EMBLEMHEALTH

837I (Encounter)
HIPAA Transaction Standard Companion Guide

Refers to the Implementation Guides Based on ASC X12 version 005010

Based on CAQH-CORE v5010 Master Companion Guide Template

Disclosure Statement

The Health Insurance Portability and Accountability Act (HIPAA) was signed into federal law on August 21, 1996. HIPAA mandates standards for electronic data interchange (EDI) transactions and code sets and establishes uniform health care identifiers for providers. EmblemHealth has been following the evolution of the Administrative Simplification provisions of HIPAA since its inception in 1996. Our goal is to ensure our systems, supporting business processes, policies and procedures successfully meet the standards and implementation guidelines.

Preface

This Companion Guide to the v5010 ASC X12N Implementation Guide(s) and associated errata adopted under HIPAA clarifies and specifies the data content when exchanging electronically with EmblemHealth. Transmissions based on this companion guide, used in tandem with the v5010 ASC X12N Implementation Guides, are compliant with both ASC X12 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.

EDITOR'S NOTE:
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INTRODUCTION

This section describes how ASC X12N Implementation Guides (IGs) adopted under HIPAA will be detailed with the use of a table. In compliance with the CAQH CORE CG Template and the ASC X12 Fair Use and Copyright statements, EmblemHealth will only provide pertinent information as necessary to convey anything specific to EmblemHealth's processing but will not contradict CAQH CORE's Template's requirements. 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 EmblemHealth.

Additional rows may be used to describe EmblemHealth's usage for composite and simple data elements and for any other information. Notes and comments are placed at the deepest level of detail. For example, a note about a code value will be placed on a row specifically for that code value and not in a general note for the item.

Scope

This Companion Guide (CG) is limited to the transaction(s) EmblemHealth has listed in the TRANSACTION SPECIFIC INFORMATION TABLE. Additional transaction may be added as this CG evolves or separate CGs may be published for individual transactions.
To this end, it is recommended by EmblemHealth to first understand all sections of the front matter and appendixes of this CG and use the Table of Context links to go directly to the desired transaction CG within the Transaction Specific Information Table.

Overview

EmblemHealth requires all trading partners/vendors to set up the Electronic Data Interchange (EDI) with EmblemHealth. All necessary logistics will be vetted and set up after a formal project is initiated.

HIPAA includes provisions for administrative simplification. This requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. HIPAA directs the Secretary to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard.
HIPAA's Administrative Simplification provision serves to:

- Create better access to health insurance
- Limit fraud and abuse
- Reduce administrative costs

References

This Companion Guide(s) is an ever-evolving document. As a result, EmblemHealth will continue to update all pertinent documents and posting them on the EmblemHealth website: https://www.emblemhealth.com/Providers/Claims-Corner/Coding/EmblemHealth-5010-HIPAA-Transaction-Standard-Companion-Guides

Keep in mind the Companion Guide(s) is a supplement to the HIPAA Implementation Guides (also known as Technical Report Type 3 – TR3s) and are to be used along with the v5010 ASC X12N Technical Reports Type-3 (TR3s), which can be obtained from: http://store.x12.org/.

EmblemHealth will comply with the CAQH CORE CG Template and the ASC X12 Fair Use and Copyright statements, as required by 45 § 162.920: Availability of implementation specification and Operating

Rules. For this reason, the CG provided by EmblemHealth only list Loop/Segments/Elements for which specific guidance from EmblemHealth is pertinent. For example, the CG might reference a Situational Segment in the middle of a Loop and yet not make any reference to the first segment in the Loop.

Getting Started

Prior to any meetings, data exchange and set ups, it is essential for a Trading Partner Agreement (TPA) and Non-Disclosure Agreement (NDA) to be executed. Please refer to the Contact Section below to initiate the set up for the partnership. In most instances a Relationship Manager from EmblemHealth will initiate the process.

Testing

EmblemHealth requires the trading partners (TPs) to test all transactions being implemented. Once projects are formally initiated by the internal business units or Relationship Manager (RM), the EDI Operations Support area will be engaged to facilitate the processing of test files.

It is also very important to use "T" as the Usage Indicator (Data Element ISA15) during the testing phase and only after all testing has been concluded and agreed upon to move to production should the Usage Indicator be sent as "P".

Test File Size Limits

It is required to use a limited data set for testing. For example, when testing 837-Claims it is suggested to limit the files to no more than 100 claims (CLM Segments). Similarly, for 834-Enrollment it is suggested to use files of no more than 100 INS (Member Information) Segments.

File Naming Convention

EmblemHealth follows a naming convention which is essential for internal file reconciliation purposes. The RM assigned to each project will work with his/her counterpart on the TP side to coordinate this requirement. Among other things, following are some of the elements (Nodes) that make up the file name for an Outbound file: sent from EmblemHealth to an external TP. Each Node is separated by an Underscore Character ("_").

File name Node	Description
Company Name	Our Business Entity – EH = EmblemHealth, CCI = Connecticare
Third Party Name	Name/initials of the Third Party (vendor name)
Line of Business	The LOB types - HHMO, HPPO, CCOM, MULTI, etc.
Data Domain	The type of data – 834, 837x, xxxxxCLM, etc.
Source System ID	The originating system – Facets, EDL, External, etc.
File Type Frequency Sequence Number	This Node combines three (3) elements: 1. Type of file – Full, Change, or "X" when not applicable. 2. Frequency – Yearly, Quarterly, Monthly, Weekly, Daily, etc. 3. Sequence # - large files may need to be split and in logical parts.
Environment	Type of data – Test or Production
Date&Time Stamp	Date & Time in this format: CCYYMMDDHHMMSS
File Extension	.TXT, .837, .835, etc.

The **Sequence Number** Node is very important, especially when dealing with large amounts of data. For example, 834-Enrollment files can be huge when transmitting Full Files. EmblemHealth will split full files (Interchanges) into manageable, logical files and will sequence them accordingly. For each batch of file(s), the Sequence always starts with "01".
Larger physical files can be supported if previously agreed upon.

