



Standard Companion Guide Transaction Information

*Instructions Related to 837 Health Care Institutional &
Professional Claims Transactions Based on ASC X12
Implementation Guides, Version 005010*

*ASC X12N 837I (005010X223, 005010X223A1 & 005010223A2)
ASC X12N 837P (005010X222 & 005010222A1)*

Companion Guide, Version #1
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Preface

Tufts Health Plan® is accepting X12N 837 Institutional (837I) & X12N 837 Professional (837P) Health Care Claims, as mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The X12N 837I and 837P versions of the 5010 Standards for Electronic Data Interchange Technical Report Type 3 and Errata (also referred to as Implementation Guides) for the Health Care Institutional and Professional Claims has been established as the standard for Health Care claims transaction compliance.

This document has been prepared to serve as a Tufts Health Plan’s specific companion guide to the 837I and 837P Transaction Sets. This document supplements but does not contradict any requirements in the 837 I&P Technical Report, Type 3. The primary focus of the document is to clarify specific segments and data elements that should be submitted to Tufts Health Plan on the 837 Institutional & Professional Claim Transactions. This document will be subject to revisions as new versions of the 837 Institutional & Professional Health Care Claim Transaction Set Technical Reports are released.

This document has been designed to aid both the technical and business areas. It contains Tufts Health Plan’s specifications for the transactions as well as contact information and key points.

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Transaction Instruction (TI)

1 TI Introduction

1.1 Background

In order to submit a valid transaction, please refer to the National Electronic Data Interchange Transaction Set Technical Report & Errata for the Health Care Claim: Institutional ASC X12N 837 (005010X223, 005010X223A1 & 005010X223A2) and the Health Care Claim: Professional ASC X12N 837 (005010X222 & 005010X222A1). The Technical Reports can be ordered from the Washington Publishing Company's website at www.wpc-edi.com.

For questions relating to the Tufts Health Plan's 837 Institutional Claim Transaction, and the 837 Professional Claim Transaction, or testing please contact the EDI Operations Department at 888-880-8699 x4042 or email your questions to EDI_Operations@Tufts-Health.com.

Tufts Health Plan's billing guidelines are not included in this document. Please refer to our website at <http://www.tuftshealthplan.com/> for these guidelines, or contact Provider Services at 888-884-2404.

Please note Tufts Health Plan is not responsible for any software utilized by the submitter for the creation of an ASC X12N 837I or ASC X12N 837P transactions.

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 Guides for which specific transaction instructions apply and which are included in Section 3 of this document.

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

3 Instruction Tables

These tables contain one or more rows for each segment for which a supplemental instruction is needed.

Legend
BOLDED and SHADED rows represent “loops” or “segments” in the X12N implementation guides.
NON-SHADED rows represent “data elements” in the X12N implementation guides.

005010X223A2 Health Care Claim: Institutional

Loop ID	Reference	Name	Codes	Notes/Comments
1000A	NM1	Submitter Name		
1000A	NM109	Submitter Identification Code		The existing trading partners will continue using the six-digit submitter code. Tufts Health Plan will work with new trading partners prior to implementation to determine the six-digit submitter code.
2010AB		Pay-To Address Name		This loop has been changed to indicate a separate address for payments to the Billing Provider. Please note that Tufts Health Plan will continue making payments to the address in our backend system database instead of the address submitted in 2010AB.
2000B	SBR	Subscriber Hierarchical Level		
2000B	SBR01	Payer Responsibility Sequence Number Code		This data element is NOT a payer counter. It is a code that indicates the order of responsibility for payment.
2010BA	NM1	Subscriber Name		

Loop ID	Reference	Name	Codes	Notes/Comments
2010BA	NM109	Identification Code		Each Tufts Health Plan member is uniquely identified by his or her member ID. Thus we require treating all members as subscribers, and submitting member ID in Element NM109 of Loop 2010BA.
2010CA	NM1	Patient Name		Each Tufts Health Plan member is uniquely identified by his or her member ID. All members should be considered as subscribers, and providers should submit member ID in Element NM109 of Loop 2010BA. Tufts Health Plan will not accept any data in the Patient Loop and will REJECT accordingly.
2300	REF	Payer Claim Control Number		
2300	REF02	Reference Identification		For frequency types 5, 7, and 8, Original Reference Number (Claim Number) must be submitted as stated in the technical report. Tufts Health Plan also strongly recommends sending Original Reference Number with frequency types 2, 3, and 4.
2300	HI01-2	Occurrence Code		If a claim is accident or employment related, Tufts Health Plan requires the appropriate occurrence code. We will only process one iteration of HI01.
2300	HI01-4	Date Time Period		If a claim is accident or employment related, Tufts Health Plan requires the appropriate occurrence date. We will only process one iteration of HI01.

