required under HIPAA. If these fields are blank, HealthLink will populate the following data in the data elements listed below:

ANSI Data Element	ANSI Loop	Data Element Name	Defaulted Data Element Value
NM101	2010AB	Entity Identifier Code	"87" (Pay-To)
NM102	2010AB	Entity Type Qualifier	"1" (Person)
NM103	2010AB	Provider Last Name	"XX"
NM104	2010AB	Provider First Name	"XX"
NM108	2010AB	ID Code Qualifier	"34"
NM109	2010AB	Pay-To Primary Identifier	"999999999"

Subscriber Name (2010 BA)

Occasionally, we will receive electronic claims with Subscriber information but no Subscriber name and/or Subscriber ID for this, which is required under HIPAA (see Section 12 Subscriber Identifiers in this guide for more information). If these fields are blank, HealthLink will populate the following data in the data elements listed below:

ANSI Data Element	ANSI Loop	Data Element Name	Defaulted Data Element Value
NM101	2010BA	Entity Identifier Code	"IL" (Subscriber)
NM102	2010BA	Entity Type Qualifier	"1" (Person)
NM103	2010BA	Last Name	"XX"
NM104	2010BA	First Name	"XX"
NM108	2010BA	ID Code Qualifier	"MI"
NM109	2010BA	Primary Identifier	"999999999"

Payor Name (2010 BB)

Occasionally, we will receive electronic claims with Payor information but no Payor name and/or Payor ID for this, which is required under HIPAA. If these fields are blank, HealthLink will populate the following data in the data elements listed below:

ANSI Data Element	ANSI Loop	Data Element Name	Defaulted Data Element Value
NM101	2010BB	Entity Identifier Code	"PR" (Payor)
NM102	2010BB	Entity Type Qualifier	"2" (Non-Person)
NM103	2010BB	Payor Last Name	"XX"
NM104	2010BB	Payor First Name	"XX"
NM108	2010BB	ID Code Qualifier	"P"
NM109	2010BB	Payor Primary Identifier	"999999999"

Responsible Party Name (2010 BC)

Occasionally, we will receive electronic claims with Responsible Party information but no Responsible Party name, which is required under HIPAA. If these fields are blank, HealthLink will populate the following data in the data elements listed below:

ANSI Data Element	ANSI Loop	Data Element Name	Defaulted Data Element Value
NM101	2010BC	Entity Identifier Code	"QD" (Responsible Party)
NM102	2010BC	Entity Type Qualifier	"1" (Person)
NM103	2010BC	Last Name	"XX"
NM104	2010BC	First Name	"XX"

Supervising Provider (2310 E)

Occasionally, we will receive electronic claims with Supervising Provider information but no Provider name and/or Provider ID for this physician, which is required under HIPAA. If these fields are blank, HealthLink will populate the following data in the data elements listed below:

ANSI Data Element	ANSI Loop	Data Element Name	Defaulted Data Element Value
NM101	2310E	Entity Identifier Code	"DQ"
NM102	2310E	Entity Type Qualifier	"1" (Person)
NM103	2310E	Provider Last Name	"XX"
NM104	2310E	Provider First Name	"XX"
NM108	2310E	ID Code Qualifier	"34"
NM109	2310E	Provider Number	"999999999"

Billing Provider Communication Number

Per CMS HIPAA guidance, telephone numbers should consist only of ten numeric digits. Dashes and parenthesis marks are invalid characters. If this field has invalid characters, HealthLink will populate the data in the following manner:

ANSI Data Element	ANSI Loop	Data Element Name	Defaulted Data Element Value
PER04 PER06 PER08	2010AA	Billing Provider Communication Number	"0000000000" (ten zeros)

Provider Signature on File and Assignments of Benefits

If these fields are blank, HealthLink will populate the following data in the data elements listed below:

ANSI Data Element	ANSI Loop	Data Element Name	Defaulted Data Element Value
CLM06	2300	Provider Signature on File	"Y"
CLM07	2300	Medicare Assignment Code	"A" (Assigned)

Claim Frequency Type Code (Original and Adjustments)

If the claim is original to HealthLink, CLM05-3 in the 2300 loop will be populated with "1" ("Original claim"). If this is an adjustment to a claim previously processed by HealthLink, CLM05-3 will be populated with "7" ("Replacement claim").