File Naming Convention Example

These are example of files originated from EmblemHealth – Outbound examples:

EH_ACME_MULTI_837I_FA_XW01_PROD_CCYYMMDDhhhmmss.837
EH_ACME_GPPO_ACCUM_EDL_XD01_TEST_CCYYMMDDhhmmss.TXT

For files originated from the TP, there is an additional Node that is necessary to denote the file is Inbound to EmblemHealth:
EH_ACME_**IN**_MULTI_837I_**EX**_XW01_PROD_CCYYMMDDhhmmss.837
Also, since EmblemHealth does not know the origin of the data, the 6th Node changes from "FA" (Facets) to "EX" (external).

However, Response files (TA1, 999, 277CA) In/Outbound may adopt the name of the originating file, with the exception that the File Extension must be changed to reflect the type of response. For example, when ACME sends the 999-Response related to the first example above for EmblemHealth's "MULTI_837I", the 999-Response will look as follows and will not need the additional "_IN" Node. It shall simply need the Extension changed accordingly:

EH_ACME_MULTI_837I_FA_XW01_PROD_CCYYMMDDhhmmss**.999**

This will allow EmblemHealth to reconcile this 999-Response to the original file sent out, since the file names are practically the same.

CONNECTIVITY/COMMUNICATIONS WITH THE PAYER

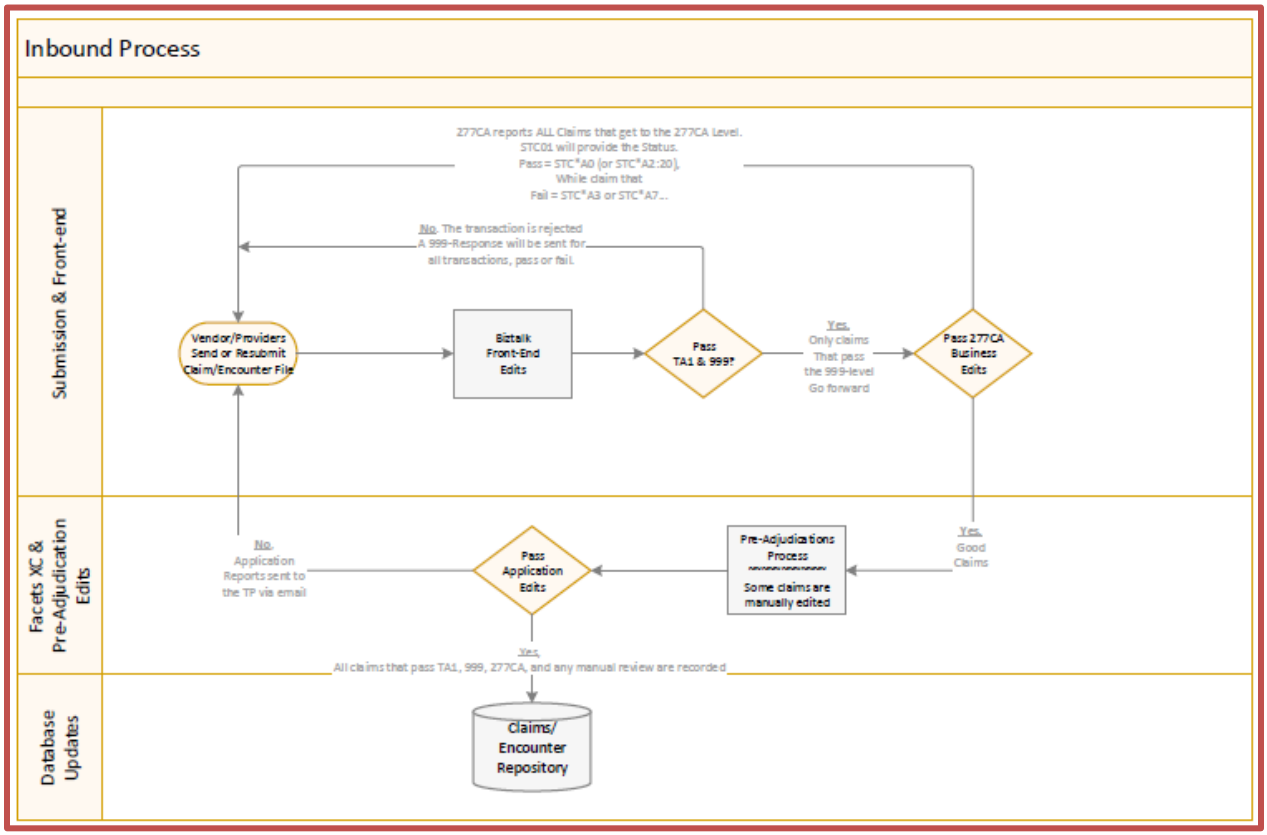
Process Flow

EmblemHealth encourages the use of electronic processing to maximize automation. All X12 formatted transactions will undergo editing during the front-end process.

EmblemHealth will provide 999-Functional Acknowledgements and for Inbound claims will also send 277CA-Claim Acknowledgements.

In similar fashion, **EmblemHealth expects to receive Acknowledgements in response to all Outbound X12 transactions EmblemHealth transmits.**

For a complete review of the Acknowledgement process, including the TA1, please refer to the Acknowledgement Section below.



Transmission Administrative Procedures

EmblemHealth will engage a Relationship Manager (RM) for each project. The RM will initiate the exchange of administrative information and requirements with the TP.
Once the logistics are settled (exchange of Receive/Drop-off Locations, passwords, TP sender/Receiver-IDs, etc.), then TP profiles are defined. Data Control protocol will be followed to establish all data transmissions.

EmblemHealth will provide response files for all received X12 transactions and expects the TP to consume them, as our processes are fully automated, and no phone calls/emails will be sent to report normal front-end errors.
EmblemHealth will generate success/failure email notifications in response to all Inbound 837s and 999/277CA responses.

Contact

All inquiries and comments regarding trading partner setup, submission and technical support should be directed to the respective Units below.