Loop ID	Reference	Name	Codes	Notes/Comments
2310E	NM1	Service Facility Location Name		Tufts Health Plan REQUIRES that Service Facility Information always match Billing Provider Information given that the payee should always equal the provider on institutional claims.
2320		Other Subscriber Information		
2320	SBR	Other Subscriber Information		Required by Tufts Health Plan to understand the payer responsibility sequence.
2320	AMT	COB Payer Paid Amount		Tufts Health Plan requires the total amount paid at the claim level.
2330A	NM1	Other Subscriber Name		Tufts Health Plan requires this segment for COB claims.
2330B	NM1	Other Payer Name		Tufts Health Plan requires this segment for COB claims.
2430	SVD	Line Adjudication Information		
2430	SVD02	Monetary Amount		Tufts Health Plan requires the amount paid by the payer in 2330B for this line.
2430	CAS01	Claim Adjustment Group Code	CO – Contractual Obligations	Used to validate total amount billed in SV1 segment.
2430	CAS01	Claim Adjustment Group Code	PR – Patient Responsibility	Also used to validate total amount billed in SV1 segment. (if applicable)

005010X222A1 Health Care Claim: Professional

Loop ID	Reference	Name	Codes	Notes/Comments
1000A	NM1	Submitter Name		
1000A	NM109	Submitter Identifier		The existing trading partners will continue using the six-digit submitter code. Tufts Health Plan will work with new trading partners prior to implementation to determine the six-digit submitter code.
2010AB		Pay-To Address Name		This loop has been changed to indicate a separate address for payment to the Billing Provider. Please note that Tufts Health Plan will continue making payments to the address in our backend system database instead of the address submitted in 2010AB.
2000B	SBR	Subscriber Hierarchical Level		
2000B	SBR01	Payer Responsibility Sequence Number Code		This data element is NOT a payer counter. It is a code that indicates the order of responsibility for payment.
2010BA	NM1	Subscriber Name		
2010BA	NM109	Identification Code		Each Tufts Health Plan member is uniquely identified by his or her member ID. Thus we require treating all members as subscribers, and submitting member ID in NM109 of loop 2010BA.
2010CA	NM1	Patient Name		Each Tufts Health Plan member is uniquely identified by his or her member ID. All members should be considered as subscribers, and providers should be submitting member ID in Element NM109 of Loop 2010BA. Thus Tufts Health Plan will not accept any data in the Patient Loop and will REJECT accordingly.

Loop ID	Reference	Name	Codes	Notes/Comments
2300	REF	Payer Claim Control Number		
2300	REF02	Reference Identification		For frequency types 5, 7, and 8, Original Reference Number (Claim Number) must be submitted as stated in the technical report. Tufts Health Plan also strongly recommends sending Original Reference Number with frequency types 2, 3, and 4.
2320		Other Subscriber Information		
2320	SBR	Other Subscriber Information		Required by Tufts Health Plan to understand the Payer Responsibility sequence.
2320	AMT	COB Payer Paid Amount		Tufts Health Plan requires the total amount paid at the claim level.
2330A	NM1	Other Subscriber Name		Tufts Health Plan requires this segment for COB claims.
2330B	NM1	Other Payer Name		Tufts Health Plan requires this segment for COB claims.
2430	SVD	Line Adjudication Information		
2430	SVD02	Monetary Amount		Tufts Health Plan requires the amount paid by the payer in 2330B for this line.
2430	CAS01	Claim Adjustment Group Code	CO – Contractual Obligation	Used to validate total amount billed in SV1 segment.
2430	CAS01	Claim Adjustment Group Code	PR – Patient Responsibility	Also used to validate total amount billed in SV1 segment. (if applicable)

4 TI Additional Information

4.1 Business Scenarios

Please refer to the business scenarios presented in the Implementation Guides or visit <http://www.wpc-edi.com/837> for additional or corrected examples.

4.2 Payer Specific Business Rules and Limitations

4.2.1 Category 1: General Instructions

- All NPIs on claims submitted to Tufts Health Plan must be registered with the Provider Information Department prior to transmission. Please call (888) 880-8699 x3153 to verify or register the NPIs of your organization with Tufts Health Plan.
- Tufts Health Plan will require a valid NPI when NM109 is used in any provider loops and will not accept Provider Secondary Identification after the mandated NPI Implementation date.
- New submitters must go through the appropriate set-up/authorization process in order to transmit electronic claims with Tufts Health Plan. Please refer to the Communications/Connectivity Component of this document for details.
- Tufts Health Plan will accept 837 Institutional and 837 Professional Claim Transactions for all business products, however the 837 Institutional and 837 Professional claim files must be sent separately. They cannot be sent on the same file.
- As stated in the technical reports, a maximum of 5000 CLM segments will be accepted by Tufts Health Plan.
- Tufts Health Plan is adhering to structural specifications for required and situational fields as stated in the technical reports. If the incoming 837I or 837P has a single ST/SE and the structure does not comply, the entire file will fail in the validation process. If the incoming 837I or 837P has multiple ST/SEs, only the failed ST/SEs in the file will fail in the validation process. The submitter receives a 999 acknowledgement for notification for the ST/SEs that failed.
- Tufts Health Plan will capture payee information from the Billing Provider Name loop (Loop 2010AA).
- The Pay-To Address Name loop (Loop 2010AB) in 5010 has been changed to enter a separate billing provider address where payments should be sent. Please note that Tufts Health Plan will continue making payments to the addresses in our backend system database instead of the addresses submitted in loop 2010AB.

