

**HM Benefits Administrators
HIPAA EDI Reference Guide**

INSTITUTIONAL CLAIM (837I)

VERSION 1.1



Table of Contents

1.0 INSTITUTIONAL CLAIM (837I)	3
1.1 GENERAL INFORMATION AND GUIDELINES FOR SUBMITTING AN 837I.....	4
1.2 DATA THAT IS NOT USED.....	4
1.3 DATA DETAILS FOR 837I.....	5
<i>GS Functional Group Header</i>	6
<i>NM1 Submitter Name</i>	6
<i>NM1 Submitter Name</i>	6
<i>PRV Provider Specialty Information</i>	7
<i>NM1 Billing Provider Name</i>	7
<i>NM1 Payer Name</i>	7

1.0 Institutional Claim (837I)

The 837 I transaction is utilized for institutional claims and encounters. The national transaction set implementation guide and Addenda dated 10/2002 named in the HIPAA Administrative Simplification Electronic Transaction rule is the primary source for definitions, data usage, and requirements. This companion document contains clarifications and payer-specific requirements related to data usage and content when submitting an 837I to HM Benefits Administrators, hereafter known as “The Organization” based on the national 837I implementation guide.

The Organization accepts electronic claims for payment. The payer is identified by the EIN in the 2010BC destination payer loop of this transaction. At this time, the payer must also be identified in the GS03 element of the GS Functional Group Header due to internal routing requirements. The EIN must also be used for the interchange receiver (ISA08) in the ISA Interchange Control Header, and the transaction receiver (NM109) in the 1000B Receiver Name loop of the transaction.

The health care payer and corresponding codes represented in Sections 8.1 and 8.2 of this guide are:

- HM Benefits Administrators - 25-1128451

1.1 General Information and Guidelines for Submitting an 837I

The 997 (functional acknowledgement) will be based on levels 1-4. Codes that are not HIPAA compliant will be denied.

1.2 Data that is Not Used

While the claim information listed below can be (and in some instances must be) contained in a standard claim transaction, the Organization's processing does not currently use the following information:

1. 2000A: *Foreign Currency Information (CUR)*
2. 2010AA: *Billing Provider Secondary Identification (REF), Credit/Debit Card Billing Information (REF).*
3. 2010AB: *Pay To Provider Information Loop.*
4. 2000B: *Patient Information (PAT).*
5. 2010BA: *Subscriber Secondary Identification Number (REF).* This segment can be submitted, but the Organization will not use in processing.
6. 2010BA: *Property and Casualty Number (REF).*
7. 2010BB: *Credit/Debit Card Account Holder Name Loop.*
8. 2010BC: *Payer Address (N3), Payer City/State/Zip Code (N4), Payer Secondary Identification (REF).*
9. 2010BD: *Responsible Party Name.* The Organization **will only use information submitted on appropriate legal documentation and maintained on internal file.**
10. 2000C: *Patient Information.* The Organization will not use the patient relationship to determine the patient, will use relationship on file.
11. 2010CA: *Patient Address (N3), Patient/City/State/Zip Code (N4), Patient Secondary Identification (REF), Property and Casualty Claim Number (REF).* The Organization will use patient address information on file.
12. 2300: *Claim Supplemental Information (PWK), Contract Information (CN1), Payer Estimated Amount Due (AMT), Patient Estimated Amount Due (AMT), Credit/Debit Card Maximum Amount (AMT), Adjusted Repriced Claim Number (REF), Repriced Claim Number (REF), Claim Identification Number for Clearinghouses and Other Transmission Intermediaries (REF), Original Reference Number (ICN/DCN), Investigational Device Exemption Number (REF), Service Authorization Exception Code (REF), Peer Review Organization*

