

VERSION 2.3r1
Provider Agency and RSN Trading Partner Agreement for 837P
Effective 1/1/2012

The Health Insurance Portability and Accountability Act (HIPAA) requires that DSHS, and all other covered entities in the United States, comply with Electronic Data Interchange (EDI) standards for health care transactions as established by the Secretary of Health and Human Services (HHS). The ANSI X12N Implementation Guides have been established as the standards of compliance for health care transactions. The implementation guides for each transaction are available electronically at www.wpc-edi.com.

The following information is intended to serve only as a companion document to the HIPAA ANSI X12N Implementation Guides. The use of this document is for the purpose of clarification only, and does not contradict any requirements in the X12N Implementation Guides with the exception of the allowed length of loop 2400 REF02 Line Item Control Number reference identifier. Specifically, where the implementation guides allow the Trading Partners to make a choice, this document specifies the data elements and values to use in a standard HIPAA transaction. The exception is to allow Greater Columbia Behavioral Health Regional Support Network (RSN) to maintain uniqueness in its database. In terms of optional data elements as identified by the implementation guides, the RSN will only accept those optional elements identified below.

NOTE: Only one of the HIPAA ANSI X12N Transactions is necessary for Agencies to report outpatient mental health service utilization to the RSN. This is the 837Professional used to report Outpatient Services. Transactions between other trading partners or covered entities are not covered by this trading partner agreement.

General Requirements

Item No.	Loop Id – Description	Data Element – Description	IG Page #	RSN Requirements
1	General – Compression	General	NA	Compression of files using zip compression software is not supported for transmissions between the submitter and the RSN.
2	General – Delimiters Allowed	Data Element Separator	A.4	The data Element Separator is byte 4 of the ISA. Recommended use is the Asterisk '*'. *
		ISA16 – Component Element Separator	A.4	Sub Element Separator required use is the colon ':'.
		Segment Terminator	A.4	Recommended to use Line feed character as Segment Terminator. This character is defined in the ISA segment as the character following the Data Element Separator (ISA16). For display purposes only, throughout this Trading Partner Agreement, the tilde character '~' has been used.
3	General – Files Invalid in Syntax and Structure	All Segments and Elements	NA	Only loops, segments, and data elements specified in this trading partner agreement (TPA) are allowed. Non-specified data and/or loops will be dropped, will not be considered in processing, may cause inaccurate data to be recorded and reported, and may cause the file to fail.

VERSION 2.3r1

Provider Agency and RSN Trading Partner Agreement for 837P

Effective 1/1/2012

Health Care Eligibility Inquiry (270) Requirements - NOT REQUIRED as part of this agreement

Health Care Eligibility Response (271) Requirements - NOT REQUIRED as part of this agreement

Claim Status Inquiry (276) Requirements - NOT REQUIRED as part of this agreement

Claim Status Response (277) Requirements - NOT REQUIRED as part of this agreement

Referral Inquiry (278) Requirements - NOT REQUIRED as part of this agreement

Referral Response (278) Requirements - NOT REQUIRED as part of this agreement

Health Plan Premium Payment (820) Requirements - NOT REQUIRED as part of this agreement

Health Plan Enrollment (834) Requirements - NOT REQUIRED as part of this agreement

Remittance Advice (835) Requirements - NOT REQUIRED as part of this agreement

Health Care Claim – Institutional (837 - I) Requirements - NOT REQUIRED as part of this agreement

Health Care Claim – Dental (837 - D) Requirements - NOT REQUIRED as part of this agreement

Error Response (997) Requirements - NOT REQUIRED as part of this agreement

VERSION 2.3r1
Provider Agency and RSN Trading Partner Agreement for 837P
Effective 1/1/2012

Health Care Claim – Professional (837 - P) Requirements

IMPORTANT: The key fields that form a unique record are RUID, CID, and the Line Item Control Number in loop 2400. When resubmitting services, all subsequent submissions must retain the original submission's key field values. If any of these three fields are changed, a new record will be created or a different record affected. The intended record or error will not be changed or cleared respectively.

