



Dean

H E A L T H P L A N

Companion Document



*For use with the
X12N 837 (004010A)
Health Care Claim – Professional and Institutional
Implementation Guide and Addenda*

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Introduction

This guide serves as a Dean Health Plan (DHP) specific companion document to the *837 Health Care Claim, Professional and Institutional Transaction Set Implementation Guide*. This document provides information related to specific requirements of the *837 Health Care Claim, Professional and Institutional* transactions, but does not change the definition, data condition, or use of a data element or segment in a standard, add data elements or segments to the maximum defined data set, use any code or data elements that are either marked “not used” in the standard’s implementation specification or are not in the standard’s implementation specification(s), or change the meaning or intent of the HIPAA standards implementation specification.¹

For a valid transaction, Providers should program according to the National Electronic Data Interchange Transaction Set Implementation Guide & Addenda: *837 Health Care Claim, Professional and Institutional*. This transaction guide is available from the Washington Publishing Company’s website (<http://wpc-edi.com>).

All instructions in this document were written using information known at the time of publication and are subject to change. DHP is not responsible for software used by the submitter to complete these transactions.

For questions related to the DHP Health Care Claim, Professional and Institutional, please contact the DHP EDI Team at 1-800-356-7344 x4320 or email your question to dhpedi@deancare.com.

General Transaction Information

General Overview

The ANSI ASC X12 837 Health Care Claim, Professional and Institutional transaction will transfer professional and institutional claims from a provider or a designated agent of the provider to DHP. This transaction was designed to expedite data interchange health encounter/claims processing the payment environment.

Business Use

The following business events are supported by the 837 Health Care Claim, Professional and Institutional transaction.

- Execution of electronic information pertaining to a health encounter or health claim from provider-to-payer or from payer-payer.
- To accelerate the processing and payment of a claim or encounter.

¹ Standards for Electronic Transactions, Federal Register, Vol. 65, No. 160, August 17, 2000 pg. 50368

DHP Specifications/Requirements

This section covers the information that DHP requests to process your files efficiently. Please see the matrix for any detailed information that may be needed by DHP to process claims data.

Please Note: The information in Loop 2010AA should pertain to the pay-to-billing entity. If a billing company is being used, the information pertaining to the billing company should be in Loop 1000A

Segment ID	Element ID	Element Name	Loop ID	Valid Value(s)	Format Example
ISA	01	Authorization Information Qualifier	N/A	Always "00" (zero-zero) No authorization	00
ISA	02	Authorization Information	N/A	Always blank (Fill with 10 spaces)	
ISA	03	Security Information Qualifier	N/A	Always "00" – No authorization	00
ISA	04	Security Information	N/A	Always blank (Fill with 10 spaces)	
ISA	05	Interchange ID Qualifier (Sender)	N/A	Always "ZZ" – expected value in this field	ZZ
ISA	06	Interchange Sender ID	N/A	Name of sender submitting file. This field must be 15 bytes (alphanumeric) and left justified.	YOURIDHERE
ISA	07	Interchange ID Qualifier (Receiver)	N/A	Always "ZZ" – expected value in this field	ZZ
ISA	08	Interchange Receiver ID	N/A	Please use "391535024" in this field	391535024
ISA	09	Interchange Date	N/A	Interchange Creation Date	030520 (YYMMDD)
ISA	10	Interchange Time	N/A	Interchange Creation Time	0843 (HHMM)
ISA	16	Component Element Separator	N/A	Use a delimiter from the following list: >, *, ~, ^, and :	REF*1L*123>
GS	02	Application Sender's Code	N/A	Same as ISA06	YOURIDHERE
GS	03	Application Receiver's Code	N/A	Same as ISA08	391535024
BHT	02	Transaction Set Purpose Code	N/A	Always "00" – Original	"00"
BHT	06	Transaction Type Code	N/A	Always "CH" – Chargeable	"CH"
CUR	02	Currency Code	2000A	Always "USA" – United States	"USA"

