



HIPAA Transaction
Companion Guide
837 Professional Health Care Claims

**Refers to the Implementation Guides
Based on X12 version 004010 Addendum
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Disclaimer Statement

The Health Insurance Portability and Accountability Act (HIPAA), sections 160 and 162, requires health care providers, health plans, and health care clearing houses comply with the EDI standards for health care. The HIPAA implementation specifications for ASC X12N standards may be obtained through the Washington Publishing Company on the Internet at <http://www.wpc-edi.com>. The complete Implementation Guide is a combination of both the version 4010 and the 4010 addenda as adopted for use under the HIPAA regulation. The combined version is referred in this document as the X12N 4010A1.

The purpose of this companion guide is solely to supplement the HIPAA ASC X12N standards, to provide clarification to the ASC X12N standards, and should not be interpreted as a contract, amendment to a contract or an addendum to a contract. In any instance where this companion guide differs from the HIPAA ASC X12N Implementation Guides, the HIPAA ASC X12N standards shall govern.

Substantial effort has been taken to minimize errors; however, Apex Benefits Services, its agents, employees, directors and shareholders shall not be liable or responsible for any errors, omissions or expenses resulting from the use of the information in this document.

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1 Introduction

1.1 Overview

The purpose of this Companion Guide is to provide support for the submission of the HIPAA compliant 837 Professional claim and ensure the proper processing of claims submitted to Apex Health Plan. This Companion Guide identifies unique information processing or adjudication needs specific to Apex Benefits Services in its implementation of the 837 Professional Health Care Claim Transaction and should be used in conjunction with the *HIPAA Implementation Guide*. Throughout this document, “APEX” represents Apex Benefits Services. This companion guide contains three categories of information:

- General information applicable to the processing of claims and business edits performed by APEX.
- The transaction table outlining specific requests for data format or content within the transaction, or describing APEX handling of specific data types.
- Additional information containing a sample scenario and frequently asked questions (FAQ).

While APEX accepts all ASCX12 compliant transactions, the HIPAA Implementation Guides allow for some discretion in applying the regulations to existing business practices. Understanding APEX business practices may expedite claims processing for trading partners as they exchange EDI transactions with APEX.

Electronics submission of claims will follow these guidelines:

- Claims currently filed on CMS-1500 format will be sent as an 837P
- Claims currently filed on ADA format will be sent as an 837D
- Claims currently filed on UB-92 format will be sent as an 837I

1.2 EDI Registration

As of May 23, 2007, any provider that submits claims using their National Provider ID (NPI) at the required levels specified in section five of this guide is not required to go through the registration process.

All Trading Partners must complete the EDI registration process before sending any transactions to APEX. This process is detailed separately in the Communication Companion Guide and on the APEX Website.

Prior to submitting claims electronically, all providers must complete an EDI Registration Form. A Trading Partner Agreement may also be required.

Furthermore, all providers are required to file a change in registration with APEX when the following occurs:

- Changes in Clearinghouse, Billing Service, Software Vendor or any Vendor handling the provider’s electronic data information
- Change in address
- Change or addition of your Tax Identification Number (TIN)
- Change in name

1.3 Testing Prior to Production

All Trading Partners must complete transaction testing prior to submission of transactions in production. This process is detailed separately in the Communication Companion Guide and on the APEX Website.

Prior to submitting production claims electronically, all providers or their designated vendor must complete successful transaction testing. Providers must maintain a successful level of transaction submission to remain in production.

2 Claims Processing

2.1 Special Billing Situations

2.1.1 Service Lines

Any claim submitted cannot exceed 99 service lines. If greater than 99 service lines, then split the claim into two claims to submit.

2.1.2 Coordination of Benefits

When submitting an 837 transaction for members after billing their other insurance sources, the other payer's adjudication details that were provided on the 835 Remittance transaction must be supplied to Apex. The other payer's adjudication details, both at the line level and the claim level, are required to process the claim.

Trading partners should review the Implementation Guides for both the 837 HealthCare Claim Transaction and the 835 HealthCare Claim Payment/Advice Transaction plus the crosswalks provided to fully understand the COB process. Reviewing section 1.4.5 of the 837 Implementation Guides will explain where to place the data within the 2320 loop.