Documentation Conventions:

Periods are used to fill spaces in fixed-width data

Underlined text indicates hard-coded entries/values that do not change where there is only one choice per the implementation.

Items in {} are suggested mutually agreed to default values between Agencies and the RSN.

{{}}Indicate default values for the Agency to RSN transmission

<1234> indicates Implementation Loop.

[xxx] Indicates an ID field

Item No.	Loop Id – Description	Data Element – Description	RSN Requirement Notes
1	Interchange Control Header	<u>ISA*00*.....*00*.....*ZZ*</u> {Provider RUID}.....*ZZ* *{{413.23}}.....*YYMMDD*HHMM*^* <u>00501*[ID1]*0*P*~</u>	ISA15 - T=test data P=production data The ISA segment is a 105 byte fixed length record. ISA08 reflects the TPA format used
2	Functional Group Header	<u>GS*HC*</u> {Provider RUID}*{{413}}*CCYYMMDD*HHMM*[ID 2]*X*005010X222A1~	
3	Transaction Set Header	<u>ST*837*[ID3]*005010X222A1~</u>	ST/SE – Common ID code for txn Start/End
4	Beginning of Hierarchical Transaction	<u>BHT*0019*00*[ID4]*CCYYMMDD*HHM M*RP~</u>	
5	Submitter Name <1000A>	<u>NM1*41*2*</u> {Provider Name}* <u>****46*</u> {Provider RUID}~	
6	Submitter EDI Contact Information <1000A>	<u>PER*IC*</u> {IT Contact Person at Agency}* <u>TE*</u> {Ph# For IT Contact Person at Agency}~	Start with area code (don't use 1)
7	Receiver Name <1000B>	<u>NM1*40*2*</u> {{RSN}}* <u>****46*</u> {413}~	
8	Billing Provider Hierarchical Level <2000A>	<u>HL*</u> HierarchicalID* <u>**20*1~</u>	The hierarchical ID should begin with one (1) and increment by one for each HL segment in the file

VERSION 2.3r1
Provider Agency and RSN Trading Partner Agreement for 837P
Effective 1/1/2012

Item No.	Loop Id – Description	Data Element – Description	RSN Requirement Notes
9	Billing Provider Specialty Information <2000A>	PRV*BI*PXC*{ProviderTaxonomyCode}~	
10	Billing Provider Name <2010AA>	NM1*85*2*{ProviderName}~	Service Provider name
11	Billing Provider Address <2010AA>	N3*AddressLine1*AddressLine2~	
12	Billing Provider City/State/ZIP <2010AA>	N4*City*State*ZIP~	
13	Billing Provider Tax Identification <2010AA>	REF*{{EI}}*_{Provider EIN}~	
14	Billing Provider Contact Information <2010AA>	PER*IC*SubmitterContactName*TE*PhoneNumber~	Start with area code (don't use 1)
15	Subscriber Hierarchical Level <2000B>	HL*HierarchicalID*ParentHierarchicalID*22*{0}*~	Hierarchical ID increments from 1 Parent is HL segment to which the current HL segment is subordinate.
16	Subscriber Information <2000B>	SBR*{{P}}*18*{Agency's Unique Consumer ID}*_{Provider RUID}****{MC}~	
17	Subscriber Name <2010BA>	NM1*IL*1*LastName*FirstName*MiddleNameIfKnown**SuffixIfKnown*MI*_{ProviderOne ID if Medicaid, Agency's Unique Consumer ID if not Medicaid}~	Suffix=Generational ProviderOne IDs must be 11 digits, comprised of 9 numbers followed by "WA", for example "123456789WA"
18	Subscriber Address <2010BA>	N3*Address1*Address2IfNecessary~	If client is homeless or address is unknown, use "Unknown" in N301
19	Subscriber City/State/ZIP Code <2010BA>	N4*City*State*ZIP*CountryCodeIfOutsideUS~	If 2010BA N301 is "Unknown", use City, State & ZIP of service provider or client
20	Subscriber Demographic Information <2010BA>	DMG*D8*DOB*Gender~	If DOB is unknown, enter CCYY0101 (January 1st for month & day and best guess for year.) Use "F", "M", or "U" for male, female, or unknown respectively.
21	Subscriber Secondary Identification <2010BA>	REF*SY*SSN~	Only a social security number is allowed.
22	Payer Name <2010BB>	NM1*PR*2*{{MHD}}****PI*{{400}}~	
23	Claim Information <2300>	CLM*ClaimSubmitIdentifier*{{0}}***Facility	<ul style="list-style-type: none"> This ID must be globally unique per RUID, may