Provider Service & Technical Assistance Contact Information

Entity	Unit	Provider Service Phone Number
ConnectiCare Inc. (CCI)	Medicare	1-877-224-8230
	Commercial	1-800-828-3407

EmblemHealth	GHI PPO	1-800-624-2414
	Medicare PPO	1-866-557-7300
	Medicare HMO	1-866-447-9717
	GHI HMO	1-877-244-4466
	HIP	1-866-447-9717

CONTROL SEGMENTS/ENVELOPES

EmblemHealth uses Qualifier "ZZ" for its Sender/Receiver identification. During set up, it is expected the Trading Partner (TP) will inform EmblemHealth of the Qualifier and Sender-ID to be used. EmblemHealth expects the TP will not re-use the Interchange Control Number (ISA13) or Group Control Numbers (GS06). Every new file shall have unique control numbers. The Transaction Set Control Number (ST02) may be repeated within each Group at the sender's discretion.

Transactions Sent to EmblemHealth (INBOUND)

Normally the EmblemHealth Receiver-ID will be "EMBFACETS". This may change depending on the situation. If different, the RM will communicate the Receiver-ID and Qualifier to the TP. Here are other IDs EmblemHealth may use in agreed upon situations:

- HIP/NY – EMBFACETS
- CCI – 78375
- PPO – 13551
- HIP - 55247

ISA-IEA

Transaction	ISA06 (Sender ID)	ISA08 (Receiver ID)
837 batch	TO BE POPULATED WITH Sender ID	EMBFACETS

GS-GE

Transaction	GS02 (Sender ID)	GS03 (Receiver ID)
837 batch	TO BE POPULATED WITH Sender ID	EMBFACETS

Note: This list may expand if/when other transactions are added to this CG.

Transactions Sent by EmblemHealth (OUTBNBOUND)

Normally the EmblemHealth Sender-ID will be "EMBFACETS". This may change depending on the situation, in which case a different Sender-ID will be communicated to the TP.

ISA-IEA

Transaction	ISA06 (Sender ID)	ISA08 (Receiver ID)
837 batch	EMBFACETS	TO BE POPULATED WITH RECEIVER ID

GS-GE

Transaction	GS02 (Sender ID)	GS03 (Receiver ID)
837 batch	EMBFACETS	TO BE POPULATED WITH RECEIVER ID

Note: This list may expand if/when other transactions are added to this CG.

EmblemHealth Data Format Requirements

EmblemHealth expects inbound files in stream format, as blocked data formats are not supported. Similarly, outbound files will resemble this requirement.
The use of Carriage Returns and/or Line Feeds in the inbound production files is not permitted.

Production Batch Transaction Size Limits

EmblemHealth expects the inbound 837 transactions to be submitted with one (1) claim per ST-SE Transaction Set.

Emblem requests that you limit the claim count per 837 to 5,000, where you create a maximum of 5,000 ST-SE Transaction Sets.

If you have more than 5,000 claims to submit in a given cycle, change the frequency value in the file name from X*01 to X*02, etc.

Acknowledgements

EmblemHealth expects for the TPs to process all response files, as these are the automated mechanisms to provide status of all X12 transactions received.

A 999 Response will be sent for all X12 inbound transactions. A TA1-Response may be provided depending on the Indicator in ISA14 of the Inbound transaction(s) sent by the TP. When ISA14 = 0, EmblemHealth will send the TA1 only when the file fails to meet the expected X12 Interchange Control Structure. In other instances, the TA1 may be sent at EmblemHealth's discretion.

In addition, for 837-Claim transactions EmblemHealth will also send the 277CA-Response.

Acknowledgement Sequence

X12 Transaction validation will consist of the following editing during the front-end process:

Syntax and Compliance checking (TA1 & 999)

EmblemHealth will send Response files for all Inbound interchanges. It is very, very important for Trading Partners to process the Responses and correct/resubmit any rejected transactions.

- TA1-Interchange Acknowledgement
  If the Inbound Interchange passes structure compliance, it will proceed to the next level. When the Interchange files at this step, the entire file is rejected.
- 999-Functional Acknowledgement
  Files or Interchanges that pass the TA1 validation will reach this level.

The 999 is designed to respond to single Functional Group. However, since TPs may send multiple Transactions (ST-SEs) within a Group, the 999 may respond and report some transactions that failed and other transactions that pass from the same Group.
Transactions that fail at this level will be rejected back to the submitter and will not be forwarded to the next level.

277CA-Business Level Editing and Claim Acknowledgement

- The editing consists of valid providers, members, Rate/Procedure Codes, Diagnosis codes, Revenue Codes, eligibility span, duplicate claims, balancing, etc. Please refer to the Duplicate Claim and Balancing Appendices.
  Claims that fail at this level will be reported in the 277CA and nowhere else. Rejected claims will not be forwarded to the adjudication system.
  Encounter claims will not be recorded in EmblemHealth's system, so it is very important for the Delegates/Vendors to correct and resubmit those rejections for EmblemHealth to be able to report those encounters to our clients, when required.
- Additional to the 277CA, there may be checks and balances performed downstream. As a result, some claims may be rejected manually. Reports will be created for the business units to review and in some circumstances emails/calls may be initiated with the submitters to address those issues.

Transaction Audit and Controls

Trading Partners (TPs) or submitters are expected to keep track of all file submissions and verify all items (i.e. claims) are accounted for.
The EDI control structure provides the mechanism to verify that all items submitted are included in at least one of the responses (TA1, 999, or 277CA when applicable). For example, when a file is submitted containing five (5) transaction sets (ST-SE) and each transaction set contains one (1) claim, the submitter receives the TA1-Response with an Interchange Acknowledgement Code equal to "A" (Accepted). This will inform the TP that EmblemHealth has received the file and found it to be structurally correct. At this point the submitter knows that the 5 claims sent in the file are in EmblemHealth's hands.
EmblemHealth passes the file to the next validation level: the 999, and here it may be found that one of the claims in one of the transaction sets has an invalid Date of Service or is missing a required segment. The 999-Response is sent to the submitter informing them that one transaction set containing one (1) claim has been rejected back to them. They are expected to correct the issue and resubmit the rejected claim (1) at some point. Likewise, the 999-Response is also telling them the other 4 claims passed the 999-validation level and were forwarded to the next level: the 277CA.
The 4 claims are then individually edited by the front-end process based on previously set business criteria. The 277CA-Claim Acknowledgement is designed to report each individual claim. In other words, 4 claims in - 4 claims out. Some claims may be rejected at this level and will have to be corrected and resubmitted by the TP at some point. Other claims will be accepted and forwarded to EmblemHealth's adjudication system.