- Tufts Health Plan cannot currently support billing for atypical provider type submissions.
- For Frequency Types 5, 7, and 8, (Element CLM05-3), Tufts Health Plan's original claim number (Original Reference Number – Element REF02) must be submitted as stated in the technical report. We also strongly recommend sending the Original Reference Number with Frequency Types 2, 3, and 4.
- When contacting Tufts Health Plan with questions for claims with Frequency Types 2, 3, 4, 5, 7, and 8, (Element CLM05-3), please use the original claim number even though a new claim number for that submission will be assigned.
- The Tufts Health Plan implementation of Coordination of Benefits (COB) Information utilizes claim header information in the COB Header Other Subscriber Information (Loop 2320), Other Subscriber Name (Loop 2330A), and Other Payer Name (Loop 2330B) as well as line level information in the Line Adjudication Information Details (Loop 2430) within the 837 transactions. We strongly recommend closely reviewing these loops in the technical reports before submitting COB information. Many data segments have been changed or deleted.
- Although the HIPAA Transaction Set technical report allows the repeating of Billing Provider Name loop (2010AA Loop) for each claim, the size of transmission files can be reduced by up to 20% by using only one repeat of Billing Provider Name loop followed by all subscriber and claim information for that Provider. Transmission files can be further reduced by grouping the claims of each subscriber together.
- ICD-10 Codes will not be accepted until the regulatory compliance effective date of October 1, 2013.
- For compliance purposes, Tufts Health Plan will only accept qualifier MJ for minutes when billing anesthesia procedure codes. UN is a valid qualifier for procedures other than anesthesia.
- Tufts Health Plan is unable to accept claims submitted electronically with charges total one million dollars (or more) due to system limitations.

4.2.2 Category 2: Acknowledgements

- Tufts Health Plan will not support the 277 CA at this time.
- Tufts Health Plan will return the **999 IMPLEMENTATION ACKNOWLEDGMENT FOR HEALTH CARE INSURANCE** as per the Technical Report, Type 3. The standard format is below.

ST Transaction Set Header
AK1 Functional Group Response Header LOOP ID - 2000 - AK2 TRANSACTION SET RESPONSE HEADER
AK2 Transaction Set Response Header LOOP ID - 2100 - AK2/IK3 ERROR IDENTIFICATION
IK3 Error Identification
CTX Segment Context
CTX Business Unit Identifier LOOP ID - 2110 - AK2/IK3/IK4 IMPLEMENTATION DATA ELEMENT NOTE
IK4 Implementation Data Element Note
CTX Element Context
IK5 Transaction Set Response Trailer
AK9 Functional Group Response Trailer
SE Transaction Set Trailer

4.2.3 Category 3: Present On Admission (POA) Indicators

Provider Types Affected

- Hospitals who submit claims to fiscal intermediaries (FI) or Medicare Part A/B Administrative Contractors (A/B MACs) for Medicare beneficiary inpatient services.
- Tufts Health Plan recommends that your billing staff is aware of this requirement, and that your physicians and other practitioners and coders are collaborating to ensure complete and accurate documentation, code assignment and reporting of diagnoses and procedures.

Reporting Options and Definitions

N	(No) Not present at the time of inpatient admission
U	(Unknown) Documentation is insufficient to determine if condition is present at time of inpatient admission
W	Not Applicable
Y	(Yes) Present at the time of inpatient admission

- The POA data element on your electronic claims has been moved from the K3 segment (version 4010A1) to the HI - PRINCIPAL DIAGNOSIS and HI - OTHER DIAGNOSIS INFORMATION segments.

NOTE: The value of "1" has been removed in 5010.

Example: Below is an example of acceptable coding on an electronic claim:

HI*BF:4821:.....N*HI*BF:25000:.....Y

4.2.4 Scheduled Maintenance

The systems used by the 837 transaction have a standard maintenance schedule of Sunday 8PM to 12AM EST. The systems are unavailable during this time. Email notifications will be sent notifying submitters of unscheduled system outages.

4.3 Frequently Asked Questions

4.3.1 General Claim Questions

Q. Who do I contact for setup issues?

A. Contact EDI Operations, edi_operations@tufts-health.com, for setup issues.

Q. Is there an EDI setup form?

A. Yes, you can find the EDI setup form on the Tufts Health Plan Web site (www.tuftshealthplan.com) or in this guide ([see Section 6.5, EDI Set-up Form](#)).

Q. What is Tufts Health Plan's Payer ID#?

A. Contact EDI Operations by sending email to edi_operations@tufts-health.com to obtain Tufts Health Plan Payer ID number. It is important to make sure your NPI is on file at Tufts Health Plan and that you are set up to submit claims via a clearinghouse.