VERSION 2.3r1
Provider Agency and RSN Trading Partner Agreement for 837P
Effective 1/1/2012

Item No.	Loop Id – Description	Data Element – Description	RSN Requirement Notes
		tyCode: <u>B</u> :ClaimFrequencyTypeCode*{{Y}}*{{A}}*{{Y}}*_ROICode_~	<p>contain multiple services per claim, and must not be longer than 20 characters.</p> <ul style="list-style-type: none"> Valid Facility Codes are listed in the Service Location (SLOC) table in Section II of the GCBH Data Dictionary Claim Frequency Type Code <ul style="list-style-type: none"> 1-Original = Add 7-Replacement = Change 8-Void = Delete <p>To adjust a previously transmitted encounter, use “7”. If Voiding a previously transmitted encounter, use “8” in the claim frequency code.</p> <ul style="list-style-type: none"> CLM09-Use ‘I’ or ‘Y’ per Implementation Guide.
24	Claim Note <2300>	<u>NTE</u> *ReferenceCode*Description_~	Use per IG.
25	Health Care Diagnosis Code <2300> (May have up to eleven diagnosis.)	<u>HI</u> * <u>BK</u> :ICD-9* <u>BF</u> :ICD-9_~	<p>HI01 - If diagnosis not available, use either 799.9 (deferred) or V71.09 (unknown) - (e.g. for crisis). It is expected that the primary diagnosis be Mental Health. Use HI01-2 for the primary diagnosis. Up to 10 additional diagnoses may be submitted by repeating HI02-1 & HI02-2.</p> <p>NOTE: Don't have a blank field between diagnoses and use decimal points.</p>
26	Service Line <2400>	<u>LX</u> *Counter_~	Counter increments by one (1) for each service line
27	Professional Service <2400>	<u>SV1</u> *{HC};ProductOrServiceCode;ProcedureModifier1;ProcedureModifier2;ProcedureModifier3;ProcedureModifier4*{0}*UnitOfMeasurement*Qty*FacilityCode Value**DiagnosisCodePointer****EPSDTIndicator_~	<p>Use only HCPCS or CPT codes. SV101-3 through SV101-7 - Procedure Modifiers to be used to further clarify service when necessary. Unit or Basis for measurement code based on HCPCS/CPT code used. Facility Code Value (Place of Service) - use the list at http://www.cms.hhs.gov/MedHCPCSGenInfo/Downloads/Place_of_Service.pdf for current values, or refer to the Service Location (SLOC) table in Section II of the GCBH Data Dictionary. SV111 indicate service is a result of an EPSDT referral. Only necessary to report if true.</p>
28	Date - Service Date <2400>	<u>DTP</u> *472*D8*_ServiceDate_~	
29	Line Item Control Number	<u>REF</u> *6R*_LineItemControlNumber_~	This number must be globally unique per RUID and may only

VERSION 2.3r1
Provider Agency and RSN Trading Partner Agreement for 837P
Effective 1/1/2012