2.1.3 Sending Attachments or Paperwork to Support a Claim

SummaCare accepts supporting documentation by mail only. Illegible information will delay processing. All documentation and Attachment Cover Sheets must be received within 14 calendar days of the electronic transmission otherwise the claim will be denied.

2.1.4 Corrected Bills

The Claim Frequency Type Code located in segment CLM05-03 determines the processing of corrected bills.

- A corrected bill is indicated by placing a "7" in this field.

2.2 Code Sets

When entering codes in an 837 Professional transaction, carefully follow the 837 Professional Implementation Guide (IG). Use HIPAA-Compliant codes from the current versions of the sources listed in the 837 Professional IG, Appendix C: External Code Sources

- Only use standard CPT/HCPCS Codes that are valid at the date of service.
- Use only ICD-9-CM diagnosis codes. No decimal point should be used for diagnosis codes. The decimal point is assumed. This is consistent with the specifications of the 837 Professional IG.
- APEX will accept all HIPAA standard codes, however acceptance of these codes or modifiers will not alter the plan's covered benefits or current payment policies, guidelines or processes.

2.3 Data Format/Content

APEX accepts all compliant data elements on the 837 Professional Claim. Follow the points outlined below for consistent data format and content issues:

2.3.1 Dates

- 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.
- Future dates will be rejected.

2.3.2 Decimals

- No decimals should be used in a diagnosis code.

2.3.3 Monetary Amounts, Unit Amounts, and Numeric Values

- The transaction will be rejected if the monetary amounts do not balance.
- APEX accepts monetary amounts only in US dollars. If codes related to foreign currencies are used, the claim will be denied.
- Unit amounts must be in whole numbers only
- Negative values for monetary or unit amounts may not be processed and may result in the claim being rejected if submitted in the following segments, Loop 2300, Loop 2320 and Loop 2400:
 - CLM02 Monetary amount – Total Submitted Changes (837P IG, P.172)
 - SV102 Monetary amount – Line Item Charge Amount (837P IG, P.402)
 - SV104 Quantity – Service Unit Count (837P IG, P.403)
 - AMT02 Monetary amount – COB Payer Paid Amount (837P IG, P.332)
 - AMT02 Monetary amount – COB Allowed Amount (837P IG, P.334)

2.3.4 Phone Numbers

Telephone numbers should be presented as contiguous number strings. Do not use dashes or parenthesis markers. Area codes should always be used.

2.4 HIPAA Compliance Checking and Business Edits

997 Acknowledgement will be returned indicating any problems with ANSI syntax areas within the transaction.

2.5 Data Retention

All claims data will be held for seven years.

2.6 Time Frames for Processing

All claim files received by 7:00 PM EST will be processed the day received. Any claim files received after 7:00 PM EST will be processed the next business day.

2.7 Batch Volume

There are no limits placed on volumes.

3 Identification Codes and Numbers

3.1 Provider Identifiers

APEX requires all submitters to use the Rendering Network Provider Identification (RNPI) number assigned to the provider by the Provider Data Department along with the provider's Tax Identification Number (TIN). ****As of May 23, 2007 APEX will accept the provider's National Provider ID (NPI) in place of or in addition to the APEX assigned RNPI number.****

Failure to use the correct number will result in the claim being rejected, denied or paid to the incorrect provider.

3.1.1 Providers in a Group Practice

If you are a provider in a Group Practice and your checks are issued to the Group Practice, please use the RNPI number assigned to you specifically. If you use another provider's RNPI number within the Group Practice, it will result in the check being issued correctly to the Group Practice, however, the Explanation of Payment (EOP) or the 835 Health Care Payment Advice will indicate the incorrect rendering provider. An example follows:

Dr. Smith is part of Radiology Group. He has been assigned an RNPI of 1234 and he uses the Tax Identification Number (TIN) of the group. If the 837 Health Care Claim Professional is submitted with the incorrect RNPI, such as 4321 which is assigned to Dr. Jones in the same practice, the payment will be issued to the Radiology Group, but the EOP or 835 Health Care Payment Advice will list Dr. Jones as the rendering provider.

