OREGON HEALTH AUTHORITY
OREGON HEALTH LEADERSHIP COUNCIL
ADMINISTRATIVE SIMPLIFICATION GROUP

Oregon Companion Guide

For the Implementation of the

ASC X12/005010X223

HEALTH CARE CLAIM: INSTITUTIONAL (837)

(Based on Version 5, Release 1 - May 2006)

AUGUST 2013
VERSION 1.1

Disclaimer
The following Oregon Companion Guide is intended to serve as a companion document to the corresponding *Health Care Claim transaction ASC X12/005010X223 (Institutional 837)* - throughout the rest of the document, the ASC X12 technical report is referred to as 005020X223.

The document further specifies the requirements to be used when preparing, submitting, receiving, and processing electronic health care administrative data. The document supplements, but does not contradict, disagree, oppose, or otherwise modify the *005010X223* in a manner that will make its implementation by users to be out of compliance. Further this guide is not a replacement for using the TR3: the TR3 is required for the compliant implementation of this transaction. Using this companion guide does not mean that a claim will be paid. It does not imply payment policies of payers or the benefits that have been purchased by the employer or subscriber.

Statutory Authority
It is intended that this companion guide will be adopted and its use will be mandated for all HIPAA covered entities (payers, providers, and clearinghouses) conducting business or licensed in the state of Oregon.

Document Changes
The content of this companion guide is subject to change. The version, release, and effective date of the document are included in the document, as well as a description of the process for handling future updates or changes.

About the Oregon Health Authority
The Oregon Health Authority (OHA) was created by the 2009 Oregon legislature to bring most health-related programs in the state into a single agency to maximize its purchasing power. Although the state is in the planning stages for organizing the new agency, work to change the health care system has already begun. The OHA works with a nine-member, citizen-led board called the Oregon Health Policy Board. Members are appointed by the Governor and confirmed by the Senate. The Health Authority will transform the health care system in Oregon by; improving the lifelong health of Oregonians; Increasing the quality, reliability, and availability of care for all Oregonians; Lowering or containing the cost of care so it's affordable to everyone in the state.
http://www.oregon.gov/OHA/

About the Oregon Health Leadership Council
The Oregon Health Leadership Council is a collaborative organization working to develop practical solutions that reduce the rate of increase in health care costs and premiums so health care and insurance is more affordable to people and employers in the state. Formed in 2008 at the request of the Oregon business community, the council brings together health plans, hospitals and physicians to identify and act on cost-saving solutions that maximize efficiencies while delivering high quality patient care.
http://www.orhealthleadershipcouncil.org

About the Administrative Simplification Group
The Administrative Simplification group was first formed in the spring of 2008 by the Oregon Medical Association, Oregon Association of Hospitals & Health Systems and Regence BlueCross BlueShield of Oregon. After the formation of the Oregon Health Leadership Council, the workgroup became one of the four Leadership Council's workgroups.
This group identifies effective ways to simplify the administrative challenges faced by physicians and other healthcare professionals in order to streamline the business side of health care and provide cost-savings to the entire system. Three sub-groups were formed to explore increasing use of web sites for eligibility and claims information, investigate a common credentialing solution, and work toward standardization and automation of key processes.

http://www.orhealthleadershipcouncil.org/administrative-simplification

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All published Oregon Companion Guides may be found at the following location:
http://www.oregon.gov/oha/OHPB/pages/health-reform/admin/index.aspx

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837 Oregon Companion Guide Revision History

Ver.	Revision Date	Summary Changes
1.0	July 7, 2011	Version 1 of Oregon Companion Guide (837 Institutional)
1.1	August 31, 2013	Format changes and corrections for consistency across all OCGs

1 EXCERPT FROM STATEMENT: OREGON HEALTH AUTHORITY

The 2009 Oregon Legislative Assembly directed the Office for Oregon Health Policy and Research (OHPR) to bring together a work group to recommend uniform standards for insurers for, at a minimum, eligibility verification, claims processes, payment remittance advice, and claims payment. The Oregon Health Policy Board asked the work group to expand the legislative direction and include a broad strategy for administrative simplification, including specifying the appropriate role for the state, and to estimate the potential for cost savings that can be achieved through administrative simplification.

The goal of administrative simplification is to reduce total system costs and reduce the amount of provider resources that must be devoted to administrative transactions between providers of care and payers by simplifying and streamlining these activities.

