



Forum Companion Document

For use with ANSI ASC X12N
Health Care Claim: Dental
Implementation Guide and Addenda

Health Care Claim: Dental 837

ASC X12N 837 (004010X097A1)

“Developing and Troubleshooting the Transaction”

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Getting an Electronic Version of this Document

An electronic version of this document, and other 837 related documents, can be found at www.wahealthcareforum.org/hipaa/work_products.asp. From the home page, the path is HIPAA Services, Work Products, Companion Documents for the HIPAA Transactions.

Participants in the 837D Companion Document Initiative

Washington Healthcare Forum Services (The Forum) is a state-wide consortium of healthcare payer and provider organizations. The Forum focuses its efforts on simplifying administrative processes between health plans, hospitals, and dental/medical groups. For additional information about The Forum see www.wahealthcareforum.org.

Health plans/TPAs participating in this HIPAA 837D initiative include:

- *First Choice Health Administrators,*
- *Premera Blue Cross,*
- *Regence BlueShield,*
- *Washington Dental Service*

Dental provider organizations participating in this HIPAA 837D initiative include:

- *Children's Hospital and Regional Medical Center*
- *Odessa Brown Children's Clinic*

Intended Use of the 837D Companion Document

The Forum is publishing this Companion Document to accompany the Implementation Guide and Addenda for the ASC X12N Health Care Claim: Dental (837D) Transaction.

A complete version on the Implementation Guide can be accessed at

www.wpc-edi.com/hipaa/HIPAA_40.asp.

This Companion Document is designed to help dentists/providers in their efforts to:

- *Become familiar with the HIPAA transaction and how that transaction will be processed by participating health plans*
- *Develop software to implement & exchange the HIPAA transaction with participating health plans*

- *Develop specification materials for their vendor(s) who will implement the transaction*
- *Resolve possible issues that might arise in the process of exchanging the transaction with participating health plan.*

*This Companion Document should be a useful guide for dentists/providers and other 837D transaction submitters that are exchanging transactions **directly** with participating dental plans/health plans (listed above).*

This Companion Document is likely to become one part of any trading partner agreement between a dentist/provider, or electronic submitter, and a dental plan/health plan. The term, '*trading partner agreement*', is used to refer to a verbal or documented understanding between organizations. It is not intended to imply any type of contractual commitment. Organizations may refer to this documented understanding by other names.

All conventions should be stated clearly in the *trading partner agreement* so that implementation and operations expectations are defined unambiguously. Conventions that are established in a *trading partner agreement* take precedence over any conventions that are contained in this document.

*This Companion Document may be less useful when a dentist/provider, or other 837D transaction submitter, is not exchanging transactions directly with participating dental plans/health plans. Information contained in this document **may not** apply to exchanges between:*

- Providers and public programs such as Medicare and Medicaid: Information about these programs is available at: **www.cms.gov**
- Dentists/Providers and Clearinghouses: Dentists/Providers should note that clearinghouses, and other intermediaries, may implement the transaction differently than what is outlined in this Companion Document. The clearinghouse may reformat the dentist's/provider's transaction before passing it along to the dental plan/health plan. This reformatting may add unforeseen complexity to the process of transaction exchange.

Scope of the 837D Transaction

Within Scope of this Document:

The Health Care Claim Dental transaction is used to convey information from dentists/providers and billing organization to dental plans/health plans about claims for payment for services provided. This includes claims to primary, secondary and/or tertiary payers.

Outside Scope of this Document:

- Claims transactions between dentists/providers and billing organization to payers for the purpose of repricing,
- Claim transactions between dental plans/health plans for the purpose of Coordination of Benefits (COB) are outside of the scope of this Companion Document.
- Information about how a particular claim is adjudicated by a dental plan/health plan is outside the scope of this Companion Document. That information is contained in a Remittance Advice 835 transaction.

Recommended Business Practices for Exchanging 837D Claims

Claims can be submitted to participating dental plans/health plans for services that have been delivered to a patient. Dental Plans/Health Plans will acknowledge receipt of each batch of claims with a 997 transaction.

At any time after submitting the claim, a dentist/provider can check on the status of the claim using the HIPAA 276/277 transaction or by accessing the dental plan's/health plan's web site. Unless instructed by the dental plan/health plan, dentists/providers should avoid resubmitting claims. Resubmitting claims as a method of checking on claims status will complicate the processing cycle.

