County Medically Indigent Services Program (CMISP), Physicians Emergency Medical Services (PEMS), and Non-contracted Hospital ER Services Policy (NHERSP)

Standard Companion Guide Transaction Information

Instructions related to Transactions based on ASC X12 Implementation Guides, Version 005010

Companion Guide Version Number: 1.7

June 2012

Preface

Companion Guides (CG) 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 limited by ASCX12’s copyrights and Fair Use statement.

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1 Change Summary

Version	Date	Section(s) changed	Change Summary
1.0	11/9/2011	Original	
1.5	12/2/2011	Inserted Control Segments Section	
1.6	4/30/2012	Instruction Tables Control Segments / Envelopes	Added additional DHHS requirements
1.7	6/7/2012	Instruction Tables Control Segments / Envelopes	Updated Notes/Comments Updated accepted code values for 837I Facility Code field

Transaction Instruction (TI)

2 TI Introduction

2.1 Background

2.1.1 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

2.1.2 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).

2.1.3 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.

2.1.4 Program Descriptions - CMISP, NHERSP, and PEMS

CMISP

The County Medically Indigent Services Program (CMISP) is a program of "last resort" designed to meet the health care needs of individuals in our community who are not otherwise eligible for healthcare programs such as Medi-Cal, Medicare or private health insurance, and who meet the County's "last resort" socioeconomic eligibility standards. CMISP is a program mandated by the State of California, Title 17 of the Welfare and Institutions Code, to provide access to medical care for medically indigent persons.

The program is administered as a combined effort of the Sacramento County Departments of Health and Human Services and Human Assistance. The Department of Health and Human Services includes the Office of Medical Case Management under the direction of the Chief of Primary Health Services, Medical Case Management is responsible for provider payments and patient billing in Accounting and Fiscal Services for secondary and tertiary care.

NHERSP

The Non-Contracted Hospital Emergency Services Policy has been established to allow the County Medically Indigent Services Program (CMISP) to provide reimbursement to hospital providers for emergency medical services rendered at a non-contracted hospital to CMISP-eligible patients when the services are determined by the County to be medically necessary for treatment of an emergency medical condition and meet the definition of "Emergency Services". CMISP performs retrospective review of emergent outpatient visits and emergency inpatient admissions provided at hospital-based community emergency departments.

Emergency medical services are included within the scope of services available to CMISP eligible persons, regardless of whether the services are rendered at a contracted or a non-contracted hospital.

NHERSP accepts and processes referrals for services tendered no earlier than September 1, 2009, and prospectively to recipients of emergency medical services at

the emergency rooms of hospitals in Sacramento county that have not contracted with the County to provide emergency medical services under CMISP.

The reimbursement for emergency medical services rendered at a non-contracted hospital shall not exceed the Fee-for-Service Medi-Cal rates established by the State of California Department of Health Care Services as published on their internet web download rate table (http://files.medi-cal.ca.gov/pubsdoco/Rates/rates_download.asp) at the time that services are rendered. Selected medical and surgery services are reimbursed at a higher rate when performed in a hospital emergency room. The higher emergency room rates for these services are listed in the "Emergency Room Rate" column on the website. The remainder of services will be reimbursed at rates that do not exceed the rates listed in the "Basic Rate" column.

PEMS

The Physicians Emergency Medical Services (PEMS) fund program is outlined in county code – TITLE 6 HEALTH AND SANITATION, Chapter 6.105 EMERGENCY, OBSTETRIC, PEDIATRIC MEDICAL SERVICES DISTRIBUTION OF PENALTY ASSESSMENT AND TOBACCO TAX FUNDS.

2.2 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.

3 Included ASC X12 Implementation Guides

This table lists the X12N Implementation Guides for which specific transaction instructions apply and which are included in this document.

