CMS

Companion Guide Transaction Information

Instructions related to the Non-Standard Use of the 837 Health Care Claim: Institutional Transaction as a Home Health Notice of Admission based on ASC X12 Technical Report Type 3 (TR3), version 005010A2

Companion Guide Version Number: 1.1

May 2021

Preface

Companion Guides (CGs) may contain two types of data, instructions for electronic communications with the publishing entity (Communications/Connectivity Instructions) and supplemental information for creating transactions for the publishing entity while ensuring compliance with the associated ASC X12 IG (Transaction Instructions). Either the Communications/Connectivity component or the Transaction Instruction component must be included in every CG. The components may be published as separate documents or as a single document.

The Communications/Connectivity component is included in the CG when the publishing entity wants to convey the information needed to commence and maintain communication exchange.

The Transaction Instruction component is included in the CG when the publishing entity wants to clarify the IG instructions for submission of specific electronic transactions. The Transaction Instruction component content is in conformance with ASC X12's Fair Use and Copyright statements.

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Transaction Instruction (TI)

1. TI Introduction

1.1 Background

1.1.1 Overview of HIPAA Legislation

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 carries 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 serves to:

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

1.1.2 Compliance according to HIPAA

The HIPAA regulations at 45 CFR 162.915 require that covered entities not enter into a trading partner agreement that would do any of the following:

- Change the definition, data condition, or use of a data element or segment in a standard.
- Add any data elements or segments to the maximum defined data set.
- Use any code or data elements that are marked “not used” in the standard’s implementation specifications or are not in the standard’s implementation specification(s).
- Change the meaning or intent of the standard’s implementation specification(s).

1.1.3 Compliance according to ASC X12

ASC X12 requirements include specific restrictions that prohibit trading partners from:

- Modifying any defining, explanatory, or clarifying content contained in the implementation guide.
- Modifying any requirement contained in the implementation guide.

1.1.4 Use for a Non-HIPAA Transaction

This Transaction Instruction uses a standard transaction format for the submission of home health Notices of Admission (NOAs). The NOA is not a HIPAA-covered transaction. It does not meet the definition of a claim or

encounter at 45 CFR § 162.1101 because it does not request payment or report health care services.

While the contents of this Transaction Instruction meet the compliance requirements described in sections 1.1.2 and 1.1.3, this is a non-standard use of 837I Implementation Guide. Medicare-participating home health agencies may adopt the use of this Transaction Instruction for NOAs on a strictly voluntary basis and as an optional extension of their existing trading partner agreement with the Medicare program and their Medicare Administrative Contractor.

Medicare encourages home health agencies to submit groups of NOAs in separate batch transmissions from groups of claims. This practice may reduce the risk that translator-level rejections related to NOAs, if they occur, could impact payments to the home health agencies.

NOAs will receive 277CA acknowledgements. They will not be reported on the 835 remittance advice.

1.2 Intended Use

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

2. Included ASC X12 Implementation Guides

This table lists the X12N Implementation Guide for which specific transaction Instructions apply and which are included in Section 3 of this document.

Unique ID	Name
005010X223A2	Health Care Claim: Institutional (837)

3. Instruction Table

This table contains rows for where supplemental instruction information is located. The order of table content follows the order of the implementation transaction set as presented in the corresponding implementation guide.

Category 1. Situational Rules that explicitly depend upon and reference knowledge of the transaction receiver's policies or processes.

Category 2. Technical characteristics or attributes of data elements that have been assigned by the payer or other receiving entity, including size, and character sets applicable, that a sender must be aware of for preparing a transmission.

Category 3. Situational segments and elements that are allowed by the implementation guide but do not impact the receiver's processing (applies to inbound transactions).

Category 4. Optional business functions supported by an implementation guide that an entity doesn't support.

Category 5. To indicate if there needs to be an agreement between PAYER and the transaction sender to send a specific type of transaction (claim/encounter or specific kind of benefit data) where a specific mandate doesn't already exist.

Category 6. To indicate a specific value needed for processing, such that processing may fail without that value, where there are options in the TR3.

Category 7. TR3 specification constraints that apply differently between batch and real-time implementations, and are not explicitly set in the guide.

Category 8. To identify data values sent by a sender to the receiver.

Category 9. To identify processing schedules or constraints that are important to trading partner expectations.

Category 10. To identify situational data values or elements that are never sent.