3.1.2 Individual Providers & Individually Paid Providers

If you are an individual provider or a provider in a Group Practice and your checks are issued to the individual physician, please use the RNPI number assigned to you specifically. If you use another provider's RNPI number, the claim will be processed erroneously. The EOP or 835 Health Care Payment Advice will be issued to the physician associated with the RNPI that was submitted. An example follows:

Dr. Smith is assigned to RNPI number 1234. Dr. Jones is assigned to RNPI number 4321. If Dr. Smith submits a claim using the RNPI number assigned to Dr. Jones (4321), the claim will be processed as submitted and the EOP or 835 Health Care Payment Advice will be returned to Dr. Jones along with the payment.

3.1.3 RNPI number Inquiries

Please direct all inquires regarding RNPI numbers to:

Provider Services Unit
(330) 996-8400
1-800-996-8401

3.2 Subscriber Identifiers

Submitters should be careful to use the member’s identification number as it appears on their APEX member ID card. If the member’s identification number is not submitted, the claim may be rejected or denied. Each member of the family receives his/her own identification card with their individual member number. **Make sure the name of the patient is the same as the name on the identification card.**

4 Reporting

4.1 Audit Report

The day following receipt of 837 Professional Health Care Claims, an audit report will be sent. The table below defines the status codes found in the audit report.

CLAIMS STATUS CROSS REFERENCE					
SummaCare EDI #	Description	Return Status	Return Status Description	Action	Action Description
0000	Valid Claim	A9	Payer acknowledges receipt of claim, no further updates to follow	W	Do not resubmit
0001	More Than 99 Service Lines Per Claim	8Z	Claim receiver is unable to process this claim electronically	Y	Resubmit on paper
0002	Member Not on File	BF	Subscriber/member id not found	W	Do not resubmit
0005	Provider Not on File	5Z	Incoming provider data invalid or missing - please call payer for further instructions on this claim	X	Resubmit electronically with the corrected information
0006	Not in Member Date Range	8L	Inactive patient for claim date of service	W	Do not resubmit
0008	Invalid Medicaid Number	5Z	Incoming provider data missing/incorrect - attending physician UPIN number	X	Resubmit electronically with the corrected information
0011	No Rendering Provider	5Z	Invalid provider id prevents carrier from processing claim	X	Resubmit electronically with the corrected information
0013	Invalid Primary Diagnosis	8P	Primary diagnosis invalid for this carrier	X	Resubmit electronically with the corrected information
0014	Procedure Code Missing	8U	Invalid procedure code for this carrier	X	Resubmit electronically with the corrected information
0017	Attending Provider Invalid	61	Carrier unable to receive claim provider not approved as an electronic submitter	X	Resubmit electronically with the corrected information
0022	Missing or invalid data prevents processing of claim	51	Missing or invalid data prevents carrier from processing this claim	X	Resubmit electronically
0024	Payable	3L	Pending: claim waiting for final approval	W	Do not resubmit
0025	Pended	30	Claim is pending at receiver site	W	Do not resubmit
0026	Denied	40	Claim adjudication process has been completed by payer	W	Do not resubmit
0027	Denied	5T	Member sent under the wrong Payer ID	W	Do not resubmit
0028	Denied	QA1	Invalid billed amount submitted on claim- Negative dollar amounts are not accepted	X	Resubmit electronically with the corrected information

5 Data Element Table: Professional

After the claim transmissions have passed Implementation Guide compliance checks for acceptance into the Apex system, business edits, specific to Apex, are then applied to the incoming HIPAA compliant claims. The business edits include security validation and the verification of proprietary business requirements. The following [837 Professional Health Care Claim – Detail Data Element Table](#) contain only data elements that require instructions to efficiently enhance the claims processing through Apex systems. If a data element does not need specific information for Apex processing, then it is not documented in this Data Element Table. Use this table in conjunction with the ASC X12N 837 Implementation Guide (837 IG) for Professional Claims. All alpha characters should be formatted as UPPERCASE only.

Florida Medicaid providers must review Florida Medicaid’s Companion Guide specifications in conjunction with Apex’s Companion Guide specifications for claims submissions. The Florida Medicaid Companion Guide can be accessed through the following internet address <http://floridamedicaid.acs-inc.com/index.jsp>. On the home page left click the link [HIPAA Information](#) and then the link [Companion Guides](#).