2 OVERVIEW

On January 16, 2009, the U.S. Department of Health and Human Services (HHS) published rules (CMS–0009–F) announcing the adoption of new versions of the federal transaction standards, known as ASC X12/005010 ("Version 5010"). The compliance deadline to implement the 5010 version of the transaction standards, on a nationwide basis, is January 1, 2012.

The transaction included in this version upgrade is the **Health Care Claim: Institutional (837)**. Please refer to section 2.2 for relevant publications of the 837 standard addressed in this document.

The purpose of the transaction is to:

a. Submit either health care claim billing information or encounter information from providers of health care services to payers,

b. Transmit health care claims and billing payment information between payers who have payment responsibilities toward the same claim/service (Coordination of benefits (COB)) is required, or

c. Between payers and regulatory agencies to monitor the rendering, billing, and/or payment of health care services within a specific health care/insurance industry segment.

Submission of information may be either directly or indirectly via intermediary billing services and claims clearinghouses. Though the transaction is intended to originate with the health care provider or the health care provider's designated agent (e.g. billing entity), in some instances, a health care payer may originate an 837 to report a health care encounter to another payer or sponsoring organization.

Beginning January 1, 2012, Health Care Providers and Health Plans executing the Health Care Claim: Institutional (837) transactions may only use the 5010 version of the transaction (005010X223).

2.1 Purpose of the Oregon Companion Guide

The purpose of the OCG is to clarify, supplement, and further define specific data content requirements to be used in conjunction with the 005010X223 TR3 created for the electronic transaction standard, mandated by the HIPAA regulations. Its purpose is to provide a common standard that can be easily and consistently applied by all Health Plans and Health Care Providers (refer to definitions in section 2.3) and yet, would continue to be fully compliant with federal regulations. The OCG may include best practices and other operational requirements, but these will always be compliant with the current standard – 005010X223.

The term "Oregon Companion Guide" or its abbreviation "**OCG**" will be used consistently throughout this document to refer to the OCG being created at the request of the Oregon Health Authority.

2.2 Key Abbreviations

The following publications have been addressed in this document. The abbreviations in **bold** are used extensively throughout this document

837	The 005010X223 Health Care Claim: Institutional transaction. *Please note that in context this abbreviation could also refer to the Professional and/or Dental Claims transaction.*
005010X223	Collective reference for the Health Care Claim Institutional transaction and published errata – inclusive of the following 4 documents ASC X12/005010X223 (May 2006) ASCX12/005010X223A1 (October 2007) ASCX12/005010X223E1 (January 2009) ASCX12/005010X223A2 (June 2010)
TR3	Technical Report Type 3 – formerly known as the Implementation Guide (IG)
OCG	Oregon Companion Guide – this guide *The term "Oregon Companion Guide" or its abbreviation "**OCG**" will be used consistently throughout this document*

2.3 Applicability

Effective October 1, 2012, all Health Care Providers and Health Plans, or their agents/representatives, that submit claims or encounter information electronically, must use the rules defined in this OCG, and implement fully operational transactions within the timelines required under proposed Oregon rules (see Section 3.4). The only exceptions to the statutory requirements are as follows:

- The requirements in this OCG do not apply to health care claims with:
  - Medicare
  - Federally Administered programs
  - Property and Casualty insurance plans
  - Workers' Compensation programs

- The requirements in this OCG do not apply to web applications, created by Health Plans, to enable Providers to submit health care claims on-line directly to the Health Plan carrier.

- Atypical Providers are not directly covered by this OCG. However, if they wish to submit Health Care Claims electronically they are required to conform to standards described in the 005010X223 TR3. Please refer to identified section for more information:

  - Atypical Providers – section 3.1.1

2.3.1 OREGON SENATE BILL 94

The Oregon Companion Guides are authorized by OHA and DCBS regulations established under Oregon's Senate Bill 94. The next paragraph is quoted from the Oregon Legislative Senate measure summary. The complete text of the bill is available at the following location:

http://www.leg.state.or.us/11reg/measpdf/sb0001.dir/sb0094.intro.pdf

WHAT THE MEASURE DOES: Authorizes the Department of Consumer and Business Services (DCBS) to adopt uniform standards for health care financial and administrative transactions, including uniform standards for: (a) eligibility inquiry and response; (b) claim submission; (c) payment remittance advice; (d) claims payment or electronic funds transfer; (e) claims status inquiry and response; (f) claims attachments; (g) prior authorization; (h) provider credentialing; or, (i) other health care financial and administrative transactions identified by a stakeholder workgroup. Requires that uniform standards to apply to: (a) health insurers; (b) prepaid managed care health services organizations; (c) third party administrators; (d) self-insurance plans; (e) health care clearinghouses; and, (f) other persons that process health care financial and administrative transactions. Requires the Oregon Health Authority (OHA) to convene a stakeholder workgroup to recommend standards. Requires work group to consider applicable national standards when developing recommendations. Requires DCBS and OHA to confer and reconcile any differences between their respective requirements for health care financial and administrative transactions. Makes the Department of Human Services (DHS) subject to uniform standards. Declares emergency, effective on passage.