For encounter submissions, EmblemHealth requires vendors to send an email notification containing control totals. EmblemHealth also requires vendors to establish and follow strict schedule for submissions. If submitter is not able to submit a file for any reason during regularly scheduled time frame, EmblemHealth must be notified through the RM. If regularly scheduled transmissions are not received during the expected time frame, failure email notification will be triggered. Vendors must respond to this notification to acknowledge when the issue is being addressed or to schedule the outstanding transmission.

EmblemHeatlh will be performing SNIP compliance validation Level 1 - 5. Rejections will be reported in the 999 and 277CA

Duplicate Claim Checking

New Claims

New claims are submitted when CLM05-3 (Frequency Code) is equal to "1" and no REF*F8 is present. Please refer to the Duplicate Claim Checking (Encounter) Appendix within this document to understand the criteria used by EmblemHealth to validate new claims for duplicate or near-dupe status. Claims submitted as "new" and found in EmblemHealth's database will be rejected as duplicate at the 277CA Level.

It is important to understand that claims will be processed in the order received. For this reason, submitters should be mindful when sending new claims and adjustment or voided claims within the same file, because they may not be processed in the desired order. This may cause inadvertent rejections/additions. When submitting adjustment or voids, it is best to submit them in subsequent days, after the new/original claim is already recorded in EmblemHealth's database.

Adjustments & Voids Checking

EmblemHealth expects to receive REF*F8 in Loop 2300 ONLY when CLM05-3 is equal to "7" or "8" (Adjustment or Void, respectively). REF*F8 must never be sent for a new claim.

If CLM05-3 is equal to "1" (New Claim) and REF*F8 is present, the claim will be rejected at the 277CA level.

Adjustment

When a claim is being adjusted, EmblemHealth does not expect a void iteration. Submitters are expected to only send the adjustment with CLM05-3 = 7 and the claim number in REF*F8 of the claim to be adjusted/replaced. Our system will take care of replacing the original claim data with the new submission.

Void

When voiding a claim, submitters are expected to send the Frequency Code (CLM05-3) = 8 and the claim number in REF*F8 of the claim to be voided. If the claim is found in our database, our system will nullify/void the original claim.

Once a claim is voided, EmblemHealth does not expects to receive further updates to that claim. A claim cannot be adjusted once it is voided, and EmblemHealth will reject and report back in the 277CA any attempts made to update a previously voided claim. Only a totally new claim (CLM05-3=1 and new Claim # in REF*D9) can be submitted after a claim is voided.

Delegate Claim/encounter Reporting

EmblemHealth expects fully compliant transactions. EmblemHealth's front-end editing will be used to verify that all transactions are syntactically correct as well as to check certain defined business scenarios for every claim.

Note: New York Medicaid, HARP, Essential Plan, QHP (HIX) and Child Health Plus claims must adhere to the NY State's All-Payer Database (APD) TIER-2 EDIT rules, published and maintained on NY State's website: https://nyshc.health.ny.gov/web/nyapd/apd-submitters

Member Identification

EmblemHealth identifies each member with unique Member-ID and expects its assigned Member-ID in Inbound transactions. Example, for Facets members the format is as follows:
K12345678**NN**, where **NN** could be 01 for Subscriber, or 02, 03, etc. for Dependents.

Supported Transactions

EmblemHealth supports the following transactions:

005010X279A1	Health Care Eligibility Benefit Inquiry and Response (270/271)
005010X212	Health Care Claim Status Request and Response (276/277)
005010X220A1	Benefit and Enrollment Maintenance (834)
005010X221A1	Health Care Claim Payment/Advice (835)
005010X223A2	Health Care Claim Institutional (837)
005010X222A1	Health Care Claim Professional (837)
005010X224A2	Health Care Claim Dental (837)
005010X217	Health Care Services Review-Request for Review and Response (278)
005010X214	Health Care Claim Acknowledgement (277)
005010X218	Payroll Deducted and Other Group Premium for Insurance Products (820)
005010X231A1	Implementation Acknowledgement for Health Care Insurance (999)

The Implementation Guides are available at: http://store.x12.org/

*Note: This Companion Guide (CG) is an evolving document and the **Transaction Specific Information** Section below may be expanded in the future to contain a separate subsection for each of the supported transactions.*

--- --- --- --- TRANSACTION SPECIFIC INFORMATION TABLE --- --- --- ---

Inbound Transactions:

837I 005010X223A2: Health Care Claim Institutional (837) – Inbound-Encounter

The 837I-Inbound Institutional Encounter, as implemented by EmblemHealth has very few fields/elements that require explanations. Besides the ISA and GS information provided in the above CONTROL SEGMENTS/ENVELOPES, the following are the elements with noteworthy entries. For everything else, please refer to the 837I-005010X223 Implementation Guide (TR3) and Addendum, if applicable.

Loop ID	Reference	Name	Codes	Length	Notes/Comments
N/A	BHT	Beginning of Hierarchical Transaction			
	BHT02	Transaction Set Purpose Code	00	2	EmblemHealth expects “00” (Original) only.
	BHT06	Transaction Type Code	RP	2	EmblemHealth expects “RP” for Encounters.
2010BA	NM1	Subscriber Name			
	NM108	Identification Code Qualifier	MI		
	NM109	Identification Code		16	EmblemHealth expects its assigned Member-ID. Example, for members already migrated to Facets, the format is K12345678**NN** (where **NN** could be 01 for Subscriber, or 02, 03, 04, etc. for Dependents)
2300	CLM	2300 CLAIM INFORMATION			
	CLM01	Patient Control Number		18	EmblemHealth expects unique Patient Account Numbers (PA#) for different claims.
	CLM02	Total Claim Charge Amount		11	For FACETS, this will be used for the Total Submitted Amount.
	CLM05-3	Claim Frequency Code	1,2,3,4,7,8		EmblemHealth expects: 1 = Original 7 = Adjustment 8 = Void