Unique ID	Name
[005010X222A1	Health Care Claim: Professional (837)
[005010X223A2	Health Care Claim: Institutional (837)

4 837 Envelope Details

4.1 Interchange Control Header (ISA)

Reference	Name	Codes	Notes/Comments
ISA01	Authorization Information Qualifier	00	No Authorization Information present
ISA02	Authorization Information		Fill with 10 spaces
ISA03	Security Information Qualifier	00	No Security Information present
ISA04	Security Information		Fill with 10 spaces
ISA05	Interchange Sender ID Qualifier	ZZ	Mutually defined
ISA06	Interchange Sender ID	(Trading Partner ID)	Send the Trading Partner ID (as specified in the DHHS Trading Partner Agreement forms) ; Left justified; Followed by spaces to fill the minimum character length
ISA07	Interchange Receiver ID Qualifier	ZZ	
ISA08	Interchange Receiver ID	SACCOUNTYHHSEDI	
ISA11	Repetition Separator	^	The value of "^" is accepted. Other values will cause your file to reject
ISA13	Interchange Control Number		This number must remain unique throughout the lifetime of our adjudication system
ISA14	Acknowledgement Requested	0 1	If requested, a TA1 segment will be included in the 999 response file.
ISA15	Usage Indicator	T P	"T" for Test data "P" for Production data
ISA16	Component Element Separator	:	Use a colon for the component element separator

4.2 Functional Group Header (GS)

Reference	Name	Codes	Notes/Comments
GS02	Application Sender's Code	(Trading Partner ID)	The same trading partner ID from ISA06, except without the trailing spaces.
GS03	Application Receiver's Code	SACCOUNTYHHSEDI	
GS06	Group Control Number		This number should match the control number used for ISA13

5 Instruction Tables

The following tables contain supplemental information for segments that are expected (by DHHS) to be present in the inbound 837 file.

5.1 [005010X222A1 Health Care Claim: Professional]

Loop ID	Reference	Name	Codes/Values (that DHHS accepts)	Notes/Comments
ST		Transaction Set		The maximum number of CLM segments per Transaction Set (ST-SE) is 5000
	ST03	Implementation Convention Reference	005010X222A1	
BHT		Beginning of Hierarchical Transaction		
	BHT02	Transaction Set Purpose	00	DHHS will treat every transaction as an original Original (00)
	BHT03	Reference Identification		
	BHT04	Date		
	BHT05	Time		
	BHT06	Transaction Type Code	CH	DHHS expects all transactions to be claims. Chargeable (CH)
1000A	NM1	Submitter Name		
	NM102	Entity Type Qualifier	2	Non-Person Entity (2)
	NM103	Submitter Name		This name must remain the same once established as stated in the trading partner agreement.
	NM108	Identification Code Qualifier	46	Electronic Transmitter Identification Number (ETIN)
	NM109	Submitter		The submitter ID will be the

Loop ID	Reference	Name	Codes/Values (that DHHS accepts)	Notes/Comments
		Identification Code		"vendor ID" assigned by DHHS. This ID will be provided to the trading partner upon initiation and certification of 837 submittals. This is the same "vendor ID" that is used in ISA06 and GS02.
1000A	PER	Submitter EDI Contact Information		DHHS requests a contact name and telephone number be sent.
	PER02	Submitter Contact Name		EDI submitters' contact person name
	PER03	Communication Number Qualifier	TE	Telephone (TE)
	PER04	Communication Number		Phone number formatted like: "9995551111" (no hyphens).
1000B	NM1	Receiver Name		
	NM103	Receiver Name/Organization	PEMS CMISP NHERSP	Use either "PEMS", "CMISP", or "NHERSP" according to the type of claims being submitted.
	NM108	Identification Code Qualifier	46	Electronic Transmitter Identification Number (ETIN) (46)
	NM109	Receiver Identification Code	01 16 57	Populate as follows for CMISP, PEMS, and NHERSP "01" - for CMISP "16" - for PEMS "57" - for NHERSP
2010AA	NM1	Billing Provider Name		
	NM103	Billing Provider Name		
	NM108	Identification Code Qualifier	XX	Centers for Medicare and Medicaid Services National Provider Identifier (XX)
	NM109	Identification Code		Billing Provider NPI number
2010AA	N3	Billing Provider Address		