2.4 Covered Entities - Definitions

The following definitions apply to HIPAA covered entities that will establish trading relationships using this OCG and are consistent with the definitions in the Code of Federal Regulations (CFR) 160 and 164.

2.4.1 HEALTH PLAN

Health Plan *is defined as follows:*

***Note*:** *This definition reproduced from Subtitle D—Privacy, Section 13400. Definitions, that appear in the Conference Report on page H1345 of Congressional Record—House, February 12, 2009.*

An individual or group plan that provides, or pays the cost of, medical care (as defined in section 2791(a)(2) of the Public Health Service Act, 42 U.S.C. 300gg-91(a)(2)).

(1) Health plan includes the following, singly or in combination:

- A group health plan
- A health insurance issuer
- An HMO
- Part A or Part B of the Medicare program under title XVIII of the Act.
- The Medicaid program under title XIX of the Act, 42 U.S.C. 1396, et seq.
- An issuer of a Medicare supplemental policy (as defined in section 1882(g) (1) of the Act, 42 U.S.C. 1395ss (g) (1)).
- An issuer of a long-term care policy, excluding a nursing home fixed- indemnity policy.
- An employee welfare benefit plan or any other arrangement that is established or maintained for the purpose of offering or providing health benefits to the employees of two or more employers.
- The health care program for active military personnel under title 10 of the United States Code.

- The veterans' health care program under 38 U.S.C. chapter 17.
- The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) (as defined in 10 U.S.C. 1072(4)).
- The Indian Health Service program under the Indian Health Care Improvement Act, 25 U.S.C. 1601, et seq.
- The Federal Employees Health Benefits Program under 5 U.S.C. 8902, et seq.
- An approved State child health plan under title XXI of the Act, providing benefits for child health assistance that meet the requirements of section 2103 of the Act, 42 U.S.C. 1397, et seq.
- The Medicare + Choice program under Part C of title XVIII of the Act, 42 U.S.C. 1395w-21 through 1395w-28.
- A high risk pool that is a mechanism established under State law to provide health insurance coverage or comparable coverage to eligible individuals.
- Any other individual or group plan, or combination of individual or group plans, that provides or pays for the cost of medical care (as defined in section 2791(a)(2) of the PHS Act, 42 U.S.C. 300gg-91(a)(2)).

- "Health Plan" includes an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974(ERISA)(29 U.S.C. 1002(1)), including insured and self-insured plans, to the extent that the plan provides medical care, as defined in section 2791(a)(2) of the Public Health Service (PHS) Act, 42U.S.C. 300gg–91(a)(2), including items and services paid for as medical care, to employees or their dependents directly or through insurance, reimbursement, or otherwise, that (1) Has 50 or more participants (as defined in section 3(7) of ERISA, 29 U.S.C. 1002(7)); or (2) Is administered by an entity other than the employer that established and maintains the plan. (*Note: This item included from HIPAA regulations*)

(2) Health plan excludes:

- Any policy, plan, or program to the extent that it provides, or pays for the cost of, excepted benefits that are listed in section 2791(c)(1) of the PHS Act, 42 U.S.C. 300gg-91(c)(1)
- A government-funded program (other than one listed in section 1 of this definition):
  (A) Whose principal purpose is other than providing, or paying the cost of, health care; OR
  (B) Whose principal activity is?
    a. The direct provision of health care to persons; or
    b. The making of grants to fund the direct provision of health care to persons.

Health Plans may also be referred by the industry colloquial - **payers.**

2.4.2 HEALTH CARE PROVIDER

Health Care Provider *is defined as follows:*

A person or organization that provides health care or medical care services within Oregon for a fee, and is eligible for reimbursement for these services. For purposes of this subdivision, "for a fee" includes traditional fee-for-service arrangements, capitation arrangements, and any other arrangement in which a provider receives compensation for providing health care services or has

the authority to directly bill a Health Plan, health carrier, or individual for providing health care services. This definition includes licensed nursing homes, licensed boarding care homes, and licensed home care providers.

