ASC X12
837 – Health Care Claim
Specification

Interim Version 1.4

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About this Document

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This*X12 837 Interim Specification* document explains the functional specifications for a connection between Healthix and a participating organization for the purpose of receiving from claims (837) data.

Important notes:

- This document maps to the HIPAA_5010:837apP standards
- The Healthix technical platform is being upgraded to InterSystems HealthShare version 2015.1

Interim note: *Healthix is currently building a new platform, whose development and testing may result in updates to this specification through mid-2015. Interim notes throughout this document highlight areas in which the specification is likely to change.*

Revision History

Version	Date	Author	Description
0.1	March 31, 2015	Nathan Hardesty-Dyck	Draft for technical review Source documents: • InterSystems Preliminary X12 834 Member Enrollment Documentation (Rev 2.0) • InterSystems Preliminary X12 837 Member Enrollment Documentation
0.2	April 3, 2015	Nathan Hardesty-Dyck	Minor updates
0.3	April 10, 2015	Nathan Hardesty-Dyck	Incorporate expert feedback
0.4	April 28, 2015	Nathan Hardesty-Dyck	Remove 834 into separate document. Now focus only on 837.
0.5	May 01, 2015	Naitik Patel	Added Changes • Business Process • Updated hierarchical looping structure • Created segment column in data mapping table. • Added Required or Situational column in data mapping table • Added more Segments in data mapping table • Added Examples of 837 file format
1.0	May 7, 2015	Naitik Patel	Updated with outstanding comments from Mike and Nathan Published Interim version V1.0
1.1	May 12, 2015	Naitik Patel	Removed all data elements pertaining to Monetary value
1.2	May 14, 2015	Naitik Patel	Added changes
1.3	May 19, 2015	Naitik Patel	Added Business scenarios for Subscriber's demographic information
1.4	Sept. 22, 2016	Naitik Patel	Added changes

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1 Introduction

X12 is a standard for electronic data interchange developed by the Accredited Standards Committee (ASC) of the American National Standards Institute (ANSI). The X12 standard contains hundreds of document types, a subset of which support the Health Insurance Portability and Accountability Act (HIPAA) requirement of widespread use of electronic data interchange in the United States.

HIPAA schemas (e.g. HIPAA_5010) further define the structure and characteristics of particular X12 document types.

Healthix consolidates patient data in various formats and from many data sources. X12 documents provide important healthcare coverage and clinical data that Healthix adds to the unified patient record.

This specification details the process of transmitting X12 documents to Healthix and the capability of Healthix to digest the documents' data. The Healthix software platform is InterSystems HealthShare 2015.1.

Healthix supports the import of the following document types:

- Health Care Claim: HIPAA_5010:**837**apP

Note that Healthix stores but does not display or use any financial information included in the adjudicated claims data it receives.

2 Transactions

2.1 Sending Data to Healthix: Process Summary

During implementation, Healthix provides credentials to the participant to enable the participant to access Healthix's Secure File Transfer Protocol (SFTP) directory, used to submit X12 documents. Healthix processes new X12 documents on a constant basis.

Healthix processes each incoming X12 document, extracting data according to the details provided later in this specification. After processing, the static X12 document itself may be archived or discarded. In either case, the Healthix system does not reference the static X12 document for the use or display of data.

X12 document upload process:

1. Using an FTP client (e.g. WinSCP), establish a connection to the Healthix FTP siteusing the SFTP protocol (`sftp:\\`)
    a. The Healthix SFTP host name is `sftp.healthix.org`(Port 22)
    b. Healthix provides each participant with a SFTP account and directory during project implementation
2. When prompted, authenticate using the credentials Healthix assigns during implementation
3. Transfer the X12 document(s) to the SFTP site
4. Healthix processes the X12 documents as they arrive at the SFTP site

2.2Business process

Healthix will work with existing and prospective participants by taking their existing 837 and designing a new interface if necessary for each distinct formats. This is with the assumption that all participants have established claims business process on their end and are actively working with payers for the claims processes with their existing 837 format. Healthix will accommodate changes and mapping on its side to make sure that all the data segments that are coming across in 837 from different participant are sourced correctly into its database.