Item No.	Loop Id – Description	Data Element – Description	RSN Requirement Notes
	<2400>		be up to 25 characters in length. If the number submitted does not begin with the RUID of the provider, the RUID will be appended to the beginning which may bring the value up to the 30 characters allowed in the IG.
30	Line Note <2400>	<u>NTE*ADD*LineNoteText~</u>	<p>Line Note Text is to be used to denote the service provider/ credential type (see listing below) in columns 1-2, as well as other data required in columns 3-80 as specified with a transaction ID value in cols 3-8 (see co-occurring transaction 121.01 for formatting examples used through column 12).</p> <p>Co-Occurring Disorder reporting: Col 3-8 = Transaction ID '121.01' Col 9 = IDS Screening Score Col 10 = EDS Screening Score Col 11 = SDS Screening Score Col 12 = Assessment Quadrant value</p> <p>Service Provider Identification: Col 13-18 = Staff or subcontractor Internal Identifier reported previously in native transaction 100 or 105. Required for non-per diem encounters. Optional for per diem encounters.</p> <p>Place a space or spaces to account for a blank value or values in the screening/assessment scores. For an Internal Identifier shorter than 6 characters, start data in column 13, leaving empty space after the ID.</p>
31	Transaction Set Trailer	<u>SE*[#ofIncSegments]*[ID3]~</u>	
32	Functional Group Trailer	<u>GE*[#ofTSIncluded]*[ID2]~</u>	
33	Interchange Control Trailer	<u>IEA*[#ofFuncGroups]*[ID1]~</u>	

VERSION 2.3r1
Provider Agency and RSN Trading Partner Agreement for 837P
Effective 1/1/2012

Provider Type Codes

Code	Credential/Provider Type	Code	Credential/Provider Type
10	RN	50	BA/BS
11	LPN	51	AA/AS
20	ARNP	52	BELOW AA (INC HS DIPLOMA/GED)
21	PA (PHYSICIAN'S ASSISTANT)	53	CERTIFIED MEDICAL ASSISTANT
30	MD/DO PSYCH	60	PEER COUNSELOR
31	MD/DO OTHER	70	MENTAL HEALTH SPECIALIST
40	MA/MS (and Masters not Mental Health field i.e. MEd)	71	Bachelor Level with Exception/Waiver (RSN approval only)
41	PHD-LICENSED CLINICAL	72	Master Level with Exception/Waiver (RSN approval only)
42	PHD-OTHER	73	Designated Mental Health Professional
43	LCSW	74	Other (RSN approval only)
44	MSW	75	CD Specialist
45	MFT	80	NOT APPLICABLE (i.e. per diem codes)

VERSION 2.3r1
Provider Agency and RSN Trading Partner Agreement for 837P
Effective 1/1/2012

GCBH Native and Encounter Data Submissions

GCBH will provide a method by which agencies may submit data files containing each of the transactions described in the Data Dictionary and Trading Partner Agreement.

DATA PROCESSING:

Importing

All batch files are imported in a random undetermined order. The order of import does not affect the more important order of processing. On import, the upload timestamp is recorded for use in Core Performance Measures and other reporting, but is not typically used in processing (see exceptions below). Importing is scheduled to run nightly but may be run manually or delayed as necessary.

Processing

Processing passes submitted records through a number of scripts. These scripts trim records, clean data, and perform data validation. Record State Codes are assigned to each record based on the outcome of this processing. These record state codes are returned on the Batch Summary Report.

When multiple identical records are received during a single processing cycle, only the latest version is processed. Identical records are defined as records with identical values in the primary key fields. Primary key fields are identified in this document and in the GCBH Data Dictionary Section One. A processing cycle is defined as the time between executions of the processing script. The determination of the latest version is outlined below by record type (service encounters and natives).

When a previous outstanding error record is identified with the same primary key values, the error is cleared before processing the new version of the record. This happens regardless of the final record state of the new record after processing. This is the only cause of a record error not being cleared when a correcting record is submitted and processed.

Following processing, providers must review the Batch Summary Report to confirm successful acceptance of the submitted records. If any records failed, they must begin their error correction process. Outstanding Error Reports and the report "Complete Error List" (providing all possible errors and correction methods) can be retrieved from the Provider Portal at <https://www.gcbh.org/providerportal>. Requirements for error correction timelines are outlined in the agency's PIHP contract with the RSN.

Processing is scheduled to run nightly but may be run manually more frequently or delayed as necessary.