Health Care Providers may also be referred by the industry colloquial - **providers.**

2.4.3 CLEARINGHOUSE

Clearinghouse *is defined as follows:*

An entity contracted by Health Plan(s) or Health Care Provider(s) to create, send, receive, process, manage, or administrate standard electronic transactions are also subject to comply with the OCG. This would include entities that process the health care claim (837) and other HIPAA standard X.12 transactions as or on behalf of a HIPAA covered entity.

2.4.4 TRADING PARTNER

The term Trading Partner is used in the most general sense of its meaning, in EDI terms, within this document. It essentially means any entity that exchanges EDI transactions with another entity, addressed by the scope of the OCG. The entity could be a direct submitter (such as a **Health Plan** or **Health Care Provider**) or an entity that provides EDI and billing services (such as a **Clearinghouse**).

As described in the beginning of this section, this OCG applies to all institutional health care claims submitted electronically on or after October 1, 2012 that use the 005010X223 transaction standards and corresponding *TR3*. The Code of Federal Regulations, title 45, part 162, subpart K specifies that the standard for dental, professional, and institutional health care claims is the ASC X12 837 transaction.

2.5 Usage of Oregon Companion Guide – Consistency of Application

This document provides the agreed upon 'foundation' for the transmission of the 837 transaction. This document does not prevent trading partners from agreeing to make more specific/detailed information available in the transaction. However, covered entities must all be in compliance with the requirements included in this document.

1. No trading partner may unilaterally or collectively require any other trading partner(s) to conform to standards that are not included in this OCG.
2. Once adopted through Oregon State mandates, no additions or modifications may be made to this OCG by Health Plans or Health Care Providers through their own companion guides or by establishing other requirements.
3. All transactions must fully comply with the current version of the HIPAA 837 transaction TR3 (current versions referenced in section 2.2) in force at the time of executing the transactions.

2.6 Updating the Oregon Companion Guide

This OCG will be reviewed and updated periodically to conform to prevailing rules and standards that change and evolve over time. The current set of rules and guidelines are described in the TR3 for the 837 transaction.

2.6.1 FUTURE UPDATES TO OREGON COMPANION GUIDE - PROCESS

The EDI Workgroup undertook responsibility to develop this 837 OCG and it is intended that the group will continue to track industry changes and best practices in the implementation of this, and other OCGs (for the 270/271, 276/277, and 835 transactions).

Once approved and published, the OCGs are operationally regulated and executed by the OHA. OHA may request a review, changes, or updates to operational OCGs based on industry and related developments. The OHA is the owner of these OCGs and any updates/changes to published guides must be conducted with their approval and involvement.

In order to incorporate relevant changes or updates to the OCGs, the workgroup will retain its membership and organizational structure even after the first versions of the OCGs are completed.

The workgroup will schedule to meet once every quarter, at the minimum, to review industry news during the quarter, and make any recommendations to the Administration Simplification Executive Committee that may result in a change to the guide or operational aspects of executing transactions.

The EDI Workgroup co-Chairs will retain the option of not calling the meeting if there are no newsworthy or pressing items that need discussion. Interest in scheduling a quarterly meeting may also be confirmed by polling the group sometime before the meeting.

When issues or changes come to light that must be addressed by the workgroup, the team will collectively make appropriate recommendations to the Executive Committee, for their approval, with a new schedule and resource requests necessary to complete the work or resolve the issue(s) or incorporate valid changes to the OCG(s).

The specific process for updating OCG documents, including submitting and collecting change requests, reviewing and evaluating requests and making recommendations, adopting and publishing a new version of the guide will be available from the OHA's - Oregon Office of Health Information Technology. Their website is as follows:
http://www.oregon.gov/oha/OHPB/pages/health-reform/admin/index.aspx

2.7 Addressing Code Set Issues in the Oregon Companion Guide

Code sets utilized in HIPAA electronic transactions are classified as:

- Internal Transaction Codes (included and defined inside the 005010X223).
  The OCG does not redefine existing internal code sets used in the transactions.

- External Code Sets (referenced by 005010X223 defined and maintained by external bodies) including:

    1. Non-Medical External Code Sets (such as NUBC codes, Product/Service codes, Zip Codes etc). These values must be valid on the date the transaction is created. In the case of a reversal, the codes used must be valid based on the original transaction date.

    2. Medical and Dental External Code Sets (such as ICD-9, ICD-10, HCPCS; CDT). These values are effective based upon service date.