Although Healthix's system HealthShare can store monetary segments that come across 837, due to data sensitivity, these segments has been removed from this specification document.

Some Participants will not send subscriber's demographic information in 837 file. For these participants, Healthix will use MRN to match the subscriber data and add claim record. If the MRN doesn't exist in Healthix database for particular subscriber, the subscriber claim record will be rejected and will be sent back to participant on the error report.

For Participants sending subscriber's demographic information on 837 file. If a subscriber comes across in 837 file without matching MRN, Healthix will create a new record for such subscriber and record all the information provided in 837 file.

3 X12 Document Structure and Healthix Processing

3.1 Health Care Claim (837)

Healthix supports the import of the Health Care Claims document HIPAA_5010:837apP (referred to as "837" in this specification). The 837 follows a hierarchical looping structure, with each loop indicated by an identifier (e.g. "2000A"):

1000A – Submitter
1000B – Receiver
2000A – Billing Provider
    2010AA Billing Provider Name
    2010AB Pay to the Address
2000B – Subscriber
    2010BA Subscriber Secondary Identification
    2010BB Payer Name
2300 – Claim
2400 – Claim Line
    2100C- Provider
    2100D-Patient
    2200D-Claim

The following table outlines the data that Healthix consumes from the 837. Any data elements not listed in this table are not currently stored within Healthix.

Required	ELEMENT	ELEMENT DESCRIPTION	Value	DESCRIPTION
Loop 1000A				
R	**NM1**	**SUBMITTER NAME-1000A**		
R	0	ENTITY IDENTIFIER CODE	41	Submitter
R	0	ENTITY TYPE QUALIFIER	1, 2	1-Person, 2-Non-person entity
R	0	ORGANIZATION NAME/LAST NAME		Submitter Name
S	0	FIRST NAME		Subscriber First Name
S	0	MIDDLE NAME		Subscriber Middle Name
NOT USED	0	NAME PREFIX		NOT USED
NOT USED	0	NAME SUFFIX		NOT USED
R	0	IDENTIFICATION CODE QUALIFIER	46	Electronic Transmitter ID number
R	0	IDENTIFICATION CODE		Submitter tax ID
Loop 1000B				
R	**NM1**	**RECEIVER NAME-1000B**		
R	0	ENTITY IDENTIFIER CODE	40	Receiver
R	0	ENTITY TYPE QUALIFIER	2	2-Non-person Entity
R	0	ORGANIZATION NAME	Payer Name	Receiver name
S	0	NAME FIRST		
S	0	NAME MIDDLE		
S	0	NAME PREFIX		

NOT USED	0	NAME SUFFIX		NOT USED
R	0	IDENTIFICATION CODE QUALIFIER		Electronic Transmitter ID number
R	0	IDENTIFICATION CODE	141650868	Receiver Identifier
Loop 2000B				
R	**SBR**	**SUBSCRIBER INFORMATION 2000B**		
				Primary Payer, Secondary Payer If claim is for primary payer then “P” else if claim is
S	0	INDIVIDUAL RELATIONSHIP CODE	18	18-Self (required when subscriber is
S	0	REFERENCE IDENTIFICATION		Group number
S	0	NAME		Group name
S	0	INSURANCE TYPE CODE		Type of policy
S	**PAT**	**PATIENT INFORMATION 2000B**		
S	0	DATE QUALIFIER	D8	CCYYMMDD
S	0	DATE TIME PERIOD		Date of death
S	07	UNIT CODE	01	Actual pounds
S	0	PATIENT WEIGHT		Patient weight
S	0	YES/NO CONDITION OR RESPONSE	Y	Pregnancy indicator
Loop 2010BA				
R	**NM1**	**SUBSCRIBER SECONDARY**		
R	0	ENTITY IDENTIFIER CODE	IL	Insured or subscriber
R	0	ENTITY TYPE QUALIFIER	1	Person
R	0	NAME LAST		Subscriber last name
S	0	NAME FIRST		Subscriber first name
S	0	NAME MIDDLE		Subscriber middle name
NOT USED	0	NAME PREFIX		NOT USED
S	0	NAME SUFFIX		Subscriber suffix
R	0	IDENTIFICATION CODE QUALIFIER	II, MI	Member Identification number
R	0	IDENTIFICATION CODE		MVP subscriber member number
S	**N**	**SUBSCRIBER ADDRESS 2010BA**		
R	0	ADDRESS INFORMATION		Subscriber address
S	0	ADDRESS INFORMATION		Subscriber address 2
S	**N**	**SUBSCRIBER ADDRESS 2010BA**		
R	0	CITY NAME		Subscriber City
R	0	STATE		Subscriber State
R	0	POSTAL CODE		Subscriber Zip code
S	**DMG**	**SUBSCRIBER DEMOGRAPHIC**		
R	0	DATE FORMAT QUALIFIER	D8	CCYYMMDD
R	0	DATE TIME PERIOD		Subscriber date of birth
R	0	GENDER CODE	F, M, U	Female, male, unknown
Loop 2010BB				
R	**NM1**	**PAYER NAME**		
R	0	ENTITY IDENTIFIER CODE	PR	Payer