Q. Is my NPI on file at Tufts Health Plan?

A. To determine if your NPI is on file, contact our Provider Information department, 888-306-6307 x3153.

Q. Is there an NPI registration form?

A. Yes, you can find the NPI registration form on the Tufts Health Plan Web site. It is located at:

[http://www.tuftshealthplan.com/providers/pdf/Request for Out of Plan Legacy ID Number Form.pdf](http://www.tuftshealthplan.com/providers/pdf/Request_for_Out_of_Plan_Legacy_ID_Number_Form.pdf)

Q. What should I do if I change clearinghouses?

A. If you change your clearinghouse, inform EDI Operations by sending email to: edi_operations@tufts-health.com.

Q. Can I send claims to Tufts Health Plan over the Internet?

A. No, you cannot send claims over the Internet. Tufts Health Plan does not offer claims submission over the Internet.

Q. How do I add or delete payees?

A. Contact EDI Operations by sending an email to edi_operations@tufts-health.com to add or delete payees.

Q. Can I send paper claims?

A. Yes. However Tufts Health Plan strongly recommends electronic claims submission; when you send paper claims, you must clearly print paper claims on original CMS 1500 or UB04 RED forms.

Q. Will Tufts Health Plan accept a P.O. Box or Lock Box in loop 2010AA?

A. No, P.O. boxes or Lock Boxes are not allowed in loop 2010AA per Implementation Guides and claims that contain them will be rejected. As specified in the Implementation Guides, P.O. Box or Lock Box can be sent in loop 2010AB, Pay-To Address Name, if necessary.

Q. Will Tufts Health Plan accept a 5-digit zip code in loop 2010AA?

A. No, per Implementation Guides, only 9-digit zip codes can be accepted. If the claim contains a 5-digit zip code, the claim will be rejected.

4.3.2 Tufts Health Plan Product Type Questions

Q. Can I send all Tufts Health Plan product types in one electronic file?

A. Yes, all products can be submitted in one file. However, the 837 Institutional and 837 Professional claim files must be sent separately. They cannot be sent on the same file.

Q. To submit CareLink claims do I have to do a separate setup with Tufts Health Plan if I already have one with CIGNA?

A. Yes, contact EDI Operations by sending email to edi_operations@tufts-health.com. Although you may be credentialed and set up with CIGNA, you must also be credentialed and setup with Tufts Health Plan to submit CareLink claims.

Q. Can I send CareLink claims electronically?

A. Yes, CareLink claims can be submitted with all other Tufts Health Plan claims.

Q. Can I submit Medicare Preferred claims electronically?

A. No. Secure Horizons is no longer a Tufts Health Plan product. Tufts Health Plan's Medicare Advantage products are Tufts Medicare Preferred plans and those claims can be submitted electronically.

Q. Can I submit Uniformed Services Family Health Plan (USFHP) claims electronically to Tufts Health Plan?

A. Yes, USFHP claims can be submitted to Tufts Health Plan with all other Tufts Health Plan claims. By referring to the back of the member's ID card, you can tell that the member is covered by USFHP, administered by Tufts Health Plan. The back of the ID card will include the following statement:

"Administrative services for the Uniformed Services Family Health Plan from Brighton Marine are provided by Tufts Health Plan, Inc. US Family Health Plan is a designated provider of the TRICARE Prime Uniform Benefit."

4.3.3 Direct 837 Claims Questions

Q. Is testing required to send 837 claim files to Tufts Health Plan?

A. Yes. Please refer to section 6.2 in this Companion Guide for testing process details.

Q. For how long are submitter/scrubber reports available?

A. Submitter/scrubber reports are retained in your mailbox for one week.

4.3.4 Electronic Funds Transfer

Q. Does Tufts Health Plan offer electronic funds transfer (EFT)?

A. Tufts Health Plan understands the community interest regarding EFT and adding this service is under consideration.

4.4 Other Resources

4.4.1 Submitter/Scrubber Reports

- When a compliant file is received, the submitter reports (EPZ 1 & 2) – commonly referred to as “the scrubber reports” - will typically be available within one business day.
- The Claims Acceptance Summary Report (EPZ1) includes basic file information: submission status, submission date, claims submitted, claims rejected and claims accepted.
- The Claims Acceptance Detail Report (EPZ2), include basic file information: submission status, submission date, reasons for claim rejections, and claim numbers for accepted claims.
- For rejection criteria and associated error messages that are sent on submitter reports, see Communications/Connection section 6.4.

5 TI Change Summary

Revision	Revision Date	Comments
1	02/2011	Version 5010

6 Communications/Connectivity (C/C) Instruction

6.1 Setup Process

6.1.1 Direct Submitters

Providers interested in submitting electronic claim transactions should contact EDI Operations at Tufts Health Plan via email or telephone to request setup. Please refer to the “6.3” section for contact details. A direct submitter EDI setup form can be found in the “6.5 EDI Set-up Form” section.

EDI Operations will coordinate the appropriate process to set up an electronic data interchange. This includes completing enveloping requirements in Communications/Connection section 6.6.

Upon setup completion, EDI Operations notifies the submitter and reviews the testing procedures. After this review, test claim files can be sent to Tufts Health Plan.