Segment ID	Element ID	Element Name	Loop ID	Valid Value(s)	Format Example
NM1	08	Identification Code Qualifier	2010AA	Always "XX" – Health Care National Provider Identifier	XX
NM1	09	Billing Provider Identification Code	2010AA	National Provider ID (NPI #)	1234567890
REF	01	Reference Identification Qualifier	2010AA	Always "BQ" – Health Maintenance Organization Code	BQ
REF	02	Billing Provider Identifier	2010AA	Vendor ID number assigned by DHP *Should NOT be Tax ID #*	123456
NM1	08	Identification Code Qualifier	2010AB	Always "XX" – Health Care National Provider Identifier	XX
NM1	09	Pay-to-Provider Identifier	2010AB	National Provider ID (NPI #)	1234567890
REF	01	Reference Identification Qualifier	2010AB	Always "BQ" – Health Maintenance Organization Code	BQ
REF	02	Pay-to-Provider Identifier	2010AB	Vendor ID number assigned by DHP *Should NOT be Tax ID #*	123456
NM1	08	Identification Code Qualifier	2010BA	Always "MI" – Member Identification Number Code	"MI"
NM1	09	Subscriber Primary Identifier	2010BA	Subscriber ID number assigned by DHP	12345678901
NM1	08	Identification Code Qualifier	2010CA	Always "MI" – Member Identification Number Code	"MI"
NM1	09	Patient Primary Identification Number	2010CA	Member ID number assigned by DHP	12345678902
CLM	02	Total Submitted Charges	2300	Must equal the sum of the line item monetary amounts (SV102)	100.00
REF	01	Reference Identification Qualifier	2310A	Always "1G" – Provider UPIN Number	"1G"
NM1	08	Identification Code Qualifier	2310B	Always "XX" – Health Care National Provider Identifier	XX
NM1	09	Rendering Provider Identification Code	2310B	National Provider ID (NPI #)	1234567890
REF	01	Reference Identification Qualifier	2310B	Always "G2" – Provider Number assigned by DHP if different the Vendor ID *Should NOT be Tax ID #*	123456
SV1/SV2	01 – 1	Product/Service ID Qualifier	2400	Always "HC" – Health Care Common Coding System	"HC"
SV1/SV2	02	Line Item Charge Amount	2400	Monetary amount submitted for the service line.	100.00
REF	01	Reference Identification Qualifier	2400	Always "6R" - Provider Control Number	"6R"