005010X223A2 Health Care Claim: Institutional Submitted as a Home Health Notice of Admission (NOA)

Loop ID	Reference	Name	Codes	Notes/Comments	Category
				Errors identified for business level edits performed prior to the SUBSCRIBER LOOP (2000B) will result in immediate file failure at that point. When this occurs, no further editing will be performed beyond the point of failure.	9
				The billing provider must be associated with an approved electronic submitter. NOAs submitted for billing providers that are not associated to an approved electronic submitter will be rejected.	9
				Contractor will convert all lower case characters submitted on an inbound 837 file to upper case when sending data to the Medicare processing system. Consequently, data later submitted for coordination of benefits will be submitted in upper case.	2

Loop ID	Reference	Name	Codes	Notes/Comments	Category
				Only loops, segments, and data elements valid for the HIPAA Institutional Implementation Guides will be translated. Submitting data not valid based on the Implementation Guide will cause files to be rejected.	9
				Medicare requires the National Provider Identifier (NPI) be submitted as the identifier for all NOAs. NOAs submitted with legacy identifiers will be rejected.	6
				National Provider Identifiers will be validated against the NPI algorithm. NOAs which fail validation will be rejected.	2
				All dates that are submitted on an incoming 837 transaction must be valid calendar dates in the appropriate format based on the respective qualifier. Failure to submit a valid calendar date will result in rejection of the NOA or the applicable interchange (transmission).	2
	ISA05	Interchange ID Qualifier	28, ZZ	Contractor will reject an interchange (transmission) that does not contain 28 or ZZ in ISA05	6
	ISA06	Interchange Sender ID		Contractor will reject an interchange (transmission) that does not contain a valid ID in ISA06.	6
	ISA07	Interchange ID Qualifier	28, ZZ	Contractor will reject an interchange (transmission) that does not contain 28 or ZZ in ISA07.	6
	ISA12	Interchange Control Version Number		Contractor will reject an interchange (transmission) that does not contain 00501 in ISA12.	6
				Contractor will only process one transaction type (records group) per interchange (transmission); a submitter must only submit one GS-GE (Functional Group) within an ISA-IEA (Interchange).	4
				Contractor will only process one transaction type per functional group; a submitter must only submit one ST-SE (Transaction Set) within a GS-GE (Functional Group).	4
	GS03	Application Receiver's Code		Contractor will reject an interchange (transmission) that is submitted with an invalid value in GS03 (Application Receivers Code) based on the contractor definition.	6

Loop ID	Reference	Name	Codes	Notes/Comments	Category
	GS04	Functional Group Creation Date		Contractor will reject an interchange (transmission) that is submitted with a future date.	6
				Contractor will only accept claims and NOAs for one line of business per transaction. Claims submitted for multiple lines of business within one ST-SE (Transaction Set) will cause the transaction to be rejected.	4
	ST01	Transaction Set Identifier Code	837	Trading partners acknowledge that although '837' is the submitted in this data element, an NOA is not a health care claim under the HIPAA definition.	5
	ST02	Transaction Control Set		Contractor will reject an interchange (transmission) that is not submitted with unique values in the ST02 (Transaction Set Control Number) elements.	6
	BHT02	Transaction Set Purpose Code	00	Transaction Set Purpose Code (BHT02) must equal '00' (ORIGINAL).	6
	BHT06	Claim/Encounter Identifier	CH	Claim or Encounter Indicator (BHT06) must equal 'CH' (CHARGEABLE). This is because the NOA is simulating a claim, not because any charges are being made.	6
1000A	NM109	Submitter ID		Contractor will reject an interchange (transmission) that is submitted with a submitter identification number that is not authorized for electronic claim submission.	5
1000B	NM103	Receiver Name		Contractor will reject an interchange (transmission) that is not submitted with a valid Part A MAC name (NM1).	5
1000B	NM109	Receiver Primary Identifier		Contractor will reject an interchange (transmission) that is not submitted with a valid Part A MAC code (NM1). Each individual Contractor determines	5
2000B	HL04	Hierarchical Child Code	0	The value accepted is "0". Submission of "1" will cause your file to reject.	6
2000B	SBR01	Payer Responsibility Sequence Number Code	P	Submit all NOAs as "P" for primary, since payer sequence is not relevant to identifying an admission.	6
2000B	SBR02, SBR09	Subscriber Information		For Medicare, the subscriber is always the same as the patient (SBR02=18, SBR09=MA). The Patient Hierarchical Level (2000C loop) is not used.	6
2010AC	Loop Rule	PAY TO PLAN LOOP		Must not be present. Submission of this loop will cause your NOA to reject.	4