ANSI Data Element	ANSI Loop	Data Element Name	Defaulted Data Element Value
CLM05-3	2300	Claim Frequency Type Code	"1" if original claim "7" if adjustment

Patient Signature Source Code

If CLM09 (Release of Information Code) does not equal "N", this code is required. If CLM10 is blank, HealthLink will populate the data in the following manner:

ANSI Data Element	ANSI Loop	Data Element Name	Defaulted Data Element Value
CLM10	2300	Patient Signature Source Code	"P" (Signature Generated by Provider)

Related Causes Code

If an Accident Date is provided on the claim the assumption is that the condition being reported is Accident or Employment related. In these cases a Related-Causes Code is required in the 837. If this field is blank, HealthLink will populate the following data in the data elements listed below:

ANSI Data Element	ANSI Loop	Data Element Name	Defaulted Data Element Value
CLM11-1	2300	Related Causes Code	"OA" (Other Accident)

Accident Date

If an Accident indicator is provided on the claim the assumption is that the condition being reported is Accident or Employment related. In these cases an Accident Date is required in the 837. If this field is blank, HealthLink will populate the following data in the data elements listed below:

ANSI Data Element	ANSI Loop	Data Element Name	Defaulted Data Element Value
DTP01	2300	Date/Time Qualifier	"439" (Accident)
DTP02	2300	Accident Date Format	"D8" (CCYYMMDD format)
DTP03	2300	Accident Date	"19000101"

Admission/Discharge Date

If an admission date is present on the claim, the discharge date is required. If the discharge date is present on the claim, the admission date is required in the 837. If one of these dates is blank or invalid, HealthLink will populate the following data in the data elements listed below:

ANSI Data Element	ANSI Loop	Data Element Name	Defaulted Data Element Value
DTP01	2300	Date/Time Qualifier	"435" (Admission Date)
DTP02	2300	Admission Date Format	"D8" (CCYYMMDD format)
DTP03	2300	Admission Date	"19000101"
DTP01	2300	Date/Time Qualifier	"096" (Discharge Date)
DTP02	2300	Discharge Date Format	"D8" (CCYYMMDD format)
DTP03	2300	Discharge Date	"19000101"

Onset of Current Symptom, Illness

If the claim indicates there was a related illness or symptoms but does not have a valid date, HealthLink will populate the following data in the data elements listed below:

ANSI Data Element	ANSI Loop	Data Element Name	Defaulted Data Element Value
DTP01	2300	Date/Time Qualifier	"431" (Onset of Current Symptoms/Illness Date)
DTP02	2300	Onset Date Format	"D8" (CCYYMMDD format)
DTP03	2300	Onset Date	"19000101"

Referring/Ordering Physician Information

Occasionally, we will receive claims with Referring/Ordering Physician information but no Provider name and/or Provider ID for this physician, which is required under HIPAA. If these fields are blank, HealthLink will populate the following data in the data elements listed below:

NOTE: In NM109 below, HealthLink will populate the tax ID of the provider if the Provider Number is not provided. If the tax ID is not provided, then the element will be populated with "999999999".

ANSI Data Element	ANSI Loop	Data Element Name	Defaulted Data Element Value
NM101	2310A	Entity Identifier Code	"DN" (Referring Physician)
	2420E		"DK" (Ordering Physician)
	2420F		"DN" (Referring Physician)
NM102	2310A	Entity Type Qualifier	"1" (Person)
	2420E		
	2420F		

ANSI Data Element	ANSI Loop	Data Element Name	Defaulted Data Element Value
NM103	2310A 2420E 2420F	Provider Last Name	"XX"
NM104	2310A 2420E 2420F	Provider First Name	"XX"
NM108	2310A 2420E 2420F	ID Code Qualifier	"24"
NM109	2310A 2420E 2420F	Provider Number	"999999999"