R	0	ENTITY TYPE DESCRIPTION	2	Non-Person Entity
R	0	NAME LAST OR ORGANIZATION	Payer Org. Name	Payer Name
R	0	NAME FIRST		
S	0	NAME MIDDLE		
S	0	NAME PREFIX		
S	0	NAME SUFFIX		
R	0	IDENTIFICATION CODE QUALIFER	XV, PI	Payer Identification PI Prior to mandated
R	0	IDENTIFICATION CODE NUMBER	141650868	MVP Health Care's Tax Identification
S	**N**	**PAYER ADDRESS 2010BB**		
R	0	ADDRESS INFORMATION		PAYER ADDRESS LINE
S	0	ADDRESS INFORMATION		PAYER ADDRESS LINE
R	**N**	**PAYER CITY, STATE, ZIP CODE**		
R	0	CITY NAME	FREEFORM	PAYER CITY NAME
S	0	STATE OR PROVINCE CODE		PAYER STATE OR PROVINCE CODE
S	0	POSTAL CODE		PAYER POSTAL ZONE OR ZIP CODE
S	0	COUNTRY CODE		
LOOP 2300				
R	**CLM**	**CLAIM INFORMATION 2300**		
R	0	CLAIM SUBMITTER'S IDENTIFIER		Patient account number
R	0	HEALTH CARE SERVICE LOCATION		Place of service
R	05-1	FACILITY CODE VALUE		Facility code
R	05-2	FACILITY CODE QUALIFIER	B	Place of service Codes for Professional or
S	05-3	CLAIM FREQUENCY TYPE	1-5-7-8	Original-claim frequency
S	0	RESPONSE CODE	Y or N	Provider signature on file
S	0	PROVIDER ACCEPT ASSIGN	A, B, C	Provider accept Medicare assignment code
S	11 - 1	RELATED CAUSES CODE	AA, EM, OA	Auto Accident, Employment, Other
S	11 - 2	RELATED CAUSES CODE	AA, EM, OA	Used if more than 1 applies
S	11 - 4	STATE		State where accident occurred
S	11 - 5	COUNTRY		Country where accident occurred
S	1	SPECIAL PROGRAM CODE		Special circumstances
S	2	DELAY REASON CODE		Delay reason code
R	**DTP**	**DATE - LAST SEEN DATE 2300**		
R	01	DATE/TIME QUALIFIER	304	Last Visit or Consultation
R	02	DATE TIME PERIOD FORMAT	D8	Date format: CCYYMMCC
S	03	DATE TIME PERIOD		Last Visit or Consultation
S	**DTP**	**DATE OF ADMISSION 2300**		
R	0	DATE QUALIFIER	435	Admission date
R	0	DATE FORMAT	D8	Date format: CCYYMMDD
R	0	DATE ADMISSION		Date of Admission
S	**DTP**	**DATE OF DISCHARGE 2300**		