					EmblemHealth reserves the right to use other Codes as follows in the future: • *2 may also be treated as Original* • *3 & 4 may be treated as Adjustments*
2300	DTP	Claim Received Date			EmblemHealth expects this segment for Delegate/Vendors to pass their Claim Received Date.
	DTP01	Date/Time Qualifier	050	3	
	DTP02	Date/Time Period	RD8	3	
	DTP03	Date		17	Enter the date the claim was received by the delegated entity (claim processor). Format is CCYYMMDD
2300	CN1	Contract Information			
	CN101	Contract Type Code	04, 05	2	04 = Flat 05 = Capitated
	CN102	Contract Amount		11	EmblemHealth expects the Total Allowed Amount.
	CN104	Contract Code		16	EmblemHealth expects the check number.
2300	AMT	Patient Responsibility Amount			EmblemHealth expects to receive the Total Patient Liability, if applicable.
	AMT01	Qualifier	F3	3	
	AMT02	Patient Amount Paid		11	
2300	REF	Payer Claim Control Number			EmblemHealth expects this segment ONLY when a claim is being voided or adjusted

	REF01	Reference Identification Qualifier	F8	2	EmblemHealth expects this Qualifier to identify an original or adjusted Claim # in REF02 (when CLM05-3=7 or 8).
2300	REF	Claim Identifier for Transmission Intermediaries			EmblemHealth REQUIRES this segment ALWAYS. REF02 of this segment represents the vendor's current Claim Number.
	REF01	Reference Identification Qualifier	D9	2	EmblemHealth expects this Qualifier to identify the most current/new Claim# in REF02
2320	CAS	Claim Level Adjustment			EmblemHealth expects to receive all applicable adjustments. EmblemHealth will capture all Patient Responsibility (PR) Amounts to update accumulators.
2320	AMT	Coordination of Benefits (COB) Payer Paid Amount			EmblemHealth expects to receive this segment.
	AMT01	Payer Paid Amount Qualifier	D	1	
	AMT02	Payer Paid Amount		11	EmblemHealth expects to receive the Claim Total Paid Amount. This Total must balance to the Sum of all Line Payments: SVD02. Zero is acceptable.
2330B	DTP	Claim Check or Remittance Date			EmblemHealth expects this segment for Delegate/Vendors to pass the Check/EFT Payment Date.
	DTP01	Date/Time Qualifier	573	3	
	DTP02	Date/Time Period	D8	2	

	DTP03	Date		8	Enter the Date the claim was paid. The Check-Date, Format CCYYMMDD
2400	SV2	Institutional Service Line			EmblemHealth expects to receive all pertinent Line Level data needed for the claim. Balancing will be enforced and edited against the Claim Level data for the amount fields.
2400	HCP	Line Pricing/Re-Pricing Information			
	HCP01	Pricing Methodology	02	2	Priced at the Standard Fee Schedule
	HCP02	Monetary Amount		11	EmblemHealth expects the Line Allowed Amount for each detail line. The line allowed amount equals the paid amount from 2430/SVD02 plus any cost share from 2430/CAS*PR for CARC = 1, 2, 3.
2430	SVD	Line Adjudication			EmblemHealth expects to receive the line level payment amount. Zero is acceptable
2430	CAS	Line Adjustment			EmblemHealth expects to receive all applicable adjustments when the line charge is not paid in full. EmblemHealth will capture all Patient Responsibility (PR) Amounts to update accumulators.
2430	DTP	Line Check or Remittance Date			EmblemHealth expects this segment for Delegate/Vendors to pass the Check/EFT

					Payment Date.
	DTP01	Date/Time Qualifier	573	3	
	DTP02	Date/Time Period	D8	2	
	DTP03	Date		8	Enter the Date the claim was paid. The Check-Date, Format CCYYMMDD

Appendices:

Appendix 1 – Sample Files

All sample files are created using deidentified data. It is also worth noting that all Sample files provided by EmblemHealth are presented in unwrapped format. In Production the data needs to be wrapped – one long, contiguous, single record.

Sample Inbound 837I-Encounter

```
ISA*00*  *00*  *ZZ*Sender  *ZZ*EMBFACETS  *200211*1038*^*00501*000127083*1*T*:~
GS*HC*Sender*EMBFACETS*20200211*1038*127035*X*005010X223A2~
ST*837*29461500*005010X223A2~
BHT*0019*00*OATI7338*20200207*103729*RP~
NM1*41*2*Sender CARE*****46*Sender~
PER*IC*EDI ADMIN*EM*Sender@CARE.COM~
NM1*40*2*EMBLEM*****46*EMBFACETS~
HL*1**20*1~
PRV*BI*PXC*156FX1800X~
NM1*85*2*Care Of Vision*****XX*1831244953~
N3*2 Broadway~
N4*Passaic*OH*450400101~
REF*EI*987654321~
HL*2*1*22*1~
SBR*S**1014199******CI~
NM1*IL*1*Last-Name*First-Name****MI*K1234567801~
NM1*PR*2*Sender*****PI*55247~
HL*3*2*23*0~
PAT*19~
NM1*QC*1*Last-Name*Dependent~
N3*1 Broadway*Apt 1~
N4*Paterson*NY*100360101~
DMG*D8*20080101*F~
NM1*PR*2*EmblemHealth*****PI*55247~
N3*55 Water Street~
N4*New York*NY*100410014~
CLM*2O21287352A1-1*1316.43***13:A:1**A*Y*Y~
DTP*434*RD8*20200314-20200314~
DTP*50*D8*20200320~
CL1*3*1*01~
CN1*05*63.2**Check#44242008344791~
AMT*F3*0~
REF*D9*200870039400~
REF*EA*12345~
NTE*ADD*20200326!123~
HI*ABK:Z418~
```

```
HI*APR:Z418~
HI*ABF:C9000*ABF:Z01818*ABF:D472*ABF:G629*ABF:G4700*ABF:I10*ABF:K089*ABF:E785~
SBR*P*18*******CI~
CAS*PR*2*267.57~
AMT*D*1048.86~
OI***N***Y~
NM1*IL*1*Unknown*Unknown****MI*999999999~
NM1*PR*2*Emblem*****PI*Emblem~
N3*1400 Front Avenue  Ste 300~
N4*Lutherville*MD*21093~
DTP*573*D8*20200416~
LX*1~
SV2*0341*HC:78452*1316.43*UN*1**0~
DTP*472*D8*20200429~
HCP*02*63.20~
SVD*Emblem*1048.86*HC:78452*0341*1~
CAS*PR*2*267.57*1~
DTP*573*D8*20991231~
SE*53*29461500~
GE*1*127035~
IEA*1*000127083~
```