Loop ID	Reference	Name	Codes/Values (that DHHS accepts)	Notes/Comments
2010AA	N4	Billing Provider City/State/Postal Code		
	N401	City Name		
	N402	State		
	N403	Postal Code		
2010AA	REF	Billing Provider Tax Identification		
	REF01	Reference Identification Qualifier	EI	Employer's Identification Number (EI)
	REF02	Reference Identification		Tax ID
2000B	HL	Subscriber Hierarchical Level		
	HL02	Hierarchical Parent ID Number		
	HL04	Hierarchical Child Code	0	No Subordinate HL Segment in this Hierarchical Structure (0). Subscriber is always the Patient for claims submitted Sacramento County.
2000B	SBR	Subscriber Information		
	SBR01	Payer Responsibility Sequence Number Code	P	Primary (P)
	SBR02	Individual Relationship Code	18	Self (18)
	SBR09	Claim Filing Indicator	MC	Medicaid (MC)
2010BA	NM1	Subscriber Name		Subscriber is always the Patient for claims submitted Sacramento County.
	NM102	Entity Type Qualifier	1	Person (1)

Loop ID	Reference	Name	Codes/Values (that DHHS accepts)	Notes/Comments
	NM103	Subscriber Name		Last Name of Subscriber
	NM108	Identification code Qualifier	MI	Member Identification Number (MI)
	NM109	Subscriber Primary Identifier		County Medical Record Number. Required for NHERSP and CMISP processing. For PEMS only, if unknown submit “0000000”. Do not send the SSN here.
2010BA	N3	Subscriber Address		
	N301	Address information		If patient information not available, populate with “UNKNOWN”. If patient is homeless, populate with “HOMELESS”
2010BA	N4	Subscriber City/State/ZIP Code		If the patient information is unknown, or, if the patient is homeless, then use the city state and zip code of the clinic.
	N401	City Name		
	N402	State		
	N403	Postal Code		
2010BA	DMG	Subscriber Demographic Information		
	DMG01	Date Time Period Format Qualifier	D8	Date Expressed in Format CCYYMMDD (D8)
	DMG02	Date Time Period		Subscriber Date of Birth
	DMG03	Gender Code		
2010BB	NM1	Payer Name		
	NM103	Name Last or Organization Name	CMISP NHERSP PEMSES PEMSOB	“CMISP” for all CMISP claims “NHERSP” for all NHERSP claims

Loop ID	Reference	Name	Codes/Values (that DHHS accepts)	Notes/Comments
			PEMSPE	"PEMSES" for Charity Care/Emergency Physicians "PEMSOB" for Charity Care/Obstetrics "PEMSPE" for Charity Care/Pediatrics
	NM108	Identification Code Qualifier	PI	Payer Identification (PI)
	NM109	Identification Code	SACCOUNTYHHSEDI	Must send "SACCOUNTYHHSEDI"
2300		Claim Information		
	CLM01	Claim Submitter's Identifier		DHHS will only support the first 20 characters submitted
	CLM02	Monetary Amount		Total Claim Charge Amount
	CLM05	Health Care Service Location Information		
	CLM05-01	Facility Code Value	NHERSP submissions only accept: 21 23	DHHS accepts place of service codes from the X12 external code source #237. However, specific business rules will apply depending upon the program (receiver). Inpatient Hospital (21) Emergency Room – Hospital (23)
	CLM05-02	Facility Code Qualifier	B	Place of Service Codes for Professional or Dental Services (B)
	CLM05-03	Claim Frequency Type Code		
2300	DTP	Date – Admission		Segment required for NHERSP Hospital and CMISP I/P Hospital submissions
	DTP01	Date/Time Qualifier	435	Admission (435)

