837P & 837I Health Care Claim: Professional

Functional Group=HC

Purpose: 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 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 brought about by EDI, transactions and code set standards have been developed to be implemented consistently by all organizations involved in EDI.
The standardized data requirements (transactions requirements and code sets) to be implemented for all health care claim electronic submissions are detailed in the ANSI X12N 837 Health Care Claims Transaction Implementation Guides (hereafter, "Implementation Guides"). An addendum has been published for each of the nine Implementation Guides; the addenda must also be used to properly implement EDI transactions.

PURPOSE OF THE COMPANION GUIDE: The purpose of this Companion Guide is to document any assumptions, conventions, or data issues that may be specific to DMH business processes when implementing the HIPAA ASC X12N Implementation Guides. This Companion Guide does NOT replace the Implementation Guides, nor does it attempt to amend any of the rules therein or impose any mandates on DMH trading partners. Readers of this Companion Guide should be acquainted with the Implementation Guides, their structure and content. Information contained in the HIPAA Implementation Guides has not been repeated here, although the Guides have been referenced when necessary.
The Companion Guide provides information necessary for trading partners to submit claims/encounters electronically to DMH for adjudication and processing through the Short-Doyle Medi-Cal (SD/MC) II system. Included are data elements that are either required, or required in certain circumstances, to meet HIPAA validation and SD/MC II processing requirements.
Note that certain information is not within the scope of this document, specifically:

- Information related to claim transactions for the purpose of Coordination of Benefits (COB).
- Information about how DMH adjudicates specific claims.
- Privacy and security protection regarding the use of the system or application technology to send and receive a transaction set. For example, registration and management of users, assignment and exchange of passwords, user IDs, digital certificates, authentication, authorization, and other access restrictions are not addressed in detail in this Companion Guide. This document assumes that the transaction exchange will take place in a processing and communication environment that is secure at both ends for the senders and the receivers of data.

835 Health Care Claim Payment/Advice

Functional Group=HP

Purpose: This Draft Standard for Trial Use contains the format and establishes the data contents of the Health Care Claim Payment/Advice Transaction Set (835) for use within the context of the Electronic Data Interchange (EDI) environment. This transaction set can be used to make a payment, send an Explanation of Benefits (EOB) remittance advice, or make a payment and send an EOB remittance advice only from a health insurer to a health care provider either directly or via a financial institution.

997 Functional Acknowledgment

Functional Group=FA

Purpose: This guide contains the format and establishes the data contents of the Functional Acknowledgment Transaction Set (997) for use within the context of an Electronic Data Interchange (EDI) environment. The transaction set is used to define the control structures for a set of acknowledgments to indicate the results of the syntactical analysis of the electronically encoded documents. The encoded documents are the transaction sets, which are grouped in functional groups, used in defining transactions for business data interchange.

The 997 transaction is returned to a submitter once validation of a submitted claims file by the Short-Doyle Phase 2 system has been completed.

276 Health Care Claim Status Request

Functional Group=HR

Purpose: The purpose of this companion guide is to provide the information necessary to submit a claim status request and receive a claim status response electronically from ADP or DMH. The 276 transaction is used as a request for claim status and the 277 as a response to that request. This companion guide is to be used in conjunction with the ANSI X12N 276/277 Health Care Claim Status Request and Response Transactions Implementation Guides (IGs). They are commonly called Implementation Guides (IGs) and are referred to as IGs throughout this document. The companion guide supplements, but does not contradict or replace any requirements in the IGs or ADP or DMH regulations, Letters, and Notices. This transaction set is not intended to replace the Health Care Claim Transaction Set (837), but rather to occur after the receipt of a claim or encounter information. The request may occur at the summary or service line detail level.

277 Health Care Claim Status Notification

Functional Group=HN

Purpose: This Draft Standard for Trial Use contains the format and establishes the data contents of the Health Care Claim Status Notification Transaction Set (277) for use within the context of an Electronic Data Interchange (EDI) environment. This transaction set can be used by a health care payer or authorized agent to notify a provider, recipient, or authorized agent regarding the status of a health care claim or encounter or to request additional information from the provider regarding a health care claim or encounter. This transaction set is not intended to replace the Health Care Claim Payment/Advice Transaction Set (835) and therefore, will not be used for account payment posting. The notification may be at a summary or service line detail level. The notification may be solicited or unsolicited.