Sample Inbound 837I-Encounter Adjustment

In this scenario, the claim above is being adjusted a few days later after originally submitted. Please note how CLM05-3 simply changes from 1 (Original) to 7 (Adjustment) and REF*F8 is added to provide the claim # to be Adjusted at EmblemHealth.
Since this is an adjustment, EmblemHealth expects a new claim number was generated by the submitter, so there must be a new Submitter's Claim Number in REF*D9.
CLM01 – the Patient Account # - may remain the same or can change at the discretion of the submitter.
The change/adjustment being made to this claim is the principal diagnosis code. (this is just for illustration purposes. Nevertheless, note that since REF*F8 has been added, the Total Segment Count in SE01 has been adjusted).

```
ISA*00*       *00*       *ZZ*Sender       *ZZ*EMBFACETS    *200211*1038*^*00501*000127083*1*T*:~
GS*HC*Sender*EMBFACETS*20200211*1038*127035*X*005010X223A2~
ST*837*29461500*005010X223A2~
BHT*0019*00*OATI7338*20200207*103729*RP~
NM1*41*2*Sender CARE*****46*Sender~
PER*IC*EDI ADMIN*EM*Sender@CARE.COM~
NM1*40*2*EMBLEM*****46*EMBFACETS~
HL*1**20*1~
PRV*BI*PXC*156FX1800X~
NM1*85*2*Care Of Vision*****XX*1831244953~
N3*2 Broadway~
N4*Passaic*OH*450400101~
REF*EI*987654321~
HL*2*1*22*1~
SBR*S**1014199******CI~
NM1*IL*1*Last-Name*First-Name****MI*K1234567801~
NM1*PR*2*Sender*****PI*55247~
HL*3*2*23*0~
PAT*19~
NM1*QC*1*Last-Name*Dependent~
N3*1 Broadway*Apt 1~
N4*Paterson*NY*100360101~
DMG*D8*20080101*F~
NM1*PR*2*EmblemHealth*****PI*55247~
N3*55 Water Street~
N4*New York*NY*100410014~
CLM*2O21287352A1-1*1316.43***13:A:7**A*Y*Y~
DTP*434*RD8*20200314-20200314~
```

```
DTP*50*D8*20200320~
CL1*3*1*01~
CN1*05*63.2**Check#44242008344791~
AMT*F3*0~
REF*F8*200870039400~
REF*D9*200870039400-1~
REF*EA*12345~
NTE*ADD*20200326!123~
HI*ABK:Z3800~
HI*APR:Z418~
HI*ABF:C9000*ABF:Z01818*ABF:D472*ABF:G629*ABF:G4700*ABF:I10*ABF:K089*ABF:E785~
SBR*P*18******CI~
CAS*PR*2*267.57~
AMT*D*1048.86~
OI***N***Y~
NM1*IL*1*Unknown*Unknown****MI*999999999~
NM1*PR*2*Emblem*****PI*Emblem~
N3*1400 Front Avenue  Ste 300~
N4*Lutherville*MD*21093~
DTP*573*D8*20200416~
LX*1~
SV2*0341*HC:78452*1316.43*UN*1**0~
DTP*472*D8*20200429~
HCP*02*63.20~
SVD*Emblem*1048.86*HC:78452*0341*1~
CAS*PR*2*267.57*1~
DTP*573*D8*20991231~
SE*54*29461500~
GE*1*127035~
IEA*1*000127083~
```

Sample Inbound 837I-Encounter - Void

In this scenario, the claim above, which was previously adjusted is being voided a few days later. Please note how CLM05-3 simply changes to 8 (Void). REF*F8 points to the claim # to be voided at EmblemHealth.
REF*D9 now has the latest claim # in the submitter's Practice Management System. EmblemHealth requires this to be a new Claim #, which will be recorded at EmblemHealth's for audit purposes.
The rest of the data can stay the same.
NOTE: Once a claim has been voided, no further action can be taken on that claim. This means no transactions can be sent referring to the claim # referred in the REF segments in this void (REF*D9 nor REF*F8). Only a new/original claim can be sent, with a new claim# in REF*D9.

PLEASE NOTE: Very important to understand that this is a separate and unrelated example from the Adjustment above. In other words, it is NOT necessary to first send an Adjustment to send a Void.

```
ISA*00*       *00*       *ZZ*Sender       *ZZ*EMBFACETS    *200211*1038*^*00501*000127083*1*T*:~
GS*HC*Sender*EMBFACETS*20200211*1038*127035*X*005010X223A2~
ST*837*29461500*005010X223A2~
BHT*0019*00*OATI7338*20200207*103729*RP~
NM1*41*2*Sender CARE*****46*Sender~
PER*IC*EDI ADMIN*EM*Sender@CARE.COM~
NM1*40*2*EMBLEM*****46*EMBFACETS~
HL*1**20*1~
PRV*BI*PXC*156FX1800X~
NM1*85*2*Care Of Vision*****XX*1831244953~
N3*2 Broadway~
N4*Passaic*OH*450400101~
REF*EI*987654321~
HL*2*1*22*1~
SBR*S**1014199******CI~
NM1*IL*1*Last-Name*First-Name****MI*K1234567801~
```

```
NM1*PR*2*Sender*****PI*55247~
HL*3*2*23*0~
PAT*19~
NM1*QC*1*Last-Name*Dependent~
N3*1 Broadway*Apt 1~
N4*Paterson*NY*100360101~
DMG*D8*20080101*F~
NM1*PR*2*EmblemHealth*****PI*55247~
N3*55 Water Street~
N4*New York*NY*100410014~
CLM*2O21287352A1-1*1316.43***13:A:8**A*Y*Y~
DTP*434*RD8*20200314-20200314~
DTP*50*D8*20200320~
CL1*3*1*01~
CN1*05*63.2**Check#44242008344791~
AMT*F3*0~
REF*F8*200870039400-1~
REF*D9*200870039400-2~
REF*EA*12345~
NTE*ADD*20200326!123~
HI*ABK:Z3800~
HI*APR:Z418~
HI*ABF:C9000*ABF:Z01818*ABF:D472*ABF:G629*ABF:G4700*ABF:I10*ABF:K089*ABF:E785~
SBR*P*18*******CI~
CAS*PR*2*267.57~
AMT*D*1048.86~
OI***N***Y~
NM1*IL*1*Unknown*Unknown****MI*999999999~
NM1*PR*2*Emblem*****PI*Emblem~
N3*1400 Front Avenue  Ste 300~
N4*Lutherville*MD*21093~
DTP*573*D8*20200416~
LX*1~
SV2*0341*HC:78452*1316.43*UN*1**0~
DTP*472*D8*20200429~
HCP*02*63.20~
SVD*Emblem*1048.86*HC:78452*0341*1~
CAS*PR*2*267.57*1~
DTP*573*D8*20991231~
SE*54*29461500~
GE*1*127035~
IEA*1*000127083~
```