Purchased Service Provider Name

Occasionally, we will receive electronic claims with Purchased Service Provider information but no Provider name and/or Provider ID for this physician, which is required under HIPAA. If these fields are blank, HealthLink will populate the following data in the data elements listed below:

ANSI Data Element	ANSI Loop	Data Element Name	Defaulted Data Element Value
NM101	2310C	Entity Identifier Code	"QB" (Purchased Service Provider)
NM102	2310C	Entity Type Qualifier	"1" (Person)
NM103	2310C	Provider Last Name	"XX"
NM104	2310C	Provider First Name	"XX"
NM108	2310C	ID Code Qualifier	"24"
NM109	2310C	Purchased Service Provider Primary Identifier	"999999999"

Other Insurance Coverage Information

If the claim contains other insurance information or indicates there is other coverage, then additional other insurance coverage information is required. Additionally, Other Subscriber Demographic information that is required may not be present. If the other insurance coverage information fields are blank, HealthLink will populate the following data in the data elements listed below:

ANSI Data Element	ANSI Loop	Data Element Name	Defaulted Data Element Value
SBR01	2320	Payor Responsibility Sequence Number Code	"S" (Secondary)
SBR02	2320	Individual Relationship Code	"21" (Unknown)
SBR03	2320	Reference Identification	"UNKNOWN"
SBR04	2320	Name	"UNKNOWN"
SBR05	2320	Insurance Type Code	"OT" (Other)
SBR09	2320	Claim Filing Indicator Code	"ZZ" (Unknown)
DMG01	2320	Date Time Period Qualifier	"D8" (CCYYMMDD format)
DMG02	2320	Date Time Period	"19000101"
DMG03	2320	Gender Code	"U" (Unknown)

ANSI Data Element	ANSI Loop	Data Element Name	Defaulted Data Element Value
OI03	2320	Benefits Assignment Certification Indicator	"Y" (Yes)
OI04	2320	Patient Signature Source Code	"C"
OI06	2320	Release of Information Code	"A" *
NM101	2330A	Entity Qualifier Code	"IL" (Insured or Subscriber)
NM102	2330A	Entity Type Qualifier	"1" (Person)
NM103	2330A	Last Name	"XX"
NM104	2330A	First Name	"XX"
NM108	2330A	Identification Code Qualifier	"ZZ" (Unknown)
NM109	2330A	Identification Code	"999999999"
NM101	2330B	Entity Identifier Code	"PR" (Payor)
NM102	2330B	Entity Type Qualifier	"2" (Non-person)
NM103	2330B	Organization Name	"XX"
NM108	2330B	Identification Code Qualifier	"PI" (Payor)
NM109	2330B	Identification Code	"999999999"

* "A" means the appropriate release of Information on File at Health Care Service Provider or a Utilization Review Organization.

Rendering Provider Code Qualifier and ID

Occasionally, we will receive electronic claims with "Rendering Provider" information but no Provider ID Number for this physician, which is required under HIPAA. If no Rendering Provider information is supplied, HealthLink will not populate this loop. If the provider number or qualifier is blank, HealthLink will populate the following data in the data elements listed below:

ANSI Data Element	ANSI Loop	Data Element Name	Defaulted Data Element Value
NM108	2310B or 2420A	Provider ID Qualifier	"24"
NM109	2310B or 2420A	Rendering Provider Identifier	"999999999"

Units of Service

Occasionally, we will receive electronic claims without the required Units of Service field. If this is blank, HealthLink will populate the data element as listed below:

ANSI Data Element	ANSI Loop	Data Element Name	Defaulted Data Element Value
SV104	2400	Units of Service	"1"

8 HealthLink’s Document Control Number

HealthLink assigns a unique Document Control Number (“DCN”) (11 digits) to each claim that it processes. The DCN assigned to the claim has a structure described below, which uses the DCN “E1804021010” as an example:

Character Position	Value	Description
1	‘E’	The claim batchers assigned designator. If this value is equal to ‘E’ then the claim was received electronically; any other letter indicates that the claim was received on paper and scanned into the HealthLink system.
2-3	‘18’	The number of batches that claim batcher has batched for that day; this is the 18 th batch created for ‘E’. This is an alpha/numeric field.
4-5	‘04’	The year the claim was received; this was batched in 2004
6-8	‘021’	The Julian date that the claim was received; this was batched on January 21.
9-10	‘01’	The exact number of the claim within the batch; this is the first claim in the batch.
11	‘0’	The last position designates if the claim has been adjusted and if so, which iteration it is. ‘0’ designates the claim as the original claim, ‘1’ would mean that it is the first adjustment, etc. The values for this position are ‘0-9’ and ‘A-Z’

This DCN can be found in the following data elements:

ANSI Data Element	ANSI Loop	Data Element Name	Qualifier
REF02	2300	Repriced Claim Reference Number	‘9A’ (Original HealthLink DCN)
REF02	2300	(Adjusted) Repriced Claim Reference Number	‘9C’ (Adjusted DCN)
REF02	2300	Clearinghouse Claim ID	‘D9’

9 HealthLink’s Provider Identifier

Every provider, participating and non-participating, in HealthLink’s system is assigned a unique 6-digit provider ID within each network (e.g. HealthLink, NCPPO, AHI). Because a provider may have multiple locations and multiple billing vendors, an additional four digits are appended to the provider ID to uniquely identify the provider and corresponding location and vendor. The following table provides the provider ID format and example:

Character Position	Example Value	Description	
1-6	‘109345’	Unique provider ID in a network (may be numeric or alpha-numeric).	
7-8	‘01’	Location Address Index	A number from 01 to 99 that refers to a specific location of the provider.
9-10	‘01’	Billing Vendor Index	A number from 01 to 99 that refers to a specific billing address for the provider.

The 10-digit HealthLink provider ID can be found in the following data elements:

ANSI Data Element	ANSI Loop	Data Element Name	Qualifier
REF02	2010AA	Billing Provider Secondary Identification	'G2'

The full 10-digit identifier will be populated in the 2010AA loop, and can be matched to the provider identifier supplied in HealthLink provider par files. If during processing the specific location address index or billing vendor index cannot be determined, the default value of '99' will be used. The 6-digit identifier also may be found in other provider loops, such as rendering and pay to provider, if submitted by the provider.

10 Net Pay

HealthLink offers a Net Pay product for select providers, e.g. PHO's, IPA's, etc. Net Pay inserts HealthLink into the payment stream on the PPO side, where provider payments are sent to HealthLink by the payor. HealthLink in turn processes the payment and returns to the provider a single payment with the provider administrative fee deducted as well as a consolidated Remittance Advice. HealthLink has a contractual "right" or "obligation" to perform the net pay functions for select providers participating in this program.

Depending on the requirements of the provider group, some of the data values received on the original claim sent by the provider may be changed during processing at HealthLink. These data values will be the ones sent to the payor. The possible modifications are the following:

Date Element	Notes
Provider Pay To Tax ID	The provider group or facility may require that the tax ID be changed to a special HealthLink tax ID of the provider group or facility.
Provider Pay To Address (Address, City, State, and Zip)	The provider group may require that the "pay to" address information be changed to that of a specific lock box address.
Patient Control Number	HealthLink may set up a rule for the provider group that exchanges the Patient Control Number (PCN) with HealthLink's DCN, in order to more efficiently process the payments made to HealthLink on behalf of the provider group, restoring the PCN upon payment to the provider.

One of the main reasons a provider group may want these values changed is to have the Net Pay service implemented without much change on the providers' part. So, providers would continue to submit their claims as usual and HealthLink would make the necessary modifications to the claims. The payor will receive the modified values. The providers will receive their original data values on their Remittance Advices generated by HealthLink (or NCPPO).

NCPPO also utilizes a Net Pay product, but their version does not "change" the provider's tax ID, and is programmed by the payor at the network and "par" record status. This allows for claims payments and EOBs to be sent by payors to NCPPO directly. NCPPO, in turn, forwards consolidated payments to participating providers. The patient control number change does apply to the NCPPO claims flow.

