Driscoll Health Plan

HIPAA Transaction Standard Companion Guide

835 Healthcare Claim Payment/Advice

Refers to the Implementation Guides
Based on ASC X12 835, version 005010
May 2023
V1.2

Disclosure Statement

Disclaimer

This information is provided by DHP for education and awareness use only. Even though all information in this document is believed to be correct at the time of writing, this document does not purport to provide legal advice. The information provided here is for reference use only and does not constitute the rendering of legal, financial, or other professional advice or recommendations by DHP.

Preface

This Companion Guide to the v5010 ASC X12N Implementation Guide and associated errata adopted under HIPAA clarifies and specifies the data content when exchanging electronically with Driscoll Health Plan (DHP) and its contracted agent, Change Healthcare. Transmissions based on this companion guide, used in tandem with the v5010 ASC X12N Implementation Guides, are compliant with both ASCX12 syntax and those guides. 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.

NOTE: DHP forwards X12N 835 files to Change Healthcare after every Financial Cycle. ALL 835s originate from DHP for medical and behavioral health claims and are forwarded to Change Healthcare. Therefore, connectivity and registration, for the service is between the submitter (which in some cases is another clearinghouse) and Change Healthcare. See the DHP registration form on Change Healthcare's website here:

https://support.changehealthcare.com/customer-resources/enrollment-services/medical-hospital-era-enrollment-forms.

Instructions for form completion and submission can be found on the DHP Provider Portal.

Remittance and Status Advice for other payers who process claims for DHP members that include Dental, Vision, CHIP Perinate Dental and Pharmacy services will be available through those payers, please contact them directly.

Table of Contents

1. INTRODUCTION

This section describes how ASC X12N Implementation Guides (IGs) adopted under HIPAA will be detailed with the use of a table. The tables contain a row for each segment that DHP has something additional, over, and above, the information in the IGs. That information can:

1. Limit the repeat of loops, or segments
2. Limit the length of a simple data element
3. Specify a sub-set of the IGs internal code listings
4. Clarify the use of loops, segments, composite, and simple data elements
5. Any other information tied directly to a loop, segment, composite, or simple data element pertinent
   to trading electronically with Acme Health Plan

In addition to the row for each segment, one or more additional rows are used to describe DHP's usage for composite and simple data elements and for any other information. Notes and comments should be placed at the deepest level of detail. For example, a note about a code value should be placed on a row specifically for that code value, not in a general note about the segment.

The following table specifies the columns and suggested use of the rows for the detailed description of the transaction set companion guides. **NOTE:** This table is only sample data and may not be relevant to the Healthcare Claims Payment/Advice transactions.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
193	2100C	NM1	Subscriber Name			This type of row always exists to indicate that a new segment has begun. It is always shaded at 10% and notes or comments about the segment itself goes in this cell.
195	2100C	NM109	Subscriber Primary Identifier		9	This type of row exists to limit the length of the specified data element
196	2100C	REF	Subscriber Additional Identification			
197	2100C	REF01	Reference Identification Qualifier	18, 49, 6P, HJ, N6		These are the only codes transmitted by DHP.
			Plan Network Identification Number	N6	Makes it clear that the code value belongs to the row immediately above it	This type of row exists when a note for a particular code value is required. For example, this note may say that value N6 is the default. Not populating the first 3 columns makes it clear that the code value belongs to the row immediately above it.

1.1 Scope

Under the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the Secretary of the Department of Health and Human Services (HHS) is directed to adopt standards to support the electronic exchange of administrative and financial healthcare transactions. The purpose of the Administrative Simplification portion of HIPAA is to enable health information to be exchanged electronically and to adopt standards for those transactions.

This Companion Guide is intended for Trading Partners submitting ASC/X12N 005010 835 Claim Payment/Advice files. Trading partners include vendors, clearinghouses, Providers, and billing agents.

This guide is intended to supplement information from the ASC X12 Technical Reports Type 3 (TR3s)

1.2 Overview

In accordance with the Council for Affordable Quality Healthcare and Committee on Operating Rules for Information Exchange (CAQH/CORE), this guide is composed of the following sections:

- Section 1: Introduction, Scope, Overview, and related references.
- Section 2: Getting Started: How to interact with the Change Healthcare Implementation Team, how to register as a trading partner and complete payer enrollment, and an overview of testing and certification
- Section 3: Testing
- Section 4: Connectivity
- Section 5: Contact Information: How to get help.
- Section 6: Control Segments/Envelopes: ISA/IEA, GS/GE, and ST/SE values
- Section 7: Payer Specific Business Rules and Limitations:
- Section 8: Acknowledgments and Reports
- Section 9: Trading Partner Agreements
- Section 10: Transaction Specific Information

The purpose of this document is to assist the provider with DHP-particular data sets for information specified in the National Electronic Data Interchange Transaction Set Implementation Guide for the file type. The federal government has set standards to simplify Electronic Data Interchange (EDI). To comply with the standard, DHP has updated the data sets for EDI files to be in accordance with HIPAA and is utilizing the ASC X12 nomenclatures.