Upon successful testing between Tufts Health Plan and the new submitter, the submitter migrates to a production status.

6.1.2 NEHEN Submitters

Providers interested in submitting electronic claim transactions via the NEHEN eGateway should contact their vendor directly who will then facilitate setup with EDI Operations. EDI Operations will provide an IP address for the submitting provider, working through the NEHEN support staff.

Upon setup completion, EDI Operations notifies the submitter and NEHEN technical support staff that the eGateway and telecommunications are set up. The submitter can then configure its eGateway to send the claims transactions to our test eGateway.

Upon successful testing between Tufts Health Plan and the new submitter, the submitter migrates to a production status.

6.2 Testing

EDI Operations will work with the new submitter to setup a username name and password. After establishing a username name and password, the submitter can begin sending claim transactions to the test environment.

1. During the testing process, EDI Operations examines submitted test transactions for required elements. EDI Operations also ensures that the submitter gets a response during the testing mode. Submitters are encouraged to review their 999s and EPZ (submitter/scrubber reports) for errors.
2. EDI Operations notifies the submitter upon the successful completion of testing.
3. When the submitter is ready to send an 837 transaction to the production mailbox, they are notified by EDI Operations, and given a GO LIVE date to move to the production environment.
4. The submitter's username name remains the same when moving from test to production.
5. Tufts Health Plan recommends each test file includes no more than 100 claims.

6.3 Contact Information

The following sections provide contact information for any questions regarding HIPAA, 837 transactions, EDI, documentation, or training.

6.3.1 For General Claims Submission Questions

Go to <http://www.tuftshealthplan.com/providers> and select the [Electronic Services](#) link.

6.3.2 For 837 Transaction Questions

The following table provides specific contact information by department and responsibility.

For Questions Regarding...	Contact	Phone Number	Email Address
General 837 Initial Contact for Setup and Testing	Kevin Whalen	(888) 880-8699 x3344	Kevin_Whalen@tufts-health.com
EDI Claims Submission (i.e., file submissions, claim rejections)	Tufts Health Plan EDI Operations	(888) 880-8699 x4042	EDI_Operations@tufts-health.com
HMO, POS or PPO Claim Information (i.e., claim denials, payment policies)	Tufts Health Plan Provider Services	(888) 884-2404 Fax: 617-972-9452	
Medicare Preferred Claim Information (i.e., claim denials, payment policies)	Tufts Health Plan Medicare Preferred Customer Relations	(800) 279-9022 Fax: 617-972-9487	
NPI registration and credentialing	Tufts Health Plan Provider Information	(888) 880-8699 x3153	

6.4 Rejection Criteria/Error Messages on Submitter Reports.

The grid below outlines electronic claim error messages that appear on Tufts Health Plan submitter reports.

Rejection Criteria for 837 Institutional Claims

Message	Criteria
Claim Accepted	Tufts Health Plan accepted the claim submitted.
INVALID MEMBER ID	Member ID/Suffix is not in Tufts Health Plan system.
INVALID SUBSCRIBER	Subscriber is not in Tufts Health Plan system.
ADMIT/REF NPI NOT ON FILE AT PAYER	Admit/Ref NPI is not in Tufts Health Plan system.
PROVIDER NPI NOT ON FILE AT PAYER	Provider NPI is not in Tufts Health Plan system.
INVALID PRIMARY DIAG CODE	Primary diag code is not in Tufts Health Plan system, or the 1st position of diag code is E-Code.
INVALID SECONDARY DIAG CODE	Secondary diag code is not in Tufts Health Plan system.
INVALID ADDR-SUFFIX	Payment address suffix is incorrect.
INVALID PAT. DOB	Patient's date of birth does not match Tufts Health Plan patient date of birth on file.
DOB EXCEEDS DOS FOR MEMB-ID	Member's date of birth is after date of service.
WRONG DATE OF BIRTH FOR MEM	Date of birth is not within 7 days of member's date of birth.
PAT. ACCT. SPACES	Patient account number is not submitted.
INVALID BEGIN DOS	Beginning date of service is invalid.
INVALID END DOS	End date of service is invalid for type of bill. [Except for frequency types 2 or 3 (Interim Bills) that do not require end date of service.]
DOB > BEGIN DOS	Date of birth is greater than the date of service.
DOB > TODAY	Date of birth is greater than today's date.
INVALID SEX	Value does not equal 'F', 'M', or 'U'.
ASSIGN BEN. MUST = Y	Value does not equal 'Y'.
INVALID TYPE OF BILL	Value is not a valid type of bill as defined by HIPAA.
INSTITUTE INPAT. NOT ACCEPTED	Type of bill is not valid for type of submission.
INSTITUTE OUTPAT. NOT ACCEPTED	Type of bill is not valid for type of submission.
BEGIN DOS > TODAY	Begin date of service is after today's date.
19970101 IS > THAN BEGIN DOS	Begin date of service is before 01/01/1997.
BEGIN DOS NOT = ADM. DATE	Begin date of service does not equal the admit date.

