Geisinger Health Plan

Companion Guide for the 835 Health Care Claim Payment/Advice

Refers to the Implementation Guides

Based on X12 version 005010X221A1

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Preface

This is a Companion Guide to the ASC X12N Implementation Guides adopted under the Health Insurance Portability and Accountability Act (HIPAA). It should be used when interacting with Geisinger Health Plan (GHP). This document describes the data element requirements of GHP's trading partners for submission of EDI HIPAA compliant transactions. This guide is not meant to replace HIPAA's Implementation Guides but should be used in conjunction with them.

Disclosure Statement

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1. Introduction

In an effort to reduce the administrative costs of health care across the nation, the Health Insurance Portability and Accountability Act (HIPAA) was passed in 1996. This legislation requires that health insurance payers in the United States comply with the electronic data interchange (EDI) standards for health care, established by the Secretary of Health and Human Services (HHS). For the health care industry to achieve the potential administrative cost savings with EDI, standard transactions and code sets have been developed and need to be implemented consistently by all organizations involved in the electronic exchange of data. The ANSI X12N 835 Health Care Claim Payment Advice transaction implementation guides provide the standardized data requirements to be implemented for all health care claim electronic submissions.

HIPAA does not require that a provider submit health care claims electronically. Providers may continue to submit paper claims and receive a paper remittance advice. However, if the provider elects to conduct business electronically, HIPAA does mandate the use of the standard transactions and code sets.

1.1 Scope

This Companion Guide explains the procedures necessary for trading partners of the Health Plan to transmit Electronic Data Interchange (EDI) for the 835 Health Care Claim Payment Advice transactions. This Companion Guide is not intended to replace, contradict or exceed the X12N Implementation Guides; rather it is intended to be used in conjunction with them

1.2 Overview

The first part of this Companion Guide explains its purpose and the trading partner's role working with the Health Plan. It also provides important information on the communication process and detailed Health Plan contact information.

1.3 References

This Companion Guide should be used in conjunction with the Implementation Guides, which can be obtained from the Washington Publishing Company on their web site at http://www.wpc-edi.com/content/view/817/1.

Other important websites:
Workgroup for Electronic Data Interchange (WEDI) – http://www.wedi.org
United States Department of Health and Human Services (DHHS) – http://aspe.hhs.gov/admnsimp/
Centers for Medicare and Medicaid Services (CMS) – http://www.cms.hhs.gov/HIPAAGenInfo/
Designated Standard Maintenance Organizations (DSMO) – http://www.hipaa-dsmo.org/
National Council of Prescription Drug Programs (NCPDP) – http://www.ncpdp.org/
National Uniform Billing Committee (NUBC) – http://www.nubc.org/
Accredited Standards Committee (ASC X12) – http://www.x12.org/

2. Getting Started

2.1 Trading Partner Registration

You may request Health Plan authorization to submit and/or receive HIPAA- compliant ASC X12 electronic transaction(s). To do so, a Health Plan Electronic Data Interchange (EDI) Provider Enrollment Application (Dev. 5/03) is required by the Health Plan. This enrollment application can be found at www.thehealthplan.com. or be mailed or faxed to you by the Health Plan. The application is required to be **completed in its entirety**, including the **authorized representative's signature,** and returned to the address or fax number listed below:

Geisinger Health Plan
Provider Network Management/Operations Manager
100 North Academy Ave.
Danville PA 17821-3020
Fax: (570) 271-5341

Upon receipt and approval of your Health Plan (EDI) Provider Enrollment Application, the Health Plan will send you the following information:

- ✓ Your Health Plan assigned provider number(s) and/or office number(s)
- ✓ Health Plan EDI contact persons and telephone numbers
- ✓ Health Plan Companion Guide information for electronic interchanges.

Please note: Providers are strongly encouraged to follow the below recommendations prior to electronic transmission of information to the Health Plan:

- ✓ Provider review of the HIPAA Implementation Transaction and Code Set Guides and required addenda, which are available for download at www.wpc-edi.com
- ✓ Provider's claim submission software vendor/billing company has taken all necessary steps to confirm all required data elements are captured and populating the appropriate field/location as indicated in the Health Plan Companion Guide
- ✓ Testing for such requirements has been successfully completed.

Failure to demonstrate the ability to send compliant, error-free electronic transactions will result in unnecessary costly delays and rejections.

2.2 Certification and Testing Overview

The Workgroup for Electronic Data Interchange (WEDI) and the Strategic National Implementation Process (SNIP) have recommended seven types of HIPAA compliance testing, these are:

1. Integrity Testing – This is testing the basic syntax and integrity of the EDI transmission to include: valid segments, segment order, element attributes, numeric values in numeric data elements, X12 syntax and compliance with X12 rules.

2. Requirement Testing – This is testing for HIPAA Implementation Guide specific syntax such as repeat counts, qualifiers, codes, elements and segments. Also testing for required or intra-segment situational data elements and non-medical code sets whose values are noted in the guide via a code list or table.