    Complete list of External Code Sources is included in Appendix A of the TR3 for this transaction.

3 TRANSACTION DEFINITIONS AND REQUIREMENTS

This section includes specific definitions, requirements, and implementation schedule relevant to this OCG.

3.1 Definitions

For purposes of this OCG, the following terms have the meaning described in this section. These definitions apply to both the claim and line level. For other definitions related to the institutional health care claim, please refer to section 1.5 of the 005010X223.

The definitions in this section relate specifically to the inclusion of content in the 837 transactions. For definitions of entities covered by the scope of this OCG, please refer to section 2.4.

Billing Provider Names:

The Billing Provider Name (loop 2010AA) is the name of the entity receiving the reimbursement from the payer. Titles must not be used as part of the individual's name as there is a separate field to report titles.

Billing Provider Address

The Billing Provider Address (loop 2010AA) is the physical address of the billing provider. PO Box or Lock Box addresses are not acceptable in this loop and will be rejected if sent. Use the Pay To Address if the reimbursement is to go to an address other than the Billing Provider Address.

Pay-To Address

The Pay-To Address (loop 2010AB) allows the billing provider to indicate a reimbursement address that is different than the billing address.

Subscriber

A person identified by a unique identification number. This may include a unique suffix to the primary policy holder's identification number. The subscriber may or may not be the patient. See Section 1.5 Business Terminology of the 005010X223 for further details.

Patient

Patient loop (loop 2000C) should only be sent if the patient is not the same person as the subscriber. See Section 1.5 Business Terminology of the 005010X223 for further details.

3.1.1 ATYPICAL PROVIDERS

Atypical providers are service providers that do not meet the definition of health care provider. Examples include taxi drivers, carpenters, personal care providers, etc. Although, they are not eligible to

receive an NPI (National Provider Identifier), these providers perform services that are reimbursed by some health plans. As a result, the 5010 Technical Report3 (TR3) implementation guides have been enhanced to accommodate both the NPI (to identify health care providers) and proprietary identifiers (to identify atypical/non-health care providers).

If Atypical providers submit Health Care Claim transactions electronically, then they must conform to rules, identified in this OCG, that are applicable to them after October 1, 2012 (refer to section).

3.2 Transaction Requirements

During review of the TR3, the EDI Workgroup agreed that the TR3, as written, did not require further definition. However, the group does reserve the right to add clarification, if during implementation, disagreements or concerns arise about the intent and use of the TR3.

A thorough review and understanding of various sections of the TR3, together, allow for a successful implementation. These include:

a. the sections on business purpose and implementation
b. the TR3 notes applicable to specific loops and/or segments
c. the notes applicable to specific data elements
d. the usage of REQUIRED, SITUATIONAL and NOT USED for data elements, segments and loops

This OCG does not add new or different values to those defined in the 005010X223 TR3, and is fully compliant and consistent with the X12 837 transaction.

3.2.1 TR3 Business Information

This section of the TR3 provides discussion regarding the purpose as well as implementation principles. Within these sections are details of requirements which may not be obvious by reviewing only the technical sections of the report.

3.2.2 TR3 Notes

TR3 notes are designed to provide clear implementation detail regarding usage such as but not limited to:

- The number of times a loop or segment may or may not be repeated in a given situation.
- Dependencies when the loop or segment may be required based on data provided in another loop or segment.
- When data may be required based on the type of trading partner or intermediary.

3.2.3 Loops, Segments and Data Elements

This OCG does not reference the required and situational Loops, Segments, and Data Elements contained in the 005010X223. The specific instructions associated with the transaction tables included in the TR3 are fully applicable to the covered entities without modification or qualification.

This Companion Guide does NOT include any of the Loops, Segments, or Data Elements defined as NOT USED in the Reference *005010X223*. Consistent with the HIPAA requirements and *005010X223* instructions, the NOT USED Loops, Segments, and Data Elements are not permitted to be submitted or received when conducting this transaction.

3.2.3.1 Required Loops, Segments and Data Elements

The Companion Guide adds no new or different values to those defined in the 005010X223.

3.2.3.2 Situational Loops, Segments and Data Elements

The Companion Guide accepts the conditions and values of Situational Loops, Segments, and Data Elements to one of the following possibilities:

o Required, this means that in Oregon, group purchasers do consider and need this data for proper adjudication of the transaction and that the Loop, Segment and Data Element will be REQUIRED for ALL values further defined in the Oregon Companion Guide.

o Situational, with or without further definition of condition: this means that the Loop, Segment or Data Element will retain in the Oregon Companion Guide the original Situational classification given in the 005010X223, and that the Oregon Companion Guide will follow either:

- The exact same conditions and values defined in the 005010X223 (because the conditions and values are close-ended, unambiguous, and straight-forward); or
- A set of further refined conditions and values applicable to that Situational Loop, Segment or Data Element should the need arise as implementation progresses.