Message	Criteria
END DOS > TODAY	End date of service must be before today's date. [Except for frequency types 2 or 3 (Interim Bills) that do not require end date of service.]
DOB > END DATE	Date of birth cannot be after the end date. [Except for frequency types 2 or 3 (Interim Bills) that do not require end date of service.]
BEGIN DOS > END DOS	Beginning date of service cannot be after the end date. [Except for frequency types 2 or 3 (Interim Bills) that do not require end date of service.]
ADM HR REQUIRED FOR INPATIENT CLAIM	The admit hour is not submitted.
INVALID ADM. HOUR	Admit hour is invalid.
SOURCE OF ADM. REQ. FOR INPATIENT CLAIM	Source of admission is not submitted.
INVALID SOURCE OF ADMISSION	Source of admission is invalid.
SOURCE OF ADMISSION NOT NUMERIC	Source of admission must be a valid value. [Can not be numeric.]
DISCHARGE HR NOT NUMERIC	Discharge hour must be numeric. [Except for frequency types 2 or 3 (interim bills) that do not require a discharge hour.]
DISCHARGE HR REQ FOR INPATIENT CLAIM	Discharge hour is not submitted. [Except for frequency types 2 or 3 (interim bills) that do not require a discharge hour.]
INVALID DISCHARGE HOUR	Discharge hour is invalid. [Except for frequency types 2 or 3 (interim bills) that do not require a discharge hour.]
RELEASE OF INFO. FLAG MUST BE OBTAINED	Release of information code does not equal Y.
INVALID ADMIT DATE	Admit date is invalid.
DOB > ADM DATE	Date of birth is greater than the admit date.
ADM DATE > TODAY	Admit date is greater than today's date.
19970101 IS > THAN ADM DATE	Admit date is before 01/01/1997.
ADM. DATE NOT = BEG. DOS	Admit date does not equal the begin date of service.
INVALID DISCHARGE DATE	Discharge date is invalid. [Except for frequency types 2 or 3 (interim bills) that do not require a discharge date.]
BEGIN DOS > DISCHARGE DATE	Begin date of service is greater than the discharge date, [Except for frequency types 2 or 3 (interim bills) that do not require a discharge date.]
ADM. DIAG. REQUIRED FOR INPATIENT CLAIM	Admit diag is not submitted.
INVALID ADM. DIAG	Admit diag is invalid.
ADMISSION TYPE REQUIRED	Admission type is not submitted.

Message	Criteria
INVALID ADMISSION TYPE	Admission type is invalid.
ADM TYPE XREF INVALID - MUST BE 1-4,9	Admission type is invalid.
ADMISSION TYPE MUST BE 1-4, 9	Admission type does not equal 1-4 or 9.
DISCHARGE STATUS REQUIRED	Discharge status is not submitted. [Except for frequency types 2 or 3 (interim bills) that do not require a discharge status.]
INVALID DISCHARGE STATUS	Discharge status is not valid. [Except for frequency types 2 or 3 (interim bills) that do not require a discharge status.]
INVALID DISCHARGE STATUS RANGE	Discharge status range is not valid. [Except for frequency types 2 or 3 (interim bills) that do not require a discharge status range.]
ATT PHYS ID IS REQUIRED	Attending Physician ID is not submitted.
INVALID OTHER DIAG2 – OTHER DIAG24	Not a valid diagnosis code in Tufts Health Plan's system.
PAYEE ID IS NOT EQUAL TO PROVIDER ID	Payee ID and Provider ID do not equal. [Tufts Health Plan requires that Payee ID and Provider ID equal on institutional claims.]
PAYEE NPI NOT ON FILE AT PAYER	Payee NPI value is not found in THP Provider NPI Source System.
INVALID PRIM-PROC	Primary procedure code is invalid and/or not effective on the beginning date of service of claim.
INVALID PRIM-PROC MODIFIER	Modifier is invalid and/or not effective on beginning date of service of claim.
INVALID PRIM-PROC MODIFIER 2	Modifier is invalid and/or not effective on beginning date of service of claim.
INVALID PRIM-PROC MODIFIER 3	Modifier is invalid and/or not effective on beginning date of service of claim.
INVALID PRIM-PROC MODIFIER 4	Modifier is invalid and/or not effective on beginning date of service of claim.
INVALID 001414 PRIM-PROC	Procedure must have a valid admit refer ID.
DOS > RECEIPT DATE	Date of service is greater than date received.
INVALID DOS	Date of service is invalid.
INVALID NOS - NOT NUMERIC	Number of service is invalid. [Must be numeric.]
DISCHARGE HOUR IS REQ. FOR THIS REV. CODE	Discharge hour not submitted for type of claim or type of bill [Specifically for revenue codes 760, 761, 762 or 769.]
AMT. BILLED NOT NUMERIC	Amount billed is invalid. [Must be numeric.]
REV. CODE REQUIRES AMT. BILLED > 0	Amount billed is invalid for service line. [Must contain amount greater than 0.]