When a claim has been processed, dental plans/health plans will communicate with the dentist/provider using the HIPAA 835 transaction and/or a paper remittance advice (see the Companion Document for the 835 transaction).

Dictionary of Important 837D Transaction Terms and Definitions

These definitions relate to data elements/descriptions within the 837D transaction and are intended to clarify where information should be placed within the transaction. *Be sure to check with the dental plan/health plan for their specific billing requirements, e.g. which data elements are required under what conditions.*

Term	Definition
Claim	A bill for services delivered to an individual patient. Within an 837D transaction, a CLM segment identifies each claim.
Batch of Claims	All claims that are contained within an ST-SE Loop of an 837D transaction. (Multiple claims are typically contained within an 837D.)
<ul style="list-style-type: none"> • Dentist • Provider 	Any individual (e.g. practitioner), organization (e.g. clinic) or institution (e.g. hospital) that provides healthcare services to patients.
<ul style="list-style-type: none"> • Rendering Provider • Assistant Surgeon 	Dentist/Providers that delivered services to the patient.
Referring Provider	Dentist/Provider who referred the patient to the Rendering Provider.
Pay To Provider	Provider to whom the health plan will send payment for claims submitted on the 837D.
<ul style="list-style-type: none"> • Billing Organization • Billing Service 	Organization that submits an 837D transaction on behalf of a Provider.
<ul style="list-style-type: none"> • Billing Provider • Submitter 	Original sender of the 837D, e.g. Provider or Billing Organization – whichever sent the electronic 837D transaction
Rejected Transaction	An 837D transaction that was received by a dental plan/health plan but could not be processed by their system because it was not compliant with HIPAA data formatting or data content requirements.
Rejected Claim	A Claim, contained in an 837D transaction, that was received by the dental plan/health plan, but was not accepted into their claims processing system
Denied Claim	A claim that was received by a dental plan/health plan, processed by their system and wasn't paid.
Trading Partner	A Sender (e.g. Provider, Billing Organization) or Receiver (e.g. Clearinghouse, Health Plan) of an 837D transaction.
Clearinghouse	An intermediary organization between a Dentist/Provider/Billing Organization and a Dental Plan/Health Plan.

Helpful Hints for Developing the 837D Transaction

This section of the 837D Companion Documents provides hints that may be helpful in developing and submitting an 837D transaction. Following these hints should expedite turnaround time on the claim.

These hints apply to the batch implementation of the 837D transaction. Batch implementation means that the submitting organization sends the 837D transaction to the dental plan/health plan through some means of telecommunications and does not remain connected while the dental plan/health plan processes the transaction.

1. Creating an electronic envelope (ISA-IEA) for the claim transaction

The X12N structure allows for either one or multiple transaction types to be transmitted in an ISA-IEA envelope. Participating dental plans/health plans prefer that each different type of transaction is contained with its own ISA-IEA envelope. For example, if an electronic transmission contains claims and referrals, two ISA-IEA sets are preferred; one for the claims (837D) and one for the claims status review transaction (276/277).

2. Structuring the transaction (GS-GE & ST-SE)

- A separate GS-GE set is preferred for each dentist/provider organization that originated a batch of claims and for each type of claim, e.g. Professional (837P), Institutional (837I), or Dental (837D).
- Within a GS-GE set, it is preferred that information between an ST and the corresponding SE relate to claims from one Billing Provider (i.e. one submitter/receiver combination). For that Billing Provider, there can be multiple pay-to providers multiple subscribers, multiple patients, and multiple claims.
- The Transaction Set Control Numbers in ST02 and SE02 must be identical. Submitters could begin sending transactions using the number 0001 in this element and increment from that starting point. The number must be unique within a specific functional group (GS-GE) and interchange set (ISA-IEA) but can repeat in other groups and interchanges.

3. Formatting Data in the Transaction

- Any character used in a data element cannot be used as a delimiter, separator, or terminator. Ideally, the following characters should not be contained in data fields: asterisks, single ticks, double ticks, number sign, colon, and tilde (*, ` , `` , # , : , ~).
- By convention, preferred field delimiters are: '*' (asterisk) for data element separator, ':' (colon) for sub-element separator, '~' (tilde) for segment terminator.
- If a name cannot be parsed into individual components (e.g., last name, first name, MI) in an NM1 segment, then NM102 should contain a '2' to indicate a non-person entity.