3. Balance Testing – This is testing the transaction for balanced totals, financial balancing of claims or remittance advice and balancing of summary fields.

4. Situational Testing – This is testing of inter-segment situations and validation of situational fields based on rules in the Implementation Guide.

5. External Code Set Testing – This is testing of external code sets and tables specified within the Implementation Guide. This testing not only validates the code value but also verifies that the usage is appropriate for the particular transaction.

6. Product Type or Line of Service Testing – This is testing that the segments and elements required for certain health care services are present and formatted correctly. This type of testing only applies to a trading partner candidate that conducts the specific line of business or product type.

7. Implementation Guide-Specific Trading Partners Testing – This is testing of HIPAA requirements that pertain to specific trading partners such as Medicare, Medicaid and Indian Health. Compliance testing with these payer specific requirements is not required from all trading partners. If the trading partner intends to exchange transactions with one of these special payers, this type of testing is required.

The WEDI/SNIP white paper on Transaction Compliance and Certification and other white papers are found at http://www.wedi.org/snip/public/articles/index%7E12.htm.

3. Connectivity / Communications

The Health Plan has a communication server with secure internet access for transmitting and receiving EDI transactions. Please contact our EDI Technical Contact listed in Section 4 for the account set up and software requirements.

4. Contact information

4.1 Health Plan E-Help Desk

If you have any questions or need additional EDI information, please contact the Health Plan's E-Help Desk at the following:

Contact Name: E-Help Desk
100 N. Academy Avenue
Danville, PA, 17822
Telephone: 1-800-447-4000
Fax: 570-271-5871
Email Address: edi@thehealthplan.com
Weekdays 8:00am – 5:00pm.

4.2 Applicable websites

For on-line EDI information, including the Health Plan's companion guides and the EDI enrollment application, access www.thehealthplan.com.

5. Payer Specific Business Rules and Limitations

5.1 Headers

ISA	Interchange Control Header	Loop: N/A

To start and identify an interchange of zero or more functional groups and interchange-related control segments

Element Summary:

Ref	Id	Element Name		Req	Type	Min/Max
ISA05	I05	**Interchange ID Qualifier**		M	ID	2/2
		Code	**Name**			
		ZZ	Mutually Defined			
ISA06	I06	**Interchange Sender ID**		M	AN	15/15
ISA07	I07	**Interchange ID Qualifier**		M	ID	2/2
		Code	**Name**			
		ZZ	Mutually Defined			
ISA08	I08	**Interchange Receiver ID**		M	AN	15/15

The Health Plan prefers the Interchange Control Header required data elements to be formatted in the ISA segment as follows:

ISA05 is set to ZZ (Mutually Defined)
ISA06 is set to the Health Plan’s Payor ID 75273

ISA07 is set to ZZ (Mutually Defined)
ISA08 is set to the mutually agreed upon receiver identification number

GS Functional Group Header

Loop: N/A

To indicate the beginning of a functional group and to provide control information.

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max
GS03	124	**Application Receiver's Code**	M	AN	2/15

The Health Plan prefers the Functional Group Header required data elements to be formatted in the GS segment as follows:

GS03 is set to the Health Plan's U.S. Federal Tax Identification Number of 23-2311553

5.2 Detail

BPR Financial Information

Loop: N/A

To indicate the beginning of a Payment Order/Remittance Advice Transaction Set and total payment amount, or to enable related transfer of funds and/or information from payer to payee to occur

Element Summary:

Ref	Id	Element Name		Req	Type	Min/Max
BPR01	305	**Transaction Handling Code**		M	ID	1/2
		Code	**Name**			
		I	Remittance Information Only			
BPR04	591	**Payment Method Code**		M	ID	3/3
		Code	**Name**			
		CHK	Check			
BPR16	510	**Date**		O	AN	9/9

The check date will appear in segment BPR16.

REF Receiver Identification

Loop: N/A

To specify identifying information

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max
REF01	128	**Reference Identification Qualifier**	M	ID	2/3

Code	Name
EV	Receiver Identification Number

Code	Name
F2	Version Code - Local

CLP Claim Payment Information

Loop: 2100

To supply information common to all services of a claim

Element Summary:

CLP02	1029	**Claim Status Code**	M	ID	1/2

Geisinger Configuration Note: *GHP uses the following values:*

Code	Name
1	Processed as Primary
2	Processed as Secondary
3	Processed as Tertiary
4	Denied
19	Processed as Primary, Forwarded to Additional Payer(s)
20	Processed as Secondary, Forwarded to Additional Payer(s)
21	Processed as Tertiary, Forwarded to Additional Payer(s)
22	Reversal of Previous Payment
23	Not Our Claim, Forwarded to Additional Payer(s)
25	Predetermination Pricing Only - No Payment

6. Acknowledgements and or Reports

6.1 Report Inventory

GHP supports the following response transactions and acknowledgements to the 835 Transaction:

- 997 Functional Acknowledgement

Appendix

Summary of Changes

Date of Change	Change Description
10/24/11	Creation of version 1.0