5.1 837 Professional Health Care Claim - Header

The 837 Header identifies the start of a transaction, the specific transaction set, and the transaction’s business purpose. Also, when a transaction set uses a hierarchical data structure, a data element in the header, BHT01 (Hierarchical Structure Code) relates the type of business data expected within each level. The following table explains the header segments and data elements that require specific information for APEX processing.

Table 1 - Header					
Envelope/Section Label	Element	Description	Value Options for APEX	Description/Comments	IG page
Beginning of Hierarchical Transaction	BHT06	Transaction Type Code	CH	APEX recognizes all submissions as chargeable	65
Beginning of Hierarchical Transaction	REF02	Transmission Type Code	004010X098A1	The REF02 (Transmission Type Code) will not be used to distinguish between test and production. APEX will determine "Test" or "Production" based on the value in the ISA15 data element only.	66
LOOP ID - 1000A - Submitter Name					
Individual or Organizational Name	NM109	Identification Code	Sender/Submitter Identifier	Enter the EDI Sender ID assign to you by APEX. This Sender ID should be identical to the value in ISA06 and GS02.	69
LOOP ID - 1000B Receiver Name					
Individual or Organizational Name	NM103	Last Name or Organization Name	APEX	Represents the Receiver Name as APEX	75
Individual or Organizational Name	NM109	Identification Code	34196	The receiver primary identifier (APEX Payer Identification Number)	75

5.2 837 Professional Health Care Claim - Detail

The 837 Detail level has a hierarchical level (HL) structure based on the participants involved in the transaction. The three levels for the participant types include:

- Information Source (Billing provider)
- Subscriber (can be the patient when the subscriber is the patient)
- Dependent (when the patient is not the subscriber)

5.2.1 837 Detail: Information Source/Provider Hierarchical Level

The first hierarchical level (HL) of the 837 details is the Information Source HL, also known as the Billing/Pay-to Provider HL.

Table 2 - Detail - Information Source Hierarchical Level

Envelope/Section Label	Element	Description	Value Options for APEX	Description/Comments	IG page
LOOP ID - 2000A Billing/Pay-to Provider Hierarchical Level					
Provider Information	PRV01	Provider Code	BI or BT	BI - Billing Provider PT - Pay-to	79
Currency	CUR02	Currency Code	USD or "Blank"	USD - US Dollars APEX recognizes monetary amounts as US dollars only.	82
LOOP ID - 2010AA Billing Provider Name					
Billing Provider Name	NM108	Identification Code Qualifier	24	24 - Employers Identification Number	86
Billing Provider Name	NM109	Identification Code	Tax Identification Number	Enter the billing provider's tax identification number.	86
Billing Provider Secondary Identification	REF01	Reference Identification Qualifier	G2	Identifies to APEX a Rendering Network Provider Identification Number	92
Billing Provider Secondary Identification	REF02	Reference Identification	Rendering Network Provider Identification (RNPI) number	Enter the Rendering Network Provider Identification (RNPI) number assigned to you. This number must be sent to process the claim. If the RNPI is not present in this loop it must be sent in the 2310B REF02 loop. If a valid number is not provided, the claim will be rejected.	92
Billing Provider Secondary Identification	REF01	Reference Identification Qualifier	1D	Identifies the Billing Provider's State assigned Medicaid number.	92
Bill Provider Secondary Identification	REF02	Reference Identification	Billing Provider Medicaid Number	Providers must submit their State assigned Medicaid Number for all Medicaid Member Claim Submission's for correct payment. If you are a Florida Medicaid Provider please contact our Provider Relations Department at 1-866-270-2468 if you have a question concerning which Medicaid number must be submitted for correct payment.	92

5.2.2 837 Detail: Subscriber Hierarchical Level

The second hierarchical level (HL) of the 837 details is the Subscriber HL. APEX encourages our trading partners to submit one claim per transaction set (ST-SE) to eliminate the impact of errors on other clean claims within the same interchange; our X12 and HIPAA compliance edits will reject the entire transaction set if an error is found