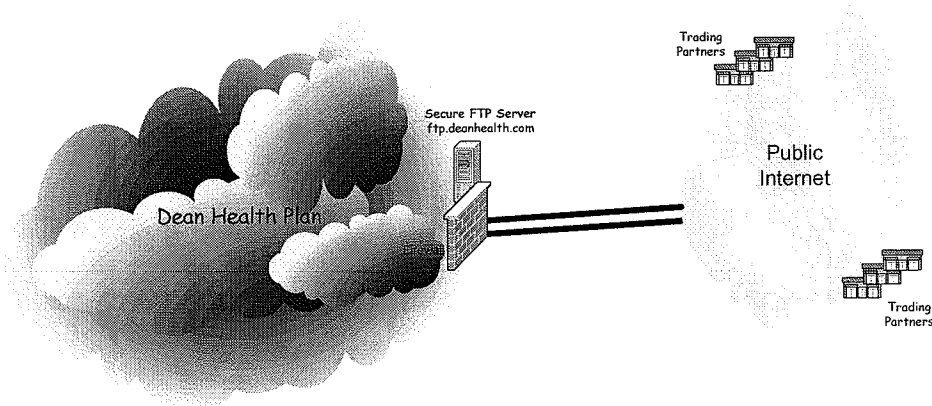
SVD	02	Service Line Paid Amount	2430	Monetary amount paid for the service line	100.00
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- 837 claim data must be submitted using the basic character set as defined in Appendix A of the 837 Implementation Guides. In addition to the basic character set, lower case characters and the “@” symbol from the extended character set may be submitted. Any other characters submitted from the extended character set may cause the interchange (transmission) to be rejected at the carrier translator.
- When sending the CAS segment all similar group codes should be sent in one segment unless another CAS segment is necessary to transmit additional similar Group Codes applicable to the claim line.
- All monetary amounts should be formatted with a decimal point.
- The maximum number of characters to be submitted in the dollar amount field is nine (9). Claims in excess of 9,999,999.99 may be rejected.
- Negative values submitted in the following fields may not be processed and may result in the claim being rejected: Total Claim Charge Amount (2300 Loop, CLM02), Patient Amount Paid (2300 Loop, AMT02), Patient Weight (2300 and 2400 Loop, CR102), Transport Distance (2300 and 2400 Loop, CR106), Payer Paid Amount (2320 Loop, AMT02), Allowed Amount (2320 Loop, AMT02), Line Item Charge Amount (2400 Loop, SV102), SV104), Total Purchased Service Amount (2300 Loop, AMT02), and Purchased Service Charge Amount (2400, PS102).
- Diagnosis codes have a maximum size of five (5). DHP does not accept decimal points in diagnosis codes.
- DHP will process service unit counts (units or minutes) based on the three (3) digits prior to the decimal point (SV104).
- Submitting delimiters not supported within the matrix may cause an interchange (transmission) to be rejected. Members of the Base Control Set and the Extended Control Set will not be accepted as delimiters.
- Only loops, segments, and data elements valid for the HIPAA Institutional or Professional Implementation Guides will be translated. Submitting data not valid based on the Implementation Guides may cause files to be rejected.
- All dates that are submitted on an incoming 837 claim transaction should be valid calendar dates in the appropriate format based on the respective qualifier. Failure to submit a valid calendar date may result in rejection of the claim or the applicable interchange (transmission).
- Reference Identification (BHT03) must be sent and be unique to each file submitted. Duplicate values in this segment will result in a rejected transaction.
- DHP 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). For each vendor number within a file, a new ST-SE (Transaction Set) should be submitted.
- DHP may reject an interchange (transmission) that is submitted with a submitter identification number that is not authorized for electronic claim submission.
- DHP may reject an interchange (transmission) that is submitted with an invalid value in GS03 (Application Receivers Code) based on the carrier definition.
- Up to eight diagnosis codes may be submitted per claim. If diagnosis codes are submitted, the primary diagnosis must be pointed to for each service line.

- Up to four modifiers may be submitted; however, the last two modifiers may not be considered. The DHP processing system may only use the first two modifiers for adjudication and payment determination of claims.
- A 997/functional acknowledgement will be provided within an hour of file receipt, with the exception of the maintenance window noted below. The 997/functional acknowledgment files should be retrieved on or before the first business day after the claims is submitted, but no later than five days after the file submission.
- DHP may reject any files that are found to be a duplication of a previous submission.
- For every claim that is submitted via electronic media, for all legal and other purpose will be considered signed by the provider or Provider's authorized representative.
- Dean Health Plan recommends that descriptive information be sent in the NTE segment when using non-specific codes or sending dental claims in the professional format.
- **Please note the following in regards to processing times:**
 - Cutoff time at DHP is approximately 12:00 p.m. Monday through Friday. Files transmitted beyond that time will not be processed until the following business day.
 - DHP reserves the hours between 12:00 p.m. and 2:30 p.m. as a maintenance window. During this time, files may be submitted to DHP. However, the 997/functional acknowledgment will not be available until after 2:30 p.m.

Connecting with DHP

DHP will be utilizing a FTP server to exchange transactions with trading partners. Trading partners will be set up on the FTP server upon their request. Please see Appendix A – Interface with FTP server for detailed instructions on how to put and pick up files on the FTP server.



Set Up Process

Trading partners interested in submitting Health Care Claims, Professional and Institutional to DHP should contact the EDI team via e-mail or telephone with a completed set up request. Please see Appendix B for the Set Up Request Form.

Testing

Please note that any files sent to a test area will never be run in production. To avoid any processing issues, it is critical that you do not change the manner in which you currently submit your data until you receive notification from DHP stating that production files can be sent electronically.