Sample TA1, in Response to Inbound 837

The TA1 will let the submitter know whether the X12 Interchange that was received by EmblemHealth was Accepted or Rejected. The Interchange Acknowledgment Code (TA104) provides the status, and TA105 provides the status or error code.

```
ISA*00* *00* *ZZ*EMBFACETS *ZZ* VendorRECVer-ID*180418*0604*^*00501*000000591*0*T*:~
TA1*000000017*180417*1150*A*000~
IEA*0*000000591~
```

Sample 999, in Response to Inbound 837

The 999 will report the status of each transaction that passes TA1 validation.
The example below shows the response to a Functional Group (GS-GE) that had 1,418 individual transactions (ST-SEs) within an Interchange (ISA-IEA).
Segment IK5 will indicate whether the transaction was Accepted/Rejected on Element IK501.
Segment AK9 provides a summary of the Group results and shows how many transactions were received and how many were accepted.

```
ISA*00*       *00*       *ZZ*EMBFACETS    *ZZ*Receiver-H    *200117*1807*^*00501*000003316*0*T*:~
GS*FA*EMBFACETS*Receiver-H*20200117*1807*2199*X*005010X231A1~
ST*999*906543*005010X231A1~
AK1*HC*1*005010X222A1~
AK2*837*000000001*005010X222A1~
IK5*A~
...
AK2*837*000000036*005010X222A1~
IK5*A~
AK2*837*000000037*005010X222A1~
IK3*HI*26**8~
IK4*12**3~
IK5*R*5~
AK2*837*000000038*005010X222A1~
IK5*A~
...
AK2*837*000001418*005010X222A1~
IK5*A~
AK9*E*1418*1418*1417~
SE*2842*906543~
GE*1*2199~
IEA*1*000003316~
```

Sample 277CA, in Response to Inbound 837

Transactions that are accepted pass the 999-Level will reach the 277CA-Level.
The example below is an excerpt from an 837I file that was received containing 3,422 individual claims, each in its own transaction (ST-SE). One of those transactions was rejected at the 999-Level due to an invalid segment. The remaining 3,421 transactions/claims are reported in this 277CA-response.
Below, the QTY*90 Segment indicates that 3,418 claims were Accepted and passed 277CA editing, while the QTY*AA Segment conveys that three (3) of the 3,421 claims received at the 277CA-Level had some issues.

Claims that pass the 277CA-Level are reported with either “STC*A0:16:QD” or STC*A2:20.

On the other hand, claims that fail 277CA editing will be reported with STC*A3: or STC*A7:

```
ISA*00*       *00*       *ZZ*EMBFACETS    *ZZ*Receiver-H    *190620*0828*^*00501*000002376*0*P*:~
GS*HN*EMBFACETS*Receiver-H*20190620*0828*1565*X*005010X214~
ST*277*1603*005010X214~
...
QTY*90*3418~
QTY*AA*3~
...
HL*3*2*19*1~
NM1*85*2*Provider#1*****XX*1234567890~
HL*4*3*PT~
NM1*QC*1*Last-Name*First-Name*X***MI*K1234567801~
TRN*2*PA#60876700005~
STC*A0:16:QD*20190202*WQ*91.85~
DTP*472*RD8*20190202-20190202~
...
HL*5185*2*19*1~
NM1*85*2*Provider#2*****XX*0101010202~
HL*5186*5185*PT~
NM1*QC*1*Last-Name2*First-Name*R***MI*AD123456701~
TRN*2*PA#100600014~
STC*A3:54*20190404*U*125~
```

```
DTP*472*RD8*20160404-20160404~
...
SE*23981*1603~
GE*1*1565~
IEA*1*000002376~
```

Appendix 2 – Balancing Example

Balancing must be maintained at the Line and Claim Levels. First, the Charge Amounts must be in balance. This is accomplished by adding all the Line Charge Amounts reported in SV203 of Loop 2400 and comparing the sum to the Total Claim Charge Amount reported in CLM02 of Loop 2300. Refer to the data in red below.
Second, the Claim Payment Amounts must be balanced reported in SVD02 of Loop 2430 and comparing the sum to the Total Paid Amount in AMT02 of Loop 2320 where AMT01 = D. Refer to the data in green below.

Note: this transaction balancing example is based on an 837 Institutional Claim.