Table 3 - Detail - Subscriber Hierarchical Level

Envelope/Section Label	Element	Description	Value Options for APEX	Description/Comments	IG page
LOOP ID - 2000B Subscriber Hierarchical Level					
Subscriber Information	SBR01	Payer Responsibility Sequence Number Code	P, S, T	P - Primary S - Secondary T - Tertiary Usage of 'S' or 'T' accompanies information populated in loop 2320. This will give us the other payer's information.	110
Subscriber Information	SBR02	Individual Relationship Code	18	18 - Self	111
Subscriber Information	SBR03	Reference Identification	Contract Holder's Member ID Number	Enter the ID number exactly as it appears on the front of the contract holder's ID card, including the two-digit suffix.	111
LOOP ID - 2100BA Subscriber Name					
Individual or Organization Name	NM108	Identification Code Qualifier	MI	Member Identification Number	119
Individual or Organization Name	NM109	Identification Code	Patient's Member ID Number	Enter the ID number exactly as it appears on the front of the ID card, including the two-digit suffix.	119

5.2.3 837 Detail: Patient Hierarchical Level

The third hierarchical level (HL) of the 837 detail is the Patient HL APEX encourages our trading partners to submit one claim per transaction set (ST-SE) to eliminate the impact of errors on other clean claims within the same interchange; our X12 and HIPAA compliance edits will reject the entire transaction set if an error is found.

Table 4 - Detail - Patient Hierarchical Level					
Envelope/Section Label	Element	Description	Value Options for APEX	Description/Comments	IG page
LOOP ID - 2300 Claim Information					
Claim Information	CLM01	Patient Account Number	Provider's Patient Account Number	As indicated in the IG, APEX supports a maximum of 20 characters in this data element. This number is echoed back to the submitter in the 835 and other transactions.	171
Claim Information	CLM02	Monetary Amount	Total Claim Charge Amount	This field must equal the total amount of submitted charges in Loop 2400, SV102.	172
Claim Information	CLM05-03	Claim Frequency Type Code	1, 7	1 - Original (Admit Through Discharge Claim) 7 - Replacement (Replacement of Prior Claim) The only accepted values are 1 and 7. Claims received that are replacement/corrected claims must be a 7 or they can/may be denied as a duplicate claim.	173
Claim Supplemental Information	PWK02	Report Transmission Code	BM	By Mail APEX accepts supporting documentation by mail only. Illegible information will delay processing. All documentation and Attachment Cover Sheets must be received within 14 calendar days of the electronic transmission otherwise the claim will be denied.	216
Claim Supplemental Information	PWK05	Identification Code	AC	Attachment Control Number	216
Claim Supplemental Information	PWK06	Identification Code	Self-Assigned	This field is reserved for a unique self-assigned attachment control number.	216
Original Reference Number	REF01	Reference Identification Qualifier	D9	Unique number assigned by the clearinghouse/submitter of claims	239
Original Reference Number	REF02	Reference Identification	Self-Assigned	Clearinghouse Trace Number The value carried in this element is limited to a maximum of 20 positions.	239
Claim Note	NTE01	Note Reference Code	ADD	General claim notes/remarks must be submitted with this qualifier	247
Claim Note	NTE02	Description	Claim Note Text	Claim notes/remarks	247

Table 4 - Detail - Patient Hierarchical Level (continued)