Message	Criteria
DOS NOT IN RANGE OF BEG. AND ENDING DOS	Date of service is not in range of the beginning and ending date of service. [Except frequency type 2 or 3 (interim bills) that do not require ending date of service.]
DOS=0 AND BEG. AND ENDING DOS ARE NOT EQUAL	Date of service is not submitted on the service line.
REV. CODE REQUIRED FOR INSTITUTIONAL CLAIM	This revenue code requires a valid procedure code.
INVALID REVENUE CODE	Revenue code invalid and/or not effective for beginning date of service of claim.
INVALID PRINCIPLE PROCEDURE	Not a valid HCPCS/CPT code if qualifier is 'BP' from the beginning to end date of service. Not a valid ICD-9 procedure code if qualifier is 'BR' from the beginning to end date of service.
ANESTHESIA UNITS MUST BE BILLED WITH QUALIFIER "MJ"	Version 5010 Requires Anesthesia claims to be submitted with the MJ qualifier.

Rejection Criteria for for 837 Professional Claims

Message	Criteria
Claim Accepted	Tufts Health Plan accepted the claim submitted.
INVALID MEMBER ID	Member ID/Suffix is not in Tufts Health Plan system.
INVALID SUBSCRIBER	Subscriber is not in Tufts Health Plan system.
ADMIT/REF NPI NOT ON FILE AT PAYER	Admit/Ref NPI is not in Tufts Health Plan system.
PROVIDER NPI NOT ON FILE AT PAYER	Provider NPI is not in Tufts Health Plan system.
PAYEE ID CANNOT EQUAL PROVIDER ID#	Payee/Pay To ID # submitted cannot be used as Provider/Rendering ID #.
CLAIM TYPE NOT ACCEPTED	Provider type not authorized to submit professional claims.
INVALID PRIMARY DIAG CODE	Primary diag code is not in Tufts Health Plan system or if 1 st position of diag code is E-Code.
INVALID SECONDARY DIAG CODE	Secondary diag code is not in Tufts Health Plan system.
INVALID ADDR-SUFFIX	Payment address suffix is incorrect.
INVALID PAT. DOB	Patient's date of birth does not match Tufts Health Plan patient date of birth on file.
DOB EXCEEDS DOS FOR MEMB-ID	Member's date of birth is after date of service.
WRONG DATE OF BIRTH FOR MEM	Date of birth is not within 7 days of member's date of birth.
PAT. ACCT. SPACES	Patient account number is not submitted.
DOB > TODAY	Date of birth is greater than today's date.
INVALID SEX	Value does not equal 'F', 'M', or 'U'.
ASSIGN BEN. MUST = Y	Value does not equal 'Y'.
INVALID EMPLOYMENT FLAG	Employment flag is invalid.
INVALID AUTO ACCIDENT FLAG	Auto accident flag is invalid.
INVALID OTHER ACCIDENT FLAG	Other accident flag is invalid.
PATIENT OR AUTH SIGNATURE MUST BE OBTAINED	Patient or Authorization signature has not been obtained.
INSURED OR AUTH SIGNATURE MUST BE OBTAINED	Insured or Authorization signature has not been obtained.
INVALID TYPE OF BILL	Value is not a valid type of bill as defined by HIPAA.
RELEASE OF INFO. FLAG MUST BE OBTAINED	Value does not equal 'Y'.
INVALID PLACE OF SERVICE CODE	Place of service is invalid.
DOS BEYOND RECEIPT DATE	Date of service cannot exceed the receipt date.
INVALID PRIM-PROC	Primary procedure code is invalid and/or not effective on the beginning date of service of claim.

Message	Criteria
INVALID PRIM-PROC MODIFIER	Modifier is invalid and/or not effective on beginning date of service of claim.
INVALID PRIM-PROC MODIFIER 2	Modifier is invalid and/or not effective on beginning date of service of claim.
INVALID PRIM-PROC MODIFIER 3	Modifier is invalid and/or not effective on beginning date of service of claim.
INVALID PRIM-PROC MODIFIER 4	Modifier is invalid and/or not effective on beginning date of service of claim.
INVALID 001414 PRIM-PROC	Procedure must have a valid admit refer ID.
INVALID DOS	Date of service is invalid.
INVALID NOS - NOT NUMERIC	Number of service is invalid. [Must be numeric.]
AMT. BILLED NOT NUMERIC	Amount billed is invalid. [Must be numeric.]

6.6 Enveloping Specifications

Trading Partner1 (SENDER)	<Sender ID>
Trading Partner2 (RECEIVER)	170558746
APRF (Application Reference)	837
Segment Terminator (OPTIONAL)	LF (Line Feed)
Element Separator (OPTIONAL)	

6.6.1 ISA (Interchange Control Header Segment)

The ISA is a fixed record length segment and all positions within each of the data elements are required. The first element separator defines the element separator used through the entire interchange. The segment terminator used after the ISA defines the segment terminator to be used throughout the entire interchange.

The **Input Data** column below contains text in *[bracketed italics]*, which indicates special input data dependent on sender, time, date, etc.