11 Cycle Billing

For institutional claims, the cycle billing placement of the type of bill is located in the 2300 Loop CLM05. The third position in the type of bill indicates if it is an interim bill. Valid 3rd position codes for interim bills are:

ANSI Data Element	ANSI Loop	Data Element Name	Data Element Value
CLM05-3	2300 (837I)	Claim Frequency Type Code	"2" (Interim 1 st Claim) "3" (Interim Continuing Claim) "4" (Interim Last Claim)

12 Subscriber Identifiers

The subscriber identifier for a claim is found in loop 2010BA, Segment NM1, field NM109. HealthLink populates this field with the subscriber ID received on the inbound claim. If no value is received, or the claim is manually entered, then the subscriber SSN from the payor's eligibility file is used. If still blank, HealthLink's internal subscriber ID is used. In addition, HealthLink creates up to two additional REF segments in the 2010BA loop.

Qualifier (REF01)	Identifier (REF02)
SY	Subscriber's SSN from payor's eligibility file.
IG	Payor's Policy Number (or Payor's Privacy ID) from payor's eligibility file.

These REF segments are only created if the corresponding value is available.

13 National Provider Identifier (NPI)

In January 2007, Healthlink will begin to send the NPI associated with provider data in the standard 837 locations, as are submitted by providers via their clearinghouses (compliance date is 5/23/07).

14 Transmission Methods

HealthLink supports the FTP data communication method for exchanging Electronic Claims with its Trading Partners. Trading Partners can use FTP to connect to HealthLink's FTP server over the Internet to pick up their claims from their mailbox.

Alternatively, HealthLink can "push" the claims to trading partners via FTP. HealthLink requires that PGP encryption is used which requires the use of PGP encryption software.

15 Acknowledgement Files (997s)

HealthLink strongly encourages Trading Partners to send HealthLink fully populated 997s for all received 837 transactions. The only naming convention requirement is the file should contain the text "997" within the file name. Acknowledgements will help ensure that the receiving party has accepted the claim files sent by HealthLink.

For any non-standard acknowledgement files, HealthLink requests the trading partner to email these files to the Help Desk (helpdesk@healthlink.com).

HealthLink has developed a routine, daily file status process whereby payors are notified by phone in the event their claims files are not "picked up" timely. HealthLink will work with payors on problem files or rejected files as needed.

16 EDI Claims Problems

If your firm encounters electronic claims issues, please contact:

- HealthLink's Information Technology Help Desk at (314) 989-6123 (all clients), or helpdesk@healthlink.com.
- Payor Relations at (877) 284-0101, ext 6132 (for payors), or PayorRelations@HealthLink.com, or the specific account manager's email address.
- Client Services at (314) 989-6256 (for self-funded, self-administered clients)

17 Payor Edits

Payors who utilize edits or filters for claims arriving electronically from either clearinghouses or from HealthLink will need to provide "rejection reports" or "claims filter reports" to HealthLink to ensure integrity of the claims files. For example, in the event the payor doesn't accept a transmitted claim for "insured policy number not found," the network requires notification so that the claim can be correctly routed.

18 File Naming Conventions

HealthLink has established standard naming conventions for inbound and outbound ANSI transactions for automated transaction processing.

Outbound 837 Files

Outbound 837 files use the following naming convention:

PGP Encrypted Files:

HealthLink assigns a unique outbound file name to each encrypted outbound 837, such as 837i_20050601_1.pgp. The name assigned to the file has a structure described below.

Character Position	Description
1-4	The ANSI transaction type. Professional transaction will be named as "837p" and institutional as "837i"
6-13	The date the file was created by the HealthLink batch process for outbound submission. The data does not reflect the date the file was created or posted for pickup, but the date of the nightly batch process in which the file was generated.
15	The transaction type file count. This position will increment by 1 for each additional file submission for the same date. Generally, only one file of each transaction type is submitted each day. Additional files will be submitted when previous days files failed and have been corrected.

Decrypted files:

HealthLink assigns a unique outbound file name to each decrypted outbound 837, such as 34719201-XXXX_837i_20050202_1.txt. The name assigned to the file has a structure described below.