4. Staying Compliant With HIPAA Transaction Versions and Code Sets

- Per HIPAA regulations, Dental provider organizations must submit, and dental plans/health plans must be able to process, only the legally mandated version of the transaction. HIPAA regulations do not allow health plans to process earlier or future versions of a transaction in their production systems. Only the current version of the transaction can be supported.
- Per HIPAA regulations, Dental provider organizations must submit, and dental plans/health plans must be able to process, the dental data code sets that are valid at the time that the service was rendered. (The validity of the medical data code set is determined by the service date not the transaction submission date.) This means that dental plans/health plans must be able to process versions of the code sets that precede the current version.
- Current versions of many of the code sets are available at www.wpc-edi.com/codes/.

5. Identifying the Submitting Organization, the Billing Provider & the Pay-To Provider

- The organization that submitted the 837D transaction to the dental plan/health plan is considered the Submitting Organization. That organization should be identified in ISA06, GS02, and in the Submitter Loop 1000A 'Submitter Name'.

Likely situation: When a Dental provider organization uses a billing service to submit their claims, the billing service is the Submitting Organization.

- The organization that originated the claims is considered to be the Billing Provider. The organization to be paid by the dental plan/health plan for the services is considered to be the Pay-To-Provider.

The organization that originated the claim should be indicated in Loop 2010AA 'Billing Provider'.

The dental plan/health plans will determine the 'Pay-To Provider' based upon their contract. Even though a dentist/provider may be indicated in Loop 2010AB 'Pay-To Provider Name', the dental plan/health plan will always make payment according to the contract. Loop 2010AB 'Pay-To Provider Name' is not used by the dental plan/health plan for adjudication.

6. Identifying Rendering and Referring Providers

The rendering provider is generally the dental practitioner who performed the services. However, because of contractual arrangements, the supervising provider may appear as the rendering provider.

- In some cases the Rendering Provider is the same as the Billing or Pay-To Provider. In other cases, the Rendering Provider may be different than the Billing/Pay-To Provider.

Only fill in Loop 2310B ‘Rendering Provider Name’ if the Rendering Provider is different than the Pay-To Provider AND Billing Provider. In other words, only use Loop 2310B if the Rendering Provider is different than what is contained in . . .

- Loop 2010AB ‘Pay-To Provider’, or
- If Loop 2010AB ‘Pay-To Provider’ is left blank, the Rendering Provider is different than 2010AA ‘Billing Provider’

Otherwise, leave Loop 2310B ‘Rendering Provider Name’ blank.

Any Rendering Provider identified at the Service Line level — Loop 2420A — is not used for claim adjudication.

- Referring Provider may be identified at the Claim Level (Loop 2300). A Referring Provider would be put in Loop 2310A.

7. Sending Explanation Of Payment information

Ideally, dental plans/health plans would like to receive the full set of Explanation of Payment (EOP) information as described in Loops 2320 — Other Subscriber Information and 2430 — Line Adjudication Information. However, it is unlikely that Dental provider organizations will have the capability to fully populate these Loops from the Health Care Claim Payment/Advice 835 ANSI ASC X12N transaction (835). As a minimum, Dental provider organizations should supply the following information.

EOP Information	837 fields
Other Insured Name & Number	Loop 2330A: <ul style="list-style-type: none"> • NM101= ‘IL’ • NM102= ‘1’ or ‘2’ • NM103-105 is Other Insurance Name Information • NM108 = ‘MI’ • NM109 is Identifying Number
Amount Paid by Primary Payer ^{*1}	Loop 2320—COB Payer Paid Amount: <ul style="list-style-type: none"> • AMT01 = ‘D’ • AMT02 is Amount Paid
Zero Payment Indicator ^{*2} (only if Primary Payer was billed and paid amount = \$0.00)	See explanatory note #2 below Loop 2300 Segment NTE <ul style="list-style-type: none"> • NTE01= ‘ADD’, • NTE02 = ‘COB-Z’ or information about the \$0.00 payment contained on the paper EOP.
Payer Name	Loop 2330B: <ul style="list-style-type: none"> • NM101= ‘PR’ • NM102 = ‘2’ • NM103 is Payer Name Information