R	0	DATE QUALIFIER	096	Discharge date
R	0	DATE FORMAT	D8	Date format: CCYYMMDD
R	0	DATE DISCHARGE		Date of Discharge
2300				
R	**H**	**HEALTH CARE DIAGNOSIS CODE**		
R	HI01	HEALTH CARE CODE INFORMATION		
R	HI01-1	CODE LIST QUALIFIER	ABK, BK	Principal diagnosis ICD-9 codes
R	HI01-2	DIAGNOSIS CODE		Diagnosis code
R	HI01-3	DATE, TIME PERIOD FORMAT		
R	HI01-4	DATE TIME PERIOD		
R	HI01-6	QUANITY		
R	HI02-1	DIAGNOSIS TYPE CODE		
R	HI02-2	DIAGNOSIS CODE		DIAGNOSIS CODE
R	HI02-3	DATE, TIME PERIOD FORMAT		
R	HI02-4	DATE TIME PERIOD		
S	HI03	HEALTH CARE CODE INFORMATION		DIAGNOSIS CODE
R	HI03-1	DIAGNOSIS TYPE CODE	ABF, BF	
R	HI03-2	DIAGNOSIS CODE		
				DIAGNOSIS CODE
S	HI03	HEALTH CARE CODE INFORMATION		
R	HI03-1	DIAGNOSIS TYPE CODE	ABF, BF	
R	HI03-2	DIAGNOSIS CODE		DIAGNOSIS CODE
S	HI03-3	DATE TIME PERIOD FORMAT		
S	HI04	HEALTH CARE CODE INFORMATION		DIAGNOSIS ICD-9 CODES
R	HI04-1	DIAGNOSIS TYPE CODE	ABF, BF	DIAGNOSIS CODE
R	HI04-2	DIAGNOSIS CODE		
S	HI05	HEALTH CARE CODE INFORMATION		
R	HI05-1	DIAGNOSIS TYPE CODE	ABF, BF	
R	HI05-2	DIAGNOSIS CODE		
S	HI06	HEALTH CARE CODE INFORMATION		
S	HI06-1	DIAGNOSIS TYPE CODE		DIAGNOSIS CODE
S	HI06-2	DIAGNOSIS CODE		
S	HI07	HEALTH CARE CODE INFORMATION		
S	HI07-1	DIAGNOSIS TYPE CODE		DIAGNOSIS CODE
S	HI07-2	DIAGNOSIS CODE		
S	HI08	HEALTH CARE CODE INFORMATION		
S	HI08-1	DIAGNOSIS TYPE CODE		DIAGNOSIS CODE
S	HI08-2	DIAGNOSIS CODE		
Loop 2310A				
S	**NM1**	**REFERRING PROVIDER NAME 2310A**		
S	0	ENTITY IDENTIFIER CODE	DN	Referring provider
S	0	ENTITY TYPE	1	MUST BE A PERSON
R	0	LAST NAME		Referring physician last name

S	0	FIRST NAME		Referring physician first name
S	0	NAME MIDDLE		Referring physician middle initial
S	0	NAME SUFFIX		Referring physician suffix
S	0	IDENTIFICATION CODE QUALIFIER	XX	National Provider ID
S	0	IDENTIFICATION CODE		NPI Number
Loop 2310B				
S	**NM1**	**RENDERING PROVIDER NAME**		
R	0	ENTITY IDENTIFIER CODE	82	Rendering provider
R	0	ENTITY TYPE QUALIFIER	1	Person
R	0	NAME LAST OR ORGANIZATION		Rendering provider last name
S	0	NAME FIRST		Rendering provider first name
S	0	NAME MIDDLE		Rendering provider middle initial
S	0	NAME SUFFIX		Rendering provider suffix
R	0	IDENTIFICATION CODE QUALIFIER	XX	National Provider ID
R	0	IDENTIFICATION CODE		NPI Number
2310C				
R	**NM1**	**SERVICE FACILITY LOCATION 2310C**		
R	0	ENTITY IDENTIFIER CODE	77	77-Service location
R	0	ENTITY TYPE QUALIFIER	2	Non-person entity
R	0	NAME LAST OR ORGANIZATION		Laboratory/facility name
S	0	NAME FIRST		
S	0	NAME MIDDLE		
S	0	NAME PREFIX		
S	0	NAME SUFFIX		
S	0	IDENTIFICATION CODE QUALIFIER	XX	National Provider ID
S	0	IDENTIFICATION CODE		NPI Number
R	**SV**	**PROFESSIONAL SERVICE 2400**		
R	01-1	COMPOSITE MEDICAL PROCEDURE	ER, HC, IV, WK	HC-HCPCS codes,
R	01-2	PRODUCT/SERVICE ID		Procedure Code
S	01-3	PROCEDURE MODIFIER		Procedure Modifier 1
S	01-4	PROCEDURE MODIFIER		Procedure Modifier 2
S	01-5	PROCEDURE MODIFIER		Procedure Modifier 3
S	01-6	PROCEDURE MODIFIER		Procedure Modifier 4
S	01-7	DESCRIPTION	FREEFORM	DEFINITIVE DESCRIPTION OF
S	01-08	PRODUCT/ SERVICE ID		Line item charge amount
R	SV103	MINUTES (ANESTHESIA)	MJ	MINUTES - Effective 7/1/2010
R	SV104	QUANTITY		MINUTES
S	0	FACILITY CODE VALUE		Place of service
S	0	SERVICE TYPE CODE		
R	0	DIAGNOSIS CODE POINTER		
R	07-1	DIAGNOSIS CODE POINTER		Diagnosis Code Pointer
S	07-2	DIAGNOSIS CODE POINTER		Diagnosis Code Pointer
S	07-3	DIAGNOSIS CODE POINTER		Diagnosis Code Pointer
S	07-4	DIAGNOSIS CODE POINTER		Diagnosis Code Pointer
S	0	YES/NO INDICATOR	Y	Emergency indicator