The instructions in this companion guide are not intended to be stand-alone requirements documents and must be used in conjunction with the associated ANSI ASC X12N National Implementation Guide. This companion guide conforms to all the requirements of any associated ASC X12 Implementation Guide and is in conformance with ASC X12's Fair Use and Copyright statements.

1.3 References

ASC X12N/005010221 Healthcare Claim Payment/Advice, herein referred to as the TR3.

You are expected to comply with the requirements set forth in the TR3. You can purchase these guides from the ASC X12 store at http://store.x12.org/. The TR3s are copyrighted.

1.4 Additional Information

Security and Privacy Statement
Covered entities were required to implement HIPAA Privacy Regulations no later than April 14, 2003. A covered entity is defined as a health plan, a healthcare clearinghouse, or a healthcare provider who transmits any health information in electronic form in connection with a HIPAA transaction. Providers that conduct certain electronic transmissions are responsible for ensuring these privacy regulations are implemented in their business practices. Health and Human Services Commission (HHSC) is a HIPAA Covered Entity. Accordingly, Texas Medicaid is operating as a HIPAA Business Associate of HHSC as defined by the federally mandated rules of HIPAA. A Business Associate is defined as a person or organization that performs a function or activity on behalf of a covered entity but is not part of the covered entity's workforce.

The privacy regulation has three major purposes:

- To protect and enhance the rights of consumers by providing them access to their health information and controlling the appropriate use of that information.
- To improve the quality of healthcare in the United States by restoring trust in the healthcare system among consumers, healthcare professionals and the many organizations and individuals committed to the delivery of healthcare.
- To improve the efficiency and effectiveness of healthcare delivery by creating a national framework for health privacy and protection.

2. GETTING STARTED

Interested parties should complete the registration form mentioned above and primarily contact their software vendor/Clearinghouse, as many of them already receive or contract with providers who obtain Electronic Payment/Advice through Change Healthcare. The change on the submitter end will merely be a change to adding or activating the DHP Payer ID within the provider software. If the software vendor is not already established with Change Healthcare, see section 5 for contacting them. Your organization will be provided with a submitter ID and password, Payer IDs for testing and certification, enrollment forms as needed, production interchange sender IDs and passwords, once assigned.

Once the vendor/Clearinghouse has been established with Change Healthcare, they will be provided with Payer specific instructions for specific field values.

3. Testing

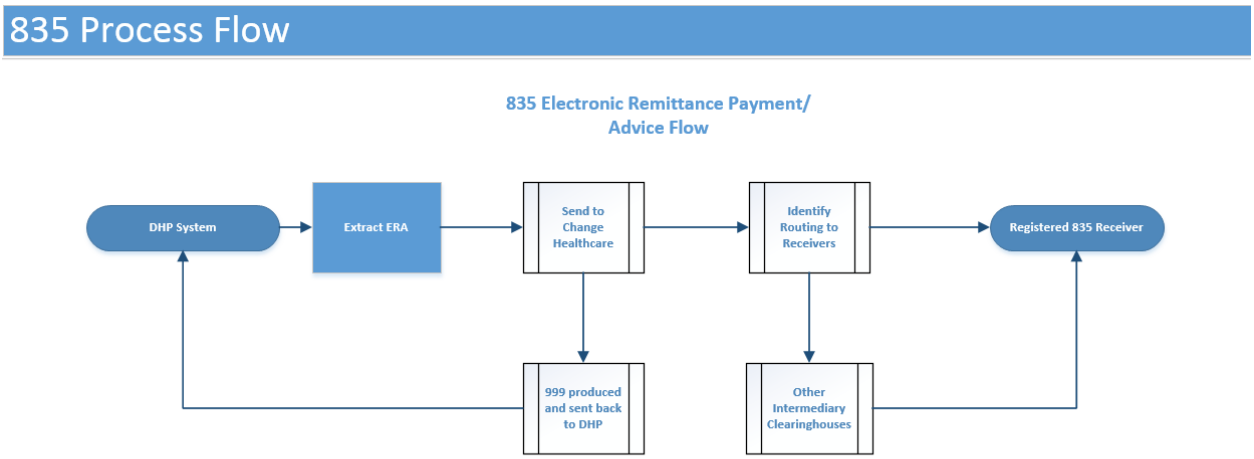
Testing for new submitters to the Change Healthcare Clearinghouse is advisable; refer to Change Healthcare Companion Guides, Connectivity Guides, and other resources, www.changehealthcare.com.