Loop ID	Reference	Name	Codes	Notes/Comments	Category
2010BA	NM102	Subscriber Entity Type Qualifier	1	The value accepted is 1. Submission of value 2 will cause your NOA to reject.	6
2010BA	NM108	Subscriber Identification Code Qualifier	MI	The value accepted is “MI”. Submission of value “II” will cause your NOA to reject.	6
2010BA	NM109	Subscriber Identification Code		Medicare Beneficiary Identifier (MBI): Must be 11 positions in the format of: C A AN N A AN N A A N N ("C" represents a constrained numeric 1 thru 9, "A" represents alphabetic character A - Z but excluding S, L, O, I, B, Z, "N" represents numeric 0 thru 9 and "AN" represents either "A" or "N".) Submission of other formats will cause your NOA to reject.	6
2010BA	DMG02	Subscriber Birth Date		Must not be a future date. Must be present.	6
2010BA	REF – Segment Rule	SUBSCRIBER SECONDARY IDENTIFICATION		Must not be present. Submission of this segment will cause your NOA to reject.	4
2010BB	NM108	Payer Identification Code Qualifier	PI	The value accepted is “PI”. Submission of value “XV” will cause your NOA to reject.	6
2010BB	REF – Segment Rule	PAYER SECONDARY IDENTIFICATION		Must not be present. Submission of this segment will cause your NOA to reject.	4
2010BB	REF – Segment Rule	BILLING PROVIDER SECONDARY IDENTIFICATION		Must not be present. Submission of this segment will cause your NOA to reject.	4
2000C	HL – Segment Rule	PATIENT HIERARCHICAL LEVEL		Must not be present. Submission of this segment will cause your NOA to reject.	4
2000C	PAT – Segment Rule	PATIENT INFORMATION		Must not be present. Submission of this segment will cause your NOA to reject.	4
2010CA	Loop Rule	PATIENT NAME LOOP		Must not be present. Submission of this loop will cause your NOA to reject.	4
2300	CLM02	Total Submitted Charges		NOAs are submitted with a zero charge amount.	8
2300	CLM05 - 1	Facility Type Code	32	Must identify the facility type as a home health agency	6

Loop ID	Reference	Name	Codes	Notes/Comments	Category
2300	CLM05-3	Claim Frequency Type Code	A or D	Must report a valid NUBC code representing an NOA or NOA-related transaction.	6
2300	DTP03	Admission Date		Must not be a future date.	6
2300	CL102	Admission Source Code	1	Not normally required by an NOA, but required by the 837I format. Submit a default value of '1.'	6
2300	CL103	Patient Status Code	30	Not normally required by an NOA, but required by the 837I format. Submit a default value of '30.'	6
2300	CN1 – Segment Rule	CONTRACT INFORMATION		Must not be present. Submission of this segment will cause your NOA to reject.	4
2300	REF – Segment Rule	PAYER CLAIM CONTROL NUMBER		Must not be present. Submission of this segment will cause your NOA to reject.	4
2300	HI segment with BK qualifier	Principal Diagnosis Code		Not normally required by an NOA, but required by the 837I format. Submit any valid diagnosis code. This value will not be stored on HH admission periods or compared to claims.	6
2310A	REF – Segment Rule	ATTENDING PROVIDER SECONDARY IDENTIFICATION		Must not be present. Submission of this segment will cause your NOA to reject.	4
2400	SV2 segment	INSTITUTIONAL SERVICE LINE		Not normally required by an NOA, but required by the 837I format. Submit a single SV2 segment with the default values listed below.	6
2400	SV201	Product/Service ID	0023	Submit revenue code 0023 (Home Health PPS)	6
2400	SV202-1	Product or Service ID Qualifier	HP	Submit qualifier HP.	6
2400	SV202-2	Product/Service ID	1AA11	Not required by a HH NOA, but required by the 837I format. Submit HIPPS code 1AA11 as a placeholder value, since differing HIPPS codes may apply over the course of an HH admission.	6
2400	SV203	Monetary Amount		Submit a zero charge amount.	6
2400	SV205	Quantity	1	Submit 1 unit.	6

Loop ID	Reference	Name	Codes	Notes/Comments	Category
2400	DTP03	DATE - SERVICE DATE		Must not be a future date. Not required by a HH NOA, but required by the 837I format. The admission date may be duplicated to satisfy this requirement.	6

The instructions in the table above supplement Medicare guidance on submission of NOAs in Pub. 100-04, chapter 10, section 40.1, which satisfy many other required fields on the 837I. Additional fields may be required by the 837I claim which can be completed based entirely on instructions in the TR3 itself.

4. TI Additional Information

4.1 Change Log

Version	Date	Change Summary
1.0	April 2021	Original publication of this Guide.
1.1	May 2021	Added instruction for HI segment, BK qualifier.