Once a trading partner is set up with access to the FTP server, DHP will test trading partner transactions. DHP will complete the following tasks within the testing process:

1. Create test folder on FTP server for the trading partner.
2. For inbound transactions, DHP will test trading partner files with Claredi to ensure that transactions are valid using the following testing categories.
 - Integrity Testing
 - Requirement Testing
 - Balancing Testing
 - Situation Testing
 - Code Set Testing
 - Product Types/Types of Service Testing
3. Work with trading partner to eliminate all identified errors.
4. Process transaction in test environment to ensure accurate results.
5. Notify trading partner that transaction testing is complete and schedule a mutually agreed upon date to move the transaction to production.
6. Set up production folder for trading partner on FTP Server. Send trading partner a User ID and password to be used for logging into the FTP server.

Contact Information

Contact the appropriate department to resolve any questions or issues:

Electronic Transaction Questions

EDI Team – IS Department
Phone: (800) 356-7344
Ext.: 4320
Fax: (608) 836-6335
Email: dhpedi@deancare.com.

Dean Health Plan
Attention: EDI Team
1277 Deming Way
Madison, WI 53717

Specific Transaction Information

DHP Customer Service
(800) 279-1301
(608) 828-1301
or Fax: (608) 827-4212

Business Description of Terms

This section defines a few basic terms that are widely used in the transmittal and processing of electronic data at Dean Health Plan. Please see http://www.wedi.org/public/articles/hipaa_glossary.pdf for a complete listing of terms and their definitions.

Companion Guide: Data clarifications that supplement the specifications in the Implementation Guide should be placed in a separate addendum. Companion Guides can include data elements where the Implementation Guide explicitly defers to other sources such as a contract or state law requirements. It can also include identifiers or codes where a national standard source is not recognized (such as the provider identifier prior to the National Provider Identifier standard being passed).

Covered Entity (CE): Under HIPAA, this is a *healthplan*, a *health care clearinghouse*, or a *health care provider* who transmits any health information in electronic form in connection with a HIPAA transaction. Also see Part II, 45 CFR 160.103.

Data Mapping: The process of matching one set of *data elements* or individual code values to their closest equivalents in another set of them. This is sometimes called a *cross-walk*.

FAQ(s): Frequently Asked Question(s).

Format: Under HIPAA, format refers to those *data elements* that provide or control the enveloping or hierarchical structure, or assist in identifying data content of, a transaction.

Health Care Clearinghouse: Under HIPAA, this is an entity that processes or facilitates the processing of information received from another entity in a nonstandard format or containing nonstandard *data content* into standard *data elements* or a standard transaction, or that receives a standard transaction from another entity and processes or facilitates the processing of that information into nonstandard format or nonstandard *data content* for a receiving entity. Also see Part II, 45 CFR 160.103

Health care provider: means a provider of services (as defined in section 1861(u) of the Act, 42 U.S.C. 1395x(u)), a provider of medical or health services (as defined in section 1861(s) of the Act, 42 U.S.C. 1395x(s)), and any other person or organization who furnishes, bills, or is paid for health care in the normal course of business.

Transaction: means the transmission of information between two parties to carry out financial or administrative activities related to health care. It includes the following types of information transmissions:

- 1) Health care claims or equivalent encounter information – 837
(Institutional, Professional, and Dental)
- 2) Health care payment and remittance advice – 835
- 3) Coordination of benefits -837
- 4) Health care claim status – 276/277
- 5) Benefit Enrollment and Maintenance – 834
- 6) Eligibility for a health plan – 270/271
- 7) Health plan premium payments – 820
- 8) Referral certification and authorization – 278

Appendix A – Interface with FTP

General Information

This documentation is written to give you information on the connection, transmittal, and exchange of information between you and Dean Health Plan (DHP) using the FTP Server.

Connectivity Instructions

The FTP server can be accessed via Internet. If you should have any questions or problems, please contact the EDI team at **dhpedi@deancare.com**. DHP reserves the right to change the process time due to holidays, system upgrades, or etc. Please check the log window for any informational messages.

Software Interface

Trading partners will be required to use FTP client software that will support 128 SSL Data encryption to exchange transactions with DHP.