EOP Information	837 fields
	<ul style="list-style-type: none"> • NM108 = 'PI' • NM109 is payer identification information (the entered value is unimportant as it won't be used by the health plan)

- *1 The 'Amount Paid by Primary Payer' field should only contain the amount paid by the payer, excluding the contract adjustment. (If the coverage from the primary payer is a capitated product, the amount paid will be considered to be equivalent to a fee for service amount. This secondary claim will be processed as all other Coordination of Benefit claims.) Using this field for the amount paid by the patient, such as copay amount or patient responsibility amount, will slow down the adjudication process. When a dental plan/health plan sees an amount in that field that appears to be a co-pay amount, e.g. \$10 or \$15, the claim will be pended until the other payer can be contacted to confirm that the amount was paid by them.

For Washington Dental Service

If there is no dollar amount in the field and the WDS database indicates that another payer who is Prime, the claim will be paid as \$0.00 with the appropriate reason code.

- *2 The 'Zero Payment Indicator' should be included when the primary payer was billed and remitted \$0.00. (An example of this situation is when the patient's deductible has not been met.)

For Washington Dental Service

If the amount paid by the primary payer is \$0.00, the paper EOP from the primary payer does not need to be sent.

For all other participating Dental Plans/Health Plans

If the amount paid by the primary payer is \$0.00, the dental plan/health plan needs additional information from the primary payer. In these situations, ***claims are likely to be turned around faster if they are submitted on paper along with the paper EOP*** from the primary payer.

If you choose to submit the claim electronically, fill in all of the fields outlined in this table;

- If information about the zero payment is not included on the electronic claim, the claim may be denied with an action code indicating that a paper EOP is required.
- Otherwise, the dental plan/health plan will usually try to obtain the remaining information from the primary payer. If they are unable to do so, the claim will be denied. If this happens, resubmit a paper claim with the paper EOP from the primary payer and be sure to attach the Supporting Documentation Standard Cover Sheet.

8. Testing Your Transaction

When testing the transaction, limit the number of inquiries in the batch to 50 or less. Once the testing process has been completed, the number of inquiries can be increased.

Testing your transaction with a validation tool/company is strongly recommended. This process will make it significantly easier to test the transaction with your dental plan/health plan or other intermediary. Examples of validation tools/companies include EDIFECS and ClarEDI. These companies are listed as examples. This listing is not intended as an endorsement.

Participating Dental Plans/Health Plan request that EDI batches that contain any test data be sent separate from EDI batches that contain production data. The values in ISA15 and REF02 of the BHT segment should correspond. Both should indicate either test data or production data.

Trouble Shooting Questions and Answers

This section of the 837D Companion Documents provides answers to commonly asked questions that may arise during the process of tracking claims that have been submitted.

1. What acknowledgment should we receive from health plans?

Dental plans/Health plans intend to respond to every 837D transaction received, in most cases with a Functional Response transaction (997). The 997 will be sent immediately upon receipt of the 837 transaction by the dental plan/health plan.

Per HIPAA regulations, if the information associated with any of the claims in the 837D ST-SE batch is not correctly formatted from a syntactical perspective, all claims within the ST-SE set are rejected. The dental plan/health plan notifies the submitting organization of the rejection *via* a 997 transaction or other method agreed upon in the *trading partner agreement*. Dental provider organizations should consider this possible response when determining how many patients and claims they submit in a single 837D ST-SE.

If a 997 shows a rejected batch or batches, practitioners should fix the error and resend everything that was contained within the ST-SE of the rejected 837D transaction.

If some or all of the ISA segment is unreadable or does not comply with the Implementation Guide and Addenda, AND there is sufficient routing information that can be extracted from the ISA, the health plan will respond with an appropriate TA1-997 transaction **OR** will contact the physician or other healthcare Dental provider *via* phone/fax whenever possible. In this case, the batch is not processed.

In all other cases, the dental plan/health plan responds with an appropriate 997 transaction to acknowledge receipt of the Batch. The 997 transaction indicates whether or not the batch can be processed. If the GS segment of the batch does not comply with the Implementation Guide and Addenda, the dental plan/health plan may not be able to process the transaction.

2. What are possible processing issues that might occur at the dental plan/health plan?

Once an 837D transaction is accepted by the dental plan/health plan, all claims contained within that transaction will be processed according to their standard adjudication processes. Contact the dental plan/health plan if you are unclear about their adjudication process.