If the Provider or Billing Agent utilizes a Clearinghouse to retrieve ERAs from the Change Clearinghouse, it's quite possible they have tested previously, and no further testing is required for adding trading partners.

While testing, DHP provides access to downloadable and printable PDFs of Explanation of Payments (EOP).

4. Connectivity

Connectivity starts from DHP through Change Healthcare, then any other clearinghouse between Change Healthcare and the provider:



NOTE: additional clearinghouses may be present between the receiving provider/entity and the Change Healthcare Clearinghouse.

4.1 Transmission Administrative Procedures

Change Healthcare may have schedules downtimes for maintenance; check their websites/documentation for scheduled maintenance times. DHP may invoke short periods of maintenance that may affect connectivity. Maintenance is usually scheduled outside of business hours to reduce provider/trading partner impact.

4.3 Communication Protocol Specifications

Change Healthcare provides connectivity that complies with the CORE Safe Harbor principle (§5 Safe Harbor) according to the CORE Connectivity Phase III Rule 350. Information receivers can submit claims via Safe Harbor. Change Healthcare uses security protocols based on Username/Password. Obtain them from the appropriate entity.

5. Contact Information

5.1 Phone Support

Technical assistance with Change Healthcare is available via phone during regular business hours at 1-866-742-4355.

Data content can be discussed with DHP Customer Service at:
Hidalgo Service Area (1-855-425-3247)
Nueces Service Area (1-877-324-3627)

5.2 Applicable Websites/E-Mail

www.changehealthcare.com

www.driscollhealthplan.com/providers

6. Control Segments/Envelopes

6.1 DHP Inbound Control Envelopes

837 ISA/IEA

Element	Value	Additional Notes and Conditions
ISA		
ISA01	00	
ISA02		Space fill, 15 digits/spaces
ISA03	00	
ISA04	Submitter ID	Change Healthcare or intermediary

Element	Value	Additional Notes and Conditions
		clearinghouse
ISA05	ZZ	
ISA06	Receiver ID	Left Justify, space fill. Assigned by vendor or Change Healthcare:
ISA07	ZZ	
ISA08		Left Justify, space fill
ISA11	| (pipe)	
ISA13	See TR3	
ISA14	Acknowledgment requested	0
IEA		
IEA01	1	

837 GS/GE - Change Healthcare's Real-time Exchange Services support only one functional group per request and response.

Element	Value	Additional Notes and Conditions
GS		
GS02	Submitter	Same as ISA06
GS03	Receiver	Same as ISA08
GE		
GE01	1	

837 ST/SE – change Healthcare's Real-time Exchange Services support only one transaction set per functional group.

Element	Value	Additional Notes and Conditions
ST		
ST01	835 = Healthcare Payment/Advice	
ST02		Assigned by Change Healthcare
ST03		Must match GS08
SE		
SE02		Must match ST02

7. Payer Specific Business Rules and Limitations

Change Healthcare collects the 835 from DHP and disperses to end users based on registration and receiver IDs. The file contains 835 compliant data, making it importable to other systems.

8. ACKNOWLEDGMENT AND/OR REPORTS

Although an Acknowledgment is passed back to DHP from Change Healthcare, it is not expected to receive anything from a clearinghouse/provider back to Change Healthcare. No action is required on the receiver's part. If a discrepancy is found, please open a Customer Ticket through the DHP Customer Service line and it will be assigned to a DHP Analyst to resolve.

9. TRADING PARTNER AGREEMENTS

Trading Partner agreements are not required for DHP Submitters, but Registration with Change Healthcare is required.

10. HEALTHCARE TRANSACTION SPECIFIC INFORMATION

In addition to the row for each segment, one or more additional rows are used to describe DHP's usage for composite and simple data elements and for any other information.