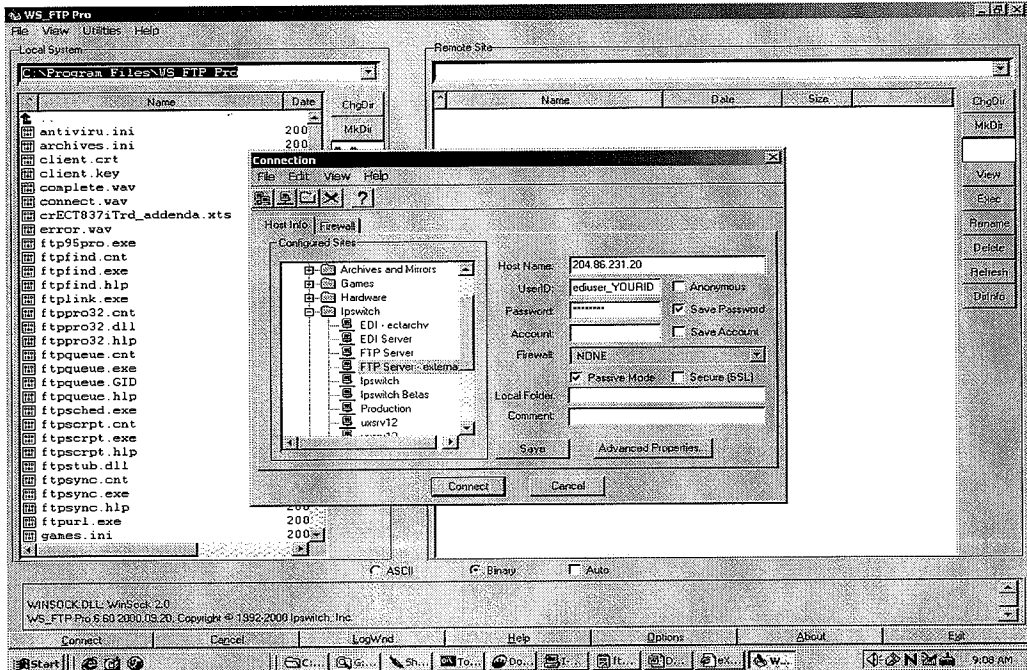
WSFTP Pro is the software that DHP has tested. The following instructions outline how to access the DHP FTP server using WSFTP Pro.

For more information on WS-FTP Pro please access their website
http://www.ipswitch.com/Products/WS_FTP/features.html

Any questions related to FTP connect should be directed to software provider or internal technical staff.