Envelope/Section Label	Element	Description	Value Options for Apex	Description/Comments	IG page
LOOP ID - 2310B Rendering Provider Name					
Individual or Organizational Name	NM101	Entity Identifier Code	82	82 - Rendering Provider If this segment is submitted, then the REF01 and REF02 segments with the specified data requested must also be submitted. Failure to submit the combination of these segments will result with the claim being rejected.	291
Individual or Organizational Name	NM102	Entity Type Qualifier	1, 2	1 – Person 2 – Non-Person Entity	291
Individual or Organizational Name	NM103	Name Last or Organization Name	Rendering Provider's Last Name or Name of the Organization	Represents the Rendering Provider's Last Name or Name of the Organization	291
Individual or Organizational Name	NM104	Name First	Rendering Provider's First Name	Represents the Rendering Provider's First Name	291
Individual or Organizational Name	NM108	Identification Code Qualifier	24	24 - Employers Identification Number	292
Individual or Organizational Name	NM109	Identification Code	Tax Identification Number	Enter the rendering provider's tax identification number.	292
Rendering Provider Secondary Identification	REF01	Reference Identification Qualifier	G2	Identifies to APEX the provider's Rendering Network Identification Number.	296
Rendering Provider Secondary Identification	REF02	Reference Identification	Rendering Network Provider Identification (RNPI) number	Enter the Rendering Network Provider Identification (RNPI) number assigned to you. If the RNPI is not present in this loop it must be sent in the 2010AA loop. If a valid number is not provided the claim will be rejected.	297
Rendering Provider Secondary Identification	REF01	Reference Identification Qualifier	1D	Identifies the Billing Provider's State assigned Medicaid number.	296
Rendering Provider Secondary Identification	REF02	Reference Identification	Rendering Provider Medicaid Number	Providers must submit their State assigned Medicaid Number for all Medicaid Member Claim Submission's for correct payment. If you are a Florida Medicaid Provider please contact our Provider Relations Department at 1-866-270-2468 if you have a question concerning which Medicaid number must be submitted for correct payment.	297
LOOP ID - 2320 Other Subscriber Information					
Other Subscriber Information	SBR01	Payer Responsibility Sequence Number Code	See page 319 of IG	Usage of 'S' requires that 'P' be present Usage of 'T' requires that both 'P' and 'S' be present	319
LOOP ID - 2330B Other Payer Name					
Other Payer Name	NM108	Amount Qualifier Code	PI	Submitters are required to send all known information on other payers in this Loop ID-2330.	360
Other Payer Name	NM109	Other Payer Primary Identifier	Self-Assigned	This number must be identical to SVD01 (Loop ID-2430) for COB.	361
LOOP ID - 2400 Service Line					
Service Line Number	LX01	Assigned Number	1 - 99	APEX requires that service lines are limited to 99 lines. Claims submitted with more than 99 lines will be rejected.	399

Table 4 - Detail - Patient Hierarchical Level (continued)

Envelope/Section Label	Element	Description	Value Options for Apex	Description/Comments	IG page
Professional Services	SV101-3	Procedure Modifier	Procedure Modifier 1	APEX considers the modifiers listed in the CPT and HCPCS manuals to be compliant. An anesthesia modifier must be used with any anesthesia service to correctly identify the service as anesthesia.	401
Professional Services	SV101-4	Procedure Modifier	Procedure Modifier 2	APEX considers the modifiers listed in the CPT and HCPCS manuals to be compliant. An anesthesia modifier must be used with any anesthesia service to correctly identify the service as anesthesia.	402
LOOP ID - 2400 Service Line					
Professional Services	SV101-5	Procedure Modifier	Procedure Modifier 3	APEX considers the modifiers listed in the CPT and HCPCS manuals to be compliant. An anesthesia modifier must be used with any anesthesia service to correctly identify the service as anesthesia.	402
Professional Services	SV101-6	Procedure Modifier	Procedure Modifier 4	APEX considers the modifiers listed in the CPT and HCPCS manuals to be compliant. An anesthesia modifier must be used with any anesthesia service to correctly identify the service as anesthesia.	402
Professional Services	SV102	Monetary Amount	(Line Item Charge Amount)	The sum of the service lines charges reported in this field must be equal the Total Claim Charge Amount in Loop 2300, CLM02	402
Professional Services	SV103	Units or Basis for Measurement Code	MJ, UN	MJ - Minutes (required when submitting claims for anesthesia) UN - Units	403
Professional Services	SV104	Quantity	Service Unit/Minute Count	APEX accepts values greater than or equal to one. The service unit count may not exceed 999. If the quantity exceeds 999 the claim will be rejected.	403

6 837 Professional Health Care Claim Sample

6.1 Claim Scenario

APEX member, Johnny Doe, went to his PCP, Dr. Joel Smith at Smith's Family Practice, on September 15, 2003. Dr. Smith submitted the claim to a clearinghouse. The clearinghouse transmitted the claim to APEX in the 837P file format.