Loop ID	Reference	Name	Codes/Values (that DHHS accepts)	Notes/Comments
2300	DTP	Date – Discharge		Segment required for NHERSP Hospital and CMISP I/P Hospital submissions
	DTP01	Date/Time Qualifier	096	Discharge (096)
2300	REF	Prior Authorization		Segment required for NHERSP and CMISP submissions
	REF01	Reference Identification Qualifier	G1	Prior Authorization Number (G1)
	REF02	Reference Identification		
2300	HI	Health Care Diagnosis Code		
	HI01-01	Code List Qualifier Code	BK	International Classification of Diseases Clinical Modification (ICD-9-CM) Principal Diagnosis (BK)
2400	LX	Service Line Number		
2400	SV1	Professional Service		
	SV101-C00301	Composite Medical Procedure Identifier - Product/Service ID Qualifier	HC	Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes (HC)
	SV102	Line Item Charge Amount		Total Charge Amount for this Service Line
	SV103	Unit or Basis for Measurement Code		
	SV104	Quantity		
2400	DTP	Service Date		
	DTP01	Date/Time Qualifier	472	Service (472)
	DTP02	Date Time Period Format Qualifier	D8 RD8	Date Expressed in Format CCYYMMDD (D8)

Loop ID	Reference	Name	Codes/Values (that DHHS accepts)	Notes/Comments
				Date Range Expressed in Format CCYYMMDD-CCYYMMDD (RD8)
2400	REF	Line Item Control Number		
	REF01	Reference Identification Qualifier	6R	Provider Control Number (6R)
	REF02	Reference Identification		DHHS will only support the first 30 characters submitted
2000C		Patient Hierarchical level		DHHS will not accept claims submitted on this level. Claims must be submitted at the Subscriber level.

5.2 [005010X223A2 Health Care Claim: Institutional]

Loop ID	Reference	Name	Codes	Notes/Comments
ST		Transaction Set		The maximum number of CLM segments per Transaction Set (ST-SE) is 5000
	ST03	Implementation Convention Reference	005010X223A2	
BHT		Beginning of Hierarchical Transaction		
	BHT02	Transaction Set Purpose	00	DHHS will treat every transaction as an original Original (00)
	BHT03	Reference Identification		
	BHT04	Date		
	BHT05	Time		
	BHT06	Transaction Type Code	CH	DHHS expects all transactions to be claims. Chargeable (CH)
1000A	NM1	Submitter Name		
	NM102	Entity Type Qualifier	2	Non-Person Entity (2)
	NM103	Submitter Name		This name must remain the same once established as stated in the trading partner agreement.
	NM108	Identification Code Qualifier	46	Electronic Transmitter Identification Number (ETIN) (46)
	NM109	Submitter Identification Code		The submitter ID will be the “vendor ID” assigned by DHHS. This ID will be provided to the trading partner upon initiation and certification of 837 submittals. This is the same “vendor ID” that is used in ISA06 and GS02.
1000A	PER	Submitter EDI Contact Information		DHHS requests a contact name and telephone number be sent.

Loop ID	Reference	Name	Codes	Notes/Comments
	PER02	Submitter Contact Name		EDI Submitters' contact person name
	PER03	Communication Number Qualifier	TE	Telephone (TE)
	PER04	Communication Number		"9995551111" format (no hyphens).
1000B	NM1	Receiver Name		
	NM103	Receiver Name	CMISP NHERSP	Use either "CMISP" or "NHERSP" according to the type of claims being submitted.
	NM108	Identification Code Qualifier	46	Electronic Transmitter Identification Number (ETIN) (46)
	NM109	Receiver Identification Code	01 57	Populate as follows for CMISP and NHERSP "01" - for CMISP "57" - for NHERSP
2010AA	NM1	Billing Provider Name		
	NM103	Billing Provider Name		
	NM108	Identification Code Qualifier	XX	Centers for Medicare and Medicaid Services National Provider Identifier (XX)
	NM109	Identification Code		Billing Provider NPI
2010AA	N3	Billing Provider Address		
2010AA	N4	Billing Provider City/State/Postal Code		
	N401	City Name		
	N402	State		
	N403	Postal Code		
2010AA	REF	Billing Provider Secondary Identification		
	REF01	Reference Identification	EI	Employer's Identification Number (EI)