Elements	Size	Name	Input Data	Remarks
ISA01	2	Authorization Information Qualifier	00	No Authorization Information Present.
ISA02	10	Authorization Information	<i>[Submitter-specific ID number, or ten-space placeholder]</i>	If no Authorization Information number is present, simply enter 10 spaces in this field.
ISA03	2	Security Information Qualifier	00	No Security Information Present.
ISA04	10	Security Information/Password	<i>[Submitter-specific ID number, or ten-space placeholder]</i>	If no Authorization Information number is present, simply enter 10 spaces in this field.
ISA05	2	Interchange ID Qualifier/Trading Partner Qualifier	ZZ	Mutually Agreed.
ISA06	15	Interchange Sender ID/Trading Partner ID	<i>[Tufts Health Plan Submitter ID]</i>	Sender ID (Provided by Tufts Health Plan).
ISA07	2	Interchange ID Qualifier/Tufts Health Plan Qualifier	01	DUNS (Dun & Bradstreet).
ISA08	15	Interchange Receiver ID/Tufts Health Plan ID	170558746	Tufts Health Plan DUNS.
ISA09	6	Interchange Date	<i>[Enter the date using the format YYYYMMDD; for example, January 1, 2012 would be entered as 120101]</i>	Date of the interchange.

Elements	Size	Name	Input Data	Remarks
ISA10	4	Interchange Time	<i>[Enter the time using the format HHMM; for example, 1:30 PM would be entered as 1330]</i>	Time of the interchange.
ISA11	1	Repetition Separator		The repetition separator is a delimiter and not a data element; this field provides the delimiter used to separate repeated occurrences of a simple data element or a composite data structure; this value must be different than the data element separator, component element separator, and the segment terminator.
ISA12	5	Interchange Control Version Number		Version Number.
ISA13	9	Interchange Control Number/Last Control Number	<i>[Sender-specific control number]</i>	Assigned and maintained by the interchange sender, must be identical to the associated Interchange Trailer, IEA02. Must increment by one number at the end of the value with each file submitted within the same business day (12:00 am to 11:59 pm).
ISA14	1	Acknowledgement Request	<i>[Enter either 0 or 1]</i>	The 999 will be sent regardless of Input Data.
ISA15	1	Interchange Usage Indicator/ Acknowledgment Test Indicator	<i>[Enter either T or P]</i>	T - Test Data, P - Production Data.

Elements	Size	Name	Input Data	Remarks
ISA16	1	Component Element Separator (Sub-Element)	<i>[Enter any separator character, for example : or >]</i>	Used to separate component data elements within a composite data structure; must be unique. ASCII Value - Component element separator.

6.6.2 IEA (Interchange Control Trailer Segment)

This segment defines the end of an interchange of zero or more functional groups and interchange-related control segments.

The **Input Data** column below contains text entered in *[bracketed italics]* indicates special input data dependent on sender, time, date, etc.

Elements	Size	Name	Input Data	Remarks
IEA01	1/5	Number of Included Functional Groups	<i>[Submitter-specific ID number]</i>	A count of the number of functional groups included in an interchange.
IEA02	9	Interchange Control Number	<i>[Submitter-specific ID number]</i>	A control number assigned by the interchange sender.

6.6.3 GS (Functional Group Header Segment)

This segment indicates the beginning of a functional group and to provide control information.

The **Input Data** column below contains text entered in *[bracketed italics]* indicates special input data dependent on sender, time, date, etc.

Elements	Size	Name	Input Data	Remarks
GS01	2	Functional Identifier Code	HC	Health Care Claim.
GS02	2/15	Application Sender's Code	<i>[Tufts Health Plan Submitter ID]</i>	Code identifying party sending transmission.
GS03	2/15	Application Receiver's Code	170558746	Code identifying party receiving transmission.
GS04	8	Date	<i>[Enter the date using the format YYYYMMDD; for example, January 1, 2012 would be entered as 20120101]</i>	Functional Group creation date.

Elements	Size	Name	Input Data	Remarks
GS05	4/8	Time	<i>[Enter the time using the format HHMM; for example, 1:30 PM would be entered as 1330]</i>	Functional Group creation time. Time expressed in 24-hour clock.
GS06	1/9	Group Control Number/Last Control Number	<i>[Submitter-specific number]</i>	Assigned and maintained by the sender, must be identical to the associated functional group trailer, GE-02.
GS07	1/2	Responsible Agency Code	X	Accredited Standards Committee X12.
GS08	1/12	Version/Release/Industry Identification Code	005010X223A2 or 005010X222A1	Health Care Claim for Institutional Health Care Claim for Professional.

6.6.4 GE (Functional Group Trailer Segment)

The **Input Data** column below contains text entered in *[bracketed italics]* indicates special input data dependent on sender, time, date, etc.

Elements	Size	Name	Input Data	Remarks
GE01	1/6	Number of Transaction Sets Included	<i>[Submitter-specific number]</i>	Total number of transaction sets included in the functional group or interchange (transmission) group terminated by the trailer containing this data element.
GE02	1/9	Group Control Number	<i>[Submitter-specific number]</i>	Assigned number originated and maintained by the sender.