Claim Information:

Claim Date: 9/17/2003

Claim Time: 9:39 am

Sender: Clearinghouse

Sender Electronic Transmitter ID: Type 46, 999999999

Receiver: APEX

Receiver Electronic Transmitter ID: Type 46 - 34196

Professional Claim: 004010X098A1

Billing Provider: Smiths Family Practice

Tax Identification Number: Type 24 (TIN), 123456789

Provider Address: 123 MedCenter Drive Akron, OH 44308

Provider Contact Information: Smiths Family Practice Phone (330) 555-5555

Provider Commercial Number: G2

Rendering Network Provider Identification (RNPI) number: 0001

Subscriber: Jonathan Doe

Subscriber ID: 98765432100

Group #: V99999

Birth date: 4/5/74

Sex: M

Insurance/Payer ID: APEX, 34196

Patient: Johnny Doe

Patient ID: 98765432102

Patient Address: 100 Patient RD Akron, OH 44308

Date of Birth: 10/28/02

Sex: M

Provider's Patient Account Number at Claim level: 0027833

Clearinghouse Claim Reference Number: Type D9, 01234567890

Diagnosis: ICD-9, 780.6 - Fever

Rendering Provider at Claim level: Dr. Joel C. Smith, DO

Rendering Provider ID at Claim level: Type 24 (TIN), 34-1131413

Rendering Provider Commercial Number at Claim level: G2

Rendering Network Provider Identification (RNPI) number at Claim level: 0001

Service Procedure CPT: 99212 – Office visit, unfocused, 15 min

Charged Amount: \$50.00

Units: 1

Date of Service: 9/15/03

6.2 837P – Claim Example ANSI X12

ST*837*000000001~
BHT*0019*00*000000001*20030917*0939*CH~
REF*87*004010X098A1~
NM1*41*2*CLEARINGHOUSE*****46*999999999~
PER*IC*CLEARINGHOUSE*TE*8005555555~
NM1*40*2*APEX*****46*34196~
HL*1**20*1~
NM1*85*2*SMITHS FAMILY PRACTICE*****24*123456789~
N3*123 MEDCENTER DRIVE~
N4*AKRON*OH*44308~
REF*G2*0001~
PER*IC*SMITHS FAMILY PRACTICE*TE*3305555555~
HL*2*1**22*1~
SBR*P**V99999*****CI~
NM1*IL*1*DOE*JONATHAN****MI*98765432100~
DMG*D8*19740405*M~
NM1*PR*2*APEX*****PI*34196~
HL*3*2*23*0~
PAT*19~
NM1*QC*1*DOE*JOHNNY****MI*98765432102~
N3*100 PATIENT RD~
N4*AKRON*OH*44308~
DMG*D8*20021028*M~
CLM*0027833*50***11::1*Y*A*Y*Y*C~
REF*D9*01234567890~
HI*BK:7806~
NM1*82*1*SMITH*JOEL*C**DO*24*341131413~
REF*G2*0001~
NM1*77*2~
N3*123 SUMMA DRIVE~
N4*AKRON*OH*44308~
LX*1~
SV1*HC:99212*50*UN*1***1~
DTP*472*D8*20030915~
SE*35*000000001~