Service Encounters

Order of determination (only if the fields' values equal will the next field be evaluated):

1. ISA09 Date (latest)
2. ISA10 Time (latest)
3. File upload timestamp (latest)

VERSION 2.3r1
Provider Agency and RSN Trading Partner Agreement for 837P
Effective 1/1/2012

4. Row position (preference given to later records)

Natives

Order of determination (only if the fields' values equal will the next field be evaluated):

1. Transaction type (020.*nn* is always first)
2. Header record date (latest)
3. File upload timestamp (latest)
4. Row position (preference given to later records)

Record State Codes after Processing

1. I = Imported: The record was accepted and successfully processed
2. N = Ignored:
 - a. Identical records not processed
 - b. "Delete" records for which no corresponding record can be found in the database to delete
3. F = Failed: The record generated an error and was not accepted
4. P = Pending: The record was not processed. This indicates a processing error and should never be seen on a Batch Summary Report.

FILE NAMES:

File names must follow a specific naming scheme. The first segment of a file name can be anything the provider desires that is supported by Microsoft Windows operating systems. The file extension must be the RUID of the submitting provider. If another entity is submitting on behalf of the provider, this extension must be the RUID of the provider. Files submitted with an extension other than the RUID found in the data within the file will be rejected.

SECURITY/ENCRYPTION:

GCBH uses Microsoft SQL to store and manage data. Data and report transfers between GCBH and the provider network are encrypted.

TESTING AND ACCEPTANCE:

Each provider must successfully submit a test file before submitting production data. GCBH maintains a testing environment that is available to providers for this purpose. The test database is refreshed/overwritten nightly with a copy of the production database. A successful test is defined as the submission of at least one data file with a minimum of 100 claims being processed through completion by the system resulting in normal reporting with no data errors returned.

VERSION 2.3r1
Provider Agency and RSN Trading Partner Agreement for 837P
Effective 1/1/2012

Change Summary

2.3r1

ISA11 & ISA12 changed (as per new standard)
CLM 05-2 required value stipulated (as per new standard)

2.3

Version changed to 2.3 because some copies of 2.1r1 & r2 were released with a title of 2.2
Implementation Guide Page # column removed
Interchange Control Header ISA08 update to reflect version change
X12 version number updated in Group Header GS08 (as per new standard)
X12 version number added to Transaction Set Header ST03 (as per new standard)
Transmission Type Identification (REF*87) removed (as per new standard)
Billing Provider <2000A> loop renamed (as per new standard)
Billing Provider Specialty Information <2000A> segment PRV added (as per new standard)
Billing Provider Name <2010AA> unnecessary situational data removed (as per new standard)
Billing Provider Tax Identification <2010AA> REF segment renamed and changed (as per new standard)
Claim Information <2300> CLM09 possible values changed (as per new standard)
Claim Information <2300> CLM10 situational and should never be required (as per new standard)
Health Care Diagnosis Code <2300> modified (as per new standard)
Rendering Provider Name <3210B> removed as unnecessary
Line Note <2400> NTE field use expanded to include data previously included in Rendering Provider <2420A> loop
Loop <2420A> removed (segments NM1, REF*LU and REF*EI or REF*SY) (as per new standard)

2.1r2

Identified primary key fields
Rendering provider "situational" reference removed to reflect current practice
Added explanation of import and processing functions

2.1r1

Documented current practice for reporting rendering provider <2420A>

2.1

Notes changes on page 1
Formatting changes throughout document
Claim Information <2300> - notes changes

VERSION 2.3r1
Provider Agency and RSN Trading Partner Agreement for 837P
Effective 1/1/2012

2.0

Numerous changes have been made throughout the entire document to verbiage including comments and field names. Major changes are listed below. Other changes to the TPA may result in a change for some providers and not for others. It is strongly recommended that every provider familiarize themselves with the document to determine which changes will impact their processes and/or system.

Significant Changes

Only loops explicitly defined in this document will be accepted.

Subscriber Information <2000B> - requires ProviderOne ID instead of PIC or CID for non-Medicaid consumer (effective only when ProviderOne goes live)

Professional Service <2400> - required to use appropriate unit for code instead of always using "MJ" (effective only when ProviderOne goes live)

The narrative at the end of the document has changed considerably

Segments Added

Subscriber Secondary Identification <2010BA> - line 21

Claim Note <2300> - line 24

Segments Removed

Billing Provider Secondary Identification <2010AA> - formerly used to report EIN of provider

Prior Authorization or Referral Number <2300> - not used

Medical Record Number <2300> - redundant unnecessary data