R	DTP	DATE- SERVICE DATE		
R	0	DATE/TIME QUALIFIER	472	SERVICE DATE QUALIFIER
R	0	DATE/TIME FORMAT	D8, RD8	Date Time Period Format Qualifier
R	0	DATE/TIME PERIOD	CCYYMMDD-	SERVICE DATE

3.2 Example837

Description	Default Delimiter
Data element separator	* Asterisk
Sub-element separator	: Colon
Repetition separator	^ Carrot
Segment Terminator	~ Tilde

ISA*00* *00* *ZZ*010101010 *33*7306849549*110406*0857*^*00501*000000312*1*P*:~
GS*HC*010101010*7306849549*20110406*0857*312*X*005010X222A1~
ST*837*0001*005010X222A1~
BHT*0019*00*1*20110406*085755*CH~
NM1*41*2*LINE MEDICAL ASSOCIATES*****46*010101010~
PER*IC*KEVIN*TE*4124541000~
NM1*40*2*UPMC*****46*7306849549~
HL*1**20*1~
PRV*BI*ZZ*208000000X~
NM1*85*1*LINE*WILLIAM*J***XX*01010101~
N3*123 PEPPER ST~
N4*PITTSBURGH*PA*15123~
REF*EI*260110222~
PER*IC* KEVIN*TE*4124541000~
HL*2*1*22*0~
SBR*P*18**BEST UPMC FOR YOU*****CI~
NM1*IL*1*KENT*CLARK*S***MI*00000000101~
N3*123 FAKE STREET~
N4*PITTSBURGH*PA*15123~
DMG*D8*20060503*M~
NM1*PR*2*UPMC HEALTH PLAN*****PI*7306849549~
N3*1 CHATHAM CENTER 112 WASHINGTON*PO BOX 2995~
N4*PITTSBURGH*PA*15230~
CLM*2152414902600312*47.28***11::1*Y*A*Y*Y*B~
DTP*304*D8*20110405~
DTP*431*D8*20110405~ REF*D9*21524 149026~
HI*BK:V053*BF:V068*BF:V0382~
NM1*77*2*DOCTORS OFFICE*****XX*010101010~
N3*123 PEPPER ST~
N4*PITTSBURGH*PA*15123~
LX*1~
SV1*HC:90744*15.76*UN*1*11**1~
DTP*472*D8*20110405~
LIN**N4*00006498100~
LX*2~
SV1*HC:90698*15.76*UN*1*11**2~

DTP*472*D8*20110405~
LIN**N4*49281051005~
LX*3~
SV1*HC:90670*15.76*UN*1*11**3~
DTP*472*D8*20110405~
SE*41*0001~
GE*1*312~
IEA*1*000000312~