837P – COB Claim Example ANSI X12

ST*837*0001~
BHT*0019*00*1*20040616*08280000*CH~
REF*87*004010X098DA1~
NM1*41*2*SUGARHILL BILLING SERVICE*****46*00123~
PER*IC*TECHNOLOGY SUPPORT CENTER*TE*3305554321~
NM1*40*2*MULBERRY HEALTH SYSTEM*****46*441XX234~
HL*1**20*1~
NM1*85*2*JACK SPRAT INC*****24*300300123~
N3*PO BOX 1687~
N4*FOREST HILL*OH*441234107~
REF*1C*0123456789~
PER*IC* BARBIE*TE*2165552020~
HL*2*1*22*0~
SBR*S*18*731062*****ZZ~
NM1*IL*1*GREEN*MARY****MI*98799432100~
N3*1506 MAGIC DR~
N4*AKRON*OH*44308~
DMG*D8*19220101*F~
REF*IG*012345678D~
NM1*PR*2*ABC HEALTH PLAN*****PI*44123C123~
N3*17 TECHNOLOGY~
N4*COLUMBIA*SC*29219~
CLM*TV12345678987654*59.28***12::1*Y*A*Y*Y*C~
REF*F5*N~HI*BK:496~
NM1*82*2*LINUS INC*****24*300300123~
REF*1C*0123456789~
SBR*P*18***MB****MB~
AMT*D*24.46~
AMT*AAE*30.57~
AMT*B6*30.57~
DMG*D8*19220101*F~
OI***Y*C*Y~
NM1*IL*1*GREEN*MARY****MI*270123456D~
N3*1506 MAGIC DR~
N4*AKRON*OH*443081234~
NM1*PR*2*XYZ HEALTH PLAN, INC *****PI*00123~
PER*IC*COORDINATION OF BENEFITS*TE*8885551105*FX*8885550008~
REF*F8*0123456789000~
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LX*1~
SV1*HC:E0434:RR*59.28*UN*1*12**1~
DTP*472*D8*20040520~
AMT*AAE*30.57~
NM1*DK*1*JOHNSON*DAVID~
N3*2400 MONTY RD~
N4*NORFOLK*VA*245510687~
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SVD*00123*24.46*HC:E0434:RR**1~
CAS*CO*96*28.71~
CAS*PR*2*6.11~
DTP*573*D8*20040527~
SE*54*0001~
GE*1*1~
IEA*1*000000001~

7 Frequently Asked Questions

1. What is Electronic Data Interchange?

Electronic Data Interchange (EDI) allows providers to submit claims, retrieve remittance advices and retrieve claim file acknowledgements from their computer system via modem and phone lines to the insurance carrier or clearinghouse.

2. How many claims do you currently receive electronically?

Approximately 70% of claims are received electronically.

3. Why submit claims electronically?

Electronic claims are not subject to postal delays, are faster and more accurate and claims may be transmitted 24 hours a day seven days a week.

4. Which claims may be submitted electronically?

We accept all claims electronically. However, if you are submitting a claim with an attachment such as Explanation of Benefits or other supporting documentation, then you must submit the claim with the attachment on paper and indicate that an attachment is coming. See section 5.2.3 on how to indicate attachments.

5. Do you accept secondary claims electronically?

We accept secondary claims electronically. However, the Explanation of Benefits information is required. It may be either sent with the claim electronically, detailing the COB information at the line level or an attachment will need to be indicated and sent via mail.

6. Will Apex Benefits Services (Apex) employ a contingency plan?

Yes. In response to the Center for Medicare & Medicaid Services' (CMS) contingency plan, Apex will delay full implementation of the NPI HIPAA mandate until **January 1, 2008**. This will allow our providers an additional timeframe to communicate and use their NPI number in Health Insurance Portability and Accountability Act (HIPAA) standard electronic transactions. **Beginning January 1, 2008, providers must include their NPI number on all claims submitted via Electronic Data Interchange (EDI). Electronic claims submitted to Apex on or after January 1, 2008, without an NPI will be rejected.**

7. Will Apex reject claims submitted electronically without the NPI number on May 23, 2007?

No. On May 23, 2007, Apex will accept NPI only, legacy number only or a combination of NPI and legacy identifier. Apex encourages all providers who have their NPI to communicate and use it beginning May 23, 2007, in all HIPAA standard EDI transactions.

8. **Will you require NPI for primary providers (Billing, Rendering) and secondary providers (Referring, Attending, Supervising, etc.)?**

On January 1, 2008, we will reject 837 transactions received without an NPI value. This rejection will occur at the primary provider level only.

9. **Are providers required to register their NPI with Apex prior to sending NPI on electronic claim transactions?**

No. We will not employ a registration system for the NPI number. However, Apex encourages all providers to obtain their NPI and to share it. If you have your NPI number and have not yet communicated it to us, please do so by:

- Sending an e-mail to contactproviderservices@summacare.com. Please include your name, APEX RNPI number(s), tax identification number(s) (TIN), and NPI number(s).
- Downloading the NPI Submission Form from our website: www.summacare.com. Please click on the “Provider” section.
- Calling Provider Support Services at 800-996-8401.
- Contacting your Provider Relations Representative.