CLM*2O21287352A1-1***1316.43*****13:A:1**A*Y*Y~
DTP*434*RD8*20200314-20200314~
DTP*50*D8*20200320~
CL1*3*1*01~
CN1*05*63.2**Check#44242008344791~
AMT*F3*0~
REF*D9*200870039400~
REF*EA*12345~
NTE*ADD*20200326!123~
HI*ABK:Z418~
HI*APR:Z418~
HI*ABF:C9000*ABF:Z01818*ABF:D472*ABF:G629*ABF:G4700*ABF:I10*ABF:K089*ABF:E785~
SBR*P*18*******CI~
CAS*PR*2*267.57~
AMT*D***1048.86**~
OI***N***Y~
NM1*IL*1*Unknown*Unknown****MI*999999999~
NM1*PR*2*Emblem*****PI*Emblem~
N3*1400 Front Avenue Ste 300~
N4*Lutherville*MD*21093~
DTP*573*D8*20200416~
LX*1~
SV2*0341*HC:78452***1316.43***UN*1**0~
DTP*472*D8*20200429~

HCP*2*63.20~
SVD*Emblem***1048.86***HC:78452*0341*1~
CAS*PR*2*267.57*1~
DTP*573*D8*20991231~
SE*53*29461500~
IEA*1*000127083~

For a claim to balance, all individual lines must also balance. Claims adjudicated by previous payer(s) may contain payments, adjustments or both. Each prior payer's adjudication information is identified by the Payer-ID in SVD01 of Loop 2430, as balancing of payment is done payer by payer.
Each payer's Paid Amount is reported in AMT*D of Loop 2320, and the Payer-ID is defined in NM109 of Loop 2330B. SVD01 of Loop 2430 and NM109 of Loop 2330B are used to associate line adjudication information by payer at the claim level.
Adjustments are reported in the CAS Segment (Loop 2320/Loop 2430). Negative adjustment amounts increase the payment, while positive amounts decrease it.

Appendix 3 – Front-End Editing

Duplicate Claim Checking (Encounter)

These are the fields used by EmblemHealth's front-end editor for 837-Institutional encounters. The front-end editor will check the database for the following combination of fields:

Loop	Segment	Element
2010AA	REF_BillingProviderTaxIdentification	REF01_ReferenceIdentificationQualifier='EI' or 'SY' or TJ
		REF02_BillingProviderTaxIdentificationNumber
2010BA & 2010CA	NM1_SubscriberName	NM103_SubscriberLastName
	NM1_PatientName	NM103_PatientLastName
	NM1_SubscriberName	NM104_SubscriberFirstName
	NM1_PatientName	NM104_PatientFirstName
	DMG_SubscriberDemographicInformation	DMG02_SubscriberBirthDate
	DMG_PatientDemographicInformation	DMG02_PatientBirthDate
	DMG_SubscriberDemographicInformation	DMG03_SubscriberGenderCode
	DMG_PatientDemographicInformation	DMG03_PatientGenderCode
2300	CLM_ClaimInformation	CLM01_PatientControlNumber
		CLM02_TotalClaimChargeAmount
		C02303_ClaimFrequencyCode
		C02301_PlaceofServiceCode
	K3_FileInformation	K301_FixedFormatInformation
	REF_SubLoop_4	REF_PayerClaimControlNumber
	REF_SubLoop_4	REF02_ValueAddedNetworkTraceNumber
	DTP_STATEMENT DATES	DTP03_StatementFromorToDate
	HI_SubLoop **Sub node:**	C02202_DiagnosisCode
		C02202_DiagnosisCode

	HI_HealthCareDiagnosisCode	C02202_DiagnosisCode
		C02202_DiagnosisCode
		C02202_DiagnosisCode
		C02202_DiagnosisCode
		C02202_DiagnosisCode
		C02202_DiagnosisCode
		C02202_DiagnosisCode
		C02202_DiagnosisCode
		C02202_DiagnosisCode
		C02202_DiagnosisCode
2300	HI_OtherDiagnosisInformation_Loop **Sub node:** HI_OtherDiagnosisInformation	C02202_OtherDiagnosis
		C02202_OtherDiagnosis
		C02202_OtherDiagnosis
		C02202_OtherDiagnosis
		C02202_OtherDiagnosis
		C02202_OtherDiagnosis
		C02202_OtherDiagnosis
		C02202_OtherDiagnosis
		C02202_OtherDiagnosis
		C02202_OtherDiagnosis
		C02202_OtherDiagnosis
		C02202_OtherDiagnosis
2300	CLM_ClaimInformation_2	CLM01_PatientControlNumber
		CLM02_TotalClaimChargeAmount
		C02303_ClaimFrequencyCode
		C02301_PlaceofServiceCode
	K3_FileInformation_2	K301_FixedFormatInformation
	DTP_STATEMENT DATES_2	DTP03_StatementFromorToDate
	REF_PayerClaimControlNumber_2	REF02_PayerClaimControlNumber
	REF_ClaimIdentifierForTransmissionIntermediaries_2	REF02_ValueAddedNetworkTraceNumber
	HI_SubLoop_2 Sub node: HI_HealthCareDiagnosisCode_2	C02202_DiagnosisCode
		C02202_DiagnosisCode
		C02202_DiagnosisCode
		C02202_DiagnosisCode
		C02202_DiagnosisCode
		C02202_DiagnosisCode
		C02202_DiagnosisCode
		C02202_DiagnosisCode
		C02202_DiagnosisCode
		C02202_DiagnosisCode

		C02202_DiagnosisCode
		C02202_DiagnosisCode
	HI_OtherDiagnosisInformation_2_Loop **Sub node:** HI_OtherDiagnosisInformation_2	C02202_OtherDiagnosis
		C02202_OtherDiagnosis
		C02202_OtherDiagnosis
		C02202_OtherDiagnosis
		C02202_OtherDiagnosis
		C02202_OtherDiagnosis
		C02202_OtherDiagnosis
		C02202_OtherDiagnosis
		C02202_OtherDiagnosis
		C02202_OtherDiagnosis
		C02202_OtherDiagnosis
		C02202_OtherDiagnosis
2400	SV2_ INSTITUTIONAL SERVICE LINE **Sub node:** C003_CompositeMedicalProcedureIdentifier	C00302_ProcedureCode
		C00303_ProcedureModifier
		C00304_ProcedureModifier
		C00305_ProcedureModifier
		C00306_ProcedureModifier
	SV2_ INSTITUTIONAL SERVICE LINE	SV203_LineItemChargeAmount
	DTP_Date_ServiceDate	DTP03_ServiceDate
2400	SV2_ INSTITUTIONAL SERVICE LINE_2 **Sub node:** C003_CompositeMedicalProcedureIdentifier	C00302_ProcedureCode
		C00303_ProcedureModifier
		C00304_ProcedureModifier
		C00305_ProcedureModifier
		C00306_ProcedureModifier
	SV2_ INSTITUTIONAL SERVICE LINE_2	SV203_LineItemChargeAmount
	DTP_Date_ServiceDate_2	DTP03_ServiceDate