Character Position	Description
1-8	A unique HealthLink internal control number
10-13	The 4 digit HealthLink internal trading partner ID. The number will mirror the FTP login on the Healthlink FTP server (hlaXXXX).
15-18	The ANSI transaction type. Professional transaction will be named as "837p" and institutional as "837i".
20-27	The date the file was created by the HealthLink batch process for outbound submission. The data does not reflect the date the file was created or posted for pickup, but the date of the nightly batch process in which the file was generated.
29	The transaction type file count. This position will increment by 1 for each additional file submission for the same date. Generally, only one file of each transaction type is submitted each day. Additional files will be submitted when previous days files failed and have been corrected.

Appendix A -- Common Error Codes and Descriptions

Error Code	Description
029	MEMBER INACTIVE ON SVC DATE.
031	GROUP NOT ACTIVE ON SVC DATE.
036	ALLOWANCE FOR THESE CHARGES IS INCLUDED IN THE HOSPITAL'S PER DIEM RATE.
037	DUPLICATE CLAIM SUBMISSION!!! PLEASE ADVISE PROVIDER OF PAYMENT OR DENIAL STATUS ASAP.
113	SERVICES NOT AUTHORIZED; NOTIFIED BY CLAIM.
114	NOT SUBJECT TO AMBULATORY REVIEW.
116	SERVICES AUTHORIZED; UNABLE TO PRINT CERT NUMBER.
137	DUPLICATE CLAIM SUBMISSION!!! PLEASE ADVISE PROVIDER OF PAYMENT OR DENIAL STATUS ASAP.
197	PROFESSIONAL FEE ASSOCIATED WITH NON-REVIEWED OR NON-CERTIFIED SERVICES.
288	MATERNITY LENGTH OF STAY WITHIN HEALTHLINK GUIDELINES
337	CHARGES PREVIOUSLY CONSIDERED UNDER WORKERS COMPENSATION.
513	SERVICES INCLUDED IN GLOBAL.
521	MAXIMUM ALLOWABLE MET OR EXCEEDED.
615	CPT CODE INCIDENTAL TO PRIMARY PROCEDURE
623	ASST SURGEON MUST BILL ASST SURGEON FEE.
624	NO ALLOWANCE FOR ASST SURGEON ON THIS PROCEDURE.
630	CPT CODE HAS BEEN EXCLUDED IN ACCORDANCE WITH CPT GUIDELINES.
632	CPT CODE HAS BEEN REPLACED IN ACCORDANCE WITH CPT GUIDELINES.
633	CPT HAS BEEN ADDED BY CODE REVIEW.
638	MEMBER CANNOT BE IDENTIFIED AS PARTICIPATING WITH HEALTHLINK.
654	MULTIPLE SURGICAL REDUCTIONS HAVE BEEN APPLIED.
709	CHARGES NOT COVERED DUE TO CONTRACT PROVISIONS.
749	PRE/POST NATAL CARE S/B BILLED WITH DELIVERY CHRGS.
856	NEWBORN REIMBURSEMENT INCLUDED IN OBSTETRIC PER DIEM
880	CATASTROPHIC CASE LIMIT PRICING
884	THE ALLOWED AMOUNT IS THE LESSER OF BILLED CHARGES OR THE NEGOTIATED RATE.
886	AUTOMATED LAB; PROFESSIONAL COMPONENT INCLUDED IN GLOBAL ALLOWANCE.
930	CPT CODE EXCLUDED BY CODE REVIEW.
932	CPT CODE REPLACED BY CODE REVIEW.
933	CPT CODE ADDED BY CODE REVIEW.
955	CHARGES REDUCED TO ESTABLISHED UCR ON OUT OF NETWORK.
992	PACKAGED SURGICAL PROCEDURES INCLUDE OPERATION AND UNCOMPLICATED POST-OP CARE.
995	PROCEDURE CODE HAS BEEN TERMINATED.