Loop ID	Reference	Name	Codes	Notes/Comments
		Qualifier		
	REF02	Reference Identification		Tax ID
2000B	SBR	Subscriber Information		
	SBR01	Payer Responsibility Sequence Code	P	Primary (P)
	SBR02	Individual Relationship Code	18	Self (18)
	SBR09	Claim Filing Indicator Code	MC	Medicaid (MC)
2010BA	NM1	Subscriber Name		Subscriber is always the Patient for claims submitted Sacramento County.
	NM102	Entity Type Qualifier	1	Person (1)
	NM103	Subscriber Name		Last Name of Subscriber
	NM108	Identification code Qualifier	MI	Member Identification Number (MI)
	NM109	Subscriber Primary Identifier		County Medical Record Number. Required for NHERSP and CMISP processing. Do not send the SSN here.
2010BA	N3	Subscriber Address		
	N301	Address information		If patient information not available, populate with “UNKNOWN”. If patient is homeless, populate with “HOMELESS”
2010BA	N4	Subscriber City/State/Postal Code		If the patient information is unknown, or, if the patient is homeless, then use the city state and zip code of the billing clinic.
	N401	City Name		
	N402	State		
	N403	Postal Code		

Loop ID	Reference	Name	Codes	Notes/Comments
2010BA	DMG	Subscriber Demographic Information		
	DMG01	Date Time Period Format Qualifier	D8	Date Expressed in Format CCYYMMDD
	DMG02	Date Time Period		Subscriber Date of Birth
	DMG03	Gender Code		
2010BB	NM1	Payer Name		
	NM103	Name Last or Organization Name	CMISP NHERSP	"CMISP" for all CMISP claims "NHERSP" for all NHERSP
	NM108	Identification Code Qualifier	PI	Payer Identification (PI)
	NM109	Identification Code	SACCOUNTYHHSEDI	Must send "SACCOUNTYHHSEDI"
2300		Claim Information		
	CLM01	Claim Submitter's Identifier		DHHS will only support the first 20 characters submitted
	CLM02	Total Claim Charge Amount		
	CLM05	Health Care Service Location Information		
	CLM05-01	Facility Code value	11 13	DHHS only accepts Hospital Inpatient (11) and Hospital Outpatient (13)
	CLM05-02	Facility Code Qualifier	A	Uniform Billing Claim Form Bill Type (A)
	CLM05-03	Claim Frequency Type Code		
2300	DTP	Date – Discharge Date/Hour		
	DTP01	Date/Time Qualifier	096	Discharge (096)
2300	DTP	Date – Statement Dates		
	DTP01	Date/Time Qualifier	434	Statement (434)

Loop ID	Reference	Name	Codes	Notes/Comments
2300	DTP	Date – Admission Date/Hour		
	DTP01	Date/Time Qualifier	435	Admission (435)
2300	REF	Prior Authorization		
	REF01	Reference Identification Qualifier	G1	Prior Authorization Number (G1)
	REF02	Reference Identification		
2300	HI	Principal Diagnosis		
	HI01-01	Code List Qualifier Code	BK	International Classification of Diseases Clinical Modification (ICD-9-CM) Principal Diagnosis (BK)
2400	LX	Service Line Number		
2400	SV2	Institutional Service Line		
	SV202-C00301	Composite Medical Procedure Identifier - Product/Service ID Qualifier	HC	When sending a Composite Medical Procedure Identifier, DHHS expects to receive Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes (HC)
	SV203	Line Item Charge Amount		Total Charge Amount for this Service Line
	SV204	Unit or Basis for Measurement Code		
	SV205	Quantity		
2400	DTP	Service Date		
	DTP01	Date/Time Qualifier	472	Service (472)
	DTP02		D8 RD8	Date Expressed in Format CCYYMMDD (D8) Date Range Expressed in Format CCYYMMDD-

Loop ID	Reference	Name	Codes	Notes/Comments
				CCYYMMDD (RD8)
2400	REF	Line Item control Number		
	REF01	Reference Identification Qualifier	6R	Provider Control Number (6R)
	REF02	Reference Identification		DHHS will only support the first 30 characters submitted
2000C		Patient Hierarchical level		DHHS will not accept claims on this level. Must be in subscriber level