- (PRO) Approval Number (REF), Prior Authorization or Referral Number (REF), Medical Record Number (REF), Demonstration Project Identifier (REF), File Information (K3), Home Health Care Information (CR6), Home Health Functional Limitations (CRC), Home Health Activities Permitted (CRC), Home Health Mental Status (CRC), Diagnosis Related Group (DRG) Information (HI), Treatment Code Information (HI).*
13. 2305: *Home Health Care Plan Information Loop.*
 14. 2310A: *Attending Physician Secondary Identification (REF).*
 15. 2310B: *Operating Physician Name Loop.*
 16. 2310C: *Other Provider Name Loop.*
 17. 2310E: *Service Facility Secondary Identification (REF).*
 18. 2320: *Coordination of Benefits [COB] Total Submitted Charges (AMT), Diagnostic Related Group [DRG] Outlier Amount (AMT), Coordination of Benefits [COB] Total Medicare Paid Amount (AMT), Medicare Paid Amount – 100% (AMT), Medicare Paid Amount – 80% (AMT), Coordination of Benefits [COB] Medicare A Trust Fund Paid Amount (AMT), Coordination of Benefits [COB] Medicare B Trust Fund Paid Amount (AMT), Coordination of Benefits [COB] Total Non-Covered Amount (AMT), Coordination of Benefits [COB] Total Denied Amount (AMT), Other Insurance Coverage Information (OI), Medicare Inpatient Adjudication Information (MIA), Medicare Outpatient Adjudication Information (MOA).*
 19. 2330A: *Other Subscriber Name Loop.*
 20. 2330B: *Other Payer Address (N3), Other Payer City/State/Zip Code (N4), Other Payer Secondary Identification and Reference Number (REF), Other Payer Prior Authorization or Referral Number (REF).*
 21. 2330C: *Other Payer Patient Identification Number (REF).*
 22. 2330D: *Other Payer Attending Provider Loop.*
 23. 2330E: *Other Payer Operating Provider Loop.*
 24. 2330F: *Other Payer Other Provider Loop.*
 25. 2330H: *Other Payer Service Facility Provider Loop.*
 26. 2400: *Line Supplemental Information (PWK), Assessment Date (DTP), Service Tax Amount (AMT), Facility Tax Amount (AMT).* The accepted way to bill taxes will be with appropriate HCPC code.
 27. 2410: *Drug Identification*
 28. 2420A: *Attending Physician Name Loop.*
 29. 2420B: *Operating Physician Name Loop.*
 30. 2420C: *Other Provider Name Loop.*

1.3 Data Details for 837I

The following segment references are clarifications and payer-specific requirements related to data usage and content.

Segment: GS Functional Group Header

Loop:

4010 IG Page: B.8

Data Element Summary

Ref Des	Element Name	Element Note
GS02	Application Sender's Code	Sender's assigned trading partner number
GS03	Application Receiver's Code	

Segment: NM1 Submitter Name

Loop: 1000A

4010 IG Page: 63

Data Element Summary

Ref Des	Element Name	Element Note
NM109	Submitter Identifier	The Electronic Transmitter Identification Number (ETIN) is established by a trading partner agreement. Contact the Organization to get the ETIN number to use in this element.

Segment: NM1 Submitter Name

Loop: 1000B

4010 IG Page: 68

Data Element Summary

Ref Des	Element Name	Element Note
NM109	Receiver Primary Identifier	The Electronic Transmitter Identification Number (ETIN) is established by a trading partner agreement. Contact the Organization to get the ETIN number to use in this element.

Segment: PRV Provider Specialty Information

Loop: 2000A Billing/Pay-To Provider

4010 IG Page: 71

Note: The Organization will **require the taxonomy code** be populated.

Segment: NM1 Billing Provider Name

Loop: 2010AA Billing Provider Name

4010 IG Page: 76 - 84

Note: The Organization will require usage of this loop be limited to Health Care Providers only.

Segment: NM1 Payer Name

Loop: 2010BC

4010 IG Page: 128

Data Element Summary

Ref Des	Element Name	Element Note
NM109	Payer Identifier	This segment should contain the Organization's EIN number.