Appendix B – Former Version of Outbound 837 Transactions

In August 2004, HealthLink reengineered its outbound 837 Addenda process and mapping. This resulted in some changes to the 837 transaction produced by HealthLink. This appendix contains information on data that were moved or removed from the “former” version. This section is intended for those trading partners currently testing with or receiving data in the “former” version.

1 Identifying Participating Provider Status

In addition to the method in Section 1 **Identifying Participating Provider Status**, the providers participating status also is indicated in the Claim Note/Line Note segments (“NTE”). The status will be placed in the first position of the corresponding Description data field (“NTE02”). The table below describes the possible values and their meanings. Please note again that this value is in the first position – this data element is also used to communicate additional repricing specific information indicated below (see *Pricing Messages below*).

ANSI Data Element	ANSI Loop	Data Element Name	Value	Notes
NTE02 (first position)	2400 (837P), 2300 (837I)	Note Description	“P”	Indicates a participating <u>PPO</u> provider.
NTE02 (first position)	2400 (837P), 2300 (837I)	Note Description	“H”	Indicates a participating <u>HMO</u> provider.
NTE02 (first position)	2400 (837P), 2300 (837I)	Note Description	“N”	Indicates a <u>non-participating</u> provider.

If no provider information is available, HealthLink will populate this field with a dash (“-“) to preserve proper spacing.

1.1 Professional Claims (1500s or 837P)

The Providers Participating Status will be available in the Line Notes (“NTE”) at the Claim Line Level, Loop 2400. The “Note Reference Indicator”, (“NTE01”), value that identifies this Line Note segment is “TPO”.

1.2 Institutional Claims (UB92s or 837I)

The Providers Participating Status will be available in the Line Notes (“NTE”) at the Claim Level, Loop 2300. The “Note Reference Indicator”, (“NTE01”), value that identifies this Line Note segment is “ADD”.

2 Identifying Products (HMO, PPO, Open Access)

In addition to the method in section 3 **Identifying Products (HMO, PPO, Open Access)**, the payor may also utilize the provider’s participating status indicator in the NTE02 data element, described above in section 1, to determine the status of the provider who rendered the service. The table below shows the values of the provider status; and the HealthLink Open Access products and network access for each product.

Value	Meaning	HL Product	HL Provider Access
‘P’	Participating; PPO Provider	OA I	HMO, No Out of Network (1 tier)
‘H’	Participating; HMO Provider	OA II	HMO and Out of Network (2 tiers)
‘N’	Non-Participating; Out of Network	OA III	HMO, PPO and Out of Network (3 tiers)

Appendix B (Former Version of Outbound 837 Transactions) Continued

Providers on “letters of agreement” are identified as “par”, and have P or H indicators.

3 Repricing Messages

In the “former” version, repricing messages were not identified in the K3 segment. Repricing messages were communicated in the following manner.

HealthLink communicates various repricing messages for payors. HealthLink utilizes its proprietary messages that are currently in use for manual claims.

The 837 formats have a Claim Level and Claim Line Level Line Notes segment (“NTE”) for communicating such messages. The first data element of the segment NTE01 contains the code “TPO” which identifies that the following note is coming from a Third Party Organization. The table below shows how HealthLink communicates these messages in the NTE Segment.

837 Data Element	Positions	Length	Meaning
NTE02	1	1	Provider participating status (<i>see Identifying Participating Status above</i>).
NTE02	2 – 4	3	Adjustment Reason Code
NTE02	5 – 7	3	Error Code
NTE02	8 – 72	65	Error Description

Adjustment, error and rejection codes are available via the network Internet site. See Appendix A for the most common error codes and descriptions.

3.1 Professional Claims 837P (1500s)

The Pricing Messages will be available in the Line Notes (“NTE”) at the Claim Line Level, Loop 2400. The “Note Reference Indicator” (“NTE01”) value that identifies this Line Note segment is “TPO”.

3.2 Institutional Claims 837I (UB92s)

The Pricing Messages will be available in the Line Notes (“NTE”) at the Claim Level, Loop 2300. The “Note Reference Indicator”, (“NTE01”), value that identifies this Line Note segment is “ADD”.

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