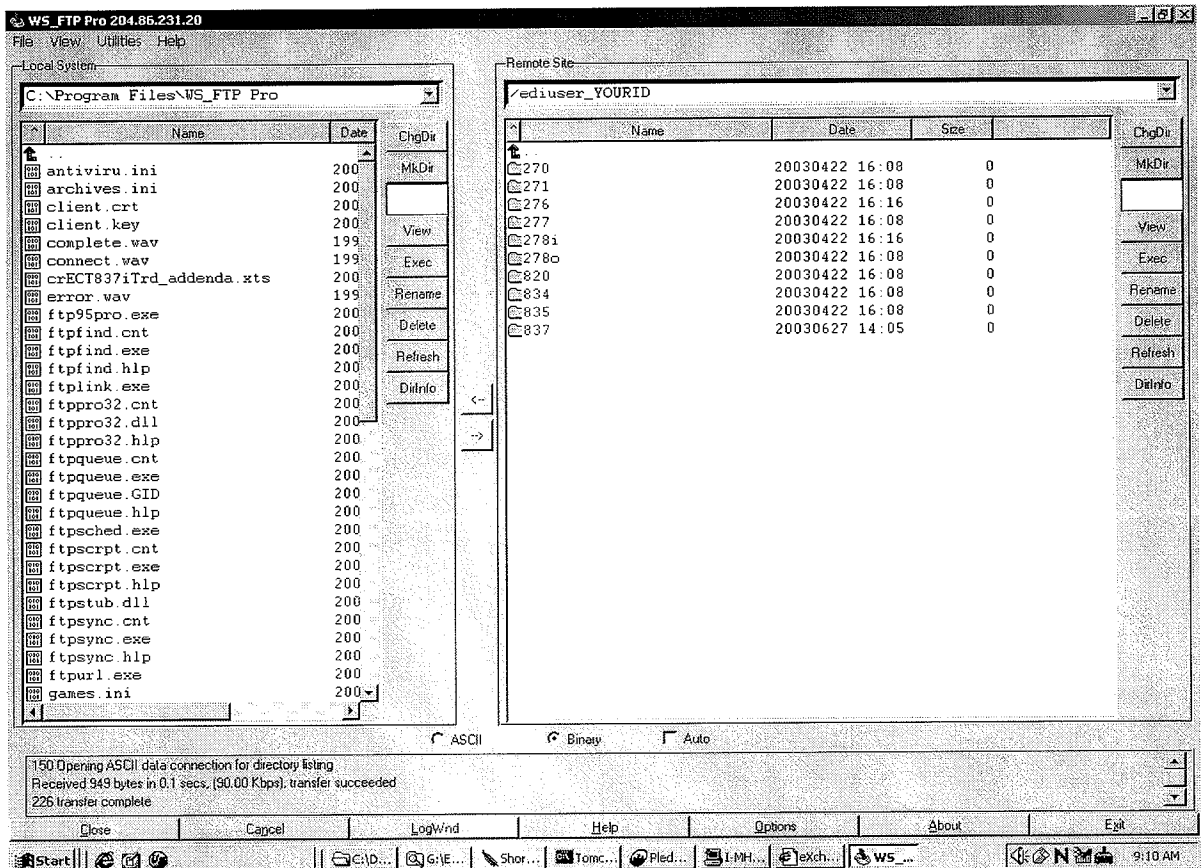
Uploading Files:

1. The first screen that appears asks you for the User-ID you received from Dean Health Plan:

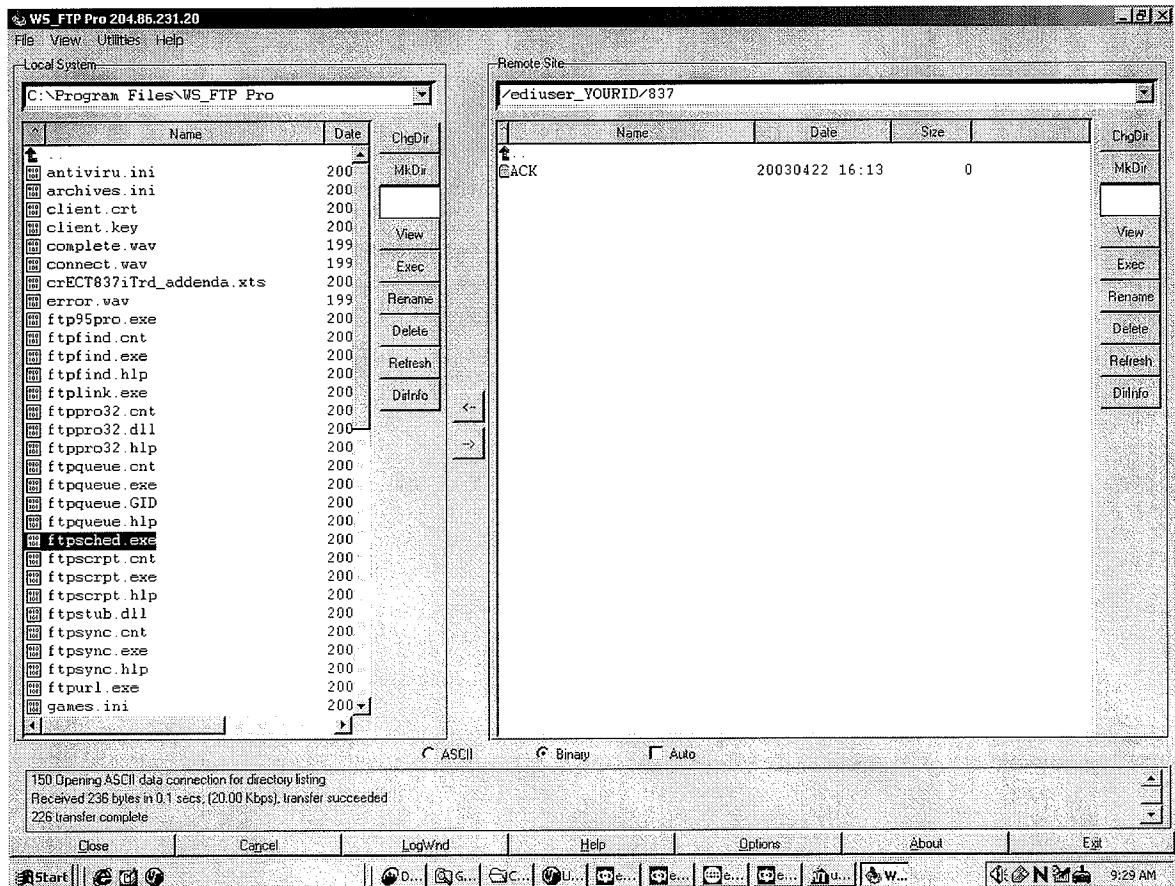


- Verify Host Name, UserID, a check on Passive Mode, and a check on Secure (SSL).
- Type your password and press **Connect**. (Your password will appear as a series of asterisks.)

2. The next screen will be a selection screen:



- The left side of the screen is the directories on your local system. This is where you will send your file from.
 - The right side of the screen is the directory on the FTP server at DHP. This is where you will be sending your file to or retrieving your file from. This will also show all of the transaction folders currently in your directory on the server.
3. Double click on a folder on the right side for the transaction that you wish to send to or receive from. This will open up the folder and show what is inside.
 4. Find the folder in which you plan on submitting from/to.
 5. Click on the file that you want to send or receive. Then click on the arrow key in the middle of the screen. If you are sending a file, use the arrow key pointing to the right (Remote Site). If you are receiving a file, use the arrow key pointing to the left (Local System).



- To select more than one file, use the Ctrl key for random files and the Shift key for files that are adjacent.
 - To resend a file, highlight the file and click on the arrow keys to upload the file again. This will overlay the file that is currently on the remote site.
 - If you sent the wrong file, you can remove the file from the remote directory by clicking on the file and then click the delete button on the remote directory side. **NOTE: If you delete a file from the local side, you are removing the file from your system and we cannot recover that file.**
6. To exit out of the system, go to File then Exit. This will close your session.



Appendix B - EDI Set-Up Form

Type of Practice/Group:	Solo <input type="checkbox"/>	Group <input type="checkbox"/>	Hospital/Facility <input type="checkbox"/>	Billing Service <input type="checkbox"/>
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Type of Account:	New <input type="checkbox"/>	Existing (indicate changes below) <input type="checkbox"/>
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Transaction Type:	837 Institutional claim <input type="checkbox"/>	837 Professional claim <input type="checkbox"/>	837 Dental claim <input type="checkbox"/>
	835 Remittance <input type="checkbox"/>	834 Enrollment <input type="checkbox"/>	270/271 Eligibility <input type="checkbox"/>
	278 Referral Request and Response <input type="checkbox"/>		820 Premium Payment <input type="checkbox"/>

Contact Information:

Name: _____ DHP Vendor Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Office Manager Contact: _____ Practice/Group Tax ID: _____

Telephone: (____) _____ Fax: (____) _____

E-Mail Address _____

If sending an 837 transaction, please fill out the next section

Confirmation Report Contact: _____	Telephone: (____) _____
Mailing address (if different than above) to mail Confirmation Report/Rejected Claims report:	

Provider/Group Information:

Name of Provider/Group	Dean Health Plan Number	NPI Number

Payment Information (if different that above):

Name of Payee: _____ DHP Payee Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Payee Tax ID: _____

If you are using a Clearing House to submit your files, please fill out the next section

Clearing House Name: _____
Contact Person: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Telephone: (____) _____ E-Mail Address: _____

Revision Listing

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Revision	Revision Date
1	8/15/03
2	05/18/08