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
68		BPR	Financial Information			
		BPR01	Transaction Handling Code	H, I	1	I when BPR05 = CHK H when BPR05 = NON
		BPR04	Credit/Debit Flag Code	C		
		BPR05	Payment Format Code	CHK NON		
77		TRN	Re-association Trace Number			
		TRN02	Check or EFT Trace Number		15	Traces back to the Check or EFT
83		DTM	Production Date			
		DTM01	Date/Time Qualifier	405	3	Production
		DTM02	Date		8	ccyymmdd
87	1000A	N1	Payer Identification			
		N101	Entity ID Code	PR		Payer
		N102	Name		60	Driscoll Heath Plan
94	1000A	PER	Payer Business Contact Information			

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
		PER03	Communication Number Qualifier	TE		Telephone
		PER04	Communication Number			Customer Service Phone Number appropriate for the Service Area
98	1000A	PER	Payer Technical Contact Information			
		PER01	Contact Function Code	BL		Technical Contact
		PER03-06	Communication Number Qualifier and Numbers			Not available
102	1000B	N1	Payee Identification			
		N101	Entity Identifier Code	PE		Payee
		N102	Name			Provider Name
		N103	Identification Code Qualifier	XX		Qualifier for NPI
		N104	Identification Code			NPI
107	1000B	REF	Payee Additional Identification			
		REF01	Reference Identification Qualifier	TJ		Qualifier for Federal Tax ID or SSN
		REF02	Reference Identification			Federal Tax ID or SSN
111	2000	LX	Header Number			
		LX01	Assigned Number	1	1	Will always be “1”
123	2100	CLP	Claim Payment Information			
		CLP01	Claim Submitter’s Identifier		38	CLP01 = CLM01 from 837
		CLP03	Monetary Amount		18	Billed Amount from CLM02/837
		CLP04	Monetary		18	Claim Payment Amount after

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
			Amount			adjudication
		CLP05	Monetary Amount		18	Patient Responsibility
		CLP06	Claim Filing Indicator	MC	2	MC for STAR/STARKIDS/CHIP
		CLP07	Reference Identification		50	DHP's Claim Number
		CLP08	Facility Code Value		2	From 837 CLM05-01/02
		CLP09	Claim Frequency Type Code		1	From 837 CLM05-03
137	2100	NM1	Patient Name			
		NM101	Entity Qualifier Code	QC	2	Note: since Medicaid members are always the subscriber, only the Patient Name loop will be provided.
		NM102	Entity Type Qualifier	1	1	
		NM103	Name Last		60	STAR/STARKIDS/CHIP member last name
		NM104	Name First		35	STAR/STARKIDS/CHIP member first name
		NM105	Name Middle		25	STAR/STARKIDS/CHIP member middle name
		NM108	Identification Code Qualifier	MI	2	Member Identification Number Qualifier
		NM109	Identification Code		9-10	Member Identification Number
146	2100	NM1	Service Provider Name			
		NM101	Entity Identifier Code		82	Rendering Provider
		NM102	Entity Type Qualifier	1/2	1	1 = individual provider 2 = organization
		NM108	Identification Code Qualifier	XX	2	Qualifier for NPI
		NM109	Identification Code		10	NPI
169	2100	REF	Other Claim Related Idenfication			

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
		REF01	Reference Identification Qualifier		EA	Qualifier for Medical Record Number
		REF02	Reference Identification Number			Medical Record ID as submitted on the inbound claim in 2300/REF*EA
173	2100	DTM	Statement From or To DOS			
		DTM01	Date/Time Qualifier	232 233		232 = Claim Statement Period Start 233 = Claim Statement Period End
175	2100	DTM	Claim Received Date			
		DTM01	Date/time Qualifier	050		Qualifier for Claim Received Date
		DTM02	Date		8	Ccyymmdd
182	2100	AMT	Claim Supplemental Information			
		AMT01	Amount Qualifier Code	AU		Coverage Amount
		AMT02	Monetary Amount			
186	2110	SVC	Service Line Information			
		SVC01-01	Product/Service ID Qualifier	HC NU		HCPCS or Revenue Code Qualifier
		SVC01-02	Produce/Service ID			HCPCS or Revenue Code
		SVC01-03 through 06	Procedure Modifier			
		SVC02	Monetary Amount			Line Item Charge Amount
		SVC03	Monetary Amount			DHP Paid Amount
		SVC04	Product Service ID			Revenue Code when not reported in SVC01-01
		SVC05	Quantity			Units of service paid
194	2110	DTM	Service Date			
		DTM01	Date/Time Qualifier	472		Date of Service Qualifier

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
		DTM02	Date			Service Date ccyymmdd
206	2110	REF	Line Item Control Number			
		REF01	Reference Identification Qualifier	6R		Qualifier for Line Item Control Number
		REF02	Reference Identification			From inbound 2400REF*6R
209	2110	AMT	Service Supplemental Amount			
		AMT01	Amount Qualifier Code	B6		Allowed Actual Qualifier
		AMT02	Monetary Amount			Service Line Allowed Amount

11. Change Log

Date	Version	Description
4/16/2019	1.0	Original document