It is important to note that the parameters of Situational elements in the *00500X223* are generally written in a manner that creates a "requirement" for the element to be used (if such conditions are met).

3.2.4 TRADING PARTNER AGREEMENTS

This OCG is not intended to replace trading partner agreements that define other transaction parameters (such as EDI transmission parameters or transaction header information). This guide also does not specify the requirement for trading partner agreements---that is a business decision between trading partners.

Should trading partner agreements be used, they may NOT add or modify the requirements established by this OCG.

Trading Partners will exchange the appropriate and necessary identification numbers to be reported in Loops 1000A and 1000B (Submitter and Receiver).

3.3 Oregon Best Practices: Health Care Claim Transaction

The Oregon Administrative Simplification Work Group is continuously working on the identification of 'Best Practices' for the implementation of administrative transactions and processes. 'Best Practices' are consensus recommendations of the EDI Workgroup to further standardize and harmonize health care administrative transactions for the entities to whom the OCG applies.

If an organization(s) cannot fulfill best practice requirements by the OCGs compliance date, or believes that the required practice cannot or does not apply to them, an application for waiver may be made to the Oregon Department of Consumer and Business Services (DCBS).

3.3.1 SUBMITTING COB CLAIMS

Some patients have insurance coverage with more than one health plan/payer. In these situations, the provider may submit multiple claims for the same service. An electronic claim is submitted sequentially to all health plans responsible for a patient's coverage.

The claim is first submitted to the primary payer responsible for coverage. The primary payer adjudicates the claim and responds to the provider with an Electronic Remittance Advice-835 (ERA) and/or Explanation of Payment (EOP) voucher. The provider then submits the claim to the secondary payer responsible for coverage, including the primary payer's adjudication information about the claim. The secondary payer requires the primary payer's adjudication information to correctly adjudicate the claim. Tertiary and subsequent payers have the same requirement as a secondary payer.

Occasionally some patient has multiple coverage with the same Health Plan. In this case send only one electronic claim should be submitted. The health plan will adjudicate the claim for both the primary and secondary coverage when the health plan determines that both subscribers are covered by them.

3.3.2 USE OF US POSTAL SERVICE RULES

Because of sensitivity to special characters, data should be stripped of punctuation including periods, commas, etc. before sending the electronic file. When reporting the nine digit zip code for U. S. addresses, the full nine digit zip code must be provided.

3.4 Implementation Schedule

October 1, 2012	All covered entities (refer to section 2.3) using 837 transactions conform to this OCG
January 1, 2013	All covered entities **must** conduct such 837 transactions electronically and conform to this OCG

3.5 TR3 Utilization - Clarifications

The workgroup felt the following two areas of the Institutional TR3 needed further explanation because of industry issues that have been observed in the past.

3.5.1 PATIENT REASON FOR VISIT 837I HI SEGMENT

Completion of this segment is only required on claims with Revenue codes 013x and 085x when Priority (Type) of Admission/Visit Codes are 1,2 or 5 AND Revenue Codes 045s, 0516, 0526 or 0762 are reported.

It may be reported on all other claims with Revenue codes of 013x (Room & Board, 3 & 4Beds) and 085x (Continuous Cycling Peritoneal Dialysis CCPD Outpatient Home) at the submitter's discretion when this information provides additional information to support medical necessity.

3.5.2 OCCURRENCE SPANS

Usage of Occurrence code dates vs. Occurrence code spans. There are two locations in the 2300 Loop to place Occurrence Codes (External Code list 132), the HI*BH segment "Occurrence Information" and HI*BI - "Occurrence Span Information". Per the TR3 the HI*BI segment should only be used when a range (span) of dates are being sent for the associated Occurrence Code.

If a single date is sent then the HI*BH segment should be used.

4 APPENDIX A: REFERENCES AND BIBLIOGRAPHY

The reference for this OCG is the Health Care Claim (837) 005010X223: Institutional (Copyright © 2008, Data Interchange Standards Association on behalf of ASC X12 Format © 2008, Washington Publishing Company. All Rights Reserved). A copy of the full 005010X223 can be obtained from the Washington Publishing Company at http://www.wpc-edi.com.

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